



# Year 5 Annual Report

*(October 1, 2008 – September 30, 2009)*

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## Abbreviations/Acronyms

AIDS	Acquired Immunodeficiency Syndrome
AMTSL	Active Management of the Third Stage of Labor
ARH	Adolescent Reproductive Health
ART	Anti-Retroviral Therapy
BHCP	Basic Health Care Package
CARE	Cooperative for Assistance and Relief Everywhere
CBA	Community Based Agents
CBV	Community Based Volunteer
CCS	Clinical Care Specialist
CCT	Clinical Care Team
CDC	Centre for Disease Control
CDCS	Communicable Disease Control Specialist
CDE	Classified Daily Employee
CHAZ	Christian Health Association of Zambia
CHN	Child Health and Nutrition
CHN	Child Health Unit
CHW	Community Health Worker
CHWk	Child Health Week
CIDRZ	Centre for Infectious Disease and Research in Zambia
C-IMCI	Community Integrated Management of Childhood Illnesses
COG	Clinical Officer General
CRS	Catholic Relief Services
CTC	Counseling Testing and Care
DBS	Dry Blood Spot
DCT	Diagnostic Counselling and Testing
DDH	District Director of Health
DfID	Department for International Development
DHMT	District Health Management Team
DHO	District Health Office
ECZ	Environmental Council of Zambia
EHT	Environmental Health Technician
EMMP	Environmental Mitigation and Monitoring Plan
EID	Early Infant Diagnosis
EmONC	Emergency Obstetric and newborn Care
EPI	Expanded Program of Immunization
FANC	Focused antenatal care
FIC	Full Immunization Coverage
F-IMCI	Facility Integrated Management of Childhood Illnesses
FP	Family Planning
GMP	Growth Monitoring and Promotion
GNC	General Nursing Council
HAHC	Hospital Affiliated Health Center
HBC	Home Based Care
HCP	Health Communication Partnership
HRDC	Human Resource Development Committee
HRTWG	Human Resource Technical Working Group
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HSSP	Health Services and Systems Program

ICC	Interagency Coordinating Committee
IEC	Information, Education and Communication
IEPPNC	Integrated Expanded Post Partum and Newborn Care
IMCI	Integrated Management of Childhood Illnesses
IPT	Intermittent Presumptive Therapy
IRH	Integrated Reproductive Health
IRS	Indoor Residual Spraying
ITGs	Integrated Technical Guidelines (for frontline health workers)
ITNs	Impregnated Treated Nets
IUD	Intra uterine device
IVCC	Innovative Vector Control Consortium
LTFP	Long Term Family Planning
MACEPA	Malaria Control and Evaluation Partnership in Africa
MBB	Marginal Budgeting for Bottlenecks
M&E	Monitoring and Evaluation
MCZ	Medical Council of Zambia
MDGs	Millennium Development Goals
MIP	Malaria in Pregnancy
MOH	Ministry of Health
MOU	Memorandum of Understanding
MNCH	Maternal, Newborn and Child Health
MTEF	Medium Term Expenditure Framework
NAC	National HIV/AIDS/STI/TB Council
NBC	New Born Care
NFNC	National Food and Nutrition Commission
NGO	Non Governmental Organization
NHA	National Health Accounts
NHC	Neighborhood Health Committee
NITCS	National In-Service Training Coordination System
NTGs	National Training Guidelines
NMCC	National Malaria Control Centre
OI	Opportunistic Infection
ORT	Oral Rehydration Therapy
PA	Performance Assessment
PAC	Post Abortion Care
PATF	Provincial AIDS Task Force
PEPFAR	President's Emergency Plan for AIDS Relief
PBN	Post Basic Nursing
PDH	Positive Deviance Hearth
PHC	Primary Health Care
PHD	Provincial Health Director
PHO	Provincial Health Office
PIA	Performance Improvement Approach
PICT	Provider Initiated Counselling and Testing
PMEC	Payroll Management and Establishment Control
PMTCT	Prevention of Mother to Child Transmission
PPE	Personal Protective Equipment
PP/PN	Post Partum/Post Natal
PRA	Pharmaceutical Regulatory Authority
RDT	Rapid Diagnostic Test
RED	Reach Every Child in Every District

RH	Reproductive Health
RHIS	Routine Health Information System
SEA	Strategic Environmental Assessment
SMAG	Safe Motherhood Action Groups
STI	Sexually Transmitted Infection
SOM	School of Medicine
SOP	Standard Operating Procedure
SP	Sulphadoxine Pyremethamine
STTA	Short Term Technical Assistance
SWAp	Sector Wide Approach
TA	Technical Assistance
TB	Tuberculosis
TOT	Training of Trainers
TSS	Technical Support Supervision
TWG	Technical Working Group
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
UTH	University Teaching Hospital
WFP	World Food Program
WHO	World Health Organization
ZHWRS	Zambia Health Workers Retention Scheme
ZNAN	Zambia National AIDS Network
ZPCT	Zambia Prevention Care and Treatment

## Executive Summary

The Health Services and Systems Program (HSSP) completed Year 5, with three months of its 15-month final project year remaining. HSSP technical areas completed their Year 5 activities and achieved, with only a few exceptions, their life-of-project targets. A few activities remain to be completed in October 2009 in Integrated Reproductive Health (IRH) and Clinical Care Specialist (CCS) -related activities only. Activities during the final quarter will focus on reporting and administrative closeout. The Indoor Residual Spraying (IRS) activities will continue into the next quarter, as the IRS season is at its peak October to November. HSSP sought USAID approval for a one-month no-cost extension to enable IRS activities to end on January 31<sup>st</sup>. However, close-out take place earlier, due to higher than anticipated levels of expenditure in IRS. All planned activities will have been completed for IRS.

The focus of Year 5 has been:

- completion of remaining results targets
- intensified efforts to ensure Ministry of Health capacity to institutionalize and carry forward HSSP-supported programs and initiatives
- documentation of HSSP's key results, innovations and products
- prepare for close-out

HSSP has made significant progress in achieving the aims set forth in its Sustainability and Exit Strategy (referenced in the RFA submission, June 2008). The generic approaches of the strategy are as follows:

- Assure that all products and deliverables are completed, approved by the Ministry of Health and delivered by end of project.
- Through involvement in the MOH planning cycle, assure that activities and programs that have benefited from HSSP support are included and budgeted for in district and central level plans from 2010 onwards. .
- Together with MOH, work to leverage the resources of partners, many of whom are already cost-sharing collaborators with HSSP, to provide on-going support in areas where MOH resources are insufficient.
- Assure the dissemination of products, tools, and results to all relevant stakeholders who may in turn make use of the knowledge and benefits gained.

All of the above strategies have been addressed during the year:

- All project deliverables to date are completed, with a very few remaining (IRS) scheduled for quarter one. A few deliverables are awaiting receipt of MOH data.
- HSSP fully supported the planning cycle, attending the national planning launch, all provincial launches, and some district launches in quarter four.
- Leveraging of activities has continued to expand our reach, exceed our targets, and enable partnerships to carry the work further.
- Finalization, review, printing and dissemination of HSSP/MOH products has taken place; dissemination of print material is ongoing, and an assessment of the use of HSSP/MOH documents undertaken.

Cooperation with the Ministry of Health and with other partners continued to be excellent during the year. The hands-on approach of HSSP staff, teaming directly with

MOH counterparts, and sharing their workload, stood HSSP in good stead. This approach is especially valued given the inadequate human resources at all levels. The willingness of HSSP's high-caliber professionals to take their skills from the central level, to the districts and out to the community, while raising the capacity of health workers at every level along the way, created an impact which Ministry partners attest was more diffused and deeper than originally envisaged

The operating environment during Year 5 has been complex and with unexpected transitions. Early in FY 09, the untimely death of the president resulted in some delays entailed by elections and new government appointments. The global economic crisis severely affected Zambia, increasing unemployment and reductions in government budgets. Finally, financial mismanagement issues in the Ministry of Health resulted in suspension of funding from several key international partners. This coincided with a general strike of health workers; all of which weakened the Ministry's ability to fully fund some of its core programs, services and training institutions. Key constraints which impacted HSSP during Year 5 included:

- The protracted restructuring of the Ministry of Health, resulting in delays in activities, staff turnover, loss of capacity due to transfers of trained staff; and unclear organizational structures.
- Sporadic lack of cooperation and refusal to participate in HSSP activities due to the demand for out-of-pocket allowances, which donors have agreed is the responsibility of the Ministry of Health.
- Budgetary constraints in the MOH were felt acutely during the second half of Year 5, as the MOH budget allocations fell far short of expected, due to poor performance of the economy, and the added challenge of some donor disbursements placed on hold. HSSP endeavored to be flexible and responsive to the Ministry to assure that key activities could be supported.

#### Highlights in achievements during Year 5

The activity which permeates all of the work of HSSP is Health Services Planning. Several important products were printed and distributed, including the District Planning Handbook, and the handbooks for hospitals, training institutions and health centers. Likewise, the Integrated Technical Guidelines document was reviewed and printed.

All teams assisted Ministry of Health partners in preparing technical updates for the annual national planning launch, which took place in July. As the planning process drew to a close, the Permanent Secretary expressed appreciation for HSSP's contribution to the planning cycle, in a letter of September 15 (excerpted below). HSSP staff actively supported the planning process at central level, all provinces, and in many districts.

*"I wish to acknowledge with appreciation the support we received from your office which has facilitated successful completion of the various stages of the planning process ... Without your support this exercise might not have been a success. Your support is especially noteworthy because it came at a time when funding to the health sector was withheld by some cooperating partners. I wish to thank you most sincerely for this important demonstration of good partnership."*

In the area of Child Health and Nutrition, the IMCI Health Facility Survey was supported by HSSP, and findings point to some improvements, but also remaining challenges in important areas such as HIV assessment. HSSP supported case

management training and adapted a handbook for pre-service IMCI training. On-the-job training of IMCI supervisors was tested and found to be a cost-effective and appropriate training approach. HSSP continued to provide leadership in newborn care through developing a newborn framework for care. A case study was conducted to assess how the HSSP package of training and technical support had contributed to integrated postpartum and postnatal services. Malaria case management training was conducted for 134 health staff followed by technical support supervision visits. Malaria diagnosis and treatment guidelines were updated.

HSSP continued to support the Reach Every Child in Every District (RED) strategy. Community participation has been enhanced, linkages to health facilities strengthened through tools such as the community register, and gains in immunization coverage have been recorded. As HSSP closes, the strong networks and partnerships created in the child health area will help to ensure continuity and sustainability of activities and improved child health indicators going forward.

In the area of Nutrition, HSSP came to the aid of the health sector when a malnutrition crisis became evident early in the year. Through reprogramming of funds, HSSP was able to train 82 health workers in infant and young child feeding, and treatment of severe malnutrition. Seven districts were supported with technical support supervision (TSS) during Child Health Week (CHWk), and eight districts were trained in Child Health Week data management. Vitamin A supplementation and deworming rates have exceeded targets, and data from the July 09 CHWk campaign remain pending.

The Indoor Residual Spraying (IRS) season was successfully concluded within the timeframe and met its targets for coverage. In addition to managing the 15 HSSP districts, the team assisted NMCC in its scale up to 36 districts by assisting in training of trainers (TOT), cascade training, and monitoring of training and spray operations. The IRS Guidelines, a 5-volume set, was published and distributed to districts. An important development has been the successful establishment of a breeding mosquito colony at the NMCC insectary for the purpose of entomological studies. All districts were trained in basic entomology. University students are engaged in on-the-job training in entomology and management of the insectary. Entomological and health facility impact surveys have been carried out. HSSP was active in environmental monitoring, has managed the export of DDT waste, and initiated the rehabilitation of three IRS storage sites. Personal protective equipment (PPE), personal data assistants (PDAs), and a plotter for generating maps, were procured for the IRS program. District ownership of the IRS program, including strengthened supervision, local funding support and strengthened management are important factors in assuring IRS program effectiveness, community support, and environmental compliance.

Integrated Reproductive Health (IRH) forged ahead in Year 5 to complete all of its challenging training targets in Emergency Obstetrics and Newborn Care (EmONC) and Long Term Family Planning (LTFP). As HSSP phases out, important tools such as the updated EmONC curriculum, the Self-Directed Learning Manual and the Family Planning Counseling Kit will contribute to quality training and reproductive health services.

In Human Resources for Health, HSSP continued to support retained health workers. A rapid assessment of doctors on the Zambia Health Workers Retention Scheme (ZHWS) confirmed that ART and other HIV/AIDS related services had been

introduced through the retained doctors, as well as EmONC services, caesarian section and minor surgery. HSSP assisted the MOH to strengthen use of an adherence to the Human Resource Planning Guidelines.

Through the Pre- and In-service training area, curriculum review activities were completed. The activities brought together technical specialists and institutions in a dynamic review process resulting in updated curricula for: medical doctors MB ChB, BSc in nursing, operating theater nurses, and enrolled nurses. These participants have also benefited from EmONC, IMCI, malaria case management, and other HSSP capacity building.

In Performance Improvement all targets were met, the most notable being accreditation for ART services of the full complement of 30 private sites. The provision of targeted technical assistance to sites seeking to improve their accreditation scores, proved to be highly successful. Further support was given to Medical Council of Zambia (MCZ) in data based development, and organizational structure review, to enable MCZ to manage the accreditation and certification systems. Printed and updated guidelines for ART accreditation and certification of ART service providers will assist inspectors and health facilities to undertake and succeed in the accreditation process.

Clinical Care Specialists (CCS) continued their multifaceted activities to improve HIV/AIDS services in the provinces and districts and improve quality and access to effective interventions. These include playing a major role in provincial HIV/TB coordination bodies, mentoring of junior doctors and other health workers, carrying out case management and record reviews, and providing training in ART/PMTCT/STI/TB management, quality improvement, and rational use of medicines. The CCSs catalyze other HSSP activities, such as private sector accreditation, performance improvement and EmONC. Guidelines and a training package for Clinical Mentorship and the establishment of the Clinical Care Team approach were spearheaded by the CCS component. Drawing on CCS expertise, these guidelines apply health systems approaches to create a sustainable means of continuous clinical strengthening and quality improvement.

The roll-out of the new HMIS is now complete, and HSSP has worked this with the MOH on synchronizing the manual and electronic (SmartCare) data systems. HIV/AIDS data from Copperbelt Province has been reviewed for consistency and completeness. Findings are being incorporated into the HMIS data management manual.

The M&E unit has focused on both routine tracking, and preparations for close-out. A compendium of HSSP success stories was prepared as a final product which illustrates the legacy of HSSP in the words and stories of beneficiaries.

## **Introduction**

The purpose of the Health Services and Systems Program, 2004-2009, is to contribute to USAID's Strategic Objective 7: Improved status of the health of the Zambian people, total fertility rate, infant mortality rate, and HIV prevalence decreased; and to contribute to Ministry of Health's goal of improving the health status of Zambians.

HSSP contributes to the following USAID Intermediate Results:

- IR7.2: Achievement and maintenance of high coverage for key health interventions
- IR7.3: Health systems strengthened

## **Technical Areas and Funding Sources**

HSSP currently receives funding from three USAID funding sources, supporting the following range of technical program areas:

### **USAID Pop/CH**

- Child Health and Nutrition (CHN):
  - Facility-based IMCI
  - Community-based IMCI
  - Immunization (EPI)
  - Vitamin A and Deworming
- Integrated Reproductive Health (IRH):
  - Safe motherhood: Post abortion care (PAC)
  - Safe motherhood: Emergency obstetric and newborn care (EmONC)
  - Family planning (FP)

### **President's Emergency Plan for AIDS Relief (PEPFAR)**

- ARV drugs
- Clinical Care Specialists
- Human Resources planning, management and training
- Performance improvement and accreditation
- Planning and strategic information
- HIV/AIDS coordination through a sector-wide approach (SWAP)

### **President's Malaria Initiative**

- Malaria and child health
- Malaria and reproductive health
- Indoor residual spraying (IRS)

## **Program Objectives**

The three HSSP Program Objectives that crosscut all technical areas are:

- Achievement and maintenance of high coverage for key child health and nutrition, integrated reproductive health, malaria and HIV/AIDS interventions
- Improvement of the quality of key health interventions
- Strengthening of health systems in the delivery of key health interventions

## **Program Approach**

HSSP's approach is to provide technical support and capacity building to the Ministry of Health, to enable achievement of program results. During Year 5, the last 15 months of the Program, HSSP is focusing on the consolidation of scaled-up systems and programs, ensuring quality, sustaining best practices, and documentation and dissemination of achievements. In this third quarter of Year 5, HSSP achieved progress to complete its targets and continued to work at all levels of the health system.

## **Organization of the Annual Report**

The Year 5 Report, October 1, 2008 - September 30, 2009 is organized by technical areas, under the three overall (funding source) areas. Up-to-date program results against key indicators are reported in the tables which precede each narrative section. The narrative provides a summary on all planned activities, as well as new and carried over activities.

## 1 Child Health and Nutrition

CHN is made up of the following four components: Facility IMCI, Community IMCI, EPI and Nutrition. The overall CHN goal is to improve the quality and increase coverage of key childhood interventions.

### 1.1 Facility-based IMCI

The specific F-IMCI objective is to expand the number of F-IMCI delivering districts from 38 to 72 by the end of 2009.

#### 1.1.1 Key Indicators: Improved CHN coverage and quality of care through facility-based IMCI

Indicators	Year 5 (Oct 2008 to Dec 2009)		End of Project (EOP)		
	Target	Achieved	Target	Total Achieved to date	% Status
1.1 Number of districts implementing F-IMCI	72	72	72	72	100
1.5 Number of people trained in child health care and child nutrition	210	505	618	3,366	Target exceeded <sup>1</sup>
1.6 Number of people trained in maternal/ newborn health	375	313	795	1,561	Target exceeded <sup>2</sup>
1.12 Number of special studies conducted	2	2	3	5	Target exceeded <sup>3</sup>
1.13 Number of information gathering or research activities conducted	5	8	9	11	Target exceeded <sup>4</sup>

<sup>1</sup> The contribution to this indicator is from all the three units of CHN. The target on health workers trained in IMCI case management training and on number of people trained in child health care and child nutrition have been exceeded because of co-funding with the respective districts to promote ownership and also because of leveraging of resources from national level partners in which case HSSP only provided TA. In retrospect, the original target was too modest

<sup>2</sup> The figure achieved increased because those trained in IRH were added to those trained in CHN in Year 3. Subsequently, it was agreed that the indicator should only apply to child health

<sup>3</sup> HSSP assisted MOH in carrying out two extra studies, Health Facility Survey and Barriers to implementation of the HIV guidelines in the IMCI algorithm among IMCI trained health workers in Zambia, which was over and above the planned studies

<sup>4</sup> HSSP assisted in gathering information for two extra activities, post implementation evaluation of new DPT vaccine, Pentavalent, and assessment of community register utilization, which was over and above the planned targets

### 1.1.2 Key Achievements

#### Monitor and evaluate IMCI implementation

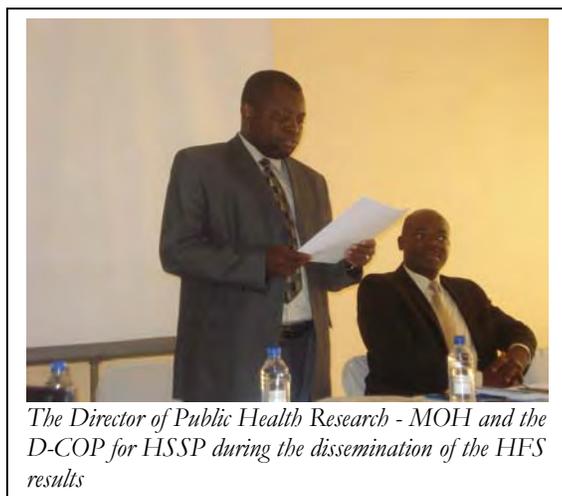
During Year 5, HSSP supported the MOH to design and conduct a National Health Facility Survey aimed at assessing the performance of the health workers who underwent IMCI training; and the available system support for program implementation. This was a follow up to the first national survey conducted in 2002 when only 31 districts were implementing F-IMCI. With HSSP support, all districts are now implementing IMCI. The survey was successfully conducted with HSSP providing both technical and financial support.

A dissemination meeting was held to share the findings. HSSP facilitated the organization of this meeting. Some of the salient findings from the survey are as follows:

- Despite the challenges faced in the health sector, the health workers remained committed to improving the care of the sick child
- The assessment, classification and treatment of the common illnesses by health workers has improved but still could be done better
- There was a general improvement in the availability of the IMCI drugs and availability of vaccines although equipment and supplies to support immunization were inadequate in some facilities.
- HIV assessment was still not well done
- Counseling of the care takers was poorly done by most of the health workers
- The referral system has remained underdeveloped



- Human resource has remained a challenge and has worsened since the 2001 health facility survey
- Supervision of health workers remained a challenge and there were fewer supervisory visits that included case management observation.



The report has since been printed and is ready for dissemination to all the PHOs, DHOs and health facilities.

Support district planning and budgeting for IMCI implementation

HSSP continued to support the Ministry of Health planning cycle. As the planning cycle began this year, HSSP worked closely with the Child Health Unit to prepare the technical updates which provided the provinces and the districts with the national focus for the next three years. This was followed by the provision of technical support during the rolling out of the provincial and district planning and review processes. HSSP also provided technical support in the development of the 2010 plan for the child health unit. The participation of HSSP and other child health partners in this exercise was critical in ensuring that future implementation of activities is well coordinated and that partners complement each other and avoid duplication of activities.

Support District F-IMCI case management training

Initial follow-up visits form an integral part of IMCI case management training and are required to be conducted four to six weeks after training. The main objective is to re-enforce skills and knowledge and to ensure a favorable environment for the trained health workers to implement what they have learned. During Year 5, HSSP provided TA and financial assistance to the PHO of Northern Province and in particular to Kasama, Nakonde and Mpika DHOs and Mwinilunga and Kasempa districts in North Western Province to conduct follow-up visits for 23 health workers.

Some of the key findings were as follows:

- Lack of drugs especially pre-referral injectable drugs and amoxicillin syrup and supplies in some of the health centers
- Absence of radio communication in some centers



*Health worker weighing a child at Kawota HAHC*

- Critical shortage of staff with some of the centres being run by a classified daily employee (CDE) or a CHW
- Adherence to waste disposal procedures not being followed in some centers
- Shortage of kerosene and/or lack of vaccines which led to a halt in the routine vaccination program

Findings were documented and feedback was given to the DHO and specific action points with time frames to address the identified gaps outlined.

Support pre-service IMCI case management

HSSP provided technical and financial support for the training of 148 student nurses from the University Teaching Hospital School of Nursing, Solwezi School of Nursing and Kalene School of Nursing. The trained students comprised 79 males and 59 females. This training will ensure that the graduates have acceptable skills and knowledge to



*A tutor demonstrating facilitation skills*

manage malaria and other common childhood illnesses at the primary level of care and thus, prevent late referrals that contribute to under-five mortality. Furthermore, strengthened IMCI pre-service implementation will contribute to program sustainability by assuring a large output of trained staff.

Although training was successfully conducted in all the schools, inadequate tutors trained to teach IMCI is still a challenge and guest lecturers have to be called in to complement the staff. During the year, 20 nurse tutors were trained in IMCI facilitator skills. These are expected to assist in bridging the gap in trainers that is currently being experienced. However due to the high attrition rate among the tutors, this has to be a continuous process.

A handbook for use in pre-service teaching of IMCI has been adapted to include the new updates in malaria case management using RDTs for diagnosis, the use of zinc and low-osmolar ORS for the treatment of diarrhea and the guidelines on ART. The handbooks have been printed through UNICEF funding and orientation of the tutors will be done before the handbooks are distributed to the respective schools. The handbook will offer an alternative way of teaching IMCI in pre-service education.

Build PHO/DHO capacity to support IMCI implementation

The substantial HSSP support to districts and nursing institutions to train health workers in IMCI similarly requires post training follow-up. HSSP has spearheaded a process to train key DHO staff in use of standard tools to conduct follow-up visits in order to address the capacity challenge. This on-the-job approach has been observed to instill ownership and foster sustainability. It is cheaper and quicker to roll out than formal training.

HSSP provided technical and financial support to train a total of six DHO and two PHO staff members from North-Western and Northern provinces in the use of the IMCI supervisory tools. The training was successful and received an enthusiastic response from the Mwinilunga DHIO.

“I have benefited a lot from this visit being in the team; usually when we conduct PA and I reach the part of assessing the IMCI clinical skills of the health worker, I just kept quiet but now I will be able to talk and advise accordingly.”

*Mr A Yamboto, Mwinilunga DHIO*

The MOH Child Health Unit has equally taken on board the approach and during the year, four teams were formed at the national level and were tasked to visit Western, Central, Copperbelt and Southern provinces to undertake similar activities. The capacity built should contribute to improved supervisory skills in IMCI among the provincial and district staff members.



*Checking for IMCI recommended drugs*

Conduct a survey to determine impact of on-the-job training

Over a two-year period HSSP provided technical and financial support to 23 districts (one third of the 72 districts in Zambia) and trained over 50 supervisors in the use of the IMCI supervisory tools using the on-the-job approach.

The approach of using on-the-job training for supervision of health workers trained in IMCI has been taken on board by the MOH Child Health Unit counterparts. HSSP felt that it was necessary to document the actual impact that this training has had as well as any challenges that may arise. To this effect, a quick survey was conducted using a questionnaire that was sent to the trained supervisors from the respective districts.

Although the respondents did not experience difficulties in conducting the supervision they all cited financial constraints as a major challenge. The results also indicated that the supervisors were comfortable with their supervisory skills following on-the-job training and were able to identify gaps in the program implementation. Some of the challenges cited included lack of tools and wall protocols, and the general inadequate staffing levels. A technical brief highlighting these findings has been written and will be shared with the MOH counterparts and other child health partners.

*Develop and pilot a comprehensive newborn health model*

HSSP continued to provide leadership in ensuring that care for the newborn at all levels is improved. HSSP, with consultant Dr. Stella Abwao, contributed to development of guidelines for care of the newborn at community level. This is within the national framework for newborn health interventions that was developed with HSSP support. Furthermore, HSSP conceptualized and conducted a case study on integrated postpartum and postnatal care, examining the continuum of care for the mother and newborn in selected sites in three districts. The final draft of this case study is being completed and will provide lessons on effective integration of MNCH services, and further contribute to documentation of postpartum and newborn care practices. In an effort to strengthen integration of maternal and child health in the care of the newborn, HSSP contributed to the support and provision of updates on the national guidelines for the care of the newborn and made a presentation entitled “*An Overview of Newborn Health in Zambia*” at the Annual Meeting of the White Ribbon Alliance.

*Build capacity and contribute to the provision of national level leadership in malaria case management*

HSSP continued to work with NMCC and provided technical and financial support for the orientation of 134 staff (85 males and 49 females) from the PHOs, DHOs and selected facilities (hospitals and health centers) and from the private sector from four provinces namely Eastern, North Western, Western, and Copperbelt in malaria case management and overall program management. These orientation programs are meant to form a basis of strengthening malaria case management at the service delivery points. This is an on-going process to cover all the nine provinces and to date, a total of five provinces have been visited.



*Part of a very attentive group of participants in Eastern Province*

Following the orientation program, technical supervisory visits were conducted for selected facilities in the provinces.

### F-IMCI facilitators oriented to the updated training materials

Following the revision of the IMCI training materials, there has been need to orient the IMCI facilitators who are in turn expected to provide technical assistance to the various PHO/DHO in updating the service providers. This is expected to be done either through scheduled district-based training programs or using the on-the-job approach during district performance assessments or technical supportive supervisory visits. HSSP has been supporting the national level to roll out the orientation training programs for the facilitators. During Year 5, eleven facilitators from Eastern Province underwent the three-day training program. The classroom and clinical sessions exposed the facilitators to the skills of assessing a newborn, diagnosis of malaria using RDTs, management of diarrhea with the use of zinc and low osmolar ORS, as well as clinical staging and paediatric anti-retroviral treatment for paediatric HIV/AIDS.



*A participant showing a mother at St. Francis Hospital good positioning for effective breast feeding*

### **1.1.3 Incomplete/new or reprogrammed activities**

HSSP, WHO, and MOH have formed a team to provide leadership and ensure that the development of the IMCI strategic plan is on course and completed by the end of 2009. A plan of work was developed and agreed upon by all stakeholders. A consultant has been engaged and availed with the key reference documents and he has since produced a draft log frame which is being reviewed. It is expected that the document will be finalized by the end of the year.

### **1.1.4 Challenges and solutions**

<b>Challenges</b>	<b>Solutions</b>
Delays in the final review of documents by MOH counterparts before printing	Constant reminder to the counterparts
Increased demands for training materials	Advocacy for more partners to come on board; CARE, and UNICEF have contributed to production and printing

### **1.1.5 Successes /best practices**

- Partner coordination, commitment, and hard work
- Evidence of institutionalization of the IMCI program both in the in-service and the pre-service
- Improved district capacities to implement IMCI-related activities

### **1.1.6 Key deliverables**

- One success story: “Supervisor Confidence Rekindled”
- One technical brief: IMCI post-training supervision: On-the-job training fills a critical missing link
- Revised malaria diagnosis and treatment guidelines
- Finalized 2008 national health facility survey report

### 1.1.7 Key issues: sustainability, handover and the way forward

- Reference guidelines and technical documents produced
- PHO and DHO capacities to plan and budget for F-IMCI enhanced
- Pool of trainers built for pre-service and in-service
- Capacities built among PHO /DHO supervisors to conduct initial post IMCI training and child health supervision
- Capacity built in malaria case management for public and private sector in five provinces
- Child Health Technical Working Group strengthened
- Development of the IMCI Strategic Plan on course

## 1.2 Community IMCI

The specific objective of Community IMCI is to scale up the number of districts with providers promoting 6 Key Family Practices from 13 to 58 districts by 2009.

### 1.2.1 Key indicators: Improved CHN coverage and quality of care through community-based IMCI

Indicators	Year 5 (Oct 2008-Sep 2009)		End of Project (EOP)		
	Target	Achieved	Target	Total Achieved to date	% Status
1.2 Number of districts with at least health worker trained in C-IMCI	72	72	72	72	100%
1.3 Number of facilities with at least one health worker trained in C-IMCI	80	110	500	593	Target exceeded <sup>5</sup>
1.4 Percent of districts with providers offering 6 key family practices	80% (58 districts)	100% (72 districts)	80% (58 districts)	100% (72 districts)	Target exceeded

### 1.2.2 Key Achievements

#### Strengthening implementation of Community IMCI

HSSP partnered with CARE International, WHO and UNICEF to support Ministry of Health with the comprehensive revision of Community Health Worker (CHW) training materials. The review process incorporated new emerging technical issues to meet the expanded roles of CHWs and improve the quality of service delivery at community level. Mainstreaming gender in the selection process and Neighborhood Health Committee (NHC), PMTCT, and Home Based Care were some of the key issues incorporated. The revision process has resulted in a comprehensive standardization of CHW training

<sup>5</sup> Leveraging of resources led to exceeding the targets for indicators 1.3 and 1.4. For indicator 1.4, MOH deemed it fit to have all the districts offering 6 key family practices

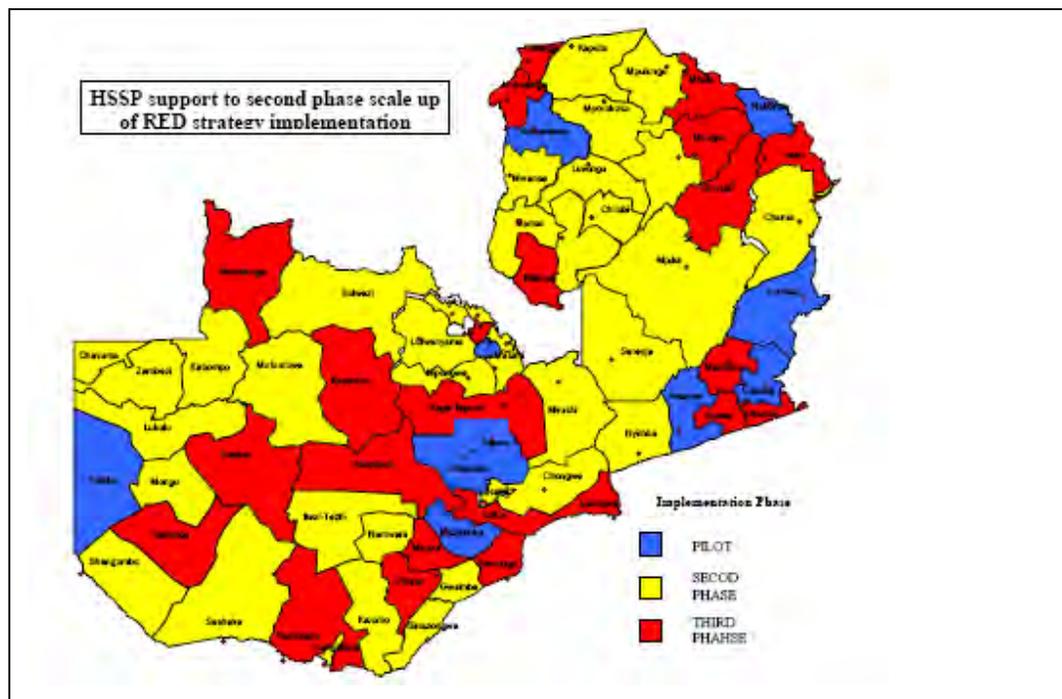
materials, and leveraging of technical and financial resources for the revision and printing process.

Technical support supervision for CHWs in targeted districts institutionalized

All ten challenged districts were monitored for application of sustainable strategies such as RED and Child Health Week to address missed opportunities in immunization. Prerequisites for CHW performance include the need to be equipped with drug kits, equipment, regular supervision, stationery supplies for reporting and bicycles to facilitate defaulter tracing and to support outreach activities. During Year 5, 80% of health facility supervisors in targeted districts conducted technical support supervision resulting in motivation and retention of 90% of CHWs for sustainability and improved quality of services.

Capacity of facility supervisors to support Community IMCI strengthened

In Year 5, HSSP supported capacity building of 110 facility supervisors trained in Community IMCI monitoring for provision of effective support to CHWs (61 males and 50 females). The trained facility supervisors have strengthened health center/community partnerships for improved motivation and performance of community volunteers.



Experiences on Community IMCI implementation documented and disseminated

HSSP supported selected districts to document CHW experiences in C-IMCI implementation. Documentation drew experiences and lessons learned from facility staff, CHWs, NHCs and community members. Areas of experience focused on CHW workload and range of activities, support systems, motivation and retention mechanisms. All CHWs interviewed carried out preventive, promotive and curative activities in the community and at health posts. Most work long hours and attend to emergencies with no monetary payment. The documentation process revealed useful insights about C-IMCI implementation, key elements of CHW motivation, and community/facility support

systems for improved service delivery. Results of the documentation will contribute to the on-going MOH policy discussions to improve future implementation strategy, retention and support for CHWs

*Sharing experiences on community case management of malnutrition*

During the year, HSSP in collaboration with NFNC, conducted technical support visits in selected districts applying the Positive Deviance Hearth (PDH) approach on community management of malnutrition. HSSP's investments in piloting the PDH approach in Lukulu District, has resulted in the scale up of PDH to 17 districts in Northern, Luapula, and Southern provinces. Selected active examples of PDH sites include Mansa, Kazungula, Nakonde, Lukulu, Choma and Chikankata Child Survival project. The Positive Deviance Hearth Developmental Approach is a cost-effective and sustainable approach that utilizes locally available foods to improve malnutrition at community level.

Positive Deviance Hearth has been introduced at the time when Zambia needs all available feeding options to improve community case management of malnutrition. Female volunteers in all the sites have been instrumental in supporting food preparation and active feeding of children while male volunteers have been active in food security and safe water supply issues. For PDH to work effectively, there is need for: demonstrated commitment and focused support by the DHMT; ability for mothers to contribute food for the feeding sessions on a daily basis; and mothers adherence to agreed feeding schedules when discharged from the PDH site.

*Success stories on Key Family Practices (KFPs) documented and disseminated*

In Luangwa District, scale up of Community Health Worker (CHW) capacity building and construction of Health Posts have facilitated implementation of the Key Family Practices. Improved community involvement through CHWs has resulted in increased health service utilization.

CHWs provide preventive and basic curative care while promoting health seeking behavior and increasing demand for and access to existing health services. CHWs are also effective vehicles for the integration of diverse health programs at community level.



*I conduct preventive, promotive and curative activities in my community. I am on 24 hour alert for emergencies even when my work is voluntary), says Mr. England Njobvu, CHW examining a newborn baby, Luangwa District*

## Key Family and Community Practices

- Exclusive breastfeeding up to 6 months
- Complementary feeding from 6 months and breast feeding up to 2 years or longer
- Micronutrient supplementation, de-worming and growth monitoring of children
- Ensuring that children sleep under ITN
- Children to complete a full course of immunization before their first birthday
- Provide appropriate home treatment for sick children and timely referral

Zambia still faces a relatively high infant mortality rate of 95/1000 live births and 80% of deaths of infants and children occurring at home due to poor access to health services and inadequate information on health care. Trained CHWs can make a difference by reinforcing the key health seeking behavior practices of households and acting as a link for prompt referrals to health facilities. HSSP and other partners have contributed to the design, development and scale-up of a national capacity building strategy of CHWs in all 72 districts. HSSP contributed to the training 615 CHWs, as well as 579 facility supervisors. Documentation of success stories on Key Family Practices in selected districts was critical as lessons learnt will be used to improve quality of future implementation and support to community IMCI.

### *Integrated case study on strengthening newborn and postpartum care conducted*

Following the formation of the MNCH partnerships, the CHN Unit worked with the IRH Unit in the development of the Postpartum and Newborn Care Guidelines and case study documentation framework. A case study on examining the status of integrated postpartum and newborn care was conducted in three districts: Chibombo, Kabwe and Sinazongwe. The case study has documented useful insights and lessons on improving integration of postpartum and newborn care practices. The report will be disseminated in the next and final quarter of HSSP.

## 1.3 Expanded Program on Immunization

The specific objectives of Expanded Program on Immunization (EPI) are as follows:

- Increase the number of children under one year of age who receive DPT3 to a cumulative total of 2,097,000 children by 2009
- Support 58 districts to attain 80% and above Full Immunization Coverage (FIC) of children under one year

### 1.3.1 Key Indicators: Improved immunization coverage and quality of care

Indicators	Year 5 (Oct 2008 – Dec 2009)		End of Project (EOP)		
	Target	Achieved	Target	Total Achieved to date	% Status
1.7 Number of districts with at least 80% of children fully immunized by age 1 year	60	58	60	58	97%

Indicators	Year 5 (Oct 2008 – Dec 2009)		End of Project (EOP)		
	Target	Achieved	Target	Total Achieved to date	% Status
1.8 Number of children less than 12 months of age who received DPT3 in the last year	1,057,000	1,087,073	2,624,000	2,620,539	100%

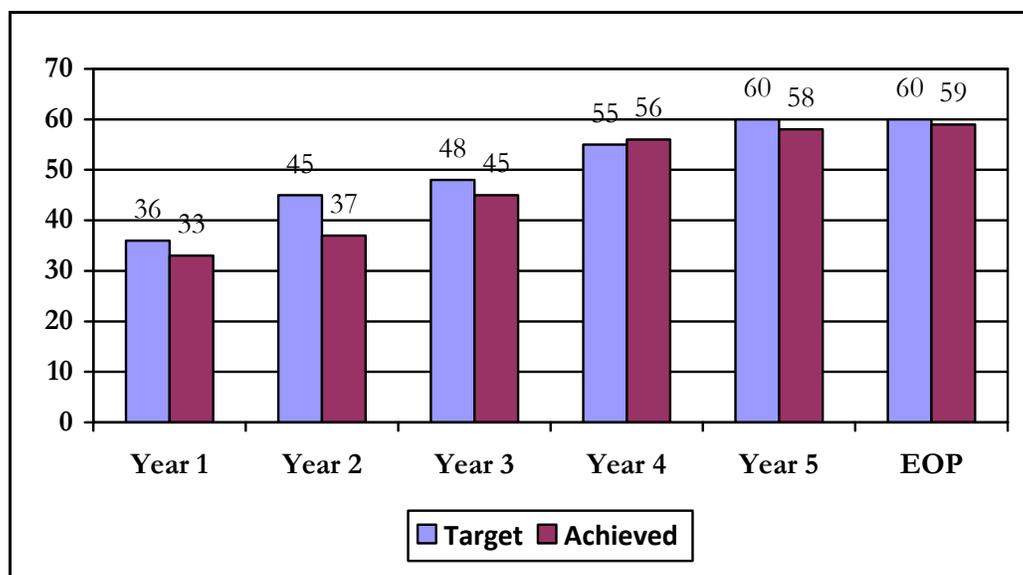
### 1.3.2 Key Achievements

#### Technical support supervision for targeted low performing districts provided

During Year 5, HSSP provided technical assistance to targeted districts to monitor and sustain immunization coverage gains made during the last 4 years. Monitoring visits reviewed sustainable strategies used within respective district resources. Emphasis was placed on the application of RED and Child Health Week strategies to address missed opportunities in immunization. With the principle of active community participation and bottom-up planning, as demonstrated in Zambia's implementation of the RED strategy, facility and community partnerships were strengthened, resulting in improved access and delivery of child health interventions including immunization.

Tools for assessment of routine EPI activities include environmental impact of injection safety and disposal practices. Results of routine supervision have found 95% adherence to good injection safety practices, while effective disposal practices have improved from 60% in 2004 (HSSP baseline survey) to 75%, (quarterly MOH/HSS, 2009 supervisory reports).

#### Number of districts with at least 80% full immunization coverage for children under 1 year



A major focus in the revision of the EPI vaccination manual was to harmonize injection safety practice policy and messages.

### ***Exchange visit participants reviewing performance data at Nakonde RHC***

#### *Support district exchange visits to improve coverage of child health interventions*

During Year 5, HSSP facilitated a coordinated exchange visit among three districts (Luangwa, Sesheke and Nakonde) to share experiences and identify replicable best practices. HSSP's technical investments in working with various provinces and districts resulted in identifying and in improving best practices that contributed to better health outcomes. The identified best practices were nurtured, technically supported and information was disseminated to other districts. District exchange visits were utilized to cross-fertilize best practices and share information. A total of five districts used exchange visits to improve or revitalize district performance.

#### *Documentation of Health System Strengthening (HSS) activities, results and lessons learned*

The health systems strengthening initiative is aimed at improving child health services by addressing barriers that impede access to services. This has been achieved by addressing human resource gaps through motivation and retention mechanisms, increasing transport and communications to improve service delivery and strengthening community involvement. During Year 5, HSSP and other collaborating partners jointly monitored 12 districts for health systems strengthening activities.



Some of the preliminary results of HSS activities include improved motivation for communities and health workers for improved quality and integration of services. Performance data has shown improved motivation of qualified health workers and CHWs. HSSP's technical assistance to the HSS tracking study has resulted in the documentation on the effect of HSS activities on quality of service delivery, motivation and retention of staff.

#### *Community register use and added value to the health system evaluated*

In 2007, HSSP took the leadership in supporting MOH/CHU to harmonize existing community registers into an integrated child health register. The harmonized format was disseminated to all provinces and selected districts to adapt and use according to respective situations. Following the dissemination, Kaoma DHMT adapted the format and added other data elements. HSSP and Kaoma DHMT co-funded the training of CHWs and facility supervisors in case management and monitoring community activities respectively. Use of community registers ensures that all children below the age of five years are entered with respective interventions received and facilitates identification of defaulters in immunization and growth monitoring. An evaluation was undertaken. Results of the second follow-up on the use of the registers revealed the following:

### **Added value on use of community volunteers (CHWS), facility and DHMT staff**

- CHWs found the community child health register to be user friendly and useful in identifying health education talks, developing the annual community action plan and for follow up of children that have defaulted in immunizations and GMP
- Monthly reporting of community activities and measuring indicator achievements based on targets has been made easier
- With 6-9 months of community registers being in use in Kaoma District, facility and DHMT staff noted decreased defaulter rate from 15% to 5% with improved community defaulter tracing which resulted in improved intervention coverage
- With the active community participation, facility staff have gained added time to add more value to the work as most of the primary activities are done by CHWs
- It was also found out that the data from the communities was not being used by the district

### **1.3.3 Successes/Best Practices**

- Community register has added value to community and facility intervention tracking and reductions in immunization dropout rates have been noted (example: 15% - 5% for Kaoma District)
- District exchange visits enhance cross-fertilization of best practices and revitalize district performance
- RED strategy sustains immunization coverage through DHMT and community partnership effort

### **1.3.4 Challenges and Solutions**

<b>Challenges</b>	<b>Solutions</b>
Timely review and endorsement of project-generated documents prior to printing	Constantly reminding the counterparts

### **1.3.5 Key products/deliverables**

- Expanded Program on Immunization vaccination manual for service providers
- Integrated Community Register
- Community Health Worker Training Manual

### **1.3.6 Key issues: Sustainability, handover and the way forward**

- Strong partnerships established through the CHN/TWG from HSSP's inception will help to ensure a continuing network for leveraging of technical and financial of support for improved Community Health Worker expansion and effectiveness.
- The establishment of provincial RED strategy Core Teams will ensure continuity in providing technical assistance to challenged districts to sustain routine immunization. Documentation on RED strategy has provided additional insights to strengthening the scale-up process.

- Ownership of the integrated community register has been demonstrated among districts (Kaoma, Mazabuka and Nakonde). A dissemination meeting for the community register is proposed for October 2009 to discuss possible scale up and printing of registers by MOH.

#### 1.4 Nutrition

The specific objective of the Nutrition area is to increase national vitamin A supplementation coverage in all districts to above 85% by 2009.

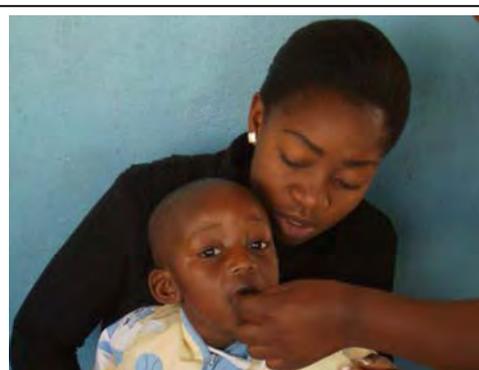
##### 1.4.1 Key Indicators: Vitamin A supplementation of children aged 6 to 59 months

Indicators	Year 5 <i>(Oct 2008-Dec 2009)</i>		End of Project (EOP)		
	Target	Achieved	Target	Total Achieved to date	% Status
1.9 Number of children aged between 6-59 months who received vitamin A	2,325,000	2,121,270	10,757, 521	9,965,338	93%
1.10 Percent of children between 6-59 months receiving vitamin A supplementation	85%	94%	85%	93%	Target exceeded <sup>6</sup>
1.11 Number of children 1-5 years who received de-worming tablets	2,325,000	2,117,732	6,940,000	8,735,423	Target exceeded <sup>7</sup>

##### 1.4.2 Key Achievements

###### *Strengthening data management of vitamin a supplementation program*

HSSP supported MOH to work on model for health facilities to manage Child Health Week data. Capacity building of provinces and nine districts (Shang'ombo, Milenge, Chililabombwe, Nakonde, Chibombo, Luangwa, Mambwe, Gwembe, and Kasempa) was conducted, using the health facility data management model. The model developed is aimed at stimulating districts to utilize child health week program data (beyond coverage data) in planning and addressing specific challenges by health centers. This entails understanding the program or data quality factors that may be affecting coverage of specific health



*Child receiving vitamin A supplementation in Choma District*

<sup>6</sup> Indicator 1.2 has been exceeded because during the recent years government has invested more resources in CHWk, enabling districts to target resources and expand coverage beyond initial targets

<sup>7</sup> Indicator 1.3 has been exceeded due to under-estimation of the targets

facilities. Through this approach it is expected that the unstable coverage can be addressed.

*Capacity building in districts to effectively manage vitamin A supplementation and de-worming programs*

HSSP participated in conducting a Child Health Week review meeting in Kabwe with the provinces. Participants were updated on various nutrition and child health technical issues. The meeting generated recommendations on strengthening Child Health Week and ensuring districts are focused on its objectives and strategy.

HSSP also supported MOH to conduct technical support supervision to the districts during Child Health Week. The aim of this is to enhance the quality of service delivery. Seven districts (Chinsali, Isoka, Kalomo, Kazungula, Livingstone, Choma and Kapiri Mposhi) were visited in partnership with the National Food and Nutrition Commission.

*Strengthen integration of nutrition interventions*

HSSP provided technical assistance in conducting a three-day meeting with nutritionists and stakeholders to integrate the Nutrition Supervisory Checklists from six nutrition program areas. The supervisory tool is aimed at strengthening the nutrition supervision of health workers at the implementation levels.

Support was also provided to the Ministry of Health to conduct technical support supervision in three provinces, namely Central (Kapiri Mposhi and Serenje), Northern (Mbala and Kasama), and Western (Mongu and Senanga). The technical support supervision was conducted with a dual purpose of supervision as well as field-testing an integrated nutrition supervisory tool.

*Training provinces in Essential Nutrition Package*

HSSP supported MOH to provide a nutrition technical update for nutritionists in emerging nutrition issues. A total of 36 nutritionists from all nine provinces were updated. The technical updates provided information on the scientific issues and program progress under the different nutrition programs. These covered seven areas: infant and young child feeding, management of malnutrition, growth monitoring and promotion, micronutrients control, maternal and adolescent nutrition, nutrition and HIV/AIDS and clinical nutrition and dietetics. It is expected that with these updates the nutritionists will serve as nutrition technical resource persons within the provinces.

*Advocate for and strengthen integration of nutrition interventions*

HSSP provided logistical and technical support in hosting a National Food and Nutrition Symposium on 28<sup>th</sup> and 29<sup>th</sup> May 2009. In addition, HSSP was able to participate in the institutional exhibitions. The symposium provided a forum for multi-sectoral exchange of ideas on how to improve the nutrition situation in the country.

*International Poster Presentations*

- *Micronutrients Forum in Beijing, China, 12-15th May 2009*  
The poster presentation was entitled: “Strengthening Health Systems Management: Prerequisites for sustaining vitamin A supplementation coverage”.
- *American Public Health Association Annual Meeting, San Diego, November 2008*  
The poster presentation was entitled: “Increasing Vitamin A supplementation coverage through the involvement of community health workers during biannual Child Health Week”.

### Nutrition Emergency

In September 2008, the University Teaching Hospital (UTH) reported an increase in the numbers of infants admitted with severe malnutrition. There had been a 15% increase in total admissions in September 2008, compared to the same period in the previous year. HSSP supported the Ministry of Health in three key areas in the nutrition emergency during the year:

1. Field-testing of a supervisory tool that will help ensure that health workers adhere to procedures and protocols for achieving better nutrition outcomes. The supervisory tool addresses the supervision required following training.
2. Training of 82 health workers: 21 health workers in basic training of infant and young child feeding counseling; 20 health workers as trainer of trainers in infant and young child feeding counseling; and 41 health workers in management of severe malnutrition.
3. HSSP printed the Essential Nutrition Package of Care for the Health Sector, Infant and Young Child Feeding Counselling Tool and the Zambia Food Composition Table.

#### **1.4.3 Successes/Best Practices**

##### Utilization of electronic reporting system

The continued use of a child health week electronic reporting system (Excel-based) at provincial level is considered a best practice. This because the tool facilitates ease of storage, utilization and will allow easy use in conducting data analysis.

##### Development of an Integrated Nutrition Supervisory Tool

An Integrated Nutrition Supervisory Tool was developed in Year 5. With effective use of the tool, there will be strengthened integration and implementation of nutrition interventions from province to health center levels.

##### Utilization of the Children's Clinic Card

The use of the revised children's clinic card in the management of malnutrition promotes integration of nutrition interventions. One example is the use of the card in tracking the rehabilitation of severely malnourished children using the positive deviance hearth approach in Mansa, Luapula Province.

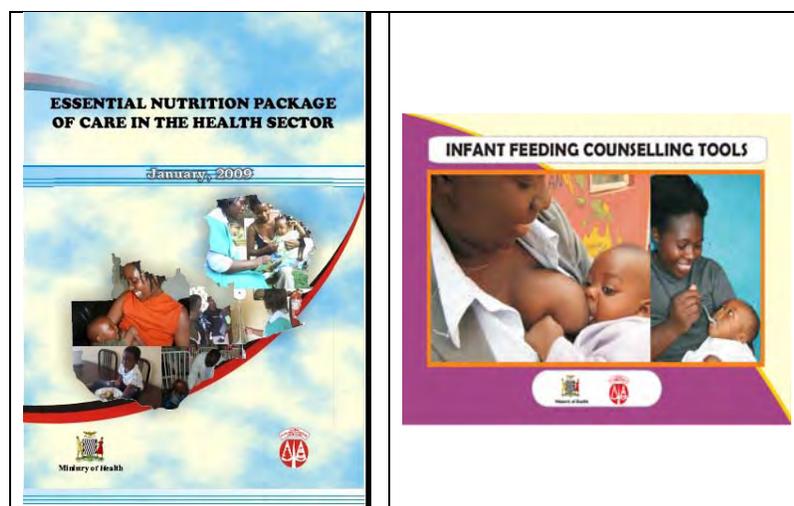


*A mother being counseled at a positive deviance hearth site in Mansa, Luapula Province*

#### **1.4.4 Key products and deliverables**

Three key products were printed in during the year:

- Essential Nutrition Package of care in the health sector
- Infant Feeding Counseling Tool



#### 1.4.5 Key issues: Sustainability, handover and the way forward

- The completion of vitamin A supplementation story will be achieved in the next quarter.

Printed documents have been handed over to the Ministry of Health and National Food and Nutrition Commission for distribution to end users.

## 2 Malaria (Indoor Residual Spraying)

The goal of the malaria program is to contribute to the national effort of reducing malaria morbidity and mortality.

The objective of the Indoor Residual Spraying (IRS) program is to provide adequate technical, logistical, and managerial assistance to the National Malaria Control Program (NMCP) to achieve its target of reducing the incidence of malaria by 85% in selected IRS areas by the end of 2011.

### 2.1 Key indicators: Improved IRS coverage and quality

Indicators	Year 5 (Oct 2008-Dec 2009)		End of Project (EOP)		
	Target	Achieved	Target	Total Achieved to date	% Status
2.1 Number of houses sprayed with insecticide with USG support	802,185 <sup>8</sup> (900,000)	762,479	802,185 (900,000)	762,479	95% (85%)
2.2 Proportion of housing units in targeted area for IRS that have been sprayed in the last 12 months	85%	95% (85%)	85%	95% (85%)	95% (85%)

<sup>8</sup> Revised targets set by districts, based on resources and geographical reconnaissance

Indicators	Year 5 <i>(Oct 2008-Dec 2009)</i>		End of Project (EOP)		
	Target	Achieved	Target	Total Achieved to date	% Status
2.3 Value of pharmaceuticals and health commodities purchased (IRS)	250,325	150,124	601,300	603,769	Target exceeded
2.4 Number of host country institutions with improved management information systems (IRS)	22	37	22	37	Target exceeded <sup>9</sup>
2.5 Number of people trained in malaria treatment or prevention (IRS)	1,725	1,195	3,956	4,196	Target exceeded <sup>10</sup>
2.6 Number of medical and para-medical practitioners trained in evidence-based clinical guidelines	213	344	547	689	Target exceeded*
2.7 Number of people trained in monitoring and evaluation (IRS)	37	28	79	104	Target exceeded*
2.8 Number of people trained in strategic information management with (IRS)	48	41	111	118	Target exceeded*
2.9 Number of special studies conducted	5	7	7	9	Target exceeded <sup>11</sup>
2.10 Number of information gathering or research studies conducted in malaria	5	8	9	9	100%

### Indoor Residual Spraying Coverage, 2008

PROVINCE/DISTRICT	POPULATION PROTECTED	TARGETED POPULATION	STRUCTURES SPRAYED	TARGETED STRUCTURES	% COVERAGE
<b>Central Province</b>					
Kabwe	143,241	220,000	38,976	40,000	97
<b>Copperbelt Province</b>					
Chililabombwe	28,753	35,354	5,656	6,428	88
Chingola	59,349	69,300	11,840	12,600	94
Mufulira	71,369	99,000	16,414	18,000	91
Kalulushi	61,658	91,025	15,933	16,550	96
Kitwe	246,664	346,500	58,926	63,000	94

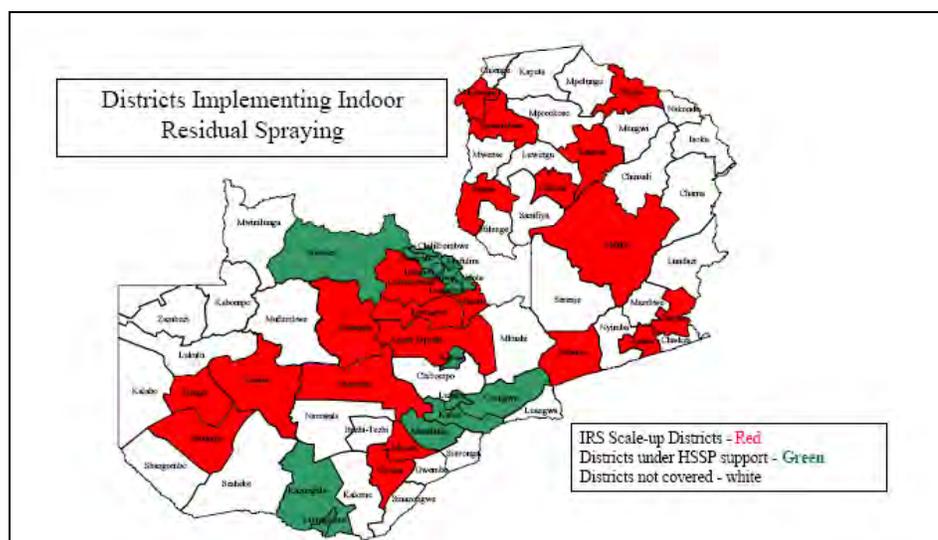
<sup>9</sup> Provided training to all 36 districts plus central level when NMCC scaled up IRS to 36 districts

<sup>10\*</sup> The number of people trained, in indicators 2.5 to 2.8, exceeded the targets because of the 21 new districts introduced into IRS in 2008 that participated in those trainings

<sup>11</sup> HSSP assisted MOH in carrying out two extra studies: Special Mapping Study (together with IVCC) and Insecticide Resistance Studies, which was over and above the planned studies

PROVINCE/DISTRICT	POPULATION PROTECTED	TARGETED POPULATION	STRUCTURES SPRAYED	TARGETED STRUCTURES	% COVERAGE
Ndola	313,318	398,981	65,332	72,542	90
Luanshya	136,381	139,618	22,608	25,385	89
<b>Lusaka Province</b>					
Lusaka	2,403,004	2,200,000	396,672	400,000	99
Kafue	121,457	151,250	22,044	27,500	80
Chongwe	90,810	159,726	27,453	29,041	95
<b>North-Western Province</b>					
Solwezi	66,007	115,500	17,510	21,000	83
<b>Southern Province</b>					
Kazungula	76,734	154,000	20,627	25,000	83
Livingstone	121,445	132,765	22,628	24,139	94
Mazabuka	79,663	79,349	19,860	21,000	95
<b>District targets and totals</b>	<b>4,019,853</b>	<b>4,392,368</b>	<b>762,479</b>	<b>802,185</b>	<b>95</b>
<b>% coverage (planned target 900,000)</b>				<b>900,000</b>	<b>85</b>

The key indicator table and the spray coverage table above show the achievements according to the preliminary national estimate targets, which were set at 900,000 overall for the districts, and the subsequent actual target of 802,185 which represents the total target set by the districts themselves. According to the latter measure, coverage was 95%, according to the original estimate, it was 85%. Given that the district targets were based on the actual resources and geographic reconnaissance work done in each district, the report references the targets set by the districts as the indicator for coverage.



## 2.2 Key Achievements

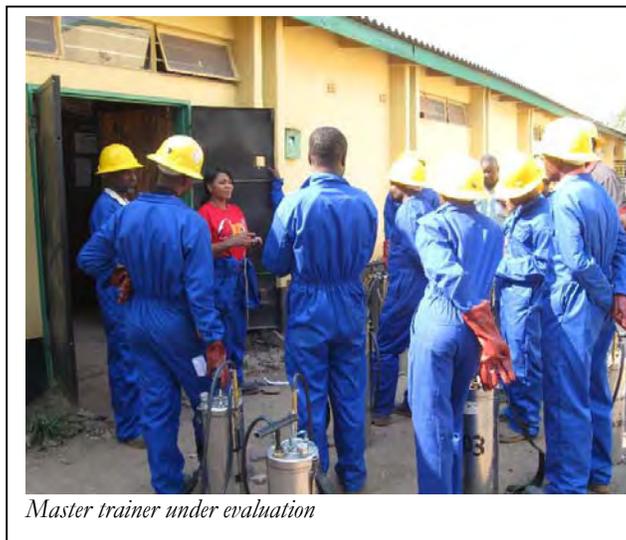
### *Strengthen management capacities at NMCC for IRS operations*

During Year 5, HSSP supported the review of the IRS Guidelines through consultative meetings with stakeholders and the subsequent formatting and printing of the guidelines. These five volumes contain detailed information on IRS operations, environmental safeguards and storage, district cascade training and guidelines on the use of insecticides, including a separate volume on DDT. During the 2009 IRS launch by the Minister of Health, Kapembwa Simbao and also attended by US Ambassador, Donald Booth, a set

of IRS guidelines was officially handed over to Mazabuka District Health Office. During Year 5, HSSP also supported the Environmental Council of Zambia (ECZ) to monitor safeguards in the districts. These activities ensure that there is standardization in the way IRS operations are conducted and above all, will enable the program to be compliant with regulatory requirements.

The IRS Post Spray Meeting took place at Edinburgh Hotel in Kitwe from 19-22 January 2009. There were 107 participants in attendance, including representatives from national, provincial, and district levels, the private sector, cooperating partners, funding agencies and representatives of other public and private bodies. Some key recommendations from working groups included rehabilitation of storage facilities, improved environmental management, better use of community motivation for compliance, improved supervision by districts, and timely disbursement of funds. The meeting provided an opportunity for districts to share experiences on the spray campaign and discuss the way forward.

A TOT orientation was held in Lusaka in June to review the TOT strategy for the IRS 2009 season. Thirty experienced trainers from selected IRS districts attended. A core group of national facilitators was established from this group to serve as national facilitators for TOT workshops as well as assisting in monitoring and supervision of IRS activities. This ensures that NMCC is well prepared for the scale up in 2010, targeted to expand IRS to 54 districts, and is a sustainability measure, given that HSSP technical support is coming to an end.



*Support NMCC by ensuring that environmental compliance is adhered to*

To ensure environmental compliance, a number of preparatory meetings to conduct a strategic environmental assessment (SEA) for the country were held with various partners under the leadership of ECZ. The SEA is a framework upon which all environmental safeguards will be based.

HSSP initiated activities to identify storage facilities for rehabilitation. Three sites were selected, Ndola, Kitwe and Mazabuka. The structures were assessed and architect's drawings prepared. These have since been approved by USAID and rehabilitation works have commenced. An environmental monitoring and mitigation plan (EMMP) was produced to assure ongoing monitoring and assurance of environmental compliance.

*Strengthening the district level management capacities for IRS implementation*

To ensure effective planning for logistics and procurement of commodities, as well as effective monitoring and evaluation of spray activities, supervisors from four districts were trained in geocoding. The objective of the workshop was to provide sufficient skills to IRS supervisors to be able to conduct geocoding in the districts with minimum

supervision from the national level. Geocoding data summary analyses for the districts were prepared by the IRS Information Specialist.

To ensure that supervisors are armed with basic knowledge to use geocoding tools in the district IRS service delivery, even after HSSP closes, seven districts were supported to carry out enumeration of structures. In addition, nine districts were supported to delineate spray areas. The latter is being carried out in collaboration with Innovative Vector Control Consortium (IVCC) under the Medical Research Council of South Africa. The purpose of spray area delineation is to improve the efficiency of planning for spray operations. In order to strengthen these activities further, HSSP procured 35 PDAs and a replacement plotter. The PDAs purchased with funding remaining after leveraging of geocoding trainings with NMCC. The plotter has replaced outdated and non-functioning equipment. Districts will now be able to have maps produced for their planning and reporting purposes.

IRS needs assessments for the 2009 round of spraying were conducted in 36 districts. Assessments ensure that planning for the next spray season is conducted early to allow for procurement of insecticides, spray pumps and personal protective equipment (PPEs) at least three months prior to the beginning of the next spray season. Conducting an early needs assessment also ensures that issues related to storage facilities are attended to in time.

The IRS team participated in the World Bank Mission meetings on IRS operations in Zambia. The mission was intended to examine gaps in the program and to chart a way forward on how to fill those gaps to ensure successful implementation of IRS in 2009.

The IRS team attended PMI Mission meetings both at HSSP and NMCC. The team also participated in the Global Fund Round 9 proposals to ensure availability of funds to support expansion of IRS activities in the country.

*Enhance the NMCC and district teams' capacities to carry out adequate monitoring and supervision activities on IRS operations in 15 districts*

To ensure effectiveness of spray operations and compliance with environmental safeguards, monitoring and supervision of spray activities during the spray season is cardinal. Visits were made to the districts for on-the-spot checks to ensure that districts applied the principles and techniques given during the training of trainers (TOT) and cascade trainings. One major observation during such visits was the weak supervision by the district. Greater district ownership and commitment is necessary in order to address this deficiency. This has since been followed up with the training of a core group of national trainers drawn from both the districts and provinces, who will serve also as supervisors.

The construction of evaporation tanks and soak pits commenced in all the 15 districts. During Year 5, inspection of these tanks and soak pits was carried out to ensure that the construction was according to the approved standards. Outstanding issues such as rain covers are being resolved.

Collection of insecticide waste was done. The waste from the northern region was stored at the Kabwe District Health Office IRS warehouse while that from the southern region was stored at the Nitrogen Chemicals of Zambia plant at Kafue. All of this DDT waste has since been transported to South Africa for disposal.

Enhance NMCC technical and operational research capacities by facilitating entomological investigations in selected districts related to monitoring and evaluation of IRS activities

To enable measurement of IRS program effectiveness, various activities including entomological studies must be undertaken. To prepare the districts to carry out entomological studies, 28 district environmental health technologists (EHTs) were trained in malaria operational entomology. This course has built capacity to conduct basic entomological studies. In addition, basic entomological equipment has been ordered for 15 districts.



Laboratory activities in the insectary

To support the operations of the insectary, HSSP supported renovations, acquired basic equipment and engaged four technicians to assist in running the insectary

and to conduct field collections. Formal and on-the-job training of these technicians was done and standard operating procedures for the insectary established. The insectary has since been maintained and improved. Intensive and sustained effort at larval collection, and also obtaining larvae from Macha Institute, has resulted in achieving viable breeding colonies of mosquitoes for use in entomological studies. Resistance studies and pre-spray entomological surveys have been conducted in selected districts.



Course participants on an entomology field exercise

Enhance NMCC and district IRS teams' capacities to undertake impact assessment studies

To measure effectiveness/impact of IRS, an impact assessment study was undertaken. The study involves three IRS districts (Kazungula, Solwezi, Kabwe) paired with three similar non-IRS districts (Sesheke, Mwinilunga, Mkushi) respectively. Entomological and health facility case data (RDT or laboratory confirmed cases) was collected. Data is currently being analyzed and will be completed in the next and final quarter.

Procurement of personal protective equipment (PPE)

Advertising, tendering and selection of vendors for procurement of personal protective equipment were carried out, and the orders processed and delivered for PPEs for the 2009 IRS season. Distribution to all the 15 districts was completed in readiness for the spray campaign.

Participation at international meetings

The IRS team participated in the 75<sup>th</sup> American Mosquito Control Association Annual Conference held in New Orleans, Louisiana. The team made two oral presentations as follows: Doing it right – the Zambian IRS Experience; and Using Personal Data Assistants in Zambia's IRS Planning Process. The team also participated in a panel

discussion on insecticides and environmental protection. One team member was sponsored by IVCC to participate in a workshop held in Durban, South Africa to discuss the planned implementation and standardization of the Malaria Decision Support System to be rolled out in the IRS districts. The purpose is to ensure that all countries in the region are using the same system. A poster was presented at the Global Health Council Annual Meeting: Using PDAs to Improve the Quality and Efficiency of IRS Service Delivery in Zambia.

### 2.3 Challenges and Solutions

<b>Challenges</b>	<b>Solutions</b>
<i>Erratic funding for implementation of spray operations</i> Slow release of funds delayed completion in some districts. MOH required that districts retire allocated funds before additional funds could be released, interrupting the progress of spray operations.	Explore possibility of MOH releasing the full funding per spraying period to avoid recurring delays.
<i>Inadequate local supervision during spraying</i> Supervision of spray operators in some districts was minimal or lacking, resulting in non-compliance with procedures, and reduced productivity. Supervisors were sometimes engaged in other district activities.	Provincial and district management were engaged during the post spraying review to define a lasting solution to this. A master trainers' workshop was conducted and a core group of trainers and monitors from districts and provinces were re-enforced.
<i>Inefficient utilization of spray operators</i> Deployment of spray operators in the field was in some cases not well coordinated, resulting in underutilization of spray operators.	This issue was revisited during the training of trainers' workshop and will be closely monitored during next spray season.
Problems in establishing mosquito colony in the insectary	Paint residue removed, improved ventilation, dusk/dawn simulator switch installed, new humidifier and heater, insectary on Genset mode.
Non HSSP districts not trained in operational entomology	Budget to train 30 submitted to NMCC for funding from other sources.
Insecticide resistance and bioassay test results incomplete	Larval collections enhanced and study protocol modified. Insectary sanitized, electrical problems addressed, and ambient environment stabilized
Lack of control of the process to export DDT waste as HSSP is not involved in the supply contracts	HSSP took the leadership to coordinate relevant stakeholders and followed up continuously.

### 2.4 Successes/Best Practices

- Certificate of excellence from MOH as appreciation for HSSP's exceptional leadership and valuable contribution to the fight against malaria in Zambia.
- Conducting of Pre- spray entomological surveys
- Disposal of DDT waste

- Created a core of master trainers for TOT, decreasing reliance on HSSP and external expertise
- Increased sustainability of geocoding by training district IRS supervisors
- Succeeded in establishing a breeding colony of mosquitoes in the insectary
- Developed district capacity in basic entomology

### 3 Integrated Reproductive Health

The integrated reproductive health (IRH) unit is comprised of three components: post-abortion care and family planning (PAC/FP), emergency obstetric and newborn care and family planning (EmONC/FP), and long term family planning (LTFP).

The IRH specific objectives are as follows:

- EmONC/FP services established in 43 districts by the year 2009
- 43 districts providing PAC/FP by the year 2009
- Increased accessibility and availability of long term family planning methods in 43 districts by the year 2009

#### 3.1 Key indicators: Improved coverage and quality of IRH services

Indicators	Year 5 (Oct 2008-Dec 2009)		End of Project (EOP)		
	Target	Achieved	Target	Total Achieved to date	% Status
3.1 Districts with at least 1 functioning PAC site	43	45	43	45	Target exceeded
3.2 Number of districts with at least 2 providers trained in PAC and working in facilities providing PAC	43	45	43	45	Target exceeded
3.3 Number of districts with at least 1 functioning EmONC site/centre	43	45	43	45	Target exceeded
3.4 Number of districts with at least 2 providers trained in EmONC and working in facilities providing EmONC	43	45	43	45	Target exceeded
3.5 % of pregnant women receiving IPTp 2 in Central and Eastern provinces	80%	48.9%	80%	48.9%	31.1% <sup>12</sup>
3.6 Number of USG-assisted service delivery points providing FP counseling or services	173	574	493	821	Target exceeded <sup>13</sup>
3.7 Number of information gathering or research activities conducted by the USG	13	10	15	18	Target exceeded <sup>14</sup>
3.8 Number of people trained in FP/RH with USG funds	661	997	1,347	1,761	Target exceeded <sup>15</sup>

<sup>12</sup> The source of data is MOH-HMIS Qs 1& 2. Frequent stock-outs of sulphadoxine-pyrimethamine for IPTp occurring in both provinces were observed. The national figure is 66% according to the Malaria Indicator Survey (MOH 2008).

<sup>13</sup> Training and updates in the provision of FP services are a component of the LTFP, EmONC, and ARH programs.

<sup>14</sup> This indicator includes research activities, such as the AMSTL study and MIP assessment, as well as site assessments undertaken at health facilities prior to all LTFP, EmONC, and ARH trainings.

Indicators	Year 5 (Oct 2008-Dec 2009)		End of Project (EOP)		
	Target	Achieved	Target	Total Achieved to date	% Status
3.9 Number of health care providers trained in Long-Term FP methods with HSSP support	150	151	408	458	Target exceeded

### 3.2 Key Achievements

#### Built capacity in EmONC service provision through training of healthcare providers

HSSP partnered with UNICEF, UNFPA, WHO, and the Ministry of Health to conduct six EmONC trainings in Year 5, training a total of 118 healthcare providers: 39 from Copperbelt Province, 21 from Central Province, 19 from Luapula Province, 20 from Lusaka District, and 20 from University Teaching Hospital (UTH).



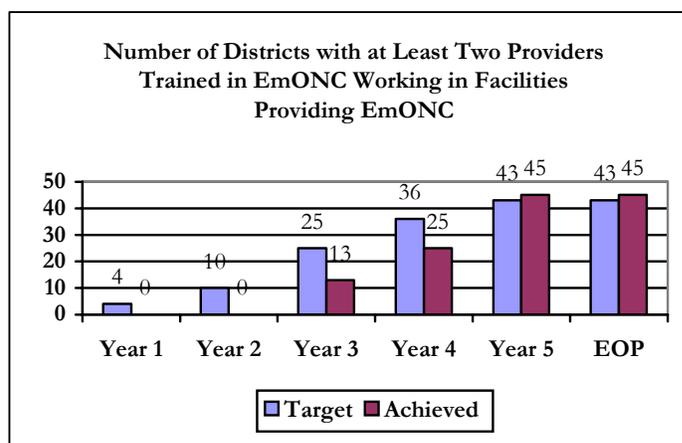
*Training of medical officer in EmONC surgical skills at UTH in Lusaka*

In the conduct of trainings, multiple partnerships were formed and resources leveraged, including with the Ministry of Health at the provincial and district levels, furthering the sustainability of the EmONC program. University Teaching Hospital, identifying an unmet need, spearheaded an EmONC training for its own providers, which was supported by MOH and HSSP. For this training, the MOH Reproductive Health and PMTCT Units worked together to obtain funding from the Global Fund,

demonstrating increased commitment to ownership of the program. HSSP, through the EmONC Technical Working Group, has also brought on board the Child Survival Project, which, with guidance and support from HSSP, will train healthcare providers in Mazabuka and Siavonga districts. This will increase the coverage of EmONC beyond the HSSP targets.

#### Provided technical support and supervision to health workers trained in EmONC

Follow-up visits were conducted in four provinces (Southern, Eastern, Western, and Northern) in order to provide technical support and supervision (TSS) to trained EmONC providers to ensure that the knowledge and skills gained during training were being applied correctly and consistently.



<sup>15</sup> All of the IRH Unit training programs, including those for community members in MIP, focus on one or more aspects and reproductive health and/or family planning.

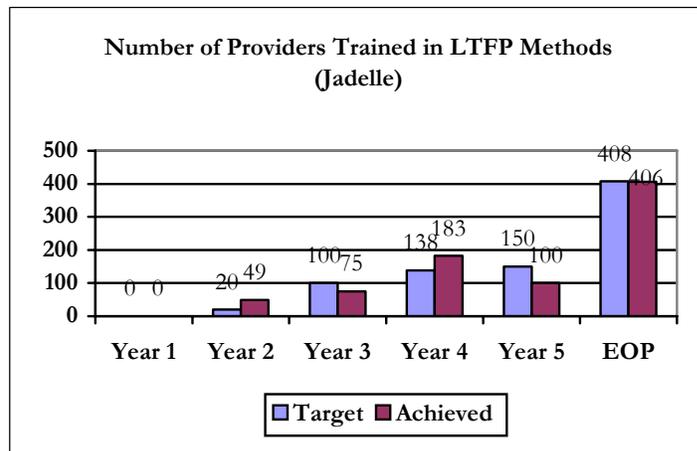
It was found that all the EmONC key signal functions were being implemented in the comprehensive sites. It was also noted, however, that health workers at basic EmONC sites require additional mentorship in managing eclampsia and removing retained products of conception. In the future, there is need for increased emphasis on TSS, particularly within the first two months post-training. The TSS visits have proven to be a method of identifying mentorship needs in the facilities. An example of this was Kasama General Hospital; consultants from UTH worked with the hospital for one week providing support in obstetrics and gynecology.

Conducted review of EmONC curriculum

The IRH Unit supported the Ministry of Health in the revision of the EmONC curriculum, utilizing multiple stakeholders: EmONC trainers, EmONC trainees, curriculum specialists, and practicing physicians and midwives. The final draft has been completed and has undergone field testing. It is currently awaiting final editing by a hired consultant. The new curriculum has been adapted to the particular needs of Zambia and will form the structure of a more streamlined training program, focused primarily on emergency management of obstetric complications.

Oriented district managers to EmONC

HSSP conducted two EmONC orientations for 53 managers from eight districts. These workshops were combined with maternal death review meetings with support from UNICEF. The managers were instructed on provision of support for the EmONC program in order to enhance district-level ownership. As a result, the districts included EmONC in their action plans and co-funded several trainings and purchased essential equipment and supplies, leading to greater sustainability of the program.



Scaled up LTFP program and increased training saturation

HSSP trained 100 healthcare providers from 36 districts in Luapula, Copperbelt, Central, and Northern provinces in Jadelle and the intrauterine contraceptive device (IUCD). For the IUCD component, HSSP continued to leverage resources with MOH and UNFPA. Through these trainings, greater saturation of trained providers was achieved in the provinces, expanding family planning choices for more women.

Provided technical support and supervision to health workers trained in LTFP

In an important step towards sustaining the LTFP program, several provinces initiated their own technical support and supervision visits to trained providers. These visits were conducted with technical and financial support from HSSP.

Finalized the Self-Directed Learning Manual (SDLM)

The IRH Unit facilitated the final formatting of the SDLM and submitted the document to partners for printing. This manual, which has been updated in collaboration with partners, will allow healthcare providers to improve their knowledge and skills in family planning on-the-job and at their own pace.



*SMAG leader teaches women and their partners about sleeping under ITNs at an ANC clinic in Kapiri Mposhi District*

Conducted follow-up visits to Safe Motherhood Action Groups

HSSP conducted follow-up visits to seven Safe Motherhood Action Groups (SMAGs) in six districts in Central and Eastern Provinces in order to determine the impact of community sensitization in malaria in pregnancy, focused antenatal care, and male involvement. Increases in the number of ANC visits attended by women and their male partners were evident at most sites. Increases in facility births were also observed.

Uptake of intermittent preventive treatment (IPTp) for malaria in pregnancy continues to be a challenge due to stock-outs of sulphadoxine-pyrimethamine (SP). In lieu of IPTp, SMAG members are also emphasizing the use of insecticide-treated bed nets. A new edition of the SMAG newsletter was published and distributed.

Conducted case study on integration of postpartum and postnatal care services

The IRH and CHN Units conducted a facility and community-level case study in three districts (Sinazongwe, Chibombo, and Kafue) which were recipients of HSSP inputs in the areas of maternal, neonatal, and child health (MNCH), HIV, and systems strengthening. The purpose was to determine whether the various programs had resulted in the delivery of an integrated package of postpartum and postnatal services to mothers and their newborns. Results showed that, while providers have the intention to provide an integrated package of care, they are frequently thwarted by human and material resource constraints, as well as the additional health system burdens posed by HIV.

**3.3 Incomplete/Reprogrammed activities**

Activity	Comments
Print 150 copies of the revised EmONC participant training manual	Manuals pre-tested; consultant hired to finalize document; MOH and partners to undertake printing
Scale-up activities in five districts to promote male involvement in RH	Funds reprogrammed to priority activities (i.e. LTFP training); male involvement incorporated into MIP activities

**3.4 Challenges and Solutions**

Challenges	Solutions
Reduction in MOH funding	Co-funded trainings with partners in EmONC (UNICEF, UNFPA, WHO, and Child Survival Project) and LTFP (UNFPA)
Frequent stock-outs of SP for IPTp at health facilities	Addressed misuse of SP in trainings in order to reduce stock-outs; SMAGs sensitizing communities to ITN use

### **3.5 Successes/Best Practices**

- Multiple stakeholders were included in the revision of the EmONC curriculum including: national and provincial trainers, EmONC training participants, technical experts, MOH officials, and a curriculum specialist. This ensured maximum and diverse input, and ownership of the final product.
- The MIP program included participants from three levels: the district, the health facility, and the community. By bringing these participants together for the training, linkages between the levels were strengthened, furthering program quality and sustainability.
- By supporting the provincial and district health offices in the conduct of EmONC and LTFP technical support and supervision, HSSP built the capacity of MOH to take ownership of the programs.

### **3.6 Key Products/Deliverables**

- Self-Directed Learning Manual (SDLM)
- Family Planning Counseling Kit
- Revised EmONC Curriculum

### **3.7 Key Issues: Sustainability, handover, and the way forward**

Strong partnerships that were developed from the outset of the EmONC program will help to ensure a continuing network of technical and financial support. The EmONC Technical Working Group, chaired by HSSP, has developed a training scale-up plan with partners that will ensure the program's continuance beyond the life of HSSP. The chair has been handed over to one of the UN agencies for sustainability.

The building of the MIP program into the existing MOH FANC and SMAG programs will promote the continuity of technical support in MIP and messaging at the community level.

The initiation of technical support and supervision in LTFP by the provincial and district levels will help to ensure that trained providers retain their competency in Jadelle and IUCD service provision and continue to provide these much-needed services to women.

## **4 Human Resources**

The human resources for health area is made up of two components: Planning and Management and the Pre- and In-service Training.

### **4.1 Planning and Management**

The goal for HR Planning and Management is to strengthen human resource capacity and retention to provide HIV/AIDS services in areas supported by HSSP. The objective of this component is to retain at least 90% of health workers in districts under the Zambia Health Workers Retention Scheme (ZHWRS) by 2009.

#### 4.1.1 Key Indicators: Improved planning and management coverage and quality

Indicators	Year 5 <i>(Oct 2008 – Dec 2009)</i>		End of Project (EOP)		
	Target	Year 5 Achieved	Target	Total achieved to date	% Status
4.1 Percent of physicians retained in C and D districts under the HSSP rural retention scheme	90%	100	90%	100	100%
4.2 Percent of C and D districts that maintain or reduce their average daily staff contacts <sup>16</sup>	70%	50%	70%	50%	71%

#### 4.1.2 Key Achievements

##### Worked with MOH to hold a semi annual meeting and monitor the performance of the ZHWRS

HSSP played an active role in tracking the general performance of the ZHWRS. One major activity was to review the overall content and context of the ZHWRS with STTA from Abt Associates. This activity was prompted by the general low performance by districts and hospitals to expand the scheme to other cadres. The main focus of this year's semi-annual meeting was to add input to this review with input from 10 HR officers invited from selected districts. This report provides two main recommendations: To decentralize the retention scheme to the district level in order to curb the bureaucratic inertia through to the MOH headquarters; and to propose an interface of the retention payroll to link to the public service payroll (PMEC). This would cut down the duplication of work in district offices.

##### Designed and implemented a rapid assessment

HSSP, working with a short-term research assistant, designed and implemented a rapid assessment to document the changes observed in districts as a result of the doctors' retention scheme. The assessment revealed the following results:

- Introduction of new ART sites, mobile ART, CTC, and DCT services
- Training of health workers by retained doctors
- Better program management (some retained doctors are District Directors of Health)
- Referrals have been reduced due to the presence of doctors
- EmONC, caesarean section, and



*Dr. Kabuswe, retained doctor serving as DHO in Petanke, with award for outstanding ART and TB services coordination*

<sup>16</sup> There are 54 C and D districts, and 27 districts showed improvement in their average daily staff-client contacts

surgery were cited as other services introduced as a result of having the new doctors.

*Support MOH to strengthen the utilization of HR planning guidelines and models*

The availability of a reliable HR information system (HRIS) and utilization of district/hospital-specific HR plans still remain a challenge in the health sector. In order to address this challenge, in August 2008, HSSP provided technical assistance to MOH to introduce district-specific HR planning guidelines. Selected provincial and district HR staff were oriented and requested to review and apply the document. In Year 5, a follow-up meeting was held to receive feedback and revise the district and hospital HR planning guidelines. The review team was composed of HR and HMIS staff from the provinces. The guidelines were reviewed and adopted by the MOH team. All districts and hospitals are now expected to develop specific HR plans that address HR requirements to deliver key health services including HIV/AIDS. In addition to the HR planning guidelines, the workshop also developed a plan to cost the decentralization of the Payroll Management and Establishment Control (PMEC) database to all districts and hospitals.

*HR Planning and Management technical support supervision*

TSS was conducted in Southern and Luapula provinces. One observation was the reported absence of HR policies and guidelines in DHMTs visited. HSSP provided the Senior HR Officers with CDs that contain HR guidelines produced by HSSP support. The PHOs and districts were also advised to make orders of Public Service Conditions of Service and all the legislative acts pertaining to HR. These are vital tools to efficiently and effectively manage and plan for staff in the health sector.

**4.1.3 Challenges and Solutions**

<b>Challenges</b>	<b>Solutions</b>
The placement of new and qualified HR officers, especially at district level, needs to be accelerated and completed in order for HR activities to be effectively managed	The restructuring process is scheduled to be completed before end of 2009. The timeframe for training of new HR officers is 2010

**4.1.4 Key products/Deliverables**

- ZHWRS review report
- ZHWRS doctors survey report
- ZHWRS technical brief

**4.1.5 Key Issues: Sustainability, handover, and the way forward**

HSSP has supported systems that will assure continuity when the project ends in December 2009. Capacity was built in HR Officers and managers in policies and guidelines for retention, recruitment, and planning. Discussions have taken place with MOH for absorption of HSSP supported health workers on the retention scheme.

## 4.2 Pre- and In-service Training

The main goal of the Pre- and In-service training component is to strengthen human resource capacity to provide ART, PMTCT and CTC. The objective of this component is to ensure that 100% of graduates from COG, SOM and nurse training schools are trained to provide ART, PMTCT, CTC and other HIV/AIDS related services by 2009.

### 4.2.1 Key Indicators: Pre- and In-service training coverage and quality

Indicators	Year 5 (Oct 2008-Dec 2009)		End of Project (EOP)		
	Target	Achieved	Target	Total Achieved to date	% Status
4.3 Percent of graduates trained to provide ART, PMTCT, and CTC services (Total)	90% (780)	24% (189)	90% (2,340)	91% (1,603)	Target exceeded <sup>17</sup>
(a) Nurses	100% (600)	100% (600)	100% (1,800)	48% (1,385)	77%
(b) Clinical Officers	100% (120)	50% (60)	100% (360)	100% (414)	Target exceeded
(c) Doctors	100% (60)	87% (52)	100% (180)	182% (327)	Target exceeded
4.4 Number of students graduating from pre-service health training institutions (Total)	1,330	1,348	1,330	1,348	Target exceeded
(a) Nurses	1,110	1,183	1,110	1,183	Target exceeded
(b) Clinical Officers	120	113	120	113	94%
(c) Doctors	50	52	50	52	Target exceeded
4.5 Number of local organizations provided with technical assistance for HIV-related institutional capacity building	21	9	21	30	Target exceeded
4.6 Number of individuals trained in HIV-related institutional capacity building	100	119	100	271	Target exceeded

### 4.2.2 Key Achievements

*Work with GNC to revise Operation Theatre Nurse (OTN) and Enrolled Nurse (EN) curricula*  
Support was given to General Nursing Council (GNC) and training institutions and other stakeholders to revise the EN and OTN curricula to incorporate HIV/AIDS, HMIS, EmONC, and other priority health elements. The ownership of curricula review processes by both MOH and GNC is a sustainable measure for pre-service education through the implementation of National Training Guidelines, a system that HSSP contributed to.

<sup>17</sup> MOH directive to increase intakes of students in all colleges led to increases in number of students recruited and training more health workers and tutors, exceeding the targets on indicators 4.4, 4.5, and 4.6

Support UNZA SOM complete MB ChB and BSc Nursing curricula

These curricula incorporated HIV/AIDS, global, regional and local trends in health care delivery. HSSP will help to leverage support the printing of these curricula to use. Graduates from the two programs will have knowledge, skills and attitudes to deliver quality health services.

Support HIV technical updates/CTS for tutors and preceptors

One hundred and nineteen (119) individuals comprising lecturers, tutors and clinical preceptors from five training institutions were trained in HIV/AIDS related services.



*PS Health launching Nursing and midwifery curricula review workshop July 2009*

These trainings build capacities of training institutions to use the revised curricula in the transfer of skills, attitudes, and in ensuring the standardization of assessing new competencies. The major positive result of these trainings is the improved collaboration between training institutions and the clinical training sites. Clinical preceptors feel there is equal partnership as they gain technical updates which build their confidence in student supervision and mentoring.

Supported training of medical students, clinical officers and nurses in HIV/AIDS

HSSP trained 52 medical doctors and 60 clinical officers in adult ART and 77 student nurses in PMTCT using leveraged resources. This is the continuation of the short term plan to increase the numbers of skilled health care providers for the provision of HIV/AIDS care and services. To date HSSP has contributed to the training of 1,603 graduates, comprising doctors, nurses, and clinical officers.

#### **4.2.3 Key Products/deliverables**

- GNC Training Needs Assessment (TNA) Tools
- TNA Report
- MB ChB Curriculum
- BSc Nursing curriculum and training materials
- EN curriculum and training materials
- OTN curriculum and training materials
- Poster Presentation: On the Relationship of Training Institutions and Clinical Training Sites, Presented at the 24th Quadrennial Congress of the ICN, July 2009, Durban, RSA.

#### **4.2.4 Successes/Best Practices**

Integrating activities to maximize the use of time and resources such as:

- During planning for Lusaka Province, PA for Livingstone Hospital/School of Nursing and document utilization audit for training materials.

- Monitoring HRDCs and support supervision to tutors and preceptors at Livingstone, Chilonga, Kasama, Mufulira, and Ndola Schools of Nursing/Midwifery during data collection for training needs assessment
- Synergy within HSSP with IMCI, PI, IRH components to strengthen technical support to cooperating partners
- Resource mobilization to train graduates and faculty in ART
- Collaboration and cost sharing with stakeholders (WHO, CHAI, UNFPA) to ensure the completion of activities

#### 4.2.5 Challenges and Solutions

Challenges	Solutions
<ul style="list-style-type: none"> <li>• Reorganization of the MOH led to delayed implementation of some HR activities</li> <li>• Competing priorities for MOH and training institutions affected planning</li> </ul>	<ul style="list-style-type: none"> <li>• Conducted some orientation of new MOH staff and rescheduled activities to ensure participation of MOH staff</li> <li>• Planned activities around other times when schools are not conducting examinations</li> </ul>

#### 4.2.6 Key issues: Sustainability, handover, and the way forward

- Revision of all curricula included stakeholders from MOH, faculty from TIs and statutory boards and cooperating partners, resulting in capacity building for future works on curricula.
- All printed materials have been handed over to the MOH, GNC and training institutions.
- Development of synergistic relationships between MOH, GNC and training institutions will ensure continuity of pre and in-service training activities beyond the life of HSSP.
- Ownership of guidelines and systems (National Training Guidelines, Essential Competencies for HIV/AIDS and Handbook on Malaria) by MOH/GNC and TIs will ensure continued use beyond project life.
- MOH, GNC and TIs will continue using curricula and training materials beyond the project life.
- The development of the Clinical Teacher/Preceptor concept paper following recommendations from the Clinical Training Skills for teaching and clinical staff will enhance the use of interactive methods of teaching HIV/AIDS and other concepts.

## 5 Performance Improvement and Accreditation

The goal of Performance Improvement is to improve the quality of case management observation/record review during supervisory visits. The objectives are to reach 60% of districts (43) conducting case management observation/record review in at least 80% of supervisory visits and accredit 30 private ART sites by 2009.

## 5.1 Key indicators: Performance Improvement and Accreditation coverage

Indicators	Year 5 <i>(Oct 2008 to Dec 2009)</i>		End of Project (EOP)		
	Target	Year 5 Achieved	Target	Total Achieved to date	% Status
5.1 Number of private sites delivering PMTCT, CTC or ART services that are assessed by MCZ	3	4	41	45	Target exceeded <sup>18</sup>
5.2 Number of private sites delivering PMTCT, CTC or ART services that are accredited by MCZ	15	15	30	30	100%
5.3 Percent of districts conducting case management observation/ record review in at least 80% of supervisory visits	60% (43 districts)	60%	60% (43)	60% (43)	100%

## 5.2 Key achievements in Year 5

### Technical support supervision focused on case management

HSSP provided technical assistance to three District Health Offices in case management. The districts supported were Mumbwa from Central Province, Mpongwe and Chingola, both from Copperbelt Province. All these districts lacked formal technical support supervision (TSS) system and most of the activities that accompany TSS were not conducted. However, these districts had some strength in that all have more than two doctors at their hospital. HSSP utilized this strength to encourage the districts to conduct supervisory visits that focus on case management. The three districts have since re-introduced weekly clinical meetings and quarterly symposia for all health workers and have also included case management activities in their annual operational plans.

### Monitoring of performance assessments

In Year 5, HSSP, in partnership with the Ministry of Health, directed resources towards conducting performance assessment at provincial level. Three provinces were assessed: Copperbelt, Eastern and Central. Poor case management was observed in most of the facilities visited. This was extensively discussed and recommendations given to all the affected institutions. One of the recommendations was to strengthen supervisory services for clinicians and improve the mentorship program.

### Support districts during planning review

HSSP routinely provides technical support to provinces and districts to ensure that performance improvement activities are included in the action plans. HSSP supported Western, Copperbelt and Luapula provinces during the provincial planning launch and district review meetings. At both meetings HSSP ensured that the action plans included performance improvement activities. It is expected that performance improvement

<sup>18</sup> More facilities providing ART needed to be accredited, thus, more facilities than targeted were assessed

activities will promote improved case management which will in turn lead to improved quality of care.

Accreditation of ART delivery sites

In Year 4, it was noted that most private sites did not meet the accreditation standards to provide ART services because of lack of guidelines and trained human resources. Therefore, in Year 5, HSSP directed its resources towards upgrading the standards of ART sites. HSSP provided 300 sets of guidelines to the private and public ART sites. One hundred health workers from 18 private ART sites were trained in national ARV logistics system, HIV test logistics system and SmartCare. SmartCare software was also installed in the 18 sites. Following this support to the 18 sites, MCZ conducted a reassessment and 15 sites were accredited. This is an indication that focused technical support enhances the accreditation process. The accredited ART sites in Year 5 are listed below.

**Accredited ART Sites**

<b>A. Copperbelt Province</b>
1. Company Clinic -Kitwe
2. Telnor-Ndola
3. Hillview Medical Centre-Kitwe
4. Kalulushi Medical Center -Kalulushi
<b>B. Lusaka Province</b>
1. CFB Hospital
2. Corpmead Clinic
3. Pendleton Family Clinic
4. Premium Medical Services
5. Victoria Hospital
6. Mums Care Clinic
7. Mutti Clinic
8. Kara Clinic
9. ZESCO Company Clinic
10. Trust Medical Centre
<b>C. Southern Province</b>
1. Chresso-Livingstone

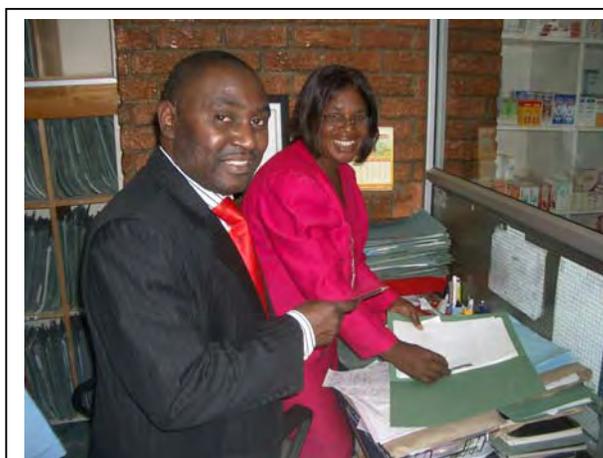
HSSP’s investments in ART accreditation, coupled with the Ministry’s policy to subsidize ARVs in the private sector, have resulted in a tripling of clients on ART in selected private sites. Konkola Copper Mine (KCM), Mopani, Victoria, Lusaka Trust and Mazabuka Sugar Company have signed a MoU with ZNAN and with MOH to receive free ARVs which are prescribed to patients free of charge.

The accreditation system has stimulated continuous improvement of ART sites enabling them to equip their laboratories, pharmacies and report their data to the district and

provincial health offices. For example, Telnor clinic in Ndola and ZESCO are now able to perform CD4 count, a service that did not exist in the clinics before.

Review of Medical Council of Zambia organizational structure

The shortage of human resources affects not only service delivery but also statutory bodies such as MCZ. Insufficient resources at the Medical Council is a primary reason for the delayed achievement of accreditation targets. HSSP supported a review



*Dr. Peter Mumba, examining medical records during the inspection visit at Victoria Hospital*

of the MCZ organizational structure with the objective of improving the efficiency and capacity of the organization. As a result, MCZ proposes to add two positions to support implementation of the accreditation program. Improved efficiency and finances should enable the organization to invest more resources in expanding and maintaining the ART accreditation system.

Certification of health workers

In 2006, the Medical Council of Zambia was mandated by MOH to establish a certification system for all ART health providers. In Year 5, HSSP supported the MCZ to develop and disseminate the ART Certification Guidelines. The guidelines were officially launched by the Minister of Health. HSSP financed the design and development of a certification database to track training received by ART providers. This database has been integrated into the overall MCZ membership database.

Revision of ART Accreditation Guidelines

In Year 4, it was observed that the ART accreditation guidelines needed updating to address concerns raised by implementers of the system in the field. In Year 5, HSSP in conjunction with MCZ, revised the ART Accreditation Guidelines. The guidelines were printed and disseminated.

Documentation

During the year, the team developed a Technical Brief for ART Accreditation in Zambia. A success story on accreditation was prepared and has been submitted to the USAID Telling Our Story website.

**5.3 Challenges and Solutions**

<b>Challenges</b>	<b>Solutions</b>
The slow pace at which the MCZ was able to assess ART sites for accreditation due to capacity constraints	HSSP supported a review of the MCZ organizational structure. As a result, MCZ has added two positions to support implementation of the accreditation system. Improved efficiency and finances should enable the organization to invest more resources in expanding and maintaining the ART accreditation system

**5.4 Successes/Best practices**

HSSP supported 18 private ART sites with guidelines and trainings. The private ART sites were better prepared during the re-assessments and hence were accredited. With this achievement they stand a better chance to receive free ARVs from government and therefore increase the ART uptake and decongest the public ART sites.

**5.5 Key products/Deliverables**

- Revised ART Accreditation Guidelines
- Certification for ART Providers Guidelines
- ART Accreditation Assessment Tools
- Trainers’ ART Accreditation Assessor Manual

- Trainees' ART Accreditation Assessor Manual
- MCZ database for certification of ART providers
- Fifteen (15) Private ART sites accredited
- Revised MCZ organizational structure report

## 5.6 Key Issues: Sustainability, handover, and the way forward

HSSP has supported systems that will assure continuity when the project ends in December 2009. To ensure sustainability, HSSP has built capacity in 43 districts in conducting case management. These activities have since been included in action plans and will be able to continue to provide technical support supervision even after HSSP has come to a close.

ART Accreditation and Certification Guidelines have been printed and distributed. Provincial assessors have been trained and these will continue with ART site assessments. In addition, HSSP supported MCZ to review its organizational structure, aimed at filling in critical positions that will also absorb the work generated through HSSP's technical contribution.

## 6 HIV/AIDS Coordination

The goal for HIV/AIDS Coordination is to assure that districts offer a minimum package of HIV/AIDS services (HBC, CTC, PMTCT, pharmacy, laboratory, ART, and OIs). The objective is to assure 60% of districts have at least one facility offering a minimum package of HIV/AIDS services by 2009.

### 6.1 Key Indicators: Improved HIV/AIDS coverage and quality

Indicators	Year 5 (Oct 2008 – Dec 2009)		End of Project (EOP)		
	Target	Year 5 Achieved	Target	Total achieved to date	% Status
6.1 Percent of districts with at least one facility offering a minimum package of HIV/AIDS services by 2009	60% (43 districts)	60% (43)	60% (43)	100% (72, NAC Reports)	Target exceeded <sup>19</sup>

### 6.2 Key achievements

#### *Print and distribute HIV/AIDS Referral Guidelines*

HSSP has been working with MOH and NAC to strengthen the HIV/AIDS referral system in public and private institutions. HSSP developed and printed 5000 copies of the National HIV/AIDS Referral Guidelines. These guidelines were distributed to health

<sup>19</sup> The goal by MOH to scale up ART services in the country led to having every district having at least one health facility offering a minimum package of HIV/AIDS services

facilities, NGOs and partners through MOH and NAC. The guidelines will be used to establish referral networks for streamlining and improving efficiency of HIV/AIDS services.

Facilitate holding of semi-annual partners meeting

HSSP facilitated the holding of two semi-annual partners meetings to foster integration of HIV/AIDS services. Partners are now able to hold meetings semi-annually to coordinate HIV activities. To ensure sustainability, this activity is now coordinated through NAC and different partners provide technical and financial support. For instance the last semi-annual meeting was co-financed with CRS.

Update ART partners' database

Following an informal assessment of the use of the partners ART database, which showed that the database was a vital tool for planning, HSSP assisted MOH to update the 2008 database. Sixteen records of the 20 partners who responded to the questionnaire were updated. Some partners indicated that they no longer support ART activities, while others stated that they provide block funding for all HIV/AIDS activities and not only for ART. This database has since been handed over to MOH after demonstrations were conducted. To ensure continuity of this activity, MOH is seeking ways of integrating the existing different ART databases in MOH and NAC.

Develop mentorship and QA training materials and train provincial trainers

Throughout the life of the program, HSSP has contributed to building capacities of health service providers at various levels, and build sustainable systems that ensure quality service provision and improved performance. In Year 5, HSSP financed the development of mentorship and QA training materials. These materials were developed by a team of experienced clinicians drawn from primary, secondary and tertiary hospitals and the Provincial Health Office. The materials were used to train 60 provincial trainers in clinical mentorship and Quality Assurance. Provincial Health Offices, hospitals and MOH will continue to use these materials for cascade training to ensure maintenance of standards and quality of case management in health facilities.

**6.3 Challenges and Solutions**

Challenges	Solutions
Inadequate ownership of HIV/AIDS Coordination Guidelines by the Ministry of Health	Draft HIV/AIDS Coordination Guidelines handed over to MOH for determination of way forward

**6.4 Successes/Best practices**

Semi-annual partners' meetings for fostering integration of HIV/AIDS services have been institutionalized and are being supported by different partners

**6.5 Key products/Deliverables**

- Updated 2009 ART partners database
- Printed National HIV/AIDS Referral Guidelines

## 6.6 Key Issues: Sustainability, handover, and the way forward

The Referral Guidelines have been disseminated to health facilities and NGOs through MOH and NAC for development of referral networks. Staff from DHMTs have been oriented to development of referral networks. These guidelines are expected to strengthen the HIV/AIDS referral system in public and private institutions.

## 7 Clinical Care Specialists

The goal for the Clinical Care Specialists (CCSs) is to improve the management of HIV/AIDS and opportunistic infections. The program objective for CCSs is to reduce the spread of HIV/AIDS and improve the quality and access to cost effective interventions.

### 7.1 Key Achievements

#### Coordination of ART services (PMTCT/CTC/TB/ART/HBC) in the Province

The CCSs facilitated quarterly Provincial ART Coordination Committee meetings. This has resulted in strong and effective partnerships on the ground that have led to more equitable distribution of available resources, and thus increased access to services by rural communities. A key output in this regard has been the rapid increase in ART sites around the country. Resources for training and implementation of services have been leveraged, and consensus on reporting tools reached in order to reduce workload on the frontline health worker, and enhance data quality.

#### Technical backstopping and supervision to junior medical doctors implementing ART activities in the Province

##### 1. Clinical Mentorship

CCSs continued to mentor clinical care managers and supported them, through their respective clinical care teams, and to mentor facility staff working in their respective districts. Clinical mentoring focused on case management observation and chart reviews. This has strengthened health worker skills and improved confidence and quality of case management.

##### 2. Technical Supportive Supervision

- a. The CCSs provided technical support to strengthen systems at provincial, district and hospital levels. This has improved planning, program implementation and overall performance.
- b. CCSs disseminated technical updates through clinical and expert meetings. Updates on ART, PMTCT, TB/HIV guidelines, and malaria case management were shared with program supervisors at district and hospital level. The supervisors were then tasked to disseminate the updates to the health workers in their districts. This proved effective in disseminating key programmatic updates to frontline health workers, and has improved HIV program management.

#### Coordinate the scale up of ART in hospitals and health centers

CCSs worked with PHOs and DHMTs to scale up, and hence provide access to, HIV/AIDS services, in 282 health facilities across the country. Innovative strategies, such as the mobile ART approach, were employed to increase access for remote communities in low resource settings.

Coordinate Provincial capacity building programs

CCSs coordinated training at provincial level, guiding participant selection, facilitating in trainings and leveraging resources for training. The table below summarizes the number of staff trained in HIV related courses.

**Number of Health Workers Trained in HIV/AIDS Services**

<b>HIV/AIDS Service</b>	<b>Number</b>
ART/OIs	460
Paediatric ART	110
PMTCT	655
DBS	167
CT	492
Mentoring	60
M&E	44
PIA	59
PEP	106

There has also been increased focus on shifting resources further down to the community level in order to facilitate task-shifting. During the year under review, 417 community agents were trained in counseling skill within ART, PMTCT, and HIV testing services.

Support to district hospitals and clinical HIV/AIDS programs and strengthen referral and continuity of care among health facilities

The CCSs have continued to strengthen HIV/AIDS programs, including referral systems in the districts, through a number of approaches. Robust sample referral systems to support ART, PMTCT and early infant diagnosis have successfully been implemented at district level, resulting in more HIV positive mothers and other patients from remote clinics to be evaluated for, and obtain access to ART.

During the year, all CCSs participated in reviewing PMTCT, ART, malaria and reproductive health programs in respective provinces. Quarterly program performance meetings are now held regularly. District teams are now well oriented in conducting performance review meetings with their own facilities in an objective way, and such meetings are now institutionalized as per MOH requirements under the PA framework.

To monitor and supervise Private Sector ART Provision

CCSs inspected and assessed for accreditation 21 private sites. They also trained 21 private practitioners in various HIV/AIDS programs. This has enhanced the quality of HIV/AIDS services provided in the private sector

ART accreditation

CCSs coordinated teams of assessors that inspected ART sites to grade readiness for accreditation assessment and quality of ART services. The process has promoted adherence to Medical Council standards of practice and ultimately promoted quality ART services.

Provincial Rational Drug Use Training

During Year 5, provincial trainers were trained in Rational Drug Use. Three provinces held provincial trainings for frontline health workers. The training is critical to the

correct functioning of drug and therapeutic committees (DTC) in the DHMTs and hospitals.

TOT in clinical mentorship

The HSSP clinical care specialist unit has taken the lead in having clinical mentoring institutionalized within MOH, and in the production of the Clinical Mentoring Guidelines and training package. To ensure sustainability, the unit trained 32 provincial trainers to cascade training to clinicians in health facilities.

**7.2 Incomplete, New, and Reprogrammed Activities**

Development of CCS operation guide

As part of the CCS exit and sustainability strategy during the final quarter of HSSP, the unit will undertake the consolidation of an MOH operational guide for the CCS/Communicable Disease Control Specialist (CDCS) offices at PHO. The guide will incorporate new innovative strategies that have proved effective in addressing clinical care services, such as clinical care teams, mobile ART and clinical mentoring.

M & E tools for strengthening PMTCT and ART

In its bid to strengthen linkages PMTCT, ART and pediatric ART, CCSs will continue to conduct retrospective and prospective operational studies. It is envisaged that the results will culminate in new proposals for monitoring PMTCT programs.

**7.3 Challenges and Solutions**

<b>Challenges</b>	<b>Actions/Solutions</b>
Lack of basic laboratory equipment in most health facilities has hampered ART scale up	This has been addressed by the development of intra-district courier systems for CD4 and other monitoring tests from peripheral sites to the district labs
Inadequate numbers of staff trained in offering the minimum basic care in HIV/AIDS	This has been addressed by supporting more task-shifting as evidenced by the larger number of community agents provided with training during Year 5
Inadequate funding to further expand formal training programs	On-site mentoring has proved to be a high impact and sustainable remedy to this challenge. As a result, health workers have been trained in Paediatric ART, PMTCT, and IMCI without having to hold a workshop. This underscores the need to consolidate clinical care teams and clinical mentoring prior to closeout
Information management in most ART sites remains a big challenge. The protracted MOH restructuring exercise has negatively impacted information systems and data quality, as all information officers have been reassigned	To bridge the gap, the CCSs have taken the initiative to steer the holding of performance review meetings, and holding data verification/defaulter tracing exercises. Consequently, the new activity based on continued facilitating of data verification/defaulter tracing and PMTCT cohort tracking during the last 3 months prior to

Challenges	Actions/Solutions
	HSSP closeout, have been planned to maintain the bridge
Coordination of training also remains a big challenge. Partners train staff from areas they operate in, leaving out staff from districts that need to be ART accredited	Facilitating ongoing provincial partner coordination meetings remains key in addressing this challenge

#### 7.4 Successes/Best Practices

- Peer support/exchange visits have been used both between provinces and between districts. Capacity building in areas clinical mentoring and program management has been achieved through such initiatives.
- Institutionalization of clinical mentoring through Clinical Care Teams in the Ministry of Health was achieved by the development of guidelines and a training package. Mentorship of clinicians in the hospitals/clinics improved their skills in case management and increased their confidence
- Establishment of mobile ART teams facilitated scale up of ART and increased access to care in low resource settings. Mobile ART sites now constitute 52% of all ART sites in the country.
- Sample referral systems established for PMTCT, ART and early infant diagnosis. This has made CD4 testing accessible to patients attending remote rural health centers.
- Effective, strong, well coordinated partnerships on the ground made it possible to scale up ART services to disadvantaged communities; coordination also made it possible to leverage resources for training. During Year 5, the development of a single reporting template for use by health facilities to provide reports to all stakeholders on HIV/AIDS services has been one such success.
- Strengthening clinical supervisory skills, and program management capacities of district clinical care experts and the clinical managers at the hospitals, was effective in improving clinical care services at district level; this is the best way of ensuring ownership and sustainability of performance improvement programs. One specific outcome of such work has been the successful ART data verification and defaulter tracing activities that have been undertaken with the leadership of the CCSs.

#### 7.5 Key Products/Deliverables

- National Clinical Mentorship Guidelines
- Clinical mentoring training package

#### 7.6 Sustainability, Handover and the way forward

CCSs have formed functional provincial clinical care teams that support district teams in mentoring frontline health workers and providing technical support supervision. The use of existing structures is the most effective and sustainable way to strengthen clinical mentoring and technical support supervision, at district level, which is the implementation level of the National Health Strategic Plan. It would be desirable to develop operational guidelines that would help the MOH CCS/CDCS to continue coordinating clinical /public health programs in the provinces.

Provinces have now begun to recruit medical doctors to fill CCS posts. HSSP proposes that CCS-assigned vehicles be allocated to Provincial Health Offices to enable continued ART mobile outreach, PA, TSS, and clinical care support.

## 8 Strategic Information and Health Services Planning

The goal of Strategic Information and Health Services Planning is to improve the quality and use of the routine health information system (RHIS) in all districts and hospitals by 2009. The overall objective is for all districts and hospitals to use RHIS for planning and management of HIV/AIDS services.

### 8.1 Key Indicators: Improved strategic information and health services planning

Indicators	Year 5 (Oct 2008-Dec 2009)		End of Project (EOP)		
	Target	Achieved	Target	Total Achieved to date	% Status
7.1: Number of districts using revised guidelines for planning	72	72	72	72	100
7.2: 90% of public facilities reporting HIV/AIDS services through the RHIS	90%	100%	90%	100%	100%
7.3: Number of institutions provided with TA in SI activities	10	33 <sup>20</sup>	93	93	100%
7.4: Number of individuals trained in Strategic Information	12	61*	720	895	Target exceeded

### 8.2 Key Achievements

#### *Synchronise report outputs between SmartCare and the paper system*

The Ministry of Health has concluded the rolling out of the HMIS to all public facilities. At facility level, HIV/AIDS data are collected through individual patient/client cards or forms. In facilities with no computer capabilities, patient records are maintained in registers, while those with computer capability transfer data from patient forms onto computers, using SmartCare.

To date, HSSP and CDC have supported the MOH in ensuring that all data summaries, regardless of the report on which they are generated, should have standard definitions just as those used in the paper system. This has since been agreed upon and programmers from CDC have finalized the inclusion of HIV/AIDS. Expected beneficiaries from this exercise among others, include ZPCT, AIDS Relief, Boston University, CIDRZ and MOH.

<sup>20\*</sup> Global Fund supported MOH with data audit for HIV/AIDS services. HSSP was a key facilitator to the data audit meetings. HSSP was called upon to be a technical resource in trainings/data audit meetings, resulting in increased institutions assisted and numbers trained on indicators.

*Develop mechanism for improving data quality and enhance usage*

The revised HMIS has been in use for over a year in many districts of the country. Review of HIV/AIDS data for 2008 on the Copperbelt has shown that these data have not yet reached an acceptable level of quality. HSSP commenced a detailed review of the data for completeness and consistency, to document the weak areas in HIV/AIDS data management. These findings were incorporated in the HIV/AIDS Data Management Manual. Five districts from the Copperbelt were chosen to provide input in the discussions around the identified weak areas.

*Update existing planning guidelines and tools based on the NHSP and other national goals*

*Revise district, hospital, health center and training institutions planning handbooks*

The adoption of new planning processes by MOH influenced the revisions to the existing planning handbooks. The district, hospital, health center and training institutions planning handbooks, were revised to incorporate processes such as marginal budgeting for bottlenecks (MBB) and Logical Framework. The processes promote internal coherence and result orientation to planning. HSSP provided support to the revision and production of the fifth edition of the planning handbooks. Subsequently, 32 staff including Clinical Care Specialists, Financial Specialists and Health Planners from the Provinces, MOH, HSSP, and WHO were trained in the use of the revised planning tools. The revised handbooks were disseminated to the districts through provincial planning meetings and were used to develop action plans for 2010-2012 Medium Term Expenditure Framework (MTEF). Feedback from the 2009 planning processes using the revised tools by district level planners has revealed inadequate understanding of the new processes due to lack of orientation of staff to the tools. The central level will consider providing orientation to provincial health staff, district and hospital level planners and other health institutions before the launch of the 2010 planning cycle.



*Part of the audience during the central level planning*

*Revision of the Integrated Technical Guidelines*

The increasing burden of disease due to increase in non-communicable diseases as well as changes to treatment protocols, for example in HIV/AIDS and malaria, were the main motivation to revise the second edition of the Integrated Technical Guidelines (ITGs) for Frontline Health Workers. HSSP provided both technical and financial support to the process which saw the production and printing of the third edition of the ITG book through a highly consultative process. A total of 1,400 copies were printed through HSSP support and disseminated through the provincial planning meetings to the districts. Each district received copies for its respective health centres. The use of the document will be monitored through the PA system.

Assess the level of use of revised guidelines in planning for HIV/AIDS by DHMT

All the sub-activities under this activity were dropped due to delayed finalization of the revised planning handbooks. Observations from the review of the health institutions' action plans for 2010-2012 indicate that, despite the fact that the institutions had not been oriented to the new planning processes, every institution did use the revised planning tools. Most institutions did, however, experience some difficulties applying the new planning concepts. This calls for MOH to design a program for orienting all planners in the application of these tools.

Provide routine support to MOH planning cycle

To ensure effective planning for health services at district/hospital levels and other health institutions, HSSP has continued to provide routine support annually to the MOH. During 2009 planning cycle, most of the planning activities received technical and financial support from HSSP such as:

1. Development of the technical planning updates for 2010-2012 MTEF
2. The launch of the 2009 planning cycle for the central level
3. Drafting of the central level action plan
4. Support to MOH teams travelling to provincial health offices for the launch and review of district, hospital and other health institutions action plans for 2010-2012
5. Consolidation of the health sector plan for 2010-2012 currently in its first draft. This has since been submitted to Ministry of Finance for comments and feedback. The plan is the basis for MOH to secure funding for implementing health interventions

MOH officially acknowledged HSSP's assistance towards the 2009 planning process through a letter:

"...I wish to acknowledge with appreciation the support we received from your office which has facilitated successful completion of the various stages of planning process which include:- Review of the Action Plan Planning Handbooks, Central Launch of the planning process, Provincial Planning Launches, Provincial Planning Review Meetings, Central level planning launch and, Consolidation of the Ministry of Health Action Plan and Budget. Without your support this exercise might not have been success.

Your support is especially noteworthy because it came at a time when funding to the health sector was withheld by some cooperating partners..."  
Dr. Velepi Mtonga, Permanent Secretary-MOH,  
September, 2009

### 8.3 Products/Deliverables

- District, hospital, health center/post and training institutions planning handbooks.
- Third edition of the Integrated Technical Guidelines (ITGs) for Frontline Health Workers

### 8.4 Successes/Best Practices

- Involvement of end users in document reviews enhances document finalization and ensures documents are representative of the situation in the field.
- The concentration of efforts on one province (Copperbelt) in understanding the bottlenecks to data quality assisted in understanding the problem in depth.
- Working with/through government structures ensures sustainability of programs when project life comes to an end.

## 8.5 Key issues: Sustainability, handover, and the way forward

- Refine the existing “Data Management Manual for HIV/AIDS” to include Frequently Asked Questions (FAQ) in HIV/AIDS Data Management. The activity will not be accomplished by the end of the project. However, the manual will be handed over to MOH to seek support in finalization and printing.
- Revise and print pocket size ITGs. The document has been revised, but requires technical review and formatting before printing. It will be handed over to MOH to seek support in finalization and printing.
- Most of the activities under strategic information and health services planning are part of the overall MOH priority areas. Part of the technical assistance provided to MOH was to build capacities of the relevant technical officers to undertake similar activities once the project had come to an end.
- Planning handbooks and ITGs will serve the MOH at all levels in the years to come and have been widely disseminated.

## 9 Monitoring and Evaluation

The goal of the Monitoring and Evaluation (M&E) Unit is to establish and maintain a system for tracking and evaluating program performance.

The overall objective of the M&E Unit is to develop tools and procedures for planning and monitoring and ensure that management and technical staff are routinely updated on the status of given program indicators.

### 9.1 Key Achievements

#### *Coordinate program planning and reporting on program indicators*

The M&E team, working in consultation with management, coordinated the development and review of Year 5. The workplan was aligned to program objectives and core activities for easy tracking. It has been used as a reference document whenever a technical staff is requesting for authority to execute a given task of his/her workplan. This has helped the supervising officers/management to monitor the activities and budgets.

Year 5 quarterly review meetings were coordinated and the reports were developed. Formats for presentations and reports were reviewed by the M&E team to strengthen presentation of achievements. USAID acknowledged the improvement in the presentation of achievements. The M&E team worked to assure that all indicators and results were promptly and correctly reported at this final stage of HSSP. All the quarterly reports were consolidated and submitted to USAID on schedule. The Year 4 annual report was finalized and submitted to USAID and the Year 5 report was drafted.

#### *Coordinate review of program performance*

#### *PEPFAR Semi-Annual Report*

The M&E team, working closely with management, coordinated the development of the semi-annual PEPFAR report which was submitted to USAID on schedule.

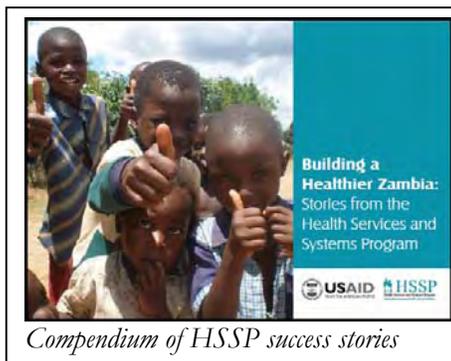
### Portfolio Review Meeting

The M&E team provided input to management during the annual and semi annual portfolio review meetings.

### ***Develop and maintain tracking systems***

#### Success Stories

With the assistance of the M&E Unit, and under the leadership of the COP, HSSP has developed a total of 25 success stories. Twenty-two of these stories have been published in the Year 4 annual report and Year 5 quarterly reports. Eight success stories have been uploaded onto the USAID Telling our Story (TOS) website, of which three have been published, and one story, “Malaria on the Retreat in Zambia” was published in the PMI annual report. The target of developing a cumulative total of 12 success stories by the end of the year was greatly exceeded. A compendium of success stories published and printed.



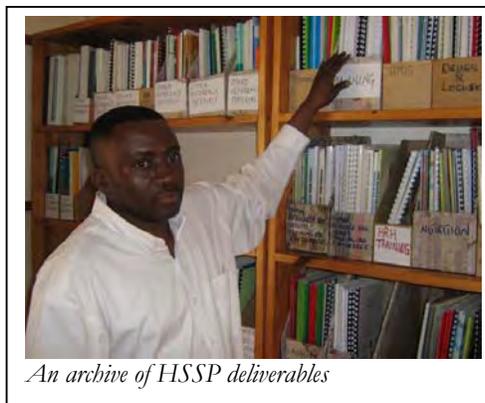
#### Technical Briefs

Six technical briefs, another form of documenting program successes, were drafted during the year:

1. ART accreditation in Zambia
2. C-IMCI/EPI: Empowered Communities Reach Every Child in Every District (RED). Immunization of Children: Measuring Progress and Determining Impact in Zambia
3. F-IMCI Post-Training Supervision: On-the-job training fills a critical missing link
4. HMIS - From vertical to routine: The experience of HSSP in integrating HIV/AIDS data into the routine health information system for Zambia
5. CCS: Building staff capacity to provide basic surgical services in district level facilities
6. Assessing the value-added of doctors on the ZHWRS

#### Archive of HSSP deliverables

The M&E Unit has maintained an archive of all HSSP products/deliverables such as manuals, guidelines, research reports, quarterly reports, annual reports, and workplans. Both hard and soft copies have been maintained. To support the archive, a product/deliverable tracking matrix was regularly updated.



#### Year 5 deliverable tracking sheet

Many documents were completed in Year 5. The M&E Unit developed a deliverable tracking sheet in order to monitor the status of documents.

### Printing matrix

Many documents and products were prepared for printing and dissemination. A printing matrix was developed and updated and was used to track the planning, progress and quantity of each document in the queue. It also acted as a standard tool for obtaining printing quotations.

### Short-term technical assistance plan

A Year 5 short-term technical assistance (STTA) plan was developed. The plan was used to assure advance planning and adequate lead times for securing STTA for each technical area and was regularly updated.

### Program documentation plan

Given that Year 5 was a final and a busy year, project documentation plans were developed and put into a matrix. The M&E team followed up responsible officers to assure that deadlines were met and regularly updated the documentation plans.

### Indicator tracking sheet

The M&E team regularly updated the indicator tracking framework every quarter and assured that associated training lists and other data verification was maintained.

## **Conduct program research and data analysis**

### ZHWRS rapid assessment on Nurse Training Institutions and MOH/HSSP Document Audit

In Year 5, the M&E Unit carried out two rapid assessments:

a) Examining the impact of the ZHWRS on student intakes and tutor recruitment in 13 Nurse Training Institutions. Data was analyzed and a report was prepared.

b) MOH/HSSP Document Audit – tracing key HSSP/MOH documents and their use in the field. Various levels of health facilities were checked to determine whether 10 key documents were in use. Availability of the materials was found to be limited, if indeed they were present. The documents are being used though there is need for periodic checking to assure their availability.

*HSSP/MOH Document Utilization Audit Handbook*



### Postnatal/ Postpartum Integration study

In collaboration with the child health and integrated reproductive health teams, the M&E Unit assisted in the planning and implementation of the Postnatal/ Postpartum Integration Study. Data was collected, analyzed and the report was reviewed.

### Retention of doctors' study

Support was provided to the HR team during the doctors' retention study to ensure technical quality.

### EmONC Curricula

The M&E unit assisted the IRH team to review the EmONC participant's and trainer's manuals. The manuals have been finalized and will be printed in limited numbers.

### Assist MOH to produce provincial health statistical bulletins

The nine provincial statistical bulletins have been finalised. The M&E Unit has planned to meet with all the provincial health data managers and CCSs to discuss how MOH should take up the initiative to prepare and print the provincial statistical bulletins on a sustained annual basis.

In Year 5, the M&E Unit contributed to the production of the 2007 National Annual Health Statistical Bulletin.

### Action Plan Guidelines Review

The M&E Unit assisted the Health Services Planning team to review the planning handbooks for the district, hospitals, training institutions, and health center/communities. The handbooks were printed and handed over to MOH, and were used in the annual planning cycle.

### Reviewing Clinical Care Specialists Indicators

Reports submitted by the nine clinical care specialists had typically been diverse in detail and content, although efforts had been made to raise standards and ensure consistency. In Year 5, five indicators for tracking the activities of the CCSs were reviewed for standardization, in a further effort to obtain more uniform and complete reports.



*Reviewing the provincial health statistical bulletin*



*District, hospitals, training institutions, and health centres/Community planning handbooks*

- MOH/HSSP document audit report
- Compendium of success stories: Building a Healthier Zambia: Stories from the Health Services and Systems Program
- PEPFAR Semi Annual Report
- Nine provincial health statistical bulletins
- STTA plan
- Nurse Tutor Study Draft Report
- 22 success stories

## **9.2 Key Products/Deliverables**

- Year 4 Annual Report
- Year 5 Workplan
- Year 5 Quarter 1 Report
- Year 5 Quarter 2 Report
- Year 5 Quarter 3 Report

### 9.3 Incomplete new or reprogrammed (ongoing) activities

No.	Activities for Next Quarter	Comments
1.	<i>Year 5 annual report</i> Consolidate and submit Year 5 annual report to USAID	To be completed and submitted in October 09
2.	<i>Transmission of archived materials</i> Transmit all archived materials according to close out plan to the home office	All assembled deliverables/ products to be sent to the home office during final quarter
3.	<i>End-of-project dissemination meeting</i> Prepare for and hold end-of-project dissemination meeting	This meeting was cancelled due to financial constraints as HSSP prepares for close-out.
4.	<i>Annual PEPFAR report</i> Prepare and submit the annual PEPFAR report to USAID using the annual PEPFAR reporting system (APRS)	This report will be prepared in October 2009
5.	<i>Country Operation Plan/ Operation Plan Report</i> Prepare and submit the OP report to USAID	This report will be prepared in October 2009
6.	<i>Portfolio review meeting</i> Prepare and submit the portfolio review report to USAID	The meeting will be held in October 2009
7.	<i>End-of-project Report</i> Prepare and submit end-of-project report to USAID	To be initiated during the final quarter of HSSP

### 9.4 Challenges and Solutions

Challenges	Actions/Solutions
Limited staff in the M&E Unit	<ul style="list-style-type: none"> <li>• Increased Chief of Party participation in the M&amp;E team</li> <li>• Prioritized key assignments</li> <li>• Hiring of STTA to assist with studies, documentation and archiving</li> </ul>

### 9.5 Key issues: Sustainability, handover, and the way forward

Development of provincial health statistical bulletins

Capacity has been built at provincial level to develop a health statistical bulletin though financial support may be required to produce the bulletins on a regular annual basis.

There will be need to refresh/orient new staff in statistical bulletin development as many new staff have taken up positions as either district or provincial data managers following the MOH restructuring process.

## 10 Cross Cutting Issues: Gender Mainstreaming and Environmental Compliance

Two cross-cutting themes that HSSP addresses are gender and environmental compliance. Strategies and activities concerning these themes are detailed below.

### 10.1 Gender Mainstreaming

HSSP has assigned targets, tracked and reported on gender distribution for training activities. Additional gender disaggregated data is also collected (e.g. male and female spray operators, gender breakdowns in pre-service education, gender of retention workers, etc.) but these are not routinely reported by the project. Some service delivery areas have an inherent gender focus (IRH), and others, such as IRS, target the entire population irrespective of age and gender.

#### 10.1.1 Addressing Gender in Child Health and Nutrition

In child health and nutrition, mainstreaming of gender has focused on assuring balanced gender participation in planning and implementation of the activities, as well as male involvement in care of the child. During planning, involvement of both female and male health workers is considered during key activities such as training and capacity building. Provinces and districts are encouraged to factor in this element when inviting participants. In addition the team participates in several technical working groups and provides support in organizing national level meetings and conferences, where efforts are made to ensure gender consideration is incorporated. At community level the perspective of gender is more critical. Communities are encouraged to balance gender in membership of Neighborhood Health Committees. The perspectives of both males and females are solicited during planning activities. The following has been observed/implemented:



- Increased participation of female members as Community Based Agents has improved the response of the community to health initiatives
- An improved gender balance in participation in CHW training, with females demonstrating high level of attention to details
- Using TSS as an opportunity to ensure that gender mainstreaming is an active principle in planning, training and NHC at community level. Out of 110 CHWs trained, 61 were males while 49 were females
- An increasing flow of information on health is targeting men, resulting in greater male involvement in child health activities

#### 10.1.2 Addressing Gender in Integrated Reproductive Health

HSSP believes and acts on the principle that both men's and women's needs should be considered concerning reproductive health decision making, and both should participate in clinic and community based RH activities. The success of planned interventions aimed at decreasing maternal and newborn morbidity and mortality relies heavily on utilizing antenatal services to the full, decreasing delays to care-seeking and on family planning decisions that lead to optimally spaced pregnancies. HSSP recognizes that the decisions regarding these health-related behaviors, are often made by the male partner in a family.

Early in Year 5 the IRH team concluded its input into the Men’s Health Kit, produced by HCP, focusing on issues of male support of his partner regarding pregnancy and childbirth, as well as other reproductive health areas. The IRH tem also contributed to the family planning counseling kit that addresses the support that men provide regarding family planning decision making.

The team worked in Year 5 with the Ministry of Health in support of SMAGs. These groups, a subset of the NHCs, are the link between the community and the facilities. Male membership has been shown to be a key element in incorporating the male perspective and activating men to play a role in safe motherhood. It has been noted that men are highly effective at mobilizing other men in the community to learn about and support the needs of pregnant women.



*SMAG member giving ANC and FP information to women and men at Lutale Rural Health Center*

HSSP conducted trainings for the SMAGs in 5 districts of Central and Eastern Provinces with emphasis on MIP, ANC and male

**Increase in Facility Deliveries:**  
Lutale Health Center, Mumbwa District

<u>Year</u>	<u>Deliveries</u>
2007	47
2008	175
2009 (Jan-Jun 125) estimated	250

involvement in RH activities. Fifty one SMAG members were trained in January 2009 of which 68% were male. The trained volunteers assist both in the community and in the antenatal care clinics providing counseling to both women and men and encouraging other men to accompany their wives to ANC. Several HSSP field visits observed a significant increase in facility

births recorded and claimed by facility personnel to be a direct result of the SMAG work.

The IRH team has provided training to both male and female health care providers in LTFP, EmONC and ARH.

**10.1.3 Addressing gender in IRS**

Gender plays a role in the implementation of IRS. Both men and women are given opportunities to



*Female and male spray operators in Mazabuka*



*Female master trainer being assessed*

take part in IRS activities, including IEC, spray operations, training and supervision. A minimum of 30% of spray operators are women, and in Year 5 women constituted 39% of the spray operator workforce (414 women and 807 men; total 2,121). To ensure that women are protected, pregnant and breastfeeding women are not allowed to handle insecticides based on national guidelines and women spray operators do not use DDT.

In the national course on operational entomology organized by HSSP, 39% of the participants were females. More needs to be done in regarding gender balance in the case of district IRS focal point persons, where only 26% of the 15 IRS focal persons are female. In the area of geocoding, an assessment of performance showed that eight out of the top 10 geocoders were female.

## 10.2 Environmental Compliance

### 10.2.1 Environmental Compliance in Child Health and Nutrition

Adherence to injection safety and disposal practices in routine immunization program activities has been addressed during the training of health workers as well during supervisory visits. The issues have included safe technique of administering vaccines to ensure that both the health worker and the client are safe, as well as the safe disposal of used syringes to mitigate risk of exposure. HSSP contributed to updated injection safety guidelines in the revised EPI vaccination manual.

Field results on the injection safety practices show that most of the service providers adhere to injection safety administration practices. Disposal and incineration practices are areas requiring more strengthening. HSSP's role has included re-enforcing implementation of injection safety and disposal guidelines to improve quality of care.

Health facility visits during the routine initial follow-up visits in IMCI involve assessing



*Safe disposal and incineration facility at rural health center*

the overall organization and environment of the health facility. Emphasis on issues of cleanliness, disposal of medically generated waste and the performance of the health workers is key to ensuring that standards are adhered to. During feedback an opportunity is given to health workers to suggest means of improvement where gaps are identified.

During Child Health Week issues of environmental safety are critical. Apart from the orientation process for health workers prior to the activity, complementary efforts are made through supervision from national and provincial levels to ensure that the specific standards in injection safety and disposal practices are adhered to. Supervisory teams ensure disposal of medically generated waste during the child health week through appropriate disposal and incineration to protect the community.

### 10.2.2 Environmental Compliance in Integrated Reproductive Health

Adherence to injection safety and disposal practices in EmONC and LTFP activities has been addressed during the training of health workers as well during supervisory visits. The issues have included safe technique of administering any injections (e.g., Depo Provera) to ensure that both the health worker and the client are safe as well as the safe disposal of the used syringes to mitigate risk of exposure. Disposal and incineration practices areas requiring more strengthening. HSSP's role has included re-enforcing implementation of injection safety and disposal guidelines to improve quality of care.

Assessments of EmONC and LTFP sites during the routine technical support and supervision visits for EmONC & LTFP involves assessing the overall organization and environment of the health facility for adherence to EmONC or LTFP procedures, practices and enabling environment. Adherence to the standards for cleanliness, disposal of medically generated waste and the performance of the health workers are assessed. Additionally, infrastructure, including water and waste disposal are examined. During feedback an opportunity is given to health workers to suggest ways of improvement where gaps are identified in their health facilities. In addition to this, manager orientations occur prior to trainings, emphasizing the importance of infrastructure and adherence to standards of practice.

### 10.2.3 Environmental Compliance in IRS

The safety of personnel in the field is paramount. To ensure this is adhered to, the appropriate personal protective equipment with the right specifications is always procured. Technical assistance is provided to ensure that these are correctly used. This is also enforced through well formulated and standardized trainings of both supervisors and spray operators.

HSSP ensures responsible use of insecticides for the IRS program by ensuring that procedures for handling insecticides are adhered to as stipulated by law. HSSP has supported ECZ in environmental monitoring as well as a Strategic Environmental Assessment. HSSP is currently supporting the refurbishment of storage facilities in three districts. These storage facilities will adhere to minimum standards required by ECZ and the UN Food and Agriculture



*Certificate verifying destruction of DDT waste*



*Soak pit (left) and evaporation tank for IRS waste water.*

Organization. An Environmental Monitoring and Mitigation Plan has been developed along with checklists to ensure environmental monitoring and compliance.

Evaporators and soak pits have been built in all the districts to prevent contamination of the environment due to insecticide waste. Export of DDT waste back to the manufacturers for disposal has been well coordinated by HSSP to ensure that DDT is handled in a professional manner as required by both national and international

regulations. HSSP has provided support to the ECZ to carry out IRS environmental assessments to ensure that environmental regulations are adhered to in the 15 districts.

HSSP has also coordinated and facilitated the collection and export of DDT waste for destruction by an approved facility. A certificate of the destruction has been obtained for the Year 5.

HSSP published and printed the following guidelines to assure environmentally sound practices:

- IRS DDT Guidelines
- Guidelines for Sound Management of IRS Insecticides
- Environmental Safeguards and Storage for IRS

Sharing with a wider group of partners and USAID officials, HSSP presented “Environmental Best Practices in IRS” at the USAID Annual Partner’ Meeting in February 2009. Environmental compliance was also addressed in a presentation: IRS in Zambia: Doing it Right, at the annual meeting of the American Mosquito Control Association in New Orleans.

## **11 Administration and Finance**

The Goals for the Administration and Finance Unit are to:

- Provide cost effective, efficient financial and administrative support for all project operations
- Provide accurate, timely reporting of all financial and administrative transactions for the project to all stakeholders

The objectives are:

- To guide HSSP to achieve 100% USAID and Abt Associates financial and administrative compliance
- To safeguard project inventory and cash
- To provide local human resources management support
- To provide logistics support to the program

### **11.1 Key Achievements**

#### *Financial accounting activities*

- Reconciled and paid Rural Retention Scheme reimbursements to MOH for retained medical doctors, nurse tutors and other medical cadres up to July 2009.
- Tracked the project close-out plan, including preparing a 3-month budget-to-closeout.
- Tracked overall project and field expenditures to ensure smooth closeout of technical areas.
- Indoor Residual Spraying (IRS) Personal Protective Equipment (PPE) procured and distributed to the 15 districts supported by USAID.
- Renovations of three IRS storage sites commenced after completing approval process from USAID and ECZ. One of the three contractors engaged is woman-owned.

### Disposition inventory

Provided inventory disposition request to USAID

### Overall budget and expenditures

As at September 25, 2009, HSSP had spent a cumulative total of \$44.3 million. The cumulative obligated amount for the same period was \$46.2 million. The total project ceiling amount is \$46.7 million. Cumulatively, HSSP had spent 95.9% of total obligated funds and 94.9% of total project ceiling funds. The remaining obligated funds as at September 25, 2009 were \$1.9 million.

### Monthly average burn rate

The overall monthly burn rate for the project is \$766,667 for the year.

### Compliance of financial contract reports

Standard Form (SF) 269 and Federal Cash Transaction Report 272 for the quarter ended June 30, 2009 were submitted to USAID on July 31, 2009. Due date for submission of these reports was August 15, 2009. The submission date of these reports for the quarter ended September 2009 is November 15, 2009, 45 days after the close of the quarter.

### Human Resources

By the end of Year 5, HSSP had a human resource establishment of 44, comprised of 3 management staff, 23 technical staff and 18 support staff. Due to resignations and closeout, three Abt Associates staff and three Jhpiego staff terminated their employment in Year 5.

## **11.2 Key products/deliverables**

The following are the key results produced during Year 5:

- Closeout plan
- Project closeout budgets – 12 months, 6 months, and 3 months budgets
- Monthly ROVs for the year, October 2008 – September 2009
- Disposition inventory
- IRS cost extension– 6 months, 8 months, and 10 month scenarios
- Final financial report

## **11.3 Key issues: Sustainability, handover, and the way forward**

- Management of closeout plan and budget tracking; implement plan for remaining staff terminations as part of closeout.
- Renovations of Mazabuka, Ndola and Kitwe IRS storage facilities
- Management of disposition of project inventory and documents

## **ANNEX 1: Sharing HSSP Best Practices in International Conferences**

### **Presentations made in Year 5**

*Increasing Vitamin A Supplementation Coverage Through the Involvement of Community Health Workers During Biannual Child Health Week*; Poster Presentation: American Public Health Association Annual Meeting, San Diego, November 2008.

*Doing it Right: The IRS Program in Zambia*; Oral Presentation: Annual Meeting of the American Mosquito Control Association, New Orleans, April 2009.

*Using Personal Data Assistants in Zambia*; Oral Presentation: Annual Meeting of the American Mosquito Control Association, New Orleans, April 2009.

*Strengthening Health Systems Management: Prerequisites for Sustaining Vitamin A Supplementation Coverage*; Poster presentation: International Micronutrient Forum, Beijing, May 2009.

*Successful Human Resource Retention Innovations in Zambia*; Panel Presentation: Global Health Council, Washington DC, May 2009.

*Using PDAs to Improve the Quality and Efficiency of IRS*; Poster Presentation: Global Health Council, Washington DC, May 2009.

*Technical Support Improves ART Accreditation Outcomes*; Poster Presentation: Global Health Council, Washington DC, May 2009.

*Integrating Active Management of the Third Stage of Labor in Zambia*; Oral presentation, American College of Nurse Midwives Annual Meeting, Baltimore, May 2009. Best research award.

*Focused Antenatal Care in Zambia: Meeting the Needs of Clients and Providers*; Poster Presentation: International Council of Nurses, Durban, July 2009.

*The Relationship of Training Institutions and Clinical Training Sites*; Panel presentation: International Council of Nurses, Durban, July 2009.

*The Practice of Active Management of the Third Stage of Labor*; Oral presentation. Annual Health Research Conference, Lusaka, Zambia, September 2009.

### **Abstracts Accepted** (conferences pending):

*Community Participation for Progress and Sustaining Immunization Improvements*; Poster presentation, American Public Health Association Annual Meeting, Philadelphia, November 2009.

*Introduction of Long Term Family Planning Methods to Address the Unmet Needs for Zambian Women*; Oral presentation: International Conference on Family Planning Research and Best Practices, Kampala, November, 2009.

*Successes and challenges in promoting the contraceptive implant in Zambia*; Oral presentation, APHA Annual Meeting, Philadelphia, 2009.