



**Ministry of Health  
Republic of Zambia**

# **2012 JOINT ANNUAL REVIEW OF THE HEALTH SECTOR, ZAMBIA**

## Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral therapy
ARV	Antiretroviral drugs
BHCP	Basic Health Care Package
CBoH	Central Board of Health
CDC	Centers for Disease Control and Prevention
CDEs	Classified Daily Employees
CHA	Community Health Assistant
CHAI	Clinton Health Access Initiative
CHW	Community Health Worker
CIDA	Canadian International Development Agency
CPs	Cooperating Partners
Ctx	Cotrimoxazole
DFID	UK Department for International Development
DHMT	District Health Management Team
DMO	District Medical Office (Officer)
DTC	Drug and Therapeutic Committee
EDMS	Essential Drugs and Medical Supplies
EMLIP	Essential Medicines Logistics Improvement Programme
EMMS	Essential Medicines and Medical Supplies
EmONC	Emergency Obstetric and Newborn Care
EPI	Expanded Programme on Immunisation
EU	European Union
FANC	Focused Antenatal Care
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
GMCSPP	Governance and Management Capacity Strengthening Plan
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HRH	Human Resources for Health
HSS	Health Systems Strengthening
IMCI	Integrated Management of Childhood Illnesses
IMR	Infant Mortality Rate
IPT	Intermittent Presumptive Treatment
ITNs	Insecticide Treated Nets
JAR	Joint Annual Review
JICA	Japanese International Cooperation Agency
LLINs	Long Lasting Insecticide Treated Nets
M & E	Monitoring and Evaluation
MDG	Millennium Development Goal
MMR	Maternal Mortality Ratio
MNCH	Maternal, Newborn and Child Health
MoCDMCH	Ministry of Community Development, Mother and Child Health
MoH	Ministry of Health
MTEF	Medium Term Expenditure Framework
NHP	National Health Policy
NHSP	National Health Strategic Plan
PBF	Performance Based Financing
PEPFAR	President's Emergency Fund for AIDS Relief
PHC	Primary Health Care
PHO	Provincial Health Office

PMTCT	Prevention of Mother to Child Transmission
PNC	Postnatal care
PR	Principal Recipient
SIDA	Swedish International Development Agency
SWAp	Sector Wide Approach
TB	Tuberculosis
TBA	Traditional Birth Attendant
tTBA	Trained Traditional Birth Attendant
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Emergency Fund
UNZA	University of Zambia
USAID	United States Agency for International Development
WB	World Bank
WHO	World Health Organisation
UNDP	United Nations Development Agency
YFHS	Youth Friendly Health Services
ZDHS	Zambia Demographic and Health Survey

## Table of Contents

Acronyms .....	i
Table of Contents .....	iii
List of Tables.....	v
List of Figures.....	vi
EXECUTIVE SUMMARY .....	i
a. Maternal, neonatal and child health .....	v
<i>Community strengthening</i> .....	vi
b. Health service delivery.....	vi
c. Health work force (human resources in health) .....	vii
d. Health information systems.....	vii
e. Access to essential medicines and other medical supplies .....	vii
f. Health care financing .....	viii
g. Leadership and Governance.....	viii
h. Community participation: demand and access.....	viii
i. Infrastructure and medical equipment and transport .....	viii
1.0 INTRODUCTION .....	10
2.0 OBJECTIVES OF THE JOINT ANNUAL REVIEW .....	12
3.0 METHODOLOGY .....	13
4.0 BACKGROUND.....	14
4.1 Pooled Funding (The Basket) .....	14
4.2 Financing of the Health System .....	15
5.0 SITUATION ANALYSIS .....	16
5.1 Epidemiological Profile.....	16
5.2 Human Resources for Health.....	16
5.3 Policies and Strategic Priorities.....	17
5.4 Governance, Leadership and Coordination.....	19
5.4.1 The National Health Policy Framework (NHP) .....	19
5.4.2 National Level Institutions and Community Level Restructuring of Primary Health Care Services .....	19
5.4.3 The Governance and Management Capacity Strengthening Plan .....	20
5.5 Prevailing issues in maternal, neonatal and child health .....	21
5.6 Child Health .....	21
5.7 Nutrition .....	22
5.8 The Revised Strategy of Maternal, Newborn and Child Health.....	22
6.0 FINDINGS .....	24

6.1	Maternal, Neonatal and Child Health .....	24
	<i>Performance Factors Driving the Success of the Programme</i> .....	24
	Gap Analysis and Factors Negating Success .....	26
	Thematic Areas .....	29
6.2	Health service delivery .....	29
	Assessment of Existing Gaps .....	31
6.3	Health Work Force (Human Resources for Health) .....	32
	Assessment of Existing Gaps .....	33
6.4	Health Information Systems .....	34
	Assessment of Existing Gaps .....	34
6.5	Access to Essential Medicines and Other Medical Supplies .....	35
	Assessment of Existing Gaps .....	35
6.6	Health Care Financing .....	37
	Assessment of Existing Gaps .....	37
6.7	Leadership and Governance .....	38
	Policy .....	38
6.8	Community Participation: Demand and Access .....	40
6.9	Infrastructure, Medical Equipment and Transport .....	42
	Assessment of Existing Gaps .....	42
7.0	RECOMMENDATIONS AND CONCLUSION .....	44
7.1	Maternal, neonatal and child health .....	44
	<i>Community strengthening</i> .....	45
7.2	Health service delivery .....	45
7.3	Health work force (human resources in health) .....	46
7.4	Health information systems .....	46
7.5	Access to essential medicines and other medical supplies .....	46
7.6	Health care financing .....	46
7.7	Leadership and Governance .....	47
7.8	Community participation: demand and access .....	47
7.9	Infrastructure, medical equipment and transport .....	47
	ANNEXES .....	49

## List of Tables

Table 1: Selected Key Health Indicators.....	11
Table 2: Facilities visited during the JAR field visits, April 2013.....	13
Table 3: Links in the Policy Goal, Strategies/Objectives and Activity Chain.....	18

## Boxes

- Box 1: Documented MNCH Quality Improvements at Facility Level
- Box 2: Observation about quality of nursing care in MNCH
- Box 3: Sex, drugs and cross border trade: Is uptake of health care compromised in border towns?
- Box 4: Perceptions of child health services, Kakoso Health Centre
- Box 5: Community perceptions of general health service, Chimwemwe and Chibolwe clinics, Kitwe
- Box 6: Have user fees really been abolished?
- Box 7: Hospital and mobile services provided and total costs for 2012
- Box 8: How is staff performance assessed at district level?
- Box 9: What functions do community structures perform in programme implementation?
- Box 10: Overview of Kitwe Central Hospital's MNCH services
- Box 11: Focus group discussion: Perceptions of quality of care in MNCH services, Chimwemwe Clinic, Kitwe
- Box 12: How successfully is the system encouraging teen mothers to attend ANC and institutional delivery?
- Box 13: Is there anything that hampers access to quality health care?
- Box 14: Focus group discussion: Perceptions of availability of transport and infrastructure, Chibolwe Clinic, Kitwe

**List of Figures**

Figure 1: 2012 Budget and Disbursements .....	15
Figure 2: 2012 Disbursements of Recurrent Departmental Charges as a Share of the Budget .....	15
Figure 3: Leading causes of morbidity and mortality.....	16
Figure 4: Enrolling and Graduating Students by cadre (2008-12).....	17
Figure 5: Trends in maternal mortality ratio, and births attended by skilled birth attendants in Zambia, 1992-2007 .....	21
Figure 6: Leading causes of deaths among children under 5 at health facilities in Zambia (Health Centres and Hospitals).....	22

## **EXECUTIVE SUMMARY**

The Joint Annual Review (JAR) was first introduced in 2004 to assess the performance of Zambia's health sector on a yearly basis. The JAR complements existing routine monitoring and evaluation systems by providing the opportunity for a harmonised and jointly-planned annual assessment process. Its objective is to facilitate collaborative sector policy dialogue and review, with the ultimate aim of optimising information-sharing, transparency and mutual accountability: key lessons and recommendations drawn from the process provide a platform to improve planning and implementation for subsequent years' programming.

The current JAR (2012) is significant as it comes in the wake of critical changes following the 2009 health sector corruption case. Coordination and dialogue between Government and Cooperating Partners (CPs) is consistently improving, with both parties collaborating to strengthen procurement and financial management and governance. While the role of the Ministry of Health (MoH) as a Principal Recipient (PR) of Global Fund grants was suspended, the Government (GRZ) and CPs are actively working to ensure continuity in funding and minimal disruption to service delivery. This has led to consensus on the Memorandum of Understanding (MoU) and the Governance and Management Capacity Strengthening Plan (GMCSPP): if effectively implemented, the GMCSPP could concretise key reforms in the sector, and see the return of donor confidence.

## **OBJECTIVES**

The 2012 JAR was implemented with four main objectives: a) assessing and scoring progress of the health sector against key indicators, including benchmarks for delivery of district based services; b) reviewing key components of the 2012 District Annual Action Plans and Activity Based budgets in the eight selected districts, with a critical lens on maternal, neonatal and child health; c) following up on recommendations from the 2011 JAR; and, d) informing the annual planning process for 2013. The Government's priority was to ensure that this exercise was participatory with all partners and utilised to consultatively plan for future actions.

It is important to highlight the reallocation of maternal, neonatal and child health (MNCH) services from the Ministry of Health to the newly restructured Ministry of Community Development, Maternal and Child Health (MoCDMCH) in 2012. MoCDMCH has assumed responsibility for primary health care (PHC) and district-level service delivery, while MoH maintains the mandate for overall policy and provision of health care at secondary and tertiary levels. Consequently, the broad focus of this year's JAR was to assess progress in MNCH service delivery against the eight key pillars of the National Health Strategic Plan (2011-15):

- a. Health service delivery
- b. Health work force (human resources in health)
- c. Health information systems
- d. Access to essential medicines and other medical supplies
- e. Health systems financing
- f. Leadership and governance
- g. Community participation: demand and access
- h. Infrastructure and medical equipment and transport



## METHODOLOGY

The JAR process entailed a comprehensive process of:

- **literature review** of key documents describing progress made during the year, as well as of strategic plans and policies that have been designed to augment implementation and coordination
- **interviews** with key stakeholders, including Government partners, CPs, representatives of civil society, community and district facility service providers, training institutions, and the beneficiaries of health services
- **field visits** to two purposively selected provinces – Northern/Muchinga and the Copperbelt – over a one week period. The following eight districts were visited:
  - Kitwe, Chililabombwe, Masaiti and Ndola (Copperbelt Province)
  - Kasama, Nakonde, Mporokoso and Chinsali (Northern/Muchinga Province)

The broad range of these districts would give a snapshot of the ability of the health sector to function in both constraint and resource-rich environments.

## FINDINGS

Below is a summary of the key findings of MNCH services and each of the eight pillars:

### i. Maternal, neonatal and child health

There is evidence of progress in MNCH, particularly in the Government's efforts to allocate additional human resources at facility level in the past year. Even though establishments are generally not filled and facilities are still critically understaffed, many facilities have a minimum of at least one qualified health personnel, and Safe Motherhood Action Groups (SMAGs) are working well with district health teams to complement MNCH at primary health care level, for example by advocating for focused antenatal care (FANC), greater uptake of institutional deliveries and postnatal care (PNC). Key indicators in immunisation, averaging 75% in the eight district visited, have met and often exceeded targets, and uptake of under-5 services continues to be high. Provision of antiretroviral therapy (ART) and prevention of mother to child transmission (PMTCT) increased over the year. Drug availability for MNCH tracer drugs was consistently above 75 per cent, showing a good availability situation and therefore improving the supply chain management and logistics system.

The MoCDMCH launched the 2012-16 Road Map for Accelerating the Attainment of the Millennium Development Goals related to MNCH (MNCH Road Map) was launched in 2012, a critical policy focused on improving MNCH outcomes and attaining Zambia's 2015 MDG targets.

**Gaps:** The most critical obstacle to effective MNCH delivery is the desperate human resource shortage, and this is impacting on facilities' ability to fully deliver timely and quality services. There is a shortfall in training in and supervision of emergency and obstetric neonatal care, and insufficient use of partographs. A major gap in transport and infrastructure is hampering referrals, particularly for emergency maternal cases, and could impact on women's decision to have institutional deliveries. Uptake of PNC, while increasing, is still too low, and distribution of insecticide treated nets for

pregnant women and under-fives is inconsistent. Nutrition monitoring is impeded by a shortage of nutritionists at district level, and does not consistently include tracking for stunting. National stock outs levels of paediatric antiretrovirals were reported, briefly but critically interrupting the otherwise successful ART programme; the same is noted for OPV and BCG vaccines which were momentarily unavailable. Family planning data is not proactively collected from private providers, potentially undermining the opportunity to effectively address unmet need.

#### **j. Health service delivery**

Notable gains were made in prevention and promotion activities, education and community mobilisation, and there is good collaboration with community structures (community health workers, SMAGs) who are advocating for greater uptake of institutional-level services. This has been scaled up following the 2012 removal of user fees, increasing accessing for the poorest and most in need. Delivery of most emergency medicines and medical supplies were timely, and there is indication of a positive contribution by the private sector to health service delivery.

**Gaps:** Stock outs of specific supplies for tuberculosis (reagents and slides), vaccines (OPV and rabies), paediatric Nevirapine solution, and malaria (SP, rapid diagnostic test kits, Coartem and chemicals for indoor residual spraying) hindered the timely delivery of critical services and outreach programmes. Strong socio-cultural beliefs (e.g. about immunisation, ART) at community level further weaken programmes' efforts to intensify drug adherence, and

#### **k. Health work force (human resources in health)**

There is a marked improvement in the availability of HRH. There has not only been an increase in staff numbers, but so too is the mix of different cadres, such as laboratory technicians, pharmacists, pharmacology technologists and nurses. This corresponds with the increase in enrolments in training institutions, in which the number of tutors is growing. The Government has finalised the Health Workers' Retention Scheme as well as the HRH Strategic Plan: the National Training Operational Plan is underway. Community volunteers are also providing much-needed administrative support in facilities.

**Gaps:** Establishments are insufficient and do not match actual numbers of staff in facilities: there is a critical shortage of essential health staff, particularly in rural and hard-to-reach areas. This disparity is resulting in an overburdened, under-supported health work force which cannot deliver quality care where required. Despite their support, volunteers are demotivated by the lack of basic incentives: conversely, many health workers are working within severely resource-constrained settings (infrastructure and supplies) and also lack motivation.

#### **l. Health information systems**

Districts are providing timely reports to provinces. The introduction of databases in 2012 by the General Nursing Council and Health Professional Council will capture accurate numbers of skilled labour in health.

**Gaps:** Districts rely heavily on specific personnel to provide data: where they are unavailable, information is not received. Data is not actively being sought from private providers (e.g. for family planning use and methods), and opportunities for addressing gaps in service provision are being lost. Although MoCDMCH has already taken on the mandate for MNCH and primary-level health functions, it does not have an active data management system and is still heavily reliant on MoH; districts are also unclear how data should be managed for different components of the sector.

There is some concern on the reliability of data, particularly at facility level as it is not always supported by source documents.

#### **m. Access to essential medicines and other medical supplies**

The national budgetary allocation for essential medicines and other medical supplies has continued to grow, and this is evident in the generally good availability of commodities both from the Medical Stores Limited (MSL) to the district level. Drug and Therapeutic Committees (DTCs) are generally working well (although the picture is mixed across different provinces), and the drug ordering system is effective – this is balanced by an increase in the number of pharmacy personnel.

**Gaps:** The pilot Essential Medicines Logistical Improvement Plan (EMLIP) appears to not have been successful, contributing to intermittent or irregular drug stocks where they occurred. There was evidence during the field visits of a fairly high value of expired medicines, highlighting the need for redress in the supply chain through planning, resourcing and stocking. The lack of clarity on the roles and functions of MSL stems from the proposal of new functions (procurement, vs its previous mandate of storage and distribution), and has implications for effectual leadership and governance in the country's supply chain management process.

#### **n. Health systems financing**

The Treasury increased the sector's national budgetary allocation by just over 70% between 2010 and 2012, from ZKr120 million to ZKr208 million. There has also been an upsurge in relations between CPs and Government, with the signing of the Governance and Management Capacity Strengthening Plan (GMCSP), and Memorandum of Understanding (MoU) symbolising a joint commitment to mitigating fiduciary risk and tightening financial and procurement controls.

**Gaps:** District-level disbursements were lower in 2012 than in previous years, creating the unprecedented need to reprioritise core activities. In addition, delayed disbursements have impacted negatively on programme implementation, such as the Indoor Residual Spraying (IRS) programme, increasing the risk of incidence and malaria treatment resistance. Fewer CPs are funding through the Basket fund, with more resources being channelled vertically to earmarked projects – this can create inefficiencies and draw key resources away from mainstream sector priorities.

#### **o. Leadership and governance**

Key decisions and measures have been undertaken in 2012 that are fostering a return of CP and civil society confidence and are re-galvanising partnership. The GMCSP extensively outlines the main gaps in procurement and financial management, as well as in human resources. Its implementation will be vital not only as a way of demonstrating the commitment to a unified health system whose roles are vested in the Government, but as a means of addressing key weaknesses in the sector. Technical Working Groups (TWGs) have also been reconstituted in an effort to make them more 'fit for purpose', and as a channel for greater mutual transparency and accountability.

As already underscored, maternal, neonatal and child health (MNCH) services were transferred from the Ministry of Health to the restructured Ministry of Community Development, Maternal and Child Health (MoCDMCH) in 2012. MoCDMCH has taken on responsibility for primary health care (PHC) and district-level service delivery, while MoH maintains the mandate for overall policy and provision of health care at secondary and tertiary levels.

**Gaps:** While the importance of the GMCSPP is unquestionable, its implications beyond central level are less clear; this is due to perceptions of the Plan being more policy-focused than service-oriented, compromising its ownership among the broader range of stakeholders. Apart from the Monitoring & Evaluation TWG, the other reconstituted TWGs have not yet convened, minimising opportunities for more effective sector consultation and accountability.

A tangible transition plan between MoH and MoCDMCH has not yet been developed, and there is a lack of clarity on mandates over planning, reporting, monitoring and accountability and ownership for specific aspects of service delivery – particularly with respect to MNCH and primary health care.

**p. Community participation: demand and access**

The sector has continued to work towards ensuring that the community structures necessary for public health interventions (e.g. SMAGs) exist and work with the District Health Management Teams (DHMTs). Hospices are plugging a small but critical gap by providing specialist care to at least 2,000 terminally ill clients each month. Various initiatives, such as construction of toilets and mothers' waiting shelters, are helping to alleviate infrastructural challenges at facility level.

**Gaps:** Communities highlighted the challenges of minimal staffing at facility level which is impacting negatively on the quality of care, efficiency of service delivery, and confidence in the health system. Reported cases of health worker negligence and delays in service provision resonated throughout the focus group discussions, as well as concerns about facilities' limitations in fully monitoring nutrition in under-5s. Access to facilities in the absence of reliable roads and transport systems is a major challenge, given the excessive distances. Demands are high for more facilities, especially in remote and hard to reach areas.

**q. Infrastructure and medical equipment and transport**

Construction in 2012 was positive, although at a more measured pace than in previous years. 70% of committed EmONC equipment was procured, and the private sector (on the Copperbelt) is partnering effectively with district facilities by assisting with transport and facilities for emergency maternal cases.

**Gaps:** The rate of improving availability and maintenance of equipment and transport is worryingly slow. Many facilities are operating without any basic EmONC equipment, laboratories, refrigerators, reliable water or electricity supplies, communication systems, ambulances or motorcycles. Where transport is available, it is often in a state of disrepair. Infrastructure is often cramped or dilapidated, and toilets are neither adequate nor clean; there are also insufficient mothers' waiting shelters for pregnant women. Training schools also have limited accommodation facilities and supplies.

## RECOMMENDATIONS

The Joint Annual Review recognises the impressive strides that the sector has made in 2012 in overall health service delivery. In order to continue harnessing the gains to the sector, the following recommendations are made:

**a. Maternal, neonatal and child health**

- Implement the Road Map for Accelerating the Reduction of Maternal, Newborn and Child Mortality (2012-2016) as a priority; in addition, implement and monitor policy commitments to MNCH. Ensure that the National Health

Strategic Plan (NHSP) and primary health care services are reviewed against the realigned health structures and factored into central and district plans

### ***Human Resources in Health (HRH)***

- Reprioritise HRH with actionable and time-bound targets for scaling up training, recruitment and deployment
- Address the challenges between the Establishment and actual staffing positions; map out deployments, confirmations and appointments within a 12 month target period
- Scale up the training, deployment, availability and retention of nurses and midwives in district facilities, especially in hard-to-reach facilities
- Ensure that the priority setting process for the health system has a well articulated framework
- Revive and implement the Community Health Workers' Strategy, provide skilled attendance at facility level, and consider the re-engagement of retired midwives to support Community Health Workers

### ***Service Provision and Quality of Care***

- Improve supervision and staffing levels to augment the quality of care at facility level; address bottlenecks contributing to sub-standard quality of care, and implement systems to address reports of negligence
- Reorient health workers on the correct and consistent use of partographs and monitoring tools for maternity services, and track their utilisation
- Prioritise the procurement and availability in all facilities of BEmONC equipment
- Scale up Emergency Obstetric and Newborn Care (EmONC) services, training and supervision
- Strengthen transport and referral systems in all districts to ensure timely transfer of all emergencies and minimise institutional deaths; provide and document routine maintenance of transport and equipment
- Ensure the uninterrupted supply of paediatric ART, and strengthen record keeping in district pharmacies
- Prioritise the construction of essential infrastructure at facility level, particularly maternity wings and mothers' waiting shelters; and procurement of additional beds for maternity wings
- Review the feasibility of integrating paediatric HIV services with immunisation campaigns as an optimal entry point for diagnosis and treatment of HIV-exposed children, particularly given the impact of HIV on childhood mortality
- Strengthen linkages between private providers and district health facilities on tracking and reporting of modern family planning utilisation and trends

### ***Community strengthening***

- Scale up advocacy at community level for the importance and uptake of:
  - ANC, PMC, PMTCT, institutional deliveries and IMCI
  - distribution and correct use of ITNs, especially for pregnant women and under-5s;
  - nutrition services at facility and community level, including growth monitoring for childhood stunting, and deployment of additional nutritionists;
- Establish an incentive scheme to motivate SMAGs and community health volunteers as they promote uptake of institutional MNCH services

### **b. Health service delivery**

- Scale up advocacy for HIV testing and early initiation on ART

- Determine and address the bottlenecks to access of IMCI, immunisation, FANC and PNC at facility level
- Reprioritise the timely implementation of preventive environmental health services (indoor residual spraying, water and sanitation programming)
- Map out preventive health service needs in overpopulated informal settlements (and in border districts) to address high rates of sex work, early pregnancy, alcoholism, and STIs
- Reprioritise adolescent health (family planning, early pregnancy, sexual and reproductive health) and put in place accessible youth friendly health services
- Include mental health as a measurable indicator in the 2013 JAR
- Conduct a cost-benefit analysis to determine the viability of providing mobile hospital services

#### **c. Health work force (human resources in health)**

- Address management bottlenecks around human resources, such as pending appointments, confirmation of acting staff, promotion, distribution imbalances, and lapses in uniformity of application of incentives (such as the health worker retention incentives)
- Prioritise the training and deployment of nurses and midwives to rural areas to ensure that existing gaps are eliminated by 2015
- Re-strategise training institutions' intake to scale up towards the 2015 goal of increasing the proportion of institutional deliveries by skilled attendance from 47% to 75% (MNCH Road Map)
- Map out an implementation plan taking forward the Community Health Worker strategy, to ensure that it does not lose momentum amid the transition between MoH and MCDMCH

#### **d. Health information systems**

- Install functional internet and data management systems, a qualified Monitoring & Evaluation Unit and strong technical capacity in MoCDMCH
- Enact a transition plan for the transfer of MNCH data from MoH to MoCDMCH with all necessary resources, capacity and supervision
- Introduce a data quality assurance or data validation system at facility level to strengthen the robustness of HMIS data
- Clarify multi-level reporting at provincial level for PMOs
- Allocate sufficient space in facilities for storage of patients' records

#### **e. Access to essential medicines and other medical supplies**

- Develop and implement a detailed five-year procurement plan, annualised and costed for each year
- Recruit and deploy qualified staff in order to strengthen procurement systems
- Continue the scale up and deployment of pharmacists and pharmacy technicians, aligning them with the needs assessment plans for emergency medicines and medical supplies (EMMS) at facility level
- Harmonise the dual procurement systems in place at district and provincial levels
- Clarify and streamline EMMS commodity procurement processes for MNCH
- Reorient Drug & Therapeutic Committees (DTCs) in all districts and hospitals, and ensure performance of joint participation and technical supportive functions by 2014

**f. Health care financing**

- Clarify budgeting and reporting systems and processes in the newly restructured health sector, streamlining them to minimise overlaps between MoH and MoCDMCH
- Ensure that the information systems and accounting systems for financial and procurement management are fully functional by 2014
- Adopt and adhere to a clear resource allocation plan for districts, in order to avert delayed programme implementation
- Include issues of equity, access, and institutional performance in the Health Care Financing Strategy

**g. Leadership and Governance**

- Develop, circulate and implement a feasible and proficient transition plan for MoH and MoCDMCH incorporating critical operational areas (HR, finance, administration, IT, planning, M&E)
- Conduct regular, high-level joint planning meetings at Permanent Secretary and Ministerial levels with key partners, to include technical expertise as a platform for sharing information, assessing progress in the transition and addressing sector bottlenecks
- Reorient stakeholders of the GMCSP to obtain sector-wide ownership, and clarify its implications for service delivery
- Commit to sharing reports and updates on implementation of the GMCSP with the CPs on a quarterly basis
- Review, clarify and disseminate the NHSP and the National Health Policy in the context of the realigned functions of MoH and MoCDMCH
- Commit to decentralisation and health systems strengthening (HSS) and reform, and strengthen community structures
- Ensure high level and timely involvement in planning for the 2013 JAR between MoH and MoCDMCH; agree key areas (thematic focus, field visits, planning) early in the planning process
- Strengthen technical capacity in MoCDMCH to meet the sector's needs, especially with skilled human resource capacity
- Engage other line Ministries to agree cross-cutting linkages (e.g. Ministry of Education on early childhood development and community mobilisation, etc) as they relate to Primary Health Care

**h. Community participation: demand and access**

- Reprioritise and implement the National Community Health Workers' Strategy to address key capacity gaps, particularly at facility level
- Introduce incentives for Safe Motherhood Action Groups and community volunteers, and scale up training and supervision
- Introduce robust nutrition programmes at community level targeting children and pregnant women
- Rationalise service delivery and utilisation costs of mobile services

**i. Infrastructure and medical equipment and transport**

- Ensure that infrastructure planning and development are sequentially related and synchronised to equipment, transport and HRH development
- Redesign the transport strategy and cold chain strategy to ensure redistribution of appropriate transport and equipment to service delivery points
- Strengthen communications at facility and district level
- Provide water tanks and generators for facilities to minimise disruption of services and strengthen cold chain

- Prioritise construction and infrastructure rehabilitation of existing facilities. Consider construction of new facilities where the need is greatest, particularly where there are no district hospitals, or in hardest to reach areas
- Prioritise maintenance of vehicles and equipment. Consider construction of improved facilities where there are no district hospitals
- Allocate and maintain minimum transportation requirements to each district (for example, two ambulances, motorcycles, utility vehicle)
- Allocate and maintain basic equipment to each district (laboratory and X-ray equipment, scales, thermometers, BP machines)
- Address training institutions' infrastructure needs (construction and/or rehabilitation of kitchens, tutors' housing, students' accommodation)



## 1.0 INTRODUCTION

The Zambian health sector over the years has relied on external health financing for health care service and health systems development. As the Cooperating Partners' (CPs) participation in the sector grew, so did the necessity of coordinated planning, implementation and management. It was partly from the need to institute joint systems to strengthen planning and strategic issues in the sector while harmonising implementation through a strengthened health system that the policy of developing and strengthening single monitoring and evaluation of health programmes similarly evolved. Joint Annual Reviews (JARs), as they are now known have been implemented since 2004 in the health sector between the Ministry of Health (MoH) and the CPs.

Part of the justification for initiating the JAR was to provide a shared platform for a joint assessment of health system development over the preceding year as part of the enhanced effort of transparency and accountability within the sector; key findings and recommendations would then be utilised to enhance planning for subsequent years' implementation.

The current JAR (2012) is significant as it comes in the wake of critical changes following the 2009 health sector corruption case. Coordination and dialogue between Government and Cooperating Partners (CPs) is consistently improving, with both parties collaborating to strengthen procurement and financial management and governance. While the role of the Ministry of Health (MoH) as a Principal Recipient (PR) of Global Fund grants was suspended, the Government (GRZ) and CPs are actively working to ensure continuity in funding and minimal disruption to service delivery. This has led to consensus on the Memorandum of Understanding (MoU) and the Governance and Management Capacity Strengthening Plan (GMCSPP): if effectively implemented, the GMCSPP could concretise key reforms in the sector, and see the return of donor confidence.

As the need for a coordinated response to address shortfalls within the sector and normalise relations evolved, consensus was reached on developing a jointly endorsed Governance and Management Capacity Strengthening Plan (GMCSPP). The GMCSPP was developed in order to identify and enhance governance and management skills capacities and other modalities within MoH. As a result of this, some partial funding resumed for purposes of meeting debt obligations within the sector.

The sector continues to be guided by the National Health Strategic Plan (NHSP, 2011-16) which is currently in its second year of implementation. Additional key documents of relevance are the National Health Policy (2011), the successor to the National Health Strategies and Policies (1993), that had radically defined the sector and instituted reform measures aimed to developing a vibrant, self sustaining and harmonised health sector; these were guided by the goals of equity and ethics in eliminating unnecessary, avoidable and unfair health disparities. Others are the Road Map for Accelerating the Attainment of the Millennium Development Goals Related to Maternal, Newborn and Child Health in Zambia (2011-16), and the Ministry of Health (MoH) Headquarters 2012 Action Plan and selected district Action Plans which were based on the list of sample districts for the current JAR. It must be noted that there are other relevant policy documents existing or in draft form in almost all key thematic areas such as health care financing, monitoring and evaluation, procurement, accounting, clinical care, supply chain and logistics management systems, human

resources for health and others. All these documents have been useful in assessing the performance of the sector during 2012.

The selected key indicators showing Under 5 Mortality Rate (U5MR), Maternal Mortality Rate (MMR) and Infant Mortality Rate (IMR) all show progressive results between the 1992 and 2007 Demographic and Health Surveys (DHS). In spite of the progress made, these indicators remain fairly high in relation to their desired levels. For instance the 2007 DHS show that these indicators were 119 per 1,000 live births for U5MR, 70 per 1,000 live births for IMR and 529 per 100,000 live births for MMR, which are still comparatively high if Zambia is to attain its 2015 Millennium Development Goal (MDG) targets.

The key indicators which were reviewed are set against a background of the epidemiological profile in the country, which gives a breakdown of the leading conditions recorded at health facilities for outpatient and in-patient visits.

**Table 1: Selected Key Health Indicators**

<b>Programme Area</b>	<b>Programme Activities</b>	<b>2012</b>	<b>2013</b>	<b>2014 Target</b>	<b>Output</b>
Primary Health Care Services	Maternal health	52%	56%	60%	Skilled deliveries
	Newborn and Child Health	80%	80%	80%	Fully immunised coverage
	Malaria Prevention and Control	152	127	102	Reduction in incidence of malaria
	HIV Prevention and Control	37%	41%	46%	Number of adults (15-49) CT
		85%	87%	90%	Number of people (adults and paediatric) placed on ART
	Mobile Hospital Services		9		Procurement of mobile facilities to ensure two units per province
Hospital Referral Services	Non-communicable diseases	10%	10%	15%	Reduction in incidence of non-communicable diseases
Human Resources Management and Development	Training of health workers	35%	50%	60%	Training output increased
		60%	70%	80%	Number of health facilities with at least one skilled health worker
Essential Drugs and Medical Supplies	Procurement and Distribution	100%	100%	100%	Availability of EDMS and in which no stock out of EDMS

The above table summarises the key programme area targets as captured by the NHSP, which show various levels of targets to be achieved annually over its course.

## 2.0 OBJECTIVES OF THE JOINT ANNUAL REVIEW

The JAR was first introduced in 2004 to assess the performance of Zambia's health sector. The JAR complements existing routine monitoring and evaluation systems by providing the opportunity for a harmonised and jointly-planned annual assessment process. Its objective is to facilitate collaborative sector policy dialogue and review, with the ultimate aim of optimising information-sharing, transparency and mutual accountability: key lessons and recommendations drawn from the process provide a platform to improve planning and implementation for subsequent years' programming.

The JAR process further serves the purposes of jointly evaluating:

- Progress in the implementation of the National Health Strategic Plan, (NHSP, 2011-15); the Road Map for Accelerating the Attainment of the MDGs related to Maternal, Newborn and Child Health in Zambia MNCH Roadmap); the National Health Policy; the Medium Term Expenditure Framework (MTEF); the Governance and Management Capacity Strengthening Plan (GMCSPP, 2012-16), and central and district Annual Plans
- Effectiveness and efficiency of service delivery and the quality of care (actual and perceived), particularly at community/primary health care level, alongside the performance of human resources in health
- Annualised trends in key performance indicators as outlined in the Health Management Information Systems (HMIS)
- Resource flows and applications to overall programme delivery and performance with respect to accountability, transparency and coordination.

The 2012 JAR has been designed to provide an assessment of the sector through the perspective (or "lens") of Maternal, Neonatal and Child Health (MNCH). The selection of this priority area follows the Government's 2012 structural realignment of health coordination, in which the mandate for Primary Health Care (PHC) - the health posts, health centres, district hospitals and district medical offices – were transferred to the Ministry of Community Development, Maternal and Child Health (MoCDMCH). The Ministry of Health (MoH) has retained responsibility for overall policy and provision of health care at secondary and tertiary level institutions, including setting of standards and performance audits. Key human resource staff and the budget share for district health services funding have been relocated to MOCDMCH: this will have significant implications for effective planning, budgeting, monitoring and evaluation (M&E), reporting and implementation.

Progress in the health sector and MNCH was measured against the following eight pillars, which are drawn from the NHSP:

- Health service delivery
- Health work force (human resources in health)
- Health information systems
- Access to essential medicines and other medical supplies
- Health systems financing
- Leadership and governance

- Community participation: demand and access
- Infrastructure and medical equipment and transport

It is against these thematic areas that the findings and main recommendations of the 2012 JAR are made.

### 3.0 METHODOLOGY

The 2012 JAR process focused largely on a qualitative approach, using the methods below to collect and analyse information and data:

- **Literature review** of key documents describing progress made during the year, relevant policy documents, reports and annual plans that have been designed to augment implementation and coordination
- **Interviews** with key stakeholders, including Government partners, CPs, representatives of civil society, community and district facility service providers, training institutions, and the beneficiaries of health services
- **Field visits** to two purposively selected provinces – Northern/Muchinga and the Copperbelt – over a one week period. The following eight districts were visited:
  - Kitwe, Chililabombwe, Masaiti and Ndola (Copperbelt Province)
  - Kasama, Nakonde, Mporokoso and Chinsali (Northern/Muchinga Province)

The selection of these districts was based on purposive sampling, and on a rotational basis as determined by the JAR: the rationale was that the range of districts would provide a snapshot of both constraint and resource-rich environments, and would effectively demonstrate the ability and challenges faced by the health sector in functioning in such settings. Health facilities, ranging from central hospitals to urban clinics to rural health posts were visited to demonstrate the significant differences of health service delivery within posts of such varied magnitudes.

The field visits were guided by both qualitative and quantitative data/information collection tools which were applied at different levels. A four-pronged approach was undertaken: a) consultations at provincial level; b) consultations with DHMTs; c) discussions with health providers in facilities, and with training institutions where they were available; d) semi-structured focus group discussions with beneficiaries of health services.

**Table 2:** Facilities visited during the JAR field visits, April 2013

Province	Number of Facilities	Tertiary + Secondary	District Hospital	Health Centres - rural	Health Centres - urban	Health Posts
Northern and Muchinga	204	2 (2 <sup>nd</sup> level)	6	120	15	37

Out of which Facilities Visited - Northern		1 (= 1 TI)	1	9	2	1
Copperbelt Province	236	9 (2 <sup>nd</sup> Level) 3 (3 <sup>rd</sup> Level)	8	53	137	26
Out of which Facilities Visited - Copperbelt		2 (+ 2 TIs)		10	4	1

## 4.0 BACKGROUND

### 4.1 Pooled Funding (The Basket)

The health Sector Wide Approach (SWAp) as a management concept and operational tool has been in use for both planning as well as operational purposes. This principle has been established domestically through the sector Memorandum of Understanding (MoU) as well and internationally, such as through the International Health Partnerships Plus (IHP+) and Aid Effectiveness structures.

This has been a foundation for the leadership and governance functions performed by MoH and the donors. At the height of the pooled funding mechanism between 2000 and 2009, a stable amount totalling about US\$40 million per annum was disbursed into the sector. This accounted for approximately 90% of district funding. Since 2009 the scenario has changed. In 2012 the district budget was K120 billion for primary health care (PHC) and the releases which accounted for 90% of district funding was met by the Government.

The bilateral and multilateral funding modalities have been mixed. The key CPs have been more pronounced in how they have channelled their support and coordinated programme support. The Swedish International Development Agency (SIDA) supports the sector through the Basket. The Canadian International Development Agency (CIDA) is restructuring its operations and the current Agreement is therefore not subject to renewal in 2013, while the UK Department for International Development (DFID) is continuing with Budget Support as well as some vertical programmes, as is the European Union (EU). Other partners such as the United States Agency for International Development (USAID) and its affiliates (e.g. Presidents Emergency Fund for HIV/AIDS Relief – PEPFAR, Clinton Health Access Initiative - CHAI), the Japanese International Cooperation Agency (JICA) and the Global Fund continue to manage their funding and programmes in a parallel arrangement, operating outside the SWAp mechanism. Other multilateral agencies such as the United Nations System continue to provide vertical funding.

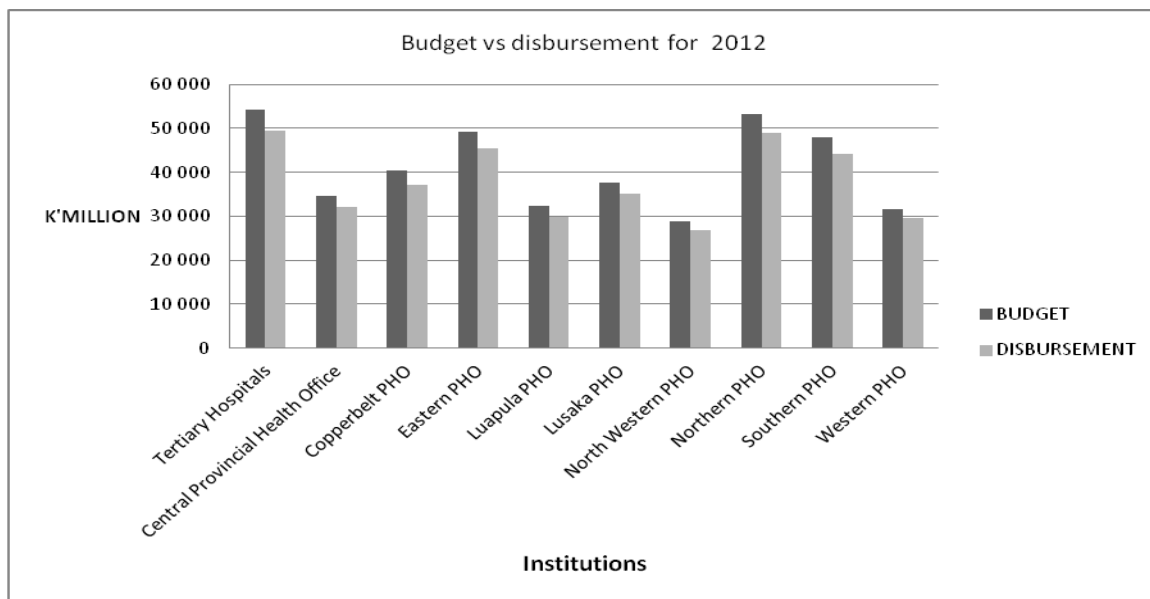
Partners continue to provide support outside of the pooled funding arrangement, despite the MoU and other related principles. There is a risk that earmarked projects can potentially divert attention and critical resources away from joint planning, implementation, and mutual accountability; in addition, they risk undermining the essence of coordination and leadership. It is essential, therefore, that parallel and

vertical programmes maintain accountability to the sector, adhere to existing leadership and coordination functions, guarantee the efficient utilisation of resources, and emphasise the overall principle of health systems strengthening (HSS).

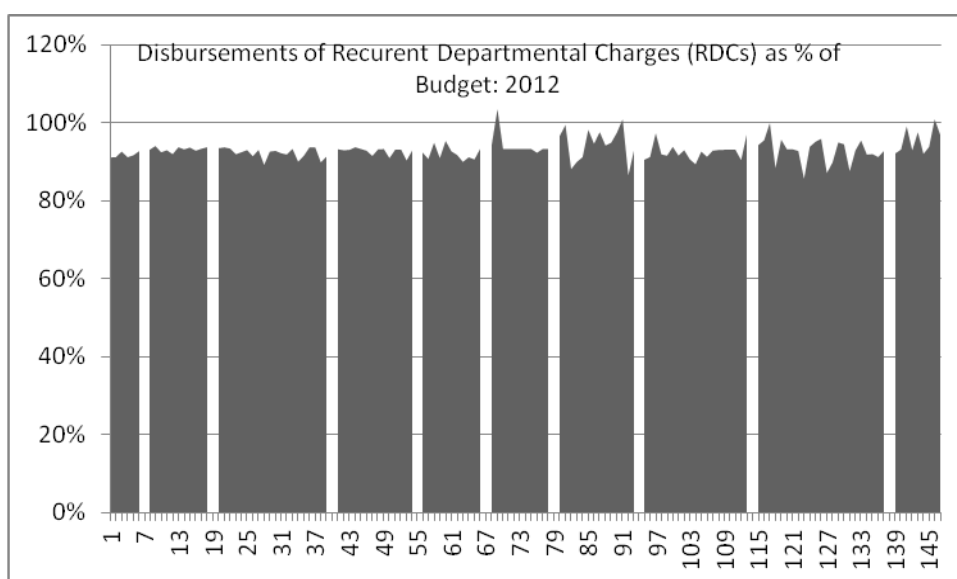
#### 4.2 Financing of the Health System

The financial resources available for 2012 declined partially in relation to 2011. The figures below show the available resources against the budgeted amounts for the year. The disbursements were in virtually all instances lesser than the planned budgets for the year.

**Figure 1: 2012 Budget and Disbursements**



**Figure 2: 2012 Disbursements of Recurrent Departmental Charges as a Share of the Budget**

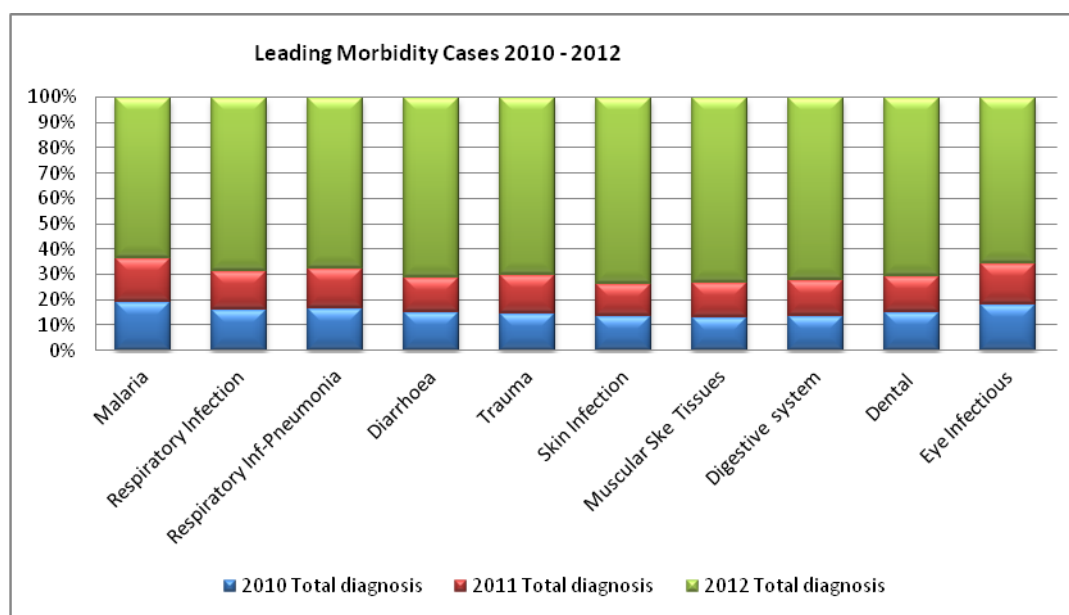


## 5.0 SITUATION ANALYSIS

### 5.1 Epidemiological Profile

The disease burden in Zambia is predominantly composed of infectious diseases. The graphs below of the diagnosed cases from the health facilities show the trends in the distribution of diseases between 2010 and 2012. This distribution includes the ranking of the leading conditions in the country: of these, the leading causes of morbidity and mortality are malaria followed by respiratory infections and trauma. The trend shows that in almost all the cases the total diagnosis more than doubled between 2011 and 2012.

**Figure 3: Leading causes of morbidity and mortality**

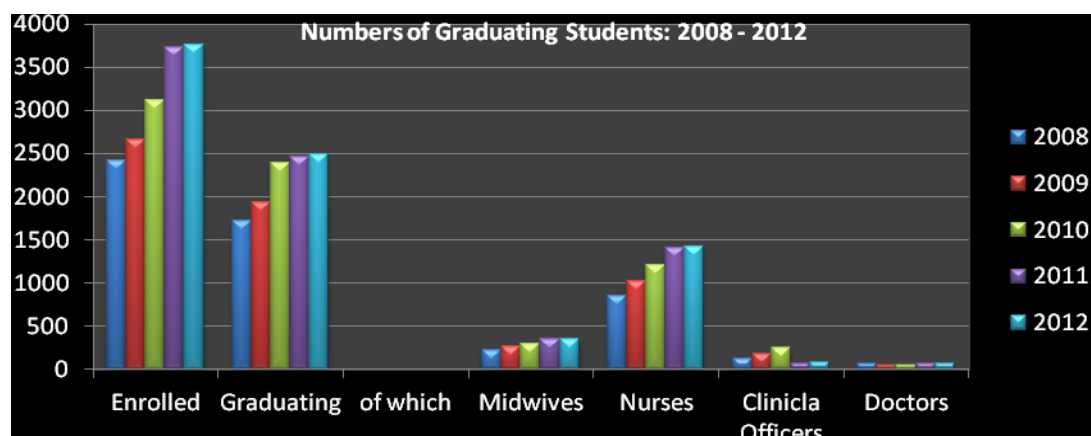


Source: Ministry of Health: Draft HMIS Report for 2012

### 5.2 Human Resources for Health

Human resources for health have been identified as one of the leading bottlenecks in the achievement of key health outcomes, including in maternal and under-5 mortality, and other related indicators. In general, international studies have demonstrated that changes in the absolute numbers of HRH together with changes in the supply chain, and transportation have significant implications for child and maternal health outcomes. Zambia began to experience significant attrition in the health sector from the late 1990s as external migration took a toll on the health system. The World Health Organisation (WHO) has recommended a doctor to population ratio of about 2.5 per 1,000 and a nurse to population ratio of 14 per 1,000 population. In the last health worker survey in 2009, the Copperbelt Province had the leading number of health care staff per population (1:371) while the Northern Province ranked 5<sup>th</sup> of the 9 (1:655).

Table 3 below demonstrates increases in enrolment of students in health training institutions between 2008 and 2012, broken down by cadre (nurses, midwives, clinical officers, and doctors).

**Figure 4: Enrolling and Graduating Students by cadre (2008-12)**

Source: Ministry of Health (2012) National Training Operational Plan: Field Assessments, Analysis and Scale-Up Plans for Health Training Institutions.

The training of key clinical cadres show year on year increases for both new intake and completing students. However, it is evident that, while the rate of graduating students is generally increasing, there are still insufficient numbers of doctors and clinical officers entering the health system:

**Table 3: General percentage increases in health training institution intake/graduation (2009-12)**

Year	2009	2010	2011	2012
Percentage Increase	10%	17%	20%	1%

The National Community Health Worker Strategy (NCHWS) was formulated in 2010 in recognition of the role served by the community health worker (CHW) as a cadre. The rationale behind this was to create a cadre (the CHW) with the potential of meeting a critical aspect of community health within the continuum of health care: it would be focused on prevention and promotion with some elements of treatment. Further, by formalising it, it would eliminate the existing high levels of demotivation, uncertainty and low training, and instead seek to arrest its high drop-out rates.

### 5.3 Policies and Strategic Priorities

The table below outlines the relationship among the various policy and operational documents. It has been observed that the recently passed National Health Policy (NHP) does not correspond as a long term statement of intent with the ruling Party Manifesto on health, and it is therefore recommended that there be a process through which correlation is established. The Manifesto outlines a number of key policy issues which are not addressed in either the NHP or the NHSP such as:

- i. Defining and providing people with access to basic services through the definition of an Essential Package of Health Services.
- ii. Removal of user fees and co-payments
- iii. Enactment of a health services Act to fill the void left by the Health Services (Repeal) Act of 2005.



- iv. Institutional and organisational reforms in the sector (it may be the case that the restructuring of the MoH and MoCDMCH are an aspiration of this).

These areas have direct service provision implications, and there is need to ensure a connection between key policies and strategies with political aspirations of health service delivery. Furthermore, they have implications such as on resource allocation and the setting of priorities and institutional reforms within the health sector.

**Table 3: Links in the Policy Goal, Strategies/Objectives and Activity Chain**

Programme Area	Document				
	National Health Policy	National Health Strategic Plan	GMCSPP	MoH Action Plan	District Action Plan
Guiding principles (ethics)	Equity: Ensure equitable access to health care for all people. Primary Health Care: Adherence to PHC Decentralisation	Equity; Affordability: Cost-Effectiveness; Decentralisation	Accountable, transparent systems; Performance-oriented and skilled HRH	Prevention, Promotion and curative care; health promotion; gender sensitive, family centred	Achieve MDGs through PHC based activities
PHC and Curative Services Priority Framework	Affordability Primary Health Care	Basic Health Care Package	Basic Health Care Package restated and decentralisation		Some gaps e.g. Reproductive Health as a priority in spite of evidence to the contrary
Maternal, Neonatal and Child Health	Family and Community Health; Multi-Sectoralism	Reduce MMR, Reduce IMR/UFMR, Increase accessibility, improve population – staff ratios, (Increase institutional deliveries)	Priorities set accordingly within BHCP	Improved equipment placement, FANC, PNC, CARMMA, Improved commodity stocking, Adolescent health care, PMTCT, Immunisation, Reduced CFR, Ctx prophylaxis, ART	FANC, Deliveries, FP, PAC, Environmental, promotion, outreach, prevention education and facilitation Immunisation,
HRH	Availability of staff, Student enrolments, HRH management planning in place	Improved availability and distribution; development; capacity to oversee technical support by level	Priorities set accordingly with BHCP		
Leadership and Governance	Decentralisation, ratification of international agreements, SWAP, Financial and Management control systems	Strengthen fiduciary systems, sector collaborative mechanisms, PBF, Decentralisation	SWAp Coordination		Community structures and community involvement
Essential Medicines and Medical Supplies	Availability of EMMS, Coordination of partners	RDU, HR, Availability of EDMS	Essential Medicines and Medical Supply Chain Management,	Availability of EDMS, procurement efficiency, RDU and LMS	Availability of EDMS, procurement efficiency, RDU and LMS

			Procurement and HRH capacity	improvement	improvement
		Standard equipment listing and equipment availability			
Equipment	All facilities with essential equipment		BHCP Prioritised		
Health Care Financing	PHC tax financed, 2 <sup>nd</sup> /3 <sup>rd</sup> level – SHI/Tax financing, Harmonised and aligned external financing, legal framework for SHI	Finalising HCF Policy; explore PBF/Contracting and Resource mobilisation	Comprehensive HCF Strategy; complemented by PBF and meeting BHCP service delivery		

## 5.4 Governance, Leadership and Coordination

### 5.4.1 The National Health Policy Framework (NHP)

The NHP has been formulated and adopted by MoH. The NHP replaces the use of the NHSPs of 1993 that was used to guide sector policies and operational plans in the past. The two policy documents compare as shown in the table below. It is not known yet if the new NHP will be subjected to a wider consultative process. The views of some stakeholders raised the prospect that there was a communication gap in the understanding and commitment towards the objectives of the NHP.

The effect of the current policy framework appears to be the lack of an institutional framework for implementing health care programmes. This aspect may be exemplified by the re-structuring of the MoH and MoCDMCH. This reform process is not addressed in the Policy document. Despite that this may be argued to have been out of the realm of control by MoH, yet the failure of the document to recognise the inevitability to reform the sector structures in any meaningful way is an omission. This issue was addressed more directly by key informants in terms of the lack of evidence to adherence by MoH to the Governance and Management Capacity Strengthening Plan (GMCSPP).

### 5.4.2 National Level Institutions and Community Level Restructuring of Primary Health Care Services

Programmatically, there appears to have been general consensus that prior to the changes in the primary health care functions between MoH and MCDMCH, the strategic direction was clearer and programme implementation could be pursued with confidence. However, the changes in 2011 and 2012 have introduced uncertainty in the health sector.

The Government announced initial structural changes in the Child Health Programme Area during 2011. This was followed during the course of 2012 by a more radical reform measure which involved divesting Primary Health Care (PHC) functions relating to ambulatory and first level clinical care services and all public health functions performed by the District Health Management Teams (DHMTs) from MoH to MoCDMCH.

According to available information MoH maintains the provision of referral services; policy issues and oversight of training schools in the country. The modalities of how the mandates of the restructuring measurements impacted on management and leadership structures at the central level and at the level of health care providers however appear not to be well documented at MoH.

#### **5.4.3 The Governance and Management Capacity Strengthening Plan**

The Governance and Management Capacity Strengthening Plan (GMCSPP) was developed in 2011. It focuses on the strengthening of systems in the Ministry of Health. This approach is based on the premise that all accountability and information management systems are part of an integral governing and management system to improve not simply the performance of individuals working in the sector, but ensure improved service delivery.

The Plan is cardinal in assisting MoH and the CPs to bridge the gaps that were created during 2009. Improved systems are therefore a pre-requisite towards ensuring that the existence of trust, confidence and partnership desirable for MoH to assume strategic leadership functions is once again restored. Two characteristics are associated with this process namely:

- Improved and strengthened accountability and
- A greater attainment of transparency in accounting, financial management, procurement, funding and resource allocation, as well as human resource management among other functions.

The functions more prone to issues around transparency and accountability following serious financial and procurement leakages included but were not limited to:

- i. Accounting and Financial Management
- ii. Planning, procurement and distribution of pharmaceuticals

On a wider level and in order to ensure the existence of a wholly integrated system, related support systems included:

- i. Human Resources Planning and Development.
- ii. Health care financing and funding mechanisms
- iii. Coordination, governance and leadership structures
- iv. Decision making space and institutional framework

The essential principle of the GMCSPP was to, apart from developing the systems, ensure that there was the commitment to and realisation of the confidence and trust essential to the growth of the partnership and leadership needed between MoH and its key stakeholders especially on the funding side. However, as highlighted in the Findings sections of this report, there is less buy-in and ownership of the GMCSPP beyond central level than perhaps anticipated by the major proponents of the Plan. Perceptions that the GMCSPP is applicable predominantly to policy-level priorities, with less clarity on its relation to service delivery or programme implementation by civil society partners were noted. It also risks losing its significance as a sector-wide priority given additional perceptions that there is little linkage between it and the National Health Strategic Plan: observations from stakeholders highlight concerns over the apparent elevation of the GMCSPP over the NHSP as a Government priority, and this will have ramifications for implementation and accountability if not clarified.

## 5.5 Prevailing issues in maternal, neonatal and child health

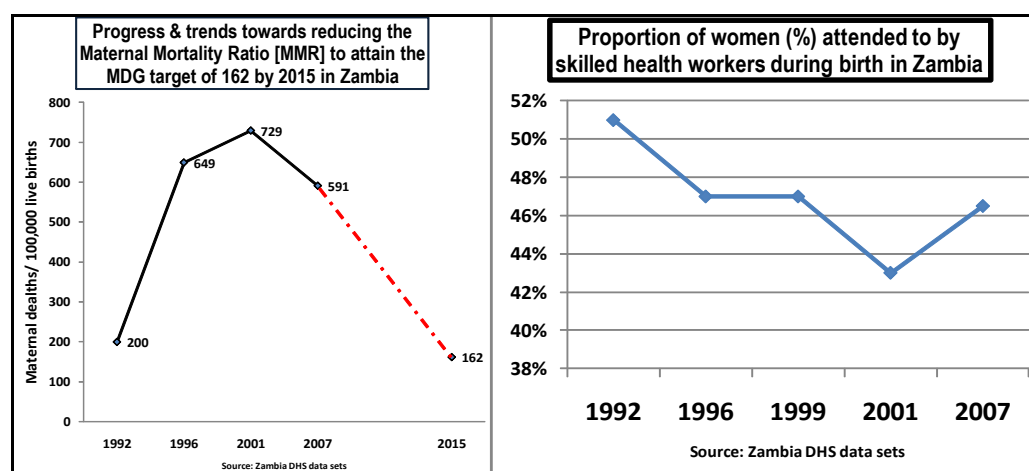
Globally, the leading causes of maternal morbidity and mortality are due to:

1. complications in pregnancy and childbirth and post-delivery
2. delays in accessing services
3. weak health systems and poor referral systems
4. indirect causes, including HIV, malaria and TB

According to the Zambia's Road Map for Accelerating the Attainment of the MDGs Related to MNCH, the leading causes of maternal mortality nationally are post-partum haemorrhage (34%), sepsis (13%), obstructed labour (8%), as well as pregnancy hypertensive disorders/eclampsia (5%), while abortion complications account for about 30% (MOH, 2011). All five conditions account for 65% of maternal morbidity and mortality causes. Indirect causes are attributed to malaria and HIV/AIDS, which account for 11% and 10%, respectively. Additional conditions include tuberculosis, anaemia, respiratory diseases and cardiovascular conditions, such as induced by high blood pressure. Long distances and difficulties in accessing health care services are key in contributing to maternal mortality.

Figure 5, drawn from the Maternal Health Roadmap, exhibits improving trends in recent years towards addressing maternal mortality rates and the proportion of women delivering with skilled attendance. Although rates are progressing from a low base, the magnitude of the problem is still high and basic factors need to be addressed.

**Figure 5: Trends in maternal mortality ratio, and births attended by skilled birth attendants in Zambia, 1992-2007**



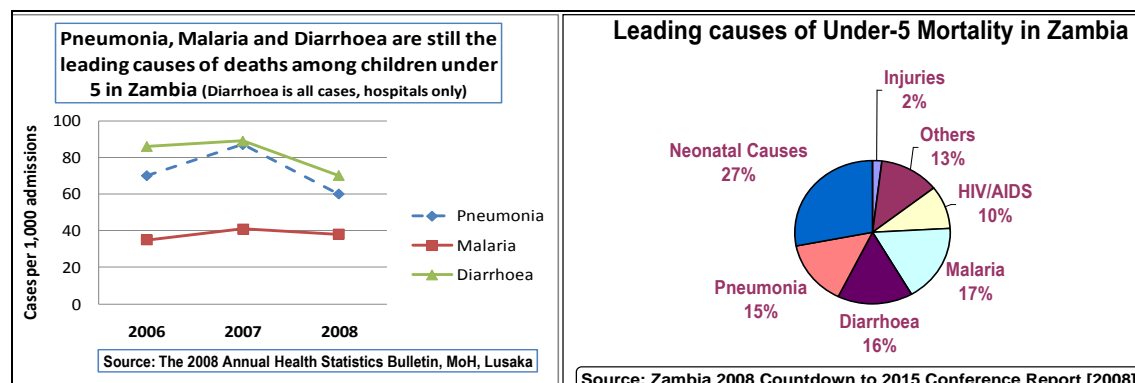
Source: Road Map for Accelerating the Attainment of the MDGs related to MNCH in Zambia, 2011-16

## 5.6 Child Health

The leading causes of death for children in Zambia are shown in the figure below. As highlighted in the MNCH Roadmap, under-5 mortality remains high, despite a decrease from 168/1,000 live births in 2002 to 119/1,000 live births in 2007 (ZDHS, 2007). Infant mortality dropped from 102/1,000 live births in 2006 to 70/1,000 in 2007, but neonatal mortality rose from 37/1,000 in 2002 to 40/1,000 in 2004 (UNICEF, 2002: State of the World's Children). Up to 40% of neonatal deaths in Zambia occur in the immediate postnatal period (due predominantly to sepsis, prematurity and asphyxia): worryingly, uptake of postnatal care is limited, although more facilities are utilising a variety of innovative methods to encourage mothers to

return to facilities with their newborns at six days but this is successful only where access or distance is not a challenge.

**Figure 6: Leading causes of deaths among children under 5 at health facilities in Zambia (Health Centres and Hospitals)**



The State of Africa's Children Report (UNICEF, 2008) notes that it is essential to undertake the following to make any meaningful policy changes if maternal, newborn and child health trends are to be reversed:

- Create a supportive environment for maternal, newborn and child survival and health
- Develop and strengthen the continuum of care across time and location.
- Scale up packages of essential services by strengthening health systems and community partnerships

## 5.7 Nutrition

As many as 19% of women have a low body mass index (BMI) of less than 18.5; as many as 45% of children under five demonstrate evidence of stunting, 5% wasting and 15% underweight, contributing to 42% of under five deaths in the country (MNCH Road Map, MoH, 2011).

As highlighted in the MNCH Roadmap, despite years of implementing the Expanded Programme on Immunisation (EPI), Integrated Management of Childhood Illnesses (IMCI) and nutritional supplement programmes, progress has not taken place at a rate sufficient enough to meet the MDG targets by the year 2015.

## 5.8 The Revised Strategy of Maternal, Newborn and Child Health

MNCH serves as a measure of two elements in public health: firstly, as a measure of the performance of the health system itself, and secondly as a measure of the state of population per se. It is against this rationale that the main theme of the JAR is being approached in this report.

Programmes under MNCH such as EPI, focused antenatal care (FANC), postnatal care (PNC), early infant feeding (EIF), IPT, bednet coverage, and clinical care standards are being implemented with varying degrees of success. An assessment of the previous Strategic Plan states:

*“the previous implementation of maternal, newborn and child health programmes by the Zambian government was confronted by many challenges that included: (i) unpredictable, inadequate and un-sustained political will, (ii) inadequate and short – term financial resources (iii) poor coordination and “handovers” among partners, a weakened health system, with weakened referral systems and absence of emergency systems for handling obstetric, neonatal and child health emergencies (iv) poor logistics for management of drugs, family planning commodities, vaccines and equipment. Over the years, this has been made worse by a shortage of human resource, brought about by a combination of low HRH development, ineffective management practices...Other factors that prevented attainment of high outcome coverage rates include (a) high medical bias in programme implementation and (b) unclear policies governing relevant professional practice environments and task-shifting approaches.”* Ministry of Health (December 2011).

Some of these challenges were: a) an inadequacy of skilled health workers. The stop gap intervention of recruiting and using trained traditional birth attendants (tTBA) failed to effectively reduce maternal and neonatal mortality: approximately 23% of women were being attended to by tTBA and about 46% by skilled health workers; b) coverage and access to health care services in the rural areas, which are a critical barrier to immediate and effective management of pregnancy conditions and child birth. It is estimated that only 60% of pregnant women are able to have at least four FANC visits; c) the referral systems, communication and transportation continue to be poor, resulting in home deliveries. These issues are compounded by cultural influences which, in some cases, are a barrier towards seeking timely care by skilled workers (MNCH Roadmap, MoH 2011).

The Roadmap emphasises the need for a comprehensive and strengthened SWAp arrangement and commitment to the GMCSP for systems strengthening and resource mobilisation purposes (MNCH Roadmap, MoH, 2011). It, therefore, endeavours to do the following:

- Avail skilled attendance during pregnancy, child birth and postnatal period at all levels of the health care system
- Strengthen the capacities of individuals, families, and communities, line ministries and the private sector to share responsibilities
- Provide a package of interventions in childbirth and postnatal period, provide delineation of mother and child (postpartum and neonatal periods) to avert 70% of likely deaths, support preventive adolescence and pre-pregnancy complications.

## 6.0 FINDINGS

### 6.1 Maternal, Neonatal and Child Health

#### *Performance Factors Driving the Success of the Programme*

The most significant development in MNCH was the restructuring of the Ministry of Health in 2012, resulting in the relocation of all MNCH and Levels 1 and 2 service delivery (including the district health system) to the Ministry of Community Development, Maternal and Neonatal Health (MCDMCH). Its rationale is to integrate health service delivery with Community Development and Social Welfare, and intensify primary health care/outreach in through the synergies provided working with community structures.

The Government's five-year MNCH Roadmap was also finalised, a critical policy commitment whose aim is to accelerate reductions in maternal, newborn and child mortality to enable Zambia attain its 2015 Millennium Development Goal (MDG) targets. Its theme, "A Promise Renewed on Child Survival", places additional emphasis on the importance of an effective continuum of care (from adolescence through pregnancy and into childhood). If comprehensively implemented, it will attain its specific objectives to: a) provide skilled attendance during pregnancy, childbirth and at postnatal level; b) strengthen the capacities of individuals, families, communities, line Ministries and private sector to share responsibility and play their role in helping to significantly improve MNCH outcomes for universal coverage to attain the set MDGs.

Improvements were noted in MNCH service delivery in 2012: a general increase in the number of nurses and midwives at facility level (e.g. from 425 in 2011 to 795 in 2012 in the Copperbelt) contributed to a notable increase in skilled deliveries at facility level and increasing uptake of institutional MNCH services. The increase in uptake was further enhanced by the abolition of user fees. Improvements have also been realised in child immunisation (with many districts exceeding their annual targets), Focused Ante-Natal Care (FANC), Post-Natal Care (PNC), and the training of Safe Motherhood Action Groups (SMAGs). SMAGs are collaborating effectively with District Health Management Teams (DHMTs) to encourage women to return to the facilities for PNC; this has been problematic in previous years, and more still needs to be done to ensure that newborns are receiving critical immunisations. Classified Daily Employees (CDEs) have been trained to take on more roles, such as monitoring in labour to alleviate some of the staffing shortages.

Progress has been made in HIV service delivery. Provision of antiretroviral therapy (ART) and Prevention of Mother to Child Transmission (PMTCT) were delivered in line with set targets. 84,000 were initiated on PMTCT against a target of 67,000. There are more women accessing antenatal care (ANC) and testing for HIV with opt-in rates averaging almost 100% (MoH, HIV data 2012). This has led to a provision of a better entry point for PMTCT. Partner Initiated Testing and Counselling (PITC) is working very well in paediatric wards, contributing to more children receiving ART. Although there were some stock outs of ARVs experienced, the overall supply was not sufficiently adverse as to negatively affect service provision. Commodities were generally in very good supply, with stock positions the range of 70-95% for MNCH tracer medicines. The assessment noted the increasing share of budgetary allocations for medicines and medical supplies

**Box 1: Documented MNCH Quality Improvements at Facility Level****CHINSALI DISTRICT - MULANGA MISSION HEALTH CENTRE***(72 km from Chinsali)***Services offered**

- *Laboratory diagnosis which some of the leading diagnosis undertaken include malaria, TB, RPR, CD4*
- *FANC, PNC and deliveries with the facility experiencing about 3-4 deliveries daily or an average about 35 deliveries per month, partographs are used in the management of cases.*
- *In-patient and Outpatient (average visits per day)*
- *Other Services that were areas of focus in 2012 focus were PMTCT, VCT, preventative, measures for infections in collaboration with CHAZ, ART ( HIV, ART clinics held every Friday, SMAG awareness in the communities, 100% expectant mothers screened and started on prophylaxis.*
- *Inpatient wards: male (empty), female (empty), children's (2 kids), PNC, maternity (1 woman)*
- *Vaccination programme for women and children*
- *Health promotion and prevention outreach programmes*

**Staff**

- *3 staff (2 EN, 1 EM, 2 clinical officers, 5 CDEs, accountant, 1 laboratory technologist, including locally-trained staff (CDEs).*
- *no MD in 2012*
- *no staff on retention scheme, though they qualify*
- *2 nurses are Sisters of Charity*

**Infrastructure, equipment:**

- *All essential equipment available all working: suction machine, resuscitator, oxygen concentrator, incubator, emergency trolley, hand washing, toilets/showers, machine to make several delivery packs.*
- *National grid power supply and solar panels (lights, fridge, and possibly equipment)*
- *Noted labour ward very clean and well maintained*

**Drugs**

- *Well stocked, use extra funds from private donations to supplement if necessary, storage in good condition with air conditioning; no shortages. Run by a nurse who has no pharmacy training. Do not stock or provide family planning.*

Child health improved notably: most districts exceeded their immunisation targets achieving over 90% coverage, and uptake of under-5 services continues to be high. Incentives, such as allowing fathers who bring their children in for under-5 services to go to the front of the queue, are promoting dual parental responsibility for children while also prioritising child health.

**Picture 1: Paternal uptake in under-5 clinics is being promoted at community level**





Beneficiaries interviewed in the two sampled provinces expressed general contentment at the level and quality of care for under-5s at facility and community level, where health staff seem better equipped to provide these services.

Improvement has also been noted in infrastructure: for example, in Ndola, many facilities have taken the initiative to build new toilets, renovate existing buildings to more ably cater to expanding communities, and construct mothers' waiting shelters. These are critical in ensuring women's timely access to institutional deliveries. There is also more recognition for the need for larger maternity wings and labour wards.

### Gap Analysis and Factors Negating Success

Improvements in performance were limited predominantly by a critical shortage in human resources, and this is most evident in facilities' ability to effectively deliver timely and quality maternal health services. A significant proportion of health facilities remain with unfilled establishments and insufficient staff. In Nakonde district, communities spoke of Classified Daily Employees (CDEs) who are unskilled administrative staff assisting with maternal deliveries: this practice should be discouraged. This is to alleviate the pressure on health workers who are overworked, overburdened and unable to provide the required attention to patients, resulting in some cases of delayed attendance and reported negligence. Should these human resource gaps remain unfilled, gains made thus far in scaling up institutional deliveries will be grossly compromised.

#### **Box 2: Observation about quality of nursing care in MNCH**

*"I didn't have a birth plan when I came to this facility to deliver my baby. I wasn't monitored by the nurse on duty when I was in labour. I ended up spending the night on my own. When she came in to see me, she forced me to push before I was fully dilated. But I couldn't. I wasn't ready. It was a difficult labour. She could have made me lose my baby."*

Mwaka, 27

Training in emergency obstetric care (EmONC) and supervision need to be intensified, especially in health facilities which have very basic infrastructure. Supervision at all levels, particularly monitoring the correct and consistent use of partographs in all health facilities, is a priority.

District-level disbursements in the health sector in 2012 declined partially, resulting in the reprioritisation of activities at district level: amid the rationalisation of funds, fewer resources are being committed to maintenance or procurement of vehicles, particularly ambulances and motorcycles. This has a potentially devastating impact on referrals of complicated maternal cases, and could be encouraging home deliveries. The rate of improving equipment and transport is worryingly slow. There are facilities without any basic emergency and obstetric care equipment; if not addressed, this will decelerate any progress in reducing maternal and newborn mortality.

There has been a relative expansion in infrastructure, where communities are collaborating with the health facilities to contribute to basic renovations or construction of maternity waiting shelters. Further, there is still a shortage of maternity wings, or a desperate need to renovate them to permit more privacy during childbirth. Where there are no shelters or maternity wings, fewer women are arriving

before the onset of labour, increasing the risk of complications during childbirth or delivering at home.

**Picture 2: Flooded roads and broken down ambulances make access very difficult**



Women are being discharged in some facilities after six to eight hours due to bed space constraints; there is urgent need to ensure that facilities have adequate beds to accommodate mothers before and after delivery, which will enable closer monitoring of potential post-natal complications.

The stocking position of vaccines during the year under consideration was erratic. There were notable stock-outs of OPV and DPT3. The budget for vaccines may be managed adequately given that this budget line continues to generate external support. The gaps in quantification (discussed later in this section under Infrastructure, equipment and transport) require firming up, and the guidelines will need to be based on more critical assessment of the quantification process. Similarly other aspects of the supply chain management (resource mobilisation, financing and procurement) plan require will more detail and clarity.

Zambia's unmet need for modern family planning (27%) is high. It is evident that long acting family planning methods (LAPM, e.g. IUDs, Jadelle) are being effectively provided by health facilities. Although community-based distribution agents (CBDAs) have now been trained to administer short-term family planning methods, there is inadequate data on uptake for contraceptives, or on preferred method mixes. Provinces are not actively collecting family planning data from private providers, thus undermining the opportunity to effectually address where the needs are. MCDMCH is expected to work closely with Medical Stores Limited (MSL) to robustly track distribution and usage.

**Box 3: Sex, drugs and cross border trade: is uptake of health care compromised in border towns?**

*Cecilia, 56, has lost four of her eight children – she now looks after five of her orphaned grandchildren. She assists as a volunteer at Kakoso Health Centre in Chililabombwe district, and speaks of the challenges of encouraging her granddaughter to access antenatal health care:*

*“My granddaughter is young, but she’s already married. I noticed that she was putting on weight and asked if she was alright, and she said yes. I kept asking and she kept denying it, although I knew she must be expecting. Later on I discovered that she was pregnant, but she was hiding the pregnancy from her husband. We asked her why and she said that the*

*pregnancy wasn't her husband's. She had not been for ANC and she had been tying her stomach to hide the pregnancy from her husband, can you imagine? She could have hurt the baby."*

*Although this case is not representative of the national picture, discussants in this district highlight an increase in rates of early pregnancy, as well as in multiple partnerships – even within marriage. Rapid population growth in Chililabombwe follows the recent opening of Konkola Mines, which has brought with it burgeoning cross-border trade, a mushrooming of informal settlements (specifically the PPZambia: Poor People's Zambia settlement close to the border with the Democratic Republic of Congo, DRC), and an influx of foreign traders in local communities.*

*Statistics on age of sexual debut or preferred method of modern family planning methods in this border town are not readily available, nor is there data on the incidence of sexually transmitted infections: according to medical staff, this is rising mostly due to transactional sexual exchanges between young women and older tradesmen along the border. In a town where the symbiotic relationship between truckers and sex workers thrives, it is observed that people who eventually become infected prefer to cross the border into the DRC to purchase medication.*

*"Rather than come to Kasumbalesa Health Post where they would be counselled and tested for HIV and any STI and then treated, for some reason people cross the border and buy antibiotics and other drugs that are sold illegally on the streets. Maybe they want to avoid the stigma of HTC, so they self-diagnose and self-medicate. They don't even know if the drugs they're buying are real, or if they're the right drugs to treat their infections, and sometimes they end up spending more money on these drugs as they get more and more sick, then they come to the health facility when the STI is well advanced," says a nurse at the health post.*

Community volunteers are working well to ensure the prioritisation of nutrition, particularly for pregnant women and children under 5; all facilities are measuring for malnutrition (weight for age) especially among HIV-exposed children. However, there is a need to intensify nutrition monitoring: more nutritionists are needed at district level to provide support, demonstrations and information; and to encourage facilities to monitor stunting (height for age), which has a critical and long-term impact on childhood development.

ART targets were on track in 2012; however, a temporary stock out of paediatric Nevirapine solution was experienced in several districts, resulting in a momentary break and reconstitution of treatment to children, which could potentially impact on the efficacy of paediatric ART.

#### **Box 4: Perceptions of child health services, Kakoso Health Centre**

*Child services are generally well delivered in health facilities, and are appreciated at community level. Health education is following the continuum of care, being provided to pregnant women attending antenatal care, right through to under-five services. Health facility staff are skilled and supportive, and the quality of care is high.*

*Opinions of out-patient care, on the other hand, are mixed. Parents feel that hospital personnel take too long to attend to paediatric cases, particularly those that arrive during the night. Expectations that a child in critical condition will be taken to the front of the queue are not met, and communities concede that this must be addressed to minimise child mortality.*

*There is also a general expectation among communities that children presenting with fever should be administered with malaria treatment, even where malaria tests have come back negative. A women-only focus group at the health centre observed that they have had to buy*

*SP from private pharmacies after their children's fevers did not improve, even after being provided with only Panado at the health centre.*

*One mother said, "These people just prescribe Panado for different ailments. For anything, they give Panado. One comes with a cough, they get Panado. The other comes with a fever, they get Panado. Are they really picking up what the children are suffering from?"*

*There is a clear need for better communication between the health provider and the patient, where the provider is mandated to explain the diagnosis and corresponding treatment, and the patient is empowered to follow up. This would avert unnecessary procurement of privately sourced drugs and improve uptake of institutional care.*

Inconsistent distribution and utilisation of insecticide treated nets (ITNs) was a challenge. Few cases were recorded of receipt of ITNs in under-5 or ANC; this is critical for the prevention of malaria which is in the top 3 disease burdens in the country.

Post Natal Care (PNC), while improving, needs to be scaled up. District structures and community volunteers are operating effectively to encourage more institutional deliveries, but more needs to be done to ensure that women are returning with their newborns, particularly for BCG vaccines. For example, when women are discharged from Kakoso Health Centre, their newborns' under-5 health passports are retained at the facility until the mothers return with their babies for their BCG vaccines. As a result, women are bringing their babies back for their 6-day check up and first immunisation.

## Thematic Areas

### 6.2 Health service delivery

Notable gains were realised in prevention and promotion activities, education and community mobilisation, resulting in a general increase in uptake of institutional services. As previously highlighted, unprecedented progress was made in child immunisation.

In addition, the status of Emergency Medicines and other Medical Supplies (EMMS) was improved markedly, with few incidences of stock outs and mostly timely delivery to facilities.

As highlighted under MNCH, MoH's HIV programme saw distinct improvements in 2012:

- 415,000 people have been initiated on ART on a cumulative basis, against a target of 438,000. A cohort analysis of drop-out rates for ART clients from 2011- December 2012 indicated that 80% were still on treatment
- 8 million male and female condoms were distributed against a target of 5 million.
- 84,000 women were accessing PMTCT exceeding the target of 67,000.
- 176,000 people were screened for sexually transmitted infections (STIs) against a target of 225,000. This decline is an indication of progress, and confirms the efficacy of new interventions (including advocacy for male

circumcision and HIV testing and counselling) in reducing new infections. It is evident that early and syndromic management of STIs are anchors for effective treatment

The removal of user fees has contributed to an increase in uptake of facility-level care, thereby improving access to the poorest and most in need. Mobile services are seen to successfully complement hospital services; however, due to the costs to the system (financial, human resource and infrastructure/transport), it is not always perceived to be the most cost-effective way of providing care.

**Box 5: Community perceptions of general health services, Chimwemwe and Chibolwe clinics, Kitwe**

**What is working**

*“Cleanliness inside the clinic has improved.”*

*“There is an improvement in outreach services.”*

*“Community volunteers need to be compensated: they do a lot of work and get nothing for it.”*

*“The community volunteers go into the community to find TB cases and ensure they follow treatment. This is good.”*

*“HIV counselling and testing are OK, so is ART.”*

*“ART medicines are available and stigma for treatment is better.”*

*“Babies get referred when it’s needed.”*

*“The clinic has good outreach for immunisation and HIV.”*

**What is not working**

*“Nutritional support for children has decreased.”*

*“There is no change – things are worse than ten years ago.”*

*“In 2009 there was a doctor here.”*

*“Medications should be available at the clinic. Patients should not have to travel to buy medicines.”*

*“Service delivery is deteriorating as the years go by.”*

*“The clinic is too small for the numbers seen here.”*

*“Lab hours need to be increased. If you need a lab test, you must be here by 06.00 hours. The lab is only open to draw blood from 06.00 to 08.00 and you have to stand in queue to get the blood drawn.”*

*“This clinic should be upgraded to a hospital, this clinic serves the second largest compound in Zambia. There are over 50,000 people in the catchment area and we have only one clinic to serve the population.”*

Several facilities highlighted the availability of essential medicines, averaging at least 80%. The private sector is collaborating effectively in scaling up health services; for example, mining companies in the Copperbelt often provide treatment and care for urgent referral cases from the health facilities.

### Assessment of Existing Gaps

Tertiary and secondary level health services are working under severe stress as evidenced through the congestion of inpatients and the long waiting times and crowding at the filter clinics and outpatient services in general. This reflects in a relative measure of high unmet need for health care services. Furthermore, according to the classifications of minimum standards for secondary hospitals, there should be a minimum of four specialists, yet, in some cases there are no specialists, compounding the issue of unmet health care need.

In spite of the progress achieved in STI management, fewer cases than projected are being presented. While this could be attributed to improving sexual behaviours and better education, it also implies lower levels of detection or increases in self-diagnosis/treatment. There is still a need to intensify training in STI detection, management and treatment, which will, in turn, complement progress in the HIV programme.

The country has three PCR machines, but there are still delays in access of samples from household to facility and back. Investments in courier services have been compromised by cessation of some courier routes. Procuring additional viral load machines would address this gap.

Several ART clients are being lost to follow up, or drop out of treatment for socio-cultural reasons. There is strong evidence of religious beliefs, immune boosters, claims for cures, and traditional/alternative medicines being the major determinants of non-adherence.

#### **Box 6: Have user fees really been abolished?**

*"We just hear that user fees have been removed. We don't know if that's really true. We don't pay for child services and that's good, but we have to pay for delivering our babies in this facility. If we having to pay for some things but not for others, have user fees really been removed? I came here without any money to have a baby, and then I was told to pay Kr2 for gloves, and Kr5 for a cord clamp. On top of that I was told to pay Kr2 for examination. I wasn't prepared.*

*"The same thing happened to my friend who delivered twins here. She had already paid the Kr2 for the examination and other things, then she was told to pay extra for the other baby. Was it her fault for having twins? How do they expect us to afford to pay for deliveries, especially if services are meant to be free?"*

*Grace, Kakoso clinic*

Stock outs of specific supplies (TB reagents and slides, rabies vaccines, paediatric Nevirapine solution, SP, Rapid Diagnostic Test kits, and Coartem) hampered the timely delivery of critical services, including IRS chemicals which subsequently delayed the programme by several months.

Many health services are centralised around Lusaka; however, although the range is wider, the quality of care is often lower than in non-urban settings. There is need to evaluate the disparity between health service allocation and quality of care.

It is acknowledged that mobile hospital services are an important avenue for scaling up access to health services, particularly for hard-to-reach communities; however, costs can be high and may draw critical staff from providing essential services at facility level. It is essential that a cost-benefit analysis is conducted to determine the viability of conducting mobile services.

**Box 7: Hospital and Mobile Services Provided and Total Costs for 2012**

*The mobile hospital services raise issues on the need to provide access to health care and improve utilization of health services. However, at the same time, in line with the health sector principle, questions around priority setting and resource allocation have to be addressed to ensure that there is a balance between socio-political objectives and socio-economic objectives for maximizing health outcomes at the most affordable costs. During the first full year of operations, the following scenario has emerged:*

*“The mobile extension services have been an eye opener to the demand for health care services and how underprovided services are...however as a (2<sup>nd</sup> level) hospital we operate like a large health centre”....[Due to the lack of specialized services, maintenance, equipment]*

*Conditions attended to through Mobile Hospital Outreach Services:*

*Cost: Kr1,200,000.00*

*Visits: Approximately 22,000 for 2012*

**Constraints:** *Low batteries for BP machines, record keeping is difficult, stock-outs of drugs and supplies, no reagents for chemistry and haematology analyzers, faulty x-ray equipment, laboratory motor vehicle faults, and missing equipment.*

### 6.3 Health Work Force (Human Resources for Health)

The availability of Human Resources in Health (HRH) generally improved in 2012. More nurses and midwives were deployed to district facilities. Communities highly commended the quality and efficiency of child health services, adding that staff were usually available to attend to their children. The Government's commitment to strengthening HRH in 2012 is evident in its finalisation of the Health Workers' Retention Scheme and the HRH Strategic Plan; the National Operational Training Plan is underway, and a positive drive to take forward a comprehensive strategy for Community Health Workers was initiated – this is a critical cadre that will assist in plugging the HR gap at household level. There is a marked improvement in the availability of HRH. There has not only been an increase in staff numbers, but so too is the mix of different cadres, such as laboratory technicians, pharmacists, pharmacology technologists and nurses.

An increase in enrolments in training schools has seen a corresponding improvement in outputs. The number of tutors has also improved, as has the range of courses offered. For example, Lusaka Nursing Institute introduced training for clinical officers in 2012 (having initially only provided training for registered nurses when it opened in 2005: currently 132 COs and 226 nursing students are registered).

## Assessment of Existing Gaps

In spite of the increased deployment of nurses and midwives in 2012, there are serious gaps in HRH. For example, establishments are deemed to be insufficient and do not match the actual numbers of staff in facilities. Furthermore, the confirmation, appointment and redistribution of staff having outstanding and unresolved issues, leading to a worrisome situation limiting health care access and utilisation. The incentive structure appears pervasive and fragmented in both approach and practice, bringing about ongoing levels of demotivation in staff. Staff absences (study leave, vacation, training) when not properly planned have serious implications on the timely submission of reports or service delivery.

### **Box 8: How is staff performance assessed at district level?**

*“We have an annual appraisal of performance which is confidential. We recently adopted a new appraisal system called APAS. We use our annual plans and we’re graded according to performance and achievement of our management objectives. When there are complaints against health workers, action is taken against the individual. For example, there were complaints of negligence against a nurse in Chimfushi – the nurse was negligent and a baby died. Procedures were followed and sanctions were applied.”*

DHMT staff, Chililabombwe

Many staff are typically working long hours, manning facilities with limited staff, and are unable to attend to patients’ needs. This is further compounded by the population increases per facility, compromising the ability of the service providers to deliver a high calibre package. Although community volunteers provide some assistance (e.g. basic administrative support, education and sensitisation), they are unskilled and cannot provide essential clinical care. They are not a substitute for skilled professionals.

Health workers expressed concern about an unequal distribution of staff, with the hardest-to-reach sites being the least equipped with the necessary staff. Many posts are dependent on nurses-in-charge or clinical officers, and do not have doctors; this shortage, combined with a shortage of functional basic equipment, is straining those facilities that receive referrals from other sites. In addition, staff felt that incentives were inconsistently applied with no clear formula on how they are applied.

The scale and expansion of training schools is not in tandem with the existing human resource needs: as demonstrated in Figure 4 (rates of graduating students per cadre), insufficient levels of doctors and clinical officers are enrolling and graduating to effectively plug capacity gaps. There is a need review levels of investments into human resource development for the specified cadres. Training institutions experienced four major challenges in 2012:

- insufficient funding, hampering their capacity to increase student intake and deliver the required training;
- a shortage of funding, compromising their ability to retain tutors;
- the high cost of student fees, resulting in high levels of drop outs, or students who proceed with their courses with loans obtained from the training institutions
- Inadequate infrastructure (i.e. classrooms, residences) and supplies (training aids, materials)



The Community Health Worker cadre, as already detailed earlier in this report, is critical to alleviating the constraints in skilled human resources and was originally led by MoH: since the restructuring, it is unclear whether MoH or MCDMCH will take the strategy forward and implement it.

**Box 9: What functions do community structures perform in programme implementation?**

*“Neighbourhood Committees are in place and they’re giving input into planning, but recently they haven’t been very active because they don’t have incentives. The Community Health Volunteers aren’t paid. You’d be surprised that all they’re asking for sometimes is just a simple badge or even a branded t-shirt or chitenge, just so that they can be easily identified when they go into the communities.*

*“For those who have the more difficult job of travelling from village to village, they need basic transportation like a reliable bicycle. A motorcycle would be even better, but they’re expensive to maintain and they break down a lot, so a bicycle would be just as good. But they don’t have these, so they don’t perform any functions.*

*“You’ll see that the same ones who are refusing to work without a t-shirt become active when they’re funded by projects. This is unfortunate because they play a very important role. Their focus is on household level and they’re a major pillar for primary health care and sensitisation. Something has to be done.”*

DHMT staff, Chililabombwe

## 6.4 Health Information Systems

Health information systems are working well, with high levels of districts providing timely reports to Provincial Health Offices. Community volunteers are also providing support at facility level where HR gaps exist, by assisting with filing and recording patient inflows and outflows.

In addition, the General Nursing Council and Health Professional Councils introduced databases in 2012 to track relevant skilled health personnel, including those actively working or not working in health service positions, as well as retirees.

### Assessment of Existing Gaps

The greatest impediment to the efficiency and validity of health data is the realignment of functions between MoH and MCDMCH: there is no transition plan to ascertain how data will effectively be managed by two separate Ministries, and this will impact on the quality of national level data. Basic systems (network connectivity, technical staff) have not yet been implemented in MCDMCH for the migration of critical data, and it is unclear where the ownership currently lies. The realignment has also created multiple levels of reporting, where data will now have to be collated for the two different Ministries, and Provincial Medical Officers (PMOs) will report to three different Permanent Secretaries.

Although health surveillance committees conduct surveys, customer satisfaction questionnaires are not being done.

Districts are heavily dependent on Information Management Officers for health data returns: where these officers are absent (e.g. on training or vacation), returns are delayed or incomplete.

While health facility data is mostly readily available, information is not actively being collected from non-Government providers (such as private providers or military facilities). For example, information on family planning commodities provided by private facilities is unavailable at MoH, presenting a major shortfall in data.

Reliable, consistent and valid data are three elements determining the relevance of the data. This appears to be a concern of the existing HMIS data. In one instance it was observed that the discrepancy in the data collected and reported to the PHO had a difference as high as 70 per cent between the actual data from source documents and what was actually reported following a data audit that was undertaken. While the problem may not be perverse in the system and a national wide audit may not be feasible, it raises the spectre that it is a concern.

## 6.5 Access to Essential Medicines and Other Medical Supplies

The budgetary allocation for Essential Medicines and other Medical Supplies (EMMS) has been characterised in the last three years by a steady increase while the districts and hospitals have confirmed good commodity security. The drug ordering system is functioning sufficiently well, and this is balanced by an increase in the staffing position of pharmacists. Medical Stores Limited (MSL) had sufficient supplies which were mostly deployed on time to facilities.

The efficiency of Drug and Therapeutic Committees (DTCs) is mixed: In some facilities and districts these exist and do some work while in others they are non-existent. It is essential that their mandate is standardised to ensure their role of technical oversight in promoting rational drug use and pharmacovigilance as well as reviewing and updating treatment guidelines is actually taking place effectively.

### Assessment of Existing Gaps

The Essential Medicines Logistical Improvement Plan (EMLIP) programme was developed and piloted with the intentions of ensuring minimal lead time between ordering and receiving of commodities through the functionality of a pull system. However, the pilot appears to have been unsuccessful and contributed to intermittent interruptions in stock levels in 2012, such that the “push” system of drug kits had to be re-introduced in all the 27 districts in which EMLIP had been scaled up. Currently EMLIP continues to exist in these districts alongside the kit system, leading to a dual supply chain management system in this regard. It is not recommended that EMLIP is continued, while a more efficient strategy and operational mechanism is identified.

#### **Box 10: Overview of Kitwe Central Hospital's MNCH services**

*The field visit to Kitwe district revealed a growing population, driven predominantly by the copper industry and expansion of mines. Incoming populations are creating additional strain on already stretched health systems, and facilities' outpatient departments are constantly*

overflowing. However, Kitwe Central Hospital is providing essential services, even amid the challenges of limited human resource and excessive demand.

With 3 to 4 trained midwives based in the labour ward during the day and a minimum of 4 at night, the hospital delivers between 300-400 babies each month. Caesarean section rates are high, and 15 maternal deaths were registered in 2012: this is attributable to Kitwe being a major referral hospital, where many maternal cases arrive in the advanced stages of complicated labour, and the lives of both mother and baby are severely at risk. This underscores the critical challenges of the referral system, where unreliable transport and communication systems frequently fail the very populations they are meant to serve. This is compounded by a shortage of skilled attendance at the facility level, many of whom will be attending to other deliveries at any given time.

Staff in the hospital make the following recommendations:

- Invest in the construction of a maternity annex for increased space, for MNCH education and to enable for more privacy for counselling and family planning
- Increase the establishment for midwives. Most nurses would like to be trained as midwives, but are demotivated because there would be no compensation if they were
- Provide ambulance services for incoming referral cases; this applies too to returning patients, many of whom live far away from the hospital and rely on its transportation. Where there is no ambulance to take them back home immediately, they stay on at the facility for up to five days, occupying much-required space for other ill patients
- Offer training and updates for nurses providing emergency obstetric care (EmONC) and the integrated management of childhood illnesses (IMCI) care: these nurses are filling the gaps created by the shortage of medical doctors, and require the training in order to provide quality care.

It was noted that the value of expired medicines was as high as 25 per cent of the stock position in some facilities in the Northern province. This level of value of expired drugs may inherently be as a consequence of the duality of the systems in combination with the human resources and planning systems that remain notably weak. The case for addressing these elements of the supply chain and logistics system cannot be further emphasised.

The areas that require to be strengthened included the related function of procurement staff, procurement systems and procurement planning. The constraints related to the availability of pharmacists and pharmacy technologists continue, with some districts and health facilities not having the services of either staff cadre. Procurement officers continue, as well, to be in short supply. The mix of these two professional categories affects the entire supply chain through planning, resourcing and appropriate stocking on one part, while the availability of resources and procurement activities impact the supply chain from the other side.

The GMCSP categorically states the need to ensure that the gaps in procurement systems and human resources are bridged as quickly as possible, which will have a direct bearing on the performance of the sector, such as improving the accountability and transparency of resource use, leading to better results achievement.

There continues to be an environment of ambiguity surrounding the roles and functions of Medical Stores Limited (MSL). Part of this appears to stem from the uncertainty of the supply chain and logistics management systems in existence which have yet to be resolved, the other comes from who the managers of MSL ought to be; other uncertainty arises from the additional and new functions that are being proposed for MSL such as procurement in addition to its traditional functions (storage and distribution). In addition to all this is the new investment proposed for MSL which is the addition of new storage and re-distribution centres at the provincial levels.

Contracting out the functions of MSL by MoH may be an ideal way to proceed. However, the process – including the recruitment of senior managers and the awarding of contracts – has to be guided by a transparent and accountable process and criteria which all stakeholders should be agreed to. Furthermore, an extension of this discussed under Governance and Leadership conforms with the decentralisation goals of the Government and the sector.

## **6.6 Health Care Financing**

The health sector experienced an increase in its national budgetary allocation from ZKw120 billion in 2010, to ZKw208 billion in 2012, and a resumption of Cooperating Partner (CP) confidence. The Government has taken seriously implementation of tighter fiduciary controls and accountability mechanisms, as evidenced in the 2012 GMCSF agreement between GRZ and CPs following the financial irregularities which were uncovered during 2009.

A piloting scheme of Performance-Based Financing shows improvement in attitudes, results and management in contracting. The flow of district grants remained unchanged in 2012, although disbursement levels were lower than in previous years.

### **Assessment of Existing Gaps**

Disbursements in 2012 at district level have been lower than in previous years (see above), resulting in reprioritisation of activities. Subsequently, programmes such as environmental health have been sidelined or deferred in order to finance other activities. In addition, fewer CPs are committing funding to the basket, preferring to finance the sector through General Budget Support (e.g. DFID, SIDA) or through earmarked projects.

A combination of delayed disbursements and the prevalence of vertical funding is distorting districts' ability to effectively plan, account for and implement programmes. Where not properly managed and overseen, funding to earmarked programmes is increasing inefficiency among the implementing partners by diverting their time and resources away from mainstream sector priorities. The draft Memorandum of Understanding reiterated the well known inefficiencies in resource use and the structural ineffectiveness rendered through the existence of vertical programmes. Some donors continue to provide support through vertical programming and management without due regard to the weaknesses that is induced to a fragmented and weak health system. Whether funding is provided through Government or discretely through projects, it is essential that the basic tenets of health systems strengthening (HSS) and coordination are observed.

In other cases, delayed funding disbursements have impacted negatively on programme implementation. For example, late funding for the indoor residual spraying (IRS) meant that this critical component of the malaria programme result did not commence until well into the rainy season, several months after the anticipated date, increasing the risk of incidence and resistance to malaria treatment. This is significant, as malaria is one of the top five leading causes of morbidity and mortality in Zambia, contributing to about half of under-5 mortality.

Stock-outs were also recorded for Nevirapine paediatric solution, TB reagents and slides, SP, rabies vaccines, Rapid Diagnostic Test kits, and Coartem. The concept of

a 'one stop shop' is not working well if patients are required to either source drugs privately, or to return to the facility at a later stage when drugs are expected to be available.

Further, following the country's positive classification as a lower middle income country, some civil society organisations have experienced a decline in funding from their off-shore donors, as the donors cannot justify the expenditure.

## **6.7 Leadership and Governance**

### **Policy**

Several significant policy documents were finalised in 2012, including the Memorandum of Understanding (MoU) between GRZ and Cooperating Partners; the Governance and Management Capacity Strengthening Plan (GMCSPP 2012-16); and the National Health Policy. All are symbolic of renewed commitments to the health sector with the partners following strained relations in 2009 as well as the Government's own pursuit and recognition of the health sector as a core service area. However, the effectiveness of these commitments will only be evident in the extent of their application and implementation and in their ultimate objective of strengthening the health sector; GRZ has the opportunity to demonstrate its commitment to prioritising reform at all levels.

The reconstitution and rationalisation of Technical Working Groups (TWGs) also provides the opportunity to streamline information sharing and transparency, and enhance efficiency in decision making and mutual trust.

### ***Realignment of Sector Functions – District Health Services***

The realignment of MoH and MoCDMCH was the single most important policy announcement of 2012, whose objective was to improve health sector efficiency and reduce levels of morbidity and mortality. The focus on primary health care is intended to reprioritise decentralisation and provide services to those most in need at household and community levels, particularly in maternal and child health.

Maternity and child health are a priorities at community level, with strong drives from both facilities and community volunteers, who are using innovation to emphasise their significance. There is clear buy-in for the new Ministry to take on MNCH as a focus area, although there is recognition that additional sensitisation among partners both at central and district level needs to be provided to clearly explain partnership roles and opportunities.

### ***Assessment of Existing Gaps***

#### ***Policy***

While there is a general recognition that the GMCSPP is a necessary and important policy document, there is less clarity among stakeholders of its implications beyond central level. The GMCSPP is perceived to be more policy-focused than service-oriented, and is ambiguous about its applicability to the NHSP or to annual action planning. Further, some civil society organisations felt insufficiently consulted during its development, pointing to the heavy role played by the CPs in taking it forward; there is, therefore, room for greater ownership of the GMCSPP as a concrete cross-sectoral priority.

The TWGs are not meeting frequently (except for M&E), thus negating their mandate of promoting transparency, information sharing and policy guidance. This is a critical bottleneck, as there are few other avenues in which to take forward matters of significance in the sector. In addition, planning for core annual activities – particularly Joint Annual Reviews – is erratic. While this is an opportunity to highlight the sector's successes, there are frequent delays or postponements of activities, and there is need for reprioritisation of this process if stakeholders are to participate in full.

### **Realignment**

A tangible transition plan between MoH and MCDMCH has not yet been developed or implemented, creating ongoing confusion about the mandate for planning, accountability and ownership for specific aspects of service delivery. For example, District Health Management Teams (DHMTs) were aware of the restructuring, but continue to conduct 'business as usual' as no explicit guidance has been shared as to what has or will change. In particular, reporting and monitoring need to be rationalised in order to minimise the risk of double-counting, which could affect the viability of the HMIS and other data sources.

Clarity is absent on where the ultimate mandate for planning, budgeting, implementing, monitoring, and reporting lies for primary health care and district level functions; MCDMCH should have assumed this responsibility in 2012, but many of these functions remain firmly rooted in MoH. This could be due in part to insufficient technical capacity in MCDMCH, but as highlighted in the Health Information Systems analysis, action must be taken to bring the MCDMCH systems and personnel up to speed.

There is need to ensure that parallel systems are not being created at field (provincial, district) level; reporting lines must be very clear and specific with no risk of duplicating information.

#### **Box 11: Focus group discussion: Perceptions of quality of care in MNCH services, Chimwemwe Clinic, Kitwe**

*"I came to deliver my baby at 06.00 hours and I was having difficulty with the labour. I was told by the nurse to go by myself to deliver, then the nurse went to sleep. Finally by 01.00 hours I was referred to the main hospital to deliver. I came in because I was having complications, the nurses were negligent."*

*"Sometimes sick people must wait outside for hours to be seen by the nurse or clinical officer. I waited for six hours today. I was here at 06.00 hours. One has to get at the health centre early to be seen by the nurse. If there is a Medical Officer, they don't even come in until 09.00 hours. When I went to the clinic's pharmacy for Coartem they didn't have any. Now I will have to travel to another pharmacy and I have malaria, and I don't have extra money."*

*"We have been in meetings like this before and there still have been no changes or improvements. We get no feedback after we provide feedback after we provide information to MoH."*

*"There is need for staff improvements on attitude and compassion."*

*"Provide more trained staff – more midwives, more birth attendants."*

*"We need more nurses, clinical officers and 2 doctors. People can be waiting 6 to 8 hours to be seen."*

*“We need our own ambulance. If you call for an ambulance it may be far away and needs to travel even up to an hour just to reach you.”*

*“There is improvement towards children’s care, but not towards pregnant women delivering.”*

*“They need to train more traditional birth attendants.”*

*“There is a lack of information in the community regarding giving birth at the facility. Better education is needed.”*

The Government plans to pursue the implementation of the National Decentralisation Policy (NDP) in due course. Given its experience from being the first sector to have already rolled this out, the health sector is optimally placed to help guide this process, but it has not capitalised on this opportunity. If taken up, it would enable the sector to influence and capitalise on efficiency and meaningful collaboration with other line Ministries.

## 6.8 Community Participation: Demand and Access

Participation at community level is mixed: Neighbourhood Health Committees, Neighbourhood Health Advisory Committees and Safe Motherhood Action Groups (SMAGs) are evident and performing effectively in some districts (e.g. Nakonde and Kakoso). Many are collaborating with health facilities and communities to ensure optimal uptake of child health services, as well as with Trained Traditional Birth Attendants (tTBAs) to scale up women’s access to institutional maternal health services.

**Picture 3: Focus Discussion Groups during the 2012 JAR Consultative Process**



Communities are appreciative of the availability of drugs, (skilled) staff, and outreach programmes. In addition, the availability of PMTCT and ART services were noted as a positive development, impacting favourably on health service performance.

Hospices are providing specialist care to at least 2,000 terminally ill clients at a national level on a monthly basis, alleviating critical bed space in the health facilities. Communities recognise the need for increased training and provision of nutrition programmes. This will strengthen facilities’ ability to track nutritional outcomes and design the relevant preventive interventions, especially for stunting (height for age) and in chronically ill children under five.

## Assessment of Existing Gaps

Communities had reservations about the number of staff and their capacity to contribute meaningfully towards changing or improving health outcomes. They recognised the increasing burden on staff time as populations increase, especially along border districts. Strong reservations were communicated about staff attitude and quality of care, particularly with regard to adolescent and maternal health programmes and services.

The mobilisation, formation and development of community structures as a means of increasing the efficacy of interventions was observed to have lost some momentum in the past decade, according to information emanating from the field surveys and focus group discussions, particularly in the Northern Province. The safe motherhood groups and community health neighbourhood structures should continue to be a key strategic feature and activity of the primary health care services, in order to strengthen promotion and prevention interventions.

### **Box 12: How successfully is the system encouraging teen mothers to attend ANC and institutional delivery?**

*There are several constraints in getting more adolescents to attend antenatal care: many feel that maternal health services aren't youth friendly, and that they are stigmatised for being teen mothers. Respondents spoke of teens being told off by both health workers and other pregnant women for wearing tight clothing, trousers or leggings, or if they didn't wear a chitenge to antenatal clinic visits. Subsequently, uptake by teen mothers is lower than expected, creating a critical gap in mitigating the risk of mother to child transmission of HIV, vaccination of the mother, and monitoring progress of the pregnancy. Communities observed that even fewer teens deliver in health facilities, because they don't want other mothers to notice that they don't have new clothes for their newborns, or because they themselves can't afford the supplies or fees that they're expected to provide - even though user fees were abolished.*

*"I think there's a lot of competition among teenagers about how they look or what they wear. Some of them want to wear modern things like these leggings which are so fashionable these days. Others feel inferior and they're afraid their friends will laugh at them if their newborns don't have new clothes. So they don't come. We actually have to go around the communities and force them to come, and then we have to follow them up afterwards. It's not easy," says Mercy (29), an HIV+ community educator who encourages pregnant women to get tested for HIV.*

*Evidence proves that the inclusion of youth friendly health services (YFHS), both in facilities and communities, impacts on young girls' uptake of a range of services, including sexual and reproductive health services, family planning choices, and testing for HIV and STIs. This targeted mode of educating young people has a positive spill over effect on their decisions on when to get pregnant and how many children to have*

*More needs to be done to ensure that health facilities are providing YFHS; in addition, greater awareness of the risks of delayed antenatal care and PMTCT – particularly for HIV positive adolescents – must be undertaken at community level, with follow up provided.*

There is often confusion between the definition and functions of Home Based Care (HBC) and Hospices; in addition, hospices incur heavier costs due to their levels of specialist care, but funding from external sources is diminishing.



There is growing concern at community level about increasing levels of malnutrition among under-5s; health facilities are not measuring for stunting, and there are limited established nutrition support programmes with even fewer qualified nutritionists providing services.

Access to health services is impeded by long distances; although there is great demand for outreach or mobile hospital services, their operational costs need to be assessed. There is a greater demand for stationery health posts in hard-to-reach rural areas which would significantly improve access but also lighten patient loads in larger health centres. Communities also recognise the need for more efficiency in the provision of a range of services in one visit – a ‘one stop shop’ – rather than being referred to different units on different days.

## 6.9 Infrastructure, Medical Equipment and Transport

Construction of health facilities continued in 2012, although at a slower pace than the previous year under review. Some facilities are constructing mothers’ waiting shelters, easing pressure in labour wards but also minimising home/unskilled deliveries.

Support from the Cooperating Partners has been ‘very good’, and 70% of required EmONC equipment has been procured. The private sector is also partnering well with the districts to assist with transport and maternity delivery facilities in emergency cases: this is particularly evident among the mining companies on the Copperbelt.

### Assessment of Existing Gaps

The response to requests for equipment and transport has been slow: several facilities and health posts are without telecommunication systems, functional motorcycles or ambulances, and equipment maintenance is erratically provided. This is affecting the facilities’ ability to efficiently refer maternal and emergency cases to bigger hospitals (frequently relying on staff for use of telephones and personal vehicles). The impact is hardest on rural facilities which are already understaffed. DHMTs recommend a minimum requirement of two ambulances and several motorcycles per district.

#### **Box 13: Is there anything that hampers access to quality health care?**

*“Yes – access and distance. Many people live very far away from health facilities, and the peri-urban services don’t have good quality of equipment. To make it worse, staffing levels aren’t as they are on paper. Some cadres are overstaffed. But we need more nurses and midwives, especially now that we have more centres conducting deliveries. This area needs to be expanded. So quality is compromised.*

*“Our structures were not originally designed for large numbers of patients. When user fees were removed in the second quarter of 2012 we saw an increase in uptake by more than 50%, and the services that are most in demand are curative and OPD services. So now you have centres like Lubengele operating like a hospital for 24 hours, when in fact it’s only meant to be an outpatient clinic.*

*“We also don’t have a district hospital, so needy patients are referred to Chingola at a high cost of 21% because we have a contract with them. This 21% caters for the patient’s lab*

*services, food, laundry and medication. This would not be the case if we had a district hospital of our own.”*

Health worker in Chililabombwe

The breakdown of motor cycles and motor vehicles at the district and hospital management offices and facilities was one of the more evident aspects of the challenges of health service provision particularly in the rural areas. For instance, a provincial centre such as Kasama was endowed with only one ambulance at the District Health Management Team offices.

This contrasts with the knowledge available that states that as much as 60 per cent of child deaths are due to late referrals.

Insufficient or non-functional refrigeration equipment is compromising an already impaired cold chain system at district level. This is especially problematic where there is no district hospital, and facilities are reliant on an erratic electricity supply. The cold chain in particular is of concern, as there is evidence of refrigerators breaking down without replacement or repair, or a lack of storage facilities for lab samples. Staff in one district in Kitwe admitted to using personal household refrigerators for storing children’s vaccines as a last resort. Frequent power outages and the absence of generators are further impeding the correct storage of supplies. Many facilities are without basic equipment, such as BP machines, thermometers, scales and chemical analysers. The breakdown in the cold chain raises two issues: a) a lack of structured or scheduled maintenance and repairs; b) imperfect scheduled investment and procurement planning, which is impacting on the ability of the sector to operate and provide full scale service delivery. These two functions need to be refined in order to maintain and successfully manage the immunisation programme in particular.

There is also a shortage of laboratory and x-ray equipment, resulting in a backlog of patients’ diagnoses and results. The ambulance system is worsening, with some districts not have access to any transportation services for their emergency responses – if not addressed as a priority, this could increase institutional maternity deaths, discourage women from delivering their babies in a health facility, and could curtail outreach services.

There is evidence of dilapidated infrastructure, putting the lives and safety of occupants and staff at risk. Mothers’ waiting shelters or toilets are not always available (and water supply is often unreliable, as evidenced in Masaiti district), and communities raised concerns about the lack of privacy in delivery wards. ART-accredited facilities admitted the absence of CD4 machines, which are hampering their ability to function efficiently. Training schools are also experiencing a shortage of accommodation facilities, kitchen facilities, and training aids. In the pursuit of improved access, equity and utilisation distribution, MoH and MCDMCH should do an appraisal of the health facilities in the country based on existing data, and determine the balance of ideal locations linked to overall resource requirements, including human resource, basic equipment and transport. This in effect may constitute a sector master investment plan that would take into account the basic or essential health care package

**Box 14: Focus group discussion: Perceptions of availability of transport and infrastructure, Chibolwe Clinic, Kitwe**

*“We need to upgrade this (Chimwemwe) clinic to a hospital – we need two clinics to care for patients in this area because of the large numbers of people who come here.”*

*“We need our own ambulance. If you call for the ambulance, it may be far away and needs to travel even up to one hour just to reach you.”*

*“We need more equipment that works in the clinic. There is only one thermometer, no stethoscope, and one BP cuff. How can you listen to a child’s lungs if you do not have the stethoscope?”*

*“There is only one toilet for men and one toilet for women at the clinic for all of these people waiting to be seen.”*

*“The facility is small and has not been improved since it was built; it is not adequate to serve the number of patients.”*

*“Patients should not have to provide things like Jik, pads, wrappers and other things.”*

## **7.0 RECOMMENDATIONS AND CONCLUSION**

The Joint Annual Review recognises the tremendous strides that the sector has made in 2012 in overall health service delivery. In order to continue harnessing the gains to the sector, a number of recommendations are hereby presented based on the findings and evidence generated from key informant consultations, the literature review as well as the field work that was undertaken. **It is proposed that all of the proposed recommendations are put in place by 2014**, as many of them are already underway, or are contained within key policy frameworks for implementation by 2015.

### **7.1 Maternal, neonatal and child health**

- Implement the Road Map for Accelerating the Reduction of Maternal, Newborn and Child Mortality (2012-2016) as a priority; in addition, implement and monitor policy commitments to MNCH. Ensure that the National Health Strategic Plan (NHSP) and primary health care services are reviewed against the realigned health structures and factored into central and district plans

#### ***Human Resources in Health (HRH)***

- Reprioritise HRH with actionable and time-bound targets for scaling up training, recruitment and deployment
- Address the challenges between the Establishment and actual staffing positions; map out deployments, confirmations and appointments within a 12 month target period
- Scale up the training, deployment, availability and retention of nurses and midwives in district facilities, especially in hard-to-reach facilities
- Ensure that the priority setting process for the health system has a well articulated framework
- Revive and implement the Community Health Workers’ Strategy, provide skilled attendance at facility level, and consider the re-engagement of retired midwives to support Community Health Workers

#### ***Service Provision and Quality of Care***

- Improve supervision and staffing levels to augment the quality of care at facility level; address bottlenecks contributing to sub-standard quality of care, and implement systems to address reports of negligence
- Reorient health workers on the correct and consistent use of partographs and monitoring tools for maternity services, and track their utilisation
- Prioritise the procurement and availability in all facilities of BEmONC equipment
- Scale up Emergency Obstetric and Newborn Care (EmONC) services, training and supervision
- Strengthen transport and referral systems in all districts to ensure timely transfer of all emergencies and minimise institutional deaths; provide and document routine maintenance of transport and equipment
- Ensure the uninterrupted supply of paediatric ART, and strengthen record keeping in district pharmacies
- Prioritise the construction of essential infrastructure at facility level, particularly maternity wings and mothers' waiting shelters; and procurement of additional beds for maternity wings
- Review the feasibility of integrating paediatric HIV services with immunisation campaigns as an optimal entry point for diagnosis and treatment of HIV-exposed children, particularly given the impact of HIV on childhood mortality
- Strengthen linkages between private providers and district health facilities on tracking and reporting of modern family planning utilisation and trends

### ***Community strengthening***

- Scale up advocacy at community level for the importance and uptake of:
  - ANC, PMC, PMTCT, institutional deliveries and IMCI
  - distribution and correct use of ITNs, especially for pregnant women and under-5s;
  - nutrition services at facility and community level, including growth monitoring for childhood stunting, and deployment of additional nutritionists;
- Establish an incentive scheme to motivate SMAGs and community health volunteers as they promote uptake of institutional MNCH services

## **7.2 Health service delivery**

- Scale up advocacy for HIV testing and early initiation on ART
- Determine and address the bottlenecks to access of IMCI, immunisation, FANC and PNC at facility level
- Reprioritise the timely implementation of preventive environmental health services (indoor residual spraying, water and sanitation programming)
- Map out preventive health service needs in overpopulated informal settlements (and in border districts) to address high rates of sex work, early pregnancy, alcoholism, and STIs
- Reprioritise adolescent health (family planning, early pregnancy, sexual and reproductive health) and put in place accessible youth friendly health services
- Include mental health as a measurable indicator in the 2013 JAR
- Conduct a cost-benefit analysis to determine the viability of providing mobile hospital services

### **7.3 Health work force (human resources in health)**

- Address management bottlenecks around human resources, such as pending appointments, confirmation of acting staff, promotion, distribution imbalances, and lapses in uniformity of application of incentives (such as the health worker retention incentives)
- Prioritise the training and deployment of nurses and midwives to rural areas to ensure that existing gaps are eliminated by 2015
- Re-strategise training institutions' intake to scale up towards the 2015 goal of increasing the proportion of institutional deliveries by skilled attendance from 47% to 75% (MNCH Road Map)
- Map out an implementation plan taking forward the Community Health Worker strategy, to ensure that it does not lose momentum amid the transition between MoH and MCDMCH

### **7.4 Health information systems**

- Install functional internet and data management systems, a qualified Monitoring & Evaluation Unit and strong technical capacity in MoCDMCH
- Enact a transition plan for the transfer of MNCH data from MoH to MoCDMCH with all necessary resources, capacity and supervision
- Introduce a data quality assurance or data validation system at facility level to strengthen the robustness of HMIS data
- Clarify multi-level reporting at provincial level for PMOs
- Allocate sufficient space in facilities for storage of patients' records

### **7.5 Access to essential medicines and other medical supplies**

- Develop and implement a detailed five-year procurement plan, annualised and costed for each year
- Recruit and deploy qualified staff in order to strengthen procurement systems
- Continue the scale up and deployment of pharmacists and pharmacy technicians, aligning them with the needs assessment plans for emergency medicines and medical supplies (EMMS) at facility level
- Harmonise the dual procurement systems in place at district and provincial levels
- Clarify and streamline EMMS commodity procurement processes for MNCH
- Reorient Drug & Therapeutic Committees (DTCs) in all districts and hospitals, and ensure performance of joint participation and technical supportive functions by 2014

### **7.6 Health care financing**

- Clarify budgeting and reporting systems and processes in the newly restructured health sector, streamlining them to minimise overlaps between MoH and MoCDMCH
- Ensure that the information systems and accounting systems for financial and procurement management are fully functional by 2014
- Adopt and adhere to a clear resource allocation plan for districts, in order to avert delayed programme implementation

- Include issues of equity, access, and institutional performance in the Health Care Financing Strategy

### **7.7 Leadership and Governance**

- Develop, circulate and implement a feasible and proficient transition plan for MoH and MoCDMCH incorporating critical operational areas (HR, finance, administration, IT, planning, M&E)
- Conduct regular, high-level joint planning meetings at Permanent Secretary and Ministerial levels with key partners, to include technical expertise as a platform for sharing information, assessing progress in the transition and addressing sector bottlenecks
- Reorient stakeholders of the GMCSP to obtain sector-wide ownership, and clarify its implications for service delivery
- Commit to sharing reports and updates on implementation of the GMCSP with the CPs on a quarterly basis
- Review, clarify and disseminate the NHSP and the National Health Policy in the context of the realigned functions of MoH and MoCDMCH
- Commit to decentralisation and health systems strengthening (HSS) and reform, and strengthen community structures
- Ensure high level and timely involvement in planning for the 2013 JAR between MoH and MoCDMCH; agree key areas (thematic focus, field visits, planning) early in the planning process to maximise stakeholder participation
- Strengthen technical capacity in MoCDMCH to meet the sector's needs, especially with skilled human resource capacity
- Engage other line Ministries to agree cross-cutting linkages (e.g. Ministry of Education on early childhood development and community mobilisation, etc) as they relate to Primary Health Care

### **7.8 Community participation: demand and access**

- Reprioritise and implement the National Community Health Workers' Strategy to address key capacity gaps, particularly at facility level
- Introduce incentives for Safe Motherhood Action Groups and community volunteers, and scale up training and supervision
- Introduce robust nutrition programmes at community level targeting children and pregnant women
- Rationalise service delivery and utilisation costs of mobile services

### **7.9 Infrastructure, medical equipment and transport**

- Ensure that infrastructure planning and development are sequentially related and synchronised to equipment, transport and HRH development
- Redesign the transport strategy and cold chain strategy to ensure redistribution of appropriate transport and equipment to service delivery points
- Strengthen communications at facility and district level
- Provide water tanks and generators for facilities to minimise disruption of services and strengthen cold chain

- Prioritise construction and infrastructure rehabilitation of existing facilities. Consider construction of new facilities where the need is greatest, particularly where there are no district hospitals, or in hardest to reach areas
- Prioritise maintenance of vehicles and equipment. Consider construction of improved facilities where there are no district hospitals
- Allocate and maintain minimum transportation requirements to each district (for example, two ambulances, motorcycles, utility vehicle)
- Allocate and maintain basic equipment to each district (laboratory and X-ray equipment, scales, thermometers, BP machines)
- Address training institutions' infrastructure needs (construction and/or rehabilitation of kitchens, tutors' housing, students' accommodation)

It is anticipated that the findings and recommendations made in this report will be utilised, as in past Joint Annual Review processes, in the planning and prioritisation of core activities for the 2013 programme year.

## ANNEXES

- Annex 1: List of participants/stakeholders/interviewees
- Annex 2: Sector Advisory Group (SAG) presentation of JAR preliminary findings
- Annex 3: Field visit District t presentations
- Annex 4: JAR 2013 Planning Guide

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