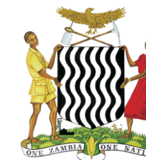
World Health Organization

REGIONAL OFFICE FOR Africa




# WHO COUNTRY COOPERATION STRATEGY 2008-2013

# ZAMBIA

World Health Organization

REGIONAL OFFICE FOR Africa

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# ZAMBIA

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# CONTENTS

**MAP OF ZAMBIA** ........ v

**ABBREVIATIONS** ........ vii

**EXECUTIVE SUMMARY** ........ viii

**PREFACE** ........ xi

**Section 1 INTRODUCTION** ........ 1

**Section 2 COUNTRY HEALTH AND DEVELOPMENTAL CHALLENGES** ........ 2
- 2.1 Country Health and Developmental Challenges ........ 2
- 2.2 Maternal, Adolescent and Child Health ........ 3
- 2.3 Disease Burden ........ 7
- 2.4 Health Policy and Systems ........ 10
- 2.5 Summary of Challenges in the Health Sector ........ 13

**Section 3 DEVELOPMENT COOPERATION AND PARTNERSHIP** ........ 14
- 3.1 Development Assistance ........ 14
- 3.2 Partner Programmes ........ 15
- 3.3 Harmonization and Alignment ........ 15
- 3.4 United Nations Development Assistance Framework (UNDAF) 2007-2010 16
- 3.5 Challenges in Partnership ........ 16

**Section 4 PAST AND CURRENT WHO COOPERATION IN ZAMBIA** ........ 18
- 4.1 WHO Country Presence ........ 18
- 4.2 Contribution of WHO Cooperation Strategy 2002-2005 ........ 19
- 4.3 Support from the Regional Office and WHO Headquarters ........ 20
- 4.4 Implementation Challenges ........ 20
- 4.5 Summary of Issues for Future WHO Cooperation ........ 21

**Section 5 WHO POLICY FRAMEWORK: GLOBAL AND REGIONAL DIRECTIONS** 22
- 5.1 Goal and Mission ........ 22
- 5.2 New Emphases ........ 22
- 5.3 Strategic Directions ........ 22
- 5.4 Core Functions ........ 23
- 5.5 Global and Regional Priorities ........ 23
- 5.6 Making WHO More Effective at Country Level ........ 24

**Section 6 STRATEGIC AGENDA FOR WHO COOPERATION** ........ 25
- PRIORITY AREA 1: Health Security ........ 25
- 6.1 Strategic Approach 1: Ensure Health Security by Reducing Morbidity and Mortality due to Communicable and Noncommunicable Diseases ........ 25
- 6.2 Strategic Approach 2: Strengthening Preparedness and Control of Epidemics and other Emergencies ........ 28

PRIORITY AREA 2: Health Systems Capacity and Governance ................. 29
6.3 Strategic Approach 3: Strengthening the Capacities and Performance of the Health Systems ........ 29
PRIORITY AREA 3: Partnerships, Governance, Gender and Equity ........... 30
6.4 Strategic Approach 4: Strengthening Health Sector Partnerships: Governance, Gender and Equity ........ 30

**Section 7 IMPLEMENTING THE STRATEGIC AGENDA ........ 31**
7.1 Implications for WHO Country Office ........ 31
7.1.1 Expanding the use of Country Cooperation Strategy ........ 31
7.1.2 Core Competencies and Capacities of WHO Country Office ....... 31
7.1.3 Integrated Programmatic and Technical Support from Regional Offices and Headquarters ........ 32
7.1.4 Effective Functioning of the Country Office ........ 32
7.1.5 Better Knowledge Management ........ 33
7.1.6 Working with Organizations of the United Nations System and Development Partners ........ 34
7.2 Implications for WHO Regional Office for Africa ........ 34
7.3 Implications for WHO Headquarters ........ 34
7.4 Results-Based Management: Monitoring and Evaluating the Country ........... Cooperation Strategy ........ 35

**8. CONCLUSION ........ 36**
**9. BIBLIOGRAPHY ........ 37**

**ANNEX**

Annex 1: Health Cooperating Partner Coordination Matrix ........ 38
Annex 2: Swot Analysis for Implementing the CCS ........ 39
Annex 3: Improved Lives and Protection of the Vulnerable–targeted Results ....... 40
Annex 4: Zambia Country Cooperation Strategy (2008-2013) development Process ........ 41

## LIST OF TABLES

**Figure 1:** Zambia Under-five Mortality Projection ........ 3
**Figure 2:** Trends of Maternal Mortality ........ 4
**Figure 3:** Non–Polio AFP Rate by Year ........ 6
**Figure 4:** Trends of the 6 Major Causes of Visitation to Health Facilities ........ 7
**Table 1:** Staffing Levels against Recommended Levels 2005 to 2007 ........ 11
**Table 2:** Estimated Funding for NASF 2006-10 (in US$) ........ 14
**Table 3:** Cooperating Partners Priority Areas ........ 15
**Table 4:** Country Office Professional Staff 2008 ........ 32
**Figure 5:** WHO Country Office Organizational Chart ........ 33

# MAP OF ZAMBIA

# ABBREVIATIONS

| | | |
|---|---|---|
| ADB | : | African Development Bank |
| AIDS | : | Acquired Immunodeficiency Syndrome |
| AFRO | : | WHO Regional Office for Africa |
| CBOH | : | Central Board of Health |
| CCA | : | Common Country Assessment |
| CCS | : | Country Cooperation Strategy |
| CSO | : | Central Statistics Office |
| DALE | : | Disability Adjusted Life Expectancy |
| DANIDA | : | Danish International Development Agency |
| DHB | : | District Health Board |
| DHS | : | Demographic and Health Surveys |
| DFID | : | Department for International Development (UK) |
| DOTS | : | Directly Observed Treatment, Short-Course |
| GAVI | : | Global Alliance for Vaccines and Immunization |
| GDP | : | Gross Domestic Product |
| GNP | : | Gross National Product |
| HDI | : | Human Development Index |
| HDR | : | Human Development Report |
| HIPC | : | Heavily-Indebted Poor Country (Initiative) |
| HIV | : | Human Immunodeficiency Virus |
| HMB | : | Hospital Management Board |
| HMIS | : | Health Management Information System |
| IDS | : | Integrated Disease Surveillance |
| IEC | : | Information, Education and Communication |
| IMCI | : | Integrated Management of Childhood Illness |
| IMF | : | International Monetary Fund |
| IMR | : | Infant Mortality Rate |
| JICA | : | Japan International Cooperation Agency |
| MDG | : | Millennium Development Goals |
| MMD | : | Movement for Multiparty Democracy |
| MMR | : | Maternal Mortality Ratio |
| NHSP | : | National Health Strategic Plan |
| NPO | : | National Professional Officer |
| RBM | : | Roll Back Malaria |
| SIDA | : | Swedish International Development Agency |

| | | |
|---|---|---|
| SSA | : | Special Services Agreement |
| SWAps | : | Sector Wide Approaches |
| UNCT | : | United Nations Country Team |
| UNDAF | : | United Nations Development Assistance Framework |
| UNDP | : | United Nations Development Programme |
| UNFPA | : | United Nations Population Fund |
| UNHCR | : | United Nations High Commission for Refugees |
| UNICEF | : | United Nations Children's Emergency Fund |
| USAID | : | United States Agency for International Development |
| WB | : | World Bank |
| WCO | : | WHO Country Office |

# EXECUTIVE SUMMARY

WHO has been providing technical support to the Government of Zambia and its development partners since 1965. The Country Cooperation Strategy (CCS) defines the strategic framework for the work of WHO in the country. It articulates the organization's strategic priorities for supporting the national and development agenda for the period 2008-2013. The CCS is anchored on WHO policies, strategies, core objectives aligned with national priorities. Zambia's CCS is focused on World Health Organization's normative role to effectively engage Government and development partners at country level. It is the outcome of a collaborative work by the Government and partners anchored on frameworks that include the Fifth Development Plan, the National Health Strategic Plan, and the Millennium Development Goals (MDGs) and harmonized with the work of the United Nations and other partners in Zambia.

The WHO Global and Regional Policy Frameworks provide vital direction for the CCS 2008-2013. The Eleventh General Programme of Work (GPW), currently the highest policy document for WHO, provides a global health agenda targeted at all health agencies internationally. WHO, as a global health body of the United Nations Organization, contributes to this agenda by concentrating on its core functions, which are based on its comparative advantage. The regional priorities have been expressed in the "Strategic Orientations for WHO Action in the African Region 2005-2009". In order to ensure effective support for all UN member states, the WHO Country Focus Policy adapts the operations of WHO to the needs of each country.

In Zambia, although significant progress has been made in terms of political, economic and social development since its independence in 1965, malaria, HIV and AIDs remain the major drivers of the disease burden, with an adult HIV prevalence rate of 14% (in 2007).The health sector is challenged by a number of factors that have continued to present significant obstacles to health service delivery, including: critical shortages and unbalanced distribution of qualified health workers at all levels of the public health system; shortages and erratic supply of essential drugs and medical supplies, attributed to several challenges, including, notably procurement and logistics management problems. Inadequate and poor state of essential infrastructure, equipment and transport, particularly in rural areas and inadequate funding of the health sector, which is currently below the 15% of the discretionary budget recommended by the Abuja Declaration. The Government of Zambia has acknowledged the severity of the situation and there is renewed political and financial commitment to improving the health status of the people of Zambia.

Other health development challenges that are being addressed through the Ministry of Health's National Health Strategic Plan 2006-2010 include: reducing under five and maternal deaths, improving equity and access to health services, containing the increasing trend of major noncommunicable diseases(NCDs), strengthening epidemic alert and emergency preparedness, human resource development, financing health care and coordinating the alignment and harmonization of development partners' contribution to support the health sector.

The previous WHO Country Cooperation Strategy for Zambia (2002-2005) significantly contributed to the enhancement of WHO's position in the country as a credible source of evidence-based knowledge, and its successful implementation benefited from a clear and

strong government leadership and coordination within the Sector Wide Approach (SWAp), donor coordination and harmonization framework supported by the United Nations Development Assistance Framework (UNDAF) and related Theme Groups. The United Nations (UN) commitment in supporting the Government to attain its national health and development goals enabled Zambia to move towards the attainment of the national vision of providing cost-effective quality care close to the household.

The 2002-2005 WHO Country Cooperation Strategy endeavoured to focus, among other objectives, on upstream policy mandate of WHO with limited emphasis on implementation of routine activities. The key activities included the Strengthening of Health Systems, the control of HIV/AIDS, Tuberculosis, Malaria, other communicable diseases, noncommunicable diseases (NCDs) and the conduct of advocacy for health. Notable challenges included limited availability of resources, particularly funds at country level, high prevalence of HIV/AIDS and inadequate human resources for health.

The development of WHO's current Cooperation Strategy received support from bilateral and multilateral partners led by the Ministry of Health and its Monitoring and Evaluation instruments, such as the Ministry of Health Policy and Partners Management Meetings. Consequently, the second generation CCS, unlike the former CCS, includes a section on monitoring and evaluation of the CCS. In order to improve its effectiveness, its development took cognizance of the strategic objectives, core competences and management capabilities at different levels of WHO. The implementation of the 2008–2013 CCS will cover three consecutive Biennial Programme work plans/budgets.

In line with the WHO results-based management system, the newly-introduced Global Management System (GSM) which is aimed at streamlining management operations in the World Health Organization, would facilitate smooth monitoring of activities. The in-built Monitoring and Evaluation will permit effective tracking of progress of the CCS to ensure that WHO Programme has an impact on national socioeconomic development.

The renewed World Health Organization is geared towards a results-based management framework consisting of strategic objectives; organization-wide expected results, and regional expected results covering biennial workplans and budgets.

The current WHO Cooperation Strategy takes cognizance of the significant progress made in nearly all health programme areas during the period covered by the last CCS and seeks to address concerns noted by the Ministry of Health and Cooperating Partners on the need for greater involvement of the WHO Country Office in providing strategic guidance to all stakeholders and harmonization of their inputs.

The strategic focus that will form the basis for country cooperation in the coming years will include: providing support to the strengthening of health systems; fostering partnerships in harmonized inputs in the execution of the Fifth National Development Plan; and ensuring dissemination of scientific knowledge in support of evidence-based policy formulation and programme implementation. The attainment of these objectives should result in measurable progress towards the national goal of "improving the health status of the people in Zambia".

# PREFACE

The WHO Country Cooperation Strategy (CCS) crystallizes the major reforms adopted by the World Health Organization with a view to intensifying its interventions in the countries. It has infused a decisive qualitative orientation into the modalities of our institution's coordination and advocacy interventions in the African Region. Currently well established as a WHO medium-term planning tool at country level, the cooperation strategy aims at achieving greater relevance and focus in the determination of priorities, effective achievement of objectives and greater efficiency in the use of resources allocated for WHO country activities.

The first generation of country cooperation strategy documents was developed through a participatory process that mobilized the three levels of the Organization, the countries and their partners. For the majority of countries, the 2004-2005 biennium was the crucial point of refocusing of WHO's action. It enabled the countries to better plan their interventions, using a results-based approach and an improved management process that enabled the three levels of the Organization to address their actual needs.

Drawing lessons from the implementation of the first generation CCS documents, the second generation documents, in harmony with the 11th General Work Programme of WHO and the Medium-term Strategic Framework, address the country health priorities defined in their health development and poverty reduction sector plans. The CCSs are also in line with the new global health context and integrated the principles of alignment, harmonization, efficiency, as formulated in the Paris Declaration on Aid Effectiveness and in recent initiatives like the "Harmonization for Health in Africa" (HHA) and "International Health Partnership Plus" (IHP+). They also reflect the policy of decentralization implemented and which enhances the decision-making capacity of countries to improve the quality of public health programmes and interventions.

Finally, the second generation CCS documents are synchronized with the United Nations development Assistance Framework (UNDAF) with a view to achieving the Millennium Development Goals.

I commend the efficient and effective leadership role played by the countries in the conduct of this important exercise of developing WHO's Country Cooperation Strategy documents, and request the entire WHO staff, particularly the WHO representatives and divisional directors, to double their efforts to ensure effective implementation of the orientations of the Country Cooperation Strategy for improved health results for the benefit of the African population.

Dr Luis G. Sambo
WHO Regional Director for Africa

# SECTION I

## INTRODUCTION

The WHO Country Cooperation Strategy (CCS) defines the broad framework for WHO's work with the Republic of Zambia for 2008-2013. It serves as a basis for implementing activities for 2008-2009, 2010-2011 and 2012-2013. The CCS is the result of an interactive, participatory and continuous consultative process, aimed at articulating the vision and priorities of WHO, as distinct from those of Government and other development partners.

Under the leadership of the WHO Representative, the CCS development team conducted in-depth reviews and analysis of the key health sector issues. The team also conducted broad consultations and advocacy during the preparation of the CCS 2008-2013, and secured the active involvement of key stakeholders, including the MoH, the UN, bilateral and multilateral organizations and staff of the WHO Country Office (WCO).

The aim of WHO is to be more responsive to country needs by focusing on critical activities, while the CCS also reflects WHO's own values, principles and corporate and regional strategies. It is based on a systematic assessment of Zambia's policies and expectations and activities of other development partners. The CCS will also offer WHO the opportunity to contribute in a more coherent manner to the achievement of the Millennium Development Goals.

In accordance with the new organizational structure as laid out in the Medium-Term Strategic Plan (MTSP) 2008-2013, sixteen (16) Strategic Objectives (SOs) were identified, out of which Zambia adopted 13. These SOs replace the previous thirty-six (36) Areas of Work (AOW). The MTSP thus introduces a broad strategic perspective of WHO's work and will be used as the basis for the planning process.

The main strategic directions of the CCS are:

(i) ensuring health security by reducing morbidity and mortality due to communicable and noncommunicable diseases;

(ii) strengthening preparedness and control of epidemics and other emergencies;

(iii) strengthening the capacities and performance of health systems;

(iv) strengthening health sector partnerships: governance, gender and equity.

The CCS presents an analysis of information about the country's health and development challenges, development assistance, aid flow and partnerships for health development, current levels of WHO cooperation and support, and the WHO policy framework, including global and regional directions. It also outlines WHO's strategic directions and the strategic approaches that would be the focus of WHO's work during the period 2008-2013, and identifies implications for the work of WHO at Country, Regional and HQ levels.

# SECTION 2

# COUNTRY HEALTH AND DEVELOPMENTAL CHALLENGES

## 2.1 COUNTRY HEALTH AND DEVELOPMENTAL CHALLENGES

### *2.1.1 Socioeconomic Situation*

Zambia is a landlocked country, covering an area of 752 612 square kilometres, situated within central-southern Africa. It shares borders with eight other countries: Tanzania and the Democratic Republic of Congo (DRC) in the north; Malawi and Mozambique in the East; Zimbabwe, Botswana and Namibia in the south; and Angola in the west. Zambia's economy has experienced modest growth in recent years with Gross Domestic Product (GDP) estimated at US$ 11.16 Billion[1] and a per capita GDP $1300[2] . In 2005, Zambia qualified for debt relief under the Heavily Indebted Poor Country Initiative, consisting of approximately US$ 6 billion in debt relief. Although poverty continues to be a significant problem in Zambia, the economy has strengthened, with a relatively stable exchange rate and increasing levels of trade. The Zambian Government has developed the Vision 2030 and the Fifth National Development Plan (FNDP) 2006 to 2010 that will guide the Government and its partners towards improving the current socio-economic situation.

The country had an estimated population of 11.6 million in 2007[3] and an annual growth rate of approximately 2.9%, divided almost equally between males and females. The total fertility rate was 6.2 in 2007. Approximately 40% of the population lives in urban areas and 60% in rural areas. Sixty-four percent (64%) of the population lives in poverty (less than US$1 per day). Zambia is ranked 166$^{th}$ out of 177 countries on the Human Development Index (HDI).[4]

Public spending on water and sanitation has been low at 0.4% of GDP with Government spending 0.01%. Peri-urban areas are under-serviced, while in rural areas the provision of sanitation remains the responsibility of households, and in some cases nearly 80% of the population lacks adequate facilities.

### *2.1.2 Health Status Indicators*

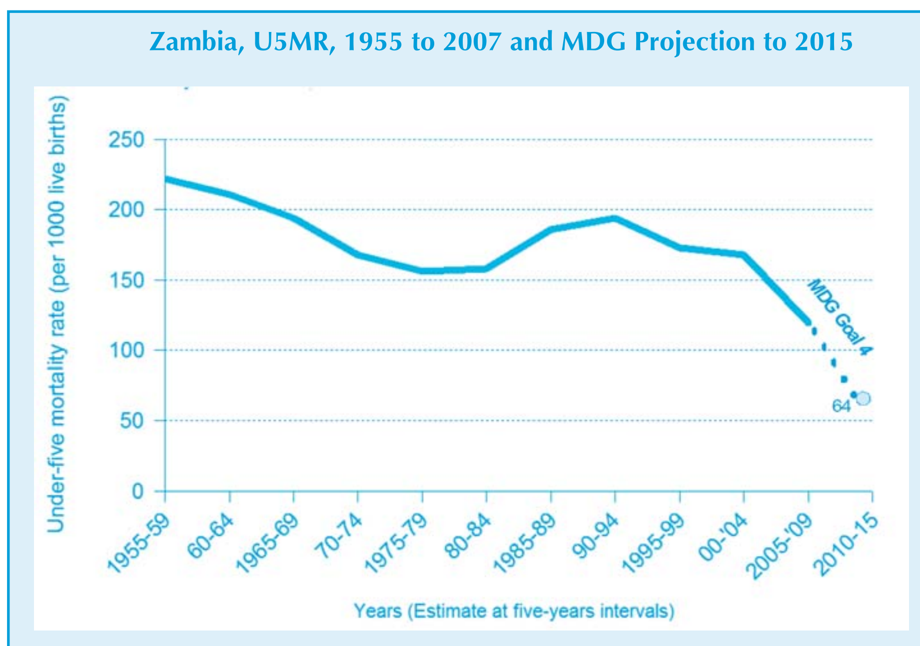
Life expectancy at birth rose from 40.5 years in 1998 to 50 years in 2000[5]. A gain has been recorded in terms of child health and nutrition. Infant Mortality Rate (IMR) decreased from 95 deaths per 1000 live births in 2001/2 to 70 deaths per 1000 live births in 2007 while

---

1 World Bank 2007.
2 IMF Report 2007.
3 Census 2000 Projections.
4 UNDP Report 2007.
5 Central Statistical Office 2005.

under–five mortality rate also decreased from 168 per 1000 live births in 2001 to 119 per 1000 live births in 2007[6].

**Figure 1: Zambia under five mortality projection**




**Source:** World Health Chart, WHO, 2001, ZDHS 2002 and 2007

NMR is currently 34 per 1000 live births. The major causes of child mortality are malaria, respiratory infections, diarrhoea, malnutrition and anaemia. Approximately 15% of children under five are underweight, 45% are stunted and 5% are considered wasted. Maternal mortality is currently estimated at 449/100 000. Among the general population aged 15-49 years, HIV prevalence rate is estimated at 14.3%, and contraceptive prevalence rate at 41%[7].

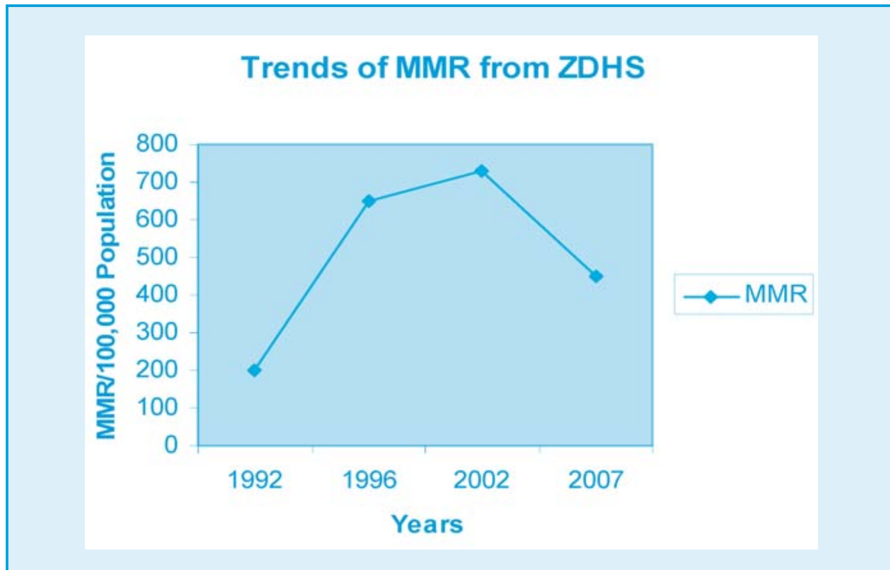
## 2.2 MATERNAL, ADOLESCENT AND CHILD HEALTH

### *2.2.1 Maternal Health*

Reducing the burden of maternal and under-five illnesses and deaths is vital to the socioeconomic and health development of Zambia. Despite the decline in Maternal Mortality Ratio (MMR) from 729/100 000 live births in 2000 to 449/100 000 live births in 2007; the country has one of the highest MMR in the region[8].

[6] ZDHS 2007.
[7] ZDHS 2007.
[8] ibid.

**Figure 2: Trends of Maternal Mortality**




HIV/AIDS prevalence rate among pregnant women attending ANC is 19%. The leading causes of maternal mortality include: abortion, injuries, eclampsia, obstructed labour and septicaemia. Several factors contribute to the choice of delivery. They include: distance to the nearest health facility, staff attitudes, traditional beliefs and practices, inadequate and inappropriate infrastructure, inadequate drugs and medical supplies and reluctance to be delivered by male health provider. As a result, despite the high rate of ANC coverage, estimated at 94 percent, the majority (53%) of deliveries take place at home with the assistance of either TBAs or relatives and friends with no midwifery skills[9]. Currently, there is no systematic way of accurately capturing the vital statistics on maternal deaths in the communities.

### *2.2.2 Adolescent Health*

The adolescent population constitutes a particularly vulnerable age group that is prone to risky behaviour and, as such, need special attention. Premature deaths and adult-related diseases have been associated with conditions/behaviours that began in adolescence. The majority of adolescents reach adulthood with inadequate knowledge on sexual and reproductive health, making them vulnerable to sexually-transmitted infections, including HIV and AIDS. Absence of HIV and AIDS interventions and information specific for the youth and youth-friendly health services compounds the vulnerability of this particular age group. Of the 1.3 million people living with HIV, 7.7% are young people aged 15-24 years. This is of great concern to the health sector in the country as marriages occur relatively early with 70%of young women getting married around the age of 20 years. On average, by the age of 20, between 60 and 70% of Zambian women have either given birth to or are pregnant with their first child and contraceptive use in this age group is extremely low. Among this population group, a pregnant adolescent is more likely to have complications during delivery and may have had poor ANC attendance. Negative consequences, among others, include unsafe abortions.

[9] Joint Annual Reports 2006/2007.

Alcohol abuse is among the major problems noted among adolescents in Zambia. About 42% of adolescents abuse alcohol.[10]. It has also been noted that risky behaviour and sedentary lifestyles (32.6%)[1] by adolescents put them at risk of trauma, diabetes and hypertension in adulthood. Information on substance abuse and dangers on adopting sedentary lifestyles for the youth is often inadequate. These problems have been worsened by poor enforcement of age restriction of admittance to bars and other drinking places and inadequate recreation and rehabilitation facilities, which at times are not easily accessible to the youth.

Despite their vulnerability to sexually-transmitted infections, notably HIV, adolescents remain largely excluded from and are underserved by the current reproductive health service delivery system. Adolescents also remain mostly excluded from guidance on sexuality and relationship within their own home environments. Some of the reasons include lack of training for health providers and cultural attitudes regarding sexuality.

### *2.2.3 Child Health*

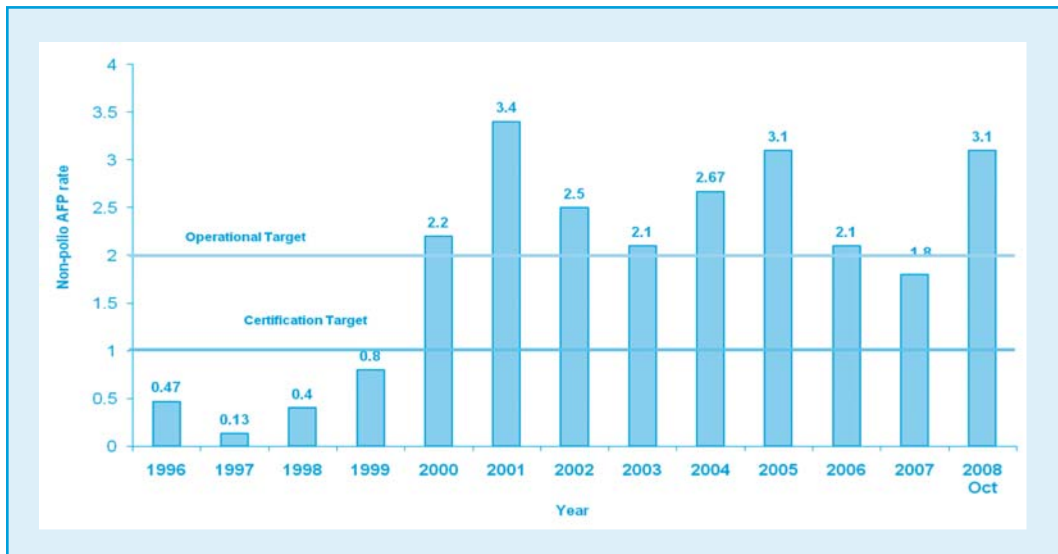
The major causes of child morbidity and mortality remain the same: malaria, respiratory infections, diarrhoea, malnutrition and anaemia. The Integrated Management of Childhood Illnesses (IMCI) is a strategy that is being used to address management of these common childhood illnesses. In terms of malaria in children, the recently completed 2008 Malaria Indicator Survey (MIS) shows dramatic achievement in nearly every indicator since the 2006 MIS. Nationally, the parasitaemia rate in children under age 5 has declined by more than 50%, from 21.8% to 10%. This has contributed significantly to the reduction of severe anaemia in children by 62%, declining from 13.3% in 2002 to 5% in 2007.

Malnutrition, a serious public health problem, has worsened over the years. The latest figures indicate that 47% of Zambian children are stunted, 28% are underweight and 5% are wasted. Micro-nutrient deficiencies such as Vitamin A deficiency continue to be a public health concern. MOH records indicate that 5% of the children have severe Vitamin A deficiency (VAD), 49.1% have moderate VAD and 45.9% have normal VAD. Anaemia is another source of concern. Baseline studies show that 50% of women attending ANCs and 15% of children under the age of 15 are anaemic. There are problems associated with therapeutic feeding programmes for severe malnutrition. Recently, reports from the University Teaching Hospital (UTH) showed case fatality rate (CFR) of 30-50% for children admitted with severe and complicated malnutrition. Lower CFRs are reported from the pilot projects of the Community Therapeutic Centres (CTC), which deal with mild-moderate malnutrition in Lusaka, where CFR of < 5% is more typical. While treatment for severe malnutrition is receiving some attention, there is little on offer for those with moderate or mild malnutrition, apart from counselling. This gap needs to be addressed to prevent more children from slipping into severe malnutrition.

Mother-to-Child Transmission (MTCT) of HIV is the largest source of infection of children below five years of age. HIV prevalence rate among women of child-bearing age was 16.1% in 2007 making the risk of HIV infection a looming threat to expectant mothers and their children. Experience demonstrates that 90% of all newborn babies that are HIV-positive acquire the virus before birth, during birth or through breastfeeding. The present estimate is that of the 400 000 babies born annually in Zambia, the HIV virus will infect 25 000 of them. This translates into 70 new HIV infections in babies per day. Fortunately, the high ANC coverage rate provides a window of opportunity for the prevention of mother-to-child transmission (PMTCT) of the HIV. The current PMTCT Programme is, however, constrained by inadequate trained safe motherhood providers and the high turnover of suitably trained and experienced manpower. Other limitations to PMTCT services include non-inclusion of

HIV-negative mothers, stigma, and non availability of care and support for the family and inadequacy of family planning services in preventing unintended pregnancies.

**Figure 3: No–Polio AFP Rate by Year**




The Acute Flaccid Paralysis (AFP) surveillance performance indicators for the year 2007 were at certification level; however, the operational indicator for non-polio AFP rate was not achieved. The national level non-polio AFP rate stood at 1.8 per 100 000 children aged below 15 years. The Neonatal Tetanus indicator is 0.7 per 1000 live births, TT2+ coverage is 77% and fully-immunized children coverage is 77%.

In 2007, Zambia conducted an assessment of vaccine management, using the eleven criteria for vaccine management logistics performance indicators. This revealed that the country performance was below the satisfactory benchmark of 80%. This is particularly true from provincial to facility level. This led to adoption of the Multi Dose Vial Policy (MDVP), which is being implemented nation-wide at all levels.

The Zambia Immunization and Visions Strategy (ZIVS) set the vision of the national immunization programme and how the programme can be improved during the period 2006-2010. The ZIVS articulates four primary pillars and goals:

(i) protecting more women and children;

(ii) introducing new vaccines;

(iii) sustainable immunization financing; and

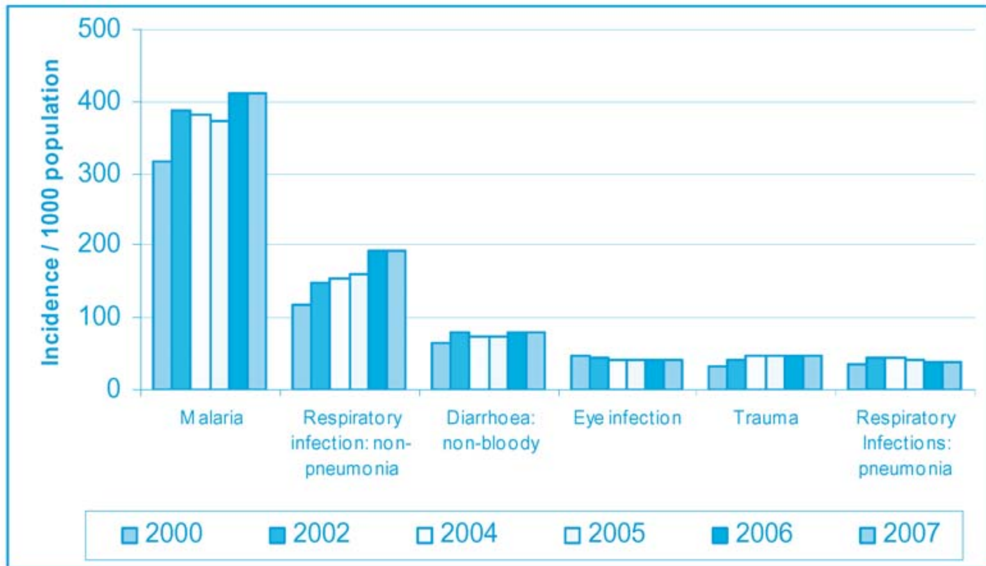
(iv) integrating immunization and other interventions, including surveillance in the context of health systems.

These also formed the focus of the Immunizations and Vaccine Preventable Disease (IVD) plan for the year 2007.

## 2.3 DISEASE BURDEN

Zambia has never conducted an analysis of overall burden of ill-health and trends. However, indications from the HMIS summarized in the MoH annual statistics bulletin suggest a high, and unchanging disease burden.

**Figure 4: Trends of the 6 major causes of visitation to Health Facilities**




**Source**: Annual Health Statistical Bulletin 2005 and 2007

### *2.3.1 HIV/AIDS, Tuberculosis and Malaria*

Zambia is among countries in the African Region with a high prevalence of HIV though over the years the burden of the disease has been declining. According to the 2007 ZDHS, the adult HIV prevalence is currently 14.3 percent. About 1.3 million people are estimated to be living with HIV, 7.7% of whom are young people aged 15-24 years. Approximately, 332 000 people with HIV require Antiretroviral Treatment, including 40 000 children. Women continue to be more affected than men, with a prevalence of 16.1% compared to 12% prevalence for men, making women 1.3 times more likely to be living with HIV. The HIV prevalence also varies with the geographical location; populations in urban areas have a higher HIV prevalence of 19.7%, which makes them twice more likely to have HIV than those in the rural areas (10.3%)[11].

Tuberculosis is one of the major public health challenges in Zambia. It is ranked as one of the top 5 causes of morbidity and mortality, especially among the young and economically productive adults aged 15-49 years. The number of notified cases has been rising in the past 23 years from 100/100 000 inhabitants in the late 1980s to 500/100 000 inhabitants in 2007. The deteriorating TB situation is a result of high HIV prevalence. It is estimated that between 60% and 70% of TB patients in Zambia are also co-infected with HIV[12]. The interaction between TB and HIV presents challenges in the management of those that are co-infected. Directly Observed Treatment Short-course (DOTS) activities have reached all districts, but

[11] Reproductive Health Policy.
[12] HMIS Reports.

its application and quality vary within and between districts. There has been a constant supply of anti-TB drugs in the past few years through the Global Drug Facility but the TB laboratory network is inadequate. The Stop TB Strategy, which includes components of DOTS was adopted in 2006 and its components are gradually being implemented. Programme performance is assessed using several indicators including case detection rate (CDR), cure and treatment success rates, and default and mortality rates. CDR for 2007 was 52% (below the WHO target of 70%) and there has been a decline in TB notifications since 2005. Both cure and treatment success rates have been rising from 77% in 2002 to 85% in 2006. Mortality rate has been declining since 2002 and stood at 7% in 2006 but default rate shows an upward trend in the past three years to 3% in 2006. Diagnosis and treatment of tuberculosis in children remains a challenge.

Malaria continues to be a major public health concern in Zambia. It causes illness in about 3.5 million people annually. The burden is highest among children under the age of five years and negatively affects pregnant women. It accounts for 40% of overall child deaths, while in pregnancy malaria accounts for 20% of overall maternal mortality. About 359 malaria cases per 1000 and 6149 deaths were recorded in 2007. The goal for the national malaria control programme is to reduce malaria incidence by 75% and malaria deaths significantly in order to contribute to all cause mortality by 20% in children under 5 years old. However, the country has experienced a net reduction in both indicators. At the national level, the incidence rate has declined from 373 cases to 358 cases per 1000 inhabitants, while the hospital case fatality rate has been reduced from 32.1 deaths to 29.0 deaths per 1000 admissions[13]. The gains reflected in the HMIS appear somewhat limited because the system does not have the capacity to distinguish between confirmed and unconfirmed malaria (fever) incidences.

Zambia has increased ownership of Insecticide-Treated Nets (ITN) per household from 5% in 2001 to 60% in 2007 and 32% of pregnant women sleep under an ITN. About 3 286 514 people out of 4 614 585 targeted populations were protected with Indoor Residual Spraying (IRS) and 80% of the population should access prompt diagnosis and treatment within 24 hours of onset of symptoms. IRS coverage has increased from five districts to 15 districts over the period 2003-2007[14]. The country has switched to the use of Artemisin-based Combination Therapy (ACT). This led to the introduction of *Artemether Lumefantrine* (AL) in 2003 as the first line drug for treating uncomplicated malaria. About 21% (of the 1400 health facilities in Zambia) have functional microscopes and about 2 million rapid diagnostic tests (RDTs) have been procured and distributed. Intermittent Presumptive Treatment (IPT) for pregnant women has also been delivered nationwide with 61% coverage. Resources (financial and technical) have been mobilized from different financiers. Operational research was promoted on malaria diagnosis and Long Lasting Insecticide-Treated Nets and the information was used for planning purposes[15].

### *2.3.2 Other Communicable Diseases*

Most infectious and parasitic diseases affect poor people, with women, children and the elderly being most vulnerable to illness and disability. In the last decade or so diseases, such as schistosomiasis, trypanosomiasis and leprosy have been observed to have made significant contributions to the overall disease burden in the country. The Bilharzia Control Programme was launched in 2005 under both MoH and Ministry of Education (MoE) to reduce morbidity of schistosomiasis and STH's in children and adults, and foster demand for treatment. So far,

[13] MoH Annual Report.
[14] MoH Annual Report.
[15] ibid.

it has had commendable achievements. Mass drug administration (Praziquantel) has been carried out in over 1.3 million children, in collaboration with MoE through its schools, and other partners. In addition to government funding, some non-traditional partners are supporting interventions, such as the Izumi Foundation (now called Children Without Worms). Filariasis mapping is ongoing while that of HAT was completed in 2008. In-depth HAT surveys are still being conducted in identified at-risk districts. Mapping for trachoma is also ongoing.

### 2.3.3 Noncommunicable Diseases:

Over the past years, Zambia experienced a steady increase in noncommunicable diseases, namely, hypertension, cardio-vascular diseases, diabetes and cancer. The country also has a long history of road traffic accidents. In 2007 alone, 1266 road traffic accidents occurred (the lancet 2008)[16]. Data routinely collected from all health facilities (Health Management Information System, HMIS) in the country indicate that trauma with an estimated incidence of 48/1000 population in 2006 (accidents, injuries, wounds, burns) is the fourth leading cause of morbidity in the country after malaria at 412/1000 in 2006, respiratory infections (non-pneumonia) at 192/1000 and diarrhoea (non-bloody) at 81/1000[17]. The recent WHO STEPwise Approach survey carried out in the general population in Lusaka in 2008 found that the rate for current tobacco smoking was 6.8%, alcohol consumption 20.7%, hypertension 12.5%, impaired glucose levels/diabetes 4.0%, overweight/obesity 39.3%, consumption of vegetables and fruits per week 94.9% and 23.6% respectively. Hypertension, hypercholesterolemia, alcohol consumption and overweight/obesity are already on the increase.

### 2.3.4 Emergency and Epidemic Alert and Response

The country is vulnerable to natural disasters, including droughts and floods and the vulnerability is further compounded by the fragile structures and the impact of the HIV/AIDS pandemic, collectively termed the ‘triple threat’. The vulnerability on account of natural disasters impacts negatively on the health sector with major health concerns that this vulnerability would give rise to:

(i) high childhood and early adult mortality;

(ii) high mortality (and resignation rates) among health service staff;

(iii) high levels of malnutrition;

(iv) high morbidity combined with poor access to health care; inadequate and poor quality health services; and weak health systems.

The strategic focus in this area of work is to support the strengthening of implementation of the Integrated Disease Surveillance and Response (IDSR) strategy, by achieving greater coverage of understanding and use in districts. In spite of the reduction in financing from traditional disease surveillance agencies, the program area has remained relatively functional, as seen from the high achievement against the IDSR core indicators.

[16] Lancet 2008.

[17] Economic Report 2007.

## 2.4 HEALTH POLICY AND SYSTEMS

### *2.4.1 National Health Policy and Planning*

The National Health Strategy Plan 2006-2010 constitutes a summary chapter of Vision 2030 and the Fifth National Development Plan. The targets to be achieved under the Vision 2030 include attaining health MDGs, increased access to health facilities and availability of health workers. The NHSP 2006-2010 identifies twelve (12) priority interventions for attaining the health improvement through effective coordination, implementation and monitoring of health services. The objectives of Health Systems Governance were:

- To provide a comprehensive policy and legal framework for effective coordination, implementation and monitoring of health services;
- To ensure efficient and effective organization and management of health service delivery at all levels;
- To ensure that the different situations and requirements of men and women are catered for so as to promote gender sensitivity and equity in delivery and access to health services; and,
- To strengthen SWAp management and coordinating mechanisms in order to improve health sector performance.

Zambia has a mature Sector-wide Approach (SWAp) mechanism. The MoH coordinates all planning activities, using a range of medium and short-term plans for the sector. The sector uses the Medium-Term Expenditure Framework (MTEF) budget to allocate resources for implementation. Support is needed to allocate resources across facilities in their districts. Costs of inputs are provided and districts are advised to use annual inflation rates, but recent fuel price increases have had an impact on the spending power of districts. All known resources that come under MoH management are included in the MoH resource envelope and the MTEF.

### *2.4.2 Health Care Financing and Social Protection*

The annual health spending (Government + donors) increased from about US$ 109 million (2004/05) to US$ 234 million (2007) mainly due to increased in-flows towards HIV programmes and projects. Donor annual commitments to HIV alone increased from US$ 22 million in 2005 to about US$ 180 million in 2008 – surpassing the total spending for all other health interventions. For 2008, the total budget allocation for Infrastructure is US$ 4.8 million and a further US$ 9.32 million for training institutions. This is a considerable increase in the resource allocation from previous years. Despite this increase, the country will still require an additional US$ 45-60 million for ARVs over the duration of the NHSP in order to sustain the ART scale-up programme plus the switch-rate from current D4T-based regimens to new TDF-based regimens. If other new drugs and technologies, HR financing, and cost of treatment abroad are included, provision will have to be made in the budget for an annual additional amount of about US$ 45 million.

On a per capita basis, actual health spending (Government + donors) has increased from around US$ 10 (2004) to about US$ 23 (2007); US$10 below a standard of US$ 33 recommended by the WHO Commission on Macroeconomics and Health. Financing in the context of the NHSP is, therefore, critically needed.

A recent NHSP costing exercise, giving three scenarios, suggests that the health sector will require an additional US$ 7.8 per capita to fund its minimum expectation and US$ 16.3 to fund its highest expectations by 2010.

Out of pocket payment on health care still constitutes a large proportion of household expenditure, with private households' out of pocket payment (as a % of PvtHE) increasing from 71.6% (K618 billion) in 2004 to 79.9% (K668 billion) in 2006[18]. Noting that user fees had a tendency to push some families into a poverty trap because of their regressive nature, Government in 2006 passed a law to remove user fees and explore other alternative health care financing mechanisms such as social health insurance.

### *2.4.3 Human Resources for Health*

The 2005-2006 data from the Health Facility Census gives a ratio of 1.04 health workers per 1000 people. There are approximately 0.08 doctors and 0.69 nurses per 1000 people. This ratio does not take into account the skill mix and productivity levels of all health workers or the quality of care provided.

**Table 1: Staffing Levels against Recommended Levels 2005-2007**

| Staff Category | 2005 | 2006 | 2007 | % Change | Recommended | Variance | Staff : Population Ratio |
|---|---|---|---|---|---|---|---|
| Doctors | 646 | 718 | 815 | 13.5% | 2300 | 1485 | 16 016 |
| Clinical Officers | 1161 | 1254 | 1386 | 10.5% | 4000 | 2614 | 9170 |
| Nurses | 8369 | 8650 | 9190 | 6.2% | 22 332 | 13 142 | 1329 |
| Laboratory Technicians | 417 | 432 | 460 | 6.4% | 1560 | 1100 | 26 620 |
| Pharmacists | 108 | 133 | 158 | 18.7% | 162 | 4 | 86 466 |
| Other Paramedics | 1138 | 1396 | 1682 | 20.4% | 9006 | 7324 | 8237 |
| **Total** | **11 839** | **12 583** | **13 691** | ~ | **39 360** | **25 669** | ~ |

**Source: MoH and Economic Report 2007**

Government recruited a total of 1108 frontline medical personnel in an effort to improve on the human resource situation which remained inadequate in 2006 with all categories of staff estimated at 12 583, less than the recommended 39 360 staff establishment (see Table 1 above). Nurses and other paramedics still constituted the worst hit category of staff. The Ministry of Health in collaboration with CPs has embarked on improving the work environment for health workers in rural and remote areas. Rural retention scheme was implemented and scaled up with 65 doctors and 91 nurse tutors being introduced to the scheme in 2007 and K4.8 billion disbursed for rehabilitation of nursing schools. Health institutions operate below 50%[19] of the recommended staff establishment with some officials being more deficient.

### *2.4.4 Service Delivery*

Health services delivery requires a functional health system, which in turn needs key elements and essential inputs to make it work. At present, several challenges are affecting the effectiveness of Zambia's health system. In particular, human resources crises and inadequate

[18] NHSP Costing Report (MoH).
[19] HRH Strategy 2006-2010
[20] Zambia Health Sector Public Expenditure Review 2006

numbers of health facilities. Significant gap exists in the number and distribution of facilities required to cover the population. In total, Zambia has 1327 health facilities, including 97 hospitals, 1210 health centres, and 20 health posts. The majority of the health facilities belong to GRZ. The existing network of health facilities, especially at the lowest level, is not adequate to cater for the entire population. There is acute shortage of primary health care facilities, in particular[20]. For example, the target is to have 3000 health posts but currently only 20 have been commissioned; the target for health centres is 1385 but currently only a total of 1210 health centres have been built.

### *2.4.5 Information for Health Planning and Management*

To ensure adequate use of available health sector information for action, the health management information system is being strengthened. WHO supported the setting up of GIS equipment for supporting the Health Information Management Systems (HMIS), in collaboration with HMN. The HMN planning was pilot tested and closely aligned with WHO's framework on health systems strengthening.

### *2.4.6 Health Systems Research*

Health Systems Research is a contributing factor to the Health-for-all strategy by focusing on its primary role within the framework of primary health care. The commissioning of Health Systems Research by the Ministry of Health in 1991 has emphasized the importance of health development research in attaining equity. Health Research has been identified as a tool for managing health systems programmes at all levels of health care through its capacity and evaluation processes. In addition, WHO is supporting Government to strengthen Health Systems Research to provide evidence for health policy and programmes in order to meet the health-related Millennium Development Goals and national health targets. However, there are challenges that make the attainment of these targets difficult, notably:

- Inadequate human resource to carry out the activities;
- Inadequate transport to conduct monitoring and evaluation of research in the field;
- Inadequate funding for health systems research training for Districts.

### *2.4.7 Essential Medicines and Technologies*

Essential medicines save lives, reduce suffering and improve health, but only if they are of good quality, safe, available, affordable and properly used. Almost 2 billion people, representing one-third of the world's population, do not have access to essential medicines. The use of traditional medicines or complementary and alternative medicines in Zambia (like in many developing countries) is widespread and constitutes a source of growing expenditure.

Over the past 5 years, the bulk supply of essential drugs and other medical supplies were erratic, with more than 50% of essential drugs being out of stock. Shortages and inappropriate clinical use of drugs and medical supplies still remain a major problem in Zambia. Dissemination and enforcement of compliance with recognized/recommended treatment guidelines and compliance with prescription also remain a challenge. The critical shortage of qualified pharmacists in the country has contributed to a weak supply chain management and inadequate coordination of available resources and programmes to achieve the goals of the National Drug Policy. In addition, issues related to drugs and medical supplies in the framework of Supply Chain Management are not adequately addressed. The Ministry of Health has strengthened the capacities of existing staff in the Drugs and Medical Supplies Logistics

Management System in order to improve accountability, availability and quality. However, effective implementation of the system is still a challenge. The national expenditure of medicines in the health sector is very high.

The central priority remains expanding access to essential medicines, one of the health-related Millennium Development Goals to which Zambia is committed. Three out of eight MDGs, 8 out of 16 MDG targets, and 18 out of 48 MDG indicators are health-related and most of them cannot be achieved without medicines. Implementation of the WHO Medicines Strategy 2008-2013 including WHO Strategy for traditional medicines, and the use of generic medicines remain critical. WHO will support and provide guidance on the formulation, implementation and monitoring of the National Drug Policy (NDP) to help improve access to essential medicines, including traditional medicines and assure safety, quality and rational use. NDP priority areas for implementation and monitoring will be improved in all hospitals, districts, academic institutions and statutory bodies, including the private sector, through the on-going training sessions, community sensitization campaigns, technical support and cooperation at various levels.

## 2.5 SUMMARY OF CHALLENGES IN THE HEALTH SECTOR

The health sector in Zambia was faced with several challenges such as the high burden of preventable diseases, particularly in the areas of HIV, malaria, TB, diarrhoeal and respiratory diseases. The situation for TB is improving but case detection remains low, especially in children. Knowledge on HIV status and use of counselling and testing services is inadequate. Indoor residual spraying for malaria prevention has proved an effective intervention but is applied in a limited number of districts. There is also increasing burden of noncommunicable diseases, particularly diabetes, obesity and hypertension. The current maternal and child mortality levels remain high and Zambia is unlikely to attain the related MDGs at current rate of reduction. The deaths are mostly occurring at the perinatal stage. Maternal deaths are mostly caused by clinical factors. Information on adolescent sexuality needs to be scaled up. Access to the different components of IMCI services is not adequately available. Prevalence of malnutrition among children and pregnant women remains high. EPI coverage is up but there are significant variations between districts. Cold chain storage capacity at the national, provincial and district levels is less than desired and will be further challenged in the light of the possible introduction of new vaccines.

The persistent inadequate availability of skilled health professionals has resulted in low access to health services in all communities and facilities. The profile shows an aging professional cohort, particularly among medical staff. The training institutions are insufficient to meet the projected needs, with most of them operating below capacity. They are also poorly distributed, particularly among rural and urban areas. Physical access to functional health centres is poor in rural areas. Where they exist in urban areas, their capacity is limited leading to congestion in facilities. There is still lack of specialist care in key areas responsible for high disease burden e.g. cardiovascular and renal conditions, and a number of diagnostic procedures still require sending patients abroad at a high cost. There are difficulties in the referral systems with geographical barriers (terrain, transport, etc.,) to access.

Health financing is below acceptable levels for programme implementation. Out of pocket expenditure is high. Donor support is a significant component of the budget; however, it is mainly earmarked for a few programme areas. The existing health information systems need to be strengthened at all levels.

# SECTION 3

# DEVELOPMENT COOPERATION AND PARTNERSHIP

Donor funding remains a significant part of health financing in the country, contributing 31.9% of the total health budget in 2007.

## 3.1 DEVELOPMENT ASSISTANCE

The assistance from the development partners over the last decade has consistently been a significant part of the health sector expenditure. The Medium-Term Expenditure Framework (MTEF) plan formed the basis for current donor support to the health sector. Financial contribution from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), US President's Emergency Plan for AID Relief (PEPFAR) and the Global Alliance for Vaccines and Immunizations (GAVI) constitutes an important component of the aid flow to Zambia. GFATM and PEPFAR funds are channelled through the Government and NGOs, whereas the GAVI funds are allocated only to the Government. With the approval of the TB component in Round-5, and HIV/AIDS in Round-6, the approved support from GFATM since 2004 will now total about US$ 9.7million. In addition, funds will be available in the country from the vaccine fund of the GAVI Alliance, which will enhance the responsiveness of the health system.

Based on committed funding up to 2008 and on conservative estimates of 50% for anticipated levels of external support and increases in GRZ contribution from debt relief dividends thereafter, the NASF presents the following financing scenario, which excludes the pending GFATM Round 6 proposal[21]:

**Table 2: Estimated Funding for NASF 2006-2010 (in US$)**

| | 2006 | 2007 | 2008 | 2009 | 2010 | 2006-10 |
|---|---|---|---|---|---|---|
| UN Family (Includes WB) | 20 000 000 | 20 000 000 | 20 000 000 | 11 600 000 | 11 600 000 | 83 200 000 |
| JICA | 3 205 785 | 3 205 785 | 3 205 785 | 3 205 785 | 3 205 785 | 16 028 925 |
| USG* | 149 000 000 | 149 000 000 | 149 000 000 | 74 000 000 | 74 000 000 | 595 000 000 |
| NORAD | 2 850 000 | 2 850 000 | 2 850 000 | 2 850 000 | 2 850 000 | 14 250 000 |
| Netherlands | 1 210 090 | 1 210 090 | 1 210 090 | 1 210 090 | 1 210 090 | 6 050 450 |
| DCI (Ireland) | 3 751 279 | 3 751 279 | 3 751 279 | 3 751 279 | 3 751 279 | 18 756 395 |
| SIDA | 3 933 333 | 3 933 333 | 3 933 333 | 3 933 333 | 3 933 333 | 19 666 667 |
| Global Fund** | 52 800 000 | 52 800 000 | 52 800 000 | 19 800 000 | 19 800 000 | 198 000 000 |
| DFID (UK) | 7 065 200 | 7 065 200 | 7 065 200 | 7 065 200 | 7 065 200 | 35 326 000 |
| EU | 4 033 633 | 4 033 633 | 4 033 633 | 4 033 633 | 4 033 633 | 20 168 167 |
| Private Charities & Foundations | 10 000 000 | 10 000 000 | 10 000 000 | 10 000 000 | 10 000 000 | 50 000 000 |
| GRZ*** | 15 000 000 | 15 000 000 | 15 000 000 | 15 000 000 | 15 000 000 | 75 000 000 |
| **TOTAL** | **272 849 320** | **272 849 320** | **272 849 320** | **156 449 320** | **156 449 320 1** | **131 446 600** |

**Source:** Borrowed from 2006-2011 NASF

[21] NASF 2006.

## 3.2 PARTNER PROGRAMMES

The main multi-lateral CPs in the health sector in Zambia are; World Bank, African Development Bank (ADB), European Union and UN Agencies, especially WHO, UNICEF, UNFPA and UNDP. The main bilateral CPs in the Health Sector are; United Kingdom (DFID), The Netherlands, Sweden (SIDA), Japan (JICA), USA (USAID), Denmark (DANIDA) and Ireland. Many of these partners have interest in supporting specific areas in health. The major priorities are shown in Table 3 below.

**Table 3: Cooperating Partners Priority Areas**

| Programmes | Cooperating Partners | |
|---|---|---|
| | Lead partners | Active partners |
| Human Resources | SIDA, USAID | DfID, JICA, RNE, UNFPA, WB,WHO,EU,CIDA |
| Procurement and Supplies / Medical Stores Limited (MSL) | DfID, CIDA | EU, JICA, RNE, UNICEF, WB,WHO,USAID, |
| HMIS/Surveillance/M&E | USAID, DfID, EU, WHO | JICA, RNE, UNFPA, WB, SIDA, |
| Infrastructure, Transport and Management | JICA, | UNICEF, SIDA, WHO, DfID |
| Planning, Expanded Basket, Health Financing, Resource Allocation and Audit | DfID, SIDA | RNE, USAID, WB, WHO, EU |
| Hospital Reform | SIDA | USAID, WB, WHO, JICA |
| SWAp Management, Sector Performance Monitoring, General CP Coordinator | SIDA | DfID, JICA, RNE, UNFPA, WB,WHO,EU, UNICEF, USAID |
| HIV/AIDS and Global Fund | UNAIDS, USG, DfID, JICA, WHO | SIDA, UNFPA, RNE, IA, WB, EU |
| Reproductive Health | UNFPA, USAID, WHO | RNE, WB, SIDA, DfID, UNAIDS, JICA, UNICEF |
| Child Health | UNICEF, USAID, CIDA, WHO | WB, JICA |
| Tuberculosis | CDC, JICA, WHO | WB,USAID |
| Malaria | USAID, MACEPA, WHO | UNICEF, WB, JICA |
| Nutrition | UNICEF | USAID, WB, JICA WHO |
| Avian Influenza | WHO | USAID, DfID, EU, WB |

## 3.3 HARMONIZATION AND ALIGNMENT

The various partner interests have resulted in a certain level of fragmentation and over-funding in some very limited areas. The Government of Zambia in a bid to address this issue, demonstrated leadership of the health sector and put in place a Sector-Wide Approach (SWAp) in 1994. This is in line with the "Paris Declaration on Aid Effectiveness, 2005"[22]. The core elements of the Zambian SWAp mechanisms are: common basket funding mechanisms, harmonization of systems and procedures, strengthening resource allocation, resource mobilization, strengthening financial reporting mechanisms, capacity building and training and institutionalized policy dialogue. Under the SWAp mechanism, seven (07) indicators have been identified to monitor performance of the health sector[23].

[22] WHO2006: a guide to WHO's role in sector –wide approaches to health development.
[23] MTR Report 2004.

The health partners are coordinated by the MoH through the Directorate of Planning and Development (DPD). The MoH has developed a *Memorandum of Understanding* that defines the expectations of the Ministry of Health and those of the partners for improved harmonization. In order to strengthen government ownership and leadership, partners engage the Ministry of Health at various forums namely, Monthly Policy Meetings, Sector Advisory Group (SAG) Meetings, Annual Consultative Meeting, Joint Annual Review (JAR) Meeting, Monitoring and Evaluation (M&E) Meeting and Minister's & Head of Mission Meeting. The Government-led mechanism facilitates the exchange of information and policy dialogue between the Cooperating Partners and the Government on all matters related to the health sector. The JAR, SAG and policy meetings are chaired by the Permanent Secretary and the annual consultative and Head of Missions meeting are chaired by the Minister of Health. The Director, Directorate of Planning and Development, chairs the M&E meeting and are held bi-monthly. Other fora through which the health partners share ideas, experience and discuss challenges include the UN Expanded Theme Group on HIV and AIDS and Country Coordinating Mechanism (CCM) for the Global Fund for AIDS, TB and Malaria. The meetings are convened monthly. There are two co-chairs for all health partners. One chair represents the UN agencies while the other represents the other partners. MoH has developed Terms of Reference for these coordinating committees. In addition, there are other mechanisms to coordinate resources from different agencies. The Country Coordination Mechanism (CCM) is actively involved in policy-making and monitoring of the GFATM activities, and an Inter-agency Coordination Committee is functioning for GAVI-funded activities and for maternal, newborn and child health.

## 3.4 UNITED NATIONS DEVELOPMENT ASSISTANCE FRAMEWORK (UNDAF) 2007-2010

The United Nations Development Assistance Framework (UNDAF), an umbrella programming mechanism of the UN Country Team, works in close cooperation with and has aligned its priorities to that of the Government. The current UNDAF, which reaffirms the commitment of the UN Country Team to supporting the efforts of the Government and toward realizing the long-term national Vision 2015 goals, covers the period 2007-2010[24]. The framework is also used for monitoring progress made by Government towards achieving MDG targets by 2015. The UNDAF responds to national development priorities as articulated in the FNDP. The UNDAF is focussed around four thematic areas namely: Governance; HIV and AIDS; Food Security, and Basic Social Services. As a specialized agency of the UN system, WHO has ensured that the CCS is integrated into the UNDAF as a way of ensuring the support of UN system for its implementation.

## 3.5 CHALLENGES IN PARTNERSHIP

Since 2005, some CPs have 'migrated' to other sectors in line with GRZ and JASZ/ Harmonization in Practice policy of decongesting over-subscribed sectors. It is estimated that this has led to the MOH losing close to US$ 25.2 million per annum. Direct Earmarked Funding, using donor systems that are off-budget, has also become the largest pool of funds available in the health sector (see financing section for analysis on per capita expenditures). Indeed, almost all the partners, including basket funders, the signatories to the Global IHP

[24] UNDAF Report.

Compact, allied initiatives and UN agencies in health run directly-financed vertical programmes, using Direct Earmarked Funding. This is further compounded by a more recent infusion of large amounts of funds that are earmarked for specific diseases or programs from the various Global Health Initiatives (GHIs) such as: GAVI, the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM), the US President's Emergency Plan for AIDS Relief (PEPFAR), the Bill and Melinda Gates Foundation, the Clinton Foundation and the World Bank Malaria Booster Programme. With the inclusion of funds from PEPFAR and Global Fund alone, mainly for HIV/AIDS, public per capita expenditure moved from US$ 11 million to approximately US$ 34 million.

While the Cooperating Partners remain committed to supporting the MoH in health development programmes, the need for improvements in the coordination of financing of the health sector and attainment of health outcomes assumes greater urgency. The International Health Partnership/Harmonization for Health in Africa initiatives, to which Zambia is a signatory are considered positive avenues and opportunities to improve commitments and systems towards greater harmonization and alignment.

# SECTION 4

# PAST AND CURRENT WHO COOPERATION IN ZAMBIA

## 4.1 WHO COUNTRY PRESENCE

Zambia was admitted into membership of the World Health Organization in 1965. The WHO Country Office was established in 1965, following the signing of the Basic Agreement between the Government of Zambia and the World Health Organization in 1965 for implementing mutually-agreed plans relating to technical cooperation. In 2002, the WHO Country Office in collaboration with the Ministry of Health and development partners, developed the first Country Cooperation Strategy.

The essential focus of WHO is to provide technical support for health development. In Zambia

WHO support to the Government is focused on the offer of technical and financial assistance to priority health programmes, which included the following areas:

(i) reproductive health (RH);

(ii) child health; malaria;

(iii) HIV and AIDS; health promotion;

(iv) epidemic preparedness and response;

(v) communicable disease prevention and surveillance;

(vi) and prevention and management of noncommunicable diseases (NCDs). Other areas of support include human resource management;

(vii) essential drugs and medical supplies;

(viii) health care financing, social protection and health systems strengthening.

In addition, WHO aims to provide leadership and foster partnerships in order to achieve effective outcomes. These interventions are developed more specifically as the "WHO core functions", which include:

- providing **leadership** in matters critical to health and engaging in partnerships where joint action is needed;
- shaping the **research** agenda, and stimulating the generation, dissemination and application of valuable knowledge;
- setting **norms and standards**, and promoting and monitoring their implementation;
- articulating ethical and evidence-based **policy options**;
- providing **technical support**, catalyzing change and building sustainable institutional capacity;
- **monitoring** the health situation and assessing health trends.

As a technical agency, WHO places particular emphasis on its normative role and the promotion of skills development. These are considered as keystones to the successful implementation of quality health services that are accessible by all.

## 4.2 CONTRIBUTION OF WHO COOPERATION STRATEGY 2002-2005

In the 2000/2001 biennium, WHO provided US$ 2 947 000 as Regular Budget (RB). This support has been maintained. Thus, in the biennial period 2006/7 a sum of US$ 2 995 000 RB and US$ 6 521 000 Extra Budget (EB) were provided to the MoH.

During the period under review, significant achievements were made in the implementation of most of the WHO country programmes. The various activities that were successfully conducted included: the training of health workers in Emergency Obstetrics Care (EmOC), which was supported by WHO and other cooperating partners; the commencement of a degree programme for environmental health officers at the University of Zambia (UNZA); and the revision of the Integrated Disease Surveillance and Response (IDSR) technical guidelines, to incorporate Avian and Human Influenza (AHI). In the area of Expanded Programme on Immunization (EPI), WHO supported the scaling-up of the Reaching Every District (RED) strategy to cover a total of 46 districts and also supported capacity building for effective vaccine management, training, monitoring and supervision. Other achievements included support to the UNZA School of Medicine, through the provision of financial incentives to 20 lecturers[25].

During the same period, the health sector recorded notable improvements in health service delivery, compared to the 2006 position, particularly in the areas of EPI, malaria, HIV/AIDS, Tuberculosis, human resources, infrastructure development and implementation of the User Fee Removal Policy. This is also supported by the preliminary report on the Zambia Demographic and Health Survey 2007 (ZDHS 2007), which was officially released in May 2008.

Major progress by the WHO Cooperation Strategy includes support to the MoH to attain its targets indicated in the National Health Strategic Plans and MDGs earlier mentioned. For example, on disease prevention and control, several significant contributions have been made. For example, a comprehensive WHO strategy in country has strengthened prevention, treatment, care and support for people living with HIV and AIDs, which contributed to a reduction in adult national prevalence from 16% to 14% by 2007[26]. In the case of malaria, the country witnessed a halting and reduction in malaria cases in the period 2000-2007 after years of steady increases between 1970 and 2005. This was achieved through a combination of effective anti-malaria medicines, high coverage with preventive and promotive interventions, a robust partnership and initiatives (WHO's advocacy for reduced prices of ACTs (Co-arterm), Prequalification programme, 3x5 Initiative, Roll Back Malaria, DOTS programme for TB treatment) strongly facilitated by WHO's presence in the country. In case of TB, the country has recorded increased TB cure rates and treatment completion while at the same time failure rates have remained low.

Notable progress was also recorded in the area of infrastructure, equipment and transport, where significant resources and support from partners were invested in constructions,

[25] WHO Annual Report 2007.
[26] ZDHS 2007.

renovations and expansions of health facilities, procurement and distribution of appropriate medical equipment, and procurement and distribution of 164 operational motor vehicles and 560 motorcycles to all districts. Further, the Government also pursued the implementation of the user fees removal policy in the targeted rural districts. In this respect, guidelines were developed for exemption from paying user fees for populations living outside the 20-kilometre radius from the nearest health facility in 18 Municipal Councils.

However, notwithstanding the several achievements made, the health sector continued to face various constraints, which presented significant challenges to health sector performance. The major constraints included: the high disease burden; the human resources for health crisis; persistent problems in the procurement and distribution of drugs and medical supplies; availability, distribution and condition of health infrastructure, medical equipment and transport; and the persistent inadequate funding of the health sector. Malaria remained the leading cause of morbidity and mortality, while HIV/AIDS-related cases, both suspected and confirmed, were the second leading cause of mortality in the country. At the same time, even though the ZDHS-2007 has reported major improvements in maternal and infant mortality rates, the levels are still high and constitute a major source of concern: Maternal Mortality Ratio (MMR) at 449 per 100 000 live births; Infant Mortality Rate at 70 per 1000 live births, and Under-5 Mortality Rate at 119 per 1000 live births[27].

Finally, as a member of Troika, WHO provided support on coordination of the work of development partners by supporting and participating in Ministry of Health/Cooperating Partners monthly policy meetings and health sector reviews.

## 4.3 SUPPORT FROM THE REGIONAL OFFICE AND WHO HEADQUARTERS

The WHO Country Office in Zambia receives a lot of support from WHO/AFRO, Zimbabwe IST, and WHO Geneva. The Regional Office for Africa and the HQ supported participation of WHO staff as well as government officials in meetings of WHO Governing Bodies, technical and programme review meetings, joint mission to countries, production of advocacy and training materials, and increasing information exchange. All this support has led to strengthened relations between the Ministry of Health and the WHO Country Office.

## 4.4 IMPLEMENTATION CHALLENGES

Many of WHO's achievements may be attributed to the ability of the WHO Country Office in Zambia to build and maintain productive partnerships with other development partners, NGOs and the Ministry of Health. The technical expertise of the staff within the country office, along with the support from the Regional Office, has bolstered the continuing achievements of WHO in the country.

However, weaknesses of the current CCS included inadequate marketing of the CCS and Plan of Action to stakeholders, weak monitoring within the country and overloaded staff members due to thin staffing of the Office.

[27] Ibid.

## 4.5 SUMMARY OF ISSUES FOR FUTURE WHO COOPERATION

The positive national public health agenda needs to be supported. Priority areas of support will be improvement of maternal, neonatal and child health programmes with the aim of reducing mortality and morbidity by emphasizing basic antenatal care, emergency obstetric care and delivery. This should include strengthening child survival and development strategies, improvement of nutrition and a broad focus on communicable diseases, including HIV and AIDS, TB, Malaria and other infections. Disparities in the prevalence of HIV by province will require different targeted strategic responses to contain them. The lifestyle-related noncommunicable diseases (hypertension, diabetes, obesity, cancer) and the increasing levels of substance abuse, road traffic accidents and domestic violence, violent crime and suicide among the population are of major concern. A focused social and behaviour change programme and the generation and analysis of relevant evidence for decision-making are required. Programme support for the various areas will be fundamental. Given the country's involvement with the International Health Partnerships Initiative, a stronger health system and financing programme needs to be developed in support of the country.

At current capacity, the Country Office is neither adequately staffed nor resourced to technically deal with the challenges facing the country or to administratively meet the expectations of management. The office intends to increase the current staffing level, as well as the office space to accommodate the expected growth of the team. Connectivity, security and Minimum Operating Security Standards compliance are consistent with the UN Common Services System.

# SECTION 5

# WHO POLICY FRAMEWORK: GLOBAL AND REGIONAL DIRECTIONS

WHO has been and is still undergoing significant changes in the way it operates, with the ultimate aim of performing better in supporting its Member States to address key health and development challenges and the achievements of the health-related MDGs. This organizational change process has as its broad frame the WHO Corporate Strategy.

## 5.1 GOAL AND MISSION

The mission of WHO remains "the attainment by all peoples of the highest possible level of health" (Article 1 of WHO Constitution). The WHO Corporate Strategy [24], the 11th General Programme of Work 2007-2015 [25] and the Strategic Orientations for WHO action in the African Region outline key features through which WHO can make the greatest possible contribution to health. The Organization aims to strengthen its technical, intellectual and policy leadership in health matters, and its management capacity to respond to the needs of Member States[28].

## 5.2 NEW EMPHASES

The WHO 11th General Programme of Work emphasizes the following WHO responses to the changing global environment:

- Providing support to countries in moving to universal coverage with effective public health interventions;
- Strengthening global health security;
- Generating and sustaining action across sector to modify the behavioural, social, economic and environmental determinants of health;
- Increasing institutional capacities to deliver core public health functions under the strengthened governance of ministries of health; and
- Strengthening WHO leadership at global and regional levels and supporting the work of governance at country level.

## 5.3 STRATEGIC DIRECTIONS

On the basis of these new emphases, WHO has set out a seven point global health agenda underlying its contribution to building healthy populations and combating ill-health.

[28] MSTP 2008-2013.

The agendas, which are interrelated, provide a broad framework for the technical work of the Secretariat:

- Investing in health to reduce poverty;
- Building individual and global health security;
- Promoting universal coverage, gender equality and health-related human rights;
- Tackling the determinants of health;
- Strengthening health systems and equitable access;
- Harnessing knowledge, science and technology; and
- Strengthening governance, leadership and accountability.

The Director-General has refocused and simplified the above into a six-point agenda, namely

(i) health development,
(ii) health security,
(iii) health systems,
(iv) evidence for strategies,
(v) partnerships, and
(iv) improving performance of WHO.

The Director-General has also indicated that the health of women and the African population are essential indicators of global health development.

## 5.4 CORE FUNCTIONS

The WHO core functions, articulated in the 11th General Programme of Work and presented below, is based on the comparative advantage of the Organization at all levels:

- Providing leadership on matters critical to health and engaging in partnerships where joint action is needed;
- Shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge;
- Setting norms and standards, and promoting and monitoring implementation;
- Articulating ethical and evidence-based policy options;
- Providing technical support, catalyzing change, and building sustainable institutional capacity;
- Monitoring of the health situation and assessing health trends[29].

## 5.5 GLOBAL AND REGIONAL PRIORITIES

In order to be more effective and efficient in its interventions, the WHO Country Office developed a Medium-Term Strategic Plan with thirteen (13) strategic objectives based on priorities outlined in the 11th General Programme of Work to guide implementation for the next six years (2008–2013). The main health challenges to be addressed include: maternal,

[29] WHO Country Focus 2007.

child and adolescent health, malaria, HIV and AIDS and TB; noncommunicable diseases (cancer, cardiovascular diseases and diabetes); tobacco; emergency preparedness and response; socioeconomic determinants and health; food safety and nutrition; mental health; safe blood; health systems and promotion of healthy lifestyles.

The 55th session of the WHO Regional Committee for Africa approved five priority areas as strategic orientations for WHO action in the African Region. These are:

(i) Strengthening the WHO country offices;

(ii) Improving and expanding partnerships for health;

(iii) Supporting the planning and management of district health systems;

(iv) Promoting the scaling-up of essential interventions related to priority health problems and;

(v) Enhancing awareness and response to key determinants of health. Special attention was to be paid to HIV and AIDS, malaria, tuberculosis, maternal and child health within the context of strengthened health systems. In this regard, the African region is responding to all the thirteen strategic objectives in addressing the enormous health challenges in the Region.

All the above recognize the need for accelerating action and removing the barriers for scaling-up toward attaining national, regional and internationally-determined goals, including the health-related Millennium Development Goals.

## 5.6 MAKING WHO MORE EFFECTIVE AT COUNTRY LEVEL

The development of the WHO Corporate Strategy, the 11th General Programme of Work and the Medium-Term Strategic Plan at country level will vary from country to country, taking into consideration country-specific health and development challenges. The involvement of health development partners in implementing the WHO agenda to support national government agenda will aim at getting the balance right between WHO's key functions at country level and the comparative advantage of these partners. Generally, the Organization will act more as an adviser, a broker and a catalyst and will involve itself in routine implementation in case of specific, clearly identified initiatives, with a time-limited perspective. A working typology of WHO functions at country level has been developed, based on the broader core functions presented above. Accelerated actions are to be pursued to increase health security, strengthen health systems, improve maternal and child health care, prevent HIV infection, strengthen partnership, advocate for increased resource mobilization and allocation to health and work to bridge the access gap between health services and communities in the context of primary health care. The medium of action is by catalyzing the adoption of technical strategies and innovations; country-specific adaptation of guidelines; and providing high-level policy and technical advice.

# SECTION 6

# STRATEGIC AGENDA FOR WHO COOPERATION

The mission of WHO in Zambia, in accordance with the WHO Constitution, remains "the attainment, by the people of Zambia, of the highest possible level of health". This mission is in line with the vision of the National Health Strategic Plan (NHSP) 2006-2010, which is to "...provide the people of Zambia with equity of access to cost-effective, quality healthcare as close to the family as possible…"..

In pursuance of building and expanding partnerships as part of the key strategic orientation in Zambia, WHO will work with cooperating partners and other stakeholders in the health sector to support the delivery of Healthcare services. Furthermore, WHO will endeavour to enhance dialogue on planning and implementation of agreed priority activities with the Ministry of Health through regular consultative meetings. These meetings are co-chaired at the highest level of leadership by the Ministry of Health.

Based on the analysis of health and development challenges, current WHO collaborative programmes, its comparative advantage, and a review of work of development partners, five

Strategic directions have been identified. The strategic directions fall within three WHO organization–wide strategic domains:

(i) Domain 1: Health security;

(ii) Domain 2: Health Systems Capacities and Performance; and

(ii) Domain 3: Partnerships, Gender and Equity.

## PRIORITY AREA 1: HEALTH SECURITY

### 6.1 STRATEGIC APPROACH 1: ENSURE HEALTH SECURITY BY REDUCING MORBIDITY AND MORTALITY DUE TO COMMUNICABLE AND NONCOMMUNICABLE DISEASES

HIV&AIDS, tuberculosis and malaria are major public health problems and the leading causes of morbidity and mortality in Zambia. They cut across all ages, regardless of their socio-economic status and geographical location. The three diseases have had a devastating impact on the general socio-economic situation of the country and overstretched the already inadequate human resources for health and the health service delivery capacities. WHO will support the MoH and other partners at national, provincial and district and lower levels to combat communicable and noncommunicable diseases in order to attain national health goals as defined in the National Health Strategic Plan and other programme-specific national documents.

**Main Focus**: Strengthening control of HIV and AIDS

- Promoting knowledge of STI/HIV and HIV sero-status through client-initiated testing and counselling and provider-initiated testing and counselling;
- Accelerating access to comprehensive HIV prevention services, including the possible promotion of male circumcision, condom use, treatment of STIs, reduction in multiple partners and trans-generational sex;
- Accelerating the scale-up of HIV treatment and care by focusing on treatment of opportunistic infections, access to ARVs and palliative care;
- Scaling-up prevention of mother-to-child transmission and expanding essential prevention for people living with HIV&AIDS.

**Main Focus**: Strengthening Tuberculosis control

- Improving access to information and increasing human and diagnostic capacities and services for case detection at community and facility levels;
- Improving early detection and management of TB in children and in HIV-infected persons;
- Strengthening and scaling-up comprehensive implementation of the "Stop TB" strategy.

**Main Focus**: Strengthening Malaria control

- Improving availability and access to diagnostic services at community and health facility;
- Improving access to anti-malarial drugs, IRS and ITNs, especially for children under 5 years and pregnant women;
- Improving knowledge in home-based management and access to case management of malaria at community and health facility level.

The strategies will be guided by global, regional and local protocols, guidelines and declarations such as the Millennium Development Goals, Universal Access, UNGASS, the Abuja Declaration, the Maputo Declaration and the Addis Ababa Declaration. Supporting the implementation of the Stop TB strategy will be the main approach.

**Main Focus**: Supporting efforts to reduce the burden of communicable diseases, including vaccine-preventable diseases.

WHO reaffirms its commitment to improving the health of children through the eradication of debilitating diseases, including polio and the control of other vaccine-preventable diseases in the context of health system strengthening. The strengthening of disease surveillance and response is considered core to this approach. In the next five years, WHO will support the Government in strengthening immunization systems, accelerating disease control, and introducing new vaccines and relevant technologies, and tools.

- Strengthening the Integrated Diseases Surveillance and Response systems in all districts;
- Providing technical support for the introduction of the new vaccines (pneumococcal, rotavirus) and build capacity and the management of vaccines and cold chain;
- Supporting vaccine stock and cold chain management at central, provincial, district and health facility levels;

- Improving and building capacity for EPI data collection and management at community and health facility level;
- Supporting surveillance and diagnostic activities for communicable diseases and sustaining the certification levels for polio eradication;
- Improving and sustaining vaccination; case-based and disease surveillance and diagnostics for communicable diseases including cholera, measles and tetanus.

In providing technical support, World Health Organization will collaborate with other partners such as the International Financial Facility for immunization, and the intended introduction of pneumococcal vaccine through the GAVI programme. By achieving coverage in all districts, the government will be able to improve preparedness, early detection of outbreaks and response for all diseases. The effort to also reduce measles mortality and elimination of specific diseases is also considered a priority. The various strategies will be aligned with these initiatives to achieve the country's determined goals. Particular attention will be paid to Neglected Tropical Diseases namely, Filariasis, Human African Trypanosomiasis, Trachoma, Schistosomiasis and Soil-transmitted helminthiasis.

**Main Focus:** Supporting efforts to reduce maternal, newborn and child morbidity and mortality and improving sexual and reproductive health, and nutrition in children and women

MMR, IMR and malnutrition remain unacceptably high. Special efforts will be made to reduce these in line with the MDGs. Through the implementation of the MNCH Roadmap with an emphasis on attaining universal child intervention and high impact maternal and newborn interventions, WHO, in collaboration with partners, will support the MoH and other agencies to:

- Improve and ensure access to quality skilled attendance during pregnancy, childbirth and postnatal care and reduce maternal and neonatal morbidity and mortality;
- Enhance and increase access to integrated health services, especially family planning and STI services for adolescents;
- Scale-up services aimed at decreasing incidences of unsafe abortion;
- Increase access to quality integrated antenatal care services, including nutrition, PMTCT and IPT services;
- Improve and increase access to proven interventions that reduce child morbidity and mortality through scaling-up of the IMCI strategy;
- Promote knowledge and scale-up proven interventions on appropriate child feeding, especially for infant and young children at community and health facility levels;
- Improve detection and management of malnutrition and micronutrient deficiencies in children and women at community and health facility levels.

WHO will enhance Government's role in coordinating other agencies in the attainment of the United Nations Millennium Development Goals through the implementation of the RH Maputo Plan of Action, MNCH Roadmap, Infant and Young Child Feeding Operational Strategy and other internationally-agreed goals and targets relating to maternal, newborn, child and adolescent health.

## 6.2 STRATEGIC APPROACH 2: STRENGTHENING PREPAREDNESS AND CONTROL OF EPIDEMICS AND OTHER EMERGENCIES

WHO will provide support to achieve minimum core capacities required by International Health Regulations (IHR) of 2005 for the establishment and strengthening of alert and response to, and coping with major epidemic and pandemic prone diseases (e.g. avian influenza, cholera, haemorrhagic fevers, plague and typhoid).

In addition, as Zambia continues to be a major recipient of refugees from many parts of Africa and its affinity to recurrent natural disasters arising from floods and drought. WHO will foster the development of national health capacity for emergency preparedness and response; Provide assistance to undertake risk analysis and disease surveillance; and work closely with the Government, UN Agencies and other stakeholders to improve effectiveness of collaboration, on the basis of clearly-defined roles and responsibilities.

**Main Focus**: Supporting efforts to reduce the health consequences of emergences, disasters, crises and conflicts and minimizing their social and economic impact through:

- Provision of catalytic funding for emergency response;
- Provision of catalytic funding to support comprehensive vulnerability and risk assessment;
- Provide technical support for emergency preparedness.

Strategic Approach 6: Promoting health and development and preventing/reducing major risk factors for noncommunicable diseases

**Main Focus**: Supporting efforts to reduce disease, disability and premature death from chronic noncommunicable conditions, mental disorders, violence and injuries.

Due to changes in lifestyle, diseases such as diabetes, hypertension, renal failure, tumours and substance abuse are becoming more prevalent. Projections are that, if these diseases are not managed properly, morbidity and mortality rates could rise to 65% by 2020. WHO will support focus on promotion of healthy lifestyles, enforcement of relevant laws and generation of evidence for programmes through:

- Supporting capacity building on Integrated Management for Emergency and Essential Surgical Care (IMEESC);
- Supporting the strengthening of the Zambia National Cancer Registry (ZNCR) on surveillance and data management;
- Supporting the implementation of the WHO Stepwise Approach for surveillance of major risk factors for noncommunicable diseases (NCDs);
- Supporting the surveillance, prevention and control of eye diseases/conditions;
- Supporting the surveillance and data management of other NCDs, e.g., tobacco abuse, alcohol abuse, etc.

# PRIORITY AREA 2: HEALTH SYSTEMS CAPACITY AND GOVERNANCE

## 6.3 STRATEGIC APPROACH 3: STRENGTHENING THE CAPACITIES AND PERFORMANCE OF THE HEALTH SYSTEMS

WHO support will focus on strengthening national health systems with special emphasis on health information management, decentralization, health financing, human resource capacity building and evaluation of health care interventions in order to expand coverage of priority health interventions tailored to the needs of local communities. WHO will also support the Ministry of Health to improve its capacity to increase access to quality medicines. WHO will, together with other partners, support the Ministry of Health in the implementation of its National Health Strategic Plan, the Fifth National Development Plan and Vision 2030 to ensure the attainment of health outcomes and impact of health interventions in attainment of the health-related Millennium Development Goals.

**Main Focus**: Strengthening of Health Systems, budgeting, accountability and service delivery

- Supporting the planning and development of human resource policies and implementation;
- Supporting alternative healthcare financing to ensure equitable access to health care;
- Strengthening country health systems, knowledge management, and health research and evidence for better decision-making;
- Strengthening the organizational and managerial capacity of the national and local health systems for delivering accessible, quality and safe care to the communities, with special focus on vulnerable groups;
- Enhancing the national capacity to ensure access to quality essential medicines, vaccines and medical technologies.

WHO will play a more strategic role in advocating and supporting the Government to strengthen national policies and systems for medicine procurement, supply chain, rational use, research and development, regulatory and quality assurance. Further support will be provided to ensure effective implementation and enhance access to blood transfusions and quality public health laboratories.

**Main Focus**: Health Systems Research: Contributing to the generation of evidence–based information for use by policy-makers and managers at all levels of the health system. WHO support will focus on strengthening coordinating mechanisms for research at all levels of service delivery (PHO, District, Hospital and Tertiary Institutions):

- Supporting activities of the National Health Research Advisory Committee at the national level;
- Organizing DHMT and hospital training in Health Systems Research Methodology at district and hospital levels;
- Organizing DHMT and hospital training in Data Analysis and Report Writing at district and hospital levels;
- Supporting activities of the National Health Research Advisory Committee;
- Strengthening coordinating mechanisms for research;

- Supporting activities of the National Health Research Advisory Committee;
- Strengthening research activities in traditional medicines.

# PRIORITY AREA 3: PARTNERSHIPS, GOVERNANCE, GENDER AND EQUITY

## 6.4 STRATEGIC APPROACH 4: STRENGTHENING HEALTH SECTOR PARTNERSHIPS: GOVERNANCE, GENDER AND EQUITY

**Main Focus**: Providing leadership, strengthening governance and fostering partnerships

The United Nations System in Zambia is undergoing an important transformation in the way it does business in line with the principles articulated in the Paris Declaration. To this end, the United Nations System is in the process of repositioning itself so as to engage with GRZ, alongside other major development partners under the JASZ, as a means of radically boosting aid effectiveness. Through the UNDAF and JASZ framework, WHO will provide technical assistance to the Ministry of Health and development partners in support of the health sector programmes. WHO will also continue to liaise with global alliances/funds, foundations and Nongovernmental Organizations. Specifically, WHO will facilitate coordination and networking among all stakeholders at country level, in order to promote advocacy and communication in an effort to stimulate inter-sectoral action and increase investment in the health sector. Specifically, WHO will:

- help to harmonize bilateral development assistance through active participation in the health component of JASZ;
- work with other UN agencies and the World Bank to make the best use of their resources for health;
- enhance the work of NGOs through recognition of their contribution;
- promote public/private partnerships to harness the resources of the private sector;
- help to develop guidelines for the safe and effective application of traditional healthcare practice.

WHO will develop and establish global health mechanisms such as the International Health Partnerships to provide more sustained and predictable technical and financial resources for health on the basis of a common health agenda that responds to the health needs of Zambia. WHO will also provide technical advice to MoH and NGOs to develop and adequately prepare themselves for the International Health Partnerships (IHP+).

# SECTION 7

# IMPLEMENTING THE STRATEGIC AGENDA

The strategic agenda in section 6 has articulated the future strategic directions, approaches and priority areas for WHO collaborative work in Zambia for the period 2008-2013. In order to ensure effective implementation for the CCS, it is essential to outline the implications for the WHO Country Office in Zambia, for the WHO Regional Office for Africa (AFRO), based in Brazzaville, as well as for WHO Headquarters (HQ) in Geneva.

## 7.1 IMPLICATIONS FOR WHO COUNTRY OFFICE

Implications of the CCS 2008-2013 for the WHO Country Office (WCO) in Zambia will be outlined in terms of the following:

(i) Expanding the use of country cooperation strategy;

(ii) Core competencies and capacities of WCO in Zambia;

(iii) Integrated pragmatic and technical support from Regional Offices and Headquarters;

(iv) Effective functioning of Country Offices;

(v) Knowledge management and information; and

(vi) Working with organizations of the United Nations System and development partners.

### 7.1.1 Expanding the use of the Country Cooperation Strategy

As a basis for developing a "One WHO country strategy, plan and budget" the WHO Country Office in Zambia will ensure that the CCS will remain central to all planning and budgeting processes. The CCS will also be the basis for the WCO biennial and annual Workplan, and will also be used to foster dialogue with stakeholders in Zambia. The CCS will be revised as required based on appropriate consultations with all stakeholders, especially the Government of Zambia.

### 7.1.2 Core Competencies and Capacities of the WHO Country Office

The WHO Country Office in Zambia has the required set of competencies to effectively and efficiently perform WHO core functions and implement the CCS. The current contractual changes in WHO has helped to bring to the Country Office new competences such as the NPO/MPN, thus strengthening the capacities of the Office. The current composition of technical staff at the Country Office required for successful implementation of WHO collaborative programmes under each strategic direction is provided below. However there is need to recruit staff to strengthen our support to the Ministry of Health in the areas of Nutrition, Water Quality/Food Safety, Blindness Prevention, Environmental Health, Vaccine-Preventable Diseases, Noncommunicable Diseases. All efforts will be made to strengthen and ensure effective capacity to meet the need of the new strategic agenda contained in the CCS. This will be done through technical backstopping from both the Regional Office and Headquarters.

**Table 4: Country Office Professional Staff 2008**

| National Professional Officers | Numbers | |
|---|---|---|
| | Current | Establishment |
| NSO | 4 | 4 |
| NPO/HIV | 1 | 1 |
| NPO/CAH | 1 | 1 |
| NPO/MPS | 1 | 1 |
| NPO/MPN | 1 | 1 |
| NPO/MAL | 1 | 1 |
| NPO/TUB | 1 | 1 |
| NPO/EDM | 1 | 1 |
| NPO/EPI | 1 | 1 |
| NPO/ICT | 1 | 1 |
| NPO/HIP | 1 | 1 |
| NPO/DPC | 1 | 1 |
| NPO/NUT | 0 | |
| **TOTAL** | **15** | **16** |

### 7.1.3 Integrated Programmatic and Technical Support from Regional Offices and Headquarters

In order to implement the "One WHO country plan and budget" based on the CCS, and to respond swiftly to epidemics and other emergencies, an integrated programmatic and technical support will be required from AFRO and the WHO Intercountry Support Team for Eastern and Southern Africa (IST). The WHO Global Management System (GSM), which will soon be operational, will support this process.

### 7.1.4 Effective Functioning of the Country Office

An enabling work environment, with increased administrative and managerial efficiency as well as adequate logistics and field security will allow the Zambia country team to carry out WHO core functions in line with the CCS. All staff will be provided with the training needed to effectively utilize the GSM and related information systems that support greater decentralization and increased accountability. In order to strengthen WCO's support to the Ministry of Health for better health outcomes, there is need for full time focal persons for the following programmes: Nutrition, and Food Safety/Water Quality, Environmental Health and IVP/NCDs. This will be needed to improve WCO participation in UNCT joint programming process and several other Ministry of Health Technical Working Groups. This will be done in order to encourage horizontal linkages of programmes within the WCO Zambia. Funding for recruitment of focal points for nutrition, environmental health, etc, is required. The WCO has been organized into three clusters, two for programmes and one for health systems.

These are:

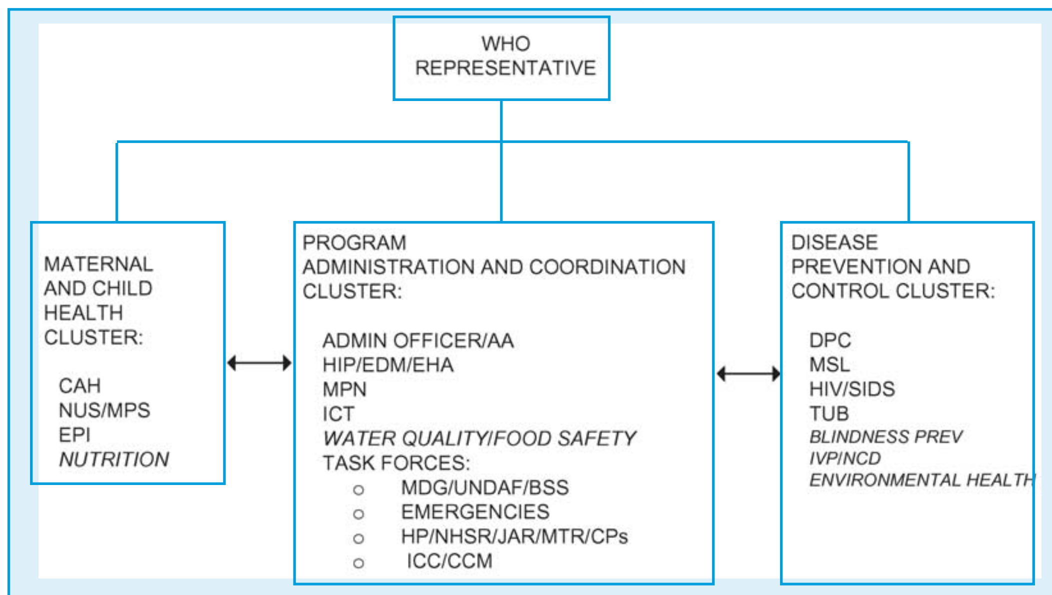
(1) Maternal and Child Health cluster;

(2) Program Administration and Coordination cluster;

(3) Disease Prevention and Control cluster.

Each cluster will be coordinated by a senior member of that cluster. The proposed organizational structure is as shown in Figure 5 below.

**Figure 5: WHO Country Office Organizational Chart**




An incremental approach will be adopted to respond to pressing need and post creation. Technical officers, administrative and secretarial support will be recruited as and when needed, in consultation with the Government and partners and according to collaborative initiatives with partners. Wherever possible, local experts and institutions will be used to provide technical assistance on short-term basis. In the framework of the CCS, WHO will jointly review the current biennial plan of action with the Ministry of Health.

Institutional strengthening of the Country Office in its role as a knowledge-based organization will be done through;

(a) direct computer access of all WHO staff to online science journals and databases;

(b) upgrading of computer capacity in the Country Office;

(c) increasing the running costs for the expanded office and ensuring an efficient pool of vehicles; and

(d) expanding the archives and strengthening library services with computers and access to online services for journals and databases.

### 7.1.5 Better Knowledge Management

Better knowledge management, using modern technologies is critical for improving online access to update information on countries from all parts of the Secretariat. The Country Support Unit (CSU) network portal provides a link to enhance country intelligence and learning through the sharing of good practices. WCO Zambia will strive to make efficient use of aggregate knowledge to promote better health in Zambia. The WCO will also strive to become better at learning and knowledge sharing, and will ensure that up-to-date information on countries and WHO Country Offices is available and easily accessible to shareholders. The WCO Zambia website will become operational in 2010.

### 7.1.6 Working with Organizations of the United Nations System and Development Partners

Partnerships have become a key feature of WHO's work. WCO Zambia's input into the common Country Assessment/United Nations Development Assistance Framework (CCA/UNDAF) and other frameworks of the United Nations System is based on the CCS. It helps to position WCO Zambia within Sector-Wide Approaches (SWAps), the Fifth National Development Plan and other health and development processes in Zambia. The WCO will be proactive in identifying the new opportunities for harmonizing and aligning its work with that of other UN Agencies and development partners. Above all, the WHO Country Office is committed to providing high quality technical support to all stakeholders to facilitate the attainment of "Health for All" in Zambia.

## 7.2 IMPLICATIONS FOR WHO REGIONAL OFFICE FOR AFRICA

The Regional Office will continue providing technical support to the Country Office for implementing the strategic agenda in areas where the relevant expertise is not available in country. With the establishments of Intercountry Support Teams (IST), it is expected that the IST/Eastern and Southern Africa, based in Harare, Zimbabwe, will provide the needed additional technical support, as may be necessary. Moreover, Regional and IST assistance will usually be required to address emergency and humanitarian situations in order to provide timely support. The Global Management System (GSM) will facilitate better integrated programmatic and technical support from AFRO and the Intercountry Support Team.

The WHO Regional Office for Africa (AFRO) and the Intercountry Support Teams will disseminate the documents to key donors and stakeholders in health and provide appropriate orientations to the regional and technical advisers at the Regional, IST and Headquarters levels to support implementation.

The Regional Office will also provide guidance on how the CCS is translated into biennial programme budgets to meet the needs of the Region and achieve Organization-wide Expected Results (OWERs). Considering the need for additional resources to support the implementation of the strategic agenda, AFRO will use the document to mobilize more resources for the Country Office. Regular monitoring of the impact of the CCS will be provided and support given to implement the recommendations arising from this exercise. AFRO will ensure that the lessons learnt will be integrated into the WHO managerial process.

## 7.3 IMPLICATIONS FOR WHO HEADQUARTERS

The WHO Headquarters, in keeping with its mandate, will continue supporting the Regional and Country Office with a global policy advice, directives on health development, and guidance on global norms and standards. In addition, it will advocate the cause of the country and take action for resource mobilization for the country at the global level. With their broad-based networks the Regional Office and HQ are also required to facilitate intercountry collaboration and multicountry activities for transfer of technology, sharing of experience, expertise and resources between countries within and outside the Region. This will enable WHO Zambia to address common issues of interest and learn of best practices, effective strategies and approaches for health development in other countries.

The WHO Headquarters will provide sufficient publications and other technical materials in relation to global resolutions and conventions as well as policy briefs that impact on health. Like the Regional Office, Headquarters will disseminate the CCS document to

international health development partners, HQ clusters and departments, to increase resource mobilization and facilitate the implementation of the strategic agenda.

While the Country Office has to be proactive in mobilizing resources required for effective implementation of the strategic agenda in Zambia, in line with the principle of "ONE WHO", Headquarters will work with AFRO and the Country Office to mobilize resources and provide technical support for the implementation of the CCS. Headquarters will also work with AFRO to document lessons arising out of the CCS process and the impact of CCS on WHO work as a whole. Finally, Headquarters will adopt the CCS document, review progress made every two years, in collaboration with the Regional Office, based on the monitoring and evaluation framework of the Corporate Strategy, and use the outcomes as a basis for informing the biennial plans and the WHO reform agenda.

## 7.4 RESULTS-BASED MANAGEMENT: MONITORING AND EVALUATING THE COUNTRY COOPERATION STRATEGY

### 7.4.1 Result Framework and CCS Alignment

The CCS is explicitly rooted in a results framework, which links Zambia's overall goal of the PRSP and FNDP to specific strategic objectives that are measured by long-term outcomes, paying attention to cause and result linkages. The main focus of the planned WHO activities is to improve the health outcomes through interventions that remove obstacles to a longer term strategies for health outcomes (See Annex 3). Where appropriate, quantitative targets to be reached during the CSS period will be specified. During this period, WHO will track progress on specific CSS outcomes and intermediate progress indicators that are directly affected by WHO interventions.

### 7.4.2 CCS Monitoring and Evaluation

The WHO Country Cooperation Strategy (CCS) establishes, through a highly consultative process, the strategic direction for WHO's work in Zambia and defines the competencies needed for this work. WHO contribution to the national development agenda as well as the country input through the organization to the global health agenda have to be assessed over the period covered by the CCS.

The Strategic Agenda will be implemented through three consecutive biannual programme budgets and workplans. Within the framework of the WHO results-based management system, these workplans include a robust monitoring framework of intervention specific indicators, which include office specific expected results and key products. WHO's regular six-monthly monitoring of workplan implementation progress will be complemented by a periodic in-depth evaluation of selected programmes to determine their outcomes and impact on national health development. The thematic evaluation of some key areas/issues will also be undertaken, when necessary. In addition, the core CCS benchmarks will be derived from the PRSP/FNDP targets. These benchmarks reflect the selective benchmarks:

(i) reflect WHO involvement under the CCS;

(ii) cover the key challenges that Zambia must address and that WHO is best placed to assist with;

(iii) and are achievable within the CCS timeframe.

At the midpoint of the CCS period, WHO will review the indicators and targets to assess progress in implementing technical assistance and adjust the WHO strategy as necessary.

# SECTION 8

## CONCLUSION

The strategic agenda articulated in this CCS calls for coordinated actions at all levels of the organization. All WHO technical departments planning activities in Zambia should draw their country plans of action based on this agenda. In addition, there are some areas in the agenda where the capacity of the Country Office is presently inadequate, and where support will be required, the Office will collaborate with other levels of the organization.

# SECTION 9

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# ANNEX 1: HEALTH COOPERATING PARTNER COORDINATION MATRIX

| | Human Resources | Procurement & Supplies/MSL | HMIS / Surveillance / M&E | Capital Investment TWG | Health Care Financing TWG | IHP/CP Coordination | HIV/AIDS and TB | CCM(GFATM) | Gender | Maternal Newborn and Child health (MNCH)) & EPI | Inter Agency Coordination Committee (ICC) | Malaria | IEC/Health Promotion | Nutrition | Epidemics and other Emergencies (NEPPC&MC) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Focal Point - Sub-sectoral Lead** | SIDA<br>USAID<br>EU<br>DFID<br>**WHO**<br><br>CIDA | CIDA<br>DFID | USAID<br>DFID<br>EU<br>**WHO** | JICA<br>WHO | SIDA<br>DFID<br>EU<br>WB<br>**WHO** | DFID<br>SIDA<br>**WHO**<br>WB | UNAIDS<br>USG<br>DFID<br>JICA<br>CDC<br>JICA<br>**WHO** | DFID<br>**WHO**<br>SIDA | SIDA<br>UNFPA<br>UNICEF<br>**WHO** | UNFPA<br>USAID<br>**WHO**<br>SIDA | UNICEF<br>USAID<br>CIDA<br>**WHO** | USAID<br>**WHO**<br>MACEPA | **WHO**<br>UNICEF | UNICEF<br>EU<br>**WHO** | **WHO**<br>UNICEF<br>CIDA |
| **Reference Group - Active** | | | | | | | | | | | | | | | |
| **For Information Only - Background** | | | | | | | | | | | | | | | |
| **Government Focal Ponit** | | | | | | | | | | | | | | | |
| **WHO Focal Point** | | | | | | | | | | | | | | | |

# ANNEX 2: SWOT ANALYSIS FOR IMPLEMENTING THE CCS

The possible strengths, weaknesses, opportunities and threats have been identified for implementation of the CCS, as reflected in the table below.

| Strengths | Weaknesses |
|---|---|
| • Broad consultations during development of 1st generation CCS;<br>• Team spirit within WHO Country Office;<br>• Consultative leadership style of the current WR Office;<br>• Adherence to recruitment policy, facilitated recruitment of competent staff;<br>• The re-profiling, posts established and competent staff recruited;<br>• Disease prevention and control programmes are going well; for example Tuberculosis, malaria and child immunization. | • Inadequate circulation of the CCS document to stakeholders;<br>• CCS not sufficiently used as a planning tool;<br>• Absence of monitoring and evaluation plan;<br>• Unclear role of WHO in implementation;<br>• Unclear cause-effect relationship (attribution);<br>• Strong evidence of efforts to improve HRH but no success stories;<br>• No evidence of capacity building for health services;<br>• No clear evidence for policy initiatives;<br>• Health promotion totally neglected;<br>• Determinants of health not addressed at all, probably because other sectors are involved e.g. environment, water, etc.;<br>• Cannot attribute results to individual contributors; nor contributors to specific frameworks;<br>• Inadequate marketing of CCS and POA to stakeholders;<br>• CCS not sufficiently used as a planning tool;<br>• Overloaded staff members due to thin staffing of the Office. |
| **Opportunities** | **Threats** |
| • Easy access to technical support (AFRO,HQ);<br>• Presence of other cooperating partners to support the health sector;<br>• Availability of clear guidelines and tools for development and implementation of CSS and for ensuring compliance with WHO regional and global priorities;<br>• Availability of multi-professional human resource in WHO. | • Inadequate commitment of the MOH to WHO operations;<br>• Perceptions that WHO is a funding institution;<br>• Lack of ownership of the CCS from other key role players in health;<br>• Human resource crisis in health sector;<br>• New 2nd generation CCS coverage period not aligned to NHSP 2006-2010 and the FNDP 2006-2010 and JASZ 2007-2010;<br>• Poor indicators for maternal health. |

# ANNEX 3: IMPROVED LIVES AND PROTECTION OF THE VULNERABLE – TARGETED RESULTS

| Sector | Key Performance Indicators | Baseline Value 2005 |
|---|---|---|
| **Strategic, long-term country outcome** | **CCS outcome indicators which this CCS aims to influence and which are aligned to the longer term country outcomes** | |
| *Better health and long-term survival, with particular focus on at risk and vulnerable groups*<br>• Reduce infant mortality from 95 (2001) per 1000 live births;<br>• Reduce under five mortality from 168 (2001) per 1000 live births;<br>• Reduce maternal mortality from 729 (2001/2) per 100 000 live births;<br>• Reducing stunting (low height for age) from 47% (2001/2). | **Key constraints for improving health outcomes are reduced as measured by:** | |
| | **Indicator** | **Baseline value (2005)** |
| | Percentage of deliveries assisted by midwives, nurses, doctors or clinical officers | 43% |
| | Percentage of fully immunized children under one year of age in 20 worst performing districts | 50% |
| | Malaria case fatality rate among children under five years | 24 / 1000 |
| | Utilization rate of PHC facilities | 0.48 |
| | % MoH releases to district level | 55% |
| *Reverse the spread of HIV/ AIDS: decrease prevalence among*<br>*Women from 18% (2001/2) to 17% (2015);*<br>*Men from 13%(2001/2) to 12% (2015);*<br>*Reduction in % of infants born to HIV-infected mothers who are infected (currently 39%, target 20% reduction by 2005 and 50% by 2010).* | **Vulnerable populations impacted by HIV/AIDS use prevention, care and mitigation services as measured by:** | |
| | **Indicator** | **Baseline value 2005** |
| | Number tested for HIV at VCT and receiving the test results | 150 000 |
| | Number of HIV+ pregnant women receiving a complete course of ARV prophylaxis | |
| | Number of persons with advanced HIV infection on ART (a) men (b) women (c) total | (a) 12 656<br>(b) 17 456<br>(c) 30 112 |
| | Number of workplaces, including line ministries, with developed workplace policies and programmes for HIV and AIDS | 628 |
| | Amount of funds spent on HIV and AIDS in the past 12 months | |
| *Improved living conditions, including in drought-prone areas with a particular focus on poor/vulnerable households and communities as measured by disaggregates of the MDGs (see above.* | **Poor households and communities in areas prone to frequent droughts benefit from risk management mechanism (which are available in a sustainable manner) as measured by:** | |
| | **Indicator** | **Baseline value 2005** |
| | % Stunting (0–59 months) | 47% |
| | % Underweight (0–59 months) | 23% |
| | %Prevalence Vitamin A Deficiency (6–59 months) | 54% (2003) |
| | Prevalence Iron Deficiency (6–59 months) | 52% (2003) |
| | Proportion of women attending ante-natal classes who are malnourished. Disaggregated by<br>(a) rural and<br>(b) urban | (a)<br>(b) |

# ANNEX 4: ZAMBIA COUNTRY COOPERATION STRATEGY (2008-2013) DEVELOPMENT PROCESS

A CCS taskforce was constituted in 2006, headed by the WR Zambia, WCO National Professional Officers and Ministry of Health –Directorate of Planning officials. Initially, Dr Joseph Kasonde was engaged as a local consultant and the WHO/AFRO team was consulted through Zimbabwe IST. The review of the first Country Cooperation Strategy (CCS -1) for the period 2002-2005 was conducted to assess the implementation status of the CCS-1 and to address the gaps identified in the second generation Country Cooperation Strategy (CCS 2008-2013) for the period 2008-2013. The findings of this review, including recommendations of the review of the CCS- together with additional information in the documents from AFRO, were utilized and reflected in the 2008-2013 CCS.

The review and development of the 2008-2013 CCS involved, among others, the following methodology:

- In-depth review and analysis of key health sector issues, including the factors that influence the health status of Zambia;
- Broad consultations and advocacy for the CCS 2008-2013 preparation process, to ensure that the process was inclusive and participatory;
- Active involvement of key stakeholders, especially the MOH, including multilateral and bilateral partners as well as WCO staff.

In reviewing the first generation CCS, we had to acquaint ourselves and understand a number of documents that indicated the health priorities for Zambia for the period 2002-2005, the priorities of WHO at global, regional and country levels. These included the Medium-Term Strategic Plan (MTSP), the WHO Country Focus, Health Policies and Strategies, The Joint Annual Review (JAR), Mid-Term Review Reports, Annual Reports and several progress reports of the health sector and WHO Country Office and those that contained policies and guidelines for the health sector. The review of the first generation CCS was supplemented by scheduled face to face interviews and the administration of a structured questionnaire. The interview was done with all WHO Country Office technical staff and with stakeholders, including MoH staff, line ministries, UN agencies, the University of Zambia, development partners, NGOs and the Private sector.

The questionnaire gathered information that assessed the first generation CCS development process, knowledge about the CCS, the CCS 2001-2005 appropriateness in reflecting the health priorities at the global, regional and country levels, the implementation process, achievements and the gaps. To get a broader picture, an additional review of relevant documents was undertaken. These documents included, among others, the Medium-Term Expenditure Framework (MTEF) for the health sector in Zambia for the period 2004-2005 and 2006-2007, the National Health Strategic Plan (NHSP) for the period 2002-2005, the Fifth National Development Plan, Vision 2020, the United Nations Development Assistance Framework for Zambia. The priorities gathered from these, together with the gaps and recommendations from the review of the CCS 2002-2005, defined the priority areas of the CCS 2008-2013.

We took advantage of the Ministry of Health and Cooperating Partners (CPs) monthly meetings including the WHO/MoH Coordination Meeting and the Sector Advisory Working Group Meeting to share the CCS 2008-2013 priorities and processes. The comments from the MoH and other partners were incorporated into a draft document. This was followed by

several internal discussions and consultations within the Zambia Country Office to fine-tune and improve the quality of the document. All these consultations provided the needed alignment with the national health priorities.

We express our gratitude to the Regional Office and IST Harare for their comments and support in finalizing the document.