World Health Organization

Annual Report

of the WHO Country Office Zambia 2011

Foreword and Acknowledgements

During the year 2011, WHO country Office (WCO) in response to the growing burden of diseases in Zambia made significant progress towards the attainments of its goals to reduce disease burden, strengthen health systems and partnerships. In keeping with its core functions, WHO provided leadership in convening strategic partnership meetings, facilitated development of norms and standards, ethics and health monitoring.

Through its Technical leadership role WCO facilitated the finalisation of the Five-Year National Health Strategic Plan (NHSP) 2011 – 2015, the Five-Year National Malaria Strategic Plan (NMSP) 2011-2015; and annual plans for Tuberculosis and the HIV-AIDs national response. In-depth joint annual reviews at national and district level, documentation of important lessons learnt in communicable and non-communicable diseases, supported Sector wide planning (SWAp) and Country Coordinating Mechanism (CCM) Meetings to strengthen partnership and supported the national health authorities to hold successful National Health Research Conferences to strengthen and shape the national research health agenda.

In pursuance of the one UN WHO, collaborated with other UN agencies within the United Nations Development Assistance Framework (UNDAF) action plan to strengthen further the national health development in the country. WHO is grateful to several partners including; the USAID and others for financial support that enabled implementation of its planned programme.

This report provides major achievements and bottlenecks in the year under review.

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Acronyms

ACTs	Artemisinin Combination Therapies
AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-retroviral Therapy
CCM	Country Coordinating Mechanism
CIDA	Canadian International Development Agency
DMMU	Disaster Management and Mitigation Unit
CCS	Country Cooperation Strategy
CIDRZ	Centre for Infectious Diseases and Research in Zambia
GRZ	Government of the Republic of Zambia
EPI	Expanded Programme on Immunization
DRC	Democratic Republic of Congo
IHR	International health regulation
IPTp	Intermittent Preventive Therapy in pregnancy
IRS	Indoor Residual Spraying
IYCF	Infant and Young Child Feeding
LLINs	Long lasting Insecticidal nets
MOH	Ministry of health
MC	Male Circumcision
MDGS	Millennium Development Goals (MDGs)
MOH	Ministry of Health
NCDs	Non-Communicable Diseases
NGOs	Non-governmental organisations
NMCP	National Malaria Control Programme
NT	Neonatal Tetanus
NTDs	Neglected Tropical Diseases
PCR	Polymerase Chain Reaction
PMTCT	Prevention of Mother to Child Transmission
PRA	Pharmaceutical Regulatory Authorities
SAGS	Sector Advisory Committees
SWAp	Sector Wide Approach
HAART	Highly Active Antiretroviral Therapy
PEPFAR	President's Emergency Plan for Aids Relief
PLHIV	People Living with Human Immunodeficiency virus
RED	Reach Every District Strategy
TB	Tuberculosis
TET	Therapeutic Efficacy Testing
UN	United Nations
UNDAF	United Nations Development Assistance Framework
UNICEF	United Nation Child Fund UNICEF
VPDs	Vaccine Preventable Diseases
VDPV	Vaccine Derived Poliovirus
WCO	WHO Country Office
WHO	World Health Organisation

1.0 INTRODUCTION

The health care system in Zambia is faced with diverse challenges ranging from provision of equitable and quality health care to critical shortage of human resources such as doctors, nurses and laboratory staff. The situation is worsened by the burden of communicable and non-communicable diseases.

The HIV and AIDs, Tuberculosis (TB) and malaria are mutually aggravating and perpetuate poverty, impacting on the social and economic development of the country. The national adult HIV prevalence rate is 14% but urban rates are approximately twice those in rural areas. Although the TB treatment success rate improved in the period 2008 to 2010 from 85% to 88%, the TB notifications per 100,000 populations declined from 378 to 373 per 100,000 in the same period. Vaccine preventable childhood diseases and epidemic prone diseases are still a significant cause of morbidity and mortality. Also, infant mortality rate remains a concern at 95 per 1000 live births while under-five mortality rate is 168 per 1000 live births. The Maternal Mortality Ratio (MMR) currently at 591 per 100,000 live births needs an accelerated response to attain the national and Millennium Development Goals (MDGs) by 2015. Further, the country is now experiencing increasing morbidity and mortality from non-communicable diseases such as hypertension, diabetes, cancers and accidents.

In 2011, the World Health Organisation Country office (WCO) worked closely with the Zambian national health authorities and partners in the health sector to address national health priorities. WCO delivered its technical support through 13 Strategic Objectives (SOs) agreed upon with the national health authorities [Box 1]. Planned activities were implemented through a framework provided by the WHO Cooperation Strategy 2008-2013, set out in the Global Health Agenda of the Eleventh General Programme of Work anchored on the National Health Strategic Plan 2005-2011, the global Millennium Development Goals (MDGs) and United Nations Development Assistance Framework (UNDAF).

The 2011 report highlights progress, challenges and lessons in specific strategic areas (Box 2). Substantial progress was made in strengthening Integrated Disease Surveillance and Response for Vaccine Preventable Diseases, monitoring and evaluation for all interventions, at all levels, supporting access to prevention, care and support and medical products such as antiretroviral treatments, scaling-up malaria interventions, delivering quality TB services, including the Stop TB Strategy, response to disasters, emergencies and non communicable diseases.

Table 1: Strategic Objectives

SO 1. To reduce the health, social and economic burden of communicable diseases

SO 2. To combat HIV/AIDS, tuberculosis and malaria.

SO 3. To prevent and reduce disease, disability and premature death from chronic non communicable diseases, mental disorders, violence and injuries and visual impairment.

SO 4. To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy ageing for all individuals.

SO 5. To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact.

SO 6. To promote health and development, and prevent or reduce risk factors for health conditions associated with use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex.

SO 7. To address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrates pro-poor, gender-responsive, and human rights-based approaches.

SO 8. To promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health.

SO 9. To improve nutrition, food safety and food security, throughout the life-course, and in support of public health and sustainable development.

SO 10. To improve health services through better governance, financing, staffing and management informed by reliable and accessible evidence and research.

SO 11. To ensure improved access, quality and use of medical products and technologies.

SO 12. To provide leadership, strengthen governance and foster partnership and collaboration with countries, the United Nations system and other stakeholders in order to fulfil the mandate of WHO in advancing the global health agenda as set out in the Eleventh General Programme of Work.

SO 13. To develop and sustain WHO as a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively.

Table 2: Topics covered in the 2011 Report

- ❒ Vaccine Preventable Diseases (VPDs)
- ❒ HIV & AIDS, TB and malaria
- ❒ Non communicable diseases, mental health disorders and violence / injuries
- ❒ Maternal, new born, adolescence and sexual reproduction health
- ❒ Response to disasters - emergence humanitarian action
- ❒ Health promotion
- ❒ Social and economic determinants
- ❒ promoting a healthier environment
- ❒ Nutrition, food safety and security
- ❒ Medical products and technologies
- ❒ Health System Strengthening
- ❒ Building WHO's efficiency and capacities in health responses
- ❒ Global health agenda

The SOs seek to reduce the health, social and economic burden of communicable diseases, to improve health during all stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, sexual and reproductive health, promote healthy ageing; reduce risk factors associated with tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex; address underlying socio- economic determinants of health through policies and programmes to enhance health equity, pro-poor, gender- human rights-based approaches, improve health services (financing, staffing and management) promoting a healthier environment and use of medical products and technologies, improve nutrition, food safety and food security. In addition, the WCO supported efforts to strengthen partnerships within UN system and other partners.

2.0

DISEASE PREVENTION AND CONTROL

2.1. Vaccine Preventable Diseases (VPDs)

Zambia's Immunization Vision and Strategy (ZIVS), which is the Expanded Programme on Immunization (EPI)'s Comprehensive Multi-year Plan (cMYP) aims at delivering effective immunization to contribute to improved Child Survival (MDGs 4 to 6) by 2015. Most of the children in the year 2011 were vaccinated during the bi-annual Child Health Weeks. In 2011 WCO provided technical leadership to support effective planning and implementation of the national Immunization programme and Child Health Weeks to ensure effective monitoring and surveillance of vaccine preventable diseases despite financial challenges the country faced.

Key achievements

❒ In 2011, the WHO Country office in Zambia supported various aspects in VPDs including; planning, surveillance, and logistics and provided financial support and capacity building to national health staff. WHO facilitated the country to conduct polio supplemental immunization Activities (SIAs) in 8 polio high risk districts bordering Angola from 27 to 29 July 2011 in children below 5 years.

❒ Zambia's Immunization Vision and Strategy were revised to include a proposal for introduction pneumococcal and measles in 2012 and rotavirus vaccine in 2013. Hence, Supported the development of Cold Chain Expansion Strategy in view of the new vaccine introduction plans.

❒ WCO supported MOH to mobilise financial resources from local partnership to expand vaccines cold chain facility at all levels and facilitated the procurement process and installation of cold chain equipment at central and provincial levels. Through this support, warehouses at the central stores were rehabilitated. WHO also provided vehicles to strengthen the immunization programmes in Western, Luapula, Northern, Lusaka and Copperbelt Provinces.

❒ A mopping up activity was conducted to interrupt any possible transmission of wild poliovirus in 8 polio high risk districts. The overall immunization coverage was 92% as reported in the Independent Monitoring Report.

❒ Leadership and resource mobilization; WHO through the Inter-agency Coordinating Committee (ICC) for Maternal, Newborn and Child Health facilitated funding of the child health weeks and supported MOH to revise the GAVI proposal for the planned introduction of the Rotavirus vaccine in 2013, as a conditionality for Cold Chain expansion strategy. In collaboration with Absolute Return for Kids (ARK), Centre for Infectious Diseases and Research in Zambia (CIDRZ) and other Partners WHO supported the Ministry of Health to prepare for the introduction of the Rotavirus vaccine (Rotarix) in Lusaka Province in January 2012 as a demonstration to pre-introduction of the vaccine countrywide in the year 2013.

❒ Formative Guidance: WHO supported the Ministry of Health to conduct surveillance

training for District Medical Officers and Provincial Surveillance Officers in the Southern, Luapula and Eastern Provinces and to conduct the Reach Every District (RED) strategy training for Copperbelt, Luapula and Lusaka Provinces for District MCH Coordinators and Health Facility EPI staff.

- Routine Implementation: Supported the Ministry of Health in Effective Vaccine Management (EVM) training and assessment. EVM was conducted to prepare for new vaccines introduction. WHO organized an EVM training course in collaboration with MoH, UNICEF Zambia and Centre for Infectious Disease Research in Zambia (CIDRZ). The training took place from 8 to 14 July 2011 in Livingstone for 30 participants from national and provincial levels. Most of the children in the year 2011 were vaccinated during the bi-annual Child Health Weeks in July and November.

- Injection Safety: In the area of injection safety, WCO supported Ministry of Health in the installation of 4 Macro-burn Incinerators.

- WHO also supported the planning and implementation of bi-annual Child Health Weeks which was integrated with mopping up immunisation in 8 high risk districts bordering Angola and DRC.

- WHO provided technical and financial support to the Ministry of Health and partners to plan, implement, supervise and monitor the countrywide biannual integrated Maternal Child Health Weeks.

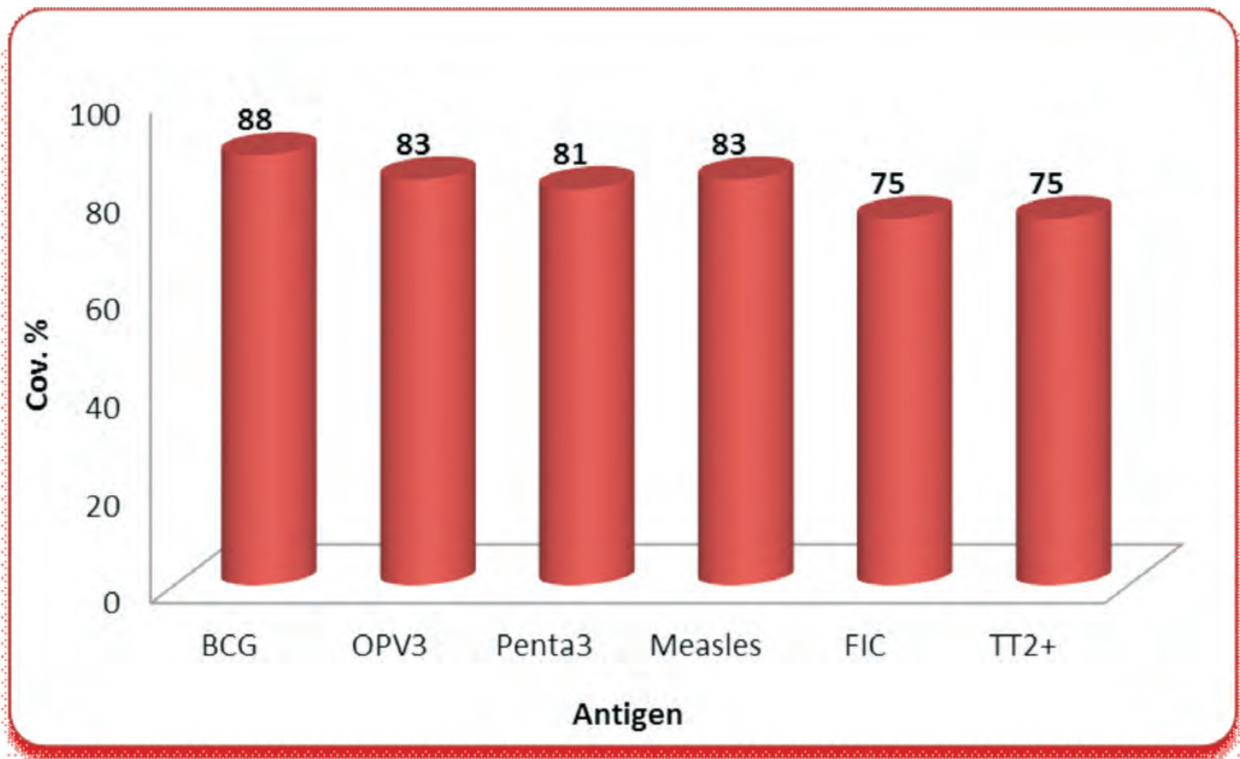
- WHO continued to enhance partnership support during the implementation of CHWK in collaboration with UNICEF and other partners.

- WHO supported the WHO polio/measles laboratory at UTH supported Influenza surveillance.

- Capacity building in the RED strategy; WCO provided financial and technical support to the MoH and partners to plan, prepare and conduct training in RED strategy for 100 provincial, district and health facility staff in Copperbelt Province and 50 provincial, district and health facility staff in Luapula Province. WHO provided funds and technical expertise towards the orientation of provincial, district Health Management staff in integrated disease surveillance for VPDs in Southern and Luapula provinces, data management to strengthen routine immunization and integrated disease surveillance in selected health facilities of districts with high numbers of un-vaccinated children (Lusaka, Copperbelt and Southern Provinces).

- WHO supported training of MOH staff in Vaccine and Injection Safety and health care waste management and on the cold chain and polio/measles laboratory at the University Teaching Hospital (UTH), which passed the accreditation process. Following acquisition of skills and capacities in Polymerase Chain Reaction (PCR) testing, staff at UTH were able to report on Intra Typic Differentiation (ITD) of poliovirus and Vaccine Derived Poliovirus (VDPV) results beginning 1st October 2011.

Figure 1: Routine Immunization Coverage percentage (cov %) in Zambia, 2011



Source: EPI/Ministry of Health

Figure 2: Routine Immunization Coverage by province, 2011

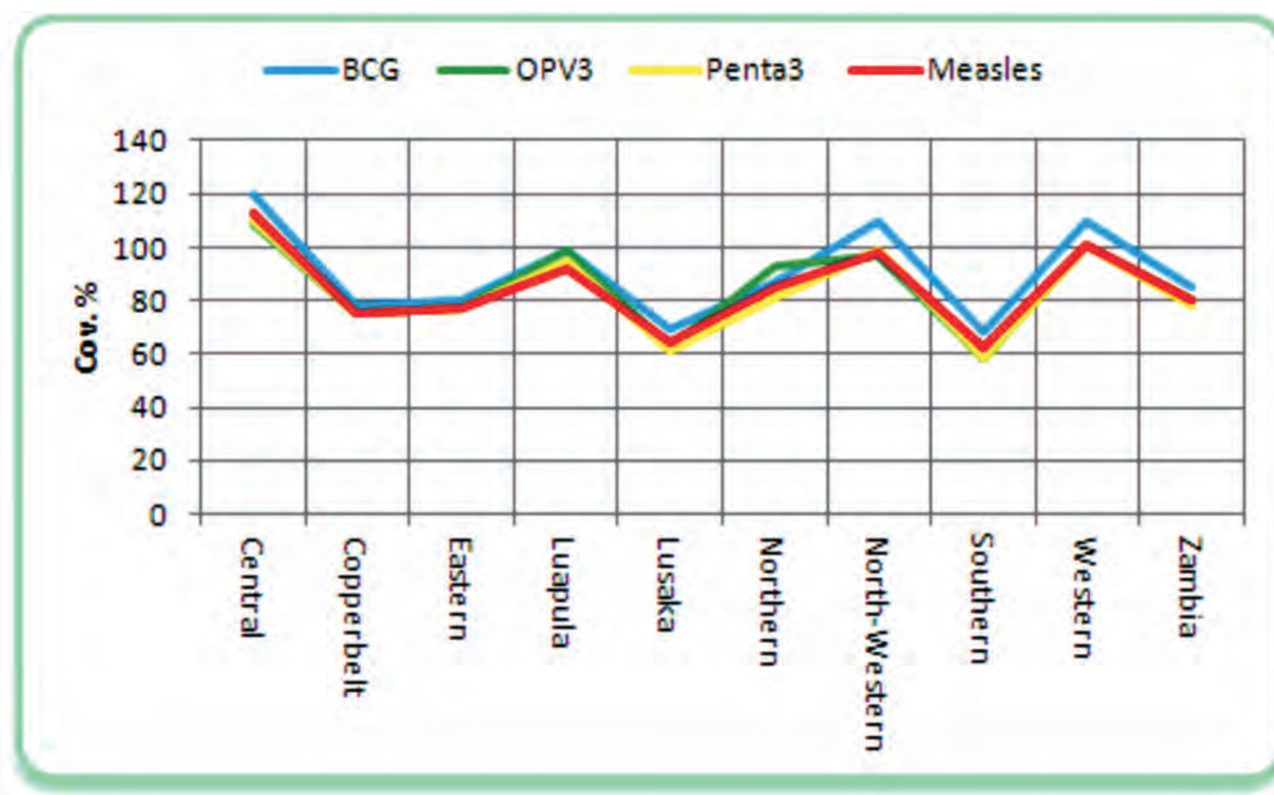


Table 3: Immunization coverage for bOPV in the 8 high risk districts, 2011

Provinces / Districts	U-5 population	Vaccinated Children	Coverage (%)	Never vaccinated before	Never vaccinated before (%)	Independent Monitoring Report*
North-Western	***70,741***	***83,762***	**118%**	***2,836***	3.4%	**93.6%**
Chavuma	6,860	7,824	114%	168	2.1%	93.0%
Kabompo	18,688	21,170	113%	482	2.3%	99.3%
Mwinilunga	26,856	38,426	143%	1,863	4.8%	97.0%
Zambezi	18,337	16,342	89%	323	2.0%	85.0%
Western	***75,806***	***82,253***	***109%***	***2,566***	***3.1%***	***90.5%***
Kalabo	26,993	31,158	115%	296	0.9%	93.0%
Lukulu	17,133	16,270	95%	684	4.2%	94.0%
Sesheke	14,282	12,557	88%	143	1.1%	80.0%
Shangombo	17,399	22,268	128%	1,443	6.5%	95.0%
Zambia	**146,547**	**166,015**	**113%**	**5,402**	**3.3%**	**92.0%**

Source: EPI/Ministry of Health

Surveillance, Monitoring and Evaluation activities

WCO provided technical support on AFP, measles, neonatal surveillance to several activities in different ways as follows:

WCO provided a surveillance vehicle for use in conducting surveillance activities, particularly on vaccine preventative diseases in the context of IDSR in Western and Copperbelt Provinces and supported implementation of AFP surveillance activities. Zambia has achieved a detection rate of >2.6 per 100,000 children in those aged above 15 years and stool adequacy rate of 8.9% with surveillance index of 2.3.

WCO provided technical and logistics support to the rotavirus surveillance sentinel site at UTH.

WCO supported supervision, surveillance and mop-up polio immunisation campaign in 8 selected districts in Western and North-Western Provinces that have a high risk of polio importation with coverage rate of 92%. This was integrated with bi-annual child health weeks.

In addition, WCO provided technical support to the Ministry of Health and partners to plan, implement, supervise and monitor the AFP surveillance activities which led to sustaining the Polio Eradication Initiative and AFP surveillance Indicator.

Figure 3: WHO donated a surveillance vehicle to Northern Province

With WHO support, MOH has successfully sustained the AFP/polio surveillance indicators for polio eradication for the past four years and achieved its operational and certification level performance for non-polio AFP rate (NPAFP) or more than 2 per 100,000 children less than 15 years. Stool adequacy was $\geq$ 80%.

WHO donated a vehicle each to the Provincial Health Offices of the Ministry of Health in Luapula and Northern Provinces for use in conducting integrated surveillance activities particularly of vaccine preventative diseases in the context of IDSR (Figure 3).

Table 4 : AFP surveillance indicators by province and year, 2005-2011

	2005		2006		2007		2008		2009		2010		2011	
	NPAFP	Stool Ad	NPAFP	Stool Ad	NPAFP	Stool Ad	NPAFP	Stool Ad	NPAFP	Stool Ad	NPAFP	Stool Ad	NPAFP	Stool Ad
Central	3.4	90%	2.8	76%	2.1	85%	2.5	100%	3.2	100%	3.6	92%	3.3	86%
Copperbelt	2.3	71%	1.3	92%	1.1	100%	2.0	83%	2.9	89%	2.5	96%	2.8	85%
Eastern	2.9	100%	1.1	100%	1.4	100%	2.7	91%	2.8	96%	3.8	85%	2.5	100%
Luapula	2.2	90%	1.1	80%	1.9	89%	2.9	86%	2.4	92%	2.9	100%	2.3	91%
Lusaka	2.7	100%	2.6	95%	1.9	94%	3.5	90%	3.6	84%	2.1	84%	2.1	83%
Northern	3.2	92%	2.2	94%	2.1	100%	2.4	90%	2.9	96%	1.7	100%	2.0	94%
North-Western	2.4	88%	2.3	88%	2.8	90%	3.3	100%	3.5	85%	2.1	88%	3.4	92%
Southern	3.0	95%	1.7	92%	1.4	100%	4.7	89%	3.9	83%	3.1	96%	2.5	80%
Western	8.0	94%	2.5	80%	2.0	100%	4.7	81%	4.9	95%	3.8	94%	3.7	94%

Source: EPI/Ministry of Health

Challenges

- Inadequate staffing to implement the planned activities due to staff restructuring, rapid turnover and low output from training institutions.

- Inadequate financing toward immunisation services to revitilise outreach services to reach all the children on immunisation services leading to sub-optimal implementation of the Reaching Every District (RED) strategy.

- The preceding challenges have contributed to declining immunisation coverage leading to accumulation of unvaccinated children. This situation has led to outbreaks of vaccine preventable diseases such as measles.

- Data management for case - based surveillance requires further strengthening to enable adequate characterizations of disease cases by place, person and time.

Lessons Learnt

- WHO encouraged the country to conduct Vaccine Management Assessment (VMA) to ensure that there was adequate capacity to store and manage vaccines. Key findings from the assessment indicated that there was inadequate cold chain capacity and skills for vaccine management. To address these findings, MOH, WHO, UNICEF and other partners undertook two key strategies: cold chain expansion and skills strengthening.

- With the planned introduction of new vaccines - the rotavirus vaccine, the pneumococcal vaccine and second dose of measles vaccine, the 2009 and 2010 Vaccine Management Assessment (VMA) revealed gaps in the country cold chain capacity and vaccine management.

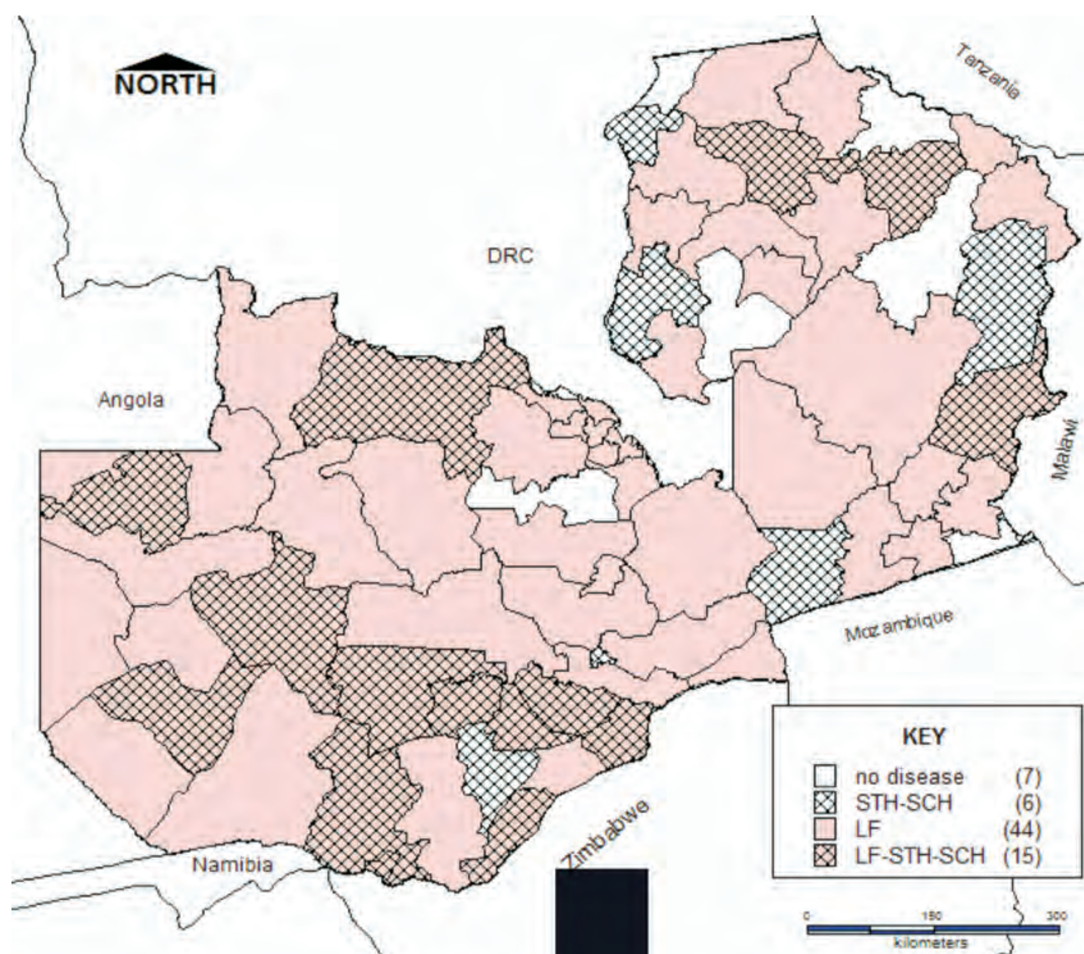
- Arising from the VMA findings, Zambia has made major steps to address challenges in vaccine management such as the development of Country Cold Chain Expansion Strategy whose recommendations are being adequately implemented. WHO supported the Ministry of Health in procuring and installing of the cold chain equipment, and building staff capacity in vaccine management.

2.2 Neglected Tropical Diseases Control

Communicable diseases such as Neglected Tropical Diseases (NTDs) are usually not associated with high mortality rates but often cause long-life disability and economic consequences. They usually affect the poor communities located in underserved remote areas. WHO supports countries in the Region, including Zambia to develop Master Plans for Neglected Tropical Diseases (NTD) 2011 2015.

In the year under review, WCO donated medicines for Lymphatic Filariasis (LF) programme to conduct mass drug administration (MDA) for Western Province which has been found to have high (up to 50%) prevalence of LF in some communities (Figure 4). WCO also facilitated the MOH to produce a draft document of the Master Plan on NTDs and facilitated national health authorities to convene the Annual Review Meeting on Neglected Tropical Diseases in the African Region at Golf view Hotel on 06 to 10 June 2011.

Figure 4: Distribution of Lymphatic Filariasis (LF) in Zambia, 2011



2.3

HIV/AIDS, TUBERCULOSIS AND MALARIA

Table 5: HIV, TB and Malaria at a Glance

HIV/AIDs: Zambia's adult prevalence rate is at 14% in the 15-49 year age group (DHS, 2007). Estimates suggest that 226 new adult infections occur each day, with 25 of these occurring among children. Urban areas are typified by higher HIV prevalence ,approximately. double, (20%) than rural areas (10%). Co-infection of TB and HIV is common, with 70% of TB patients in Zambia co-infected with HIV. However counselling and testing rates are extremely low (15%), (DHS 2008). New infections contribute 1.6% to this estimate. Increased access to ART allows HIV-infected people to live longer. Zambia has the second highest number of orphans and vulnerable children (OVC) in Africa; with 50% of the estimated 1.3 million orphans and vulnerable children due to HIV and AIDS.

Tuberculosis: Zambia has in place a viable National Tuberculosis Programme (NTP). A total of 48,591 all forms of TB were notified in 2009. Of these 39,454 were adult new patients, 3,804 adult retreatment patients, 5,134 paediatric new and 199 paediatric retreatment patients. Treatment success rate has been maintained at 85% and above in the past 3 years, an attainment of one of the Stop TB Partnership 2015 targets. In 2011, the country office provided significant financial and technical support to NTP and supported MOH to develop the TB plan through the NTP and partners and provided leadership in the delivery of quality integrated services for TB, strengthening the development of guidelines, policies strategies and other tools, strengthening surveillance, monitoring and evaluation, resource mobilization, partnerships and coordination as well as improving access to TB medicines, diagnostics, commodities and other services.

Malaria: Malaria is endemic throughout Zambia**.** However**,** the burden is higher in children under the age of five years where it accounts for 40% of child mortality and in pregnant women where it accounts for 20% of maternal mortality. It is higher among rural population and vulnerable than other population groups. Thus, malaria remains a public health challenge in Zambia. The national malaria goal in 2011 was to "reduce malaria incidence by 75% and reduce deaths due to malaria of the 2005 baseline by the end of 2010". In response the Zambian government identified malaria to be among national public health priorities and implemented a comprehensive national malaria prevention and control programme, guided by a five year National Malaria Strategic Plan within the National Health Strategic Plan (NHSP) and the fifth and sixth national development plans. The 2006-10 NMSP came to end in the 2010-2011 WHO's biennial plan. Therefore, WCO's efforts strategically provided leadership in the development of a new malaria strategic plan (2011-15) to mobilise technical and financial resources for the smooth implementation, surveillance of activities and monitoring of the strategic plan and advocacy.

2.3.1 HIV AND AIDS

The WHO, in collaboration with the UN Country Team in Zambia and other partners facilitated a national HIV prevention second Convention convened by the National HIV/AIDS/STI/TB Council and Ministry of Health. The Convention was held under the theme "Securing Zambia's future through combination HIV of prevention, palliative care and treatment" at Mulungushi International Conference centre in Lusaka. The convention brought together all partners involved in prevention and response to HIV with the goal of contributing to the reduction of people who become infected with HIV, increasing access to care, improving health outcomes for people living with HIV, reducing HIV-related health disparities. During this meeting key players in HIV and AIDS response reviewed progress made in the implementation of resolutions adopted at the first HIV prevention convention in 2009 and the 2009-2010 annual ART seminar recommendations on diverse themes and issues including, multiple and concurrent partnerships, low and inconsistent condom use, low levels of male circumcision, mobility and migrant labour and treatment for prevention, vulnerability and marginalized groups, laboratory and medical supplies and data integration, multi-sectoral prevention response management and coordination, TB/HIV interaction and behaviour change communication.

The WHO Representative at a male circumcision for HIV prevention meeting, Lusaka, 2011.

The occasion was officially open by the Minister of Health, Dr Joseph Kasonde, MP. 515 delegates attended together with the UN Resident Coordinator, Ms Kanni Wignaraja, the first Republican President of Zambia, His Excellency, Dr. Kenneth David Kaunda and the WHO Representative, Dr Olusegun Babaniyi and H.E Mark Storela, US Ambassador, government departments and ministries, district and provincial medical officers, clinical officers from public and private hospitals, NGOs, research and academic Institutions, traditional leaders and community-based organizations. Resolutions and declaration on MC, strategic direction in HIV response were made to facilitate implementation of national life saving interventions, empowerment of traditional leaders to lead scale up efforts on MC and PMTCT, mobilise local and external funding for Early initiation of HAART to all eligible PLHIV including, HIV positive pregnant women and children, data harmonization, Operation research, Evaluation, Efficiency and Effectiveness studies that will support programming, coordination of HIV and AIDs interventions at sub-national level and revision of the HIV policy.

Joint Strategy to accelerate scale-up of Voluntary Medical Male Circumcision for HIV Prevention in East and Southern Africa: Zambia contributed to the development of the Joint Strategy to accelerate scale-up of Voluntary Medical Male Circumcision for HIV Prevention in East and Southern Africa. The WHO Country Office hosted a stakeholder's consultative meeting on 26th October 2011 to review the draft five-year Joint Strategy for accelerating the scale up of Voluntary Medical Male Circumcision for HIV Prevention in priority countries in East and Southern Africa. This strategy was developed by WHO and other partners to ensure that by 2016, countries with

generalized HIV epidemics and low prevalence of medical male circumcision would have established sustainable national male circumcision programmes. The countries are expected to attain 80% coverage of male circumcision for adult men, and 80% for newborns, adolescents and young men.

The MC strategy will also contribute to the Millennium Development Goal number 6, which is targeted at ensuring halting HIV/AIDS by 2015. It is also aimed at accelerating progress towards reducing new HIV infections by 50% among young people aged 15-24 years in accordance with the HIV/Global Health Sector. Zambia is among the 13 priority countries which were identified by WHO and UNAIDS for scale-up of voluntary medical male circumcision. Others include Botswana, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, South Africa, Swaziland, Uganda, the United Republic of Tanzania and Zimbabwe. The WHO Country Office therefore convened the consultative meeting to provide a forum for partners to critically examine the draft strategic framework in terms of its content and structure and to make recommendations in relation to the country situation and priorities in order to enhance its focus and relevance. The meeting also provided a forum for engaging partners in a discussion on the status of implementation of male circumcision in the country, successes scored, challenges and suggestions for improvement. Comments and contributions were that there was need to separate the vision from the goals, to define the objectives of the document and the intended target audience, to articulate better the health benefits women would access if there partners were circumcised, include the cost analysis or a financial information page as well as devices in the document.

Male Circumcision (MC) Programme: In 2011, WHO played a major role in supporting MOH to coordinate and lead the implementation of the MC programme in Zambia. Since the inception of MC program in 2007, over 167,000 MCs have been performed nationally. Eighty eight (88) % of these MCs have been performed in the past two years; over 61,000 performed in 2010 and 85,000 in 2011. However, the number of MCs performed each year falls short of the annual targets and also falls short of the 2015 targets in the operational plan (Figure **6** and Figure **7**). There were 287 sites in Zambia providing MC services in December 2011 compared to 135 in 2010.

Service delivery and demand generation is mainly partner-driven with two main models: 1) a dedicated MC service delivery model with a hub and outreach teams sent to public and private helth facilities on designated days, and 2) a non-dedicated service provided on an ad hoc basis as patients present and as providers are available.

WHO supported the re-casting of national targets to align them with global targets. An estimated 1,949,000 MCs are required to reach 80% by 2015. To meet the overall target, the program is planning for an exponential smooth scale-up with a target of approximately 200,000 in 2012 rising to 800,000 in 2015. To facilitated scale up and meeting these required targets, WHO and other partners further supported a capacity assessment of the MC programme to identify gaps and challenges on the ground. This exercise was a building block for the development of key strategic documents in the programme.

Figure 5. Annual Male Circumcision (MC) volumes (2007-11).

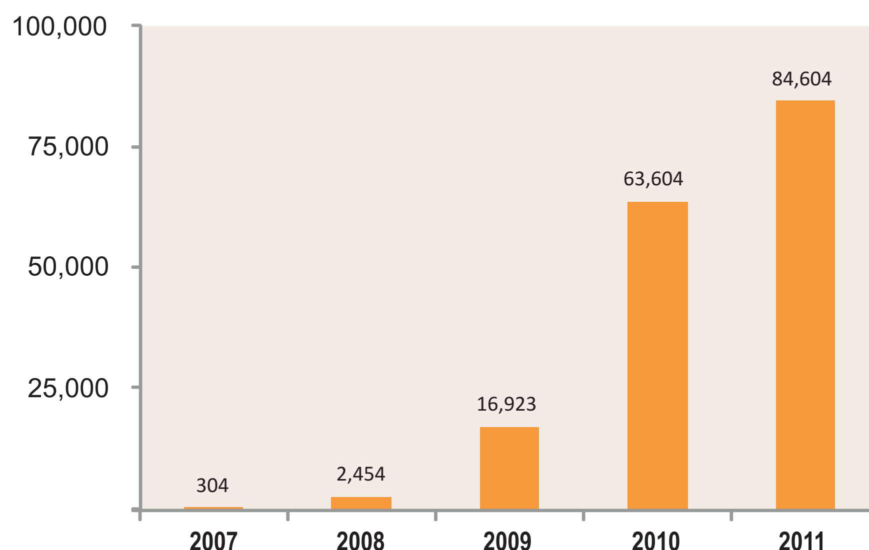
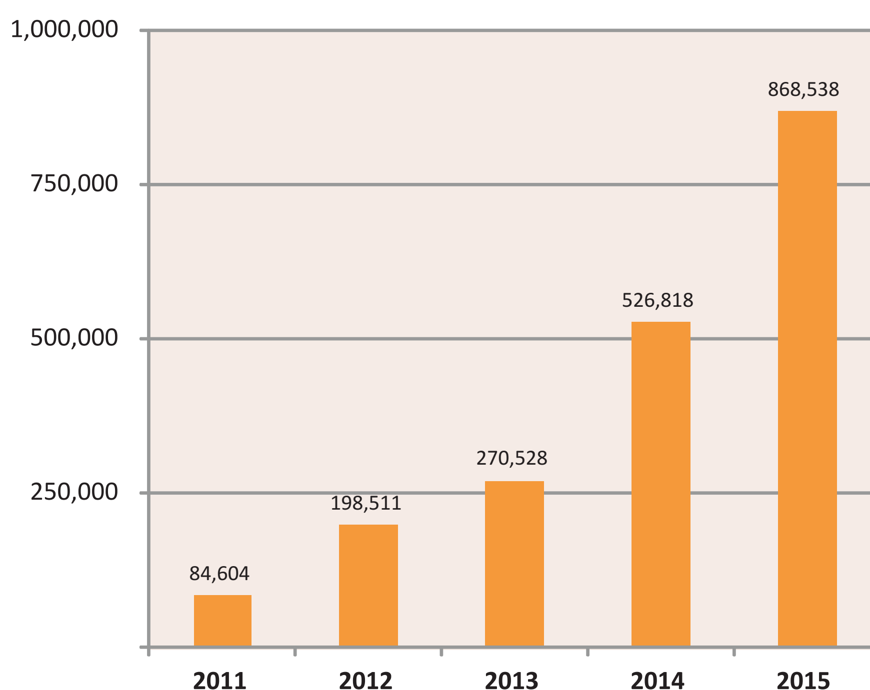


Figure 6: Annual MC needed to achieve targets in 2015 (gradual scale up)



Normative Guidance on HIV and AIDs; In order to strengthen Anti-retro Viral (ARV) services WHO provided technical support in the development of National Third line ART Treatment Guidelines for the administration and monitoring of third line ART treatment regimens.

MC M&E Framework which will be integrated in the national M&E Framework of the Ministry of Health. The MC M&E framework will strengthen the HIV national routine data collection and overall evaluation of the prevention programme and ultimately improve quality and effectiveness.

The National MC training guidelines were provided for both Neonatal and Adults and Adolescents. Also, National standards that will guide and improve quality of MC service provision were developed.

National HIV Communication Strategy and the Male Circumcision Communication strategy were provided. Key components of the MC communication strategy have been integrated in the draft National HIV Communication Strategy. These documents are tools that will be used to create demand and guide the messages and information on MC to ensure that the public is given the right information.

HIVDR training materials were provided to build capacity in Comprehensive HIVDR monitoring and surveillance system which ultimately is expected to improve the quality of ART service provision.

The review of Hospital HMIS data collection tools and performance assessment tools were conducted. New programmes such as male circumcision have been included in these tools. Data on MC will be collected in HMIS and the Ministry of Health institutions will be assessed regarding MC service provision.

WHO supported the development of integrated Scale up plan-eMTCT, ART aimed at covering the continuum of care.

provided technical support to the review of the report on 'Preparing for the future of HIV/AIDS in Africa to foster a shared responsibility' which helps to define the actions to be taken by African Countries during the phase out of PEPFAR and HIV response.

Capacity Building; WCO supported MOH to train 111 health workers in Basic ART package (IMAI), [an integrated package that covers all the critical areas in HIV management] and to train 19 midwives working in maternal and child health unit at primary health facilities to equip them with skills in diagnosis and management of optimistic infections seen in HIV/AIDS patients and to initiate pregnant women and children on ART as part of the PMTCT programme. Capacity building of midwives ensured continuum of care for infants and enhanced access to HIV care and treatment among pregnant women. WCO also supported MOH to build capacity in HIV monitoring and surveillance system to ensure patients stay on first line ART regimens longer. In this regard, 18 health workers from three pilot sites in Wusakile, Liteta and Kafue were trained on HIV Drug Resistance monitoring for early Warning Indicators.

WCO provided technical support in the accreditation of 23 sites that were assessed using the MC accreditation guidelines, an exercise that seeks to improve the quality of MC services. Seven (7) out of the 23 sites were accredited.

Resource Mobilisation: WCO provided technical support in the development of a proposal to leverage and use CDC seed money for the Elimination of MTCT of Syphilis and HIV. This funding is expected to support the development of initial demonstration sites for the integrated HIV and Syphilis elimination program through production of materials and training of trainers at provincial level.

WCO supported the reprogramming of Global Funds for HIV/TUB/MALARIA Round 8 which resulted in increased funding for MC activities and commodities for an accelerated scale-up of MC activities and increased access to HIV prevention interventions and STI treatment.

2.3.2 Tuberculosis

The year 2011 marked the end the biennium work plan and beginning of a 5 year TBCARE 1 project. The key issues for TB control in Zambia in 2011 was maintaining/improving case detection and treatment success rate and operationalizing programmatic management of drug resistant TB. The target on case detection for smear positive TB cases was 70% and above and treatment success rate of 87% and above. It was planned that there would be 3 treatment sites for MDR-TB in Zambia by end of 2011.

The main interventions were based on the 6 components of the Stop TB Strategy as contained in the national TB strategic plan (NTBSP). The main activities undertaken in 2011 were support to provincial training in Community TB, provincial TB/HIV technical review meetings, provincial support supervisory visits, development/updating of selected NTP documents.

Key Achievements

- Treatment success rate of 87% (among TB smear+), case detection rate of 73% (both for 2010) and improving TB/HIV activity indicators.
- The country office provided financial and technical support to provincial trainings in community TB.
- The country office provided financial and technical support to provincial TB/HIV technical review meetings.
- The country office provided financial and technical support to NTP in the development of the 2011-2015 National TB Strategic Plan.
- The country office provided technical support to the NTP and Eastern Province provincial office in national commemoration of the World TB Day that was held in Chipata District of the Eastern Province.
- Provided technical support to NTP in various activities such as national TB/HIV coordinating meetings, TB/HIV technical meetings, development and revision of TB/HIV documents.
- Provided technical support in the establishment of management system for MDR-TB patients.
- Participated as an external consultant in the review of the TB programme for Malawi, Global Drug Facility (GDF) mission in Lesotho, Green Light Committee (GLC) monitoring mission to Botswana and Regional workshop on TB technical assistance planning including Global Fund in the African Region.
- Provided support to NTP in conducting provincial leprosy support missions and Provincial Trainings in Community TB.
- The Country Office provided financial and technical support to provincial community

training of trainers workshop for Central, Northern, Copperbelt, Luapula and North Western provinces.

- A total of 125 facility based participants were drawn from all the districts of the 5 provinces. Eight consultants contracted by the Country Office and provincial trainers were the main facilitators. A variety of teaching methods were used including lectures and role plays. The course covered the following main areas:

- ***TB/HIV Technical Meetings;*** The Country Office provided financial and technical support to provincial TB/HIV technical review meetings for Central, Northern, Copperbelt, Luapula and North Western provinces. Participants were district TB focal point persons, laboratory and pharmacy staff, provincial Communicable Diseases Specialists, laboratory and pharmacy specialists. Partners and Non-Governmental Organizations (NGOs) and Civil Society also participated. Districts compiled, cleaned and analyzed their data, this was followed by district and provincial presentations.

- ***National TB/HIV data review meeting:*** The Ministry of Health (MoH) through the National TB Programme (NTP) held a TB and Leprosy data review workshop at which the national TB and Leprosy data for the 2009 cohorts and the 2010 notifications were compiled, analyzed and consolidated. It was attended by provincial TB/leprosy focal point persons and provincial lab, pharmacy and communicable diseases specialists, central level staff and partners.

- Partners shared their planned support to the programme for 2011. Among the updates, the NPO/TB shared the 'onion' model WHO is promoting to estimate the number of TB cases routine notifications may be missing.

- ***Workshop on the Finalization of the National TB Strategic Plan, 2011-2015;*** The national TB strategic plan (NTSP) was finalized with financial and technical support from the Country office. Participants were from the NTP, the Southern provincial office and partners.

- ***Provincial support supervisory visits;*** The Country Office provided financial and technical support for supervisory visits to the provincial health office of North Western and Central provinces. Visits were conducted to provincial, district and health facilities in each province.

- ***National TB documents;*** Several documents were updated during the year, including The TB manual, TB/HIV guidelines, supervisory checklist and MDR-TB referral system form.

- ***MDR-TB treatment sites:*** Two treatment sites were fully operational by end of 2011, in the University Teaching hospital (UTH) and Ndola Central Hospital. Trained staff, second line drugs and guidelines were available. Reports were regularly submitted to IST.

- ***World TB Day:*** The commemoration was held in Chipata, Eastern Province. Activities included school debates on TB/HIV, community sensitization through drama performances, radio discussion programmes on TB/HIV. The main event was on 24 March with participation of provincial traditional and political leaders, civil servants, members of the public and school going children. The Regional Director's speech was delivered to the gathering.

- ***Technical support:*** NPO-TUB provided technical support within country at national and provincial TB/HIV technical meetings and trainings, provincial technical support visits, World TB Day preparations and commemoration, development and updating of national TB/HIV documents.

- ***Skills upgrading:*** NPO-TB attended the 42nd International Union Against TB and Lung Diseases (Union) Conference 26-30 October 2011 in Lille, France whose theme was 'Partnership for Scaling-up and Care

- ***NPO-TUB Missions:*** The NPO-TUB participated as an external consultant to the review of the Malawi NTP, consultant to the NTP Lesotho on a Global Drug Facility monitoring mission and as consultant for the Green Light Committee monitoring mission to Botswana NTP.

Figure 7: Hazards of field trips, a bid log blocked the gravel road between Mwinilunga and Kabompo during a supervisory mission in North Western Province.

Figure 8 Zambia Cure and Treatment Success

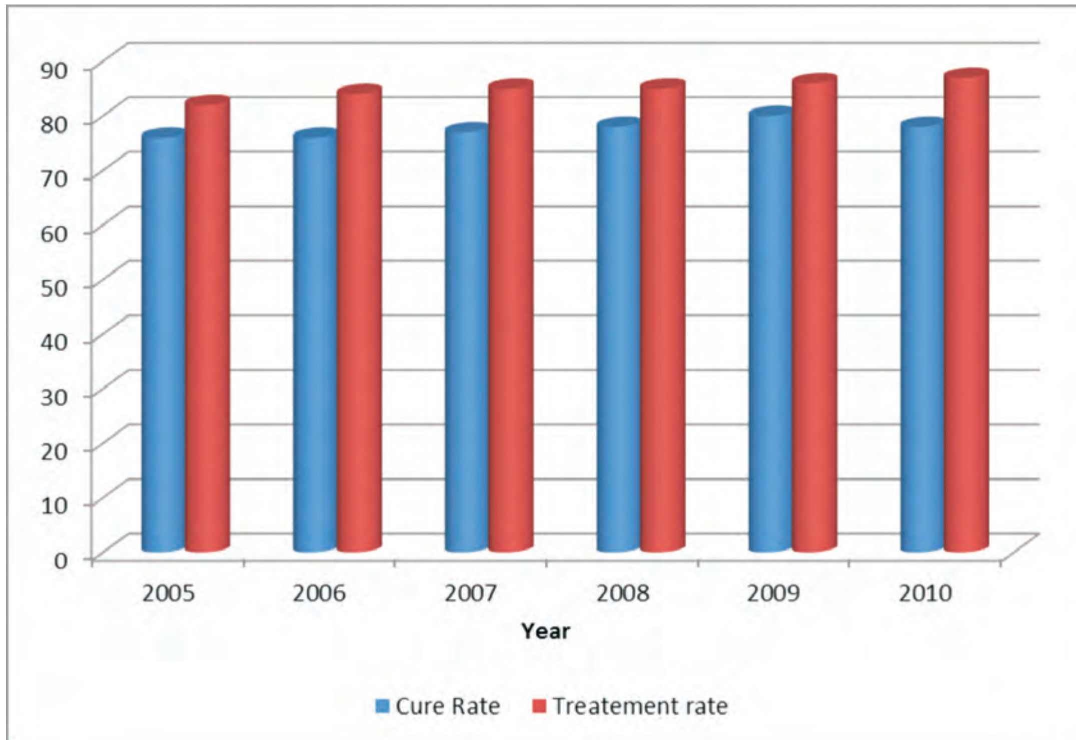
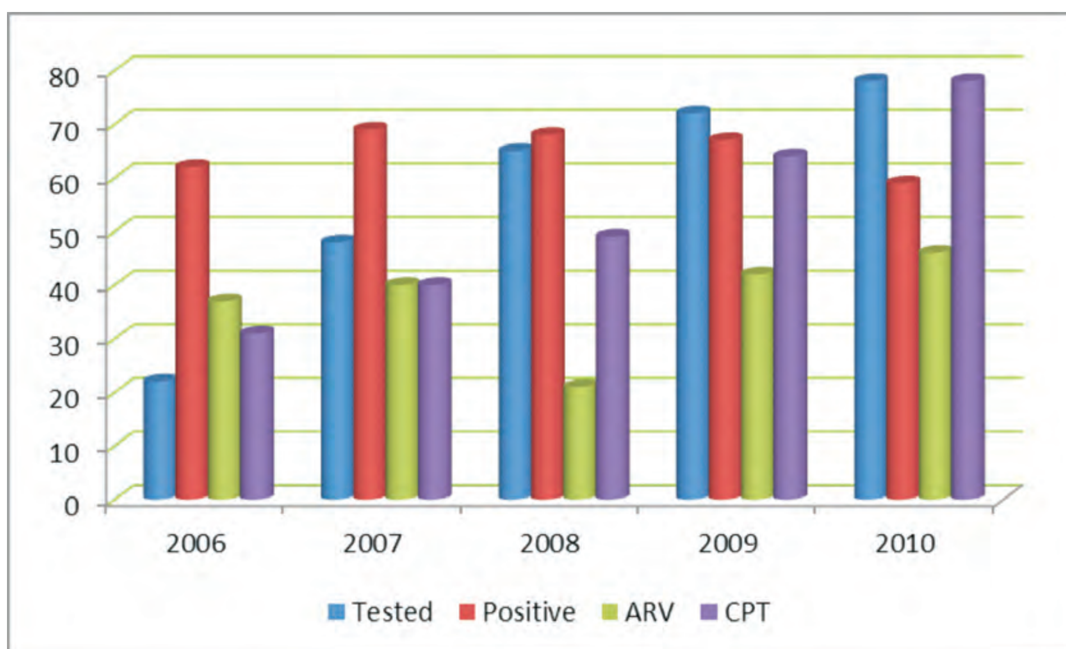


***Figure 9:** Zambia TB/HIV activities, 2006 - 2010*



Challenges/constraints

The main constraint was the late receipt of funds that were only accessed from July 2011. This exerted a lot of pressure because of the limited time for conducting planned activities especially with the new GSM .

It is recommended that: Technical assistance, both local and external, should be routinely planned and budgeted for in annual plans and use of consultants should be considered whenever need arises to facilitate implementation and completion of given priority activities. This will help in mitigating shortage of technical human resources in the MoH.

2.3.3 Malaria

Zambia's national response to malaria is strong and effective. The country adopted three main strategies for prevention and control of malaria in its 2006-2010 NMSP, namely: *Selective Vector Control*, including, Indoor Residual Spraying (IRS) in eligible areas and the use of Insecticide Treated Nets (ITNs) for prevention of malaria; *Intermittent Preventive Therapy (IPTP)* in pregnancy to reduce malaria in pregnancy through a comprehensive package of interventions, in collaboration with other programmes, particularly the Reproductive Health, Newborn and Child Health and the HIV/AIDS programmes; and *Malaria Case Management*, which promotes early identification and prompt treatment of malaria, with improved access to malaria diagnostics.

WHO Strategy and focus of technical support in 2011: In the year under review, WHO continued supporting Zambia's efforts towards promotion of the adoption and use of the most appropriate evidence-based anti-malaria interventions and health systems strengthening, aimed at ensuring efficient and effective prevention and control of malaria in the country. Through this support, the MOH successfully implemented its strategic plans (2005-2010). However, this plan came to an end in 2010. Therefore, WHO's priority in the year under review was to support MOH to develop a new malaria strategic plan 2011-2015, and, related planning documents and supported the convening of meetings, advocacy through commemorative events to increase malaria awareness and resources.

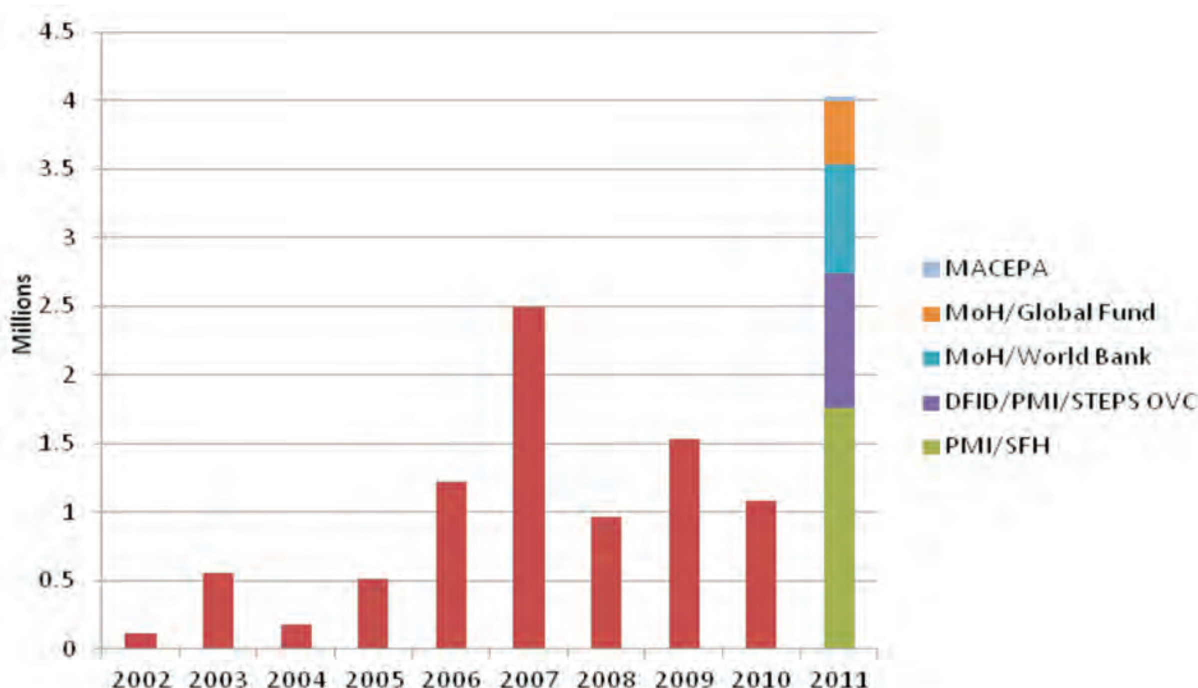
Programme Performance; achievements: Through its technical leaders, WHO facilitated the national malaria programme to make significant progress in three critical areas; strategic planning, the promotion of the adoption and use of evidence-based interventions advocacy (for resources and awareness), and documentation of the evidence.

Delivery of malaria interventions: Zambia has one of the largest IRS programs in Africa, with 54 of 72 districts conducting spray operations in 2010-2011 and commencing in all districts from 2011-2012 season. The programme has distributed about 4 million LLINs in 2011 (Figure 11).

Intervention	***Year***	
	2000	***2011***
ITN household ownership (%)	***≤ 5***	***64***
Indoor Sprayed Districts	5	72
Population Protected	≤ 500	4,000,000
Treatment - 1st line	chloroquine	Combination therapy (artemether lumefantrine)
Treatment efficacy (%)	< 50	98

Table 6: Scaling up Malaria Interventions in Zambia, 2011

Figure 10: *Broad partnership support ITN Distributions; 2005-2011*



Advocacy and convening roles; WHO and other partners including, the USAID-PMI, UNCEF, MACEPA facilitated the national malaria programme to successfully commemorate the 2011 World Malaria Day (WMD), which fell on 25th April 2011. During this event, malaria testing of the communities was conducted to enhance confidence in the rapid diagnostic tests (RDTs), Malaria messages on prevention and treatment were disseminated through print and mass media. WHO also participated in a high level discussion at the Country Coordination Mechanism (CCM) to mobilise resources and consensus to deliver a coordinated malaria programme. WHO and MOH mobilised several partners to contribute to funding and implement the malaria programme in addition to GRZ (PMI, World Bank Booster, The Global Fund and NGOs and research).

Figure 11: Commemoration of the 2011 World Malaria Day, 2011.

Stanbic Bank Staff matching during the World Malaria Day 2011 commemoration.

Intermittent Preventive Therapy (IPTp2); During the year under review, over 70% pregnant women nationwide received two doses of Intermittent IPT2 with *sulfadoxine pyrimethamine* and also received LLINs at public health centres during these routine health service.

Prompt and effective diagnosis and case management; WHO and partners JSI Deliver (programme funded under PEPFAR) supported quantification and forecasting of artemether lumefantrine, RDTs to improve access to essential malaria diagnostic and treatment commodities for deliver effective management of malaria services.

Lessons learnt; Periodic joint analyses of malaria performance including programmatic and finacial gap analyses was found to be very useful as they strengthened partnerships and ensured evidenced-based planning during the development of malaria strategic plan, proposal development and resource mobilization.

2.4

NON-COMMUNICABLE DISEASES, MENTAL DISORDERS, VIOLENCE AND INJURIES

2.4. NON-COMMUNICABLE DISEASES, MENTAL DISORDERS, VIOLENCE AND INJURIES

Developing countries are undergoing an epidemiological transition, from Communicable or Infectious to Non-Communicable Diseases (NCDs). Thus, globally, cardiovascular disease, chronic respiratory diseases, cancer, and diabetes are reported to be responsible for 60% of all deaths, with more than 75% of these deaths occurring in developing countries. Unhealthy diet, physical inactivity, tobacco and alcohol use are important preventable major risk factors for chronic diseases that are related to lifestyle choices.

Table 7: Non-Communicale Diseases (NCDs) needs in Zambia

Disease	Lack / inadequate drugs and lab reagents (%)	Lack or inadequate diagnostic facilities (%)	Lack or inadequate expertise (%)	Lack of community awareness (%)
Diabetes	89.6	80.6	73.1	76.1
Hypertension	13.4	53.7	50.7	74.6
Cancer Cervix	64.2	86.6	86.6	79.1
Breast Cancer	50.7	89.6	85.1	76.1
Prostate Cancer	59.7	91.0	85.1	80.6
Asthma	23.9	65.7	50.7	52.2
Epilepsy	28.4	89.6	68.7	70.1

Key achievements

Support to surveys: As part of monitoring the implementation of the United Nations Decade on Road Safety 2011-2020, Zambia participated in the data collection and analysis in the 2nd Survey on Road Safety. The WCO facilitated preparation of Agreement of Performance of Work (APW) and a stakeholders' meeting that was held in October 2011.

Policy and strategic support: Though MoH has now strengthened the establishment of NCDs programme through recruitment of a focal point person and creation of a budget line, the draft policy is yet to be finalized. The challenge has been lack of data to substantiate the rising burden of disease. It is hoped that the WHO STEPs surveillance once completed will

provide the necessary information to feed into the available draft document. Development of a strategic plan on NCDs is also underway and WHO has been providing support.

Advocacy: Technically and financially Supported launch of United Nations Decade of Action on Road Safety 2011 -2020. The support amounting to ZMK3.5Million was for provision of venue for the memorial service at Cathedral of the Child Jesus on 10 May 2011. WHO facilitated the orientation of the National Data Coordinator (NDC) in preparation for the 2nd Road Safety Survey to be conducted in July / August 2011. The orientation was held from 25-26 May 2011, in Douala, Cameroon.

Challenges and Constraints

Inadequate funding for NCDs prevention and control by Government, WHO and lack of funding by other partners is one of the major challenges that has hampered the collection of data on risk factors and establishment of strengthened NCDs programme. Lack of policy framework and a strategic plan adversely affects implementation rate. Inadequate staff of the NCD Unit in the Ministry of Health and inadequate knowledge and understanding by communities about risk factors for NCDs are challenges to successful implementation.

Lessons learnt

The cost of conducting STEPs survey is much higher than the estimated cost which resulted in delayed implementation of fieldwork. The strengthening of ZNCR was difficult due to absence of skilled personnel in cancer registration.

2.5

IMPROVING MATERNAL, NEW BORN, CHILD AND REPRODUCTIVE HEALTH

2.5.1 MATRNAL AND REPRODUCTIVE HEALTH

The burden of Maternal and Newborn Morbidity and Mortality is a challenge in Zambia, with a Maternal Mortality ratio of 591/100,000 live births and Newborn mortality of 34 per 1000 live births in 2007 (Figure 13).

The risk of a woman dying as a result of pregnancy or childbirth during a lifetime is about 1 in 6 compared with about 1 in 30,000 in Northern Europe. This poses a huge challenge in meeting the Fifth Millennium Development Goal to reduce Maternal Mortality by 75% between 1990 and 2015. The Maternal and Newborn deaths are clustered around labour, delivery and immediate post partum period with main causes of death that include Haemorrhage (34%), Sepsis (13%), Obstructed Labour (8 %), Hypertensive Conditions (5%) and Abortion (4%). The main indirect causes are Malaria (11%) and HIV (10%). The main causes of Newborn deaths include Asphyxia (28%) and Infection (29%) among others.

The coverage of appropriate and effective quality health care around Pregnancy, Labour, Childbirth and Postpartum is not adequate and does not reach each pregnant woman and the newborn. The main goal for maternal, new born and sexual reproduction is to accelerate reduction of Maternal, Newborn Morbidity and Mortality to attain set targets by 2015 and specific objectives set in the MNCH Strategic Plan: To reduce Maternal Mortality from 591 (in 2007) to 162 per 100,000 live births and to reduce Neonatal Mortality from 34 to 20 per 1000 live births

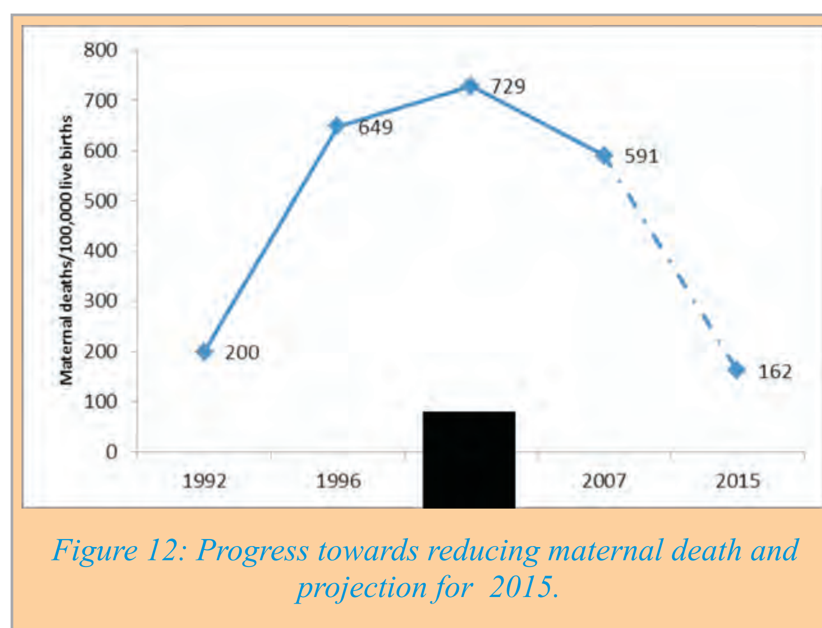


Figure 12: Progress towards reducing maternal death and projection for 2015.

TARGETS; Reduce unmet need for contraception in married women from 27% to 14%; Increase the percentage of women accessing 4 or more visits of focused Antenatal Care from 60% to 80%; Increase the proportion of institutional deliveries by skilled attendants from 47% to 75% and to Increase the coverage with EmONc facilities to all districts from 68% to 100%.

WHO Strategy: In 2011, activities focussed on capacity building for Pre Service, In Service and Communities on Maternal, Newborn and Sexual Reproductive Health, Development and Adoption of Policies, Standards and Guidelines, Strengthening District Health Planning and Management for maternal and newborn and Sexual Reproductive Health, Fostering Partnerships and Collaboration among partners including Communities and Supporting implementation of MNCH Roadmap.

Key achievements

The WHO MNCH team collaborated with other partners in providing technical and/or financial support to the activities jointly planned for with MOH.

- Provided technical support to the MOH's Joint Annual Review
- Completed the situation analysis on Healthy Ageing in Zambia
- Supported proposal development of the UN Joint Programme in Maternal, Newborn Child, Adolescent Health and Nutrition
- Capacity building of health workers in FANC, EmONC, SMAGS, Family Planning
- Supported the development of Reproductive health commodity security strategy

Challenges / Constraints

The main challenges include a weak health system coupled with inadequate financial and human resources to support the scaling up of proven high impact intervention and in turn this affects the pace of implementation of various Maternal, Newborn and Sexual Reproductive Health services. It is recommended that:

- MOH in collaboration with partners should continue to lead the development of policies and guidelines for high quality and culturally sensitive maternal care which add Women's Health and Social needs.
- Engage other sectors in the implementation of policies and guidelines/protocols that addresses the " 3 delays" for accessing maternal, Neonatal and newborn health care.
- Advocate to incorporate minimum physical infrastructure requirements that support the delivery of quality Maternal newborn and sexual reproductive health care services

2.5.2 CHILD AND ADOLESCENT HEALTH

Improving maternal, newborn, child and adolescent health remain a priority and cornerstone to achieving the health related Millennium Development Goals (MDGs) in Zambia. The major childhood killers have remained neonatal causes, malaria, respiratory infections, diarrhoea and HIV and AIDS.

Malnutrition underlies about a third of all deaths and remains a serious public health problem with stunting levels of 47% and significant micronutrient deficiencies (particularly vitamin A deficiency and anaemia).

In the year under review, there was a general increase in trend in the number of children less than five years visiting the health facilities for malaria, respiratory tract infection-non pneumonia, diarrhoea and pneumonia.

- The Ministry of Health has continued to scale up high impact interventions to improve child health and nutrition, namely; Expanded Programme of Immunization, Integrated Management of Childhood Illnesses (IMCI) Strategy and Infant and Young Child Feeding (IYCF). IMCI has been introduced in all but the 5

new districts. IYCF training of health worker has been done in all districts with Community IYCF scaling up to all the provinces.

- Mother to child transmission of HIV continues to a major contributor towards Paediatric HIV. The PMTCT programme has significantly scaled up reaching coverage of about 94% of pregnant women attending ANC. The Paediatric HIV programme has also been scaled up increased to three sites offering early infant diagnosis and thus decreasing the turn round time of receiving results. Use of SMS technology has contributed to reducing the period between testing and receiving the result.

- The adolescent population constitutes 27% of the population. This age group accounts for a significant number of maternal deaths as well as neonatal deaths. Among this population group, a pregnant adolescent is more likely to have complications during delivery and may have had poor ANC attendance if any at all. HIV prevalence is high (7.7%) in young people aged 15 to 24 years with more than two thirds (70%) of Zambian women having given birth or pregnant by the age of 20 years. Unsafe abortions are some of the negative consequences of early pregnancies in this age group.

- Developing a strategy and guidelines on implementation of Adolescent Health was an important priority for MOH during the year under review.

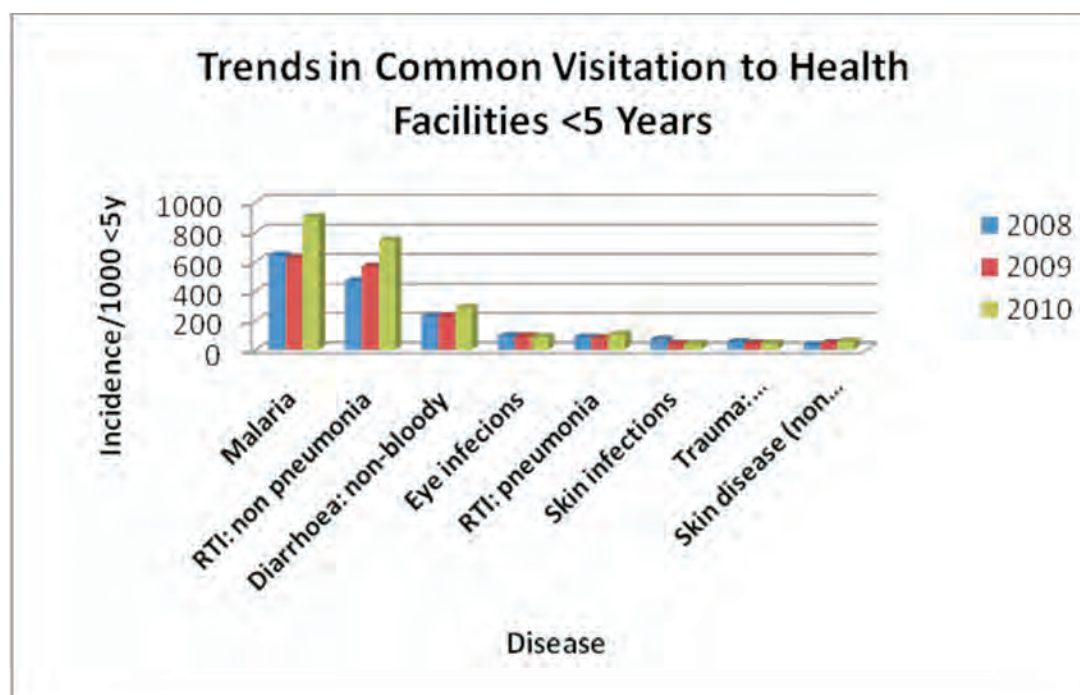


Figure 13: Common reasons for Visitations to Health Facilities 2008-2010.

Issues

- ❒ Coverage for the proven interventions that contribute significantly to the attainment of MDGs 4 & 5 remains sub-optimal. The largest contributor to infant mortality is in the newborn period which is closely linked to maternal health. With only 47% of mothers delivering in health facilities, and only 39% of mothers and newborns being seen within 48 hours after delivery, strategies/interventions of taking care of the newborn should be focused at both community and health facility levels. Innovative ways of getting mothers to deliver in health facilities are being explored and the building of mothers' shelters at health facilities has seen some success in the districts implementing this strategy.

- ❒ IYCF practices remain sub-optimal and this contributes to the underlying malnutrition and increased disease burden. Although there have been cascade trainings for IYCF for health worker, the community component has lagged behind. The Baby friendly Hospital Initiative which is a strategy that was developed to support and improve the early initiation of breastfeeding as well as sustained breastfeeding within the health facilities. Integrated Management of Acute Malnutrition (IMAM) needs to be strengthened. IMAM Guidelines have been developed, but are yet to be finalized and be disseminated. This has led to partners using different guidelines in managing acute malnutrition.

- ❒ Critical level of saturation for the IMCI strategy to be optimal has not yet been reached in the districts. This contributes to sick children not receiving the best care. Training health workers in the IMCI strategy is expensive and the shorter abridged course as well as the introduction of a computer based training module for IMCI will assist in trying to reach this critical mass especially at the pre-service level where training is most cost-effective.

- ❒ Early Infant Diagnosis has been scaled up, but the follow-up of mother infant pair still remains a challenge despite the high PMTCT coverage. EID is important in bettering the outcome of an infant as treatment commended early will translate into a better survival rate as the infant can access other services in a timely fashion. The turn round time for receiving results has been a challenge, especially in the rural areas where the mothers have to travel long distances for child health care. Exploring innovative ways such as use of SMS technology, in which this delay can be addressed are welcome interventions. The country has adopted breastfeeding with ARV for the mother and infants during the duration of breastfeeding. This is intended to optimize the nutritional status of the infant as well as protect the child from common childhood illnesses. Availability of continuous supply of ARVs during this period becomes an important factor.

- ❒ Lack of Adolescent Health Strategy has contributed to fragmented effort in addressing adolescent health issues. Having a strategy in place and guidelines for standard of care for this vulnerable group is important. Re-vitalizing the Youth

Friendly Corners and developing others in areas where adolescents are found will greatly contribute towards reduction in maternal and newborn deaths.

Achievements

Using the comparative advantage and the core functions of WHO, WCO supported the MOH in developing a number of strategies and guidelines that focus on improving the health of children and adolescents. The fifth National Health Strategic Plan was finalized with support from WHO. The national Integrated Management of Childhood Illnesses (IMCI) Strategic Plan 2011-2015 was finalized with support from the country office. Both technical and financial supports were rendered. WCO was involved in the selection of a consultant to lead the process, collating of information, editing and finalization of the document. Additionally, WCO supported the Ministry of Health to develop an Adolescent Health Strategic Plan (ADH SP) 2011-2015 that was based on the Adolescent Health Situation Analysis that was conducted in 2009 with WHO support. WHO supported the MOH identify a consultant, collate information and edit the ADH SP. The Regional Office and Headquarters actively supported the process. Also WCO supported development and/or review of the following guidelines;

- ❖ National Adolescent Health Standards and Care Guidelines
- ❖ Maternal and Child Health Week Implementation Guidelines
- ❖ Infant and Young Child Feeding (IYCF) Guidelines

- ❒ This involved participation in the guideline development workshops, editing and finalization of the documents. The ADH standards and IYCF guidelines will be finalized by the second quarter of 2012. The initial workshop for the development of ADH standards was attended by about 15 participants from non-governmental organizations (NGOs) and other stakeholders.

- ❒ The country office supported the MOH in improving the implementation of IMCI strategy by funding the Chief IMCI officer to attend training of the IMCI computerized Adaptation and Training Tools (ICATT) in Malawi. The WCO further assisted the Child Health Unit in operationalizing the ICATT training Package targeting the health training institutions to use of this method of teaching IMCI.

- ❒ WCO was actively involved in fostering partnership and mobilizing funds jointly with other UN agencies and partners. The UN Joint team on Maternal, Newborn and Child Health (MNCH) and Nutrition successfully mobilized funds for the MOH to scale up high impact interventions to accelerate progress towards attaining Millennium Development Goals (MDGs) 4 and 5. The office also supported mobilizing resources for linking HIV, Sexual Reproductive Health focusing on the adolescent. WCO supported mobilization of resources for the implementation of the Community Health Worker Strategy and capacity building for the health sector. The Maternal and Child Health week was successfully implemented jointly with MOH

and other partners. Additionally, the WCO participated in the national launch of the World Breastfeeding Week. Support has continued to the fortnightly child health technical working group meeting that in addition to discussing, reviewing and planning for implementation of activities in the MOH action plan, mobilizes resources for activities that were not funded in the action plan.

- Led by the WHO Representative, three NPOs participated in the Global Learning Programme (GLP) training for NPOs held in Harare, Zimbabwe. The NPOs were able to orient the other NPOs in the office on the GLP.

- Challenges/Constraints Funding was an important constraint at both the Ministry of Health and WCO. This led to postponement and many a times, cancelling of planned activities.

2.6

RESPONSE TO EMERGENCIES, DISASTERS, NEGLECTED TROPICAL DISEASES

2.6.1 INTEGRATED DISEASES STRATEGY (IDS)

Communicable diseases are the most common cause of illnesses, disabilities and death in Zambia. While these diseases present a serious threat to the well-being of Zambian communities, there are well known interventions that are available for controlling them, as long as accurate data on outbreaks of such diseases and the necessary resources and logistics are made available in a timely manner. Zambia has been implementing Integrated Diseases Surveillance and Response (IDSR) since 2002 using the adapted Technical Guidelines. However, in the effort of strengthening surveillance in the Region, a generic IDSR Technical Guideline 2nd Edition was shared was with other countries.

The 56th WHO Regional Committee for Africa has called for implementation of the International Health Regulations in the context of the Integrated Disease Surveillance (IDS) Strategy.

International Health Regulations (IHR): Zambia is among the 194 countries bound by the International Health Regulations (IHR) which was adopted by the 58th World Health Assembly in May 2005. The IHR entered into force on 15th June 2007 and requires "State Parties" to conduct a situation assessment and to develop a plan for building core capacities. In this connection, WHO in Zambia provided US$30,000 (ZMK147 million) to the development of the IHR Plan of Action 21-28 November 2011 and a desk review process. The draft Plan of Action matrix will be finalized in 2012.

Zambia has been experiencing a number of outbreaks in various parts of the country. WHO supported technically the response to outbreak of anthrax in Chama District, Muchinga Province. The office also supported MoH to prepare the notification to WHO AFRO using the Event Management System (EMS).

Response to Anthrax Outbreak: Zambia experienced an outbreak of anthrax in Chama District, Eastern Province. The disease was primarily in hippopotami. Over ninety of them have died of the disease, which spread to humans through contact and/or ingestion of infected meat of the carcasses. A total of 511 people fell sick and five died in the communities as of 29 September 2011, after which no new cases were reported. WHO provided technical leadership in data management (collection, cleaning and analysis).

WHO supported the Ministry of Health technically and financially in adaptation of the guidelines which included a chapter on International Health Regulations (IHR) 2005. WHO also supported development and finalization of draft guidelines on cholera, typhoid and Rapid Response Teams (RRTs).

In the quest to strengthen Disease Surveillance and Response WHO Country Office has been conducting familiarization tours of provinces to learn more about programme implementation. The Country Office has also used the opportunity to strengthen surveillance through donation of refurbished provincial surveillance vehicles. In some instances, the office was able to support selected projects as was the case for Copperbelt

Province's cold-room facility.

Preparedness and response to Influenza: In order to strengthen influenza sentinel surveillance systems in the African Region of WHO, the WHO Global Influenza Program (GIP), the WHO Regional Office for Africa (AFRO) and the *Agence de Medecine Preventive* (AMP) are closely collaborating to implement the project "Strengthening Influenza Sentinel Surveillance in Africa" (SISA). WCO facilitated a Regional Consultant mission to review implementation of the previous (July 2011) assessment recommendations. A new sentinel site was opened on the Copperbelt as part of the programme strengthening.

As part of the strengthening of influenza surveillance, the WCO supported a mission by WHO/AMP Consultant who conducted an independent assessment of implementation of influenza surveillance in the four Zambia's influenza sentinel sites, namely: University Teaching Hospital (UTH) for [SARI] and three [ILI] at Chipata, George and University Teaching Hospital Adult Filter Clinics]. The mission visited all the four sites and produced a technical report and some recommendations.

Challenges/Constraints

The main challenges include the non-availability of National Focal Point on a 24-hour basis as recommended by WHO. The absence of human resource capacity at MOH and limited funding affected implementation of the activities, including those related to IDS in the year under review. Therefore, the MOH will need to allocate more funds in order to ensure that the IDSR is rolled-out to all the provinces. There is need to improve the effectiveness of the epidemic preparedness and rapid response committees, given that the country still continues to experience disease outbreaks. Incorporating IDSR data on disease outbreak into the HMIS remains a challenge, which has resulted into MoH having no database.

The channels of communication with other relevant Ministries such as the Ministry of Agriculture, Transport and Communication needs strengthening and formalization possibly though a Memorandum of Understanding (MoU). Although the country developed a Plan of Action to deliver IDSR, it has not received support from partners and Government in terms of funding of planned activities. Timely notification of events to WHO is still a challenge due to poor services. For example, the formal use of cell phones is still under consideration.

Lessons Learnt

The absence of a data focal point at national level continued to affect data collection, analysis and utilization.

2.6.2 DISASTER PREPAREDNESS AND RESPONSE (DPR)

Zambia is one of the countries most affected by drought in Southern Africa. It has experienced a relatively small occurrence of sudden onset of disasters, mostly related to floods. However despite local cultural awareness and resilience in flood risk prone areas, the country remains highly vulnerable to major floods in the main river basins.

Chronically poor sanitary conditions in the most affected districts exacerbated by flooding, increased the risk of outbreaks such as cholera and other diarrhoeal diseases. The stagnant floodwater also greatly increased the risks of malaria infections. Furthermore, floods continued to disrupt normal operations of the essential health care system.

In the year under review, WHO supported the national authorities particularly Disaster Management and Mitigation Unit (DMMU) efforts to mitigate the effects of disasters through rapid assessment of ill-health related to floods or drought and the preparation of a disaster risk reduction (DRR) plan focused on floods, drought and epidemics.

Achievements

The WHO supported the United Nations Disaster Management Team (UNDMT) through the provision of regular information to the UNDMT on the status of epidemic and pandemic diseases for alert and response.

In terms of WHO's support to improve Information management, WHO supported the office of the MOH's National Epidemiologist by helping to strengthen data capture, cleaning and analysis during outbreaks of anthrax, cholera and typhoid.

WHO also strengthened capacities of preparedness, prevention and response to epidemics and disasters. WCO also provided technical support to ensure regular convening and smooth discussion of issues on EPR during the bi-weekly National Epidemics Preparedness Prevention Control and Management Committee (NEPPC&MC) meetings.

With respect to Resource mobilization through the UNDMT and in partnership with DMMU, WHO supported development of a DRR plan which has since been distributed to cooperating partners for support in response to disasters. However, resource mobilization has achieved limited success given that the country is considered to be less disaster prone compared to other countries in the region.

Challenges / Constraints

Inadequate capacity to implement long-lasting solutions to address floods remains a major constraining factor to providing a timely effective response. Therefore, WHO in the year 2012 will seek to strengthen collaboration on the basis of clearly defined roles and responsibilities to ensure that Government, UN Agencies and other stakeholders work closely together to improve response to disasters.

Lessons learnt

Strengthening coordination mechanisms by Government is still a challenge. Therefore, the participation of line Ministries in response to emergencies is inadequate. Likewise, the strengthening of DMMU will add strength towards improving national coordination for effective response to emergencies and disasters.

2.7

HEALTH PROMOTION

2.7. HEALTH PROMOTION

Zambia has a high burden of communicable diseases such as Malaria, Tuberculosis, and HIV/AIDS. Outbreaks of diarrhoeal diseases are common especially in urban settlements with poor access to clean water, sanitation and waste disposal. Zambia is also experiencing a growing burden of Non-Communicable Diseases arising from tobacco smoking, alcohol misuse, physical inactivity and unhealthy diets. Equally, Maternal mortality and Under five mortality rates are high. Although there is improved public awareness about diseases and their prevention, the gap between knowledge and behaviour remains wide. This situation calls for improved capacity for implementation of health promotion actions targeting individuals and communities. The need for healthy policies, guidelines and standards to guide implementation cannot be overemphasized. Equally, the need for multisectoral action, coordination, resource mobilization and capacity building are challenges which need to be addressed.

The WHO objectives for the health promotion programme during the biennium 2010-2011 included the following;

- To build capacity for health promotion through training and development of policies, guidelines and standards.
- To develop evidence-based and ethical legislations and strategies to address /prevent public health problems associated with tobacco and to support implementation of the Framework Convention on Tobacco Control (FCTC)
- To improve prevention of public health problems associated with unhealthy diets and physical inactivity using evidence-based and ethical policies, strategies, recommendations, standards, guidelines and strengthen capacity for implementation of policies on alcohol.
- Training/orientation of all the health promotion officers at provincial and district level on implementation of health promotion strategies for priority health programmes;
- Production of health promotion guidelines, strategies policies for priority healthy programmes;
- To support the process of amending the Tobacco legislation and the completion of the process of developing the National Alcohol Policy;
- Increased public awareness, knowledge and skills on health issues including positive behavioral change through health education, and behavior change strategies.

- Community empowerment and participatory activities implemented.

Achievements

During 2011, the programme focus was to continue with the activities aimed at achieving the targets listed above. Good progress was made in 2010 towards the achievement of biennial targets. For example training of health promotion officers was conducted. Health promotion strategies were integrated into priority health programme strategic documents particularly the National Action Plan for NCDs 2011-2015 and the Malaria Strategic Plan for 2011-2015. Developing of the alcohol policy and amendment of the Tobacco legislation commenced in 2010. Communication strategies were implemented including health campaigns and commemoration of World Health Days to raise public awareness on health issues. Specific achievements are listed below:-

***Capacity building for health promotion*:** Provincial and district workshops were conducted by MOH and its partners for District and Provincial health promotion officers for orientation and skills building in development and implementation of health promotion strategies for priority health programmes.

Health promotion strategies were incorporated into national strategic documents which were developed in 2011. Notably the Non- Communicable Diseases Strategic plan for the period 2010-2011 which included the development of health promotion strategies to reduce the main shared modifiable risk factors for NCDs especially tobacco use, unhealthy diets, physical inactivity and harmful use of alcohol. WHO also supported the development of the Malaria Strategic Plan 2011-2015 which also has a large component on health promotion and communication.

The Ministry of Health revived the Technical meetings for the multi-sectoral health promotion committee. The quarterly meetings served as a platform for coordination of health promotion activities and as a forum for discussing policy related matters.

Development and Implementation of communication strategies: Meetings and workshops were conducted to review the first editions of the Malaria and HIV/AIDS communication strategies. WHO also provided both technical and financial support to MOH to implement communication strategies in support of priority health programmes. Notable activities in this area include; development of health learning and communication materials on different health topics notably on malaria and child health. Mass media strategies were also used to disseminate key messages to the public e.g. radio/TV discussion programmes, documentaries and announcements. Social mobilization activities were conducted during health campaigns particularly the bi-annual child health week campaigns and the SADC malaria week campaign. WHO also supported the implementation of the joint United Nations Communication Plan by contributing articles to the production of the UN newsletter, UN website, and participated in activities such as the MDGs campaign and

other UN related communications and events such as the UN day.

The WHO Country Office supported the commemoration of health days during the period under review. These include the World TB Day, The International Women's Day, and World Health Day, World Malaria Day, SADC Malaria Week, World Heart Day, bi-annual Child Health week campaign and the national epilepsy campaign.

In order to improve the visibility of the WHO Country Office, several tools were used. These include; The WHO Country Office WCO electronic Newsletter, The United Nations Newsletter, UN website, WHO/AFRO Website, WHO Press Releases and the WHO media mailing list. Furthermore, Media outreach activities continued during 2011. For example, journalists from various media institutions were invited to participate in various meetings organized by WHO and accompanied WHO country Office Teams on tours to the districts and provincial offices and several reports were produced in the media about the work of WHO.

2.7.1 TOBACCO CONTROL

WHO provided technical support during meetings which were organized by MOH to review the Tobacco legislation in the country. Technical support was given to the Ministry of Health to ensure that the amendments reflected the provisions of the Framework Convention on Tobacco Control. WHO continued to support anti-smoking campaigns and other advocacy activities for implementation of provisions of the Framework Convention on Tobacco Control.

2.7.2 ALCOHOL AND OTHER PSYCHOACTIVE SUBSTANCES

During the Period under review, the Ministry of Health continued with the process of developing the National Alcohol Policy with funding from SHARE II, a USAID project. A stakeholders' consultative meeting was convened by MOH during the first quarter of 2011 to review the existing draft document. A programme for training of health workers on implementation of strategies on Alcohol and substance abuse and provision of treatment and counselling services was commenced by MOH in 2011. The programme is expected to continue in 2012 to cover all the 9 provinces.

Achievements

The process amending the Tobacco legislation in the country to reflect the provisions of the Framework Convention on Tobacco Control was completed. The Draft Tobacco control Bill was submitted to the Ministry of Justice by MOH for Legal drafting.

The final draft of the National Alcohol policy was produced in July 2011. It addresses among

other things, the regulation of the alcohol market, public education and communication, workplace measures, protection of children and young people, treatment and care of those with alcohol related problems, research and capacity building.

A final stakeholder consultative meeting is planned for in 2012 for finalization and adoption of the document. The process of reviewing the National Malaria communication strategy and the National HIV/AIDS communication strategy was completed. The documents will be launched and implemented during the first quarter of 2012.

Challenges

The main constraint was inadequate funding from WHO. Hence some activities were deferred or cancelled. The Ministry of Health also experienced financial difficulties in 2011 due to the withdrawal of Donor funding to the health sector. This affected the implementation of planned activities.

Implementation of health promotion at the district level remains a challenge because the position of health promotion officer is not established. Focal point officers are given this responsibility, because they are assigned to other programmes and there is high turnover of staff.

The introduction of the GSM delayed the release of funding for programmes in the initial stages. In order to address the above problems it is recommended that: there should be an improvement in regular budget to serve as sufficient seed funding to initiate activities. WHO/AFRO/HQ should provide timely technical support to facilitate the implementation process where necessary and WHO activities should be aligned with MOH annual work plans to facilitate implementation. Work plans should be used to serve as tools for resource mobilization and joint planning with MOH and other partners.

There is need to harmonise implementation and pooling of resources and to ensure adequate allocation of resources for health promotion actions by programmes.

2.8

HEALTH SYSTEMS STRENGTHENING

2.8.0 HEALTH SYSTEMS STRENGTHENING

2.7.1 Health management Information System (HMIS)

Health management information systems (HMIS) is a facility based routine information system designed to collect data on related indicators that support monitoring and evaluation of the health sector. The HMIS has over the years demonstrated that it is a useful facility based information system. However more work still needs to be done especially in the area of staff capacity strengthening if the quality of HMIS data and its reliability are to be enhanced. Since the introduction of the HMIS as a monitoring tool and evaluation tool in 1997,the system has not undergone a review process to keep pace with the increasing demand for other health indicators such as the millennium development goals (MDGs). In order to achieve these targets, MoH planned to develop new data sets and targets by revising the entire HMIS operational procedure manual. WHO in collaboration with the HMN supported MOH to establish a Demographic surveillance System for HIV and AIDs, TB and malaria in three districts of Zambia. In addition, WHO supported the Ministry of Health to update and enrich the country health intelligence portal (CHIP) in order to build the information and evidence for consultations.

In collaboration with the Geneva Office and AFRO, WHO supported Ministry of Health to develop Terms of Reference for the Joint Annual Review(JAR)2010, refine data collection tools, participated in and, provided support to key planning meetings for the JAR, and supported identification of themes including document review and analysis. In addition, WHO supported the Joint Mission to the field for the JAR.

Challenges

- Lack of comprehensive health management information systems and financial administration management system(FAMs)
- Inadequate staff
- Parallel Monitoring and Evaluation systems

2.8.2 Human Resources for Health (HRH)

Human resource for health is critical to ensuring improved health service delivery to the people of Zambia. In order to address the Human resources for health needs, WHO and other partners supported MOH to develop the second HRHP 2012-2015. The HRH plan sets out strategies and options to tackle human resource challenges in the health sector. The Overall aim of the HRH plan is to ensure that an adequate number of appropriately

motivated, skilled and equitably distributed health workers provide quality health services.

The key HRH issues include the need to ensure that HRH planning is coordinated across the health sector and is based on the best available data. There is also a need to increase the current staff establishment through training and equitable distribution. There are also challenges in competence and capacity. Although th HR crisis is still existing, significant progress has been made in increasing health workforce.

Achievements

The WCO supported training of 'Fellows' abroad in South Africa, Zimbabwe and Ghana. So far, two have graduated in Dental surgery and pathology while three are still in training. WHO also supported the development of a proposal for resource mobilization to support Local fellows; essential health workers and community health workers and supported the development of the HRH strategic plan. WHO contributed funds to the development of the CHW strategy, HRH strategic plan for 2011-2015.

Challenges

- Shortage of trained health workers
- Poor conditions of service
- Poor working environment
- Limited support supervision that contribute to low morale of health workforce
- Brain drain locally and externally
- Health workforce distribution not according to workload and needs

Lessons Learnt

- Implementation of the HRH 2006-2010 was negatively impacted by:
    - The prolonged restructuring process of MoH
    - High staff turnover within the HRH Directorate
    - Reduced funding to implement the plan
    - High costs of staff retention in rural areas
- Draft HRH Strategic plan has reached an advanced stage and will be launched soon.

2.8.3 Health Financing

WHO provided technical support for the design and implementation of the Social Health Insurance scheme (SHI). In collaboration with partners who supported gap identification of the first actuarial assessment scheme and supported development of the roadmap for SHI. WHO also Supported the development of a proposal for the 5th round General NHA and Subaccounts study. To date, tools for the same have been finalized.

Challenges

- ❐ Underfunding is still below US$7 per capita
- ❐ National Health care financing policy is not yet finalized
- ❐ SHI is not yet developed

2.8.4 Health Systems

WHO Supported ministry of health efforts to step up efforts towards poverty reduction and sustain development through development of guidelines, policies and Strategies. WHO Supported the Ministry of Health to finalise its 2011-2015 NHSP and 2011-2020 NHP Framework. The two documents are undergoing final review at Steering Committee level. The next steps will include adoption and launching the documents.

2.85 Leadership and Governance

In 2011, WHO planned to provide support to Government to enhance and sustain harmonization and alignment principles. The following were the achievements: WHO supported and participated in all partner and sector coordination meetings i.e., Monthly MoH and Cooperating Partners policy Meetings; SAG; Planning Launch, Annual Consultative meetings and the Joint Technical and Governance Committee meetings.

2.9

ENVIRONMENTAL HEALTH

2.9 ENVIRONMENTAL HEALTH

Zambia has prioritized delivery of occupational and environmental health related services. The focus is to address the root causes of environmental health problem and thus, seek to improve drinking water, sanitation and reduced risks to foodborne diseases. However, risks associated with poor management of the environment abound. For example, fewer people have access to safe drinking water. ZDHS 2007 reports only 41% population access to improved source of drinking water. The policy frame work on environment was conducted in 2011 but has not been yet finalized. Environmental health training materials are inadequate in learning institutions. The WCO Zambia's focus in 2011 included technical capacity to MOH to assess environmental health risks in various populations including children in school and sourcing for financial materials. WCO supported a project conducted by University Teaching Hospital (UTH) in collaboration with Ministry of Education (MOE) on paraffin and other substance poisoning in Zambia.

Achievements

Progress in this area included; WHO collaboration with UTH and MOE and commencement of a study to assess the magnitude of paraffin poisoning in Zambia. Also WHO collaborated with other UN agencies, government ministries and NGOs in advocacy in climate-related issues and in development of an action plan on climate change. WCO continued to provide technical leadership towards dissemination of materials on International Health Regulation documents and facilitation of national participation in the Codex Alimentarius Commission.

Challenges

The pace and scale of mainstreaming of environmental health into national policies and of establishing viable coordination framework on occupational health and environment remains limited. Systematic risk assessments and documentation of the risk factors regarding occupational health and environment are also limited.

2.10

NUTRITION, FOOD SAFETY AND FOOD SECURITY

2.10 NUTRITION, FOOD SAFETY AND FOOD SECURITY

In Zambia malnutrition underlies up to 52% of all under-five deaths. Stunting rate in under-five children stands at 45%, 5% being acutely malnourished (wasted) and 15% underweight. The rates of micronutrient deficiencies are also high, with 53% Vitamin A deficiency and 46% Iron deficiency anaemia (NFNC, 2003), while 4% of school aged children were at risk of mild to severe iodine disorders deficiency (NFNC, 2002).

Achievements

WHO provided support in the implementation of various activities. For example;

- WHO supported the commemoration of the breastfeeding week in 2010
- WHO Supported the development of the Community IYCF training materials
- WCO gave financial and technical support in training of a nutritionist and MNCH focal persons in IYCF. Forty-eight health workers were trained from two provinces
- WCO supported the development of the Manual for Enforcement of the Breast milk Substitutes Law. This has since been printed and trainings for law enforcers was planned for 2011.
- Submission of manuscript for publication of the operational research on use of IYCF counseling cards.
- Publication on WHO website the 2008 IYCF assessment report

2.11

MEDICAL PRODUCTS AND TECHNOLOGY

2.11 MEDICAL PRODUCTS AND TECHNOLOGY

WHO has been working with MoH to address issues related to the pharmaceutical sectors such as inadequate human resources, lack of quality control, absence of competition, price regulation in private pharmacies and poor drug distribution systems.

Essential Medicines save lives, reduce suffering and improve health, but only if they are of good quality, safe, available, affordable and properly used. Almost 2000 million people, one third of the world's population, do not have access to essential medicines. Poor quality and irrational use of medicines causes concern. The use of traditional medicines or complimentary and or alternative medicines in Zambia and many developing countries, is wide-spread and a source of growing expenditure globally. WHO’s support is aimed at strengthening the medicines regulatory system, the supply management system and the procurement system in order to improve access and availability of quality, safe and efficacious medicines in Zambia.

The central priority remains the expansion of access to essential medicines, one of the health targets of MDGs. With the high disease burden particularly due to Malaria, TB and HIV/AIDS and other opportunistic infections and the increasing number of patients on life treatment with ARVs the major challenge of Zambian Pharmaceutical sector still remains shortage of pharmaceutically qualified staff at all levels and lack of representation of pharmaceutically qualified person at policy level in the Ministry of Health to provide expert guidance in all matters of pharmaceutical management including traditional medicine.

WHO'S efforts to a strategic response: WHO's response to the key Essential Medicines issues in Zambia is in the areas of Access, availability and affordability; Quality Assurance and; Rational Use of Medicines providing support for the development, implementation, monitoring and revision of national policies, Standard Treatment Guidelines and the National essential Medicines List and support country's medicines regulatory body in ensuring that the medicines on the market are of good quality, safe and effective.

Achievements

WHO has successfully advocated and supported strengthening of priority areas of the National Drug Policy (NDP). In 2011, WCO collaborated with other partners to provide technical and/or financial support for activities jointly planned by the Ministry of Health and WHO. WCO Supported the finalization of the draft 2nd Edition of the National Medicines Policy and its Implementation Plan and finalization of the draft 3rd Traditional, Complementary and Alternative Medicines and its Implementation Plan. WCO also

supported the Ministry of Health to develop the National Health Policy, the National Health Services Act and the draft 2nd Medicines Supply Chain Coordination Plan in Zambia, dissemination of Medicines Supply Chain System in Zambia and the Medicines Prices, Availability, Affordability (Part I) and Price Components (Part II), the Zambia National Formulary Committee in reviewing and printing of the National Essential Medicines List/Standard Treatment Guidelines.

Challenges

Inadequate and unavailability of funds for some planned activities has hampered progress in implementation of the plan of work. The development of the National Policy on traditional medicine has been slow and follow up on implementation of other activities difficulty due to a lack of focal person on Traditional medicine.

Lessons Learnt

Planning and implementation of an effective essential drugs management system requires availability of appropriate human resource and infrastructure support of all aspects of pharmaceutical services. Effective partnerships and collaboration with local partners allows implementation of activities in the Plan of Work and medical products including Essential Medicines activities as a whole.

3. WHO COUNTRY OFFICE CAPACITIES

In the quest to strengthen managerial capacity for programme implementation, the WHO Representative introduced cluster approach. This approach was seen as one of the requirements for GSM implementation at country level. The Country Office has in existence four clusters namely, Disease Prevention and Control; Maternal, Neonatal and Child Health; Health Systems Strengthening and, Administration. The cluster approach provided an opportunity for positive team spirit, open communication and sharing of information among different programmes.

Global Service Management; Preparations for the Global Management System (GSM) to go live continued and were stepped up in 2010 - 2011. GSM helped to simplify and harmonize WHO's global work by integrating a wide range of management and administrative systems and processes. GSM went live on 1st January 2011 in the African Region. This integration enabled a global view of the management of health programs, facilitate decentralization to improve timeliness and accuracy of information and contributed towards improved WHO's global programmatic reporting and controls. ICT infrastructure was upgraded to conform to the requirements of GSM. State of the art equipment including Video Conferencing and teleconferencing facilities were installed in the WHO country office.

Staffing; The staff establishment of the WHO Country Office was comprised of international staff, national professional officers and general service staff. During the year under review the office was strengthened thorough filling up of created position and conversion of a number of staff to fixed term. New equipment and furniture were provided where necessary to a number of staff for use in daily duties.

The main challenges were financial constraints following economic downturn affecting both staff salaries and programme implementation. Despite the economic downturn the Country Office continued to strengthen its capacity. All the staff on fixed term contracts were included in GSM. The office also adopted deliberate effort to mobilize resources locally to support activities.

4. GLOBAL HEALTH AGENDA

WHO Country Office has been working towards improved governance and development of string partnerships in order to advance the Global Health Agenda. The partnerships resulted from WHO's active participation in SWAp coordination mechanisms of the health development partners, contribution to the UN reform process (e.g. One UN), and as a permanent member of the health troika.

Leadership and Governance; WHO country office activities are guided by the 2nd generation Country Cooperation Strategy (CCS) 2008 2013. The CCS is based on the thirteen selected strategic objectives and implementation is within the context of the WHO 11th Global Programme of Work (GPW) and the WHO Medium Term Strategic Plan 2008 2013. Who has been offering technical assistance and tools to MoH and other institutions to carry out a number functions in leadership and governance. The assistance includes support to development of NHSP, NDP6, NHP, MoU / IHP+ compact, MTR (TB & Malaria), costing models for the health budget and Primary Health Care (PHC) strengthening. WHO has also been promoting harmonization and alignment of external aid within the national health policies thereby enhancing MoH stewardship role.

Partnerships: In the recent past a number of initiatives and partnerships emerged as a result of growing need to achieve the health Millennium Development Goals (MDGs). In February 2008, Zambia hosted the International Health Partnerships meeting in Lusaka and since then the country embarked on revision of the existing MoU. This was necessary not only to fill up the existing gaps but also to mobilizing additional resources to address MDGs. WHO actively supported the process of revision of the MoU into a compact to strengthen alignment, harmonization and timely translation of commitments by partners into action.

Collaboration with the United Nations: The United Nations in Zambia is undergoing an important transformation in the way it conducts business. The introduction of One UN through creation of joint programmes contributed greatly to improved coordination, harmonization and resource pooling and reduced transaction costs.

WHO Country Office is the representative of the United Nations in Zambia to the Government on matters of health. Through the United Nations Development Assistance Framework (UNDAF) 2011-2015, and the Joint Assistance Strategy for Zambia (JASZ) technical assistance will be provided to MoH.

Civil Society and NGOs; Zambia has seen the growth of a number of national and international non-Governmental Organizations over the years who are primarily working on bringing basic health services and health promotion to communities. However, their impact has been hampered by inadequate orientation on the country's priorities and plans and week representation at national fora and poor coordination amongst themselves.

WHO has continued to provide support to MoH by being active in dialogue processes in order to strengthen the work of NGOs and civil society. WHO has supported MoH in the creation of troika representation of NGOs and Civil Society to better align their work, improve coordination and harmonization.

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5. WAY FORWARD

PRIORITIES FOR 2012

5.1 TB priorities

These include:

- Strengthening DOTS expansion through broader involvement of community based TB/ HIV practitioners and the private sector
- Strengthening technical monitoring through enhanced support visits and technical review meetings
- Develop ACSM strategy
- Update PMDT guidelines and tools

5.1.2 Malaria Priorities

These include:

- Capacity development in data collection management, analysis and documentation
- Resource mobilisation in support of the NMSP to sustain the gains made on population based coverage targets for ITNS, IRS and IPTp.
- Supporting effective forecasting, quantification, procurement and monitoring of anti-malarials, RDTs, LLINs to improve access through public health services.
- Support finalisation and launch of the 2011-2015 NMSP
- Planning and implement action of the 2012 Malaria Indicator Survey and the ZDHS.
- Support Therapeutic Efficacy Testing (TET), implementation.

5.2 Maternal Neonatal and Sexual Reproduction

Work closely with Government, UN agencies and other stakeholders to scale up proven based high impact interventions nationally for maternal, new born , sexual and reproductive health services

- Continue to support government in strengthening capacity for delivering quality

maternal, new born ,sexual and reproductive health services.

- Work with government and other stakeholders to generate and provide data on maternal and newborn deaths through MDSR.

- Continue to advocate for more resources both financial and human to support implementation of MNCH

- Conduct short programme review for MNCH in selected districts.

5.3 Child and Adolescent

- Focus on supporting MOH in planning for scaling up interventions that will prevent deaths among the newborns especially at community level. This will entail developing/adapting of strategies and guidelines to further guide implementers at health facility and community levels.

- Support the MOH in scaling up implementation of the IMCI strategy at both facility and community level in all the districts will be another area of focus. Planning on the best way to saturate the health facilities with skilled health workers especially pre-service will be important. Developing/adapting tools to monitor IMCI implementation at both levels will also be a priority. Support will be given to the child health unit to advocate for inclusion of priority IMCI drugs in the community health worker kit.

- Supporting Ministry of Health in monitoring the IYCF scale-up plan especially at community level will be an important activity in 2012. WCO will support the Ministry of Health and National food and Nutrition in finalizing the Nutrition Policy and development of the IYCF Operational strategy. Additional support will be given to the MOH to complete the IMAM and IYCF guidelines.

- WCO will support the MOH in finalizing of the Adolescent Health Standards of Care guidelines and their dissemination. Additionally implementation of the standards and monitoring of the implementation will be supported. Support for the development of Adolescent Youth friendly Corners in areas where adolescents are found will be an important factor in contributing positively towards the health of both the adolescents and newborns.

- Continue joint resource mobilization for accelerating progress towards attaining MDGs 4 & 5.

5.4 Health Promotion

- The priorities for 2012 include the following:-

- Build capacity for health promotion through training and development of policies, guidelines and standards.
- Increase knowledge, skill on major risk factors to health and implementation of communication and behavior change strategies.
- Address public health issues associated with tobacco through implementation of the Framework convention on Tobacco Control
- Address public health problems associated with use of Alcohol and other psychoactive substances.
- Improve prevention of public health problems associated with unhealthy diets and physical inactivity through public education and development of evidence based policies, strategies and guidelines.

5.5 Environmental Health (EH)

- Support Joint planning, Monitoring and evaluation of EH programmes.
- Support assessment of environmental health Risk factors including; through supporting consultative meetings to assess feasibility of establishing poison centres for Southern and Eastern African Regions.
- Support a Joint Study with MOH, UTH and WHO to develop IEC materials in Schools.

5.6 Health Systems Strengthening

- Support ministry of health to improve production, distribution, skills mix and retention of health workforce.
- Provided support to ministry of health to develop and finalise implementation of the Social health insurance scheme and conduct another round of the NHA.

Annex 1

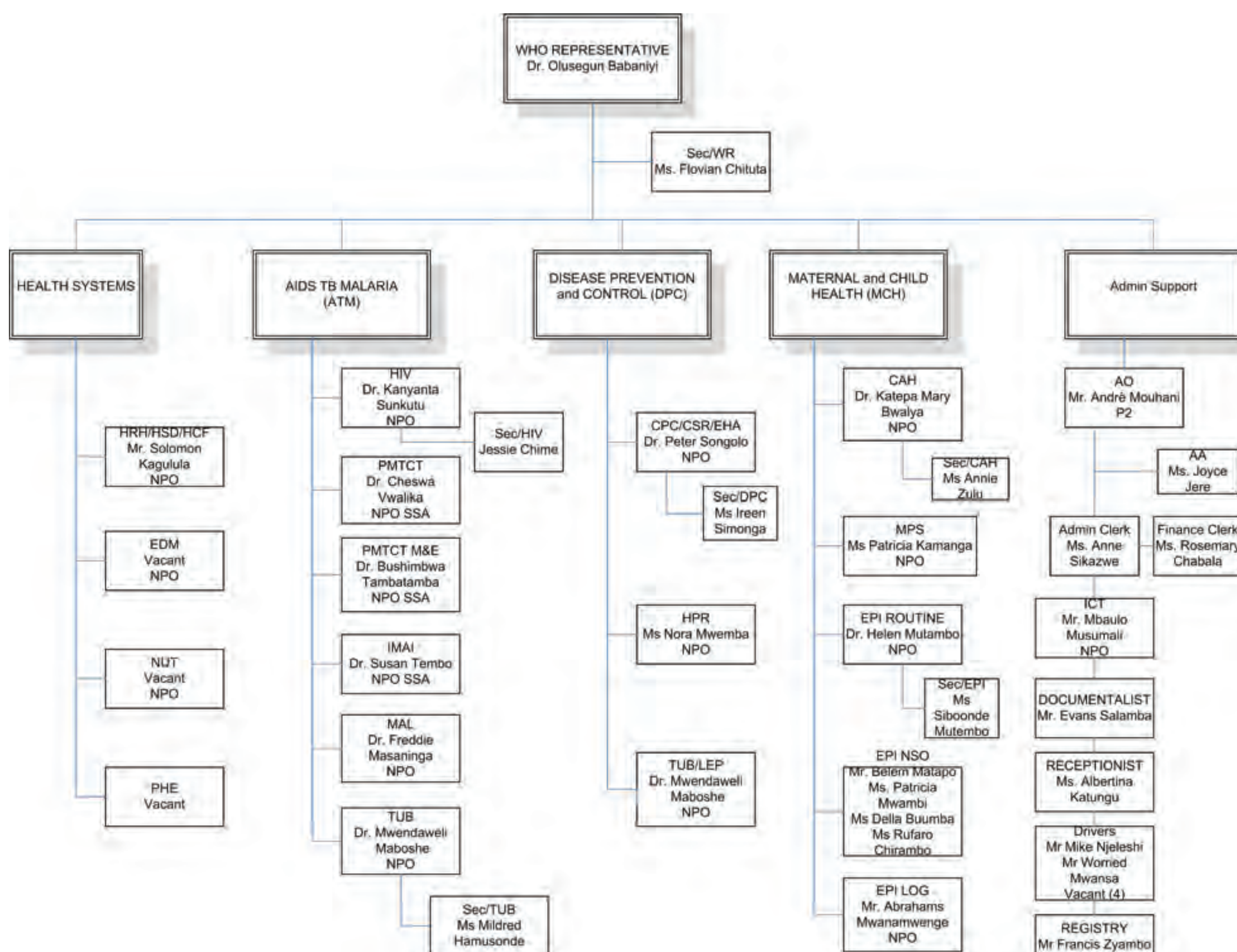
WHO COUNTRY OFFICE STAFF LIST AS ON 31 DECEMBER 2011

S/N	NAME	TITLE
A.	International Staff	
1	Dr O. Babaniyi	WHO Representative
B.	National Professional Officers	
2.	Dr. M. Maboshe	NPO/TUB
3.	Mrs. P. Kamanga	NPO/MPS
4.	Mr. S. Kagulula	NPO/MPN
5.	Dr. H. Mutambo	NPO/EPI
6.	Dr. F. Masaninga	NPO/MAL
7.	Dr. Katepa Bwalya	NPO/CAH
8.	Dr. P. Songolo	NPO/DPC
9.	Mr. B. Matapo	National Surveillance Officer
10.	Mrs. D. Buumba	National Surveillance Officer
11.	Mrs. R. Chirambo	National Surveillance Officer
12.	Mrs. P. Mwambi	National Surveillance Officer
13.	Mr. A. Mwanamwenge	NPO/LOG
14.	Mrs. M.L.M. Liwewe	Laboratory Scientist – UTH
15.	Mrs. I.M. Ndumba	Laboratory Scientist – UTH
16	Dr Susan Zimba Tembo	NPO/MC
17	Ms. N. Mweemba	NPO/HIP

C.	**Finance and Administrative Staff**	
18.	Mrs. J. K. Jere	Administrative Assistant
19.	Mrs. A Sikazwe	Administrative Clerk
20.	Mr. M. Musumali	ICT Officer
21.	Mr. F. Zyambo	Machine Operator
22.	Mrs. R. M. Chabala	Finance Clerk
D.	**Secretaries and Receptionists**	
23.	Mrs. F Chituta	WR Secretary
24.	Ms. M. Siboonde	Secretary – EPI

Annex 2

ORGANIZATION STRUCTURE WHO COUNTRY OFFICE ZAMBIA



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