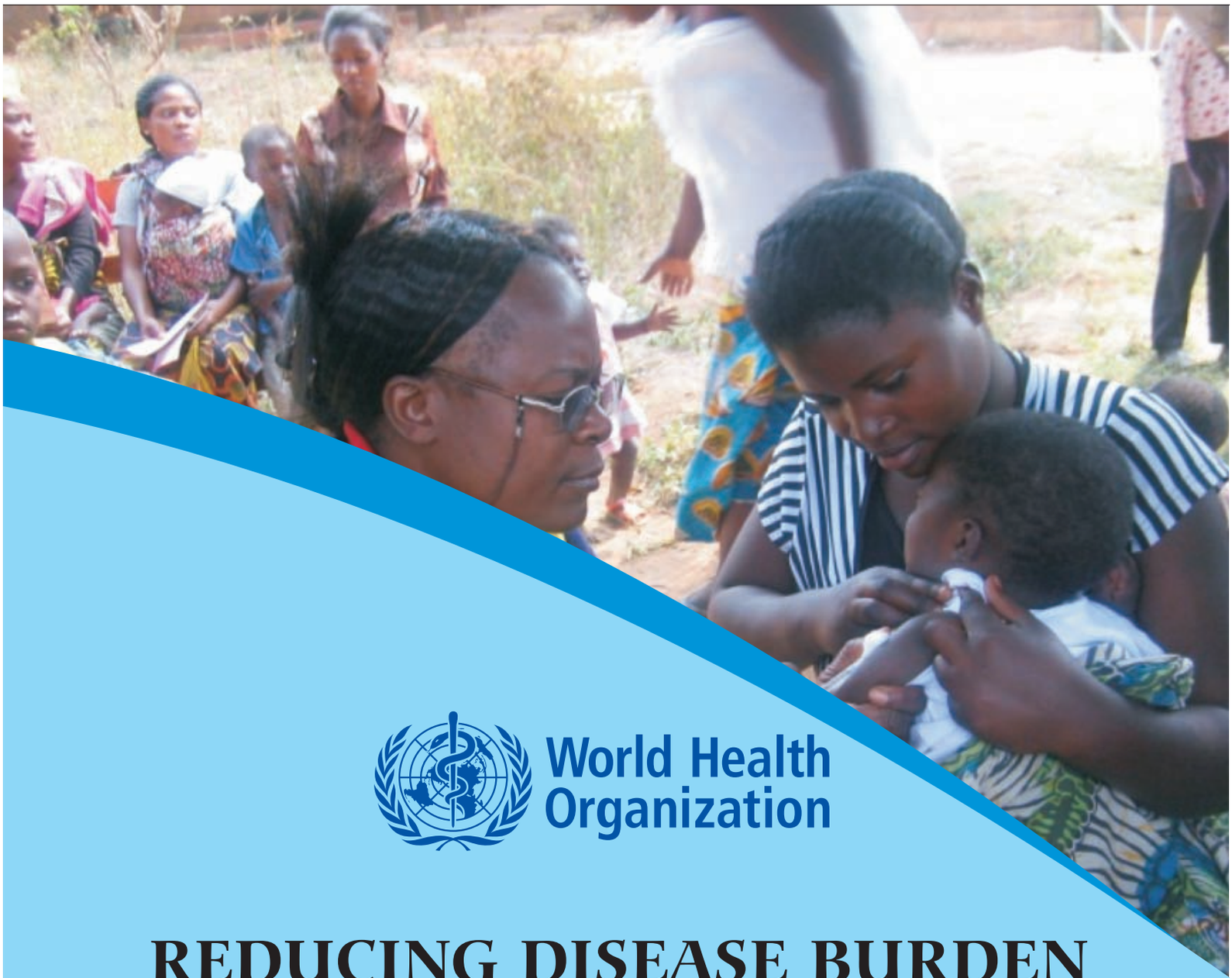


World Health Organization

REDUCING DISEASE BURDEN

WHO Zambia Country Office
Annual Report - 2010

CONTENTS

Foreword....ii
Acronyms....iii
Introduction....1
Communicable Diseases....3
Vaccine Preventable Diseases (VPD)....5
Neglected Tropical Diseases Control....13
HIV/AIDS, Tuberculosis and Malaria....14
Tuberculosis....22
Malaria....26
Non-communicable Diseases, Mental Disorders and Violence/Injuries....29
Maternal, Newborn and Sexual and Reproductive Health....32
Child and Adolescent Health....36
Emergency Humanitarian Action....40
Health Promotion....42
Nutrition, Food Safety and Security....46
Health Systems and Services....47
Medical Products and Technology....48
Global Health Agenda....50
Management and Special Events....51
Special Events....53
Annexes:....56

FOREWORD

During the year 2010, the WHO country Office in Zambia made a lot of progress in implementation of the plan of action to support effort in reducing disease burden, strengthening of health systems and partnerships.

Significant work was undertaken in supporting the generation of evidence which included major programme reviews such as national tuberculosis and malaria programmes. The on-going WHO STEPwise survey on major non-communicable risk factors was conducted in the Copperbelt Province. The drug resistant survey was undertaken to provide information on the efficacy of the available regimen. The on-going sentinel surveillance for influenza has continued to generate data on the various existing viruses. In the quest for finding innovative ways for prevention and control of HIV infection, WHO supported trials for Pre-Exposure Prophylaxis (PrEP).

The data generated has greatly assisted in the development and finalization of various guidelines, protocols and strategies, especially the five-year National Health Strategic Plan (NHSP) 2011 - 2015 which WHO supported both technically and financially.

Under health system strengthening WHO donated and commissioned a cold room facility worth US$130,000 at the Copperbelt Provincial Medical Office in Ndola. The cold room will serve as a storage facility and distribution point for vaccines for the Copperbelt, North Western and Luapula Provinces. WHO provided vehicles for strengthening of immunization programmes to Western, Luapula, Northern, Lusaka and Copperbelt Provinces. The revision of the National Health Policy was conducted with the support of WHO both financially and technically; it is hoped that the NHSP and National Health Policy will shape the health agenda of the country. In response to the growing burden of communicable diseases support was provided to strengthening the office of the National Epidemiologist through provision of necessary tools and equipment.

WCO continued to support the Ministry of Health and partners in raising the profile of the pregnant mother and child, especially the newborn, whose health indicators impact on Zambia's attainment of the health related Millennium Development Goals (MDGs).

This report provides some of the major achievements by the Government of Zambia with the support of the WHO Country Office, in some instances with the participation of the other health development partners.

LIST OF ACRONYMS

ACM	Annual Consultative Meeting
ACTs	Artemisinin Combination Therapy
ADH	Adolescent Health
AEFI	Adverse Events Following Immunization
AFP	Acute Flaccid Paralysis
AFRO	Regional Office for Africa
AIDS	Acquired Immunodeficiency Syndrome
AL	Artemether Lumefantrine (AL)
ANC	Antenatal Clinic
ART	Anti retroviral Therapy
ATM	AIDS, Tuberculosis & Malaria
AU	African Union
BCC	Behavior Change Communication
CARMMA	Campaign for Accelerated Reduction in Maternal Mortality in Africa
CARMMZ	Campaign for Accelerated Reduction in Maternal Mortality in Zambia
CCM	Community Case Management
CCM	Country Coordinating Mechanisms
CCS	Country Cooperation Strategy
CDC	Centre for Diseases Control
CERF	Central Emergency Revolving Fund
CFR	Case Fatality Rate
CIDA	Canadian International Development Agency
CP	Cooperating Partner
CPT	Co-trimoxazole Preventive Therapy
CSO	Central Statistical Office
CYMP	Comprehensive Multi-Year Plan
DCT	Diagnostic Counselling & Testing
DHMT	District Health Management Team
DHS	Demographic Health Survey
DMMU	Disaster Management & Mitigation Unit
DoTs	Daily Observed Therapy Short-Course
DPC	Disease Prevention & Control
DRC	Democratic Republic of Congo
EDM	Essential Drugs & Medicines
EmONC	Emergency Obstetrics & Neonatal Care
EPI	Expanded Programme on Immunization
FANC	Focused Antenatal Care
FHI	Family Health International
GPW	Global Program of Work
GSM	Global Management System
HDI	Human Development Index
HFS	Health Facility Survey

HIV	Human Immunodeficiency Syndrome
HMIS	Health Management International System
HQ	Headquarters
HRH	Human Resources for Health
ICC	Inter-Agency Coordinating Committee
ICHA	International Classification of Health Accounts
iCCM	Integrated Community Case Management
ICT	Information Communication & Technology
IDS	Integrated Disease Surveillance
IDSR	Integrated Disease Surveillance & Response
IEC	Information, Education & Communication
IHP	International Health Partnerships
IHR	International Health Regulations
IMAI	Integrated Management of Adolescent & Adult Illness
IMCI	Integrated Management of Childhood Illness
IPT	Intermittent Preventive Treatment
IPTp	Intermittent Preventive Therapy in Pregnancy (IPTp)
IPTP2	Intermittent Preventive Therapy Two Doses
IRS	Indoor Residual Spraying
IST	Inter-Country Support Teams
IUATLD	International Union Against Tuberculosis and Lung Diseases
IUCD	Intra-Uterine Contraceptive Device
IYCF	Infant and Young Child Feeding
JASZ	Joint Assistance Strategy for Zambia
LAN	Local Area Network
LCD	Liquid Crystal Display
LLIN	Long-Lasting Insecticide Treated Nets
LOG	Logistician
M&E	Monitoring & Evaluation
MAL	Malaria
MC	Male Circumcision
MDGs	Millennium Development Goals
MDR	Maternal Death Review
MDR-TB	Multi-Drug Resistance Tuberculosis
MMR	Maternal Mortality Ratio
MNCAH	Maternal Neonatal Child & Adolescent Health
MNCH	Maternal, Newborn & Child Health
MoH	Ministry of Health
MoU	Memorandum of Understanding
MPN	Managerial Processes in Health Development Networks
MPS	Making Pregnancy Safer
MTR	Mid Term Review
NCD	Non Communicable Diseases
NDP	National Drug Policy

NDP6	Sixth National Development Plan
NEPPC & MC	National Epidemics Preparedness Prevention, Control & Management Committee
NFNC	National Food & Nutrition Commission
NGOs	Non-Governmental Organization
NHA	National Health Accounts
NHP	National Health Policy
NHSP	National Health Strategic Plan
NPAFP	Non-Polio Acute Flaccid Paralysis
NPO TUB	National Professional Officer, Tuberculosis
NT	Neonatal Tetanus
NTDs	Neglected Tropical Diseases
NTP	National Tuberculosis Programme
OPV	Oral Polio Vaccine
OVC	Orphans & Vulnerable Children
PETS	Public Expenditure Tracking Survey
PHC	Primary Health Care
PLHIV	People Living with Human Immunodeficiency Virus
PMTCT	Prevention of Mother to Child Transmission
PPP	Public Private Partnerships
PrEP	Pre-Exposure Prophylaxis
QA	Quality Assurance
RAF	Resource Allocation Formulary
RBM	Roll Back Malaria
RDTs	Rapid Diagnostic Tests
RED	Reaching Every District
RNCV	Royal Netherlands Chemical Society
SAG	Section Advisory Group
SHA	Social Health Accounts
STI	Sexually Transmitted Infection
SWAPS	Sector-Wide Approaches
TA	Technical Assistance
TB	Tuberculosis
TB CAP	Tuberculosis Control Assistance Programme
TDRC	Tropical Diseases Research Centre
TOPV	Tetra Oral Polio Vaccine
ToT	Training of Trainers
TUB	Tuberculosis
TV	Television
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDAF	United Nations Development Assistance Framework

UNDMT	United Nations Disaster Management Team
UNFPA	United Nations Fund for Population Activities
UN 4H + 1	United Nations 4H+1 organizations (WHO, UNFPA, UNICEF, the World Bank plus UNAIDS)
UNICEF	United Nations International Children's Emergency Fund
USA	United States of America
USAID	United States Agency for International Development
UTH	University Teaching Hospital
WCO	World Health Organization Country Office
WHO	World Health Organization
ZISSP	Zambia Investment System Support Programme
ZIVS	Zambia's Immunization Vision & Strategy
ZNCR	Zambia National Cancer Registry

INTRODUCTION

The report has covered the main contributions by the WHO Country Office in support of MoH and other partners in health for the period 01st January 2010 to 31st December 2010. The report is prepared in accordance with the Country Office's existing Strategic Objectives 1 -12 namely; communicable diseases; HIV/AIDS, Tuberculosis and Malaria; non-communicable diseases, mental health and violence/injuries; maternal, newborn and child health; emergency humanitarian action; health information and promotion; socio-economic determinants of health; environmental health; nutrition, food safety and security; health services delivery; essential drugs and medicines and; global health agenda.

Country context

"The Zambian economy continues to gather satisfactory program strength and performance especially for programs receiving adequate support. Growth accelerated further in 2010, private sector credit has recovered to pre-global financial crisis levels, the current account is in surplus, and international reserves are solid. Prospects of strong growth provide an opportunity for more rapid poverty reduction and employment creation. Enhanced access to social and economic facilitiesincluding health and water, transportation, markets, and financial servicesis needed, particularly in rural areas where poverty is still high.

"The fiscal program for 2011 is appropriate. The expenditure mix is set to shift toward social and capital spending. As the authorities tap the sovereign bond market to finance capital spending, it will be important to strengthen debt and liquidity management capacity. Containing spending pressures, including with regard to wages and maize purchases, is critical to safeguard priority poverty-related and investment spending. Sequential bumper crops have revealed the limitations of the current maize pricing and marketing system. The government needs to modulate its maize marketing role to minimize distortions, contain fiscal risks, and provide incentives for the private sector to develop.

"The authorities' inflation target for 2011 is appropriate. Keeping inflation low and stable requires close attention to underlying inflation developments. As inflation expectations, nonperforming loans, and operating costs are reduced, and credit risk concerns ease, bank lending rates should come down.

The country has taken action to bring domestic borrowing back in line with the program, and to improve data compilation and monitoring.

The Ministry of Health was concluding the implementation of the National Health Strategic Plan (NHSP) 2005 2010. The plan falls under the framework of the Government's five year National Development Plan. Alongside the NHSP are several health specific plans such as the Human Resources for Health (HRH) Plan, National HIV Strategic Plan, Roadmap for Maternal and Child Health, National Tuberculosis Strategic plan and National Malaria Strategic Plan and National Mental Health Strategic Plan. The documents provide strategic direction for interventions on specific priority diseases and are developed by MoH in consultation with health partners.

However, Zambia has been experiencing an increase in the number of health partners thereby introducing new modalities for funding. The rapid growth of partners in health has in some instances

brought with it challenges in harmonization/alignment to Government framework despite the existence of the SWAP mechanisms. It is one of reasons that Zambia hosted the International Health Partnership (IHP+) in order to strengthen coordination structures. However, Zambia is in the process of finalization of the IHP+ initiative with its partners.

WHO Mission and Core Functions

The mission of WHO is 'the attainment by all people of the highest level of health'. The work of WHO at country level was guided by the Country Cooperation Strategy (CCS) 2008 2013 and the United Nations Development Assistance Framework (UNDAF) 2005 2010. The CCS also guides the development and implementation of the country's bi-ennial Plan of Action (2010 2011). The six main core functions of WHO can be summarised as follows:

1. Contribute to policy dialogue and advocacy
2. Manage information and stimulate research and development
3. Provide technical and policy support
4. Work in partnership with Ministry of Health and other stakeholders in health
5. Set norms and standards and ensure their application
6. Promote use of appropriate technologies, tools and guidelines

WHO Guiding Principles in Zambia

The WHO bi-annium operational plan 2010-2011 is based on the strategic directions provided by the 2nd generation Country Cooperation Strategy (CCS) 2008 2013.

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

The strategic focus that which forms the basis for country cooperation include: support to strengthening of health systems; fostering of partnerships, and; the dissemination of scientific knowledge in support of evidence based policy formulation and programme implementation. The attainment of these objectives should result in measurable progress towards the national goal of “improving the health status of the people in Zambia”.

COMMUNICABLE DISEASES

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.

International Health Regulations

The international Health Regulations came into effect on 15 June 2007. The 56th WHO Regional Committee for Africa called for implementation of the Regulations in the context of the Integrated Disease Surveillance (IDS) Strategy.

However, Zambia has not made progress in the implementation of IHR (2005) as they are yet to orient key stakeholders. This has been due to lack funds to conduct an orientation workshop for identified stakeholders.

Through the support of WHO, IHR (2005) 2nd Edition has been widely disseminated to most of the districts in the country for their use. MoH are in the process of printing more copies for sharing with other stakeholders. MoH has with the support of WHO conducted core capacities for surveillance and response in accordance with IHR (2005) at major entry points using A/H1N1 as the tracer. The assessment was conducted prior to the commencement of A/H1N1 outbreaks in the country.

Furthermore Zambia has received the generic Integrated Diseases Surveillance and Response (DSR) guidelines 2nd edition which also incorporates IHR (2005). Preparations are under way for the adaptation of the guidelines to the local situation. MoH has also prepared and submitted a proposal for undoing for orientation of identified key staff on IHR (2005).

Integrated Diseases Surveillance and Response

WHO has continued to provide support to MoH to scale-up training of district health staff on Integrated Disease Surveillance and Response (IDSR) technical guidelines. Despite the inadequate funding, implementation of IDSR progressed fairly well. WHO provided both technical and financial support towards scaling-up of IDSR to provinces. The main achievement is that the entire country has been covered as far as roll-out of IDSR is concerned. All provinces/districts have trained staff in IDSR and copies of technical guidelines for future reference.

WHO has supported the establishment of strong diseases surveillance system (IDSR) and offers technical support to the National Epidemics Preparedness, Prevention, Control and Management Committee (NEPPC&MC). WHO has been supporting the Ministry of Health (MoH) in conducting rapid assessments of the situation in affected areas and identify key needs, actions required and gaps.

WHO-Country Office with support from the Inter-Country Support Team (IST), Harare, upon request from the Ministry of Health of the Republic of Zambia, conducted an assessment of the cholera control interventions in Lusaka's Chipata, Kanyama and John Laing Compounds from 02nd 12th February 2010. The main objective of the mission was to identify factors influencing the observed pattern of cholera in Zambia, particularly Lusaka

district. Since cholera outbreaks are associated mainly with inadequate sanitation and limited access to safe water supplies, it was necessary to assess and evaluate whether interventions of provision of safe drinking water, burial of shallow wells and provision of adequate sanitary facilities were appropriately and sufficiently undertaken to control cholera outbreaks in Chipata, Kanyama and John Laing.

Preparedness and Response to Influenza

WHO has been providing technical support and training for surveillance of 'Pandemic Influenza A/H1N1 2009'. WHO supports the Ministry of Health in collection and analysis of data. There were eighty-nine confirmed cases of 'Pandemic Influenza A/H1N1 2009'and one death of a neonate since surveillance started in July 2009. Furthermore, WHO donated 1,000 courses of Tamiflu to MoH in 2010.

WCO supported and facilitated the three day meeting 3rd National Influenza Centres (NIC) meeting in the African Region from 16-18 November 2011 organised in order to strengthen the Influenza Laboratory Network in the African Region. The Network is a critical component of the WHO AFRO regional plan for surveillance of seasonal and pandemic influenza viruses. The meeting provided a forum for countries to share experiences and progress made in influenza surveillance and diagnosis and response. It addressed management and technical capacities of laboratories in the network, assess existing challenges and how to address them. Participants were also updated on the surveillance of influenza viruses and the current status and management of the Regional Influenza Laboratory Network.

Challenges/Constraints

The absence of human resource capacity at MOH has continued to affect implementation of the activities. Funds are also inadequate and MOH will need to allocate more funds for rolling-out of IDSR to the remaining provinces. There is need to improve the effectiveness of the epidemic preparedness and rapid response committees, especially that the country still continues to experience disease outbreaks. Incorporation of IDSR data on disease outbreak into HMIS is still a challenge resulting in MoH having no database.

The main challenges include the non-availability of National Focal Point on a 24-hour basis as recommended by WHO.

The channels of communication with other relevant Ministries such as Agriculture, Transport and Communications needs strengthening and formalization though probably a Memorandum of Understanding (MoU).

Though the country had developed a Plan of Action, it has NOT received support from partners and Government in terms of funding of activities. Mobilization of resources still remains a challenge.

Timely notification of events to WHO is still a challenge due to poor services the formal use of cell phones is still under discussion.

Lessons Learnt

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

VACCINE PREVENTABLE DISEASES (VPD)

The WHO Country office in Zambia provided strategic technical support and made key achievements in the area of immunisations and surveillance for vaccine preventable diseases despite financing challenges the country faced.

Leadership and Resource Mobilization

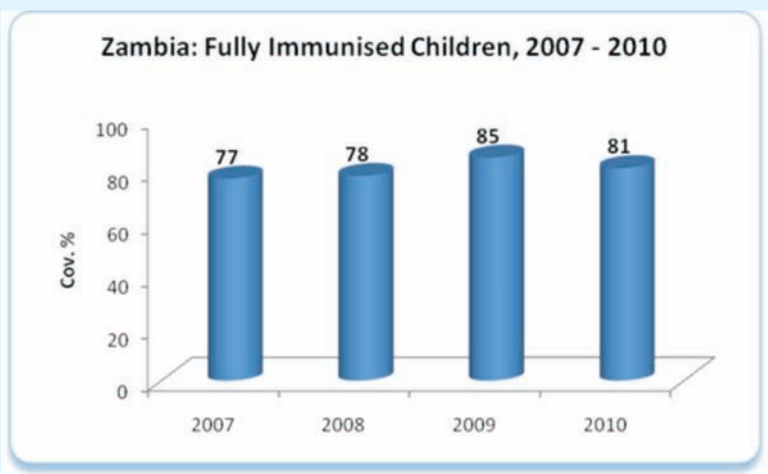
- The Inter-Agency Coordinating Committee (ICC) for Maternal, Newborn, Child Health and Nutrition facilitated funding of the two child health weeks.
- Supported the Ministry of Health to develop a proposal on immunization (vaccine deployment plan) against H1N1 and subsequent implementation.

Formative Guidance

- Supported the Ministry of Health to develop, print and distribute guidelines on H1N1 Influenza
- Supported the Ministry of Health to implement activities in the National Response Plan on Pandemic H1N1 2010 Influenza
- Zambia's Immunization Vision and Strategy (ZIVS), which is the EPI's Comprehensive Multi-year Plan (cMYP) aimed at the impact that effective immunization can contribute towards improved Child Survival (MDGs 4 to 6) by 2015 was revised to include a proposal for introduction of pneumococcal and measles in 2012 and rotavirus vaccine in 2013.

Routine Implementation

- Supported the Ministry of Health in Vaccine and Cold Chain Equipment that culminated into the installation of national Cold Chain Equipment Cold Chain in Ndola to cater for the northern region of the country. The Regional Director of WHO in Africa Dr Louis G Sambo commissioned the ultra modern equipment. This is in line with expansion strategy in preparation to introduce new vaccines and underutilised vaccines (PCV10, Measles Second Dose and Rotavirus Vaccines)
- Successfully supported the Ministry of Health and partners to plan, implement, supervise and monitor the Reaching Every District (RED) Strategy which has been scaled up to all the 72 districts of the country; GAVI Health Systems support to all the 12 selected low performing districts of the country. There was a challenge to adequately implement immunisation sessions due to reduced financing toward the immunisation programme.

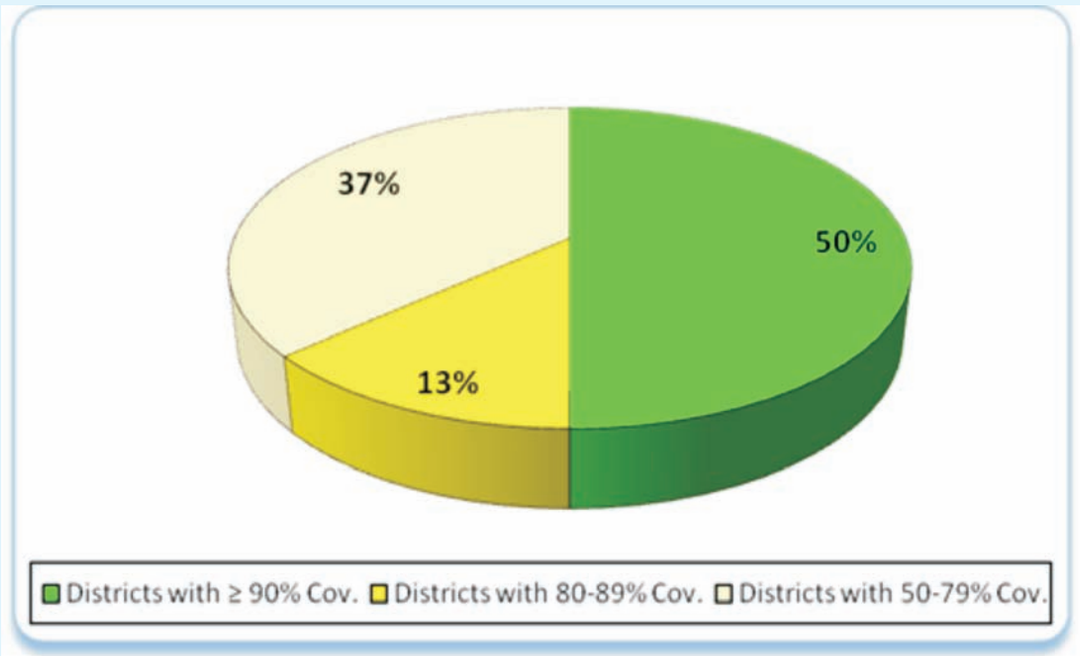


Source: EPI/Ministry of Health

Most of the children in the year 2010 were vaccinated during the bi-annual Child Health Weeks in July and November

- Supported the planning and implementation of bi-annual Child Health Weeks which was integrated with mopping up immunisation in 30 high risk districts bordering Angola and DRC and the results for the first round for OPV vaccination are indicated as follows:

Immunization coverage for tOPV in the 30 high risk districts, 2010



Source: EPI/Ministry of Health

MoH staff at various health facilities administering vaccines during child health week, 2010

The mopping up activities were aimed at interrupting any possible transmission of wild poliovirus in 30 polio high risk districts. The overall immunisation coverage was 97%.

- The WHO polio/measles laboratory at UTH supported Influenza surveillance
- 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 Routine Immunization Officer Dr Helen Mutambo (Far left) with Provincial Medical Officer for Copperbelt Province, Dr Chandwa Ngambi (Center in black coat), WHO National Surveillance Officer, Mrs. Dellah Buumba (Second from right) and Mrs. Chaswe Mwelwa(Far right) during the child health week

WHO Health Information Officer, Ms Norah Mweemba (second from left), WHO National Surveillance Officer, Mrs. Dellah Buumba (Fourth from left), WHO Routine Immunization Officer Dr Helen Mutambo (Second from right) with a team of district officials of Luanshya district during child health week campaign

Capacity Building

- Supported the Ministry of Health in training sessions on the cold chain.
- The WHO polio/measles laboratory at the University Teaching Hospital (UTH) successfully passed accreditation process.
- The National Virology Reference Laboratory was selected to be in the network used for the visual aid filming for bio-safety for medical training in the African Region (AFRO).
- Trained Ministry of Health staff in Vaccine and Injection Safety and health care waste management.

Surveillance, Monitoring and Evaluation

a) AFP surveillance:

- Supported the Ministry of Health in Western and Copperbelt Provinces with a surveillance vehicle each for use in conducting surveillance activities particularly vaccine preventable diseases in the context of IDSR
- Supported high quality measles case-based surveillance achieving a detection rate of >2 per 100,000 which stood at 2.8 per 100,000 children >15 years and stool adequacy rate of 92%

- Provided technical support to Ministry of Health on active surveillance for neonatal tetanus (NT) to maintain the detection rate.
- Provided technical support to the rotavirus surveillance sentinel site at UTH.
- Supported the Ministry of Health to conduct vaccination exercise for the health workers and pregnant women or Pandemic A/H1N1 2009.
- Supported the Ministry of Health to conduct surveillance and testing of samples for polio, measles, rotavirus, and Pandemic A/H1N1 2009.
- Supported supervision, surveillance and mop up polio immunisation campaign in 30 selected districts that have a high risk of polio importation with coverage rate of 97%. This was integrated with bi-annual child health days or weeks.
- 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 /AFP surveillance Indicators.
- Successfully sustained the AFP/polio surveillance indicators for polio eradication for the past four years and in the year under review the country achieved both operational and certification level surveillance performance indicators.

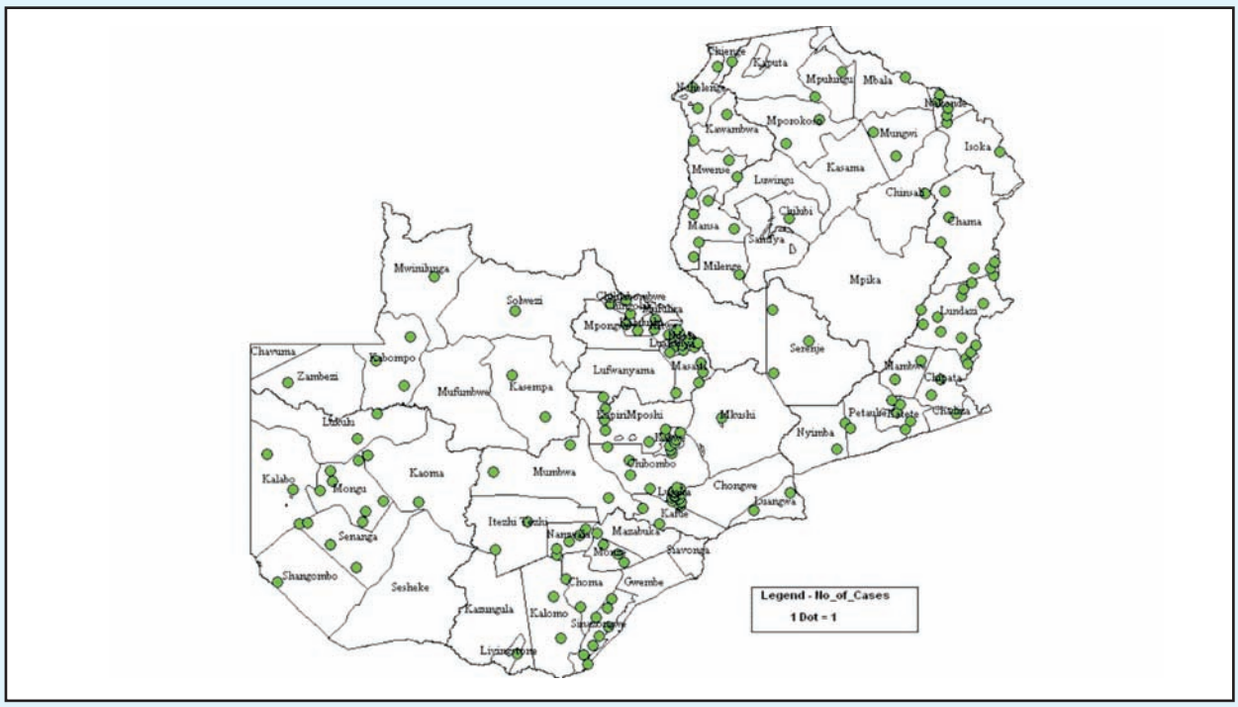
AFP surveillance indicators by province and year, 2005-2010

	2005		2006		2007		2008		2009		2010	
Province	**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%
Copperbelt	2.3	71%	1.3	92%	1.1	100%	2.0	83%	2.9	89%	2.5	96%
Eastern	2.9	100%	1.1	100%	1.4	100%	2.7	91%	2.8	96%	3.8	85%
Luapula	2.2	90%	1.1	80%	1.9	89%	2.9	86%	2.4	92%	2.9	100%
Lusaka	2.7	100%	2.6	95%	1.9	94%	3.5	90%	3.6	84%	2.1	84%
Northern	3.2	92%	2.2	94%	2.1	100%	2.4	90%	2.9	96%	1.7	100%
North-Western	2.4	88%	2.3	88%	2.8	90%	3.3	100%	3.5	85%	2.1	88%
Southern	3.0	95%	1.7	92%	1.4	100%	4.7	89%	3.9	83%	3.1	96%
Western	8.0	94%	2.5	80%	2.0	100%	4.7	81%	4.9	95%	3.8	94%
Zambia	**3.2**	**92%**	**1.9**	**89%**	**1.8**	**95%**	**3.1**	**89%**	**3.3**	**91%**	**2.8**	**92%**

Source: EPI/Ministry of Health

The country sustained both operational and certification level performance for non-polio AFP rate (NPAFP) > 2 per 100,000 children less than 15 years. This is represented by green colour on the master score board and stool adequacy was > 80%.

Zambia: Distribution of AFP cases in districts, 2010

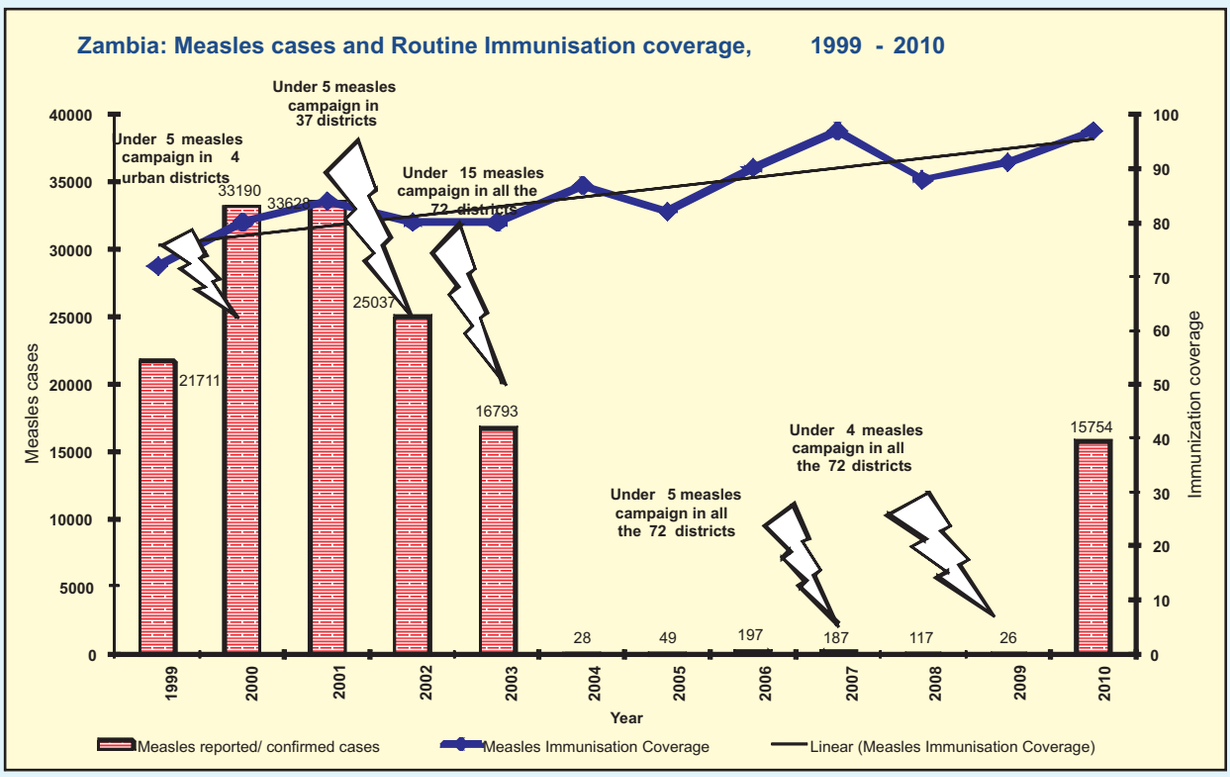


There was an even geographical distribution of investigated Acute Flaccid Paralysis cases or suspected polio cases. If there were any wild polio viruses circulating they would have been detected since the system is sensitive.

b) Measles surveillance:

- Supported measles case based and laboratory surveillance. The country experienced measles outbreak recording 15,754 cases and 160 deaths with CFR of 1.0%.
- Follow-Campaign conducted in 2007 and 2010 targeting < 5 and <4 years old; quality issues observed due to reduced financing.
- Despite high measles first dose - administrative reports, there has been resurgence of measles.
- Providing 2 doses of measles vaccine should be the standard for the national immunisation programme.
- Population immunity needs to be >95% in all districts to prevent measles epidemics; reaching and maintaining high immunization coverage remains the cornerstone of effective measles control.

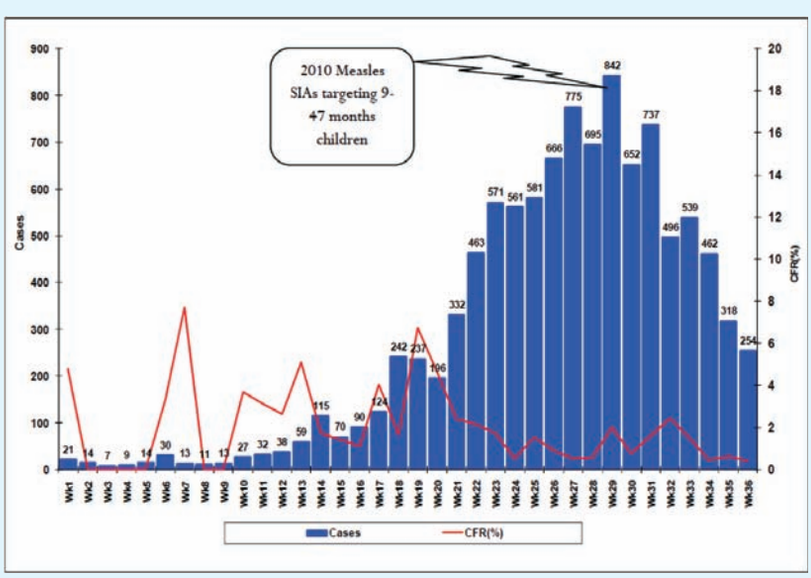
Zambia: Measles immunization coverage, supplemental immunisation and measles cases, 1999-2010



Source: EPI/Ministry of Health

Zambia: Trend of measles cases and CFR, week 1 - 36

Sustained accelerated measles control activities routine immunisation, supplemental immunisation and surveillance - aimed at measles mortality reduction have yielded good results as demonstrated in the chart above.



The planned countrywide Measles SIAs was delayed for a month due to inadequate funding. The measles declined following the campaign which targeted children aged 9 47 months except in Lusaka Province whose target was 6 59 months due to the measles outbreak.

Zambia: Age distribution of children hospitalized due to Rotavirus 2006 to 2010

Age (mths)	Number of AGE hospitalisation	Number stool specimens collected	Number (%) due to Acute Gastroenteritis AGE
0-2	257	249	71 (28.5%)
3-5	465	445	191 (42.9%)
6-8	465	710	300 (42.2%)
7-11	758	481	154 (32.0%)
12-17	520	436	107 (24.5%)
18-23	475	140	21 (15.0%)
24-59	158	100	5 (5.0%)
Total	**2746**	**2561**	**849 (33.2%)**

c) Rotavirus surveillance:

- The year 2010, was the 5th year running, WHO supporting surveillance sentinel for rotavirus at the University Teaching Hospital.

The rotavirus sentinel surveillance at the University Teaching Hospital has provided baseline information for programme management in Zambia prior to rotavirus vaccine introduction in the 2013.

- WHO Supported the Baseline Intussusception survey in nine Zambian Hospitals, 2007- March 2010 targeting the children aged 0 24 months. This was a retrospective survey in 9 hospitals which reviewed theatre log books and medical files.

Age distribution of children with Intussusception in nine Zambian Hospitals, 2010

Age (mths)	Number	Percentage
0-2	3	4.30%
3-4	12	17.40%
5-6	23	33.30%
7-8	14	20.30%
9-11	5	11.60%
12-24	10	14.50%
Total	**69**	**100%**

Profile of Intussusception (IS) in children less than 2 years in Zambia is such that most of the children with IS were from Lusaka, 68.5% (50/73) and of those with complete data, IS was common in infants, 90.1% (48/53), the age group 3-8 months making up 71.0% of the cases. The peak age for IS was 5-6 months at 33%. The Case Fatality Rate (CFR) was 41.5 % (22/53).

d). Pandemic H1N1 2009

In September 2010, WHO supported Zambia with 256,800 doses of Influenza A/ H1N1 vaccine. The Influenza A/ H1N1 2009 Vaccine Deployment Taskforce consisting of Ministry of Health and WHO staff was responsible for planning the vaccination exercise. The objectives of the exercise were:

- To protect the integrity of the health care system and the country's critical infrastructure by immunizing the health workers as a first priority, so as to protect their own lives while caring for patients
- To reduce morbidity and mortality from the influenza.
- To reduce transmission of pandemic virus within communities by strengthening the county's population immunity.

The vaccine was administered in a campaign mode. The vaccine was distributed in a timely manner to all storage points and vaccination of susceptible individuals was to start as soon as possible. Three categories of susceptible populations were identified. These were about 29,000 health workers countrywide who were targeted for vaccination as a matter of priority; pregnant women in the second trimester and Individuals older than 15 years with chronic illnesses such as respiratory, cardiovascular, renal or liver diseases. Adverse events following immunization (AEFI) were to be actively monitored.

Zambia: Results of the Pandemic H1N1 2009 Vaccination Exercise

Province	Health Workers Vaccinated	Pregnant Women Vaccinated	Chronically ill Vaccinated	Total Vaccinated
CENTRAL	-	-	-	-
COPPERBELT	5,768	9,124	11,460	26,352
LUAPULA	832	2,568	1,639	5,039
LUSAKA	2,055	4,791	20,444	27,290
EASTERN	3,691	11,806	13,397	28,894
NORTHERN	2,273	11,111	5,541	18,925
NORTH WESTERN	1,265	5,261	2,627	9,153
SOUTHERN	3,265	5,972	6,949	16,186
WESTERN	2,091	-	-	2,091
TOTALS	**21,240**	**50,633**	**62,057**	**133,930**

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 most of whom are located in underserved remote areas. Zambia is not an exception to this and has over the last decade experienced communicable diseases, such as schistosomiasis, trypanosomiasis, filariasis and trachoma, which have significantly contributed to the overall high disease burden in the country. Despite available effective interventions, scaling up of interventions has been a challenge due to limited available resources. Though the Ministry of Health has a budget line and a focal point person as some of the measures taken to prevent and control NTDs the funds allocated are inadequate. Furthermore, most of the donors are not putting resources into NTDs as is the case for AIDS, Malaria and Tuberculosis (ATM). Government is however implementing community based interventions in an integrated manner with other on-going Primary Health Care (PHC) activities. WHO has continued to advocate and support scale-up of NTD intervention in Zambia to all endemic communities.

WHO has also continued to provide technical and financial support for situation analysis and mapping of NTDs interventions in the country. However, mapping and training activities are being delayed by limited availability of resources. WHO has also supported the adaptation of data collection tools in order to strengthen data management. An integrated Plan of Action for NTDs has been developed and submitted to AFRO for support.

Challenges/Constraints

MOH has not yet recruited/assigned a focal point person for the NTDs programme in the new organization structure and staff establishment. The other main constraint is inadequate funding for the NTDs programme, which in turn affects ownership and monitoring of the programme. Furthermore, situation analysis and mapping of trachoma is expensive due to low prevalence of the disease.

Lessons Learnt

The assessment and mapping of NTDs is sometimes delayed by resource constraints. The involvement of districts in assessment of prevalence of NTDs promotes ownership and reduces costs as the district allocates resources (transport and human resources) as is the case for filariasis.

Leprosy Elimination

- The Leprosy Elimination Monitoring mission was successfully conducted led by WHO with support from KNCV

HIV/AIDS, TUBERCULOSIS AND MALARIA

HIV/AIDS

Introduction

HIV in Zambia remains a public health concern. The country has a generalized epidemic with an adult HIV prevalence of 14.3 percent and an incidence of 1.6 percent. The infection is more prevalent in females (16%) than in males (12%). This preponderance towards women holds across all age groups up to over forty when males have a slightly higher prevalence. Though the HIV prevalence has been showing a downward trend, in 2009, an estimated 82,681 adults were newly infected with HIV (59% women, 41% men) with 226 new adult infections occurring each day and 25 new infections occurring among children.

Urban areas are typified by higher HIV prevalence (approx. double, 20%) than rural areas (10%). Approximately one million people are living with HIV. Co-infection of TB and HIV is common, with 70% of TB patients co-infected with HIV; however counselling and testing rates are extremely low (15%, DHS 2007). The country 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 being as a result of HIV and AIDS.

Key Issues of Concern

The following specific issues of note in order to sustain the progress made so far and overcome the challenges:

i. HIV incidence is high. There is need to focus on reducing the rate of new HIV infections by 50% by 2015 using combination prevention strategy" and focusing on prioritized epidemic drivers. The focus should be on high impact prevention interventions that include Male circumcision, virtual elimination of mother to child transmission, effective use of condom and reduction of multiple and concurrent sexual partnerships.

ii. Sustain investment on treatment, care and support services to improve quality of life of those infected are a human right issue. Maternal mortality remains high and still a threat to HIV positive women and women in general. The health of HIV positive women during pregnancy is often compromised by HIV infection, raising the chances of maternal deaths during child birth. Universal Access to HIV and AIDS services remains low

Iii. Zambia has adopted a multi-sectoral response and there is need to invest on efficiency and effectiveness of the coordination and management of the national multi-sectoral response at all levels, and in line with implementation of the decentralization process.

Government Commitments on HIV and AIDS (2011-2015)

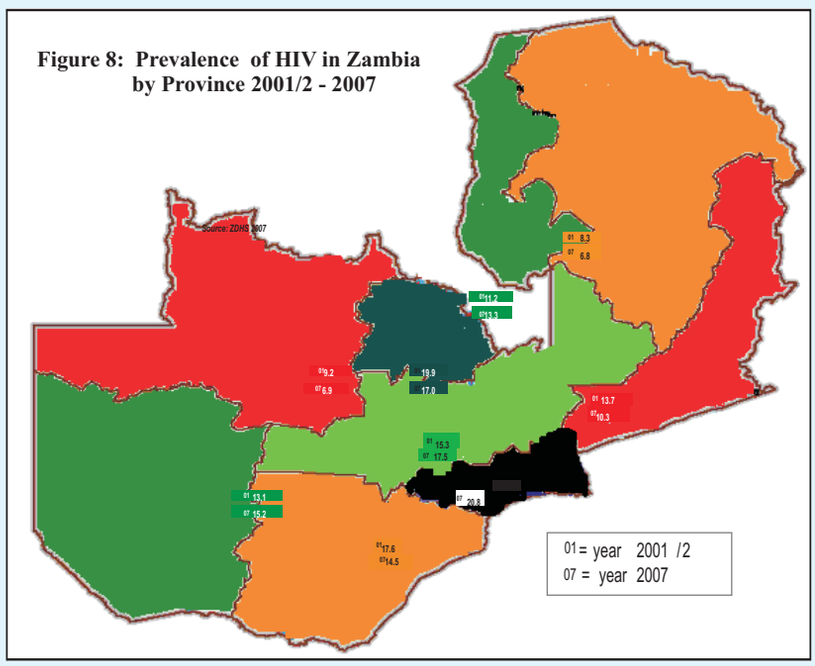
Zambia has identified the HIV and AIDS response as a national development priority. The National HIV and AIDS response is linked to Zambia's ability to improve its Human Development Index (HDI) and obtain the Millennium Development Goals (MDGs). Zambia's results-based national strategic framework is designed to contribute to HDI and MDGs by reducing risk to infection, help those who are already infected to live longer, reducing vulnerability by most at

risk populations, and mitigating against the effects of the epidemic. The impact level results anticipated for achievement in 2015 are:

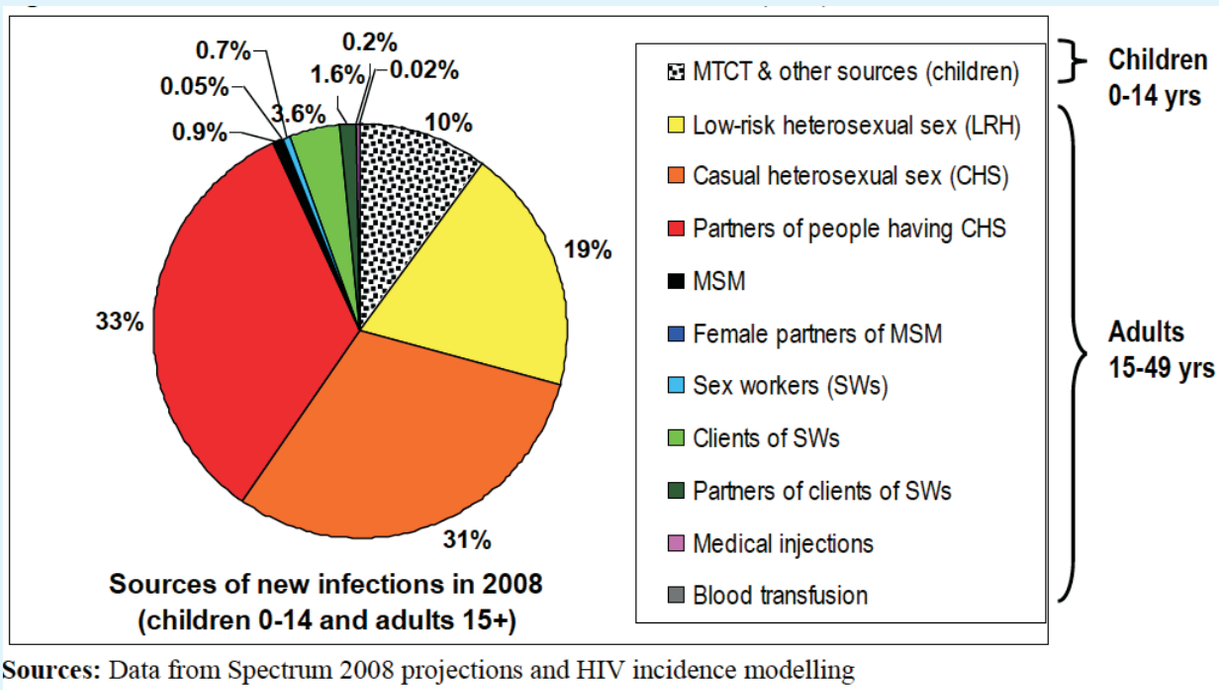
- The rate of annual HIV new infections has reduced from 1.6% to below 0.8% (82,000 annual new infections to 40,000) by 2015). Infants born of HIV positive mothers who are infected has reduced to less than 5% by 2015
- PLHIV who are alive at 36 months after initiation of antiretroviral therapy has increased to 85% by 2015
- Number of vulnerable households3 is reduced by 50% by 2015
- Response Management: The total NASF service coverage targets (output level results) that have been met in all four pillars has increased to 50% by 2013 and 90% by 2015

The Zambian epidemic is driven by a number of factors, mainly: multiple and concurrent sexual partners, low and inconsistent condom use, low levels of male circumcision in most provinces and a highly mobile population as shown in the figure below.

Figure 8: Prevalence of HIV in Zambia by Province 2001/2 - 2007



[1]Modes of Transmission, 2009, National AIDS Council

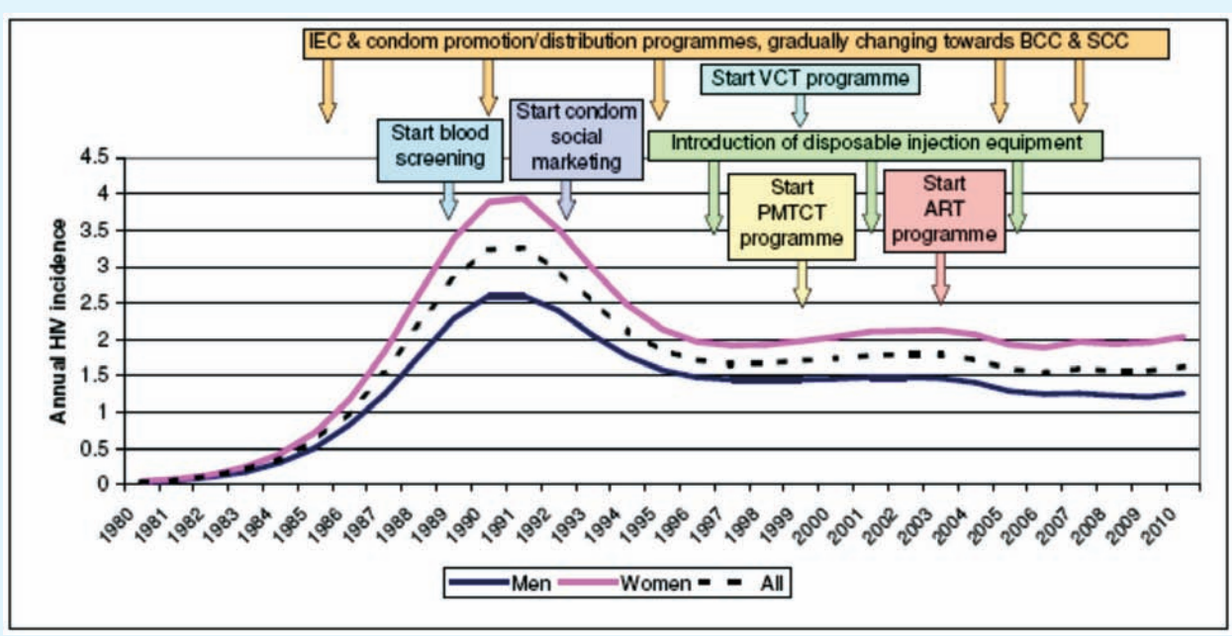


Sources: Data from Spectrum 2008 projections and HIV incidence modelling

Achievements

In an effort to respond to the HIV epidemic a number of interventions and strategies designed by WHO have been implemented. It is clear that a combination of these various prevention and treatment interventions is more likely to achieve the synergistic threshold for significant programme impact as shown in the figure below.

Figure 1: Figure showing estimated HIV incidence against interventions, 1980-2010

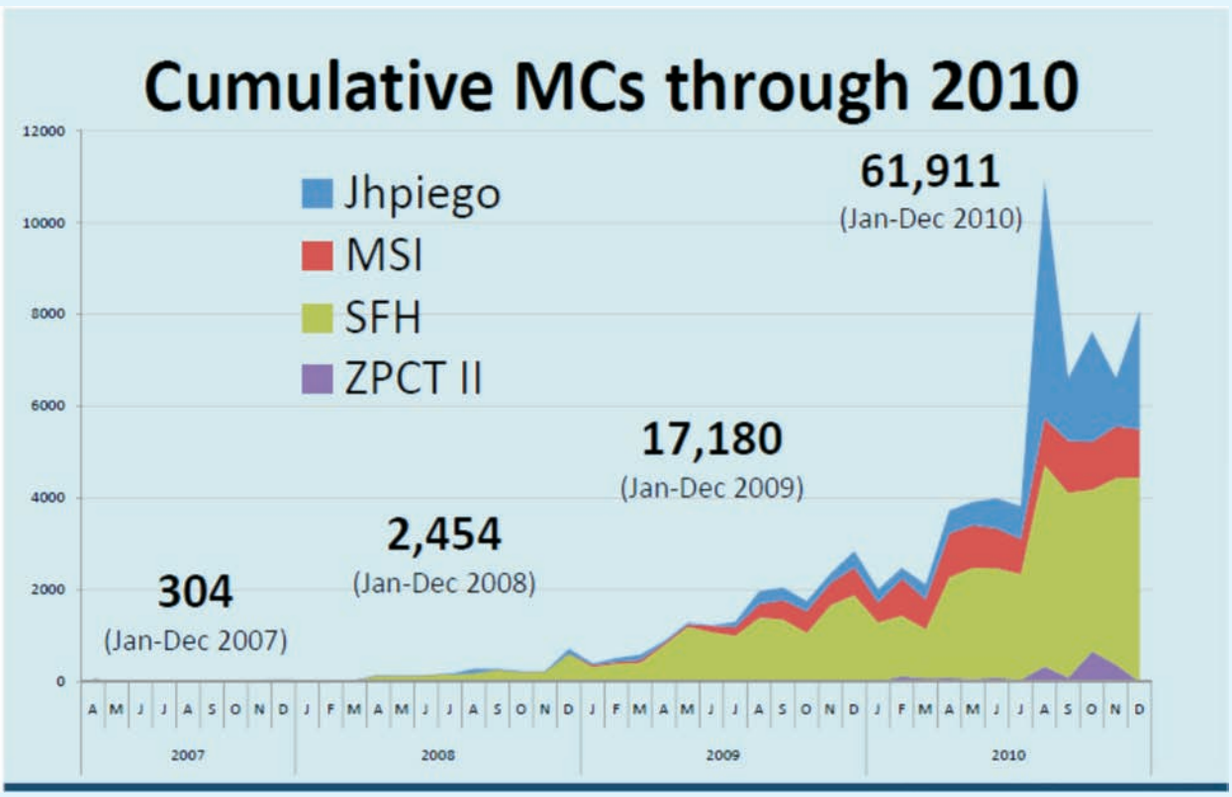


Source: CSO (2008) - 2008 HIV/AIDS projections report, table 3.1 for incidence curves.
Programme reports for data on programme initiation.

Male Circumcision

With the support of WHO, Zambia adopted male circumcision as a key prevention intervention of the Comprehensive HIV Prevention Strategy and the National AIDS Strategic Framework 2011-2015. WHO has been instrumental in the establishment of a coordination and leadership mechanism at Ministry of Health that supports the male circumcision (MC) programme with oversight, strategic planning, promotion integration, quality assurance, supervision and monitoring and evaluation. This has resulted in the 81, 849 cumulative total number of male circumcisions carried out as at 31st December 2010. The annual MC achieved in 2010 was 61, 911 accounting for 76% of the cumulative total. With an annual target of 100,000 set for 2010, annual service delivery coverage of 62% was achieved in 2010. The number of health facilities providing the minimum package of safe male circumcision services increased from 5 to 135 by end of 2010. This includes static and mobile sites.

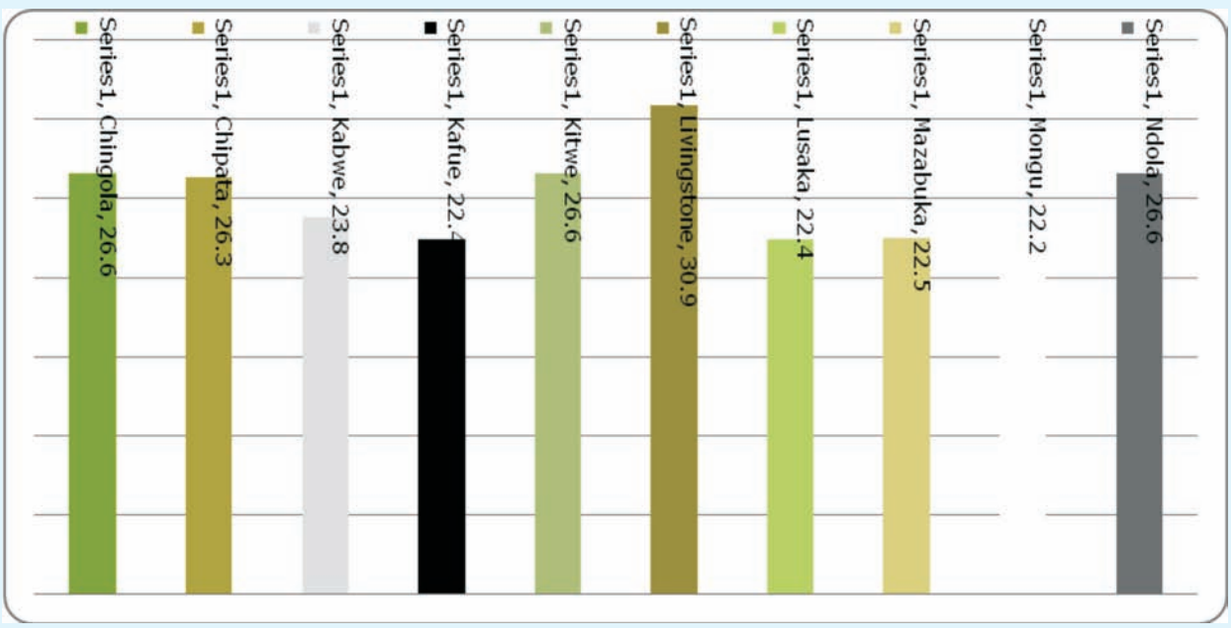
Figure 1: Cumulative MC uptakes



Prevention of Mother to Child Transmission

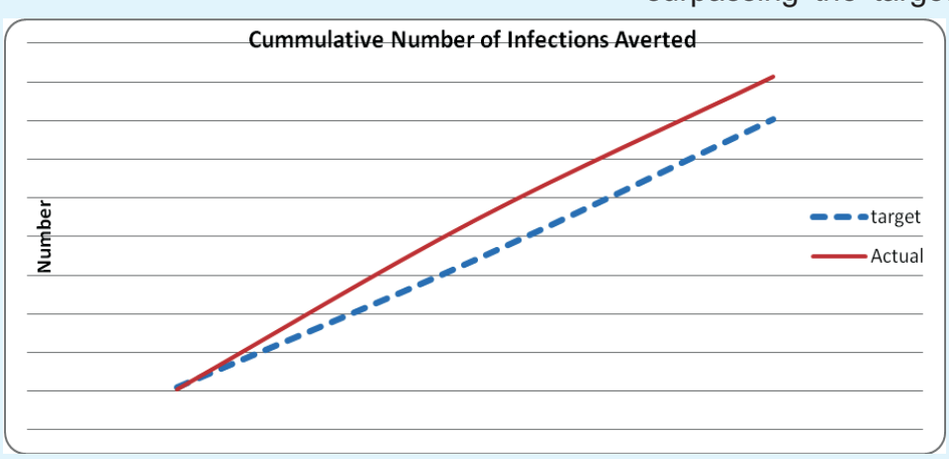
Zambia was one of the countries supported with CIDA funds to accelerate access to the PMTCT programme in 10 districts with the highest HIV prevalence. These districts were selected from six of the nine provinces in the country. The total population in the 10 selected districts was 3,970,822 in 2007, representing 33% of the country total population, this including approximately 210,000 pregnant women and 53,000 HIV exposed children.

HIV Prevalence among pregnant women in the ten high HIV prevalence districts



With technical and financial support from WHO, there was noticeable improvement in the implementation of the PMTCT programme that resulted in increased number of pregnant women accessing PMTCT interventions and increased number of infections averted.

By December 2010, cumulative total number of infections averted was 9,315, surpassing the target of 8036 with 42% (3890) averted in 2010. Overall, the PMTCT programme indicators markedly improved both nationally and in the selected districts as shown in the figure below.



PMTCT Indicators in the ten districts

Indicator	NATIONAL DATA		CIDA SITES	
	2009	2010	2009	2010
Percentage of ANC facilities that provide both HIV testing and ARVs for PMTCT	63%	80%	93%	94%
Percentage of HIV infected women received ARVS for PMTCT	60.9%	69%	62%	81.4%
Percentage of infants receiving ARVs for PMTCT	34%	54.5%	55%	62.36%
HIV testing in infants born to HIV positive mothers	47.2%	63%	50%	80%

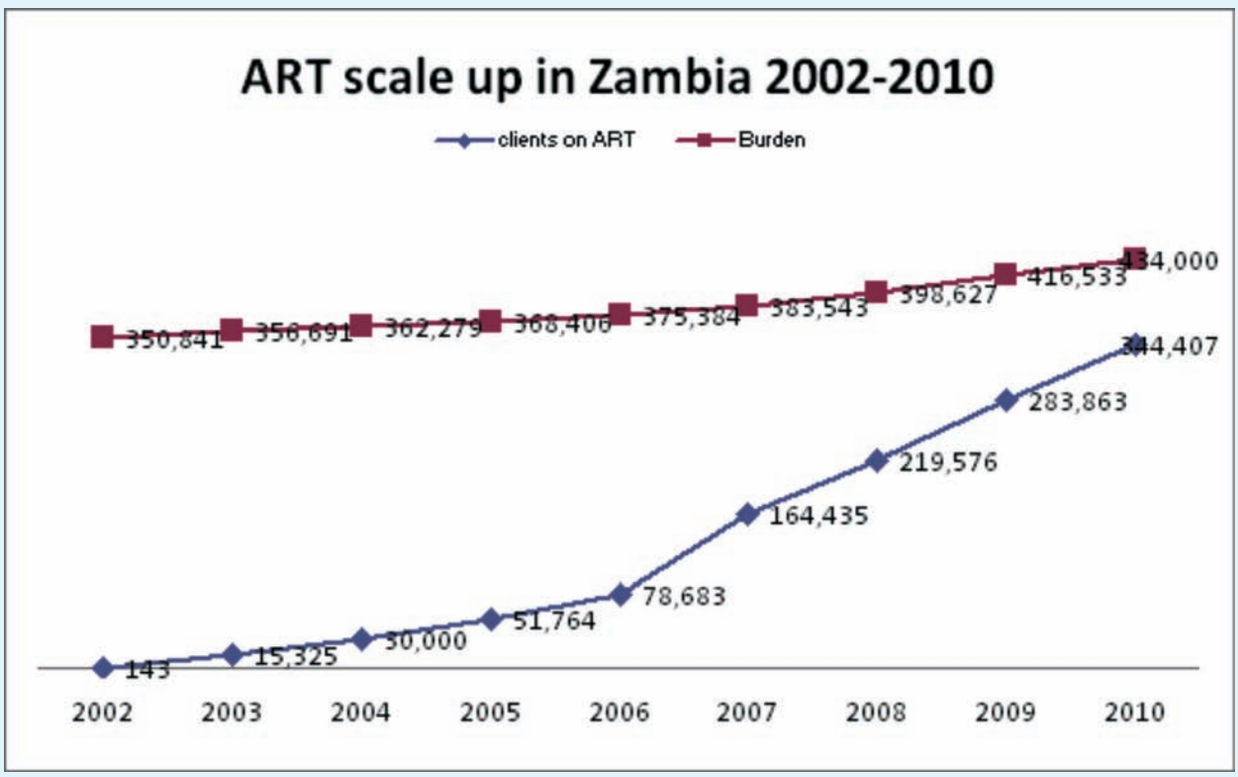
Activities that contributed to this improvement include; capacity building of health workers on PMTCT guidelines, M&E data collection tools, infant and young child feeding guidelines; supportive supervision, mentorship and data audits. Other activities included promotion of community involvement through community sensitization.

Integrated Management of Adolescent and Adult Illness (IMAI)

Implementation of Integrated Management of Adolescent and Adult Illness (IMAI), a strategy that has been adopted in Zambia as the Basic ART Package, has been scaled up. Under the leadership and technical assistance from WHO and with the support of implementing partners in the HIV programme, capacity has been built in HIV management among health workers based at primary health facilities. Eighteen (18) health workers were trained as trainers in IMAI. These were mainly medical officers. In addition, 130 health workers were trained in the management of HIV. To prepare midwives to diagnose and manage HIV patients including initiation of ART therapy, 61 of the health workers trained were midwives from primary health centres.

HIV Treatment

In an effort to accelerate action on HIV, particularly treatment, WHO provided technical support to the HIV treatment programme which has resulted in significant progress in increasing accessibility to ART among people living with HIV. By December 2010 of the 434,000 eligible for ART, 344,407 (79%) were on treatment, of these 25,000 are children below 15 years. The 79 percent treatment coverage indicates that the country is on course in meeting the international universal access targets.



Source MoH HMIS

Normative Guidance

With the support of WHO, a number of key strategic documents were developed and approved by the Ministry of Health to support service delivery.

- Male Circumcision Situation Analysis
- Male Circumcision QA tools
- Male Circumcision Accreditation Guidelines Revised
- 2010 PMTCT guidelines
- 2010 Adolescent and Adult ART
- 2010 Paediatric ART Guidelines

In addition, WHO carried out a number of activities that set the stage of setting of norms and standards in 2010.

Pre exposure Prophylaxis (PrEP) Consultative Meeting

The WHO Zambia Country Office hosted a consultative meeting with various stakeholders on HIV Pre-Exposure Prophylaxis (PrEP). The general objective of the meeting was to engage country stakeholders in a constructive dialogue on PrEP and ARV-based prevention, in order to prepare for potential roll-out of the intervention.

The major concern raised at this meeting was the operationalisation of PrEP. It was raised that It is important to understand how PrEP is being operationalised in research settings. Even though research sites may be different from Zambia, they still have important lessons to provide. The final general resolution of the consultation was that Zambia should start preparatory work to answer questions of acceptability, feasibility, cost-effectiveness, delivery models and financing, should the on-going PrEP trials prove to be effective.

Draft WHO HIV/AIDS Strategy

Zambia participated in the WHO HIV/AIDS Strategy development process. This was done through a series of consultative meetings with various key stakeholders involved in the HIV response in the country. The meetings included individual meetings, UN Theme Group meeting, Global Fund Country Coordinating Mechanism meeting, National AIDS Council meeting and General formal stakeholder consensus meeting.

There was consensus on the relevance of the strategy document though there were reservations expressed in relation to five cross-cutting issues that underpin the specific strategic actions. The current situation in the region to which the new strategy is a response; the need to emphasise quality of services in the next phase of development, the need to assess the financial environment in which the new strategy will be implemented and research as an essential element in monitoring progress.

TUBERCULOSIS

The country office provided significant financial and technical support to NTP in 2010. Major activities such as external review of the NTP, local and international trainings for MoH staff, printing of drug resistant TB guidelines and funding of national level supervisory visits mitigated against the limited financial support to the MoH and assisted in raising the profile of the office.

Situation Overview of Tuberculosis

A total of 48,591 cases of 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.

HIV testing among TB patients and uptake of co-trimoxazole preventive therapy (CPT) continued to show an upward trend but the number of TB patients put on ART though increasing is still below 50%.

Of the notified cases, 34,992 (72%) were tested for HIV of which 23,584 were positive (67.4%); 15,041 were put on CPT (63.8%) and 10, 009 (42.4%) were started on ART

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

The Country Office TB plan was developed in consultation with the Ministry of Health (MoH) through the National TB Programme (NTP) and partners such as Family Health International (FHI). The plan is focuses on the implementation of quality integrated services for TB; strengthening the development of relevant guidelines, policies strategies and other tools; strengthening surveillance, monitoring and evaluation; strengthening resource mobilization, partnerships and coordination, improving access to TB medicines, diagnostics, commodities and other services

In 2010, main activities undertaken included the external review of the NTP, printing of national TB documents, local and international training.

Technical Support

Provided technical support to NTP in various activities such World TB Day commemoration, review of the NTP, trainings, TB/HIV technical meetings.

The Ministry of Heath of the Republic of Zambia requested for an independent external evaluation of the NTP for the period 2006-2010. The review took place from 2-14 August 2010. A team of 16 reviewers were identified from the World Health Organization (Regional, Inter Country Support Team and a few Country Offices), USAID Washington Office, CDC USA, KNCV/TBCAP, and UNAIDS; supported by local facilitators drawn from in country partners. The Team Leader was Dr W Nkhoma from WHO/IST.

The WHO Country Office supported the review through technical assistance to the NTP and partners in the preparatory and implementation phases, funding of 5 external reviewers and 3 local facilitators, printing of the evaluation tools, transport and other logistical support.

The review teams visited each provincial headquarters, two districts in each province and facilities at different levels and ownership. Standard data collection tools, interviews with various stakeholders, observations and review of records were main methods of evaluation.

Preliminary findings were presented to

senior staff of the MoH, partners and other stakeholders at a debriefing meeting held at the end of the review. The final report of the review is expected soon.

NPO-TUB provided technical support within country at national TB/HIV coordinating committee meetings, various trainings of MoH staff at national and provincial levels, review of the NTP, World TB Day commemoration, revision of national training materials and development of the new national TB Strategic Plan.

The NPO-TUB provided technical support to the NTP of Mozambique in preparing for the review of its programme (pre-review TA) and was subsequently one of the external consultants that conducted the mid-term review.

NPO-TUB attended an MDR-TB training course in Maseru, Lesotho as part of a team from Zambia that included 9 MoH staff. Other missions undertaken were the Global Fund, MDR-TB and TB Team meetings in Geneva and a TB infection workshop in Harare, Zimbabwe organized by IST.

Development of Technical Tools

- The country office supported printing of revised TB and patient treatment cards and the new national guidelines for the programmatic management of drug resistant TB.
- NPO/TUB provided technical support for development and revision of TB/HIV documents and development of the new TB strategic plan

During the year 2010, the NTP revised its TB treatment and patient identity cards. The country office printed 50, 000 copies of each as was requested by the national health authority. These have been distributed to various facilities in the country

One of the recommendations of the NTP review was the printing and distribution of national guidelines on programmatic management of drug resistant TB. The country office printed copies of the guidelines on behalf of the MoH; they have since been distributed to facilities

Capacity Building

Supporting on-going training of health workers at all levels was one of the key activities planned by the MoH for 2010. This was to provide new and old staff the basic knowledge and skills for the management of TB and TB/HIV at operational levels. The training materials were WHO training modules on 'Management of TB at Health Facility Level' that were adapted to the Zambian situation earlier in the year.

In order to meet the demands of intensive training programmes and the TBCAP close up deadline of 31 December 2010, WHO/CO hired 2 consultants for the provincial TB training programmes. The WHO consultants were assisted by 2 local provincial trainers, earlier trained as Trainers.

Eight (08) local trainings and one (01) international training on MDR-TB for MoH staff were conducted between July and December 2010 and MoH staff were supported to attend 2 international courses in Lesotho and Italy.

Two national training of trainers (ToT) workshops were conducted at the end of July; one in Community DOTS and the other in 'Management of TB at Health Facility Level'. Trainees were staff from health facilities from all the provinces. Eighteen participants were trained in each of the ToT groups.

The national trainings were followed by 5 provincial trainings on 'Management of TB

at Health Facility Level' in Northern, Luapula, North Western, Copperbelt and Central Provinces, target provinces under TBCAP funding support.

The main focus of the course was on the components of the DOTS Strategy: how to detect cases of TB, how to treat TB patients, how to inform patients about TB, how to identify and supervise community TB supporters, how to monitor TB case detection and treatment and TB infection control.

Training in Diagnostic Counselling and Testing (DCT) was also conducted in North Western Province. There were 4 local trainers and one external from one of the local partners, JHPIEGO.

Twenty four staff members from three designated MDR-TB treatment sites, the University Teaching Hospital, Kabwe General Hospital in Central province and Ndola Central Hospital on the Copperbelt province underwent training on 'Programmatic Management of Drug Resistant TB'. They comprised doctors, clinical officers, nurses and provincial TB focal point persons.

The course trainers were Dr J Bayona from Peru and Dr N Ndjeka from the Republic of South Africa. These two experts were organized by collaboration between IST/Harare and HQ. The Country office supported in full Dr Bayona's participation and HQ supported Dr Ndjeka.

Nine (09) MoH staff was supported to attend an international course on management of drug resistant TB in Maseru, Lesotho in April to May 2010. Participants were from Lusaka's University Teaching Hospital and Kabwe General Hospital, designated sites for clinical management of MDR-TB cases in Zambia.

Three (03) others were supported by WHO/CO to attend an international TB course in Sondalo in Italy for 2 weeks. These were provincial Communicable Diseases Specialists who are responsible for TB control activities at provincial level.

NPO-TB attended the 41st International Union Against TB and Lung Diseases (IUATLD) Conference 11-15 November December 2010 in Berlin, Germany and facilitated presentation at a **Poster** session of which the NPO was co-author entitled "*Implementation of tuberculosis infection control strategy in Zambia"*

Furthermore NPO/TUB attended an international conference on Microbicides in Pittsburg, Pennsylvania, USA.

Disease Surveillance

As is shown in the table below there were 48,616 notifications of all forms of TB in 2010, giving a national TB notification rate of 353/100, 000 population. However, it is worth noting that surveillance for tuberculosis is both active and passive.

TB Notifications all forms per Province 2005 - 2010

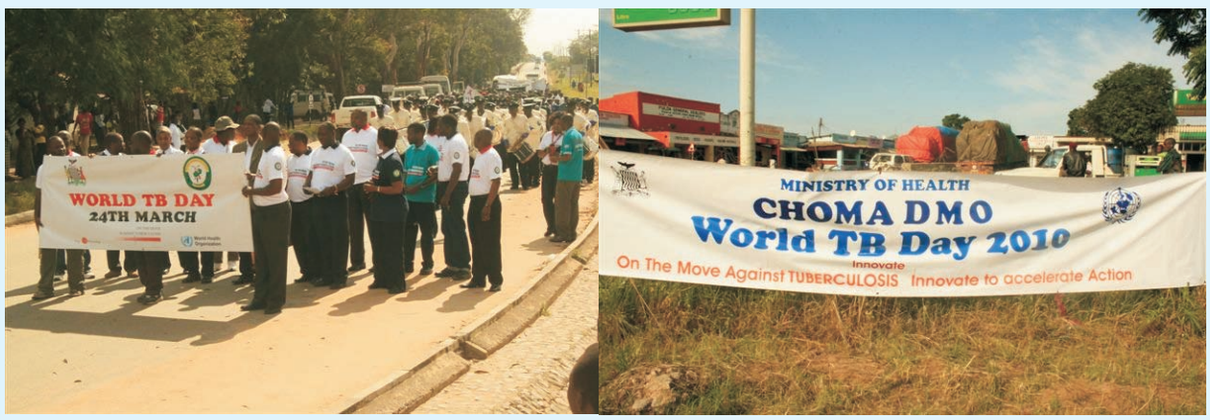
		2005	2006	2007	2008	2009	2010
1	Central	3742	3622	3454	3025	2969	2988
2	Copper belt	13213	10949	10863	9860	10586	10612
3	Eastern	3315	2972	3171	2803	2814	2623
4	Luapula	2969	2694	2318	1954	1956	1710
5	Lusaka	17601	18068	17157	16624	17649	18276
6	Northern	2466	1988	2141	2035	1833	1720
7	North-west	1891	2216	2132	1966	1887	1616
8	Southern	5939	6128	6147	6051	5988	5773
9	Western	2433	2542	3032	3015	2909	3298
	ZAMBIA	53267	51173	50415	47333	48591	48616

Resource Mobilisation and Coordination

The year 2010 marked the beginning of the biennium work plan. It was also the end of the 5-year funding support from Tuberculosis Control Assistance Programme (TBCAP). A new partner is expected to come on board in 2011 to fill up the gap left by TBCAP.

Commemoration of Global Days

The commemoration was held in Choma, Southern Province. The Guest of Honour was the Minister of Health, Honourable Simbao. Participants included traditional and political leaders in the province, civil servants, members of the public and school going children. The Regional Director's speech was delivered to the gathering through WCO.



Commemoration of the World TB day in Choma district, Southern Province, 24th Match, 2010

Challenges/Constraints

The new structure of the MoH does not have a staff dedicated to TB activities at provincial level. This has compromised the technical focus and quality of technical support to lower levels.

There was a critical shortage of anti-TB drugs during the course of the year and there was no funding from the Global Fund for in country activities.

Lessons Learnt

The WHO country office hired two consultants and employed two support staff, a strategic decision aimed at accelerating and fast tracking implementation of activities especially those under TBCAP that was closing by end of December 2010.

This strategic action contributed significantly to the completion of most of these planned activities.

Recommendations

The MoH should consider re-establishing the position of a full time TB provincial focal point person. The current structure has placed too many responsibilities on the communicable diseases specialist which is negatively affecting the support to these priority conditions.

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

MALARIA

SITUATION

WHO's comprehensive analysis of routine and Survey (2010) malaria data shows significant overall national impact on malaria; malaria in-patient cases, deaths and severity of cases and severe anaemia have all declined. Nationally, for first quarter of the year in-patient fewer than five anaemia deaths reduced by 58% and malaria deaths by at least 47% between 2001 and 2010 (Table 1). Malaria parasite prevalence attests to this progress; the prevalence has reduced from 21.8% in 2006 to 17% in 2010. Overall, treatment with *Artemether lumefantrine* (AL) has improved since 2008, with more febrile children receiving *AL* than any other anti-malarial medicines.

This impact follows improved coverage of highly efficacy interventions (Indoor Residual Spraying, Long Lasting Nets Use and Intermittent Preventive treatment. Approximately 1.4 million structures were sprayed and 1.6 million people protected nationwide with IRS in 2010 and 64% of the households having an ITN i.e. the LLIN and IPT has remained above the 60% Abuja targets (Table 1).

However, challenges remain including; inadequate funds to support operations research and training for all interventions; low completeness of reporting and stock outs of malaria commodities especially, Rapid Diagnostic Tests (RDTs) and the first line anti-malarial medicine *Artemether lumefantrine* (AL).

Achievements:

- **Development of policies, strategies, guidelines**.

  WHO supported the development of policies, strategies, guidelines and other job-aids (tools) for malaria, including;

- Overall technical coordination planning, provision of key information and resource mobilization for the development of a costed National Malaria Strategic Plan 2011-2015.

- Technical leadership in the development of the first-ever in-depth Malaria Programme Review (MPR) 2010 and sourcing of funds for implementation. The important outcome of the MPR was an independent rigorous assessment of the national malaria programme performance and a summary - Aide Memoir partner's commitment to implement agreed upon activities.

- Overall technical guidance in the development of a National Malaria Monitoring and Evaluation Strategic Plan 2011-2015.

- Technical support towards the finalisation, launch and distribution to 72 districts of the National Malaria Diagnostic and Treatment Guidelines.

- **Promoting the generation of evidence for decision-making**

  In order to contribute to WHO's mandate of promoting generation of evidence for decision-making in malaria control, the following were achieved;.

- WCO-Zambia provided technical assistance to MOH in the development of the study protocol, planning and training of field teams (enumerators) to undertake a Health facility Surveys

(HFS) in 2010 which was re-scheduled for 2011.

- WCO-Zambia provided technical leadership in developing several national key documents including; a comprehensive review paper on the Epidemiology of malaria in Zambia; 2010 Zambia's malaria success story; RBM 2010 Malaria Impact Series (featuring Zambia); a ten-year situation analysis of malaria progress made in the Zambian national prevention and control Programme which was used as historical background Chapter in the National Malaria Strategic Plan 2011-15..

- **Advocacy, Community mobilization and IEC:**

  WHO's contribution to advocacy, community mobilisation and IEC for behavior changes included the following:

- WCO-Zambia provided technical coordination and leadership in Planning, development of mass media and IEC/BCC electronic materials

- Supported the commemoration of the World malaria Day 2010.

- Supported the planning and hosting by MOH of the UN Secretary General Special Envoy on malaria, Mr Raymond Chambers, who visited Zambia on 4-5 November, 2010 to hold consultations aimed at facilitating the country to access funds quickly to avoid a gap following delayed disbursements from the GF.

- Hosting of the Roll Back malaria Board Meeting held in December, 2010 at the Inter-Continental Hotel, Lusaka Zambia.

Capacity building

- The WCO working with the Global Malaria Programme (GMP)-HQ, Geneva provided support to the NMCP to conduct training for the NMCP surveillance and M&E team in data collection, analyses and mapping of routinely collected and survey data.

Enabling factors

- Strong coordination and leadership by the NMCP, including the presence of technical working Groups is an enabling factor for smooth planning and implementation of malaria activities.

- The support by IST for East and Southern Africa timely technical support when required is also enabling.

Constraining factors

- Limited financial resources to support surveillance, monitoring and evaluation of malaria interventions were constrained by limited and late disbursements of funds

- The year 2010 experienced an increase in malaria cases and deaths following a significant reduction of cases between 2000-2008, due to limited availability of malaria commodities especially the LLINs following delayed funding disbursement by the GF.

Lesson (s) learnt

- The increased malaria cases in 2010 shows that gains in malaria control are fragile, hence, the country should develop a sustainable resource mobilization plan to leverage increased local and external

resources.

Priorities for the MOH in 2011.

- Support development of malaria strategic plans (2011-2015), operational plan (2011-2015) and the M&E Plan (2011-2015).
- surveillance, M&E to track and document progress on key malaria indicators in reports and peer review journals.

Table 2: Intervention coverage by year: 2006 2010

Indicator	Year				
Long Lasting Insecticide Treated Nets (LLINs)					
Population at risk 12.5 million	**2006**	**2007**	**2008**	**2009**	**2010**
No. LLINs distributed	1,162578	2,458,183	750,000	1,100,000	5,600,000
% Households with one ITN	44.0	53.0	62.0	62	64
% pregnant women slept in ITN	24.5	43.2	43.2	-	47.7
% under five of age slept in ITN	24.3	41.1	41.1	-	49.9

IRS	**2006**	**2007**	**2008**	**2009**	**2010**
No of districts	15	15	36	36	54
No. Structures sprayed	537,877	657,695	1,100,000	1,190,**517**	1,642,254
Operational coverage	86.7	93.5	91.0	89.7	87.0
No. of people protected	2,160,655	3,286,514	4,500,000	4,424,885	5,951,303

First-line antimalarial (ACT), *Public Sector Health facilities*					
No. of ACTs distributed	1,686,669	2,291,143	3,139,492	4,000,000	5,000,000
No. reported out-patient malaria cases	4,725,357	4,230,469	-		-
% of outpatient cases treated, ACT	35	54	-		
% fever treated with any anti-malaria	58	-	43		43
Scale of implementation	National	National	National		National

IPT in pregnant women	**2006**	**2007**	**2008**	**2009**	**2010**
Any IPTp (%)	76	-	80	-	85.8
IPTp-2 (%)	61.9	-	66.1	-	70.2

Abbreviations: ACTS=Artemisinin Combination Therapy; IRS = Indoor Residual Spraying; LLINs=Long Lasting Insecticide Treated Nets; ITNs= Insecticide Treated Nets; IPTp2=Intermittent preventive treatment two doses.

NON-COMMUNICABLE DISEASES, MENTAL DISORDERS AND VIOLENCE/INJURIES

Introduction

Developing countries are undergoing an epidemiological transition, from Communicable or Infectious to Non-Communicable Diseases (NCDs), such that cardiovascular disease, chronic respiratory diseases, cancer, and diabetes were responsible for 60% of all deaths globally in 2005, 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.

The basis for prevention is the identification of these risk factors which underlie most chronic non-communicable diseases. The leading risk factor globally is raised blood pressure, followed by tobacco use, raised total cholesterol, and low fruit and vegetable consumption.

Although limited Global School-Based Student Health Surveys and Global Youth Tobacco Survey enquiring on the lifestyles of adolescents had been conducted in Zambia, no similar studies or more comprehensive studies had been conducted before among older age groups in Zambia.

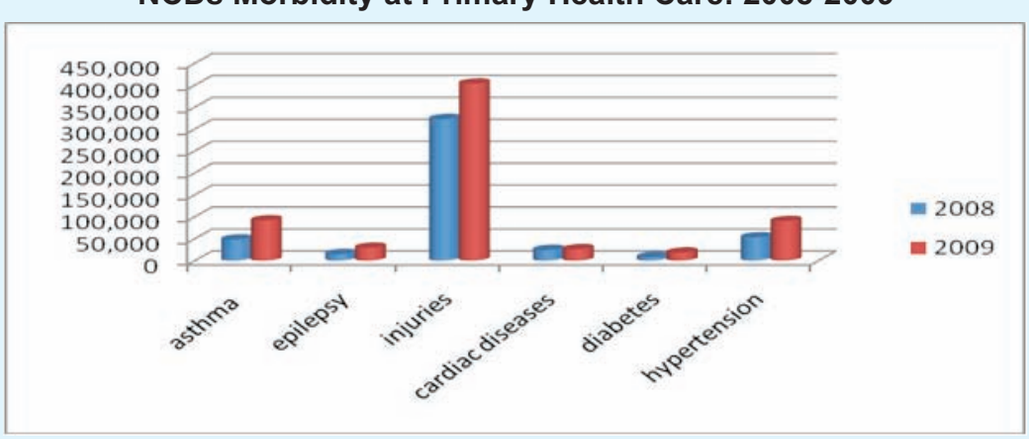
Situation Overview of NCDs

Data on risk factors collected through the WHO STEPwise Approach surveillance showed that the rate of current tobacco smoking was 6.8% and 21.7% in rural two areas and alcohol consumption rates were 20.6% in urban and 36.4% in rural areas. Fruit and vegetable consumption rates for most of the week (5-7 days) were 26.7% and 94.9%, respectively, in two urban areas; and 57.8% and 81.9%, respectively, in the two rural areas.

Physical activity was higher in rural areas at 53.7% and low in urban areas at 31.4% and overweight or obese prevalence rate was 39.3% in urban areas; and 9.6% in rural areas.

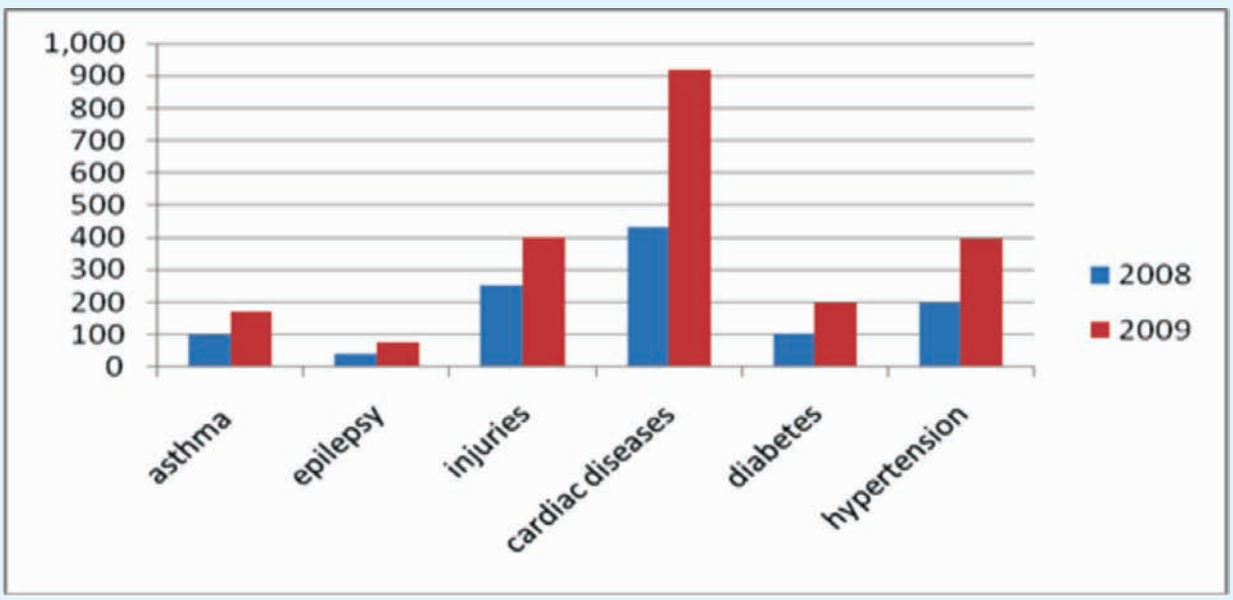
The rate for moderate or severe hypertension was 12.5% in urban areas and 6.6% in rural areas and for raised cholesterol was 15.8% in urban areas; and 3.3% in rural areas. Impaired glucose level or diabetes rate was 7.3% in urban areas; and 2.7% in rural areas.

NCDs Morbidity at Primary Health Care: 2008-2009



Source: HMIS

NCDs Mortality at Primary Health Care: 2008-2009



Source: HMIS

Developing Policy and Strategic Documents

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. It is also underway and WHO has been providing support.

Technical Support

WHO has also provided financial and technical support to the implementation of STEPs surveillance in three out of nine districts. WHO supported technically and financially the survey on the Copperbelt Province in 2010. Preliminary results indicate that alcohol abuse is one of the leading major risk factors probably as a result of job losses in mining sector following the economic melt down.

Challenges/Constraints

Inadequate funding for NCDs prevention and control by Government and WHO; 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 affect 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

Summary of the Needs Assessment on NCDs 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

Lessons Learnt

The cost of conducting STEPs survey is much higher than estimated cost resulting in delays in implementation of especially fieldwork. The strengthening of ZNCR has been difficult due to absence of skilled personnel in cancer registration.

MATERNAL, NEWBORN AND SEXUAL AND REPRODUCTIVE HEALTH

Background

Women and children constitute more than 50% of the population in Zambia. The health and development of a nation is measured by the level of women's' health and development and child survival.

Maternal mortality ratio (MMR) in Zambia decreased from 729 to 591 per 100,000 live births. This decline has not been noted in the newborn mortality rate which has remained high at 34 per 1,000 live births. The rate of decline noted in MMR is not sufficient enough to meet the government commitment to achieve the millennium development goal (MDGs) 5.
Major direct causes of maternal mortality include haemorrhage, obstructed labour, infections, unsafe abortions and eclampsia compounded by malaria, HIV and AIDS and poor nutrition.

A high proportion of pregnant women (94%) attend at least one ANC visit although only 19% core in the first trimester of all births only 47% are assisted by skilled attendants and only 39% receive post natal care within 48 hours. An increasing total fertility rate (from 5.9 in 2002 to 6.2 in 2011, 2007) and a low contraceptive prevalence rate of 41% impacts on maternal morbidity and mortality. For new born, the leading cause of death are complications of prematurity, asphyxia and septicaemia.

Current Issues and Challenges

The Ministry of Health is cognizant of the high maternal and newborn mortality in the country and challenges of meeting MDG 5 related to maternal and newborn health. It has therefore embarked on implementing various strategies for improving quality of services and reducing maternal and newborn mortality in the country. One of these efforts is the launch of CARMMA which compliments other frameworks such as the Maputo plan of action, MNCH Roadmap, The UN H4+1 proposal and the sixth national development plan (the vision chapter SNDP 2011-2015) are a few but strategic documents that indicate the country's commitment related MDGs.

WHO Strategy

The World Health Organization, Zambia country office supports the Ministry of Health and other sectors in the development of policies, guidelines, norms and standards in the area of maternal and newborn health.

Capacity building of health workers in the country and at regional level is supported to improve the quality of health services in the area of emergency obstetric care, newborn and sexual reproductive health such as family planning and screening for cervical cancer.

WHO supports Ministry of Health in institutionalizing maternal deaths review in the country to improve quality of services and reduce morbidity and mortality among mothers and newborns.
WHO advocates for community participation and involvement in the improvement of maternal and newborn health.

Achievements

Policy Guidelines, Norms and Standards

WHO supported a consultant to conduct a situational analysis in healthy aging programmes in Zambia.

WHO supported final review of the training

manual for the safe motherhood action groups.

WHO supported MOH in the development of the national scale up plan for virtual elimination of HIV and provision of care and treatment for pediatric HIV.

WHO in collaboration with other partners supported the updating of MNCH week guidelines.

Supported the MoH to produce the UN Zambia policy briefs on maternal mortality.

Participated in the situation analysis of RH community security , qualification and in the development of reproductive health commodity security strategy.

Capacity Building

WHO supported a planning meeting for orientation workshops on FANC for three provinces and facilitated in Southern Province.

Supported training of trainers in family planning for community based distributors. Supported training in the long term family planning methods Jadelle and IUCD for 14 nurses/midwifery tutors and clinical instructors from three training institutions.

Supported MoH to conduct Maternal Death Review (MDR) in Western and Northern provinces.

Supported training of health workers for new PMTCT guidelines.

Advocacy, Partnership and Resource Mobilization

The Campaign for Accelerated Reduction of Maternal Mortality in Africa was launched at the ordinary session of the African Union conference which was held in Addis Ababa in May,2009 under the theme “Universal access to Quality health Services: Improve maternal, Neonatal and Child health”. Recognizing the particularly slow progress in reducing maternal neonatal and child mortality rates in Africa the continental campaign for Accelerated Reduction of Maternal Mortality in Africa, the slogan is “Africa Cares: No Woman Should Die While Giving Life” was launched. The CARMMA hopes to build upon the Maputo Plan of Action for the implementation of the Continental Policy Framework work on Sexual and Reproductive Health and Rights, which was adopted by the African Union in 2006.

Zambia subscribed to this initiative and His Excellency Mr Rupiah Bwezani Banda, President of Zambia then, Launched the Zambian version on 12th June, 2010 under the theme: “Zambia Care: No Woman should die while giving birth”.

In his speech he reiterated the major issues that contribute to maternal mortality as delays in accessing medical care, getting to the health facilities, long distances and inadequate health workers. He however called on the nation to tackle the challenges and scale up effective interventions to reduce the maternal deaths. Further gave a directive that a working group be formed comprising of all line ministries UN, NGOs and other entities that have similar concerns to spearhead the CARMMA.

The dignitaries that attended the launch included the Minister of Health for Zambia, AU commissioner Bience Gawanas, The first lady Mrs Thadiwe Banda, Her Royal Highness Inkosikati Lambikiza, the Royal Kingdom of Swaziland, and his Royal Highness Chief Mumena, Her Excellency, Ms. Marie Anderson de Frutos Ambassador of Sweden, lead Cooperating Partner and Mr Duah Owusu-Sarfo UNFPA represented United Nations in Zambia, acknowledging efforts by all who gave solidarity messages.

His Excellency Mr Rupiah Bwezani Banda, President of the Republic of Zambia launching CARMMZ at the Mulungushi International Conference Centre

Solidarity Message by Her Royal Highness, Inkosikati Lambikiza, of the Royal Kingdom of Swaziland at the launch of CARMMZ at the Mulungushi International Conference Centre

A total of 2,000 advocacy tools were produced for CARMMZ with the aim of sensitizing and creating awareness partners and influential leaders to participate in activities that will contribute to the reduction of maternal and newborn deaths.

WHO advocated for maternal and newborn health to remain among the top priority agenda for the government and partners in health and development. To this effect, MDG 5 has been ranked high on the agenda.

The CCS document has put improving maternal and newborn health as one of the strategic priorities for WCO Zambia.

The maternal and newborn and child health interagency coordinating committee which is chaired by the Minister of Health meets quarterly to discuss progress made in the implementation of the maternal, newborn and child health interventions, challenges and recommendations. The committee is composed of all programme officers, UN agencies and health partners NGOs, training institutions and many others.

WHO is working with UN Agencies in particular UNFPA, UNICEF, UNAIDS and World Bank and other partners for the implementation of maternal, newborn and child health including PMTCT.

WHO participates in the Joint Annual reviews and maternal, newborn and child health is one of the themes that is monitored and evaluated.

Enabling Factors

The high level commitment of the government of the Republic of Zambia by putting maternal and newborn and child health among the top health and development priorities of the country.

The continuous support from IST/AFRO and Regional Office has assisted in the implementation of maternal newborn and child health interventions in the country.

The presence of technical working groups for EmONC, Safe motherhood, family planning and many others has strengthened partnership, coordination of efforts and has contributed to minimize duplication of efforts and maximizing optimal use of resources, identifying challenges and finding solutions.

Constraining Factors

The scarcity of human resources at all

levels of the health care delivery systems has hindered implementation of some key interventions.

A limited financial resource for implementing maternal and newborn and sexual reproductive health activities has slowed down the implementation.

Lessons Learnt

Cautious and persistent advocacy at high level to integrate some activities for programs especially HIV/AIDS/Malaria/TB and maternal newborn and child health may yield better results for mothers and children.

Priority Areas for Support to MOH in 2011

1. Support MOH in planning and management capacity for maternal and newborn care including family planning.
2. Support MOH in strengthening basic and comprehensive EmONC and newborn services at all levels.
3. Support MOH in the development M and E framework for MNCH
4. Support strengthening community based maternal, newborn health including family planning.

CHILD AND ADOLESCENT HEALTH

Background

Attaining the MDG4 is a priority of the government and WHO. The WHO has continued to support government in planning for implementation and evaluation of the progress towards attaining the goal. Although the under-five mortality rate has declined over the last decade, it remains high and effort to address the main gaps identified in the mid-term review of the fourth NHSP 2006 2010 and annual reviews of the performance in child and adolescent health have continued to be pursued.

Programme management for child health programmes was identified as a gap in the planning for implementation and monitoring of child health programmes. This included inadequate capacity to set district specific targets, planning for implementation and monitor implementation progress. Orientation and building capacity in maternal and child health programmes of the new staff at the provincial and district health offices continued.

Even though IMCI is being implemented in all the districts in the country, the level of saturation of health workers in the community remains inadequate to successfully implement the IMCI strategy. Only 10% of the districts sampled in the 2008 health facility survey had more than 60% of their health workers trained in IMCI. Though training of health workers has been continuous with the nursing school and medical licentiates being trained in IMCI at pre-service level, the restructuring of the MOH has impacted on the skilled staff at the health facilities with a significant number of skilled health workers leaving for greener pastures. Community implementation of important promotion preventive health activities as well as management of common childhood illnesses at community level has long been recognised as a gap that needs to be addressed in order to decrease the number of children dying in the community as well as those coming late to the health facility for care. More than half (52%) of our mothers deliver at home for various reasons. Caring for the newborn at home and community level is a strategy that needs strengthening in order to address the high neonatal mortality that continues to contribute significantly to the under-five mortality.

Adolescents account for over a quarter (27%) of the total population in Zambia. Focusing on adolescent reproductive health as a strategy to reduce maternal mortality is justified. It has been estimated that 3 in 10 young women aged 15 20 have either given birth or are pregnant in Zambia.

The pregnant teenager is at high risk of dying and/or delivering a premature new-born or a new-born needing emergency care. Young females test more (22%) for HIV than the males (10%). According to the Zambia Demographic and Health Survey of 2007 (ZDHS 2007), girls have earlier sex debuts than the boys and they are less likely to use condoms which can explain the higher HIV prevalence in girls.
To address some of the above-mentioned gaps, WCO planned to support the Ministry of Health in the following activities in 2010:

- Developing and updating strategies and guidelines in new-born, child and adolescent health. Specifically the adolescent health situation analysis laid ground for development of the adolescent health strategic plan in 2010. This was to be followed by the development of standards, tools and implementation guidelines for adolescent youth friendly health services.

- Improving planning for implementation of child health programmes by districts through capacity building especially of the MNCH focal persons. The WHO programme management for child health training manual was identified to be key in building this capacity as the principles could be applied to other health programme management

- Planning for increasing the saturation of health workers trained in IMCI in the health facilities through strengthening pre-service and in-service training capacities.

- Planning for integrated implementation of supportive supervision.

- Planning for improving management of common childhood illnesses at community level by using the WHO/UNICEF integrated community case management training manuals

- Planning for improving management of newborn care at community level using the WHO/UNICEF community management of the new-born training manual.

Achievements

During the year under review:

- WCO supported the Ministry of Health in the finalising of the adolescent health situation analysis. The report was used in identifying priority interventions for the adolescent that were included in the National Health Strategic Plan 2011-2015. The report was also used for developing the ADH Strategic Plan 2011-2015. A draft Adolescent Health Strategic Plan was developed and the finalisation of the plan was postponed to first half of 2011 to be completed concurrently with the NHSP 2011-2015.

- WHO supported the MoH to build capacity of provincial and district MNCH focal persons in Programme management for child health using the WHO training manual. During the period under review 30 focal persons were trained. The provincial focal persons and prioritised district focal persons were initially trained with the plan to train all the district MNCH focal persons.

- IMCI expanded to include integrated community case management of common childhood illnesses. WCO supported the Ministry of Health to adapt the generic WHO/UNICEF

CCM training materials and planning for the implementation and rollout of the training. WHO provided support for two experienced external consultants to facilitate at the first national training. By the end of 2010 about 1,000 community health worker had been trained with financial and technical support from WCO and other partners. The health workers were originally from 11 districts where malaria agents had been trained on community management of malaria using rapid diagnostic tests. These community health workers were trained to integrate their malaria case management with management of other common childhood illnesses. The training was expanded to 22 other districts such that by the end of 2010 a total of 33 districts had some trained health workers with the number of community health workers trained ranging from a minimum of 2 to a maximum of 125. There have been a reported total of 74 supervisors trained.

- Supported the MOH in orientation and dissemination of the IMCI orientation and planning guidelines which had been updated to conform with emerging issues in the management of Paediatrics HIV, nutrition, diarrhoea management and shortened training course for IMCI. Sixteen (16) participants from the Southern Province Office, Kazungula DHMT and Livingstone DHMT officers and partners from a USAID sponsored project ZISSP. WCO supported the MOH and government in identifying key areas in maternal and child health to which government committed itself in response to the UN Secretary General's call to women and Children's health. These were:
    - Increasing national budgetary expenditure on health from 11% to 15% with a focus on women's and children's health
    - Strengthening access to family planning increasing contraceptive prevalence from 33% to 58% in order to reduce unwanted pregnancies and abortions especially in the adolescent girls
    - Scaling up implementation of integrated community management of common diseases for women and children, to bring health closer to families and communities to ensure prompt care and treatment.
- WHO supported the MOH in planning for and supervising the child health week activities that were integrated with measles campaign.
- WCO supported MOH and the National Food and Nutrition Commission in the planning for the commemoration of the World Breastfeeding Week.
- WCO supported the resource mobilisation and planning for the commemoration of the 2010 World Pneumonia Day. Activities to raise awareness about pneumonia were done. There were discussions with the Health Committee Members of Parliament, radio discussions, match past on the 12 November 2010 and documentary on pneumonia was made which included a clip from the WHO Representative on WHO's role in the fight against pneumonia.

- WCO continued to support the MOH in the fortnightly child health technical working group and the quarterly ICC MNCH review and planning meetings.

Resource Mobilization

WCO:

- Supported the MOH in developing a proposal for accelerating maternal, newborn, child and adolescent health in one district in Zambia that has been funded.

- Supported developing a joint UN proposal on Adolescents and HIV that has since been funded by the European Union.

- Supported the Ministry of Health, Zambia Paediatric Association and other partners to raise funds to commemorate the World Pneumonia Day and thus raise awareness about it

Challenges

- Continued loss of trained supervisors and health workers trained in IMCI at the provincial and district levels has impeded the expansion of the IMCI strategy.

- Inadequate funding for activities

- Competing priorities for the child health unit and thus some planned activities were not implemented

Priority areas for support to the MOH in 2011

Priority areas for support to the MOH in 2011 will include the following:

- Finalising the Adolescent Health Strategic Plan 2011-2015 and developing standards, tools and implementing guide for Adolescent Youth Friendly Health Services.

- Continue supporting Ministry of Health in improving capacity of programme managers for child and adolescent health.

- Supporting the MOH in adapting the WHO/UNICEF newborn care at the community manual/materials and training of community health workers.

- Supporting MOH in expansion of IMCI implementation in both pre and in service in order to address the problem of saturation of skilled health workers.

- Documenting and publishing child health activities and research findings.

- Mobilising resource for maternal, newborn, child and adolescent health and nutrition.

- Planning for continued implementation and expansion of iCCM.

- Fostering partnership for strengthening capacity to improve MNCAH and nutrition within the UN system and other partners.

- Supporting MOH in conducting integrated supportive supervision for MNCAH.

EMERGENCY HUMANITARIAN ACTION

Introduction

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

Chronically poor sanitary conditions in the most affected districts have been exacerbated by flooding, increasing the risk of outbreaks such as cholera and other diarrhoeal diseases. Stagnant floodwater has also greatly increased the risks of an outbreak of malaria. Furthermore, floods have disrupted normal operations of the essential health care system.

WHO has continued to support national authorities particularly Disaster Management and Mitigation Unit (DMMU) in mitigating the effects of disasters through rapid assessment of ill-health related to floods or drought. WHO also supported report writing of the health chapter on rapid assessment floods-affected districts and the preparation of a contingency plan focusing on floods, drought and epidemics. WHO also supported the development and finalization of data collection tools for comprehensive vulnerability assessment and analysis.

United Nations Disaster management Team

WHO has also supported the United Nations Disaster Management Team (UNDMT) and United Nations Development Assistance Framework (UNDAF) meetings by leading the health sector. WHO has been providing data on a regular basis to the UNDMT on the status of epidemic/pandemic diseases for sharing with other partners in the health sector.

Improving Information Management

WHO has supported the office of the National Epidemiologist which has now been established and filled by MoH. The post was established following assessment and recommendations to have an Epidemiologist and Data Manager at national level in order to strengthen surveillance. The office strengthening by WCO has been through provision of a surveillance vehicle, computers (laptop & desktop), colour printer, LCD projector. The Data Manager has been working closely with WHO on techniques of data capture, cleaning and analysis.

Support to Capacity Building

As part of preparedness, prevention and response to epidemics / disasters, WHO supported both technically and financially Lusaka Urban District Management Team (LDHMT) to conduct training for most of the technical staff. Over 100 staff from various health centres in Lusaka district were trained in 2010 in preparation for the 2010/11 rain season.

Resource Mobilization

Through the UNDMT and in partnership with UNICEF the programme had developed and submitted a CERF proposal to support disease prevention and control activities. However, the proposal was not honoured and hence no funds were received

Challenges/Constraints

The major constraint was the lack of capacity to implement long-lasting solutions to address floods. There is need to work closely with Government, UN Agencies and other stakeholders to improve effectiveness of collaboration, on the basis of clearly defined roles and responsibilities;

Lessons Learnt

The need for strengthening coordination mechanisms by Government is still a challenge. The participation of line Ministries in response to emergencies is inadequate. The strengthening of DMMU to coordinate response to emergencies/disasters is important and

HEALTH PROMOTION

The major focus areas for WHO support to the health promotion programme during 2009 are outlined below. This section includes the following; outcomes, major success factors, lessons learnt and challenges.

Capacity Building for Implementation of Health Promotion at District Level

Integration of Health Promotion in Priority Health

WHO continued to provide technical support to the Ministry of Health for integration and implementation of health promotion activities in priority health programmes. Support ranges from development of health promotion strategies for inclusion in national policies and strategies and guidelines for various priority health programmes and implementation of the strategies. Activities were conducted for specific programmes. For example provincial workshops were supported for orientation and development of health promotion action plans on malaria control. Equally, health promotion strategies are constantly updated for the EPI programme particularly to support routine immunisation, vaccination campaigns and other child health activities. Following the launch of Campaign for Accelerated Reduction of Maternal Mortality in Africa (CARMMA), health promotion strategies were also strengthened to reduce maternal deaths. For Tobacco control, awareness campaigns and education for the general public have also been supported. Health promotion and communication activities to support HIV/AIDS programmes have also continued, in 2010. Particularly efforts were made to develop made to support male circumcision activities with health promotion and communication strategies.

Development and Implementation of Communication Strategies for Priority Health Programmes

WHO provided both technical and financial support to MOH which contributed to implementation of existing communication strategies; notable outputs include:-

I. Implementation of existing communication strategies in particular the Maternal and Child Health communication strategy, the National Malaria Communication strategy, HIV communication Strategy and the United Nations Communication Annual Plan to support the UNDAF.

II. Child health communication intensified during the child health week campaigns, breastfeeding week and routine services through TV and radio programmes, distribution of printed materials e.g. posters, leaflets etc.

III. WHO was part of collaborative communication within the United Nations especially in relation to the production of the UN newsletter, UN website, and MDGs campaign and other UN related communications and events e.g. the UN day. WHO activities were covered in the UN Newsletter and website.

IV. The WHO Country Office performed its role as a source of health information and partners through regular dissemination of information to the Ministry of Health, media organisations, partners in health and other stakeholders. Press releases from, WHO/HQ, WHO/AFRO and the WCO were sent to the media on a

regular basis and the WHO Newsletter was also circulated electronically on specific developments at country level.

Commemoration of Health Days and Health Campaigns

WHO supported financially the commemoration of the following events; World Health Day, World TB Day, World Asthma Day, African Traditional Medicine Day, and World Mental Health Day. Technical support was also provided for implementation of other world health days. During commemoration of World Malaria Day, the WCO received support from WHO/AFRO to produce a video documentary on engaging communities in malaria control which served as an important information and advocacy tool.

WHO contributed financially and technically to the implementation of the following:-

I. Technical support was provided to MOH for implementation of social mobilisation activities during the bi-annual Child Health Week. The first Round of the Child Health Week was integrated with the measles vaccination campaign. The major activities which were implemented during the campaign include production of posters, TV and radio programmes, district social mobilisation activities and other media outreach activities. WHO staff members also participated in the supervision of the campaign activities on the Copperbelt province.

II. Zambia launched the country version of the Campaign for Accelerated Reduction of Maternal Mortality in Africa (CARMMA) on Saturday 12th June 2010 under the theme "Zambia Cares, No Woman should Die While Giving Life." Various activities were conducted to create public awareness about the need to prevent maternal deaths through radio programmes, production of information kits and through advocacy meetings at various levels.

III. Financial and technical support was provided to MOH for social mobilisation activities during the H1N1 vaccination campaign. Posters and leaflets were printed by WHO for distribution countrywide. TV and radio announcements were made during the campaign.

IV. Financial and technical support was provided to the National Food and Nutrition Commission to support implementation of the Breast-Feeding Week campaign.

V. WHO joined the United Nations communication Team in organising the Millennium Development Goals campaign in Lusaka.

Framework Convention on Tobacco Control

The Ministry of Health has taken a number of steps to ensure that the provisions of the WHO Framework Convention on Tobacco Control are reflected in national policies and strategies. WHO has continued to support both the development of policies and activities targeted at reducing the supply and demand for tobacco. For example, in 2010 WHO provided technical support during meetings which were organized by MOH to review the Tobacco legislation in the country. WHO was among the partners that were involved in the process. Technical support was given to the Ministry of Health to ensure that the amendments reflected the provisions of the Framework Convention on Tobacco Control (FCTC) particularly on creation of smoke free environments, public education, regulation etc. The last consultative meeting was held in

December 2010 and a draft Bill was produced for comments.

Integration of Heath Promotion Strategies Targeting Physical Inactivity and Healthy Diets

Health learning materials were produced on healthy diets and physical activity and distributed country wide to all districts and major hospitals. Specific materials on healthy diets were produced and also messages were incorporated in education materials on various NCDs including Diabetes, High blood pressure, cancer etc. An information package on NCDs was produced and distributed at the National Health Conference which also focused on NCDs in the country. Technical support for commemoration of Health Days for NCDs (Asthma, Cancer, Diabetes,) was provided.

Lessons Learnt

- The availability of MOH strategic plans especially for the specific programme areas with focused health promotion actions and budgets facilitates implementation. The plans serve as tools for resource mobilisation and development of micro plans.

- Synchronisation of WHO plans with those of other partners removes competition and harmonises implementation and pooling of resources.

- Health promotion programmes, e.g. for TB, Malaria, PMTCT, NCDs need to leverage resources in the Regular Budget to achieve better results.

Success Factors

- Availability of seed funding from WHO through the regular budget facilitated the initiation of some activities.

- Provision of technical support from WHO through guidelines, standards and relevant information facilitated the implementation process.

- Partnership was an enabling factor to progress made in the health promotions.

- Availability of Global funding for programmes

Impediments

- The regular budget continued to dwindle leaving many activities unimplemented.

- Limited RB funding especially for NCDs, Tobacco control and Mental health.

- Voluntary contribution was not made available to the programme, some activities were deferred or cancelled.

Social and Economic Determinants of Health

The WHO Country Office had planned to support the Ministry of Health to increase its national awareness on the impact of Socio-economic factors such as resource allocation, income, poverty, adult literacy, housing, food availability and working conditions on health and quality of life of the population. Special efforts are being made to support national authorities to include in their plan of action strategies to advocate for improvement in socio-economic status and living conditions of the population as well as to increase awareness on and advocate for action by line Ministries and other stakeholders on major determinants of health such as

water, sanitation, food, hygiene, education and gender. A draft template for health systems in Transition is under review and will be utilized to collect country information to inform policy makers.

Environmental Health

Key Issues

The physical characteristics of the household dwelling, including source of drinking water and type of sanitation are important determinants of socio-economic and health status. Thus, Zambia has prioritized delivery of occupational and environmental health related services. However, risks associated with poor management of the environment abound. For example, fewer people have access to safe drinking water. The ZDHS 2007 reports that only 41% population access to improved source of drinking water, thereby increasing the risk to food-borne diseases. Also, enforcement of public health legislation is limited. The policy on frame work on environment is not yet finalized and job aids on occupational health and environmental health at training institutions are inadequate in training istitutions.

Achievements

The WCO made progress in the following areas: technical leadership in the development of a national health care waste plan, production of International Health Regulation documents, development of guidelines, manuals and legal documents were provided to the University of Zambia Environmental Health School. The WCO also facilitated national participation in the national meetings for the Codex Alimentarius Commission and in the Global Food borne infections Network training to strengthen the country's capacity in laboratory-based food borne diseases. WHO collaborated with other UN agencies, government ministries and NGOs in advocacy in climate-related issues in order to strengthen health system capacity to provide protection from climate related health risks, and to ensure that Climate-related risks are included in developmental strategies in other sectors.

Challenges

The pace and scale of mainstreaming environmental health into national policies and of establishing viable coordination framework on occupational health and environment are slow. Systematic risk assessments and documentation are limited as regards occupational health and environment are limited.

NUTRITION, FOOD SAFETY AND SECURITY

Situation

In Zambia malnutrition underlies up to 52% of all under-five deaths. Stunting rate in under-five children stands at 45% while acutely malnourished (wasted) is at 5% with underweight at 15%. 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). A number of interventions have been put in place to try and address some of the challenges identified. Integration of nutrition in all programmes has been identified as a priority activity as nutrition is cross cutting. Infant and young child feeding has continued to receive attention with management of acute malnutrition at health facilities and within the community being supported by WHO and partners.

In 2010 WHO provided support in the implementation of the following activities:

- WCO supported the planning and commemoration of the breastfeeding week.
- Supported the MOH in the development of the Community IYCF training materials.
- WCO provided financial and technical support in training of nutritionist and MNCH focal persons in IYCF. Forty-eight health workers were trained from two provinces.
- WCO supported technical review meeting for the review of the Nutrition and HIV Guidelines for Care and Support of PLHA and counselling materials. The meeting updated the nutrition and HIV materials as the information on nutrition and HIV had changed and consensus was needed on what should be included in the documents.
- WCO supported the development of the Manual for Enforcement of the Breastmilk Substitutes Law. This has since been printed and trainings for law enforcers was planned for 2011.
- WCO provided technical support for capacity building in IYCF:
  - Directed course on IYCF: An Integrated Course, for World Vision International in May 2011 in Ethiopia. There were 27 participants drawn from 11 African countries and WVI regional offices and Canada. The trained WVI staff were expected to incorporate their plans with their respective MOH plans on scaling up capacity in IYCF at both health facility and community.
  - Facilitated and directed course on IYCF: An Integrated Course, for Rwanda MOH. Five trainers and 18 participants were trained.
- Submission of manuscript for publication of an operational research on use of IYCF counselling cards was done.
- WCO supported National Food and Nutrition Commission Director to attend 8th IBFAN African conference in Mauritius, a presentation made about publication on WHO website the 2008 IYCF assessment report for Zambia

In 2011 WCO will focus on supporting MOH and partners in planning for improving capacity in nutrition at health facility and community levels. WCO will continue to advocate for integration of nutrition in all programmes. Policy and strategic plan development in nutrition will be prioritised.

HEALTH SYSTEMS AND SERVICES

Health Care Financing

Through UNDAF and JASZ framework, WHO Country Office Zambia has been providing technical assistance to Ministry of Health and other development partners to support the health sector programme. Specifically WHO is supporting the Government to develop and implement social protection mechanisms, including the social health insurance scheme in an effort to cushion households from catastrophic expenditures on health services; WHO effectively participates in SWAps to improve coordination of the various financing mechanisms (including donor assistance). In the process WHO has been supporting and advocating with health development partners to implement fully the Paris Declaration on Aid Effectiveness and its Action plan and supporting a number of SWAps meetings (ACM, SAGs, MOH/CP policy Meetings, JAR) . Preparations for the next round of the National Health Accounts have commenced and it is intended that this undertaking includes: General NHA; Child subaccounts and Reproductive Health subaccounts.

Lessons Learnt

- NHA team within MoH still require training on ICHA and SHA
- Specialized support for the development of the SHI is required
- Current MoU between Government and Partners will require review

Human Resources for Health (HRH)

The Ouagadougou Declaration calls for strengthening of the capacity of training institutions, management, and staff motivation and retention in order to enhance the coverage and quality of care. Zambia has an acute shortage of health workers in quantity as well as quality, especially in rural areas. The Country office has been involved in supporting the Ministry of Health to review the Human Resources Strategic plan 2006 to 2010. WHO supported Government to mobilize resources for HRH internally and from GHWA amounting to USD100, 000. Additional support was given to the Ministry to develop a business plan for the new medical school.

Lessons Learnt

Implementation of the HRH 2006-2010 was negatively impacted on 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.

Health Service Delivery (HSD)

WHO support in the first quarter of 2011 focused on strengthening national health systems with special emphasis on development of the National Health Strategic Plan 2011-2015 and National Health Policy 2011-2020. This takes into account the Ouagadougou Principles of PHC. In addition WHO has been supporting the review and improvement of the Zambia country Health Intelligence portal page through collaboration, Peer review and institutional capacity building with the Ministry of Health.

Lessons Learnt

Policy development and National Health Strategic Planning is a rigorous process requiring significant stakeholder input. The two should be reviewed and developed in tandem.

MEDICAL PRODUCTS AND TECHNOLOGY

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

Introduction

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 like in many developing countries, is wide spread and is a source of growing expenditure globally.

The central priority remains expanding access to essential medicines, one of the health targets of MDGs to which Zambia and indeed the international community is committed.

With the high disease burden particularly due to Malaria, TB and HIV/AIDS and other opportunistic infections and the large and 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 Response

WHO's response to the key Essential Medicines issues in Zambia is in the area 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.

Objectives

To strengthen 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

Implementation Status:

Most of the EDM activities were implemented using voluntary funds. There were 3 country expected results with 6 products and 17 activities. Of the 17 activities 11 of them were implemented bringing the implementation rate to about 65%.

Overview of Achievements

WHO has successfully advocated and supported strengthening of priority areas of the National Drug Policy (NDP). It has collaborated with other partners to provide technical and/or financial support for activities jointly planned by the Ministry of Health and WHO. Key activities implemented include:

- Supported the Ministry of Health in the holding of a stakeholders meeting for finalization of the draft 2nd Edition of the National Medicines Policy and its

Implementation Plan in June 2010

- Supported the Ministry of Health to hold a stakeholders meeting for finalization of the draft 3rd Traditional, Complementary and Alternative Medicines and its Implementation Plan.

- Supported the Ministry of Health in the development of the National Health Policy and drafting of the National Health Services Act

- Supported MOH on finalization of the draft 2nd Medicines Supply Chain Coordination Plan. The plan was adopted at the stakeholder meeting held to review the Medicines Supply Chain in Zambia

- Supported MoH in holding a stakeholders dissemination meeting for assessment of Medicines Supply Chain System in Zambia and the Medicines Prices, Availability, Affordability (Part I) and Price Components (Part II).

- Supported MOH in partnership with the Zambia National Formulary Committee in reviewing and printing of the National Essential Medicines List/Standard Treatment Guidelines.

- Supported MoH in partnership with other stakeholders in preparations for the commemoration of the 8th African Traditional Medicines Day which fell on the 31st August 2010.

Challenges/Constraining Factors

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 was very slow and follow up on implementation of other activities difficulty. This was attributed no lack of focal person on Traditional medicine and lack of a pharmaceutically qualified person at high (Policy) level in the Ministry of Health.

Lessons Learnt

Planning and implementation of an effective essential drugs management system requires availability of appropriate human resource and infrastructure support all aspects of pharmaceutical services. Effective partnerships and collaboration with local partners allows smooth implementation and facilitates cost effective delivery of the plan.

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 of functions in leadership and governance. The assistance includes support to development of NHSP, NDP6, NHP, MoU/IHP+ compact, Mid term review of TB and 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 have emerged as a result of growing need to achieve the health Millennium Development Goals (MDGs) targets. In February 2008 Zambia hosted the International Health Partnerships meeting in Lusaka and since then the country had embarked on revision of the existing MoU. This was necessary not only to fill up the existing gaps but also as a tool for use in mobilizing additional resources to address MDGs. WHO has actively supported the process of revising of the MoU into a compact which hopefully would strengthen alignment, harmonization and timely translation of commitments by partners into action.

Collaboration with 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 or programmes has 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 Non-Governmental Organisations

Over the year, Zambia has seen the growth over the years of a number of national and international non-Governmental who are primarily working to bring 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 weak 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.

MANAGEMENT AND SPECIAL EVENTS

MANAGERIAL CAPACITY OF WHO COUNTRY OFFICE

Strengthening Cluster Approach.

In the quest to strengthen managerial capacity for programme implementation, the WCO Representative introduced the cluster approach. The cluster approach provided an opportunity for positive team spirit, open communication and sharing of information among different programmes. The cluster approach is also 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.

Resource Mobilization

Global Service Management

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

Budget

The budget for the country office for the year under review is as shown below:

Zambia: Strategic objectives and country/office specific expected results	Assessed Contributions	Voluntary Contributions	All Financing
To reduce the health, social and economic burden of communicable diseases	39,000	2,041,500	2,080,500
To combat HIV/AIDS, tuberculosis and malaria	57,500	733,000	790,500
To prevent and reduce disease, disability and premature death from chronic non-communicable conditions, mental disorders, violence and injuries	38,500	60,000	98,500
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	17,500	1,273,500	1,291,000
To reduce the health consequences of emergencies, disasters, crises in conflicts, and minimize their social and economic impact	20,500	802,500	823,000

To promote health and development, and prevent or reduce risk factors for health conditions associated with the use of tobacco, alcohol, drugs and other psychoactive substances	12,500	77,000	89,500
To address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate	6,000	17,000	23,000
To promote a healthier environment, intensified primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health	6,000	53,500	59,500
To improve nutrition, food safety and food security, throughout the life-course, and in support of public and sustainable development	20,500	53,500	74,000
To improve health services through better governance, financing staffing and management informed by reliable and accessible evidence and research	28,000	528,000	556,000
To ensure improved access, quality and use of medical products and technologies	18,500	42,000	60,500
To provide leadership, strengthen governance and foster partnership in collaboration with countries in order to fulfil mandate of WHO in advancing the global health agenda	41,000	0	41,000
To develop and sustain WHO as a flexible learning organization enabling it to carry out its mandate more efficiently and effectively	66,000	47,000	113,000
GRAND TOTAL	**371,500**	**5,728,500**	**6,100,000**

Staffing

The staff establishment of the WHO Country Office comprises of international staff, national professional officers and general service staff. During the year under review the office was strengthened through filling up of created positions 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 has continued to strengthen its capacity. All the staff on fixed term contracts have been included in the GSM. The Office has also adopted a deliberate effort to mobilize resources locally to support activities.

SPECIAL EVENTS

The Regional Directors Visit to Zambia

The Regional Director for the World Health Organization (WHO), African Region, Dr Luis Gomes Sambo came to Zambia from 25th to 28th October, 2010 at the invitation of the Government of the Republic of Zambia. While in the country, he met His Excellency the President of Zambia, Mr Rupiah Bwezani Banda, visited the WHO Country Office in Zambia, held a consultative meeting with the Ministry of Health and launched the 2010 National Prevention of Mother to Child Transmission of HIV guidelines in Chongwe District, Lusaka Province.

During his visit Dr. Sambo met the Republican President, His Excellency, Rupiah Bwezani Banda who welcomed and thanked WHO for the support it had continued to provide to Government for health development. He urged WHO to continue supporting health programmes in the country for better health of the citizens.

The Regional Director visited the WHO Country Office where he held a meeting with the staff. He called upon the WHO Country Office to provide the necessary leadership in the health sector through provision of norms, standards and guidelines and resource mobilisation in order to improve the delivery of quality health services. He said that there was need for WHO to collaborate and support government in developing the National Health Strategic Plan in order to ensure that the key strategies adopted by the WHO Regional Committee were integrated.

Dr Sambo also visited Chongwe, a rural district outside Lusaka, where he launched the 2010 Zambia National Protocol Guidelines for integrated Prevention of Mother to Child Transmission (PMTCT). He recognized the tremendous efforts Zambia had made in reducing infant and maternal mortality and the need for concerted effort towards the attainment of MDGs 4 and 5. He encouraged countries to take the opportunity of the renewed focus on primary health care to redesign national health systems in order to improve health care services.

The Regional Director held a meeting with the Ministry of Health at which he commended the country for implementing most of the WHO strategies for addressing public health problems. He said there was need to maximize the application of ideas that have been proven to be effective. Dr Sambo recognized the challenges in implementation, in terms of capacity as a result of limited human resources, limited funding and access to drugs and medical technologies. However, He commended the government for the 30% increase in budgetary allocation to the sector in 2011 as it was important for sustainability of programmes. He called for stronger partnerships and harmonization of support to the health sector in line with the Paris Declaration

The Regional Director also commissioned a cold room facility worth 130,000 United States Dollars in the Copperbelt Province. The cold room was donated to the Government by WHO and will serve as a storage facility and distribution point for vaccines for the Copperbelt, North Western and Luapula provinces. While on the Copperbelt Province, he also visited the Ndola Central Hospital where he was taken on a guided tour of the facilities which will be used for the new Medical School which will be opened by the government in 2011

Dr Sambo also visited the Tropical Diseases Research Centre (TDRC) at the Ndola Central Hospital which was once a WHO collaboration Regional Centre for Africa. He mentioned that TDRC could be re-designated as a WHO centre as soon as the required standards were met.

Dr Peter Mwaba, MoH Permanent Secretary welcomes the Regional Director, Dr Luis G. Sambo at Lusaka International Airport. Looking on is WHO Country Representative, Dr Olusegun Babaniyi

The Regional Director, Dr Luis G. Sambo signing the visitors book at WHO country office. Looking on is WHO Country Representative, Dr Olusegun Babaniyi

Visit of United Nations Secretary-General Special Envoy for Malaria

The United Nations Secretary General Special Envoy on Malaria, Raymond Chambers, visited Zambia on 4-5 November 2010. He was in the country to see the progress Zambia has made in malaria control and to hold consultations with government on possible areas of assistance and collaborations with the government and partners. While in the country, the UN Envoy held a meeting with the Minister, senior health officials in the Ministry of Health and partners in malaria control.

During press conference held at the Hotel Intercontinental, the UN Envoy said that Zambia was a leader in the fight against malaria and mortality has reduced by two thirds as a result of aggressive interventions put in place. He disclosed that global partners in the fight against malaria have raised $5 billion to buy and distribute insecticide treated mosquito nets to cater for about 700 million people, mostly in the sub-Saharan region. The 2.6 million mosquito nets that he has donated to Zambia should be in the country and be distributed particularly in Luapula, Northern and Eastern provinces by 31st December 2010. This was in order to meet the UN Secretary General's goal of achieving universal coverage of key malaria interventions by the end of 2010. He emphasized the need to scale-up interventions in order to reach near zero deaths by 2015.

Dr Peter Mwaba, MoH Permanent Secretary welcomes Mr Raymond Chambers - UN Secretary General's Special Envoy on Malaria at Lusaka International Airport

Dr Peter Mwaba leads Mr Raymond Chambers to the VIP lounge at Lusaka International Airport

External Missions

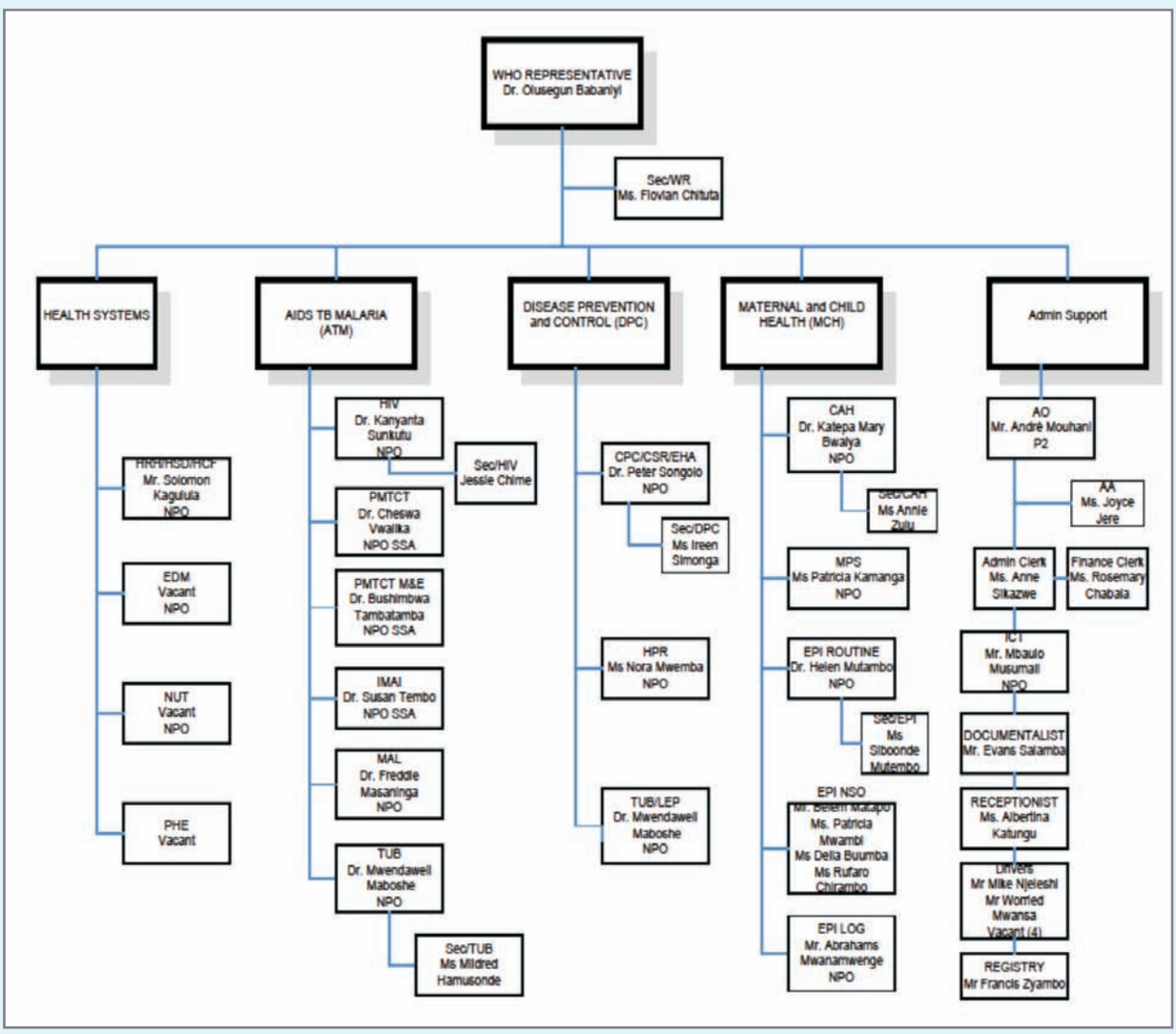
Two consultants, Dr N Ndjeka and Dr J Bayona, from South Africa and USA respectively came as external consultants to train MoH staff in MDR-TB. The latter was engaged by the country office and the former by HQ. Twenty five staff were trained comprising doctors, nurses and clinical officers from the three designated treatment sites and the provincial TB focal point persons

The training was part of the preparations to start programmatic management of drug resistant TB in Zambia.

ANNEXES:

Annex 1

ORGANIZATION STRUCTURE WHO COUNTRY OFFICE ZAMBIA



Annex 2

WHO COUNTRY OFFICE STAFF LIST AS ON 31 DECEMBER 2010

S/N	N A M E	T I T L E
A.	**International Staff**	
1.	Dr O. Babaniyi	WHO Representative
2.	Mr A. Mouhani	Administrative Officer
B.	**National Professional Officers**	
3.	Dr. M. Maboshe	NPO/TUB
4.	Mrs. P. Kamanga	NPO/MPS
5.	Mr. S. Kagulula	NPO/MPN
6.	Dr. H. Mutambo	NPO/EPI
7.	Dr. F. Masaninga	NPO/MAL
8.	Dr. Katepa Bwalya	NPO/CAH
9.	Ms. L. Lishimpi	NPO/EDM
10.	Dr. P. Songolo	NPO/DPC
11.	Mr. B. Matapo	National Surveillance Officer
12.	Dr. K. Sunkutu	NPO/HIV
13.	Mrs. D. Buumba	National Surveillance Officer
14.	Mrs. R. Chirambo	National Surveillance Officer
15.	Mrs. P. Mwambi	National Surveillance Officer
16.	Mr. A. Mwanamwenge	NPO/LOG
17.	Mrs. M.L.M. Liwewe	Laboratory Scientist – UTH
18.	Mrs. I.M. Ndumba	Laboratory Scientist – UTH

19	Dr Cheswa Vwalika	PMTCT Coodinator
20	Dr Susan Zimba Tembo	MC Coordinator
C.	**Finance and Administrative Staff**	
21.	Mrs. J. K. Jere	Administrative Assistant
22.	Ms. N. Mweemba	Health Information Officer
23.	Mrs. A Sikazwe	Administrative Clerk
24.	Mr. M. Musumali	ICT Officer
25.	Mr. E. Salamba	Documentalist
26.	Mr. F. Zyambo	Machine Operator
27.	Mrs. R. M. Chabala	Finance Clerk
D.	**Secretaries and Receptionists**	
28.	Mrs. C. M Phiri	Senior Secretary
29.	Ms. A. Zulu	Secretary – IMCI
30.	Mrs. F Chituta	Secretary
31.	Ms. M. Siboonde	Secretary – EPI
32.	Ms. A. C. Katungu	Receptionist
33.	Mrs Ireen Simonga	Secretary

Annex 3

National Health Strategic Framework 2011 - 2015

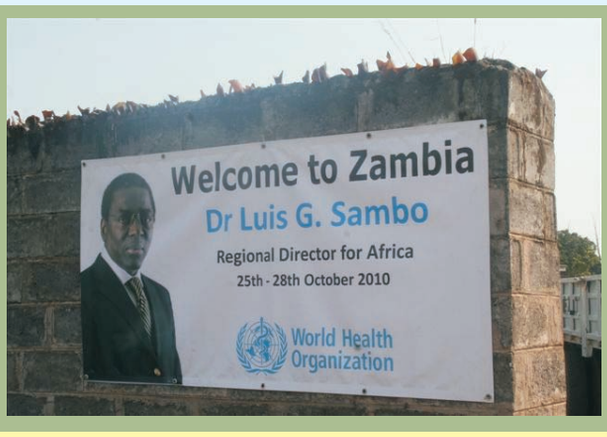
Health Strategic Framework			
No.	**Program**	**Objectives**	**Key Strategies**
1	**Leadership & Governance**	To implement accountable, efficient and transparent management systems at all levels of the Health Sector	Introducing Performance based financing
			Reviewing the overall legal and policy framework
			Introducing a management development programme
			Reviewing and strengthen the existing fiduciary systems
			Strengthen the Sector collaboration mechanisms
2	**District health services**	To provide cost-effective, quality and gender sensitive primary health care services to all as defined in the Basic Health Care Package	Expand access to access to Maternal, Newborn and Child Health (MNCH) service including immunization, safe delivery and EmONC with special focus on under-served areas
			Continued implementation of the malaria prevention and control interventions including IRS, ITN distribution Intermittent Preventive Therapy in Pregnancy (IPTp,) and prompt and effective treatment
			Continued implementation of High Quality Direct Observation Treatment Strategy and control of Multi-drug resistant with focus on high risk groups
			Expanded access to HIV/AIDS prevention services including Male Circumcision services; condom distribution, STI, Control, PMTCT and provision of safe blood
			Continued expansion of ART services for both adults and children and in both rural and urban areas.
3	**Referral hospital services**	To increase access to and quality of advanced referral medical care services.	Hospital Reforms Programme encompassing strengthened referral structures, outreach programmes from tertiary to regional referral hospitals, mobile referral services and improved quality of clinical services in hospitals
			Building capacity in Hospital Management in financial management and mobilization through cost sharing
			Promote private sector participation in the provision of specialized care
			Review and gradually rehabilitate existing facilities and building communication and transport systems
			Explore the opportunities to expand services in non-communicable diseases by strengthening diagnostic and disease management capacity at all levels

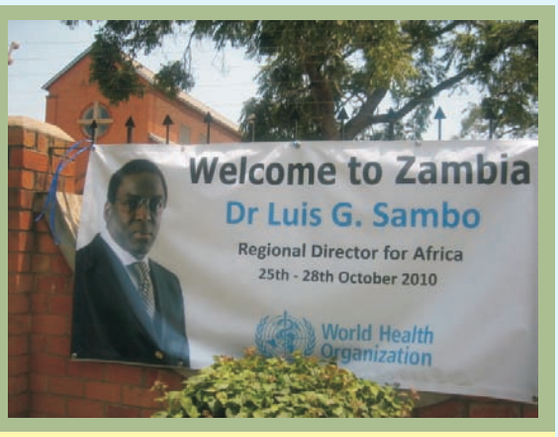
4	**Human Resource for Health**	To improve the availability of and distribution of qualified health workers in the country	Increasing the number of trained Health workers available to the sector improving the remuneration package and expanding training output
			Improve efficiency in utilization of existing staff by improving HR management and better training coordination
			Provide appropriate training and incentives to community health workers to mitigate HR shortages
5	**Medical Commodities & Logistical Systems**	To ensure availability and access to essential health commodities for clients and service providers.	Ensure availability of skilled Human Resource logistics management at all levels
			Ensure availability of adequate finances for procurement of identified medical commodities, transport and training in logistics management
			Strengthen Logistics management systems for Essential commodities
			Ensure rational use of commodities and services through provision of guidelines and Standard Treatment guidelines.
6	**Infrastructure & Equipment**	To provide sustainable infrastructure, conducive for the delivery of quality health services at all levels of the health care system	Update the existing infrastructure database and review of the HCIP to assess health facility requirements and expedite its implementation
			Develop maintenance and rehabilitation guidelines for all levels
			Construction of National Drug Quality Control Laboratory, Laboratories and Drug storage facilities
			Revision of the design of Health facilities through a consensus building process with key stakeholders
		To ensure the availability of adequate, appropriate and well-maintained medical equipment and accessories in accordance with service delivery needs at all levels	Finalise policy to support acquisition, management and maintenance of medical equipment.
			Develop capacity program for management and maintenance of medical equipment
			Development of Standard Equipment Lists at 2nd and 3rd Level Hospital Facilities
			Strengthen capacity for transport management
			Strengthen the vehicle service centres at provincial centres.
			Establish & upgrade LAN connectivity in all health facilities
			Build ICT capacity in innovative developments and progression of ICT services and infrastructure

7	**Health Management Information System (HMIS)**	To ensure availability of relevant, accurate, timely and accessible health care data to support the planning, coordination, monitoring and evaluation of health care services	Strengthening and capacity building of health information cadre at all levels in order to improve the efficiency, quality and timely availability
			Rollout and strengthening the HMIS to all public and private Hospitals and at community level
			Strengthening the harmonization and co-ordination of different health information systems among programmes
8	**Health Care Financing**	To mobilise resources through sustainable means and to ensure efficient use of those resources to facilitate provision of quality health services	Promote adoption of Health Financing Policy as a long-term guide for financial reform
			Resource Mobilization: explore alternative ways of raising health finances including PPP, private and social insurance and ear-marked taxes
			Resource Allocation: Refine RAF for Districts to account for input costs and develop RAF for other levels and inputs such as HR
			Resource Tracking: In\stitutionalize NHA and PETS and strengthen routine resource tracking systems to link inputs to outputs (SAG Reports)

Annex 4

Regional Director's visit, Dr Luis G. Sambo in pictures





Poster welcoming WHO Regional Director for African, Dr Luis G. Sambo in Chongwe DHMT(Left) and WHO Country office(Right)

Dr Luis G. Sambo (Centre) addressing staff of the Ministry of Health at Ndeke house boardroom

Dr Luis G. Sambo speaking to Dr Fred Masaninga NPO/MAL during tour of the WHO Country office

Dr Luis G. Sambo posing for a photo with WHO country office staff

Dr Luis G. Sambo addressing staff at the WHO country office

Dr Luis G. Sambo receiving a gift from the Secretary of staff association Ms Mutembo Siboonde

Dr Luis G. Sambo donating a mosquito net to a member of the Community in Chongwe district

Dr Luis G. Sambo donating bicycles to Community Health workers in Chongwe district, looking on is Dr Victor Mukonka, Director, Directorate of Public Health and Research, MoH

Dr Luis G. Sambo addressing Chongwe district staff and community at the launch of PMTCT guidelines

Dr Luis G. Sambo officially commissioning the cold room facility in Ndola, Copperbelt Province

Mr Abrahams Mwanamwenge, NPO/LOG explaining to Dr Luis G. Sambo operations of the cold room facility in Ndola, Copperbelt Province

Dr Luis G. Sambo touring the National Laboratory for tuberculosis at Ndola Central Hospital. Looking on is Dr Modest Mulenga (right) Director, TDRC, Ndola

World Health Organization