JOINT ANNUAL REVIEW 2011
Health Sector Performance Review

The Permanent Secretary
Ministry of Health
Ndeke House
PO Box 30205
Lusaka, Zambia

April 2012
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FOREWORD

It is with great pleasure that I welcome you to read this report on the Joint Annual Review of the performance of the health sector in Zambia, for financial year 2011 (JAR 2011). As you may be aware, since its introduction in 2006, the Joint Annual Review (JAR) has become an important event on the national health sector calendar of critical activities. The JAR has indeed proved to be an important tool for harmonization of the monitoring and evaluation (M&E) systems of the sector, bringing together all the partners to jointly review the performance of the sector. The feedback obtained from the JAR process, forms an important part of the evidence base for policy formulation, planning and management decision in the health sector, for both the Ministry of Health (MOH) and its partners.

As you may be aware, currently, the national health strategic agenda is being guided by the National Health Strategic Plan 2011 to 2015 (NHSP 2011-2015), which itself is anchored into the Sixth National Development Plan 2011 to 2015 (SNDP) and the Vision 2030 strategy for Zambia. One of the key principles of the NHSP 2011-2015 is that of “partnerships”. In line with this principle, Zambia has established strong partnerships with all the key stakeholders at all the levels of health service delivery. The key partners include relevant government ministries and departments, faith-based health institutions under the coordination of the Churches Health Association of Zambia (CHAZ), communities and Civil Society Organisations (CSOs), and Cooperating Partners (CPs).

In the spirit of the Paris Declaration on Aid Effectiveness of 2005, and the International Health Partnerships and related initiatives (IHP+), Zambia is committed to strengthening of harmonization and coordination of health sector partnerships. To this effect, strong partnership governance and coordination systems and structures have been established, based on the Sector-wide Approaches (SWAp). In this respect, the introduction and consistent conduct of the JAR represents a major step towards harmonization of M&E systems within the health sector. I am pleased to note here that the JAR has continued to generate significant interest and active participation of all the key sector partners.

I wish to end by assuring all our partners of our commitment to continuously strengthen the JAR process, in order to ensure its continued relevance to the health sector objectives on harmonisation. I also wish to take this opportunity to encourage all our partners to actively support and participate in future JARs.

I thank you,

Honourable Dr. Joseph Kasonde, MP
MINISTER OF HEALTH
ACKNOWLEDGEMENTS

On behalf of our ministry and all our sector partners, I am pleased to confirm that the JAR 2011 process has come to a successful conclusion. The process attracted significant interest from a broad range of partners, who actively participated and/or provided valuable technical and logistical support. In this regard, I wish to acknowledge, with thanks, the participation and support rendered to this process by all the stakeholders. Special thanks and mention to the following:

- Senior management at MOH headquarters, for the overall leadership;
- JAR planning committee, for technical leadership;
- Directors, managers, and staff within the various MOH departments, health training institutions, and statutory boards;
- Officials and staff at the Provincial Health Offices (PHOs), District Health Offices (DHOs), and health facilities visited during the field visits;
- Line ministries and government departments, which participated in the World Health Organisation (WHO) the JAR process;
- Cooperating Partners (CPs), led by the lead donors, the World Health Organisation (WHO) and the Embassy of Sweden in Zambia;
- CHAZ and their affiliated faith-based health institutions;
- The University of Zambia (UNZA);
- The private health sector and civil society.

I thank you all, for your participation and support, and look forward to yet another exciting JAR early 2013.

Dr. Peter Mwaba
Permanent Secretary
MINISTRY OF HEALTH
# ACRONYMS AND ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation/Acronym</th>
<th>Definition</th>
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</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>ACTS</td>
<td>Artemesinin-based Combination Therapies</td>
</tr>
<tr>
<td>ANC</td>
<td>Antenatal Care</td>
</tr>
<tr>
<td>ARH</td>
<td>Adolescent Reproductive Health</td>
</tr>
<tr>
<td>ART</td>
<td>Anti Retroviral Therapy</td>
</tr>
<tr>
<td>ARVs</td>
<td>Anti-Retroviral Therapy</td>
</tr>
<tr>
<td>BHCP</td>
<td>Basic Health Care Package</td>
</tr>
<tr>
<td>CDC</td>
<td>Centers for Disease Control</td>
</tr>
<tr>
<td>c-EMOC</td>
<td>Community Emergency Obstetric Care</td>
</tr>
<tr>
<td>CH</td>
<td>Child Health</td>
</tr>
<tr>
<td>CHAZ</td>
<td>Churches Health Association of Zambia</td>
</tr>
<tr>
<td>CIDA</td>
<td>Canadian International Development Agency</td>
</tr>
<tr>
<td>CPs</td>
<td>Cooperating Partners</td>
</tr>
<tr>
<td>CSO</td>
<td>Central Statistical Office</td>
</tr>
<tr>
<td>DFID</td>
<td>Department for International Development</td>
</tr>
<tr>
<td>DHBs</td>
<td>District Health Boards</td>
</tr>
<tr>
<td>DHMT</td>
<td>District Health Management Team</td>
</tr>
<tr>
<td>DOTS</td>
<td>Directly Observed Treatment Short Course</td>
</tr>
<tr>
<td>DPT</td>
<td>Diphtheria Pertusis Tetanus</td>
</tr>
<tr>
<td>DRF</td>
<td>Drug Supply Fund</td>
</tr>
<tr>
<td>DSBL</td>
<td>Drug Supply Budget Line</td>
</tr>
<tr>
<td>EDL</td>
<td>Essential Drugs List</td>
</tr>
<tr>
<td>EMOC</td>
<td>Emergency Obstetric Care</td>
</tr>
<tr>
<td>EPMS</td>
<td>Essential Pharmaceuticals and Medical Supplies</td>
</tr>
<tr>
<td>ESS</td>
<td>Epidemiological Sentinel Surveillance</td>
</tr>
<tr>
<td>EPI</td>
<td>Expanded Programme of Immunization</td>
</tr>
<tr>
<td>EU</td>
<td>European Union</td>
</tr>
<tr>
<td>FAMS</td>
<td>Financial Administrative Management System</td>
</tr>
<tr>
<td>FP</td>
<td>Family Planning</td>
</tr>
<tr>
<td>f-EMOC</td>
<td>Facility Emergency Obstetric Care</td>
</tr>
<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
</tr>
<tr>
<td>GFATM</td>
<td>Global Fund to Fight AIDS, TB, &amp; Malaria</td>
</tr>
<tr>
<td>GRZ</td>
<td>Government of the Republic of Zambia</td>
</tr>
<tr>
<td>HIPC</td>
<td>Highly Indebted Poor Countries</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HMIS</td>
<td>Health Management Information System</td>
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<tr>
<td>Acronym</td>
<td>Full Form</td>
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<tr>
<td>HQ</td>
<td>Headquarters</td>
</tr>
<tr>
<td>ZISSP</td>
<td>Zambia Integrated Systems Strengthening Programme</td>
</tr>
<tr>
<td>ICT</td>
<td>Information Communication Technology</td>
</tr>
<tr>
<td>IEC</td>
<td>Information, Education and Communication</td>
</tr>
<tr>
<td>IMCI</td>
<td>Integrated Management of Childhood Illnesses</td>
</tr>
<tr>
<td>IMR</td>
<td>Infant Mortality Rate</td>
</tr>
<tr>
<td>IRS</td>
<td>Indoor Residual Spraying</td>
</tr>
<tr>
<td>ITNs</td>
<td>Insecticide Treated Nets</td>
</tr>
<tr>
<td>IPTp</td>
<td>Intermittent Preventive Therapy in Pregnant Women</td>
</tr>
<tr>
<td>M &amp; E</td>
<td>Monitoring &amp; Evaluation</td>
</tr>
<tr>
<td>MDGs</td>
<td>Millennium Development Goals</td>
</tr>
<tr>
<td>NDP</td>
<td>National Development Plan</td>
</tr>
<tr>
<td>MMR</td>
<td>Maternal Mortality Ratio</td>
</tr>
<tr>
<td>MoFNP</td>
<td>Ministry of Finance and National Planning</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
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<tr>
<td>MoU</td>
<td>Memorandum of Understanding</td>
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<tr>
<td>MSL</td>
<td>Medical Stores Limited</td>
</tr>
<tr>
<td>MTEF</td>
<td>Medium Term Expenditure Framework</td>
</tr>
<tr>
<td>MVA Kits</td>
<td>Manual Vacuum Aspiration Kits</td>
</tr>
<tr>
<td>NGOs</td>
<td>Non – Governmental Organisations</td>
</tr>
<tr>
<td>NHSP</td>
<td>National Health Strategic Plan</td>
</tr>
<tr>
<td>NMCC</td>
<td>National Malaria Control Centre</td>
</tr>
<tr>
<td>ORET</td>
<td>Ontwikkelings Relevant Export Transakie (Development of Relevant Export Transaction)</td>
</tr>
<tr>
<td>PAC</td>
<td>Post Abortion Care</td>
</tr>
<tr>
<td>PEMFAR</td>
<td>Public Expenditure Management Financial Accounting Reform</td>
</tr>
<tr>
<td>PEPFAR</td>
<td>President’s Emergency Plan for AIDS Relief</td>
</tr>
<tr>
<td>PMTC</td>
<td>Prevention of Mother to Child Transmission</td>
</tr>
<tr>
<td>PRA</td>
<td>Pharmaceutical Regulatory Authority</td>
</tr>
<tr>
<td>QA</td>
<td>Quality Assurance</td>
</tr>
<tr>
<td>RBM</td>
<td>Roll Back Malaria</td>
</tr>
<tr>
<td>RH</td>
<td>Reproductive Health</td>
</tr>
<tr>
<td>RNE</td>
<td>The Royal Netherlands Embassy</td>
</tr>
<tr>
<td>R&amp;D</td>
<td>Research and Development</td>
</tr>
<tr>
<td>RH</td>
<td>Reproductive Health</td>
</tr>
<tr>
<td>SP</td>
<td>Sulphadoxine Pyrimethamine</td>
</tr>
<tr>
<td>SIDA</td>
<td>Swedish International Development Agency</td>
</tr>
<tr>
<td>SMAGs</td>
<td>Safe Motherhood Action Groups</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<tr>
<td>STGs</td>
<td>Standard Treatment Guidelines</td>
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<tr>
<td>SWAp</td>
<td>Sector Wide Approach</td>
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<tr>
<td>Abbreviation</td>
<td>Full Form</td>
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<td>--------------</td>
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</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>ToTs</td>
<td>Training of Trainers</td>
</tr>
<tr>
<td>TI</td>
<td>Training Institution</td>
</tr>
<tr>
<td>TTIs</td>
<td>Transfusion Transmitted Infections</td>
</tr>
<tr>
<td>TWGs</td>
<td>Technical Working Groups</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
</tr>
<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
</tr>
<tr>
<td>VCT</td>
<td>Voluntary Counseling and Testing</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
</tr>
<tr>
<td>ZANARA</td>
<td>Zambia National Response to HIV / AIDS</td>
</tr>
<tr>
<td>ZDHS</td>
<td>Zambia Demographic and Health Survey</td>
</tr>
<tr>
<td>ZNBTS</td>
<td>Zambia National Blood Transfusion Services</td>
</tr>
<tr>
<td>ZNF</td>
<td>Zambia National Formulary</td>
</tr>
<tr>
<td>ZPPA</td>
<td>Zambia Public Procurement Authority</td>
</tr>
<tr>
<td>ZMK</td>
<td>Zambian Kwacha (Zambian Currency)</td>
</tr>
<tr>
<td>&lt;5 children</td>
<td>Children under the age of five years.</td>
</tr>
</tbody>
</table>
1 EXECUTIVE SUMMARY

1.1 Introduction

Zambia is committed to the strengthening of health sector partnerships, through the establishment and maintenance of appropriate systems and structures for harmonization and coordination. The Joint Annual Review (JAR) process is an important tool for harmonization of the Monitoring and Evaluation (M&E) systems for the health sector partners. This report presents the background, process, findings and recommendations of the JAR for 2011 (JAR 2011), jointly conducted by MOH and health sector partners, between February and April 2012.

1.2 Objective, Thematic Areas and Process

1.2.1 Objective

To carry out a joint review of health sector performance for 2011, with special emphasis on selected key thematic areas, and ensuring broad participation of the partners in both the planning and execution of the review.

1.2.2 Key Thematic Areas

Focused at reviewing performance in all the six health system building blocks.

1.2.3 Process

The review process included: desk review of relevant documents and reports; semi-structured interviews with key stakeholders; field visits to the Southern and Lusaka Provinces; presentation of findings and recommendations at the Sector Advisory Group (SAG) meeting health in April 2012; and preparation of this report.

1.3 Main Findings

1.3.1 Overview

Over the past 11 years, from 2000 to 2011, the health sector has made significant progress in most of the key programme areas. However, notwithstanding the achievements made, the disease burden is still unreasonably high, and there are still some gaps in health service delivery. This part of the report presents a summary of the key findings and recommendations of the JAR 2011 process.
1.3.2 Main Findings and Recommendations

<table>
<thead>
<tr>
<th>#</th>
<th>ACHIEVEMENTS</th>
<th>CONSTRAINTS AND CHALLENGES</th>
<th>RECOMMENDATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Health service delivery</td>
<td>1. Significant increase in access to health services, due to removal of user fees at all levels.</td>
<td>Overcrowding and overloading of health workers, due to rapid increase in uptake/access to services.</td>
<td>Lobby government to</td>
</tr>
<tr>
<td></td>
<td>2. Significant reductions in malaria incidence and impact.</td>
<td>Inadequate supply of Insecticide Treated Nets (ITNs). Malaria resurgence in some areas.</td>
<td>Scale up malaria interventions, packaged according to epidemiological zones.</td>
</tr>
<tr>
<td></td>
<td>3. Increase in skilled deliveries (92% in 2010 to 93% in 2011).</td>
<td>Reduction in institutional deliveries, ANC and PNC levels.</td>
<td>Increase investment in MNCH infrastructure and logistics services.</td>
</tr>
<tr>
<td>B. Health Workforce/ Human Resources for Health</td>
<td>1. Increase in health workers, due to recruitments.</td>
<td>Health workers still inadequate.</td>
<td>Lobby for increased funding for recruitments.</td>
</tr>
<tr>
<td></td>
<td>2. Increase is outputs from health training institutions (TIs).</td>
<td>Limitations in capacities of TIs to support increased intakes of students.</td>
<td>Increase funding to capacity/infrastructure expansion at TIs.</td>
</tr>
<tr>
<td></td>
<td>3. Staff performance management system implemented at head office.</td>
<td>Staff performance management system not rolled out to lower levels, facilities.</td>
<td>Implement staff performance management system at lower levels.</td>
</tr>
<tr>
<td>C. Medical Products, Infrastructure, Equipment</td>
<td>1. Supply of Health Centre (HC) kits improved, under the “push” system.</td>
<td>Stock outs of some items ordered under the “pull” system were frequently out of stock/not delivered: ORS; DBS Bundles; X-ray films; and diabetes test strips and drugs.</td>
<td>Improve the procurement and logistics management for essential drugs and medical products</td>
</tr>
<tr>
<td>#</td>
<td>MAIN ACHIEVEMENTS</td>
<td>MAIN CONSTRAINTS AND CHALLENGES</td>
<td>MAIN RECOMMENDATIONS</td>
</tr>
<tr>
<td>----</td>
<td>-------------------</td>
<td>---------------------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>3.</td>
<td>Engagement of provincial equipment engineers for maintenance of medical equipment.</td>
<td>Shortages of essential medical equipment: e.g., Incinerators, Haemoglobinometers, Blood Count Machines, Chemistry Analysers, CD4 Machines, Centrifuges (General &amp; Haematocrit), Distillers, Autoclaves, and Dental Chairs.</td>
<td>Prioritise the procurement of essential medical equipment and accessories.</td>
</tr>
</tbody>
</table>

**D. Health Information and Research**

1. Engagement of provincial and district information/data management officers. | Shortages of data entry staff at facility level – Not included in establishments. | Consider including data entry staff at facility level in the new establishment. |
2. Improvements in report completeness and timeliness (95% facilities reporting on time). | • Shortages of HMIS stationery.  
• Challenges with the use of CSO population data for health coverage indicators. | • Ensure timely supply of HMIS stationery.  
• Engage CSO to address the issue of CSO population data. |

**E. Health Financing**

1. Increased government grants/funding. | Funding still inadequate and below the Abuja Declaration benchmark. | Increase funding, towards Abuja benchmark. Improve prioritization. |
2. IFMIS system implemented at MOH Head Office | IFMIS not rolled out to lower levels. | Roll out IFMIS and other financial and administrative systems to lower levels |
3. Support from CPs normalized. | Inadequate donor funding to MOH. | Lobby CPs for increased support and harmonization of funding systems. |

**F. Leadership and Governance**

2 BACKGROUND

2.1 Context

Zambia is committed to the establishment of efficient and effective partnerships and coordination mechanisms in the health sector. Strong and broad-based partnerships have been established with key stakeholders at all levels of health service delivery, namely at national, provincial, district and community levels. The main partners include relevant government line ministries and departments, faith-based health sector under the coordination of the Churches Health Association of Zambia (CHAZ), international Cooperating Partners (CPs), the private sector, the civil society and the communities.

The health sector partnerships in Zambia are founded upon the principles of the Paris Declaration on Aid Effectiveness of 2005 (Paris Declaration), and the International Health Partnerships and related initiatives (IHP+), which advocate for strong harmonization and coordination of health partnerships. In this respect, the introduction of the JAR since 2006 represents an important milestone towards harmonization of the M&E systems in the health sector.

2.2 Country Profile

2.2.1 Geographical and Demographic Overview

Zambia is strategically located within the central part of the southern part of Sub-Saharan Africa. It covers an area of 752,612 Km², and is surrounded by Tanzania and the Democratic Republic of Congo (DRC) in the North, Malawi and Mozambique in the East, Zimbabwe, Botswana and Namibia in the South and Angola in the West. The country is also known for its peace and political stability, which provide for a favourable environment for implementing various socio-economic programmes, including health services, in peace and tranquillity. Table 1 below presents a summary of selected demographic data.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Source</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>CSO, 2010 Census</td>
<td>13.06 million</td>
</tr>
<tr>
<td>Average Annual Population Growth Rate</td>
<td>CSO, 2010 Census</td>
<td>2.8%</td>
</tr>
<tr>
<td>Male : Female Ratio</td>
<td>CSO, 2010 Census</td>
<td>0.49 : 0.51</td>
</tr>
<tr>
<td>Population Under the Age of 15 Years (%)</td>
<td>CSO, 2010 Census</td>
<td>47%</td>
</tr>
<tr>
<td>Urban Population</td>
<td>CSO, 2010 Census</td>
<td>39%</td>
</tr>
<tr>
<td>Poverty Levels</td>
<td>CSO, ZDHS 2007</td>
<td>67% (overall)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>72% (Extreme)</td>
</tr>
<tr>
<td>Human Development Index (HDI)</td>
<td>UNDP, Zambia - Human</td>
<td>0.395</td>
</tr>
<tr>
<td></td>
<td>Development Report, 2010</td>
<td></td>
</tr>
</tbody>
</table>
2.2.2 Socio-Economic Overview

Zambia is rich in natural resources, including varied minerals, arable land and favourable climate for agriculture, water resources and wildlife. The national long-term development agenda is currently being guided by the “Vision 2030” strategy, a long-term plan, aimed at transforming the country into a “prosperous middle-income country by 2030”. This strategy is being implemented through the development and implementation of 5-year National Development Plans (NDPs), with the current one being the Sixth National Development Plan 2011 to 2015 (SNDP).

Over the past two decades, the country has registered significant socio-economic development. The average annual real Gross National Product (GDP) growth rate over the past 5 years, from 2006 to 2010, was estimated at 6.42%. This development has led to the country’s graduation from among the Least Developed Countries (LDCs), to among the Low-Medium Developed Countries (LMDCs). Table 2 presents trends in selected macro-economic indicators for the period from 2006 to 2010.

Table 2: Zambia: Trends in Selected Economic Indicators, 2006-2010

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Unit</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Real GDP Growth Rate</td>
<td>%</td>
<td>6.2</td>
<td>6.2</td>
<td>5.7</td>
<td>6.4</td>
<td>7.6</td>
</tr>
<tr>
<td>Inflation (year-end)</td>
<td>%</td>
<td>8.2</td>
<td>8.9</td>
<td>16.6</td>
<td>9.9</td>
<td>7.9</td>
</tr>
<tr>
<td>Lending Interest Rates (year-end)</td>
<td>%</td>
<td>27.9</td>
<td>24.4</td>
<td>29.9</td>
<td>29.2</td>
<td>26.4</td>
</tr>
<tr>
<td>Exchange Rate (year-end)</td>
<td>ZMK/US$</td>
<td>4,132.00</td>
<td>3,835.75</td>
<td>4,882.34</td>
<td>5,033.95</td>
<td>4,798.36</td>
</tr>
<tr>
<td>External Debt Stock (including Private and Parastatal)</td>
<td>USS’M</td>
<td>1,859.3</td>
<td>2,086.9</td>
<td>2,125.6</td>
<td>3,807.8</td>
<td>3,367.7</td>
</tr>
</tbody>
</table>

Source: Zambia – Economic Reports, Ministry of Finance and National Planning

However, it should be noted here that, the impressive economic performance that the country has recorded has not yet adequately impacted on the lives of the majority, most of whom have remained poor and marginalised, largely due to inequitable distribution of wealth across the different categories of the population. The major constraints and challenges facing the country include: the high poverty levels, particularly in rural areas; high unemployment levels, particularly among the youths; weak social-safety nets; high burden of diseases; infrastructure challenges; and geographical and social barriers. It should be noted that all these constraints and challenges have significant implications on health service delivery.
2.3 Health Sector Profile

2.3.1 Disease Burden

Zambia has over the past decade (2000 to 2010) recorded significant improvements in health, leading to reductions in the burden of disease. Major achievements included: the reductions in malaria incidence from 412 per 1000 population in 2006 to 330 in 2010 (MIS 2010); and the reduction in HIV prevalence among adults between the ages of 15 and 49 years from 16.1% in 2002 to 14.3% in 2007. Other key achievements included: the reduction in Maternal Mortality Ratio (MMR) from 729 per 100000 live births in 2002 to 591 in 2007; reduction in Neonatal Mortality Rate (NMR) from 37 per 1000 live births in 2002 to 34 in 2007; Infant Mortality Rate (IMR) from 95 per 1000 live births in 2002 to 70 in 2007; and Under-Five Mortality Rate (U5MR) from 168 per 1000 live births in 2002 to 119 (ZDHS 2007).

It should be noted though that these reductions were not adequate. As a result, the burden of disease is still high. The burden is characterized by: the high prevalence and impact of communicable diseases, particularly malaria, HIV and AIDS, and tuberculosis (TB); high levels of maternal, neonatal and child morbidity and mortality; and a growing burden of non-communicable diseases (NCDs). During the year under review, the top 10 causes of morbidity and mortality in Zambia include malaria, respiratory infections (non-pneumonia), diarrhoea (non-blood), trauma (accidents, injuries, wounds and burns), eye infections, skin infections, respiratory infections (pneumonia), ear, nose and throat infections, intestinal worms and anaemia.

2.3.2 Health Sector Structure

The health sector in Zambia could be divided into four main categories, namely: the sector governance and administrative structures, which include the SAG/SWAp structures, MOH Head Office in Lusaka, Provincial Health Offices (PHOs) and District Health Offices (DHOs); core health service delivery facilities, including hospitals at different levels, health centres (HCs), and Health Posts (HPs); health training institutions, at different levels; and statutory boards, which include service and regulatory statutory boards.

2.3.3 Health Facilities

The core health facilities in Zambia are classified at 4 main levels, namely: HPs and HCs at community level; Level-1 hospitals (L-1H) at district level; Level – 2 hospitals at provincial level (L-2H); and Level-3 hospitals (L-3H) at tertiary level.

---

1 Health Management Information System (HMIS) Reports for 2009 and 2010
As regards ownership, there are three categories of health service providers, namely: the public/state owned facilities, which include health facilities under MOH, military and other government departments; faith-based health institutions under the coordination of CHAZ; and private/civil society owned health facilities. Table 3 presents a summarized analysis of the existing core health facilities in Zambia, by level and ownership.

### Table 3: Zambia: Health Facilities by Type, Size and Ownership, 2011

<table>
<thead>
<tr>
<th>Description</th>
<th>Central</th>
<th>Copperbelt</th>
<th>Eastern</th>
<th>Luapula</th>
<th>Lusaka</th>
<th>Northern</th>
<th>North Western</th>
<th>Southern</th>
<th>Western</th>
<th>Zambia</th>
</tr>
</thead>
<tbody>
<tr>
<td>A) By Level of Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level 3 Hospitals</td>
<td>164</td>
<td>211</td>
<td>132</td>
<td>116</td>
<td>189</td>
<td>137</td>
<td>217</td>
<td>159</td>
<td></td>
<td>1,489</td>
</tr>
<tr>
<td>Level 2 Hospital</td>
<td>10</td>
<td>16</td>
<td>7</td>
<td>8</td>
<td>14</td>
<td>22</td>
<td>24</td>
<td>11</td>
<td></td>
<td>122</td>
</tr>
<tr>
<td>Level 1 Hospital</td>
<td>14</td>
<td>61</td>
<td>0</td>
<td>3</td>
<td>155</td>
<td>13</td>
<td>8</td>
<td>13</td>
<td>4</td>
<td>271</td>
</tr>
<tr>
<td>Urban Health Centres</td>
<td>32</td>
<td>137</td>
<td>8</td>
<td>1</td>
<td>182</td>
<td>14</td>
<td>18</td>
<td>34</td>
<td>10</td>
<td>436</td>
</tr>
<tr>
<td>Rural Health Centres</td>
<td>113</td>
<td>53</td>
<td>156</td>
<td>125</td>
<td>47</td>
<td>145</td>
<td>120</td>
<td>174</td>
<td>127</td>
<td>1,060</td>
</tr>
<tr>
<td>Health Posts</td>
<td>35</td>
<td>25</td>
<td>53</td>
<td>10</td>
<td>32</td>
<td>49</td>
<td>17</td>
<td>30</td>
<td>24</td>
<td>275</td>
</tr>
<tr>
<td>Total</td>
<td>188</td>
<td>235</td>
<td>227</td>
<td>142</td>
<td>279</td>
<td>216</td>
<td>167</td>
<td>254</td>
<td>174</td>
<td>1,882</td>
</tr>
</tbody>
</table>

| B) By Type of Ownership|         |            |         |         |        |          |               |          |         |        |
| Public Health Facilities| 164     | 211        | 132     | 116     | 189    | 137      | 217           | 159      |         | 1,489  |
| Mission Health Facilities| 10      | 16         | 7       | 8       | 14     | 22       | 24            | 11       |         | 122    |
| Private Health Facilities| 14      | 61         | 0       | 3       | 155    | 13       | 8             | 13       | 4       | 271    |
| Total                  | 188     | 235        | 227     | 142     | 279    | 216      | 167           | 254      | 174     | 1,882  |

Source: Health Institutions in Zambia, Ministry of Health, 2010

### 2.3.4 Health Sector Strategy and Priorities

During the year under review, the national health agenda was guided by the sector Annual Action Plan and Budget for 2011, and the National Health Strategic Plan 2011-2015 (NHSP 2011-2015). The NHSP 2011-2015 is linked to the SNDP and Vision 2030.

### 2.3.5 Mission, Vision and Principles

<table>
<thead>
<tr>
<th>Mission Statement:</th>
<th>To provide equitable access to cost effective, quality health services as close to the family as possible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision:</td>
<td>Equitable access to cost-effective and quality health care by 2030</td>
</tr>
<tr>
<td>Overall Goal:</td>
<td>To improve the health status of people in Zambia in order to contribute to socio-economic development</td>
</tr>
</tbody>
</table>
Key Principles: Primary Health Care (PHC) approach; Equity of access; Affordability; Cost-effectiveness; Accountability; Partnerships; Decentralisation and Leadership

2.3.6 National Health Priorities

Table 4 below highlights the National Health Priorities for the period from 2011 to 2015.

<table>
<thead>
<tr>
<th>S/N</th>
<th>Priority Area</th>
<th>Objective and Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Primary health care.</td>
<td>To provide cost-effective, quality and gender sensitive primary health care services to all as defined in the Basic Health Care Package.</td>
</tr>
<tr>
<td>2.</td>
<td>Maternal, neonatal and child health (MNCH).</td>
<td>To reduce U5MR from 119 per 1,000 live births in 2007 to 119 by 2015. To increase access to integrated reproductive health and family planning services and thereby, reduce Maternal Mortality Ratio (MMR) from 591 per 100,000 live births in 2007 to 159 by 2020. To mainstream the provision of comprehensive adolescent friendly health services at all levels, so as to reduce their vulnerability. To halt and reduce the incidence of malaria from 252 per 1000 population in 2010, to 75 by 2015, by targeting appropriate packages of interventions based on the identified malaria epidemiological zones. To halt and begin to reduce the spread of HIV/AIDS and STIs by increasing access to quality HIV/AIDS, STI and blood safety interventions. To halt and begin to reduce the spread of TB through effective interventions.</td>
</tr>
<tr>
<td>3.</td>
<td>Communicable diseases, particularly malaria, HIV and AIDS, STIs, TB and Neglected Tropical Diseases (NTDs).</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Non-Communicable Diseases (NCDs).</td>
<td>To significantly strengthen national response to NCDs and consistently reduce the prevalence of these diseases</td>
</tr>
<tr>
<td>5.</td>
<td>Epidemics control and public health surveillance.</td>
<td>To significantly improve public health surveillance and control of epidemics, so as to reduce morbidity and mortality associated with epidemics.</td>
</tr>
<tr>
<td>6.</td>
<td>Environmental health and food safety.</td>
<td>To promote and improve hygiene and universal access to safe and adequate water, food safety and acceptable sanitation, with the aim of reducing the incidence of water and food borne diseases.</td>
</tr>
<tr>
<td>7.</td>
<td>Hospital referral services.</td>
<td>To increase access to and quality of advanced referral medical care services, including mobile outreach services, in order to ensure efficient and effective continuity of care.</td>
</tr>
</tbody>
</table>

Source: Ministry of Health, NHSP 2011-2015
3 OBJECTIVES AND PROCESS

3.1 Objective

To carry out a joint review of health sector performance for 2011, with special emphasis on selected key thematic areas, and ensuring broad participation of the partners in both the planning and execution of the review.

3.2 Key Thematic Areas

The review focused on reviewing sector performance in all the six health system building blocks, namely: health service delivery; human resource for health; medical products, infrastructure, equipment and transport; health information; healthcare financing; and leadership and governance.

3.3 Process

The review included the following stages:

- Desk review of relevant literature, documents and reports;
- Semi-structured interviews with programme managers, sector partners and other key stakeholders;
- Field visits to the Southern and Lusaka Provinces;
- Presentation of findings and recommendations at the Sector Advisory Group (SAG) meeting in April 2012; and
- Preparation of this report.

3.4 Field Visits

The process included field visits to 2 provinces: Lusaka Province; and Southern Province. The visits covered both the urban and rural facilities. The sites visited within these provinces included:

- Provincial Health Offices (PHOs).
- District Health Offices (DHOs).
- Hospitals (public and faith-based facilities).
- Health Centres (HCs), both urban and rural HCs.
- Health Posts (HPs).
- Health training institutions (TIs) and health statutory boards (SBs).
3.4.1 Profile of Lusaka Province

3.4.1.1 Overview

Lusaka province is centrally located and comprises 4 districts, i.e. Lusaka, Chongwe, Kafue and Luangwa districts, as shown in Figure 1. Lusaka district is the capital of Zambia and the most urbanized district in the country. The following are the key statistics on Lusaka province:

- Population: 2.3 Million or 17% of the Zambian population.
- Comprises of 4 districts.
- Predominantly urban.
- A total of 279 Health facilities (see Table 6 for details).
- Service sites: 45 ART sites; 85 PMTCT Sites; 104 CT sites; 28 Delivery Sites; 18 MC Sites

3.4.1.2 Places Visited

- Districts visited: Lusaka, Chongwe, Kafue and Luangwa.
3.4.2 Profile of Southern Province

3.4.2.1 Overview

The Southern Province is located in the southern part of Zambia and shares international boundaries with Botswana, Namibia and Zimbabwe. It covers approximately 88,808 Km², representing 11.8% of the total area of Zambia and has a total of 11 districts, namely Livingstone, Choma, Mazabuka, Kalomo, Monze, Gwembe, Sinazongwe, Siavonga, Namwala, Itezhi-tezhi and Gwembe. Figure 2 presents the map of the Southern Province.

The following are the key statistics on the province:

- Population: 1.7 Million people.
- Population density: 19.14 people per K²m.
- 11 Districts, predominantly rural. Approximately 85% of the population lives in rural areas and 15% in urban areas.
- 254 Health facilities (see Table 5 for details).
- Service sites: 48 ART sites; 234 PMTCT Sites; 240 CT sites; 41 TB Sites; 245 TB Treatment sites; and 18 MC Sites
- The main causes of illness: malaria, respiratory infections, STIs and HIV/AIDS.
4 REVIEW FINDINGS

4.1 Overview

Over the past decade, the Zambian health sector has recorded significant progress in all the key priority areas. The achievements included: the significant reduction in malaria incidence and impact; reduction in HIV prevalence; increase in the number of eligible adults and children receiving free Anti-Retroviral Treatment (ART); increase in TB cure rates; and reductions in MMR, NMR, IMR and U5MR. However, whilst the health sector has continued to record significant achievements, there are still a number of challenges, which hamper its efforts towards attainment of the national health objectives.

4.2 Health Service Delivery

4.2.1 Overview

The scope of health service delivery comprises promotive, preventive, curative and rehabilitation health care services. These services are provided at different levels, from HPs and HCs at community level, up to tertiary hospital level. They also include special health programmes, targeting specific health problems, and community health services provided by community health partners. The JAR 2011 sought to review the performance of health service delivery systems at different levels. Figure 3 shows huge response, due to increased access arising from the removal of user fees.

Figure 3: Chelstone Health Centre, Lusaka – Increased access, due to removal of user fees

Source: Chelstone Health Centre, Lusaka
4.2.2 General Findings

4.2.2.1 Main Achievements

- Rapid increase in access to health facilities/services, attributed to the removal of user fees at all public and CHAZ health facilities, announced by the Government in October 2011.
- It was also observed that the ministry had continued with the construction of more health facilities, including rehabilitation of some existing facilities and construction of new facilities across the country, including hospitals, RHCs, UHCs and HPs.
- Construction of the Levy Patrick Mwanawasa (LPM) General Hospital in Lusaka was completed and the hospital was opened to the public. This is expected to help reduce congestions at the University Teaching Hospital (UTH) in Lusaka.

4.2.2.2 Main Constraints/Challenges:

- Over-crowding of health facilities and increase in workloads, due to increased access, precipitated by the removal of user fees at all health facilities.
- Infrastructure and capacity challenges at health facilities versus the rapid increase in demand for health services at all levels.
- Referral system challenges. Weak referral systems, especially between the public and private health facilities. This leads to overcrowding of higher level facilities with conditions that could be attended to at lower levels.
- Weak monitoring and control on private health facilities: weak controls on prescription of medicines, harmonization of treatment protocols, and reporting.
- Challenges with the use of Central Statistical Office (CSO) population data as denominators for coverage indicators, as opposed to head count data.

Text Box 1: Feedback from patients interviewed using the patient interview tool:

- Long waiting times, esp. in Lusaka district.
- Providers not always attentive to patients – staff attitude.
- Health conditions are often unexplained.
- Confidentiality not always respected.

HOWEVER~

- 75% of patients in Kafue listed service at facility as “Good” and helpfulness of staff to be “Good” or “Very Good”
- Most patients would return to the same facility
4.2.3 Communicable Diseases

Communicable diseases are among the key drivers of the disease burden in Zambia. The major communicable diseases, responsible for high levels of morbidity and mortality in the country, include: malaria; HIV, AIDS and STIs; TB; and the neglected tropical diseases (NTDs). The key findings in respect of these diseases are summarized below.

4.2.4 Malaria Prevention, Care and Treatment

4.2.4.1 Overview

Malaria is a major public health priority in Zambia and has for a long time remained the leading cause of morbidity and mortality. Whilst significant reductions in malaria incidence and impact have been reported, malaria still remains among the major causes of morbidity and mortality in the country. In this regard, the country, through the National Malaria Control Programme (NMP), has continued to implement high-impact control strategies, aimed at transforming Zambia into a malaria-free country, including:

- **Prevention**: Vector control, using Indoor Residual Spraying (IRS) and Insecticide Treated Nets (ITNs); Intermittent Presumptive Treatment (IPT) of Malaria in Pregnancy (MIP); and Behaviour Change Communication (BCC).
- **Treatment**: introduction and scaling out of the use of Rapid Diagnostic Tests (RDTs) in health facilities that do not have microscopy services; and Malaria Case Management (MCM), based on Coartem use.

These interventions are packaged and tailored to the characteristics and needs of the established malaria epidemiological zones. During the year under review, the country continued to make significant progress in the fight against malaria. This led to major reductions in malaria incidence and impact.

4.2.4.2 Objectives

- To halt and reduce the incidence of malaria from 252 per 1000 population in 2010, to 75 by 2015.
- To reduce Malaria Case Fatality Rate among children below the age of 5 years from 38 per 1000 in 2008 to 20 by 2015.
4.2.4.3 Main Achievements

- Generally, significant progress was reported across the country, with exceptions of the Eastern, Northern and Luapula provinces, which suffered some reversals in progress made.

- Major reductions in malaria incidence and impact were reported:
  - **Lusaka Province:** Lusaka city and its environs recorded significant reductions in parasite prevalence and transmission. Parasite prevalence remained below 1%.
  - **Southern Province:** Kazungula district: significant reductions in malaria incidence (both clinical and confirmed) were reported. Malaria incidence dropped from 20/1000 in 2010 to 6/1000 in 2011 (see Figure 4). The district has since started focusing at eradication.

- Scaling up of the use of malaria diagnostics at facility and community levels. Almost all the health facilities visited, confirmed significant increases in the use of malaria diagnostics, including Rapid Diagnostics Tests (RDTs) and microscopic tests.

- IRS was conducted in eligible districts.

- Stocks of RDTs and ACTs were generally good.

- NMCP maintained and strengthened malaria partnerships at national, district and community levels. Good working relations and support from the key partners, particularly the WHO, Unicef, the World Bank, the UN/Global Fund to Fight AIDS, TB and Malaria (GFATM); the USG Presidential Malaria Initiative (PMI), and MACEPA/PATH. Also maintained strong partnerships with local and international Civil Society Organisations (CSOs) and community partners, involved in malaria control. Malaria community agents were trained and supplied with RDTs and ACTs.

4.2.4.4 Main Constraints and Challenges

- Inadequate supply of ITNs. As a result, some regions were not adequately supported with ITNs.

- Treatment of malaria was not strictly based on diagnostic results. Even though there was a significant increase in the use of malaria diagnosis at health facilities and in the communities, it was reported that clinical decisions were not always based on diagnostic results. Whilst some health facilities, e.g. Chelstone HC reported that they strictly base their treatment on test results, other centres confirmed that they sometimes base it on clinical presentations.

- Cases of improper use of ITNs were reported. It was also reported that some people are reluctant to use ITNs, due to myths.
Figure 4: Kazungula District: Trends in Malaria Control - 2011

Source: Ministry of Health, Kazungula District Health Office

4.2.5 HIV and AIDS, and STIs Prevention, Care and Treatment

4.2.5.1 Overview

Zambia is among the countries that are most affected by the HIV and AIDS epidemic in the world. Sexually Transmitted Infections (STIs) also present a major problem. However, the country is implementing a comprehensive multi-sector HIV and AIDS strategy, with significant success. This strategy focuses at implementing high impact evidence-based interventions across the country. During the year under review, the efforts were directed at scaling up the main interventions.

- **Prevention**: BCC; Voluntary Counseling and Testing (VCT); Abstinence, Be faithful and Condom use (ABC) strategy; promotion of proper use of condoms; male circumcision (MC); Prevention of Mother-to-Child Transmission of HIV (PMTCT); blood safety and universal precautions; injection safety; and Post Exposure Prophylaxes (PEP).
- **Treatment**: expansion of access to free Anti-Retroviral Treatment (ART), for both adults and children.
- **Care and support**: expansion of access to care and support services for people living with HIV and their households. The main strategies being used include the Home Based Care (HBC) approach, Orphans and Vulnerable Children (OVC) strategy and various economic empowerment and support initiative targeted at the HIV infected and the affected.
- **Treatment of STIs**: promotion of BCC, screening and early testing for STIs, particularly syphilis, treatment and care services.
These interventions were delivered through a combination of methods, including health facilities, outreach health services, community-based interventions, family-centred approaches, and workplace policies.

4.2.5.2 Strategic Objectives

- Reduce the spread of HIV and STIs, by scaling up and increasing access to high impact HIV and STIs prevention interventions.
- Increase access to high quality curative and care services for people living with AIDS, in order to increase their quality of life and life expectancy.

4.2.5.3 Main Achievements

- Major achievements were reported in the fight against HIV and AIDS, and STIs across the country.
- HIV testing and counseling (T&C) services: Significant increases in the numbers of people testing for HIV and STIs at the designated T&C and PMTCT sites were reported:
  - Lusaka province: The percentage of people testing for HIV and collecting results increased from 82% to 95%.
  - Southern province: 4TH Qtr 2011: Tested = 98%; HIV positive =13%; Received results =100%; Referred for ART=99%.
- Male Circumcision (MC): Significant promotion and scaling up of MC services across the country, by MOH facilities, and through partnerships with civil society organizations (CSOs).
- PMTCT: Strengthening and expansion of PMTCT coverage continued:
  - National level: The percentage of HIV infected women who received antiretroviral treatment to reduce the risk of mother to child transmission increased from 81% in quarter 1 to 100% in quarter 4.
  - Increase in PMTCT sites.
- Blood safety and universal precautions: Strengthening and scaling up blood safety support towards meeting national blood needs:
  - Maintained 100% dependency on voluntary non-remunerated blood donors.
  - Strengthened mandatory laboratory screening of all donated blood, using nationally and WHO methods.
  - Scaled up promotion of appropriate clinical use of blood and blood products.
- ART support: Increases in free ART coverage:
  - National level: The total number of eligible persons living with HIV receiving ARV therapy (total including children and adults) increased from 344,426 in Quarter 4 of 2010 to 415,685 in quarter 4 of 2011.
– Lusaka province: ART uptake increased from 69,864 in 2010 to 78,978 for the 14+ age group. (see Figure 5).
– Southern province: Increase in ART clients (cumulative) from 62,273 in Q1 2011 to 71,478 in Q4 2011 (increase by 15%).

- Strong partnerships at national, district and community levels:
  – Significant financial and technical support from CPs, particularly the UN/GFATM Round 8 grant; the USG/President’s Emergency Fund for AIDS Relief (PEPFAR) phase 2 funding, provided various public and private health-related institutions, predominantly through the project mode. PEPFAR-2 will cover the period from 2010 to 2015; other bilateral partners and projects.
  – Active participation and support from various local and international Civil Society Organisations, involved in the provision of various HIV and AIDS prevention, cure, care and support services at different levels.
  – Strengthening of community participation through community HIV and AIDS partners and structures.

4.2.5.4 Main Constraints and Challenges

- Capacity challenges versus increases in demand for HIV and STIs services. At most of the facilities/sites visited, the numbers of clients for HIV testing and ART services have exceeded the established capacities by several folds.
- Limitations in laboratory capacities, leading to delays in test results. Some facilities/sites are:
  – Unable to do viral loads tests – regimen change based on immunologic failure.
  – Experience delays in obtaining results for CD 4 count.
  – In the Southern Province, it was reported that, on average, it takes approximately 2 weeks to get the test results. Follow-up labs are also behind schedule.
  – Stock outs of DBS supplies and delays in getting DBS test results were reported.
- Shortages of ARVs, experienced at the beginning of 2011. Attributed to supply and distribution challenges.
- It was also reported that at some facilities (e.g. Maramba HC in Livingstone), treatment failures are identified, but no appropriate actions taken.
- Stock-outs of syphilis/RPR test kits for testing pregnant mothers.
4.2.6 Tuberculosis Control

4.2.6.1 Overview

TB is among the major public health concerns and priorities in Zambia. The country has adopted the WHO Stop TB Strategy, based on the Directly Observed Treatment Scheme (TB-DOTS). There is universal facility coverage with TB-DOTS services in all the provinces in the country and microscopy services have been expanding progressively since 2006. Over the past 5-6 years, the country has continued to make significant progress in TB control, resulting in the reduction of TB Case Notification Rates and increase in TB cure rates. During the year under review, the health sector continued with the scaling up of effective TB prevention, treatment and care services, based on the national TB strategy.

4.2.6.2 Strategic Objectives

- To detect at least 70% of the infectious TB cases.
- To successfully treat 85% of the TB infectious cases detected.
4.2.6.3 Main Achievements

- Universal coverage of TB DOTS was maintained in all the provinces.
- Improvements in TB notification and cure rates:
  - National level: TB notification rate increased from 70% in 2009 to 91% in the 4th quarter of 2010 and 96% in the 4th quarter of 2011 (HMIS 2011).
  - Southern Province: TB Cure Rate improved, from 80% in 2006 to 86% in 2010 and 89% in 2011 (Provincial and district reports).
- Continued with the expansion of microscopy services for TB diagnosis across the country.
- Strengthening and scaling up of TB/HIV co-infection treatment services.
- TB Control: Improvements in TB cure rates. TB/HIV activities.

4.2.6.4 Main Constraints and Challenges

- Lack of TB isolation rooms at some health facilities, e.g. Kazungula.
- High TB/HIV co-infection rate, estimated at 70%.

4.2.7 Maternal, Neonatal and Child Health

4.2.7.1 Overview

Maternal, Neonatal and Child Health (MNCH) is among the national health priorities and MDGs. Even though Zambia has recorded major improvements in MNCH, the country still remains among the countries with the highest levels of maternal, neonatal and child morbidity and mortality in the world.

The country has adopted a comprehensive approach to MNCH, with high impact strategies, which include: Family Planning (FP), with special focus on Long-term Family Planning Methods (LTFP) and rural areas; expansion of Essential Obstetrics and Newborn Care (EmONC); expansion of Antenatal Care (ANC), delivery and post-natal services; establishment and rolling out of Safe Motherhood Action Groups (SMAGs); Maternal Death Reviews (MDR); screening, treatment and care for cervical, breast and prostate cancers; training, recruitment and retention of midwives; promotion of continuum of care, from Traditional Birth Attendants (TBAs) to referral health facilities; and strengthening of health education and promotion.

Child adolescent health strategies include the Expanded Programme on Immunization (EPI), Integrated Management of Child Illnesses (IMCI), and the promotion of Adolescent Friendly Health Services (AFHS).
During the year under review, efforts were directed at further strengthening and scaling up of high-impact MNCH strategies, guided by the National MNCH Roadmap 2011-2015 and NHSP 2011-2015.

### 4.2.7.2 Strategic Objectives

- To reduce Maternal Mortality Ration (MMR) from 591 per 100000 live births in 2007 to 159 by 2015.
- To reduce Under-Five Mortality Rate (U5MR) from 119 per 1000 live births in 2007 to 63 by 2015.
- To reduce the incidence of teenage pregnancies.

### 4.2.7.3 Main Achievements

- Improvements in maternal and neonatal health:
  - CARMA interventions were implemented in hard-to-reach areas.
  - Southern province reported high Antenatal Care (ANC) coverage (Southern Province - 70%; Gwembe district – 85%).
  - Increase in deliveries attended by skilled health personnel. At national level, the percentage of deliveries attended by skilled health personnel increased from 41% in 4th quarter of 2010 to 45% in 4th quarter of 2011.
  - Scaling up of Family Planning (FP) services, including promotion of Long-term Family Methods (LTFP) in both urban and rural areas. It was also reported that public health facilities are providing good Family Planning (FP) services, in both urban and rural areas.
  - High PMTCT coverage and uptake throughout the country. Southern Province: Gwembe district - 96%; Kazungula district – 75%.
  - Increased screening of women for breast and cervical cancers. Figure xx presents the trends for Lusaka Province.
  - On-going construction of new and rehabilitation of existing maternity units and mothers’ waiting shelters. In Lusaka, the maternity units at Chelstone and Chazanga were also under construction. Mothers’ shelters available in Kazungula district.
• Child and adolescent health:
  – High national immunization level. The percentage of fully immunized children under 1 year of age for the 4th quarter of 2011 stood at 94%, against the national target of 80%. The Southern Province reported high immunization coverage (Provincial - Qtr4 -88%, Kazungula – 106%; Gwembe – 98%), against the national target of 80%.
  – Scaling up of Integrated Management of Child Illnesses (IMCI) and Community IMCI (c-IMCI). Child health week activities were successfully conducted.
  – Adolescent health strategy developed.
• Commemoration of all the MNCH-related international days.

4.2.7.4 Main Constraints and Challenges

• Maternal and neonatal health:
  – Reductions in First ANC, and Post Natal Care (PNC).
  – Reductions in institutional deliveries. Lusaka reported a reduction in institutional deliveries from 67% in 2009 to 40% in 2010 and 39% in 2011. See Figure 6).
  – Increase in maternal deaths (Lusaka: from 18 to 20).
  – High Case Fatality Rate (CFR) for Asphyxia – 64% for Livingstone.
  – Inadequate infrastructure, e.g. delivery facilities and mothers’ waiting facilities.
  – Inadequate supplies for infection prevention in pregnancy.
  – Low FP uptake in some areas – e.g. Gwembe district in the Southern Province. It was also reported that Mission HCs are not providing FP, and that in the affected rural areas, there are no other alternative arrangements or facilities in place.
  – Transport and communication challenges to support referrals for maternal cases.
• Child and adolescent health:
  – Reductions in immunization. Even though the % of Fully Immunized Children under 1 year of age stood at 94% for the 4th quarter 2011, which was higher than the national target of 80%, this level represented a decline from 97% achieved in the 4th quarter of 2010. Lusaka province reported a decline in immunization from 83% in 4th quarter of 2010 to 73% in 4th quarter 2011.
  – Adolescent health services not adequately supported.
• Shortages of essential MCH equipment: Vacuum extractors, Oxygen gauges, Delivery packs.
• Weak community component: TBAs not trained as SMAGs in birth preparedness, danger signs and referral systems.
• Staffing challenges continued. This was a combination of shortages of qualified health workers, particularly midwives, and in some cases it was the poor distribution of the available health workers. The other problem related to the high health worker utilisation, due to high uptake of services against the small numbers of health workers.
4.2.8 Non-Communicable Diseases (NCDs)

4.2.8.1 Overview

Zambia is currently experiencing a major increase in the burden of Non-communicable Diseases (NCDs). The most common NCDs include cardiovascular diseases, diabetes mellitus (Type II), cancers, chronic respiratory diseases, epilepsy, mental illnesses, oral health, eye diseases, trauma/injuries (mostly due to road traffic accidents and burns) and sickle-cell anaemia. Most of these health conditions are associated with lifestyles, such as unhealthy diets, physical inactivity, alcohol abuse and tobacco use, while some are also associated with biological risk factors, which run in families. During the year under review, the focus was on the promotion of prevention, treatment and care for NCDs in facilities and communities.

4.2.8.2 Strategic Objective

To halt and begin to reverse the incidence and prevalence of NCDs throughout Zambia.
4.2.8.3 Main Achievements

- Strengthened capacities at national level by establishing the NCDs Unit at MOH Head Office, responsible for coordinating the national response to NCDs.
- Significant scaling up of capacities and support at the Cancer Diseases Hospital (CDH) in Lusaka. Rapid increases in the number of clients.
- Scaled up public awareness and education on NCDs.
- Checking for Blood Pressure (BP) included as part of routine assessments at health centres and hospitals.
- Scaled up screening for Breast and Cervical Cancers. Figure 7 presents the national trends in Breast and Cervical cancer treatment.
- MOH embarked on the development of the national NCDs strategy.

4.2.8.4 Main Constraints/Challenges:

- Policy shifts/challenges, in respect of prescription of diabetes drugs at HP/HC level.
- Inadequate public sensitisation-awareness on the risk factors, causes, prevention, the need for early diagnosis and treatment of cancer related conditions.
- Stigmatization and social-cultural myths about cancer.
- Late presentation for diagnosis and treatment.
- Shortages of cancer specialists.
- Inadequate capacities for cancer screening, treatment and care at health facilities.
- Limited community support to the chronically ill cancer patients.
- Weaknesses in the policy, legal and institutional frameworks for control of the key determinants of cancer.

Figure 7: Zambia: Lusaka Province: Trends in Cancer Screening

Source: Zambia: Ministry of Health, Lusaka Provincial Health Office
4.3 Health Workforce/Human Resources for Health

4.3.1 Overview

The Zambian health sector has for a long time been facing critical shortages of qualified health workers. In 2005, the problem reached a crisis level, with only 23,176 health workers, against the needs of 51,414 or 45% of the needs. However, through the implementation of the National Human Resource for Health Strategic Plan 2006-2010 (NHRH-SP 2006-2010), the numbers have significantly improved, from 23,176 in 2005 to 29,533 in 2009.

During the year under review, MOH focused at further strengthening of the human resource for health capacities at all levels. The key focus areas include: the expansion of capacities of health training institutions; continuous recruitment of additional health workers; rational distribution and retention of the existing health workers; and improving the productivity of the existing health workers.

4.3.2 Strategic Objectives

- To improve the availability of and distribution of qualified health workers in the country.
- To significantly increase the annual outputs of the health training institutions, to mitigate the critical shortages of qualified health workers.

4.3.3 Main Achievements

- Updated National HRH Strategic Plan 2011-2015 produced and launched.
- HR Recruitment and management:
  - Increase in the number of health workers. Recruited a total of xxx new health workers. All provinces benefited from these recruitments. Southern Province staff levels have increased by 183 in 2011.
  - Close to 70% of health facilities have 2 or more professional health staff (Medical Doctors, Nurses, Clinical Officers, and Environmental Health Technologists (EHTs)). Lusaka province: all facilities had 2 or more professional health staff.
  - All districts health offices have designated human resource officers.
• Staff training and development:
  – Staff training and development plans developed and implemented at different levels.
  – Public training institutions scaled up intakes and outputs.
  – Chainama College of Health Sciences (CCHS) increased training intakes from 90 to 300.
  – Increase in the number of private training institutions.

4.3.4 Main Constraints and challenges

• HR Recruitment, management:
  – Organisational structure/establishment challenges. Some facilities not included and while some are given inappropriate staff establishments.
  – Staff numbers still below the approved establishments – Gaps (Southern at 58% of approved establishment).
  – High staff workloads, due to increased access.
  – Inequitable distribution of health workers, especially mid-wives.
  – Criteria for retention and promotions unclear to staff.
  – Delays in processing leave, allowances, confirmations

• Training and Development:
  – Training capacities still inadequate.
  – Shortages of tutors/Establishment challenges at health training institutions.
  – Lack of training opportunities for lecturing staff.

• Private training schools:
  – Under-developed market: Low numbers of students, low fees, leading financing/viability challenges.
  – Policy challenges: Restriction on intakes in private health training institutions – significantly impacts on the financial viability of these institutions.
  – Inadequate government scholarships of pre-service students in private health training institutions.
  – Lack of special government incentives/tax reliefs to encourage investment.
  – High attachment costs for students on attachment at government health institutions.
  – Lack of appropriate support from CPs to help promote private sector growth in the health sector.
4.4 Medical Products, Infrastructure, Equipment and Transport

4.4.1 Overview

The NHSP 2011-2015 has emphasized the need for quality medical products, infrastructure, equipment and transport support to health service delivery. During the year under review, focus was directed at improving the procurement and distribution of medical products, including medicines and other medical supplies; strengthening of health infrastructure, particularly in rural areas; strengthening equipment, transport and communication equipment, to ensure efficient and effective support to health service delivery.

4.4.2 Objective

To ensure availability of adequate, quality, efficacious, safe and affordable essential medicines and medical supplies at all levels of service delivery, through efficient and effective procurement, and logistics management.

4.4.3 Main Achievements

- Essential drugs/medical supplies:
  - Supply of HC kits improved. Overall, the percentage of facilities with no stocks of tracer drugs and vaccines at HC increased from 37% in 4th quarter of 2010, to 41% in the 4th quarter of 2011.

Text Box 2: Feedback from Health Workers on health service and conditions of service

- In most sites, patient loads have increased in recent years:
  - Abolishment of user fees.
  - Government and partner initiatives that increase services available and awareness of these services.
- Most staff interviewed confirmed supervisory visits at least once every 6 months:
  - Supportive supervisory visits often not focused on needs of HCWs to improve performance.
- Performance Management Package not rolled out.
- Retention issues: criteria not clearly understood, on
  - Rural hardship allowance.
  - Staff retention scheme.
- Perceived lack of opportunities for training.
– In one district, items in stock averaged 80%, over the past 3 months.
– Stable supply of malaria diagnostics and drugs.

• Infrastructure and equipment:
  – Capital Investment Plan (CIP) developed and under implementation, with significant support from MOH/GRZ and partners.
  – Construction of new health facilities and staff houses continued.
  – Construction of maternity units and mothers’ waiting shelters continued.
  – CIDRZ support to ART infrastructure and equipment appreciated by the affected health facilities.
  – Engagement of provincial equipment engineers for maintenance of medical equipment.
• Prior to their removal, user fees supplemented procurement of various essential drugs, supplies and equipment – based on local priorities.

4.4.4 Main Constraints and Challenges

• Essential drugs/medical supplies:
  – Pharmacy stock cards not updated at some facilities.
  – Still, a number of requested items frequently out of stock/not delivered:
    ✓ ORS Sachets
    ✓ DBS Bundles
    ✓ X-ray films
    ✓ Diabetes test strips and drugs
• Infrastructure and equipment support:
  – Demand for health services has outgrown the existing infrastructure (especially in Lusaka).
  – Shortages of essential medical equipment: Incinerators, Haemoglobinometers, Blood Count Machines, Chemistry Analysers, CD4 Machines, Centrifuges (General & Haematocrit), Distillers, Autoclaves, and Dental Chairs.
  – Unfinished construction projects.
  – Lack of back up spare parts for newly installed medical equipment.
• Transport and communication:
  – Shortages of transport for service delivery, ambulances, outreach services.
  – Shortages of transport at health training institutions, for transportation of students attending practicals at health facilities, in different parts of the country.
4.5 Health Information and Research

4.5.1 Overview

The health sector in Zambia has established a comprehensive integrated health information system, which provides health information for evidence based planning, and decision making, within the health sector and external reporting. The system comprises both routine and non-routine information systems, which form part of the health sector monitoring and evaluation framework.

Routine data sources include: a facility-based Health Management Information System (HMIS), the Integrated Diseases Surveillance and Response (IDSR), the Human Resource Information System (HRIS), Drugs Logistics Management Information System (DLMIS) and government financial and administrative management systems, including the Integrated Financial Management System (IFMIS). The HMIS was initially developed in 1996, and underwent a major revision and upgrading in 2008, to improve its scope and technical capacity.

Non routine sources of health information include: population based and household surveys, antenatal sentinel surveillance. Key non-routine sources of health information include: the Zambia Demographic and Health Survey (ZDHS), Living Conditions Monitoring Survey (LCMS), Zambia Sexual Behavior Survey (ZSBS), Zambia HIV/AIDS Service Assessment (ZSPA), Malaria Indicator Survey (MIS), Health Facility Census (HFC), MDR, and the national census of population and housing.

During the year under review, focus was on the strengthening monitoring and evaluation, and research, in order to provide for appropriate and reliable evidence for policy, planning and management decision.

4.5.2 Objective

To ensure availability of relevant, accurate, timely and accessible health data, to support the planning, coordination, monitoring and evaluation of health services.

4.5.3 Main Achievements

- Continued with the implementation of the revised and upgraded HMIS.
- Improvements in report completeness.
- The percentage of facilities submitting HMIS monthly returns to MOH at prescribed times remained high, at an average of 95%.
- Employment of district information officers.
• Strengthening of health research, and use of evidence in planning and management decision. The annual health research congress was successfully held.

4.5.4 Main Constraints and Challenges

• Shortages of HMIS stationery.
• Shortages of data entry staff at facility level. Many data entry staff at facility level are working on volunteer basis, as an additional responsibility to their official duties.
• Inadequate staff trained in HMIS.
• Challenges of using CSO population data as denominators for population based health survey indicators. CSO population data does not accurately represent the actual demand for services, largely due to migrations. Head count is considered to be more accurate.
• Inadequate analysis and use of evidence.
• Poor reporting compliance from private health institutions, which distorts the national picture.

4.6 Healthcare Financing

4.6.1 Overview

Even though funding to the health sector has continued to increase, there are still gaps in meeting the health sector financing needs. Currently, the total government funding to the sector is approximately 12% of the national budget, which is lower than the 15% agreed at the Abuja Declaration on health.

The main sources of funding to the sector include: Government budget allocations; support from the CPs; support from local and international CSO and the private sector; and household health expenditure, through the payment of user fees, service charges, and other costs related to health, including transport, and procurement of prescribed drugs. Over the years, there have been significant increases in support from the CPs, but these funds are mainly targeted at vertical programs, such as HIV/AIDS, Malaria and TB, and cannot be used on financing other national health priorities. The main sources of external funding for the health sector include the GFATM; the USG, through the PEPFAR, PMI and USAID support; WHO and the World Bank; the EU; bilateral support from CPs (CIDA, SIDA); and the local and international CSOs, including the Bill and Belinda Gates Foundation, MACEPA/PATN, and Clinton Foundation.
During the year under review, the main focus was at improving the funding levels to the sector, strengthening financial management and control, improving prioritization in the allocation and utilization of the available financial resources, enhancement of accountability and transparency in the management of financial resources.

4.6.2 Main Achievements

- Increased government grants, even though the disbursements were behind by one month.
- Prior to their removal in October 2011, the user fees represented significant income for some facilities, particularly in urban areas (in some cases they were higher than the MOH grants).
- Increased funding to various infrastructure and equipment projects across the country, mainly the on-going construction and rehabilitation of health infrastructure, and expansion of capacities for health training institutions.
- Implementation of the IFMIS system at MOH Head Office. The system will rolled out to all the levels and facilities, to strengthen financial management and accountability.
- Extension of and increased funding from the CPs.

4.6.3 Constraints and Challenges

- Funding levels are below the budget and needs, and the 15% of national discretionary budget, agreed at the Abuja Declaration.
- The abolishment of user fees has widened financing gaps. Towards the end of 2011, the Government abolished the payment of user fees at all public health facilities. Even though the grants were increased, to compensate for the lost revenues, the increases in grants were considered inadequate to fill the gaps created by the removal.
- Even though health services are free at all health facilities, patients are often requested to meet some costs, such as buying some drugs and supplies (approximately 40%) from outside the facility, where such are not in stock.
- Delayed rolling out of IFMIS to lower levels, denies the lower levels of the opportunity to strengthen financial management.
4.7 Leadership and Governance

4.7.1 Overview

Good leadership and governance are critical factors in ensuring efficient and effective management of the health sector. The NHSP 2011-2015 has provided a comprehensive analysis of the leadership and governance strategic framework for the health sector, including: the policy framework; organizational and management framework; partnerships and coordination frameworks; transparency and accountability arrangements; and monitoring and evaluation.

MOH has adopted and established strong SWAp governance, organization and coordination systems and structures, to provide for effective harmonization and coordination of health sector partnerships. The SWAp is currently guided by the Joint Assistance Strategy for Zambia (JASZ) and the 2011-2015 Memorandum of Understanding (MOU) between MOH and the sector CPs.

4.7.2 Strategic Objectives

To implement an efficient and effective decentralised system of governance, ensuring high standards of transparency and accountability at all the levels of the health sector.

4.7.3 Main Achievements

- Progress on the development of the National Health Policy and the new National Health Services Act. Drafts completed and submitted to Cabinet Office for consideration.
- Significant progress on the implementation of the Health Sector Governance Action Plan, jointly developed and agreed between MOH and its partners. CPs acknowledged that significant progress was being made in this area.
- Continued with the implementation of the revised organisational and staffing structures, including the correction of identified problems and anomalies.
- Strong SWAp governance and coordination systems and structures in place, with active participation of all the key partners.
- Strong community structures and culture of participation - Neighbourhood Health Committees (NHCs) and community health partners.
- Successful conduct and conclusion of the JAR 2011, attracting significant participation of the partners.
- Successfully held all the Sector Advisory Group (SAG) meetings and scheduled consultations.
4.7.4 **Constraints/Challenges**

- Delay in completing and implementing of the new National Health Policy and National Health Services Act.
- It was reported that the organisational and staffing structures still have some serious mistakes, which need to be corrected:
  - Some facilities are not on included on the establishment.
  - Inappropriate structures and establishments for training institutions.
- Following the dissolution of the Central Board of Health (CBOH) and the District Health Boards (DHBs), the District Health Advisory Boards have not yet been established.
- Health facility committees exist, but are not always involved in planning and management of health services.
- No provisions for channeling complaints from the clients.
5 RECOMMENDATIONS

5.1 Main Recommendations on Health Sector Performance

Based on the findings of the JAR 2011, the following recommendations have been made, aimed at addressing the identified constraints and challenges:

5.1.1 Service Delivery

- Improve capacities, to adequately respond to increased service uptake – accelerate completion of constructions.
- Address maternity capacity challenges – Complete the ongoing constructions of maternity facilities.
- Review and strengthen referral systems (within public sector and with private health sector).

5.1.2 Health workforce

- Scale up recruitments and equity in distribution.
- Strengthen staff management.
- Implement the performance management system (APAS) at lower levels. Currently, it is just at head office.
- Improve communication/dissemination of HRH policies on: retention; promotion criteria; and training selection, to health workers at all levels.

5.1.3 Medical products, infrastructure and equipment

- Improve availability of essential drugs/supplies under the “pull” strategy.
- Address infrastructure challenges in: health facilities; MNCH; laboratory; and ART.
- Review the availability of essential medical equipment and address the gaps.

5.1.4 Health Information and Research

- Scale up training of staff in HMIS at facility level.
- Improve supply of HMIS stationery.
- Review and include data entry positions in the staffing establishment.
- Engage with the Central Statistical Office (CSO) to jointly address challenges regarding the use of CSO population data for health sector indicators.
5.1.5 Health Financing

- Increase funding to the health facilities, in order to adequately cover the lost revenue from the abolished user fees, and the impact of the increased uptake of health services.
- Consider advocating for the restriction of the removal of user fees to essential health services only.

5.1.6 Leadership and Governance

- Obtain Cabinet approval of the National Health Policy, and enactment of the new National Health Services Act by the National Assembly.
- Review and realign organisational and staffing structures, in order to address the identified mistakes and omissions.
- Strengthen governance structures by activating the District Health Advisory Boards/Committees.
- Strengthen partnerships with private health sector and private health training institutions.
- Strengthen community partnerships/engagement.
- Fully implement the Governance Action Plan.

5.2 Recommendations on the JAR Process

5.2.1 Process

- Start the preparation and process earlier, in order to provide for adequate time.
- All the key documents should be collected and made available before the commencement of the review process.
- Questionnaires for field visits should be prepared and sent out in good time, say at least one week before the field visits.

5.2.2 Participation

- Circulate notifications of the JAR early enough, in order to provide for broad participation.
- Include participants from local CSOs in the MOH budget and allowances for JAR field visits, in order to promote their participation.
6 APPENDICES

Appendix I: Terms of Reference for the JAR 2011

Appendix II: Description of Health Facilities in Zambia
Appendix I: Terms of Reference for JAR 2011
6.1 Appendix II: Description of Health Facilities in Zambia

a) Core health service facilities: These facilities are at the following levels:

- **Health Posts (HPs):** These are intended to cater for populations of 500 households (3,500 people) in rural areas and 1,000 households (7,000 people) in urban areas, or to be established within a 5 km radius for sparsely populated areas. The target is to have 3,000 HPs, but currently there are only 171 and this figure includes public, faith-based and private facilities (Health Institutions in Zambia, MOH 2008).

- **Health Centres (HCs):** These include Urban HCs, which are intended to serve a catchment population of between 30,000 to 50,000 people, and Rural HCs, which are intended for catchment areas within a 29km radius or population of 10,000 people. The target is 1,385 HCs, but currently there are a total of 1,294 HCs (1,029 Rural, 265 Urban), including public, faith-based and private facilities (Health Institutions in Zambia, MOH 2008).

- **1st Level Referral Hospitals (District Hospitals):** These are found in most of the 72 districts and are intended to serve populations of between 80,000 and 200,000 people with medical, surgical, obstetric, diagnostic and all clinical services to support health centre referrals. Currently, there are a total of 72 such hospitals in the country, including public, faith-based and private facilities (Health Institutions in Zambia, MOH 2008).

- **2nd Level Referral Hospitals (Provincial General Hospitals):** These are hospitals at provincial level and are intended to cater for a catchment area of 200,000 to 800,000 people with services in internal medicine, general surgery, paediatrics, obstetrics and gynaecology, dental, psychiatry and intensive care services. These hospitals are also intended to act as referral centres for the first level hospitals, including the provision of technical back-up and training functions. Currently there are 21 second level hospitals. Two provinces, namely Southern and Copperbelt, have 5 and 3 second level hospitals, respectively. There is a need to rationalize the distribution of these facilities through right-sizing (Health Institutions in Zambia, MOH 2008).

- **3rd Level Referral Hospitals (Central Hospitals):** These are intended for catchment populations of 800,000 and above, and have sub-specializations in internal medicine, surgery, paediatrics, obstetrics, gynaecology, intensive care, psychiatry, training and research. These hospitals also act as referral centres for second level hospitals. Currently, there are 6 such facilities in the country, of which 3 are in the Copperbelt and Lusaka Provinces. Again, there is a need to rationalize the distribution of these facilities and services (NHSP 2006-10).
b) **Health training institutions (TIs):** These include the School of Medicine at the University of Zambia (UNZA), Chainama Hills College of Health Sciences, various nursing and midwifery schools, bio-medical science and other paramedical training schools.

c) **Statutory Boards:** These are sub-divided into two categories, namely, *regulatory boards*, which are responsible for enforcing specific government policies, legislation and regulations, and *service boards*, which are responsible for providing specialised