

**USAID/ZAMBIA**

**SYSTEMS FOR BETTER HEALTH**

**BASELINE ASSESSMENT REPORT – Revised - January 2018**

**January 2018**

This publication was produced for review by the United States Agency for International Development. It was prepared by Abt Associates for the USAID Systems for Better Health activity.

**Contract/Project No.**: Task Order No. AID611-TO-16-00001

Contract No. AID-OAA-I-14-00032

GUC Mechanism

**Submitted to**: William Kanweka, Contracting Officer’s Representative

USAID Zambia

Prepared by:

Abt Associates

In collaboration with:

American College of Nurse-Midwives

Akros Inc.

BroadReach Institute for Training and Education

Initiatives Inc.

Imperial Health Sciences

Save the Children

**DISCLAIMER**

The author’s views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government

**Table of Contents**

[Acronyms 1](#_Toc458697833)

[Executive Summary 3](#_Toc458697834)

[CHAPTER 1: BACKGROUND 6](#_Toc458697835)

[1.1 Background to Systems for Better Health 6](#_Toc458697836)

[1.1.1 Task 1: Design, Implement, and Monitor National Level Interventions to Strengthen Health Stewardship by MoH 7](#_Toc458697837)

[1.1.2 Task 2: Design, implement, and monitor effective interventions to strengthen program management capacities of provincial and district health teams 10](#_Toc458697838)

[1.1.3 Task 3: Provide technical and financial assistance to the GRZ and CBOs to increase the quality, availability and use of priority health services at the community level in targeted districts 12](#_Toc458697839)

[1.2 Purpose of the Baseline Assessment 15](#_Toc458697840)

[CHAPTER 2: METHODOLOGY 18](#_Toc458697841)

[2.1 Sources Of Data 18](#_Toc458697842)

[2.2 Data Collection 18](#_Toc458697843)

[2.3 Limitation of the Baseline Assessment 19](#_Toc458697844)

[CHAPTER 3: BASELINE VALUES FOR GOALS 20](#_Toc458697845)

[3.1 Proportion of deliveries assisted by a medically trained provider in targeted districts **Error! Bookmark not defined.**](#_Toc458697846)

[3.2 CYP in target districts **Error! Bookmark not defined.**](#_Toc458697847)

[3.3 Percent of children aged 12 to 23 months fully immunized in targeted districts 23](#_Toc458697848)

[3.4 Percentage of adults and children known to be alive and on treatment 12 months after initiation of ART in targeted districts 24](#_Toc458697849)

[CHAPTER 4: BASELINE VALUES BY TASK 27](#_Toc458697850)

[4.1 Task 1: Design, implement and monitor national level interventions to strengthen health stewardship 27](#_Toc458697851)

[4.2 Task 2: Design, implement, and monitor effective interventions to strengthen program management capacities of provincial and district health teams 37](#_Toc458697852)

[4.3 Task 3: Provide Technical and Financial Assistance to the MOH and Community-Based Organizations to Increase Quality, Availability, and Use of Priority Health Services at the Community Level 50](#_Toc458697853)

[CHAPTER 5: SUMMARY TABLE OF INDICATORS AND PLANNED IMPROVEMENTS 54](#_Toc458697854)

[CHAPTER 6: CONCLUSIONS 60](#_Toc458697855)

[Annexes 61](#_Toc458697856)

# Acronyms

AMEP Activity Monitoring and Evaluation Plan

APAS Annual Performance Appraisal System

ART Antiretroviral Therapy

ARV Antiretroviral

BCG Bacille Calmette-Guerin

CBO Community-based Organizations

CDCS Country Development Cooperation Strategy

CHA Community Health Assistant

CHV Community Health Volunteer

CYP Couple Years Protection

DHIS2 District Health Information System Version 2

DMO District Medical Office

DPT3 Diphtheria, Pertussis, and Tetanus3

EmONC Emergency Obstetric and Neonatal Care

FP Family Planning

GRZ Government of the Republic of Zambia

HAC Health Center Committees

HCF Health Care Financing

HIV Human Immunodeficiency Virus

HMIS Health Management Information System

HR Human Resources

HRH Human Resources for Health

HRIS Human Resource Information System

MLA Management and Leadership Academy

MOH Ministry of Health

NFNC National Food and Nutrition Commission

OVC Orphans and Vulnerable Children

PA Performance Assessment

PEPFAR President’s Emergency Plan for AIDS Relief

PFM Public Financial Management

PMO Provincial Medical Office

PMP Performance Management Package

PFM Public Financial Management

QI Quality Improvement

RFTOP Request for Task Order Proposals

SBCC Social and Behavioral Change Communication

SBH Systems for Better Health

SMAGs Safe Motherhood Action Groups

TSS Technical Support Supervision

USAID United States Agency for International Development

USG United States Government

NHSP National Health Strategic Plan

# Executive Summary

The aim of this report is to document baseline benchmarks for a set of performance indicators selected to measure the results of the United States Agency for International Development (USAID)/Zambia Systems for Better Health (SBH) activity. SBH will apply these baseline benchmarks to establish appropriate performance targets, monitor implementation, measure change and results over time, and inform programming decisions at all levels.

#### Background to the SBH Project

The overall objective of USAID’s five-year (2015-2020) SBH activity is to improve health outcomes for Zambians by strengthening health systems to deliver high quality health services. Through increasing utilization of high impact health interventions at district and community level, the project expects to achieve the following outcomes:

1. Improved national level health stewardship
2. Improved capacities of provincial and district health teams to deliver high quality services through strengthened management
3. Increased quality and availability of priority health services at the community level in targeted districts
4. Increased utilization of key public health interventions

The primary goal of the SBH project is to improve health outcomes through increasing retention of patients on antiretroviral therapy (ART) to 85 percent; increasing couple years protection (CYP) by 10 percent; increasing the proportion of deliveries attended by medically trained personnel by 20 percent; and increasing the proportion of fully immunized children (12 to 23 months) to 80 percent in the 10 SBH target districts.

SBH plans to achieve these goals by building specific capacities of the Ministry of Health (MOH) at the national, provincial, and district levels through the following activities:

*Task 1: Design, implement and monitor national level interventions to strengthen health stewardship by MOH* usingevidence-based approaches to strengthen health stewardship at the central MOH based on existing MOH strategic plans for Human Resources for Health (HRH), Health Care Financing (HCF), and improvement in delivery of quality health care by the MOH and other service providers.

*Sub-task 1.1: Strengthen Human Resource Planning and Management* *to successfully support the delivery of high quality health services by ensuring that health workers in the target facilities and programs have the necessary practical and clinical skills to ensure effective delivery of high quality health service.*

*Sub-task 1.2: Improve HCF and public financial management (PFM);* *improve financial management of the health sector reforms and effective mobilization of resources.*

*Sub-task 1.3: Strengthen MOH capacity to oversee delivery of key health programs by ensuring community access and availability of high quality health services.*

*Sub-task 1.4: Design, implement, and monitor effective interventions to strengthen program management capacities of provincial and district health teams* *to deliver sustained high quality HIV, Family Planning (FP), Maternal Neonatal and Child health (MNCH) and nutrition services in targeted districts.*

*Task 2: Design, implement, and monitor effective interventions to strengthen program management capacities of provincial and district health teams*

*Sub-task 2.1: Strengthen program management capacity of provincial and district health teams to improve management capabilities in efficient management of health programs by ensuring appropriate decision making in prioritization of resource allocation.*

*Sub-task 2.2: Improve technical capacity of provincial and district health teams to deliver quality health services in all facilities through competence capacity building by linking management and accountability as well as technical and clinical skills to drive improved health outcomes.*

*Sub-task 2.3: Provide technical and financial assistance to MOH and community-based organizations (CBOs) to increase the quality, availability, and use of priority health services at the community level by delivering higher quality HIV, MNCH, FP, and nutrition services*

*Task 3: Provide technical and financial assistance to the Government of the Republic of Zambia (GRZ) and CBOs* to increase the quality, availability, and use of priority health services at the community level in targeted districts

*Sub-task 3.1: Improve capacity to deliver quality health services at the community level to increase community access to services through outreach activities, and strengthening* community *volunteers and community participation.*

*Sub-task 3.2: Strengthen linkages between the community and facility for key health interventions and establishment of effective referral system and functional health system.*

*Sub-task 3.3: Implement community level Social and Behavioral Change Communication (SBCC) interventions to increase utilization of high impact health services.*

SBH will utilize a phased implementation approach, beginning in 10 districts during the first two years of the project. This phased approach will include specific plans to ensure continued sustainability in the initial target districts. The phased approach will also enhance cost-effective, targeted use of project resources to strengthen health systems performance and health outcomes during and after the life of the project.

#### Purpose of the Baseline Assessment

The SBH Activity Monitoring and Evaluation Plan (AMEP) provide an overall framework for results measurement for the life of the project. The AMEP includes a full set of performance indicators, specific definitions, data sources, measurement approaches and initial targets. This baseline assessment operationalizes the AMEP and documents the starting values for SBH indicators. SBH will use the baseline assessment to update the AMEP targets and guide implementation decisions over time.

#### Methodology

The SBH team collected data for the baseline assessment through a desk review of secondary data. This review included MOH planning and financial reports, service data extracted from the Health Management Information System (HMIS)/District Health Information System Version 2 (DHIS2) and other program data sources with full cooperation and support of the Ministry of Health Central (Policy and Planning Directorate), Provincial Medical Offices (PMOs) and Districts Medical Offices (DMOs).

During the assessment, differences in secondary data sources presented a challenge both in comparing data collected from different periods as well as vouching for the quality of data used in the assessment.

**NOTE:** Baseline values for many indicators were updated as of September 2017 and in this revised baseline report to include two additional districts added to the project Phase 1 scope in June 2016. All baseline values have been updated accordingly.

# CHAPTER 1: BACKGROUND

This is a baseline assessment report designed to establish benchmarks for the measurements of envisaged change on specific health indicators related to the USAID SBH activity in Zambia. SBH interventions are intended to improve the health status of Zambians in selected target districts. SBH will use baseline documentation to inform programming decisions in the selected provinces and districts.

## 1.1 Background to Systems for Better Health

USAID awarded the SBH activity in Zambia to Abt Associates Inc. in October 2015. SBH project is expected to achieve the following outcomes:

1. Effective national level health stewardship
2. Improved capacities of provincial and district health teams to perform program management functions
3. Increased quality and availability of priority health services at the community level in targeted districts
4. Increased utilization of key public health interventions

SBH outcomes will be measured through the following priority indicators:

* Retention of patients on ART increased to at least 85 percent in targeted districts;
* Increased CYP by 10 percent in targeted districts;
* Proportion of deliveries with assistance from a medically trained provider increased by 20 percent in targeted districts; and
* At least 80 percent of children (aged 12 to 23 months) fully immunized in targeted districts.

SBH will assist the MOH to achieve the above outcomes by implementing the following tasks:

1. Task 1: Design, implement, and monitor national level interventions to strengthen health stewardship by MOH.
2. Task 2: Design, implement, and monitor effective interventions to strengthen program management capacities of provincial and district health teams.
3. Task 3: Provide technical and financial assistance to the GRZ and CBOs health services at the community level in targeted districts.

SBH interventions will lead to improvements at all levels of the health system by undertaking the following: Task 1 activities prioritize national level improvements and systems strengthening. Tasks 2 and 3 prioritize the provincial, district, facility, and community levels. In terms of geographic focus, SBH works in a total of five provinces (Central, Copperbelt, Eastern, Lusaka and Southern). Four target districts within each project province have been selected for intervention. The table below shows SBH targeted provinces and districts.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **SBH Target Provinces and Districts** | | | | | |
| **Province** | **Central** | **Copperbelt** | **Eastern** | **Lusaka** | **Southern** |
| **District** | Kabwe | Kitwe | Lundazi | Lusaka | Moonze |
| Kapiri Mposhi | Chililabombwe | Nyimba | Chirundu | Gwembe |
| Chisamba | Mufulira | Petauke | Luangwa | Chikankata |
| Mkushi | Chingola | Chipata | Shibuyunji | Livingstone |

SBH will implement Task 2 and 3 activities using a phased approach. In the first two years of the project, SBH will intensively carry out interventions in the first 10 districts. This initial phase of assistance will culminate in “graduation” with gradual withdrawal of intensive support and initiation of similar intensive support to a second set of 10 districts. Gradual phasing of support to target districts will allow SBH to benefit from lessons learned from earlier efforts. This approach will enable more cost-effective application of project resources to implement SBH interventions and result in strengthened health systems performance and health outcomes in each of the 15 health facilities in each targeted district. The table below lists the Phase 1 targeted districts.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **SBH Phase 1 Target Districts** | | | | | |
| **Province** | **Central** | **Copperbelt** | **Eastern** | **Lusaka** | **Southern** |
| **District** | Kabwe | Kitwe | Petauke | Lusaka | Moonze |
| Mkushi | Mufulira | Chipata | Shibuyunji | Livingstone |
|  | Chingola\* |  |  |  |
|  | Chililabombwe\* |  |  |  |

\* Note: Chingola and Chililabombwe were added to Phase 1 implementation in June 2016. **This revised baseline report reflects updated baseline values to include these two additional Phase 1 districts.**

SBH plans to undertake the following tasks and sub-tasks:

### Task 1: Design, Implement, and Monitor National Level Interventions to Strengthen Health Stewardship by MoH

SBH is currently implementing evidence-based interventions to strengthen health stewardship at the central MOH. These interventions are based on existing MOH strategic plans. They are implemented to improve systems performance in management of HRH, HCF, and improve delivery of quality health care by the MOH and other service providers.

Under Task 1, SBH is applying a three-pronged approach that includes:

* Supporting the development, implementation, and monitoring of key MOH strategies and plans
* Strengthening implementation of existing systems and processes
* Conducting baseline assessments to identify key gaps in management capacity that can be addressed through project assistance

#### 1.1.1.1. Sub-task 1.1: Strengthen human resource planning and management

SBH supports HR teams within the central MOH to implement existing strategies and systems and develop new strategies. SBH recognizes that the HR information system (HRIS) and performance management package (PMP) are critical to develop the capacity of Zambia’s health system to support the delivery of high quality health services. The HRIS subsystem enables managers at all levels to use evidence to make or advocate for decisions related to planning and allocation of resources, and holds individuals and entities accountable for delivering on stated performance goals. The planned interventions will ensure that health workers in the target facilities and programs have the necessary practical and clinical skills to ensure effective delivery of high quality health services. Capacity development of the health workers at pre-service and in-service levels and their deployment will enhance their performance at service delivery levels. SBH will complement health worker capacity building through mentoring processes. In addition, the Community Health Assistant (CHA) schools will provide pre service and post service training for community-based workers in the CHA training schools. The table below shows the indicator to be tracked under this sub task.

|  |  |
| --- | --- |
| **Sub-task 1.1: Strengthen HR Planning and Management** | |
| 8 | Number of new health care workers who graduated from a pre-service training institution or program as a result of the President’s Emergency Plan for AIDS Relief (PEPFAR)-supported strengthening efforts, within the reporting period |
| 9 | Percent of targeted provincial and district level health offices that have access to and routinely use HRIS |
| 10 | Proportion of PMO and DMO personnel who have received an annual performance appraisal in the past year in targeted districts |
| 11 | Number of non-finance based incentives to attract health professionals in remote areas identified, costed, and submitted for review by GRZ |

##### 1.1.1.2 Sub-task 1.2: Improve health care financing and PFM

Management of resources plays a crucial role in the health system’s ability to provide quality and timely services. Management of the public financial resources and budget execution in a timely manner is a key challenge in the Zambian health sector. Whereas there is some improvement in the MOH’s Governance and Management Capacity Strengthening Plan and the Ministry of Finance’s (MOF’s) broader PFM reform, financial management of the health sector still needs strengthening. Specifically, financial management in the MOH needs to utilize evidence-based planning and budgeting approaches to include a system for reporting and auditing to ensure accountability and transparency. The establishment of a comprehensive health financing strategy that reflects current health financing needs and cognizance of the country’s socio-economic situation will lead to evidence based forecasting to ensure sustainability of sector.

SBH works with the MOH to implement a national health financing strategy that supports the mobilization of resources for the sector; ensures effective allocation and management of budget; and ensures the implementation of strategic initiatives such as performance-based financing and social health insurance. In the absence of strong health financing, improvements among all other functions of the health system will be hindered, including service delivery. Improving health financing will lead to achievement of all other SBH results and sub-results. The indicators under sub-task 1.1.1.2 are shown below.

|  |  |
| --- | --- |
| **Sub-task 1.1.1.2: Improve health care financing and PFM** | |
| 13 | Percentage of national government expenditure on health out of general government expenditure |
| 16 | Number of months per year in which targeted districts receive monthly funding as per approved budget |
| 17 | Proportion of funds disbursed to targeted districts out of total approved annual  budget of districts |
| 18 | Proportion of funds disbursed (by targeted districts) to health facilities out of their approved total annual budget |

##### 1.1.1.3 Sub-task 1.3: Strengthen MOH capacity to oversee delivery of key health programs

The ultimate aim of a health system is to ensure good health through access and availability of high quality health services. The MOH must have the necessary capacity to bring together its decisions in all areas of the health system (including HR, health financing, information, and logistics/supplies). This cohesion will ensure that health services are delivered efficiently and effectively. Currently, there are insufficient resources and limited management oversight to properly roll out and ensure implementation of national policy guidance, programs, and services to lower levels of the health system.

Under this task, SBH will apply a two-pronged approach that includes:

* Strengthening program management capacity of provincial and district health teams
* Improving technical capacity of provincial and district health teams to deliver quality health services

Two indicators SBH will track related to this task are shown in the table below.

|  |  |
| --- | --- |
| **Sub-task 1.1.1.3: Strengthen MOH capacity to oversee delivery of key health programs.** | |
| 19 | Number of improvements to laws, policies, strategies, regulations, or guidelines |
| 26 | Percentage of targeted facilities submitting HMIS reports in a timely manner |

### 1.1.2 Task 2: Design, implement, and monitor effective interventions to strengthen program management capacities of provincial and district health teams

In support of Zambia’s decentralized governance approach, SBH recognizes that enabling provincial, district, and facility teams to manage programs and services more effectively is equally important to the stewardship improvements at the national level. An efficient and effective decentralized system will be complemented by a central MOH that holds lower levels accountable for their performance (result 1).

SBH’s theory of change contends that sustained improvements in management and delivery of quality health services can be achieved when:

* Managers and health providers are able to monitor their progress against performance goals, identify systems barriers and capacity gaps, and access the technical and financial resources required to support continuous improvement.
* Managers at all levels focus on production of more accurate, gender disaggregated data from existing sources, use the improved data to allocate resources, and hold individuals and teams in provinces, districts, and health facilities accountable for performance and results.
* PMOs and DMOs have the capacity to effectively coordinate the inputs and activities of health implementing partners and stakeholders, ensuring that partner plans and allocation of resources align with provincial and district plans.
* Quality Improvement (QI) Teams are functioning fully, supported by integrated application of the performance assessment (PA), technical support supervision (TSS), and clinical mentoring systems, along with needs-based in-service training.

SBH designed the interventions under Sub-tasks 2.1 and 2.2 to equip health managers and service providers at province, district, and facility levels with the necessary skills, processes, and tools to deliver high quality HIV, FP, MNCH and nutrition services in targeted districts.

##### 1.1.2.1 Sub-task 2.1: Strengthen program management capacity of provincial and district health teams

SBH recognizes that at provincial and district levels, managers do not consistently receive the necessary capacity and skills development required to support them in carrying out their vast responsibilities in managing health programs. Although the health sector has well established systems for annual planning, PA, and HMIS, there has been insufficient focus on ensuring these processes are applied rigorously to help managers utilize them in an integrated manner. This has mitigated the ability to use performance as an effective tool to ensure accountability within the health sector.

SBH improves management capabilities in targeted provinces and districts by ensuring that resources are used appropriately and decisions are made to support the delivery of priority health services at the facility and community levels. By building a stronger culture of active data use for performance management, SBH will unlock the management power of PA. SBH will enable routine use of information for better oversight and management at various levels.

With improved competencies in using information to make decisions and availability of better tools to measure performance routinely, stakeholders can both formulate decisions more effectively and ensure mutual accountability. These improvements will create a stronger sense of ownership at all levels and lead to improved performance across programmatic and clinical areas. Strengthened performance will ultimately result in the achievement of service delivery and health outcome targets. The table below shows the indicator which SBH will measure under this sub-task.

|  |  |
| --- | --- |
| **Sub-task 2.1: Strengthen program management capacity of provincial and district health teams** | |
| 6 | Percentage of target provinces /districts that demonstrate capacity to sustainably plan, manage and oversee accessible high quality health services |
| 7 | Percentage of targeted facilities in target districts that demonstrate capacity to deliver high quality health services and engage with communities in their catchment area |
| 23 | Capacity score of targeted provinces and districts |
| 24 | Percentage of targeted provinces/districts that conducted at least two reviews of their annual action plans, in the past year |
| 25 | Percentage of targeted PMOs / DMOs that use HMIS data routinely |
| 27 | Number of health managers and providers trained in management and leadership |
| 28.a | Percent of target facilities that did not experience a stock-out of Coartem (ACT) during the reporting period |
| 28.b | Percent of target facilities that did not experience a stock-out of contraceptive (injectable) during the reporting period |

##### 1.1.2.2 Sub-task 2.2: Improve technical capacity of provincial and district health teams to deliver quality health services in facilities

Improved capacity for program management is only one element of strengthening performance. While provincial and district managers require stronger management and accountability capacities, they also need the technical and clinical skills to drive improved health outcomes. SBH will link management and clinical capacity building interventions and ensure performance data drives these interventions. SBH will also utilize supportive oversight and mentoring activities to continually reinforce strategic targeting of clinical training/skills and competencies.

SBH recognizes the inefficiencies of improving individual capacities of health workers if they are unable to provide services at their facilities due to lack of equipment or supplies. SBH ensures that effective procurement planning occurs so facilities have the equipment required to provide selected priority health services. The table below shows the indicator which will be measured under this sub-task.

|  |  |
| --- | --- |
| **Sub-task 2.2: Improve technical capacity of provincial and district health teams to deliver quality health services in facilities** | |
| 30 | Number and percent of children who received Diptheria, Pertussis, and Tetanus3 (DPT3) vaccine by 12 months of age in targeted districts |
| 31 | Percentage of HIV-positive pregnant women who received antiretroviral treatment to reduce risk of mother-to-child-transmission in targeted districts |
| 32 | Percentage of targeted DMOs that have completed their semi-annual PA and TSS visits to facilities in their catchment area |
| 33 | Percentage of targeted DMOs that demonstrate specific performance improvements since their previous PA |
| 34 | Percentage of targeted primary care facilities that have received TSS or clinical mentoring in the past six months |
| 35 | Percentage of targeted facilities in targeted districts that have up-to-date and gender sensitive job aids for HIV, FP, MNCH, and/or nutrition |
| 36 | Percentage of targeted facilities in targeted districts that have initiated QI projects in ART, Prevention of mother-to-child transmission (PMTCT), MC, FP, child health and nutrition, or maternal health services with documented process results |
| 37 | Number of people trained in child health and nutrition |
| 38 | Number of people trained in maternal and newborn health |
| 39 | Number of people trained in FP/reproductive health |
| 40 | Number of new health care workers who successfully completed an in-service training program within the reporting period |

### 1.1.3 Task 3: Provide technical and financial assistance to the GRZ and CBOs to increase the quality, availability and use of priority health services at the community level in targeted districts

Effective inclusion of community involvement and participation in planning and management of the health system is essential to achieving Zambia’s health sector goals. SBH community level interventions are designed to achieve enhanced ownership of health programs by communities in targeted districts. SBH assists the MOH to effectively achieve the results under sub-results 3.1, 3.2, and 3.3. This support brings higher quality HIV, MNCH, FP, and nutrition services closer to the community and will influence the demand and use of these services. The following sub-task guides the implementation of these interventions and will ensure the following results:

* Improve capacity to deliver quality health services at the community level
* Strengthen linkages between the community and facility for key health interventions
* Implement community level SBCC interventions to increase utilization of high impact health services

##### 1.1.3.1 Sub-task 3.1: Improve capacity to deliver quality health services at the community level

Significant understaffing and lack of resources for transport limit the ability of providers to conduct routine community outreach activities, such as growth monitoring and antenatal care services. There is also infrequent monitoring of the quality of services provided by community volunteers and CHAs. Additionally, facility-community partnerships remain weak, constraining efforts to prioritize and address health issues, including those that influence health-promotive and health-seeking behaviors. Even if broad health systems improvements under Results 1 and 2 are achieved, desired improvements in the access and use of health services by Zambians will not reach their full potential without changes at the community level.

SBH uses innovative approaches to more effectively reinforce the work of community volunteers and CHAs. The project supports the engagement of communities in health planning and offers improved and integrated supportive supervision approaches. SBH realizes that it is critical to strengthen the engagement of the community level in the planning, management, and delivery of health services to reach desired improvements in access and use of priority services within targeted districts. The table below shows the indicator which will be measured under this sub-task.

|  |  |
| --- | --- |
| **Sub-task 3.1: Improve capacity to deliver quality health services at the community level** | |
| 43 | Number of CHAs that receive routine supervision (from health facility staff) in target facility catchment areas |
| 44 | Number of community volunteers (including Safe Motherhood Action Groups (SMAGs) and others that have received equipment to deliver priority community health services in targeted facility catchment areas |

##### 1.1.3.2 Sub-task 3.2: Strengthen linkages between the community and facility for key health interventions

SBH recognizes the central challenges inhibiting successful community and facility linkages:

* Health Center Advisory Committees face limited opportunities for training and orientation
* DMOs do not have an established position for community-level coordination and capacity building
* Annual budgets cannot support establishment/revitalization of Neighborhood Health Committees in every Zambian community
* Training of community level actors is not consistently paired with activities that link trained volunteers/organizations into systems of mentorship, supervision, referral, and reporting
* The health system lacks a standardized referral system for CHAs/CBOs to refer clients to facilities and to communicate feedback from facilities to community to support client follow-up

SBH elevates the community planning and health information systems in the following ways: enhancing training and supervision of community health volunteers (CHVs); establishing trained Information Education Communication/Behavior Change Communication Committees; engaging traditional leaders; and involving local non-governmental organizations and CBOs in health promotion and planning. The periodic reviews of health performance provide data that communities use to hold the health system and community members accountable to health actions.

SBH builds upon the strengthened linkages to expand the QI system to health facility/community level. QI project implementation strengthens the ability of community members to access, understand, and use health data to hold health facility staff accountable to delivery of quality, equitable services. The collaboration between health workers and community members on QI projects further builds collective ownership of health outcomes. Two indicators which will be measured under this sub-task are shown in the table below.

|  |  |
| --- | --- |
| **Sub-task 3.2: Strengthen linkages between the community and facility for key health interventions** | |
| 46 | Number of active beneficiaries served by PEPFAR Orphans and Vulnerable Children (OVC) programs for children and families affected by HIV/AIDS in target areas |
| 48 | Percentage of target health facilities with a functionalfacility/community-level QI committee |

#### 1.1.3.3 Sub-task 3.3: Implement community level SBCC interventions to increase utilization of high impact health services

SBH implements effective interventions to mobilize communities to change inappropriate health behaviors to healthy ones and increase the demand for high impact services in target districts[[1]](#footnote-1). SBH designs and implements a cohesive strategy to identify and address barriers to care, including cultural or economic barriers, provider bias, or false rumors and misinformation about FP, nutrition, MNCH and HIV practices. One indicator to be measured under this sub-task is shown in the table below.

|  |  |
| --- | --- |
| **Sub-task 3.3:** Implement community level SBCC interventions to increase utilization of high impact health services | |
| 49 | Percentage of children under five years of age who received Vitamin A from United States Government (USG)-supported programs in target districts |

## Purpose of the Baseline Assessment

The purpose of the baseline assessment is to establish monitoring benchmarks for the AMEP. The baseline provides a set of process, output, outcome, and impact level indicators that will collectively demonstrate the project’s performance and contributions to improved health indicators. SBH will use the baseline assessment to establish a baseline value for the project’s pool of performance indicators. This will enable measurement of change attributable to interventions that will be implemented over time in the target districts. In addition, the baseline assessment will also facilitate the finalization of the AMEP by refining the performance indicator reference sheets and using the baseline values to inform the revision of indicator targets.

The Performance Indicator Tracking table below provides a summary of planned improvements expected from implementation of the planned health improvement interventions.

|  |  |  |
| --- | --- | --- |
| **Summary of SBH specific indicators by links and target** | | |
| **No.** | **Indicator** | **EOP Target** |
| 1 | Proportion of deliveries with assistance from a medically trained provider in targeted districts | 20% increase over baseline |
| 2 | CYP in targeted districts increased by 10% in targeted districts | 10% increase over baseline |
| 4 | Percentage of children aged 12 to 23 months fully immunized in targeted districts | > 90% |
| 5 | Percentage of adults and children known to be alive and on treatment 12 months after initiation of antiretroviral therapy in targeted districts [[2]](#footnote-2) | >90% |
| 8 | Number of new health care workers who graduated from a pre-service training institution or program as a result of PEPFAR-supported strengthening efforts, within the reporting period | 1670  240[[3]](#footnote-3) |
| 9 | Percentage of targeted provincial and district level health offices that have access to and routinely use HRIS | 90% |
| 10 | Proportion of PMO and DMO personnel who have received an annual performance appraisal in the past year in targeted districts | 80% |
| 11 | Number of non-finance based incentives to attract health professionals in remote areas identified, costed, and submitted for review by GRZ | 3 |
| 13 | Percentage of national government expenditure on health out of general government expenditure | 12% |
| 16 | Number of months per year in which targeted districts receive monthly funding as per approved budget (within 60 days) | 12 |
| 17 | Proportion of funds disbursed to targeted districts out of total approved annual  budget of districts | 95% |
| 18.a | Proportion of funds disbursed (by targeted districts) to health facilities out of their approved total annual budget | ≥58% |
| 18.a | Proportion of funds disbursed (by targeted districts) to hospital out of their approved total annual budget | ≥30% |
| 19 | Number of improvements to laws, policies, strategies, regulations, or guidelines | 11 |
| 26 | Percent of targeted facilities submitting HMIS reports in a timely manner | 90% |
| 6.a | Percent of target provinces that demonstrate capacity to sustainably plan, manage, and oversee accessible high quality health services | 100% |
| 6.b | Percent of target districts that demonstrate capacity to sustainably plan, manage and oversee accessible high quality health services | 100% |
| 7 | Percent of targeted facilities in target districts that demonstrate capacity to deliver high quality health services and engage with communities in their catchment area | 85% |
| 23 | Capacity score of targeted provinces and districts | ↑TBD |
| 24 | Percent of targeted provinces that conducted at least two reviews of their annual action plans, in the past year | 100% |
|  | Percent of targeted districts that conducted at least two reviews of their annual action plans, in the past year | 100% |
| 25.a | Percent of targeted PMOs that use HMIS data routinely | 100% |
| 25.b | Percent of targeted DMOs that use HMIS data routinely | 100% |
| 27 | Number of health managers and providers trained in management and leadership | 250 |
| 28.a | Percent of target facilities that did not experience a stock-out of Coartem (ACT) during the reporting period | 100% |
| 28.b | Percent of target facilities that did not experience a stock-out of contraceptive (injectable) during the reporting period | 100% |
| 30 | Number and percent of children who received DPT3 vaccine by 12 months of age in targeted districts | ≥90 |
| 30.b | Number targeted districts scoring above ≥90 percentage of children who received DPT3 vaccine by 12 months of age | ≥90 |
| 31 | Percent of HIV-positive pregnant women who received antiretroviral treatment to reduce risk of mother-to-child-transmission in targeted districts | 90% |
| 32 | Percentage of targeted DMOs that have completed their semi-annual PA and TSS visits to facilities in their catchment area | 80% |
| 32.b | Percentage of targeted DMOs that have completed their self-semi-annual PA and TSS visits to facilities in their catchment area | 80% |
| 33 | Percent of targeted DMOs that demonstrate specific performance improvements since their previous PA | TBD |
| 34.a | Percent of targeted primary care facilities that have received TSS or clinical mentoring in the past six months | 90% |
| 35 | Percent of targeted facilities in targeted districts that have up-to-date and gender sensitive job aids for HIV, FP, MNCH, and/or nutrition | 100% |
| 36 | Percent of targeted facilities in targeted districts that have initiated QI projects in ART, PMTCT, MC, FP, child health and nutrition, or maternal health services with documented process results.[[4]](#footnote-4) | 85% |
| 37 | Number of people trained in child health and nutrition[[5]](#footnote-5) | 4,720 |
| 38 | Number of people trained in maternal and newborn health | 1,580 |
| 39 | Number of people trained in FP/reproductive health | 440 |
| 40 | Number of new health care workers who successfully completed an in-service training program within the reporting period | 2,650 |
| 43 | Number of CHAs that receive routine supervision (from health facility staff) in target facility catchment areas | 420 |
| 44 | Number of community volunteers (including SMAGs, others) that have received equipment to deliver priority community health services in targeted facility catchment areas | 1,824 |
| 46 | Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS in target areas | 1,500 |
| 48 | Percent of target health facilities with a functionalfacility/community-level Quality Improvement (QI) committee | 80% |
| 49 | Percent of children under five years of age who received Vitamin A from USG-supported programs in target districts | ≥80% |

# CHAPTER 2: METHODOLOGY

The baseline assessment data collection consisted of desk reviews of all available documents and reports on health programs in the target provinces and districts. SBH’s Research Monitoring and Evaluation Unit (RME) sought the cooperation and support of the Ministry of Health Central (Policy and Planning Directorate), PMOs, and DMOs, and other technical service providers to provide data and needed documents pertaining to the health program of interest to SBH.

SBH’s AMEP framework guided the design of the baseline assessment.

## Sources of Data

The SBH team identified the sources of data for the baseline assessment. They included health program implementers such as the MOH Headquarters, PMOs, DMOs, Community Service Organizations, (CSOs) and other implementing and technical assistance agencies who have specific data sets on programmes of interest to SBH.

## Data Collection

SBH compiled a list of the documents and sent out a general request to all the identified sources in the target districts to provide information and data on task specific indicators. The SBH team collected data through the compilation of existing data from the HMIS, PMOs, and DMOs. The team collected and analyzed the data on key metrics related to the project focus areas. This list comprised the following documents:

1. Zambia’s HMIS, including the newly added DHIS2
2. HRIS
3. MOH Financial Reports
4. GRZ Financial Report
5. District Annual Action Plans
6. District Financial Reports
7. PA Reports
8. TSS reports at provincial and district levels in targeted provinces and districts

SBH data collection was confined to data collected in 2015. However, there were some indicators for which data was based on alternative time periods due to non-data availability of data for the period. In addition, due to inadequacy of certain data for the reporting time periods, SBH used indicators for different time periods instead (i.e., quarterly, semi-annual, and annual as defined in the performance indicator reference sheets).

## Limitation of the Baseline Assessment

The SBH team encountered some issues in the compilation and analysis of the data obtained during the assessment. These issues were due to time period differences when the team collected data and the reliance on different sources of data. Furthermore, the MOH HMIS that was supposed to provide most of the data did not allow access to certain data sets due to its policy of not allowing outside users access to non-published data. These and other challenges constrained the accurate determination of baselines for areas of SBH interventions. We explain specific challenges in more detail in the following sections.

1. The team did not collect data on some indicators because during the period under study some of the data was not available in the HMIS as envisioned in the design of the AMEP.
2. Some data could not be accessed due to late submissions to HMIS or incomplete data for the indicator “percent of targeted facilities submitting HMIS reports in a timely manner”
3. The following indicators from HMIS showed higher (above 100%) because of the denominators used in the system from the Central Statistical Office in the census report which is lower than the catchment population:
   1. Percentage of children aged 12 to 23 months fully immunized in targeted districts
   2. Number and percentage of children who received DPT3 vaccine by 12 months of age in targeted districts
   3. Percentage of children under five years of age who received Vitamin A from USG-supported programs in target districts
4. Some data sourced through the PMOs and DMOs was self-reported

# CHAPTER 3: BASELINE VALUES FOR GOALS

This section of the report presents the details of the baseline values for the SBH indicators which we presented in the table on page 15 entitled ‘Summary of SBH specific indicators by links and target.’ The data, presented mostly as tables, are intended to give the reader an overview of the indicators and the baseline value.

To measure goal level results of SBH, USAID identified the following outcome level indicators:

* Proportion of deliveries assisted by a medically trained providers in targeted districts
* CYP in targeted districts
* Proportion of fully immunized children aged 12 to 23 months in targeted districts
* Retention of HIV patients in targeted districts on ART

## 3.1 Indicator 1. Proportion of deliveries assisted by a medically trained provider in targeted districts

Delivery by a medically trained provider is an important metric because skilled personnel can recognize complications and intervene appropriately through treatment and referral. An increase in deliveries by appropriately trained providers contributes towards the reduction in maternal and infant mortality. SBH defined the term “medically trained provider” in alignment with MOH definitions. The definition includes deliveries conducted by a midwife, gynecologist/obstetrician, nurse, clinical officer, medical licentiate, or medical officer. This indicator measures the proportion of deliveries conducted by medically trained providers in SBH targeted districts.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Proportion of deliveries with assistance from a medically trained provider in targeted districts | | | | |
| Province | District | October to December 2015 | | |
|  | Deliveries by medically trained provider | Expected deliveries[[6]](#footnote-6) | Proportion of deliveries |
| Central | Kabwe | 2,067 | 6,870 | 30% |
| Mkushi | 1,024 | 6,507 | 16% |
| Copperbelt | Kitwe | 7,178 | 24,168 | 30% |
| Mufulira | 2,238 | 6,944 | 32% |
| Chingola | 1,992 | 3,464 | 57.5% |
| Chililabombwe | 660 | 1,535 | 43.0% |
| Eastern | Petauke | 3,834 | 13,630 | 28% |
| Chipata | 9,072 | 26,435 | 34% |
| Lusaka | Lusaka | 17,998 | 110,675 | 16% |
| Shibuyunji | 848 | 3,878 | 22% |
| Southern | Monze | 4,074 | 10,978 | 37% |
|  | Livingstone | 2,100 | 8,536 | 25% |
|  | SBH Targeted Districts |  |  | 23.7% |

*Data Source: Ministry of Health-HMIS*

|  |
| --- |
| *Baseline value*  The baseline shows that 23.7% of the deliveries in October to December 2015 were assisted by a medically trained provider in target districts. |

## 3.2 Indicator 2. CYP in target districts

CYP aims to monitor progress in the delivery of contraceptive services in areas supported by the project. It is calculated by multiplying the number of each contraceptive method given to clients by a corresponding conversion factor.  This yields an estimate of the duration of contraceptive protection provided. One full CYP is the equivalent of one year of protection from unintended pregnancy for one couple.The table below shows the CYP in SBH target districts. See Annex 1 by type of method.

|  |  |  |  |
| --- | --- | --- | --- |
| CYP in targeted districts | | | |
| Province | District | CYP in target districts January to December 2015 | |
| Central | Kabwe | | 20,354 |
|  | Mkushi | | 12,349 |
| Copperbelt | Kitwe | | 56,303 |
|  | Mufulira | | 12,214 |
|  | Chingola | | 31,070 |
|  | Chililabombwe | | 10,327 |
| Eastern | Petauke | | 11,806 |
|  | Chipata | | 33,884 |
| Lusaka | Lusaka | | 93,526 |
|  | Shibuyunji | | 2,690 |
| Southern | Monze | | 16,238 |
|  | Livingstone | | 10,091 |
|  | Total | | 310,850 |

*Data Source: Ministry of Health-HMIS*

## 3.3 Indicator 4. Percent of children aged 12 to 23 months fully immunized in targeted districts

Vaccination coverage is an important metric because when a larger proportion of children are immunized the chances of immunizable disease outbreaks (e.g., measles) are reduced, and more children are protected against such diseases. This indicator measures the proportion of children aged 12 to 23 months who are fully immunized[[7]](#footnote-7) in targeted districts.

Despite the average percent of children 12 to 23 months fully immunized being above 80 percent as shown in the table below, districts including Kitwe, Mufulira, and Livingstone recorded less than 69 percent and 67 percent respectively. However, it should be noted that some districts recorded over 100 percent because of the denominator that is the Central Statistics Office provides the population that is less than the head counts used by the facilities in the districts.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Percentage children aged 12 to 23 months fully immunized in targeted districts  July to December 2015  (Except Chingola and Chililabombwe, January to March 2016) | | | | |
| Province | District | Projected Census population data of children aged 12-23 months | Number of fully immunized | Percent of children 12-23 months fully immunized |
| Central | Kabwe | 2,828 | 3,705 | 131% |
| Mkushi | 3,723 | 4,244 | 114% |
| Copperbelt | Kitwe | 13,132 | 9,061 | 69% |
| Mufulira | 3,975 | 2,743 | 69% |
| Chingola\* | 2,665 | 2,126 | 81% |
| Chililabombwe\* | 1,180 | 821 | 70% |
| Eastern | Chipata | 10,488 | 10,803 | 103% |
| Petauke | 4,588 | 4,680 | 102% |
| Lusaka | Lusaka | 47,596 | 39,505 | 83% |
| Shibuyunji | 1,328 | 1,394 | 105% |
| Southern | Livingstone | 3,421 | 2,292 | 67% |
| Monze | 4,513 | 4,378 | 97% |
|  | Targeted Districts | 99,437 | 85,752 | 86% |

*Data Source: Ministry of Health-HMIS and Central Statistics Census 2010 Projection*

|  |
| --- |
| *Baseline value*  The percent of children aged 12 to 23 months fully immunized in targeted districts was 86.2%. |

## 3.4 Indicator 5. Percentage of adults and children known to be alive and on treatment 12 months after initiation of ART in targeted districts

This indicator measures the proportion of individuals who have been retained on ART. Death and loss to follow-up are the two highest causes of patient attrition from ART, especially in the first few months after initiating therapy. High retention is one important measure of SBH success because this will specifically reduce morbidity and mortality and is a proxy for overall quality of the ART program. Monitoring the program retention level is a critical quality of service indicator at the district as it can highlight barriers to health seeking behaviors and/or gaps in access to and provision of health services. This indicator is also important for long-term sustainability of the ART programs. The data for this indicator was not available from the HMIS because it does not track patient cohorts. The data presented below was collected through PEPFAR DATIM.

The table below shows the percentage of adults and children known to be alive and on treatment 12 months after initiation of ART by targeted districts. Chingola, Chililabombwe, Shibuyunji and Mkushi had the highest retention rates, followed by Kabwe, Monze, Petauke, Livingstone and Kitwe with at least 80 percent retention rate, with the rest of the districts having less than 80 percent.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Percentage of adults and children known to be alive and on treatment 12 months after initiation of ART in targeted districts  October 2014 - September 2015 | | | | |
| Province | District | Total Initiated ART in 12 months | Alive and on treatment at 12 months after initiating ART | Retention rate |
| **Central** | Kabwe | 3,153 | 2,776 | 88% |
| Mkushi | 985 | 908 | 92% |
| **Copperbelt** | Kitwe | 5,338 | 4,360 | 82% |
| Mufulira | 1,316 | 1,017 | 77% |
| **Eastern** | Petauke | 2,125 | 1,768 | 83% |
| Chipata | 3,628 | 2,793 | 77% |
| **Lusaka** | Lusaka | 27,081 | 20,709 | 76% |
| Shibuyunji | 1,033 | 952 | 92% |
| **Southern** | Monze | 2,121 | 1,786 | 84% |
| Livingstone | 2,566 | 2,134 | 83% |

*Data Source: PEPFAR DATIM*

As noted above, baseline data for Chingola and Chililabombwe districts were collected at a different point in time than most of the Phase 1 districts. Data for these districts are shown separately as they were sourced directly from HMIS. The HMIS data differs from the DATIM data because it does track cohorts. However, we used the HMIS during for the two districts because DATIM data was not made available.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Percentage of adults and children known to be alive and on treatment 12 months after initiation of ART in targeted districts  October 2014 - September 2015 | | | | |
| Province | District | Total Initiated ART in 12 months | Alive and on treatment at 12 months after initiating ART | Retention rate |
| **Copperbelt** | Chingola | 2,511 | 2,587 | 103% |
| Chililabombwe | 711 | 675 | 94% |

*Data Source: HMIS*

|  |
| --- |
| *Baseline value*  The baseline finding shows that in all SBH targeted districts at least 77% of adults and children who initiated ART were alive and on treatment after 12 months for the period October 2014-September 2015. |

# CHAPTER 4: BASELINE VALUES BY TASK

## Task 1: Design, implement and monitor national level interventions to strengthen health stewardship

This section of the baseline assessment report presents the indicator tracked under Task 1 by its sub-tasks. The sub-tasks presented in this section are: sub-task 1.1, which will strengthen Human Resource Planning and Management; sub-task 1.2, which will improve health care financing and PFM; and sub-task 1.3, which will strengthen MOH capacity to oversee delivery of key health programs.

#### 4.1.1 Sub-task 1.1: Strengthen Human Resource Planning and Management

1. Indicator 8. Number of new health care workers who graduated from a pre-service training institution or program as a result of SBH supported strengthening efforts within the reporting period

Zambia faces a shortage of trained personnel in the health sector. SBH supports three midwifery schools and other training institutions through either direct or indirect support to increase the number of graduates from pre-service training institutions within the reporting period.

|  |
| --- |
| *Baseline value*  This is an output indicator, the baseline value is 0. |

1. Indicator 9. Percent of targeted provincial and district level health offices that have access to and routinely use HRIS

Zambia currently does not have the capacity to produce a sufficient number of health workers to meet current and projected needs. SBH helps the PMOs and DMOs develop and implement the HRIS and technical assistance through the Human Resource Specialist in the targeted provinces and districts. SBH trains, organizes data entry, procures computers for HRIS, and produces routine reports. At the subnational level, the Ministry has not fully implemented the use of HRIS to guide decisions on recruitment, training, or distribution of personnel.

One of the indicators for SBH is to measure the proportion of targeted provincial and district health offices that have access[[8]](#footnote-8) to and routinely[[9]](#footnote-9) use HRIS. To answer this indicator, SBH asked a series of questions to capture this indicator concerning availability of computers for HR, training of HR health workers through the HRIS, and routine use of HRIS.

The table below shows the percentage of targeted provincial and district health offices that have access to and routinely use HRIS. Two out of five SBH targeted provinces and only four districts (Kitwe, Mufulira, Petauke, and Monze) have access to and routinely use HRIS. Of those districts which had no access to HRIS, the district respondents mentioned lack of computers and training in HRIS.

[Note, when baseline data was collected for Chingola and Chililabombwe, the former HRIS system was no longer in use due to the MOH process of rolling out the new HRIS system.]

See Annex 2 for detailed data.

|  |  |  |  |
| --- | --- | --- | --- |
| Percentage of targeted provincial and district level health offices that have access to and routinely use HRIS  July – December 2015 | | | |
| **Provinces** | **Use HRIS routinely** | **Districts** | **Use HRIS routinely** |
| Central | X | Kabwe | X |
| Mkushi | X |
| Copperbelt | √ | Kitwe | √ |
| Mufulira | √ |
| Chingola\*\* | X |
| Chililabombwe\*\* | X |
| Eastern | X | Petauke | √ |
| Chipata | X |
| Lusaka | X | Lusaka | X |
| Shibuyunji | X |
| Southern | √ | Monze | √ |
| Livingstone | X |
| % of Provinces that meet criteria | 40% | % of Districts that meet criteria | 33% |
| √=Yes  X=No | | | |

\*\*Note: The time period for baseline for these districts was January 2016 – June 2016.

|  |
| --- |
| *Baseline value*  The baseline is 40% for provincial health offices and 33% for district health offices. |

1. Indicator 10. Proportion of PMO and DMO personnel who have received an annual performance appraisal in the past year in targeted districts

The MOH does not consistently conduct annual performance appraisals to measure staff performance and improve service delivery. As a result, the MOH has not internalized annual performance appraisals as a management tool. SBH has developed a strategy to orient health facility personnel on how to use the PMP, with a focus on the Annual Performance Appraisal System (APAS) to improve monitoring of personnel performance.

During the life of the project,SBH will track the proportion of PMO and DMO personnel in targeted districts who received an annual performance appraisal in the past year. As shown in the table below, SBH will compare the total number of personnel, verified with the HR Office, with the number of personnel appraised, using appraisal forms to track use of the APAS in each of the target districts.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Proportion of PMO and DMO personnel who have received an annual performance appraisal in the past year in targeted districts | | | | |
| Province | Number of personnel | Province/ District conducted Performance Appraisal in 2015 | Number of personnel who received performance Appraisal | Percentage of PMO/DMO staff that received annual perf appraisal |
| Central | 52 | √ | 36 | 69.2% |
| Copperbelt | 54 | √ | 46 | 85.1% |
| Eastern | 59 | X | 0 | 0.0% |
| Lusaka | 80 | √ | 17 | 21.3% |
| Southern | 56 | √ | 10 | 17.9% |
| Targeted Provinces | 301 | 80% of provinces  (4 of 5) | 109 | 36.2% |
| **Districts** | | | | |
| Kabwe | 533 | √ | 385 | 72.2% |
| Mkushi | 228 | √ | 95 | 41.7% |
| Kitwe | 752 | √ | 163 | 21.7% |
| Mufulira | 421 | √ | 96 | 22.8% |
| Chingola | 33 | √ | 19 | 57.5% |
| Chililabombwe | 21 | X | 0 | 0% |
| Petauke | 396 | √ | 347 | 87.6% |
| Chipata | 557 | √ | 296 | 53.1% |
| Lusaka | 1,800 | √ | 320 | 17.7% |
| Shibuyunji | 64 | X | 0 | 0.0% |
| Monze | 358 | √ | 18 | 5% |
| Livingstone | 365 | √ | 105 | 28.8% |
| **Targeted Districts** | 5,528 | 83.3% of districts  (10 of 12) | 1,844 | 33.3% |
| √=Yes  X=No | | | | |

*Data Source: Staff Retention Report and Appraisal Forms*

|  |
| --- |
| *Baseline value*  The baseline is 36.2% for provincial personnel and 33.3% for district personnel. |

1. Indicator 11. Number of non-finance based incentives to attract health professionals in remote areas identified, costed, and submitted for review by GRZ

The MOH is currently facing a number of challenges in retaining health professionals in remote areas despite providing rural hardship monetary incentives. According to the Zambia Health Workers Retention Scheme Guideline, remote area means that there should be a greater degree of difficulty in reaching the facility due to bad or seasonally impassable gravel or dirt roads and/or having to use a boat to get to the facility for health care. (Rural Health Centers along tarred roads do not qualify).

Traditionally, non-finance based incentives such as certificates of recognition, training, supervision, mentorship, availability of equipment, material support (accommodation, transport) have attracted health professionals in remote areas. SBH will identify more other viable options for the provision of non-financial incentives in remote areas.

|  |
| --- |
| *Baseline value*  This is an output indicator, so the baseline is 0. |

#### 4.1.2 Sub-task 1.2: Improve health care financing and PFM

This section shows the baseline values for the indicators tracked under this task. They are:

* Percentage of national government expenditure on health out of general government expenditure
* Number of months per year in which targeted districts receive budgeted monthly funding (within the month)
* Districts out of total approved annual district budget Proportion of funds disbursed (by targeted districts) to health facilities out of their approved total annual budget.

1. Indicator 13. Percentage of national government expenditure on health out of general government expenditure

SBH has in motion a program to help the MOH monitor the percentage of national government expenditure on health (with disaggregation on HIV/AIDS and other priorities in health). The baseline review shows that the percentage of total government expenditures on health was 7.00 percent in 2015, as shown in the table below. Generally, the level of GRZ funding to the health sector between 2011 and 2015 is less than the 15 percent target agreed at the Abuja Declaration on health. Current information from Zambia’s draft National Health Accounts (MOH, 2013) states that nearly 40 percent of total health expenditures were donor-financed in 2010. Donor contributions lift health spending to about 12 percent of total government expenditures, still short of the Abuja Declaration standard. Such heavy reliance on donor financing makes the country health system vulnerable to unpredictable fluctuations in donor funding.

|  |  |
| --- | --- |
| Percent of national government expenditure on health out of general government expenditure  2015 Budget (MOH/MCDMCH) | |
|  | ZMK |
| National government expenditure on health | 3,616,045,602 |
| General government expenditure | 51,684,800,000 |
| **Percentage of Total Expenditure** | **7.00%** |

*Data Source: 2015 Ministry of Health Financial Report and Bank of Zambia Annual Report 2015*

|  |
| --- |
| *Baseline value*  This will be the first time that SBH will be monitoring the national government health expenditure and will therefore use the baseline of 7.00% of the total expenditure as the baseline. |

1. Indicator 16. Number of months per year in which targeted districts receive budgeted monthly funding on time

Timely release of district budgets enables execution of planned activities. Delays in the disbursement of funds from MOF to provinces and districts have often delayed implementation of activities at district levels. SBH plans to strengthen evidence-based planning and budgeting, build skills in financial management at central, PMO and DMO levels, and improve reporting and auditing to ensure timely disbursement for increased accountability and transparency.

This indicator measures how many months in the fiscal year the district received timely funding. SBH targeted districts received timely funding in 9.75 months out of 12 months, on average, in 2015. Livingstone, Chingola and Chililabombwe received the funds for 12 months, the best record, followed by Chipata at 10 months. The poorest record was Mkushi, which received the funds in eight months, as shown in the table below.

|  |  |  |
| --- | --- | --- |
| Number of months per year in which targeted districts receive monthly funding as per approved budget | | |
| Province | District | Number of months |
| Central | Kabwe | 9 |
| Mkushi | 8 |
| Copperbelt | Kitwe | 9 |
| Mufulira | 9 |
| Chingola | 12 |
| Chililabombwe | 12 |
| Eastern | Chipata | 10 |
| Petauke | 9 |
| Lusaka | Lusaka | 9 |
| Shibuyunji | 9 |
| Southern | Livingstone | 12 |
| Monze | 9 |
| **Targeted Districts** | | **9.75** |

Data Source: District Financial Annual Report for 2015

|  |
| --- |
| *Baseline value*  The baseline is that districts received timely funding an average of 9.75 months out of 12 months among targeted districts. |

1. Indicator 17. Proportion of funds disbursed to targeted districts out of total approved annual budget of districts

SBH plans to strengthen evidence-based planning and budgeting, build skills in financial management, and improve reporting and auditing to ensure accountability and transparency. This indicator measures the proportion of funds disbursed to districts out of total approved annual district budgets. The data show that among SBH target districts, 77 percent of district budgets were disbursed in 2015. This can be related to the number of months in which the districts received the funds on time. A further analysis showed that apart from late disbursement, the disbursements amounts did not match budgeted amounts. The data shows that the districts do not receive the actual budget amounts approved. Chingola received the highest proportion, 100% percent of its approved budget, followed by Kabwe (99.1%), Mufulira (88.6%), with Chipata having the poorest record (70.1%), as shown in the table below.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Proportion of funds disbursed to targeted districts out of total approved annual budget of districts  (2015) | | | | |
| Province | District | Total annual budget | Amount disbursed | % of funds disbursed |
| Central | Kabwe | 2,764,438.00 | 2,739,313.94 | 99.1% |
| Mkushi | 2,654,700.00 | 2,022,385.00 | 76.2% |
| Copperbelt | Kitwe | 3,815,652.00 | 2,826,409.35 | 74.1% |
| Mufulira | 1,859,016.00 | 1,647,588.00 | 88.6% |
| Chingola | 2,281,572 | 2,281,572 | 100% |
| Chililabombwe | 1,367,816 | 1,284,498 | 93.9% |
| Eastern | Petauke | 4,903,538.21 | 3,324,372.78 | 67.8% |
| Chipata | 7,675,803.00 | 5,379,059.56 | 70.1% |
| Lusaka | Lusaka | 11,475,313.00 | 8,526,000.00 | 74.2% |
| Shibuyunji | 739,458.00 | 547,656.77 | 74.1% |
| Southern | Monze | 3,566,149.00 | 2,6415,93.23 | 74.1% |
| Livingstone | 1,542,000.00 | 1,142,381.00 | 74.1% |
| **SBH Target Districts** | | **44,645,455.21** | **34,362,829.63** | **77%** |

*Data Source: District Financial Annual Report for 2015*

|  |
| --- |
| *Baseline value*  Baseline is 77% of targeted district funding was disbursed. |

1. Indicator 18. Proportion of funds disbursed (by targeted districts) to health facilities out of their approved total annual budget

This indicator measures the proportion of funds disbursed by districts to health facilities out of their approved total annual budget. Data in the district annual financial report for 2015 showed that on average 56.4 percent of the total targeted districts budget went to the facility level, as the table below shows. Chipata disbursed the highest proportion of its budgeted funds to the facilities (83.6%) followed by Chililabombwe (74.5 %).

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Proportion of funds disbursed by targeted districts to health facilities out of their approved total annual 2015 budget | | | | |
| Province | District | Total annual district budget | Amount disbursed to facilities | % of budget disbursed to facilities |
| Central | Kabwe | 2,764,438.00 | 1,739,313.94 | 62.9% |
| Mkushi | 2,654,700.00 | 1,469,621.00 | 55.4% |
| Copperbelt | Kitwe | 3,815,652.00 | 1,413,204.68 | 37.0% |
| Mufulira | 1,859,016.00 | 906,173.40 | 48.7% |
| Chingola | 2,281,572.00 | 1,278,500.00 | 56.0% |
| Chililabombwe | 1,367,816.00 | 1,018,978.00 | 74.5% |
| Eastern | Petauke | 4,903,538.2 | 2,825,716.86 | 57.6% |
| Chipata | 7,675,803.00 | 6,415,433.24 | 83.6% |
| Lusaka | Lusaka | 11,475,313.00 | 5,539,626.00 | 48.3% |
| Shibuyunji | 739,458.00 | 265,175.20 | 35.9% |
| Southern | Monze | 3,566,149.00 | 1811,436.98 | 50.8% |
| Livingstone | 1,542,000.00 | 514,071.00 | 33.3% |
|  | SBH Target Districts | **44,645,455.20** | **25,197,250.30** | **56.4%** |

*Data Source: District Financial Annual Report for 2015*

|  |
| --- |
| *Baseline value*  The baseline is 56.4 percent. |

#### 4.1.3 Sub-task 1.3: Strengthen MOH capacity to oversee delivery of key health programs

This task is measured through the following indicators:

* Number of improvements to laws, policies, strategies, regulations, or guidelines
* Percent of targeted facilities submitting HMIS reports in a timely manner

1. Indicator 19. Number of improvements to laws, policies, strategies, regulations, or guidelines

SBH works with the MOH in different program areas to strengthen systems by improving laws, policies, regulations, guidelines, or systems. The main goal of this indicator is to track the number of improved laws, policies, regulation, guidelines, or systems. SBH will work with MOH to identify laws, policies, regulations, and guidelines to help the MOH adopt, implement, or institutionalize them to strengthen the health system.

This indicator measures progress in improving the enabling environment for strengthening health systems and improving access and use of high quality priority health services. The project intends to focus on the review of the National Health Strategic Plan, Human Resource Strategic Plan, Health Care Financing Strategic Plan, National Training Operation Plan, Social Health Insurance Plan, Ministry of Health Institution Plan, and guidelines, including the Planning Guidelines, Mentorship Tools, Community Health Workers Curriculum, and PMTCT and pediatric HIV care guidelines.

|  |
| --- |
| *Baseline value*  This is an output indicator, so the baseline is 0. |

1. Indicator 26. Percent of targeted facilities submitting HMIS reports in a timely manner

Generating and using of information is an important element of a strong and functioning health system. SBH will work with the MOH to improve capacities to generate and use health information at various levels to inform decision making. One element of quality health information is ensuring submission of data in timely fashion. The data management process in HMIS is measured by the following indicators: completeness; timeliness[[10]](#footnote-10); and availability of paper tools for capturing data.[[11]](#footnote-11) Of these indicators, SBH measures the timeliness of data submission.

The figure below shows the percentage of targeted facilities submitting timely HMIS reports for the period October to December 2015. This indicator measures timely submission and completeness of data submitted to HMIS through the DHIS2 by selected facilities in the respective SBH districts. SBH supports 15 facilities in each district and thus the data presented came from 15 supported facilities in each district. (The period of review was October to December 2015, except for Chingola and Chililabombwe, which covered April-June 2016).

*Data Source: Ministry of Health-HMIS*

According to the current findings, Petauke recorded the highest rate of timely facility reporting (93%), followed by Kabwe and Mkushi, which recorded 88 percent and 85 percent respectively. The lowest rates were Kitwe and Shibuyunji, with 42 percent each. Some districts had missing data from some facilities which failed to generate reports about time of submission. See Annex 3.

|  |
| --- |
| *Baseline value*  The baseline for timely submission of HMIS reports among targeted facilities ranged from 42% to 93% in targeted districts, and average of 67%. |

## Task 2: Design, implement, and monitor effective interventions to strengthen program management capacities of provincial and district health teams

This section of the baseline assessment report presents the indicator tracked under Task 2 by its sub-tasks. The sub-tasks presented in this section are: sub-task 2.1, which will strengthen program management capacity of provincial and district health teams; and sub-task 2.2, which will improve technical capacity of provincial and district health teams to deliver quality health services in facilities.

#### 4.2.1 Sub-task 2.1: Strengthen program management capacity of provincial and district health teams

The following indicators will measure the results of the proposed interventions:

* Percentage of target provinces/districts that demonstrate sustainable capacity to plan, manage, and oversee accessible high quality health services
* Percentage of targeted facilities in target districts that demonstrate capacity to deliver high quality health services and engage with communities in their catchment area
* Capacity score of targeted provinces and districts
* Percentage of targeted provinces/districts that conducted at least two reviews of their annual action plans in the past year
* Percentage of targeted PMOs/DMOs that use HMIS data routinely
* Number of health managers and providers trained in management and leadership
* Percentage of target facilities that did not experience a stock-out of indicator commodity Coartem (ACT) during the reporting period
* Percentage of target facilities that did not experience a stock-out contraceptive (injectable) during the reporting period

1. Indicator 6. Percentage of target provinces/districts that demonstrate sustainable capacity to plan, manage, and oversee accessible high quality health services

This is a composite index indicator to measure comprehensive provincial and district capacity. Several weighted measures will collectively demonstrate a sustainable combination of strengthened systems, management and technical capacity, and broad engagement.

|  |
| --- |
| *Baseline value*  The baseline for this indicator is yet to be determined as the provincial and district capacity assessment reports were not yet finalized. |

At the time of the baseline, SBH had conducted the provincial and district capacity assessment using a participatory approach with the target provinces and districts. SBH is at the point of finalizing the data analysis and report writing, which will guide the measurement and calculation of this indicator.

1. Indicator 7. Percentage of targeted facilities in target districts that demonstrate capacity to deliver high quality health services and engage with communities in their catchment area

This is a composite index indicator to measure comprehensive facility level capacity. Illustrative sub-indicators may include: evidence that priority policy/standards/procedures have been disseminated and are in use at facilities; minimum facility capacity score for selected performance domains; availability of trained staff; availability of a community action plan; broad engagement of communities; documented improvement in selected service utilization indicators (such as number of institutional deliveries) over a period of time; or others.

|  |
| --- |
| *Baseline value*  The baseline and measures for this indicator are yet determined since the community capacity assessment report were not yet finalized. |

At the time of the baseline, SBH had not yet conducted the community capacity assessment. However, SBH is preparing for the community capacity assessment, which will reaffirm some of the proposed different weights in terms of the feasibility of measuring them and identify some of the feasible metrics to be used to measure this indicator.

1. Indicator 23. Capacity score of targeted provinces and districts

A fundamental strategy of SBH to achieve and sustain its intended results is to build capacity at all levels. SBH will use a capacity assessment tool at multiple levels for routine capacity measurement against pre-determined/pre-defined performance standards. The capacity assessment will generate scores by performance domain and a total score. Performance domains include: planning systems; PA, QI, Health management information system. The assessment will enable SBH to develop a strategy for capacity building that focuses on the design and implementation of guidance documents.

|  |
| --- |
| *Baseline value*  SBH will use the results of the provincial/district and community capacity assessment to develop the capacity scores. |

1. Indicator 24. Percentage of targeted provinces/districts that conducted at least two reviews of their annual action plans in the past year

This indicator measures the proportion of provinces/districts that conducted at least two reviews of their annual action plans in the past year. The baseline review showed that 40 percent of targeted provinces and 90 percent of the targeted districts conducted at least two reviews of their annual action plans in 2015.

The table below shows the percentage of targeted provinces/districts that conducted at least two reviews of their annual action plans in the past year. The data show that Copperbelt and Southern provincial headquarters and districts conducted at least 2 reviews of their annual action plans. Other districts in the SBH target provinces conducted their annual actions plans except for Petauke in Eastern Province which was the only district not to do so in the province.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Percentage of targeted provinces/districts that conducted at least two reviews of their annual action plans in the past year  January 2015 – December 2015 | | | | |
| **Province** | **Conducted at least 2 reviews** | **Districts** | **Conducted at least 2 reviews** | |
| Central | No | Kabwe | | Yes |
| Mkushi | | Yes |
| Copperbelt | Yes | Kitwe | | Yes |
| Mufulira | | Yes |
| Chingola | | No |
| Chililabombwe | | Yes |
| Eastern | No | Petauke | | No |
| Chipata | | Yes |
| Lusaka | No | Lusaka | | Yes |
| Shibuyunji | | Yes |
| Southern | Yes | Monze | | Yes |
| Livingstone | | Yes |
| % of Provinces that conducted at least two reviews | 40% | % of Districts that conducted at least two reviews | | 83.3% |

*Data Source: 2015-Updated Action Plan*

|  |
| --- |
| *Baseline value*  Baseline value is 40% for provinces and 83.3% for districts. |

1. Indicator 25. Percentage of targeted PMOs/DMOs that use HMIS data routinely[[12]](#footnote-12)

Decision making is an important element of health system strengthening and availability. Use of information ensures that stakeholders can make evidence-based and timely decisions. SBH will support various interventions to improve the generation and use of high quality data and will promote routine use of this data by decision makers.

The indicator for this sub-task will measure the level of use HMIS data among stakeholders. The indicator will measure the percentage of targeted PMOs/DMOs that use HMIS data routinely. Information on the use of data by PMOs/DMOs will look at the availability of an Information Officer, access to DHIS2, training in DHIS2, accreditation to DHIS2, and frequency of use of information from HMIS (see Annex 4).

The assessment found that all the five PMO offices used HMIS data for planning and decision making however only 40% of DMOs ever used HMIS. The following table shows the existing trends in routine use of HMIS within the five target provinces. Use of HMIS requires being given the user access to the system, granting of user access to HMIS was found to be generally limited to information officers at provincial and district levels. Although use of HMIS at PMOs were found to be 100% it was only 50% at the district level as majority of districts did not routinely use the HMIS system for a variety of reasons.

|  |  |  |  |
| --- | --- | --- | --- |
| Percent of targeted PMOs/DMOs that use HMIS data routinely | | | |
| Use of HMIS Routinely[[13]](#footnote-13) | | | |
| Province |  | Districts |  |
| Central | √ | Kabwe | √ |
| Mkushi | X |
| Copperbelt | √ | Kitwe | X |
| Mufulira | √ |
| Chingola | √ |
| Chililabombwe | √ |
| Eastern | √ | Petauke | √ |
| Chipata | X |
| Lusaka | √ | Lusaka | X |
| Shibuyunji | √ |
| Southern | √ | Monze | X |
| Livingstone | X |
| % of targeted Provinces that use HMIS data routinely | 100% | % of targeted districts that use HMIS data routinely | 50% |
| √=Yes  X=Yes | | | |

|  |
| --- |
| *Baseline value*  The baseline value is 100% for provinces and 50% for districts. |

1. Indicator 27. Number of health managers and providers trained in management and leadership

Capacity building training in the health sector has been one of the main strategies for capacity building. Through its sub-contracting partner BRITE, SBH has been involved in in-service training of MOH managers/supervisors at target provincial, district, and hospital/ facility levels to increase their capacity to perform their management functions. BRITE has developed a Management and Leadership Academy (MLA) concept and a curriculum in collaboration with the MOH under the Zambia Integrated Systems Strengthening Project. The academy trains health managers.

The MLA training is expected to lead to improved management, leadership, planning of resources, and service delivery. This indicator will track the number of managers who complete the MLA courses after completing three mandatory training workshops, a combination that means successful completion of the training program.

The baseline indicator for this project output will be considered as 0 because the course has not been applied before.

|  |
| --- |
| *Baseline value*  The baseline value measure of the SBH indicator will be 0. |

1. Indicator 28. Percentage of target facilities that did not experience a stock-out of Coartem (ACT) and contraceptives (injectable) during the reporting period

This indicator will complement the work of the PEPFAR supply chain management system to strengthen the pharmacy professional and build skills to diagnose and solve problems related to stock-outs and excesses.

|  |  |
| --- | --- |
| Percent of targeted facilities that did not experience a stock-out  Oct – Dec 2015 | |
| Coartem  Contraceptive (injectable) | 93.3% |
| 72.3% |

The table below shows stock-out by district, number of targeted facilities, number of facilities with stock-out in Coartem and number of facilities with stock-out in Contraceptive (injectable).

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Percent of targeted facilities that did not experience a stock-out | | | | |
| Province | Districts | Number of target facility | Number of facilities with stock-out in Coartem | Number of facilities with stock-out in Contraceptive (injectable) |
| Central | Kabwe | 15 | 0 | 1 |
| Mkushi | 15 | 5 | 4 |
| Copperbelt | Kitwe | 11 | 1 | 3 |
| Mufulira | 7 | 1 | 3 |
| Chingola | 8 | 0 | 4 |
| Chililabombwe | 4 | 0 | 3 |
| Eastern | Petauke | 15 | 1 | 7 |
| Chipata | 15 | 0 | 4 |
| Lusaka | Lusaka | 15 | 0 | 2 |
| Shibuyunji | 6 | 0 | 3 |
| Southern | Monze | 15 | 1 | 2 |
| Livingstone | 15 | 1 | 3 |
| Total |  | 141 | 10 | 39 |
| 28.a Percent of targeted facilities that did not experience a stock-out Coartem 93.3% | | | | |
| 28.b. Percent of targeted facilities that did not experience a stock-out Contraceptive (injectable) 72.3% | | | | |

|  |
| --- |
| *Baseline value*  93.3% of targeted facilities did not experience a stock-out of Coartem (ACT) during the specified period.  72.3% of target facilities did not experience a stock-out of contraceptive (injectable) during the specified period. |

#### 4.2.2 Sub-task 2.2: Improve technical capacity of provincial and district health teams to deliver quality health services in facilities

The following indicators will be tracked to measure the results of the proposed interventions:

* Number and percentage of children who received DPT3 vaccine by 12 months of age in targeted districts
* Percentage of HIV-positive pregnant women who received antiretroviral treatment to reduce risk of mother-to-child-transmission in targeted districts
* Percentage of targeted DMOs that have completed their semi-annual PA and TSS visits to facilities in their catchment area
* Percentage of targeted DMOs that demonstrate performance improvements since their previous PA
* Percentage of targeted primary care facilities that have received TSS or clinical mentoring for clinical staff in the past six months
* Percentage of targeted facilities in targeted districts that have up-to-date and gender-sensitive job aids for HIV, FP, MNCH, and/or nutrition
* Percentage of targeted facilities in targeted districts that have initiated QI projects in ART, PMTCT, MC, FP, child health and nutrition, or maternal health services with documented process results in past six months
* Number of people trained in child health and nutrition program areas
* Number of people trained in maternal and newborn health
* Number of people trained in FP/reproductive health
* Number of new health care workers who completed an in-service training program within the reporting period

1. Indicator 30. Number and percentage of children who received DPT3 vaccine by 12 months of age in targeted districts

According to the World Health Organization, a child is considered fully vaccinated if he or she has received a Bacille Calmette-Guerin (BCG) vaccination against tuberculosis; three doses of vaccine to prevent diphtheria, pertussis, and tetanus (DPT); at least three doses of polio vaccine; and one dose of measles vaccine. These vaccinations should be received during the first year of life. This indicator will be used to report the percentage of children receiving the final dose (DPT3), which is an important gauge of Zambia’s childhood immunization coverage.

Seven out of 10 districts showed a coverage for DPT-HepB-Hib (3rd Dose) of at least 80 percent. Kitwe, Mufulira, and Livingstone showed less than 70 percent, as shown in the table below. The denominator for some districts leads to a proportion above 100 percent because the MOH uses the denominator from the Central Statistics Office, which may be lower than the facility catchment population.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number and percentage of children who received DPT3 vaccine by 12 months of age in targeted districts  July 2015-December 2015 | | | | | |
| Province | District | Number of living children aged 12-23 months | Number of children 12-23 month of age received DPT3 by 12 months of age | | Percentage |
| Central | Kabwe | 5,988 | | 7,844 | 131% |
| Mkushi | 5,845 | | 6,663 | 114% |
| Copperbelt | Kitwe | 25,983 | | 17,928 | 69% |
| Mufulira | 7,455 | | 5,144 | 69% |
| Chingola | 5,330 | | 4,244 | 80% |
| Chililabombwe | 2,361 | | 1,723 | 73% |
| Eastern | Petauke | 10,378 | | 10,689 | 103% |
| Chipata | 20,453 | | 20,862 | 102% |
| Lusaka | Lusaka | 85,500 | | 70,965 | 83% |
| Shibuyunji | 3,045 | | 3,197 | 105% |
| Southern | Monze | 8,591 | | 8,333 | 97% |
| Livingstone | 6,567 | | 4,400 | 67% |
|  | Targeted Districts |  | |  | 86% |

*Data Source: Ministry of Health HMIS*

|  |
| --- |
| *Baseline Value*  In SBH targeted districts, immunization coverage levels for DPT3 ranged from 67% to full coverage (100% or greater). |

1. Indicator 31. Percentage of HIV-positive pregnant women who received antiretroviral treatment to reduce risk of mother-to-child-transmission in targeted districts

This indicator measures the provision and coverage of ARV prophylaxis and treatment by regimen type for HIV-positive pregnant women. The goals are to identify progress in increasing ARV coverage (prophylaxis and treatment) among pregnant women living with HIV, assess progress toward implementing more efficacious PMTCT ARV regimens, and determine the coverage of HIV+ pregnant women on ARV prophylaxis and ART for life among all identified HIV+ pregnant women.

1. Indicator 32. Percentage of targeted DMOs that have completed their semi-annual PA and TSS visits to facilities in their catchment area

SBH helps the MOH improve the use of routine PA processes as a mechanism to reinforce accountability and ultimately help improve performance. This indicator will provide an important gauge of the degree of institutionalization of important MOH performance improvement approaches.

Shibunyunji had received both semi-annual PA and TSS visits while Mkushi, Mufulira, and Petauke had received only annual PAs. Generally, more districts received PAs compared with TSS, as shown in the table below.

While all targeted DMOs (100%) conducted at least some semi-annual PA at the facility level during the baseline period, the percent of targeted facilities that received PA varied greatly. Only 33% of targeted DMOs conducted semi-annual PA with all targeted facilities during the reporting period.

Nearly all DMOs completed at least some TSS to targeted facilities during the baseline period (all but Livingstone). The percent of targeted facilities that received TSS varied widely from 0% to 100%. Only one DMO (8% of targeted DMOs) provided TSS to all targeted facilities.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Percentage of targeted DMOs that have completed their semi-annual PA and TSS visits to facilities in their catchment area  January 2015-December 2015 | | | | | | |
| Province | Districts | Total number of facilities | Number of facilities that received semi-annual PA | Number of facilities that received TSS visits | Percentage of facilities that received semi-annual PA | Percentage of facilities that received TSS visits |
| Central | Kabwe | 46 | 25 | 25 | 54.3% | 54.3% |
| Mkushi | 18 | 18 | 6 | **100.0%** | 33.3% |
| Copperbelt | Kitwe | 53 | 31 | 31 | 58.5% | 58.5% |
| Mufulira | 25 | 25 | 9 | **100.0%** | 36.0% |
| Chingola | 18 | 7 | 6 | 39.0% | 33.0% |
| Chililabombwe | 11 | 3 | 2 | 27.3% | 18.2% |
| Eastern | Petauke | 34 | 34 | 30 | **100.0%** | 88.2% |
| Chipata | 47 | 30 | 30 | 63.8% | 63.8% |
| Lusaka | Lusaka | 66 | 49 | 36 | 74.2% | 54.5% |
| Shibuyunji | 8 | 8 | 8 | **100.0%** | **100.0%** |
| Southern | Monze | 34 | 26 | 24 | 76.5% | 70.6% |
| Livingstone | 21 | 20 | 0 | 95.3% | 0% |
| SBH Targeted Districts | | | | | 33% (4 of 12) of targeted DMOs completed semi-annual PA to all facilities | 8% (1 of 12) of targeted DMOs completed TSS visits to all facilities |

*Data Source: 2015-Updated Action Plan Report*

|  |
| --- |
| *Baseline value*  The baseline is 100% of DMO completed semi-annual PA to some facilities.  The baseline is 100% for DMO completed TSS visits to some facilities. |

1. Indicator 33. Percentage of targeted DMOs that demonstrate performance improvements since their previous PA

SBH provides technical, financial, logistical, and administrative assistance to the MOH at the national, provincial, and district levels and to CBOs. The goal is to conduct PA and TSS visits to health providers to address problems that hinder the delivery of high quality HIV prevention, care, and treatment services at facilities.

This indicator tries to demonstrate the extent to which PA is used to identify and solve problems. Nearly all the districts except for Petauke demonstrate performance improvements since their previous PA in 2015, as shown in the table below (see Annex 5).

|  |  |  |
| --- | --- | --- |
| Percentage of targeted DMOs that demonstrate performance improvements since their previous PA | | |
| Province | District | Demonstrated improvements |
| Central | Kabwe | √ |
| Mkushi | √ |
| Copperbelt | Kitwe | √ |
| Mufulira | √ |
| Chingola | √ |
| Chililabombwe | x |
| Eastern | Petauke | x |
| Chipata | √ |
| Lusaka | Lusaka | √ |
| Shibuyunji | √ |
| Southern | Monze | √ |
| Livingstone | √ |
|  | % of target Districts | 83.3% |
| √=Yes fully X=No | | |

*Data Source: 2015-Updated Action Plan Report*

|  |
| --- |
| *Baseline value*  The baseline is 83.3% of targeted DMOs demonstrating performance improvements since their previous PA. |

1. Indicator 34. Percentage of targeted primary care facilities that have received TSS or clinical mentoring for clinical staff in the past six months

SBH provides financial and technical support to target districts and health facilities to improve service delivery and quality of care. This indicator measures the proportion of targeted primary care facilities that have received appropriate support during the reporting period in alignment with MOH-supported TSS and clinical mentoring approaches.

All the facilities in Shibuyunji district received both TSS and mentorship. The next best record was Petauke, which reported that 94.1% of the facilities received TSS and 88.2% received clinical mentorship. No facility in Livingstone received TSS or mentorship, as shown in the table below.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Percentage of targeted primary care facilities that have received TSS or clinical mentoring for clinical staff in the past six months | | | | | | |
| Province | District | Total number of facilities | Number of facilities which received TSS visits | Number of facilities that received clinical mentorship | Percentage of facilities that received TSS visits | Percentage of facilities that received clinical mentorship |
| Central | Kabwe | 45 | 26 | 0 | 57.8% | 0% |
| Mkushi | 18 | 6 | 6 | 33.3% | 33.3% |
| Copperbelt | Kitwe | 53 | 31 | 31 | 58.5% | 58.5% |
| Mufulira | 25 | 9 | 5 | 36% | 20.0% |
| Chingola | 7 | 7 | 6 | 100% | 86% |
| Chililabombwe | 4 | 3 | 2 | 75% | 50% |
| Eastern | Petauke | 34 | 32 | 30 | 94.1% | 88.2% |
| Chipata | 47 | 30 | 30 | 63.8% | 63.8% |
| Lusaka | Lusaka | 66 | 36 | 29 | 54.5% | 43.9% |
| Shibuyunji | 8 | 8 | 8 | 100.0% | 100.0% |
| Southern | Monze | 34 | 24 | 5 | 70.6% | 14.7% |
| Livingstone | 21 | 0 | 0 | 0% | 0% |
| SBH Targeted Districts | | 362 | 212 | 152 | 58.6% | 41.9% |

*Data Source: This data was collected from the DMOs through SBH Staff using a standard data collection tool.*

|  |
| --- |
| *Baseline value*  The baseline is 58.6% of targeted primary care facilities that received TSS in the previous 6 months.  The baseline is 41.9% of targeted primary care facilities that received clinical mentoring in the previous 6 months. |

1. Indicator 35. Percentage of targeted facilities in targeted districts that have up-to-date and gender-sensitive job aids for HIV, FP, MNCH, and/or nutrition

The goal of SBH is to improve health outcomes for Zambians by strengthening systems that underpin the delivery of high quality health services at the district and community levels. SBH recognizes that it cannot reach its goal without acknowledging and addressing gender-based constraints to the delivery and use of health services.

SBH AMEP includes measures of male and female empowerment and disaggregates M&E data by several key attributes to help assess project performance toward addressing gender and equity. These attributes include gender, age, province/district, urban/rural, education level, and income. Further, the project ensures that gender and other equity considerations are integrated into the design, analysis, and data collection efforts. SBH works with the MOH to ensure that job aids are current and include appropriate guidance on gender and equity.

|  |
| --- |
| *Baseline value*  This indicator will be determined by facility-based assessments. |

1. Indicator 36. Percentage of targeted facilities in targeted districts that have initiated QI projects in ART, PMTCT, MC, FP, child health and nutrition, or maternal health services with documented process results

SBH provides financial and technical support for QI committees and capacity building in QI methods and performance improvement approaches. This is important to improve the quality of care and service delivery at facilities. This indicator measures the proportion of targeted facilities in targeted districts that have initiated QI projects in ART, PMTCT, MC, FP, child health and nutrition, or maternal health services and are documenting the results of QI projects.

|  |
| --- |
| *Baseline value*  This indicator baseline is 0. |

1. Indicator 37. Number of people trained in child health and nutrition program areas

SBH’s goal is to contribute to reducing childhood morbidity and mortality by strengthening the capacity of the MOH to coordinate, plan, implement, and monitor national child health and nutrition program interventions. This indicator tracks the number of people trained in child health and nutrition in target districts.[[14]](#footnote-14)

|  |
| --- |
| *Baseline Value*  This is an output indicator, so the baseline is 0. |

1. Indicator 38. Number of people trained in maternal and newborn health care

SBH has provided training assistance for it to cover training health care providers[[15]](#footnote-15) and community health workers trained in Safe Motherhood Action Groups-(SMAGs). This group was created in collaboration with the Churches Association of Zambia (CHAZ) as a networking strategy to use more personnel to care for maternal and child health services,

|  |
| --- |
| *Baseline Value*  This is an output indicator, so the baseline is 0. |

1. Indicator 39. Number of people trained in FP/RH health

SBH seeks to build the capacity of the MOH, provinces, districts, training institutions’ personnel, and CHVs in FP/RH counselling and service delivery.This indicator will track the number of people trained by SBH in FP/RH counselling and service delivery.

|  |
| --- |
| *Baseline Value*  This is an output indicator, so the baseline is 0. |

1. Indicator 40. Number of new health care workers who completed an in-service training program within the reporting period

In service capacity building is an important part of the SBH strategy to build capacity of individual health workers in target districts and provinces. This indicator will track the number of health care workers completing in-service training in clinical care mentorship and TSS. Program focus areas will include PMTCT, paediatric ART, adult ART, counselling and testing, male circumcision, laboratory, blood safety, clinical care and QI. Health system strengthening topics may include training in planning, PMP, financial management, budgeting, WISN, CHA program, gender, HRI, strategic information data audit, and M&E training.

|  |
| --- |
| *Baseline Value*  This is an output indicator, so the baseline is 0. |

## Task 3: Provide Technical and Financial Assistance to the MOH and Community-Based Organizations to Increase Quality, Availability, and Use of Priority Health Services at the Community Level

This section of the baseline assessment report presents the indicators tracked under Task 3 by its sub-tasks. The sub-tasks presented in this section are: sub-task 3, which will improve capacity to deliver quality health services at the community level; sub-task 3.2, which will strengthen linkages between the community and facility for key health interventions; and sub-task 3.3, which will implement community-level SBCC interventions to increase use of high impact health services.

#### 4.3.1 Sub-task 3.1: Improve capacity to deliver quality health services at the community level

The following indicators are tracked to measure the results of the proposed interventions:

* Number of CHAs that receive routine supervision from health facility staff in target facility catchment areas
* Number of community volunteers (including SMAGs and nutrition groups) that have received equipment to deliver priority community health services in targeted facility catchment areas

1. Indicator 43. Number of CHAs that receive routine supervision from health facility staff in target facility catchment areas

System level challenges, including staff shortages, reduced monitoring of the quality of services CHAs provided. SBH will equip the CHAs with the tools and incentives to promote preventive care, positive health seeking behaviors, and selected curative services. Supervision of CHAs will strengthen the institutionalization of the CHA strategy and build capacity among the CHAs for service delivery. This indicator measures the number of CHAs who receive routine supervision from health facility staff in target facilities.

|  |
| --- |
| *Baseline Value*  The baseline is 0. |

1. Indicator 44. Number of community volunteers (including SMAGs and nutrition groups) who have received equipment to deliver priority community health services in targeted facility catchment areas

SBH plans to procure and supply necessary equipment to enable CHVs provide priority services. The project collaborates with the MOH and Zambia Medical Stores Limited (MSL) to assure procurement plans include the necessary medical equipment kits for provision of community health services in targeted facility catchment areas. Grant recipients will train and equip community volunteers.

|  |
| --- |
| *Baseline Value*  This is an output indicator, so the baseline is 0. |

#### 4.3.2 Sub-task 3.2: Strengthen linkages between the community and facilities for key health interventions

The following indicators are used to measure the results of the proposed interventions:

* Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS in target areas
* Percentage of target health facilities with a functionalfacility/community-level QI committee

1. Indicator 46. Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS in targeted areas

Under this indicator, SBH and its partner, Save the Children Zambia, are mandated to care for children orphaned or made vulnerable by HIV/AIDS. Mitigating the impact that HIV has on children and the families that support them is integral to a comprehensive HIV response. SBH supports a variety of services to mitigate HIV’s effects to improve the health and well-being of adults and children. These services include programs that support the developmental growth of children and the quality of life of adults and children living with and affected by HIV/AIDS.

|  |
| --- |
| *Baseline Value*  This is an output indicator, so the baseline is 0. |

1. Indicator 48. Percentage of target health facilities with a functionalfacility/community-level QI committee

SBH plans to support the establishment of QI committees in the targeted areas at all levels. The QI committees will identify the gaps in management and health service delivery and address them through implementation of QI projects and clinical mentorship. To implement and coordinate mentorship at all levels, SBH will collaborate with the PHO/DHO to establish multi-disciplinary Clinical Care Teams (CCTs). Members of the CCTs will provide appropriate mentorship to health facility staff in clinical case management and help strengthen systems such as pharmaceutical management, nursing care, diagnostic services, and health information. This will promote the establishment of functional QIs in the targeted facilities.

This indicator will measure the proportion of target health facilities with a functional[[16]](#footnote-16) facility/community-level QI committee. This indicator will be complemented by the indicator on percentage of targeted facilities in targeted districts that have initiated QI projects in ART, PMTCT, MC, FP, child health and nutrition, or maternal health services with documented process results.

|  |
| --- |
| *Baseline Value*  The baseline is 0. |

#### 4.3.3 Sub-task 3.3: Implement community level SBCC interventions to increase utilization of high impact health services

The following indicators are tracked to measure the results of the proposed interventions:

1. Indicator 49. Percentage of children under five years of age who received Vitamin A from USG-supported programs in target districts

The following table shows the baseline data of the percentage of children under five years of age who received Vitamin A from SBH target districts. The data show a baseline ranging from 71 percent to over 200 percent, of the percentage of children under five years of age who received Vitamin A SBH targeted districts. The high percentage is due to use of the lower population denominator provided by Central Statistics that tends to inflate the percentage coverage. As long as the same denominator is used in during the intervention the relative increase will indicate change in any direction in the child immunization activities.

|  |  |  |
| --- | --- | --- |
| Percentage of children under five years of age who received Vitamin A from USG-supported programs in target districts | | |
| Province | District | Percentage of <5s receiving Vit A |
| Central | Kabwe | 71% |
| Mkushi | 248% |
| Copperbelt | Kitwe | 213% |
| Mufulira | 240% |
| Chingola | 184% |
| Chililabombwe | 91% |
| Eastern | Chipata | 208% |
| Petauke | 155% |
| Lusaka | Lusaka | 167% |
| Shibuyunji | 88% |
| Southern | Monze | 175% |
| Livingstone | 140% |
| Average in Targeted Districts | | 165% |

|  |
| --- |
| *Baseline Value*  The baseline is an average of 165 percent of under 5 year olds received Vitamin A in targeted districts. |

# CHAPTER 5: SUMMARY TABLE OF INDICATORS AND PLANNED IMPROVEMENTS

The table below shows the summary of SBH indicators by baseline value. This table shows the original and updated baseline values to reflect the addition of two additional Phase 1 districts in SBH targeted focus.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **SBH Goal - Improved health outcomes for Zambians by strengthening systems that underpin the delivery of high quality health services and increasing the utilization of high impact health interventions at district and community level.** | | | | | | |
| **SBH Impact and Outcome Level Indicators:** | | | | | | |
| **No** | | **Indicator** | | **Baseline for 10 Phase 1 Districts[[17]](#footnote-17)** | | **Updated Baseline for 12 Phase 1 Districts[[18]](#footnote-18)** |
| 1 | | Proportion of deliveries with assistance from a medically trained provider in targeted districts | | 23.1% | | 23.7% |
| 2 | | CYP in targeted districts | | 268,071\*\*[[19]](#footnote-19) | | 310,851 |
| 4 | | Percentage of children aged 12 to 23 months fully immunized in targeted districts | | 94% | | 86.2% |
| 5 | | Percentage of adults and children known to be alive and on treatment 12 months after initiation of antiretroviral therapy in targeted districts | | 79% | | (see table above for details) |
| **SBH Outcome and Output Level Indicators:** | | | | | | |
| **Task 1. Design, implement and monitor national level interventions to strengthen health stewardship by MOH**  **Result 1: Strengthened health stewardship of MOH** | | | | | | |
| **Sub-task 1.1: Strengthen Human Resource Planning and Management** | | | | | | |
| 8 | Number of new health care workers who graduated from a pre-service training institution or program as a result of PEPFAR-supported strengthening efforts within the reporting period | | 0 | | 0 | |
| 9 | Percentage of targeted provincial and district health offices that have access to and routinely use HRIS | | 40% PMO  40% DMO | | 40% PMO  33% DMO | |
| 10 | Proportion of PMO and DMO personnel who have received an annual performance appraisal in the past year in targeted districts | | 32.2% PMOs  33.3% DMOs | | 36.2% PMO  33.3% DMO | |
| 11 | Number of non-finance based incentives to attract health professionals in remote areas identified, costed, and submitted for review by GRZ | | 0 | | 0 | |
| **Sub-task 1.2: Improve health care financing and PFM** | | | | |  | |
| 13 | Percentage of national government expenditure on health out of general government expenditure | | 7.00%  (2015) | | 7.00%  (2015) | |
| 16 | Number of months per year in which targeted districts receive budgeted monthly funding | | 9.3 | | 9.75 | |
| 17 | Proportion of funds disbursed to targeted districts out of total approved annual  district budgets | | 68.7% | | 77% | |
| 18 | Proportion of funds disbursed by targeted districts to health facilities out of their approved total annual budget | | 55.9% | | 56.4% | |
| **Sub-task 1.3: Strengthen MOH capacity to oversee delivery of key health programs.** | | | | | | |
| 19 | Number of improvements to laws, policies, strategies, regulations, or guidelines | | 0 | | 0 | |
| 26 | Percentage of targeted facilities submitting HMIS reports in a timely manner | | 65% | | 67% | |
| **Task 2: Design, implement and monitor effective interventions to strengthen program management capacities of provincial and district health teams**  **Result 2: Strengthened program management capacities of provincial and district health teams** | | | | | | |
| **Sub-task 2.1: Strengthen program management capacity of provincial and district health teams** | | | | | | |
| 6 | Percentage of target provinces /districts that demonstrate sustainable capacity to plan, manage, and oversee accessible high quality health services | | TBD | | TBD | |
| 7 | Percentage of targeted facilities in target districts that demonstrate capacity to deliver high quality health services and engage with communities in their catchment area. | | TBD | | TBD | |
| 23 | Capacity score of targeted provinces and districts | | TBD | | TBD | |
| 24 | Percentage of targeted provinces/districts that conducted at least two reviews of their annual action plans in the past year | | 40% Province  90% District | | 40% Province  83.3% District | |
| 25 | Percentage of targeted PMOs / DMOs that use HMIS data routinely | | 100% Province  40% District | | 100% Province  50% District | |
| 27 | Number of health managers and providers trained in management and leadership | | 0 | | 0 | |
| 28 | Percentage of target facilities that did not experience a stock-out of Coartem (ACT) and contraceptive (injectable) during the reporting period | | 93.3% for Coartem (ACT)  72.3% for Contraceptive (injectable) | | 93.3% for Coartem (ACT)  72.3% for Contraceptive (injectable) | |
| **Sub-task 2.2: Improve technical capacity of provincial and district health teams to deliver quality health services in facilities** | | | | |  | |
| 30 | Number and percentage of children who received DPT3 vaccine by 12 months of age in targeted districts | | 94% | | 86% | |
| 31 | Percentage of HIV-positive pregnant women who received antiretroviral treatment to reduce risk of mother-to-child-transmission in targeted districts | | Data not available | | Data not available | |
| 32 | Percentage of targeted DMOs that have completed their semi-annual PA and TSS visits to facilities in their catchment area | | 40% Semi-annual appraisal  10% TSS | | 100% Semi-annual appraisal  100% Technical Support Supervision | |
| 33 | Percentage of targeted DMOs that demonstrate performance improvements since their previous PA | | 90% | | 83.3% | |
| 34 | Percentage of targeted primary care facilities that have received TSS or clinical mentoring in the past six months | | 57.5% TSS  41% Clinical Mentoring | | 58.6% TSS  41.9% Clinical Mentoring | |
| 35 | Percentage of targeted facilities in targeted districts that have up-to-date and gender sensitive job aids for HIV, FP, MNCH, and/or nutrition | | -- | | -- | |
| 36 | Percentage of targeted facilities in targeted districts that have initiated QI projects in ART, PMTCT, MC, FP, child health and nutrition, or maternal health services with documented process results. | | 0% | | 0% | |
| 37 | Number of people trained in child health and nutrition | | 0 | | 0 | |
| 38 | Number of people trained in maternal and newborn health | | 0 | | 0 | |
| 39 | Number of people trained in FP/RH | | 0 | | 0 | |
| 40 | Number of new health care workers who completed an in-service training program within the reporting period | | 0 | | 0 | |
| **Task 3: Provide technical and financial assistance to the GRZ and CBOs to increase the quality, availability, and use of priority health services at the community level in targeted districts**  ***Result 3: Improved capacities of MOH and community-based organizations to increase quality, availability and use of priority health services and promote better health through prevention and healthy behaviors at the community level in targeted districts*** | | | | | | |
| **Sub-task 3.1: Improve capacity to deliver quality health services at the community level** | | | | | | |
| 43 | Number of CHAs that receive routine supervision from health facility staff in target facility catchment areas | | 0 | | 0 | |
| 44 | Number of community volunteers including SMAGs that have received equipment to deliver priority community health services in targeted facility catchment areas | | 0 | | 0 | |
| **Sub-task 3.2: Strengthen linkages between the community and facility for key health interventions** | | | | | | |
| 46 | Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS in target areas | | 0 | | 0 | |
| 48 | Percentage of target health facilities with a functionalfacility/community-level QI committee | | 0 | | 0 | |
| **Sub-task 3.3:** Implement community level SBCC interventions to increase utilization of high impact health services | | | | | | |
| 49 | Percentage of children under five years of age who received Vitamin A from USG-supported programs in target districts | | 171% | | 165% | |

# CHAPTER 6: CONCLUSIONS

The baseline assessment establishes benchmarks for the measurement of the envisaged change on health indicators related to the USAID Systems for Better Health (SBH) Project Zambia interventions to improve the health status of Zambians. The design of the baseline assessment was guided by the SBH AMEP. Data was collected mainly through existing and secondary data sources. However, for some indicators, data was collected through a self-administered tool by the PMOs’ and DMOs’ staff.

The assessment report has shown the baseline values for the four key outcome indicators that SBH will track to help strengthen systems that underpin the delivery of high quality health services and increase the use of high impact health interventions at the district and community level. The result will be better health outcomes for the Zambian people. The report has shown the baseline values for the indicators that SBH will track in its three key tasks and sub-tasks.

# Annexes

**Annex 1: CYP in target districts - January to December 2015**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **CYP in target districts - January to December 2015** | | | | | | | | | | | |
| District | Male condoms distributed | Female condoms distributed | Oral pill cycle | Progesterone only pill | Medroxyprogesterone injection | Norethisterone enanthate injection | Implant | IUCD inserted | Sterilisation male | Sterilisation female | **Total CYP** |
| Petauke | 1,105 | 15 | 199 | 35 | 6,267 | 1,626 | 2,177 | 101 | 0 | 280 | **11,806** |
| Chipata | 2,861 | 104 | 1,826 | 155 | 14,826 | 372 | 11,556 | 745 | 0 | 1,440 | **33,884** |
| Shibuyunji | 280 | 1 | 212 | 22 | 1,638 | 325 | 201 | 0 | 10 | 0 | **2,690** |
| Lusaka | 3,849 | 82 | 3,030 | 484 | 30,771 | 7,864 | 40,455 | 6,541 | 0 | 450 | **93,526** |
| Kabwe | 2,892 | 19 | 707 | 30 | 8,188 | 301 | 7,243 | 405 | 0 | 570 | **20,354** |
| Mkushi | 568 | 2 | 449 | 37 | 5,557 | 31 | 4,210 | 345 | 0 | 1,150 | **12,349** |
| Kitwe | 2,107 | 21 | 1,231 | 32 | 11,409 | 1,005 | 35,503 | 4,076 | 0 | 920 | **56,303** |
| Chililabombwe | 625 | 5 | 427 | 36 | 2,193 | 642 | 5,525 | 474 | 20 | 380 | **10,327** |
| Chingola | 602 | 15 | 993 | 37 | 5,128 | 1,401 | 20,649 | 1,955 | 10 | 280 | **31,070** |
| Mufulira | 391 | 8 | 1,120 | 50 | 3,411 | 1,053 | 5,810 | 129 | 0 | 240 | **12,214** |
| Livingstone | 630 | 3 | 265 | 8 | 4,834 | 392 | 3,504 | 336 | 0 | 120 | **10,091** |
| Monze | 971 | 7 | 945 | 86 | 3,878 | 432 | 5,464 | 2,576 | 1,350 | 530 | **16,238** |
| **Total** | **16,880.19** | **280.31** | **11,403.07** | **1,012.87** | **98,098.50** | **15,444.17** | **142,298.60** | **17,682.40** | **1,390.00** | **6,360.00** | **310,850** |

**Annex 2: Percentage of targeted provincial and district health offices that have access to and routinely use HRIS**

|  |  |  |  |
| --- | --- | --- | --- |
| Percentage of targeted provincial and district health offices that have access to and routinely use HRIS | | | |
| Province | Availability of Computer for HR | HRO Trained | Routinely use (Availability of Human Resource Statistics) |
| Central | √ | √ | x |
| Copperbelt | √ | √ | √ |
| Eastern | √ | x | x |
| Lusaka | √ | √ | x |
| Southern | √ | √ | √ |
| % of Provinces that meet all criteria | 40% | | |
| Districts |  |  |  |
| Kabwe | X | X | √ |
| Mkushi | √ | X | √ |
| Kitwe | √ | √ | √ |
| Mufulira | √ | √ | √ |
| Chingola | √ | √ | X |
| Chililabombwe | √ | √ | X |
| Petauke | √ | √ | √ |
| Chipata | √ | X | √ |
| Lusaka | √ | X | X |
| Shibuyunji | X | X | √ |
| Monze | √ | √ | √ |
| Livingstone | X | X | √ |
| % of Districts that meet all criteria | 33% | | |
| √=Yes  X=No | | | |

**Annex 4. Percentage of targeted PMOs/DMOs that use HMIS data routinely**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Percentage of targeted PMOs/DMOs that use HMIS data routinely | | | | | | |
| Province | Availability of Health Information Officer | Access to DHIS2 | Trained on the use of DHIS2 | Accredited in the use of DHIS2 | Frequently use | Use of HMIS Routinely[[20]](#footnote-20) |
| Central | √ | √ | √ | √ | √√ | √ |
| Copperbelt | √ | √ | √ | √ | √√ | √ |
| Eastern | √ | √ | √ | √ | √√ | √ |
| Lusaka | √ | √ | √ | √ | √√ | √ |
| Southern | √ | √ | √ | √ | √√ | √ |
| Targeted Provinces | 100% | 100% | 100% | 100% | 100% | 100% |
| Districts |  |  |  |  |  |  |
| Kabwe | √ | √ | √ | √ | √√ | √ |
| Mkushi | √ | √ | √ | x | √√√ | √ |
| Kitwe | √ | √ | x | x | √√ | √ |
| Mufulira | √ | √ | √ | √ | √√√ | √ |
| Chingola | √ | √ | √ | √ | √√√ | √ |
| Chililabombwe | √ | √ | √ | √ | √√√ | √ |
| Petauke | √ | √ | √ | √ | √√ | √ |
| Chipata | √ | √ | √ | x | √√√ | √ |
| Lusaka | √ | √ | √ | x | √√ | √ |
| Shibuyunji | √ | √ | √ | √ | √√ | √ |
| Monze | √ | √ | √ | x | √√ | √ |
| Livingstone | √ | x | x | x | √√√ | √ |
| Targeted Districts | 100% | 92% | 83% | 33% | 100% | 100% |
| √=Yes fully  √√=Daily  √√√=Weekly/Monthly  X=No | | | | | | |

**Annex 5. Percentage of targeted DMOs that demonstrate performance improvements since their previous PA**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Percentage of targeted DMOs that demonstrate performance improvements since their previous PA | | | | |
| Province | District | Implemented the action plan developed during the previous performance review | Semi-annual performance review meetings with their health facilities | Invite partners to their planning and semi-annual review meetings |
| Central | Kabwe | √ | √ | √ |
| Mkushi | √ | √ | √ |
| Copperbelt | Kitwe | √ | √ | √ |
| Mufulira | √ | √ | √ |
| Chingola | √ | √ | √ |
| Chililabombwe | √ | x | x |
| Eastern | Petauke | x | √ | x |
| Chipata | √ | √ | √ |
| Lusaka | Lusaka | √ | √ | √ |
| Shibuyunji | √ | √ | √ |
| Southern | Monze | √ | √ | √ |
| Livingstone | √ | √ | √ |
| SBH Target Districts | | 83.3% | | |
| √=Yes fully  X=No | | | | |

1. *Chipata, Lundazi, Kabete, Nyimba and Petauke*  [↑](#footnote-ref-1)
2. The SBH contract includes the following metric “ARV retention rates in targeted districts”, which will be measured by this standard indicator per USG and PEPFAR MER indicator definitions. [↑](#footnote-ref-2)
3. These targets reflect the technical support that SBH will specifically provide to two midwifery schools. If support to pre-service training institutions is widened, the targets will be updated. [↑](#footnote-ref-3)
4. This indicator incorporates PEPFAR indicator *“Percentage of PEPFAR-supported clinical service sites with QI activities implemented that address clinical HIV program processes or outcomes and have documented process results in the last 6 months”* [↑](#footnote-ref-4)
5. In alignment with USG indicator guidance, the indicators 37, 38 and 39 will cover the following: health professionals, primary health care workers, community health workers, volunteers, and non-health personnel. [↑](#footnote-ref-5)
6. HMIS Procedure Manual (Primary Health Care), Version 1.4; 44 [↑](#footnote-ref-6)
7. *This indicator will be reported after every six months of the latest child health week.* [↑](#footnote-ref-7)
8. *Access to HRIS in this indicator means HRMOs have computers and have been trained in HRIS software.* [↑](#footnote-ref-8)
9. *The use of evidence-based decision making to recruit, reduce staffing shortages, attrition, and inequity of deployment* [↑](#footnote-ref-9)
10. *Timeliness for submission for the facility is defined as 7th of the following month.* [↑](#footnote-ref-10)
11. *Mid-Term Review of the Health Sector: 2014* [↑](#footnote-ref-11)
12. *This indicator was changed following submission of the AMEP.* [↑](#footnote-ref-12)
13. *This indicator will measure the level of accessibility to DHIS2 health program and indicator reports at the provincial and district levels. Access will be operationalized by use of DHIS2.* [↑](#footnote-ref-13)
14. *Target districts for nutrition activities include, Chipata, Lundazi, Petauke, Katete and Nyimba.* [↑](#footnote-ref-14)
15. *This includes midwives, nurses, and clinical officers.* [↑](#footnote-ref-15)
16. *We will consider the QI committee functional if it meets at least three of these criteria: meetings documented with action items or minutes at least two times per quarter; CCT includes at least one clinical mentor trained in each of the following SBH priority health areas (high-impact service): HIV/AIDS, FP, EmONC related activities; CCT includes members with experience in each of the following: pharmaceutical logistical management, nursing care, diagnostic services, health information, and clinical care; facility has QI project or minimal requirements for gender sensitive balance and participation of women’s groups.* [↑](#footnote-ref-16)
17. The values shown in the column Baseline for 10 Phase 1 Districts were included in the original SBH baseline report (submitted August 2016) and represent baseline values for the original 10 Phase 1 targeted districts. These values have been used for SBH performance reporting purposes through December 2017. [↑](#footnote-ref-17)
18. The baseline values shown in the column Updated Baseline for 12 Phase 1 Districts reflect revised baseline calculations for SBH targeted districts following the addition of two new Phase 1 districts in June 2016 (Chingola and Chilililongwe in Copperbelt Province). These revised baseline figures will be used in SBH reporting from January 2018 forward. [↑](#footnote-ref-18)
19. The data for Monze changed from 14,903 to 16,238. This could be as a result of the updated data in the HMIS [↑](#footnote-ref-19)
20. *This indicator will measure the level of accessibility to DHIS2 health program and indicator reports at the provincial and district levels. Access will be operationalized by use of DHIS2* [↑](#footnote-ref-20)