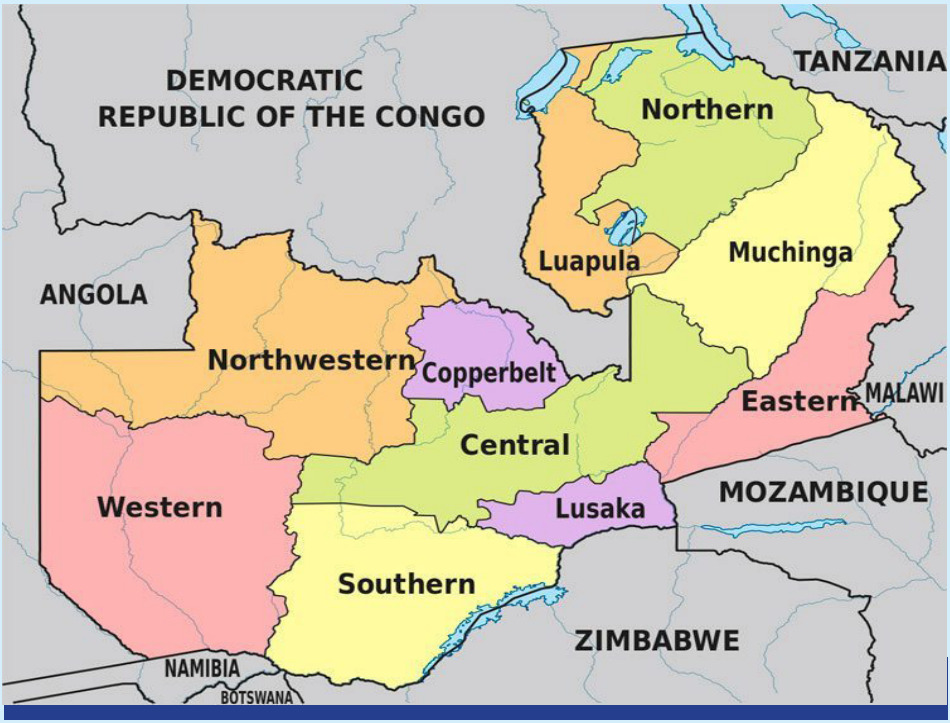
World Health Organization

Zambia

WHO COUNTRY COOPERATION STRATEGY 2017-2021

MAP OF THE REPUBLIC OF ZAMBIA



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ABBREVIATIONS AND ACRONYMS

ADR	Award Distribution Request
AFRO	Africa Regional Office
AIDS	Acquired Immune Deficiency Syndrome
AMR	Anti-Microbial Resistance
ART	Anti-Retroviral Therapy
ASRH	Adolescent Sexual Reproductive Health
AU	African union
CBR	Crude Birth Rate
CCM	Country Coordination Mechanisms
CCS	Country Cooperation Strategy
CDC	Centre for Disease Control
CDR	Crude Death Rate
COMESA	Common Market for East and Southern Africa
CPS	Cooperative Partners
CRC	Convention of the Rights of the Child
CSO	Civil Society Organization
CSO	Central Statistical office
DFID	Department for International Development
DHIS.2	District Health Information Systems Tool.2
DRM	Disaster Risk Management
DTP3	Diphtheria-Tetanus-Pertussis 3
EM	Essential Medicines
EPI	Expanded Program on Immunization
EPR	Emergence Preparedness and Response
ERF	Emergency Response Framework
ESP	Expanded Support Programme
EU	European Union
GAVI	Global Alliance for Vaccines and Immunization
GDP	Gross Domestic Product
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
GIZ	Germany Society for International Development
GPW	Global Programme of Work
GRZ	Government of the Republic of Zambia
GSRRF	Global Status Report on Road Safety
H4+	Partnership for Women and Child Health
H6	Partnership for Women and Child Health
HDF	Health Development Fund
HHA	Harmonization for Health in Africa

HIV	Human Immuno Deficient Syndrome
HMIS	Health Management Information System
HQ	Head Quarters
ICATT	IMCI Computerized Adaptation and Training Tool
ICC	Inter-Agency Coordination Committee on Health
ICCM	Integrated Community Case Management
ICT	Information Communication Technology
IDSR	Integrated Disease Surveillance and Response
IHP+	International Health Partnership
IHR	International Health Regulations
ILO	International Labour Organization
IMR	Infant Mortality Rate
JICA	Japanese International Cooperation Agency
JSI	John Snow International
M&E	Monitoring and Evaluation
MDG	Millennium Development Goals
MICS	Multiple Indicator Cluster Survey
MMD	Movement for Multi-Party Democracy
MMR	Maternal Mortality Rate
MNCAH	Maternal Newborn Adolescent and Child Health
MOH	Ministry of Health
MTEF	Medium Term Expenditure Framework
MTR	Mid Term Review
MTSP	Medium Term Strategic Plan
NATF	National Aids Trust Fund
NCD	Non-Communicable Diseases
NGO	Non-Governmental Organization
NHA	National Health Accounts
NHSP	National Health Strategic Plan
NMCP	National Malaria Control Plan
NTD	Neglected Tropical Diseases
ODA	Overseas Development Agency
OOPE	Out of pocket Expenditure
PF	Patriotic Front
PHC	Primary Health Care
PLWHIV	People Living with HIV
PMI	Presidential Malaria initiative
PMT	Programme Management Team
PMTCT	Prevention of Mother To Child Transmission

PPP	Public Private Partnerships
QoC	Quality of Care
RMNCAH	Reproductive Maternal Newborn Child and Adolescent Health
SADC	Southern African Development Cooperation
SAG	Sector Advisory Group
SDGs	Sustainable Development Goals
SIDA	Swedish International Development Agency
SOPs	Standard Operating Procedures
SRH	Sexual and Reproductive Health
SWAP	Sector Wide Approaches
TB	Tuberculosis
TWG	Technical Working Group
U5MR	Under Five Mortality
UHC	Universal Health Coverage
UN	United Nations
UNAIDS	United Nations AIDS
UNCT	United Nations Country Team
UNDGPF	United Nations Sustainable Development Goal Partnership Framework
UNDP	United Nations Development Programme
UNESCO	United Nations Education Scientific Children's Fund
UNFPA	United nations Population Fund
UNHCR	United Nations High Commission For Refugees
UNICEF	United Nations Children's Fund
UNIP	United National Independence Party
USAID	United States Agency for International Development
VMMC	Voluntary Male Medical Circumcision
WB	World Bank
WCO	World Health organization Country Office
WDI	World Development Indicators
WFP	World Food Programme
WHO	World Health Organization
WISN	Workload Indicator For Staffing Needs
WR	WHO Representative
ZDHS	Zambia Demographic and Health Survey

PREFACE

The WHO Third Generation Country Cooperation Strategy (CCS) crystallizes the major reform agenda adopted by the World Health Assembly with a view to strengthen WHO capacity and make its deliverables more responsive to country needs. It reflects the WHO Twelfth General Programme of Work at country level, and aims at achieving greater relevance of WHO's technical cooperation with Member States by focusing on identification of priorities and efficiency measures in the implementation of the WHO Programme Budget. It takes into consideration the role of partners including non-state actors that support Government and communities. The CCS is being formulated within the WHO Regional Office for Africa's Transformation Agenda that focuses on a smart focus, being result oriented, accountability and effective communication to internal and external partners.

The Third Generation CCS draws on lessons from the implementation of the first and second-generation CCS, the country focus strategy and the United Nations Sustainable Development Goals Partnership Framework. The CCS is also in line with the global health context and the move towards Universal Health Coverage, integrating the principles of alignment, harmonization and effectiveness, as formulated in the Paris Declaration of 2005 and the Busan Agreement of 2011 on Aid Effectiveness and the principles underlying the "Harmonization for Health in Africa" (HHA) and the "International Health Partnership Plus" (IHP+) initiatives, reflecting the policy of decentralization and enhancing capacity of Governments to improve outcomes of public health programmes.

The document has been developed in a consultative manner with key health stakeholders in the country and highlights the expectations of the work of the WHO secretariat. In line with the renewed country focus strategy, the CCS is to be used to communicate involvement of the WHO in Zambia; formulate the WHO Zambia workplan; advocate, mobilize resources and coordinate with partners and shape the health dimension of the United Nations Sustainable Development Goal Partnership Framework and other health partnerships in the country.

I commend the efficient and effective leadership role played by the Government in the conduct of this important exercise of developing the CCS. I also request the entire WHO staff under the stewardship of the WHO Representative to facilitate cost-

effective implementation of the programmatic orientations of this document for improved health outcomes which will contribute to better health and development in Zambia.

Dr. Matshidiso Moeti

WHO Regional Director for Africa

EXECUTIVE SUMMARY

The attainment of the highest possible standard of health for all remains the major commitment of the WHO. This third generation of the WHO Country Cooperation Strategy (CCS) for Zambia will cover the years 2017-2021. It articulates WHO's role and renewed commitment to collaborating with the Government of the Republic of Zambia for the next five years.

This Country Cooperation Strategy (CCS) is the result of an extensive and inclusive process and a systematic analysis of documents, interviews and interactions with multiple stakeholders in health. The strategic direction was defined by considering WHO's comparative advantage in relation to national health priorities.

This CCS takes into consideration agreed international and regional development goals, including those in the United Nations Millennium Declaration, World Health Assembly resolutions, African Union (AU) and SADC Health Strategy and WHO Africa Regional Committee resolutions and recommendations. The Strategic frameworks which also inform the direction of WHO's strategic agenda at national level are: Zambia Vision 2030, the Seventh National Development Plan 2017-2021 and the Ministry of Health National Health Strategic Plan 2017-2021. It is also anchored on the Transformation Agenda of the World Health Organization Secretariat in the African Region, WHO's 12th General Programme of Work 2014-19 and the United Nations Sustainable Development Goals Partnership Framework (UNSDGPF) 2016-2021.

Zambia's health profile reveals that there is an observable high disease burden, characterized by high levels of maternal, neonatal and child morbidity and mortality, high incidence and impact of communicable diseases, and a rapidly growing burden of Non-communicable diseases (NCDs). Zambia's Human Development Index (HDI) stands at 141 out of 187 countries and territories. In spite of this progress, like many other countries in Sub-Saharan Africa, Zambia's human development indicators have been disappointing. Zambia has high levels of inequality: when the country's HDI value 0.56 is discounted for inequality, it falls to 0.365. About 62.8% of the population is multi-dimensionally poor, meaning that such households suffer overlapping deprivation in education, health and living standards.

The monitoring and evaluation framework was further strengthened. The District Health Information System (DHIS) was upgraded to DHIS-2, with improved features and functions. All earmarked surveys and reviews were conducted, including the 2013-14 Zambia Demographic and Health Survey (ZDHS), Mid-term review of the National Health Strategic Plan 2011-2016, Mid-term review of the National Malaria Control Programme (NMCP), National Malaria Indicator Survey and the National Tuberculosis prevalence (TB) survey.

Since Zambia's admission as a WHO Member State in 1965, the WHO Country Office in Zambia (WCO) has seen its work portfolio and internal organization grow considerably. The office celebrated the golden Jubilee of WHO's presence in Zambia in 2015. Today, the WCO operates from the UN Annex in Rhodes Park, renting premises owned by the UNDP. The total number of staff is 38. Some of the challenges facing the country office include inadequate office space, limited funds to adequately implement all activities in the technical cooperation programme including other emerging needs, inadequate human resources in the Ministry of Health as well as little synergy among health development partners.

A review of the previous CCS for 2008-13 revealed that the Country Office made considerable achievements in the area of health systems strengthening and prevention of communicable and non-communicable diseases, maternal and child health and health promotion. Despite the achievements made, the country did not achieve most of the targets of the health- related Millennium Development Goals (MDG) except the one on child mortality. This is largely attributed to many factors such as weak health systems and limited resources. The unfinished agenda of the MDGs has been incorporated in the new CCS. It has also been domesticated in the Sustainable Development Goals (SDGs) agenda for Zambia which is aligned with the National Health Sector Strategic Plan (2017-21).

The WHO will strive to create a conducive environment needed for successful implementation of its strategic agenda. In order to adequately respond to the identified priority needs in the Zambian health sector, the new strategic agenda identifies the following five strategic priorities for the period 2017-21: to provide support for achieving and sustaining universal health coverage through and revitalized primary health care approach and sustained health service delivery through strengthening of health systems; accelerating achievement of the unfinished MDGs agenda relating to reduction of maternal, newborn , child and adolescent mortality; reducing further the burden of AIDs, Tuberculosis, Malaria, NTDs, Hepatitis and other communicable diseases; strengthening the prevention and control of NCDs including strengthening preparedness surveillance and effective response to disease outbreaks. Furthermore, the country office commits to enhancing the level of understanding of WHO's role and mandate in Zambia, and will support the Ministry of Health in building and strengthening Partner coordination while fostering private public partnerships. Finally, WCO aims to enhance its collaboration with other UN Agencies.

The progress made in implementing this strategic agenda will be assessed through regular monitoring and evaluation activities that will be carried out at both strategic and operational levels. At the strategic level, this will include annual and mid-term reviews and evaluations at the end of the lifespan of the CCS. At the operational level, biennial plans will operationalize the strategic priorities and corresponding strategies using clear indicators and targets.

1 INTRODUCTION

The Country Cooperation Strategy (CCS) is the key instrument that guides the WHO Country Office support to the member state, in this case Zambia's national health policy and national health sector strategic plan. It is the main process for harmonizing WHO's collaboration in country with other United Nations (UN) Agencies and with its development partners. The WHO uses the CCS to develop its biennial country work plans.

The Government of the Republic of Zambia (GRZ) and the WHO Country Office (WCO) have implemented the second-generation CCS for the period 2008-2013. The CCS was extended to 2016 to in order to correspond with the extension of the period of duration of the National Health Strategic Plan and the 6th National Development Plan which were extended to 2016. This third generation CCS constitutes WHO's business plan for the period 2017-2021. It takes into consideration the evaluation of the previous CCS, and is informed by a systematic assessment of recent national health development focus, emerging health needs, government policies and expectations, current issues and challenges facing the country. It is framed to ensure continued relevance of health-related goals and targets as outlined in the various Government policy documents including the implementation of the Sustainable Development Goals (SDGs) 2030 agenda - which have clearly defined health priorities. The policy documents also identify specific strategies to achieve the unfinished MDGs agenda which this CCS also seeks to address. .

This CCS is also aligned with WHO's medium-term vision for health, as defined in the 12th General Programme of Work (GPW) 2014-2019, and focuses on selected priorities for WHO's cooperation in Zambia. It provides a broad framework to build country-level priorities with a bottom-up planning process and ensures that both WHO's global and regional priorities, as well as national health priorities, inform the biennial work plan. The CCS will guide the country-level programme budget and resources allocation. Furthermore, it should help advocate for WHO's priorities in the country, and to serve as a tool for mobilizing resources for the health sector.

This CCS complies and dovetails with the WHO/AFRO Transformation Agenda which makes a commitment to positive change for accelerating the implementation of WHO reforms within the African Region[1]. To this extent, it is informed by values of the transformation agenda which have emphasis on producing results, a smart technical focus, responsive strategic operations, effective communications and partnerships in response to country needs.

In formulating this Country Cooperation Strategy, the focus remained on WHO's mission and functions as well as its role as a neutral broker and policy advisor. The CCS will serve as a reference document for WHO's work in Zambia. It is the tool to inform the biennial planning exercise and will be part of a continuum that includes the new results chain of the Global Program of Work (GPW) and regional strategic plans,

[1] The Transformation Agenda of the WHO Secretariat in the African Region 2015-2020

resolutions or mandates. There is also greater complementarity and information sharing between the CCS and the Zambia United Nations Sustainable Development Goals Partnership Framework (UNSDGPF) 2016-21 process and vice versa, in order that the two processes are mutually reinforcing and identified priorities are aligned. The development and implementation of this strategy will lead to maintaining existing partnerships and building new ones at the country level, while ensuring national and local ownership of the processes involved. It will also ensure complementarity and synergy among stakeholders and development partners in the health sector.

During the period 2017-2021 WHO will focus its efforts in Zambia on the following five broad strategic agendas:

(i) Achieving and sustaining Universal Health Coverage (UHC) through a revitalized Primary Health Care (PHC) approach and sustainable service delivery through strengthening of health systems;

(ii) Accelerating achievement of the unfinished MDGs and SDGs relating to reduction of Maternal, Newborn, Child and Adolescent Mortality; and strengthening sexual and reproductive health;

(iii) Reducing further the burden of AIDS, tuberculosis, malaria, neglected tropical diseases, hepatitis, and other communicable diseases;

(iv) Strengthening and re-orienting health and health-related systems to address the prevention and control of NCDs, including disabilities, injuries and mental health disorders, and the underlying social determinants; and

(v) Strengthening preparedness, integrated disease surveillance and effective response to public health events/emergencies and the effective management of health-related aspects of humanitarian disasters in order to improve health security.

In formulating this CCS, the WCO followed the global guideline for the formulation of the WHO Country Cooperation Strategy. An external consultant was engaged in 2015 to conduct a comprehensive evaluation of the second-generation CCS. Lessons learnt from this evaluation fed into the formulation of third generation CCS which is closely aligned to the new National Health Strategic Plan 2017-2021.

The product of this new CCS is a result of inclusive dialogue and consultation with a wide range of organizations and individuals. These included: officials from the Ministry of Health and Ministry of Community Development Mother and Child Health; other UN system organizations; bilateral and multilateral agencies; civil society and non-governmental organizations (CSOs & NGOs); community groups; academic institutions; collaborating centres and the private sector. Consultation with representatives from socially excluded or disadvantaged sub-populations, as well as national bodies concerned with human rights were also conducted. These consultations contributed to ensuring broad support and to the maximization of complementarity and synergies with partners throughout the CCS process.

2 HEALTH AND DEVELOPMENT SITUATION

This chapter provides a strategic overview of the current health situation and development issues in the country. It comprises the following sub-sections: The country's main health achievements and challenges; the country's landscape of development cooperation; partnerships and collaboration with the United Nations and obligations under regional and global resolutions; agreements and commitments and a review of the previous CCS. Under this section we summarize the analysis of the country's main health and development issues based on a comprehensive review of key national reference documents and country intelligence and application of a gender, equity and human rights framework. The section also highlights the political, social, and macroeconomic context of the country as well as the health situation analysis and the country's progress on WHO's six leadership priorities.

2.1. Political, social and macro-economic context

Zambia is a landlocked country in Southern Africa covering a total area of 752,612 square Kilometres. As a Lower Middle-Income Country with a population of about 16.2 million[2] people and a population growth rate of about 3 percent per annum, Zambia has been implementing the Vision 2030 since 2006 with the aim of transforming the country into a prosperous middle-income nation by 2030. The political environment in Zambia remains stable, characterized by a vibrant media, independent judiciary and parliamentary democracy. The country has been ruled by three parties since independence in 1964 namely: United Nations Independent Party (UNIP) until 1991, Movement for Multi-Party Democracy (MMD) until 2011 when the Patriotic Front (PF) came into power. General elections are held every 5 years. In 2016, Zambia amended and adopted the new republican constitution.

Since independence in 1964, Zambia has prepared and implemented several medium term national development plans. Each of these instruments carried a theme and strategic focus, which primarily aimed to improve the social economic conditions of citizens. The National Health Policy 2013 is guided by the following key principles: equity of access; Primary Health Care approach; affordability; cost-effectiveness; leadership; transparency and accountability; decentralization; gender sensitivity; quality assurance and quality control. It makes provision for strategies to improve social services, physical infrastructure and food security. On the other hand, the vision 2030 provides key drivers for growth comprising mining, agriculture, tourism, and enhanced support for small to medium scale enterprises. The SDGs influence the development of public policies in the country. It is planned that the new national development plans and strategies, including sectoral plans and strategies and other related plans, will all reflect the SDGs and the unfinished agenda of the MDGs.

With a per capita Gross Domestic Product (GDP) of around USD 1844 (2013)[3] Zambia is now a Lower Middle Income Country and in 2014 it progressed to the Medium Human Development category. In terms of performance, Zambia's annual GDP growth averaged 6.4% between 2005 and 2014 and inflation dropped from 15.9% to 7.9% over the same period. Although Zambia has enjoyed economic gains from the implementation of sound macro-economic policies and high foreign direct

[2] Central Statistical Office. Census. Lusaka, Zambia: 2010

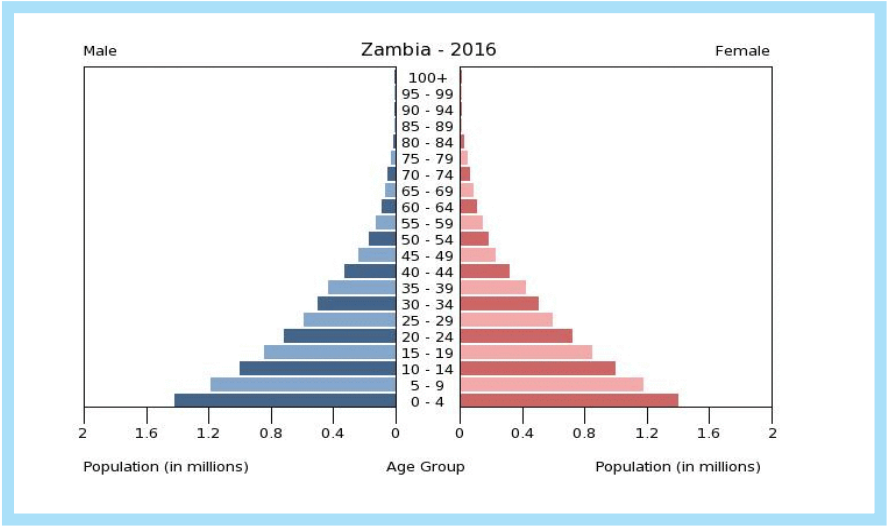
[3] World Bank datasets

investment which grew from less than USD 200 million in 2000 to USD 223 million in 2014, a large proportion of the population has not shared in this overall improvement of national prosperity. In both rural and urban areas poverty levels are highest among female headed households with extreme poverty levels of over 60% in rural areas and over 15% in urban areas. In 2010, 4.6 million children and adolescents lived in poverty, representing 65% of the total population[4] Poverty headcount for the general population stood at 78%. There is high unemployment which stands at 7.9% while underemployment stands at 10.2%[5].

Zambia's economy is marked by areas of progress and side by side with stubbornly high levels of inequalities, environmental challenges such as de-forestation and land degradation and deep-rooted harmful practices (e.g. child marriages and violence against women) that breed vulnerabilities and set back human development. The number of people in urban areas in Zambia rose from 3.5 million in 2000 to 5.1 in 2010. The population is young and poor: 52% (about 7 million people[6]) are below the age of 18 out of which 65%[7] live in poverty. This has tremendous implications on health care delivery capacity and is partly the root cause of current problems on health care indicators. In the post-2015 dialogues which focused on the theme 'The Future We Want', Zambian participants stated clearly that their future lies in a more equal Zambia, where all enjoy equitable opportunities for education, healthy, employment, where all enjoy fundamental human rights and where government institutions are more responsive and accountable to the people[8].

[4] LCMS 2010
[5] Labor Force Survey, 2012
[6] Census 2010
[7] LCMS 2010
[8] Zambia Consultation on the Post-MDG Agenda, 2013 and 2014 Reports & Zambian Voices Beyond 2015

Figure 1: Population Pyramid 2016, Zambia



Zambia is blessed with abundant natural resources but economic diversification is still a key development challenge. GDP contribution by sector reflects its Lower Middle Income status. Wholesale and retail trade contributes 18.4%, followed by mining and quarrying (12.9%), construction (10.9%), agriculture, forestry and fisheries (9.9%), and manufacturing (7.9%)[9]. The economy relies heavily on copper mining which accounts for over 70% of export earnings, although the sector employs less than 2% of the population. The majority of people in Zambia (60%) live in rural areas where they depend on subsistence agriculture. The rural areas continue to lag behind, while urban areas have benefited from the concentration on capital-intensive industries such as construction, mining and transport.

This paradox, where high economic growth is dependent on a sector that is not generating sufficient decent employment, leaves Zambia and its people vulnerable to external shocks. Given this development scenario, and considering Zambia's geographical location in both the SADC and COMESA trading blocs, agriculture, manufacturing and regional trade offer insufficiently tapped possibilities for driving broad-based and inclusive economic growth.

Zambia is urbanising rapidly with the number of people living in urban areas rising from 3.5 million in 2000 to 5.1 million in 2010[10]. It is divided into two worlds based on formal and informal economies. Urban Zambia is associated with the formal economy, but most of the rural areas are heavily rooted in the informal economy and accommodate

[9] 2013 Annual Report, Ministry of Finance
[10] UN Habitat 2013

many of the identified vulnerable groups in Zambia. By some measures, inequality in Zambia is actually getting worse: the Gini Coefficient as a measure of income inequality increased from 0.60 in 2006 to 0.65 in 2010[11], placing it in the category of most unequal countries. Thus Zambia is one of the worst performers on human development indicators. The Human Development Index (HDI) value increased from 0.422 to 0.561[12,] positioning the country at 141 out of 188 countries and territories. In spite of this progress, like many other countries in Sub-Saharan Africa, Zambia's human development indicators have been disappointing. Zambia has high levels of inequality: when Zambia's HDI value 0.561 is discounted for inequality, it falls to 0.365. 62.8% of the population is multi-dimensionally poor, meaning that such households suffer overlapping deprivation in education, health and living standards.

2.2 Health Status

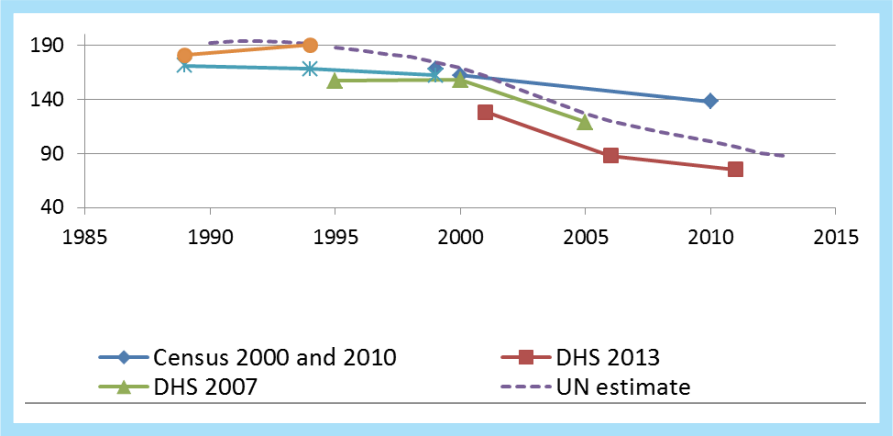
The right to health care is enshrined in the Constitution of Zambia[13] which commits the State to "Take all practical measures to ensure the provision of basic, accessible and adequate health services throughout the country". The Zambia Demographic and Health Survey (ZDHS -2013/14 [14] shows that the country made some progress in achieving the MDGs. The country has registered very good performance on all the three key childhood mortality indicators IMR dropped from 107 per 1,000 live births in 1992 to 45 in 2013, against the MDG target of 36. U5MR dropped from 191 per 1,000 live births in 1992 to 75 in 2013, against the MDG target of 63. NMR dropped from 43 per 1,000 live births in 1992 to 24 in 2013, against the MDG target of 14. The maternal mortality ratio declined from 591 per 100,000 live births in2007 to 398 per 100,000 live births in 2013. However, notwithstanding the above progress, it should be noted that these mortality levels are still unacceptably high and still require further reductions. The main challenges included: unmet family planning needs which were still high at 21% in 2013 compared to 27 % in 2007; inequalities in the coverage of maternal health services; shortages and inequitable distribution of health workers particularly midwives; iniquities in distribution of deliveries by skilled health workers which has an overall reported average of 64.2%. The country continues to have shortages of appropriate infrastructure, equipment and supplies for provision of Adolescent–Friendly Health Services (ADFHS).

Malaria was the most commonly diagnosed cause of death in all age-groups in the period 2009-2013, followed by ARI/pneumonia, non-bloody diarrhoea, anaemia and TB - (Annex 3). However, although the absolute numbers of diagnoses on admission were generally on the increase, the trend was towards modest reductions in case fatality rates of the most commonly diagnosed diseases on admission (Annex 3). For example, the case fatality rate for malaria reduced from 3.5% in 2009 to 1.4 in 2013; and for ARI/pneumonia reduced from 4.9% in 2009 to 3.5% in 2013. Among the top 10 diagnoses for admission, case fatality rates were relatively high for TB, cardiovascular diseases, and severe malnutrition. There were few diagnoses for some rarer diseases such as Cryptococci meningitis, trypanosomiasis, neonatal tetanus, meningitis, and pneumocystis carinii pneumonia but their case fatality rates were very high (Annex 4).

[11] 2013 Human Development Report in 2010
[12] UNDP Human Development Index 2014
[13] ibid
[14] ZDHS2013/14

As indicated in Figure 1 below, with IMR at 45 per 1,000 live births and U5MR at 75, it means that 1 in every 22 Zambian children die before reaching the age of one, while 1 in every 3 does not survive to their fifth birthday[15]

Figure 2: National trends in under-five mortality rates per 1,000 live births in Zambia



Source: Based on CSO and UN Estimate Reports.

Figure 1 shows the 13-year period trends for the last three Zambia Demographic and Health Surveys (ZDHS) and UN estimates. According to the 2010 Census, Zambia has a young population, with 46% of the population below the age of 14 years. Zambia has demonstrated its commitment to child survival as evidenced by ratification of international and regional treaties including the Convention on the Rights of the Child (CRC). The nutrition status of children however remains a major concern. One out of every three children in the country is malnourished, 15% of children less than 5 years of age are underweight and more than a third of children (40%) are stunted[16] and 6% of the children are wasted. Breast feeding is almost universal (98%), only 66% of infants are breastfed within one hour of birth and 73% of infants below 6 months of age are exclusively breastfed. The proportion of children 6-23 months with adequate food diversity and feeding frequency is at 22% and 42%, respectively, while consumption of foods rich in bioavailable iron is at 49%.

The recent El Nino weather phenomenon which was associated with severe droughts in many parts of the sub-region and less so in the country resulted in food insecurity and a negative impact on rural livelihoods. Food insecurity is likely to have a major impact on the nutritional status of children in particular if the current mitigation measures are not sustained. Regular assessments to monitor the nutritional trends of children in the most affected districts will be required.

[15] SO, et al., ZDHS 2013-14
[16] ZDHS 2013/14

The country has experienced a gradual decline in HIV prevalence among adults aged between 15 and 49 years, from 14.3% in 2007 to 13.3% % in 2013[17] which is predominantly a result of behaviour change programmes. Despite these gains, the current prevalence rate is unacceptably high compared to the NHSP target of 6% by 2015. The prevalence is generally higher among women (15.1%) compared to men (11.3%). The country has accomplished gains since the beginning of the millennium on high impact interventions particularly HIV testing, treatment, Prevention of Mother-to-Child Transmission of HIV, Voluntary Medical Male Circumcision (VMMC), condom use and social and behaviour change which have contributed to reduction of incidence and improved survival of people living with HIV. The number of new annual HIV infections has reduced from 90,000 in 2000 to 64,000 in 2015. Uptake for HIV Testing Services (HTS) has increased from 14% in 2001 to 37% in 2013 among men aged 15-49 and from 9% in 2001 to 46% in 2013 among women aged 15-49. [1] Voluntary Medical Male Circumcision uptake increased from 304 in 2007 to a cumulative total of 1,005,424 in men between 15 and 49 years by 2015, thus achieving coverage of 54%.

Under treatment, care and support, the number of people living with HIV accessing Anti-Retroviral Therapy (ART) has increased from 3% in 2004 to 62% (758,646) in 2015.[2] The national estimate for ART coverage based on all PLHIV criteria in 2014 was 54% for adults (15+) and 39% for children (0-14). The survival and retention of people on antiretroviral therapy at 12 months increased from 65% in 2010 to 81% in 2013 [3]. The estimated mortality rate from AIDS in adults aged 15 years and older has decreased from a peak of 8% in 2002 to 2.1% in 2013[18][4]. The burden of TB and TB/HIV in Zambia is among the highest in the African Region. A nationwide TB prevalence survey (2014) revealed that the estimated national adult prevalence of smear, culture and bacteriologically confirmed TB was 319/100,000 population, 232-406/100,000 population and 568/100,000 population respectively[19]. The risk of having TB was five times higher in the HIV positive individuals. The TB prevalence for all forms was estimated to be 455 /100,000 population for all age groups. TB/HIV co-infection rate was 61% in 2014 and the estimated MDR/RR-TB cases among notified pulmonary TB cases is 1,500 with 695 (9%) notified case for rifampicin resistance. There has been a lot of mobility within the sub-region in search of employment opportunities and trade. This predisposes people to the risk of contracting and spreading HIV and tuberculosis, including the spread of MDR/TB.

There are wide inequalities between provinces in the percentage of fully immunized children (12-23 months) and limited progress has been made in reducing the gap as it remained constant at 68% in 2007 and 2013 against the national target of 80%. The absolute inequality gap was 29% in the 2007 ZDHS and 22% in the 2013/14 ZDHS. The percentage of children who received the specific vaccines was higher in urban

[17] ZDHS, 2013-14

[18] [1] CSO; Zambia Demographic & Health Survey, 2013/14

[19] [2] National AIDS Council; Revised National AIDS Strategic Framework 2014 to 2016

than in rural areas, with no major change in the inequality gap by urban-rural residence. In the last two ZDHS for instance, the absolute urban-rural gap reduced from 13% to 10% for DPT3-HebB+Hib, but increased from 3% to 4% for BCG, and 5% to 7% for measles.

Zambia is endemic to four Preventive Chemotherapy Neglected Tropical Diseases (PC NTDs) which include soil transmitted helminths (STH), schistosomiasis (SCH), lymphatic filariasis (LF) and blinding trachoma. Recent NTD mapping results show that of the 105 districts in the country, 60 (57%) are endemic for schistosomiasis, 42 (40%) are endemic for STH and 60 (57%) for LF. Mass Drug Administration (MDA) started in 2015 for LF, SCH and STH obtaining coverage of 74% well above the WHO target of 65%. Rapid assessment of prevalence of Human Africa Trypanosomiasis (HAT) was conducted in 2011 revealing evidence of transmission in Muchinga and Eastern provinces. However, from 2013 transmission has been reported in Rufunsa District in Lusaka province and Itezhi-tezhi district in Central Province. Data collected from the Health Management Information System (HMIS) and Department of Veterinary Services indicate that rabies is prevalent in almost all the provinces. Leprosy was eliminated in Zambia, however, there are some traces of leprosy being reported and the magnitude is yet to be quantified.

The country is also prone to outbreaks of anthrax, chickenpox, cholera, dysentery, konzo, measles, ,meningitis, mumps, plague, rabies and typhoid. In addition, there is an increase in the number of Non-Communicable Diseases reported in Zambia. It is estimated that deaths from NCDs account for 22.6%[20] and cause of death by injury was 10.7 in 2012[21]. The major risk factors are cigarette smoking, physical inactivity, alcohol consumption and unhealthy diets. The last WHO Stepwise approach to Surveillance (STEPS) for NCD risk factors survey was done from 2007-2008. However, evidence from health facility-based surveillance data suggests that NCDs and conditions continue to pose a growing public health challenge. Zambia has the fourth highest cervical cancer rate in the world, and other NCDs which include cancers, diabetes, hypertension, cardio-vascular conditions, road traffic injuries and mental health conditions continue to afflict a growing number of Zambians.

A review of the top 9 NCDs shows that the total number of NCD cases reported to health facilities increased from 388,120 in 2011 to 441,187 in 2013, an increase by 14%.[22] The most prevalent NCDs in 2013 were hypertension, accounting for 41.6% of all NCD cases in 2013 (all ages) and Asthma (22.5%). Cervical and breast cancers were the lowest, with a combined percentage of 0.6% of the total cases in 2011 and 1.3% in 2013[23]. Obesity among women over 25 years with body mass index increased from 12% in 1992 to 19% in 1997. Deaths caused by road traffic injuries stood at 24.7 per 100,000 in 2013[24]. Efforts are underway to improve the capacity of public health

[20] [2] National AIDS Council; Revised National AIDS Strategic Framework 2014 to 2016
[21] TB Prevalence Survey Zambia, 2014
[22] ibid
[23] ibid
[24] MoH Technical Updates, 2015

facilities to screen, diagnose and manage these conditions and diseases through the training of health workers, procurement of diagnostic equipment and consumables as well as advocacy towards healthy lifestyles. Government is also planning to continue investing in low cost high impact primary care interventions which focus on community health and preventive care.

2.3 Health System Response

A strong health system is important for the implementation of health interventions to reduce morbidity and mortality. Zambia is experiencing a double burden of disease which is exacerbated by a weak economy. This situation has resulted in weakening of the six pillars of the health system. The health services delivery system in Zambia is focused on providing health services as close to the family as possible using a Primary Health Care approach. To achieve this, the service delivery system was designed with the following structure: community services, heath posts, health centres, 1st level hospital (district), 2nd level hospital (general), and 3rd level hospital (central). Zambia has 250 private clinics which are mostly located in urban centres. Table 1 summarises the number and type of health facilities in the country.

Table 1: Health Facilities Profile for Zambia

Facility level	Types of facilities	No. of facilities
Facilities by level	Central Hospitals	6
	Provincial hospitals	24
	District Hospitals	81
	UHC	409
	RHC	1,131
	HP	307
	Total Facilities	1,958
Facilities by Ownership	GRZ	1,592
	Polyclinics	116
	Private clinics	250
	Total health facilities by ownership	1,958
Total of all facilities		1,958

Source: Zambia Listing of Health Facilities, 2013

The National Health Strategic Plan 2017-2021 makes provision for delivering the unfinished MDGs agenda and implementation of the 2030 Sustainable Development Goals (SDGs). Government and partners have worked together to elaborate frameworks to guide interpretation of Universal Health Coverage (UHC) and SDGs. The National Health Policy explicitly spells out ways for advancing UHC, and UHC is part of the broader national efforts to deal with extreme poverty, social exclusion and gender inequity. With at least 68% of the population living in poverty, access to

health services is compromised in terms of access and affordability. In addition, health facilities face challenges of insufficient skilled human resources, drug stock outs, transport and medical equipment and technologies. Globally, partners and heads of state have lined up behind the UHC agenda as a primary driver for improving health and protection of all persons especially the poorest and those left behind. At the G7 summit in May 2016, participants issued a declaration that calls for attainment of UHC with emphasis on strong health systems and better preparedness capacities in countries. WHO in collaboration with other UN agencies supported Government through a wide consultative process of the Seventh National Development Plan and the National Health Strategic Plan 2017-2021 to domesticate the health related SDGs. (See Annex 3). Of the 17 SDGs, Goal 3 - 'Ensure healthy lives and promote well-being for all ages' directly focuses on health and is in line with the vision and goals of the National Health Policy which came into effect in 2013. The SDG targets under Goal number 3 have been selected and adapted as national sustainable development goal targets; examples include reducing maternal and child mortality, Universal Health Coverage, reducing premature mortality from NCDs, mental health, road safety, and prevention of substance abuse.

The National Health Policy outlines the country's commitment to realize the human rights of all and to achieve gender equality through the empowerment of all women and girls. This priority will integrate SDG Goals 3 and other health-related goals. Unlike past national health strategic plans, the new strategic plan encompasses a detailed monitoring and evaluation framework which will be used to assess progress through mid-term and end-term evaluations.

Although there is no comprehensive health information flow from private health care providers, the sector seems to be making significant contributions to the health care system. A policy on public-private partnerships for health is now in place and some work has started to encourage this partnership on some programmatic areas such as Maternal Newborn and Child Health. Zambia has 366 private clinics and hospitals under a well organised association of Private Health Practitioners located largely in urban settings.

In terms of health service delivery, Zambia has 20 hospital beds per 10000 population [25]Most of the health facilities are supported by expatriate and volunteer staff. This is also attributed to the low production of medical doctors and other medical professionals within the country estimated at 50-60 Doctors and 1585 nurses graduating per year. Expatriate doctors are working in at least 50% of the hospitals mostly in rural districts. An estimated 5% of the hospitals have an expatriate nurse while 14% have other expatriate staff. In addition, 3% of the rural health centres (HCs) and 10% of urban HCs report having expatriate personnel. A total of 45 out of 63 dental surgeons in the public health sector are expatriates, this is because the country never used to have a training programme for dental surgeons. The sector also depends on volunteers,

[25] HMIS,2014

specifically at HC level (32% of rural HCs and 48% of urban HCs) out of which half work full-time while the other half work part-time. In general, volunteers are less common in hospitals[26].

The health sector continues to face Human Resources for Health (HRH) challenges. There is a large unmet staffing gap, for example in 2013, the total staffing gap stood at 23,362 representing 39% of the approved staff establishment. In addition, there are iniquities in the geographical distribution of core health workers. In 2013, the North-Western Province had the highest number of clinical health workers per 10,000 population (13.2 per 10,000), followed by Lusaka at 13.1, while the lowest was Northern Province (5.4). The staff attrition rate is high and is estimated to be between 4.5% and 5.4% of the total number of staff in-post. The WHO recommends a proxy ratio of 2 medical doctors and 14.3 Nurses per 1,000 population to achieve the MDGs. None of the Southern Africa Development Community (SADC) countries are near the WHO benchmark. Zambia is in the middle of the ranking for nurses per 1,000 population ratio (7th out of 14th countries), while it fares relatively worse than its neighbours on the physicians per 1,000 population ratio (10th out of 14th countries). Table 2 below provides analysis of the health sector establishment for the period 2011 to 2016.

[26] World bank

Table 2: Health Sector Establishment Analysis 2011 to 2016

CATEGORY	2013				2014				2015 JULY 31ST				May-16			
			GAP IN ESTABLISHMENT				GAP IN ESTABLISHMENT				GAP IN ESTABLISHMENT			GAP IN ESTABLISHMENT		
	Approved Sector Est	Actual Staff	No	%	Approved Sector Est	Actual Staff	No	%	Approved Sector Est	Actual Staff	No	%	Approved Sector Est	Actual Staff	No	%
ADMIN	21350	16355	4995	23	21519	15966	5553	26	22353	17095	5258	24	22353	19254	3099	14
CLINICAL OFFICER	4813	1603	3210	67	4813	1647	3166	66	4818	1738	3080	64	4818	1814	3004	62
DENTAL	865	321	544	63	888	322	566	64	888	293	595	67	888	312	576	65
DOCTOR	2939	1249	1690	58	2939	1380	1559	53	3035	1432	1603	53	3035	1498	1537	51
ENVIRONMENTAL	2063	1504	559	27	2063	1399	664	32	2069	1569	500	24	2069	1605	464	22
LAB	2023	631	1392	69	2023	900	1123	56	2075	864	1211	58	2075	920	1155	56
MIDWIFE	6106	2783	3323	54	6106	2735	3371	55	6126	2837	3289	54	6126	3008	3118	51
NURSES	17497	10112	7385	42	17497	10785	6712	38	17814	11140	6674	37	17814	11153	6661	37
NUTRITION	330	194	136	41	330	182	148	45	344	191	153	44	344	197	147	43
PHARMACY	1108	978	130	12	1108	965	143	13	1161	1035	126	11	1161	1159	2	0
PHYSIOTHERAPY	421	378	43	10	421	415	6	1	432	424	8	2	432	441	-9	-2
RADIOGRAPHY	483	439	44	9	483	474	9	2	520	390	130	25	520	416	104	20
TOTALS	59998	36547	23451	39	60190	37170	23020	38	61635	39008	22627	37	61635	41777	19858	32

*** Source: HRH Strategy 2011-2016, MOH**

*Percentage In The Gap In Establishment Column Represents The Percentage Of The Gap Not Filled Against The Approved Establishment

The health care system in Zambia is largely financed by the government with contributions from the private sector, bilateral and multilateral agencies, NGOs, and households. In 2014, Zambia spent 1.3Billion USD on health care of which 30% was spent by households. WHO recommends that countries spend at least USD86 per capita[27] on health care. The MTR 2014 reports that financing of health services in Zambia is largely dominated by tax financing which makes about 60% of all total expenditure reviews with an out of pocket expenditure of 9% while the rest comes from development partners. Due to varied reasons, the National Health Accounts (NHA) has not been updated and health sector public expenditure studies have not been conducted. The WHO estimates for 2011 show that 16.4% of general government expenditure is spent on health, up from 12.2% in 2000. This is higher than the average African Region of 9.7% in 2011. Per capita government health expenditure has been growing from US$ 23 in 2008 to US$ 47 in 2015 which is higher than most of the countries in the region.

Zambia continues not to have adequate local industrial capacities in manufacturing of pharmaceuticals and this has led to over-reliance on imports with lengthy delivery times. The challenges in the pharmaceutical sector include: lack of revision of the procurement plan on annual basis; irregular meetings of the procurement Technical Working Group; inadequate decentralisation of Medical Stores Limited (MSL) and the Zambia Medicines and regulatory Authority (ZAMRA) operations, which affected distribution and regulation of medicines, respectively; inadequate storage facilities/ capacities at national, district and health facility levels, especially at primary health care level including inadequate coordination mechanisms in the management of the procurement of pharmaceuticals and vaccines. Other challenges include inadequate training of health workers in Rational Drug Use (RDU) and public sensitization on Adverse Drug Reaction (ADR), lack of a specific committee or structure to review the usage of vaccines in order to ensure rational use and inadequate pharmacists in the health sector (establishment vs actual).

Zambia adopted the Integrated Disease Surveillance and Response (IDSR) as a regional strategy for early detection and efficacious response to priority communicable diseases (resolution AFRO/RC/48/R2 of 1998). The IDSR technical guidelines were adapted in 2002 and revised in August 2011. Since 2007, training of health workers using the IDSR Guidelines Training had been conducted at national, provincial and district levels. At the national level, MOH established the Disease Surveillance Unit under the Disease Surveillance, Control and Research Directorate. Data is transmitted manually from the districts to the provinces and then to the national level. Even where computers and internet exist, the data is sent as scanned copies. This therefore requires that all data are re-entered manually at all levels. It is therefore difficult to timely enter and analyse the data, provide feedback to the provincial levels, issue alerts and publish the weekly epidemiological bulletin.

[27] UN Database, 2010

2.4 Cross-cutting issues

Zambia enjoys membership to the Southern African Development Community (SADC), the Common Market for Eastern and Southern Africa (COMESA), as well as the African Union (AU). The country is also a signatory to several international conventions that promote gender equality. These include the Beijing Declaration on the Platform for Action (1995) and the Convention on the Elimination of all Forms of Discrimination against Women (2011). According to Government, the country has been meeting deadlines for some requisite monitoring reports and set targets on these conventions. The Ministry of Gender developed the National Gender Policy of 2014 and the Anti-Gender based violence Act number 1 of 2011. The Zambian Government has recognized the need for equal and full participation of women and men at all levels of national development. To attain its vision of full gender equality, the government's intention is to fully implement the national gender policy. The Gender Parity Index (GPI) stood at 0.617 in 2013 and ranked number 141 in the world. The country has also effectively integrated gender, equity and human rights into public policies, strategies and operational planning. Social and economic determinants of health, including gender equality and women´s empowerment is regularly monitored and the results widely disseminated and discussed at Cluster Advisory Group meetings (CAGs). However, challenges do still remain in in terms of achieving gender balance in political and economic decision making, economic participation at all levels, and eliminating domestic violence[28].

2.5 Development Partners' Environment:

2.5.1 Partnership and development cooperation

The key development and funding partners in the health sector comprise multilateral and bilateral institutions, international NGOs, humanitarian and faith-based organizations. Funding partners comprise the European Union (EU), United States Agency for International Development (USAID), the Centre for Disease Control (CDC) and the United Kingdom's Department for International Development (DFID), JICA, SIDA, World Bank, Swiss Embassy and the UN family. WHO continues to be a permanent member of the health Troika which involves representing other health partners in high level health related meetings with government and coordinating monthly MoH/CP policy meetings including the Cluster Advisory Group meetings and Annual Consultative Meetings. WHO also chairs the United Nations Sustainable Development Goals Partnership Framework (UNSDGPF) Results Group One on Health.

Other mechanisms through which Zambia has received funding include the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), the Global Alliance for Vaccines, and Immunization (GAVI) and the multi-donor funded Health Development Fund (H6). Government in partnership with the UN family through the Zambia UN Sustainable Development Goal Partnership Framework (UNSDGPF) provides partners with regular

[28] HRH strategy 2011-2016

information on the national development agenda. There are regular strategic and yearly planning and half-yearly monitoring and review meetings during which the MOH provides partners with guidance on areas where development assistance is required.

For more than 20 years, Zambia has worked collectively with its development/ cooperating partners (CPs) to strengthen national health systems and improve health outcomes. Widespread recognition of the limited effectiveness of donor aid led to a Sector-wide Approach (SWAP) in 1994 while the implementation of the IHP+ implementation is on course. This included pooled funding delivered through national systems. The process has resulted in many positive developments including joint systems for planning, financial management, annual review and performance assessment through the health management information system. It is important to note that there have been major changes such as reorganizations of the MOH and important shifts in the focus and modalities of development assistance all of which have impacted on the process and pace of reform[29].

There has been a Memorandum of Understanding (MOU) between government and its cooperating partners setting out the objectives of the partnership. The most recent dates from 2012 and relates to the implementation of the National Health Strategic Plan (NHSP 2011-2016). Despite the existence of long standing coordination structures, there is still a problem of coordination and harmonization of efforts and resources around the national plan. While all support was aligned to the health plan, much was reported to be provided off-budget and outside the sector coordination mechanism. The 2012 reorganization of the MOH was unplanned with no clear guidelines or support to the change process. There was lack of clarity of the mandates of MOH and the Ministry of Community Development, Mother and Child Health, leading to duplication across the two ministries, concerns over the effectiveness of coordination and communication, lesson learning and increased fragmentation.

There were also reported gains in improving joined up health care and social support at the primary level. The ministry clearly needs to work without barriers and with clear guidelines and timely evaluation of the effectiveness of the reorganization. Much of the external assistance is still provided via NGOs outside the sector coordination mechanism and while government still incurs substantial transaction costs. External finance remains unpredictable and undermines rational planning. Financial flows are not transparent and are not reflected within the sector budget. There is duplication, fragmentation and the failure of lesson learning. Much aid is still provided in ways that limit its long-term effectiveness, efficiency and raises questions of the sustainability of gains in health outcome. Donors have mapped projects supported by district but there is no analysis of the exercise. Further, there is a growing concern that some donors no longer see Zambia as requiring humanitarian assistance and have expressed unease about extending support to the country. As a result, increasingly external support for some critical health programs is declining – perhaps due to competing global priorities.

[29] WHO, Health in 2015 from MDGs to SDGs, Geneva 2015

There is still need for a serious re-thinking over engagement of partners, to sustain their support to build a resilient and sustainable health system that offers quality comprehensive care and aims to progressively achieve universal health coverage.

Zambia continues to face an emerging additional health burden. Instead of diseases declining as living conditions improve, socio-economic progress is creating unintended conditions that favour the rise of non-communicable diseases. The role WHO as a neutral blocker between the MOH and partners remains critical. The MOH relies heavily on support from donors. Partners have come up with a donor mapping exercise that tabulates partners' support by regions and estimated financial implications. While these mechanisms will remain essential, there is need to explore other approaches and strategies for mobilizing financial, material and human resources from national and local stakeholders including the community. The completion of the National Health Accounts remains a priority. The country will require support in strengthening National Health Accounts analysis, health sector financing options and the possibilities that exist in the public-private partnerships (PPPs).

In an attempt to mainstream the SDGs in the country, government together with the UN system organised stakeholder workshops to raise awareness, prioritise goals and domesticate the targets. Specific strategies to achieve the unfinished MDGs and SDGs have been put in place with emphasis on health in all sectors. Specific strategies to prepare local governments for the "localization" of SDGs at sub-national level are being worked out. Stakeholder analysis of health and health related SDGs support areas is reflected in Annex 2.

2.5.2 Collaboration with the UN system at country level:

The United Nations in Zambia works in support of the Government of Zambia in collaboration with other development partners. The United Nations Country Team (UNCT) is the highest-level inter-agency coordination and decision making-body in Zambia. Under the leadership of the United Nations Resident Coordinator, all UN entities work as a team in formulating common positions on strategic issues, ensuring coherence in action and advocacy. The UNCT values its engagement with all stakeholders, including government, bilateral and multilateral donors, non-governmental organizations, civil society organizations and the private sector. The agencies working in health include: UNFPA, UNICEF, WB, UNESCO, UNHCR, UNAIDS, UNDP and WHO. The ILO and World Food Program also contribute to health through their programs that address some social dimensions of health.

The 2016-2021 UNSDGPF was designed at a strategic level to provide the Government of Zambia and the UN Country Team with a flexible and agile framework which responds in a holistic manner to the evolving national context. Increased effectiveness through UN coherence and stronger partnerships are key underlying principles for the operationalization of the UNSDGPF. The UNSDGPF provides the Government of Zambia and the United Nations Country Team with enhanced perspectives to advance the recovery and development agenda. In order to ensure

coherent and strategic action in contributing to this agenda, a Joint Implementation Plan for the 2016-2021 UNSDGPF was developed to serve as a tool for improved programming, planning, implementation, accountability, monitoring and evaluation. The UNSDGPF national priority areas have been jointly elaborated with government under the following pillars: (i) inclusive Social development; (ii) Environmentally Sustainable and Inclusive Social Development; (iii) Governance and participation. These priority areas integrate several Sustainable Development Goals (e.g. SDGs 1, 2, 3, 5, 8, 13, and 16) and are critical in addressing Social Determinants of Health.

WHO's contribution has been through informing policy, strategy and guideline formulation, building core institutional capacity, monitoring trends according to the WHO mandate and resource mobilization for key programmes. As a member of the UNCT Programme Management Team (PMT), the WCO has been actively involved in monitoring the implementation of the UNSDGPF through active participation in annual review meetings where issues pertaining to the achievement of UNSDGPF are discussed.

2.5.3 Country contributions to the global health agenda:

Zambia is a member of SADC and the African Union. It has contributed positively to health development in other countries through its efforts toward meeting the Roll Back Malaria Initiative's Global Malaria Action Plan goals and targets. The country was instrumental in cementing the Zambia-Zimbabwe, Zambia-Mozambique, Zambia-Malawi cross border malaria initiatives. This, coupled with strong local partnerships and collaboration with UN has resulted in achievement of gains for malaria control and prevention.

The national response to HIV and AIDS in Zambia is administered by Zambia's National AIDS Council. Resources from the Global Fund, bilateral and multilateral donors are administered by selected agents or institutions identified by the respective funders. Given Zambia's success in decreasing the HIV/AIDS burden there are lessons that can be learnt from this mechanism to fight the disease.

2.2.4 Review of WHO's Cooperation Over the past CCS cycle:

The second-generation CCS covered the period 2008-2013 and later on extended to 2016 in order to align it with the extended period of the NHSP and National Development Plan. The key strategic agenda of the second-generation CCS comprised of the following three domains:

(i) Health Security;

(ii) Health systems capacities and governance; and

(iii) Partnerships governance, gender and equity.

An external evaluation of the CCS was undertaken in 2015[30]. The main thrust of

[30] Zambia Millennium Development Goals 2000-2015. Final Progress Report. UNDP/Zambia. www.zw.undp.org/content/zambia/un/home/library/mdg-final-progress-report-2000-2015.html; http://hdr.undp.org

the evaluation was to provide information on the successes and challenges in its implementation, as well as lessons learnt that could be taken up in the third generation CCS .

The methodology involved a comprehensive literature review of developments in the health sector, key informant interviews and self-assessments from WCO staff. The review was undertaken at a point when the country was heavily engaged in the SDGs development processes. The focus for WHO was to advocate for adapting the SDGs to the national context and integrating national sustainable development priorities into the National Health Strategic Plan and the new CCS priorities and focus areas. Efforts were made to ensure that the new CCS captures the spirit of universality in the SDGs and their strong emphasis on equity – frequently referred to as 'leaving no one behind' – as well as promoting a multi-sectoral approach with regards to health. This is recognizing that health is represented not only in the 13 targets under SDG 3 but also in 35 additional health-related targets under the other SDGs.

It is acknowledged that WHO cannot do everything in health, hence the need for its technical cooperation programme with the country to be strategic and focused in order to maximize the effectiveness of its efforts. Given that the second-generation CCS was implemented during a period when there was significant staff attrition in the health sector, there was some degree of recall bias on the part of the key informant participants. Moreover, no CCS mid-term evaluation was conducted to inform the final evaluation.

The specific objectives of the evaluation were: (i) To assess the level of achievement of the goals in the CCS 2008-2013; (ii) To document challenges encountered during the implementation of the CCS 2008-2013; (iii) To assess knowledge and awareness of WCO staff and partners including MOH on the CCS and their perception of its relevance; and (iv) To recommend key actions to be considered by WCO during the development of the third generation CCS.

The main findings in line with these objectives were:

(i) To assess the level of achievement of the goals in the CCS 2008-2013 - the review identified some key achievements for WHO. In spite of the political, economic and major epidemiological events that had significant impact on the status of health of Zambians during the period covered by the CCS II, WHO still played a significant role in resource mobilization, advocacy and policy development. Implementation of HIV, TB and malaria programs; the Expanded Program on Immunization; maternal, newborn, adolescent and child health programs received much attention. WHO's efforts to monitor progress in these programs as part of tracking health related MDGs was commendable. WHO also played a critical role in providing support for strengthening of the pharmaceutical systems in the country including timely revision of the essential medicines list. The development and extension of the National Health Strategy and training of government staff in System of Health Accounts (SHA2011) was led by

WHO. In addition, WHO played a leading role in responding to health emergencies and disasters that occurred during this period. This included responses to the Ebola pandemic in West Africa where more than 7 staff members were deployed to support response activities. WHO also provided support for outbreaks which occurred in the country particularly Anthrax, cholera, dysentery, meningitis and typhoid including responding to the health humanitarian situation following droughts within the country.

(ii) To assess knowledge and awareness of WCO staff and partners including MOH on the CCS and their perception of its relevance- The review established that the CCS was not fully known, utilized, and appreciated as the reference point for the work of WHO in the country particularly by some stakeholders (including some MOH staff, development partners and non-government sector).

(iii) To document challenges encountered during the implementation of the CCS 2008-2013 - The CCS document functioned as a reference guide for the development of the biennial plans. The capacity of the country office to implement the biennial program of work was highly constrained by inadequate financial resources for activity implementation and staff emoluments. Despite steady growth of the country office, office space remains inadequate. It should be pointed out here that the biennial program budget did not change throughout the period of the CCS, despite inflationary factors in the Zambian economy.

(iv) To recommend key actions to be considered by WCO during the development of the third generation CCS - It was proposed that the CCS should be fully utilized as a guiding tool in the biennial program planning as well as an instrument for resource mobilization. It was also recommended that the country office should ensure that the next CCS (and future ones) are widely disseminated and regularly referenced as the guiding roadmap of WHO's work in the country. Appropriate measures should be taken to ensure that WHO is fully resourced to play its central role in health development. Furthermore, it was recommended that adequate attention should be given to the revitalization of Primary Health Care and community engagement on matters of health.

3 SETTING THE STRATEGIC AGENDA FOR WHO COOPERATION

This strategy is guided by the unfinished business from the UN Millennium Development Goals (MDGs), the UN Sustainable Development Goals (SDGs), the WHO global priorities (MTSP & GPW), the WHO African Region Orientations including the Transformation Agenda, the Zambia United Nations Sustainable Development Partnership Framework (UNSDGPF). It is also anchored on relevant regional and sub-regional initiatives, the external evaluation of the previous CCs which is elaborated in the previous chapter and it takes into consideration the importance of national development strategies as outlined in the Vision 2030.
The 2017-2021 CCS strategic agenda is aligned to the MOH mission of achieving equity and quality in health through Universal Health Coverage (UHC). The strategic priorities and related goals and targets within this CCS hinge on provision of advisory and technical support to the MOH within the spirit of universality in the SDGs and their strong emphasis on equity – frequently referred to as "leaving no one behind". It is also aimed at promoting a multi-sectoral approach with regards to health; recognizing that health is represented not only in the 13 targets under SDG 3, but also in 35 additional health-related targets under the other SDGs.

The overarching objectives of the National Health Policy are to reduce the burden of disease, maternal and infant mortality and to increase life expectancy through the provision of a continuum of quality effective health care services as close to the family as possible in a competent, clean and caring manner. The CCS is primarily aligned to these key result areas. In addition, the CCS priorities focus on outcomes of consultation with key stakeholders, lessons learnt from the review of the past CCS cycle and WHO's comparative advantage, added value and core functions, taking into account the organization's financial and human resources (present and future).

In order to support the implementation of the National Health Strategic Plan, the WHO will need to address the specific internal constraints relating to human resource capacity and programmatic funding. These issues are further elaborated in Chapter 5. In the sections that follow, we give the illustrative examples of each strategic priority, detail the focus areas within each strategic priority and provide some illustrative interventions with corresponding indicators. The specific interventions at this stage remain illustrative, however, they will be adjusted according to the evolving needs and prevailing realities of the MOH during the implementation period.

3.1. Strategic Priority 1

Achieving and sustaining UHC through a revitalized PHC approach and sustainable service delivery through strengthening of health systems.

The pursuit of Universal Health Coverage in Zambia faces considerable obstacles because of the inherent weaknesses in the health systems - shortcomings in health delivery approaches, inadequate financing schemes, drug stock outs and problems associated with availability of Human Resource for Health (HRH). This CCS therefore, emphasizes the importance of Health Systems Strengthening as the foundation of

any improvements in health delivery in Zambia. The strategic focus areas under this priority include:

Focus Area 1.1 - Strengthen HRH to ensure adequate number for the population, good skills mix, appropriate recruitment into services to match workload, training that responds to contemporary needs, equitable deployment and appropriate retention schemes (including professional development, remuneration, motivation, and improved work environment).

Focus Area 1.2 - Support efforts to improve access to safe, effective and quality assured medical products (medicines, vaccines, diagnostics and other procedures, systems and health technologies); to promote rational use of medical products; to strengthen the national health regulatory authority and to ensure that mechanisms for coordination with stakeholders have been established to increase access to essential, high-quality, effective and affordable medical products.

Focus Area 1.3 - Support MOH to make a case for appropriate healthcare financing-through regular NHA studies, resource mapping exercises, cost effectiveness analysis of healthcare programs, finalization of the health financing policy, advocating for the implementation of a national health insurance, and supporting the budget process for achieving universal health coverage.

Focus Area 1.4 - Strengthen health information systems and workforce to ensure availability of high-quality, timely and reliable data disaggregated by income, gender, age, rural-urban, as well as periodic reviews of the National Health Information & Surveillance Strategy to generate evidence to monitor trends in priority health programs for both public and private health sectors.

Focus Area 1.5 - Support national efforts to improve access to comprehensive, person-centred, integrated health services based on Primary Health Care, quality and continuity of care, and to effectively integrate gender, equity and human rights into public policies, strategies and operational planning.

The strategic focus areas for Priority 1, together with illustrative interventions and corresponding indicators are shown in Table 3.

Table 3 Strategic Priority 1 Focus Areas, Illustrative Interventions and Corresponding Indicators

Focus Areas	Illustrative Interventions	Corresponding Indicators
Focus Area 1.1	Support development of new HRH strategy.	HRH strategy (2017-2021) in place
	Advocacy for HRH strengthening retention in Health Policy Meetings.	Number of best practices reports shared.
	Sharing best practices on HRH education, equitable deployment and retention	Capacity to conduct WISN study developed.
Focus Area 1.2	Support the revision and updating of Standard Treatment Guidelines and Essential Drugs List annually	New STG and Essential Drugs List in place
	Support development and implementation of interventions for improving transparency and good governance of the pharmaceutical sector	Good Governance for Medicine (GGM) framework in place
	Support antimicrobial resistance monitoring (AMR) to curb growing antimicrobial resistance	AMR National Action Plan (NAP) in place
Focus Area 1.3	Support MOH in strengthening effective Health Development Partners Group coordinating mechanisms.	Streamlined and effective coordination mechanisms in place.
	Support MoH on the development of IHP+ Compact.	All Partners signed the IHP+
	Support MoH on UN interagency/MoH Collaborating mechanisms/ Support the development of strategic plans for institutions	Interagency meetings on place
	Support towards the development of the Health Promotion Strategy.	Health Promotion Strategy in place
	Support towards developing strategy and implementing Health in all policies	Health in all policies/strategy/ framework in place and Hiap inter-sectoral collaboration mechanisms in place
	Support towards programme communication for all priority areas	Communication strategies for communicable diseases , NCDs and other health priorities in place
	Support MOH to build capacity for effective leadership, management and governance at all levels of the health delivery system including Community level.	Number of WHO supported LMG capacity building trainings/workshops held
		LMG materials and TA provided by WHO
	Capacitate the development of annual National Health Accounts	Annual National Health Accounts reports in place
Focus Area 1.4	Support development of new Health Information System Strategy	Health Information System Strategy in place
	Support MoH on Private Hospitals/Clinics on provision of health information to MoH	Private sector provide information to the government Clinics
	Support MoH come up with regulation frameworks for the Private health facilities	Regulation framework in place
Focus Area 1.5	Support interventions for improved quality of care : patient centred approach, integration, continuity	Community Health Strategy developed

3.2. Strategic Priority 2:

Accelerating achievement of the unfinished MDGs relating to reduction of Maternal, Newborn, Child and Adolescent Mortality; and strengthening Sexual and Reproductive Health

Diseases and conditions associated with pregnancy and child birth remain a major cause of morbidity and mortality in Zambia. Despite significant progress during the period covered by the second-generation CCS, the country did not meet its RMNCAH related MDG targets. For example, maternal mortality remains unacceptably high, well above the regional average for Africa. The National Health Policy still places high priority on RMNCAH. In response to this situation, the new CCS has selected RMNCAH as a priority area guided by the Global Strategy for Women's, Children's and Adolescents' Health.

The strategic focus areas under this priority include:

Focus Area 2.1 – Strengthen MOH capacity to implement quality and affordable interventions to contribute to the reduction of maternal morbidity and mortality in the country.

Focus Area 2.2 – Strengthen the MOH capacity to implement quality and affordable interventions to end preventable death and promote thriving and health sector transformation.

Focus Area 2.3- Support MOH to ensure universal access to sexual and reproductive health-care services particularly for adolescents, and the integration of reproductive health and gender into national strategies and programs.

Focus Area 2.4 – Support MOH efforts to end all forms of malnutrition, including stunting and wasting in children under five years of age, and addressing the nutritional needs of adolescent girls, pregnant and lactating women and older persons.

The specific strategic focus areas, together with illustrative interventions and corresponding indicators identified for the period of the new CCS under this priority are outlined in Table 4.

Table 4. - Strategic Priority 2 Focus Areas, Illustrative Interventions and Corresponding Indicators

Focus Areas	Illustrative Interventions	Corresponding Indicators
Focus Area 2.1	Support development and updating of relevant strategies, policies, guidelines and tools for maternal health.	Availability of adapted or updated QOC standards, guidelines and protocols
	Support development of investment case for RMNCAH	Investment/ funding for RMNCAH secured
	Support QOC assessments and use results to improve RMNCAH	Number of QOC assessments supported
Focus Area 2.2	Support implementation of innovative health worker training methods for acceleration of child survival and thriving	Innovative approaches implemented
Focus Area 2.3	Support implementation of adolescent, sexual and reproductive health (ASRH) across the country (e.g. strengthen school health program, advocate for legislation against child marriage, enhance community awareness on ASRH) Support adaptation and strengthening of technical guidelines on mainstreaming gender equity and human rights.	Number of ASRH initiatives supported; Evidence of SRH integration Number of guidelines adapted
Focus Area 2.4	Support the MOH and other stakeholders to reduce stunting by providing guidelines ,capacity building, operationalization of centers and services to deal with malnutrition issues, including promoting multisectoral interventions	Number of nutrition guidelines adapted

3.3. Strategic Priority 3:

Reducing further the burden of AIDS, tuberculosis, malaria, neglected tropical diseases, hepatitis, and other communicable diseases

Communicable diseases remain the leading cause of ill-health and mortality in Zambia and WHO will support the country as it aspires to end the HIV, TB and Malaria epidemics by 2030 and to prevent and control vaccine preventable diseases. There is also an emerging epidemic of Hepatitis especially among PLHIV and this will need to be addressed. Malaria remains an endemic problem in low-lying areas of the country. Other communicable diseases like diarrhoeal conditions, respiratory tract and sexually transmitted infections and zoonotic diseases remain a major public health problem in Zambia. Efforts are also underway to control NTDs- soil transmitted helminthes, schistosomiasis, lymphatic filariasis and blinding trachoma.

The focus areas under this priority include:

Focus Area 3.1: Support national efforts towards attainment of HIV '90-90-90 targets'[31] by 2020.

Focus Area 3.2: Reduce TB burden in the country as well as introduce new diagnostic and treatment approaches for MDR TB.

Focus Area 3.3: Reduce malaria incidence and support efforts to move towards malaria elimination.

Focus Area 3.4: Reduce morbidity due to neglected tropical diseases.

Focus Area 3.5: Reduce morbidity and mortality due to vaccine preventable diseases.

The specific strategic focus areas, together with illustrative interventions and corresponding indicators identified for Priority 3 are outlined in Table 5

Table 5. Strategic Priority 3 Focus Areas, Illustrative Interventions and Corresponding Indicators

Focus areas	Illustrative Interventions	Corresponding Indicators
Focus Area 3.1:	Provision of technical assistance to strengthen pediatric and adolescents HIV prevention, treatment and care Development or updating normative guidelines for prevention, treatment and care for STIs, diarrhoeal diseases and respiratory tract. Review of policies and strategies on HIV. Support to program management including program reviews Provide technical assistance in the introduction and implementation of new technologies for early diagnosis, treatment and monitoring of treatment of HIV and hepatitis Support to MOH in preventing and monitoring the emergence of drug resistance associated with scaling up of HIV program Advocate to have hepatitis back on the health agenda before it reaches epidemic levels	Coverage of ART among Children and adolescents, Pregnant women. Number of guidelines, SOPs and training materials developed. Number of policies and strategies reviewed and updated Proportion of treatment failure Drug resistance surveys conducted

31 These include establishment of major global health initiatives and large multi country programmes targeted to major communicable diseases and immunization; shifts in donor focus- from project to sector support, from sector to general budget support and more recently a return to earmarked funding targeted to a few health issues, most recently reproductive, maternal, newborn and child health (RMNCH).

Focus areas	Illustrative Interventions	Corresponding Indicators
Focus Area 3.2	Strengthen implementation of the national TB program guided by normative documents which have been developed in accordance and aligned to the WHO END TB strategy Strengthen provision of quality, comprehensive and universally accessible diagnostics, and treatment and care services for programmatic management of MDR TB. Strengthen national TB surveillance, recording and reporting of quality TB data for monitoring implementation progress	National TB Strategic Plan 2017 2020 in place. National TB manual updated National TB laboratory Operational Plan developed Gene Xpert introduced National policy on the use of Gene Xpert revised Monitoring and Evaluation tools revised TB Drug resistance survey completed and results used for policy review
Focus Area 3.3:	Support the development of Malaria policies and strategic plans in line with WHO guidance Provide technical support in programme implementation for the further reduction of malaria burden and creation of malaria free zones Support in monitoring the performance of the NMCP Support in carrying out malaria therapeutic efficacy testing Support in resource mobilization for malaria control and elimination	Malaria Policy updated Malaria strategic Plan developed Proportion of population at risk of malaria protected against malaria maintained above 95% Malaria program reviews conducted Therapeutic efficacy monitoring carried out Programmatic and financial Gap analysis tables updated and concept notes developed

Focus areas	Illustrative Interventions	Corresponding Indicators
Focus Area 3.4:	Capacity development in NTD control Facilitate procurement and distribution of PC-NTD preventive chemotherapy medicines Provide technical support and guidance in prevention and control NTD stakeholder coordination Facilitate monitoring, evaluation and quality assurance activities in the implementation of NTD prevention and control activities Advocate for the integration of preventive chemotherapy as a front-line intervention to control morbidity due to NTDs. Support community and social mobilization to overcome neglected tropical diseases Facilitate development, updating and dissemination of national NTD guidelines and protocols	Number of Trainings in NTD prevention and control 100% PC-NTD medicines required, supplied and nationally administered Quarterly steering committee meetings held Annual NTD reports completed Post MDA surveys Preventive Chemotherapy integrated as front-line intervention for NTD control Improved community awareness on neglected tropical diseases Guidelines for major NTDs Developed/update
Focus Area 3.5:	Provision of technical support to polio eradication activities as stated by the Global Polio Eradication Initiative (GPEI) Supporting Neonatal Tetanus (NNT) and Measles elimination activities including related surveillance activities Supporting the MOH in achieving and maintaining high immunization coverage Mobilizing resources for new vaccines introduction Supporting operational research including periodic assessments, program reviews and evaluations; Conduct laboratory survey to identify laboratories with polio virus or related materials; Shipment of AFP specimen from districts to national level Active search of AFP cases; Implement the Reaching Every approaches to achieve universal coverage for all to quality immunization services and access to safe, effective, quality and affordable vaccines Strengthening capacity in surveillance for vaccine preventable diseases and use of immunization and Vaccine preventable diseases surveillance data for programme monitoring, reporting and response	AFP surveillance indicators (Non-polio AFP case detection rate and % stool adequacy) Measles surveillance indicators (Non-measles febrile rash detection rate and % of districts with at least one case with blood specimen per year) Measles vaccination coverage nationally and by district Percentage of districts with 80% or greater coverage with third dose of diphtheria-tetanus-pertussis containing vaccine Number of new vaccines introduced

3.4. Strategic Priority 4:

Strengthening and re-orienting health and health-related systems to address the prevention and control of NCDs, including disabilities, injuries and mental health disorders, and the underlying social determinants through people-centred primary health care and UHC

The push on NCDs will be to reduce the mortality due to NCDs in line with the Global NCD Action Plan 2013-2020. This will be achieved chiefly through efforts on reduction of incidence of the major NCDs and related risk factors.

The focus areas under this priority area include:

Focus area 4.1: Improve access to prevention and control of non-communicable diseases in line with the global action plan on NCDs (2013-2020) that speaks to the NHSP 2017-2021 through creation of enabling policy environment and implementation of sound intersectoral strategies for the prevention of NCDs risk factors. Through policy dialogue and implementation of sound inter-sectoral strategies for the prevention of NCD risk factors.

Focus area 4.2: Improve the mental health status of the population through the development and implementation of national policies and plans.

Focus area 4.3: Support the implementation of multi-sectorial actions to reduce injuries and violence, in particular gender based violence, violence against children and from road traffic accidents.

Focus area 4.4: Support provision of services for disabled people through more effective policies and integrated Community Based Rehabilitation.

Examples of specific interventions to be undertaken are illustrated in Table 6.

Table 6. Strategic Priority 4 Focus Areas, Illustrative Interventions and Corresponding Indicators

Focus area	Illustrative Interventions	Corresponding Indicators
Focus Area 4.1:	Support the development of strategies and guidelines for NCD prevention and control for all the 9 targets; Build capacity in screening, management and treatment of NCDs including cancer; Policy dialogue on NCDs' cost and burden of economy Launch mHealth for Cervical Cancer program (under the Be He@lthy, Be Mobile initiative of WHO and International Telecommunications Union (ITU); Increase knowledge of cervical cancer among women in the screening age interval (25-59 years) Provide a continuum of care for cervical cancer	NCD Strategy and action plan developed Ear and hearing health services strategy developed Adaptation and dissemination of WHO PEN guide on NCD control National CBR guidelines developed mCervical Cancer program launched and fully functional Framework Convention on Tobacco Control fully domesticated. Alcohol policy in place FCTC 2030 project implemented
Focus Area 4.2:	Increase access to services for mental, neurological and substance use disorders.	Mental health strategy developed mhGAP intervention guide adapted MH capacity developed
Focus Area 4.3:	Development and implementation of injury multi-sectorial plans Development of policies and plans against gender based violence	Injury multi-sectorial plans developed Effective Interventions to mitigate against injuries from road traffic accidents Policies and plans against gender based violence developed
Focus Area 4.4:	Development of policies to support disabled people especially for the visually impaired and those with hearing loss	Policies to support disabled people developed

3.5- Strategic Priority 5:

Strengthening preparedness, surveillance and effective response to disease outbreaks, acute public health emergencies and the effective management of health-related aspects of humanitarian disasters in order to improve health security

Zambia has been experiencing a number of sporadic disease outbreaks for many years. Outbreaks of anthrax, bubonic plaque, chicken pox, cholera, dysentery, measles, meningitis, rabies and typhoid have been reported in in different districts countrywide. In 2017, Cholera have been reported in Central and Luapula Provinces while typhoid was reported in Lusaka Zambia has recently faced a threat of importation of diseases from neighbouring countries particularly yellow fever outbreak in Angola and Ebola outbreak in DR Congo.

WHO will support the MOH in strengthening capacities for public health integrated disease surveillance, epidemic and pandemic prone diseases, as well as emergency risk and crisis management. The focus areas identified for the new CCS for this priority include:

Focus area 5.1: Improved Alert and Response Capacities through strengthened coordination mechanisms, capacity building in IDSR, IHR (2005) and the development and maintenance of IHR core capacities including Port Health capacities.

Focus area 5.2: Enhanced capacity for early detection and prompt response to epidemic and pandemic prone diseases through development and implementation of operational plans, in line with WHO recommendations on strengthening national resilience and preparedness covering pandemic influenza and epidemic and emerging diseases; setting up systems support for expert guidance in connection with disease control, prevention, treatment, surveillance, risk assessment and risk communications.

Focus area 5.3: Improve capacity for Emergency Risk and Crisis Management through maintenance of Inter Agency Coordination Committee on Health (ICC), strengthened national capacities for all-hazard emergency and disaster risk management for health, development and implementation of health sector strategy and plan, including and taking action to tackle climate change and its impacts.

Focus area 5.4: Support efforts to reduce risks to food safety through development and implementation of food safety standards and guidelines; and enhanced multi-sectoral collaboration.

Focus area 5.5: Improve capacity to respond to threats and emergencies with public health consequences guided by the WHO's Emergency Response Framework in acute emergencies with public health consequences. Table 7 shows illustrative interventions and the corresponding indicators under this priority area.

Table 7: Strategic priority 5 Focus Areas, Illustrative Interventions and Corresponding Indicators

Focus areas	Illustrative Interventions	Corresponding Indicators
Focus Area 5.1:	Capacity building in IDSR, Disaster Risk Management (DRM) and strengthening of Rapid Response Teams at all levels.	Rapid Response Teams trained in IDSR and DRM
	Advocate for introduction of pre-service training in all multidisciplinary public health training institutions	Multidisciplinary public health training institutions supported to incorporate IDSR training in their curricula
	ZNPHI to be strengthened with a view of setting up structures of NPHI at provincial and district levels	
	Advocating for improvement of IHR Core Capacities and strengthening of IHR implementation, as well as strengthening Port Health capacity and cross border collaboration at all Points of Entry (PoE).	Number of Points of Entry implementing all 12 IHR core capacities.
	WHO to support the MoH e-learning courses and help set up a website where all documents can be accessed such as the IDSR manual(CHPP website)	Country Health Policy Process (CHPP)Website functional
	Support the setting up of the Public Health Emergency Operating Centre(PHEOC)	
Focus Area 5.2	Capacity building for early detection and response to disease outbreaks and other public health emergencies.	Reports on outbreaks and other public health emergencies identified and responded to within 48hrs. Speedy development, finalization and launch of outbreak response plans for resource mobilization and timely implementation
	Support the support the strengthening of real time early detection/response system	
	Support risk communication planning and implementation particularly in response to disease outbreak support risk communication planning and implementation	Risk communication plans in place at all levels
	Community engagement strategies for prevention and response to disease outbreaks	Community engagement plans and mechanisms in place and supported

Focus Area 5.3:	Support MOH in coordination of disease outbreak response, including other public health emergencies. Support MoH implement the workplan on climate change and health for the period 2014–2019	Coordination mechanism established and maintained Health adaptation plans for climate change developed
	Support MOH in the review of their EPR Plans and development of contingency plans and speedy implementation.	Reviewed EPR Plans. Developed Contingency plans.
	Support coordination and strengthening of trauma centres	
	Provide technical support to MOH in conducting rapid health assessments during disease outbreaks and other public health emergencies.	Rapid Health Assessment Reports produced.
	Provide technical support MOH in monitoring and evaluation of field operations during emergencies.	Monitoring and evaluation Reports produced.
Focus Area 5.4	Advocate for the establishment of food safety regulatory frameworks to prevent, monitor, assess and manage foodborne and zoonotic diseases and hazards.	Food safety regulatory frameworks established.
	Support the strengthening and establishment of food safety regulatory framework	
	Support the improvement in laboratory capacities at provincial and district level	
Focus Area 5.5:	Capacitate the MoH in the application for the Emergency Response Framework (ERF) from Regional Office in crisis situations.	Number of graded emergencies meeting ERF criteria.

4 IMPLEMENTING THE STRATEGIC AGENDA

IMPLICATIONS FOR THE SECRETARIAT

The implications for the WHO Secretariat involve building capacity for the health system, providing norms and standards, support for implementation of evidence based interventions, pooling of resources and application of standard operating procedures for emergencies. Efforts will be made to ensure that the strategic agenda is adequately rooted in an understanding of the country context, paying attention to the socio-economic challenges and how they affect health development efforts. In particular, attention will be paid to ensuring that implementation of the strategic agenda does not lead to weakening of the state capacity and/or legitimacy and neither should the uneven distribution of technical support lead to an unintentional widening of social disparities.

The central focus for the Secretariat will remain strengthening the capacity for national health development. To this extent, periodic and systematic analysis of risks will be carried out in a sustained manner to ensure that interventions are not patchy but planned within the overall strategy for health system rebuilding with a special focus on capacity-building for sustainability. Recognizing the links between political and development objectives, every effort will be made to support integrated whole of government approaches and to seek the required buy-in across the various relevant sectors through inclusive dialogue and consultations.

Above all, WHO will ensure alignment of the CCS strategic agenda with national health priorities, health-related sustainable development goal targets, monitoring and evaluation including deepening alignment in strategic agenda implementation through the use of country systems. WHO will also ensure that agreed priorities and focus do not foster fragmentation, but rather seek to promote coordination of partner support for government plans and programmes. The Secretariat will stay engaged employing a mixture of strategic priorities that can meet immediate needs as well as those that assure the country of medium-term predictability of technical support based on jointly agreed benchmarks.

Looking ahead, it is important to create more awareness about the CCS to enable stakeholders to appreciate WHO's mandate and its role in health development in the country. It is noted that the last CCS paid more attention to specific diseases and conditions because of selective partner funding streams. Public-Private Partnership arrangements were weak to effectively address the gaps in health care service delivery. This is an area that needs further policy elaboration. The CCS did not also give adequate attention to the role of communities in addressing disease prevention and health promotion efforts that are targeted to disease outbreaks and non-communicable diseases. These issues should be adequately explored in the new CCS.

4.1. Core capacity of WCO

It is clear from the analysis of the WCO that further support in terms of human and financial resources, infrastructure, information and communication technology to implement the CCS Strategic Agenda. Without necessary support, it will not be possible to achieve the expected results. In line with the current review of the WCO core capacities under the Transformation Agenda, efforts should be made to sustain the current human resource capacity specifically for non-communicable diseases , providing health through the life course , gender, equity and human rights mainstreaming and social determinants of health, health systems, essential medicines, health technologies, regulatory capacity strengthening, health systems information and evidence, health security and emergencies including food safety. There is also need to sustain ICT and CSU operations. The budgetary provisions made available to the country office are not adequate.

4.2. Office space and meeting rooms

The WCO still uses rented premises for office space. Plans are in place to have a permanent office wholly owned by the WCO. The premises have a meeting room and good ICT capability. This advantage gives opportunity to hold/host partner meetings although in a limited way. There is a critical need to ensure budgetary provisions for regular maintenance and repairs of the office infrastructure. Negotiations with Government are on-going to secure land for possible construction of WHO office premises.

4.3. WCO Information and Communication Technology needs to implement the CCS

Several activities in the CCS involve training of health workers at various levels of the health delivery system at national, provincial, district and community levels. The current ICT infrastructure is not geared to support national level distance learning. WHO in consultation with other partners will explore possibilities and feasibility to support the installation of the necessary technology to support long distance learning for health workers at provincial and district levels.

4.4. Interactions with MOH:

WHO technical officers are active participants in several program level technical working groups some of which they co-chair. Adequate mechanisms will be put in place to further strengthen cooperation between WHO, MOH and other partners through regular assessment of the implementation of the CCS and the annual work plans.

4.5. Interactions with other development partners:

Successful implementation of the CCS will depend on close collaboration between WHO and other development partners active in the health sector. As part of its global leadership in health, WHO will support activities that are implemented by other partners by availing technical guidance including stimulating and supporting the development of appropriate policies. This has implications not only for the country office but also WHO/AFRO and WHO/HQ. Every opportunity should therefore be seized to not only offer WHO technical support, but also to mobilize resources to enable WCO to play its supportive, brokerage and coordination roles. WHO will continue to mobilize resources from both domestic and external sources. Currently, the WCO is receiving domestics support from DFID for the WHO Health Emergencies project (WHE), the European Union for the EU-LUX-Universal Health Coverage and H6 for the Maternal and Child Health programmes.

4.6. Support from Inter-Country Support Team, WHO/AFRO and WHO/HQ:

In implementing this CCS, technical support, guidance and catalytic funding will be expected from WHO Inter-Country Support Team for Eastern and southern Africa (ESA), WHO/AFRO and WHO/HQ.

5 MONITORING AND EVALUATION OF THE CCS

This chapter indicates how the CCS will be monitored and evaluated during the course of implementation and at the end of its life cycle. It also shows how the lessons learnt and recommendations from the final evaluation will be shared within WHO, with the government, national stakeholder and development partners.

5.1. Participation in CCS monitoring and evaluation

WHO will ensure the monitoring and evaluation of the CCS under the leadership of the WHO Representative, with the support of WHO/AFRO and WHO/HQ and in full coordination with the MOH, health-related ministries, national stakeholders and other partners. The proper monitoring and evaluation of the CCS will be the first step towards assessing WHO's performance in the country.

5.2. Timing

The CCS will be monitored at mid-term and near the end of its life cycle. The process will as much as possible be coinciding with other national review processes in the country (as relevant). This exercise will be linked with the WHO biennial work plan monitoring and assessment and with the WHO country performance assessment that looks at WHO's influence at country level based on the CCS strategic priorities and where feasible with that of the UNSDGPF.

5.3. Evaluation methodology

The midterm review will be process-oriented and will be used to assess progress towards the achievement of the strategic priorities and strategic focus areas and to correct the implementation process of the CCS as well as revise as necessary the strategic orientations of the CCS. The end term evaluation will focus on determining whether the strategic priorities have been achieved and whether their achievements have contributed to the national health strategic plan. The findings of the evaluation will inform the formulation of the next CCS.

For the final evaluation, the WCO will set aside a budget to undertake an independent evaluation of the CCS with an external evaluation team. The evaluation will be managed by the WCO with support of the WHO Regional Office for Africa and WHO/HQ. The process will engage and involve various stakeholders. This process will ensure that the new CCS is accepted by national partners and donors because the evidence generated will be more credible.

5.3.1 Regular monitoring

The main focus of the regular on-going monitoring is to continuously review whether the CCS priorities and strategic focus areas are reflected in the WHO biennial work plan and if the core staff of the country office has the appropriate core competencies

needed in the country for delivering the WHO Technical Cooperation programme in line with the CCS priorities and strategic focus areas.

The regular monitoring will function as an early warning system to alert WHO to the need for refocusing the biennial workplans and adjust as feasible the country office staffing patterns, or seek additional technical support from IST, WHO/AFRO/ and WHO/HQ to meet the requirements.

5.3.2 Midterm evaluation

The main focus of the mid-term evaluation is to determine the progress of the identified five strategic focus areas by assessing whether the expected achievement(s) are being achieved. The evaluation procedure will be guided by the analysis of the strategic interventions being implemented to realize the indicators as elaborated under each area in chapter 3.

5.3.3. Final evaluation

The final evaluation will be a more comprehensive assessment which will measure the achievement of selected national sustainable development goal targets linked in the CCS strategic agenda (see annex 2. It will also identify the main achievements and gaps in implementation in relation to the NHS performance areas, identify the critical success factors and impediments and identify the principal lessons to be applied in the next CCS cycle.

The final evaluation report will describe the main achievements, gaps and challenges and noting the lessons learnt and the appropriate recommendations. The report will be shared for comments with the WHO AFRO and WHO/HQ and the findings, lessons learnt and recommendations will be shared with other countries, government and other partners.

ANNEXES

Annex 1: Summary of WHO support to Zambia Health Sector during the period 2017 – 2021

Strategic Priorities	Focus Area	GPW Outcome	National (NHSP) Target	SDG targets
Strategic Priority 1: Achieving and sustaining UHC through a revitalized PHC approach and sustainable service delivery through strengthening of health systems	Focus Area 1.1. Strengthen human resources for health (including remuneration, motivation and improved work environment).	Policies, financing and human resources are in place to increase access to people-centred, integrated health services	Reduce vacancy rate to 10% by 2020 Increase the coverage of specialists in tertiary (provincial) hospitals to 100% by 2020.	3.8 UHC Financial Protection and 3.C Health workforce density distribution
	Focus Area 1.2. Ensure availability of affordable quality assured essential medicines and appropriate health technologies.	Improved access to, and rational use of safe, efficacious and quality medicines and health technologies	% availability of essential medicines (42-80%)	8.8 UHC index and 3.b Access to Medicines and vaccines
	Focus Area 1.3. Strengthen health information system to ensure availability of high-quality, timely and reliable data disaggregated by income, gender, age, rural-urban; and revitalize PHC	All countries have properly functioning civil registration and vital statistics systems	% health research informed by the national health research priorities	17.8 data disaggregation
	Strategic Focus Area 1.4. Support MOH to make a case for appropriate healthcare financing- through regular NHA studies, resource mapping exercise and cost effectiveness analysis of healthcare programs.	Policies, financing and human resources are in place to increase access to people-centred, integrated health services	Periodic publication of NHA and Resource Mapping	UHC 3.8 Financial Protection

Strategic Priorities	Focus Area	GPW Outcome	National (NHSP) Target	SDG targets
Strategic Priority 2: Accelerating achievement of the unfinished MDGs relating to reduction of Maternal, Newborn, Child and Adolescent Mortality; and strengthening sexual and reproductive health;	Focus Area 2.1. Strengthen MoH capacity to implement quality, affordable interventions to contribute to the reduction of maternal mortality in the country	Increased access to interventions for improving health of women, newborns, children and adolescents	Reduce maternal mortality ratio from 614 to 300 by 2020	3.1 Maternal Mortality.
	Focus Area 2.2. Strengthen the MoH capacity to implement quality affordable interventions to end preventable deaths of newborns and children under five years of age	Increased access to interventions for improving health of women, newborns, children and adolescents	To reduce Under-five mortality rate from 75 to 50 deaths per 1000 live births	3.2 Under Five Mortality rates and Neonatal mortality
	Focus Area 2.3. Support MOH to ensure universal access to sexual and reproductive health-care services, and the integration of reproductive health and gender into national strategies and programmes.	Increased access to interventions for improving health of women, newborns, children and adolescents	Reduce maternal mortality ratio from 549 to 300 by 2020	B3.1, 3.7 and 3.8 UHC RMNCAH
	Strategic Focus Area 2.4. Support MoH efforts to end all forms of malnutrition	Reduced nutritional risk factors	Reduce mortality and morbidity due to malnutrition by 50%	2.2 Child stunting, wasting and overweight
Strategic Priority 3 Further reducing the burden of AIDS, tuberculosis, malaria, neglected tropical diseases, hepatitis, and other communicable diseases	Focus Area 3.1: Attain the 90-90-90 targets by 2020, through policy dialogue, technical support, adaptation and implementation of most up-to-date norms and standards in preventing and treating paediatric and adult HIV infection.	Increased access to key interventions for peoplelivingwith HIV	Reduce HIV deaths by 50%	3.3 HIV, TB, Malaria and Hepatitis incidence & interventions against NTDs

Strategic Priorities	Focus Area	GPW Outcome	National (NHSP) Target	SDG targets
	Focus Area 3.2: By 2025 to have reduced mortality of all forms of TB by 80% from 132/100000 in 2012 to 26/100 000 and to have reduced the incidence of all forms of TB by 80% from 562/100000 in 2012 to 112/100 000 through scale up care and control, with focus on reaching vulnerable populations	Increased number of successfully treated tuberculosis patients	Reduce mortality due to TB from 10% to less than 5%	3.3 HIV, TB, Malaria and Hepatitis incidence & interventions against NTDs
	Strategic Focus Area 3.3: Reduce malaria incidence	Increased access to first-line antimalarial treatment for confirmed malaria cases	Reduce malaria incidence from 39/1000 in 2014 to 5/1000 in 2020	3.3 HIV, TB, Malaria and Hepatitis incidence & interventions against NTDs
	Focus Area 3.4: Reduce morbidity due to Schistosomiasis and soil transmitted helminthiases and other NTDs	Increased and sustained access to essential medicines for neglected tropical diseases	Prevalence of STH and SCH from 22.7% to 10% in 2020	3.3 HIV, TB, Malaria and Hepatitis incidence & interventions against NTDs
	Focus Area 3.5: Reduce morbidity and mortality due to vaccine preventable diseases through implementation and monitoring of the global vaccine action plan as part of the Decade of Vaccines	Increased vaccination coverage for hard-to-reach populations and communities No cases of paralysis due to wild or type-2 vaccine-related poliovirus globally	To reduce the Under-five mortality rate from 75 to 50 deaths per 1000 live births	3.b Access to Medicines and Vaccines

Strategic Priorities	Focus Area	GPW Outcome	National (NHSP) Target	SDG targets
Strategic Priority 4: Strengthening and re-orienting health and health-related systems to address the prevention and control of NCDs, including disabilities, injuries and mental health disorders, and the underlying social determinants through people-centred primary health care and UHC	Focus Area 4.1: Improved access to prevention and control of non-communicable in line with the global action plan on NCDs (2013–2020) through policy dialogue and implementation of sound intersectoral strategies for the prevention of NCD risk factors	Increased access to interventions to prevent and manage non-communicable diseases and their risk factors	NCDs burden reduced by 5%	3.4 NCD Mortality
	Focus Area 4.2: Mental health status of the population improved through development and implementation of national policies and plans in line with the 2013–2020 global mental health action plan. expansion and strengthening of country strategies, systems and interventions for disorders due to alcohol and substance use	Increased access to services for mental health and substance use disorders	90% increase in number of diagnosed mentally ill to the expected mentally ill patients	3.a Tobacco Use and 3.4 NCD Mortality and 3.5 Substance abuse (alcohol)
	Focus Area 4.3: Risk factors for violence and injuries reduced through development and implementation of multisectoral plans and programmes to prevent injuries, with a focus on achieving the targets set under the Decade of Action for Road Safety (2011–2020);,	Reduced risk factors for violence and injuries with a focus on road safety, child injuries, and violence against children, women and youth	Reduce disability and dependence by 50 %	3.6 Road Traffic mortality; 5.2 Women and Girls subjected to physical, sexual and physiological violence; 16.1 population subjected to physical, sexual or physiological violence

Strategic Priorities	Focus Area	GPW Outcome	National (NHSP) Target	SDG targets
	Focus Area 4.4: Disability and dependence reduced through strengthening the provision of services to reduce disability due to visual impairment and hearing loss through more effective policies and integrated services including Community Based Rehabilitation	Increased access to services for people with disabilities	Reduce disability and dependence by 50 %	3.8 Financial Protection and 3.b Access to Medicines and Vaccines
Strategic priority 5: Strengthening preparedness, surveillance and effective response to disease outbreaks, acute public health emergencies and the effective management of health-related aspects of humanitarian disasters.	Focus Area 5.1: Improved Alert and Response Capacities through strengthened coordination mechanisms; capacity building in IDSR, IHR(2005) and the development and maintenance of IHR core capacities including Port Health capacities	Country has the minimum core capacities required by the International Health Regulations (2005) for all-hazard alert and response	100% of outbreaks detected within 48 hours and controlled within 2 weeks 100% of districts with functional coordination mechanism	3.d International Health Regulations (IHR)
	Focus Area 5.2: Enhanced capacity for early detection and prompt response to epidemic and pandemic prone diseases through development and implementation of operational plans.	Increased capacity of country to build resilience and adequate preparedness to mount a rapid, predictable and effective response to major epidemics and pandemics	100% of outbreaks detected within 48 hours and controlled within 2 weeks 100% of districts with functional coordination mechanism	3.d International Health Regulations (IHR)

Strategic Priorities	Focus Area	GPW Outcome	National (NHSP) Target	SDG targets
	Strategic Focus Area 5.3: Capacity for Emergency Risk and Crisis Management improved ;; maintenance of Inter Agency coordination committee on health(ICC), strengthened; national capacities for all-hazard emergency and disaster risk management for health, WHO emergency staff	Country has the capacity to manage public health risks associated with emergencies; Country adequately respond to threats and emergencies	100% of districts with functional coordination mechanism 100% of outbreaks detected within 48 hours and controlled within 2 weeks	Strengthen the 3.d International Health Regulations (IHR)
	Focus Area 5.4: Prevent and mitigate risks to food safety through development and implementation of food safety standards and guidelines.	Country is adequately prepared to prevent and mitigate risks to food safety	100% of districts with functional coordination mechanism	3.d International Health Regulations (IHR)
	Focus Area 5.5: Capacity to respond to threats and emergencies with public health consequences improved through implementation of the WHO's Emergency Response Framework in acute emergencies with public health consequences	Country adequately respond to threats and emergencies withpublichealth consequences	100% of outbreaks detected within 48 hours and controlled within 2 weeks 100% of districts with functional coordination mechanism	3.d International Health Regulations (IHR)

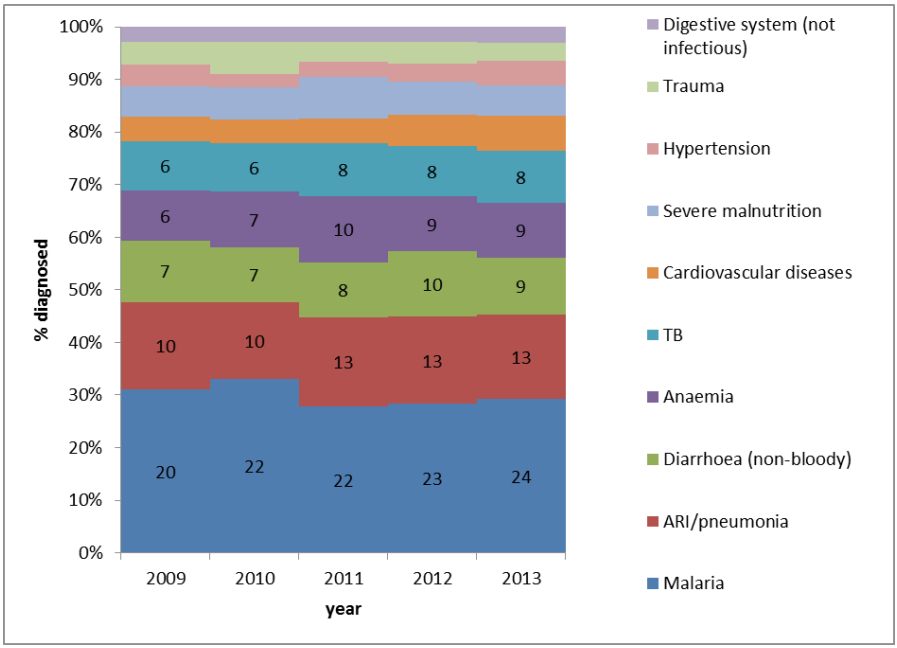
Annex 2: Basic Indicators.

% Population under 15 (2012)[2]	26
% Population over 60 (2012)[2]	3
Life expectancy at birth (2012)[3] Total, Male, Female	48 (Male) 50(Both sexxes) 52(Female)
Neonatal mortality rate (per 1000 live births(2014)[n]	21.4sexes)
Under-5 mortality rate per 1000 live births (2014)[n]	66.6
Maternal mortality ratio per 100 000 live births(2014)[n]	398
% DPT3 Immunization coverage among 1-year olds(2014)[n]	86
% Births attended by skilled health workers()[n]	64.2
Density of physicians (per 1, 000 population) (2004)	0.173
Density of nurses and midwives (per 1 000 population) ()	0.784
Total expenditure on health as % of GDP (2011)[n]	5
General government expenditure on health as % of total government expenditure (2011)[n]	16.4
Private expenditure on health as % of total expenditure on health (2011)[n]	41.7
Adult (15+) literacy rate(70.1)[n] Total	71.2
Population using improved drinking-water sources (%) (2011)[n]	63 (Rural) 85 (Urban) 49(Total)
Population using improved sanitation facilities (%) (2011)[n]	(Total) (Urban) (Rural)
Poverty headcount ratio at $1.25 a day (PPP) (% of population) ()	78
Gender-related Development Index rank out of --- countries ()[n]	141
Human Development Index rank out of --- countries (2012)[n]	141

Sources of data:

[1] Global Health Observatory 2016
http://apps.who.int/gho/data/node.cco

Annex 3: Most common diagnoses of causes of death by year (HMIS)



Annex 4: The leading diagnoses for admission, death, and disease

	2009	2010	2011	2012	2013
g Most common diagnoses on admissions (n)					
Malaria	199401	379019	390018	367368	373152
ARI/pneumonia	77349	78207	88680	82528	83782
Trauma	13816	42820	47926	50813	48420
Non-bloody diarrhea	42274	42767	42800	48147	43296
Anaemia	23774	29241	29862	25107	24113
Non-infectious digestive system disease	14312	13059	14719	15371	16264

Hypertension	8526	9903	12156	13784	15654
TB	12706	12839	12889	13748	12509
Cardio-vascular diseases	7271	6248	7388	7952	8316
Severe malnutrition (new case)	7373	7451	8479	8260	6979
Diabetes	2847	3675	3947	4611	4824
Pulmonary diseases (non-infectious)	2826	2142	2691	4128	2875
Most common diagnoses of causes of deaths (n)					
Malaria	7044	8527	6098	5830	5319
ARI/pneumonia	3757	3762	3675	3429	2903
Trauma	983	1564	801	874	621
Diarrhoea (non-bloody)	2655	2688	2312	2549	1959
Anaemia	2124	2758	2760	2153	1903
Non-infectious digestive system disease	645	758	634	595	561
Hypertension	3289	636	632	680	865
TB	2154	2376	2175	1992	1760
Cardio-vascular diseases	1041	1123	1012	1195	1238
Severe malnutrition (new case)	1316	1607	1763	1314	1025
Diabetes	241	366	269	346	293
Non-infectious pulmonary diseases	168	140	54	70	53
Case fatality rate in health institutions (%)					
Malaria	3.5	2.2	1.6	1.6	1.4
ARI/pneumonia	4.9	4.8	4.1	4.2	3.5
Trauma	7.1	3.7	1.7	1.7	1.3
Non-bloody diarrhea	6.3	6.3	5.4	5.3	4.5
Anaemia	8.9	9.4	9.2	8.6	7.9
Digestive system: (not infectious)	4.5	5.8	4.3	3.9	3.4
Hypertension	38.6	6.4	5.2	4.9	5.5
TB	17.0	18.5	16.9	14.5	14.1
Cardio-vascular diseases	14.3	18.0	13.7	15.0	14.9
Severe malnutrition (new case)	17.8	21.6	20.8	15.9	14.7
Diabetes	8.5	10.0	6.8	7.5	6.1
Non-infectious pulmonary diseases	5.9	6.5	2.0	1.7	1.8
Other diseases with high case fatality rates in health facilities (%)					
Cryptococcal meningitis	61.4	100.0	36.8	37.2	31.7

Trypanosomiasis	100.0	68.5	9.1	71.7	24.1
Other diseases with high case fatality rates in health facilities (%)					
Neonatal tetanus	35.9	59.5	33.3	40.9	21.4
Mumps	0.0	0.0	0.0	0.0	20.7
Meningitis	35.6	30.9	28.6	22.3	18.5
Rabies	33.1	19.5	17.2	34.8	17.6
Pneumocystic Carnii Pneumonia	20.3	22.0	19.4	18.0	15.6
Anthrax	100.0	96.7	175.0	0.0	15.0
Karposi Sarcoma	22.4	21.1	17.3	17.4	15.0

Source; HMIS

Annex 5: Percentage Gap in Establishment

CATEGORY	2015 JULY 31ST				May-16			
			GAP IN ESTABLISHMENT			GAP IN ESTABLISHMENT		
	Approved Sector Est	Actual Staff	No	%	Approved Sector Est	Actual Staff	No	%
ADMIN	22353	17095	5258	24	22353	19254	3099	14
CLINICAL OFFICER	4818	1738	3080	64	4818	1814	3004	62
DENTAL	888	293	595	67	888	312	576	65
DOCTOR	3035	1432	1603	53	3035	1498	1537	51
ENVIRONMENTAL	2069	1569	500	24	2069	1605	464	22
LAB	2075	864	1211	58	2075	920	1155	56
MIDWIFE	6126	2837	3289	54	6126	3008	3118	51
NURSES	17814	11140	6674	37	17814	11153	6661	37
NUTRITION	344	191	153	44	344	197	147	43
PHARMACY	1161	1035	126	11	1161	1159	2	0
PHYSIOTHERAPY	432	424	8	2	432	441	-9	-2
RADIOGRAPHY	520	390	130	25	520	416	104	20
TOTALS	61635	39008	22627	37	61635	41777	19858	32

Source: MoH 2017

Annex 6: Ministry of Health population ratio per cadre for 2009 and 2010

Cadres	2009		2010	
	Number	HRH/1000 Population	Number	HRH/1000 Population
Generalist Medical Practitioner	801	0.06	836	0.07
Nursing professional	7123	0.57	7461	0.60
Midwifery professional	2374	0.19	2471	0.20
Paramedical practitioner	1410	0.11	1462	0.11
Dentistry	241	0.02	246	0.02
Pharmacy staff	306	0.02	317	0.03
Environmental and Occupational Health & Hygiene Worker	1110	0.09	1130	0.09
Physiotherapist and Physiotherapy Assistant	191	0.02	206	0.02
Optometrist and Optician	-	-	-	-
Medical Imaging and Therapeutic Equipment Operator	226	0.02	228	0.02
Medical and Pathology Laboratory Technician	526	0.04	546	0.04
Community health workers				
Health management workers/Skilled administrative staff.	885	0.07	460	0.04
Other health support staff	12365	0.88	12365	0.99
TOTAL	27558	2.20	27728	2.21

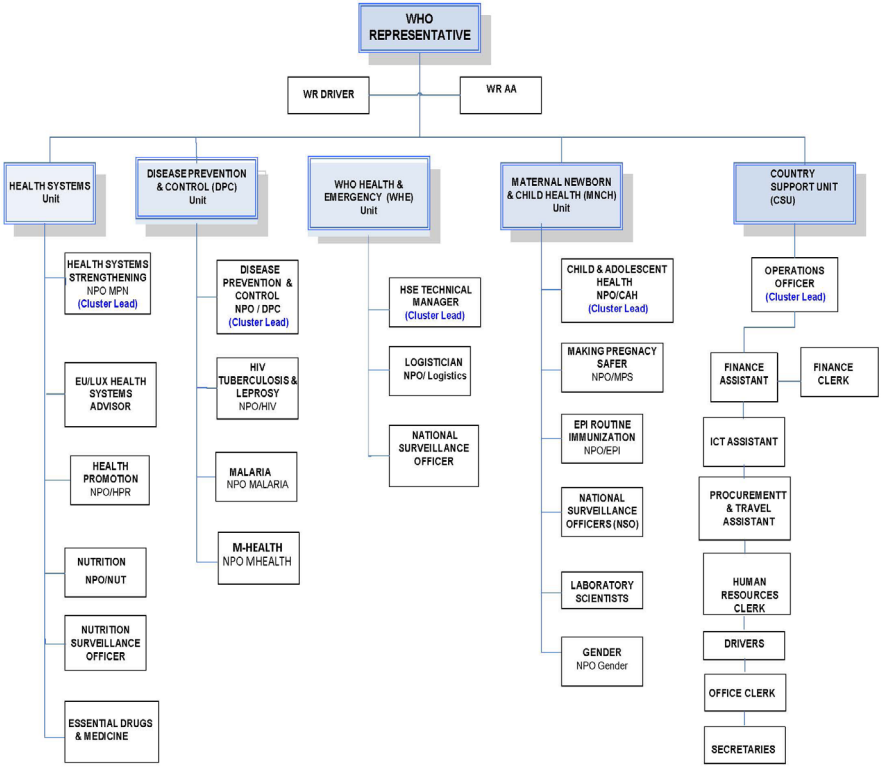
Source: WHO/AHWO 2010

Annex 7: WCO/Zambia - SWOT Analysis (Country Team)

STRENGTHS	OPPORTUNITIES
1. New CCS, developed after broad consultations 2. Consultative and supportive WR leadership, WCO Management Team meetings, open door policy 3. Good team spirit and teamwork through cluster meetings 4. Presence of skilled, competent and experienced professional staff covering most of the priority health programmes 5. Availability of guidelines and tools for development and implementation of CCS 6. WHO leadership on providing guidelines & tools to MoH and partners 7. Clear role of WHO in supporting MoH plan of Action 8. Easy access to technical support through IST, AFRO and HQ ensures quality technical support to MoH 9. Increased administrative efficiency, expanded delegation of authority 10. Timely allocation of funds for activities/ allotment notification by AFRO/HQ 11. Reprofiling, and posts establishment for most staff 12. Good ICT capacity in the WCO, fully computerized allowing communication to all WHO offices 13. Expanded pool of vehicles 14. Disease prevention and control programmes are going well Publication of WCO achievements are adequately done	1. Coordination mechanisms for cooperating partners to support the health sector and MoH plan of action 2. Permanent seat for WHO in the troika, strengthening leadership position in the cooperating partners group 3. High confidence by MoH in WHO, collaboration with counterparts in the MoH is constant 4. Acceptance by MoH/partners of having national/global mandate in health, and trusted as neutral player of first resort in many instances 5. National and international Partnerships e.g. UN and other stakeholders, well organized, and allow programmes to tap into funds 6. Presence of other partners and their financial resources so WHO rides on them for implementation of some programmes 7. GRZ plans, MDGs, Health Strategic Plan, WCO CCS aligned with WHO priorities 8. CCS a tool that can be used by WCO for advocacy and mobilization of resources in the priority strategic areas 9. CCM proposal that WHO be considered as PR for GF proposals 10. Joint UN team that works on similar programmes now planning to have more joint activities and sharing knowledge UN common services

WEAKNESSES	THREATS
1. CCS not sufficiently used as a planning tool 2. Budget allocation not aligned to CCS 3. Delays in programme implementation: - Sometimes MoH's priorities not the same as WHO (Some programmes not perceived as priority) - Bureaucracy in disbursement of funds 4. Some staff members overloaded having to cover multiple programmes 5. Inadequate staff for programmes e.g. no EDM and in area of finances 6. Need to have a forum to monitor implementation of plan of action with MoH, and look at constraints 7. Limited regular budget funds and unpredictability of XB funding for MoH 8. Inadequate funding to back up technical support to programmes (by regional office), other partners "outshining" WHO. 9. The budget ceilings for a unit sometimes too low as it may include salary component leaving very little for activities 10. Imprest ceiling inadequate 11. Increased running costs 12. Limited office space	1. Allegation of corruption at the MoH disturbed the smooth running of programmes as staff suspended, and some partners are withholding funding 2. MoH becoming suspicious towards some international organizations 3. Withdrawal of donor funding means WHO/ others to be more strategic 4. Increasing number of partners calls for further improved coordination 5. Some "competition" among partners 6. Reduced financial space due to global recession, likely to affect maintaining gains and scaling up universal coverage 7. Poverty is still a significant determinant to ill health in Zambia 8. Poor indicators for maternal health 9. Restructuring of MoH not finalized, and HR shortages in MoH 10. Critical shortage of HRH leads to poor quality implementation of programmes 11. Inadequate transport/finances in MoH to adequately implement programmes 12. Health is a multisectoral, requiring stronger intersectoral coordination mechanism. WHO may not be onboard e.g. environmental health is under Ministry of Local Government 13. Inadequate commitment of MoH to WHO operations 14. New CCS not aligned to UNDAF 15. New diseases pose pressure on WCO e.g. H1N1/resources, and divert from other planned activities 16. WHO perceived as funding agency

Annex 8 : WHO Zambia Country Office Organogram



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