Republic of Zambia

MINISTRY OF HEALTH

Annual Health Statistical Bulletin

2008

Summary Findings

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EXECUTIVE SUMMARY

The 2008 Annual Health Bulletin was designed to gather data on the number of health availability of drugs, child and maternal health, among others. These indicators are important in assessing health status, service utilisation and health outcomes for monitoring health sector interventions. The main source of this data is the health sector’s facility based routine information system called the health management information system (HMIS). Information from this bulletin is for the period 2006 to 2008 and provides the national picture; details of facility and district differentials were not included.

Number of health facilities in 2008

- In 2008, 1,563 health facilities were recorded in the country. Out of this number, 1,354 were Governments owned health facilities, 92 (private) and 117 (mission).
- There were 5 level 3 hospitals; 21 level 2 hospitals; 72 Level 1 hospitals; 1,029 rural health centres; 265 urban health centres and 171 health posts.
- Total number of beds and cots recorded in 2008 was 23,988 and 2,973, respectively.

Malaria incidence

Results from the 2008 Annual Health Bulletin show that, malaria is the leading cause of morbidity in Zambia, with an annual malaria incidence rate estimated at 252 cases per 1,000 population in 2008, a drop from 358 cases per 1,000 population in 2007. Reasons for the reduction in the incidence of malaria may be due to the following interventions:

- Use of RDTs to confirm malaria cases has helped rule out fevers not related to malaria.
- Distribution of ITNs has had a tremendous impact on the reduction of malaria incidence in all provinces.
- Intermittent Presumption Treatment (IPT), in pregnant women is an effective malaria prevention strategy.
- In-door residue spraying to high density, urban and peri-urban areas.
- Involvement of the communities in various malaria control strategies has proved to be very effective and sustainable.

The following are the main interventions on malaria that would need strengthening:

- There is need to intensify supervision in areas using RDTs.
- There is need to train more staff and/or communities using RDTs.
- Health education via local radio station is very vital and should be encouraged.
- There is need to intensify indoor – residual spraying.

Diarrhoea (non-bloody) incidence

The national incidence rate of diarrhoea (non-bloody) has continued to reduce from 81 per 1,000 population in 2006 to 76 per 1,000 population in 2007 and then to 69 per 1,000 population in 2008. The following are some key diarrhoea (non-bloody) interventions put in place:

- Most districts have sunk boreholes with support from UNICEF in 2008 and plans are still underway to sink more boreholes.
The program to promote integrated pit-latrines and hand washing supported by UNICEF has contributed to the reduction of diarrhea incidence.

Management of diarrhoea cases has generally improved and most districts have sufficient drugs and other logistics in the event of an outbreak like cholera.

Improved awareness on the use of clean drinking water is an important intervention for the reduction of diarrhoea (non-bloody).

The following are the main interventions on diarrhoea (non-bloody) that would need strengthening:

- On-going sensitization of communities on diarrhea prevention should be encouraged if the incidence of diarrhoea (non bloody) has to reduce.
- Chlorination of water sources can help reduce the incidence of diarrhea.
- There is need to conduct regular inspection of food and premises
- There is need to protect wells by fencing them
- Strengthening epidemic preparedness committees at zonal and facility level should be encouraged.

**Acute Flaccid Paralysis (AFP)**

Data from the 2008 Annual Health Bulletin show that all provinces achieved certification level of AFP surveillance for both non-polio AFP rate and stool adequacy rate indicators. The following are the main reasons for the observed variations:

- The surveillance officers at national level, provinces and districts supported by four (4) four WHO Surveillance Officers ensure that the active surveillance for suspected poliomyelitis cases or AFP cases is conducted.

**Measles Surveillance**

Results from 2008 Annual Health Bulletin indicate that the annualized measles detection rate increased from **3.84 per 100,000 population** in 2006 to **6.9** in 2008 due to increased measles surveillance.

**TB Notifications**

Results from 2008 Annual Health Bulletin indicate that the there was a general decline in the number of notifications from **51,179** in 2006 to **50,415** in 2007 and then to **47,333** in 2008. Reasons for the reduction in the number of TB notifications may be due to the following challenges:

- Poor record keeping in TB data and completing the full process of treatment and lab screenings.
- Diagnosis not adequate.
- Community awareness not adequate to sensitise people on the need for seeking TB treatment early.
- The program mainly uses the passive case finding as part of the expanded DOT strategy, which relies on a mobilized community for bringing in new cases for TB screening. This is a challenge, besides the stigma that is a major influencing factor in the health seeking behaviour of TB suspects; health facilities are faced with declining numbers of volunteers to support this type of work. This also influences the follow-up of patients that do not adhere to treatment, as
this is the key function of the TB treatment supporters.

The following are the planned activities on TB:

- Improve laboratories for accurate diagnosis, especially for TB in children and TB/HIV co-infected patients.
- Improving advocacy, communication and social mobilization for improved community awareness and addressing issues of stigma.
- There is need to begin to implement active case finding using interventions that work such as symptom screening.

The national TB program is currently using the WHO recommended program on the stop TB strategy which addresses the following 6 components:

(i) Pursuing quality DOTS expansion and enhancement.
(ii) Addressing TB/HIV, multi-drug resistance (MDR)-TB and other challenges.
(iii) Contributing to health system strengthening.
(iv) Engaging all case providers.
(v) Involving affected communities & patients
(vi) Enabling & promoting research.

**Staffing levels by province**

Data from the 2008 Annual Health Bulletin indicate that, out of **795 medical doctors** in the country, Lusaka province (367) has the highest number. Similarly, out of **1,161 Clinical Officers** in the country, Lusaka had the highest number (245). On the other hand, North-western province has the lowest number of medical doctors, clinical officers, nurses, midwives, environmental health technologists (EHTs), pharmacists and lab technologists compared to the rest of the provinces.

**Staffing levels against recommended establishment**

The 2008 Annual Statistical Bulletin collected data from the provincial human resource registers on the staffing levels against the recommended establishment, by province for 2008. This information is presented below:

- Out of the total number of **1,471 medical doctors** required in the recommended establishment in 2008, only **795** were currently available, leaving a shortfall of **676**.
- Out of the total number of **2,889 Clinical Officers** required in the recommended establishment in 2008, only **1,161** were currently available, leaving a shortfall of **1,728**.
- Out of the total number of **5,086 Midwives** required in the recommended establishment in 2008, only **2,400** were currently available, leaving a shortfall of **2,686**.
- Out of the total number of **11,037 nurses** required in the recommended establishment in 2008, only **6,691** were currently available, leaving a shortfall of **5,127**.

**Number of Clients on Antiretroviral Therapy (ART)**

The number of clients ever commenced on ART increased from **156,299** in 2007 to **219,576** in 2008, representing an increase of over 28%. The following are the main reasons for the increase in the number of clients on ART:

- Increased awareness on the availability of drugs in all the health facilities.
- Political will to focus on children.
- Increased training of health care workers.
Out of the total number of **347 Pharmacists** required in the recommended establishment in 2008, only **90** were currently available leaving a shortfall of **257**.

Out of the total number of **1,778 Environmental Health Technologists (EHTs)** required in the recommended establishment in 2008, only **948** were currently available leaving a shortfall of **830**.

**Health centre client contact**

The national figure of health centre staff daily contacts has been fluctuating over the period 2006 to 2008. The indicator reduced from **18.2** in 2006 to **17.8** in 2007 and then increased to **18.6** in 2008. The following are the main reasons for the observed variations on health centre client contact:

- Rural provinces recorded high client contacts possibly due to staff opting to work in urban areas.
- Most districts have very few staff operating at less than half the recommended human resource capacity with most of them not manned by qualified staff.
- Attrition of qualified staff due HIV/AIDS and poor conditions of service is another contributing factor to high health centre client contacts.

The following are the interventions on health centre client contact that would need strengthening:

- There is need to continue constructing health facilities & staff houses.
- Drugs should be available in all health facilities at all times.
- There is need to increase intake at nursing colleges.
- There is need to extend rural retention schemes and/or rural hardship to all professionals.
- There is need to provide incentives to attract more staff to rural facilities.

**Number of trained Traditional Birth Attendants (tTBAs) & Community health workers (CHWs)**

During the period 2006 to 2008, there has been a decrease in the number of trained traditional birth attendant (tTBAs) and Community health workers (CHWs). The following are the main reasons for the reduction in the number of tTBAs & CHWs:

- The MoH policy on reducing the number of tTBAs has contributed in most of deliveries being missed out, especially in the communities.

The following are the main interventions for tTBAs & CHWs that would need strengthening:

- There is need to intensify health education for people to deliver in health institutions.
- There is also need to ensure that staff levels are improved, MoH should find a way of giving tTBAs and CHWs incentives.

**Drugs Availability at health centres and hospitals**

The percentages of months for which drugs were in stock in health centres reduced from **74%** in 2006 to **70%** in 2007 and then **69%** in 2008. Similarly, in hospitals, the percentage of drug availability reduced from **86%** in 2006 to **84%** in 2007 and **77%** in 2008.

Reasons for the reduction in the availability of drugs may be due to the following challenges:
In the 2nd and 3rd quarter of 2008, there were limited drug kits due to limited funds.

In 2008, there were insufficient funds, compounded by weakness in the management system in drugs and supplies which resulted in the expiry of drugs.

The following are the planned activities on drugs availability:

- There is need to finalize working on the framework contracts.
- There is need to consider conducting basic training on logistics management information system.
- There is to intensify on our monitoring & evaluation for the lower levels.
- There is need to improve on human resources particularly training more pharmacists.
- There is need to lobby for more co-operating partners (CPs) support towards procurement of drug supply.

Health centre utilisation

For all provinces combined, health centre utilization increased from **0.86 per capita** attendances in 2006 to **1.22 per capita** in 2007 and then reduced to **1.10 in 2008**. The following are the main reasons for the observed variations:

- The removal of user fees in 2007 in rural facilities contributed to increased access and utilization.
- People have confidence in seeking health care services, and availability of drug.

The following are the main interventions on health centre client contact that would need strengthening:

- There is need to put in place incentives which should attract qualified health workers to work in rural areas.
- There is also need to strengthen outreach activities for health services and improve funding to districts/facilities so that services can be taken to their door steps community level.

Full immunisation coverage

For all provinces combined national immunization coverage has been fluctuating during the period 2006 to 2008. The coverage reduced from **87%** in 2006 to **85%** in 2007 and then increased to **90%** in 2008. The main reasons for the observed variations:

- The reach every district (RED) strategy introduced by WHO had an impact on the increase in immunization coverage.
- Child health week has also contributed to the upward rise.
- Improvement in the availability of logistics, vaccines & cold chain contributed to the upward rise in immunization coverage.
- Improvement in transport system for all districts, provided by the MoH headquarters contributed to the rise in immunization coverage.

The following are the main interventions on full immunization that would need strengthening:

- Although the RED strategy has an impact on the immunization coverage, there is need for more resources to follow-up defaulting children.
- There is need to put in place activities aimed at maintaining the cold chains in all the health centres;
There is need to increase the number of motor bikes to facilitate increased outreach activities.

There is need to lobby for more stakeholders so that the RED strategy can be sustained.

There is need to build cold chain storage facilities at provincial health Offices (PHOs).

The communities need to be encouraged to form *nutrition clubs* and empower them with income generating activities.

There is need to improve monitoring activities where monthly weighing and counseling in cases of underweight children.

There is need to intensify nutrition counseling to clients. This is important because it leads to increased turn-out of children for growth monitoring.

Underweight prevalence

The national underweight prevalence has been declining from **14%** in 2006 to **10%** in 2007 and then to **6%** in 2008 with *Luapula province* recording the highest underweight prevalence while *Lusaka* had the lowest prevalence. The main reasons for the reduction in underweight prevalence include:

- Data collecting tools had an impact on growth monitoring in that the demarcation of underweight was not well defined in the previous under 5 card which had children below lower line and those below dotted line. Using those below *dotted line* ended up with the picture reflected above.

- Management of severe malnutrition and IMCI are helping in sensitizing the communities.

- During child health week, a lot of children are being de-wormed.

- *Positive deviance*, where mothers with healthy babies team up to form a group that teaches other mothers on how important it is to look after a child

The following are the main interventions on underweight prevalence that would need strengthening:

Institutional deliveries

Institutional deliveries increased from **43%** in 2006 to **45%** in 2007 and **40%** in 2008. Supervised deliveries reduced from **62%** in 2007 to **60%** in 2008. The following are the main reasons for the observed variations:

- There is emphasis in using more trained health workers and less TBA, hence the reduction on the proportion of TBAs.

- Safe motherhood action group (SMAGs) have contributed to the increase in institutional deliveries

- Lack of training is incentives have contributed the drop-out rate for TBAs over the years.

The following are the main interventions on institutional deliveries that *need* to be put in place:

- There is need to improve staffing levels in health facilities

- Community sensitization for mothers to deliver in health facilities should be encouraged.

- Building mothers’ waiting shelters should be encouraged especially where mothers have to cover long distances.
Antenatal coverage

Antenatal coverage at national level increased from 92% in 2007 to 98% in 2008. Central province had the highest antenatal coverage between 2006 and 2008, compared to rest of the provinces while Copperbelt had the lowest coverage.

The following are the main reasons for increase in antenatal coverage:

✓ There has been intensified sensitization to the community to seek ANC services. Safe motherhood action group (SMAGs) have helped in sensitizing the community.

The following are the main interventions on antenatal coverage that need to be put in place:

✓ Strengthening programmes for health education, screening, treatment and care of cervical, breast and prostate cancer.
✓ Strengthening family planning (FP) and contraceptive choice programmes, with a special focus on rural districts.
✓ There is need to accelerate midwifery training, ensuring equitable distribution and retention of midwives.
✓ There is need to accelerate midwifery training, ensuring equitable distribution and retention of midwives. 

ANC services are available in all the health facilities.
✓ Outreach services have been intensified.

The following are the main interventions on antenatal coverage that would need strengthening:

✓ Strengthening programmes for health education, screening, treatment and care of cervical, breast and prostate cancer.

Performance assessment framework (PAF) Indicators on health

The overall performance against the indicators and targets included in the seven health and HIV/AIDS PAF for 2008 is about 71%. This is because only 3 out of the 4 health PAF indicators and 2 out of the 3 HIV/AIDS PAF indicators were fully met.

However, within the performance against the targets set for the overall PAF, health and HIV/AIDS indicators were amongst the indicators which showed a consistency or improvement between years even when some of the targets were not fully met. It can therefore be concluded that the Ministry of Health is making concerted efforts in improving the delivery of quality health services as close to the family as possible.