



Republic of Zambia
Ministry of Health

MID TERM REVIEW REPORT OF THE NATIONAL HEALTH STRATEGIC PLAN 2022-2026

*“Towards attainment of quality universal health coverage through
decentralization”*

MARCH, 2025

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Abbreviations:

- **8NDP:** Eighth National Development Plan
- **ACTs:** Artemisinin-based Combination Therapies
- **ADH:** Adolescent Health
- **AFRO:** African Region
- **AL:** Artemether Lumefantrine
- **ALB:** Albendazole
- **ANC:** Antenatal Care
- **ANC-1:** Antenatal Care First-Visit Attendance
- **ART:** Antiretroviral Therapy
- **AST:** Antimicrobial Susceptibility Testing
- **BCC:** Behaviour Change Communication
- **BCG:** Bacillus Calmette–Guérin (vaccine)
- **BIRCH Project:** (Project name, contextually understood)
- **CAC:** Comprehensive Abortion Care
- **CBS:** Case-Based Surveillance
- **CBR:** Community-Based Rehabilitation
- **CDF:** Constituency Development Fund
- **CHiP:** Community Health Information Platform
- **CHC:** Community Health Committees
- **CHE:** Current Health Expenditure
- **cHMIS:** Community Health Management Information System
- **CHWs:** Community Health Workers
- **CI:** Confidence Interval
- **CME:** Continuous Medical Education
- **CMV:** Combined Micronutrient Vitamin
- **CNST:** Centre for Nuclear Science and Technology
- **CO:** Corneal Opacity
- **COVID-19:** Coronavirus Disease 2019
- **CPs:** Cooperating Partners
- **CSC:** Community Scorecard
- **DDRR:** Donor Recruitment, Retention and Recall
- **DEC:** Diethylcarbamazine
- **DHIS2:** District Health Information System 2
- **DHO:** District Health Office
- **DISA:** (System name, contextually understood)
- **DOM:** Domestic Health Expenditure
- **DOT:** Directly Observed Treatment
- **DOTs:** Directly Observed Therapy
- **DQA:** Data Quality Audit
- **DR-TB:** Drug-Resistant Tuberculosis
- **DSD:** Differentiated Service Delivery
- **DST:** Drug Susceptibility Testing
- **DTG:** Dolutegravir
- **ECD:** Early Childhood Development

- **EFAR:** Emergency First Aid Responder
- **EH:** Environmental Health
- **EHR:** Electronic Health Record
- **EID:** Early Infant Diagnosis
- **eLMIS:** Electronic Logistics Management Information System
- **EMMS:** Essential Medicine and Medical Supplies
- **EmONC:** Emergency Obstetric and Neonatal Care
- **EMS:** E-patient Record Management Systems
- **EMOTIVE:** (Bundle name, contextually understood)
- **EMF:** End Malaria Fund
- **EMC:** End Malaria Council
- **ENDS:** Electronic Nicotine Delivery Systems
- **ENT:** Ear Nose and Throat
- **EQA:** External Quality Assessment
- **ESPEN:** (Program name, contextually understood)
- **GDP:** Gross Domestic Product
- **GGE:** General Government Expenditure
- **GMP:** Good Manufacturing Practices
- **GRZ:** Government of the Republic of Zambia
- **GWAN:** Government Wide Area Network
- **GYTS:** Global Youth Tobacco Survey
- **HALE:** Healthy Life Expectancy
- **HACCP:** Hazard Analysis and Critical Control Points
- **HAT:** Human African Trypanosomiasis
- **HBV:** Hepatitis B Virus
- **HCWM:** Healthcare Waste Management
- **HDU:** High Dependent Units
- **HFAs:** Health Facility Assessments
- **HI:** Human Immunodeficiency
- **HIS:** Health Information System
- **HIT:** Health Innovative Technologies
- **HLA:** Human Leukocyte Antigen
- **HMIS:** Health Management Information System
- **HNAP:** Health and Nutrition Action Plan
- **HPV:** Human Papillomavirus
- **HR:** Human Resources
- **HRH:** Human Resources for Health
- **HRIS:** Human Resources Information System
- **IAF:** Interoperability Architecture Framework
- **ICT:** Information and Communication Technology
- **IDC:** Industrial Development Corporation
- **ID NAT:** Individual Donor-Nucleic Acid Testing
- **IDSRR:** Integrated Disease Surveillance and Response
- **IEC:** Information, Education and Communication
- **IFMIS:** Integrated Financial Management Information System
- **IHR:** International Health Regulations

- **IMF:** International Monetary Fund
- **IMNCI:** Integrated Management of Childhood Illness
- **IPC:** Infection Prevention and Control
- **IQC:** Internal Quality Control
- **IRS:** Indoor Residual Spraying
- **ITNs:** Insecticide-Treated Nets
- **IYCF:** Infant and Young Child Feeding
- **JEE SPAR:** Joint External Evaluation Scorecard for Public Health Preparedness and Response
- **KIIs:** Key Informant Interviews
- **LAN:** Lions Aid Norway
- **LE:** Life Expectancy
- **LF:** Lymphatic Filariasis
- **LIS:** Laboratory Information System
- **LLINs:** Long-Lasting Insecticidal Nets
- **LMIS:** Logistics Management Information System
- **LSM:** Larval Source Management
- **M&E:** Monitoring and Evaluation
- **MAM:** Moderate Acute Malnutrition
- **MDA:** Mass Drug Administration
- **MFL:** Master Facility List
- **MH:** Mental Health
- **MIS:** Malaria Indicator Survey
- **MMD:** Multi-Month Drug Dispensation
- **MMR:** Maternal Mortality Ratio
- **MoE:** Ministry of Education
- **MoF:** Ministry of Finance
- **MoH:** Ministry of Health
- **MPDSR:** Maternal Perinatal Death Surveillance and Response
- **MR SIA:** Measles Rubella Supplementary Immunization Campaign
- **MTR:** Mid-Term Review
- **MUAC:** Mid-Upper Arm Circumference
- **NAD:** Norwegian Association of the Disabled
- **Navision:** (Financial management system)
- **NCC:** National Call Centre
- **NCDs:** Non-Communicable Diseases
- **NFL HQ:** National Food Laboratory Headquarters
- **NHC:** Neighbourhood Health Committee
- **NHA:** National Health Accounts
- **NHIMA:** National Health Insurance Management Authority
- **NHIP:** National Health Insurance Package
- **NHSP:** National Health Strategic Plan
- **NHSSP:** National Health Sector Strategic Plan
- **NICU:** Neonatal Intensive Care Unit
- **NMR:** Neonatal Mortality Rate
- **NMCZ:** Nursing and Midwifery Council of Zambia

- **NTDs:** Neglected Tropical Diseases
- **OB-Gyn:** Obstetrics and Gynaecology
- **Obs and Gyn:** Obstetrics and Gynaecology
- **OOP:** Out-of-Pocket
- **OOPE:** Out-of-Pocket Expenditures
- **OPD:** Outpatient Department
- **PACS:** Picture Archiving and Communication Systems
- **PC:** Palliative Care
- **PCR:** Polymerase Chain Reaction
- **PDSR:** Perinatal Death Surveillance and Response
- **PEs:** Personnel Emoluments
- **PEN Plus Project:** (Project name, contextually understood)
- **PEN:** Package of Essential Non-communicable disease interventions
- **PHC:** Primary Health Care
- **PHA:** Public Health Act
- **PMP:** Performance Management Package
- **PNC:** Postnatal Care
- **POC:** Point of Care
- **PoEs:** Points of Entry
- **PrEP:** Pre-Exposure Prophylaxis
- **PSMD:** Public Service Management Division
- **QA:** Quality Assurance
- **QC:** Quality Control
- **QI:** Quality Improvement
- **QMS:** Quality Management Systems
- **RCCE:** Risk Communication and Community Engagement
- **RCM:** Respiratory Care Management
- **RDTs:** Rapid Diagnostic Tests
- **RED/C:** Reach Every District/Child
- **RESOMAL:** Rehydration Solution for Malnutrition
- **RH:** Reproductive Health
- **RI:** Respiratory Infection
- **RIS:** Radiology Information Systems
- **RMC:** Respectful Maternity Care
- **RMNCAN:** Reproductive, Maternal, Neonatal, Child, Adolescent and Nutrition Health
- **RMNCAH-N:** Reproductive, Maternal, Neonatal, Child, Adolescent Health and Nutrition
- **RPR:** Rapid Plasma Reagin (test for syphilis)
- **RUTF:** Ready-to-Use Therapeutic Food
- **SAFE:** Surgery, Antibiotic treatment, Facial cleanliness, Environmental improvement (trachoma strategy)
- **SAM:** Severe Acute Malnutrition
- **SBC:** Social Behaviour Change
- **SBCC:** Social and Behaviour Change Communication
- **SCH:** Schistosomiasis
- **SDG:** Sustainable Development Goal

- **SDGs:** Sustainable Development Goals
- **SDIs:** Service Delivery Indicators
- **SIA:** Supplemental Immunization Activities
- **SOPs:** Standard Operating Procedures
- **SQA:** Service Quality Assurance
- **SSI:** Sight Savers International
- **STH:** Soil-Transmitted Helminths
- **STIs:** Sexually Transmitted Infections
- **SWOT:** Strengths, Weaknesses, Opportunities, and Threats
- **TAT:** Turn Around Time
- **TB:** Tuberculosis
- **TFR:** Total Fertility Rate
- **TSS:** Technical Supportive Supervision
- **TT:** Trachomatous Trichiasis
- **TF:** Trachomatous Follicular
- **UHC:** Universal Health Coverage
- **UHCs:** Urban Health Centres
- **UNAIDS:** Joint United Nations Programme on HIV/AIDS
- **UNDP:** United Nations Development Programme
- **UTH:** University Teaching Hospital
- **VA:** Verbal Autopsies
- **VMMC:** Voluntary Medical Male Circumcision
- **WASH:** Water, Sanitation and Hygiene
- **WDC:** Ward Development Committee
- **WHO:** World Health Organization
- **ZAMMSA:** Zambia Medicines and Medical Supplies Agency
- **ZAMSTATS:** Zambia Statistics Agency
- **ZDHS:** Zambia Demographic Health Survey
- **ZMW:** Zambian Kwacha
- **ZN BTS:** Zambia National Blood Transfusion Service

Foreword

It is with great pleasure that we present the Mid-Term Review Report of the National Health Strategic Plan (NHSP) 2022-2026. This comprehensive report, undertaken after two and a half years of implementation, utilized a blend of qualitative and quantitative data, drawing from both primary and secondary sources, including routine HMIS and administrative records, to provide a holistic overview of the health sector's performance in Zambia.

The primary focus of this report remains steadfast on the core indicators and targets set forth in the NHSP 2022-2026. It is developed within the overarching framework of Strategic Direction 1: "Strengthen Health Service Delivery to Attain Quality Universal Health Coverage (UHC) by 2030" and Strategic Direction 2: "Strengthen Integrated Health Support Systems, Towards attainment of UHC and SDG 3". Special attention has also been given to additional indicators that emerged after the NHSP's development, helping to assess progress towards national priorities and global goals.

The overarching objective of this Mid-Term Review was to assess the progress made towards achieving the NHSP 2022-2026 objectives and to subsequently revise the operational plans for the remaining duration of its implementation. Our review was guided by the health sector's Monitoring and Evaluation (M&E) framework, developed in 2022 to support NHSP performance monitoring, and adopted from the WHO-AFRO Framework of Actions for Health Systems Strengthening for UHC and Other Health Related SDGs. This NHSP itself is guided by the Eighth National Development Plan (8NDP) for the period 2022 to 2026, a crucial step towards realizing Zambia's Vision 2030 to become a prosperous middle-income country.

We are pleased to note that the Mid-Term Review highlights significant improvements across various critical areas. There has been very important progress in terms of geographical access to health services, a tremendous decrease in child mortality, and substantial improvement in maternal health indicators. HIV prevention and treatment services have been made available countrywide, with Zambia demonstrating remarkable progress towards eliminating mother-to-child HIV transmission. Furthermore, the review indicates important improvements in services for infectious diseases, the scaling up of Social Behaviour Change (SBC) programs, and robust resource mobilization mechanisms, including nearly \$2 million under the COVID-19 first wave from the Global Fund Grant. We also observed the successful digitization of the Community Health Information Platform (CHiP), increased use of Family Planning among married women, improved Antenatal Care (ANC) visits within the first trimester, and enhanced Postnatal Care (PNC) attendance within 48 hours of delivery, with projections slightly surpassing the 60% target by 2026, among other achievements.

It is our strong belief that by the culmination of the NHSP 2022-2026, the health sector will be fully capable of providing comprehensive and integrated care at all levels of service delivery in a client-friendly manner. This Mid-Term Review report will serve as a vital tool for updating the NHSP 2022-2026, ensuring the continued participation of all stakeholders. We are particularly gratified that this review was conducted through a participatory process involving all key stakeholders and has been successfully concluded.

I urge all Health Sector Stakeholders and readers to utilize this report not only as a guide for the implementation of the remaining period of the NHSP but also as a foundational document to inform future planning for the health sector.

On behalf of the Ministry of Health, I extend my sincere appreciation to all our partners in the health sector for their invaluable technical and financial support towards this mid-term review of the 2022-2026 National Health Strategic Plan (NHSP).



Hon. Dr. Elijah Muchima, MP

Minister of Health

Acknowledgements

The mid-term review of the progress and performance of the National Health Strategic Plan and its Monitoring and Evaluation Framework plan 2022-2026 is an important undertaking of the Ministry of Health. The Ministry is indebted to all those who participated in the development of this Report, which was done through a collaborative process.

The Mid-Term Review was overseen by a coordinated structure comprising the Steering Committee, Core Team, and Technical Task Teams. Special thanks and appreciation go to the Minister of Health, Hon. Dr. Elijah J. Muchima, for providing overall leadership, and to the Permanent Secretary – Donor Coordination and Administration, Dr. George Sinyangwe, for his technical guidance during the development of this Report.

Additionally, I would like to recognize and congratulate all those individuals, institutions, and organizations—public or private, national or international—that contributed to the analysis and writing of this MTR Report. These include the Staff from the Ministry of Health, Local Government and Rural Development (all local Authorities), Civil Registration Department, Private Sector, and Development Partners. To all those who contributed in one way or another to this endeavor, please accept the sincere appreciation from the leadership of the Ministry for a job well done.

I would, however, on behalf of all who contributed, like to single out a few individuals and institutions to highlight the collective effort that went into producing this Report. At the Ministry, I would like to recognize the efforts of the Technical Working Group led by the Director Policy and Planning, under the guidance of Ms. Madrin M. Mbuta, supported by Mr. Calvin B. Kalombo, Assistant Director Monitoring and Evaluation. I would also like to recognize the members of the technical working group that developed this report, including Dr. Azmach Hadush Gebregiorgis, Joseph Simuchimba, Abel Kalikiti, Yvonne Mwale, Mavis Masese, Mwango Mutale, Nkaka Puta Chellah, Ovost Chooye, and David Ngula. The Technical Task Team lead programmes included Vichael Silavwe, David Chama, Sandra Musokota M, Gabriel Lungu, and Pamela Nakombe.

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The Ministry would like to thank all those who contributed to the development of this Report (annexed).



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Executive Summary

The Mid-Term Review (MTR) Report of the National Health Strategic Plan (NHSP) 2022-2026 for the Republic of Zambia's Ministry of Health assesses the progress made towards its objectives after two and a half years of implementation. The review utilized both qualitative and quantitative data from primary and secondary sources, including routine Health Management Information System (HMIS) and administrative records. The report is structured around the two main strategic directions of the NHSP: "Strengthen Health Service Delivery to Attain Quality Universal Health Coverage (UHC) by 2030" and "Strengthen Integrated Health Support Systems, Towards attainment of UHC and SDG 3". The overall goal was to evaluate progress and revise operational plans for the remaining period of the NHSP.

Overall Progress and Achievements: The review indicates that Zambia is on track to meet its overall strategic goals and targets, with an average performance score of 72.3% across 76 quantitative indicators. Significant progress was observed in health workforce (91.99%), essential medicines and medical supplies (EMMS) (90.0%), blood transfusion (85.89%), Reproductive, Maternal, Neonatal, Child, Adolescent, and Nutrition Health (RMNCAHN) (80.23%), and Communicable Diseases (80.02%) programs, all reporting over 80% scores. Out of 561 planned interventions, 351 (64.17%) were implemented to a level of 41-100%.

Key achievements include:

- **Health Service Delivery:** Noted improvements in geographical access to health services, a significant decrease in child mortality, and substantial improvement in maternal health indicators. HIV prevention and treatment services have been expanded countrywide, with remarkable progress towards eliminating mother-to-child HIV transmission. Social Behaviour Change (SBC) programs have been scaled up (80% completion), and promotion of healthy lifestyles has progressed (40-60% achievement rate).
- **Community Health:** The National Community Health Strategy (2022-2026) was reviewed and developed, with formal dissemination up to the Provincial level. The Community Health Information Platform (CHiP), a digital health system, has been rolled out in four provinces, with 575 Community-Based Volunteers (CBVs) and 45 CBV supervisors trained, and over 47,880 households registered.
- **Reproductive and Maternal Health:** Maternal Mortality Ratio (MMR) for 2018-2024 was 187 per 100,000 live births, falling short of the 2026 target of 100, but showing a declining trend. Contraceptive use among married women increased from 50% in 2018 to 56% in 2024, approaching the 60% target. Postnatal care (PNC) attendance within 48 hours of delivery improved to 63.8% in 2024, slightly surpassing the 60% target for 2026.
- **Neonatal and Child Health:** The Neonatal Mortality Rate (NMR) for 2024 was estimated at 17 per 1000 live births, with projections indicating the country is on track to surpass the 2026 target of 12.
- **HIV/AIDS and STIs Programs:** The percentage of people living with HIV who know their status reached 94.5%, surpassing the projected target for 2024. ART coverage for children living with HIV reached 91.3%, exceeding the mid-point target. ART coverage for people living with HIV reached 98%, surpassing the projected mid-point target. Viral load suppression among people on ART was 97.5%, slightly exceeding the mid-point

target. The Mother-to-Child Transmission (MTCT) rate was reduced to 4.42%, surpassing the midpoint target. Voluntary Medical Male Circumcision (VMMC) coverage reached 88% by 2024. Pre-Exposure Prophylaxis (PrEP) uptake exceeded its target, with 247,049 individuals initiated.

- **Health Workforce:** The health workforce fill rate reached 55% (78,191 positions filled out of 140,895 established positions), indicating the country is on track to meet the 70% target by 2026. The number of qualified specialists in the country is 778, with 555 employed, including 177 in the public sector.
- **Health Care Financing:** The health sector's share of the national budget increased from 8.0% in 2022 to 11.8% in 2024. National Health Insurance Scheme (NHIS) membership reached approximately 3.4 million by 2024.

Challenges and Gaps: Despite the progress, several challenges and areas needing improvement were identified:

- **Monitoring and Evaluation Framework:** The NHSP's M&E framework was not fully aligned with the plan, leading to some programs and interventions lacking performance indicators, and some indicators not being linked to outlined programs.
- **Data Capture and Reporting:** Lack of established data capture and reporting systems for some indicators hindered performance measurement.
- **Resource Constraints:** Inadequate funding remains a significant barrier across various programs, including mental health, environmental health, and physical infrastructure development.
- **Human Resources:** Shortages of specialized staff, high staff turnover, and an uneven distribution of health workers, particularly in rural areas, persist.
- **Infrastructure and Equipment:** Many hospitals lack ambulances and essential medical equipment, and the pace of constructing and rehabilitating laboratories has been slow due to funding constraints.
- **Supply Chain Issues:** Inconsistent supply of essential medicines, medical supplies, and diagnostic tools remains a challenge.
- **Policy and Legal Frameworks:** Delays in reviewing and finalizing key policy and legal documents, such as the National Health Policy and the Mental Health Policy, hinder effective implementation.
- **Coordination and Integration:** Weak intersectoral collaboration, particularly in areas like Neglected Tropical Diseases (NTDs), and challenges in integrating different health information systems, were noted.
- **Malnutrition:** While wasting rates have decreased, stunting rates remain high (32% in 2024), indicating Zambia is not on track to meet its 2025 and 2030 targets. Low birthweight remains a concern, surprisingly higher in urban areas.
- **TB and Hepatitis B:** The TB treatment success rate for drug-sensitive TB was slightly below target, and Hepatitis B incidence increased, indicating challenges in control efforts.
- **Adolescent Health:** Teenage pregnancy remains a challenge, and strategic objectives are not well-aligned with major adolescent health problems.
- **Leadership and Governance:** Structural changes within the Ministry of Health and challenges in harmonizing reporting structures at the district level due to decentralization have impacted coordination.

Overall Recommendations: The report recommends significant recalibration to address several factors, including the increasing prevalence of Non-Communicable Diseases (NCDs) alongside existing communicable disease burdens, frequent disease outbreaks (e.g., cholera), changing epidemiological profiles (reducing fertility, increasing life expectancy), constrained health sector fiscal space (decreasing donor funding, economic challenges), and the impact of climate change.

Specific recommendations include:

- **Health System Outputs:** Implementing strategies to increase demand for preventive health interventions, developing guidelines for routine quality of care monitoring, and addressing geographical and financial barriers to accessing essential services.
- **Health System Outcomes:** Fast-tracking the implementation of remaining interventions, reducing out-of-pocket expenditure through pre-financing mechanisms, and strengthening health security capacity.
- **Service Delivery Systems:** Developing clear definitions and delivery frameworks for Primary Health Care, elaborating a precise Essential Health Care Package, and strengthening referral systems.
- **Health Leadership and Governance:** Developing comprehensive guidelines for leadership and governance structures, streamlining planning and budgeting processes, and strengthening coordination mechanisms, particularly for decentralized services.
- **Human Resources for Health:** Reviewing staff establishment, prioritizing recruitment and deployment to primary health services, and evaluating existing retention strategies.
- **Health Products and Technologies:** Streamlining procurement and distribution processes, expanding the essential medicines list to include NCD medications, and strengthening capacity for planning and managing health products.
- **Health Infrastructure:** Developing and operationalizing health infrastructure norms and standards, strengthening planning and rationalization of investments, and ensuring the availability of properly equipped ambulances.
- **Health Management Information Systems and Research:** Developing a National Health Information System (HIS) strategy, progressively digitizing reporting tools, and strengthening capacity for data analysis.
- **Health Financing:** Developing a national health financing strategy, exploring efficiency-gaining strategies, and ensuring timely disbursements of resources.

The report concludes that while significant progress has been made, continuous efforts are needed to strengthen the health system and achieve the NHSP's ambitious goals by 2026


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Director, Policy and Planning

Overview of Performance Indicators

Table 1: Indicator performance Dashboard

Indicator	Performance Against Target	Colour Code
Strategic Direction 1 - Strengthen Health Service Delivery in order to Attain Quality Universal Health Coverage (UHC) by 2030		
Number of annual blood units collected	85.89	
Number of hospitals utilizing telemedicine for management and treatment of patients	100	
Proportion of hospitals providing surgical services appropriate for the level of care	0	
Proportion of hospitals with capacity to provide Emergency Obstetric and Neonatal Care (EmONC)	93.71	
Rate of reoperations, post elective Surgery	-	
Reduction in cases of dental caries and periodontal diseases	100	
Comprehensive HIV knowledge in adolescents and young people	76.3	
Coverage of ART for those living with HIV	100	
Deaths attributed to Malaria per 100,000 population	100	
Hepatitis B Incidence per 100,000 population	66.08	
Integrate NCD services in ART services	-	
Malaria Incidence per 1,000 population	86.29	
MTCT rate	100	
Percentage of eligible population receiving advanced HIV disease package of care	-	
Percentage of people living with HI V who know their HIV status	100	
Percentage of the HIV children who receive lifelong ART	100	
Percentage of the people living with HIV on ART with suppressed viral	99.49	
Proportion of Grade 2 disability of Leprosy	43.27	
TB case detection rate (DS TB)	100	
TB treatment success rate	98.71	
Treatment success rate for Drug Resistant (DR) TB	97.56	
Uptake of PrEP in priority and key populations	100	
VMCC coverage	92.63	
Number of accredited laboratories Implementing Quality Management Systems (QMS)	100	
number of facilities providing nuclear medicine services	0	
Turn Around Time (TAT) of samples being referred to higher level facilities	100	

Indicator	Performance Against Target	Colour Code
Early detection of cancer at level 1 and 2 hospitals	80	
Number of hospitals with radiotherapy capacity in managing cancers	50	
Percentage of the population under surveillance through a Population Based Cancer Registry	92.33	
Proportion of sites providing cervical cancer elimination services	90.28	
Disease surveillance and inspections of premises at Point of Entry	100	
Establish the National Food Laboratory (NFL) HQ as a reference laboratory and centre of excellence	0	
Increase institutional capacities and mechanisms for Districts to address social determinants of health and equity of access	76.92	
Number of functional portable laboratories and consumables	100	
Number of laboratory hubs established	0	
Percentage of food establishments implementing HACCP and prerequisite programs	57.86	
Percentage of health care facilities implementing mitigation and adaptation measures to climate change	78.57	
Percentage of healthcare facilities complying with HCWM Management guidelines	76.27	
Proportion of % of districts with mechanisms for monitoring and reporting determinants of Health	90	
Proportion of healthcare facilities complying to WASH/IPC standards	83.33	
Proportion of institutions with a shared vision for prioritization of determinants of health	80	
Number of districts implementing community-based rehabilitation (CBR) services	28.57	
Number of hospitals providing comprehensive rehabilitation services	55.56	
Number of hospitals providing specialized, high- intensity rehabilitation services	0	
1st antenatal visit 1st trimester	86.59	
1st PNC within 48 hours (infant)	96.41	
1st PNC within 48 hours (mother)	100	
Fully immunized coverage <1-year	87.18	
Incidence of neonatal deaths per 1000 LB due to prematurity	82.77	
Incidence of neonatal deaths per 1000 LB due to birth asphyxia	63.26	
Incidence of neonatal deaths per 1000 LB due to infection	48.75	
Maternal Mortality (/100,000 LB)	83.96	
Neonatal mortality rate (/1,000 LB)	96.47	

Indicator	Performance Against Target	Colour Code
Number of hospitals providing quality in hospital care for small and sick new-borns	81.82	
Proportion of children underweight	8.33	
Proportion of deliveries attended by skilled personnel	100	
Proportion of districts with capacity to provide a minimum adolescent health service platform	87.22	
Proportion of health facilities with at least 60% staff trained in IMNC	71.11	
Proportion of health facilities with functional Emergency and Obstetric and Neonatal Care (EmONC), both basic and comprehensive	76.14	
Proportion of married women accessing modern contraceptives	84.13	
proportion of married women using any method of family planning	100	
Proportion of pregnant women screened for syphilis at first ANC visit	100	
Proportion of pregnant women with complications of abortion	50	
Proportion of service provision sites covered with Early Childhood Development (ECD) services	100	
Proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods	100	
Rate of adolescents' awareness and utilization of the available health services	100	
Stunting rate	53.13	
Under 5 (/1,000 LB)	73.81	
Vitamin A supplementation (6-59 months)	74.75	
Strategic Direction 2 - Strengthen Integrated Health Support Systems, Towards attainment of UHC and SDG 3		
Availability of essential medicines and supplies in all health facilities	100	
Decentralization of the regulatory network	100	
Number of specialists trained	100	
Proportion of approved posts filled by skilled personnel	83.97	
Number of active local manufacturing industries	75	
Pharmaceutical care at all levels	75	
Proportion of public hospitals with medical supply systems	100	
Overall Score	72.73	

Green means target achieved, yellow means positive progress, while red shows that target is unlikely to be achieved, unless some course corrections are undertaken. Black shows no data.

1. Introduction and Background

1.1 Governance structure and administrative context

Zambia, a landlocked nation situated in Southern Africa, encompasses an area of approximately 752,618 square kilometers. The country operates under a **unitary presidential governance system**; wherein executive authority is centralized at the national level. The President serves concurrently as the Head of State and Head of Government, overseeing the overall execution of state functions.

National Governance Architecture

The structure of the central government comprises **three constitutionally independent yet interrelated branches**:

- **Executive Branch:** This includes the President, Vice President, Cabinet Ministers, and senior national government officials tasked with implementing national policy and exercising executive power.
- **Legislative Branch (National Assembly):** Composed of elected and nominated Members of Parliament, presided over by the Speaker. The Assembly is responsible for law-making, budget approval, and government oversight.
- **Judiciary:** Encompasses the Supreme Court, Court of Appeal, High Court, Magistrate Courts, and Local Courts. This arm administers justice and interprets constitutional and statutory law.

Decentralized Governance and Local Administration

Zambia's subnational governance framework is organized across three hierarchical administrative levels:

- a) **Provinces:**
 - The country is divided into **ten provinces**: Central, Copperbelt, Eastern, Luapula, Lusaka, Muchinga, Northern, North-Western, Southern, and Western.
 - Each province is managed by a **Provincial Minister** and a **Provincial Permanent Secretary**, both appointed by the President.
 - Provinces serve as key coordination hubs for government service delivery.
- b) **Districts:**
 - The provinces are further subdivided into **116+ districts**.
 - Each district is overseen by a **District Commissioner**, who functions as the principal liaison between the central government and local administration.
- c) **Constituencies and Wards:**
 - Districts are partitioned into **parliamentary constituencies**, which are further segmented into **wards**—the smallest administrative units in the local governance structure.
 - These units facilitate electoral representation and community-level decision-making.

Local authorities, consisting of **municipal councils (urban)** and **district councils (rural)**, are charged with delivering services within their jurisdictions. These councils are led by elected officials—**Mayors** in urban areas and **Council Chairpersons** in rural localities.

- Traditional Leadership and Customary Governance

Traditional leaders—chiefs, headmen, and other customary authorities—play a pivotal role in governance at the community level. While they lack legislative authority, they contribute significantly to **conflict resolution**, **enforcement of customary law**, and **community cohesion**, particularly in rural settings.

- Geopolitical Context

Zambia shares international borders with eight countries: Angola, Botswana, the Democratic Republic of the Congo (DRC), Malawi, Mozambique, Namibia, Tanzania, and Zimbabwe. Lusaka, the capital located in Lusaka Province, serves as the country’s **principal administrative, political, and economic centre**. Other major urban centres include Ndola, Kitwe, Livingstone, and Kabwe.

Notably, Zambia is home to significant natural landmarks such as **Victoria Falls**, one of the world’s largest waterfalls, and the **Zambezi River**, which defines a substantial portion of its southern boundary.

1.2 Population and demographics

- Population Growth and Age Structure

Over the past 15 years, Zambia has experienced sustained population growth, albeit with a **gradual decline in the annual growth rate**—from approximately **3.5% in 2010** to **2.8% in 2023**. Despite this moderation, the **total population continues to expand**, underscoring persistent demographic momentum driven primarily by high fertility rates and a youthful population structure.

- Age Distribution and Dependency Ratio

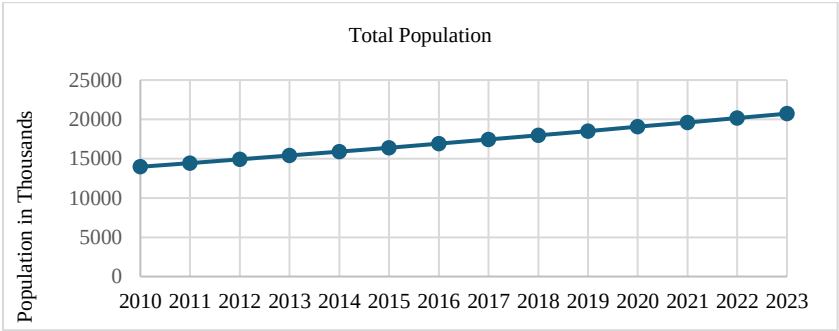
The country’s population pyramid (Figure 3) exhibits a **broad base**, indicative of a large proportion of children and adolescents, tapering gradually toward older age cohorts. This structure reflects a **high youth dependency ratio**, with individuals below 15 years constituting a substantial share of the population. This segment exerts considerable pressure on social services, particularly education, child nutrition, and primary health care.

- **Child Dependency (0–14 years)**: Estimated to account for more than **40%** of the population in recent years.
- **Working-Age Population (15–64 years)**: Represents the economic backbone but is strained by supporting both younger and older dependents.
- **Older Adults (65+ years)**: Still a smaller demographic but gradually increasing due to improvements in life expectancy.

This demographic profile places Zambia in the **early phase of a demographic transition**, presenting both a challenge and an opportunity. The challenge lies in maintaining adequate

services for a highly dependent population, while the opportunity lies in **investing in human capital** to harness potential demographic dividends in the medium-to-long term.

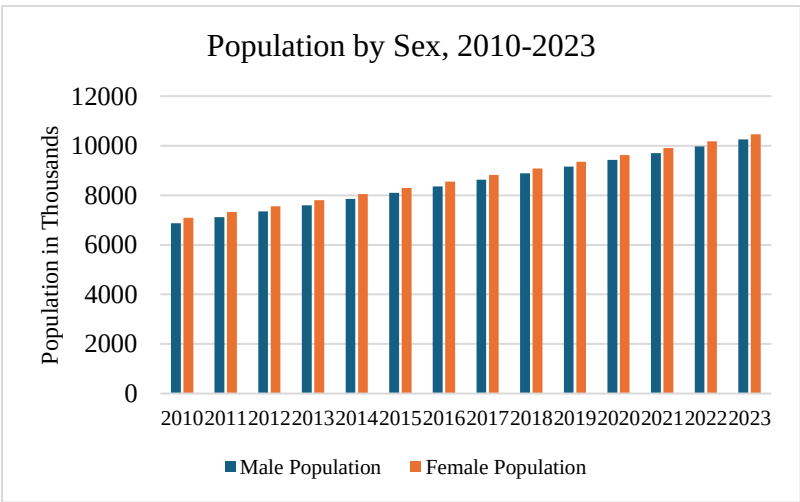
Figure 1: Population trends in the country overtime.



Urbanization and Health System Demands

Urban growth continues to accelerate, leading to **concentrated demands for health services** in urban centers, particularly Lusaka, Ndola, Kitwe, and other rapidly expanding towns. Concurrently, rural areas face persistent challenges in accessing quality care, widening health disparities. To address this dual pressure, strategic investments are required across both urban and rural health systems:

Figure 2: Population trends in the country disaggregated by sex



2.3 Urbanization and Health System Demands

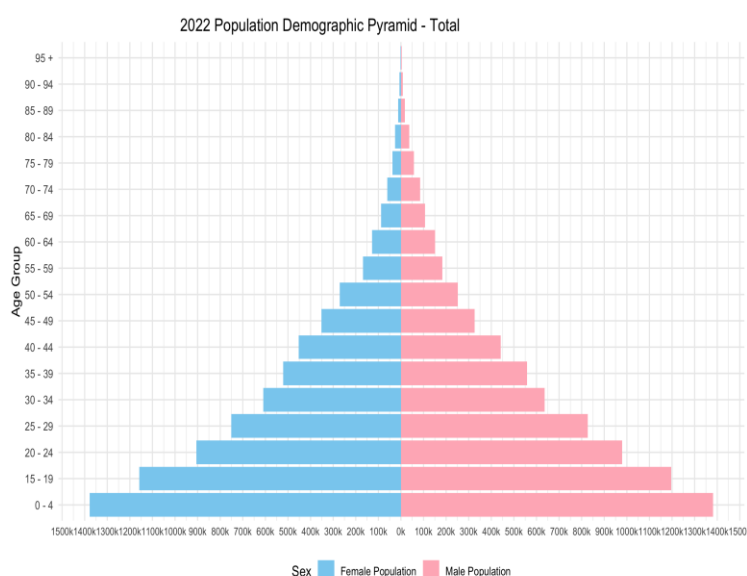
Urban growth continues to accelerate, leading to **concentrated demands for health services** in urban centers, particularly Lusaka, Ndola, Kitwe, and other rapidly expanding towns.

Concurrently, rural areas face persistent challenges in accessing quality care, widening health disparities.

To address this dual pressure, strategic investments are required across both urban and rural health systems:

- **Health Workforce Expansion:** Scaling up training and deployment of skilled health professionals, especially in underserved regions.
- **Supply Chain Strengthening:** Ensuring consistent availability of essential medicines and supplies through improved logistics.
- **Healthcare Financing:** Increasing budgetary allocations and exploring sustainable financing models to bolster service coverage

Figure 3: The population pyramid of the country



With increasing urbanization, healthcare infrastructure must be expanded to meet the rising demand for services in cities while also strengthening rural healthcare services to prevent disparities. This includes investing in health worker training, improving supply chains for essential medicines, and strengthening healthcare financing mechanisms.

1.3 Economic context

Zambia's economy is heavily dependent on the mining sector, particularly copper exports, which account for a significant portion of GDP. Other key economic sectors include agriculture, manufacturing, and service industries like tourism. Despite periods of economic growth, Zambia has faced economic challenges such as high inflation, public debt, and currency depreciation. These economic challenges have been due to among other things the challenge of servicing a huge public debt, battling the effects of climate change, including the prolonged drought in the 2023/2024 period, compounded by a slow economic growth rate. Unemployment rate in the country remains high, and poverty levels are significant, especially in rural areas.

Zambia has struggled with unsustainable debt, leading to a 2020 default on Eurobond payments. The government is negotiating debt restructuring under the IMF program. The government is

implementing fiscal and economic reforms, supported by an IMF program, to restore debt sustainability. The Zambian kwacha has been unstable, affecting inflation and increasing the cost of living. Hydropower shortages, due to droughts affecting Zambia's reliance on the Kariba Dam, have led to electricity rationing.

Moving forward, Zambia aims to expand agriculture, tourism, and manufacturing to reduce reliance on copper. Zambia is positioning itself as a hub for renewable energy, including solar and hydroelectric projects. The African Continental Free Trade Area (AfCFTA) offers opportunities for Zambia to expand its trade and industrial base.

The country has a mixed healthcare financing system, with public healthcare funding primarily sourced from government allocations, donor contributions, and out-of-pocket payments by individuals.

1.4 The national strategic development agenda in the country

Zambia's strategic economic development is primarily guided by the Eighth National Development Plan (8NDP) for the period 2022 to 2026. This plan is a continuation of efforts toward realizing the nation's Vision 2030, which aspires to transform Zambia into a prosperous middle-income country.

The 8NDP focuses on four key strategic development areas:

1. *Economic Transformation and Job Creation*: This area emphasizes facilitating trade and increasing investment to stimulate economic growth and employment opportunities.
2. *Human and Social Development*: Aimed at improving access to quality education, healthcare, and other social services to enhance the well-being of Zambians.
3. *Environmental Sustainability*: Focuses on promoting sustainable management of natural resources and addressing environmental challenges.
4. *Good Governance Environment*: Seeks to strengthen governance frameworks to ensure transparency, accountability, and the rule of law.

These strategic areas were identified through a comprehensive review of past performances and consultations with stakeholders to address persistent developmental challenges. The plan also aligns with international and regional commitments, including the Sustainable Development Goals (SDGs) and the African Union Agenda 2063.

In addition to the 8NDP, Zambia has implemented sector-specific strategies to bolster economic development. For instance, the National Health Strategic Plan 2022–2026 focuses on addressing health sector challenges and accelerating progress toward national and global health goals.

Furthermore, Zambia's Vision 2030 serves as a long-term strategic framework, outlining the nation's aspirations to become a prosperous middle-income country by 2030. This vision is operationalized through successive national development plans, with the 8NDP being the latest in this series.

Recent economic reforms and initiatives have also been pivotal in attracting foreign investments and fostering economic growth. For example, the establishment of a jointly owned metals trading unit between Zambia's Industrial Development Corporation (IDC) and Mercuria aims to enhance the country's participation in the global minerals market. These comprehensive strategies and initiatives underscore Zambia's commitment to sustainable economic development and the attainment of its long-term national goals.

1.5 Health sector strategic agenda in the country

Zambia's health sector is currently guided by the National Health Strategic Plan (NHSP) 2022–2026. This plan is aligned with the nation's Vision 2030 and the Eighth National Development Plan (8NDP), aiming to achieve Universal Health Coverage (UHC) and the health-related targets of Sustainable Development Goal 3 (SDG 3): "Good health and well-being for all."

The NHSP 2022–2026 is structured around two primary strategic directions:

1. **Strengthening Health Service Delivery:** This focuses on enhancing access to quality health services across various program areas, including:
 - Primary Health Care (PHC)
 - Reproductive, Maternal, Neonatal, Child, and Adolescent Health and Nutrition (RMNCAH-N):
 - Communicable Diseases:
 - Non-Communicable Diseases (NCDs):
 - Hospital services
2. **Strengthening Integrated Health Support Systems:** This involves bolstering the foundational elements of the health system, including:
 - **Health Workforce:** Increasing the number of trained health professionals and ensuring their equitable distribution.
 - **Essential Medicines, Medical Supplies, and Vaccines:** Ensuring a reliable supply of necessary medical commodities.
 - **Health Infrastructure, Equipment, and Transport:** Developing and maintaining healthcare facilities and providing appropriate equipment and transportation.
 - **Health Information, Research, and Innovation:** Enhancing data collection, research capabilities, and the adoption of innovative health solutions.
 - **Health Care Financing:** Securing adequate funding for health initiatives.
 - **Leadership and Governance:** Building robust leadership structures to effectively manage and oversee health services.

A key feature of the NHSP is the decentralization of health services, which aims to bring healthcare closer to communities by delegating certain functions to local authorities. This approach is intended to improve service delivery efficiency and responsiveness to local health needs

1.6 The organization of the health system in the country

Zambia's health service delivery system is structured into four main levels namely:

1. **Community Level**
 - *Community Health Workers (CHWs):* These are the frontline health providers, often based in rural areas, who offer basic health education, first aid, and referral services.

2. Primary Level

- *Health Posts*: Small facilities staffed by CHWs or enrolled nurses, providing basic preventive and curative services.
- *Rural Health Centres (RHCs)* and *Urban Health Centres (UHCs)*: These facilities provide primary healthcare services, including maternal and child health, immunizations, and treatment for common illnesses. They serve as the first point of contact for most people.

3. Secondary Level

- *District Hospitals*: These hospitals provide more specialized care than health centres, with a wider range of diagnostic and therapeutic services. They support health centres and handle cases that require more advanced care.

4. Tertiary Level

- *Provincial Hospitals*: Located in provincial capitals, these hospitals offer specialized medical services and act as referral centres for district hospitals.
- *Central Hospitals*: These are the highest referral centres in the country, providing advanced medical services, specialist consultations, and more complex procedures. Notable examples include the University Teaching Hospital in Lusaka.

Administratively, the health system in Zambia is managed and coordinated at three levels namely:

- *Ministry of Health*: At national level, which sets policies, standards, and regulations for health services. It's also responsible for coordinating health programs and partnerships.
- *Provincial Health Offices*: Oversee healthcare delivery in each province, coordinating with district health offices.
- *District Health Offices*: Manage and supervise health services within their districts, ensuring healthcare standards are met at health posts, health centres and district hospitals.

Private clinics and hospitals play a significant role in health service delivery, especially in urban areas. NGOs also contribute significantly by supporting health initiatives, particularly in rural and underserved communities.

The National Health Insurance Management Authority (NHIMA) oversees Zambia's health insurance scheme, aimed at promoting financial risk protection and equitable healthcare access.

2. Methodology of the Review

2.1 The rationale for the NHSP mid-term review

The implementation process of the 2022-2026 NHSP commenced in 2022, and a lot of investment has so far gone into the implementation of various Programmes. After two and half years of implementing the NHSP, there was a need to determine the milestones made towards meeting the set targets, identify best practices and reorganize the implementation procedures or process to achieve targets in the remaining years.

Therefore, the health Sector, undertook a process of undertaking the Mid - Term Review (MTR) of the NHSP 2022 – 2026. The review of the NHSP was to inform stakeholders of the milestones that have been achieved in the first two and half years of its implementation, in terms of meeting the set goals and objectives. The MTR of the NHSP 2022-2026 was to feed into the implementation process for the remaining years of implementation of the NHSP.

2.2 Objectives of the NHSP 2022-2026 MTR

2.2.1 Main objective

The overall goal of the NHSP 2022-2026 MTR was to assess progress towards the attainment of the NHSP 2022-2026 objectives after two and half years of implementation, and revise NHSP operational plans for the remaining duration of its implementation.

2.2.2 Specific objectives

1. To assess health sector progress towards the attainment of set targets for 2026.
2. To assess the health sector progress in the implementation of strategies/activities in the strategic plan.
3. To identify enablers and barriers for the implementation of NHSP strategic interventions and activities.
4. To review and revise the operational (Programme) plans of the NHSP

The review adopted a phased, three stream approach to data collection, analysis and report writing. These streams were:

Stream One Analysis: The primary goal for *Stream One* was to undertake quantitative data analysis to assess the health sector's performance progress towards the attainment of targets set for the NHSP along selected quantitative indicators. The analysis focused primarily on all indicators outlined in the NHSP and for which data was available. The main sources of data for this stream included routine data from DHIS2, administrative data from various MoH departments, periodic surveys, civil registration and vital statistics, UN estimates and others. Analysed stream one data is presented in form of tables, graphs, pie charts and narrative reports. The preliminary analysis of stream one – provided data to guide streams two and three work.

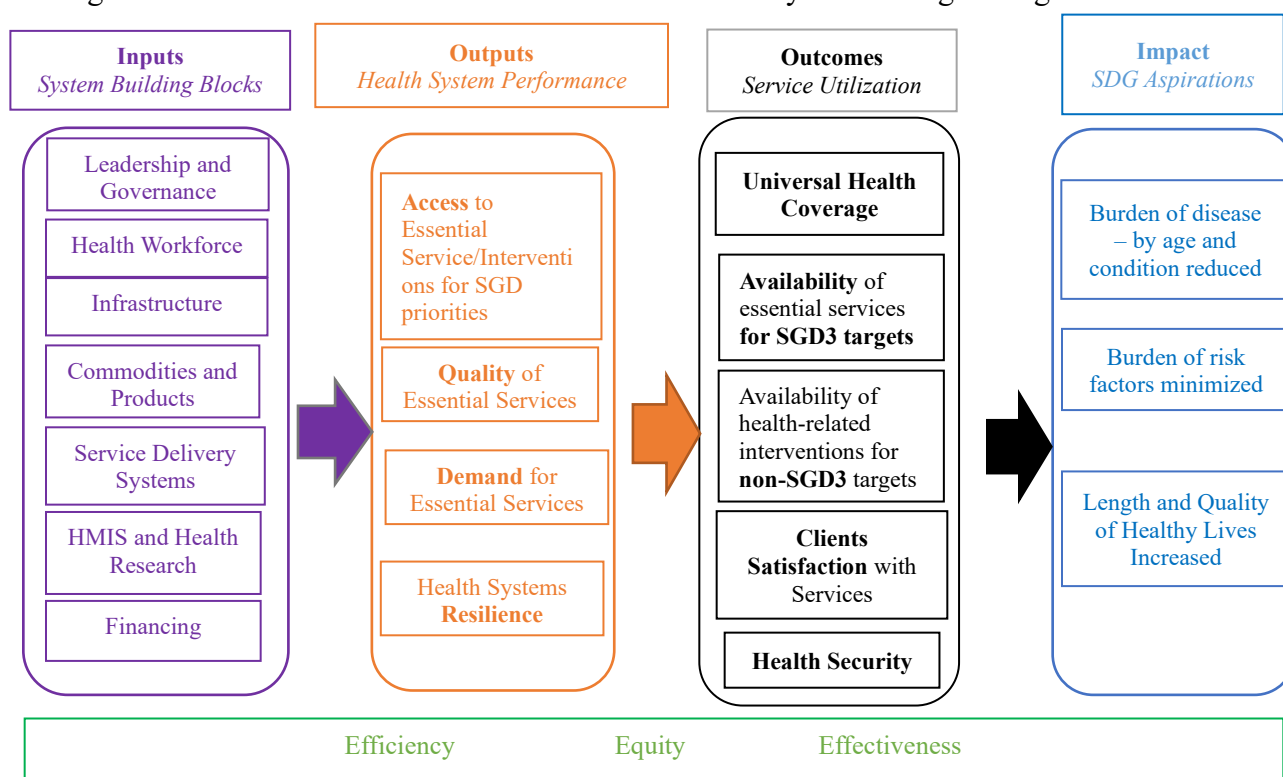
Stream Two Analysis: This stream focused on the status of implementation; and the level of alignment of implementation of priority interventions and strategies. Data for this stream is drawn from the NHSP 2022-2026, Departments and Program specific strategic, health sector annual performance reports, department and program annual performance reports, and program reviews, department and program meeting minutes and others. Analysed data for this stream is presented in the report in form of tables and narrative text.

Stream Three Analysis: focused on analysing the enablers and barriers for the implementation of NHSP strategic interventions and activities. Is sort to explain the “why” current achievements were made. This stream utilized data from Key Informant Interviews (KIIs) from various stakeholders/key informants across the different levels of the system including National MoH, UN partners, implementing partners, provincial health directors, district health directors, town clerks in local authorities, hospital superintendents and health facility in charges. In addition, this stream administered client exit interviews at various levels of health facilities, and the sub-national level functionality assessment tool.

2.4 MTR guiding framework

The MTR was guided by the health sector monitoring and evaluation (M&E) frameworks and plan that was developed in 2022 to support the performance monitoring of the NHSP. This M&E framework was adopted from the WHO AFRO Framework of Actions for Health Systems Strengthening for UHC and Other Health Related SGDs (Figure 4 below).

Figure 4: WHO AFRO Actions Framework for Health System Strengthening.



2.5 Data, data sources and data collection

2.5.1 Data sources

The MTR utilized both qualitative and quantitative data, incorporating both primary and secondary sources. Standardized data extraction tools were employed to gather information from routine HMIS and administrative records.

Stream one data sources included the following:

- Routine HMIS data
 - DHIS-2 databases
 - Annual health sector statistical reports
 - Annual health sector performance reports
- Administrative records
 - Human resources Information System (HRIS)
 - Logistics Management Information System (LMIS)
 - Administrative data on health infrastructure
 - Health financing data
- Household Surveys:
 - Demographic and Health Surveys
 - Disease specific surveys e.g. TB prevalence surveys,
 - Multiple Indicator Cluster Survey, Malaria Indicator Survey, AIDS Indicator survey, STEP surveys etc.
 - Multiple Indicator Cluster Survey.
- Civil Registration and Vital Statistics System
- Facility assessments such as SARA, HFAs, SDIs
- Census reports and modelled estimates of population denominator data by the National Statistics Office
- Data from local research studies
- UN estimates
- Other health sector reports

Stream two data sources included the following:

- The NHSP 2022-2026 under review
- The Monitoring and Evaluation Framework for the NHSP under review.
- All departmental and program specific strategic and operational plans from the Ministry of Health.
- M&E Plans/Frameworks for all departmental and program specific strategic plans
- Programme and departmental specific review reports
- Overall government (medium term) national development plans
- The national development plans annual progress reports
- All health sector reviews/reports from the MoH and partners

Stream three data sources included the following:

- Key Informant Interviews
- Client Exit Interviews.
- Health System Rapid Assessments.

For quantitative indicators, in addition to elaboration of progress, traffic light colour (Green, Yellow and Red) was used against each indicator to summarize progress. **Green** means target achieved, **yellow** positive progress, while **red** shows that target is unlikely to be achieved, unless some course of corrections are undertaken

Analysis of the qualitative data was done using an analytical framework that organized the findings thematically in terms of progress on achievement of targets, implementation of strategic interventions (and activities) planned for achievement of each strategic objective.

2.6 Ethical clearance

An official invitation from the permanent secretary (administration) of the Ministry of Health was sent to health cooperating partners, and health sector managers and stakeholders across different level of the health system to take part in the MTR interviews as key informants. Additionally, individual verbal consent was sort from all individuals who participated in the MTR

3 Progress made towards NHSP Strategic Direction One : Strengthen health service delivery to attain quality universal health coverage (UHC) by 2030

The NHSP 2022 - 2026 identified the following strategic areas to advance its strategic direction one.

- Primary Health Care
 - Health Promotion and Education
 - Community Health
- RMCAHN
 - Reproductive health
 - Maternal health
 - Neonatal Health
 - Child Health
 - Adolescent Health
 - Nutrition
- Communicable Diseases
 - Malaria control
 - HIV and STIs Programmes
 - Tuberculosis and Leprosy control
 - Viral Hepatitis
- Non-Communicable Diseases
 - Mental Health
 - Cancer Diseases
- Other Areas of Public Health Concerns
 - NTDs
 - Public Health Security
 - Social Determinants of Health
- Clinical Care Services
- *Hospital Services*
 - Surgical and anaesthesia services
 - Internal Medicine
 - Obstetrics and Gynaecology
 - Paediatrics Services
 - Mobile Emergency services
 - Palliative Care
 - Eye health services
 - Ear Nose and Throat Health Services
 - Oral Health Services
 - Cardiovascular Services
- Blood Transfusion Services
- Diagnostic Services
 - Pathology and Laboratory services
 - Radiology Services

- Nuclear Medicine
- Rehabilitative Services
- Nursing and Midwifery Services

This section reports on the progress made against targets for set indicators, progress made with the implementation of strategies, interventions and activities including level of alignment; and facilitators and barriers to performance for each of these areas

3.1 Primary health care

PHC was outlined as a key focal area under Strategic Direction 1 of the NHSP 2022-2026. The plan aimed to enhance health service delivery, contributing to the attainment of quality universal health coverage by 2030 through the provision of comprehensive essential Primary Health Care (PHC) services to all Zambians. Significant progress has been achieved in various health programs over the years. However, the rapid population growth continues to exert pressure on the healthcare system, keeping the disease burden high and necessitating an expansion of appropriate services.

The government's policy direction regarding PHC provision is guided by the National Decentralization Policy of 2023. This aligns with the Constitution (Amendment) Act, No. 2 of 2016, specifically Articles 147 and 148, which emphasize the devolution of functions, decision-making authority, and the transfer of resources from the central government to local authorities. In this context, the MoH has finalized the “Health Sector Devolution Plan,” which is currently being implemented in a phased approach.

To effectively implement primary health care, five foundational principles have been established:

- Equitable Distribution/Accessibility
- Community Participation
- Intersectoral Coordination
- Appropriate Technology
- Health Promotion

In addition, the NHSSP outlined two focal areas for PHC strategic interventions. These are:

- Health Promotion and Education
- Community Health

3.1.1 Health promotion and education

There were seven (7) Strategic Interventions set in this strategic area. These are: i) Scaling up of Social Behaviour Change programmes, ii) Enhancing promotion of healthy lifestyles, iii) Enhancing workplace health programs, iv) Scaling up of health promoting schools and other congregate settings, v) Strengthening Risk Communication and Community Engagement, vi) Enhancing health promotion to people with disabilities and, vii) Enhancing Social Marketing of health services.

Achievement Reported

The sector has made significant strides in achieving the set objectives. The most significant achievement has been the scaling up of Social Behaviour Change (SBC) programs which currently reported at about 80% completion. In addition, the development and production of SBC materials for print, social media and billboards on emerging diseases like Cholera, M-Pox, Malaria, Measles, Drought, Sexually Transmitted Infections, and Haemorrhagic Fever has continued.

The promotion of healthy lifestyles has made considerable progress and stands at approximately 40-60% achievement rate. Targeted campaigns focusing on physical activity, nutrition, tobacco smoking cessation, and avoiding harmful consumption of alcohol have been implemented. Various platforms such as radio and television presentations, public service announcement, community and national health events/ commemorations like World no Tobacco Day, Mental Health Day, World Heart Day, have been used to reach diverse populations, contributing to noticeable shift towards more health-conscious behaviours within communities.

As a way of scaling up Health- Promoting Schools, the MoH entered into a Memorandum of Understanding on School Health with Ministry of Education in partnership with Healthy Learners. In addition, School Health Nutrition Guidelines have been developed.

Risk Communication and Community Engagement (RCCE) activities have been heightened as a response to disease outbreaks. To achieve this, the Health Promotion Unit in partnership with the Zambia National Public Health Institute, Provincial Health Promotion Staff and other Partners have put in place Emergency Preparedness and Control plans for tracking disease outbreaks. There is continued development of community feedback system tool dashboards for diseases including Cholera. Coupled with this, the Ministry has conducted Advocacy Communication and Social Mobilization for Measles Rubella Supplementary Immunization Campaign (MR SIA) as well as for Oral Polio Vaccine. Engagement with community members through participatory approaches has enhanced trust in public health messaging, leading to greater adherence to health recommendations making the Ministry to score a progress rating of about 60 to 80% achievement rate.

Notwithstanding the progress made in achieving the set objective, the sector is still not on track in meeting the strategic interventions set to enhance workplace health programs, enhance of health promotion activities with People who are differently abled, and enhancing social marketing of health activities. Efforts are being made towards revamping the workplace wellness programs in all health institutions.

Recommendations

Some key recommendations to consider in the remaining period of the NHSP 2022-2026 implementation for this strategic area include the following:

- There is a need to develop comprehensive workplace policies in collaboration with key stakeholders, including government agencies, employers, and labour organizations.
- There is also need for increased funding for SBC programs especially for underserved areas.
- Furthermore, there is a need to introduce ongoing capacity building and mentorship programs alongside SBC campaigns to promote sustainable behaviour change.
- Nurturing greater community participation in designing and implementing SBC programs can ensure that interventions are culturally relevant and tailored to the specific needs of the people.
- Establishing a clear and monitoring and evaluation framework that allows for real-time assessment of SBC initiatives is key in helping the unit align with the set goals.

3.1.2 Community health

The NHSP 2022 – 2026 emphasized the country’s implementation of community health as a platform for PHC service delivery to attain Universal Health Coverage (UHC). To achieve this, the NHSP 2022-2026 outlined four (04) objectives for community health services. These were: i) Strengthening of Community Health Management Information System, II) Creation of an enabling environment for implementation of PHC, iii) Increase demand at points of access to services in the utilization of PHC as well as community health committees (CHC), and iv) Mobilize adequate resources in Primary Health Care services. Furthermore, fifteen (15) interventions were outlined across these objectives.

Intervention 1: Review the National Community Health Strategic Framework (NCHSF 2019-2021) and develop a new one for 2022-2026

In 2023, the MoH reviewed and developed the National Community Health Strategy (2022-2026). Formal dissemination of National Community Health Strategy was done up to Provincial level where all 116 districts countrywide were represented.

To achieve implementation of developed National Community health strategy, District public health teams should cascade the dissemination of developed National Community Health strategic plan alongside other associated guidelines to all partners and stakeholders in their catchment area.

Intervention 2: Develop a National PHC Strategic Framework 2022-2026

As of 2024, the selection and awarding of Technical Assistance had been done and works to develop the national PHC strategic framework has commenced. However, there was a delay in the development of the National PHC strategic framework.

The development of the National PHC Strategic Framework 2022-2026 will require more MoH commitment to expedite the development process.

Intervention 3: Develop and periodically review to update National PHC guidelines.

Periodic review to update developed National PHC strategic framework could not be done since the policy document had not been developed yet. A key challenge was the delay in the award of Technical Assistance to deliver on the development of National PHC strategic framework.

To achieve periodic review to update the developed National PHC strategic framework to follow the initial delivery of the PHC strategic framework.

Intervention 4: Strengthen policy and regulatory framework for PHC implementation,

To implement the components of PHC, the programme developed National Community Health strategy 2022-2026 and other guidelines to provide the roadmap for healthcare and stakeholders to implement community health programme in the country. Developed policy documents include National Community Health Strategy (2022-2026), Community Health Service Package, Legal Frameworks for Community Based Volunteers, Community Scorecard (CSC) guidelines and the Incentive Guidelines for CBVs. Furthermore, in 2024, the programme developed SOPs on CBV logistical supplies and supervision package for community health workforce. Furthermore, the programme reviewed Neighbourhood Health Committee (NHC) guidelines. Other notable developments to strengthen PHC implementation included training of CBVs in early warning to Integrated Disease Surveillance and Response (IDSR), event-based surveillance and facilitated the remuneration for CBVs.

Some key challenges have included the inadequate awareness to developed National community health policy documents and guidelines, Inadequate HR for Community Health at all levels, Inconsistent Supply Chain for Medicines and Equipment and Inadequate Funding for community health programme.

To achieve the strengthening of policy and regulatory framework for PHC implementation will require dissemination of all developed community health policy documents to all partners and stakeholders, improve community health workforce, consistent supply of Medicines and equipment/working tools, allocation of adequate funding for community health and provision of Technical Support Supervision for effective implementation community health service.

Intervention 5: Strengthen the structures and functions of health facility and community health management committee

In 2024, the MoH Community Health programme reviewed the Neighbourhood Health Committee constitution in line with decentralization agenda and other evolved community landscape happening at community level. Other developed community health frame works include Community health service package, Georeferenced master list for effective management of community health volunteers, Standard Operating Procedures for CBV logistics and community health supervision package.

Some key challenges include limited functionality of some NHC units due to lack of awareness, inadequate essential logistical supplies for CHWs and inadequate supervision and motivation among community workforce.

To reach the target and strengthen management of community health structures need to revamp NHC functionality, improve allocation of logistical supplies to PHC workforce, incentivize PHC workforce with work tools and allocate adequate funds to support operations.

Provide mechanisms for the referral in PHC services, capacity build PHC service providers on the referral mechanisms, roll out dissemination of Community scorecard to all community stakeholders, orient NHC/PHC teams on community score cards.

In addition, there is a need to expedite the dissemination of developed guidelines to reach all stakeholders to effectively implement community health guidelines.

Intervention 6: Establish and strengthen linkage of PHC with community structures at the ward level

There is still a weak linkage of PHC with community structures at the ward level with the Ward Development Committees. Many NHC structures at community level are non-functional, Inadequate awareness to stakeholders on developed National community health policy documents and guidelines and Inadequate HR for Community Health at all levels. Furthermore, Inadequate collaboration between NHC and WDC at ward level and Inadequate Funding for PHC activities.

To reach the target to strengthen linkage of PHC with community structures at the ward level includes, strengthen collaboration between NHCs and Ward Development Committees (WDC) at Ward level, to work closely with Local Government to create awareness among health workers/CHWs on decentralization agenda and how to access CDF to support implementation of local PHC activities demand creation for PHC management of community health structures; expedite dissemination of developed guidelines to reach all stakeholders to effectively implement community health guidelines revamp NHC functionality.

Intervention 7: Strengthen demand creation initiatives for PHC

Community health in the country has made progress to promote good access to healthcare services both at the health centre and tertiary levels. Further it has helped to empower community members with the knowledge of the availability of health services at community level.

Some key challenges have included the inadequate awareness to developed National community health policy documents and guidelines, inadequate HR for Community Health at all levels, Inadequate functionality of many of NHC at community level, lack of awareness on decentralization agenda among CHWs and limited collaboration with Ward Development Committees; and Inadequate Funding for community health programme has weakened demand creation initiatives for PHC.

To reach the target and strengthen demand creation for PHC management of community health structures; expedite dissemination of developed guidelines to reach all stakeholders to effectively implement community health guidelines revamp NHC functionality and strengthen collaboration between NHCs and Ward Development Committees (WDC) at Ward level. Additionally, there is need to work with Local Government to create awareness among health workers/CHWs on decentralization agenda and how to access CDF to support implementation of local PHC activities. Increase utilization of community health services, reinforce community health linkages and referral mechanism, improve HR in demand creation for PHC activities and allocate not only adequate but also consistent community resources to support implementation of PHC activities.

Intervention 8: Strengthen linkage between health facilities and communities

In 2023 MoH developed and launched community health guidelines to improve coordination and proper management of CBVs in the country, includes National Community Health Strategic plan 2022-2026, Community Health Service Package, Legal Framework, CBV Incentive Guidelines, web based CBV-information Management systems, Neighbourhood Health Committee guidelines and social accountability tool (Community Score Card). MoH has further developed CHW supervision package and updated NHC guidelines.

Some key challenges which among them are expired documents including: Inadequate awareness to developed National community health policy documents and guidelines, inadequate roll out of

Community Scorecard, Inadequate HR for Community Health and Inadequate Funding for community health programme.

To achieve in strengthened linkage between health facilities and communities will require dissemination of all developed community health policy documents to all community stakeholders, improve community health workforce, improve funding for community health and provision of Technical Support Supervision for effective implementation community health service

Intervention 9: Leverage on appropriate technology for information IEC

There has been a progressive improvement in the roll out to digitalization to the community health information system, and capacity building of the community health workforce to effectively collect, collate and report quality community health data and conduct community health checks.

Moving forward, there will be need to equip the community health workforce with appropriate technologies, build capacity of community health workforce in commodity and supplies forecasting and quantification and strengthen coordination and management of community health products and technologies, disseminate the IEC materials through appropriate ICT channel to the community

Intervention 10: Advocating to include PHC services in the benefit package for the National Health Insurance Scheme

No report

Intervention 11: Strengthen innovative resource mobilization mechanisms

The community health programme raised funds through resource mobilization mechanisms which include close to \$2 Million dollars under the COVID 19 first wave from Global Fund Grant to procure enablers for CHWs and for technical assistance, programme awarded \$800,000 under the BIRCH Project meant for Technical Assistance, unlocking funds amounting to \$10.8 Million Dollars and an additional \$4 Million Dollars under the COVID 19 second wave.

Some key challenges reported include Inadequate HR for Community Health at all levels, Inconsistent supply chain in medicines and basic medical equipment for the CHWs following the abolishment of community health drug kits, Lack of reliable Community Health data and slow roll out of CHMIS and Inadequate Funding to Implement the Community Health Strategy and Frameworks.

To reach the target of mobilizing adequate funds to implement PHC in the country, there is need for advocacy for increased domestic resource allocation, continuous engagement with partners and stakeholders for resource support.

Intervention 12: Strengthen PHC reporting systems and integrate in the cHMIS.

MoH developed the Community Health Score Card for service quality feedback and has since been embedded in the national HMIS. Additionally, the MoH validated Community Data Collection tools and registers, rolled out digitalization of community data (Community Health Information Platform) in four provinces and developed a Web Based Geo-Reference Master list for CBVs (earmarked for linkage to HRIS) to improve coordination and distribution of Community Based Volunteers. Furthermore, Community based Volunteers have been trained as polyvalent workers using the integrated Community Health Service Package.

However, the country is still off track to meet the 2026 target utilization of community health information system that informs decision-making and inform policy: due to slow roll-out of digital community health information systems. Several factors contribute to the slower-than-expected pace, including inadequate Funding to Implement the Community Health Strategy with all its frameworks, Weak community to facility and facility to community linkages affecting health care along the continuum of care (and leading to poor outcomes), inconsistent supply chain for medicines, verticalization of community-based interventions as some CBVs are still being trained for disease-specific interventions instead of as ‘polyvalent’ workers delivering integrated health and nutrition services.

To reach the target of strengthening access, accuracy and utilization of community health information system that informs decision-making and policy development by 2026. Achieving this will require the strengthening of community information system and enhance the use of information for decision-making and policy development. Further, MoH needs to leverage on existing opportunities and leverage its strengths to accelerate progress through validation of Monitoring and Evaluation guideline for National Community Health Strategy which is currently in draft form, expedite roll out digitalization of cHMIS to all districts, Improve HRH at all levels to support community health programme, Remuneration of CHWs for effective provision of sustainable community-based surveillance and ring fence of community funds to support the implementation of community health strategy with its associated frameworks.

Intervention 13: Strengthen PHC on DHMIS to provide quality data including event-based reports

Digitalize the community health information system

No report

Recommendation: Improve digitalization to community health information system, equip community health workforce with appropriate technologies, build capacity for community health workforce to effectively collect, collate and report quality community health data and conduct community health data quality checks. Provide mechanisms for surveillance of outbreak and epidemics of PHC related events, link PHC response team with the other response teams, conduct surveys to establish the level of emergency response. Further, strengthen coordination and management of community health products and technologies and build capacity of community health workforce in commodity and supplies forecasting and quantification

Intervention 14: Scale up use of digitized cHMIS

Zambia's Ministry of Health has developed the Community Health Information Platform (CHiP), a digital community health system that supports data collection, management, and decision-making at the community level. Developed in collaboration with partners like PATH, UNICEF, and the Gates Foundation, CHiP aims to improve community health service delivery quality and efficiency. The platform empowers Community Health Workers (CHWs) to digitally manage health data, track health services, and receive real-time decision support.

CHiP's key features include offline data collection, automated reporting, inventory management, and performance monitoring. Supervisors can track CHW performance, provide feedback, and ensure accountability. Data is collected from the community whilst providing services, and this data informs decision-making at the community, facility, and district levels, enabling efficient resource allocation and targeted health interventions. Notably, the CHiP has been successfully integrated with the DHIS2, allowing for seamless data exchange.

Additionally, significant progress has been made, with 575 Community-Based Volunteers (CBVs) and 45 CBV supervisors trained across five districts (Kazungula, Mpongwe, Ndola, Katete, and Chongwe). To date, over 47,880 households with 213,406 clients have been registered and are receiving community health services through CHiP, demonstrating its potential to enhance community health service delivery.

The next steps for CHiP include nationwide scale-up, integration with other health systems, and conduct an evaluation to assess its effectiveness in improving community health outcomes and strengthening the health system. Ongoing training and support for CHWs and supervisors are essential to ensure effective use and maximize CHiP's benefits.

Intervention 15: Strengthen compatibility and integration of different level health information systems (cHMIS, DHMIS, HMIS, eLMIS etc).

No report

3.2 Reproductive, maternal, neonatal, child, adolescent and nutrition health services

Table 2 below summarises performance against targets for key indicators outlined in the NHSSP for this strategic area.

Table 2: Summary of Performance Against Targets for RMNCAN Indicators.

Indicator	Performance Against Target	Colour Code
1st antenatal visit 1st trimester	86.59	
1st PNC within 48 hours (infant)	96.41	
1st PNC within 48 hours (mother)	100	
Fully immunized coverage <1-year	87.18	
Incidence of neonatal deaths per 1000 LB due to prematurity	82.77	
Incidence of neonatal deaths per 1000 LB due to birth asphyxia	63.26	
Incidence of neonatal deaths per 1000 LB due to infection	48.75	
Maternal Mortality (/100,000 LB)	83.96	
Neonatal mortality rate (/1,000 LB)	96.47	
Number of hospitals providing quality in hospital care for small and sick new-borns	81.82	
Proportion of children underweight	8.33	
Proportion of deliveries attended by skilled personnel	100	
Proportion of districts with capacity to provide a minimum adolescent health service platform	87.22	
Proportion of health facilities with at least 60% staff trained in IMNCI	71.11	
Proportion of health facilities with functional Emergency and Obstetric and Neonatal Care (EmONC), both basic and comprehensive	76.14	

Indicator	Performance Against Target	Colour Code
Proportion of married women accessing modern contraceptives	84.13	
proportion of married women using any method of family planning	100	
Proportion of pregnant women screened for syphilis at first ANC visit	100	
Proportion of pregnant women with complications of abortion	50	
Proportion of service provision sites covered with Early Childhood Development (ECD) services	100	
Proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods	100	
Rate of adolescents' awareness and utilization of the available health services	100	
Stunting rate	53.13	
Under 5 (/1,000 LB)	73.81	
Vitamin A supplementation (6-59 months)	74.75	

Green means target achieved, **yellow** means positive progress, while **red** shows that target is unlikely to be achieved, unless some course corrections are undertaken. **Black** shows no data.

3.2.1 Reproductive and maternal health

The NHSP 2021-2026 set out an ambition to reduce Maternal Mortality in the country from 278 per 100,000 live births in 2021 to under 100 per 100,000 live births by 2026. This means reducing maternal deaths from 1749 to 761 between 2021 and 2026. This goal implies that by the midpoint of the plan in 2024, the MMR should be approximately 116 per 100,000 live births.

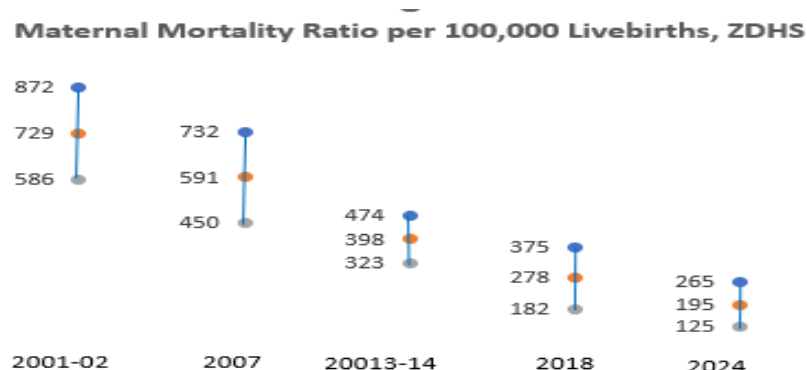
To achieve this, the NHSP 2022-2026 spelt out 10 strategic objectives designed for addressing family planning, antenatal care, skilled birth attendance, postnatal care, emergency obstetric and neonatal care, and comprehensive abortion care.

Achievement Reported

Maternal Mortality

The 2024 Zambia Demographic Health Survey (ZDHS) reveals MMR of 187 maternal deaths per 100,000 livebirths for the period between 2018 to 2024, and this averages to nearly 1400 maternal deaths annually. This falls short of getting on track to achieve 761 maternal deaths that make the target MMR of 100 by 2026. This means the current efforts must be accelerated by 64% to reduce maternal mortality to the target. Figure 5 below summaries the trends in Maternal mortality ratio in Zambia from 2001 to 2024 while Table 3 presents the number of maternal deaths from 2011 to 2024.

Figure 5: Trend in Maternal mortality ratio in Zambia 2001 to 2024. ZDHS 2024



Source: ZDHS 2024

Table 3: Maternal mortality ratio and number of maternal deaths from 2011 to 2026.

	2011	2014	2020	2024	Projection for 2026	Target set for 2026
MMR per 100 000 LBs	398	278	195	187	106	100
MDs	1911	1462	1221	888	816	770
Since MMR data was determined 7 years prior to each of ZDHS surveys, the MMR figures were assigned for the years at the mid of the survey period (2011 for ZDHS 2014, 2014 for ZDHS 2018 and 2020 for ZDHS 2024)						

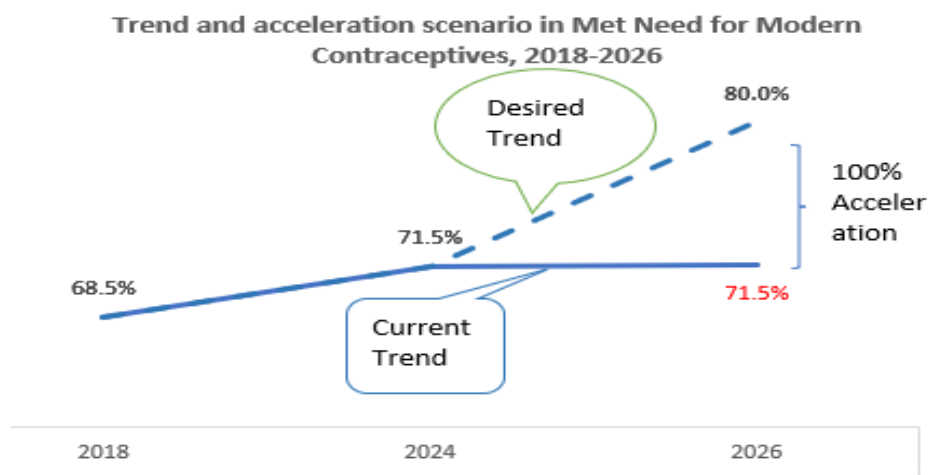
Source: ZDHS 2013/14-2024

Family Planning

The use of contraceptive methods among married women in Zambia has shown incremental progress: from 50% in 2018 to 56% in 2024, approaching the NHSP 2022-2026 target of 60% by 2026. However, this target seems underestimated compared to the broader objective for modern contraceptive use, which aims for a 70% rate by 2026 and currently stands at 53%. To meet these ambitious goals, concerted efforts are required, including a near doubling of current activities to close the gap. (Figure-6)

For sexually active unmarried women aged 15-49, contraceptive use increased from 43% to 48% over the same period yet remains far from the 60% target. Achieving this will necessitate an 86% intensification of ongoing initiatives. Furthermore, the overall met need for modern contraceptives has stagnated, moving marginally from 68.5% in 2018 to 71.5% in 2024, indicating a significant shortfall in meeting NHSP objectives. (Figure-6)

Figure 6: Trend and acceleration scenario in met need for modern contraceptives



Efforts to improve family planning have been variably implemented in the country: SQA and QI interventions along with continuity of services during the COVID-19 pandemic are fully in place, yet other critical areas such as MPDSR processes and youth-friendly services are only partly fulfilled. The implementation of strategies for marginalized groups and enhancing contraceptive awareness also requires additional focus.

Despite these challenges, there have been positive developments in specific regions with increases in new family planning acceptors, most notably in Luapula, Lusaka, and Copperbelt, driven by enhanced training, supply chain improvements, and community engagement. Nonetheless, disparities persist, particularly in Muchinga, Northwestern, and Eastern provinces, which have experienced notable declines due to various barriers including limited awareness and cultural constraints. (Table 4) below

Overall, while Zambia has made some strides in family planning access and usage, achieving the 2026 targets will require a redoubling of efforts, particularly in lagging areas, to ensure equitable and widespread uptake of contraceptive services.

Table 4: New Family Planning acceptance rate (%), 2021-2024

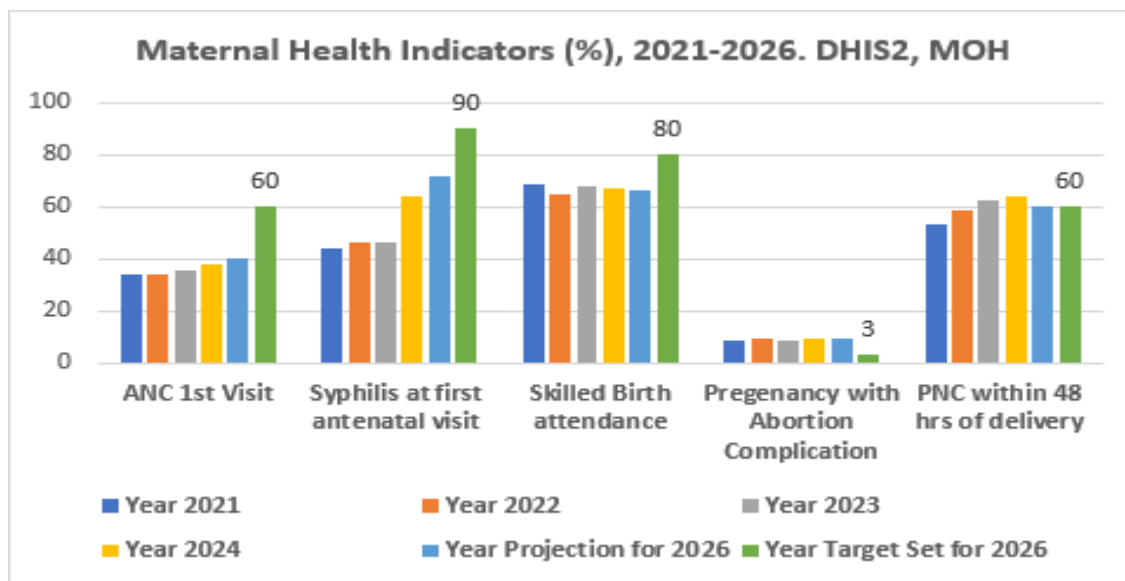
Period	2021	2022	2023	2024 (Jan-Jun)
Central	22.9	21.3	20.7	20.6
Copperbelt	19.6	21.3	19.2	31
Eastern	31.9	29.6	28.7	26.1
Luapula	42.2	42.5	48	47.6
Lusaka	14.6	15.7	16.7	27.6
Muchinga	39.3	34.9	32.4	20
Northern	32.8	32.2	32.5	31.5
Northwestern	41.7	41	41.1	20.8
Southern	25.3	23.7	25	30.9
Western	32.5	31.4	29.2	30
Zambia	27.4	26.8	26.8	28.6

Source: DHIS2, MoH

Maternal Health

Figure 7 below summarizes the trends in performance of in key maternal health indicators in the country from 2021 to 2023.

Figure 7: Trends in performance of in key maternal health indicators in the country from 2021 to 2023



Source: MoH DHIS2

Maternal health indicators reflect varying progress toward the 2026 targets. Antenatal care (ANC) visits within the first trimester have seen a slight improvement from 33.9% in 2021 to 38.1% in 2024, with a projected 40.38% by 2026, still falling short of the 60% target (DHIS2, MoH). Initiatives like ANC normative guidance, IEC materials, and communication strategies are fully implemented, while others—such as capacity building, marginalized group inclusion, and training—are less comprehensive, achieving moderate in implementation progress. Areas like community mobilization, data management, service quality, and supply chain improvements are making strides, though more work is needed.

Syphilis screening at the first ANC visit has improved significantly from 44.02% in 2021 to 63.67% in 2024, with a projected 71.61% by 2026, though it still lags behind the 90% target (DHIS2, MoH). Efforts like integrating service delivery and implementing key guidelines are fully in place, but other areas such as provider training and supply chain support remain partially completed. Continued focus on testing, training, and RH commodity distribution is required.

Skilled birth attendance has seen minor declines, from 68.9% in 2021 to 66.9% in 2024, with projections at 66.47% by 2026, falling short of the 80% target (DHIS2, MoH). There was major implementation progress in enhancing skilled delivery through Respectful Maternity Care (RMC) and integrated services, while community sensitization and infrastructure expansion are advancing at a slower pace. Efforts are ongoing but more work is needed for full implementation.

Abortion complications have worsened, rising from 8.36% in 2021 to 9.26% in 2024, with projections at 9.19% for 2026—well above the 3% target (DHSI2, MoH). Efforts to address this, including strengthening Comprehensive Abortion Care (CAC) and improving infection prevention, are at moderate (61-80%) completion. Advocacy for legal revisions and communication tools for differently abled individuals are progressing but remain partially completed. More comprehensive implementation is essential.

Postnatal care (PNC) attendance within 48 hours of delivery has improved from 53.3% in 2021 to 63.8% in 2024, with projections slightly surpassing the 60% target by 2026. Some initiatives, like supervision and expanded IEC materials, are fully implemented, while others, such as transport provision and RMC training, show slower progress. Further work is needed to sustain the gains and progress even further. This is because the target was already achieved and slightly surpassed.

Efforts toward achieving 100% functional Emergency Obstetric and Neonatal Care (EmONC) facilities by 2026 are progressing but remain partially implemented. Capacity building for health providers and scaling up service sites are at 41-60% completion, with some progress in leadership strengthening, supervision, and commodity supply chains. Ambulance services are also partially implemented, with some services in place at key locations. Full implementation is still necessary to reach the target.

Challenges in the Maternal and Reproductive Health Strategic Area

Family Planning Challenges

Setting a target for overall contraceptive use was challenging, as it fell below the specific goal for modern contraceptives. Stagnant contraceptive prevalence rates are driven by market saturation, inconsistent supply of family planning commodities, low awareness, and restrictive cultural norms and beliefs. Progress in implementing MPDSR, youth-friendly services, and the inclusion of marginalized groups remained limited.

Maternal Health Challenges

Several factors contributing to the slower-than-expected pace, including poor quality of antenatal care, compounded by periodic stock out of commodities such as ferrous and folic acid, Fansidar), RPR test kits and microcuvettes; inadequate provider knowledge and skills to identify and manage obstetric complications, and weak referral system particularly inadequate ambulances, community factors include socio-cultural factors such as poverty, long distances to health facilities, poor road network and lack of community support. The challenges for low 1st ANC in the first trimester include: Myths and Misconceptions: Some misconceptions may discourage timely ANC visits; Distance to Health Facilities: Long distances hinder access to care; and poor Quality of ANC Services with low availability of supplies and equipment for ANC.

The decline in institutional deliveries points to barriers such as long distances, lack of privacy, and insufficient waiting shelters. Challenges include a weak referral system, inadequate ambulances and EmONC skills, poor supply chains of commodities and blood products, and limited resources and IEC support for people with disabilities. Additionally, inadequate infrastructure and equipment, and traditional beliefs negatively impact maternal and reproductive health outcomes

Summary for Maternal and Reproductive Health Performance

Zambia has made progress in reproductive and maternal health but remains off-track in achieving the 2026 targets. Maternal mortality has declined but at a slower pace, requiring a 64% acceleration in efforts to reach the target of 100 per 100,000 live births. Family planning has seen moderate improvements, yet contraceptive use among married and unmarried women remains below target, with disparities among provinces. Maternal health indicators such as antenatal care (ANC) visits, syphilis screening, and skilled birth attendance show mixed progress, with some areas making strides while others lag. Alarming, abortion complications have increased rather than decreased. Challenges such as poor infrastructure, weak referral systems, commodity stockouts, and socio-cultural barriers continue to hinder progress. Despite partial progress in strengthening Emergency Obstetric and Neonatal Care (EmONC), further efforts are required to ensure access to Reproductive health services.

Key Recommendations

1. Accelerate Maternal Mortality Reduction by implementing evidence-based strategies, such as using EMOTIVE bundle (early detection of PPH through a calibrated drape for blood loss measurement, and then provides a treatment package including uterine massage, oxytocic drugs, tranexamic acid, intravenous fluids, and examination and escalation), and improving blood product supply chains with strong referral system to enhance emergency obstetric care.
2. Improve Access and Quality of Maternal Health Services by strengthening referral systems through increased ambulance availability, addressing shortages of essential ANC and EmONC supplies, including diagnostic kits and medications, and enhancing antenatal care quality through better staffing, training, and equipment.
3. Enhance Family Planning and Contraceptive Access by expanding youth-friendly services and targeted programs for marginalized populations, reinforcing supply chains for contraceptives, and intensifying awareness campaigns to dispel myths and misconceptions about contraception.
4. Expand Health Infrastructure and Transportation by utilizing constituency development funds (CDF) to enhance road networks and health facilities, increasing waiting shelters for expectant mothers in rural areas, and expanding maternity wards and other healthcare infrastructure in high-burden districts.
5. Overcome Barriers to Skilled Birth Attendance by improving privacy and service quality at health facilities to encourage institutional deliveries, scaling up Respectful Maternity Care (RMC) programs for patient-centered care, and increasing midwife training and deployment in underserved regions.
6. Strengthen Abortion and Post-Abortion Care by fully implementing Comprehensive Abortion Care (CAC) guidelines and training, enhancing infection prevention measures in post-abortion care, and advocating for legal and policy reforms to expand access to safe abortion services.

3.2.2 Neonatal health

From the NHSP 2022-2026, the country set out to reduce neonatal mortality rate from 27 to 12 per 1000 live births between 2021 and 2026. Likewise, the country plans to reduce under five Mortality

from 61/1000 live births to 25/1000 live births by 2026. To achieve the above goals, five neonatal health and three child health strategic objectives were designed for implementation in the NHSP 2022-2026. The neonatal health objectives are focused towards increasing the number of newborns receiving PNC within 48 hours, reducing incidence of neonatal deaths due to prematurity, asphyxia, and sepsis, and improving quality of in-hospital care for small and sick newborns. The child health strategies focus on increasing full immunization coverage of infants, improving availability of IMNCI trained staff in health facilities, and improving the implementation of Early Childhood Development Service.

Achievement Reported

For the 5 years preceding 2024 ZDHS, the NMR was estimated to be 17 per 1000 live births and makes the projected value for this indicator for 2026 as 8.7 per 1000 live births. This means the country is on track and is likely to surpass the target set by the NHSP provided that the current trends seen are sustained. (Table-5 below)

Table 5: Trend in Neonatal Mortality Rate per 1000 live births projected for 2015-2026. ZDHS 2018 and 2024

2015 (ZDHS 2018)	2021 (ZDHS 2024)	2022	2023	2024	2025	Projected for 2026	Target set for 2026
27	17	15.3	13.7	12.0	10.3	8.7	12
<i>N.B: The figures are the mid-points of five-year ZDHS periods, with trend analysis used to forecast the annual NMR. Thus, 2015 was referenced for ZDHS 2018, and 2021 for ZDHS 2024.</i>							

Source: ZDHS 2018 and 2024.

The baseline and target indicators established in this NHSP to measure cause-specific neonatal mortality are inaccurately defined. As these are not impact-level indicators, the baseline should reference data from 2021 rather than 2018. Furthermore, national reports on neonatal death causes do not reflect the outcome-level figures presented in the strategic plan. Instead, insights into the distribution of neonatal deaths by cause can be effectively derived from HMIS data or Perinatal Death Surveillance and Response (PDSR) data, which may also highlight shifts in the ranking of leading causes of neonatal mortality.

There is a notable difference in the reported trends of newborns receiving postnatal care within 48 hours. DHIS2 data shows a steady increase from 53% in 2021 to 66% in 2024, with a projected rise to 74% by 2026, falling short of the 80% target. In contrast, ZDHS data indicates higher coverage, increasing from 72% in 2017 to 85% in 2023, with projections reaching 91% by 2026, surpassing the 80% target. The variation suggests differences in data sources, methodologies, or regional disparities in service delivery. (Table 6 below)

Table 6: Trends in the proportion of Newborns receiving PNC within 48 hours of delivery.

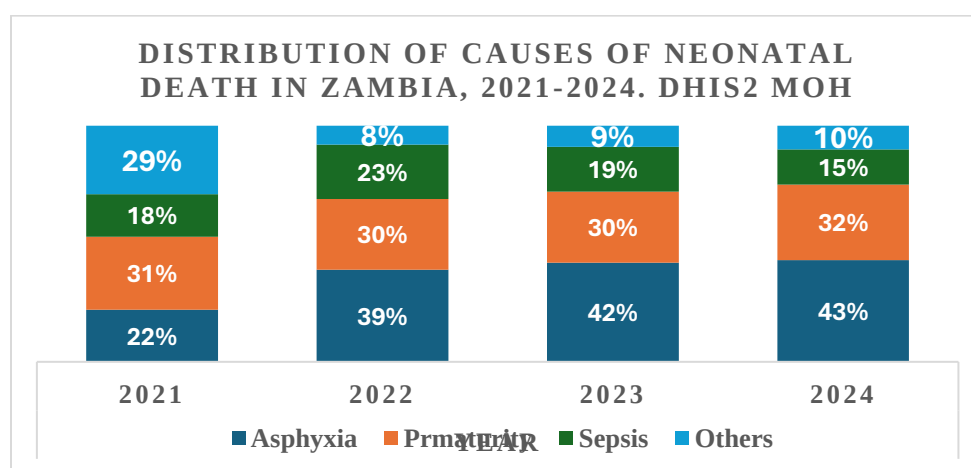
Proportion of new-borns receiving postnatal care within 48 hrs (2024 ZDHS and Projections)	2017 (ZDHS 2018)	2023 (ZDHS 2024)	Projection for 2024	Projection for 2026	2026 Target
	72%	85%	87%	91%	80%

Postnatal care within 48 hours after delivery (%), DHIS2	2021	2023	2024	Projection for 2026	2026 Target
	53%	63%	66%	74%	80%
<i>N.B: The ZDHS data were for the 2-years preceding the surveys and the mid-period is taken as a basis for trend projections. 2017 for ZDHS 2018, and 2023 for ZDHS 2024</i>					

Efforts to expand postnatal care (PNC) within 48 hours face financial challenges and limited partner support. Implementation remains low (21-40%) due to inadequate resources for service management, equipment, and training. Infrastructure expansion is minimal (1-20%) due to funding gaps and lack of targeted plans. However, PNC protocols and guidelines have progressed the most (61-80%) with strong partnerships. Weak data management, caused by the absence of regular review meetings, further hampers progress. Overall, financial constraints and weak partnerships continue to delay the 2026 target.

The distribution of neonatal death causes in the country from 2021 to 2024 shows notable trends. Asphyxia has been the leading cause, increasing steadily from 22% in 2021 to 43% in 2024. Prematurity remains a significant factor, fluctuating slightly but rising from 31% in 2021 to 32% in 2024. Sepsis, which accounted for 18% in 2021, initially increased to 23% in 2022 but declined to 15% by 2024 (DHIS2 MOH). These trends suggest a growing burden of asphyxia-related neonatal deaths, underscoring the need for targeted interventions in birth management and neonatal care. (Figure 8)

Figure 8: The distribution of causes of neonatal deaths in Zambia, 2021-2024



Source: DHIS2 MOH.

Efforts to reduce neonatal deaths due to prematurity remain limited, mainly due to financial constraints and insufficient partner support. Challenges include inadequate newborn care, neonatal resuscitation, and Kangaroo Mother Care, along with supply chain issues affecting access to essential equipment and surfactant. A shortage of skilled personnel further weakens antenatal, intrapartum, and postnatal care services, while infection prevention and hospital sanitation efforts struggle due to resource shortages.

Similarly, progress in reducing deaths from birth asphyxia has been slow, with limited implementation of community sensitization on ANC attendance, hospital delivery, and postnatal care. While neonatal resuscitation training and essential newborn care have made moderate

progress, intrapartum management and postnatal care remain underfunded. Critical drugs and equipment, such as resuscitators and oxygen, are also in short supply, further hindering effective intervention.

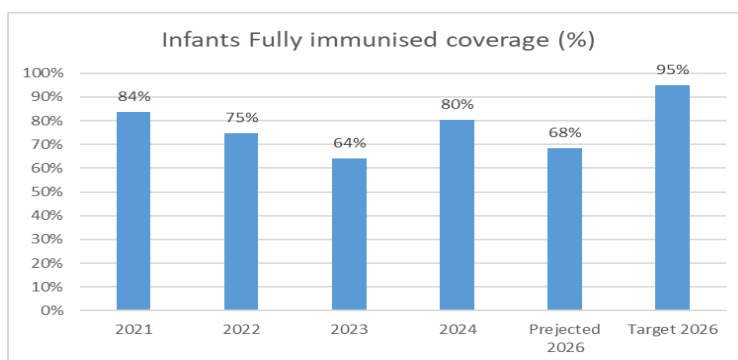
Sepsis related neonatal deaths also persist due to financial challenges and weak partner support. Many health facilities lack essential drugs, equipment, and infection prevention supplies. Screening and treatment of maternal infections have improved but still require more investment. Additionally, inadequate supervision and training limit the effectiveness of infection control measures like fumigation and swabbing in maternity wards.

Interventions to improve hospital care for small and sick newborns remain largely under implemented due to financial and logistical challenges. Referral systems are weak due to a lack of paediatric-designated ambulances, while NICU construction in districts is minimal, hindered by funding shortages and the absence of standard plans. Capacity building for neonatologists and neonatal nurses has made some progress but remains constrained by limited resources and partner support. Procurement of essential neonatal equipment and drugs is also insufficient, further limiting quality care delivery.

3.2.3 Child health

The data reveals a fluctuating trend in immunization coverage for children under 1 year old, with a notable decline from 84% in 2021 to 64% in 2023. Although coverage improved to 80% in 2024, the projected rate for 2026 is still only 68%, falling short of the ambitious 95% target (DHSI2 MOH). To meet this goal, significant efforts will be needed to address gaps and ensure near-universal immunization coverage. (Figure 9 below)

Figure 9: Full immunization coverage of infants, 2021-2026.



Source. DHIS 2, MOH

Interventions to improve full immunization coverage for children under one year show varying levels of progress. Cold chain capacity for vaccine storage and quality improvement initiatives in immunization have seen significant advancement. Data management and Supplemental Immunization Activities (SIAs) are well-established, supporting efficiency in tracking and coverage expansion. However, integrated outreach services, capacity building for community health workers, and the promotion of the reach every district/child (RED/C) strategy remain underdeveloped, indicating gaps in service delivery and community engagement. Strengthening these weaker areas is essential for achieving higher immunization rates.

Efforts to increase the number of health facilities with adequately trained staff in IMNCI have made slow progress, reaching only modest improvement since 2018. Limited funding and minimal partner support have hindered the scaling up of capacity-building activities in districts, slowing the achievement of the 80% target 2026. Strengthening financial investment and collaboration is crucial to accelerating training and improving IMNCI coverage.

Progress in expanding Early Childhood Development (ECD) services remains slow due to financial constraints and limited partner support. Capacity building for healthcare providers, availability of tools, and space for ECD services are significantly under-implemented. Nutrition support, childhood illness screening, and immunization efforts also face setbacks due to inadequate skilled personnel and funding. The provision of a baby-friendly environment for brain development and emergency triage services remains minimal. Strengthening financial investment and workforce capacity is essential to achieving the 2026 target to cover at least 50% of all service provision sites with ECD services.

Some key challenges reported in the neonatal and child health strategies areas include:

- Poorly defined newborn outcome indicators make it difficult to track progress and assess implementation effectiveness.
- Financial constraints, inadequate service management, and weak partner support hinder efforts to expand postnatal care within 48 hours.
- Neonatal mortality remains high due to asphyxia, prematurity, and sepsis, yet key interventions like neonatal resuscitation, Kangaroo Mother Care, and antenatal services face financial and personnel shortages. Sepsis-related deaths persist due to inadequate drug availability, weak infection control measures, and limited maternal screening.
- Infrastructure expansion, including NICUs and referral systems, remains minimal due to insufficient investment and a lack of paediatric-designated ambulances.
- Supply chain issues further limit access to critical newborn care essentials such as resuscitators, surfactant, oxygen, and infection prevention supplies.
- A shortage of trained healthcare workers further reduces intervention effectiveness, while underfunded capacity-building programs limit skill development for neonatologists, neonatal nurses, and maternal health providers.
- Prolonged unavailability of the Rota vaccine due to global supply constraints and the transition from a two-dose to a three-dose regimen led to missed vaccination opportunities, affecting overall immunization coverage, especially for children who were not vaccinated at the appropriate age.

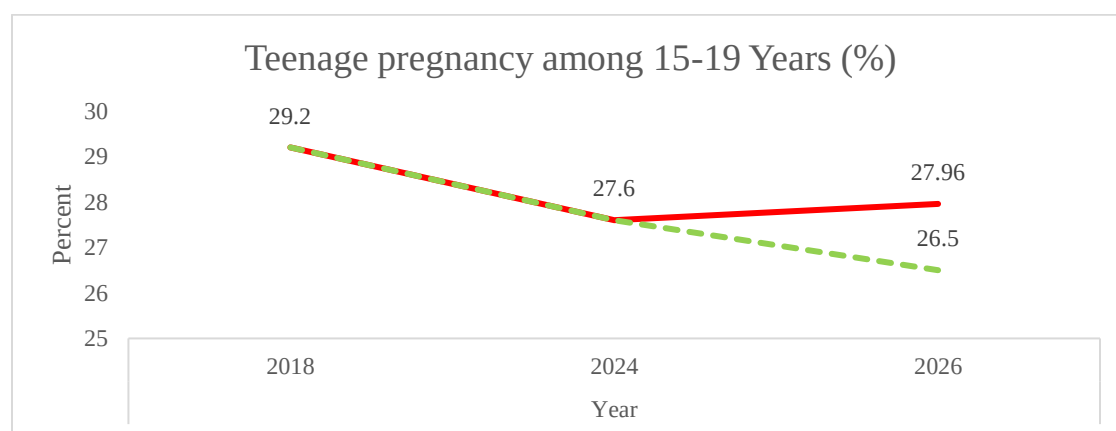
3.2.4 Adolescent health

From the NHSP 2022-2026, the country aims to create standardized adolescent health service platforms by developing systems and enhancing capacities to ensure the delivery of high-quality, comprehensive, and adolescent-friendly services at all levels. This is to be achieved by ensuring that all districts have the capacity to provide a minimum adolescent health service platform. Additionally, efforts focus on raising awareness and encouraging greater utilization of available health services among adolescents across all districts. The country also seeks to improve accessibility to adolescent health services for young people with special needs, ensuring inclusive and equitable healthcare for all.

Achievements Reported

Although teenage pregnancy is a key indicator of adolescent health and a major challenge in Zambia, it was not established as a baseline or target in the NHSP. Instead, the NHSP's adolescent health strategic objectives are measured using process indicators, which make tracking progress difficult. To address this, the teenage pregnancy rate among girls aged 15-19 was used as a key progress indicator, showing a decline from 29.2% in 2018 to 27.6% in 2024 (ZDHS 2024). However, instead of continuing to decrease, the rate is projected to rise slightly to 27.96% by 2026, deviating from the expected decline to 26.5%. This highlights a potential challenge in sustaining progress toward reducing teenage pregnancy rates.

Figure 10: Trends in teenage pregnancy among adolescent girls, 2018-2026. ZDHS 2024 and 2026 projection



In 2024, 71% of districts had the capacity to provide a minimum adolescent health service platform, up from 60% (Program data, updated Jan 2025). This initiative made limited progress. Integration of adolescent-responsive health services is 20%-40% complete, with ongoing HEADSS-based training, though infrastructure challenges persist. Training for healthcare workers and peer educators is at a similar stage, with in-service training advancing, but pre-service medical curricula still lacking adolescent health. Outreach programs to schools and communities show 41%-60% progress, with activities continuing in districts.

Progress is being made in increasing adolescent awareness and use of health services to 100%, with 41%-60% completion for SBCC platforms and peer education, outreach, and multimedia initiatives, all of which are ongoing. However, efforts to drive cultural and behavioural change remain limited (20%-40%), as implementation is currently on hold, awaiting engagement with community-based implementers. However, it is noted that comprehensive HIV knowledge among adolescents and young people increased from 39% to 42.5% (ZDHS 2024).

Efforts to improve adolescent health service accessibility for young people with special needs have seen insignificant progress (1-20%) due to a lack of targeted funding. Training healthcare workers in sign language and developing IEC materials in braille remain unfunded, as these interventions extend beyond the ADH program.

Challenges in Adolescent Health

In general, the strategic objectives are not well aligned to the major problems in adolescent health, such as teenage pregnancy, HIV/STI, mental health and other risky behaviours (Alcohol and

substance abuse). Besides, the indicators for the outcome measures are not properly set during planning.

Progress in expanding districts' capacity to provide adolescent health services has been slow, mainly due to inadequate infrastructure for adolescent-friendly spaces and the absence of adolescent health topics in the pre-service medical curriculum. Limited funding also hampers in-service capacity building and disability-inclusive interventions. Furthermore, efforts to promote behavioural and cultural changes for better adolescent health receive little support from stakeholders, including community-based implementers.

The rise in adolescent pregnancy was likely driven by a complex mix of social, economic, cultural, and educational factors. Many adolescents, both in and out of school, may lack the necessary knowledge and life skills to make informed decisions about their sexual health. Poverty can also contribute, sometimes leading to child marriages perceived as a financial relief. Additionally, open discussions about sexuality between parents and adolescents are often absent, while limited access to sexual and reproductive health services further restricts the availability of contraception and other essential resources.

Key recommendations

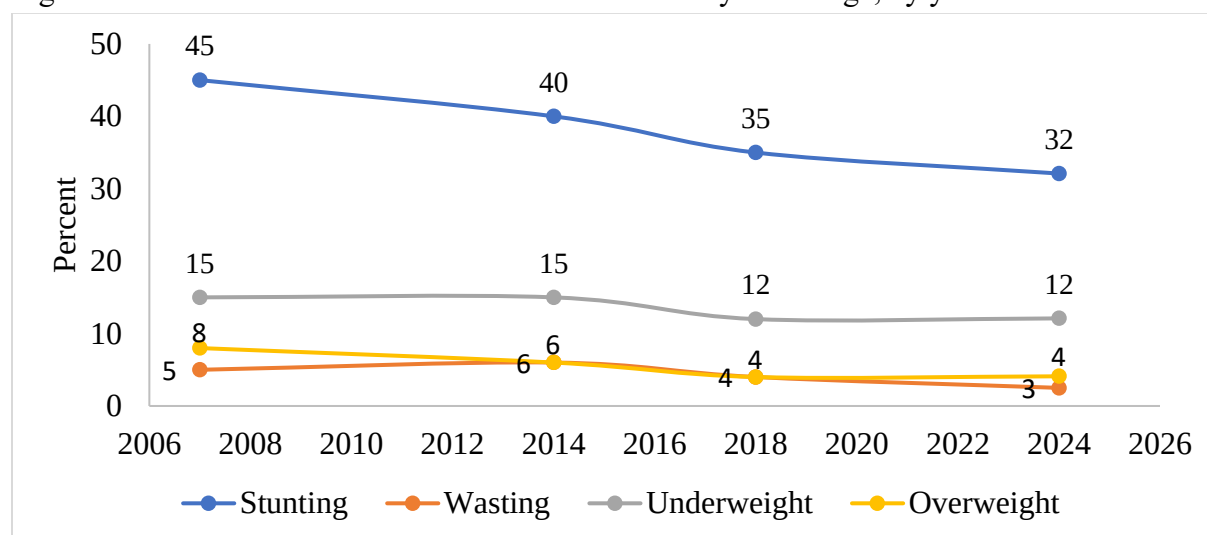
1. Policy & Strategic Alignment – Align NHSP objectives with key adolescent health challenges (teenage pregnancy, HIV/STIs, mental health, and substance abuse) and establish clear outcome-based indicators.
2. Expand adolescent-friendly infrastructure, integrate adolescent health into pre-service medical training, and secure funding for in-service training, especially for disability-inclusive services.
3. Strengthening sexuality education, promote parent-adolescent communication, and increase access to contraceptives in schools and communities.
4. Implement economic empowerment programs to prevent child marriage and engage community leaders in promoting positive health behaviours.
5. Strengthen partnerships with local implementers and resume stalled community engagement programs, particularly for risk reduction.
6. Expand SBCC platforms (radio, TV, social media) and improve outreach to schools and underserved communities.
7. Advocate for increased government and donor funding, particularly for disability-inclusive health services, and develop a sustainable financing plan.

3.2.5 Nutrition

The NHSSP 2022-2-26 outlined a goal to improve the nutritional status of the population, with a particular focus on children, adolescents, and women of childbearing age, in alignment with the Global Nutrition Targets 2030. The nutrition-related SDG targets, specifically Target 2.2 under Goal 2, aim to end all forms of malnutrition, including stunting and wasting in children under 5 years of age. This implies that by 2030, there should be no malnourished children in Zambia.

The 2013/2014 Zambia Demographic and Health Survey reported a stunting rate of 40% and a wasting rate of 6% among children under five years of age. This implies that by 2025, Zambia should reduce the stunting rate to approximately 16% and the wasting rate to below 5%.

Figure 11: Rates of Malnutrition in children under five years of age, by year



Data Source: ZDHS, 2024

Stunting, wasting, underweight, and overweight:

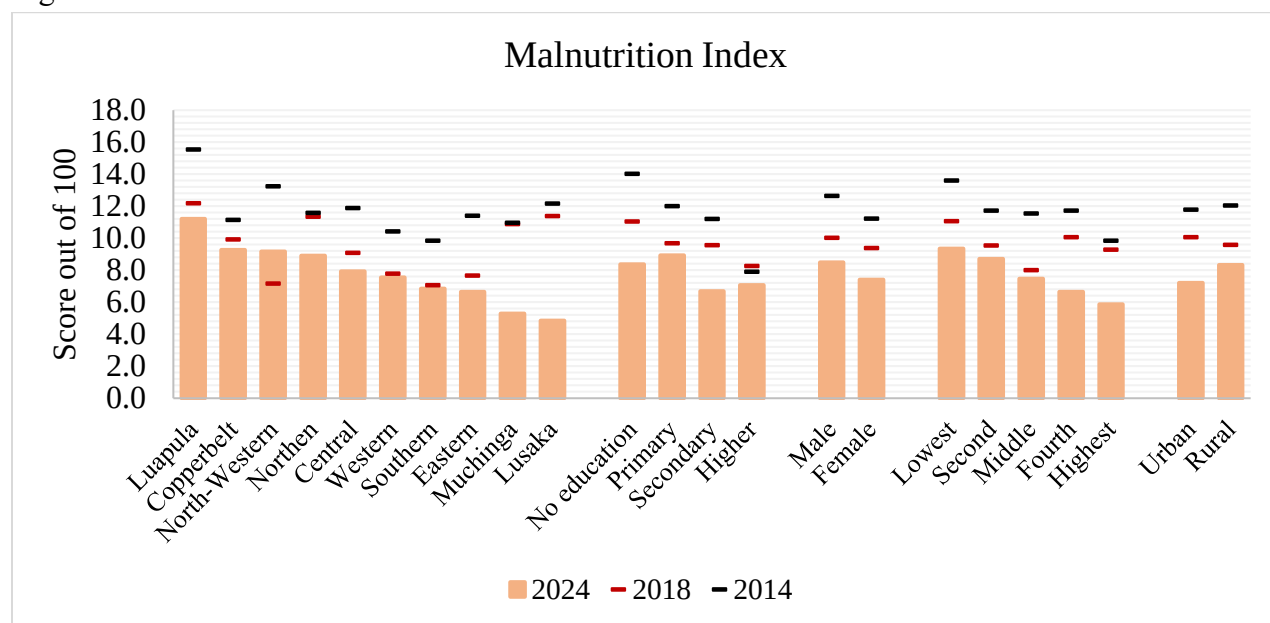
As shown in Figure 11 above, Zambia has made significant progress in reducing the wasting rate among children under five years of age, with the 2024 Zambia Demographic and Health Survey reporting a wasting rate of 3%. This brings the country closer to the goal of eliminating wasting among children under five by 2030. Projections indicate that if the current rate of reduction observed in the last three Demographic and Health Surveys continues, Zambia's wasting rate will be around 1% by 2030. However, Zambia is not on track to meet the 2025 and 2030 global targets for stunting. The stunting rate reported in the 2024 Demographic and Health Survey was 32%, which is twice the target of 16% for 2025. If the current rate of reduction observed in the recent Demographic and Health Surveys continues, the stunting rate in Zambia is projected to be around 27%, which remains alarmingly high.

A significant proportion of children under the age of five in Zambia are underweight, with 12% of them identified as underweight in both the 2018 and 2024 Demographic and Health Surveys (Figure 11 above). Meanwhile, a smaller proportion of children are overweight, with 4% identified as overweight in both surveys.

Distribution of the problem

There are significant inequalities in the rates of malnutrition across provinces, urban-rural residence, maternal education levels, and wealth quintiles (Figure 12 below). Over the past 10 years, malnutrition rates have consistently been higher in Luapula and North-Western Provinces compared to other regions in Zambia. In general, malnutrition rates in Zambia increase as the wealth and education levels of the mother decrease. Additionally, malnutrition rates are higher in urban areas than in rural ones, and slightly higher among male children compared to female children.

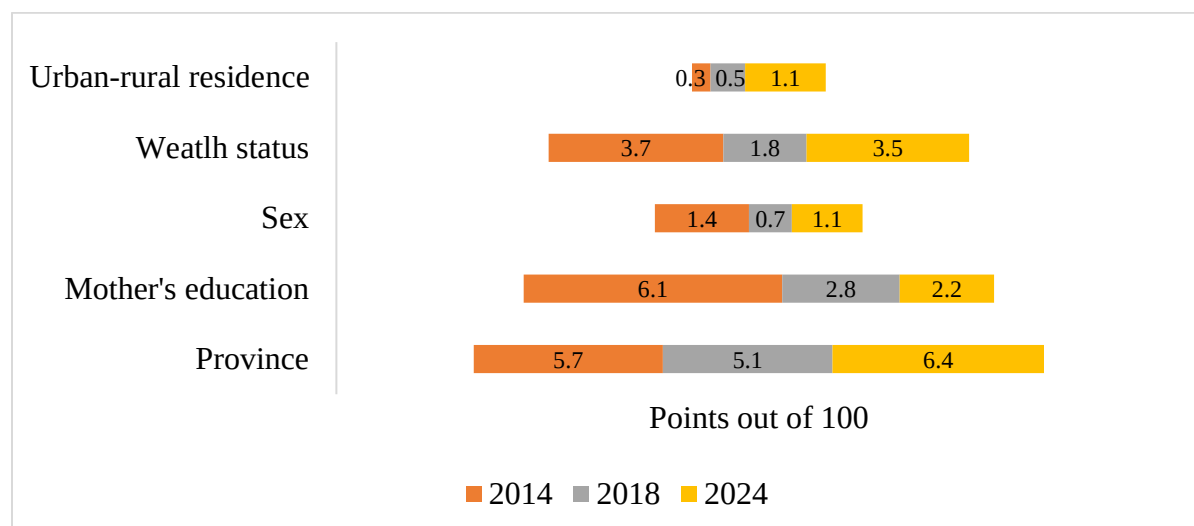
Figure 12: The Malnutrition Index



The index has been calculated as the geometric mean of the malnutrition rates for stunting, wasting, underweight, and overweight.

Over time, the inequality gaps have generally not narrowed as anticipated. For example, the gap between the province with the highest and the province with the lowest malnutrition index has actually widened, increasing from 5.7 points (out of 100 points) in the 2013-14 ZDHS to 6.4 points (out of 100 points) in the 2024 ZDHS (Figure 13 below). A similar widening of the inequality gap is also evident between urban and rural areas. The gap in inequality based on mother's education significantly decreased from 6.1 points (out of 100) in the 2014 ZDHS to 2.2 points in 2024.

Figure 13: Absolute Gap in Malnutrition Rate, by Key Equity Stratifiers

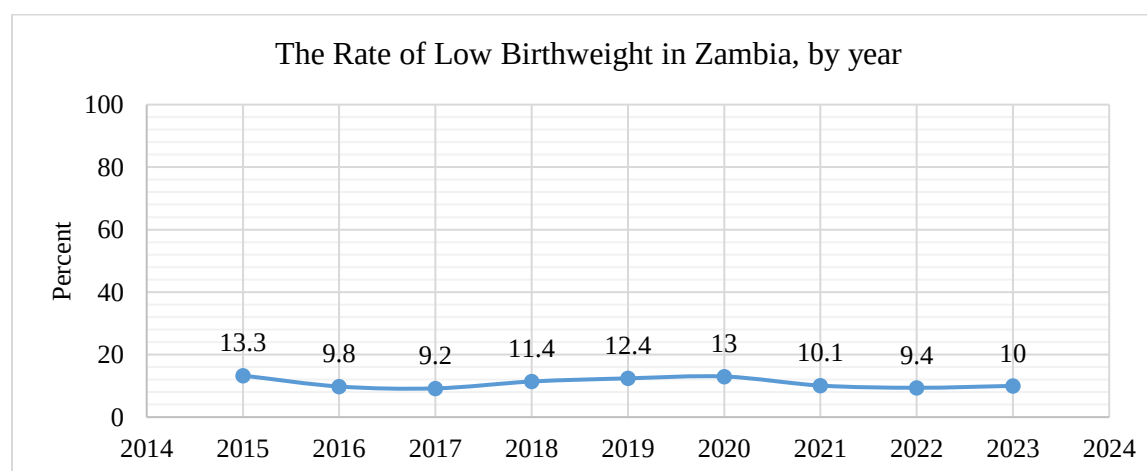


Data Source: ZDHS, 2024

Low birthweight:

While there is no specific SDG target solely for low birthweight, it is closely linked to nutrition, maternal health, and child mortality. From 2015 to 2023, Zambia has experienced fluctuations in the percentage of low birthweight births (Figure 14 below). Although the percentage increased between 2017 and 2020, there has been a decline in recent years (2021-2023), showing some positive trends in improving birth outcomes. However, further efforts are needed to continue reducing low birthweight rates. Addressing issues like maternal undernutrition, improving prenatal care, and ensuring access to reproductive health services are all strategies that indirectly support the reduction of low birthweight, contributing to the broader SDG goals of improving health outcomes for mothers and children.

Figure 14: Trends in the Rate of Low Birthweight in Zambia

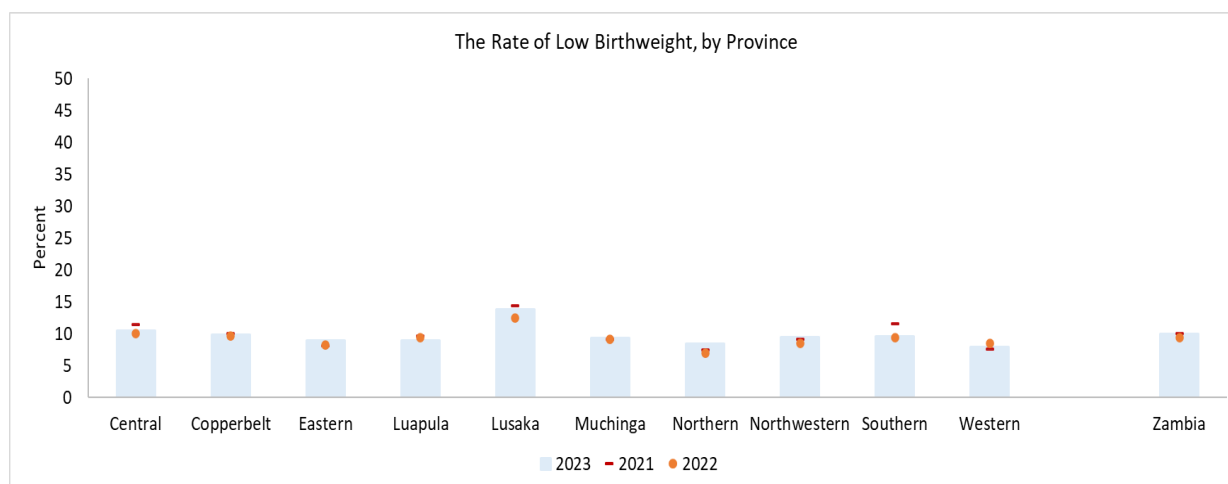


Data Source: WHO, 2025

The differences in low birthweight rates between provinces are generally modest, with the gap between the province with the highest and the province with the lowest low birthweight decreasing

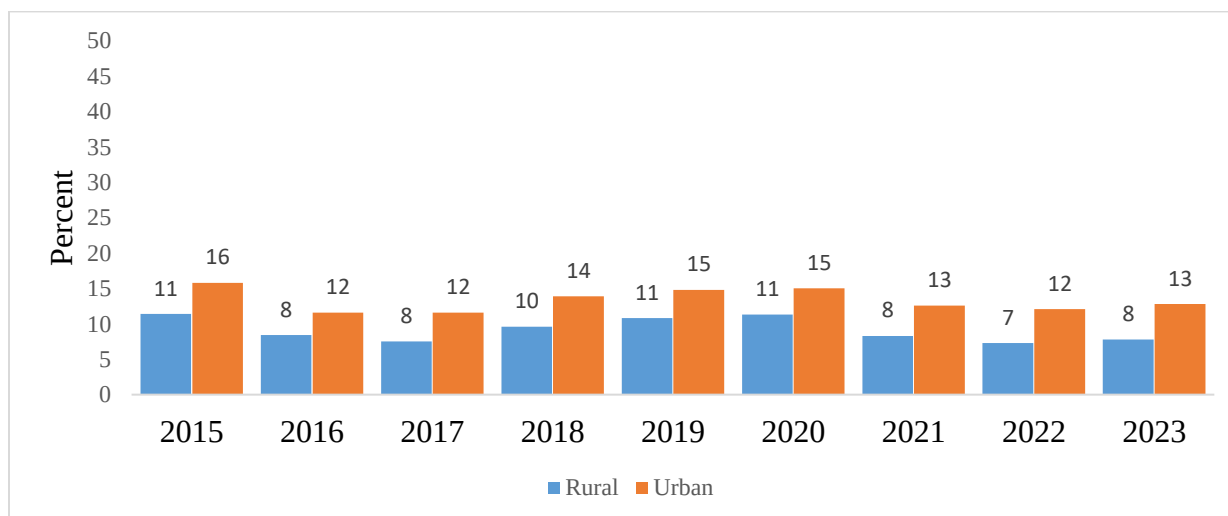
from 9% in 2018 to 6% in 2023. In 2023, Lusaka Province had a higher rate of low birthweight compared to the rest of the country.

Figure 15: Rate of Low Birthweight, by Province



Surprisingly, however, low birthweight in Zambia is higher in urban than in rural areas. The low birthweight rate in urban areas during the 2021-2023 period is roughly twice as high as the rate in rural areas.

Figure 16: The Rate of Low Birthweight, by Urban-Rural Residence



Challenges Reported in the Nutrition Program

Malnutrition management in Zambia faces several critical challenges, including inadequate resources, weak community support, and inconsistent supplies.

1. **Limited Monitoring and Assessment Tools** – Many districts, especially those without partner support, lack essential anthropometric equipment such as scales, height boards, and MUAC tapes, affecting accurate nutrition assessments.

2. Weak Community-Based Support – A shortage of trained volunteers due to inadequate incentives, unclear succession plans, and insufficient refresher training undermines local nutrition interventions.
3. Erratic Commodity Supplies – Frequent stockouts of iron and folate supplements and therapeutic supplies (RUTF, F75, F100, RESOMAL, CMV) in non-partner-supported districts force reliance on non-recommended alternatives.
4. Poor Infant and Young Child Feeding (IYCF) Practices – Food insecurity and urban poverty negatively impact complementary feeding for children aged 6–24 months.
5. Limited Anaemia Management Strategies – The absence of effective interventions, such as food supplementation and home-based fortification, contributes to persistently high anaemia rates in children.
6. Lack of Nutrition Guidelines for Special Populations – The absence of tailored guidelines leaves vulnerable groups without adequate nutritional support.
7. Irregular Supply of Data Collection Tools – Frequent shortages of under-5 cards and child health registers hinder accurate data collection, leading to the use of makeshift records.

Key Recommendations

1. Enhance Resource Availability – Equip districts with essential anthropometric tools to improve nutrition assessments, especially in underserved areas.
2. Strengthen Community Support – Improve volunteer retention through incentives, clear succession plans, and regular refresher training to sustain local interventions.
3. Ensure Stable Supply Chains – Strengthen procurement and distribution systems to prevent stockouts of essential nutrition commodities and therapeutic supplies.
4. Improve Infant and Young Child Feeding (IYCF) Practices – Address food insecurity through targeted support programs and nutrition education for mothers.
5. Expand Anaemia Management Strategies – Implement effective interventions such as food supplementation and home-based fortification to reduce childhood anaemia.
6. Develop Nutrition Guidelines for Special Populations – Create tailored guidelines to ensure adequate nutritional support for vulnerable groups.
7. Standardize Data Collection – Ensure a consistent supply of under-5 cards and child health registers to improve data accuracy and monitoring.

3.3 Communicable diseases

Table 7 below provides a summary of performance against targets for all key priority indicators outlined in the NHSP under this strategic area.

Table 7: Summary of Performance Against Targets for Indicators for Communicable Diseases

Indicator	Performance Against Target	Colour Code
Comprehensive HIV knowledge in adolescents and young people	76.3	
Coverage of ART for those living with HIV	100	
Deaths attributed to Malaria per 100,000 population	100	
Hepatitis B Incidence per 100,000 population	66.08	

Indicator	Performance Against Target	Colour Code
Integrate NCD services in ART services	-	
Malaria Incidence per 1,000 population	86.29	
MTCT rate	100	
Percentage of eligible population receiving advanced HIV disease package of care	-	
Percentage of people living with HI V who know their HIV status	100	
Percentage of the HIV children who receive lifelong ART	100	
Percentage of the people living with HIV on ART with suppressed viral	99.49	
Proportion of Grade 2 disability of Leprosy	43.27	
TB case detection rate (DS TB)	100	
TB treatment success rate	98.71	
Treatment success rate for Drug Resistant (DR) TB	97.56	
Uptake of PrEP in priority and key populations	100	
VMCC coverage	92.63	

Green means target achieved, **yellow** means positive progress, while **red** shows that target is unlikely to be achieved, unless some course corrections are undertaken. **Black** shows no data.

3.3.1 Malaria control program

Malaria remains a high priority area of concern in the country. The main goal in the NHSSP 2022-2026 was to reduce malaria infection, disease and death in Zambia by 2026. Two objectives were outlined for this strategic area:

The first objective under this strategic area of the NHSSP is to reduce malaria incidence from 340 cases per 1,000 population in 2021 to 201 cases per 1,000 population by 2026. This goal implies that by the midpoint of the plan in 2024, the malaria incidence should be approximately 263 cases per 1,000 population. To achieve this reduction, two (2) strategic objectives were set, including implementing High impact interventions; vector control (IRS, LLINS, LSM), SBC and enhanced Surveillance at all levels.

Achievements

The National Malaria programme has developed a robust system for routine and periodic data collection, including the rolling out of DHIS2 to all districts and expanded the community surveillance system to complement the national HMIS in 107 Districts. According to the midterm review report (2024), timeliness of reporting increased from 68% in 2021 to 91% in 2023. The Program has also rolled out web-based scorecard that tracks malaria indicators and programme implementation. The establishment of the multisectoral End Malaria Council (EMC) and End Malaria Fund (EMF) has helped to expand political commitment, ownership, and domestic resource mobilization. Despite this progress the country has some challenges.

According to the 2024 HMIS report malaria incidence was at 304.8 per 1000 population [CI: 275.1 – 334.5], reflecting a 10.35% increase from the baseline. This rise in cases is primarily due to the incomplete implementation of IRS due to drought response and the 2023/2024 cholera outbreaks

which caused diversion of resources from malaria control efforts. Additionally, inconsistent use of ITNs, reluctance to seek treatment, and preference for traditional remedies may have contributed to rising cases.

Zambia is still slightly off track to meet both the 2026 target for malaria incidence reduction to 201 cases in the strategic plan and the 2030 SDG target 3.3, aiming to end malaria epidemics by 2030. At the current rate of increase, projections indicate that the malaria incidence will be at 281.3 cases in 2026 and 234.4 cases in 2030.

The rise in malaria incidence could be attributed to several factors including sub-optimal utilisation of vector control interventions, such as low utilisation of ITNs. According to the Malaria Indicator Survey (MIS 2024) 59.1% of all households used an ITN (use defined as having slept under an ITN the night before the Survey). Several factors contribute to the slower-than-expected pace. The Midterm review (MTR 2024) for the malaria programme reported delayed procurement of malaria commodities. The MTR 2024 report also highlighted stockouts of malaria commodities as a major bottle neck, including stockouts of Rapid Diagnostic tests (RDTs) artemether lumefantrine (AL), injectable artesunate and Sulphadoxine pyrimethamine used for malaria prevention during pregnancy. Additionally, the national and provincial level requires strengthening of appropriately skilled human resources needed to support implementation of the NMESP. The negative effects of climate change could also have supported high malaria vector densities (Source: malaria MTR 2024). This could have promoted increased malaria transmission

To reach the malaria incidence target, Zambia will need to reduce the malaria incidence by 11.4% annually (27 cases per 1,000 population per year from 2023 onward). Achieving this will require a more aggressive reduction strategy is needed, requiring faster implementation of malaria control measures such as enhanced case management, vector control (IRS, ITNs), improved surveillance, and community engagement.

The second objective under the malaria interventions of the NHSSP is to reduce malaria deaths from 8 deaths per 100,000 population in 2021 to 4.7 deaths per 100,000 population by 2026. This goal implies that by the midpoint of the plan in 2024, the malaria incidence should be approximately 6 deaths per 100,000 population. To accomplish this goal, the strategic intervention focused on strengthening case management at both facility and community levels.

Achievements Reported

According to the 2023 Annual Progress report malaria deaths were at 6 per 100,000 population [CI: 4.48 - 7.52] reflecting a 25% decrease from the baseline year. This decrease in malaria deaths can largely be attributed to improved case management through early diagnosis, prompt treatment with artemisinin-based combination therapies (ACTs), and the expansion of community health worker programs. Strengthened vector control measures, including widespread distribution of insecticide-treated nets (ITNs), indoor residual spraying (IRS), and environmental management, have significantly reduced mosquito populations. Increased public awareness campaigns have improved preventive behaviours, while enhanced surveillance systems have enabled early outbreak detection and targeted interventions. Additionally, improved healthcare infrastructure, better access to treatment, and sustained funding from governments and global health organizations have played a crucial role in reducing malaria mortality.

According to Zambia's "Vision 2030," aiming to achieve "malaria elimination" by 2030, which includes reducing malaria deaths to less than five per 100,000 people through strategies like

increased insecticide-treated bed net usage and indoor residual spraying; aligning with the global Sustainable Development Goals to end malaria epidemics by 2030.

At the current rate of increase, projections indicate that the malaria deaths will be at 4.7 deaths in 2026 and 2 deaths in 2030, meaning the program is on course to attaining their target.

To continue reducing malaria deaths and improving case management, interventions should focus on strengthening vector control through IRS, ITNs / LLINs distribution, community engagement & BCC, environmental management; early diagnosis through availability of rapid diagnostic tests (RDTs) and microscopy; effective treatment by ensuring adequate supply of antimalarial drugs (ACTs); and improved healthcare access in hard-to-reach areas.

3.3.2 HIV, Hepatitis and STIs Programs

Zambia's NHSP aligns with global HIV response efforts, aiming to achieve the 95-95-95 UNAIDS targets, where 95% of people living with HIV know their status, 95% of those diagnosed receive sustained treatment, and 95% of those on treatment achieve viral suppression. With current progress, the program is on track to achieving its 2026 target and accelerating efforts toward HIV epidemic control by 2030.

One of the primary goals under communicable diseases is to reduce the HIV incidence from 28,000 in 2021 to 15,000 by 2026. To achieve this, 11 Objectives were set out in the NHSP 2022-2026.

The first objective under HIV/AIDS control is to increase the percentage of people living with HIV who know their HIV status from 89% in 2021 to 95% in 2026. Achieving this goal is crucial to ensuring that those diagnosed with HIV can access treatment services, ultimately contributing to a reduction in new infections.

Achievements

Based on the baseline and target, an annual increase of 1.2% was expected, implying that by the midpoint of the plan in 2024, the percentage of people living with HIV who knew their status should have reached approximately 92.5%. However, according to the 2024 Spectrum File, the percentage of people aware of their HIV status had already reached 94.5%, surpassing the projected target. This success can largely be attributed to the implementation of various high-impact interventions, including:

- i. Strengthening universal HIV testing at all points of health service delivery.
- ii. Expanding targeted HIV testing through innovative approaches, such as self-testing for key and priority populations, including adolescents and young people.
- iii. Scaling up Index Testing, including Index Partner Testing/ Partner Notification services.
- iv. Enhancing peer and social network testing for key populations, hard-to-reach men, hotspots, at home, and safe spaces.
- v. Promoting workplace HIV testing, including the integration of self-testing options.

The second objective aimed to increase the percentage of children living with HIV who know their status and receive lifelong antiretroviral therapy (ART) from 72% in 2021 to 90% in 2026. Ensuring high ART coverage is essential in reducing new infections, as there is a strong correlation between ART coverage and viral load suppression, which in turn plays a critical role in preventing HIV transmission.

Achievements

Based on the annual target of 3.6%, the expected ART coverage for 2024 was 82.8%. However, according to the 2024 Spectrum File, the percentage of children living with HIV who had received lifelong ART had already reached 91.3%, surpassing the projected mid-point target.

This remarkable achievement can be attributed to the implementation of several key interventions, including:

- i. Expanding coverage of newer paediatric ARVs, including dolutegravir (DTG), to ensure 100% availability for the target populations.
- ii. Strengthening early HIV diagnosis and linkage to care through the "Know Your Child's HIV Status" initiative.
- iii. Introducing multi-month drug dispensation (MMD) to improve adherence and treatment continuity.

Zambia's NHSP aligns with global commitments to end AIDS in children, ensuring that all HIV-positive children receive timely and effective treatment. With current progress exceeding targets, the country is well on track to achieving its 2026 goal and advancing toward HIV epidemic control for children.

The third objective under HIV/AIDS control program planned to maintain and increase ART coverage for people living with HIV from 95% in 2021 to 96% by 2026. This goal implies that by the midpoint of the plan in 2024, ART coverage should be approximately 95.5%. To accomplish this goal, the strategic intervention focused on strengthening ART retention, patient tracking, and accessibility of treatment services.

Achievements

According to the 2024 DHIS2 and Spectrum report, ART coverage for people living with HIV reached 98%, surpassing the projected mid-point target of 95.5%. This achievement was largely attributed to the intervention strategies set including:

- i. Strengthen ART retention and follow up differentiated service delivery model (DSD).
- ii. Strengthen patient tracking and follow up systems through establishing the patient master register system.
- iii. Link the ART services to the National Health Insurance Management Authority (NHIMA)

Sustaining high ART coverage and ensuring treatment adherence are critical to achieving epidemic control. This aligns with global Sustainable Development Goals (SDGs), particularly SDG 3.3, which aims to end the AIDS epidemic by 2030.

At the current rate of progress, projections indicate that Zambia is on track to maintain and exceed its ART coverage targets, ensuring continued improvements in treatment outcomes. To sustain this success, interventions should focus on further strengthening ART retention through innovative DSD models, improving tracking systems for patient follow-up, expanding access to newer antiretroviral regimens, and enhancing financial protection for people living with HIV through NHIMA.

The fourth objective under HIV/AIDS control programme is to increase the percentage of people living with HIV on ART with suppressed viral load from 96% in 2021 to 98% by 2026. This goal

implies that by the midpoint of the plan in 2024, viral load suppression should be approximately 97.2%. To accomplish this goal, the strategic intervention focused on strengthening viral load monitoring and expanding access to suppression services.

Achievements

According to the 2024 HMIS, LIS, and Spectrum reports, 97.5% of people on ART were virally suppressed, slightly exceeding the mid-point target of 97.2%. This achievement was attributed to the establishment and strengthening of an electronic viral load monitoring system through improved interoperability of health information systems. Additionally, efforts to scale up viral load testing, particularly in areas with low coverage and suppression rates, contributed to this success.

Achieving and maintaining high levels of viral load suppression is critical for Zambia's goal of ending AIDS as a public health threat by 2030, in alignment with the Sustainable Development Goals (SDGs). Sustained suppression reduces HIV transmission, contributing to epidemic control. At the current rate of progress, projections indicate that the viral load suppression target of 98% in 2026 is attainable.

To further improve viral load suppression, interventions should focus on strengthening electronic monitoring systems, expanding access to viral load testing, enhancing adherence support programs, and increasing targeted interventions in areas with low suppression rates.

The fifth objective under HIV/AIDS control is to scale up the advanced HIV disease package or Care to 95% of all eligible populations by 2026.

Achievements

Various activities were undertaken by the program but there was no data to measure the progress made. Some of the activities which were implemented included establishing intensive Advanced HIV mentorships across the country in all 116 districts in Zambia and strengthening monitoring, using the Tele-ECHO for mentoring and guidelines dissemination. Another key intervention included strengthening the screening through training of health workers in all districts.

The sixth objective was to Integrate NCD services in ARI services to 60% of all people on ART by 2026. The program did not have available indicators to measure. However, the program implemented the following interventions:

- i. Operationalize NCD/ART integration guidelines.
- ii. Streamline for the provision of NCD services input in ART service points.
- iii. Use the Tele -ECHO for mentoring and guidelines dissemination.

The seventh objective was to reduce the Mother-to-Child Transmission (MTCT) rate from 8% in 2022 to $\leq 5\%$ by 2026. This goal required an annual reduction of 0.6%, with a mid-point target of 6.2% in 2024.

Achievements

According to the 2024 Spectrum file, the MTCT rate was successfully reduced to 4.42%, surpassing the midpoint target. This achievement was driven by key interventions, including increasing population-based antenatal care first-visit attendance (ANC-1) to 95% or more, ensuring at least 95% of pregnant women were tested for HIV, and expanding maternal ART coverage to at least 95%.

Reducing MTCT is critical for achieving Zambia's goal of eliminating paediatric HIV and aligns with global targets to end AIDS in children by 2030.

At the current rate of progress, projections indicate that the 2026 target of $\leq 5\%$ is on track to be met.

To sustain and further improve progress, interventions should focus on maintaining high ANC-1 attendance, strengthening routine HIV testing for pregnant women, ensuring universal maternal ART coverage, and enhancing follow-up care for HIV-exposed infants.

The eighth objective aimed at promoting comprehensive HIV knowledge among adolescents and young people was to increase awareness from 39% in 2021 to 95% by 2026. By the mid-term review, survey results from the Zambia Demographic and Health Survey were not yet available to assess progress.

Achievements

Several interventions were implemented to enhance HIV knowledge and awareness. These included reinforcing protective sexual behaviours by addressing knowledge gaps, shaping positive attitudes, building essential skills, and influencing social norms to support informed decision-making among adolescents and young people. Strengthening these efforts is crucial to achieving the 2026 target and ensuring sustained impact in HIV prevention among young populations.

The ninth objective under the HIV prevention program was to increase the coverage of Voluntary Medical Male Circumcision (VMMC) among males aged 15-49 years, with a particular focus on the 15-29 age group, to 95% by 2026. This intervention was designed to contribute to the reduction of new HIV infections.

Achievements

By the midpoint of the strategic plan in 2024, the program aimed to achieve significant progress toward this target. According to the DHIS2, 88% of males had undergone circumcision by 2024, indicating positive progress. This achievement was driven by several key interventions, including expanding the existing capacity to provide comprehensive VMMC services through innovative and sustainable service delivery models. Additionally, efforts were made to eliminate missed opportunities by integrating male circumcision services into other health programs at all levels of care.

To sustain progress and achieve the 2026 target, continued efforts should focus on increasing service accessibility, strengthening demand creation, and ensuring the integration of VMMC within broader HIV prevention strategies.

The tenth objective under the HIV prevention program was to increase the uptake of Pre-Exposure Prophylaxis (PrEP) among priority and key populations from 110,000 in 2021 to 220,000 annually by 2026. To achieve this target, the program aimed to increase the number of individuals initiated on PrEP by 22,000 each year.

Achievements

By the midpoint of the strategic plan in 2024, the target was to have 176,000 people initiated on PrEP. According to DHIS2, the program exceeded this target, with 247,049 individuals started on PrEP, demonstrating significant progress in scaling up HIV prevention efforts.

The success of this initiative can be attributed to key interventions, including the introduction of injectable PrEP, increased access to combination HIV prevention interventions, and efforts to promote equity in comprehensive HIV prevention services. Moving forward, the program should continue to enhance awareness, improve service accessibility, and strengthen demand creation to sustain and further accelerate progress.

The eleventh objective under HIV/AIDS was STI prevention and control program is to raise awareness of sexually transmitted infections (STIs) among the general population while ensuring targeted protection for key populations, including mobile, migrant, and internally displaced individuals at higher risk.

Achievements

Although the indicator was not being tracked during the period, the program has focused on increasing awareness creation and education on STIs, promoting preventive measures, and encouraging early diagnosis and treatment. Additionally, the rollout of updated STI guidelines has been a critical intervention to standardize case management, improve service delivery, and enhance the capacity of healthcare providers in STI prevention and treatment.

Moving forward, efforts should be intensified to track the program and continue expanding existing outreach programs, integrating STI services into existing health platforms, and strengthen partnerships to ensure comprehensive and inclusive STI prevention strategies.

3.3.3 Tuberculosis and leprosy control program

Tuberculosis Control

Tuberculosis is one of the leading causes of mortality in Zambia as well. To reduce the mortality associated with TB, the TB program implements various interventions aimed at reducing the mortality among the TB patients. Within the NHSSP 2022-2026, the TB control program set out a goal to reduce TB incidence from 319/100,000 in 2020 to 169/100,000 population by 2026. To achieve this, the program outlined various interventions.

Achievements Reported

On the target to increase case detection from 68% in 2020 to 86% by end of 2026, this indicator was not included in the M&E framework and was therefore not systematically tracked.

To improve TB case detection and ensure early diagnosis and treatment, the program has implemented several key strategies, including:

- i. Introduced and scaled up program quality and efficiency for increasing TB case detection in health facilities.
- ii. Implemented systematic and routine contact investigations for all TB cases.
- iii. Strengthened TB services for high-risk groups.
- iv. Implemented intensified case finding approaches.
- v. Strengthened TB services at community level.

On the target to achieve the 86% detection target by 2026, it is crucial to strengthen surveillance, integrate TB screening into routine health services, and enhance community engagement for early detection and treatment initiation.

One of the interventions under TB is to increase the treatment success rate for drug sensitive TB 90% in 2020 to at least 95% in 2026. This goal implies that by 2024, the treatment success rate

should be approximately 93.2%. According to the 2024 DHIS2 report, the TB treatment success rate was recorded at 92%, which is slightly below the mid-point target. This indicates the need for strengthened interventions to accelerate progress toward the 2026 goal.

To improve TB treatment outcomes and patient adherence, the program has implemented several key strategies, including:

Enhancing patient follow-ups and scaling up treatment support through Directly Observed Treatment (DOT).

- i. Strengthening the management of TB patients at all levels of care.
- ii. Promoting nutrition support to improve treatment outcomes.
- iii. Ensuring appropriate TB treatment for all detected patients.
- iv. Enhancing patient-centered care and optimizing the quality of care.

To stay on course toward achieving the 95% treatment success target by 2026, it is essential to intensify efforts in patient monitoring, treatment adherence, and access to quality TB care across all health service delivery points.

Another target for the program was to increase the treatment success rate for Drug Resistant (DR) TB from 78% in 2021 to 85% in 2026. This goal implies that by the midpoint of the plan in 2024, the treatment success rate for DR-TB should be approximately 82%.

According to data from DHIS2, the treatment success rate for DR-TB was at 80% in 2024, falling below the mid-point target. Several factors contributed to this shortfall, including limited access to specialized treatment centres, challenges in patient adherence to prolonged DR-TB treatment regimens, and inadequate social support mechanisms for affected individuals. Additionally, delays in Drug Susceptibility Testing (DST) have hindered timely initiation of appropriate treatment regimens.

To enhance treatment success rates and achieve the 2026 target, the following key interventions have been implemented:

- i. Enhancing early case detection.
- ii. Expanding and strengthening capacity for treatment of DR-TB.
- iii. Improving the social welfare of drug-resistant TB patients.
- iv. Accelerating access to Drug Susceptibility Testing (DST) through decentralization of DST.

Despite being slightly off track, the country can still reach the 85% treatment success target by 2026 with sustained efforts in case detection, patient-centered care, and improved access to specialized DR-TB treatment.

Management and Control of Leprosy

One objective under the leprosy program is to reduce the proportion of Grade 2 disability of Leprosy from the 70% in 2020 to 10% by 2026. This target implies that by the midpoint of the plan in 2024, the G2D proportion should be reduced to approximately 22.5%.

According to the 2024 DHIS2 report, the G2D proportion was at 52%, falling short of the mid-point target of 41.2%. The slower-than-expected reduction is attributed to factors such as delayed diagnosis, low awareness at the community level, and inadequate screening efforts. Additionally, stigma and reluctance to seek medical care have contributed to late-stage presentations, making it difficult to achieve the intended reduction.

Despite this shortfall, the program has made notable progress through the implementation of key interventions, including:

- i. Strengthening leprosy index of suspicion and diagnostic capacity among health care workers.
- ii. Enhancing the provision of single dose rifampicin.
- iii. Enhancing community case finding in leprosy hot spots.

To achieve the 2026 target, the program will need to intensify active case-finding strategies, strengthen health worker capacity, and enhance community engagement to improve early detection and treatment as well as to reduce stigma and encourage early treatment-seeking behaviour.

3.3.4 Viral hepatitis control program

One of the primary objectives under Viral Hepatitis Control Program is to reduce Hepatitis B incidence to less than 1.8 cases per 100,000 population by 2026. This goal implies that by the midpoint of the plan in 2024, Hepatitis B incidence should be approximately 1.5 cases per 100,000 population. To achieve this reduction, two main objectives were outlined in the NHSSP 2022-2016 as follows:

1. To raise awareness of Hepatitis B (including other viral hepatitis infections A, C, D and E)
2. To increase access to comprehensive Hepatitis B control services (including other viral hepatitis infections A, C, D, and E) at all levels.

According to the 2024 annual HMIS report, Hepatitis B incidence was at 2.27 cases per 100,000 population, reflecting a 26.11% increase from the baseline and indicating that incidence remains 51.33% above the 2026 target. The performance for this indicator stood at 66.08%, underscoring the challenges in reaching the targeted reduction. This rise in Hepatitis B cases is primarily attributed to low community awareness of the disease, insufficient access to testing and treatment services, and inadequate funding for vaccination coverage, particularly among at-risk populations such as mobile, migrant, and internally displaced individuals.

Despite efforts, Zambia remains off track to meet the 2026 target for Hepatitis B incidence reduction, which aims to combat viral hepatitis. At the current rate of increase, projections indicate that Hepatitis B incidence will remain high and thus Zambia will not reach its target.

To reach the Hepatitis B incidence target, Zambia will need to implement more robust strategies focusing on reducing incidence by 11.4% annually. Key actions include intensifying public awareness campaigns, scaling up prevention, testing, and treatment services, enhancing healthcare provider training, and introducing HBV birth-dose vaccinations for newborns of HBV-positive mothers. Strengthening surveillance and community engagement are critical to reversing current trends and achieving Hepatitis B objectives.

3.4 Noncommunicable diseases

The goal as outline in the NHSP was to reduce Morbidity and Mortality due to NCDs and to Promote Mental Health and wellbeing by 2026 and among the strategic. To achieve this reduction, 3 strategic objectives were set which included, to reduce the incidence and prevalence of NCDs through enhanced health promotion, to reduce disability and mortality through early detection and

management of NCDs at primary health care level and to provide evidence for programming and policy making on NCDs at prevention and control. Fourteen (14) strategic interventions were outlined.

To reduce the incidence and prevalence of NCDs through enhanced health promotion, several activities were undertaken which included development and dissemination of the social behavioural change communications materials, commemoration of the national and international NCDs day such as World Heart Day, World Diabetes Day, World Mental health days, World No Tobacco Day, World Suicide Prevention Day, World Cancer Day were successfully held. Zambia Introduced support groups for Sickle cell disease and Type 1 diabetes through the PEN Plus Project and further enhanced health lifestyles such as physical activity and health dieting. There is also promotion of regular check-up and screening for Non-communicable diseases at primary health care level using the PEN approach. Awareness campaigns intensified tobacco use have intensified and promotion of Alternative livelihood activities for tobacco use and growing to tobacco users and farmers.

To reduce disability and mortality through early detection and management of NCDs at primary care level, several interventions were set and implemented which included the following; development of the PEN package and 30 trainer of trainers were trained with 230 Primary health care providers capacity built on the package, Zambia adopted and adapted the WHO PEN PLUS package and opened 3 sites with capacity built staff and appropriate equipment for PEN Plus program. 14 mentorship and supervision for NCDs and Mental Health have been conducting to the PEN Plus sites and other levels of care from the target 48 by 2026. Zambia has also enhanced the integration of NCDs in HIV using the Treatment Guidelines for advanced HIV management.

To provide evidence for programming and policy making on NCDs prevention and control. Zambia planned to develop an NCDs strategic plan and enact a Tobacco Control Bill by 2023, The NCDs strategic plan is partially done currently in its draft form due to limited financial resources to finalize it. The tobacco control bill is still undergoing stakeholder consultation.

Despite this progress, Zambia is still off track to meet the 2026 target for NCDs in the strategic plan due to several factors contributing to the slower than expected pace including inadequate policies/legislation to support enforcement, prevention and control of NCDs. Insufficient community sensitizations on prevention and control of NCDs risk factors, Inadequate awareness of NCDs leading to several disease and complications. Inadequate medical supplies for NCDs, Inadequate infrastructure to support screening, diagnosis, treatment and care particularly at Primary health care levels. There is inadequate integration of NCDs into routine disease monitoring and surveillance systems.

To reach the strategic targets set for 2026, Zambia will need to strengthen capacity for management, rehabilitation of NCDs & MH including referrals, there is need to build capacity building for Primary health care health workforce in early detection of NCDs, Mental Health and Epilepsy and improve palliative and terminal care for patients with NCDs. Further there is need to strengthen social behavioural change activities and campaigns, strengthen suicide screening, detection and prevention and establish de-addiction centres. Strengthening health information for NCDs and mental health is cardinal for decision making.

3.4.1 Mental health

Mental and neurological disorders are common public health problems in Zambia and have continued to increase particularly during the pandemics, epidemic mainly due to stress or anxiety, depression, harmful use of alcohol and drugs, self-harm and suicidal behaviours. In addition, alcohol and substance abuse, particularly among adolescents continue to surge. Approximately, 1/1000 epilepsy cases were notified at health 9 facilities in Zambia with health facility mortality of 3/1000 (Chainama Hills Hospital; 2020 Report).

The NHSP 2022-2026 set out a strategic goal targeted to mitigate the disease burden arising from mental health disorder using comprehensive promotional, preventive, curative and rehabilitative services. To achieve this, four (4) objectives were outlined.

Strategic objective 1: To increase promotion of mental health care and preventive services to all people including vulnerable populations (children, women, the aged, migrants and refugees)

To achieve this objective, 6 six (6) strategic interventions were set which included, i) develop national policy and strategy for mental health that are in line with international and regional human rights instruments, ii) facilitate functionality of multi-sectoral mental health promotion and prevention programmes, iii) Scaling-up ACSM (including commemoration of World Mental Health and Suicide Prevention Days). iv) Enhancing collaboration with traditional health practitioners, religious leaders and mental health services users on mental health delivery. v) Strengthening the legislation for mental health care and mobilize and align international mental health funding and partnerships for research initiatives in mental health.

Achievement Reported

During the period under review, Zambia has not conclusively reviewed the mental health Policy and still uses the outdated policy of 2005 and has not developed the Mental Health strategy mainly due to inadequate financial resources. Treatment guidelines for mental health disorders were developed. Multi-sectoral mental health promotion and prevention programs were facilitated with various line ministries, stakeholders and partners incorporating mental health in their programming. Advocacy, communication and social mobilization programs were scaled up with increases media and community engagement. All planned commemorations were successfully held. There was enhanced collaboration with the mental health services users and religious leaders has been enhance improved. Six Mental Health Technical Working meetings were health out of the possible 8 meetings. The Mental Health Act No.6 of 2019 is in place and the Mental Health Council has been put in place and operational.

Despite the progress made midway, Zambia is still lagging behind meeting the 2026 set targets and fall short to meeting the WHO action plan 2013-2030 vision of having a world in which mental health is valued, promoted and protected, mental disorders are prevented and persons affected by these disorders are able to exercise the full range of human rights and to access high quality, culturally appropriate health and social care in a timely way to promote recovery, in order to attain the highest possible level of health and participate fully in society and at work, free from stigmatization and discrimination. This is attributed to weak legal frameworks, limited financial resources, inadequate specialized mental health personnel, Poor infrastructure for mental health and high stigma and discrimination against mental health, and inadequate demand creation and advocacy.

In order to achieve 2026 NHSP targets, Zambia needs to strengthen the legal framework for mental health by fully operationalizing the mental health act no.6 of 2019 and developing the mental health regulations, further improve the infrastructure for mental health, improve the health workforce for mental health and intensify the awareness to increase health seeking behaviours and mitigate stigma.

Strategic objective 2: To improve curative services of mental health care to all people including vulnerable populations (children, women, the aged, migrants and refugees).

To achieve this, four (4) strategic interventions were outlined as follows.

- i. Increase health facilities providing mental health services in the provinces.
- ii. Enhancing capacity building for health care providers at primary health care level to adequately foster integration of mental health at community level.
- iii. Strengthen the availability, distribution and use of cost-effective psychotropic medicines.
- iv. Scale-up the provision of mental health services at all levels of care.

Achievements Reported

Twelve active Public mental health admission were created, and 103 Outpatient service points have been established in the 1 to 3rd levels hospitals across the country. 222 health care workers at primary health care level were capacity build and 121 were recruited during the period under review, availability and distribution of psychotropic medication has been and stands at 75% from the initial 52% in 2021 and Mental health services are accessible at all levels care.

However there still exists disparities in data capture and segregation as well as measurable indicators for mental health. Human resource for mental health is inadequate human resource as specialized mental personnel such as Psychiatrists are no existence in all the 10 provinces. Only one Province (Lusaka) has Psychiatrists. Infrastructure for mental health require improvement as the country depends on one (1) psychiatric hospital for all specialized mental health cases. Majority of the existing mental health infrastructure is old and dilapidated and construction of the 2nd Psychiatric hospital at Ndola Teaching Hospital has stalled for close to 5 years. The country is also lagging behind on meeting the target on providing the services for children, women, migrants and refugees due to inadequate mental health workforce and lack of Inclusive policies availability of specialized mental health services.

There is urgent need to improve human resource for mental health particularly Psychiatrists to be deployed in each province to provide specialized psychiatric expertise. Infrastructure for mental health needs to be improved to at least have one for each Province of the prototypes of Kalindawalo and Chinsali general hospitals. Further the supply chain needs to be stabilized with procurement of new and high potent psychotropic medications.

Strategic objective 3: To improve rehabilitative services for mental health care to all people including vulnerable populations (children, women, the aged, migrants and refugees).

To realize this objective, one strategic intervention was set and focused on establishing and strengthening capacity of mental health services for referral and rehabilitation, integrated at all the levels of care. Capacity building for mental health were enhances and referral pathways established at all levels. However, there is no improvement in the rehabilitation services and there is no rehabilitation centre that is well established.

There is need to Invest in infrastructure for mental health services and set up a state-owned rehabilitation centres as the three (3) rehab centres namely Nsadzu, Kawimbe and Litambya are dilapidated obsolete and not fit for human habitation.

Strategic objective 4: To increase the provision of epilepsy health care to all patients.

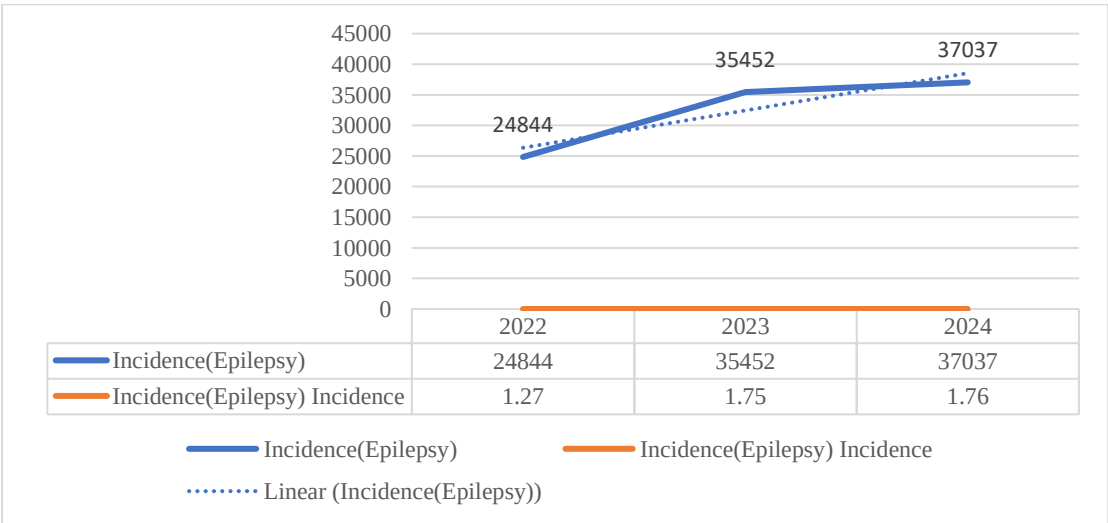
Four (4) interventions were set to achieve this objective. These were i) Scale-up ACSM to reduce negative perceptions about those suffering from epilepsy (including commemoration of World Epilepsy Day). ii) Strengthen the availability, distribution and use of cost-effective anti-epileptic medicines. iii)Enhance collaboration with traditional health practitioners, the religious leaders and service users on epilepsy.

Achievement Reported

There are some positive interventions that have been conducted such commemorations of international epilepsy days however the trend of epilepsy cases continues to show a significant increase (Figure 17 below). The supply chain of anti-epileptic drugs has partially stabilised as there is still dependence on the traditional anti-epileptic drugs.

Even though there is slight improvement in the implementation of the awareness campaigns targeting to reduce stigma, Health seeking behaviour for epilepsy remains a major challenge due to community myths and misconceptions about epilepsy. Patients with epilepsy suffer stigma and discrimination due to insufficient information in the community.

Figure 17: Trends in Epilepsy cases in the country



There is urgent need to address the stigma associated with epilepsy to improve health seeking behaviours for people living with epilepsy. Anti-epileptic drugs need to be made available at all levels of care.

3.4.2 Cancer diseases

Table 8 below provides a summary of key indicators outlined in the NHSP for this strategic area.

Table 8: Summary of Performance Against Trages for Cancer Indicators

Indicator	Performance Against Target	Colour Code
Number of facilities providing nuclear medicine services	0	
Turn Around Time (TAT) of samples being referred to higher level facilities	100	
Early detection of cancer at level 1 and 2 hospitals	80	
Number of hospitals with radiotherapy capacity in managing cancers	50	
Percentage of the population under surveillance through a Population Based Cancer Registry	92.33	

The overall program goal is to reduce premature mortality from adult cancer by 30% and improve childhood cancer survival to over 60% by 2030. The country has prioritized the cervical cancer elimination program, as well as early diagnosis and treatment for breast, childhood, prostate and colorectal cancers. The NHSSP 2022–2024 aimed at reducing Cancer incidence by type per 100,000 populations from 58 in 2016 to 52.3 in 2021. However, a total of 15,296 new cancer cases with a corresponding 9770 deaths were recorded in 2022 alone. The top 5 cancers in 2022-2024 in the country were cervical cancer, Kaposi's sarcoma, prostate cancer, breast and oesophageal cancers.

To achieve this reduction, 5 strategic objectives were set, including i) To increase the number of sites providing cervical cancer elimination services from 55% in 2018 to 80% in 2026. ii) To increase the number of hospitals with radiotherapy capacity in managing cancers from 1 hospital in 2021 to 3 hospitals by end of 2026. iii) To increase early detection of cancer at level 1 and 2 hospitals by 50% by December 2026.

Achievement Reported

Three population-based Cancer Registries have been established. The rehabilitation and re-equipping of the Cancer Diseases Hospital is underway. Vaccination against HPV is at 63% The Ndola Cancer Centre will also be opened this year in 2025. The decentralization of cervical cancer prevention and screening to 355 facilities country wide representing 65% Introduction of training programmes for cancer control at various levels, Inclusion of cancer services on the National Health Insurance Package (NHIP). Additionally, Development of policy documents, guidelines and IEC materials for cervical, breast and childhood cancers has been done

However, despite this progress, Zambia is still off track to meet both the 2026 target for elimination of cervical cancer with the use of HPV DNA as the primary test which is below 30%. This is because the cost of HPV commodities is high. Additionally, Low awareness levels of risk factors and health-seeking behaviour among the public, Inadequate funding mechanisms for cancer early diagnosis and treatment, Limited access to cancer prevention, diagnostic and treatment services for pre-invasive and invasive cancers, Limited access to infrastructure, equipment, medicines and supplies, Inadequate coverage of cancer data in the national health data management systems, further constraining opportunities for cancer research

To reduce premature mortality from adult cancer by 30% and improve childhood cancer survival to over 60% by 2026 the strategies and interventions should be implemented at a simultaneously

and at a scale. Multisectoral approach is required both for internal and external funding for cancer control.

3.5 Other areas of public health concerns

3.5.1 Neglected tropical diseases (NTDs)

Zambia bears a high Neglected Tropical Diseases (NTDs) burden. Of the 20 NTDs recognized by WHO 16 are found in the country (8 are known to be endemic and 8 are suspected.) The NTDs that are common in Zambia include Elephantiasis (Lymphatic Filariasis), Bilharzia (Schistosomiasis), Intestinal worms (Soil-transmitted helminthiasis), Trachoma, Sleeping sickness (Trypanosomiasis), snake bites, Leprosy and Tape worm infestation (Taeniasis). The NTDs can be controlled and eliminated through the implementation of five evidence-based strategies: preventive chemotherapy, innovative and intensified disease management, vector control, veterinary public health measures for zoonotic diseases and the provision of clean water, sanitation, and hygiene services. The goal is to eliminate NTDs in Zambia. The first specific objectives are two-fold.

The first objective under this strategic area of the NHSSP is to raise awareness on trachoma, Schistosomiasis, STH and Lymphatic Filariasis through the strengthening of multi-sectoral collaboration in NTDs prevention and control interventions.

Achievements

To raise awareness on Trachoma, Schistosomiasis, Soil transmitted helminths (STH) and Lymphatic Filariasis the NTD programme is:

- The Zambia NTD program has developed appropriate structures for the ***governance, management***, and effective delivery of coordinated by the NTD Unit. There is, however, limited collaboration in planning and implementation for NTDs among the different stakeholders at country level. Coordination mechanisms and stakeholder responsibilities as well as effective coordination and working processes to implement relevant interventions such as One Health approaches and integrated vector management are not yet fully established. However, there has been a significant shift towards greater inclusiveness, where stakeholders in NTDS can collaboratively plan and agree to implement collectively prioritized NTD activities within their respective sectors to enhance synergies. Research and innovation towards NTDs have been hampered due to inconsistencies in funding as activities re largely donor dependent. Strategies for resource mobilization to address these funding challenges have not yet been developed.
- Using a ***One Health approach*** that seeks to address the multi-faceted determinants of NTDs through strengthening intersectoral collaboration among human, animal, and environmental health. The partners include the Government Line Ministries (Ministry of Health, Ministry of Education, Water development and Sanitation, Local Government and Rural development, green economy and Environment, Tourism, Agriculture, Fisheries and Livestock and Education).

The ***Ministry of Education (MoE)*** has played a particularly key role in several health programmes by availing schools as service delivery sites, advocacy and mobilizing students through the School Health and Nutrition programme. In Zambia. the MoE has also facilitated the incorporation of NTDs into school curricula and dissemination of key

messages. With 45.7% of the Zambian population being aged under 15 years, this includes the age groups at greatest risk of infection with NTDs.

There is also participation from Nongovernmental Organisation such as Lions Aid Norway (LAN), who have supported surveys on Trachoma and Sight Avers International (SSI) who have provided technical and financial support into NTDs planning and reviews, held under the One Health approach.

Holds annual commemorative events on NTDs with participation of various partners (involving the public and private sector and NGOs).

Despite progress on awareness for the NTDs, the programme faces the challenge of inadequate coordination and limited intersectoral collaboration necessary for the elimination of NTDs

The **second objective** is to conduct Preventive Chemotherapy and Case management. The major diseases requiring Preventive Chemotherapy in Zambia include: Schistosomiasis (SCH), Soil Transmitted Helminths (STH), Lymphatic filariasis (LF) and Trachoma. Schistosomiasis is endemic in all, except two districts (Chilubi and Ndola). The SCH prevalence across the country ranges from less than 1% in Ndola to 88.6% in Kafue district. The disease prevalence is equal or greater than ($\geq$) 50% in Chongwe, Luangwa, Rufunsa and Milenge districts. Approximately 4 million people are infected with schistosomiasis in Zambia. Trachoma is an infectious eye disease caused by the bacterium *Chlamydia trachomatis* spread by eye-seeking flies, dirty fingers, and contaminated cloth from infected person.

The Trachoma (disease) morbidity progresses through trachomatous follicular (TF) inflammation of the eye lids scarring (TS) then Trachomatous Trichiasis (TT) and leads to corneal opacity (CO) and eventual blindness if not treated.

In Zambia, there are four soil-transmitted helminths (STH) of public health importance: *Ascaris lumbricoides* (roundworm), *Trichuris trichiura* (whipworm), *Ancylostoma duodenale* and *Necator americanus* (hookworms). According to the NTD Master Plan 2022-2026, The prevalence ranges from 0.84% to 54.56%. Mapping was done between 2012- 2013

Achievements

All the Preventive Chemotherapy-Treatment NTDs have been mapped in Zambia. In addition, The NTD Programmes has conducted Mass Drug Administration (MDA) as follows:

- **Lymphatic filariasis;** Albendazole (ALB) and Diethylcarbamazine (DEC) are used for MDA. Treatment is by Directly Observed Treatment (DOTs). Zambia has successfully conducted 5 rounds of MDA for LF in all the endemic districts between 2014 and 2021. The coverage rates have been between 87-92%, which is above the 65% threshold of WHO. Mid-point sentinel site surveys in 2017 indicated 0% antigen prevalence. All the five LF MDAs were validated by independent coverage surveys as per international standard practice.
- Lymphedema/hydrocele case identification was integrated into the MDA campaigns to establish the number of suspected hydroceles and lymphedema in the targeted districts.

- ***Schistosomiasis***: Mapping of Schistosomiasis was successfully conducted between 2004 and 2020. Praziquantel was used for MDA, mainly delivered within school and community settings according to the WHO guidelines for treatment of schistosomiasis. The SCH MDA target school aged children 5-14 years. In high-risk areas where the prevalence is above 50%, the MDA included adult population. The MDA was conducted in Eastern and Southern provinces. Both school-and-community-based treatment approaches were adopted and delivered as Directly Observed Therapy (DOTs) by teachers or community drug distributors.
- ***Soil transmitted helminths (STH)***: The NTD programme in Zambia has successfully implemented Mass drug administration. The MDA for STH is integrated into LF and SCH MDA implementation. STH treatment is also integrated in the mainstream primary health care services, which is delivered during Child Health week, conducting bi-annually.
- ***Trachoma***. The MoH NTD programme has successfully implemented the WHO recommends multifaceted strategy called SAFE between 2007 and 2024; The Surgery (S) for persons that have reached the blinding stage of trachoma, Antibiotic treatment (A) for population with an active trachoma prevalence of above 5%, and behaviour change that priority Facial cleanliness (F) and environmental improvement to reduce the transmission of trachoma.
- More than 3,600 sight saving trichiasis trachoma (TT) surgeries were reported in 2024 to beef up preventive chemotherapy in the elimination efforts of Trachoma.
- The NTD has conducts annual Technical Supportive Supervision and Mentorship, with the latest TSS on HAT having been held in 2024. These TSS have contributed to improved Case Detection through enhanced skills of frontline health workers in early diagnosis of NTDs; increased the Treatment Success Rates, enhanced reporting and surveillance and promoted development of and use of Standardized Protocols. Supervised healthcare workers are better able to follow standardized treatment protocols, ensuring that patient care remains consistent with international guidelines and management.

Despite progress on awareness, the NTD programme faces the following challenge in diagnosis and management NTDs.

- There is no point-of-care diagnostics for early detection at community and health facility levels.
- There are inadequate diagnostic services in health facilities, with some health centres still lacking essential diagnostic tools or having outdated equipment, making it difficult for trained healthcare workers to perform accurate tests for NTDs such as human African trypanosomiasis (HAT). There are also geographic and logistical barriers due to the remoteness or long distances of some districts, worsened by lack of infrastructure impedes regular visits and effective supervision from supervisors and delivery of commodities.
- There is insufficient resources and staff-turnover limited financial resources, shortage of trained healthcare workers, and high staff-turnover in endemic areas can undermine the effectiveness of mentorship and supervision programs. Shortage of drugs remains a challenge in the country. Insufficient funding despite government allocation and support from partner such as the ESPEN support.
- There has been no sustained capacity building in forecasting, quantification, procurement, and management of NTD commodities.

3.5.2 Public health security

No report

3.5.3 Social and environmental determinants of health

Table 9 below provides a summary of performance for key indicators identified in the NHSP for this strategic area.

Table 9: Summary of Performance Against Targets for Social and Environmental Determinants of Health Indicators

Indicator	Performance Against Target	Colour Code
Increase institutional capacities and mechanisms for Districts to address social determinants of health and equity of access	76.92	
Proportion of % of districts with mechanisms for monitoring and reporting determinants of Health	90	
Proportion of healthcare facilities complying to WASH/IPC standards	83.33	
Proportion of institutions with a shared vision for prioritization of determinants of health	80	

The NHSP 2022-2026 outlined eight objectives under this strategic area. These were: i) To increase the proportion of healthcare facilities complying to WASH/IPC standards from 45% in 2020 to 70 % by 2026, ii) To increase the percentage of healthcare facilities complying to HCWM Management guidelines from 40 % in 2019 to 70% by 2026, iii) To increase the number of functional portable laboratories and consumables from 45 in 2021 to 60 by 2026, iv) To increase disease surveillance and inspections of premises at Point of Entry from 14 points in 2021 to 24 by 2026, v) To increase the percentage of health care facilities implementing mitigation and adaptation measures to climate change from 55 % in 2020 to 80% by 2026, vi) To increase the percentage of health care facilities implementing mitigation and adaptation measures to climate change from 55 % in 2020 to 80% by 2026, vii) To establish the National Food Laboratory (NFL) HQ as a reference laboratory and centre of excellence by 2026, and viii) To establish 20 laboratory hubs around the country by 2026.

Achievement Reported

The following progress has been made in this strategic area: Access to safe Water Supply in the country is reported at 72%, while access to basic sanitation is reported at 54% according to the ZDHS, 2018. Compliance with hygienic standards of Public Premises has improved. Adherence to good practices in HCWM by health facilities is reported at 76%. 14/41 (34%) designated and 24/41 (59%) authorized POEs are offering Port health services while 20/61 (33%) are none designated or authorized (porous border entry points). The authorized and designated POEs have developed Public Health Emergency Response Plans. The MoH commenced review and finalization of the National Food Safety Policy. Training of 25 Provincial Inspectors in salt Fortification compliance was conducted. Strengthened participation in Codex work through Codex Trust Fund was done. The MoH Revamped the National Fortification Alliance. Capacity building

for all Unit officers in the digitization process for food import and exports permit issuance was done.

Some Key challenges reported in this area include Inadequate budgetary allocation towards Environmental Health programs, infrastructure for POEs in the newly created districts with high volume, Slow pace to review, appeal and amend the PHA cap 295 of the laws of Zambia, EH indicators not incorporated in the electronic HMIS and HNAP to climate change expired.

Moving forward there will be need on focusing efforts to, Support the healthcare facilities with IPC/WASH infrastructure and logistics, compliance to WASH/IPC in healthcare facilities., Strengthen compliance to healthcare waste management guidelines, Improve provision of primary waste and final waste disposal facilities, Improve provision of portable laboratories and consumables, Strengthen water quality monitoring and control, Strengthen coordination with local authorities, Strengthen the capacity of Points of Entry, Strengthen implementation of mitigation and adaptation measures to climate change in healthcare facilities. Increase the laboratory space by construction of annex building, Equip the institution with the basic minimum of high precision equipment, Train staff in modern method of analysis, Identify and develop premises into laboratories in conjunction with local authorities, Provide basic laboratory equipment for water and food safety analysis,

There is also great need to enhance Capacity Building and Policy Enforcement in order to: Strengthen environmental health workforce training programs, increase funding and resources for environmental health initiatives, Improve monitoring, enforcement, and compliance with environmental health regulations.

3.6 Clinical care services

3.7 Hospital services

Table 10 below summarises the performance against targets for priority indicators identified in the NHSP for this strategic area.

Table 10: Summary of Performance Against Targets for Indicators for Hospital Services

Indicator	Performance Against Target	Colour Code
Number of annual blood units collected	85.89	
Number of hospitals utilizing telemedicine for management and treatment of patients	100	
Proportion of hospitals providing surgical services appropriate for the level of care	0	
Proportion of hospitals with capacity to provide Emergency Obstetric and Neonatal Care (EmONC)	93.71	
Rate of reoperations, post elective Surgery	-	
Reduction in cases of dental caries and periodontal diseases	100	

From the data provided, there were generally good (above) performance across most indicators identified for this strategic area, apart from the indicator on proportion of hospitals providing surgical services appropriate for the level of care which recorded zero (0) performance rating. There was no data available for the indicator on rate of reoperations, post elective surgery. The review identified that this indicator is vague, hence the inability to capture and report on any data about it.

3.7.1 Surgical and anaesthesia services

According to the MoH Annual Report, 2021, every year more than 18,010 patients get surgical services in tertiary hospitals in Zambia. Perioperative mortality ranges from nearly 0.6% in tertiary hospitals to 0.43% in district hospitals of Zambia, and around 62% of perioperative deaths are from avoidable surgical or anaesthesia related problems, such as delays in surgery, 12 lack of the availability of blood, and poor postoperative care.

Nearly 88% of health centres and hospitals in Zambia provide minor surgical procedure. Only 55% of hospitals perform major surgeries in Zambia; where only 36% conduct laparotomy, 14% conduct cataract surgery, and 16-19% conduct orthopaedic surgery. Likewise, only 60% of hospitals in the country perform caesarean section, while only 45% and 21% of hospitals perform tubal ligation and obstetric fistula repair, respectively. However, only 42% of hospitals perform paediatric surgeries, such as repairs of anorectal malformation, cleft lip and palate, clubfoot, and congenital hernia, 14 paediatric escharotomy / fasciotomy and contracture release (Harmonized health facility census). Slightly greater than a quarter of hospitals that provide major surgical services have staff trained in surgery, and overhead operating light, basic operation table and basic set of surgical instruments are available in only half of these hospitals. Similarly, anaesthesia machines are available in only 43% of hospitals that offer major surgical care; while on average, 47% of these facilities have medicines and commodities for anaesthesia. In general, the specialist health workforce density per 10,000 population is 0.16 for anaesthesiologists, 0.18 for obstetricians and gynaecologists, and 0.06 for surgeons.

Achievement Reported

One of the primary objectives of the NHSSP 2022-2026 was to reduce the rate of reoperation, post elective surgery from 100% in 2021 to 50% by 2026 and to increase access to quality and timely aesthetic and critical care services by 2026. Four strategic interventions under surgery and two under anaesthesia were outlined. These were: i) Create programs focusing on Quality Improvement/Quality Assurance that track health outcomes (no implementation information currently), ii) Improve patient flows and overall service delivery in Surgery (no implementation information currently), iii) Strengthen adherence to surgical guidelines and protocols (no implementation information currently), iv) Establish trauma centres in accident hot spots (no implementation information currently), v) Ensure availability of surgical equipment and consumables which has partially been implemented 60-81% currently, vi) Improve the availability of surgeons of different specializations (partially implemented 60-81%), vii) Strengthen the provision of quality, essential and emergency aesthetic and Critical care services at all levels which has been partly implemented at 70%, vii) Provide appropriate equipment for safe delivery of anaesthesia and critical care at all levels of the health care system which has been partially implemented (65%).

There was no data and reports to report on the progress at the time of the review.

Some of the key challenges reported in this area include, limited human resources, outdated equipment, Infrastructure shortcomings, limited access to essential supplies, skill gaps, human resource development and equipment acquisition

3.7.2 Internal medicine

Achievements Reported

Renal services in Zambia have significantly evolved to address the increasing burden of kidney disease. The MoH, in collaboration with local and international partners, has expanded access to dialysis, kidney transplant services, and nephrology care. Dialysis centres have now been established in all ten provinces, while the University Teaching Hospital (UTH) has introduced a kidney transplant and fistula training program to strengthen specialized care. There are now 15 dialysis centres nationwide, expanding access to life-saving renal care.

Efforts continue to focus on specialized training, enhanced diagnostics, and expanded access to renal replacement therapy, ensuring equitable and high-quality care for all Zambians affected by kidney disease. The MoH has established dialysis centres in all ten provinces and, with support from the American College of Surgeons, has introduced a transplant and fistula training program at the University Teaching Hospital (UTH) to train young local surgeons.

By the end of the first quarter, three renal pathologists will have completed their training. Additionally, two nephrologists (one adult and one paediatric) have received fully funded scholarships to begin their training in Kenya this year. Two nurses are currently undergoing training for kidney transplant coordination, while three scientists are set to travel to India for specialized training in Human Leukocyte Antigen (HLA).

Looking ahead, the Ministry of Health plans to send:

- Two doctors for nephrology training annually.
- Ten nurses per year for nephrology training.
- Six biotechnicians for HLA training in total.

Some of the key challenges reported in this strategic area include lack of a clearly defined objectives and narratives within the NHSSP 2022-2026, which affects structured growth and funding. Strengthening these services will require increased training opportunities for nephrologists, kidney transplant surgeons, and specialized nurses to meet the growing demand for renal care.

Moving forward, the following key actions are recommended:

1. Integration into the National Health Strategic Plan
 - Define clear objectives and implementation strategies for renal and transplant services within Zambia's National Health Strategic Plan to ensure structured growth and funding.
2. Training and Capacity Building
 - Increase training opportunities for nephrologists, renal pathologists, transplant surgeons, and dialysis nurses to meet the rising demand for specialized kidney care.

- Facilitate continuous medical education (CME) programs for healthcare professionals managing kidney disease.

3. Infrastructure and Equipment Investment

- Upgrade existing dialysis units and transplant facility with modern medical technology to enhance service delivery.
- Establish renal pathology laboratories to improve diagnostic accuracy and patient management.

3.7.3 Obstetrics and gynaecology

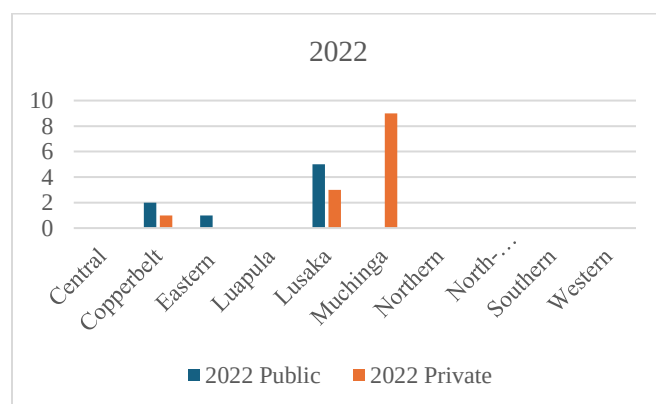
One of the objectives of the NHSP 2022-2026 under this strategic area was to increase the number of hospitals with capacity to provide Emergency Obstetrical and Neonatal Care (EmONC) from 60 % in 2021 to 80% by 2026. This goal implies that by the mid-point of the plan in 2024, an increase in the number of hospitals with capacity to provide Emergency Obstetrical and Neonatal Care (EmONC) should be at 70%. Additionally, the plan was to expand access to obstetrics and Gynaecology (Obs and gyn) services appropriate for the level of care to all health care facilities by 2026.

To achieve this increase, 9 strategic objectives were set, including improving the availability of OBs and Gyn, essential OB-Gyn medicines, equipment and surgical supplies in provinces, setting up High Dependent Units (HDU) and triage to manage critical maternal cases as well as setting up operating theatres for caesarean sections in all high delivery facilities. Other strategic interventions include improving availability of obstetricians in all provinces, building capacity of staff in quality control and improvement and clinical management, strengthening adherence to protocols and standards and referral system for paediatric patients referred within 48 hours of admission and paediatrics triage system.

Achievements Reported

At the time of the mid-term review, OBs and Gyn services in all 10 provinces were strengthened through the provision of essential medical equipment like caesarean sets, delivery sets, cervical sets distributed in 5 provinces with equipment challenges that was identified through weekly Maternal Perinatal Death Surveillance and Response (MPDSR) reports. The goal for improving availability of obstetricians in all provinces has been fully implemented. Nevertheless, as of 2022, only 3 provinces in the country had a trained Obs and Gyn staff. (Figure 18 below)

Figure 18: Distribution of trained Obs and Gyn Staff by Province



Setting up High Dependent Units (HDU) and Triage to manage critical maternal cases has been partially implemented. The program was unable to procure equipment for the establishment of HDUs. However, it re-planned to establish 500 HDUs in the next 5 years targeting 100 units per year beginning in 2025 under World Bank support. Setting up operating theatres for caesarean sections in all high delivery facilities has been partially implemented.

Building capacity of staff in quality control and improvement has been partially implemented. Capacity building of healthcare providers has been on-going through targeted mentorships to the health care providers in selected health facilities with sufficient equipment to address specific gaps in the MPDSR reports. Future orientation will be integrated into other MNH trainings to ensure more providers are knowledgeable and adhering to standard.

Strengthening adherence to protocols and standards and Referral Guidelines has been partially implemented. Four (4) referral guidelines have been developed but not yet printed, limiting the number of all providers that have access to the guidelines.

As at the time of this MTR, there was no data on strengthening referral system for paediatric patients referred within 48 hours of admission, strengthening Paediatrics triage system and building capacity for clinicians in clinical management.

Some key challenges reported in this strategic area include: the high doctor-to-patient and nurse-to-patient ratios strain the healthcare system, high staff attrition rates further exacerbate the situation, non-availability or malfunctioning of referral facilities, particularly ambulances, hinders timely access to critical care, many second and third-level facilities lack the necessary space for expansion of neonatal intensive care units (NICU) and struggle with outdated medical equipment, especially in existing NICUs.

Moving forward, to strengthen this strategic area, the sector will need to have a continuous recruitment and retention system of qualified OBS and gyn personnel, continue lobbying for advanced ambulances to enhance the quality referral services and have adequate funding for procuring new NICUs equipment for all facilities.

3.7.4 Paediatrics services

Paediatric services in Zambia are an essential component of the country's healthcare system, focusing on the medical care of infants, children, and adolescents. These services are provided at different levels of the healthcare system, including primary health centres, district hospitals, provincial hospitals, and tertiary referral hospitals.

One of the primary objectives under the strategic intervention area 2.8 is to strengthen paediatrics triage system. This goal implies that by mid-point of the plan in 2024, there is improvements in patient assessments, sick children are prioritized and directed to appropriate care based on the severity of the condition. This goal also implies that there is a well-functioning triage system ensures that critical cases receive immediate attention while less urgent cases are managed efficiently, reducing delays and improving patient outcomes.

Achievements

As of 2024, interventions to strengthen paediatrics' triage system has been partially implemented (21 - 40%). The current efforts hinge on the National Health Care Standards that emphasize the importance of organized workflow processes and effective triage system and development of tools. Among the tools is, "an Interagency Integrated Triage Tool" a three-tier colour coded system

adapted from WHO. In addition, Zambia has adapted the Emergency First Aid Responder (EFAR) System Model, focusing on training community members to act as responders and being piloted in two rural districts.

Challenges Reported

- Absence of formal pre-hospital emergency care system leads to delays in patient assessment and initial management which is a crucial component of effective triage.
- Insufficient healthcare provider training in emergency care and triage protocols, leading to inconsistent patient assessment and prioritization across facilities.
- Resource limitations for essential resources like equipment necessary for effective triage.
- Geographical and transportation barriers that delay the initiation of triage and subsequent care.
- Legal and policy gaps – absence of legal and policies mandating universal access to emergency care services.

Key recommendations

- To disseminate the triage protocols across the country.
- To enhance training of healthcare personnel in effective triage.
- To increase budget allocation to emergency services
- To monitor and evaluate the effectiveness of the triage system.
- To roll out the EFAR system to all rural health facilities.
- To consider a legal and policy framework for mandating emergency services.

3.7.5 Mobile emergency services

Mobile and emergency health services in Zambia play a crucial role in expanding access to healthcare, particularly in remote and underserved areas. The MoH, in collaboration with partners, has implemented mobile clinics, ambulance services, and emergency response systems to strengthen healthcare delivery. Mobile health services provide essential medical care, immunization, maternal and child health services, and disease screening to communities with limited access to health facilities. Additionally, the emergency medical services (EMS) system has been enhanced through the deployment of ambulances, paramedic training, and emergency response coordination to improve pre-hospital care and reduce mortality rates.

To strengthen outreach services to hard-to-reach rural districts via aero-medical services and establish more emergency health units by 2026. The goal is to ensure timely, equitable, and life-saving medical interventions for all Zambians, regardless of location.

Achievement Reported

In 2022, the MoH, through the Zambia Flying Doctor Services, provided outreach healthcare services to 7,023 patients in the third and fourth quarters. The outreach program expanded in **2023**, reaching 105,433 patients, and further in 2024, where 174,197 patients received medical care. This brings the total number of patients treated through outreach services to 286,653 between 2022 and 2024. The Zambia Flying Doctor Services previously operated with two fixed-wing Caravan planes and one helicopter. In January 2025, a new aircraft was procured, further strengthening the country's aero-medical response capacity.

However, despite this progress, Zambia remains off track in meeting its 2026 target for mobile and emergency services. Most hospitals lack ambulances, which significantly affects emergency response and patient transportation.

To address this challenge, the Ministry of Local Government has procured 11 ambulances, while the Zambia National Public Health Institute has acquired 12 ambulances in 2024, more ambulances are yet to be procured in 2025. However, there remains a significant gap, and more ambulances are urgently needed in hospitals to strengthen Zambia's mobile and emergency healthcare services.

Moving forward, to Strengthen this strategic area, the following actions will need to be implemented

1. Increase Ambulance Procurement and Distribution

- The government should prioritize the procurement and equitable distribution of ambulances to hospitals and rural health facilities.
- Partner with the private sector and international donors to bridge the existing ambulance gap and enhance emergency response capacity.

2. Expand Aero-Medical Services

- Strengthen the Zambia Flying Doctor Services by increasing the number of aircraft and flight crews to reach more remote areas.
- Invest in maintenance and fuel supply to ensure consistent operations of aero-medical services.

3. Establish and Strengthen Emergency Health Units

- Set up dedicated emergency health units in major hospitals and strategically selected rural areas to enhance emergency care.
- Equip these units with trained personnel, emergency drugs, and life-saving equipment.

4. Improve Emergency Medical Training and Capacity Building

- Train more paramedics, emergency medical technicians (EMTs), and first responders to improve pre-hospital care.
- Conduct continuous refresher courses and simulations for healthcare workers to enhance emergency response skills.

5. Enhance Communication and Dispatch Systems

- Develop a centralized emergency response system with a nationwide toll-free number for quicker access to ambulance and aero-medical services.
- Utilize digital technology to track ambulances, monitor emergency calls, and ensure timely patient transfers.

6. Improve Infrastructure and Road Access

- Upgrade road networks leading to health facilities, especially in remote and rural areas, to facilitate faster emergency response.

3.7.6 Palliative care

Palliative care helps patients, and their families deal with the physical, psychological, social, and spiritual difficulties that come with a life-threatening illness. Additionally, caregivers' quality of life improves. Palliative care services are currently being offered in selected health facilities in the country. As of 2016, six (6) health facilities were providing palliative care services with functional palliative care teams, and these are Livingstone Central Hospital, Cancer Diseases Hospital, Ndola Teaching Hospital, Mphanshya Mission Hospital and Mazabuka General Hospital. Access to the palliative care services could be expensive to those who are not in close proximity to the facilities that are offering the services.

In 2016, the country was ranked Level 4a in terms of palliative care service provision because hospice palliative care services were at a stage of preliminary integration into mainstream service provision.

One of the primary objectives under the strategic intervention area 15 of the NHSP was to increase access to quality Palliative Care services in the country. This goal implies that by mid-point of the plan in 2024, the palliative care services should increase to other health facilities in the country.

Two (2) strategic objectives were developed in order to increase the number of facilities offering palliative services. These strategic objectives include providing quality, safe, and affordable essential supplies for palliative care services at all levels of care and strengthening community structures for PC provision.

Achievements

As of 2024, interventions to increase access to quality Palliative Care services in the country and provide quality, safe, and affordable essential supplies for palliative care services at all levels of care and strengthen community structures for PC provision have been partially implemented. A national Palliative Care Strategic Plan 2021 – 2026 was developed to guide on improving quality of life through medical, psychological and spiritual services. In Line with the Strategic plan, capacity building of healthcare workers is on- going.

Challenges Reported

- Insufficient Healthcare Professionals – there are few trained palliative care specialists and limited integration of palliative care into the general health care systems.
- Limited Community-Based Services – Most palliative care services are hospital based, with minimal home based or community outreach programs.
- Inadequate funding – underfunded in the national health budget leading to resource constraints in training and commodities and supplies.

Key recommendations

1. To strengthen availability of commodities and supplies.
2. Develop partnerships for financial and technical support
3. Strengthen collaborations for Community-Based Services like establishment of more home-based palliative care programs to reach patients in rural and remote areas.
4. Lobby for increase in budget allocation for palliative care services

3.7.7 Eye health services

Interventions to enhance eye health services, including cataract surgery and specialist availability, are partially implemented due to financial and logistical challenges. Surgical equipment remains insufficient at lower levels, and infrastructure upgrades face budget constraints. Specialist training and recruitment progress slowly due to lengthy courses and limited access to international training. However, capacity-building initiatives continue, and the Ministry of Health is recruiting midlevel personnel to address shortages. Overcoming financial and training barriers is essential for full implementation.

One of the primary objectives under the strategic intervention areas 1 and 11 of the NHSP was to expand access to comprehensive quality eye health services to cover all 116 district hospitals by 2026. This goal implies that the midpoint of the plan in 2024, the access to the eye health services should have increased by 25 more health facilities offering the services, making a total of 91 health facilities offering the services.

To achieve the expansion of eye health services, five (5) strategic objectives were set out.

- building capacity of eye health personnel in cataract surgery
- increasing training outputs for eye health specialists
- scaling up recruitment of eye health specialist,
- establishing and equipping the eye clinic department and
- improve availability of infrastructure and cataract consumables.

Achievements

Interventions to expand surgical eye services from two hospitals in 2021 to six by 2026 remain **partially implemented**, facing financial and logistical challenges. Surgical equipment shortages at lower levels and budget constraints on infrastructure upgrades slow progress. Specialist training and recruitment are hindered by long training durations and limited access to international programs, though capacity-building initiatives continue, with the Ministry of Health recruiting midlevel personnel to bridge gaps. Expanding eye health services to all 116 district hospitals is also progressing **at 41-60% implementation**, but the erratic supply of essential drugs from ZAMMSA remains a major barrier. Strengthening funding, training, and supply chains is crucial for achieving full implementation.

Key challenges reported

- Limited pharmaceutical storage facilities.
- Inadequate human resources including specialist for eye health services.
- Weak supply chain system
- Limited financial resources for capacity building

Key recommendations

- Improve medicines supply management by enhancing commodity re/distribution including disposal of expired medical products.
- Strengthen Medicines and Therapeutics Committee through orientations and sensitizations
- Plan for the rehabilitation of pharmaceutical storage facilities to improve storage.

- Capacity building of health workers in Leadership, management, Basic Sign language Preceptorship & Respectful Care in the institution.
- Strengthen Social Behaviour Change Communication approaches towards some emerging issues (awareness creation).
- Identify and address QI capacity-building needs for the facility to promote the application of the Continuous Quality Improvement Model for improvement across health interventions

3.7.8 Ear, nose and throat health services

At least 5.5% of the Zambian population has significant hearing loss that requires intervention and according to the WHO, 60% of the causes of hearing loss are preventable, or reversible. At the Cancer Disease Hospital, laryngeal carcinoma is the commonest head and neck cancers (25.5%) followed by the nasopharyngeal carcinoma (18.4%). Majority of the patients present with late-stage disease, stage III (24.5%) and stage IV (51%). Only 6.1% present with stage I disease, this complicates surgical treatment for head and neck cancers in Zambia.

To provide comprehensive Ear Nose and Throat services in an equitable manner, the NHSSP 2022-2026 outlined the following objectives:

- Strengthen health facilities capacities to provide comprehensive ENT services across the country (Primary ENT services - 30% and ENT tertiary level - 60%)
- Increase the number of skilled workforce in ENT, audiology and speech therapy (ENT surgeons-30%, Audiology -50% and Speech therapist - 10%)

Achievements Reported

The numbers and scope of surgeries have increased this year due to an increased number of surgical camps with visiting specialists at UTH and LMUTH. These visiting surgeons are from Czech and USA. The number of qualified ENT surgeons is 6 and 1 Audiologist. Currently 5 students training to become qualified ENT surgeons while Audiology training is being supported by the development of a training program in collaboration with South Hampton University using Beit Cure Hospital. The training will be provided by external faculty, and lessons will be delivered in a hybrid mode. This is a degree program, and students will graduate with a certification from South Hampton University. Training commences in 2025. Another supporting institution is Starkey Hearing Institute which continues to train audiology technicians. There are 3 functional ENT/audiology units with comprehensive equipment.

However, even with this progress, primary ENT only delivered in Lusaka, Eastern, Southern, Central, Muchinga, Luapula, Northern Province through outreach service by Beit Cure Hospital. There is no ENT drugs and consumables on the essential drug list and there is no accessibility to assistive hearing devices in public hospitals.

Moving forward, to strengthen this strategic area, the sector will need to find resources to spread efforts to the remaining provinces and to also build capacity amongst Primary health care workers., There is need for supporting surgical services with equipment, drugs and consumables, and a need to support local curriculums by employing more faculty members to deliver training. The speech therapy program at LMUTH has stagnated due to lack of lecturers in the field.

3.7.9 Oral health services

Oral diseases disproportionately affect the most vulnerable and disadvantaged populations with people of low socioeconomic status carrying a higher burden of oral diseases throughout the life course. About 80% of the Zambian population is currently experiencing a high burden of oral diseases. These include but not limited to dental caries (among the top 10 leading of morbidity in Zambia), periodontal disease, malocclusions, oro-facial injuries, bad breath, and oral cancers. Oral diseases like other Non- Communicable Diseases are associated with lifestyles, such as unhealthy diets, physical inactivity, alcohol and substance abuse, and tobacco use.

One of the primary objectives in the NHSSP 2022-2024 in this strategic area was to reduce cases of dental caries and periodontal diseases from 80% in 2021 to 70% by 2026. To achieve this reduction, three (3) strategic interventions were outlined namely i) Expand staff establishment of oral health personnel and include specialists, ii) Procuring 90 dental chairs and instruments and dental commodities and, iii) Strengthening the oral health information system and research.

Achievements Reported

At the time of the mid-term review, the three interventions in the plan had not yet been fully implemented. The staff establishment of the oral health personnel has increased from 1,050 to 1895 dental personnel. The number of Dental Prosthetists(technologists) in both private and public health facilities increased from 20 in 2021 to 28 in 2022. This shows that the number of specialists is increasing.

Figure 19 below shows the trends in total oral health staffing establishment in public health facilities from 2021 to 2024, while figure xxx shows the numbers by cadre of oral health staff.

Figure 19: Trends in total oral health staffing establishment in public health facilities from 2021 to 2024

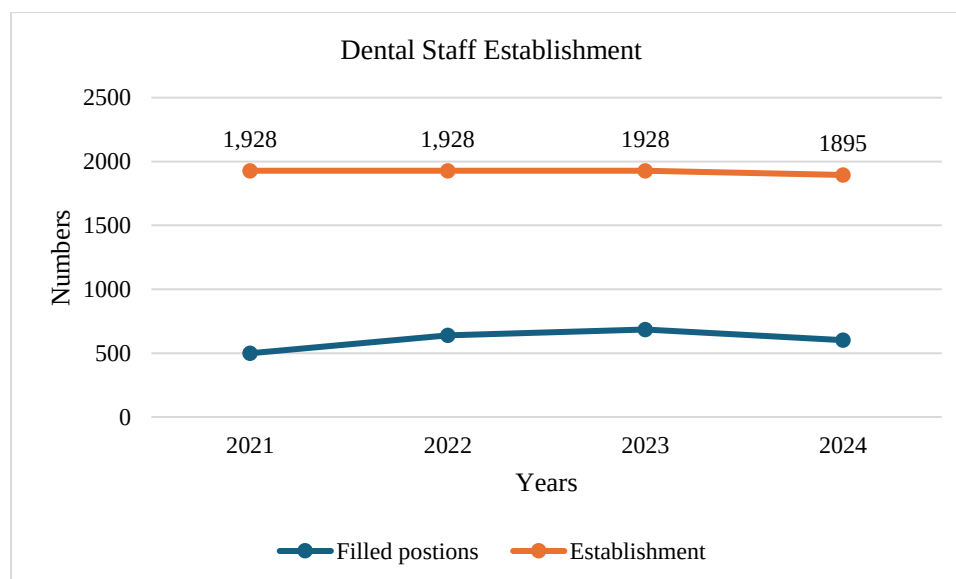
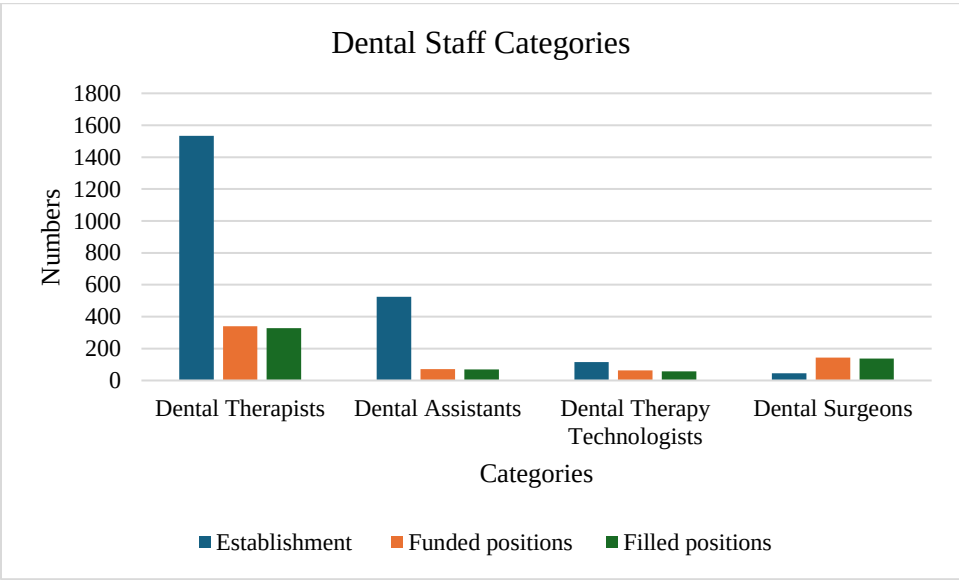


Figure 20: Dental staff categories in public health facilities



At the time of the mid-term review, the three interventions in the plan had been partially implemented. The staff establishment of the oral health personnel has increased from 1,050 to 1895 dental personnel. The number of Dental Prosthetists (technologists) in both private and public health facilities increased from 20 in 2021 to 28 in 2022. This shows that the number of specialists is increasing.

At the time of the mid-term review, the process for the procurement of the initial 30 dental chairs, instruments, dental x ray machines, autoclaves and micromotors are at evaluation stage. Contracts for supply of dental commodities were signed through ZAMMSA in 2024, and these commodities are expected in the country in the first quarter of 2025. However, through collaborations, nine (9) dental chairs have been donated and are in transit.

The oral health information system has been partially implemented. Some indicators were included in the DHIS2, but do not capture all the keys areas of the oral health services. Furthermore, the findings of the four (4) research conducted by mid-term review show that the dental caries has reduced to 67% from 80% in 2024. This achievement has surpassed the plan’s target of 70%. Implementation of the interventions in this strategic area has is mainly affected by Inadequate human resource for the dental services, limited infrastructure for the dental services, Inconsistent supply of dental commodities, Obsolete equipment in most health facilities, Inadequate services and research capacities to reach the required standards in providing quality oral health services.

Moving forward, to strengthen this strategic area, there will be a need to include more indicators in the DHIS tool, a to lobby for training of more specialists in dental services.

3.7.10 Cardiovascular services

No data

3.8 Blood transfusion services

Strategic objective 1: Increasing the annual blood collection from 110,000 units in 2021 to 400,000 units in 2026.

This was planned to be achieved through Strengthening and expanding blood donor retention schemes, using the Donor Recruitment, Retention and Recall (DRRR) strategy. Also, through Setting up a National Call Centre (NCC), as part of marketing tool under Donor Recruitment, Retention and Recall (DRRR). Other planned strategic interventions included Securing adequate transport for collection, distribution of blood and post donation counselling activities.

Achievements Reported

Significant progress has been made in the implementation process of the NHSP interventions. The total amount of blood collected by December 2024 was 190 479 units which was a 46% increase from the previous year. The Donor Recruitment Retention and Recall Strategy has been partially implemented through the usual current Donor Recruitment drives in the communities during which educational sessions are conducted. The fleet of transport has been boosted as vehicles were bought for each province resulting in easing up transport during mobile blood collection distribution and post donation counselling. Most transfusing facilities (Hospitals) which were visited during the NHSSP MTR appreciation that blood stocks have significantly improved.

Table 11: Blood Collection Projection vs actual collection

Year	2023	2024	2025	2026
Projected	180,000	260,000	360,000	400,000
Actual	130,166	190,479	325,000	400,000

The current improvements, notwithstanding some intended interventions such as the creation of the Donor Call Centre and full implementation of the Communication strategy, has not yet been done due to lack of funding. The Cabinet Office under Public Service Management Division (PSMD) approved the ZNBTS staffing level to the tune of 270 positions but so far treasury authority has not yet been fully granted. Staffing shortages are constraining current efforts for increasing blood collection.

Going in the second half of the NHSSP implementation, pertains to objective 1, there is need to accelerate full implementation of all the strategic interventions such as the creation of the Donor Call Centre and Blood Donor loyalty programs which are under a comprehensive communication strategy and earlier planned in order for the Blood Service to collect the projected 400 000 units by the year 2026

Strategic objective 2: To improve the availability and accessibility of safe blood and blood components in all health facilities by 2026.

To achieve this, it was planned that there should be an uninterrupted supply of essential blood transfusion commodities, reagents and consumables. Also, there was need to Extend capacities for automated blood processing at Provincial centres from the current one (1) to eventually all the ten

(10) Centres. Further, procurement of cold chain equipment to increase storage capacity for blood and blood components. In addition, setting up a total of 20 District Secondary Hubs (2 per province) as additional Blood Storage and distribution points was envisioned as one way of improving accessibility to Blood and Blood components by patients as this would result in a total of three (3) points of blood distribution per province from the current one (1) point which is the Provincial Blood Centre.

Achievement Reported

There have been very minimal interruptions in the availability of essential commodities, reagents and consumables as ZAMMSA has improved in the procurement and delivery processes. Availability of essential supplies from ZAMMSA stands at about 80%. This enabled 100% fulfilment of testing collected blood for Transfusion Transmissible infections inclusive of HIV, Hepatitis B, Hepatitis C and Syphilis.

The following Cold Chain equipment for Secondary Hubs were procured, installed and commissioned at the Secondary Hubs : 20 Blood Bank Refrigerators, 20 Plasma Freezers, 96 Transport Cooler Boxes. In addition, 10 Platelet incubators were procured for the (10) Provincial Blood Centres. Figure 21 below are images of some of the new cold chain equipment in some of the health facilities.

Figure 21: Images of some of the new cold chain equipment in some of the health facilities



Nevertheless, even with this progress, the refurbishment of the Primary Hubs to Good Manufacturing Practices (GMP) standards has not been completed yet. Construction of Secondary Hubs has not been completed yet. The Covid 19 epidemic preparedness and Health Systems Strengthening Project, under the World Bank came to an end on the 31st of December 2024 and funds were no longer available to be expended for refurbishment and construction works.

Moving forward, the refurbishment of Primary Hubs which are Provincial Blood centres where Blood is processed and tested should be considered for funding by the Ministry of Health under the World Bank HIT Project needs to be prioritized.

In addition, the construction of the secondary Hubs at selected Districts should also be considered for funding under the World Bank Health Innovative Technologies (HIT) Project needs to be finalized.

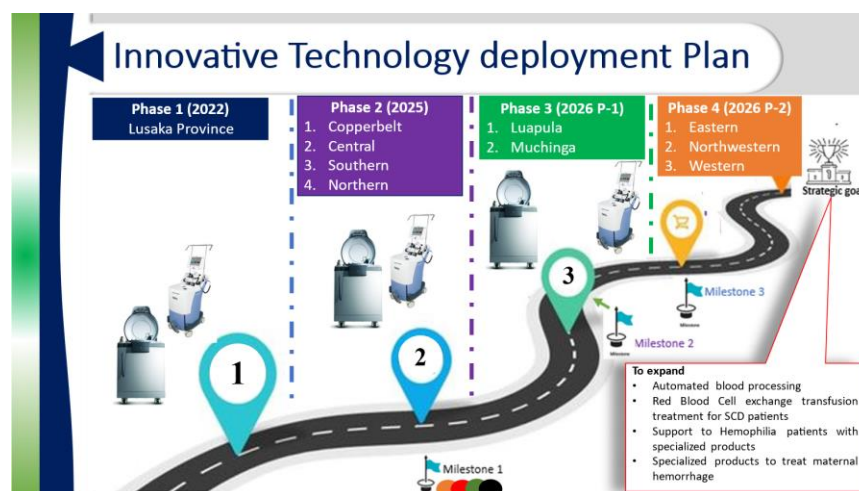
Strategic objective 3: To expand capacities for apheresis procedures to meet the National needs for Plasma and cellular therapies by 2026

This was to be achieved through Introduction of Individual Donor-Nucleic Acid Testing (ID NAT) which is one of the prequalification requirements for Contract fractionation and extension capacities for Apheresis procedures to all Provincial Blood Centres.

Achievement Reported

Deployment of Equipment for apheresis procedures to cover additional Provincial centres has been planned in a phased manner (Figure 22 below). Extended installation and commissioning will commence the month of March 2025. This will bring a number of Provincial Centres with capacity for apheresis procedures to 5 by second quarter of 2025 and eventually to cover all the ten (10) Centres.

Figure 22: Schematic Presentation of Equipment Deployment phases



Even with this progress, the equipment for Individual Nucleic Acid testing has not yet been acquired as the procurement process is planned for the year 2026.

Strategic objective 4: To set up National Centre for tissue/HLA typing and Human genetic analysis and paternity testing by 2026

This was to be achieved through Establishment and operationalization of the National Centre for Tissue, Human Leucocyte Antigen (HLA) typing and Human Genetics as well as Reviewing and finalization of the Blood Transfusion, Tissue and Transplant Act

Progress so far: The activities have been planned to commence in the year 2026

Challenges: The foreseeable risk is failure to create and actualize the National Centre for Tissue/HLA typing if the Blood Transfusion, Tissue and Transplant Act is not reviewed

Strategic Objective 5: To strengthen institutional and regulatory framework by 2026.

This was to be achieved through Reviewing and finalization of the Blood Transfusion, Tissue and Transplant Act. Also to strengthen and enact the institutional and regulatory framework by 2026. Review and finalize the Blood Transfusion, Tissue and Transplant Act

Progress so far: Activities are planned to commence in the second half of the NHSSP commencing the year 2025

Challenges: The foreseeable risk is failure to strengthen institutional and regulatory framework by end of 2026, if the Tissue and Transplant Act is not reviewed

3.9 Diagnostic services

3.9.1 Pathology and laboratory services

Strategic objective 1: Increasing the proportion of hospitals providing laboratory services appropriate for the level of care by 2026

Progress so far

Some of the progress made in this objective includes:

- Strengthening National Laboratory Testing Capacity (50% Implementation)
 - Progress made includes policy and legal framework development (50%) and infrastructure improvements (reagents and equipment at 60%, workforce at 65%).
 - Laboratory Information Systems (LIS) have been expanded to 50% of the targeted facilities.
 - Quality Management Systems are at 60%, with external quality assessments increasing.
 - Biosafety and Biosecurity initiatives have progressed to 50%.
 - Multi testing platforms have been introduced to ensure prudent use of equipment i.e. GeneXpert and Cobas 6800 can do TB, VL and HPV testing.
 - Molecular testing such as PCR and Genomic Sequencing has been introduced in all 10 provinces.
- Strengthening Laboratory Supply Chain Management (75% Implementation)
 - Laboratory supply chain management systems have been strengthened across laboratory networks.
 - Improved forecasting and procurement planning have enhanced reagent availability.
 - No significant progress due to lack of mandate over this intervention. A draft infrastructure has been developed and awaits finalization.
- Laboratory Equipment Management, Maintenance, and Disposal (40% Implementation)
 - Equipment maintenance programs have been initiated through the 3-year contact framework for the equipment linked tests, but funding delays has affected progress, there are challenges in spare parts procurement for other auxiliary equipment

Some of the challenges encountered included:

- Policy and Legal Framework: Still requires further strengthening to improve enforcement and compliance.
- Infrastructure: No progress in constructing or rehabilitating laboratories due to funding constraints and lack of mandate.

- Supply Chain Issues: While progress is significant, stockouts still occur due to logistical challenges.
- Equipment Maintenance: Procurement delays and inadequate spare parts affect functionality.
- Workforce Gaps: Despite 65% progress, the retention of trained personnel remains a challenge.
- Data Systems: Laboratory Information Systems are only at 50% integration, limiting data-driven decision-making.

Moving forward, the following considerations will be needed:

- Policy and Governance: Advocate for increased government funding and streamlined regulatory frameworks.
- Infrastructure Development: Identify funding opportunities to support laboratory construction and rehabilitation.
- Supply Chain Optimization: Enhance forecasting and procurement mechanisms to reduce reagent and equipment stockouts.
- Create Laboratory Director Positions at Zammsa for enhanced response to challenges facing laboratory commodity management
- Workforce Strengthening: Improve incentives and career progression to retain trained laboratory personnel.

Strategic objective 3: To expand QMS implementation, strengthen electronic laboratory information systems, provide training for accreditation, standardize internal quality control, and improve external quality assessment schemes

Progress So Far

- Establishment of QA positions: 0% implementation – Still under discussion regarding scope and requirements implementation of QMS programs has progressed with 65 labs on the program and only one GRZ staff leading the but remains below target.
- National QMS Standardization: 12% implementation 65 of 534 labs, national QMS templates developed; 51 staff have been trained to implement the program, but this remains slow.
- LIS Expansion: 50% implementation – 267 out of 534 laboratories have some form of electronic LIS that is DISA, DISA POC, DISA link, eLabs and Smartcare. Though the rolled out has progressed well but require further integration
- QMS Training & Mentorship: 90% implementation – Frameworks and guidelines have been developed. Training of over 500 staff have been conducted using local and international programmes, and accreditation progressing well with 14 labs being accredited as of 2024.
- Internal Quality Control (IQC): 50% implementation based on the accreditation and certification; and level II labs with equipment linked testing. Some improvements have been observed in standardizing internal quality control, but further expansion is required to ensure uniform application across all facilities.
- External Quality Assessment Schemes: EQA subscription for all tests increased from 25 laboratories (4.7%) to 55 laboratories (10.3%) in 2024. Microbiology (AST), molecular (EID) and Rapid Serological (HIV RT, Recency, syphilis and Malaria) EQA panels produced locally

but there is need additional funding and technical support to be fully implemented across all laboratories.

Some of the challenges reported during implementation include:

- Limited Resources and Funding: Financial constraints continue to hinder the expansion of QMS implementation and training programs.
- Inconsistent QMS Implementation: Variability in adoption across different facilities due to lack of structured oversight.
- Gaps in Training and Mentorship: While training programs exist, there is a need for more hands-on mentorship to ensure quality standards are met.
- Electronic System Integration Issues: Some facilities face challenges in integrating laboratory information systems with existing hospital infrastructure and system integration.

Moving forward, the following considerations will need to be made for this objective.

- Accelerate the formalization of QA positions at central and provincial levels.
- Strengthen stakeholder engagement for QMS standardization and implementation.
- Strengthen training initiatives with a focus on practical application and continuous mentorship.
- Invest in digital infrastructure to improve connectivity and efficiency in laboratory information management.

Strategic objective 4: Strengthening laboratory networking systems for specimen referral, enhancing digital laboratory information systems, and building staff capacity in sample management

Progress so far

- The integrated sample courier system. Some progress in networking systems, but inefficiencies remain in sample transport.
- Digital laboratory information systems have been partially implemented.
- Training programs for sample management have been conducted but need further expansion.
- Lab Networking for Sample Referral: Progress data missing.
- Digital LIMS Implementation: 50% completion – Several facilities have adopted digital systems for sample tracking and management.
- Capacity Building for Sample Handling: Progress not explicitly reported

Some of the implementation challenges reported include:

- Delays in sample transport due to logistical constraints.
- Limited infrastructure i.e. motorbikes and vehicles to support fast sample transport.
- Delayed adoption of digital LIMS in some facilities due to budget constraints.
- Inconsistent sample handling practices across different healthcare levels.

Moving forward, some of the key considerations for this objective will include:

- Strengthen the specimen transport network by having dedicated staff and motorbikes to sample referral
- Expand digital infrastructure for laboratory management.
- Full Government funding support to enhance sustainability
- Standardize sample management protocols and training.
- Conduct refresher training for laboratory staff on best practices in sample handling.

Strategic objective 5: Developing a regulatory framework for laboratory services, implement occupational health systems, and establish a national laboratory research agenda

Progress So Far

- Regulatory Framework for Laboratory Services (0 %Implementation)
 - Nothing was done.
- Occupational Health Systems for Laboratory Staff (0% Implementation)
 - Health and safety protocols not been introduced.
- National Laboratory Research Agenda (0% Implementation)
 - No significant progress has been made in developing a structured research agenda.
 - Though the QMS does discuss the agenda in the QMS TWG
 - Lack of funding and limited collaboration with research institutions have hindered implementation.

Some of the key challenges reported in this area included:

- Regulatory Gaps: While policies are being drafted, legal enforcement is still weak, and private laboratories lack standardized oversight.
- Workforce Retention Issues: Staff shortages persist, and incentives for laboratory professionals remain inadequate.
- Occupational Health Deficiencies: Implementation of occupational health measures is inconsistent across facilities, with limited budget allocation for staff well-being.
- Lack of Research Focus: No coordinated research agenda exists, making it difficult to prioritize laboratory-driven public health and clinical research.
- Training Gaps: Limited opportunities for continuous professional development and specialized training hinder skills advancement.

Moving forward, some key considerations for this objective shall include:

- Regulatory Strengthening: Finalize and implement the laboratory regulatory framework, ensuring compliance and oversight for both public and private laboratories.
- Workforce Development: Increase recruitment efforts, provide better incentives, and offer career growth opportunities to improve staff retention.
- Occupational Health Expansion: Implement standardized occupational health policies across all laboratory facilities, including mental health support and workplace safety programs.
- Research Integration: Establish partnerships with universities, research institutions, and funding bodies to develop and support a national laboratory research agenda.

- Training and Capacity Building: Expand training programs, mentorship initiatives, and scholarships for laboratory personnel to enhance expertise and performance in research

3.9.2 Radiology services

One of the primary objectives in the NHSSP 2022-2024 was to increase the proportion of hospitals providing imaging services appropriate for the level of care by 2026.

To achieve this increase, 4 strategic objectives were set including improve availability of imaging equipment and supplies, improve availability of staff appropriate for each level of care, build capacity at all levels of care for imaging supplies, assessment, quantification, procurement and management as well as Assess and update the register for imaging services being provided by each level.

Achievement Reported

The MTR found that improving availability of imaging equipment and supplies has been partially implemented at 40% out of the projected 80% in 2026. In 2023, medical equipment such digital X-ray Machines, Mobile Digital X-ray Machines, Ultrasound Equipment, CT Scanners, Infant incubators, infant resuscitators, beds, and Mattresses were procured and distributed to health facilities. In terms of improving the availability of staff appropriate for each level of care, data shows that the availability of staff was at 40%, this was due to the low numbers of medical imaging personnel on recruitment annual priority list. For capacity building of staff at all levels of care for imaging supplies, assessment, quantification, procurement and management, this was at 20% as at the midpoint of the NHSP assessment. Unfortunately, there was no data on the assessment and updating of the register for imaging services being provided at each level.

Some of the challenges reported in this objective included:

- Limited X-ray Film Supply: Delays in procuring X-ray film has hampered service delivery at all levels.
- Workforce Shortages: A shortage of radiologists to interpret scans and specialized radiographers to perform specialized imaging procedures.
- Reporting Delays: Long turnaround times for radiology reports are a concern.
- Poor supply chain management system for imaging consumables and Inadequate QA/(QC) in medical imaging.

Moving forward, the following considerations will need to be undertaken:

- Moving forward, increasing digitization of radiology equipment will significantly reduce reliance on films,
- Training of more radiologists
- Training and certifying experienced radiographers in basic radiography image interpretation and reporting thereby alleviating the pressure on radiologists.
- Installing Picture Archiving and Communication Systems (PACS) and Radiology Information Systems (RIS) in all facilities with digital equipment, these systems will improve accessibility and reporting efficiency.

3.9.3 Nuclear medicine

Nuclear medicine plays a vital role in diagnosing and treating various diseases, especially cancers. It utilizes radioactive materials (radionuclides) to create images and assess organ function. Unfortunately, Zambia faces challenges in this crucial field. The University Teaching Hospitals (UTH) Adult Unit, the sole provider of nuclear medicine services in Zambia has experienced a significant service reduction due to a broken SPECT gamma camera.

One of the primary objectives in the NHSSP 2022-2026 was to increase the number of facilities providing nuclear medicine services from 1 health facility in 2021 to 4 health facilities by 2026. This goal implies that by the mid-point of the plan in 2024, the number of health facilities has increased to 2 health facilities.

To achieve this increase, 5 strategic objectives were set including improving the availability of nuclear medicine equipment and supplies in the old centre as well as the new ones, establishing E-patient record Management Systems (EMS) and strengthening the integration of nuclear medicine in national healthcare system development. Further, building capacity in nuclear medicine diagnosis and therapy and supporting the local production of radioisotopes through the establishment of the Centre for Nuclear Science and Technology (CNST) were also set to support the increase.

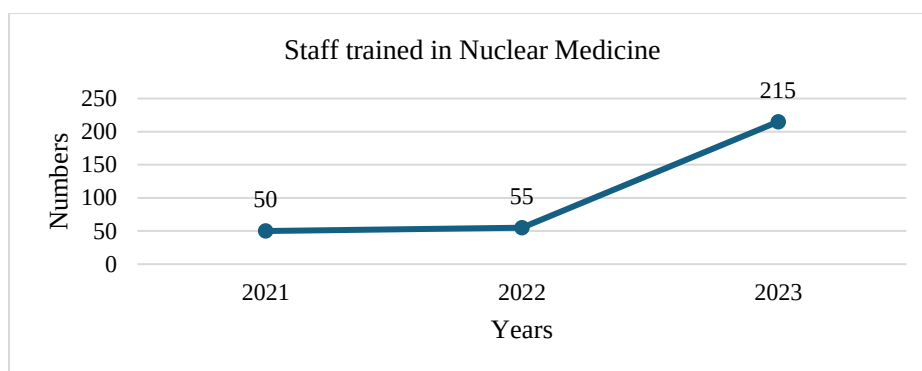
Achievements Reported

This review found that improving the availability of Nuclear Medicine equipment and Supplies in the old and new Centres has been partially implemented. In 2023, medical equipment such digital X-ray Machines, Mobile Digital X-ray Machines, Ultrasound Equipment, CT Scanners, Infant incubators, infant resuscitators, beds, and Mattresses were procured and distributed to health facilities. Additionally, a modern SPECT/CT system has been procured to improve availability of equipment for the services. The provision of the equipment has been estimated to have increased the number of well-equipped health facilities by 60%, significantly enhancing their capacity to deliver comprehensive healthcare services.

The establishing of the E-patient Record Management Systems (EMS) has not been implemented. The strengthening of integration of nuclear medicine in the national healthcare system has been partially implemented though integration of nuclear medicine into the decentralized oncology services has not been done.

Further, building capacity in nuclear medicine diagnosis and therapy has been partially implemented. The trainings have been ongoing since 2021, and Figure 23 below shows the progression in the number of personnel trained in nuclear medicine diagnosis and therapy.

Figure 23: Number of personnel trained in nuclear medicine diagnosis and therapy.



Supporting the local production of radioisotopes through the establishment of the Centre for Nuclear Science and Technology (CNST) were also set to support the increase has not been implemented.

Some challenges reported in this area include:

- Inadequate funding to support procuring of essential commodities and equipment, servicing and repairs of the equipment that is frequently breaking down and invests in human resources.
- Inadequate equipment selection and distribution leading to inefficiencies.
- Limited invests in human resources e.g., limited number of technologists and nurses trained in nuclear medicine.
- Limited Nuclear Medicine centres leading to underutilization of the services by clinicians.
- The establishment for nuclear medicine is still not populated.

Moving forward, the following considerations will need to be incorporated:

- To secure dedicate funding towards nuclear medicine services to enhance healthcare services country wide through infrastructure improvements, essential logistics and supplies, guidelines developments and wider implementation of the EQA program, and address accreditations and calibration costs
- To strengthen collaborations and innovative approaches to improve service delivery.
- Investing in human resources by developing and retaining qualified personnel for efficient laboratory operations.

3.10 Rehabilitative services

Table 12 below provides a summary of the performance for indicators outlined in the NHSP for this strategic area.

Table 12: Summary of Performance Against Targets for Rehabilitative Services Indicators

Indicator	Performance Against Target	Colour Code
Number of districts implementing community-based rehabilitation (CBR) services	28.57	
Number of hospitals providing comprehensive rehabilitation services	55.56	

Indicator	Performance Against Target	Colour Code
Number of hospitals providing specialized, high- intensity rehabilitation services	0	

Rehabilitation is primarily focused on improving functioning so that people can perform to their maximum capacity, allowing inclusion and participation in society. It covers multiple areas of health and functioning, including physical, mental health, vision and hearing. The physical rehabilitation disciplines include physiotherapy, orthotics and prosthetics, occupational therapy, speech and language therapy. It has been estimated that only 20% of people who need an assistive device have access to one, demonstrating inadequacy in the provision of Assistive Health Technology, a component of rehabilitation which entails provision of assistive products for mobility, vision and hearing. The NHSSP set out four objectives in this strategic area.

Objective 1: To ensure efficient and effective rehabilitative services at all levels of care, in order to contribute to improved health outcomes is attained

For this objective five specific interventions were planned among them were to Improve the provision of infrastructure for rehabilitation services, Expand services to Primary Health Care (PHC) and the communities, in order to improve service delivery and accessibility, Expand prosthetics/orthotics, occupational, speech and language therapy to second and first level hospitals, Building capacity in HR at all levels of care and Improve the procurement of equipment and supplies for service provision.

This objective was partially achieved as only 5 hospitals are providing comprehensive rehabilitative services, namely YTH Hospitals, Kitwe Teaching Hospital, Ndola Teaching Hospital, Livingstone teaching Hospital and Arthur Davison Hospital showing an addition of only one hospital from the initial 4

Objective 2: To scale up the implementation of community-based rehabilitation (CBR) services from 6 districts to 24

Three interventions were planned and included Develop a National Rehabilitation Plan to strengthen governance, strengthen mentorship and technical support supervision, improve transport logistics to support CBR programmes.

There was a reduction in the number of districts implementing Community based Rehabilitation (CBR) from 6 to 4 districts. This is partially due to the lack of specialized personnel spearhead the implementation. However, outreach services for children with Neuro Developmental conditions, club foot, Ear Nose and throat (ENT) and Eye care services were conducted in Northern, Southern, Muchinga and Copperbelt Provinces supported by partners such as Christians Blind Mission (CBM), Norwegian Association of the Disabled (NAD) and Sight Savers.

Objective 3: To increase the number of hospitals providing specialized, high- intensity rehabilitation services from 0 to 4 hospitals.

For this objective, four Interventions were planned and included the following: Strengthen the provision of assistive products, develop a priority list for assistive devices to support provision of services, Build capacity of staff in provision of technologically advanced rehabilitation services,

Improve the procurement of products and components/materials for manufacture of assistive devices.

Priority list of the assistive devices was done, and capacity building was conducted, and procurement of some assistive devices has been concluded though the quantities have been not adequate and very slow process.

However, there has been improved service provision in Physiotherapy services due to increased numbers of recruited professionals and timely service delivery. There has been an increased numbers of Children with neurodevelopmental conditions, Clubfoot and other conditions accessing Physiotherapy services, Eye care and Orthopaedics, audiology and assistive technology services.

There are lies several challenges to adequately meet the NHSP targets Zambia intends to achieve for the rehabilitative services which include, lack of appropriate infrastructure especially for the rural communities. Inadequate professionals and advanced and the latest equipment and assistive devices

It therefore recommended that the infrastructure for rehabilitative services be expanded and modernized, Procurement of Assistive devices be expedited and more professional be recruited and capacity built.

3.11 Nursing and midwifery services

The NHSSP 2022-2026 had two objectives in this strategic area. These were to produce educated, competent, compassionate and motivated nursing and midwifery workforce and to provide safe, acceptable, equitable and timely nursing and Midwifery services to clients at all levels of care. Eighteen (18) strategic interventions were planned to be conducted to achieve these objectives.

The review established that 12 interventions have been successfully implemented leaving out 6 which would be implemented in the remaining time of the plan. The implementation of the strategic intervention of the Nursing and Midwifery Services is on course and may be fully implemented at the end of the plan.

According to routine data available, the Ministry working in conjunction with the Nursing and Midwifery Council of Zambia (NMCZ) developed key policy documents which are aimed at improving efficiency and setting standards relating to nursing and midwifery education, training, practice and conduct. Capacity building and training was to enhance skills and competencies for nurses and midwives. Preceptorship trainings were conducted and trained 50 nurses and midwives. There is improvement in nursing care offered to patients as a result of nursing/midwifery audits, monitoring, supervision and mentorship. Leadership and management orientations given to nurse/midwife leaders has also assisted in strengthening of management skills. Some facilities are auditing nursing and midwifery care being offered for example, UTH Children's Hospital, Chainama Hills Hospital, Chikankata, Monze and Mwami Mission Hospitals, Mazabuka General Hospital and Nchanga North General Hospital. As at the midterm review the proportion of health facilities providing services according to the package of care was 90.6%.

Despite marked improvements, there are still a number of challenges that need to be addressed in order to strengthen nursing and midwifery services and education. These include lack of transport which hinders prompted responses to facilities within and especially outside Lusaka district, inadequate office furniture and equipment like printers, photocopier and computers, inadequate

hospital linen and basic equipment for both health facilities and skills laboratories in Nursing and Midwifery training institutions to facilitate provision of nursing and midwifery education and care. Furthermore, some of the health facilities do not have treatment rooms and sluice rooms making work for nurses and midwives difficult.

Nursing and Midwifery Training Institutions will continue with capacity building of Nurse/Midwife Educators in Basic Sign Language and Ultrasonography to effectively teach the Units that have been introduced in the curriculum for Registered Nurses and Midwives, capacity building of Nurse/Midwife Educators in Leadership and Management, Preceptorship and Respectful Maternity Care and Basic Sign Language to continue, provision of Technical Support, nursing and midwifery Audits and mentorship to continue. Procurement of equipment for the skills lab e.g. Mankins, Simulators, transport for training institutions need to be given the attention as well.

To fully achieve the objectives set out in implementing the Nursing and Midwifery Services, there would be need to implement the pending 6 strategic interventions. These are:

- Strengthen and expand the availability of facilities by providing specialized nursing and midwifery services at all levels of health service delivery.
- Strengthen provision of public health nursing services.
- Improve documentation of nursing and midwifery care.
- Build capacity in nursing and midwifery educators to enable them train specialized nurses and midwives.
- Develop a stakeholder engagement and coordination mechanism.
- Build capacity of nurses and midwives in conducting research.

4 Progress towards NHSP Strategic Direction 2: Strengthen integrated health support systems to facilitate attainment of the targets under SDG 3 and UHC

The NHSP 2022 - 2026 identified the following strategic areas to advance its strategic direction two.

- Health Workforce
- Essential Medicines and Medical Supplies
- Physical Infrastructure, Medical Equipment and Transport
- Health Information, Research and Innovation
- Health Care Financing
- Leadership and Governance

This section reports on the progress made against targets for set indicators, progress made with the implementation of strategies, interventions and activities including level of alignment; and facilitators and barriers of performance for each of these areas

Table 13 below summarises the performance against targets for the priority indicators outlined in the NHSP for this strategic area.

Table 13: Summary of Performance Against Targets for Strategic Direction Two Indicators

Indicator	Performance Against Target	Colour Code
Availability of essential medicines and supplies in all health facilities	100	
Decentralization of the regulatory network	100	
Number of specialists trained	100	
Proportion of approved posts filled by skilled personnel	83.97	
Number of active local manufacturing industries	75	
Pharmaceutical care at all levels	75	
Proportion of public hospitals with medical supply systems	100	

4.1 Health workforce

To address the human resource challenge in the health sector, the NHSP 2022-2026 set out to increase availability of skilled, motivated and equitably distributed health workforce through the following objectives; i) To increase the health workforce fill rate from 48% (63878) in 2021 to 70% (98,627) by 2026; ii) To improve performance of health workers at all levels; iii) To increase the number of specialized training from 500 in 2021 to 700 specialists by 2026 and iv) To provide adequate appropriate utility transport for efficient logistical support.

Objective 1: To increase the health workforce, fill rate from 63878 to 98,627 by 2026

To achieve this, the midpoint performance for the NHSP in 2024 should be approximately at 85003 HWs. Two strategic interventions were established to facilitate this objective. These were Scaling up recruitment of health workers in accordance with the approved staff establishment and treasury authority in addition to improving the equitable distribution of health workers through the needs and priority identification approach.

Achievement Reported.

According to the 2024 field data review, the establishment has since been increased to 140,895 and 78,191 (55%) of the positions are filled from the 140,895 established positions leaving a variance of 62,704 (44%). Table 14 below shows the health workforce filled positions against established positions.

Table 14: Health workforce filled positions against established positions by cadre

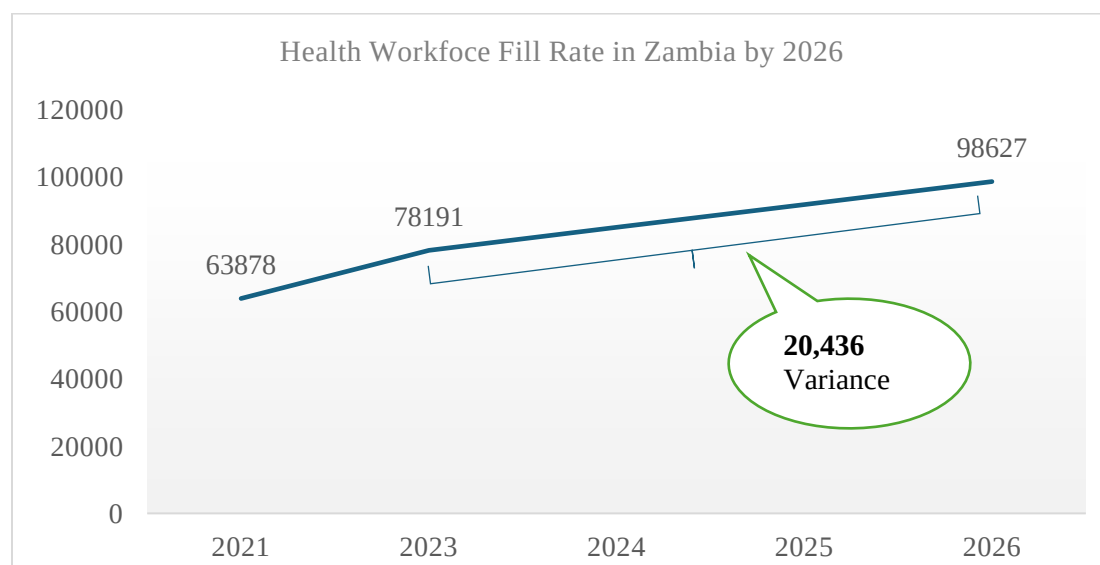
Cadre	Establishment 2024	Filled by 2023	Variance
Administration	52,472	25,002	27,470
Audiology	132	4	128
CHAs	4,022	2,095	1,927
Clinical Officer	8,271	5,639	2,632
Dental	1,895	602	1,293
Environmental Health	5,669	3,473	2,196
Laboratory	3,246	3,031	215

Medical Doctor	6,308	3,501	2,807
Medical Physicists	5	3	2
Midwife	11,963	4,803	7,160
Nurse	36,811	24,296	12,515
Nutrition	1,832	768	1,064
Orthopaedics	103	18	85
Optometry	39	22	17
Pharmacy	2,943	2,087	856
Physiotherapy	1,179	1,051	128
Radiology	1,963	1,172	791
Teaching	2,042	624	1,418
Grand Total	140,895	78,191	62,704

Source-field visit data.

Thus, to reach the 70% fill rate target by 2026, 98,627 positions should be filled, of which 78,191 positions are currently filled leaving a variance of 20,436.

Figure 24: Health workforce fill rate



The country is thus on track in terms of meeting the 2026 target of increasing the health workforce establishment to 70%. This tremendous progress is attributed to the 2022/2023 recruitment of 11,276 health workers and 7,568 replacements making a total of 18,834 health workers engaged as indicated in the 2023 annual progress report. Further, The MoH has been recruiting and deploying staff to various parts of the country including rural and remote facilities as shown in the Table 15 below.

According to the field data review, Zambia has a health workforce density of 35.25 which is significantly higher than the current WHO minimum threshold of at least 23 health workers per 10,000 population. However, there are still challenges in the retention of the health workforce due to factors such as, Brain-drain due to inadequate motivation and better opportunities elsewhere, Lack of promotions for upgraded staff, Inadequate specialized staff, Limited skills mix, shortages

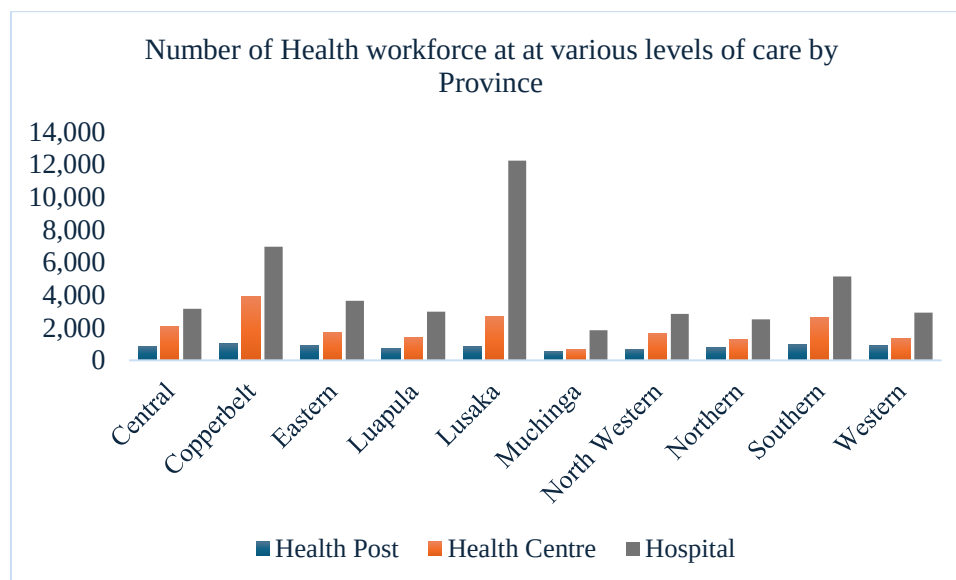
of skilled workforce at lower health facility levels causing facilities to operate with minimal personnel, affecting service delivery. Table 15 below shows Lusaka (16,766) and Copperbelt (12,690) having the highest number of the health workforce deployed with Muchinga (3,531) and Northern province (5,218) having the least number of the health workforce.

Table 15: Health workforce distribution in public facilities by Province

<i>Cadre</i>	<i>Central</i>	<i>Copperbelt</i>	<i>Eastern</i>	<i>Luapula</i>	<i>Lusaka</i>	<i>Muchinga</i>	<i>North Western</i>	<i>Northern</i>	<i>Southern</i>	<i>Western</i>	<i>Grand Total</i>
<i>Administration</i>	1,664	3,617	1,879	1,554	6,081	850	1,456	1,386	2,823	1,581	22,891
<i>Audiology</i>					1						1
<i>CHAs</i>	200	140	245	234	141	147	250	257	276	250	2,140
<i>Clinical Officer</i>	657	860	613	522	774	327	507	502	867	544	6,173
<i>Dental</i>	60	126	61	48	139	29	35	39	114	52	703
<i>Environmental Health</i>	372	464	436	330	575	219	277	309	510	320	3,812
<i>Laboratory</i>	276	648	246	187	557	148	163	178	434	184	3,021
<i>Medical Doctor</i>	223	619	250	210	1,127	149	207	185	351	166	3,487
<i>Medical Physicists</i>					3						3
<i>Midwife</i>	554	951	530	380	797	263	408	396	705	413	5,397
<i>Nurse</i>	2,082	4,098	2,058	1,754	5,138	997	1,946	1,474	3,292	1,834	24,673
<i>Nutrition</i>	91	92	81	57	141	46	58	42	104	61	773
<i>Optometry</i>	5	6	5	3	9	7	6	5	8	1	55
<i>Orthopaedics/Prosthetics</i>	1	7	1		6				2		17
<i>Pharmacy</i>	182	376	180	107	541	85	119	102	231	145	2,068
<i>Physiotherapy</i>	91	200	107	76	182	46	69	77	141	75	1,064
<i>Radiology</i>	122	243	118	82	244	55	64	81	188	84	1,281
<i>Teaching</i>	39	102	42	38	167	22	48	44	78	52	632
<i>Grand Total</i>	6,760	12,690	6,993	5,723	16,766	3,531	5,754	5,218	10,265	5,903	78,191

To reach the 70% target by 2026, the MoH will need to continue recruiting and deploying staff to various parts of the country including rural and remote facilities putting into consideration the various skills mix. Figure 25 shows that the distribution of the health workforce is more in hospitals than in health centres and health posts. To achieve universal health coverage, there is a need to strengthen and increase the health workforce in primary health care settings.

Figure 25: Health workforce distribution by level of care in the 10 Provinces of Zambia



Source-HR Office

Objective 2: To increase the number of specialized trainings from 500 in 2021 to 700 specialists by 2026

In reference to the performance rating conducted by HR, currently there are a total of 778 qualified specialists in the country. However, according to the Health Labor Market analysis 2023 report, the stock of qualified Specialist medical practitioners was found to be 589 of which a total of 555 are employed and of these 177 are employed in the public health sector and 378 are employed in the Private health sector. This is shown in Table 16 below. The distribution of the health workforce in terms of specialists highlights disparities between the public and private sectors. There are also shortages of specialists in rural areas thus, efforts towards training more specialists should continue in order to create a more equitable healthcare system and therefore improve health outcomes across the country. Additionally, harmonization of HR data is key in addressing issues of disparities from various HR data sources.

Table 16: Number of employed Specialist medical practitioners

Specialist medical practitioners	Stock of qualified health workers	Number Employed in Public Sector	Employed in Private Sectors	Total Number employed
<i>Adult Nephrologist</i>	1	0	1	1
<i>Adult Neurologist (Specialist)</i>	11	0	0	0
<i>Anaesthesia and Critical Care Specialist</i>	31	8	0	8

<i>Dermatology and Venerology Specialist</i>	2	0	2	2
<i>General Surgery Specialist</i>	94	94	0	94
<i>Internal Medicine and Gastroenterologist</i>	2	0	2	2
<i>Internal Medicine and infectious diseases specialist</i>	4	0	4	4
<i>Internal Medicine Specialist</i>	55	55	0	55
<i>Neonatologist</i>	1	0	1	1
<i>Obstetricians and Gynaecologists</i>	106	10	96	106
<i>Obstetrics and Gynaecology Oncologist</i>	5	2	3	5
<i>Ophthalmologist</i>	19	0	19	19
<i>Orthopaedics and trauma Surgeon</i>	48	0	48	48
<i>Pathologist</i>	19	1	18	19
<i>Paediatric and Child Health (Specialist)</i>	72	2	70	72
<i>Paediatric Surgeon</i>	9	0	9	9
<i>Psychiatrists</i>	10	3	7	10
<i>Urologist</i>	25	0	25	25
<i>Public Health Specialist</i>	53	0	53	53
<i>Radiologist</i>	22	2	20	22
Total	589	177	378	555

Source- Health Labor Market Analysis

To enhance staff retention, the MoH has been providing both monetary and non-monetary incentives to health workers in addition to using the decentralized approach where the Ministry has been recruiting health workers with a preference to local residents. This practice has ensured that deployed staff suffer less inconveniences with settling in a new environment. The Constituency Development Fund is also being used at local level to improve rural facilities by providing the required social amenities such as housing and school infrastructure.

To improve the performance of health workers at all levels of care, 3 strategic interventions were employed. The first being to strengthen the implementation of the Performance Management Package (PMP) of which the Digital APAS tools have been developed and have reached an advanced stage as the system testing is in progress. The second intervention was to strengthen implementation of the Human Resource Information System (HRIS) to support HR planning, training and decision making thus, the HRIS has been deployed to all districts and is currently being utilized. The last intervention was to strengthen retention mechanisms for health and teaching staff in health facilities and training institutions and so far, 116 out of 200 promotional posts for Teaching Staff have been implemented. Therefore, the country is on track in terms of meeting the 2026 target of improving performance of health workers at all levels of care.

4.2 Essential medicines and medical supplies

The NHSP 2022-2026 set out 10 objectives and 29 strategic interventions for Essential Medicine and Medical Supplies (EMMS).

Achievement Reported

As at the time of the review, 23 strategic interventions were successfully implemented, while 6 strategic interventions have not been implemented.

Drug availability has been maintained at 86% for Health Centres and 76% for Hospitals. During the period between 2022 and 2024, on average 3.7 number of medicines were prescribed to patients. The health facilities were able to supply at least 81% at every incidence which medicines were readily available. These medicines were readily fulfilled by available stock. This is mainly due to procurements from ZAMMSA whilst Districts and Hospitals were supplementing purchase of these drugs from the grants and NHIMA contributions. All the 42, 000 Health centre kits were delivered and consistent supply of vaccines. The proportion of the provinces with a scaled-up decentralisation of the regulatory framework is now at 91.5%. the number of active local manufacturing industries has increased from 5 to 6 and Proportion of public hospitals with medical supply systems standards at 100%. Pharmaceutical care had improved from 40% to 60% in all health facilities.

Despite marked improvements, there are still a number of challenges such as non-availability of an electronic system for managing stock of medicines that need to be addressed in order to strengthen Essential Medicines and Medical Supplies. These challenges also include inadequate skills of staff handling procurement of Medicines and Medical Supplies. Inadequate budget for the purchase of Medicines and Medical Supplies. The status of availability of medicines and medical supply is better due to the support received from Cooperating Partners especially in areas such as primary health care service.

To fully achieve the objectives set out in the NHSP by 2025, there would be need to implement the pending 6 strategic interventions. Continuous skills development for staff engaged with procurement and management of Medicines and Medical Supplies is required.

4.3 Physical infrastructure, medical equipment and transport

Physical health infrastructure and medical equipment are important inputs that are essential for the delivery of quality health services. The goal of Physical health infrastructure and medical equipment in the NHSP 2022-2026 was to increase the availability and access to health infrastructure by 2026. It had five (5) objectives, and fifteen (15) strategic interventions.

Achievement Reported

As at the time of this MTR, 12 out of the 15 strategic interventions set out under this strategic area had been successfully implemented. 3 were yet to be implemented.

The classification of health facilities In Zambia is in five (5) categories including 1st level hospitals, 2nd level hospitals, 3rd level hospitals, health centres and health posts. These facilities are distributed in provinces as outlined in the table 17 below:

Table 17: Distribution of Public and Private Health Facilities by Province and Facility Level in the Country

Province	1st Level Hospital	2nd Level Hospital	3rd Level Hospital	Health Centre	Health Post	Total
Central	11	1	1	173	159	345
Copperbelt	16	9	4	237	154	420
Eastern	13	2	1	207	183	406
Luapula	17	1		154	144	316
Lusaka	41	2	11	163	115	332
Muchinga	6	2		71	92	171
Northern	12	2		122	186	322
North-Western	10	3		182	143	338
Southern	14	7	1	235	209	466
Western	12	2		158	172	344
Total	152	31	18	1702	1557	3460

The proportion of health posts and centres with functional maternity wings and annexes was targeted at 55%. This was achieved at 55.5%. This drive was accelerated by the Government policy directive to have all health centres and health posts endowed with a functional maternity wing or annex. The table 18 below shows the number of functional maternity wings/ annexes that are functional at health centres and health posts by province:

Table 18: Number of maternity wings and annexes by province

S/n	Province	Maternity wings / Annexes
1	Central	151
2	Copperbelt	126
3	Eastern	248
4	Luapula	167
5	Lusaka	55
6	Muchinga	59
7	Northern	55
8	North-Western	102
9	Southern	154
10	Western	61
11	Total	1178

This information shows that for every four (4) health centres or health posts, there is at least (1) maternity wing or annex available for the maternity service to be provided. This improvement towards extending the provision of maternity health services to Zambians is therefore on course.

The Proportion of facilities with recommended waste management facilities targeted at 50% was achieved at 64.4%

According to data available from the programme, in terms of availability of functional ambulances at health centre level, the achievement was 19.8% against a target of 80% whilst at 1st, 2nd and 3rd level hospitals only 29.6% of the targeted 80% ambulances were functional.

The MoH, ensured that all functional medical hubs were maintained at 100%. The proportion of functional essential equipment at each level of care (1st Level Hospital) was targeted at 59%. This was achieved at 69.8% for the first level hospitals, 74.2% for second level hospitals and 28% for level three hospitals all which, were targeted at 50%.

Despite marked improvements, there are still a number of challenges that need to be addressed in order to strengthen Physical Health Infrastructure and Medical equipment, these include inadequate transport though the Ministry had purchased a number of vehicles for general use and received transport from Cooperating Partners for the same purpose, the transport availability situation did not improve.

The budget for infrastructure is inadequate despite the growing demand for infrastructure. Specialised medical equipment are available in some health facilities were the skills and competencies to use are not available to utilize the medical equipment.

4.4 Health information, research and innovation

The NHSP 2022-2024 set out an overall goal of Health Information, Research, and Innovation were to enhance health information system governance structures through the use of digital health technologies, with the aim of generating high-quality, reliable, and timely information to support decision-making. Additionally, other goals included strengthening national health research systems through improved resource mobilization and research governance to foster the generation of research evidence for evidence-based policies and decisions.

To achieve this, two strategic objectives, which are i) to strengthen integrated health information systems, and ii) to strengthen the National Health Information Management and Research were outlined with, a total of 16 interventions.

Achievements Reported

Under routine Health Information, the following strategy documents and systems have been developed:

- Community Health Information platform
- DHIS2 Integration (Yathu DHIS2 Integration)
- Master facility Registry
- Development of the M&E framework
- Interoperability framework
- Health Information Strategy
- Revised HMIS Tools
- Data integration between global fund reporting portal and HMIS system

The application and implementation of the above has made the MoH make strides in the area of routine health information system, research and technological innovation.

To contribute to improving service delivery, the Monitoring and Evaluation (M&E) Unit, in collaboration with the HIV program in the MoH, implemented HIV Case-Based Surveillance (CBS) using the National Data Warehouse for the HIV program. This initiative was extended to

improve HIV mortality data and verbal autopsies (VA) in collaboration with ZAMSTAT and the Ministry of Home Affairs.

In terms of providing health information and networking infrastructure, the Digital Health Strategy 2022-2026 was implemented. This included the digitization of paper-based systems and the scaling-up of the Electronic Health Record (EHR) system, specifically SmartCare Plus. By the end of 2023, SmartCare Plus had been deployed in 362 out of 3,411 health facilities. As of mid-2024, 1,389 health facilities were still using the legacy SmartCare system, and all were scheduled to be upgraded to SmartCare Plus in a phased manner. Additionally, a Telemedicine pilot was launched across 34 sites in five provinces during the first phase.

The MoH also developed and deployed a Master Facility List (MFL) application, through which 1,556 health facilities were validated and assigned HMIS codes, enabling better integration with other systems like SmartCare. Other initiatives included the migration of the HPV and MPDSR modules to the DHIS2-based COVAX Tracker and e-registers.

To enhance ICT connectivity, six out of Zambia's ten provincial health offices (Central, Eastern, Northern, Lusaka, Southern, and Western) were connected to the Government Wide Area Network (GWAN). Furthermore, 15 District Health Offices (13 in Southern Province, Lusaka DHO, and Chipata DHO), 18 hospitals nationwide, and seven health centres in Lusaka District were also connected. All provincial and district health offices were trained on the Navision financial management system for planning, budgeting, and expenditure tracking across the healthcare system. By the end of 2023, all districts were utilizing the system.

Despite the progress made in improving health information and research, several challenges hinder the implementation of key interventions. According to the M&E staffing pipeline, some M&E positions have yet to be created and funded. There are still issues with inadequate ICT infrastructure, poor internet connectivity, and frequent power outages across the country. Additionally, funding for printing registers and the full implementation of the Digital Health Strategy remains a challenge. Regarding health information data flow, there continues to be parallel implementation between mainstream and partner-coordinated systems.

Moving forward, the following considerations should be factored:

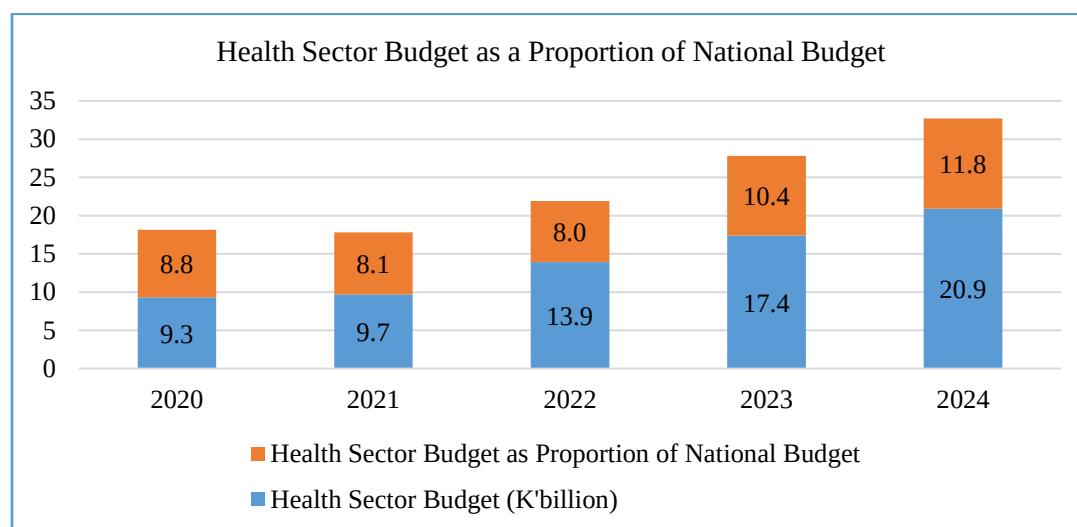
- Establish a dedicated basket fund to finance activities outlined in the Digital Health Strategy, ensuring sustainable and coordinated funding for its implementation.
- Smart Zambia Institute should prioritize providing high-speed internet to all health facilities and deploy additional ICT staff to support the delivery and maintenance of Digital Health services across the country.
- Fast-track the design, development, and deployment of an Interoperability Architecture Framework (IAF) to ensure seamless integration and communication across various health information systems.

4.5 Health care financing

The NHSP 2022-2026 projects a modest growth in Zambia's health budget. To achieve full financing of the NHSP, an additional 17% of total resources—combining Government and Cooperating Partners (CPs) contributions—is required. This projection is based on assumptions that the Government allocates 12% of its total expenditure to health, improves the coverage and performance of the National Health Insurance Scheme (NHIS), engages constructively with CPs,

and achieves cost savings through enhanced performance and prudent resource management. During the mid-term review period, the health sector's share of the national budget increased from 8.0% in 2022 to 11.8% in 2024, reflecting the Government's commitment to increasing domestic health financing. However, this allocation remains below the Abuja Declaration target of 15%.

Figure 26: Trend analysis of government allocation to health as a percentage of national budget



Cooperating Partners play a critical role in Zambia's health financing landscape. In 2022, 88% of CP assistance was off-budget, managed through vertical projects implemented by Non-Profit Institutions Serving Households (NPISH) or above-site programs. Only 12% of CP resources were channelled through government structures, a trend that persisted during the evaluation period. This has resulted in limited revenue pooling, with the two primary funding pools—the Treasury (including on-budget CP support) and vertical programs by CPs—operating largely in parallel. To address these challenges, the Ministry of Health convened national health financing dialogue meetings in 2023 and 2024, advocating for increased on-budget support from CPs and greater private-sector participation through public-private partnerships.

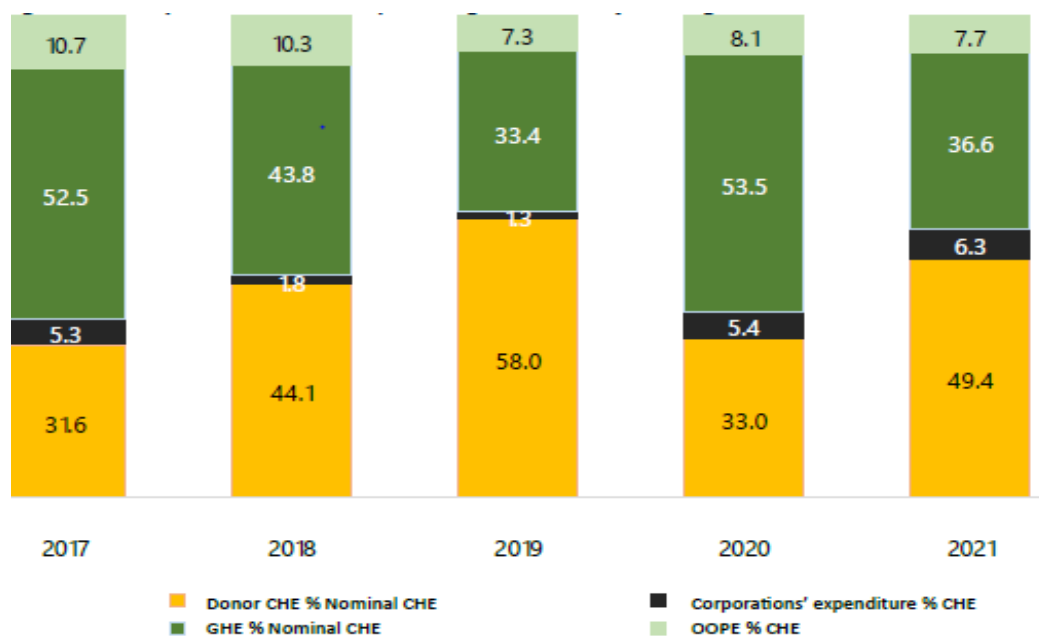
Table 19: CPs on budget support to the health sector

YEAR	PEs	Non-PEs	CP On budget support	MoH Total Budget (ZMK)	Sector Budget
2022			1.9 billion	12.4 billion	13.9 billion
2023	7.7 billion	7 billion	1.3 billion	16.1 billion	17.4 billion
2024	9 billion	7.4 billion	1 billion	18.7 billion	20.9 billion

Currently, there is no updated data on the current sources of financing for the health sector. However, the National Health Accounts (NHA) report for 2017-2021 indicated that government health expenditure as a percentage of total Current Health Expenditure (CHE) fluctuated significantly. It declined from 52.5% in 2017 to 33.4% in 2019, rose to 53.5% in 2020, and then

dropped again to 36.6% in 2021. The report highlights that the Zambian government and cooperating partners are the primary sources of healthcare financing, collectively contributing an average of 87% of the total CHE as shown in the figure below.

Figure 27: Health Expenditure by source of funding



Source NHA 2017-2021 report (in publishing)

The Government has made strides in implementing the NHIS to improve healthcare access and financial sustainability. By 2024, NHIS membership reached approximately 3.4 million, covering both formal and informal sectors, with around 1.5 million beneficiaries. Despite this progress, coverage remains limited, particularly among informal sector workers, who represent a significant portion of Zambia's labour force. Additionally, efforts to include vulnerable populations are being piloted through a three-year initiative (2024-2026) under the Social Cash Transfer program, which currently supports 16,000 households. However, this program covers only 1.3% of the poor and vulnerable population, underscoring the need for the Government to scale up efforts to extend NHIS coverage to those without contributory capacity.

To enhance effectiveness, efficiency, and equity in resource allocation and utilization, the Ministry of Health, with support from partners, updated the district and hospital resource allocation formula. This update incorporates global health trends and emerging issues, among other factors. Despite these efforts, Public Financial Management (PFM) challenges persist. The Government has demonstrated commitment to strengthening the PFM system, with plans to develop a four-year PFM Strategy to operationalize the PFM Act of 2018. Additionally, the review and amendment of the Public Procurement Act are underway, with the expectation that the health sector's needs will be prioritized. The implementation of the Planning and Budgeting Act is also anticipated to improve stakeholder involvement in the planning and budgeting processes, benefiting the health sector.

On the operational front, the Ministry rolled out the Navision system to all districts, linking budget, disbursement, and expenditure to performance. Furthermore, during the review period, the

Ministry initiated the institutionalization of the National Health Accounts (NHA) by conducting a two-phase capacity-building program for headquarters staff, which will be extended to district-level staff. Following this training, the Ministry is developing a NHA institutionalization roadmap to ensure sustainable health financing monitoring and evaluation.

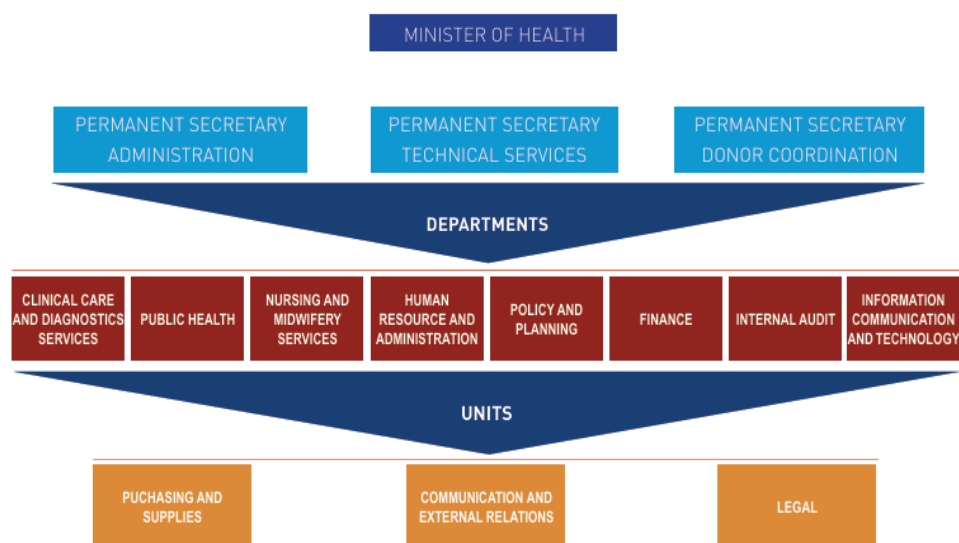
In conclusion, while significant progress has been made in advancing the NHSP's objectives, challenges remain in achieving adequate revenue pooling, expanding NHIS coverage, and addressing PFM inefficiencies. Continued efforts to strengthen health financing mechanisms, enhance stakeholder collaboration, and scale up initiatives for vulnerable populations will be critical to realizing the NHSP's goals by 2026.

4.6 Leadership and governance

The leadership and Governance at National level is headed by the Minister who is in charge of Government Policies, assisted by three technical Permanent Secretaries, eight departments headed by Directors and three units headed by assistant directors.

At Provincial Level, the Provincial Health Office manages the province and all the health facilities in that Province, while at District level the District Health Office is in charge of the District Health facilities. However, note taking for Districts is that the Local Authority has been given some devolved functions under primary health care, making the District Health Office and the Local Authority to now work together. Figure 28 below is an outline of the MoH organogram and national level.

Figure 28: The MoH organogram and national level



To strengthen the sectors Leadership and Governance performance, the NHSP 2022-2026 set out 5 objectives with 24 interventions to help in meeting the target by 2026. Among the strategies employed is the devolvment of primary functions to Local Authorities, Promoting health care financing, Infrastructural development. The attainment of Leadership and Governance co-exist with the other 6 building blocks.

Achievements Reported

The MTR reported the following progress made in this strategic area:

During the period under review, the MoH set out to review the National Health Policy and develop the National Health Services Bill by 2025 Progress has been made towards the attainment of the Policy and the Bill; however, the process has not yet been completed as the process covers a wide range of stakeholder consultations.

The Ministry of Health developed a collaborative framework to facilitate inter-ministerial/multi sectorial coordination and integration. Further, continuous yearly meeting of consultative meeting where the Minister has been meeting the Cooperating Partners. Quarterly Policy meeting to give guidance and performance of the Sector and Policy direction. Further, Continuous meeting on technical working groups which are Advisory, Joint Annual Review Policy to support performance and technical support on matters such as RAMCHAN.

Government has introduced financing models which allow for finances to be profiled however, money sent is direct to the beneficiary Institution. Further, Government has introduced Navision System which is an electronic accounting payment system and currently capacitating Local Authorities. Recruitment of human Resource to aid provision of health care service delivery has been enhanced

Held joint planning of MoH, Local Authorities and Ministry of Finance and National Development Planning. Government has issued a circular directing that Primary Health Care be devolved to all the 116 Local Authorities. Implementation of the directive started in January 2024 and staffs performing primary Functions have been attached to Local Authorities. Further, Government has issued other Circulars No. 04 and No. 14 of 2024 respectively to local authorities to provide guidance in the opening Sector Accounts and Guidance on utilization of sector grants for purposes of implementing the devolved functions. Monies have since been sent direct to the opened Sector Accounts.

Continuous provision of Policy direction, through the National Decentralization Policy of 2023, is mandated to provide Policy direction and set standards for devolved function, conduct monitoring and evaluation and build capacity in devolved functions to Local Authorities and other governance issues. Government has also commenced orientation meetings for Local Authorities and District Health Officers to facilitate coordination transparency and accountability for decentralized services to prevent corrupt practices.

Continuous sensitization in Public Finance Act and Public Procurement Act and other pieces of legislation to deal with compliance.

Despite the progress made in reviewing and development of the National Health Policy and National Service Bill, several factors led to the failure of non-completion amongst them are structural changes at the Ministry HQ, long Policy and lengthy legislative processes.

The Ministry of Health was recently restructured making some key department to be removed for example Directorates such as Quality Assurance, Policy, Infrastructure, among others have been incorporated in other Departments. On the resource component Government has managed to save some resources by coming up with a small number of departments at National level, but the impact has been failed in certain services as human resource which was key to these departments no longer work in these departments leaving a gap.

Furthermore, there are significant changes in the Ministry for example devolving of Primary Health Care services to Local Authorities. The Policy and Regulatory Framework needed to change in order to incorporate elements of devolution. The structural change to incorporate the management of Local Authorities has remained a big problem as the reporting structure for Local Authorities is different from the Ministry of Health. At District level positions have not been harmonized to clearly iron out the reporting of The District Health Officer and the Town Clerk/Council Secretary. This situation has made it difficult for many Districts to work hand in hand in achieving the primary health services devolved to the Local Authority.

Moving forward, the following recommendations need to be factored in this strategic area:

- In order to complete the process of reviewing the National Health Policy and the development of the National Health Services Bill by 2025, the Ministry will need to engage other key stakeholders that have not given input. Achieving this will require Management buy in, at all levels to review and develop the legal framework. Additionally, engage Cabinet Office (Policy and Analysis Coordination Division) and Ministry of Justice to speed up the approval processes.
- Strengthen Leadership coordination at Headquarters and harmonize the operation of Local Authorities and the District Health Office.
- Promote equitable resource allocation to all population by considering the geographical position of some districts especially.
- Build capacity across the continuum of health service provision as well as strengthen community participation in identifying problems, planning and decision making on issues affecting communities.
- Continuous sensitization, orientation, induction and training on Government Policies, laws and contract procedures.

5 Progress towards the attainment of health sector aspirations

In addition to tracking the progress on the NHSP strategic direction one and two, the M and E framework of the NHSP also outlined tracking mechanism and indicators for the health system outputs and impact in line with the WHO AFRO *Framework of Actions* for health system strengthening for UHC and other health related SDGs. This section presents an overview of the health sector progress along various elements of the health system outputs and health systems impact domains of the framework.

5.1 Progress in health system outputs

The framework outlines four elements of the health system output domain as listed below.

- Access to health services
- Demand for Health Services
- Quality of Health Services
- Health System Resilience

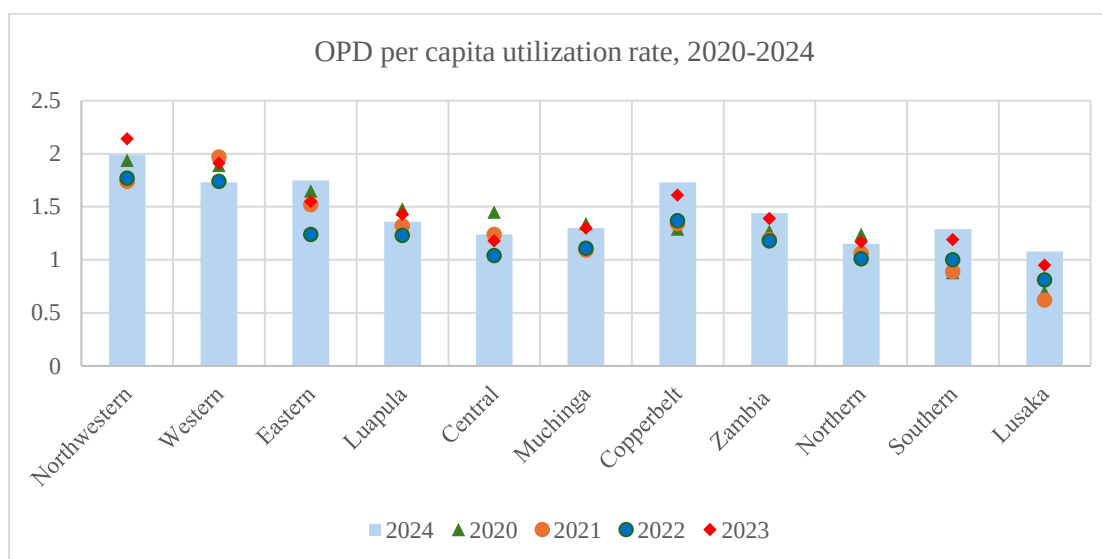
5.1.1 Progress in enhancing access to essential health services

Access to essential health services is a critical component of achieving UHC and other health related SDGs priorities. The Framework of Actions tracks access from various aspects including geographic/physical access barriers, financial/economic access barriers, and socio-cultural access barriers.

A key indicator for tracking geographic/physical access is the proportion of the population living within 5 km of a health facility. However, data for this indicator is currently unavailable. The lack of data poses challenges in assessing geographical accessibility and identifying underserved areas. Improving data collection on this metric would facilitate targeted interventions to enhance healthcare access in rural and peri-urban regions.

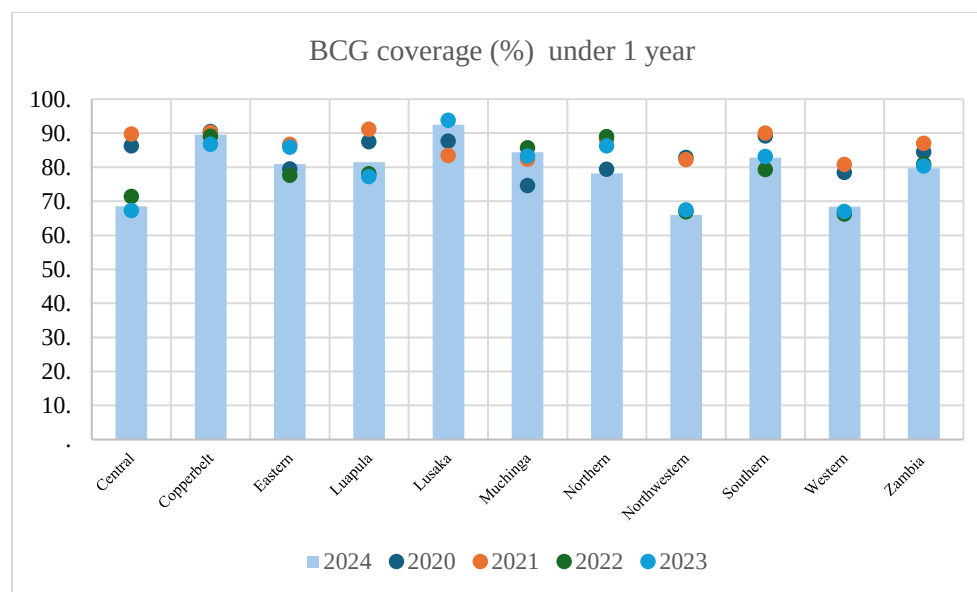
The outpatient department (OPD) per capita utilization rate is an essential proxy measure of healthcare access and service use. Figure 29 illustrates OPD utilization trends across different provinces in Zambia from 2020 to 2024. The highest OPD utilization rates are observed in Northwestern and Western provinces, exceeding 1.5 visits per capita annually. Conversely, Lusaka and Southern provinces report lower OPD utilization rates, potentially indicating barriers such as overcrowding in urban health facilities or inadequate service availability in certain districts. These variations underscore the need for localized strategies to improve health service utilization.

Figure 29: OPD per capita utilization rate, 2020-2024



BCG coverage is another critical proxy indicator of access to preventive healthcare services. Figure 30 presents BCG coverage rates over recent years, reflecting efforts to expand immunization programs. While Zambia has made progress in maintaining high BCG coverage, disparities remain among different regions. This demonstrates the varies geographic access barriers to essential health services across the different regions in the country.

Figure 30: BCG Coverage rate



Out-of-pocket (OOP) expenditures directly impact household financial protection and equitable access to care thus posing as a significant access barrier to essential health service. Table 20 shows that OOP expenditures as a percentage of CHE have remained below 11% over the past five years. While this suggests relatively low direct financial burdens on households, it is essential to monitor

affordability, especially for marginalized populations. Strengthening prepayment and insurance schemes can further alleviate financial barriers and promote universal health coverage.

Table 20: Health Financing Indicators for Zambia NHA Estimates 2017-2021

Indicator	2017	2018	2019	2020	2021
Nominal CHE (ZMW millions)	11,774.7	13,125.8	20,290.3	20,983.9	29,383.0
Nominal CHE (US\$ millions)	1,239.4	1,250.1	1,572.9	1,146.7	1,461.8
Government Health Expenditure (CHE) (ZMW Mns)	6,181.9	5,745.7	6,785.1	11,216.4	10,745.9
Donor Current (ZMW millions)	3,718.7	5,789.6	11,765.9	6,925.4	14,526.5
Out of Pocket Expenditure (ZMW Millions)	1,255.1	1,348.8	1,471.5	1,702.6	2,078.8
Corporations	619.0	241.7	267.8	1,139.5	2,031.9
Government CHE % Nominal CHE	52.5	43.8	33.4	53.5	36.6
Donor CHE % Nominal CHE	31.6	44.1	58.0	33.0	49.4
Per capita CHE (US\$)	71.7	70.1	85.6	60.6	75.1
Government CHE per capita (US\$)	37.6	30.7	28.6	32.4	27.5
Donor CHE per capita US\$	22.6	30.9	49.6	20.0	37.1
CHE % GDP	4.8	4.8	6.8	6.4	6.8
Government CHE % GDP	2.5	2.1	2.3	3.4	2.5
Government CHE/ GGE %	9.6	7.5	7.6	9.9	8
Out of Pocket Expenditures (OOPE) % CHE	10.7	10.3	7.3	8.1	7.7
Corporations' expenditure % CHE	5.3	1.8	1.3	5.4	6.8
Source: NHA Survey 2022					

Source: WHO, NHA

Table 21: Trend in Health Expenditures, 2017-2022, Source: WHO, NHA

Indicator	2017	2018	2019	2020	2021	2022
Domestic Health Expenditure (DOM) as % of Current Health Expenditure (CHE)	68	56	42	67	51	59
Out-of-pocket (OOPS) as % of Current Health Expenditure (CHE)	11	10	7	8	7	10

Source: WHO, NHA

In conclusion, based on the key indicators considered here, Zambia has made strides in improving access to health services, as reflected in OPD utilization rates and immunization coverage. However, disparities across provinces, fluctuating health financing trends, and reliance on donor contributions pose challenges to sustainable healthcare access. Addressing these issues requires strengthening domestic financing, enhancing geographical accessibility, and implementing policies to improve service utilization, particularly for underserved populations.

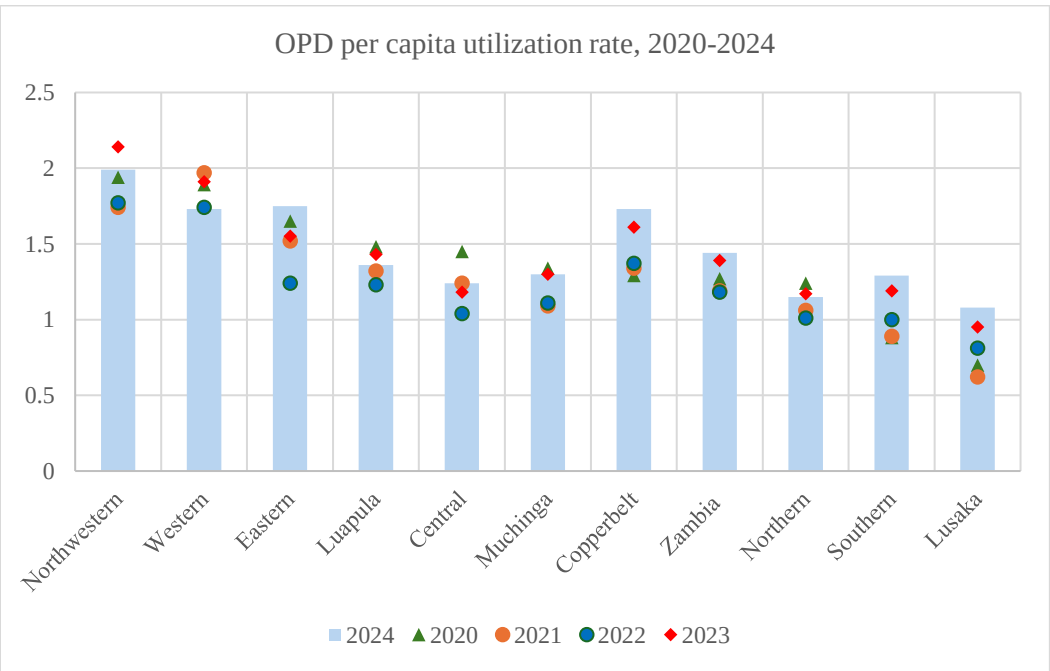
5.1.2 Progress in enhancing demand for essential health services

A well-functioning health system needs to promote and stimulate continuous demand for essential health service.

As reported in section three, the sector has made significant progress in implementing interventions for demand creation under the health promotion program in the MoH.

OPD per capita utilization rate is a key proxy indicator for tracking population level demand for health services. Figure 31 below, on OPD utilization reveals significant regional variations and temporal trends in outpatient healthcare service usage. Northwestern province consistently exhibits the highest OPD per capita utilization rates across all years, peaking above 2.0 in 2020 and 2021, before experiencing a slight decline by 2024. Similarly, Western and Eastern provinces maintain relatively high utilization rates, though not as pronounced as Northwestern. In contrast, Lusaka and Southern provinces consistently display the lowest utilization rates, remaining below 1.2 throughout the observed period. These differences suggest disparities in population level demand for health services and differences in population health-seeking behaviour across regions.

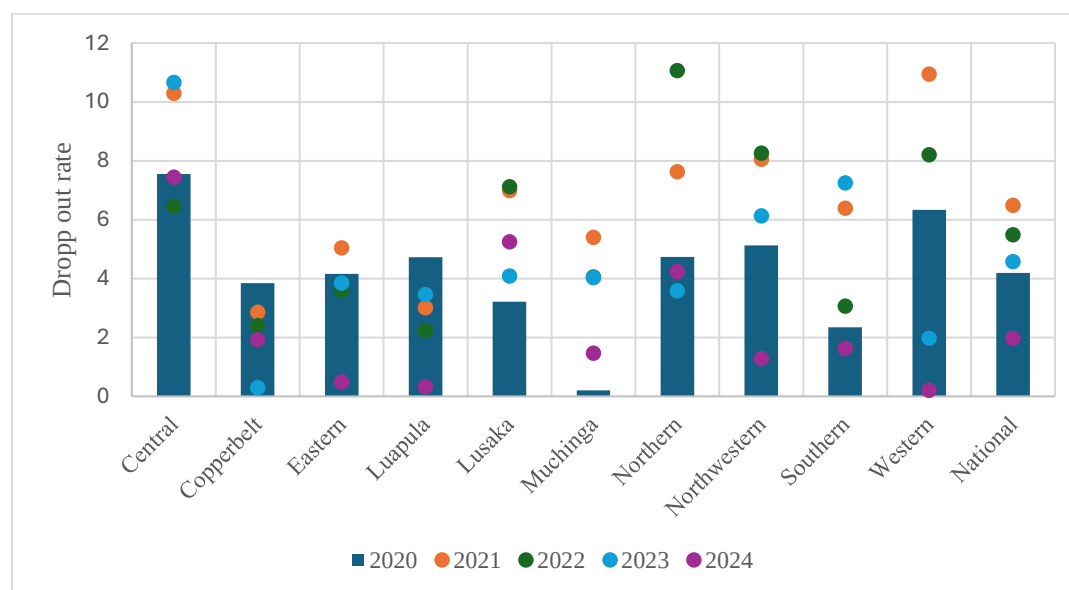
Figure 31: OPD per capita utilization rate, 2020-2024



DPT1/PENTA1 - DPT3/PENTA3 dropout rate is another key proxy indicator for tracking population level demand for health services.

Figure 32 below shows the DPT1-DPT3 dropout rates from 2020 to 2024. In 2020, the drop-out rate was around 4%, but it peaked at over 6% in 2021, indicating fluctuating demand to essential health services over time. Although the drop-out rate remained relatively high in 2022 and 2023, it significantly decreased in 2024, reaching approximately 2%. There are significant disparities in immunization drop-out rates across provinces. Central Province recorded the highest drop-out rate in 2020, exceeding 8%, followed by Northwestern and Western provinces. In contrast, Muchinga Province had one of the lowest drop-out rates throughout the years, suggesting better retention in immunization programs.

Figure 32: DPT1-DPT-3 dropout rates by province 2020-2024



The trends observed in both the OPD per capita utilization rate (2020-2024) and the DPT1-DPT3 dropout rates highlight fluctuating demand to essential health services over time. The OPD utilization data reveals a consistent decline in outpatient visits after peaking in 2020 and 2021, which may reflect changes in healthcare-seeking behaviour. Regional disparities in OPD usage, with provinces like Northwestern maintaining higher rates compared to urban areas like Lusaka, suggest differences in healthcare demand, and health seeking behavior.

5.1.3 Progress in enhancing quality of essential services

The quality of essential health services is a cornerstone of effective healthcare systems, directly influencing patient outcomes, community health, and overall public trust in healthcare institutions.

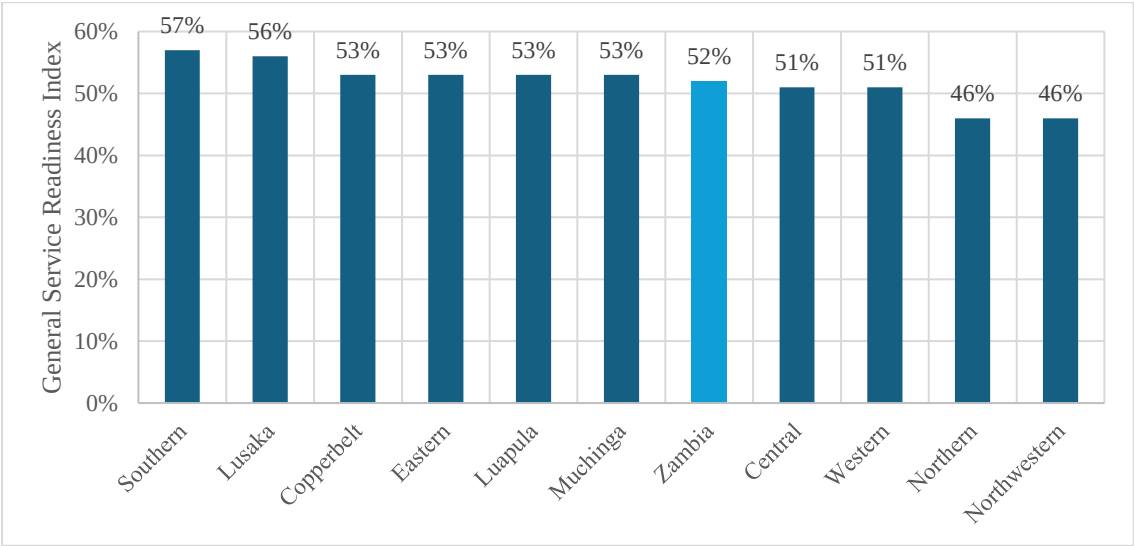
In Zambia, the quality of essential health services is evaluated through various metrics, reflecting both service readiness and health outcomes. The Zambia HHFA Report, 2022, provides valuable insights into the general service readiness across provinces, highlighting disparities and areas requiring targeted interventions. Complementary indicators such as TB treatment success rates, maternal mortality, stillbirth rates, and client satisfaction indices offer a comprehensive view of the status of the quality of health services in the country.

The General Service Readiness Index for 2022, as depicted in the provided Figure 33, illustrates significant variations in healthcare readiness across Zambia's provinces. Southern Province leads with a readiness index of 57%, followed closely by Lusaka at 56%. These provinces demonstrate relatively better preparedness in delivering essential health services, potentially reflecting better availability of equipment, infrastructure, resource allocation, and management practices. In contrast, Northwestern and Northern provinces lag with the lowest readiness scores of 46%, indicating critical gaps in service availability, infrastructure, or workforce capacity that could hinder effective healthcare delivery.

The national average, represented by Zambia's overall readiness index of 52%, suggests moderate service readiness but underscores the need for improvements to achieve uniform healthcare quality across all regions. The data points to a potential urban-rural divide, with urbanized provinces like

Lusaka performing better, while more remote areas struggle with resource limitations. Addressing these disparities requires strategic investments in healthcare infrastructure, training programs for healthcare providers, and robust supply chain systems to ensure equitable service delivery.

Figure 33: General Service readiness index, 2022

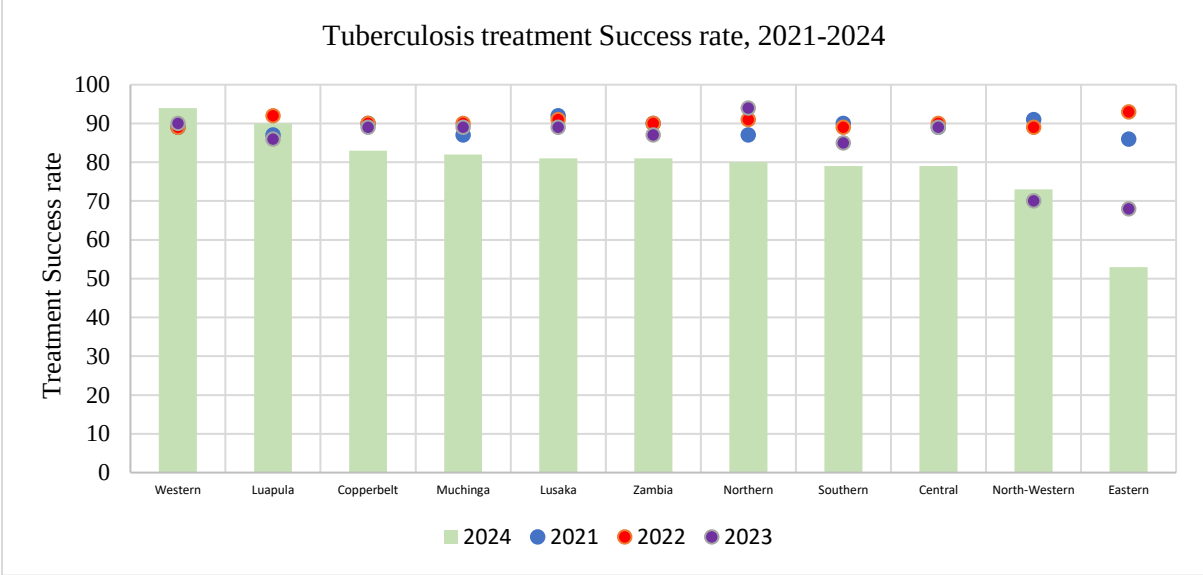


Source: Zambia HHFA Report, 2022

As shown in Figure 34 below, the TB treatment success rate from 2021 to 2024 shows a fluctuating trend, indicating variable effectiveness in TB management across the years. A noticeable improvement in the success rate in 2022 suggests successful interventions or enhanced case holding during that period. However, any subsequent decline in 2023 or 2024 may point to emerging challenges such as, patient adherence issues, or resource constraints.

Regional disparities in TB treatment outcomes may also reflect broader systemic issues, including healthcare access, diagnostic capabilities, and patient follow-up mechanisms. Strengthening community health programs, ensuring consistent drug supply, and enhancing healthcare worker training can help sustain high treatment success rates and address potential declines.

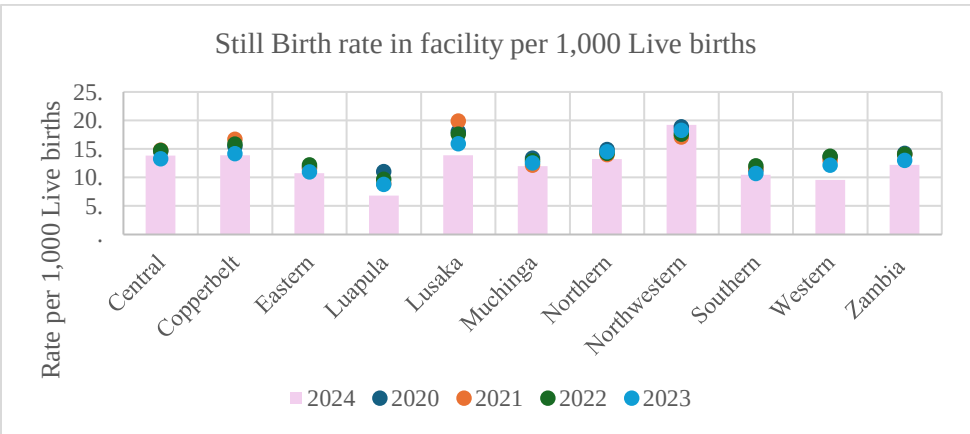
Figure 34: TB treatment success rate, 2021-2024



The indications from Figure 35 below on the fresh stillbirth rate is a critical indicator of maternal and neonatal healthcare quality. Trends show that there are disparities with high rates reported in Northwestern and Lusaka, the general trend point to a decline however, fluctuations could reflect the effectiveness of prenatal and intrapartum care. A declining trend would indicate improvements in maternal health services, better monitoring of pregnancies, and timely interventions during labour. Conversely, an increasing trend highlights gaps in maternal care, possibly due to inadequate healthcare infrastructure, delayed access to care, or insufficient skilled birth attendants.

Addressing high stillbirth rates requires targeted interventions, including enhancing antenatal care services, improving emergency obstetric care, and ensuring timely referral systems. Public health campaigns focusing on maternal health awareness and access to quality prenatal services are also vital in reducing stillbirth rates.

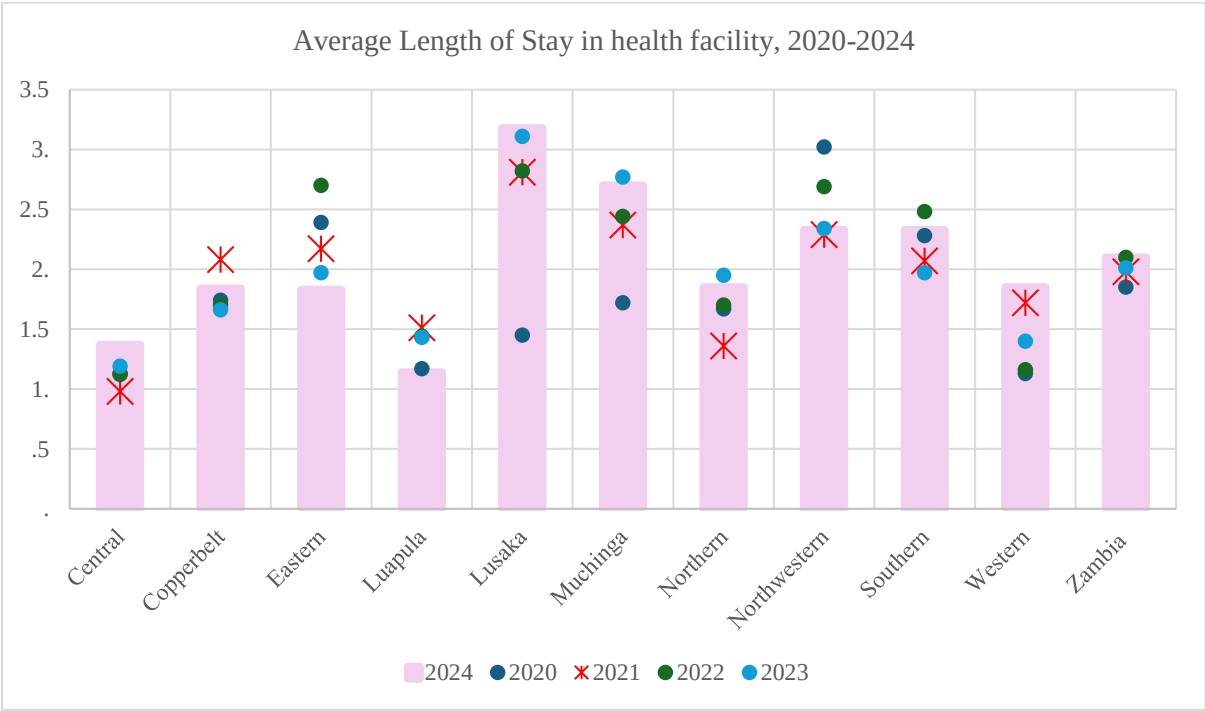
Figure 35: Fresh stillbirth rate



As shown in Figure 36, below the average length of inpatient stay in health facilities from 2020 to 2024 reveals distinct patterns across provinces: with Lusaka showing a steady increase from 1.45 days in 2020 to 3.18 days in 2024, indicating potential inefficiencies in patient management

processes. Northwestern province initially reported the highest stay in 2020 at 3.02 days but showed a reduction to 2.33 days by 2024, suggesting improvements in inpatient care. Eastern Province displayed fluctuations, peaking at 2.7 days in 2022 but reducing to 1.83 days by 2024. In Southern province, it showed relatively consistent inpatient stays around 2 days, while Western province fluctuated between 1.13 and 1.85 days.

Figure 36: Average length of inpatient stay



As shown in figure 37 below, the number of maternal deaths reported per province from 2020 to 2024 reveals critical insights into regional disparities in maternal healthcare.

Comparing maternal death rates across provinces highlights significant patterns in healthcare quality. Provinces demonstrating a consistent reduction in maternal deaths likely benefit from effective maternal health policies, improved healthcare infrastructure, and better-trained healthcare personnel. In contrast, provinces with stagnant or increasing maternal death rates may require targeted interventions to address systemic healthcare gaps.

Figure 37: Number of maternal deaths reported per province, 2020-2024

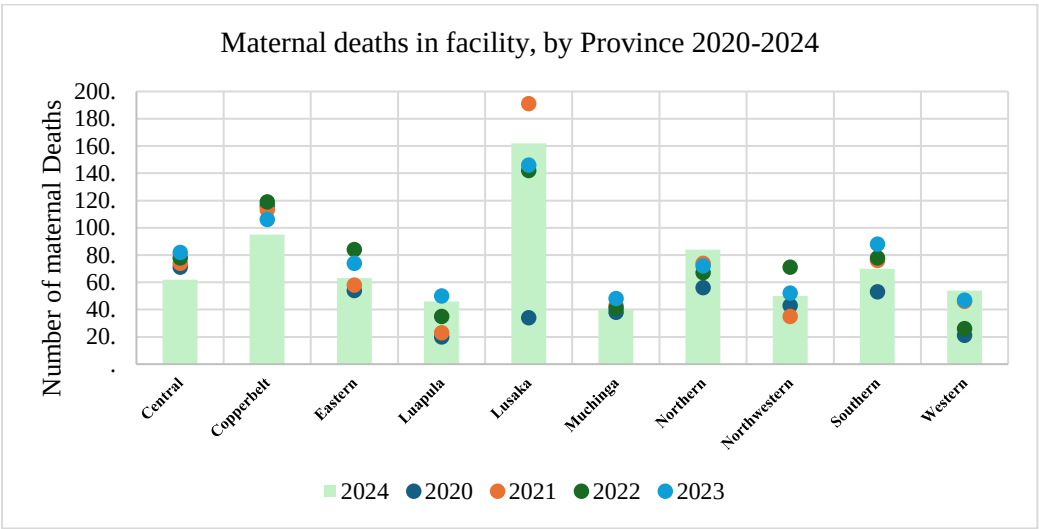
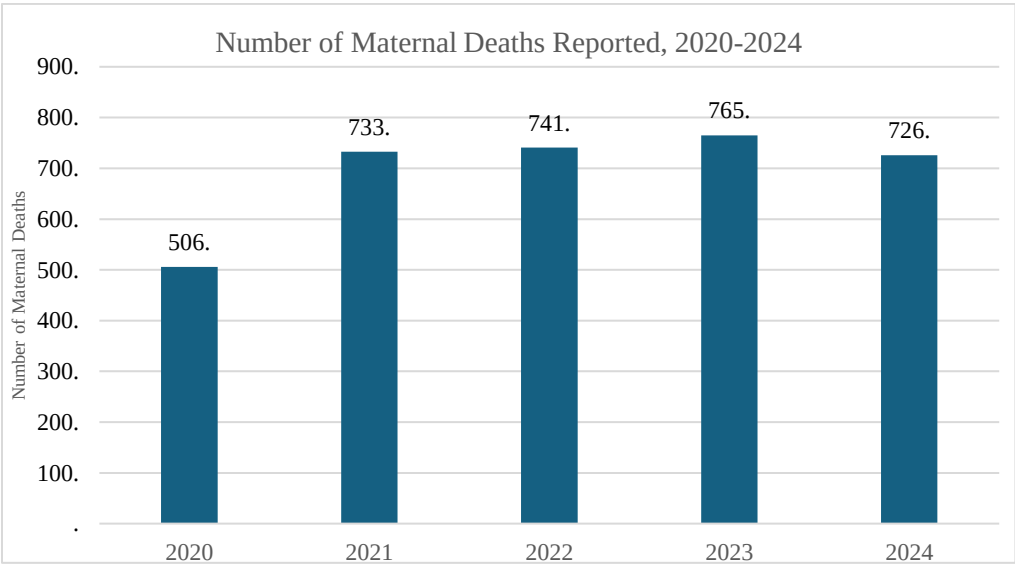


Figure 38 below shows the total number of maternal deaths reported nationally from 2020 to 2024 highlights overall trends in maternal health outcomes. A declining trend suggests improvements in maternal care, increased access to skilled birth attendants, and better emergency obstetric services. Conversely, an upward trend or fluctuations may indicate systemic issues, such as gaps in healthcare access, socio-economic barriers, or healthcare resource constraints.

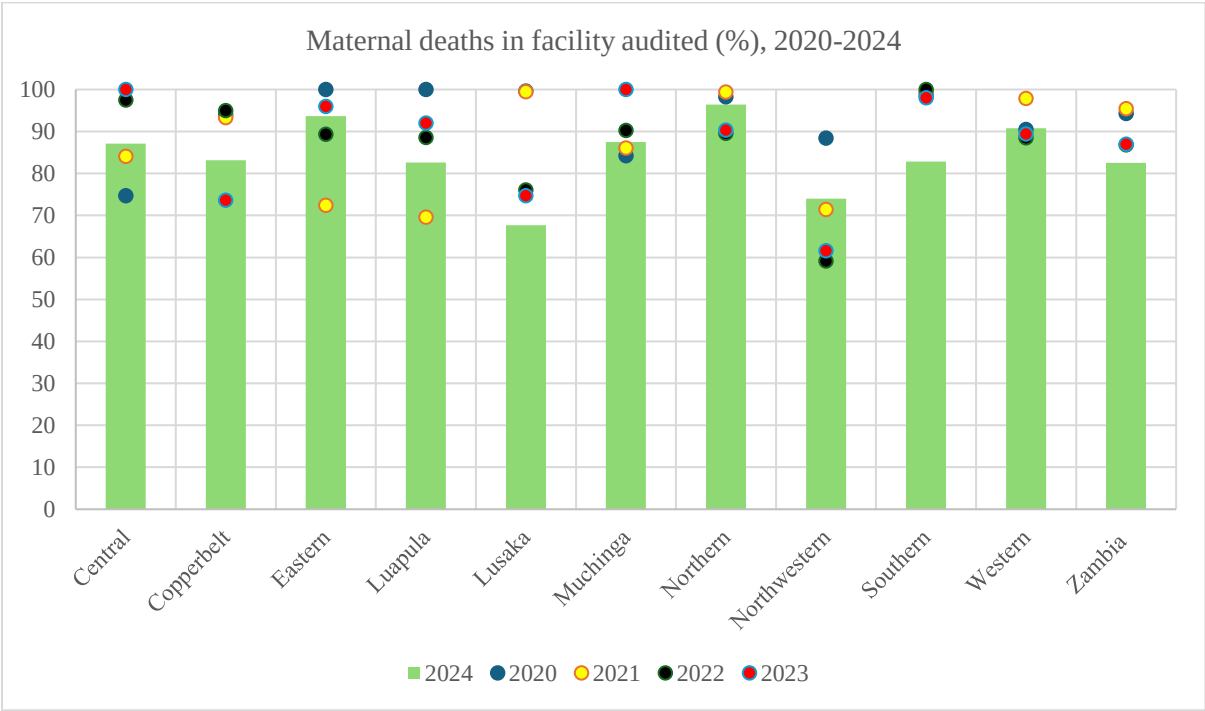
Figure 38: Total number of maternal deaths reported, 2020-2024



The proportion of facility maternal deaths audited is an indicator of accountability and continuous improvement in healthcare services. A high proportion suggests a robust audit system, enabling healthcare facilities to identify and address gaps in maternal care. Conversely, low audit rates indicate missed opportunities for learning and improvement, potentially perpetuating preventable maternal deaths.

Comparative analysis across provinces as shown in Figure 39 below may reveal varying levels of commitment to quality improvement. Across most of the provinces they show high audit rates demonstrating a proactive approach to addressing maternal health issues, while Lusaka and Northwestern provinces show lower rates and may require policy changes and training to enhance audit practices and improve maternal health outcomes.

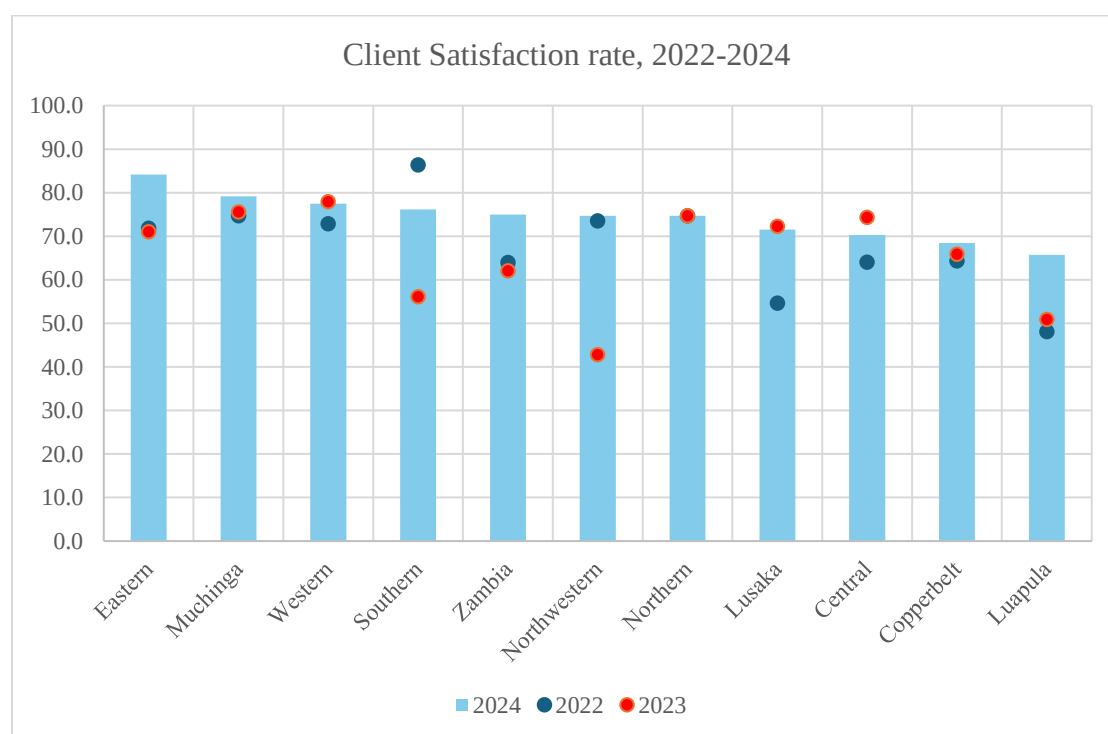
Figure 39: Proportion of facility maternal deaths audited



As shown in Figure 40, below shows the client satisfaction index from 2022 to 2024 reveals significant fluctuations and disparities across provinces in Zambia. Southern Province experienced a sharp decline from a high of 86.4% in 2022 to 56.1% in 2023, before partially recovering to 76.2% in 2024. This volatility suggests potential systemic issues in service delivery.

Muchinga maintained high satisfaction rates, increasing from 74.7% in 2022 to 79.2% in 2024, indicating stable and reliable healthcare services. However, Northwestern Province exhibited a significant drop from 73.5% in 2022 to 42.8% in 2023, followed by a strong rebound to 74.7% in 2024, suggesting corrective actions were implemented effectively. Nationally, Zambia's client satisfaction improved from 63.9% in 2022 to 75.0% in 2024, highlighting overall progress in healthcare service delivery. Luapula Province, however, consistently reported the lowest satisfaction scores, though improving from 48.1% in 2022 to 65.7% in 2024, indicating gradual but necessary improvements.

Figure 40: Client satisfaction index



In conclusion, the disparities highlighted in the General Service Readiness Index, along with other health indicators such as TB treatment success rates, maternal mortality, and client satisfaction, point to uneven healthcare quality across Zambia. While some provinces demonstrate strong performance, others face significant challenges that could adversely affect health outcomes. To bridge these gaps, targeted policy interventions and resource allocation are necessary, focusing on underperforming regions to strengthen their healthcare infrastructure, workforce, and service delivery capabilities.

A comprehensive approach involving stakeholder engagement, continuous monitoring, and adaptive strategies is essential to improve the overall quality of health services. Emphasizing equity in healthcare access and quality, investing in health worker training, and enhancing health information systems will contribute to more consistent and reliable health services across Zambia.

5.1.4 Progress in enhancing health systems resilience

Health systems resilience refers to the ability of a healthcare system to prepare for, respond to, and recover from health crises while maintaining essential services. In Zambia, building a resilient health system has become a national priority, particularly in the wake of challenges such as the COVID-19 pandemic, recurring outbreaks of diseases like cholera, and the strain of managing both communicable and non-communicable diseases. Strengthening health infrastructure, ensuring a reliable supply of medical resources, and enhancing the capacity of healthcare workers are central to improving the system's resilience. Additionally, community engagement and robust health information systems play critical roles in maintaining service delivery during emergencies.

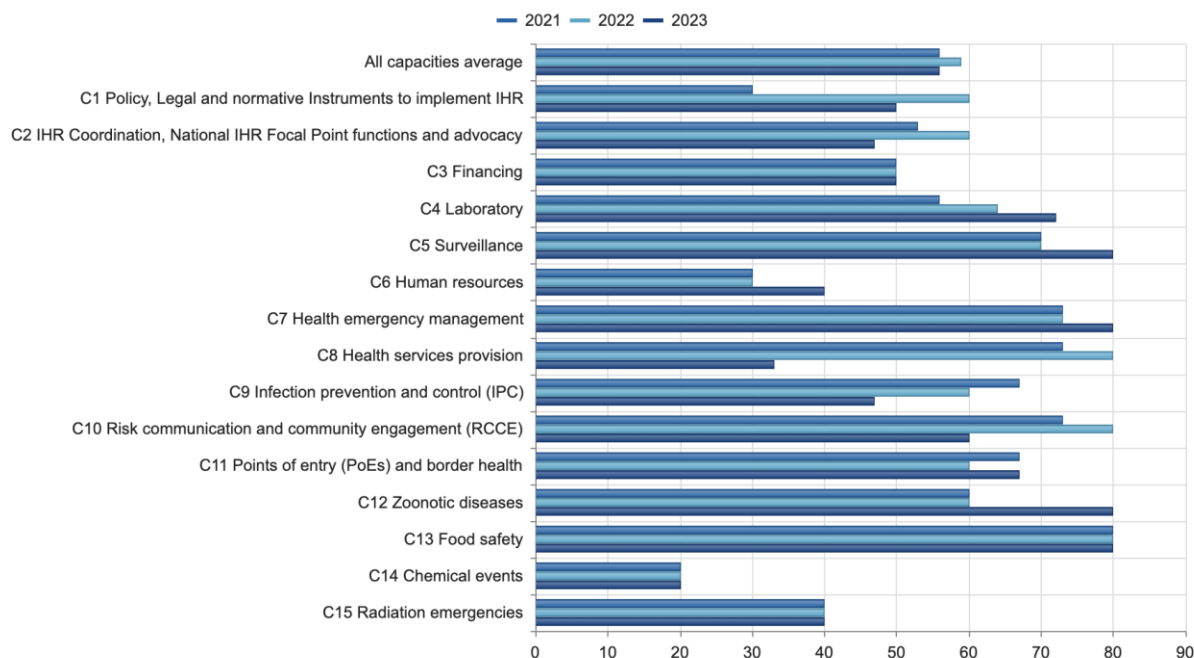
A key proxy measure of health system resilience is the International Health Regulations (IHR) Core Capacity Index, which assesses the country's ability to detect, assess, report, and respond to public health threats. This index evaluates various capacities, including surveillance, laboratory

services, emergency response operations, risk communication, and healthcare workforce preparedness. Zambia has made progress in several areas, particularly in strengthening disease surveillance and improving laboratory diagnostic capabilities. However, gaps remain, particularly in emergency response coordination, healthcare infrastructure, and ensuring equitable access to essential health services across all regions. As shown in Figure 41 below, the International Health Regulations (IHR) Core Capacity Index data from 2021 to 2023 provides insights into Zambia's progress in strengthening its health system resilience. The overall average for all capacities rose slightly from 56 in 2021 to 59 in 2022, before declining back to 56 in 2023. This fluctuation suggests that while some capacities saw improvement, others experienced setbacks, reflecting the complex dynamics of health system development. Key areas like surveillance (C5) and food safety (C13) consistently performed well, with surveillance increasing from 70 in 2021 to 80 in 2023 and food safety maintaining a steady high score of 80 across all three years.

Specific capacities such as Health Emergency Management (C7) and Zoonotic Diseases (C12) demonstrated notable improvements. Health Emergency Management increased from 73 in 2021 to 80 in 2023, indicating progress in preparedness and response mechanisms for public health emergencies. Similarly, the capacity to manage zoonotic diseases improved from 60 in 2021 to 80 in 2023, reflecting enhanced efforts to monitor and control diseases that transfer between animals and humans. However, certain areas showed persistent weaknesses. For instance, Chemical Events (C14) remained stagnant at 20 throughout the three years, and Radiation Emergencies (C15) consistently scored 40, highlighting critical gaps in emergency preparedness for these specific threats.

Conversely, there were areas of regression. Health Services Provision (C8), after peaking at 80 in 2022, dropped significantly to 33 in 2023, suggesting challenges in maintaining consistent service delivery. Similarly, Infection Prevention and Control (C9) saw a decline from 67 in 2021 to 47 in 2023, possibly indicating resource constraints or operational setbacks. These fluctuations highlight the need for sustained investment and strategic planning to ensure continuous improvement across all health system capacities. The data underscores Zambia's commitment to strengthening its health system but also reveals areas where targeted efforts are required to build a more resilient and responsive healthcare infrastructure.

Figure 41: Average Capacities for Zambia, 2021-2023, Source JEE SPAR,



Source JEE SPAR

Continued investment in the IHR core capacities is essential for Zambia to enhance its health system resilience. By addressing these gaps and building a more adaptable, responsive healthcare system, the country can better protect its population from future health threats. Strengthening partnerships with international health bodies, investing in healthcare worker training, and leveraging technology for surveillance and service delivery will be key strategies in ensuring that Zambia's health system can withstand and recover from public health emergencies while continuing to meet the needs of its population.

5.2 Progress in health system impact

The framework outlines four elements of the health system output domain as listed below.

- Population Trends in the Country
- Progress in Reducing Population Level Burden of Disease - by Age and Health Condition
- Progress in addressing Population Level Burden of Health Risk Factors in the Country
- Progress in Improving Length and Quality of Healthy Lives

5.2.1 Population trends in the country

As reported in section one of this report, Zambia has experienced a steady population growth over the past decade, with the country's total population rising from approximately 13 million in 2010 to close to 21 million in 2023. This consistent growth suggests a high fertility rate and declining mortality rates, driven by improvements in healthcare access and social development. The increasing population, if not strategically managed, has potential for putting pressure on essential public services such as healthcare, education, and infrastructure. There is thus a necessity for

targeted strategic government interventions to ensure sustainable development even in the context of population growth.

Figure 42: Population trends in the country overtime.

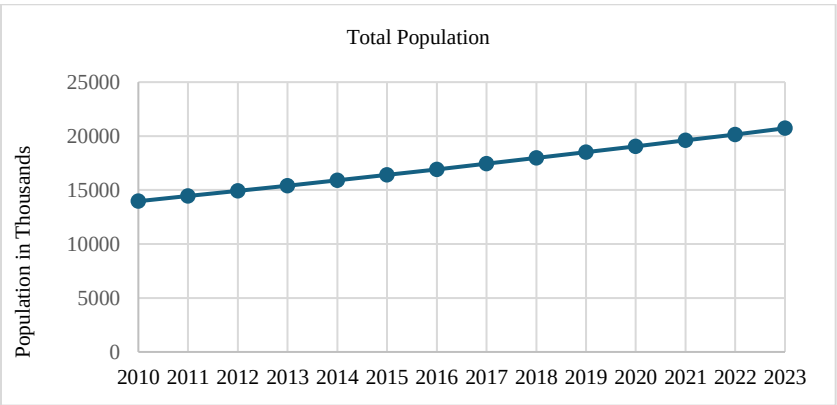
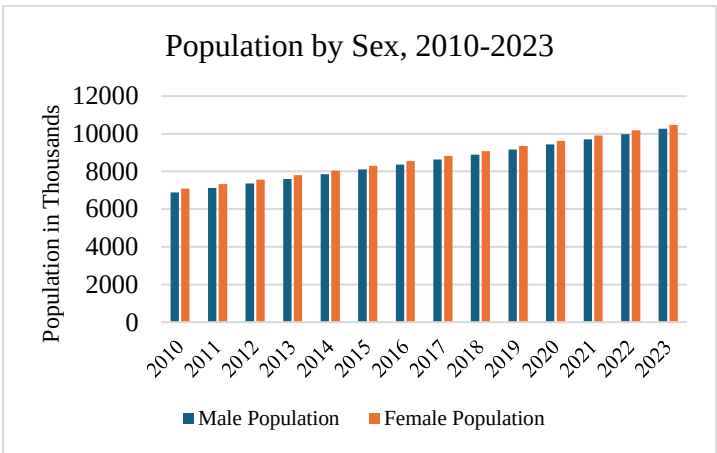
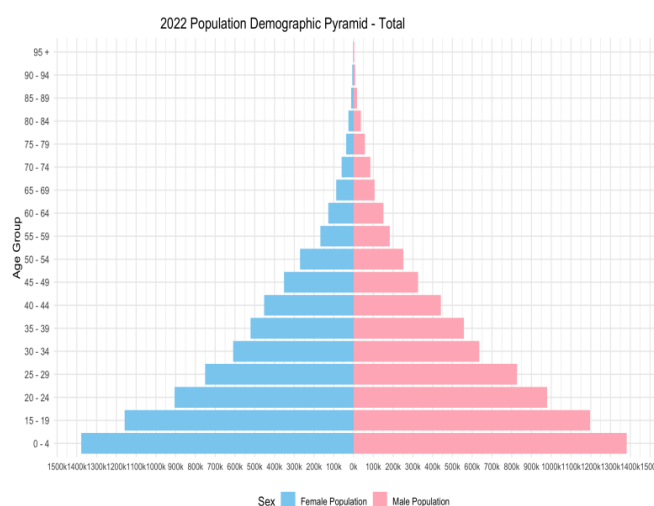


Figure 43: Population trends in the country disaggregated by sex.



Even with the apparent increase in population, the population growth rate in the country has had a gradual decline in the past decade from 3.5% in 2010 to approximately 2.8% in 2023. The population age distribution in the country shows a “normal” distribution structures shown by a population pyramid depicting a wide base and a tapering peak. Figure 44 below is an illustration of the population pyramid of the country. This demographic structure emphasizes the need for a robust healthcare system to cater to the growing population.

Figure 44: The population pyramid of the country



With increasing urbanization, healthcare infrastructure must be expanded to meet the rising demand for services in cities while also strengthening rural healthcare services to prevent disparities. This includes investing in health worker training, improving supply chains for essential medicines, and strengthening healthcare financing mechanisms.

5.2.2 Progress in reducing population level burden of disease

Morbidity and mortality are key indicators of a population's health status, reflecting the prevalence of diseases and causes of death over time. Morbidity encompasses both communicable and non-communicable diseases, measured by incidence and prevalence rates, highlighting the burden of illness on different age groups. Mortality, on the other hand, measures the frequency and distribution of deaths, providing insights into the leading health threats. Understanding these patterns is crucial for healthcare planning, resource allocation, and the development of targeted interventions to reduce disease burden and improve health outcomes.

In Zambia, morbidity and mortality trends reveal a persistent burden of infectious diseases such as respiratory infections, malaria, and diarrhoea, particularly among children under five. Meanwhile, non-communicable diseases, including cardiovascular diseases, diabetes, and hypertension, are emerging as major causes of morbidity and mortality among older populations. This report analyses the morbidity and mortality data from 2021 to 2024, highlighting trends across different age groups and providing evidence-based recommendations to strengthen healthcare policies and interventions.

General Morbidity (All Ages)

The morbidity trends from 2021 to 2024 highlight persistent health challenges in Zambia, with respiratory infections (non-pneumonia) consistently ranking as the most common cause of illness. This condition remained the top cause in 2021, 2022, and 2024, only briefly dropping to second place in 2023. The continued dominance of respiratory infections suggests a high burden of communicable diseases, potentially exacerbated by environmental factors such as air pollution, seasonal weather changes, and overcrowding in urban areas. Malaria, another major health concern, fluctuated between the first and second positions, reflecting ongoing transmission despite control efforts. The brief peak of malaria as the leading cause of morbidity in 2023 could be attributed to seasonal outbreaks or variations in vector control effectiveness.

Diarrheal (non-bloody) has remained the third most common morbidity condition across all four years, indicating persistent issues related to waterborne diseases, sanitation, and hygiene. The sustained high ranking of gastritis and musculoskeletal disorders suggests an increasing burden of non-communicable diseases (NCDs), possibly linked to dietary changes, stress, and occupational factors. The presence of injuries/wounds and dermatitis within the top 10 rankings indicates that trauma and skin-related infections are ongoing health concerns. The steady ranking of conjunctivitis (allergic) and acute tonsillitis suggests seasonal fluctuations in allergic reactions and infections, particularly in children.

Overall, the morbidity trends indicate that while infectious diseases remain a significant challenge, non-communicable conditions are steadily contributing to the disease burden. The continued presence of musculoskeletal disorders and gastritis among the top conditions underscores the need for increased attention to lifestyle-related health risks. The shifts in disease ranking also highlight the importance of targeted interventions, such as improving respiratory infection management, strengthening malaria prevention programs, and addressing hygiene-related illnesses. These insights can help inform policy adjustments and healthcare strategies to reduce disease incidence and improve overall population health outcomes.

Table 22: All ages Morbidity Trends (2021-2024), cases per 1,000 population

No	Condition	2021	2022	2023	2024
1	Respiratory Infection: non-pneumonia	334.5	334.5	359.3	449.4
2	Malaria Confirmed Cases	313.8	303.4	395.9	280.5
3	Diarrhoea (non-bloody)	66.5	71.4	83.7	100.7
4	Gastritis disease	35.7	35.2	35.0	45.9
5	Musculoskeletal disorders	42.5	41.5	44.0	43.6
6	Dental Caries	17.8	18.3	21.5	21.3
7	Injuries/Wounds	18.2	17.3	18.5	20.7
8	Dermatitis disease	17.4	19.2	20.6	19.6
9	Conjunctivitis (Allergic)	16.9	19.0	14.2	17.0
10	Acute Tonsillitis	12.0	12.8	17.0	17.0

Table 23: All ages Ranking of Top 10 Morbidity Conditions Across Years

Rank	Condition	2021	2022	2023	2024
1	Respiratory Infection: non-pneumonia	1	1	2	1
2	Malaria Confirmed Cases	2	2	1	2
3	Diarrhoea (non-bloody)	3	3	3	3
4	Gastritis disease	4	4	5	4
5	Musculoskeletal disorders	5	5	4	5
6	Dental Caries	6	6	6	6
7	Injuries/Wounds	7	7	7	7
8	Dermatitis disease	8	8	8	8
9	Conjunctivitis (Allergic)	9	9	9	9
10	Acute Tonsillitis	10	10	10	10

Table 24: Leading Morbidity Conditions (Under 5 Years)

Rank	Condition	2021	2022	2023	2024
1	RI: Non-pneumonia	1	1	1	1
2	Malaria	2	2	3	2
3	Diarrheal (non-bloody)	3	3	2	3
4	Skin diseases (not infectious)	4	4	4	4
5	RI: Pneumonia	5	5	5	5
6	Digestive system (not infectious)	6	6	6	6
7	Allergic conjunctivitis	7	7	7	7
8	Throat diseases	8	8	8	8
9	Trauma (other injuries)	9	9	9	9
10	Allergic rhinitis	10	10	10	10

Children under five years remain highly susceptible to communicable diseases, with respiratory infections leading as the primary cause of morbidity. Malaria and diarrhoea continue to be significant health concerns, emphasizing the need for improved vector control programs and better sanitation practices. The consistency in ranking for pneumonia further highlights the vulnerability of young children to lower respiratory tract infections, likely influenced by poor nutrition and limited access to healthcare.

Skin diseases, digestive system infections, and allergic conditions also rank among the top conditions affecting children, suggesting an interplay of environmental and genetic factors in child health. The presence of trauma and throat diseases among the top ten conditions indicates risks related to injuries and infectious diseases, reinforcing the need for child-focused healthcare policies and preventive health measures.

Mortality Trends (All ages)

Mortality refers to the incidence of death within a population over a specific period. It is a crucial indicator of public health, reflecting the burden of disease, the effectiveness of healthcare systems, and broader socio-economic factors influencing health outcomes. Mortality data provides insights into the leading causes of death, guiding policymakers and healthcare providers in prioritizing interventions to reduce preventable deaths. Understanding trends in mortality across multiple years allows for the assessment of progress in disease management and the identification of emerging health challenges.

As shown in the table 25 and 26 below, the data from 2021 to 2024 on the top ten causes of mortality for all ages reveals several key trends and shifts in the ranking of disease conditions. Malaria and respiratory infections (pneumonia and non-pneumonia) consistently rank among the leading causes of death, emphasizing the ongoing public health challenge posed by infectious diseases. In 2021, malaria was the leading cause of mortality, followed closely by respiratory infection (pneumonia). However, by 2024, respiratory infection (pneumonia) became the top cause of mortality, overtaking malaria, which dropped to the second position. This shift may suggest improved malaria interventions or increased severity and impact of respiratory infections, possibly exacerbated by external factors such as environmental changes or reduced vaccine coverage.

Anaemia has remained consistently in the third position across all four years, indicating a persistent challenge in managing this condition. Anaemia is often linked to nutritional deficiencies, chronic diseases, and maternal health, suggesting a need for targeted interventions, particularly for vulnerable populations. Other non-communicable diseases, such as congestive heart failure, hypertension, and stroke, have also maintained stable rankings within the top ten causes of mortality. Congestive heart failure remained at the fourth position from 2022 to 2024, while hypertension ranked fifth in all years. The stability of these conditions highlights the growing burden of non-communicable diseases (NCDs) and the need for sustained efforts in preventive care, lifestyle modifications, and improved management of cardiovascular conditions. Tuberculosis, which was ranked fourth in 2021, dropped to the sixth position in subsequent years. While this may suggest some progress in TB control measures, it remains a significant cause of mortality, indicating that more efforts are needed to sustain and enhance TB prevention and treatment programs. Diabetes, which was ranked tenth in both 2021 and 2022, improved slightly to the ninth position in 2024, reflecting ongoing efforts in diabetes care but also a possible increase in disease prevalence due to lifestyle and dietary changes. Meanwhile, diarrhoea (non-bloody) saw fluctuations in ranking, moving from eighth place in 2021 to tenth in 2024, highlighting the importance of sanitation and access to clean water in controlling diarrhoeal diseases.

Table 25: Top 10 Causes of Mortality for all ages, 2021-2024

No	Disease Condition	2021	2022	2023	2024
1	Respiratory Infection: pneumonia	1550	1450	1322	1303
2	Malaria Confirmed Cases	1430	1350	1540	1152
3	Anaemia	900	870	1023	956
4	Congestive Heart Failure Disease (new)	700	750	885	954
5	Hypertension	650	700	814	905
6	Tuberculosis	800	850	1007	792
7	Respiratory Infection: non-pneumonia	660	600	689	565
8	Stroke disease (new)	500	520	601	551
9	Diabetes	450	460	378	478
10	Diarrhoea (non-bloody)	400	420	585	472

Table 26: Ranking of 10 Causes of Mortality for all ages, 2021-2024

Disease Condition	2021 Rank	2022 Rank	2023 Rank	2024 Rank
Malaria Confirmed Cases	1	1	1	2
Respiratory Infection: pneumonia	2	2	2	1
Anaemia	3	3	3	3
Tuberculosis	4	6	6	6
Congestive Heart Failure Disease (new)	5	4	4	4
Hypertension	6	5	5	5
Respiratory Infection: non-pneumonia	7	7	7	7
Diarrhoea (non-bloody)	8	8	9	10
Stroke disease (new)	9	9	8	8

Diabetes	10	10	10	9
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Trends in Infant Mortality (Deaths Among <1 Year)

As shown in tables 27 and 28 The data on infant mortality from 2021 to 2024 indicates a shift in the leading causes of death among children under one year. Respiratory Infection: Pneumonia was the leading cause of death in 2021, 2022, and 2023 but was overtaken by Malaria Confirmed Cases in 2024. Pneumonia deaths showed a steady number between 2022 and 2023 (326 deaths) before rising to 381 in 2024. Meanwhile, malaria-related deaths remained constant at 193 from 2022 to 2023 but saw a sharp increase to 457 in 2024, making it the deadliest condition for infants in that year. This shift suggests a worsening malaria burden in 2024, possibly due to increased mosquito activity, reduced intervention effectiveness, or higher transmission rates.

Another significant trend is the dramatic rise in Severe Acute Malnutrition (SAM) deaths, which remained steady at 73 deaths from 2021 to 2023 but surged significantly to 303 deaths in 2024. This fourfold increase highlights a growing concern about infant nutrition and food security, which may be driven by economic hardships, food scarcity, or decreased access to healthcare and nutritional support programs. Anaemia, a related condition, also increased in fatalities from 104 deaths in 2021 to 162 in 2024, showing a similar worsening trend.

On the lower end of the rankings, conditions like injuries/wounds, tuberculosis, and diarrheal diseases have remained fairly constant in terms of mortality burden over the years, though injuries/wounds saw an unexpected jump from 24 deaths in 2021-2023 to 84 in 2024, indicating an increase in trauma-related deaths. Interestingly, dermatitis and sickle cell disorders, which previously contributed to some deaths, were completely absent from the mortality data in 2024, suggesting possible improvements in early diagnosis and management of these conditions. The overall trends highlight an urgent need for strengthened malaria control, improved nutrition interventions, and enhanced trauma prevention strategies for infants in Zambia.

Table 27: Number of deaths among <1 year (Infants)

Disease Condition	2021	2022	2023	2024
Respiratory Infection: pneumonia	309	326	326	381
Malaria Confirmed Cases	238	193	193	457
Diarrhoea (non-bloody)	288	145	145	237
Anaemia	104	88	88	162
Severe acute malnutrition disease (new)	74	73	73	303
Injuries/wounds disease (new)	24	24	24	84
Tuberculosis	21	21	21	38
Diarrhoea due to viral Infection	20	20	20	25
Dermatitis disease (new)	19	19	19	0
Sickle Cell disorders disease (new)	14	14	14	0

Table 28: Ranks of the number of deaths among <1 year (Infants)

Disease Condition	2021	2022	2023	2024
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Respiratory Infection: pneumonia	1	1	1	2
Malaria Confirmed Cases	3	2	2	1
Diarrhoea (non-bloody)	2	3	3	4
Anaemia	4	4	4	5
Severe acute malnutrition disease (new)	5	5	5	3
Injuries/wounds disease (new)	6	6	6	6
Tuberculosis	7	7	7	7
Diarrhoea due to viral Infection	8	8	8	8
Dermatitis disease (new)	9	9	9	9
Sickle Cell disorders disease (new)	10	10	10	9

Trends in Under-5 Mortality (Deaths Among <5 Years)

As shown in table 29 and 30 below, the mortality trends for children under five years from 2021 to 2024 indicate a consistent burden of malaria and respiratory infections as the leading causes of death. Malaria remained the number one cause of death in this age group across all four years, although the absolute number of deaths declined from 711 in 2021 to 457 in 2024. Similarly, Respiratory Infection: Pneumonia maintained its second position in rankings, with deaths declining from 502 in 2021 to 381 in 2024. These reductions may be attributed to improvements in treatment access, vector control measures, and pneumonia vaccination programs. However, the fact that malaria still holds the top rank despite this decline highlights that the disease remains a major challenge for young children.

Severe Acute Malnutrition (SAM) has consistently been the third leading cause of death over the years, with a slight increase from 297 deaths in 2021 to 303 in 2024. This trend suggests that malnutrition remains a persistent issue among young children, possibly due to food insecurity, poverty, or limited access to healthcare services. Diarrhoea (non-bloody) has also remained in the fourth position throughout the years, showing a decrease in deaths from 274 in 2021 to 237 in 2024, suggesting possible improvements in hygiene, sanitation, and access to clean drinking water. Anaemia, which ranked fifth, showed a more substantial decline from 231 deaths in 2021 to 162 in 2024, possibly indicating better nutritional interventions or early detection and treatment.

On the lower end of the ranking, Trauma: Burns, Tuberculosis, and Diarrhoea due to Viral Infection have remained relatively stable in their rankings, but some conditions like Sickle Cell Disorders and Moderate Acute Malnutrition (MAM) have disappeared from the mortality statistics in 2024. This could be due to improved early diagnosis, better management strategies, or underreporting of these specific conditions. However, burn-related deaths increased from 63 in 2021 to 84 in 2024, suggesting a rising burden of injuries among young children, possibly due to inadequate child safety measures. Overall, while some progress has been made in reducing mortality in this age group, malaria, pneumonia, and malnutrition continue to be major threats, requiring sustained intervention efforts.

Table 29: Deaths among <5 years

Disease Condition	2021	2022	2023	2024
Malaria Confirmed Cases	711	674	711	457
Respiratory Infection: pneumonia	502	472	502	381

Severe acute malnutrition disease (new)	297	322	297	303
Diarrhoea (non-bloody)	274	263	274	237
Anaemia	231	231	231	162
Trauma: Burns	63	81	63	84
Tuberculosis	49	49	49	38
Diarrhoea due to viral Infection	43	43	43	25
Sickle Cell disorders disease (new)	38	38	38	0
Moderate acute malnutrition disease (new)	34	34	34	0

Table 30: Ranking of deaths among <5 years

Disease Condition	2021	2022	2023	2024
Malaria Confirmed Cases	1	1	1	1
Respiratory Infection: pneumonia	2	2	2	2
Severe acute malnutrition disease (new)	3	3	3	3
Diarrhoea (non-bloody)	4	4	4	4
Anaemia	5	5	5	5
Trauma: Burns	6	6	6	6
Tuberculosis	7	7	7	7
Diarrhoea due to viral Infection	8	8	8	8
Sickle Cell disorders disease (new)	9	9	9	9
Moderate acute malnutrition disease (new)	10	10	10	9

Progress in addressing population level burden of health risk factors in the country

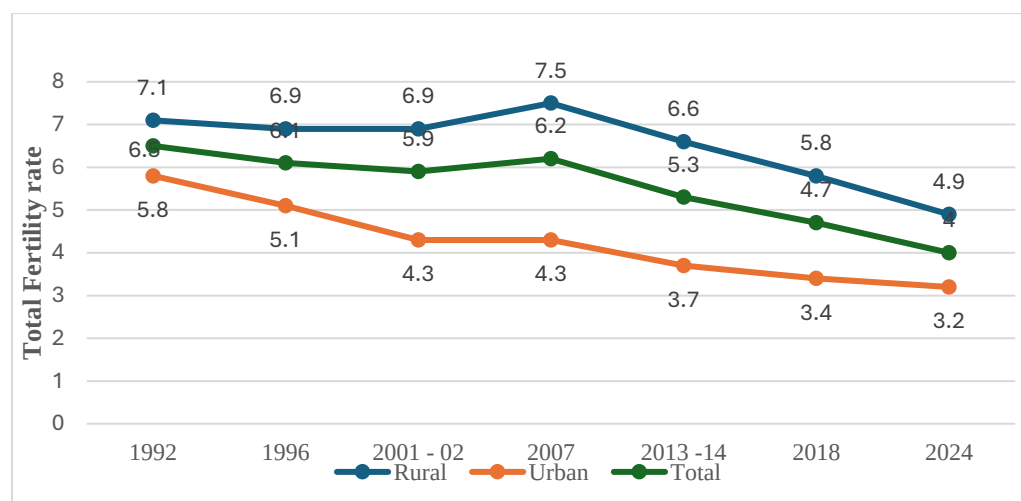
5.2.3 Trends in fertility rates in Zambia

The fertility rate in Zambia has shown a consistent decline over the years, as illustrated in Figure 4. In 1992, the total fertility rate (TFR) was relatively high at 6.5 children per woman, with a notable difference between rural and urban areas. Rural fertility rates were significantly higher at 7.1, compared to 5.8 in urban areas. This trend highlights the influence of socio-economic factors, healthcare access, and cultural norms on reproductive behavior. Over the years, the fertility rate in both rural and urban settings has steadily declined, reflecting shifts in family planning, education, and economic changes.

A peak in rural fertility was observed in 2007 at 7.5 children per woman, after which a noticeable decline occurred. By 2024, the rural fertility rate had dropped to 4.9, while urban fertility fell to 3.2, bringing the national average down to 4.4. This overall decline in fertility rates suggests increased access to contraception, improved education—especially among women—and enhanced healthcare services. Urban areas have consistently maintained lower fertility rates, likely due to better access to family planning services, higher literacy rates, and economic constraints that encourage smaller families.

The steady decline in fertility rates has important demographic and economic implications for Zambia. A lower fertility rate can lead to a shift in the population structure, reducing the dependency ratio and potentially fostering economic growth as the working-age population increases relative to dependents. However, ensuring that rural areas continue to experience improved access to reproductive health services is crucial for maintaining this downward trend. Continued investments in education, healthcare, and economic opportunities, particularly for women, will be essential in sustaining the progress made in fertility reduction and supporting Zambia's broader development goals.

Figure XXX: Trends in fertility rates by residence



Source: Zambia Demographic and health survey

5.2.4 Tobacco use in the country

Based on the findings from the 2021 Global Youth Tobacco Survey (GYTS) Zambia survey, tobacco use among Zambian youth aged 13-15 years remains a public health concern. The survey indicates that 12.9% of students were current tobacco users, with higher prevalence among males (14.0%) compared to females (11.8%) (Zambia MOH, 2021). Alarming, 29.1% of students reported having ever used tobacco, and 9.0% were current smokers. The prevalence of cigarette smoking stood at 5.6%, with males (6.9%) smoking more than females (4.3%). Additionally, 6.3% of students used smokeless tobacco products, suggesting a shift toward alternative tobacco consumption methods. The report also highlighted the growing use of electronic cigarettes (16.3%), which calls for urgent intervention to regulate emerging tobacco products among youth (Zambia MOH, 2021).

Access to tobacco products remains an issue, with 38.3% of current cigarette smokers purchasing cigarettes from various sources, despite regulations on underage sales (Zambia MOH, 2021). More than 59.3% of students were not prevented from buying cigarettes due to age restrictions, indicating weak enforcement of existing tobacco control policies. Exposure to secondhand smoke was also significant, with 24.1% of students reporting exposure at home and 40.4% in enclosed public spaces. Additionally, tobacco marketing remains prevalent, with 26.8% of students noticing tobacco advertisements at points of sale, further contributing to the normalization of smoking among youth (Zambia MOH, 2021).

Efforts to quit smoking were notable, with 58.4% of current tobacco smokers attempting to quit within the previous 12 months, though 27.2% of students found quitting difficult (Zambia MOH, 2021). These findings emphasize the need for enhanced cessation programs targeting young smokers. Public awareness campaigns and stricter advertising regulations are also necessary to counteract pro-tobacco influences. The increasing popularity of electronic nicotine delivery systems (ENDS) highlights a new challenge, as these products are often perceived as less harmful but still pose significant health risks.

The survey findings underscores the urgent need for comprehensive tobacco prevention and control strategies, including the enactment of stronger tobacco control legislation. Current gaps in policy enforcement, weak restrictions on sales to minors, and continued tobacco marketing contribute to sustained youth tobacco use. Strengthening public health education, increasing enforcement of smoke-free policies, and expanding cessation support services will be crucial in reducing tobacco use among Zambian youth and safeguarding their long-term health (Zambia MOH, 2021).

5.2.5 Malnutrition Trends in the country

Figure 45: Exclusive breastfeeding rate

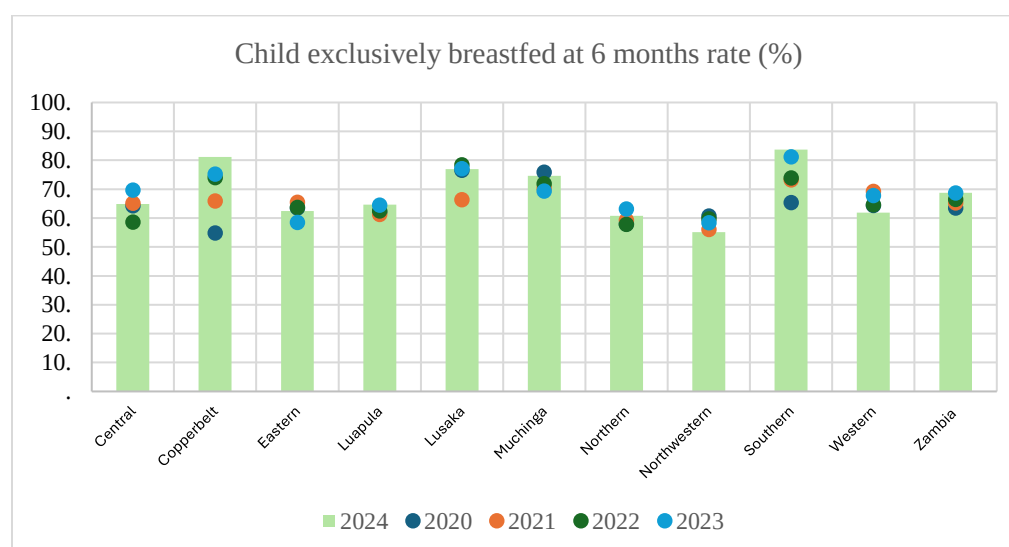
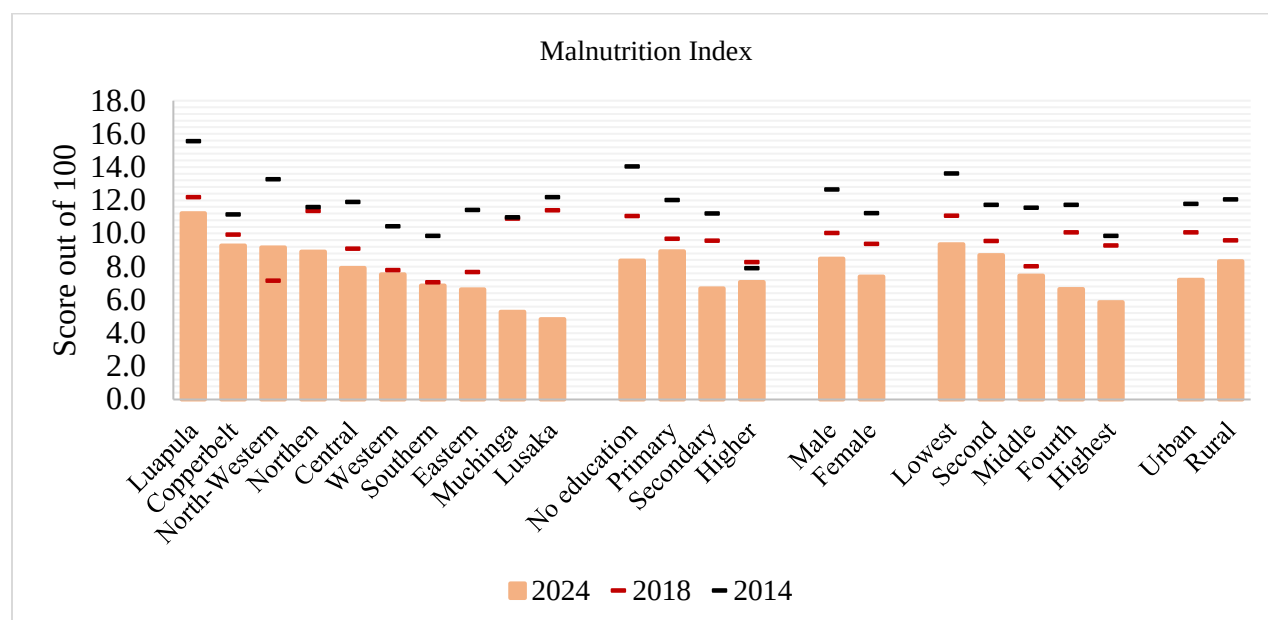


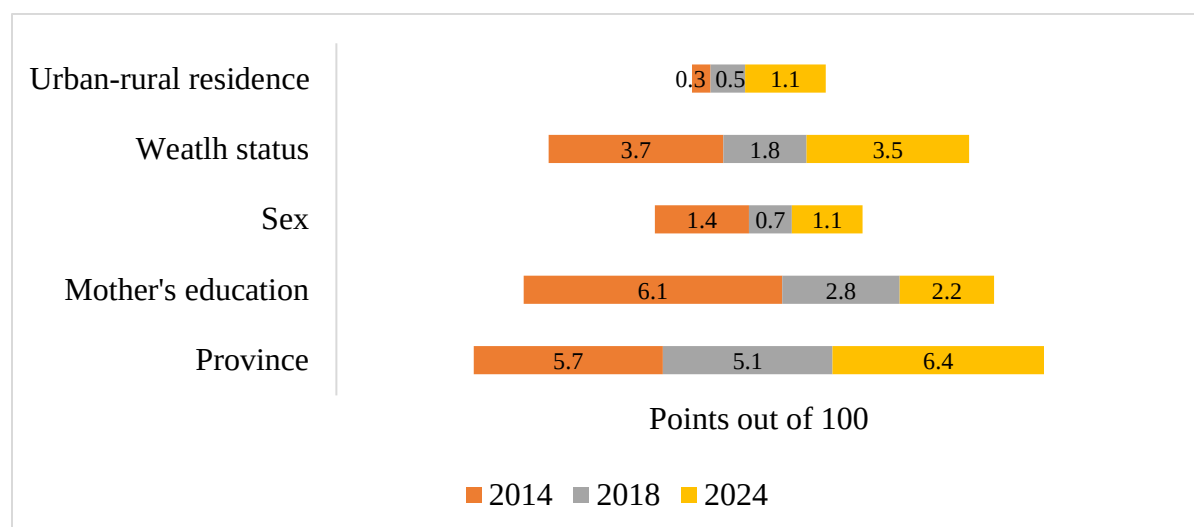
Figure 46: The Malnutrition Index



The index has been calculated as the geometric mean of the malnutrition rates for stunting, wasting, underweight, and overweight.

Over time, the inequality gaps have generally not narrowed as anticipated. For example, the gap between the province with the highest and the province with the lowest malnutrition index has actually widened, increasing from 5.7 points (out of 100 points) in the 2013-14 ZDHS to 6.4 points (out of 100 points) in the 2024 ZDHS (Figure 47 below). A similar widening of the inequality gap is also evident between urban and rural areas. The gap in inequality based on mother's education significantly decreased from 6.1 points (out of 100) in the 2014 ZDHS to 2.2 points in 2024.

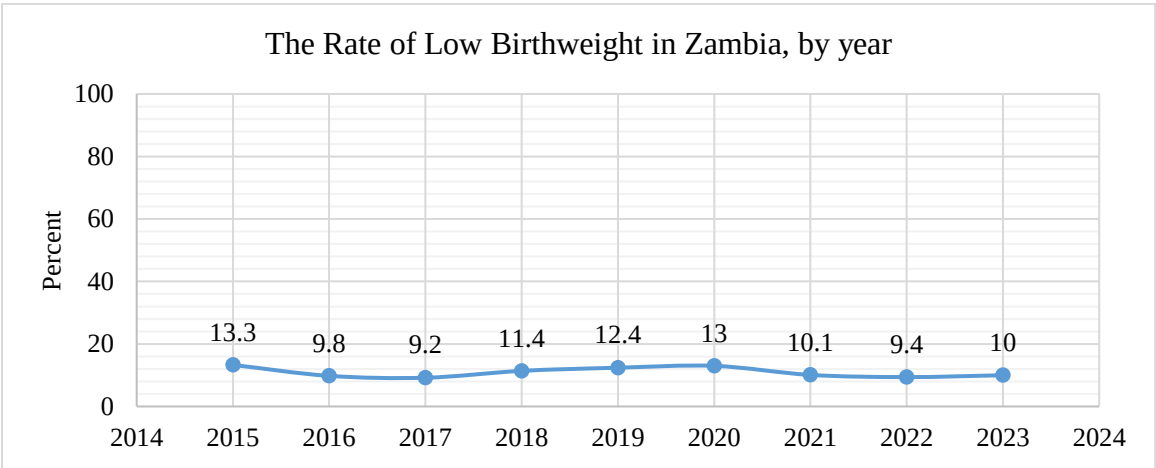
Figure 47: Absolute Gap in Malnutrition Rate, by Key Equity Stratifiers



Data Source: ZDHS, 2024

From 2015 to 2023, Zambia has experienced fluctuations in the percentage of low birthweight births (Figure 48 below). Although the percentage increased between 2017 and 2020, there has been a decline in recent years (2021-2023), showing some positive trends in improving birth outcomes.

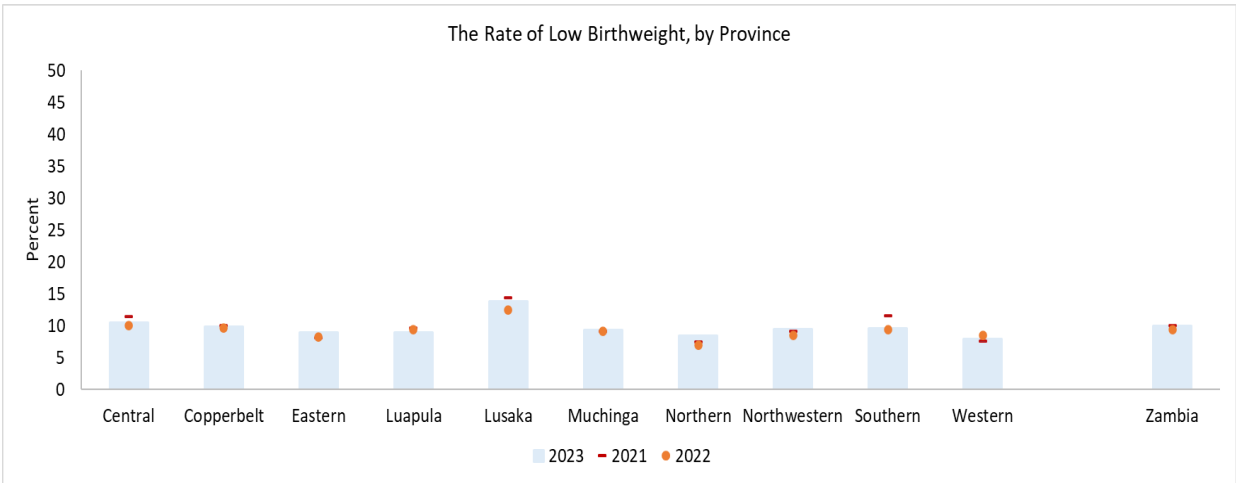
Figure 48: Trends in the Rate of Low Birthweight in Zambia



Data Source: WHO, 2025

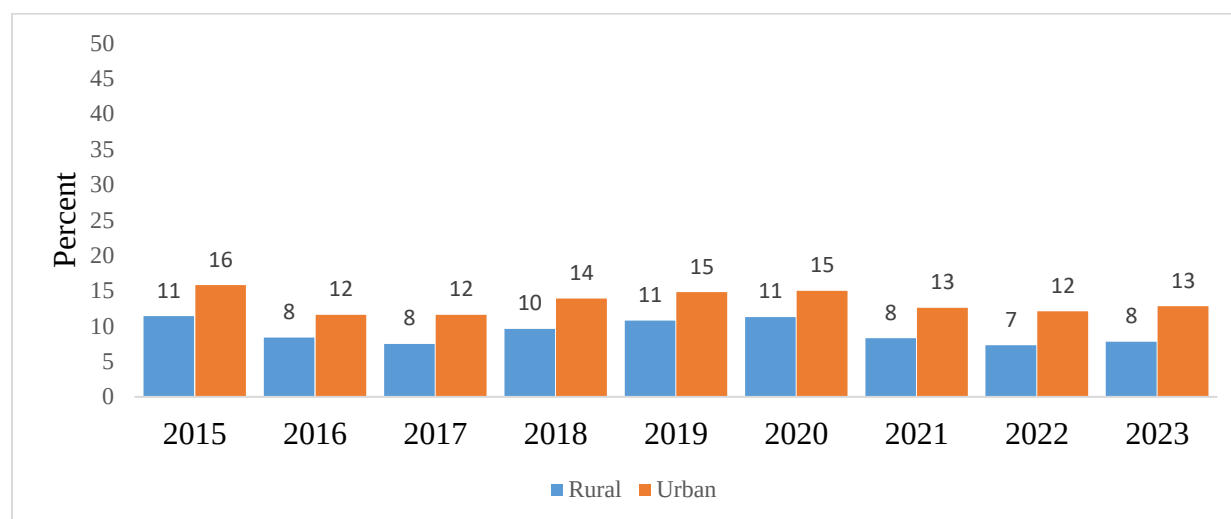
The differences in low birthweight rates between provinces are generally modest, with the gap between the province with the highest and the province with the lowest low birthweight decreasing from 9% in 2018 to 6% in 2023. In 2023, Lusaka Province had a higher rate of low birthweight compared to the rest of the country.

Figure 49: Rate of Low Birthweight, by Province



Surprisingly, however, low birthweight in Zambia is higher in urban than in rural areas. The low birthweight rate in urban areas during the 2021-2023 period is roughly twice as high as the rate in rural areas.

Figure 50: The Rate of Low Birthweight, by Urban-Rural Residence



5.2.3 Progress in improving length and quality of healthy lives

Life expectancy at birth and health life expectancy in Zambia

As shown in Figure 51 below, Zambia's life expectancy (LE) and healthy life expectancy (HALE) at birth from 2010 to 2024, shows a gradual increase over time. Life expectancy has steadily risen from approximately 55 years in 2010 to over 60 years by 2024, reflecting improvements in healthcare, nutrition, and living conditions (WHO, 2024). Healthy life expectancy, which measures the number of years a person can expect to live in good health, follows a similar trend but remains consistently lower than total life expectancy, highlighting the burden of non-communicable diseases (NCDs), infectious diseases, and healthcare accessibility issues (UNDP, 2023). Despite this progress, Zambia still faces health system challenges that impact the quality of life in later years.

The Figure 52 presents healthy life expectancy (HALE) at birth disaggregated by sex, showing a steady increase for both males and females from 2010 to 2026. The data indicates that females tend to have a slightly higher HALE than males, a pattern observed in many countries due to biological, behavioral, and healthcare-seeking differences (World Bank, 2023). The increase in HALE across both sexes suggests improvements in public health interventions, vaccination programs, and maternal health services. However, the persistence of gender disparities in health outcomes and disease burdens, particularly in access to reproductive healthcare and chronic disease management, remains an area requiring targeted interventions.

Although life expectancy and healthy life expectancy have improved, Zambia still faces health challenges such as high maternal mortality rates, the burden of HIV/AIDS, and the growing prevalence of non-communicable diseases (Ministry of Health Zambia, 2022). Investments in universal health coverage, improved access to primary healthcare, and enhanced disease prevention programs are crucial to sustaining these positive trends. Additionally, addressing risk factors such as poor nutrition, inadequate healthcare infrastructure, and environmental health hazards can further improve the overall well-being of Zambia's population.

Figure 51: Life Expectancy and Health Life Expectancy at Birth by Year

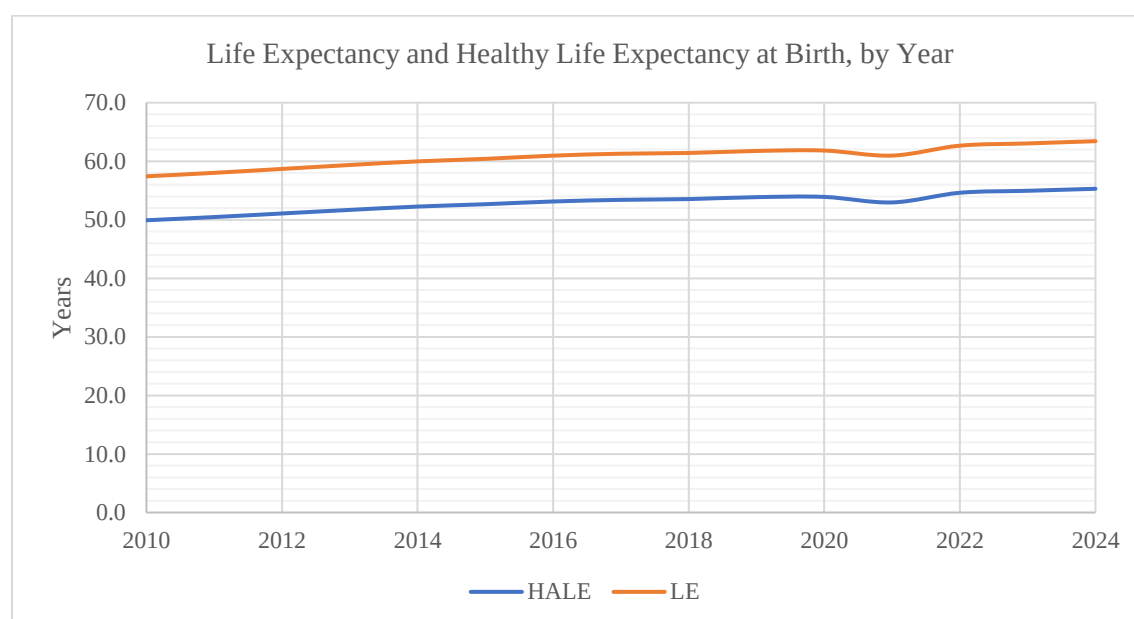
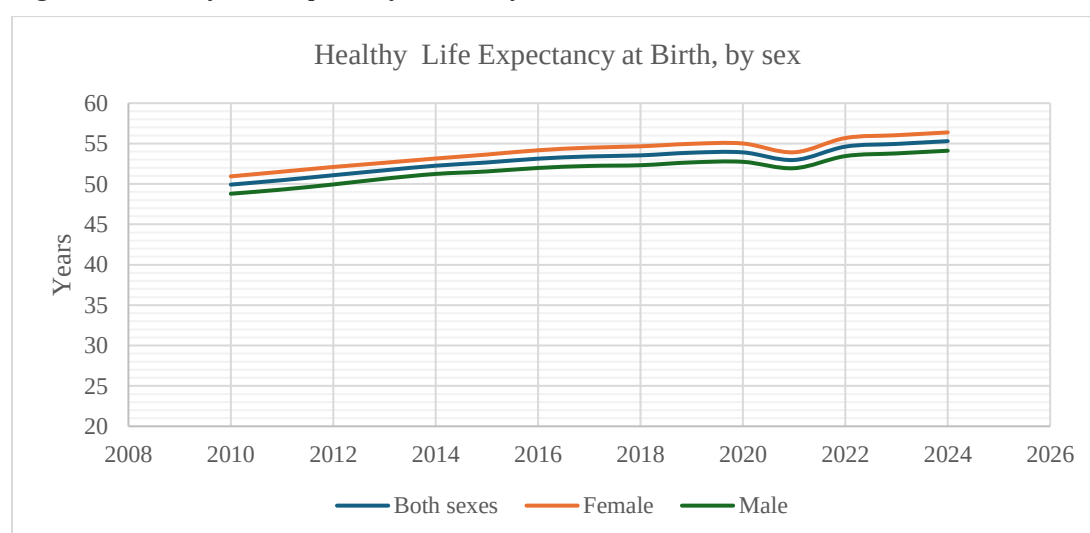


Figure 52: Healthy Life Expectancy at Birth by Sex



The figure 53 and 54 below, compare Zambia's life expectancy (LE) and healthy life expectancy (HALE) at birth with the WHO African Region (AFRO) and Southern African Development Community (SADC) averages. While Zambia has shown steady improvements, increasing from 55 years in 2010 to over 63 years by 2024, it remains slightly below regional averages. This trend suggests gaps in healthcare access, disease control, and socioeconomic factors that influence health outcomes (WHO, 2024). Similarly, Zambia's HALE has improved but still lags behind AFRO and SADC, highlighting the ongoing burden of infectious diseases, non-communicable diseases (NCDs), and maternal health challenges.

Figure 53: Zambia's life expectancy (LE) Compared to the WHO AFRO and SADC Averages.

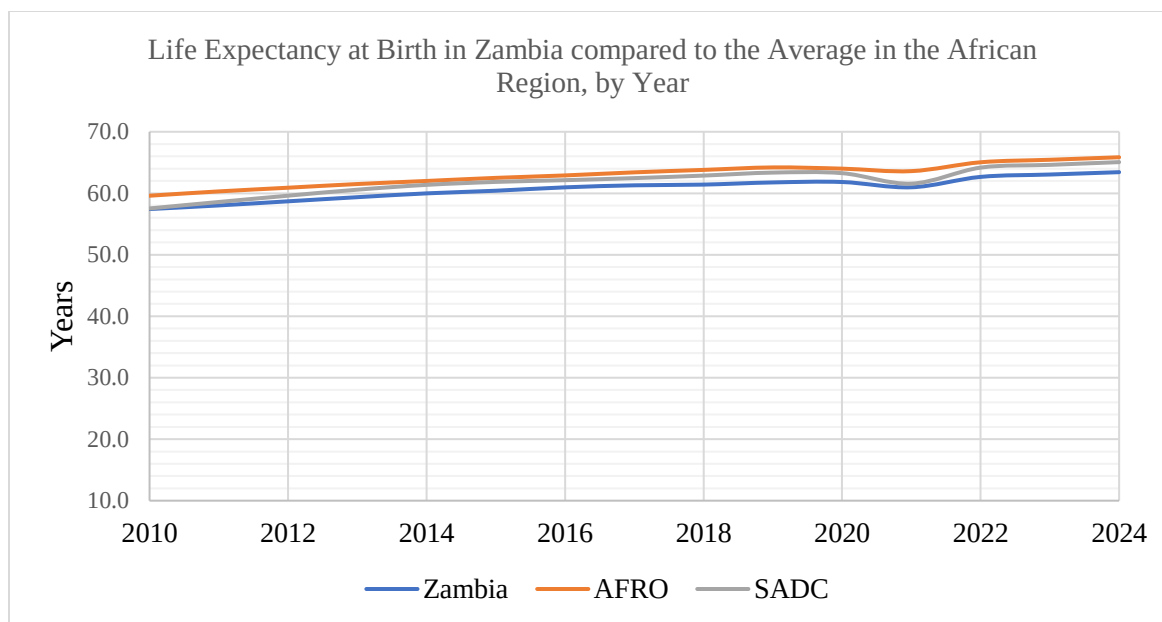
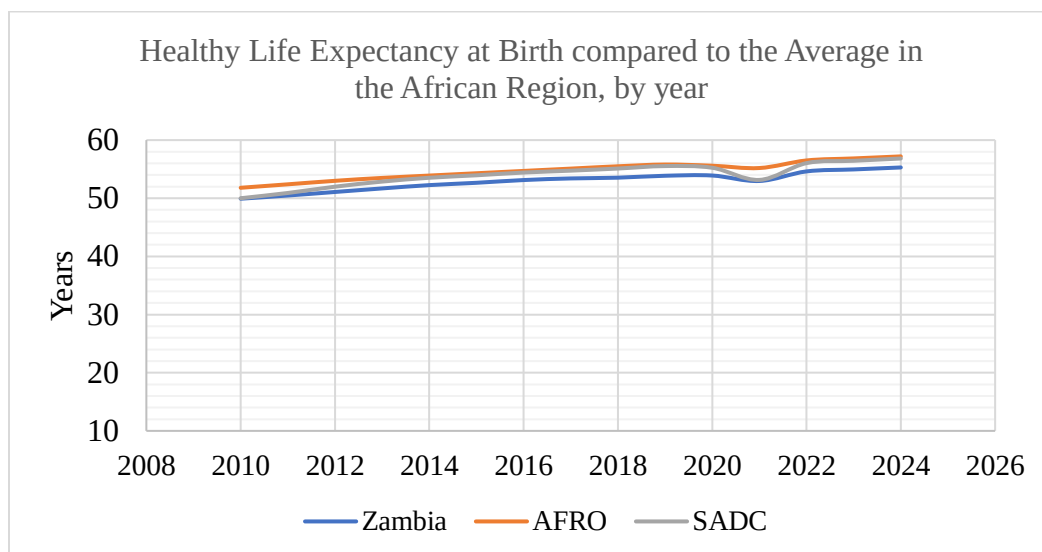


Figure 54: Zambia’s healthy life expectancy (LE) Compared to the WHO AFRO and SADC Averages.

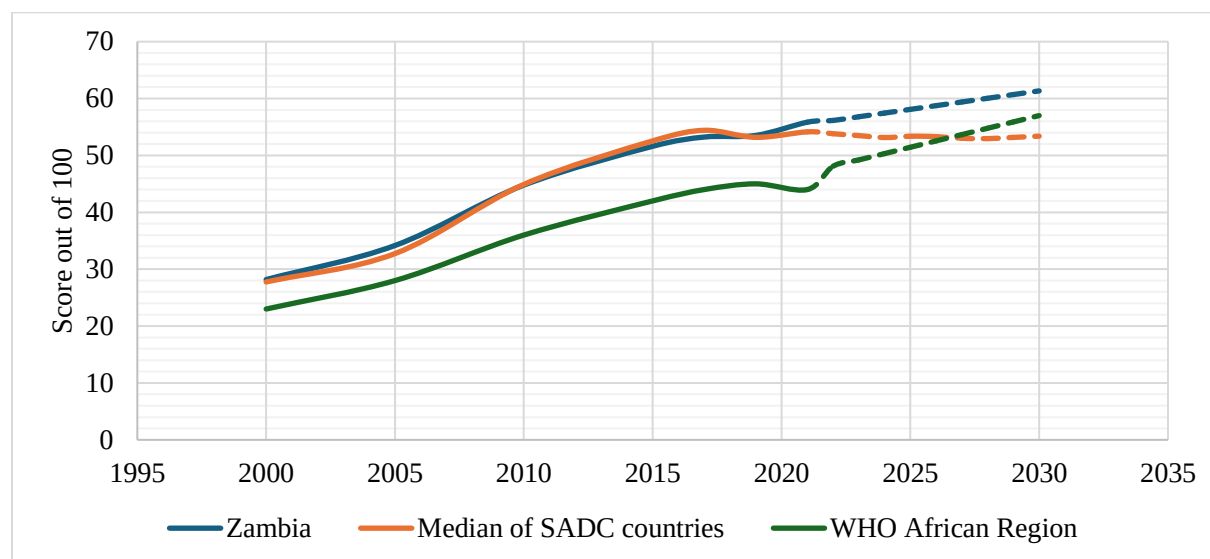


5.3 Progress towards universal health coverage and other SDGs in the country

The global commitment to Universal Health Coverage (UHC) centers on ensuring access to high-quality, comprehensive essential health services. Achieving UHC involves expanding the scope and availability of these services, with a special focus on reaching the most vulnerable populations.

WHO estimates¹ indicate that UHC service coverage in Zambia is gradually increasing (Figure 1). The coverage has risen from 28 out of 100 points in 2000 to 52 points in 2015, and 56 points in 2021. This suggests that by 2021, just over half of the population had access to the essential services they needed. Projections based on trends from 2015 to 2021 indicate that Zambia's UHC service index is expected to rise to 58 points in 2025 and 61 points in 2030.

Figure 6: Comparison of Trends in Zambia's UHC Service Coverage Index with the Median of SADC Countries and the Average for the WHO African Region:



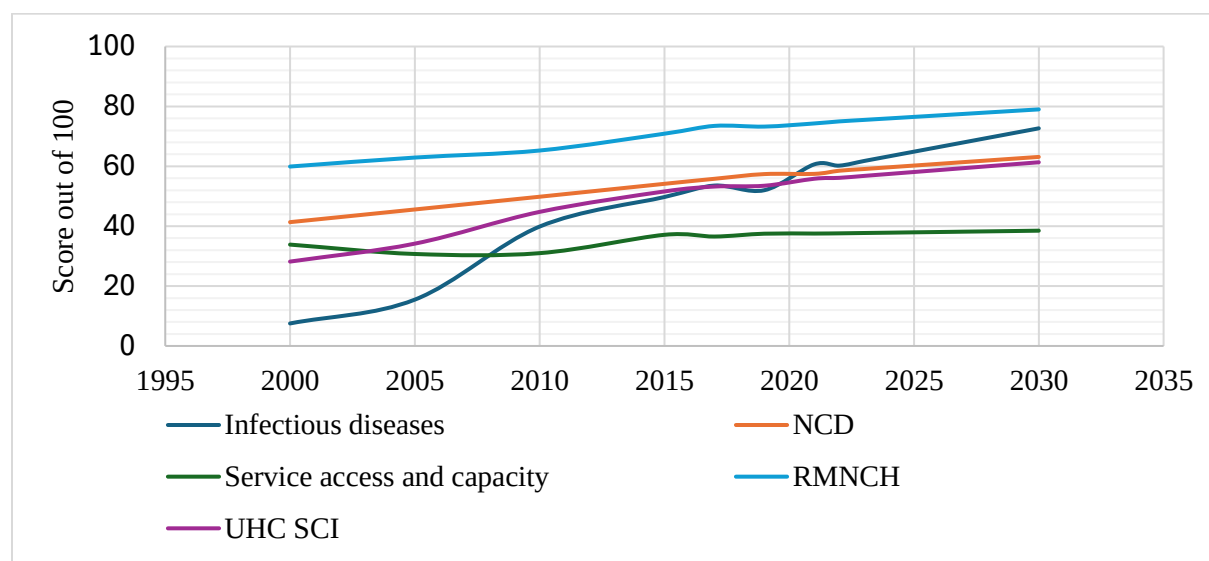
(Data source: WHO, 2023)

Since 2017, Zambia's service coverage index has been higher than the average for the WHO African Region, as well as the median for SADC countries (Figure 1).

In Zambia, coverage for reproductive, maternal, newborn, and child health services has consistently been higher than for other services; however, these areas are not the primary drivers of the UHC service coverage index. Improvements in these services have been relatively slow. The main contributor to the increase in the UHC service coverage index has been the improvement in services for infectious diseases, which rose sharply from 8 points in 2000 to 50 points in 2015 and 61 points in 2021 (Figure 2).

¹ WHO (2023). The Universal Health Service Coverage Index. Available online at: <https://www.who.int/data/gho/data/indicators/indicator-details/GHO/uhc-index-of-service-coverage>. Accessed on 20 March 2025

Figure 7: Trends in UHC Service Coverage Index by Domain:



Data source: WHO, 2023

To accelerate progress toward Universal Health Coverage (UHC), Zambia must continue enhancing its health infrastructure and expanding access to essential health services, particularly for non-communicable diseases. Achieving this will require increasing health financing by allocating sufficient and sustainable public funds to the healthcare system, while also strengthening domestic resource mobilization through improved tax collection and innovative financing mechanisms. Additionally, Zambia should focus on strengthening its health systems by improving governance, leadership, and management to ensure efficient and equitable service delivery. Promoting the integration of services across primary, secondary, and tertiary care levels will help reduce fragmentation and enhance accessibility. Expanding health insurance coverage to include vulnerable populations is also critical, as well as guaranteeing financial protection for all and encouraging universal health insurance schemes that provide equitable access to essential services without causing financial hardship. Furthermore, strengthening the collection, analysis, and use of health data will be crucial to effectively monitor progress toward UHC, guide policy decisions, and optimize resource allocation.

6 Key contextual factors affecting health sector organization and functioning in the country

6.1 Implementation status of planned interventions of the NHSP

The review assessed the implementation status of all strategic interventions across all the static areas of both strategic direction one and two of the NHSP 2022-2026. Table 31 below provides a summary of the implementation status/score of strategic interventions across each strategic area, while table 32 provides a summary of the implementation status by program area.

Table 31: Implementation Status of Planned Interventions (Implementation Score)

Program Area	Total Interventions	Implementation Score (Avg)
Tuberculosis and Leprosy	17	4.24
Malaria	3	4.00
Neglected Tropical Diseases	3	4.00
HIV/AIDS and Sexually Transmissible Infections (STIs)	28	3.89
Reproductive and Maternal Health	68	3.81
Health Information, Research and Innovation	15	3.78
Nutrition	8	3.50
Health Care Financing	15	3.33
Nursing and Midwifery Services	22	3.14
Public health security	19	3.11
Health promotion and Education	16	3.00
Cancer Diseases	16	3.00
Essential Medicines and Medical Supplies	30	3.00
Clinical Care Services	68	2.96
Non-communicable diseases	15	2.93
Social Determinants of Health	13	2.77
Child Health	16	2.75
Physical Infrastructure, Medical Equipment and Transport	15	2.69

Environmental Health, Food Safety and Occupational Health	16	2.69
Leadership and Governance	24	2.67
Adolescent Health	9	2.25
Community Health	15	2.20
Rehabilitative Services	12	2.17
Diagnostic Services	31	2.14
Neonatal and Child Health and Development	26	2.08
Mental Health	14	1.86
Blood Transfusion Services	11	1.73
Viral hepatitis	5	1.40
Health Workforce	11	0.00

Table 32: Summary by Program Area (Status of Implementation)

Program Area	Not Implemented	Partly Implemented (1 - 20%)	Partly Implemented (21 - 40%)	Partly Implemented (41 - 60%)	Partly Implemented (61 - 80%)	Partly Implemented (81 - 99%)	Fully Implemented	No Data	Total Interventions
Health promotion and Education	0	0	2	13	1	0	0	0	16
Community Health	3	3	1	6	1	0	1	0	15
Reproductive and Maternal Health	2	0	2	19	35	2	8	0	68
Neonatal and Child Health and Development	0	5	15	5	1	0	0	0	26
Child Health	0	1	6	5	4	0	0	0	16
Adolescent Health	0	2	3	4	0	0	0	0	9
Nutrition	0	0	0	4	4	0	0	0	8
Malaria	0	0	0	0	3	0	0	0	3
HIV/AIDS and Sexually Transmissible Infections (STIs)	0	2	3	3	8	10	1	0	28
Tuberculosis and Leprosy	0	1	1	1	4	10	0	0	17
Viral hepatitis	1	2	1	1	0	0	0	0	5

Program Area	Not Implemented	Partly Implemented (1 - 20%)	Partly Implemented (21 - 40%)	Partly Implemented (41 - 60%)	Partly Implemented (61 - 80%)	Partly Implemented (81 - 99%)	Fully Implemented	No Data	Total Interventions
Non-communicable diseases	0	1	1	11	2	0	0	0	15
Mental Health	0	6	5	2	1	0	0	0	14
Cancer Diseases	1	1	2	5	7	0	0	0	16
Neglected Tropical Diseases	0	0	0	0	3	0	0	0	3
Environmental Health, Food Safety and Occupational Health	2	1	1	8	4	0	0	0	16
Public health security	0	2	5	5	4	2	1	0	19
Social Determinants of Health	0	1	5	5	1	0	1	0	13
Clinical Care Services	3	5	7	19	12	3	2	5	68
Blood Transfusion Services	3	1	2	3	1	0	1	0	11
Diagnostic Services	5	1	2	3	2	1	1	3	31
Rehabilitative Services	0	6	2	2	1	0	1	0	12
Nursing and Midwifery Services	0	1	4	9	6	0	1	0	22
Health Workforce	0	1	2	7	0	1	0	0	11
Essential Medicines and Medical Supplies	0	5	3	11	10	0	1	0	30
Physical Infrastructure, Medical Equipment and Transport	0	2	4	5	1	0	1	0	15
Health Information, Research and Innovation	2	0	0	1	1	3	2	1	15
Health Care Financing	0	0	2	8	3	2	0	0	15
Leadership and Governance	1	3	10	3	3	4	0	0	24
Total	23	53	91	168	123	38	22	9	561
Percentage	4.10%	9.45%	16.22%	29.95%	21.93%	6.77%	3.92%	1.60%	100.00%

6.2 Alignment of strategies, plans, and activities within sector

The review assessed the level of alignment between the NHSSP 2022-2026 with other sectoral plans including program level and department specific strategic and operational plans. Table 33 below provide a summary of the alignment of strategies within the sector, with the NHSSP 2022-2026

Table 33: Summary by Program Area (Alignment to Strategic Plan)

Program Area	Aligned	Not Aligned	No Information	Total Interventions
Health promotion and Education	16	0	0	16
Community Health	13	1	1	15
Reproductive and Maternal Health	67	0	0	68
Neonatal and Child Health and Development	26	0	0	26
Child Health	16	0	0	16
Adolescent Health	8	0	0	9
Nutrition	8	0	0	8
Malaria	3	0	0	3
HIV/AIDS and Sexually Transmissible Infections (STIs)	27	0	0	28
Tuberculosis and Leprosy	17	0	0	17
Viral hepatitis	5	0	0	5
Non-communicable diseases	15	0	0	15
Mental Health	14	0	0	14
Cancer Diseases	16	0	0	16
Neglected Tropical Diseases	3	0	0	3
Environmental Health, Food Safety and Occupational Health	16	0	0	16
Public health security	19	0	0	19
Social Determinants of Health	13	0	0	13
Clinical Care Services	51	0	5	68

Blood Transfusion Services	11	0	0	11
Diagnostic Services	10	0	7	31
Rehabilitative Services	12	0	0	12
Nursing and Midwifery Services	21	0	0	22
Health Workforce	0	0	0	11
Essential Medicines and Medical Supplies	30	0	0	30
Physical Infrastructure, Medical Equipment and Transport	13	0	0	15
Health Information, Research and Innovation	7	0	3	15
Health Care Financing	15	0	0	15
Leadership and Governance	24	0	0	24

6.3 Broader contextual factors - health sector SWOT analysis

6.3.1 Analysis of health sector strengths and opportunities

Table 34 below provides a summary of the assessment and analysis of the Strengths and Opportunities within the health sector.

Table 34: Analysis of Health Sector Strengths and Opportunities

Strategic Area	Strengthens	Opportunities
Sector Management, Leadership and Governance -	1. Coordination of health programs through involvement of local authorities and other stakeholders (NGOs, Cooperating partners). 2. Capacity building to enhance governance and operational efficiency. 3. Effective Monitoring and evaluation of health programs due to sector partnership coordination. 4. Availability of Transparency and accountability mechanisms in implementing government policies. E.g. Decentralisation/ Devolution of health services to local authorities. 5. Established communication channels in the health system facilitate an efficient and seamless flow of information.	1. The government has pronounced and implemented the policy of decentralization. 2. The government has created an enabling environment for overall improvement of the health sector management.
Human Resources for Health	1. There is Continuous Professional Development (CPDs) for In-service training 2. Expansion in the development of Health workforce through increased number of Health Training institutions. 3. Health worker promotion (funding positions and opening new positions) through mass recruitment 4. Partner support supplementing Government efforts in recruitment of staff. 5. Knowledge and skills transfer through provision of technical support.	1. Construction and upgrading of health facilities has provided an opportunity for more skilled manpower. 2. Local resource mobilization will be enhanced due to decentralization. 3. Government has opened opportunities for training staff including private institutions.
Essential Medicine and Medical Products	1. Availability of Essential Medicines and Medical Products in the period. 2. Stable supply chain through establishments of Regional ZAMMSA hubs. 3. Efficient tracking of Essential Medicines and Medical Products through use of eLMIS. 4. Availability of blood and blood products at transfusing facilities. 5. Increased distribution of blood and blood products points from 10 to 30 countrywide through creation of country hubs.	1. Opportunity for local pharmaceutical manufacturing sector to reduce reliance on imports. 2. Availability of ZAMMSA hubs will attract more funding for procurement of more drugs.

Infrastructure, Equipment and Transport	1. Increased number of health facilities (less than 3000 to 3406). 2. Through CDF there's upgrading, rehabilitation and construction of health facilities.	1. Availability of CDF funds to support health facility construction, rehabilitation and upgrading. 2. Government pronouncement on energy mix has provided an opportunity to install Solar and other forms of Power supply (leading to reduced costs of electricity). 3. Availability of CDF funds to procure ambulances. 4. Government policy and Partner involvement has provided an opportunity for MOH to enhance ICT infrastructure.
Health Information System, Technology and Research.	1. DHIS2 available and data is utilised at decision making. 2. Digitalization of health records improving data management 3. Integration of digital tools for disease surveillance and outbreak response (COVID, Cholera). 4. Above 90% of Primary and secondary health systems reported in DHIS2 5. 80% of reports submitted on time (exceeding the 75% target). 6. Regular Data Quality Audits (DQAs) conducted regularly. 7. Available guidelines for data management at district and facility level 8. Use of scorecards and dashboards at national and subnational level enhances data use.	1. Presence of Stakeholders and partners to support data management at facility and district levels in various programs e.g. HIV/TB/Malaria and other public health areas. 2. Availability of national Data warehouse for integration of other reporting systems. 3. Interoperability of various systems used in the health sector – Dhis2, SmartCare, IDSR
Health Care Financing	1. MOH budgetary increment from previous 8% to 10.4% (2024) 2. Decentralization of funds disbursement from Ministry of Finance (MOF) to the provinces and districts. 3. Autonomy and Improved accountability of funds according to budget. 4. NHIMA funds are supplementing Health facility budgets. 5. Strengthened financial management systems (IFMIS, NAVISION) to optimize resource allocation	1. Government political will to improve health care financing
Service Delivery Systems	1. Availability of Mentorship and Technical Support Services (TSS) 2. Availability of systems (DISA) of sample pick-up and delivery of results. 3. Performance monitoring through performance assessments 4. NHIMA funds supplements procurement of commodities and products for improved service delivery 5. Heightened health promotion and development of service charters. 6. Availability of tools to monitor quality of care.	1. CDF and other funding for improved infrastructure leading for quality of care. 2. Human resource employment leading to improvement of service delivery.

6.3.2 Analysis of health sector weaknesses and threats

Table 35 below provides a summary of the assessment and analysis of the Weaknesses and Threats within the health sector

Table 35: Analysis of Health Sector Weaknesses and Threats

Strategic Area	Weaknesses	Threats
Sector Management, Leadership and Governance -	- Administrative appointments - Inadequate orientation with regards to decentralization - Rigidity in budget adjustments during implementations which makes it difficult to adopt in evolving health needs - Inadequate monitoring and accountability mechanism with regards sector Partnership Coordination mechanisms - Misalignment of Management Monitoring System and with the yellow book	- Constant restructuring of the ministry of health - Outdated National Health Policy - Delayed approval and implementation of policy and strategy documents - Parallel implementation of funded programmes
Human Resources for Health	- Selective sponsorship for further training (including specialized disciplines) of health workers - No established positions in institutions to retain staff that have acquired high education - Non-adherence to Retention guidelines - Requested Health workers mix is not included in both recruitment and deployment - High Staff turn-over - Only 58% filled establishment	- Doctor/patient (1:12,000 against the target of 1: 5,000 population) and Nurse/Patient (1:1,000 against the target of 1: population) ratio is low. - Low Staff retention (internal transfers, attrition and brain drain)
Essential Medicine and Medical Products	- Districts and health facilities are using part of their grants to supplement the purchase of essential medicines and medical supplies. - Only 1200 out of 3190 public health facilities are using eLMIS	-
Infrastructure, Equipment and Transport	- 11 out of 18 third level hospitals are in Lusaka - 41 out of the 152 general hospitals are in Lusaka	- Vulnerability to data breaches and unauthorized access to sensitive data

	- Only 19.8% of ambulances are functional for health centres and health posts - Only 29.6% ambulances are functional for Hospitals (1st, 2nd and 3rd level) - Only 1,083 maternity wings and annexes for 3,259 health facilities - Inadequate hardware and connectivity - Only 1,340 facilities are using EHR out of 3,259 facilities -	- Difficulty to control outbreak of epidemics - Disruption of internet connectivity caused by power outages
Health Information System, Technology and Research.	- Only 50% of health facilities are able to enter data in the DHIS2 and the rest depend on the district for data entry. - Only 5 out of 14 EHR systems are connected to DHIS2 - 80% of private facilities and only 40% of community reports are reported in the dhis2. - There is no curriculum for data management for clinical staff - Low demand in the utilization of health data amongst line ministries.	- Parallel DHIS2 systems developed by partners hence affecting data quality. - unavailability of Health data captured by parallel systems not linked to MoH DHIS2 - unavailability of complete data for decision making of public health interventions in the community
Health Care Financing	- Unable to fully implement the Management Monitoring System - Rigid Budget and adequate funding - Dependence of partner funding - The health sector budget has increased from 10.4% in 2023 to 11.8% in 2024. However, in 2025, the allocation to the Health Sector budget has reduced to 10.7% from 11.8% as a percentage of the national Budget. This reduction means that the momentum gained towards attaining the Abuja declaration, which requires that every country allocates at least 15% of the national budget to the health sector, has been overturned.	- Infrastructure sub-programme whose releases were as follows: - Primary health services Programme only 0.52% was released - Hospital Services programme, 0.31% was released. - Some of these resources were realigned to the drought response plan
Service Delivery Systems	- Delay in patient referral - Prolonged turnaround time for sample movements - Service disruption due to health worker movement - Limited resources - Mechanisms for creating health service demand are available but they are not fully utilized by the health	• emerging public health diseases can disrupt delivery services • dissatisfied patients • Resource constraints for development of quality standards

	care providers. Infrequent feedback collection by all levels of care. - Tools for monitoring quality of care are available but there is limited self service quality assessments by healthcare providers. Limited staff training on quality monitoring	

7 Overall impression and recommendations

7.1 Overall progress towards the realization of the national health sector strategic goals

From the findings of this review, the country is on track to meeting its if overall strategic goals and targets as spelt out in the NHSP.

In relation so performance against set targets for indicators outlined in the NHSP, the NHSP outlined a total of 76 indicators for quantitative performance monitoring. The review established an average performance score of 72.3%. There was however wide variation for average performance across programs with indicators for health workforce (91.99%), EMMS (90.0%) blood transfusion (85.89%), RMNCAHN (80.23%) and Communicable Diseases (80.02%) programs reporting over 80% scores, while indicators for Rehabilitative Services (28.04 %) recoded very low scores. The review noted a couple of challenges for the NHSP monitoring. These included i) the Monitoring and Evaluation Framework developed for the NHSP was not aligned to the NHSP and as thus, some programs and interventions outlined had no dictators for tracking performance; and similarly, some indicators outlined were not linked to the outlined programs and interventions ii) In addition, there was no data capture and reporting system established to track some of indicators outlined and as thus the review could not measure performance of these indicators. The would be a need to review and revise the M& E framework of the NHSP to align it with the outlined priority interventions in the remaining period of implementation of the NHSP.

In relation to the implementation of planned interventions and activities, the outlined 561 interventions across 29 program areas. This review established that 351 intervention accounting for 64.17% had been implemented to a level of between 41-100% implementation status. The review however noted a wide variation in the implementation status (score) across different program with TB & Leprosy program (4.24), Malaria program (4.0) and NTD program (4.0) all achieving an implementation score of 4 and above, out of a maximum score of 5; while Viral Hepatitis program (1.64 and Mental health (1.86) program achieved an implementation score of below 2.0. There will thus be need for doing programmatic deep dives for the low scoring programs to identify and remove the barriers of implementation so as to Fastrack the implementation of the outlined interventions in the NHSP in the remaining portion of the NHSP implementation.

On the overall contextual factors affecting the implementation of the NHSP, the review established that's there exist a good level of alignment between the NHSP and the various programmatic and departments plans within the sector. This ensures that the day today efforts conducted by various departmental and programs in the MoH are geared to implementing and meeting the NHSP.

From the review finding, the health sector moving forward will have to significantly recalibrate to address the following:

- Increasing importance of mixed epidemiology characterised by increasing prevalence of NCDs and existing high burden of communicable diseases and NTDs.
- Increasing numbers of disease outbreaks e.g. – the major cholera outbreaks of 2023 and 2024.
- Progressively changing epidemiological profile characterised by reducing fertility rate and increasing life expectancy in the country.
- Increasing constrained health sector fiscal space characterised by decreasing external (donor) funding and ongoing economic challenges in the country.

- Impact of ongoing climate change and extreme weather events (e.g. the severe drought of 2023/24) and its direct (population level) impact on health and the health system.
- Ongoing broader government governance reforms relating to devolution; and its effects of coordination and delivery of health services

8 Overall recommendations

8.1 Recommendations focusing on Strategic Direction One

Health System Outputs

- Implement strategies for increasing **effective demand** and utilization for preventive health interventions and health promotion in the country
- Develop guidelines for institutionalizing a routine quality of care improvement and monitoring system across various service delivery levels in the country.
- Implement strategies for addressing geographical and financial barriers to access essential services across various service delivery levels in the country.
- Progressively improve **health system resilience** through nurturing health system capacity for developing and expanding the various aspects of the *inherent resilience* capacities.

Health System Outcomes

- Fastrack the implementation of remaining interventions and activities across all various programs outlined in the NHSP
- Progressively reduce out-of-pocket expenditure through implementing various forms of pre-financing mechanisms for the health sector.
- Strengthening health security **capacity** by strengthening disease surveillance and outbreak response systems at national, provincial, district, and health facility levels.

8.2 Recommendations focusing on Strategic Direction Two

Service delivery systems.

- Develop a clear definition of and delivery framework and approach for Primary Health Care in the country, focusing on disease prevention and health promotion.
- Elaborate a precise Essential Health Care Package for the country outlining all services/interventions for all population age cohorts and different service delivery levels.
- Strengthen service delivery referral across levels of care through revising/updating the referral policy in the country to compressively outline processes and mechanisms for the four elements of referral, namely: i) patient movements, ii) Expert/service provider movements, iii) Patient samples movements and iv) patient parameters movements. The policy should also include guidelines on entry into care and a gatekeeping mechanism across the various levels to avoid crowding higher levels of care.
- Develop and operationalise a framework for routinely monitoring and tracking quality of care across the various levels of the health care delivery systems

Health Leadership and Governance

- Develop Health Sector Leadership and Governance Guidelines to guide the establishment, composition, and competencies of health sector leadership and governance structures across the various levels of coordination (national, provincial, district, and health facility).
- Streamline the health sector the planning, budgeting, and review processes to ensure clear linkages within and across levels of government within the sector.
- Strengthening coordination within and across the various levels of management and coordination within the sector
- Streamline the implementation of health sector decentralisation through development of operationalise guidelines and training/orientation of various sub-national actors (local authorities and district teams) on respective roles within the health sector decentralisation policy.
- Strengthen the functioning of the regulatory bodies within the sector with clear standards and guidelines.
- Strengthen the organisation and functioning of health sector governance structures at subnational levels, including health sector involvement by local authorities and facility management boards/committees.
- Strengthen partnership and coordination processes within the sector by developing and operationalising a comprehensive health sector partnership framework.

Human Resources for Health

- Review the staff establishment for MoH to accommodate new posts for emerging needs.
- Re-focus and prioritize recruitment and deployment of HRH to primary health services
- Evaluate the existing retention strategies and packages (e.g., the hardship allowance).
- Create a conducive working environment in the rural areas (e.g., provision of decent accommodation).
- Strengthen the HR Strategies (implementation of the National HRH Strategy,).

Health Products and Technologies

- Streamline the commodity procurement, warehousing, and distribution processes across various level of the system.
- Strengthen the systems for routine monitoring and tracking the availability of essential health commodities at service delivery levels.
- Review and expand the essential medicines list to include essential NCD medication at primary care levels.
- Establish and operationalize Medicines & Therapeutic committees at provincial, district, and facility levels to ensure rational drug use and quality management of health products and technologies.
- Strengthening facility, district, and provincial level capacity for strategic planning and management of health products and commodities
- Decentralize and provide resources for establishing regional blood collections and transfusion centers.

Health Infrastructure

- Develop and operationalize health infrastructure norms and standards for various service delivery levels linked to the essential health package; to guide rationalization in the construction (of new) and expansion of health facilities in the country
- Strengthening planning and rationalization of infrastructure investments linked to appropriate needs for respective service delivery level
- Develop and implement routine preventive/service maintenance for infrastructure across all health systems levels
- Ensure availability of properly equipped ambulances for emergency response and transportation of patients,

Health Management Information Management Systems and Research

- Develop a National HIS strategy and revise the health sector M&E framework to guide the processes for developing health data collection, management, analysis, reporting, and tracking systems linked to the NHSP.
- Develop a HIS legal framework, policies, SOPs, data sharing agreement, and guidelines to compel the facility to report.
- Progressive digitization of reporting tools at all the levels to reduce manual data collection
- Include and integrated the community health services reporting into routine HIS
- Develop and implement guidelines and standards to guide EHR systems in the country.
- Strengthen capacity for data analysis and information used for decision-making across levels.
- Establish a national health observatory.

Health Financing

- Develop a national health financing strategy that clearly outlines resource mobilization strategies, pooling arrangements, and purchasing arrangements for health services as part of the implementation of the national UHC goal.
- Explore efficiency gaining strategies in health sector resource allocation and utilisation maximise health outputs and outcomes with available health sector resources
- The national government to ensure timely disbursements of resources to provinces, districts, and health facilities.
- Explore, implement, and strengthen mechanisms for enhancing routine finance management autonomy for health service delivery and coordination units under the decentralisation policy.

8: List of members of the MTR team

The Mid-Term Review of the National Health Strategic Plan 2022–2026 was overseen by a coordinated structure comprising the Steering Committee, Core Team, and Technical Task Teams. Below is a list of personnel who actively participated in the MTR process through to the development of the final report.

	Name	Designation	Organisation	Role In the MTR
1.	Dr. George Sinyangwe	Permanent Secretary – Donor coordination and Administration	Ministry of Health	Steering Committee Chairperson
2.	Madrine B. Mbuta	Director – Policy and Planning	Ministry of Health	Technical Working Group Chairperson
3.	Calvin Kalombo Mpendwa	Assistant Director – Monitoring and Evaluation	Ministry of Health	Technical Working Group Co-Chairperson
4.	Dr Azmach Hadush Gebregiorgis	Health Systems Advisor & ULC Cluster Coordinator	World Health Organization	Technical Working Group Co-Chairperson
5.	Joseph Simuchimba	Principal Monitoring and Evaluation Officer – Programmes	Ministry of Health	MTR Manager
6.	Abel Kalikiti	Monitoring and Evaluation Officer	Ministry of Health	Core Member of the MTR Secretariat
7.	Yvonne Mwale	Senior Monitoring and Evaluation Officer	Ministry of Health	Core Member of the MTR Secretariat
8.	Mavis Masese	Planner – Development Cooperation	Ministry of Health	Core Member of the MTR Secretariat
9.	Mwango Mutale	Chief Monitoring and Evaluation Officer – RHIS	Ministry of Health	Technical Task Team Lead - Data
10.	Nkaka Puta Chellah	Acting Chief Monitoring and Evaluation Officer – RM&E	Ministry of Health	Technical Task Team Lead - Data
11.	Ovost Chooye	Principal Monitoring and Evaluation Officer – Research	Ministry of Health	Technical Task Team Lead - Data
12.	David Ngula	Principal Monitoring and Evaluation Officer – Output	Ministry of Health	Technical Task Team Lead – Data
13.	Vichael Silavwe	Chief IMCI Officer	Ministry of Health	Technical Task Team Lead - Programmes
14.	David Chama	National Laboratory Manager	Zambia National Blood Transfusion	Technical Task Team Lead - Programmes
15.	Sandra Musokota M	Senior Health Promotion Officer	Ministry of Health	Technical Task Team Lead - Programmes
16.	Gabriel Lungu	Mental Health Officer	Ministry of Health	Technical Task Team Lead - Programmes

17.	Pamela Nakombe	Principal Planner – Planning and Budgeting	Ministry of Health	Technical Task Team Lead - Programmes
18.	Dr. Chrispin Sichone	Decentralization Coordinator	Ministry of Health	Technical Task Team - Member
19.	Mildred Tolosi Kaunda	Senior Monitoring and Evaluation Officer	Ministry of Health	Technical Task Team - Member
20.	Tedson Simwanza	Senior Monitoring and Evaluation Officer	Ministry of Health	Technical Task Team - Member
21.	Chika Muziya	Quality of Care and Service Delivery Technical Officer	World Health Organization	Technical Task Team - Member
22.	Albert Hitima	District Health Information Officer	Rufunsa DHO	Technical Task Team - Member
23.	Chikosenu Makayi	Senior Health Information Officer	UTHs	Technical Task Team - Member
24.	Jeremiah Mwamba	Principal Planner – Planning and Budgeting	Ministry of Health	Technical Task Team - Member
25.	Lotson Buumba	Senior Monitoring and Evaluation Officer	Ministry of Health	Technical Task Team - Member
26.	Dainess Nyirenda	Planner – Health Care Finance	Ministry of Health	Technical Task Team - Member
27.	Paul Chewie Ngwenyufu	Principal Biomedical Engineer	Ministry of Health	Technical Task Team - Member
28.	Dr. Job Kasweshi	Chief ART Officer	Ministry of Health	Technical Task Team - Member
29.	Taimolo Chiseka	Chief Human Resource Officer	Ministry of Health	Technical Task Team - Member
30.	Ilambe Mizanda	Acting Senior Quality Assurance Officer	Ministry of Health	Technical Task Team - Member
31.	Dr. Beatrice Mulambya	Clinical Care Infectious Diseases	Ministry of Health	Technical Task Team - Member
32.	Chimuka Sianyinda	Strategic Information Officer	Ministry of Health	Technical Task Team - Member
33.	Peter Funsani	Head – M&E	Zambia National Public Health Institute	Technical Task Team - Member
34.	Gates Banda	Head - Planning	Zambia National Public Health Institute	Technical Task Team - Member
35.	Munsaka Sianyinda	Monitoring and Evaluation Officer	Ministry of Health	Technical Task Team - Member
36.	Mukube David Sitali	Senior M&E Officer	Ministry of Health	Technical Task Team - Member

37.	Vuscovic Chanda	Senior Community Health Officer	Ministry of Health	Technical Task Team - Member
38.	Zakeyo Mvula	Chief Environment Health Officer	Ministry of Health	Technical Task Team - Member
39.	Mabel Mweemba	Chief Adolescent Health Officer	Ministry of Health	Technical Task Team - Member

The Mid-Term Review of the National Health Strategic Plan 2022–2026 was technically supported by a team from the World Health Organization Regional Office for Africa. Below is a list of the WHO personnel who were deployed to Zambia to provide technical assistance throughout the review process.

1.	Prof. Benjamin Tsofa	Health Policy and Systems Specialist	World Health Organization Regional office for Africa	Main Consultant
2.	Dr. Benson Droti	Team Lead - Health Information System	World Health Organization Regional office for Africa	Consultant
3.	Dr Hillary Kipruto	Technical officer	World Health Organization Regional office for Africa	Consultant

