I. Project Context

Country Context

Zambia is a lower-middle income country (per capita gross national income (GNI) US$1,350 in 2012), with a population estimated at 14.08 million in 2012. Forty percent of the population lives in urban areas with high urbanization rates. Zambia has a vast land area of 752,612 square kilometers and the population is sparsely distributed (low density of 18 people per square kilometer). This density is particularly low in rural areas, making service delivery a challenge. Annual economic growth has been sustained at about six percent in recent years. The country has had a long period of political stability and has experienced five successful multiparty elections since 1991.

Despite political stability and robust annual economic growth in the last decade, poverty, particularly in rural areas, remains stubbornly high. The effect of economic growth on overall poverty reduction has been small and urban centered growth has not generated higher incomes and better basic services for the majority of Zambians living in rural areas. Rural poverty at 78 percent in 2010 is more than double urban poverty of 28 percent in the same year. Over the past decade, the Gini coefficient worsened from 0.47 to 0.52, especially in rural areas.
Zambia has defined its development agenda through its Vision 2030 and the revised Sixth National Development Plan. Specific development goals include fostering a competitive and outward-oriented economy, significantly reducing hunger and poverty, and reaching high middle income status. Recognizing that there are benefits in bringing decision making and implementation closer to the people, the Government is moving towards greater transfer of authority and resources to local government. In this regard, the national decentralization policy has recently been revised and approved. Primary health care (PHC) is among those activities prioritized for decentralization.

**Sectoral and institutional Context**

In the last decade, Zambia has made notable progress in improving selected health outcomes. Incidence and death rates from HIV/AIDS and malaria have dropped for all age groups. However, progress is insufficient to achieve health and nutrition Millennium Development Goals (MDGs) by 2015. While under-five mortality decreased from 154 to 83 deaths per 1,000 live births between 2000 and 2011, this is still high compared to the average for lower middle income countries (62 deaths per 1,000 live births), and insufficient to achieve MDG 4. The maternal mortality ratio also fell from 540 to 440 deaths per 100,000 live births between 2000 and 2010, but this reduction is too low to achieve the MDG 5 target. Zambia has one of the highest fertility rates in the world (total fertility rate (TFR) of 5.9 in 2010), contributing to both under-five and maternal mortality and increased malnutrition. Although stunting in under-five children has decreased from 53 percent in 2002 to 45 percent in 2007, this remains high compared to regional averages (35 percent) and is far from the MDG 1c target of 23 percent. An estimated one-third of under-five mortality and almost a quarter of maternal mortality are associated with malnutrition, which affects immune status, physical and cognitive development, learning performance and productivity in adult life.

5. Zambia’s coverage and utilization of high impact maternal, newborn and child health (MNCH) and nutrition interventions present a number of challenges, particularly high urban-rural disparities. Rural parts of the country are worse off in many indicators (Table 1). For example, TFR is 7.0 births per woman for rural and 4.6 for urban; and deliveries assisted by a skilled birth attendant is 31.3 percent for rural and 83.0 percent for urban. Although measles immunization coverage is 83 percent (versus 75 percent regionally), full immunization coverage for children aged 12 to 23 months has been stagnant during the past decade at around 70 percent. While overall ITN coverage has increased substantially in recent years, 43 percent of under-five children still do not sleep under an ITN. Sixty percent of under-five children with suspected malaria do not receive antimalarial drugs, and only 36 percent receive deworming tablets. Whereas 60 percent of women receive four antenatal care (ANC) visits (better than the regional average of 43 percent), the quality of ANC is questioned and only 46.5 percent of births are attended by skilled providers (versus 49 percent regionally). With HIV prevalence at 14.3 percent among adults aged 15-49 years, prevalence is high among women (16.1 percent) compared to men (12.3 percent). Contraceptive prevalence rate (CPR) is low (32.7 percent), contributing to poor reproductive health outcomes, such as high fertility, high teen pregnancy and low birth spacing.

Table 1: Selected health status and utilization indicators

<table>
<thead>
<tr>
<th>Outcome indicators</th>
<th>Urban</th>
<th>Rural</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total fertility rate (births per woman)</td>
<td>4.6</td>
<td>7.0</td>
<td>5.9</td>
</tr>
<tr>
<td>Contraceptive prevalence (% of women ages 15-49)</td>
<td>42.0</td>
<td>27.6</td>
<td>32.7</td>
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<tr>
<td>Chronic malnutrition prevalence (% of under-5 children)</td>
<td>39.0</td>
<td>47.9</td>
<td>45.4</td>
</tr>
<tr>
<td>HIV prevalence (among 15-49 % who are HIV positive)</td>
<td>19.7</td>
<td>10.3</td>
<td>14.3</td>
</tr>
</tbody>
</table>
Service coverage indicators
Delivered by skilled provider (% of pregnant women) ** 83.0 31.3 46.5
Full immunization (% of children ages 12-23 months) ** 71.2 66.2 67.6
ARI treatment coverage for under-5 children (% of under-5 children) ** 63.4 38.9 46.6
Under-5 children with diarrhoea who received ORT or increased fluid (%) ** 75.7 73.6 74.3
Under-5 children with fever who sought treatment from a facility/provider same day/next day (%) *** 25.2 24.3 24.5
Under-5 children who slept under an ITN last night (%) *** 50.9 60.1 57.0
Pregnant women who slept under an ITN last night (%) *** 52.3 60.9 58.2

Low coverage and utilization of MNCH and nutrition services, particularly in rural parts of the country, are attributed to demand as well as supply side constraints. On the demand side, rural communities often lack information on preventive practices, including early detection of health and nutrition complications. In addition, long distances to functioning health facilities and lack of transportation often limit access to services. On the supply side, despite the increase in the number of health facilities in recent years, including primary care, service utilization remains low due to bottlenecks such as: (i) stock-outs of essential health and nutrition supplies and consumables due largely to supply chain issues; (ii) insufficient and inequitable distribution of skilled health workers to carry out facility-based and outreach activities especially in the management of childhood illnesses, midwifery, and obstetric complications; and (iii) low productivity of health workers due to tardiness, low morale, and absenteeism. The for-profit private sector owns about 14 percent of the total number of health facilities, reflecting Zambia’s limited experience with public - private partnerships in the health sector.

Fiscal constraints and allocative inefficiencies in health financing, exacerbate the challenges in the health sector. According to the 2010 National Health Accounts (NHA), Zambia’s total health expenditure per capita was US$59 (50 percent from Government, 39 percent from donor funding, and 7 percent from out-of-pocket payments). An analysis of changes over time in Zambia and other Africa comparators in health outcomes (e.g. under five mortality, maternal mortality and life expectancy), and system capacity (e.g. beds, physicians) shows poor health returns despite relatively high health sector expenditures.

There are proven, cost effective high impact interventions and life-saving technologies to reduce Zambia’s morbidity and mortality. The challenge is to improve access to and quality of basic services and scale up utilization of high impact interventions. Some of the constraints can be relieved, in the short term, by mobilizing additional funds to: (i) train existing health workers; (ii) procure life-saving technologies, including ITN and vaccines; (iii) diagnose and treat common childhood illnesses such as malaria, diarrhea and pneumonia; (iv) promote family planning by choice; and (v) promote nutrition in women and children. Others require multiple changes in the mix and quality of inputs, some of which take time to realize at scale. For example, it takes time to train and deploy (or redeploy) skilled midwives in remote, under-served locations, and to ensure high-quality maternity services.

The Government is committed to improving maternal and child health as reflected in policy documentation and wide ranging institutional reforms. Vision 2030, the revised Sixth National
Development Plan (2013-2016), the National Health Policy, the National Health Strategic Plan (NHSP, 2011-2015), and the Roadmap for Accelerating Reduction of Maternal, Newborn and Child Mortality (2013-2016) all specifically identify maternal and child health as a priority. The National Food and Nutrition Strategic Plan (2011 – 2015) which emphasizes the importance of reducing all forms of malnutrition is operationalized through the “Scaling-Up Nutrition (SUN)” First 1000 Most Critical Days Implementation Plan. Commitment to strengthening service delivery at the community and primary levels of care is reflected in wide ranging institutional reforms including the Human Resources for Health (HRH) Strategic Plan (2011-2015) and the national decentralization policy that aims to devolve responsibility of service delivery from the central and provincial levels to the district and community levels. These policies reflect the importance of ensuring skilled care: (i) across the continuum of care (pre-pregnancy, pregnancy, childbirth and the postnatal period, and childhood), and (ii) at all levels of the health care delivery system, including at individual, family and community level to improve MNCH and nutrition outcomes.

Health services are delivered through the MOH and MCDMCH, and are organized into three levels: (i) the PHC level (promotive, preventive, curative, and rehabilitative health services based on a basic health care package at health posts, health centers, and district/first level referral hospitals); (ii) the secondary level that consists of more than twenty (20) general/second level referral hospitals providing curative care in internal medicine, pediatrics, obstetrics and gynecology, and general surgery; and (iii) the tertiary level that consists of six (6) central hospitals (including the University Teaching Hospital) providing specialized and sub-specialized care.

The Government has assigned the responsibility for PHC (including maternal and child health) to the MCDMCH, reflecting commitment to scale up community access to these services. Recognizing that the formal health sector confronts a formidable range of communicable and non-communicable disease priorities, and that community development and social welfare have strong links to maternal, newborn, and child well-being, the Government decided that the ministry best positioned to provide access to preventive and basic care would be MCDMCH, given its community-focused mandate.

The Government, in collaboration with Cooperating Partners (CPs), is forging a concerted effort to remove systemic bottlenecks hampering the delivery and scaling up of health and nutrition services. With 1991 health policies and strategies, the Government of Zambia has been committed to the Sector-Wide Approach (SWAp) for coordination of health sector development. Health reforms helped to catalyse donor harmonisation and alignment through initially pooled financing (basket funding) of district health plans whose focus was on primary health care - recognition that 80 percent of diseases could be dealt with at PHC level. More recently a National Aid Policy and an overall national policy framework (Vision 2030) is in place. Through the health SWAp, health sector CPs has generously responded with financial, technical and in-kind material resources to improve health service delivery in Zambia.

However, the Government’s goal of pooled funding, with CPs supporting a single costed National Health Strategic Plan under government leadership, and using country systems, has remained a challenge despite CPs signing the Joint Assistance Strategy for Zambia (JASZ) and the Memorandum of Understanding (MOU) to implement the National Health Strategic Plan. CPs support has remained fragmented mainly through short-term financing for specific, and often, non-fungible activities.
Nevertheless, CPs have recognized the need for improved coordination and collaboration, with heightened leadership and ownership from the Government, to reach universal health coverage (UHC) and equity in health. The focus is to have a common and coordinated approach to support: (i) a package of high impact MNCH and nutrition interventions, (ii) health systems development and strengthening including HRH, health financing, supply chain management, monitoring and evaluation systems, and health information systems, (iii) strengthening fiduciary capacity at national through district levels, (iv) strengthening community health namely demand generation and service provision at community level including social accountability mechanisms, and (v) strengthening evidence generation and policy analysis and formulation. The major CPs providing support or planning future support to MNCH and nutrition include Canada, Ireland, the European Union, the United Kingdom, United Nations agencies (UNFPA, UNICEF, WFP, WHO), and the United States.

II. Proposed Development Objectives
The project development objective is "to contribute to improved delivery and utilization of maternal, newborn and child health and nutrition services in project areas."

III. Project Description
Component Name
Component 1: Strengthen capacity of primary and community level MNCH and nutrition services
Comments (optional)

Component Name
Component 2: Support country systems using results-based approaches to improve availability of essential commodities
Comments (optional)

Component Name
Component 3: Strengthen project management, monitoring and evaluation, policy analysis, and establishing a results verification mechanism
Comments (optional)

IV. Financing (in USD Million)

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<th>Amount</th>
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<td>International Development Association (IDA)</td>
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<td>Health Results-based Financing</td>
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V. Implementation
A. Institutional and Implementation Arrangements
The project will be implemented by two ministries - the MOH, and the MCDMCH under a newly created co-ministerial framework for project management. Each Ministry will be given the responsibility to execute specified activities in line with their gazetted portfolio functions, recognizing that such assignments may be modified as Government reviews and revises how it delegates, budgets, and integrates local government authorities in the provision of services. The Permanent Secretaries from the two Ministries will each be responsible for the execution and effective performance management of the project activities assigned to their Ministries including the budget. Day-to-day operations will be the responsibility of the respective Directorates of Policy and Planning in each Ministry, who will be responsible for overall coordination. A number of designated Directorates and Units will be accountable for the implementation of project activities.

To effectively coordinate the various activities under the project, a Joint Coordination Committee (JCC) will be established, with MOH and MCDMCH staff designated to provide administrative support for the JCC. Membership to the JCC will comprise technical staff from the two Ministries, and representatives from the Ministry of Finance, Ministry of Local Government and Housing, Ministry of Chiefs and Traditional Affairs, training institutions, Medical Stores Limited (MSL), the National Food and Nutrition Commission (NFNC), health professional associations and other relevant bodies, and interested CPs. The role of the JCC will be to oversee the implementation of the project by the two Ministries and resolve issues as they arise. The JCC will be organized under the auspices of the health Sector Wide Approach programming (SWAp) mechanisms, the umbrella organ for joint coordination in the Zambian health sector.

The two Ministries will be selectively supported by the project to enhance: (i) ministry capacity to provide leadership for MNCH and nutrition project efforts, particularly at decentralized levels, (ii) program administration-capacity for the day-to-day administration of project activities, monitoring resource use, processing all central procurement activities, administering withdrawal and disbursement procedures, consolidate the FM aspects of project implementation, and consolidate project reporting; and (iii) monitoring and evaluation of the project implementation activities. This includes collection, analysis, reporting and dissemination of the data on inputs, outputs, outcomes and impact from various sources; and (iv) support to strengthen the national and district level M and E system based on the identified gaps and weaknesses.

The arrangements for the co-ministerial institutional structure, the principles for governing project coordination, implementation and management, as well as technical advisors/specialists to be provided under the project are outlined in Annex 3 and to be elaborated in detail in the project implementation manual (PIM).

B. Results Monitoring and Evaluation
A comprehensive description of the project’s results framework and the arrangements for monitoring and evaluation (M&E) are described in Annexes 1 (Results Framework and Monitoring) and 3 (Implementation Arrangements), respectively. The results framework will be tracked and a mid-term review will provide the opportunity to assess progress and make appropriate mid-course corrections. The Directorates of Policy and Planning of the MOH or MCDMCH will be responsible for monitoring the project. The agreed PDO indicators and a set of key intermediate outcome indicators are to be monitored during the life of the project.

Sources of data and data collection mechanisms: The National Health Management Information System (HMIS) will be primarily used to collect monitoring data, with additional support provided
by the project to integrate community level information. During the project implementation period, two Demographic and Health Surveys (DHS) will be undertaken, with one to be available in early 2014, and the second expected in five years. Results from the DHS and other population-based surveys will be used to recalibrate results of key services used and outcome indicators. In addition, the project implementation agencies will also collect additional key information specific to the project, including annual facility surveys to be conducted by an external entity for measuring and verifying agreed results on pharmaceutical and supply chain management, which will be used as a basis for disbursement under Component 2.

Evaluation and verification of data: An independent evaluation involving two special surveys at the beginning and end of the project is planned to measure the contribution of the project to the achievement of outcomes. The evaluation study will be contracted out. For timely feedback and unbiased monitoring, other process monitoring systems including operational research will be incorporated. There will also be an independent, third party verification of activities under Component 2, as well as verification of any new community-based demand side approaches.

C. Sustainability

The Government has historically shown a willingness to finance health sector and social welfare efforts from its own resources, and continues to do so, through partnership within the SWAp with roughly 50 percent of per capita health expenditure from public sector resources. The Government will be financing most recurrent costs such as salaries for health workers and medical supplies from the regular budget envelopes of both the MOH and MCDMCH.

The project will use existing systems and institutions, improve HRH capacity, complemented with provision of critical inputs utilizing a more efficient supply system to be able to reach the "last mile" and better serve those who are the intended beneficiaries. Enhancing the capacity of community, district and provincial health workers, efficient provision of health consumables, and strengthening supervision of health workers are all fully consistent with the Government's objectives to pursue a decentralized policy. Community empowerment will be a major contribution to better basic health care, especially in under-served areas. Over the medium to long term, as experience grows with the project interventions, and as the evidence of improvements in health outcomes obtained in the project areas become available, it is reasonable to assume that the various interventions supported by the project will ultimately be sustained and scaled up nationwide.

VI. Safeguard Policies (including public consultation)

<table>
<thead>
<tr>
<th>Safeguard Policies Triggered by the Project</th>
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<th>No</th>
</tr>
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<tbody>
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<td>Environmental Assessment OP/BP 4.01</td>
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<td>Natural Habitats OP/BP 4.04</td>
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<td>Projects on International Waterways OP/BP 7.50</td>
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