Churches Health Association of Zambia

Annual Report 2011

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Acknowledgements

The Churches Health Association of Zambia would like to express its gratitude to all those who made its work possible this year, which support enabled CHAZ and its members to make a contribution to health service delivery in Zambia.

Particular thanks go to funding agencies and partners: Ministry of Health (MoH) at National, Provincial, District and Community levels; The Global Fund to Fight HIV and AIDS Tuberculosis and Malaria, Cordaid, The JFA partners -Irish Aid, Embassy of the Kingdom of Netherlands, Danish Embassy and the Joint Country Program; Norwegian Church Aid, DanChurchAid and Christian Aid, AIDSRelief, The Embassy of Japan, Ministry of Finance and National Planning (Rural Finance program), CDC, ZPCT 1, Local Funding Agent (LFA), Regional AIDS Training Network, National AIDS Council

CHAZ Secretariat special thanks go to to all members and partners for their active participation, energy, and commitment and work at the front line of faith based health care services delivery to the people of Zambia.

Finally CHAZ wishes to express deep appreciation to the CHAZ Board Without their leadership and guidance, CHAZ would not have achieved its goals for this year.

List of acronyms

AIDS	Acquired Immune Deficiency Syndrome
AC	Annual Council
ACTs	Artesimine Based Combined Therapies
ANC	Ante Natal Clinic
ART	Anti Retro-viral Therapy
ARVs	Anti Retro-Virals
BCC	Behavioural Change Communication
BICC	Brethren In Christ Church
CCM	Country Coordinating Mechanism
CCZ	Council of Churches in Zambia
CDC	Centre for Disease Control
CDEs	Classified Daily Employees
CHAZ	Churches Health Association of Zambia
CHI	Church Health Institution
CHWs	Community Health Workers
CMAZ	Churches Medical Association of Zambia
CMML	Christian Missions in Many Lands
CORDAID	Catholic Organization for Relief and Development Aid
CPT	Care and Prevention Teams
CRS	Catholic Relief Services
CT	Counselling and Testing
DANIDA	Danish International Development Agency
DCA	DanChurchAid
DCT	Diagnostic Counseling and Testing
DOTs	Directly Observable Treatment
EAA	Ecumenical Advocacy Alliance
ECZ	Evangelical Church in Zambia
EFZ	Evangelical Fellowship of Zambia
EKN	Embassy of the Kingdom of the Netherlands
EU	European Union
FBOs	Faith Based Organizations'
GF	Global Fund
GRZ	Government of the Republic of Zambia
HBC	Home Based Care

HIV	Human Immuno-deficiency Virus
HPP	Health for the Poorest Population
IGAs	Income Generating Activities
ITNs	Insecticide Treated Nets
JAR	Joint Annual Review
JFA	Joint Financing Arrangement
JCTI	James Cairns Training Institute
LSRs	Lead Sub-Recipients
MC	Male Circumcision
M&E	Monitoring and Evaluation
MoH	Ministry of Health
MoU	Memorandum of Understanding
NBUZ	National Baptist Union of Zambia
NGO	Non-Governmental Organisation
NMCC	National Malaria Control Centre
OIs	Opportunistic Infections
OIG	Office of the Inspector General
OVC	Orphans and Vulnerable Children
PATH	Program for Appropriate Technology in Health
PBF	Performance Based Funding
PMTCT	Prevention of Mother to Child Transmission
PLWHAs	People Living with HIV/AIDS
RATN	Regional AIDS Training Network
RCZ	Reformed Church in Zambia
RDF	Revolving Drug Fund
RDT	Rapid Diagnostic Test
RHCs	Rural Health Centres
RR	Report and Requisition
SA	Salvation Army
SDA	Seventh Day Adventist
SOPs	Standard Operating Procedures
TB	Tuberculosis
TEVETA	Technical Educational Vocational and Entrepreneurship Training Authority
UNAIDS	Joint United Nations Programme on HIV/AIDS
USA	United States of America

USAID	United States Agency for International Development
V-SAT	Very Small Aperture Terminal
ZAC	Zambia Anglican Council
ZEC	Zambia Episcopal Conference
ZIHRM	Zambia Institute of Human Resources Management
ZNAN	Zambia National AIDS Network
ZNBC	Zambia National Broadcasting Corporation
ZPCT	Zambia Prevention Care and Treatment

Message from the Board Chairperson

The year 2011 was by no means an ordinary year for the Association and I am proud to be associated with the numerous milestones that we have made as an organisation.

On 20th September 2011, Zambia held tripartite elections to elect The President, Members of Parliament and Councilors. As a result a new Government was put in place under the leadership of His Excellency Mr. Michael Chilufya Sata. CHAZ leadership congratulated the President-elect and the new Minister of Health and pledged to work with the new Government in the delivery of health care in Zambia. The President pledged to continue supporting the work of the Church in the health sector. In addition, the Executive Board paid a courtesy call on the new Minister of Health, Dr. Joseph Kasonde, on 14th December 2011. The meeting was quite fruitful as, among other issues, it established the need for CHAZ and the MOH to devise a routine mechanism for dialogue and partnership on diverse issues.

The long awaited signing of the Memorandum of Understanding (MoU) with the Ministry of Health MoH was finally signed on 4th May 2011. This means that the Association has renewed its formal relationship with the Ministry as opposed to the last five years when cooperation was based on an outdated MoU. Among other provisions, the new MoU guarantees Government's continued commitment to funding operational costs and secondment of health workers to mission health facilities. The MoU also ensures that mission health facilities appoint Administrators for their facilities in consultation with relevant authorities.

The Association revised the Constitution and developed its 2011 – 2015 Strategic Plan and both documents were unveiled at the General Council meeting which was held on 23rd June 2011 at Andrews' Motel. The new Strategic Plan which was developed within the framework of the National Health Strategic Plan (NHSP) has three (3) Strategic Directions: Improve Health Service Delivery, improve overall organizational effectiveness and ensure sustainability. The Plan has also been intertwined with the World Health Organisation's (WHO's) six building blocks, namely: Health service delivery; Health workforce; Medical products, infrastructure, equipment and transport; Health information; Health care financing; and Leadership and Governance. Of particular importance is the high premium that has been placed on ensuring that the Association attains sustainability.

The 41st General Council was successfully hosted on 23rd June 2011 at Andrews Motel. The unique aspect about this General Council was that members of the Association footed their bills for attending the meeting. This was very inspiring to the Board as it showed how committed members were to the life of the Association. The following were some of the resolutions passed by the 41st General Council:

- CHAZ Constitution - The Council adopted the reviewed CHAZ Constitution;
- Auditors - the Council reappointed Deloitte & Touché as CHAZ Auditors for a period of two years until the 42nd General Council;
- CCM Representative - the Council elected Bishop Thuma Hamukanga'ndu as the new FBO representative to the CCM; and
- Extension of Board Mandate - The GC extended the Board's mandate to 2013.

On 8th July 2011, the CCM-Zambia requested CHAZ to Manage and Administer ZNAN's Global Fund HIV Rounds 8 and 10 grants on an interim basis. After consultations with diverse stakeholders the requests were accepted. Global Fund Secretariat responded positively to the CCM-Zambia's request and the Secretariat developed and submitted concept notes and implementation frameworks to the CCM. The Board feels that the request is a demonstration of CCM and Global Fund's confidence in CHAZ's capability to implement the programs.

Based on recommendations arising from institutional assessments undertaken by partners - including the Global Fund's Office of the Inspector General (OIG) report, the Health Resources Service Administration (HRSA) and the JFA supported pre-funding assessment undertaken by KPMG - a number of the Association's systems were strengthened. These include the Grants Manual, the Human Resources Policy and the

Accounting Manual which were revised to bring them to internationally accepted standards. Furthermore, a restructuring assessment was conducted by a consultant from the Netherlands, Mr. Aad van der Meer. The Board in the meeting of December 2011 resolved to adopt option A from recommendations by the Consultant and the new structure would be implemented in 2012.

In conclusion, I wish to applaud the Executive Director, Mrs. Karen Sichinga, and her hard working team at the Secretariat for their tireless efforts and resourcefulness that have resulted in the achievements made in 2011. I also wish to thank the membership for the support rendered to the Secretariat by dully implementing programs to the expectations of the diverse donors. As we look forward to the Association accomplishing more results in 2012, I wish to remind each one of us that we need to complete the journey we have embarked on by way of the 2011 – 2015 Strategic Plan. May we play our various roles and ensure that this Strategy is delivered to the highest possible standard.

I thank you and may God bless!

Dr. Joop Jansen

Foreword

I am pleased to present the first Annual Report of the 2011 – 2012Strategic Plan period. This report provides a summary of the many activities carried out by CHAZ secretariat and the church health institutions for the period 1st January 2011 to 31st December 2011.
In spite of severe financial constraints faced this year, CHAZ has emerged a stronger and more focused organization through adoption and application of new strategies. One notable achievement in the year was completion of a review of the organisation structure of CHAZ, on which the restructuring of the organisation will be based. A key determination of the organisation is to implement economic activities that generate resources for investment into health care system to achieve sustainability of the services that our holding churches espouse so keenly.

The 2011-2015 Strategic Plan places the Church Health facilities at a central place in the organisation, identifying the primary role of CHAZ as being to strengthen and support CHIs in order for them to deliver improved health services. Needless to say, if CHAZ as an organisation fails to capacitate and support the CHIs, it fails in its mandate. For this reason, the majority of the CHAZ activities were aimed at supporting CHIs in order for them to not only meet their obligations and contribution to the national health care targets, but also to do so with attention to quality of services. Through CHAZ and CHI efforts, I am pleased that our achievements remain impressive. For example, CHIs continued to provide access to HAART to people living with HIV/AIDS. Seen from the perspective that the majority of those served are located in remote and hard to reach areas of the country, the CHAZ achievements are remarkable.

Indeed, access to ART increased from 41,336, in 2010 to 42, 525 end of December 2011. The PMTCT program recorded remarkable improvements with a total of 61 health facilities now implementing the program, and 9,757, pregnant women (62%) out of the 15, 737 first ante natal clinic attendees counseled and tested for HIV. Through this, CHAZ is making a significant contribution to prevention of transmission of HIV.

The CHAZ activities are of course firmly located within the national health plan and activities spearheaded by the Ministry of Health, with whom we reached a significant milestone marking our partnership. A new MOU was signed between CHAZ and MOH in xxx. Through this, MOH continued to provide a monthly grant to CHIs, along with deployment of health workers. On their part, CHAZ and CHIs continued to mobilise and contribute resources for health services in the country.

2011 saw the beginning of a new 5 year program terms The CHAZ AIDSRelief Transitioning (CART) Program. CHAZ was also awarded a grant worth US$100,000 by the Japanese Embassy for building the Medical equipment maintenance workshop. These and other projects represent substantial contributions to the national health budget. CHAZ put in place robust monitoring of progress of implementation, including more targeted technical support to health facilities to ensure achievement of set goals..

Diverse challenges and constraints confronted the Organization in 2011, which impacted negatively on its performance in several areas. Due to resource constraints, the TB and Malaria program underperformed on set targets. This demonstrated the vulnerability of donor dependent programs, and emphasised to us the need for us to seek our own and more sustainable sources of funds for health care. .

As we leap forward into 2012, we do so filled with a deep sense of appreciation of the challenges that lie ahead. These include meeting the three organizations Strategic directions of improving health service delivery by CHAZ member institutions at all levels, improving overall organisational effectiveness, through appropriate strengthening of all support systems and sustainability of holistic, quality and affordable CHAZ health services to the poor and underserved communities, through increased internal generation of resources.

I wish to thank all CHAZ members, for their unfailing efforts to reach the poor of our country. I also I wish to thank the Board for the leadership role given to the Secretariat. My gratitude also goes to the entire management and staff of CHAZ Secretariat, for their commitment and dedication to duty.

Mrs. Karen Sichinga, MPH

1 INTRODUCTION

The members of the Churches Health Association of Zambia work towards providing equitable quality health care services to the less privileged communities of Zambia. These CHIs compliment the work of the Ministry of Health (MoH) in the delivery of health care services, accounting for over 30% of the formal bed count in the country, and 60% of services in hard-to-reach rural areas.

This report presents the achievements of CHAZ and its members in the period January to December 2011. The achievements represent not only steps to realize the CHAZ vision but a significant contribution towards the country's attainment of the Millennium Development Goals.

The report also identifies the constraints faced during efforts and activities to provide equitable access to quality health services to communities in the hard–to reach areas of Zambia. This report is structured as follows:

- Section 1 innovative strategies/activities implemented to improve the overall organizational effectiveness of CHAZ,
- Section 2 Activities aimed at improving health service delivery by CHAZ member institutions at all levels. This section also highlights some key achievements in various in key areas of service delivery by CHIs,
- Section 3reviews activities to increase the financial sustainability of holistic, quality and affordable health services provided by CHAZ and its members.

In its quest to contribute to the improvement of the quality of care provided to the CHI clients / patients CHAZ lobbied and obtained a grant from the Embassy of Japan for the construction of the Medical Equipment maintenance and repair workshop. During the period under review, CHAZ also conducted the assessment for the restructuring process and the report recommendations were submitted to the Board for approval by the end of the year. The restructuring exercise would be implemented in the first quarter of 2012.

In 2011, CHAZ was confronted with a situation of increasing demand for services and rising health care costs, while at the same time facing a stagnating resource base. CHAZ was faced with financial problems to implement the ART, TB and malaria programs supported by the Global Fund of which the grants ended in 2010 amidst the high demand for the service. The Church Health facilities continued to provide the service with no funding and support from the Secretariat which resulted in low performance of these program. CHAZ continued to write proposals to other funders and was able to have funding for the CHAZ/AIDSRelief transition facilities for the support of the ART/PMTCT program. The funding for this program started coming in December 2012. The other proposal which went through was the Malaria proposal with UNICEF.

2 BACKGROUND

2.1 National Background

Over the past two decades, increased vulnerability to disease and ill health have threatened the lives, well-being and livelihoods of many Zambians, especially children and women. HIV and AIDS, tuberculosis (TB), malaria, childhood diseases, pneumonia, acute respiratory infection (ARI) and sexually transmitted infections (STIs) persist, and create a significant constraint to social and economic development. These combine to form multiple, concurrent epidemics, absorbing household time and capacity, and undermining the much-needed human resource base. At household and community level, ill health exerts huge stress, while the poor health of the nation negatively affects economic growth. With children and women especially vulnerable, the deficits and demands of ill health undermine the fabric of family life, culture and society. (UNICEF report: Situation Analysis of Children and Women 2008)

Childhood diseases continue to pose huge challenges for the health and survival of children in Zambia. The main causes of illnesses in children are pneumonia, diarrhoea, skin infections, Acute Respiratory Infections (ARI) in addition to HIV and TB. The combination of these is a major contributing factor to child mortality. Child mortality remains high even though most of the child deaths are preventable. Equity of access to health care has not been adequately achieved. Although there are known effective child survival interventions, their impact on child mortality is threatened by limited coverage and inadequate resource investment.

The prevalence of HIV and AIDs in Zambia still remains high at 14.3% with the lowest provincial prevalence rates of 7% found in the Northern and Northwestern provinces. Lusaka province at 21% has the highest prevalence rate. (ZDHS 2007)

Notified TB cases of all forms have been declining in Zambia from 409/100,000 in 1996 to 389/100,000 by 2007. At provincial level, the declining trend has held out except in Southern and Western Provinces where cases have at best stabilised, and in Lusaka province where cases have rebound lately. Approximately two thirds of the country's TB burden occurs in three provinces: Lusaka, Copperbelt and Southern.

Zambia is currently experiencing a major increase in the burden of non-communicable diseases (NCDs). The common NCDs include cardiovascular diseases, diabetes mellitus (Type II), cancers, chronic respiratory diseases, epilepsy, mental illnesses, oral health, eye diseases, injuries (mostly due to road traffic accidents and burns) and sickle anaemia. Most of these health conditions are associated with lifestyles, such as unhealthy diets, physical inactivity, alcohol abuse and tobacco use, while some are also associated with biological risk factors, which run in families.

2.2 Organisational Background

Highlights of New MOU

Signed on 4th May2011.

- Reaffirms the Government's continued commitment to supporting CHAZ member Church Health Institutions (CHI).
- The MoU has also reaffirmed the need for CHI autonomy.

The Churches Health Association of Zambia (CHAZ) is an umbrella organization of church operated health services and facilities. It was formed in 1970 to represent the interests of the founding 16 church denominations in health services provision and delivery. The churches account for 35% of the formal hospital bed count in the country.

CHAZ programs are aimed at building capacity of the CHIs to implement preventive and curative services for communicable and non-communicable diseases including Malaria, TB and HIV/AIDS. CHAZ has contributed to spearheading the concept of Home Based Care (HBC), based on community voluntarism. CHAZ and member CHI objectives and activities are all within the National Health Strategic Framework. CHAZ has a Memorandum of Understanding with the Zambian Ministry of Health (MOH) which commits the MOH to paying salaries of health workers, and 70% of the running cost and medicines for the CHIs.

CHAZ: 146 Members

- 36 Hospitals
- 81 Health Centres
- 29 Community Based Organizations
- 9 Nurse and Lab technician Training Schools

CHAZ members leverage their rural and community location to contribute services that are underpinned by Christian values. CHAZ Secretariat employs various key public health and management experts to support the CHIs in their activities, to build CHI capacity to deliver quality health care services.

The CHAZ activities are guided by the 2011-2015 Strategic Plan. These fall into 3 distinct areas as articulated in the strategic plan:

a) Activities to improve the overall organizational effectiveness of CHAZ, through appropriate strengthening of all support systems;

b) Activities to improve to improve health service delivery by CHAZ member institutions at all levels, in order to contribute to the attainment of the national health objectives and MDGs and;

c) Activities to increase the financial sustainability of holistic, quality and affordable CHAZ health services to the poor and underserved communities, through increased internal generation of resources.

Vision:

A Zambian Society where all people are healthy and live productive lives, to the glory God

Mission:

Serving poor and underserved communities with holistic, quality and affordable health services, that reflect Christian values

2.3 Organisational Capacity Building of CHAZ

Various activities to build the institutional capacity of CHAZ Secretariat were implemented. These were aimed at increasing the capacity of Secretariat to discharge its mandate to support CHIs in the programs and activities. Established in 1970, CHAZ growth has been evolutionary. Its structural development has been reactive, in response to prevailing circumstances. Starting off as a purely administrative and coordination office in a Lusaka suburb, CHAZ Secretariat had need to build an office block, in the central commercial district of the city in the early 90's. The first technical staffs employed were a medical officer and a nurse in 1988. These focused on primary health care and nutritional programs.

CHAZ developed and operationalized an audit charter in May 2011. The Charter has greatly helped in refining and outlining the internal audit mission, scope, mandate, ethics, authority and responsibilities among other things. Internal audit function of the association adopted a risk-management approach which ensures that audits provide assurance to all key stakeholders some and took care of risks related to grant management and programme implementation both at the Secretariat and member units and sub-granted organizations.
During the year 2011 CHAZ audited 56 organizations out of the 110 and followed up audit recommendations for 19 institutions funded in addition to auditing secretariat departmens.

By the late 1980s, the focus of organization turned to HIV/AIDS, with CHAZ playing a major pioneering role in the home based care and community based care strategies. St. Francis Hospital, Katete and Chikankata Hospitals, Mazabuka, were leading pioneers of the early responses to the HIV/AIDS pandemic, with Chikankata going on to become a global learning centre.

A pharmacist came on board to establish pharmaceutical support services in 1994, in response to insufficient service levels provided by Government operated Central Medical Stores. This included an expansion of existing infrastructure to establish a central storage facility alongside the CHAZ offices. The number of staff at CHAZ Secretariat increased from a mere 7 in 1992, to 29 in 2003, at the onset of scaled up availability of ART in the country.

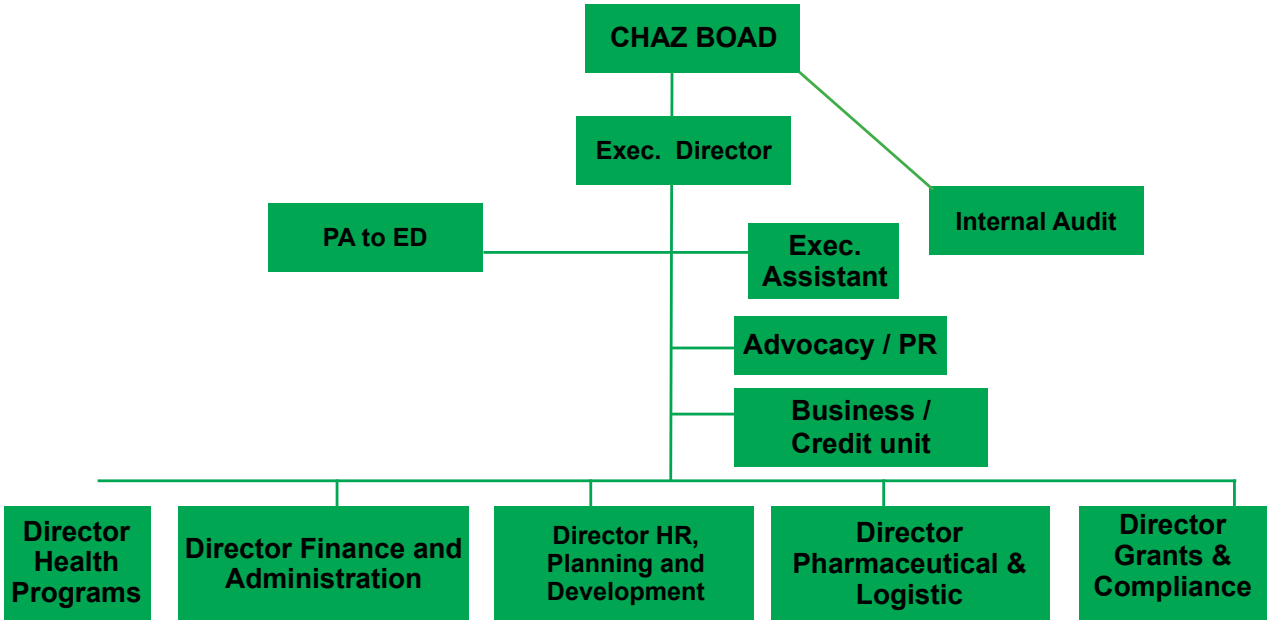
2003 saw the advent of the PEPFAR and Global Fund with CHAZ - two large scale funding mechanisms focusing resources on HIV/AIDS, TB, and Malaria. The grant management experience of CHAZ provided a readymade institution to channel HIV/AIDS and Malaria resources to needy communities in Zambia. CHAZ assumed a fund recipient role and grant management responsibilities for both the USAID funded AIDS relief and the Global Fund. This led to unprecedented growth in CHAZ Secretariat to facilitate new and expanded responsibilities to provide technical and other support to CHIs implementing HIV/AIDS, TB and Malaria programs. CHAZ now has 106 staff, including senior accountants and management staff, complementing over 30 health professionals.

The 41st General Council[1] (Held 23rd June 2011 at Andrews Motel with the theme: "Responding to the challenges in health service delivery in a new era; with God all things are possible") saw the adoption of a new five year strategic plan. The new plan provides a blueprint for systematic refocusing of the critical areas of CHAZ capacity, and its role in assisting CHI health care delivery and financial sustainability of services. The new Strategic framework is also within the national plan and speaks to the World Health Organization's six building blocks, namely: Health Service Delivery; Health Workforce; Medical Products, Infrastructure, Equipment and Transport; Health Information; Health Care Financing; and Leadership and Governance.

2.3.1 Key Activities/Achievements to Build CHAZ Secretariat Capacity

Based on its new strategic Plan CHAZ Secretariat embarked on an organizational restructuring process. A consultant was engaged to facilitate stakeholder consultation to take on board inputs from the CHIs, Board of Directors, management and members of staff as wells cooperating partners. In November 2011, a new organizational structure including 5new director positions was adopted by the CHAZ Board of Directors. Restructuring of Secretariat will continue in 2012.

New CHAZ Structure



CHAZ under took reviews of its systems to ensure continuous system strengthening in order to make the organization more effective. The reviews provided a basis for updating the Grants Manual, the Human Resources Policy, Internal Audit Charter and the Accounting Manual. All these were completed in 2011.

In November 2011, CHAZ contracted a long term (1-2 years) Procurement Expert to assist the organization to systematize procurement systems as well as build procurement staff capacity to perform and manage large scale public procurement of health and non-health products and services.

Range of Expertise at CHAZ Secretariat

- Advocacy
- Medicine
- Nursing
- Pharmacy
- Project Management
- Grant making
- Financial management
- Auditing
- Resource mobilization
- Supply Chain Management
- Training

In 2011, CHAZ received funding of ZMK 480 million (102,181 US $) from the Embassy of Japan, for the construction of aMedical Equipment Maintenance and Repair Workshop in Lusaka as well as for the procurement and installation of equipment and tools for the workshop. The workshop will also be used for training and skills transfer for staff with equipment maintenance responsibilities at CHIs. The construction work started in august 201. The construction works and by the end of the year the structure had been roofed.

1 The Annual General Council is CHAZ's highest policy making body

2.4 Building CHI Capacity for Quality Health Care Delivery

Church health institutions (CHIs) are responsible for 35% of the formal hospital bed count in Zambia. They have the distinct advantage of being community based through integration with religious and church based activities. Historically, churches operating health services have invested their infrastructure, staff and financial resources to health care services they provide.

CHAZ support to CHIs takes the form of advocacy on behalf of CHIs, mobilisation of resources for investment in CHI infrastructure and health systems, training and skills of health workers in various health care delivery and disciplines. CHAZ support also involves considerable travel for visits to CHIs to provide hands-on technical support and mentoring. These visits are employed to provide monitoring and evaluation, as well as financial and general administrative support.

2.5 Key Activities/Achievements to Build CHI Capacity for Quality Health Service Delivery

2.5.1 Representation and Advocacy Support:

CHAZ represented CHIs in; the six health sector working groups that reviewed the National Health Strategic plan -: consultative meeting to inform the Swedish embassy support to the Zambian Health sector, The Joint Annual Review (JAR) of the Health Sector for the year 2010 was undertaken during the period of March – April, 2011. CHAZ was represented in all the review groups and at all stages. CHAZ represented civil society in all the Health Sector Advisory Group (SAG) meetings held during the year 2011 to review sector performance and approve disbursements and plans.

Mrs. Sichinga (2nd from left) making a Submission on behalf of Civil Society at the November Health SAG Meeting.(L to R; CP Representative, Ministry of Health Permanent Secretary and Director Policy and Planning

CHAZ also engaged the MoH concerning, among other issues, the need for equitable distribution of Health resources. At a meeting with the Minister of health on 14thDecember 2011, CHAZ presented evidence of the low levels of funding to health institutions and their impact on service delivery. The presentation was based on a CHAZ desk review of health care financing in the country(published May 2011).

Meeting attendees included (from left): Technical Assistant to the ED, Mr Kakoma; CHAZ Board Chairman, Dr. Joop; CHAZ Board Vice Chairperson, Rev Chitumbo; MOH Permanent Secretary, Dr. Mwaba; CHAZ Board Treasurer, Mr. Hanna; Minister of Health Dr. Kasonde; CHAZ Executive Director, Mrs. Sichinga; MOH Director Clinical Care, and Dr. Siakantu.

2.5.2 Support Visits to CHIs:

In total, 284 visits to CHIs were completed by CHAZ staff. The visits included general support visits undertaken by the Executive Director and visits associated with grant management, monitoring and evaluation, planning and development and health program visits.

Table of visits

Program/Team	Number of Sites visited
Executive Director	6
Monitoring and evaluation Team	93
Grants unit	74
Internal Audit	56
Health Programs	55

2.5.3 Training Activities:

The CHAZ training activities were carried out on various programs with the aim of increasing skills and capacity of CHI health workers. CHAZ training courses are designed to provide on the job skills to frontline health workers operating in remote and under-resourced locations. The training contributed towards ensuring that the HIV/AIDS, TB, Malaria, and other health programs offered by CHIs are delivered at appropriate quality. Those trained are then better able to effectively manage various disease interventions at the CHIs and their communities.

Course Title/description of training activity conducted	Program	Duration (days)	Total Number of CHIs	Total Number of Participants
Community leaders trained on PBF	PBF	3	12	40
Training of Local Purchasing Agent (LPA) in PBF international course	PBF	14	1	2
Workshop on client satisfaction survey follow up	PBF	4	12	78
Malaria home management training	malaria	5	2	61
Training the CHIs Administrators in Management and Supervisory Skills.	Global Fund R 8	5	20	20

2.5.4 Provision of Laboratory Equipment and reagents

A total of 13 CD_4 BD FACS count machines were procured distributed and installed at 13 selected CHI ART sites. The lab personnel working at these sites were trained on-site on the use and maintenance of the machines. 3 Chemistry analysers, Pentra 250 were procured and distributed to 3 CHIs for use in patient monitoring and management in the ART programmes.

Technical support visits were conducted to Laboratories in CHIs. These support visits revealed that twenty (20) RHC laboratories are in need of renovations as the rooms used as laboratories were not of the recommended standard.

2.5.5 PMTCT

CHAZ continued to strengthen the collaboration between these CHIs and other nearest health centres offering ANC services to improve reporting. In order to achieve 100% reach, CHAZ will strengthened efforts for mothers to deliver at health facilities through provision of baby mama kits among other interventions. Furthermore, CHAZ will continue to sensitize communities on male involvement in PMTCT to break stigma associated with ARVs, encourage openness and disclosure of HIV status and provision of mother waiting homes.

CHAZ Secretariat provided technical support and mentorship to the CHIs. They in turn mentored staff in sites which were not visited by staff from CHAZ Secretariat head office. Other forms of support provided included procurement and distribution Mama/baby packs to many of the CHAZ supported PMTCT sites and provision of vehicles to collect DBS specimens from all the 61 PMTCT sites and delivering test results back to the sites. The program is working well as it has facilitated the turn round time for DBS results

2.5.6 Medical Equipment Support:

CHAZ supported health facilities with medical equipment and, infrastructure maintenance and installation, including installation of solar PV systems at 17 health facilities: Kanyanga, Chipembe, Kuzeyi, Ndaiwala, Mphanshya, Mphanshya Nursing School, Nyamphande, Chilala, Sinde, Jembo and Makunka. The others are Simwatachela, Chaanga, Mambwe, Sioma, Kapatu, and Fiwila.

2.5.7 Medical equipment

Hospitals have continued asking CHAZ secretariat to assist with installation and maintenance of medical

equipment. In view of this, CHAZ has continued to strengthen the Medical equipment maintenance unit through service and repair. CHAZ has been working towards improvement of the available essential medical equipment and accessories so as to ensure effective delivery of services. It is with this background, that CHAZ sought support from the Embassy of Japan for the construction of medical engineering maintenance workshop.

CHAZ continued to provide Medical equipment repairing on a small scale during the year under report. Different medical equipments were repaired which included like Ventilators, suction machines, Cauterize /Diathermy Machine, Resuscitators, electronic BP machines, cardiac Monitors, an aesthetic machines, autoclaves to mention a few.

2.5.8 Infrastructure Assessment and rehabilitation

Most of the infrastructure in CHAZ facilities is very old and poses danger to the safety anddelivery of quality healthcare services. In response to the assessment, facilities came up withBOQs submitted to CHAZ for further submission to the donors especially the global fund (GF)for staff houses and the mother waiting homes.

2.5.9 Solar PV system

CHAZ under took a solar assessment last year (2011) during the assessment, and the report reviewed the need for Solar lighting for facilities not connected to the national grid as well as those facilities that were facing power outrages that have been affecting the delivery of the health services.

During the year a total of eighteen (18) CHIs had solar lighting installed and sixteen (16) facilities received solar fridges.

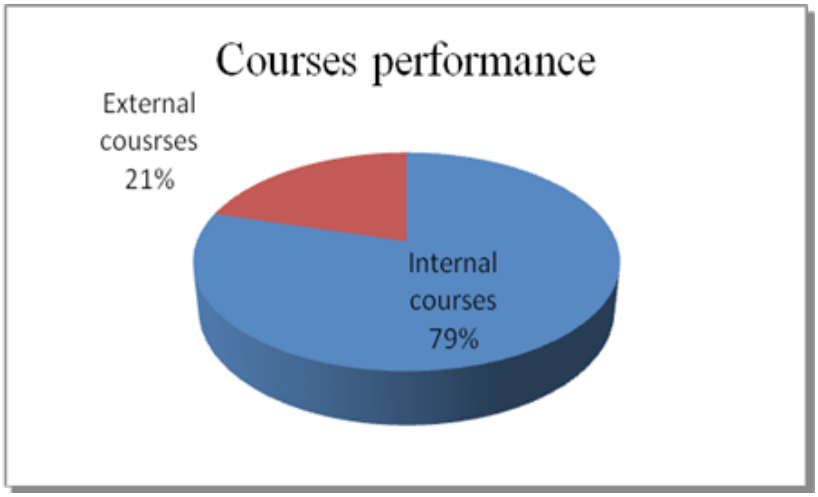
A Solar fridge given to Kanyanga RHC

Technician installing solar PV at Kanyanga RHC

Left: These ladies were happy to see solar power being installed in the ward. They said to the team "Mulungu akudalitseni nanchito yanu ipitilize" (may the Lord God bless you and may he bless your works).

2.5.10 Develop Health and non Workforce -JCTI

In terms of performance of the year under review, JCTI managed to independently host some courses and won a bid to implement a Monitoring and evaluation course through a request for proposal that was floated by Regional AIDS Training Network (RATN).

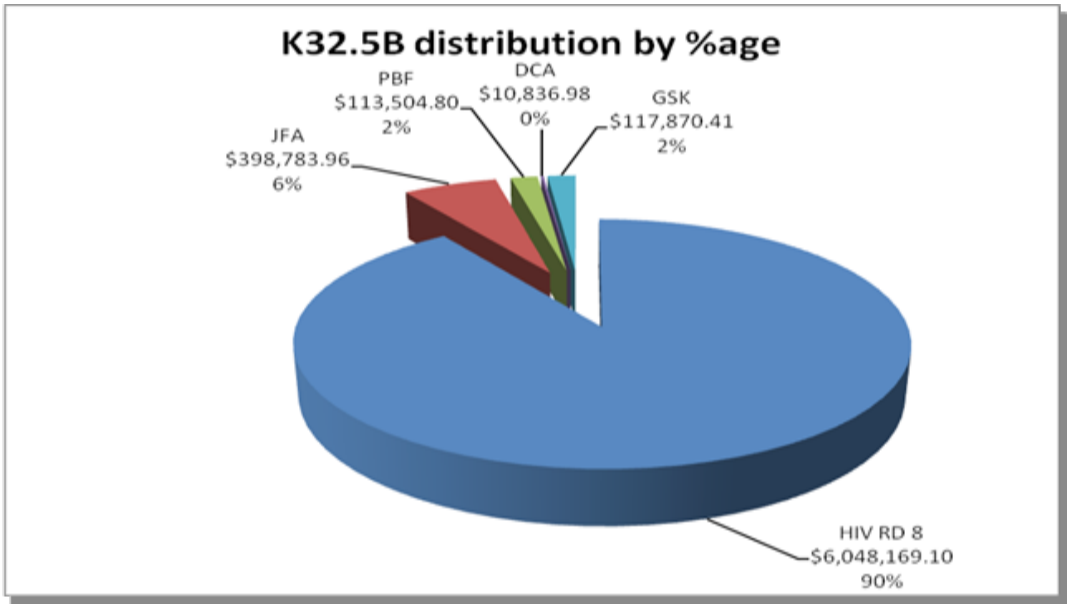


JCTI plans to host joint courses with other partners within the country and region such the Health, Development and Performance (HDP) of Rwanda in Performance Based Financing.

2.5.11 Grant Management Support

A key activity of CHAZ is to mobilise resources for investment into CHI health systems and programs. CHAZ continued to be principal recipient for Global Fund, AIDS Relief and JFA funds, which funds were either spent on CHAZ capacity building activities in support of CHIs and other sub-recipients or disbursed to these facilities for utilisation at that level. During the period under review CHAZ disbursed a total of K32.5bn (US$6.69m) compared to K64.1bn ($13.6m) in 2010 representing a 49% reduction in total disbursed funds to SRs for 2011.

The pie chart below highlights the total amount disbursed to SRs by grant type



Grant Management/Support Activities include assessment and selection of SRs, preparation of budgets and monitoring and reporting of grant activities and expenditures. During the period under review, pre-award capacity assessments were conducted in 91 CHIs and FBOs under the GF R10 and R7 grants while detailed and precise budgets were prepared for existing and new potential sources of funding. Lastly, the finalization and launch of the revised grants manual provided a key direction to efficient and effective compliance reviews by the department while providing overall guidance and direction of our SR compliance management.

2.5.12 Distribution of Medical Products

CHAZ provided support to CHIs and other grant aided units with health and non-health supplies. Provisions were based on forecasting and quantification undertaken in collaboration with Government at national level. CHAZ also supported CHIs with training and hands on technical support and mentorship to increase CHI skills and capacity for appropriate management and use of health products, including medicines and laboratory supplies.

Through the Global Fund grants, the unit supported 57 ART sites (50 sites for CHAZ and 7 for ZNAN) including 521 health facilities in the 22 districts under the malaria programme.

Under the treatment component, the unit distributed ARV's, ACT's, OI's and diagnostic reagents including equipment on behalf of Medical Stores Limited (MSL).

During 2011 the unit managed to distribute ACT's, ARV's, OI's and laboratory commodities to facilities to a total value of USD 9,177,080.72 broken down as follows:

- The total value of ARV's distributed to facilities was USD 8,042,661.21
- The total value for medicines for opportunistic infections (OI's) was USD 261,118.91
- While, for ACT's was USD 873,300.60

2.5.13 onsumption and distribution data

The Supply centre managed to analyze data from facilities and come up with the consumption data. During the year 2011 CHAZ managed to distribute the total of 866,670 units of different types of ARVs (Annex 1) to facilities and was able to meet the requirement amidst the financial constraint CHAZ faced for transportation and procurement of the drugs. With permission from the Global Fund CHAZ was able to buy ARVs using balance of funds and also was able to get some of the drugs from the MoH. The distribution of ARVs was done on monthly basis to mitigate stock outs of these essential medicines.

2.5.14 Laboratory services

A total of 13 CD_4 BD FACS count machines were procured using ART funds and were distributed to 13 selected CHI ART sites. The equipment were distributed and subsequently installed by the supplier, BD diagnostics. The lab personnel working at these sites were trained on-site on the use and maintenance of the machines. Under HIV Round 8, 3 Chemistry analysers, Pentra 250 were procured and distributed to 3 CHIs for their use in patient monitoring and management in the ART programme.

Technical support visits were conducted to Laboratories in CHIs and it was has been noted that most RHC laboratories are in need of renovations as the rooms used as laboratories were not of the recommended standard.

2.6 Health Care Financing

2.6.1 Performance Based Finance (PBF)

The CHAZ PBF pilot project is part of the Multi-Country project implemented in Seven Countries in Africa. These are Rwanda, Congo DR, Burundi, Cameroun, Central African Republic Tanzania and Zambia. The project is co-financed by CORDAID, a Dutch Non-Government Organization (NGO), and the European Community in which Zambia was given to implement a pilot test the project in conformity with the ideal principles of performance based financing.

PBF is a bottom-up systemic approach with an orientation on results defined as quantity and quality of service outputs. Payments are made to influence behavior of service providers in private and public settings to increase availability and quality of services, and to positively influence actions of clients towards health services such as pregnant women to demand or utilize such services in health facilities instead of delivering at home. PBF aims at improving coverage and utilization and the approaches may be developed from both the supply side (health worker, facility, DHMTs, community) and the demand side (patient/community members) of the health system.

In the year under review PBF achieved 83% of the planned activities some of which are detailed as follows:

1. A total of 40 community representatives from Health Centre and Neighbourhood Health Committees were trained on their roles and responsibilities.

2. Samfya Community of Care Providers (SCCP) in Samfya and Development Aid from People to People (DAPP Child Aid Project) in Mpika, were hired as Local Purchasing Agencies for the CHAZ PBF project after meeting the set criteria.

3. To improve community participation, CHAZ conducted a client satisfaction survey in all health facilities and the outcome was discussed with the respective health facilities.

4. Survey follow-up workshops with stakeholders were conducted in the pilot districts and the participants commended CHAZ for according them the opportunity to contribute to the project implementing process through the forum.

5. The Zambia project shared lessons during the steering committee meetings (Kigali, Bujumbura and Bangui). CHAZ also shared the PBF activities during the development of the National Health Strategic Plan 2012-2015 finalisation meeting in Livingstone.

6. Five technical support visits to assess the functionality of the PBF project in conformity with the principles and concepts were conducted to the PBF sites three of which were by CHAZ secretariat program staff while two were conducted jointly with staff from CORDAID (Frank Van De Looij) and Health Development and Performance (HDP the regional center for PBF).

7. CHAZ facilitated performance verification (Data Audit) by the LPA to verify performance figures in the PBF facilities to inform the process of determination of the quarterly bonuses for the period January to December 2011. Noteworthy, after the establishment of the local purchasing agents and decentralization of the District Health Office in the project, the decentralized agents conducted the assessment independently for the first time in the period under review.

During the period under review, quality and quantity assessments or audits were conducted every quarter to determine payment. A cumulative performance figure of 336,810 services from the 12 incentivised indicators was purchased at the cost of ZMK 1,128,665,587. From this amount, ZMK 123,103,128 was provided as seed fund to stimulate production at the beginning of the project while ZMK 162,274,943 for Q3 2011 was processed later. Furthermore, 224,305 cases were purchased at the cost of ZMK 604,493,381.

2.7 Monitoring and Evaluation Activities

During 2011 a number of activities were planned and implemented to strengthen health information, some of these activities were

2.7.1 Dissemination of PMTCT reporting tools

Revised PMTCT reporting tools were also disseminated to all the PMTCT implementing CHIs. Specific programme officers were guided on how to report using the new reporting tool.

2.7.2 Review and Planning meeting

Review and planning meetings for AIDS Field Officers under the JFA programme was conducted. The training of 30 AIDS Field Officers and 4 Provincial M&E staff in M&E skills was also conducted. The development and operationalization of the M&E dashboard was implemented.

2.7.3 Data analysis

The department analyzed data and provided disease trends picture performance of three diseases (HIV, TB and Malaria) in the health programmes. The disease trends analysis reviewed underperformance during the 2011.

The implementation of M&E activities for the period January-December 2011 were not implemented as planned due to limited funds and lack of funds to conduct most of the activities planned. The majority of activities implemented did not need financial support. The underperformance of the programmes was attributed to the non-availability of funds.

3 Service Delivery Achievements of CHIs

3.1 AIDS Care and Prevention Programme

The CHAZ AIDS Care and Prevention program is implemented to contribute to reduction of the HIV/ AIDS epidemic in the rural communities of Zambia. The program is aligned to the National AIDS Strategic Framework (NASF 2011-2015), the National Health Strategic Plan 2011 – 2015 whose theme is "Towards attainment of health related Millennium Development Goals and other National Health Priorities in a clean, caring and Competent environment".

Both the NASF and the National Health Strategic Plan buy into the Vision 2030, the Sixth

National development Plan, the Decentralization Policy and the Millennium Development goals.

The CHAZ AIDS programme focuses on HIV prevention through social and behavior change strategies, Impact Mitigation and response Management:

- Social and Behavior change strategies: include condom distribution, Male Circumcision, PMTCT services, counseling and Testing, Care and support, nutrition, livelihood and material assistance to PLWHA.
- Impact Mitigation: addresses Orphan and Vulnerable children support, livelihood and nutrition support.
- Response Management: addresses issues of Human Rights, gender, advocacy monitoring and evaluation and HIV research.

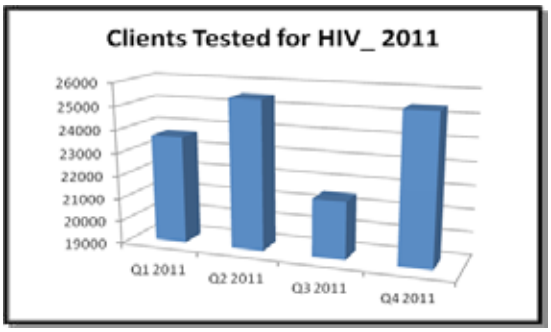
CHAZ coordinates its own collective efforts on scaling up prevention, within the ambit of universal access to prevention, care, support and treatment, through building on the comparative advantages of the CHIs and lead sub recipients to support scale up of high quality, comprehensive HIV prevention programmes at all levels.

3.1.1 Prevention of HIV and AIDS Behavior Change and Communication Strategies

During the year 2011 CHIs managed to implement preventive activities through BCC. A total of 308,219 people where reached with awareness messages against the target set of 348,570 in order to reduce the risk behavior and prevent further transmission of the virus. This stands for an achievement of 86%.

3.1.2 Facility-based VCT and Provider Initiated Testing and Counseling

Through its multipronged approach to foster positive behavior change in the communities, CHIs managed to test 101,625 (104%) and provided them the results against the target of 98,112, through facility-based VCT, including the promotion of Provider Initiated Testing and Counseling (PITC. Due to inadequate resources no community campaigns and mobile VCT were conducted.



3.1.3 Couple Counseling and testing

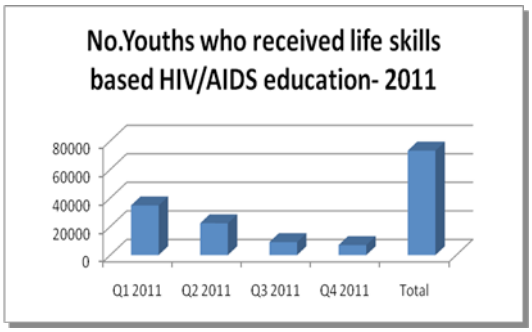
Couple counseling has been promoted as a strategy by CHAZ to improve the uptake of HIV preventive interventions in order to minimize adverse social outcomes associated with disclosure of HIV status. In 2011 a total of 244 couples were counseled, tested and given their results.

3.1.4 Care and support for the chronically ill:

The number of individuals provided with HIV-related palliative care was 13,513 out of the targeted 20850 giving CHIs 65% achievement. The home care system is a strong and dependable system in rural Zambia. In home care, communities participate in the care process for people affected by HIV and AIDS ensuring that optimum care is provided.

3.1.5 Support for Orphans and vulnerable Children:

A total of 22,082 OVC were supported with school fees, uniforms, medical aid and food supplements out of a targeted number of 49110.



3.1.6 Life Skill Education

CHIs managed to reach a total of 73,260 peers with HIV education in the year 2011, representing an achievement of 37%.

3.1.7 Improved knowledge on home gardening and nutrition among PLWHA and their households

The objective of the home gardening program is to improve knowledge on home gardening and nutrition among PLWHA and their households. In the year under report a total of 306 people were reached with information on organic gardening and a total of 1,580 people were trained in nutrition, food processing and preservation. Five different seeds for vegetable were procured and distributed to the community groups to enhance home gardening.

3.1.8 Human Rights and Gender

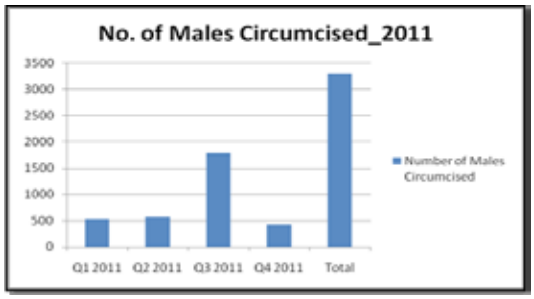
A total of 7,841 community members were sensitized, trained on human rights and advocacy (duty bearers and claim holders).

3.1.9 STI diagnosis and Treatment

This is one key activity under the CAPP, a total of 10,106 people with Sexually Transmitted Infection (STI) were treated during the year. This represents a much higher achievement compared to 2010 achievement of 6,449 who were treated. CHAZ has also provided RPR test kits and STI drugs to CHIs to enhance quick diagnosis and treatment.

3.1.10 Voluntary Medical Male Circumcision (VMMC)

Being relatively new strategy, CHAZ deliberately intensified education on VMMC in order to motivate the men and also women to support their spouses to undergo circumcision. CHIs recorded improvement with a total of 5,798 compared to 2010 when 2,539 maleswere circumcised in the CHIs. CHAZ continued to provide financial support to facilities that are offering male circumcision to facilitate procurement of the perishable requirements for circumcision.



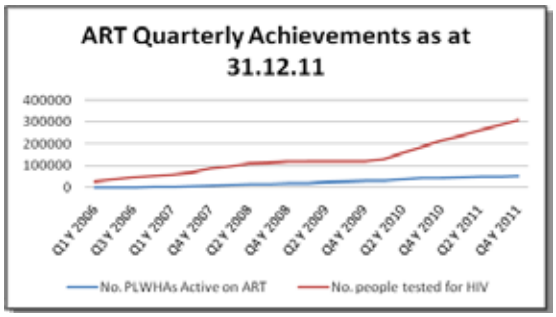
3.1.11 Condom distribution

The use of condoms is an integral .component to the prevention of HIV transmission among high risk groups. However research has shown that the use of condoms across Zambia is low and that more men than women are likely to use condoms when having sex with a non regular sexual partner (ZSBS, 2005). Faced with this reality, CHAZ continued to consider condom promotion and distribution as one of the core

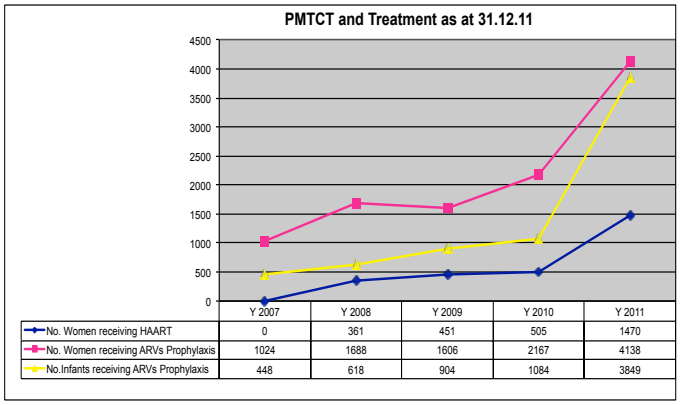
activities in the prevention of further transmission of HIV and STIs. During the year 2011, a total of 1,264,402 Condoms were distributed. CHIs have been distributing condoms through various service points such as; the MCH, ART/TB clinic, community volunteers, outreach activities and OPD.

3.1.12 ART Treatment

The GF Rd 4 funding came to an end in December 2010, but facilities continued to provide the ART services. During 2011 the number of clients enrolled continued to increase and cumulatively a total of over 32,000 clients had accessed ARVs in our facilities.



3.1.13 Prevention of Mother to Child Transmission (PMTCT) of HIV and AIDS

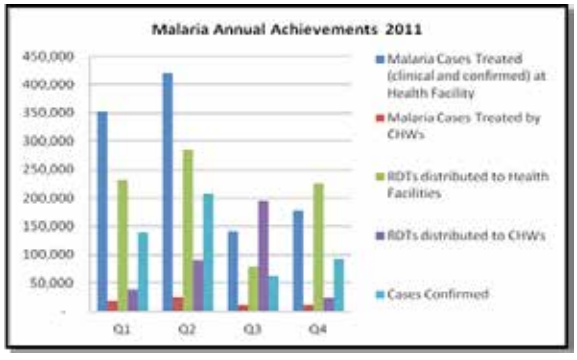


	Y 2007	Y 2008	Y 2009	Y 2010	Y 2011
No. Women receiving HAART	0	361	451	505	1470
No. Women receiving ARVs Prophylaxis	1024	1688	1606	2167	4138
No.Infants receiving ARVs Prophylaxis	448	618	904	1084	3849

CHAZ has taken PMTCT as a very important program and in 2011 CHAZ supported a total of 61 health facilities to implement the program. CHAZ also lined up a number of activities to enhance the provision of the PMTCT program. During the year a total of 9,757, pregnant women (62%) out of the 15, 737 first ante natal clinic attendees were counseled, tested and given their results. Out of the women tested positive, 4,138 (69%) received antiretroviral drugs to reduce the risk of mother-to-child transmission. In 2011, CHIs managed to assess 2,172 out of the 6,033 HIV positive women for ART eligibility giving us a result of 36%. The reason for the under achievement is that women attending PMTCT clinics in the CHIs are still being assessed by CD4 count only. CHAZ will continue to strengthen the use of CD4 count and WHO staging criteria through provision of on-site technical support

CHAZ facilities reported 3,849 exposed infants covered with antiretroviral prophylaxis and a total of 2,673 (55%) infants received co-trimoxazole.

3.2 Malaria Control Programme



The CHAZ malaria Round 7 (CCM proposal), entitled "Rapid Scale up of Malaria Interventions for Sustained Impact in Zambia", contributes to the on-going initiatives of the NMCP which focuses on scaling up ITN coverage, the expansion of the use of Rapid Diagnostic Tests (RDTs), prompt and effective treatment through administering Artemisinin-based Combination Therapies (ACTs), expansion of IEC/BCC (Information, Education and Communication / Behavioral Change Communications), Monitoring & Evaluation and the support of program management.

Activities implemented during the year 2011 included re-programming and budgeting of the malaria 7 phase 2 work plan. One of the key achievements during the period under review therefore was the finalization and submission of the Malaria 7 Phase 2 Grant Work plan, Budgets, Performance framework (PF) and the training plan. CHAZ also developed a proposal of the Poorest Population (HPP) Project and budget by UNICEF So far the proposal has been approved and a contract agreements has been signed and awaiting the release of funds to initiate project implementation.

3.2.1 World Malaria day preparations and commemoration

The World Malaria Day (WMD) which falls on 25th April every year was commemorated in Mkushi district, CHAZ participated in the preparatory and the commemoration activities.The 2011 theme was "achieving progress and impact" and was held in Mkushi. The theme was particularly aimed at engaging all partners and stakeholders in a joint effort aimed atreducing the impact of malaria and the achievement of the Millennium Development goals. It also meant, identifying and addressing the barriers that impede the implementation of the national policies and strategies such as resource gaps to scale up interventions and limited capacity to control Malaria.

The commemoration of the event was two- phased; preparatory and the commemoration of the actual event. In the preparatory stage, CHAZ trained 15 CHWs in Home Management of Malaria These CHWs participated in the testing and treatment of the general public during the actual commemoration day. The training was financially supported by the National Malaria Control Centre (NMCC) while CHAZ provided the technical support (training.) and supervision during the testing and treatment.Two hundred and six (206) community members were therefore tested with 74 being positive while 132 were negative. The Central Province Minister, Hon. Ackimson Banda, Mkushi District Commissioner and many other dignitaries also volunteered to be tested. The 74 who were found positive were observed taking the first dose (direct observed therapy) and then given the remainder of the treatment course. Additionally, everyone who got tested received a free mosquito net.

3.3 Tuberculosis Control Programme

The components of the CHAZ TB control program include programmatic, laboratory, Income Generation Activities (IGA), Monitoring and Evaluation (M&E). The program implementation is aligned to the National TB Program (NTP). The data source documents, diagnosis, TB/HIV and treatment guidelines were all NTP approved documents.

CHIs implemented the TB control program within the member Church Health Institutions (CHIs) and Faith Based Organization (FBOs) which were found to be eligible at the time of assessment. A total of 68 diagnostic and 32 treatment centres were targeted for support during the year under review.

During the year 2011 a total of 51 community TB Treatment supporters were trained in order to enhance the Direct Observed Treatment (DOT).A total of 102 TB patients were supported by the TB treatments supporters against a target of 450 TB patients earmarked for support due to late receipt of TB funding. All though 51 Community TB Treatment Supporters from 34 CHIs were trained to provide DOT to patients, the number was not adequate. In addition, some Treatment Supporters did not have patients to support within their catchment areas during the reporting period

while other patients were reported to have been transferred out of the districts making DOT impossible, hence the underachievement

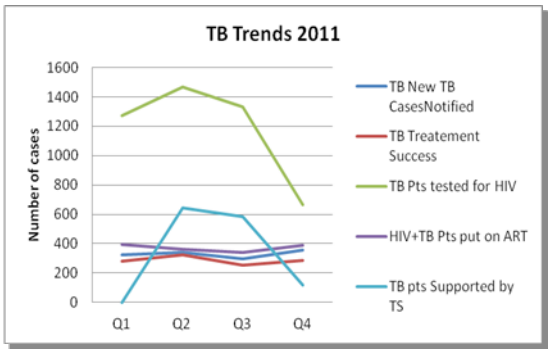
TB Key Results

3.3.1 TB - SUCCESSFULLY TREATED

The success rate for the year under review was 64%. The target to successfully treat 89% of new smear positive TB patients was not reached because funds for monitoring, onsite mentoring and training were not available on time. The target was to counsel and test 6305 TB patients for HIV and this was based on the planned number of TB cases (all forms) to be notified. 5609 TB patients were counseled and tested which translated to 89%. Health workers were not trained to provide Directly Observed Therapy (DOT) and follow-up of patients within the community.

3.3.2 TB HIV collaboration

TB still remains the main cause of death of PLWH in Zambia. During 2011 despite the challenges of shortage of drugs and funding CHAZ continued with promotion and strengthening of capacity of CHIstaff in early diagnosis of TB/HIV co infection. Through the CART program a total of 5,714 against a target of 4,962 of Adults and children on ART, were screened for TB, STI, treated for OI & received clinical monitoring, adherence counseling, were also evaluated and managed for any adverse drugs events.



TB/HIV guidelines were being revised in the year under review and CHAZ would disseminate them to the CHIs once the process is complete. On the other hand the PR has had embarked on onsite mentoring for Health Workers on the management of TB/HIV co-infection but only a few sites were reached due to late receipt of funds. The denominator used to calculate ART uptake for TB/HIV co-infected patients is 3,926. This figure is the 70% of all TB patients counseled and tested for HIV (5609) because it is assumed that 70% of TB patients will test positive for HIV and it came from the achievement.

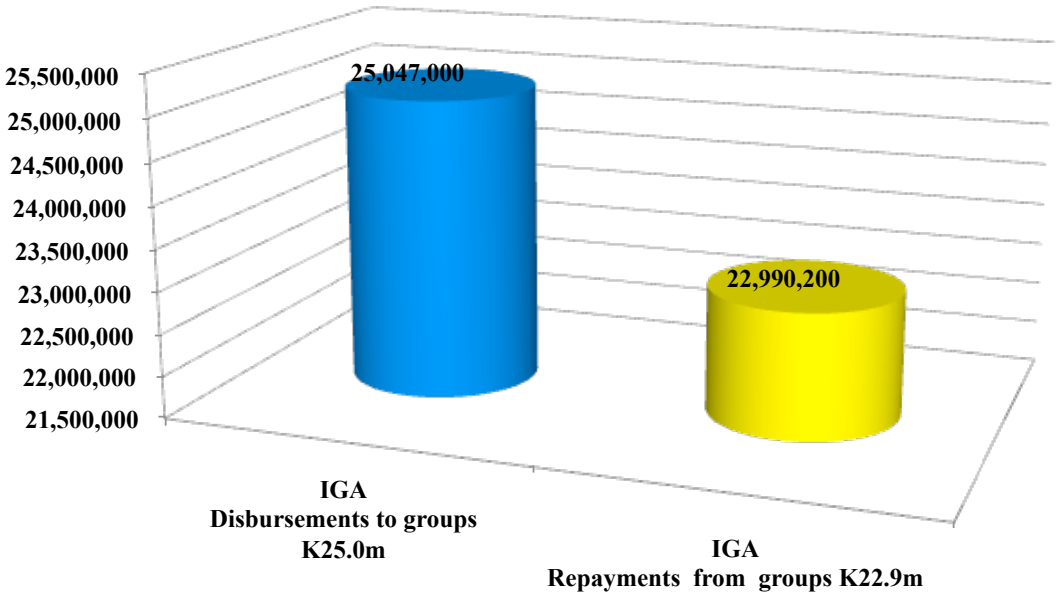
4 Towards Sustainability

4.1 Income Generating Activities (IGAs) - livelihood

CHI and Community Income Generating Activities (IGAs) are one way to alleviate poverty, provide care and support to people living with HIV/AIDS, and empower the orphans and vulnerable children including women and those on TB treatment. IGAs are a sure way of sustaining program activities at community level even in the event that donor support is no longer feasible.

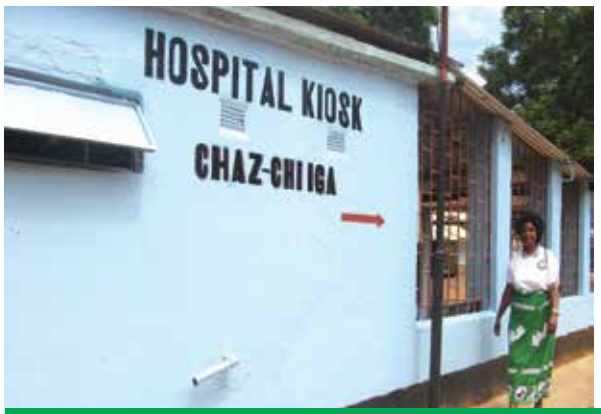
In the period under review and with a focus to strengthen CHIs and community IGAs, CHAZ Secretariat disbursed a total of K70, 000,000.00 to one (1) CHI for IGA investment and K2, 100,000.00 for Administration. CHAZ did not disburse any funds for community IGA investment but CHAZ was committed to strengthening the PASS ON strategy to ensure other groups benefited as per CHAZ IGA Guide lines.

However, during the period under review, a total of Twenty five million kwacha and forty seven thousand (K25, 047,000.00) was disbursed from the local revolving funds accounts at CHI level to local community groups for IGA investment, while the groups repaid a sum of Kwacha Twenty two million nine hundred ninety thousand two hundred (K22, 990,200) as a contribution to the revolving fund as indicated on the graph below.



Disbursement and repayment

At CHI level, funds disbursed were used to refurbish old buildings to create guest houses, renovate canteens procure harmer mills, invest in crop and animal husbandry.

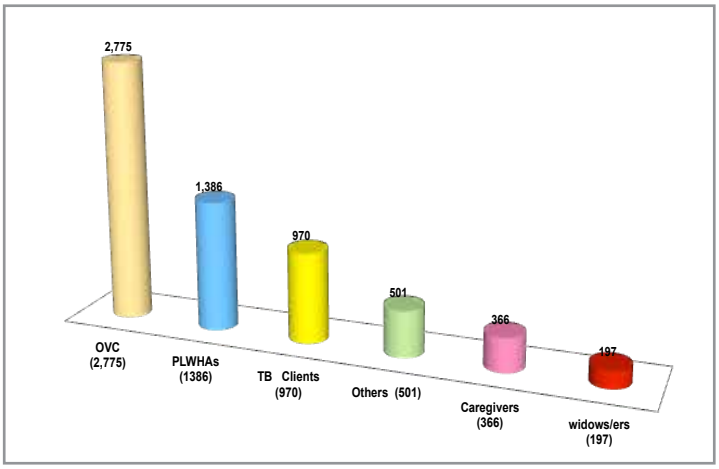


St. Theresa's renovated the Kiosk (left and) Minga renovated the guest house (right)

At community level funds were used for establishing grocery shops, fish farming, vegetable growing, goat and pig rearing to mention but a few.

Potential Benefits and Future Results

Profits realised from both CHI and Community IGAs are channelled to support TB and ART clients, Orphans and vulnerable children (OVC), caregivers, provide food, education, transport money to and from schools and hospitals respectively. In the period under review, the total of beneficiaries from both CHI and community IGAs was 6,195.



Sr. Sabina – Mpanshya M. Hospital distributing bags of mealie meal to a client

4.2 Village Banking/Community Savings and Credit Scheme

Village banking is a banking system that is implemented in economically challenged environments in order to help those that cannot save and access loans from formal Financial Institutions (FIs).

CHAZ in partnership with the Joint Country Programme for Zambia (JCP) and Ministry of Finance and National Planning (MoFNP) Rural Finance Program (RFP) started implementing two pilot projects in October, 2010 andJuly, 2011 respectively, focusing on village banking. The pilot projects are implemented at: (Chipembi, in Chibombo District, Central Province, supported by JCP; Fiwale, in Masaiti District, Copper belt Province and Minga, in Petauke District, Eastern Province, supported by RFP.

The projects are promoting the culture of saving among different categories of people in the catchment areas of Chipembi, Minga and Fiwale ranging from workers in the lower income brackets such as teachers, nurses, and police men to self-employed small entrepreneurs, famers and house wives.

The CHAZ Village Banking has been operating as an informal bank run by the community of a village in the target catchment areas of Chipembi, Fiwale and Minga. The bank's customers, who are at the same time members and owners, deposit money with the group, for savings and borrowings of small loans for various

Members of the saving group performing their saving and lending activities

purposes. The income obtained through interest on loans is redistributed to owners at yearly sharing out. The interest rate charged is determined by individual groups. The groups elect their own leaders, prepare their own constitutions and keep their own records.

The basic structure of a village bank is much more like a support group (10 - 25 people). The CHAZ village banking approach was introduced as a way of taking IGA projects a step forward in order to improve the financial and food security of targeted rural communities.

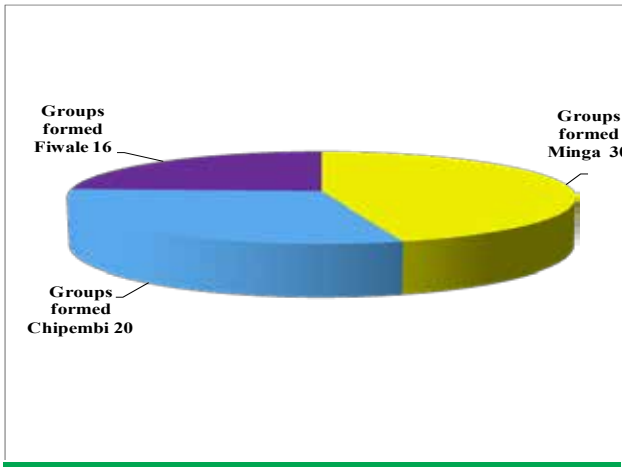


Fig: 1 No of groups formed per project site

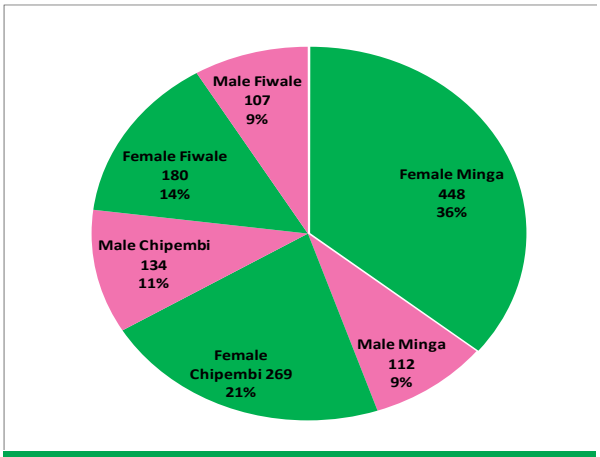
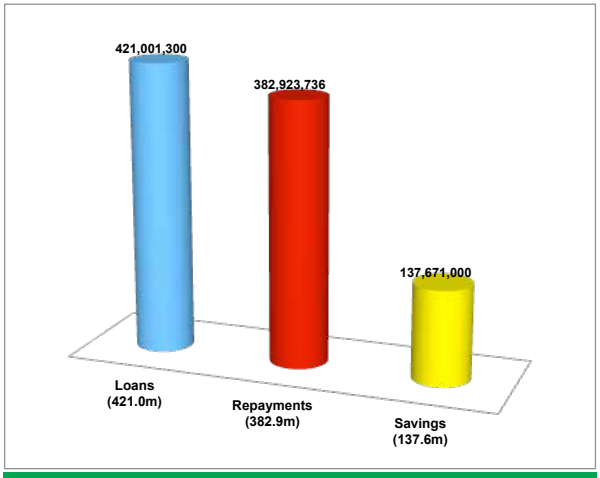


Fig 2: membership per site according to gender

In the year 2011, CHAZ Village banking recorded a total number of sixty six (66) saving groups (Minga - 30, Chipembi - 20, Fiwale -16) and a total number of one thousand two hundred and fifty (1,250) saving group members (Minga - 448 Female and 112 Male, Chipembi - 269 Female and 134 Male, Fiwale - 180 Female and 107 Male). The saving group membership represents 72% women and 28% men.



Repayment performance

In the same period, CHAZ Village banking data base recorded total loans given out to saving group members of Kwacha four hundred twenty one million and one thousand three hundred (K421,001,300): Minga – K5,955,000, Chipembi – K406,413,300, Fiwale – K8,633,000. Repayments of Kwacha three hundred and eighty two million nine hundred twenty three thousand seven hundred and thirty six (K382, 923,736): Minga – K7, 166,000, Chipembi – K365, 418,736, Fiwale – K10, 339,000. Savings of kwacha one hundred and thirty seven million six hundred seventy one thousand (K137, 671,000): Minga – K4, 402,000, Chipembi – K128, 129,000, Fiwale – K5, 140,000.

Members display their merchandise: "We are very happy with Village banking program because we are now able to save and borrow from our own bank. We have borrowed more than six times and have paid back the loans. We may not borrow soon because we have enough capital to continue with our businesses and enough money to support our children at school and other members of our families."

Potential benefit

The village banking program provides community members and working poor with loans and financial services they couldn't otherwise obtain from financial institutions. The program also targets the poorest families with the necessary tools to raise their own incomes. In addition it inspires community members and promotes a proven solution to poverty.

5 CHALLENGES:

1. The major challenge encountered in 2011 which impacted negatively on the overall achievement of results was the non-availability of funds to implement activities as planned at Secretariat, CHI and community level.

2. Reduced budgets from partners resulting in the constant search for efficiency savings and gains.

3. The lack of adequate administration coverage for SRs also resulted in a lot of requests to amend budgets. One notable effect this challenge had was the lack of capacity to retain qualified accounting staff at SR level coupled with the inability to train new staff due to training plans that were not approved by GF until the end of the year.

4. Endless cuts of unit costs pushed to the lowest figures possible, leaving no room for price adjustments or budget flexibility.

5. This in addition to new grant CPs resulted in signing delays of grants.

6. The lack of adequate space at the Secretariat continues to make the working environment difficult as accommodating more numbers becomes a growing challenge.

7. Despite the high priority that CHAZ gives to Advocacy it was unable to realize all its Advocacy activities because of Resource limitations.

8. Other challenges included inadequate staff to provide M&E services in all the 146 CHIs/SRs; no persons assigned to managing M&E data at CHI and SR level. This affected the quality of reports submitted to the Secretariat.

9. Male partner involvement is insufficient in most settings, male involvement and support is critical to improving women's uptake of core PMTCT services as well as for primary prevention of HIV and avoiding unintended pregnancies.

10. Delay in starting antenatal is an issue if we are to succeed with the prevention of HIV transmission from mother to child, low postnatal attendances; low family planning use is another issue in preventing unintended pregnancies.

11. Dilapidated infrastructure and staff housing is one of the greatest challenges mission facilities face.

12. Lack of adequate and appropriate accommodation contributes significantly to staff attrition and difficulties to attract qualified staff especially to rural areas.

6 CONCLUSION

2011 marked the first year of implementing CHAZ's 2011 – 2015 Strategic Plan. The year had a lot of funding challenges due in part to delays in funding by some of our partners but predominantly due to the fact that

a number of programmes were commencing their operations in 2011 (i.e. the JFA, ZPCT II and the CART). Only modest achievements were achieved during the year but it is expected that with most programmes being under way currently most targets for 2012 will be achieved.

CHAZ would like to thank its various partners that currently include but not limited, the Government of the Republic of Zambia/ Ministry of Health, AIDS Relief/CDC, The Global Fund to Fight HIV and AIDS Tuberculosis and Malaria, EU/CORDAID, FK-Norway, the JFA partners i.e. Irish Aid, the Embassy of the Kingdom of the Netherlands (EKN), the Danish Embassy and The Joint Country Program (JCP) partners (DanChurchAid, Christian Aid and Norwegian Church Aid) and the Ministry of Finance-Rural Finance Program.

7 PRIORITIES FOR 2012

1. Implement the governance and constitutional changes,
2. Mobilise resources for programmme implementation and infrastructure refurbishment,
3. Strengthen sustainability initiatives,
4. Scale up proven strategies to contribute towards the attainment of the MDGs,
5. Strengthen and broaden partnerships.

ANNEXES

Annex 1: Financial statement for the year to 31st December 2011

FINANCE AND ADMINISTRATION

CHAZ has continued to strengthen its financial management systems in order to create and sustain confidence from the donors and the members. The year 2011 saw continued flow of funds from the various cooperating partners. The Financial highlights below are based on the audited Financial Statements for the year ended 31 December 2011.

Income:

The total income received during the year 2011 was K113,382 million comprising K98,690 million for Programs and K14,692 million for Administration. In the previous year, the total income received was K68,267 million comprising K61,499 million for Programs and K6,768 million for Administration. Overall, this represents an increase in income of 66.1%. This increase is attributed to the continued funding from Global Fund for the Malaria and TB Round 7 Grants which entered Phase II. We also received funds for the HIV R8 extension. A new Grant, HIV R10 which replaced the Round 4 Grant also commenced in 2011 and the funds were received in December 2011. There was also additional funding received from the Royal Danish Embassy under the JFA. The Danish Embassy Funds were committed to the 2012 JFA budget.

Expenditure:

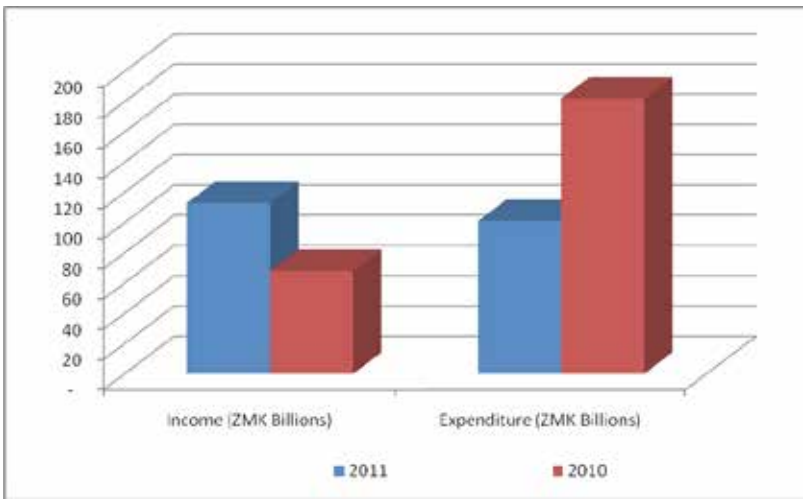
The total expenditure incurred during the year 2011 was K101,361 million comprising K85,734 million for Program and K15,627 million for Administration. In the previous year, the total expenditure incurred was K182,296 million comprising K171,487 million for Programs and K10,809 million for Administration. Overall, this represents a decrease of 44.4%. The decrease in expenditure was due to a decrease in the overall level of activity in 2011 compared to 2010. Most of the funds from Global fund and JFA (Denmark Embassy) were received towards the end 2010, precisely between November and December 2010. A lot of activities are now being carried out in 2012.

Surplus:

At the beginning of the year 2011, CHAZ had funds brought forward from 2010 amounting to K13,422 million. These funds were spent on various program activities during the course of the year 2011.

The Association achieved a surplus of K12,021 million as at 31st December 2011. The reason for the surplus is mainly due to the funds for programs (GF and JFA) that were received towards the end of the year for which the related activities will be carried out in 2012.

Figure 1: Income and Expenditure



CHURCHES HEALTH ASSOCIATION OF ZAMBIA

STATEMENT OF RESPONSIBILITY FOR ANNUAL FINANCIAL STATEMENTS

The Board is required to prepare financial statements for each financial year which present fairly the financial position of the Churches Health Association of Zambia (the "Association") and its financial activities for that period.

In preparing the financial statements, the Board

- Select suitable accounting policies and then apply them consistently;
- Make judgements and estimates that are reasonable and prudent; and
- Comply with International Financial Reporting Standards.

The Board are also responsible for ensuring that the Association keeps proper accounting records which disclose with reasonable accuracy at any time the financial position of the Association. It is also responsible for safeguarding the assets of the Association and taking reasonable steps for the prevention and detection of fraud and other irregularities.

The Association is also responsible for the systems of internal control. These are designed to provide reasonable but not absolute, assurance as to the reliability of the financial statements, and to adequately safeguard, verify and maintain accountability for assets, and to prevent and detect material misstatements. The systems are implemented and monitored by the suitably trained personnel with an appropriate segregation of authority and duties. Nothing has come to the attention of the Association to indicate that any material breakdown in the functioning of these controls, procedures and systems has occurred during the year under review.

In the opinion of the Association the financial statements are drawn up so as to present fairly the financial activities of the Association for the year ended 31 December 2011 and its financial position as at that date and have been prepared in accordance with International Financial Reporting Standards and in the manner required by the financing agreements signed with the Cooperating partners.

The financial statements on pages 4 to 34 were approved by the board and authorised for issue on 22 June 2012 and were signed on its behalf by:

DR. JANSEN JOOP) CHAIRMAN

MR. GORDON HANNA) TREASURER

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INDEPENDENT AUDITOR'S REPORT

To the members of
Churches Health Association of Zambia

Report on the financial statements

We have audited the accompanying financial statements of the Churches Health Association of Zambia, which comprise the statement of financial position as at 31 December 2011, and the statement of comprehensive income, statement of movement in accumulated fund and statement of cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Board's responsibility for the financial statements

The members of the Board are responsible for the preparation and fair presentation of these financial statements in accordance with International Financial Reporting Standards and in the manner required by the Cooperating Partners as stipulated in the financing agreements, and for such internal control as the Board determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with International Standards on Auditing. Those Standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements present fairly, in all material respects, the financial position of the Churches Health Association of Zambia as at 31 December 2011, and of its financial performance and cash flows for the year then ended in accordance with International Financial Reporting Standards and in the manner required by the Cooperating Partners as stipulated in the financing agreements.

Deloitte & Touche
DELOITTE & TOUCHE

DATE: 22/06/2012

CHURCHES HEALTH ASSOCIATION OF ZAMBIA

STATEMENT OF COMPREHENSIVE INCOME
for the year ended 31 December 2011

Kwacha '000

	NOTES	Programme funds	Administration funds	2011	2010 Restated	2009
Revenue						
Income from donors	7	91,474,817	-	**91,474,817**	49,704,817	139,318,233
Other income						
Net exchange gains	8	1,429,367	403,022	**1,832,389**	1,863,695	9,711,595
Administration fees	9	-	6,734,217	**6,734,217**	4,615,251	4,994,092
Other income	10	2,410,157	7,475,932	**9,886,089**	4,276,629	5,424,947
Other administration income		-	78,641	**78,641**	732,446	-
Deferred income	11	3,376,089	-	**3,376,089**	7,073,912	6,119,108
		7,215,612	14,691,812	**21,907,424**	18,561,933	26,249,742
Total income		98,690,429	14,691,812	**113,382,241**	68,266,750	165,567,975
Expenditure						
Programme expenses	12	(85,734,772)	-	**(85,734,772)**	(171,033,201)	(148,583,234)
Employee benefits expenses		-	(5,501,684)	**(5,501,684)**	(6,886,572)	(4,813,881)
Other operational costs		-	(2,851,164)	**(2,851,164)**	(2,756,882)	(5,796,423)
Depreciation	13	-	(7,273,845)	**(7,273,845)**	(12,550,690)	(1,465,242)
Total expenditure		(85,734,772)	(15,626,693)	**(101,361,466)**	(193,227,345)	(160,658,780)
Surplus (deficit) for the year	6	12,955,657	(934,881)	**12,020,776**	(124,960,595)	4,909,196
Other comprehensive income						
Fair value gain on equity	14	-	-	-	22,472	20,988
Total comprehensive income (loss)		12,955,657	(934,881)	12,020,776	(124,938,123)	4,930,184

CHURCHES HEALTH ASSOCIATION OF ZAMBIA

STATEMENT OF FINANCIAL POSITION
at 31 December 2011

Kwacha '000

	NOTES	2011	2010 Restated	2009
ASSETS				
Non-current assets				
Property and equipment	13	**30,580,138**	14,585,335	16,387,659
Equity investments	14	**75,260**	75,260	52,788
Employee receivables	15	**-**	18,248	45,931
Total non-current assets		**30,655,398**	14,678,843	16,486,378
Current assets				
Inventories	16	**2,966,055**	21,530,618	9,628,924
Employee receivables	15	**149,995**	307,893	168,744
Other receivables	17	**-**	-	77,606
Subscriptions due from member institutions	18	**141,962**	44,129	43,340
Bank and cash balances				
- Restricted funds	19	**41,913,822**	12,462,268	130,947,842
- Unrestricted funds	19	**934,442**	975,951	3,740,550
Total current assets		**46,106,276**	35,320,859	144,607,006
TOTAL ASSETS		**76,761,674**	49,999,702	161,093,383
FUNDS AND LIABILITIES				
Restricted funds - Accumulated funds		**53,290,387**	40,334,730	160,858,747
Contribution capital		**1,574**	1,574	1,574
Revaluation reserve		**6,097,684**	6,097,684	6,492,922
Unrestricted funds - Accumulated deficit		**(23,423,073)**	(22,488,192)	(18,469,324)
		35,966,571	23,945,795	148,883,919
Capital grants	20	**31,547,936**	15,562,602	6,717,870
		67,514,507	39,508,396	155,601,789
Non-current liabilities				
Deferred liabilities - employee provisions	21	**1,162,623**	2,101,549	1,037,206
Current liabilities				
Employee provisions	21	**2,698,831**	1,748,360	2,673,160
Amounts due to member institutions	22	**50,516**	61,175	129,561
Government grants	23	**878,429**	801,078	302,730
Other payables	24	**4,452,245**	2,382,006	592,450
Deferred income	11	**4,523**	3,380,612	756,486
Bank overdraft - Administration funds		**-**	16,525	-
Total current liabilities		**8,084,544**	8,389,756	4,454,388
TOTAL EQUITY AND LIABILITIES		**76,761,674**	49,999,702	161,093,383

CHURCHES HEALTH ASSOCIATION OF ZAMBIA

STATEMENT OF MOVEMENTS IN ACCUMULATED FUND
for the year ended 31 December 2011

Kwacha '000

	Contributed capital Restricted	Revaluation reserves Restricted	Accumulated funds		Total
			Restricted	Unrestricted	
Balance at 1 January 2010	**1,574**	**6,492,922**	**160,858,747**	**(18,469,324)**	**148,883,919**
Deficit for the year	-	-	(109,988,218)	(4,041,340)	(114,029,559)
Other comprehensive income - Fair value gain on equity	-	-	-	22,472	22,472
Amortisation of revaluation reserves	-	(395,238)	395,238	-	-
Balance at 31 December 2010 as previously stated	**1,574**	**6,097,684**	**51,265,767**	**(22,488,192)**	**34,876,832**
Prior year adjustment (Note 28)	-	-	(10,931,037)	-	(10,931,037)
Balance at 31 December 2010 as restated	1,574	6,097,684	40,334,730	(22,488,192)	23,945,795
Surplus for the year	-	-	12,955,657	(934,881)	12,020,776
Amortisation of revaluation reserves	-	-	-	-	-
Balance at 31 December 2011	**1,574**	**6,097,684**	**53,290,387**	**(23,423,073)**	**35,966,571**

CHURCHES HEALTH ASSOCIATION OF ZAMBIA

STATEMENT OF CASH FLOWS
for the year ended 31 December 2011

Kwacha '000

	NOTES	2011	2010 Restated	2009
OPERATING ACTIVITIES				
Surplus (deficit) for the year		**12,020,775**	(124,960,595)	4,909,196
Adjusted for non cash items:				
Depreciation	13	**7,273,845**	12,550,690	1,465,242
Loss on disposal of property and equipment		**-**	2,524	16,487
Capital grants disposals		**-**	(8,446)	(19,976)
Amortisation of capital grants	20	**(7,181,492)**	(1,478,720)	(1,035,310)
Employee provisions - charge for the year	21	**2,698,831**	1,748,360	2,965,783
Operating cash inflows before changes in operating funds		**14,811,959**	(112,146,187)	8,301,421
Decrease (increase) in inventories		**18,564,563**	(11,901,694)	(3,249,022)
Decrease (increase) in employee receivables		**176,146**	(111,466)	687,071
Decrease (increase) in other receivables		**-**	77,606	(65,062)
Increase in amounts receivable from member institutions		**(97,833)**	(789)	(43,340)
(Decrease) increase in amounts payable to member institutions		**(10,659)**	(68,386)	102,294
Increase in other payables		**2,070,239**	1,789,556	38,911
Net (decrease) increase in deferred income		**(3,376,089)**	2,624,126	(722)
Cash generated from (utilised in) operations		**32,138,326**	(119,737,234)	5,771,551
Employee gratuity paid	21	**(2,687,286)**	(1,608,818)	(446,271)
Net cash generated from (used in) operating activities		**29,451,040**	(121,346,052)	5,325,280
INVESTING ACTIVITIES				
Purchase of property and equipment	13	**(23,268,649)**	(10,752,187)	(5,475,394)
Proceeds from disposal of property and equipment		**-**	1,298	19,953
Net cash used in investing activities		**(23,268,649)**	(10,750,889)	(5,455,441)
FINANCING ACTIVITIES				
Capital grants received during the year	20	**23,166,826**	10,331,898	4,788,186
Government grants received	23	**8,512,084**	7,879,522	5,148,588
Government grants utilised	23	**(8,434,730)**	(7,381,173)	(5,669,496)
Net cash generated from financing activities		**23,244,180**	10,830,247	4,267,278
Net cash inflows (outflows)		**29,426,571**	(121,266,695)	4,137,117
Net bank and cash balances at beginning of the year		**13,421,695**	134,688,391	130,551,274
Net bank and cash balances at end of the year		**42,848,264**	13,421,695	134,688,391
Comprised of:				
Bank and cash balances	19	**42,848,264**	13,438,220	134,688,391
Bank overdraft		**-**	(16,525)	-
		42,848,264	13,421,695	134,688,391

NOTES TO THE FINANCIAL STATEMENTS
for the year ended 31 December 2011

1. GENERAL INFORMATION

The Churches Health Association of Zambia's (the "Association") principal activity is the co-ordination of the activities of Church administered health institutions. The principal place of business is Plot 9306, Ben Bella Road.

2. APPLICATION OF NEW AND REVISED INTERNATIONAL FINANCIAL REPORTING STANDARDS (IFRSs)

2.1 New and revised IFRSs affecting amounts reported in the current year (and/or prior years):

The following new and revised Standards and Interpretations have been adopted in the current period and have affected the amounts reported in these financial statements. Details of other Standards and Interpretations adopted in these financial statements but that have had no effect on the amounts reported are set out in section 2.2.

New and revised IFRSs affecting presentation and disclosure only

Amendments to IAS 1 Presentation of Financial Statements (as part of Improvements to IFRSs issued in 2010)	The amendments to IAS 1 clarify that an entity may choose to disclose an analysis of other comprehensive income by item in the statement of changes in equity or in the notes to the financial statements. In the current year, for each component of contributed capital, the Association has chosen to present such an analysis in the notes to the financial statements, with a single-line presentation of other comprehensive income in the statement of changes in equity. Such amendments have been applied retrospectively, and hence the disclosures in these financial statements have been modified to reflect the change.
IAS 24 Related Party Disclosures (as revised in 2009)	IAS 24 (as revised in 2009) has been revised on the following two aspects: (a) IAS 24 (as revised in 2009) has changed the definition of a related party and (b) IAS 24 (as revised in 2009) introduces a partial exemption from the disclosure requirements for government-related entities. This has had no impact on the financial statements of the Association.

2.2 New and revised IFRSs applied with no material effect on the financial statements

The following new and revised IFRSs have also been adopted in these financial statements. The application of these new and revised IFRSs has not had any material impact on the amounts reported for the current and prior years but may affect the accounting for future transactions or arrangements.

Annex 2

The table below shows the regimens given in 2011.

	2011 AGGREGATED CONSUMPTION DATA AT ALL FACILITY LEVEL		
NO	**PRODUCT**	**AMOUNT DISPENSED TO CLIENTS**	**PERCENTAGE**
1	Abacavir	15,520	1.79
2	AbacavirSusp	599	0.07
3	Didanosine	1,751	0.20
4	Efavirenz 600mg	207,028	23.89
5	Efavirenz 50mg	4,018	0.46
6	Lopinavir/Ritonavir 200/50mg	14,632	1.69
7	Lamivudine 150mg	14,514	1.67
8	Lamivudine Susp	3,477	0.40
9	Lamivudine/Stavudine/Nevirapine 150/30/200mg	76,686	8.85
10	Lamivudine/Stavudine/Nevirapine 6/30/50mg	591	0.07
11	Lamivudine/Stavudine/Nevirapine 12/30/100mg	12,199	1.41
12	Lamivudine/Stavudine 150mg/30mg	16,424	1.90
13	Lamivudine/Zidovudine/Nevirapine 30/60/50mg	11	0.00
14	Lamivudine/Zidovudine 30/60mg	62	0.01
15	Lamivudine/Zidovudine 150/300mg	66,829	7.71
16	Tenofovir/Emitricitabine	262,484	30.29
17	Tenofovir/Emitricitabine/Efavirenz	2,915	0.34
18	Tenofovir/Lamivudine	968	0.11
19	Zidovudine 240ml	2,608	0.30
20	Zidovudine 300mg	3,070	0.35
21	Zidovudine 100ml Susp	3,943	0.45
22	Nevirapine 100ml	210	0.02
23	Nevirapine 200mg	139,079	16.05
24	Nevirapine 10mg/ml PMTCT	36	0.00
25	Nevirapine 240ml - 10mg/ml	6,649	0.77
26	Stavudine Suspension	2,690	0.31
27	Cotrimoxazole 240ml/5mg Suspension	1,688	0.19
28	Cotrimoxazole 480mg tablet	5,989	0.69
	TOTAL	866,670	100.00

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