PART THREE

MANAGEMENT AND ORGANISATIONAL SUPPORT SYSTEMS

CHAPTER SEVEN: Organisation of the Ministry of Health

CHAPTER EIGHT: Partnership

CHAPTER NINE: Financial, Administrative and Management Systems (FAMS)

CHAPTER TEN: Monitoring and Evaluation/Health Management Information System (HMIS)

CHAPTER 7: ORGANIZATION OF THE REFORMED MINISTRY OF HEALTH

7.1 Introduction

The reformed health care system has management and support needs and responsibilities at each level from the household to the central Ministry of Health. The linkages between the levels of the system are interwoven: the district and national levels are intended to directly respond to support needs at the household and community, as well as through the hierarchy of the formal system. Defined responsibility for performing management and support functions have been allocated to the various levels of the system in a way which will ensure that real needs are addressed in the most cost-effective manner.

7.2 Vision

To provide for a strong decentralised system in which the District Health Management are enabled to offer quality, equitable and community based health services.

7.3 Linkages

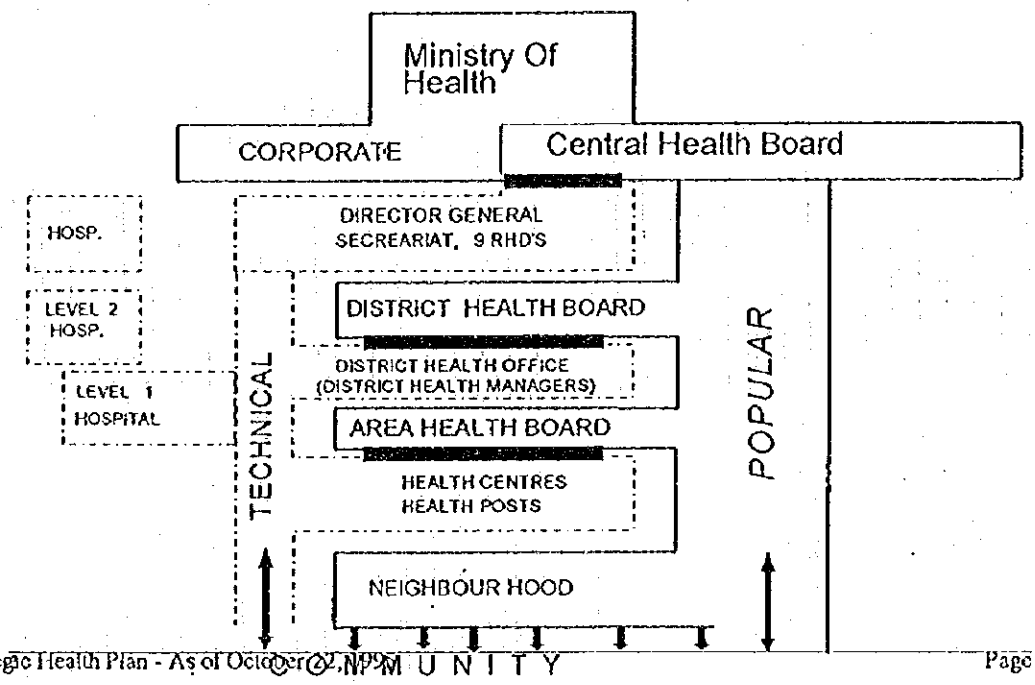


Figure 1: The structures for community involvement and policy making as well as structures for management and service delivery are outlined.
The structure reflects the getting together of popular\political concerns and technical expertise. The technical health service delivery (through teams and secretariat) is intersected at three levels by representation of popular/political concerns (Boards). The Boards control the service delivery at their respective levels. The health service delivery teams and secretariat serve as the executive arms of the Boards.

The interactions between the Boards and their teams/secretariat ensure that real needs and demands of the community are professionally translated into feasible and affordable quality health care and interventions.

7.4 ROLES AND RESPONSIBILITIES:

7.4.1 The Health Post

- responsible for a population of 500 households (3,500 people) in rural area and 1000 households (7,000 people) in the urban areas.
- responsible for outreach activities in catchment area.
- staffed with one (polyvalent health worker) public health practitioner whose role will be to provide 80% of his time to primary preventive activities in the community and 20% to emergency curative services at health post.
- responsible for supervision of traditional birth attendants and community health workers.

7.4.2 Health Centre

- first point of contact with the formal health care system.
- the urban health centre (UHC) will have a catchment area of 30,000-50,000 and a rural health centre (RHC) will cover a catchment area of 10,000.
- UHC will have up to 30 beds excluding maternity beds.

- RHC will have 10-12 beds.
- Both UHC+RHC will operate on a 24 hours basis.
- Health centres will be staffed by (polyvalent health workers) public health practitioner.
- Health Centres will provide clinical services (including laboratory support) and back up service to health posts.
- the health centre will have increased functions. It should be able to:
  - perform blood tests for malaria;
  - conduct deliveries;
  - treat tuberculosis;
  - perform contact tracing;
  - test for intestinal parasites;
  - provide immunizations;
  - pre-natal care;
  - growth monitoring;
  - nutrition counselling

- Urban Health Centres will in addition provide dermatology, dental and optometry services (population large enough to justify placement of such competences at this level).
- Current OPD's at level 1 hospitals will be designated to provide the health centre package for a catchment area population equivalent to that defined for UHC or RHC depending on the location of the hospital. The activities carried out therefrom will be budgeted for by the district and the staffing levels will be in line with those of a health centre.

7.4.3 Area Boards of Health

These are critical especially in large urban cities like Lusaka where there is a district population of 1.5 million. In this situation, Area Boards of Health are meant to divide the population into manageable "health district". Elsewhere, Area Boards of Health will facilitate community participation in district level health planning.

The function of the Area Boards are to:

- recruit, and support CHWs,
- request training from the district as necessary
- monitor and support the function of health centres.

7.4.4 First referral hospital (level 1 hospital)

- will serve a population of 80,000-200,000;
- will provide medical, surgical, obstetric services and any other clinical services required to support the health centre referrals;
- will provide technical back up services and capacity building to the health centre;
- will provide a fairly sophisticated diagnostic services.

7.4.5 District Health Board

- primary management unit in the decentralised health system;
- administer the affairs of the district health service.
- responsible for planning for the district;
- responsible for ensuring that local priorities are recognised and addressed.
- responsible for coordinating with other sectors e.g. agriculture, local government etc.
- responsible for motoring performance of health centres and level 1 hospital against established standards;
- responsible for providing training for district staff.

7.4.6 Regional Health Office

I. Technical Support Function

- Development of Action Plans and budgets;
- Advise on implementation of action plans;

- Provide consultancy on specific identified needs;
- Training;
- Financial management;
- Human resources development;
- Epidemic preparedness

II **Monitoring and Evaluation**

- Action plan implementation;
- Quality assurance;
- Financial management;
- Systems development and management of districts;

III **Health Management Information System and Health Systems Research**

- Capacity building;
- National information system;
  * consolidate district reports feed-back to district and feed up to national data base.

IV. **Logistical Support**

- Supply of equipment, drugs vaccines etc. supplied from national level;
- Economy of scale functions e.g. maintenance of cold chain;

V. **Communication**

- Translate national policies into practical instructions to District Health Boards.

VI. **Mediation**

- Clarify roles of District Directors, District Health Boards etc.
- Strengthen relationships among different actors;
- Guidance in restructuring number of health centres and hospitals in line with what is stated in the strategic plan.

7.4.7 2nd Referral Hospital (level 2 Hospital/General Hospital)

- Catchment area for level 2 hospital will be 200,000 to 800,000;
- Will provide medical, surgical, paediatric, obstetrical, gynaecological,

dental, psychiatric and intensive care services;
- Will offer any other clinical services necessary to support level 1 referrals;
- Will provide training services;
- Will provide technical back-up services and capacity building for level 1 facilities.

7.4.8 3rd Referral Hospital (Central Hospital)

- Level 3 catchment area is 800,000 and above;
- Will provide general surgery, urology, other paediatrics, ophthalmology, dental, ENT, medical, obstetrics and gynaecology, intensive care;
- Will provide training and research;
- Will provide technical back-up services and capacity building to level II facilities;
- Will offer referral services from level II;
- Staffing levels and other inputs are stipulated in the level III packages.

7.4.9 Central Board of Health

Responsible for:-

a. Supervision, advising and monitor ing of the technical performance of management boards;

b. Setting financial objectives and the framework for management boards;

c Providing technical consultancy to management boards and assist Non-Governmental Health Providers;

d. Coordinate the technical capacity of management boards;

e Promoting conductive social and physical environment for good health and all matters affecting public health;

f Advising the Ministry on the role of the public and private sector in providing health care.

7.4.10 Ministry of Health

The restructured Ministry of Health will be accountable for the following functions:

a. Development of sectorial policies and ratification of technical ones;

b. Forward strategic planning;

c. Legislation (interpretation, amendment and drafting of new legislations);

d. Resource mobilisation (material, finance and human);

e. External Relations (multi-a dn bilateral as well as regional organisations) and multisectorial collaboration with other Ministries, NGOs and the private sector.

f. Performance audit of the Central Board of Health, as well as other Statutory Bodies, in relation to agreed targets.

VII. Central Board of Health

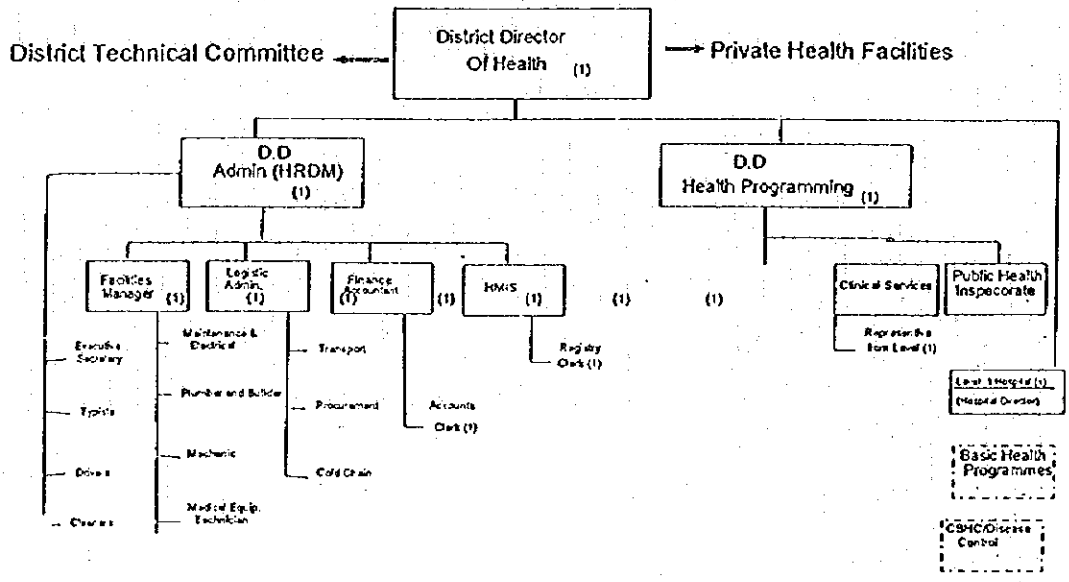
The Central Board of Health is a national administrative agency for overall technical management of the Health Sector. It is responsible for overall production of quality health care service.

7.7.5 Organisation Structures

The main emphasis of the new management and support structures is managing for quality health care through a District Health Management System.

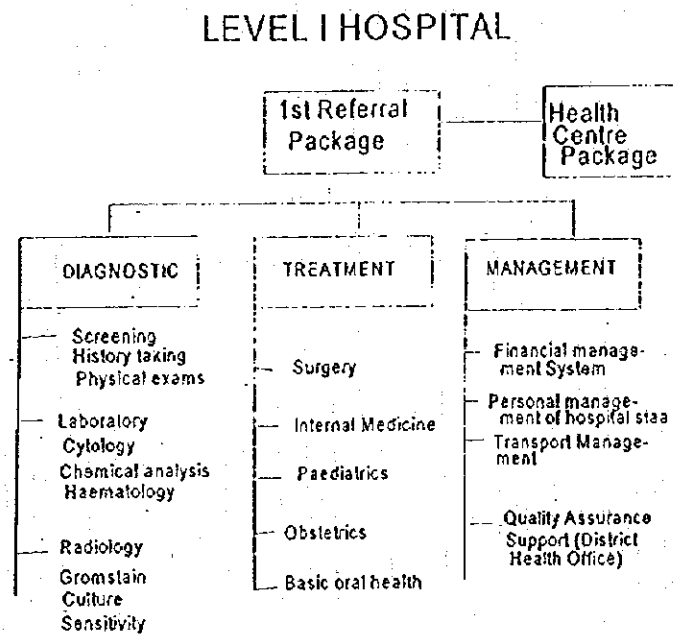
Figure 2.

DISTRICT HEALTH MANAGEMENT ORGANISATION



7.5.1. First Referral Hospitals: (Level 1 Hospitals) - Wee-functioning health centres require back-up for more complicated health problems, the first level of referral will be a district hospital. Working together, these two tiers have demonstrated their capacity to provide relatively comprehensive and effective care to the communities they serve.

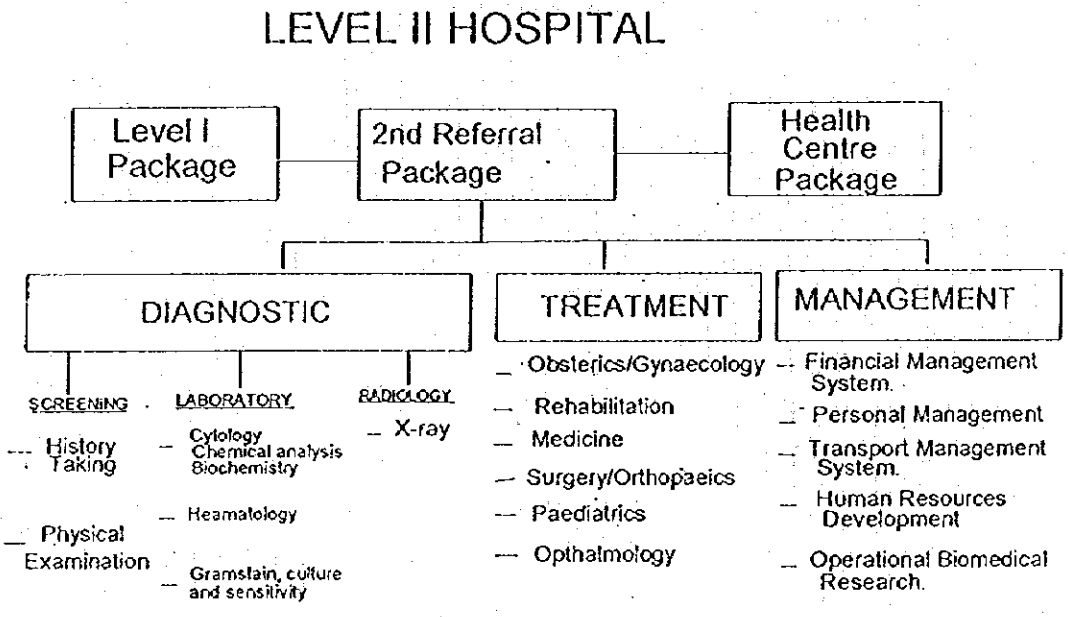
Figure 3.


LEVEL I HOSPITAL
1st Referral Package
Health Centre Package
DIAGNOSTIC
TREATMENT
MANAGEMENT
Screening
History taking
Physical exams
Laboratory
Cytology
Chemical analysis
Haematology
Radiology
Gromstain
Culture
Sensitivity
Surgery
Internal Medicine
Paediatrics
Obstetrics
Basic oral health
Financial management System
Personal management of hospital staa
Transport Management
Quality Assurance
Support (District Health Office)

7.5.2 Second Referral Hospitals (Level 2 Hospitals) - These hospitals are defined as those which provide the first referral services for their immediate population, but are also equipped to respond to the needs for infrequent, specialized services which are part of the essential package, in particular in the areas of orthopaedics, obstetrics, surgery and paediatrics. Level II hospitals will provide Health Centre functions for its immediate catchment area and 1st referral functions for the district in which it is physically situated. It will provide second referral functions.

Figure 4.

7.5.3 Third Referral Hospitals (Level 3 Hospitals) - Building on the premise

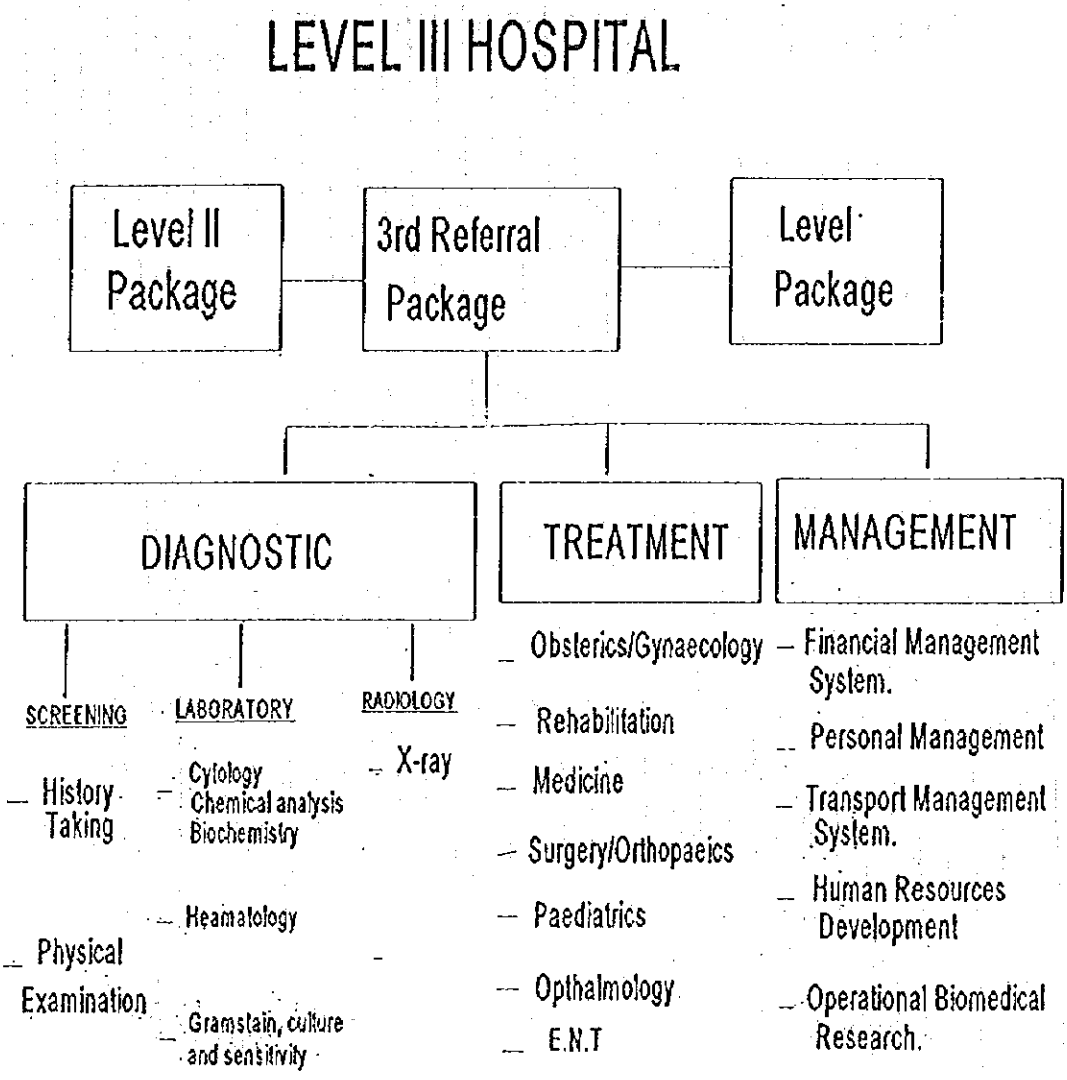


that a well-functioning health centre and first referral hospital can serve up to 98 percent of preventive and curative health care needs, the reformed level III will be expected to provide technical back-up and some support by training health personnel for service.

Figure 5.

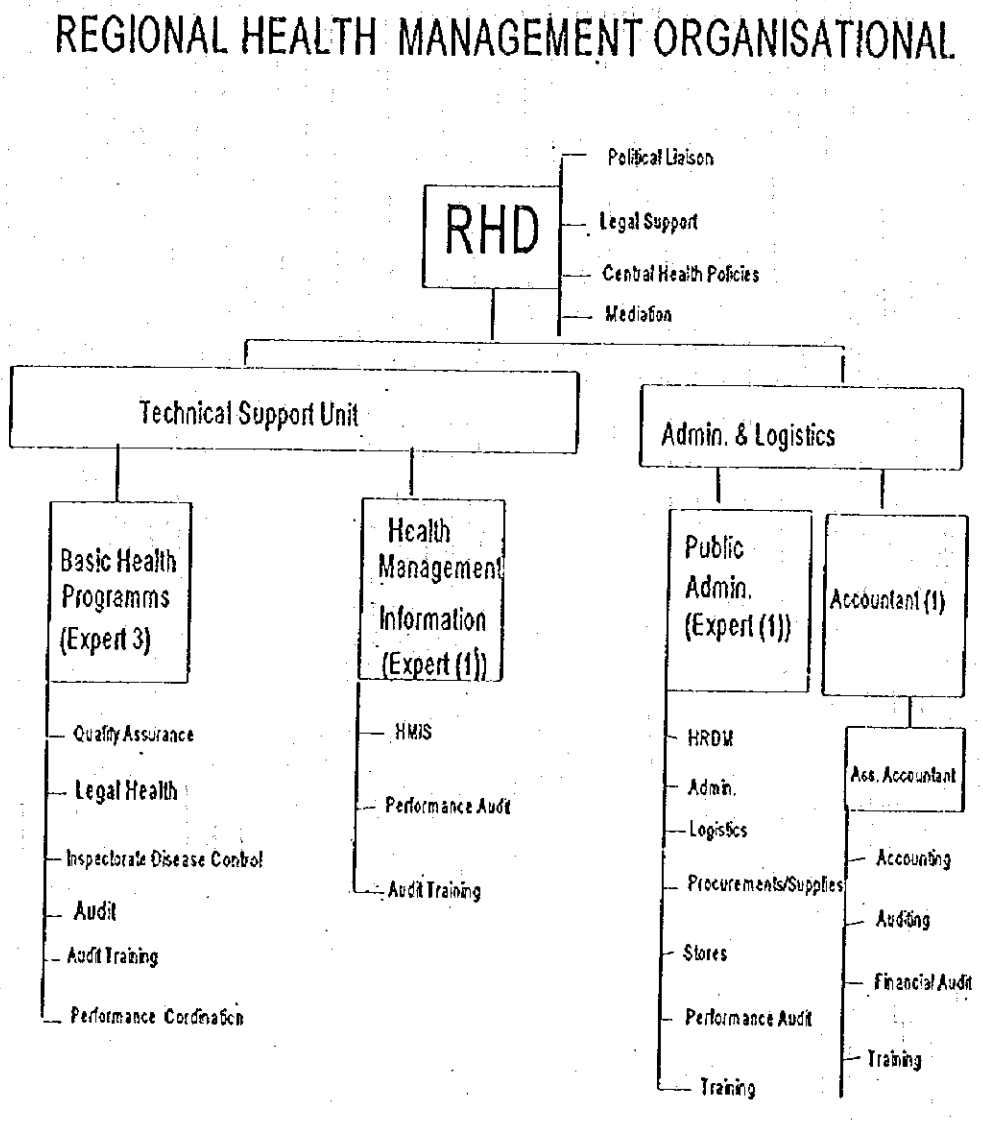
7.5.4 Regional Health Office

Being an extended arm of the Central Board of Health, the Regional office



will discharge responsibilities similar to those of the Central Health Board secretariat.

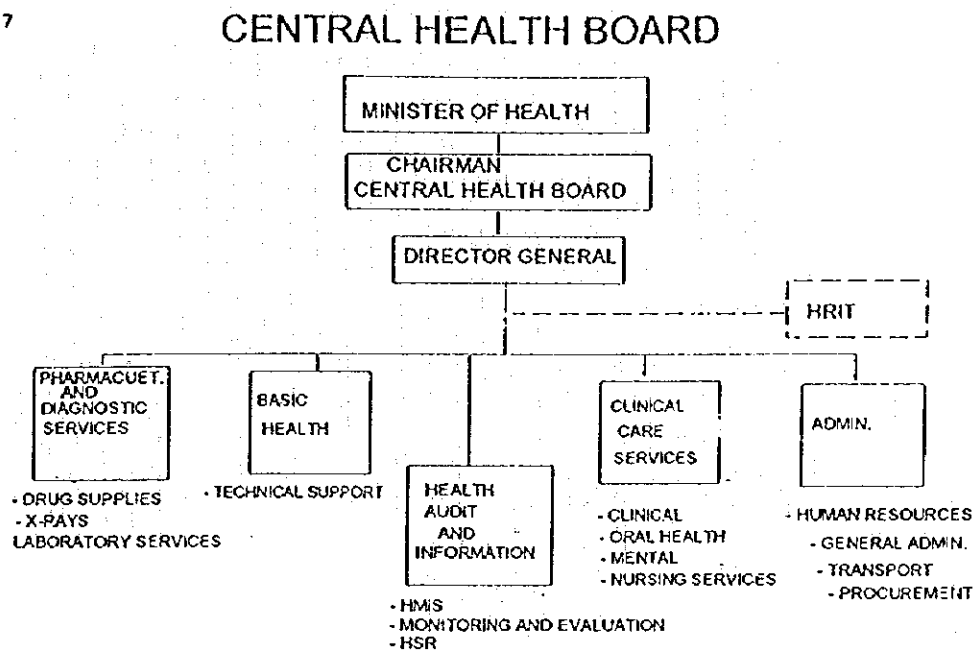
Figure 6.



7.5.5 Central Board of Health

The Central Board of Health is the national administrative agency for overall technical management of the Health Sector. It is responsible for overall

fig. 7

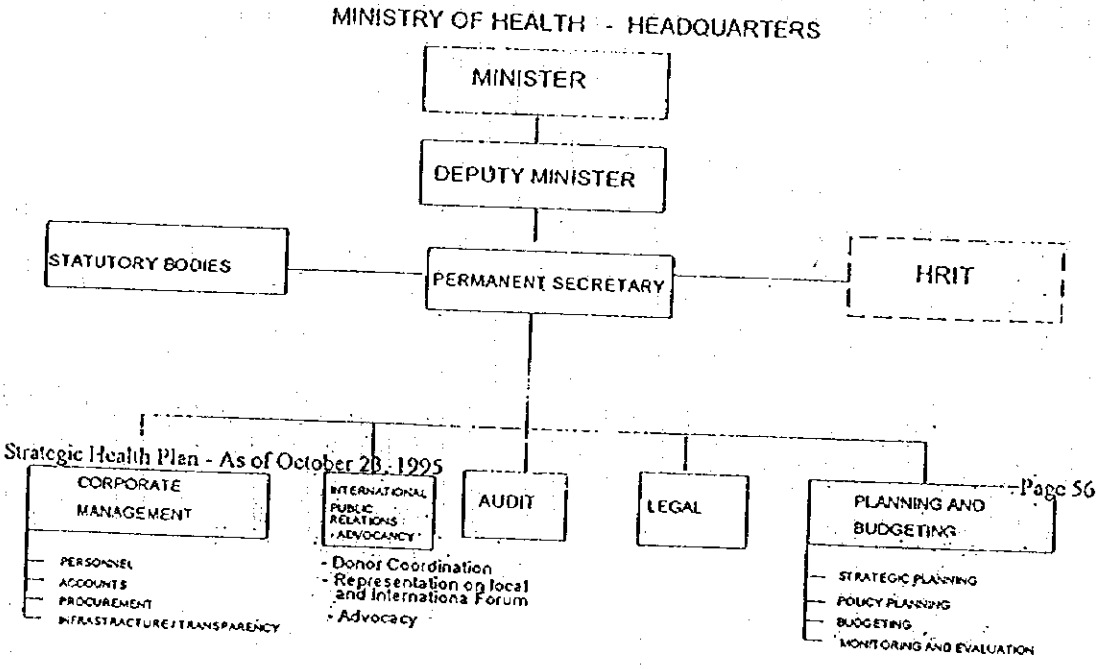


production of qualify health services.

7.5.6 MINISTRY OF HEALTH

The Ministry of Health is the overall body for policy formulation, resource mobilization and forward planning for the health sector.

Fig. 8



CHAPATER EIGHT:PARTNERSHIP

8.1. Vision

The Ministry of Health and all its collaborating partners will share commitment to the health reforms and attain a common vision which will be reflected in the investment of the required effort to achieve a mutually beneficial outcome while maintaining the integrity of all partners.

8.2. Principles

Based on the above definition the following principles to facilitate effective partnerships apply at all levels of interaction.

8.2.1. Recognition of comparative strengths and limitations of partners leading to clearly defined roles and responsibilities; and

8.2.2. Mutual transparency; and

8.2.3. Need for effective communication among all partners; and

8.2.4. Acceptance of diversity of choices and options; and

8.2.5. Building consensus through regular consultation; and

8.2.6. Respect for local initiatives and autonomy; and

8.2.7. Shared ownership; and

8.2.8. Whenever appropriate, partnerships should be inclusive and enabling.

8.3. Potential Constraints

It is important to recognise the multiplicity of different types of partnerships. Each of these partnerships may pose specific constraints.

Among partners there may be competitiveness for resources, target groups, ownership and identity. Though competition can be a positive phenomenon, it should not obscure the common objective of achieving improved health status.

There are existing inequalities among partners at all levels (such as donor-recipients, formal-informal sectors, male-female). These inequalities should be recognised and addressed especially at the community level.

Institutional bureaucracies may inhibit interaction among partners.

There may be differing perceptions due to social, cultural, economic diversity.

8.4. Types of Partners

Partnerships in the context of Health Reforms are frequently developed with one or more of the following partners:

A. Communities
B. NGOs
C. Missions
D. Private Sector
E. Intersectoral
F. Donors
G. GRZ

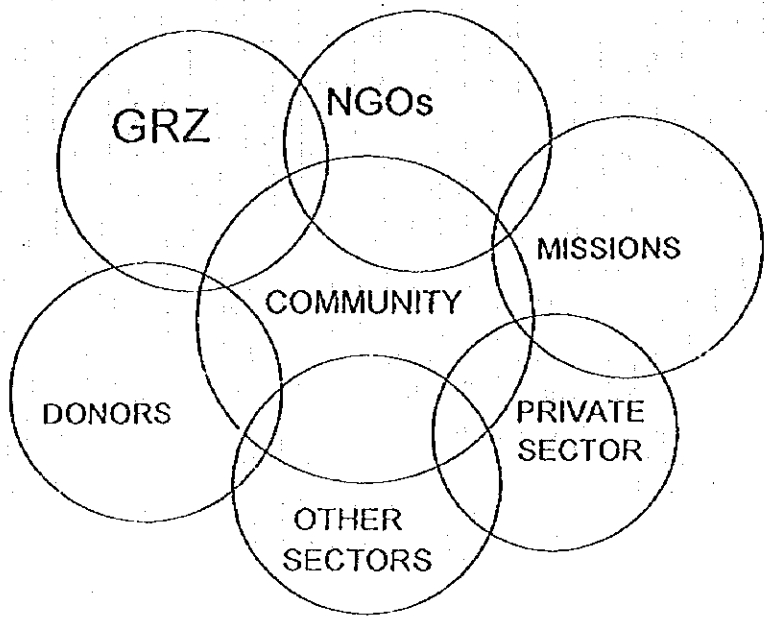
Partnerships express themselves though a complexity of direct and indirect relationships, horizontal and vertical interactions, multi-partner partnerships, and multi-level dimensions. Levels where partnerships exist and can be expanded to support Health Reforms include:

- local (household/community/health services, partners)
- district (boards, management teams, health services, partners)
- region (management teams, partners)
- national (boards, management teams, partners)

While it is not possible to fully depict these complexities on paper, the following diagram attempts to demonstrate that local-level Zambian communities are

intended to be the central partner and beneficiary of all partnerships.
The diagram also reveals the interlinkages between all partners and highlights the importance of promoting effective partnerships.

Fig. 1. Types of Partners



8.5. Partnership Enhancement Strategies

This section describes specific partnership enhancement strategies that could be adapted and applied with any number of partners at any level of activity.

A. Use participatory methods to:

1. Identify stakeholders and partners.
2. Identify common challenges and problems.
3. Identify common vision/goals.
4. Develop roles and responsibilities.
5. Develop strategies.
6. Develop implementation/action plan (including indicators).
7. Review and monitor progress and modify the action plan.

B. Methods for formalising partnerships:

1. Committees
2. Boards
3. Memoranda of Understanding
4. Registration/legalisation
5. Contracts/grants
6. Working groups

C. Exchange of experiences and lessons learnt:

1. Establishment of resource centres
2. Establishment of fora for sharing experiences
3. Cross fertilization exchange visits

D. Partners share and promote supportive publicity:

1. Media
2. Bulletins/newsletters
3. E-mail
4. Other publications

E. Funds to support partnership building

F. Incentives to reward successful partnerships and create enabling environment.

G. Skills/training/capacity building for partnerships (eg training for

transformation)

8.6. Rationale for Implementation Plan

A. Community Partnerships Activity

Summary of the ongoing HRIT Community Partnerships Activity.

Organize TOT of partnership methods such as DEP, VIPP (Visualization in Participatory Programmes) and base on local initiatives.

B. Partnership Promotion Information Sharing

Establish resource/information centres at national, regional and district levels.
Start e-mail conference and get connections at all levels.
Cross-fertilisation visits including partners - districts/health centres (to be organizes by RHO).

C. Resources to Promote Community/District Innovative Partnerships

Ideas for terms of reference for how MOH could coordinate this.

The Community/District Innovation Fund aims at providing facilities to District Health Management Teams in Zambia to embark on innovative programmes working in the spirit of Health Reforms. The funds supplied to districts are given on top of the regular budgets for district health services. The results of such innovative programmes to be funded will be used nationwide to improve and refine the National Health Packages.

D. District Capacity Building to Promote Partnerships

Guidelines and manual for district level inventory of partners.

After training health staff in participatory methods through capacity building, they should adapt participatory planning processes.

Reorganize DHMT/technical committee to include partners (review and advice Minister on composition of Boards to include partners).

E. National-level Partnership Promotion Working Group

Review process/success of former working group
Re-establish a broadbased partnership promotion working group at national

level.
Ideas for the terms of reference of this group.

F. Public/Private Partnership in Health

The conference "Public/Private Partnership in Health" took place in Siavonga in June, 1995 and was attended by about 60 participants representing relevant agencies from GRZ, the Ministry of Health, Donors, and other key stakeholder groups e.g. Traditional Healers, Unionist, etc.

The objectives of the conference were:

1. To provide a forum for the Public and Private Sectors to communicate with each other.
2. To identify actual and potential areas of collaboration.
3. To identify contraints and solutions to Private Sector development, and recommend critical next steps.

Areas of Public/Private Sector linkages were identified. They includ in broad terms activities of the Public Sector (both in financing and provision) that would have impact on Private Sector behavior, taxes and subsidies, regulations, franchising and contracting arrangements.

Interests and expectations of each sector were identified in general and areas for possible collaboration were explored. Franchising and contracting were identified as promising areas for collaboration.

At the end of the workshop recommendations and plan of action were based on the following broad categories:

a) Political and Legislative Constraints
b) Strengthening Public/Private Linkages
c) Financial and Economic Constraints
d) Human Resources Constraints
e) Removing Constraints to Commodities, Medical Supplies, and Pharmaceuticals
f) Action Plan: an activity plan was drawn whose lead time covered anything from 3 months to 5 years.

A task force of five members drawn from Ministry of Health, GPs, THPAZ, CMAZ, ZCCM, the representatives of consumers and the University would be appointed to work with the Ministry of Health on the follow-up of

implementation with conference recommendations.

8.7. Implementation Plan

A. Organize TOT of partnership methods such as DEP, VIPP (Visualization in Participatory Programmes) and base on local initiatives.

B. Establish resource/information centres at national, regional and district levels.

C. Re-establish a broadbased partnership promotion working group at national level.

D. Solicit and coordinate funds under MOH for promotion of partnerships (e.g. District Innovation Fund; Community Partnership Fund).

E. Guidelines and manual for district level inventory of partners.

F. After training health staff in participatory methods through capacity building, they should adapt participatory planning processes.

G. Reorganize DHMT/technical committee to include partners (review and advice Minister on composition of Boards to include partners)

H. Start e-mail conference and get connections at all levels.

I. Cross-fertilisation visits including partners - districts/health centres (to be organizes by RHO).

J. Follow-up public/private symposium and establish a focal point in MOH to guarantee follow-up (refer to recommendation in June, 1995 Siavonga Report).

CHAPTER NINE: FINANCIAL AND ADMINISTRATIVE MANAGEMENT SYSTEMS

9.1. Financial and Administrative Management Systems

The ultimate goal of the Financial and Administrative Management System (FAMS) is to make transparency, accountability and effective and efficient use of funds prevail in the Zambian health sector. In order to achieve this, one, joint, simple, comprehensive, timely and reliable system for planning, budgeting, accounting, store keeping, financial and progress reporting for all levels of the health sector is utilized.

The Financial and Administrative Management System is in the first place intended to streamline and rationalize the cycle of planning, implementation and assessment within the Ministry of Health. The system facilitates analysis following traditional accounting lines (cost-items), as well as analysis following health programmes (cost-centres). The FAMS is also intended to enable donors to contribute to the Zambian health sector meeting donor requirements for disbursement, accounting and reporting, without overburdening the Zambian health sector with extra procedures.

Conditions for Effectiveness

The following criteria must be met in order to widen donor committment to providing financial sup[port to one GRZ MOH Budget:

- Funds are utilized on agreed-upon purposes at all levels
- Management of funds meet international standards on accounting and reporting
- A budget steering committee is put in place and operational with a strong monitoring capacity with a final responsibility for:

  - approving and authorizing all expenditures and disbursements by the MOH
  - approving consolidated financial and progress reports

- A strong monitoring and internal audit unit is operational in the Ministry of Health
- Reliable external audit are conducted according to international standards.

In order to facilitate the utilization of funds according to agreement, the planning procedure must be clear, both within the Ministry of Health (Districts, Hospital Boards, Central Health Board) and between the Ministry of Health and donors. The yearly planning process should end in a kind of "contract" between Ministry of Health and all Health Management Boards. In this "contract" conditions may be put in place, e.g. Districts Health Boards may spend a maximum 20% on allowances, or at least 50% percent of the district budget is spent at Health Centre and

Community level.

Equally donors and Ministry of Health will make a mutual commitment on funding and spending of funds, that is, agree upon a sufficiently detailed budget from which only specified percentage deviations between line items is allowed.

The budget steering committee mentioned is to be established within the reorganized Ministry of Health or Central Health Board. The budget steering committee may delegate tasks to sub-committees or units within the Ministry or Central Health Board. At present the task of approving disbursements and the task of consolidating reports is delegated to two different committees. External audit will be conducted by the Auditor General of Zambia.

Implementation of FAMS

FAMS was introduced in 1991 with the piloting of direct funding to district health services, and has since then gone through a number of stages of refinement. FAMS has so far c. . .entrated on the District level.

The following elements are being developed under the FAMS programme:

a) A uniform system for planning, budgeting and management
b) A uniform system for store keeping and pharmaceutical procedures.
c) Accounting and financial reporting.
d) Progress reporting and performance audit
e) Audit and Internal control

Each of the elements is elaborated below, including a time frame for implementation

a) A uniform system for planning, budgeting and management

District level (District Office, 1st Referral Hospital, Health Centre, Community) :
The format for planning and budgeting has been developed and implemented. This part has been operational since 1993. Management Guidelines have been worked out. Final approval is expected in October 1995.

Provincial level:
The format for planning and budgeting has been developed and used experimentally since 1995. The format will be fully implemented in all provinces from January 1996 onwards. The new roles and responsibilities for the Provinces have been defined, and are worked out under the PCB programme.

Hospital Management Boards:

A format for planning and budgeting has been worked out, was used experimentally in 1995 and will be implemented fully from July, 1996. Development of Management Guidelines has started, and is expected to be finalised by 2nd quarter 1996.

Ministry of Health Headquarters/Central Board of Health:

A draft format for planning and budgeting has been worked out, and is expected to be utilized from January 1996, or soon afterwards.

b) A uniform system for store keeping and pharmaceutical procedures.

Audits carried out have shown that there is an urgent need for a uniform system for store procedures of all kinds of goods at all levels. A situation analysis of the problems has been made.

District and Province level :

Draft forms for store keeping have been developed, and will be pilot tested in October/November 1995. Stores Guidelines are being developed and training will take place in December 1995/January 1996. Immediately thereafter new procedures will come into place.

Hospital Management Boards:

Forms and guidelines for stores procedures will be implemented from July 1996.

Ministry of Health Headquarters/Central Health Board:

Forms and guidelines for stores procedures will be implemented from July 1996.

c) Accounting and financial reporting.

District and province level:

Formats and training manual (including guidelines) have been finalised, training is being carried out and the new system will be fully implemented by January 1996. Districts are submitting quarterly progress and financial reports, via the Provincial Office to MOH/HQ. From January 1996, the Provinces will submit quarterly progress and financial reports to MOH/HQ. Funding for the coming quarter is based on approval of reports over a previous quarter by the budget steering committee.

Hospital Management Boards:

Forms for 2nd referral hospitals have been developed (similar to district level). Forms for Central Hospitals will be developed separately, and are planned to be ready by July 1996. Guidelines will be completed, and the new system is planned to be fully implemented from 3rd quarter 1996, or so much earlier as possible.

Ministry of Health Headquarters/Central Board of Health

Accounting and financial reporting at headquarters' level have two elements, namely consolidated reporting on different Boards, and accounting and reporting on headquarters itself. As far as consolidated reporting for Boards concerns: a draft format for reporting from MOH/HQ to the different Donors supporting the disbursements of funds from MOH/HQ to the different levels/institutions has been developed. A consolidated, quarterly report on district expenditure has been developed and will be fully implemented from January 1996.

With regard to accounting and reporting on units within headquarters, a system can be put in place after the planning format has been accepted. In the course of 1996 as start will be made with a new accounting and reporting system.

d) Progress reporting and performance audit

Dis t level:

Progress reporting formats, based on the budget spread sheet, have been finalised and will be operational throughout the country from January 1996 onwards. All Districts are submitting quarterly progress reports, through the Province, to MOH/HQ. A Performance Audit Checklist is under preparation, will be field tested in November 1995 and is planned to be implemented from January 1996.

Provincial level:

A progress reporting format, based on the budget spread sheet, is being worked out. From January 1996, the Province will submit quarterly progress reports to MOH/HQ. A Performance Audit Checklist is under preparation, and is planned to be implemented from January 1996.

Hospital Management Boards:

Progress reporting format and performance audit checklist is planned to be completed and implemented from July 1996.

MOH Headquarters/Central Health Board

A progress reporting format is under consideration, and may be introduced for all units in the course of 1996, depending on the reorganization of the central ministry.

Consolidated Financial and Progress Reports

Quarterly, the Ministry of Health Headquarters (possibly a small committee under final responsibility of the budget steering committee) will produce a consolidated financial and progress report for all levels of the health services. The report will be presented to the Minister and collaborating partners not later than three (3) months after the end of the quarter. The first consolidated report (as far as possible) will be presented by 30 June

1996.

Yearly the budget steering committee will produce an annual report, consolidating the quarterly reports and analysing the successes and failures compared to the year plans for the previous year. This report will be presented by 31 March every year.

e) Audit and Internal control

High priority has been given to implement proper audit procedures, both financial audit and performance audit, at all levels in the Health Reform. Since the decentralisation process started at district level, the focus started at the lowest level. In 1996, priority will be given to the higher levels, Hospital Management Boards and MOH/HQ.

District level:

Internal control procedures for financial matters are implemented at district level through FAMS forms and guidelines. Internal control procedures for stores will be implemented by January, 1996. Accounting staff from the Regional Health Offices are carrying out two-monthly support visits to the districts.
Internal Audit of the districts is carried out by audit teams from HRIT/MOH. In 1996, training of auditors will be carried out. A systematic internal auditing programme will be put in place. If possible in 1996 all health management boards will be audited.

The Auditor General's Office carried out external audit in 1/3 of the districts in 1995. For 1996, it is planned that the Auditor Generals Office will audit all districts, if possible. This will provide a baseline information. Later the external auditing will be scaled down to random and spot checks, covering a realistic percentage of all institutions.

Province level:

Internal control procedures for financial matters are implemented at province level through FAMS forms and guidelines. Internal control procedures for stores will be implemented by January, 1996. Internal Audit of the provinces is carried out by audit teams from HRIT/MOH. External Audits of the provinces will be carried out by the Auditor General's Office. In 1996 all offices will be audited, to be scaled down later.

Hospital Management Boards:

The HMBs have been audited by auditors from MOH and Auditor Generals Office. Only financial audits have been carried out at this level. In 1996, performance audits will also be carried out.

Ministry of Health Headquarters/Central Board of Health:

The MOH has an audit function, carried out by internal auditors from Ministry of Finance, seconded to MOH. There is an approved programme of work covering districts,

hospital management boards, provincial offices, and head quarter units in principle once per year.

"Basketing" of Funds

The long-term aim is both to streamline and rationalize financial and administrative procedures, and to facilitate the channelling of all financial donor support to the health sector in a simple and efficient way. This provision of un-tied financial support to the MOH budget (or in the interim, the district grant and/or provinacial grant componnets of the budget) has become known as "basketing". When FAMS forms, procedures and guidelines are all in place, it is envisaged that the Ministry of Health and the different donors to the Health Sector can move closer towards fully "basketing" their funds. This implies that donors will support the Health Sector by financing a single, agreed-upon budget administered by the Permanent Secretary, MOH.

The proposed disbursement procedures are:

Donors will be asked to disburse to the MOH quarterly . The contribution from each Donor will depend on the Donor's commitment to the total budget.

- Monthly the Ministry of Finance makes disbursements to the Ministry of Health account.
- Each month, money will be disbursed to districts, hospitals, provincial offices or other units according to recommendations or approvals of funding. The boards or units approved for funding will receive one cheque from MOH Accounts Unit.
- At the receiving end, one account will be kept, and one financial and progress reports.

Procedures for reporting:

It is planned that the different financials supporters of the MOH budget will receive the following reports from the MOH, submitted not later than three months after the end of each quarter:

Monthly bank statements on the individual donor account.
Bank reconciliation statement on the individual donor account.
Monthly bank statements on all accounts.
Bank reconciliation statement on all accounts.
Quarterly reports on disbursement of funds to the different districts, hospital boards or units showing each contributor's share of the total disbursement.
Consolidated report on expenditure for the quarter ended three months earlier.
Consolidated report on district, hospital or unit performance, based on progress reporting and performance audit by higher levels.

The Budget Steering Committee will be responsible for approving the reports before forwarding them to the donor organizations.

STEP BY STEP INTRODUCTION OF BASKET FUNDING

Since the FAMS for the Community, Health Centre, 1st Referral Hospital and District Office levels will be fully in place by January, 1996, a number of donors to the Health Sector are ready to "Basket" part of their funds for suppoprting the recurrent costs of district level health services from 1 January 1996. Though this restriction of basketing to one level of the health services is a compromise, it enables the collaborating partners to gain experiences on "basketing". As a measure of transition, the District budget and Provincial/PCB budget will be managed separately, in order to keep procedures of disbursement, consolidation of reports simple. Also, the pace of introduction is not equal for both levels.

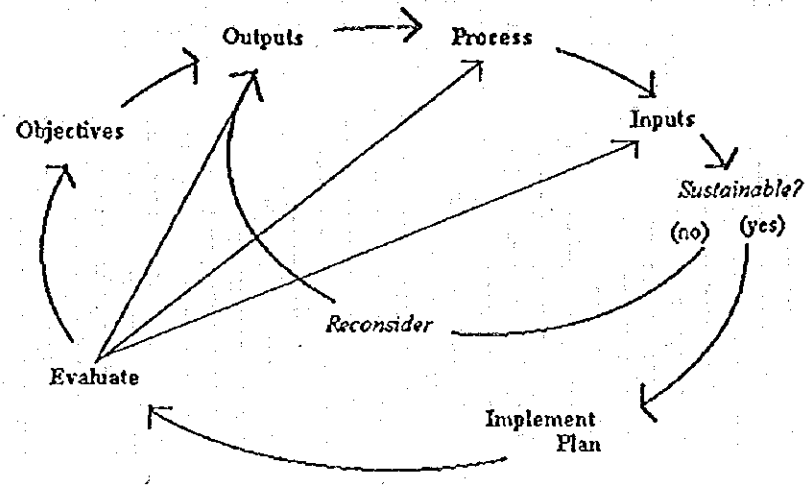
The vision of one "basket", i.e., one comprehensive MOH is a long-term aim. Successful experiences in 1996 will be crucial for convincing donors to move towards this aim.

FAMS INSTITUTIONALIZATION

1996, a start will be made with the creation of a Health Monitoring and Evaluation Unit within the Ministry of Health. It is envisaged that gradually activities related to the FAMS, presently carried out under the HRIT, will be incorporated in this unit. As accountability has a great deal of monitoring in it, the choice for incorporation in the M&E Unit is a logical one. In the FAMS, the linkage of financial and progress reporting is an essential element. Clearly, the M&E Unit will have very strong ties with the accounting unit and the planning unit, as both units are equally strongly involved in FAMS.

In 1996 the FAMS working group under the HRIT will anticipate the integration, and will work closely with MOH Units related to the FAMS programme.

CHAPTER TEN: MONITORING AND EVALUATION



10.1. Introduction

The goal within the reformed system is to *establish a self-sustaining monitoring and evaluation system which will improve decision making at all levels of the system with timely, valid and appropriate information required to increase the effective utilization of quality health services.*

The intention is to monitor and evaluate implementation of the plan through a process of constantly assessing whether standards are being met and maintained, and to review their appropriateness. This will require an assessment of:

- the ability of the system to achieve standards - producing the anticipated outputs, functioning according to prescribed processes, and utilizing inputs as intended;
- the accuracy of the assumptions made regarding the linkages between the use of inputs, processes (or system organization and structure), and outputs;
- the accuracy of the assumptions made between regarding the linkages between outputs and outcomes are supported by anticipated changes in health status.

Achieving the new standards defined within this Strategic Plan at the household, community, health care facilities, and management and support institutions for the use of inputs, processes and outputs will be determined by quality assurance (adherence to

standards). Whereas the linkages between outputs, processes and inputs is a measure of whether the defined standards are realistic. The linkage between outputs and outcomes is critical. In order to actually achieve the goals of reform, the outputs produced by the health care system must be those which will most cost-effectively achieve the desired outcomes.

The maintenance of standards will be monitored through programmatic and financial accounting, as well as assessments of whether systems are organized as defined. Poor adherence to specific standards may indicate incorrect assumptions about the ability of the input standards combined with the process standards to produce the expected outputs. Assessments will have to be made as to whether realistic and achievable standards have been defined. Consistently poor adherence to standards will indicate a need to consider whether sufficient support has been provided for each level of the system to meet standards, or whether standards are unrealistic (e.g., the unit cost was underestimated or planned system organization does not sufficiently support the maintenance of standards.

The major *parameters* to be monitored and evaluated include:

(a) COVERAGE with the essential package of health services.
(b) Provider and client perceptions on quality of health services.
(c) Management and development of human resources.
(d) Availability of drugs and supplies.
(e) Status of infrastructure, equipment and logistics.
(f) Morbidity and mortality rates.
(g) Equity (including gender issues).
(h) Financial (costs and expenditures).
(i) Health Reforms Process

10.2. Implementing Standards

The design of the reformed Zambian Health Care System describes standards for formal institutions as well as the household and community. Although these standards (adapted at district level, and approved by the central MOH) will be mandatory for institutions receiving government funding, the effective implementation of the system also depends upon the maintenance of standards by individuals in the community. Certain preventive and curative health care actions are expected to be performed in the home or community, and referral to the first level of the system (and not by-passing levels of referral) is expected to occur when conditions present which require care from the formal sector.

Standards for health care at the household and community address what health care

needs will be provided for at the home or with the assistance of a Community Health Worker, what inputs (information and supplies) are required to produce these services, and when individuals should be referred to the first formal level of the health care system. The Ministry is considering ways of encouraging appropriate health care seeking behaviour. Employing user charges to dissuade individuals from by-passing the referral system, and social marketing quality health care services at the health centre will help ensure that communities follow the standards of the reformed system. Information and education strategies will be critical for enforcing standards at the household and community level, as will the support (provision of Community Health Workers, availability of materials and supplies, access to chloroquine, ORS, contraceptives) necessary to enable communities to achieve and maintain the standards of the reformed system.

The private sector will also be encouraged to operate according to national standards. Through providing information on cost-effectiveness, and efficiency, the Ministry of Health will actively encourage the private sector to complement public sector efforts to ensure the provision of the essential package of care to all Zambians. Those private institutions which receive public resources will be treated similarly to the National Institutions in that the Government of Zambia will only finance services which are defined within the essential package of care.

Government institutions will be monitored against established standards, and allocation of financing to districts will be dependant upon maintenance of standards.

10.3. Organization of Monitoring and Evaluation

The current situation is very disaggragated. The Planning and Management Unit has a Health Information Unit whose mandate focusses on the compilation and dissemination of health statistics, and the auditing and accounting offices which monitor resources and expenditures at the national level. The HRIT encompasses the Financial and Management System project in the HRIT which collects financial and performance data from district and provincial level; the Health Management Information System project which has begun developing computerized systems for collecting, compiling and, when appropriate, transmitting information from communities, health centres, districts and provinces; and large-scale data collection and storage projects for human resource and infrastructure. Monitoring systems for drugs are also likely to be developed within 1996, under a "project"

What is clearly essential in order to move towards the vision, is the coordination of all of these activities. Although, data collection, storage and use will continue to be managed, supervised and used by different units and levels, some "umbrella" is required. A single Monitoring and Evaluation Office would represent an understanding of the

broad range of disciplines reequired: epidemiology, statistics, accounting, computer programming/data management, etc.

The justification for the new office:

- The existence of a single umbrella office headed by a senior person would enable the institutionalization of current donor-financed *projects* which must become part of a programme - specifically, FAMS, HMIS, human resource development database and infrastructure databases.

- The coordination of financial and programmatic monitoring and evaluation would enable better informed decision making at all levels.

- It may be the only way to more efficiently and effectively respond to mutiple demands for information (from donors, researchers, MOH staff and others), for example, by producing a single joint monitoring and evaluation system, producing comprehensive quarterly and annual reports, and implementing a single donor annual review each spring.

Responsibilities of the new Office which will be in charge of Monitoring and Evaluation include:

- Coordination of the broad range of activities which acquire, develop, analyze and use health and management information.

- Produce and disseminate quarterly reports and annual reports

- Coordinate and oversee all of the following:

  - Health Systems Research
  - Health and Management Informations System
  - National Health Survey and Demographic and Health Survey
  - Performance audits
  - Databases on human resources and infrastructure

- Forming effective linkages with the following:
  - Surveys conducted by other institutions or ministries - FANIS, LSMS
  - Financial Auditing and Accounting

The Ministry of Health shall within this corporate Monitoring and Evaluation function be responsible for:

- Defining and examining precision of monitoring and evaluation indicators.
- Establishing baseline data on health status and updating the data periodically.
- Establishing and reviewing national disease surveillance systems.
- Reviewing and approving integrated reporting formats.
- Approving changes in National and District health information system.
- Facilitating the HMIS in Data processing, analysis and dissemination of results.
- Selective and random field monitoring of activities in collaboration with relevant units (e.g. QA, Regional HMIOfficers etc).
- Compiling annual monitoring and evaluation report.

The accounting unit shall be responsible for monitoring the accounting system using defined indicators as part and parcel of the management information system. Performance of the accounting system will be the monitored by financial auditing system.

A Regional HMI Officer shall within the HMIS framework be responsible for:

- Drawing a programme for monitoring and evaluation (performance audit) of all districts in the province.
- Orientation of the Provincial team to monitoring and evaluation activities.
- Data processing, analysis and feedback to districts.
- Drawing and implementing a training programme to upgrade skills of district staff in monitoring and evaluation.

The District Health Office shall within the HMIS framework be responsible for:

- Orientation and training of Health Centres in collection and use of health information.
- Monitoring use of health information by health centres in drawing up health plans.
- Data collection, analysis and disseminating results.
- Compiling district monitoring and evaluation reports based on agreed indicators.

As systems development continues to evolve the Health Sector's monitoring and evaluation work shall require suitably qualified personnel to run efficiently as well as effectively. Members of the Monitoring and Evaluation Group (most of whom also serve as members of the HMIS Management Group) determine the human resource requirements at headquarters, provinces and districts in view of the functions of disease surveillance, improving information access and dissemination, as well as research.

Computerised resources centres are in process of being established at MOH and all Provincial Offices to facilitate the process of documentation, information sharing, and ready access.

10.4. Operations Research

The linkage between system outputs (immunization, treatment of infectious disease, household diet) and the outcomes (reduced incidence of immunisable diseases, reduced deaths due to infectious disease and better indicators of nutritional status) requires special studies. Many of these assumptions are validated by international research and experience, but certain alternatives for determining what outputs will most-cost effectively achieve desired outcomes may require specific investigation in the Zambian context (e.g., what strategies will most cost-effectively reduce malarial deaths.

The National Strategic Planning Exercise has identified certain priority areas for research. Those health problems for which little community-based incidence data is available and which have the potential to impact significantly upon the costs of the system are being identified. Strategies for giving responsibility for more sophisticated care to auxiliary health workers and/or developing new positions for outreach workers will need to be pilot tested. The area of financing demands immediate attention. Information on household expenditures, willingness to pay, and its temporal relationship to improvements in quality, the resource generating potential of financing schemes, and the affect of cost-sharing on equity must be explored before final decisions on financing strategies can be defined.

10.5. Periodicity and formats for assessment

An intention in 1996 is to develop a single Monitoring and Evaluation Process which would meet the needs of all users, including all donors.

Achieving a unified system for reporting to all donors will require an:

- assessment of existing demands/reporting requirements by donors
- willingness on donors side to compromise on what information and what format they require
- committment made by each donor to limit evaluation missions to the scope, scale and time scheduled each March or April by the ministry
- a joint MOH/donors team for developing a proposal which could be presented to all donors.

The description of national standards will be continuously improved through monitoring their implementation, feedback from the districts through their district

plans, and refinement of the information used to draft the national standards. The process of defining national standards will never be completed as they must constantly be adapted to reflect the needs and resources of the nation.

10.6. Indicators

Under the HMIS project the requirements for setting up the system have been defined; the subsystems for generating and using information at the level of collection shall be developed as phase two gets implemented. While HMIS takes time to develop, transition from the existing information system shall be managed based on a strategy and process currently being studied for concrete recommendations by an external consultant. Indicators for monitoring the parameters during transition were defined in 1994. In the final analysis a fully developed HMIS shall keep track of indicators for monitoring the defined parameters and hence constitute an integral part of overall sectoral monitoring and evaluation.

Indicators for monitoring in 1996 are selected with a focus on what is achievable and what is realistically feasible. The aspects to be tracked are based on the following guide:

Selected indicators for monitoring in 1996

Aspect	Critical activity	Indicator
Decentralisation	Publish statutory instrument providing for legal establishment of District Health Boards and Central Health Board.	
	Minister's authorisation for reorganising Ministry of Health using a reformed structure presented to Cabinet Office.	
	Permanent Secretary circular directing on procedure for reorganisation of District Health Office issued based on reformed structure.	
	Permanent Secretary circular directing procedures for reorganisation of provincial medical offices issued based on reformed structure.	

	Districts, provinces, and Central Health Board compliance to the new Financial and Administrative Management Systems evidenced in planning, budgeting and reporting system.	
	Districts compliance to approved District Health Management Guidelines-1995 verified during performance audit.	
Process of Health Reforms	MOH/HRIT Integrated Work Plan for 1996 tracked using defined process indicators during quarterly performance audit.	
	Integrated performance audit checklist put into routine use.	
	HRD - Initiation of training for Polyvalent Health Workers.	

Aspect	Critical activity	Indicator
Process of Health Reforms	Essential health package components incorporated in 1996 planning.	
	Health Financing Policy approved by Minister.	
	Drugs policy document produced and approved by Minister.	
	Political committment and leadership - A concrete strategy document and guidelines on leadership developed and adopted by ministerial policy makers.	
	HMIS - Training plan for orientation to a new integrated information system developed based on the essential health package.	

	Partnership development promoted to cover at least 50% of DHMTs in each province	
	Unified reporting, accounting, and auditing system adopted and used in the context of 'basket' financing.	

A principle is that most data will be for use at the point of collection and frequency will be determined according to the new HMIS. Transition from old system to the new system is in the process of being defined.

PART FOUR

HEALTH CARE FINANCING

CHAPTER ELEVEN: Financing

CHAPTER ELEVEN: FINANCING

11.1. Introduction

To reduce the financial shortfall in the Zambian health sector, action is required on several fronts simultaneously. In the public sector, more revenue is clearly needed for public health goods and services. The increase in political commitment to health, evidenced in the increased share of Government expenditure from 8% in 1993 to 13% in 1994 must be maintained. The current strengthening of the tax system will also hopefully improve the future tax base for public expenditure as a whole. Equally important is the need to make better use of available public funds by reallocating them from expensive curative care to preventive and primary health care, and increasing the efficiency with which existing resources are used. Avenues for mobilising increased resources from the private sector in the form of out-of-pocket payments must also be explored.

Vision: **To mobilise resources through appropriate and sustainable means, and to ensure efficient use of those resources, in order to guarantee equity of access to cost-effective, quality health care as close to the family as possible**

The Government is committed to the provision of an essential package of cost-effective quality health services as close to the family as possible as described in Chapter 2. In the current economic climate in Zambia, Government budget estimates far exceed revenues, and projections for 1996 indicate that funds available for non-salary expenditures will be significantly less than in 1995. Commitment to the health sector as evidenced by the GRZ budget was slightly reduced in 1995, with only 12% being allocated as opposed to 13% in 1994, but corrective action has been taken by the Ministry of Finance through the increase to 14% in 1995. Action to mobilise resources from a variety of sources is therefore critical for the successful delivery of the package, although in the context of a high degree of poverty (69%) among the Zambian population, sensitivity must be exercised in the design of health financing mechanisms.

Available funding sources may be divided into three categories:

- internal public funds (Ministry of Health, other Government departments)
- external public funds (multilateral and bilateral donor agencies)
- private funds (NGOs, household out-of-pocket expenditures etc)

In the absence of sufficient funding to meet all demands upon the health sector,

clear principles for the allocation of the scarce available funds among the competing needs must be applied within the Ministry of Health. Public funds, both internal and external, will be employed guaranteeing a package of services which prioritises important public health activities, such as health promotion. Cost-effective interventions for conditions which represent a significant burden of disease in Zambia, together with necessary management and support activities will also be supported under the packages. Private funds will be channelled towards services with a more "private" benefit, and which therefore fall outside the "package", e.g., open heart surgery, radiotherapy and treatment outside the country.

11.2. The 1996-1999 budget

The allocation given by MOF to MOH for 1996 represents a gross underfunding of the estimated needs for MOH to keep the levels of quality and services given in 1995. The allocation to the MOH has decreased in real terms in comparison to the 1995 budget allocation. The allocation in 1995 amounted to K55,657,595,000 (excluding donor funding). The allocation from MOF for 1996 amounts to K60,470,000,000, which is a decrease in the funding in real terms. Using estimated exchange rates for 1995 and 1996 respectively, the allocation for 1995 amounted to USD 79,510,730 (using the estimated exchange rate of USD1=K700) in comparison to USD 64,047,000 for 1996 (using the estimated exchange rate of USD1=K1000) However, the estimated need for MOH for 1996 amounts to USD 86,714,855, which implies a gap of USD 26,244,855 (see further Annex A). In per capita terms, the allocation in 1995 amounted to USD 8.83 whereas the allocation as given by MOF for 1996 is USD 6.37, thus highlighting the real decrease. The estimated need for 1996 in per capita terms is USD 9.1.

Table 11.2 Government Health Expenditure by level 1994 - 1996

	1994	1995	1996
MOH HQ & Province	10.04%	7.25%	7.55%
Hospitals (2nd and 3rd ref.)	42.35%	42.84%	36.86%
District services	41.84%	44.47%	51.76%
Other	5.77%	5.26%	3.84%
TOTAL	100%	100%	100%

The estimated need of USD 4.65 per capita for district services is in addition to the allocation of USD 1.49 per capita that is allocated by donors to contribute to district funding. The donor contributions to districts include basket funding by Danida, Sida and UNICEF, support for drugs, vaccines etc. by Sida, UNICEF, IDA, DGIS and others.

1996 allocations to districts were based on a per capita figure of $2.00, at the exchange rate of $1:K1000 which prevailed at the time the budget estimates. These figures were then weighted according to population density, following the classification of each district as either high, medium or low density. High density districts were given an 80% weighing, and low density districts a 120% weighing, in order to reflect the assumption that a number of costs such as transport, costs are lower in a more densely populated district.

In 1996, funding is again being channelled to districts on the basis of a formula, but with the addition of weightings reflecting immunisation coverage, cholera proneness, and an index of fuel prices. Hospitals are being funded on the basis of bed capacity and occupancy, and the size of any training school. It is recognised that this is less than ideal, but in the absence of accurate cost information it represents an improvement in transparency compared with previous years.

The 1996 budget allocation represents a further reallocation of the budget from central levels to more decentralised levels, where health care services can be provided much more cost-effectively. The allocation to districts has increased, and is based on the desire to uphold the bare minimum of USD 2 per capita for running costs at district level (excluding expenses for drugs and salaries). The break down of the districts' estimated requirement for 1996 are shown in Annex A. The allocations to provincial levels (including provincial offices and general hospitals) are based on an increase representing the estimated inflation of 15% for 1995. Allocations for central hospitals (including UTH) and the MOH HQs have been reduced in both real and nominal terms.

The major reasons why the estimated budget need for 1996 has increased are:

- Personal Emoluments (PEs, which includes salaries, bonuses, allowances etc.) have increased from K13,500,000,000 to an estimated K37,500,000,000. This increase is mainly due to a 30% increase in salaries for civil servants and a 300% increase in salaries for medical doctors during 1995. This increase was financed by supplementary allocations from MOF for 1995, but has not been sufficiently reflected in the 1996 budget. Expenditures for Long service bonuses and travelling on leave were not included in the 1995 budget estimates, which has caused problems and severe complaints during the year. The long service bonus is a condition of service and is therefore not possible to exclude or reduce. For 1996, estimates for these have been included, and amount to K2,300,000,000 for all levels of the health care system (see further annex B). PEs represented 25% of the total budget in 1995 whereas it represents

62% of the budget allocated by MOF in 1996.

- Allocations for students at hospitals have increased following a decision by the Minister that students should not contribute to the costs of their education. K300,000 per student and year was allocated in 1995 whereas the allocation for 1996 amounts to K1,026,000 per student and year. The total increase for students is K1,9 billion (shown under "training" in annex A).

- The increase in the budget for MOH in Kwacha amounts to 7.8%, whereas the inflation for 1995 is estimated at 15%, thus representing a real decrease in the funding. In addition, the exchange rate changed from an estimated USD1=K700 to USD1=K1,000, which represents an increase of 43%.

In order to solve some of the Ministry's problem of underfunding in 1996, it is being recommended that donors revise their plans, and consider reallocating some of the funds to support the running costs in the district, e.g. through joining the basket funding. Some suggested areas for reallocation of donor funding are summarised in Annex C "Possible areas of negotiations with donors to increase financial support to districts, 1996".

11.3. The financial plan 1996-1999

In appendix A is shown the estimated budgetary need for 1996 to 1999 as well as the estimated gap. The estimations are based on further reallocation in the budget from central levels to lower levels. The gap is based on the difference between the estimated need as calculated by MOH and the budget allocation as given by MOF. The estimated need for MOH is based on the desire to keep the USD 9.05 per capita constant over the years. The reallocation between levels continued over the years, as shown in the tables. The budget allocations are based on the following assumptions:

- The population increase is based on an estimated national average of 3,2% per year (except for 1996 where it is based on the total increase per district).

- The share of the total GRZ budget for health as indicated by MOF amounts to 14.2% for 1995, and is thereafter increased by 0.1 each year. It is assumed that the total GRZ budget in USD is constant over the period. In case of an increase in the GRZ incomes, the allocation from MOF will increase and thus the gap will decrease. On the other hand, if the total GRZ revenues decrease, the gap will widen as the total allocation by MOF will be lower.

- It is estimated that the efficiency in the budget will increase over the years as PEs will stay stable and thus allowing for an increase in allocations to service provision.

- The estimated gap has been identified based on the assumption that DANIDA, SIDA and UNICEF are contributing to the basket funding and that DGIS, IDA, UNICEF and SIDA are allocating funds for procurement of drugs, vaccines etc.

(b) Donor funding

Donor funding up to and including 1994 was largely in line with individual donor priorities, and channelled to recipients for specific activities or items through a variety of mechanisms - directly to districts, to institutions within districts, to individual programme areas, through the Ministry of Health, or through NCDP in the form of capital projects. One exception to this was direct recurrent budget support included within the DANIDA programme from October 1993, and provided through ODA, EEC, UNICEF and SIDA for the third quarter of 1993.

Mobilising private resources

i) Short-term strategy (to mid-1996)

Given the current situation of widespread poverty in Zambia (54% "core poor", and 69% very poor), in the short term the Government will guarantee the financing of the essential package at all levels through public funds from GRZ and the donor community.

- A nominal fee will be charged at the lowest level of the reformed health system for access to the essential package. This is justified on three grounds:

  efficiency: to promote rational use of the health system
  partnership: to foster a sense of ownership among the population in order and to encourage demands to be made in terms of quality
  educational: to sensitise the population to the fact that health care costs money

- The fee will be determined at local level, through consultation between health post staff and community members in order to reflect ability to pay, and subject to a ceiling determined by the Central Health Board *(possibly varying between areas?)*

- The fee will be linked to receipt of treatment rather than consultation to reflect consumer willingness to pay for quality (as proxied by availability of drugs)

- The first visit by a patient to any health facility will incur a higher fee in order to encourage continued attendance at the same facility. Justifications for this

include:

- administrative cost of establishing new patient medical records
- benefits in terms of continuity in diagnosis due to availability of complete medical history
- the principle of per capita-based allocation of public funds for the health sector

- Bypass of the referral system is to be discouraged through imposition of a penalty fee subject to a given quality of care at lower levels *(how should the penalty fee be set?)*

- In order to overcome seasonal fluctuations in the cash income of household, prepayment of the nominal fee will be an option. This will entitle the patient to a given number of contacts with the health system. *(further work to be done on cash and in-kind options)*

- Secondary and tertiary level referral facilities will offer high cost options for all health services. Fees for services within these high cost wings will be set at full-cost recovery levels + profit.

- Monitoring mechanisms to be established immediately to enable assessment of the fee system. Specific issues for monitoring:

  - individual household expenditures over a year to determine whether any ceiling should be set on these
  - referral patterns to ensure no shifting of burden of treatment to higher levels

ii) Medium-term strategy (July 1996 - end 1997)

- the current prepayment scheme is not sustainable in the long run and therefore evaluation should be undertaken and research is required to design a new model

- Establishment of insurance scheme for services outside the esesntial package *(social or private? - for further discussion)*

iii) Long-term strategy (1998 onwards)

- identification and establishment of appropriate health financing mechanisms to cover the essential package (subject to analysis of acceptability of essential package and appraisal of options)

The main options for supplementary resource mobilization highlighted in the policy are:

- **Health insurance**, focusing at an initial stage on a compulsory scheme for formal sector employees and their dependents:

  The three recommended components of health insurance are:

  (a) Immediate private insurance options for services outside the package, e.g. low cost effectiveness interventions, care, of the sick outside Zambia.

  (b) Development of insurance options for those able to pay for the essential package (private or social)

  (c) Exploration of options for (social) insurance in order for long term financing of the essential package for those unable to contribute in other ways.

- A prepayment scheme, to be introduced on a voluntary, national basis to serve the informal sector in rural and urban areas;

- User fees, to continue at a nominal level at the primary level in order to serve as an incentive for joining one or other scheme, and at full-cost recovery rates (or higher) for services outside the essential package:

- Locally initiated community financing schemes to supplement the above.

1996 Ministry of Health financing gap

The 1996 financing gap was estimated at US $86,530,368. The breakdown is as follows:

(a)	Capital	US $61,530,368
(b)	Recurrent	US $25,000,000

For detail refer to chapter 12 - implementation.

The Ministry of Health is working together with the Ministry of Community Development and Social Services to strengthen existing mechanisms for meeting the health care needs of the poor. A prepayment scheme whereby funds from the Public Welfare Assistance Scheme are channelled to DHBs on a quarterly basis in accordance with the numbers of "indigent" registered with the District Social Welfare

Office is currently under discussion. Another proposed mechanism for exempting the poor is through official declaration of areas suffering drought or other disasters, and suspension of all fees and schemes during the period of disaster.

PERCENTAGE DISTRIBUTION OF THE MOH RECURRENT BUDGET 1995-1999					
	1995	1996	1997	1998	1999
1b. MOH HQ		2.89%	2.40%	2.00%	2.00%
1a. Central Health Board	5.39%	2.03%	2.00%	2.00%	2.00%
1c. Province	1.66%	2.34%	2.30%	2.30%	2.30%
2. MOH HQ central procureme	1.42%	1.06%	0.00%	0.00%	0.00%
3. Training institutions	1.18%	2.99%	2.00%	2.00%	2.00%
4. UTH Board	13.52%	10.77%	9.00%	8.00%	7.00%
5. Central hospital boards	13.28%	9.35%	9.00%	8.00%	7.00%
6. Statutory boards/bodies	5.17%	3.52%	2.00%	1.00%	0.50%
7. Prov/General hospital board	14.10%	13.84%	14.50%	14.50%	14.50%
8. Others	0.49%	0.37%	0.30%	0.20%	0.20%
9. District health services	43.78%	50.86%	56.50%	60.00%	62.50%
TOTAL	100.00%	100.00%	100.00%	100.00%	100.00%
*Allocations for procurement will appear under each individual level after 1996					

PE estimates for 1996 compared with 1995

	PEs 1995	PEs 1996	Increase	% increase
HQS	577,947,001	1,527,806,807	949,859,806	164.35%
Kitwe CHB	628,761,118	973,056,541	344,295,423	54.76%
Ndola CHB	886,784,147	1,676,192,245	789,408,098	89.02%
Chainama CHB	449,937,092	609,763,160	159,826,068	35.52%
Arthur Davison	202,320,363	436,781,961	234,461,598	115.89%
UTH	1,525,979,775	3,835,009,600	2,309,029,825	151.31%
P/General hosp.	1,102,290,540	3,252,163,096	2,149,872,556	195.04%
PMOs	254,374,740	1,233,989,561	979,614,821	385.11%
Districts	7,122,492,720	22,324,516,028	15,202,023,308	213.44%
Mission inst. *	1,327,746,570	1,686,699,516	358,952,946	27.03%
TOTAL	13,500,687,065	37,555,978,515	23,477,344,450	178.18%

** Mission inst. includes salraies for Mission general hospitals, mission hospitals and mission health centres*

PEs 1996

	Salaries	TOL	LSB	Sub. allowance	ZNPF	Total
MOH HQs	1,304,732,963	28,860,000	34,213,844	160,000,000		1,527,806,807
Kitwe CHB	908,056,541	30,000,000	5,000,000	30,000,000		973,056,541
Ndola CHB	1,267,495,245	50,000,000	80,000,000	278,697,000		1,676,192,245
Chainama CHB	529,755,160	9,000,000	16,000,000	55,008,000		609,763,160
Arthur Davison	416,536,815	7,200,000	13,045,146	0		436,781,961
UTH	3,765,009,600		70,000,000			3,835,009,600
Gen. hosp.	2,268,238,096	247,275,000	172,350,000	558,000,000	6,300,000	3,252,163,096
PMOs	523,439,561	237,150,000	380,700,000	90,000,000	2,700,000	1,233,989,561
Districts	14,656,307,695	2,017,575,000	1,533,133,333	4,087,000,000	30,500,000	22,324,516,028
Missions	1,650,996,868	0	34,702,648	1,000,000		1,686,699,516
TOTAL	25,985,835,581	2,598,200,000	2,304,931,127	5,099,705,000	39,500,000	36,028,171,709

	Yearly allocation	Monthly allocation
Salaries 1995 (based on Aug. salaries)	24,060,958,872	2,005,079,906
Salary increase in 1995	10,560,271,807	

ESTIMATED DISTRIBUTION OF THE MOH REC. BUDGET 1995-1999 IN CONSTANT USD AS ALLOCATED BY MOF					
	1995	1996	1997	1998	1999
1b. MOH HQ		1,746,836	1,461,429	1,226,315	1,234,772
1a. Central Health Board	4,287,497	1,226,586	1,217,857	1,226,315	1,234,772
1c. Province	1,323,202	1,412,112	1,400,536	1,410,262	1,419,988
2. MOH HQ central procureme	1,128,600	639,347	0	0	0
3. Training institutions	940,899	1,806,751	1,217,857	1,226,315	1,234,772
4. UTH Board	10,746,074	6,511,358	5,480,358	4,905,259	4,321,702
5. Central hospital boards	10,557,797	5,656,902	5,480,358	4,905,259	4,321,702
6. Statutory boards/bodies	4,110,726	2,126,211	1,217,857	613,157	308,693
7. Prov/General hospital boards	11,213,843	8,367,199	8,829,466	8,890,781	8,952,097
8. Others	389,893	220,872	182,679	122,631	123,477
9. District health services*	34,812,199	30,755,826	34,404,470	36,789,441	38,586,626
TOTAL	79,510,730	60,470,000	60,892,867	61,315,734	61,738,601
*Including basketed funds, drugs and vaccines from donors 1996					
Share of total GRZ budget	14.20%	14.30%	14.40%	14.50%	14.60%

ESTIMATED NEED FOR RECURRENT EXPENDITURES 1995-99 IN CONSTANT USD					
	1995	1996	1997	1998	1999
1a. MOH HQ		2,484,338	2,128,560	1,828,100	1,900,500
1b. Central Health Board	4,287,497	1,744,442	1,773,800	1,828,100	1,900,500
1c. Province	1,323,202	2,008,296	2,039,870	2,102,315	2,185,575
2. MOH HQ central procureme	1,128,600	909,274	0	0	0
3. Training institutions	940,899	2,569,548	1,773,800	1,828,100	1,900,500
4. UTH Board	10,746,074	9,260,406	7,982,100	7,312,400	6,651,750
5. Central hospital boards	10,557,797	8,045,206	7,982,100	7,312,400	6,651,750
6. Statutory boards/bodies	4,110,726	3,023,881	1,773,800	914,050	475,125
7. Prov/General hospital boards	11,213,843	11,899,770	12,860,050	13,253,725	13,778,625
8. Others	389,893	314,123	266,070	182,810	190,050
9. District health services	34,812,199	43,740,715	50,109,850	54,843,000	59,390,625
TOTAL	79,510,750	86,000,000	88,690,000	91,405,000	95,025,000

Donor 38%

drugs 11%

ESTIMATED GAP FOR RECURRENT EXP. FOR 1995-99 IN CONSTANT USD					
	1995	1996	1997	1998	1999
1a. MOH HQ	0	737,502	667,131	601,785	665,728
1b. Central Health Board	0	517,856	555,943	601,785	665,728
1c. Province	0	596,184	639,334	692,053	765,587
2. MOH HQ central procureme	0	269,928	0	0	0
3. Training institutions	0	762,797	555,943	601,785	665,728
4. UTH Board	0	2,749,049	2,501,742	2,407,141	2,330,048
5. Central hospital boards	0	2,388,304	2,501,742	2,407,141	2,330,048
6. Statutory boards/bodies	0	897,671	555,943	300,893	166,432
7. Prov/General hospital boards	0	3,532,571	4,030,684	4,362,944	4,826,528
8. Others	0	93,251	83,391	60,179	66,573
9. District health services	0	12,984,889	15,705,380	18,053,559	20,803,999
TOTAL	0	25,530,000	27,797,133	30,089,266	33,286,395

PER CAPITA ALLOCATION FOR RECURRENT EXP. IN CONSTANT USD AS ESTIMATED BY MOH 1995-99					
	1995	1996	1997	1998	1999
1a. MOH HQ		0.26	0.22	0.18	0.18
1b. Central Health Board	0.48	0.18	0.18	0.18	0.18
1c. Province	0.15	0.21	0.21	0.21	0.21
2. MOH HQ central procureme	0.13	0.10	0.00	0.00	0.00
3. Training institutions	0.10	0.27	0.18	0.18	0.18
4. UTH Board	1.19	0.97	0.81	0.72	0.63
5. Central hospital boards	1.17	0.85	0.81	0.72	0.63
6. Statutory boards/bodies	0.46	0.32	0.18	0.09	0.05
7. Prov/General hospital boards	1.25	1.25	1.31	1.31	1.31
8. Others	0.04	0.03	0.03	0.02	0.02
9. District health services	3.87	4.60	5.11	5.43	5.66
TOTAL	8.83	9.05	9.05	9.05	9.05
Estimated population	9000000	9500000	9800000	10100000	10500000
(based on a constant growth rate of 1.003280, which is based on 1980-1990 growth rates)					

AVAILABLE FOR CAPITAL INVESTMENTS IN CONSTANT USD 1995 - 1999 (Donor Investment)

	1995	1996	1997	1998	1999
1a. MOH HQs			100,000	100,000	
1b. Central Health Board			400	400	
1c. Province					
2. MOH /HQ Central Procurement					
3. Training Institutions					
4. UTH Board					
5. Central Hospital Boards		1,500,000	580,000	100,000	
6. Statutory Boards/Bodies					
7. Provincial/General Hospital Boards		1,786,200	786,200	336,200	100,000
8. Others					
9. District Health Services		6,669,841	12,614,300	12,317,300	4,000,000
TOTAL		9,956,041	14,080,900	12,853,900	4,100,000

PART FIVE

IMPLEMENTATION

12.1. Introduction

During the past three years the focus has been on creating the environment for change and reform in the health system. This has included the establishment of the policy framework, legal structures, mechanisms and initiating the process of decentralisation financial responsibility at the district and capacity building of district teams. Attention is now being turned to ensuring the delivery of essential quality care. This effort will concentrate on the development and implementation of the Essential Health Care Package and the realignment of the support systems and organisation structures to ensure the delivery of quality care. A major facet of this plan will be to establish partnerships with communities, other sectors, NGOs and donors in ensuring that the changes are made in such a way that they are consistent with the overall reform vision.

In 1996 implementation activities will concern themselves with improving the delivery of health care. To this end activities will include the development of the operational policies and technical guidelines for health care delivery, quality of care, drug management, medical equipment, FAMS, HMIS, transport and communication. Pilot testing of essential health care packages and support

systems will be undertaken. A major effort will be directed toward providing health workers with the necessary technical and managerial skills to deliver essential health care to communities. To sustain these initiatives, capacity building activities, rehabilitation and equipping facilities with the required inputs to ensure the sustainability and continuity of quality of care. With the view towards the long term, activities will be initiated in two important areas of financing of the health system and monitoring and evaluation.

The process of implementation will be reviewed annually and adjusted in consultation with all the coorporating partners. To ensure that all stakeholders share a commitment into this plan. Accordingly, it is expected that during the year of the implementation, all concerned partners will agree to a scheduled periodic review of the implementation. This will greatly enhance the efficiency of implementation and utilisation of all resources committed to this process. The review will consider the major activities to be implemented in each year including the estimated cost and critical gaps which need to be addressed to ensure the successful implementation of the strategic plan.

These activities are organised according to the key components of the strategic health plan. Milestones to be achieved during 1996 are summarised below.

These will include be to provide technical Capacity building of the human resource for the delivery of integrated health care and the realignment of management support systems at all levels.

IMPLEMENTATION PLAN

SUB-COMPONENT	MILESTONE	COST	FINANCING	RESPONSIBLE	NOV.	DEC.	JAN.	MAR.	APR.	MAY	JUN.	JUL.	AUG.	SEP.	OCT.	NOV.	DEC.
Essential Health Package	Finalise Essential Package	000	GRZ														
	Develop policy guidelines on the operationalisation of the package	20,000	GRZ	IHRIT													
	Pilot implementation of package in 18 rehabilitated health centres	50,000	SIDA/GRZ	IHRIT/DU													
	A formulation of laboratory/Operational guidelines	158000	IRISH	LAB GROUP													
Human resource development	Redesign organisation structures and provide job descriptions	18,000	ODA	IHRD/IHRD													
	Develop national human resource plan	19,000	GRZ/ODA	IHRD													
	Develop a retension system	20,000	GRZ/DGIS	IHRD													
	Develop personnel management system guidelines	10,000	GRZ/ODA	IHRD													
	Training at all levels	800,000	USAID/SIDA/ODA EU/GRZ/DANIDA/IMR	IHRD													
	PCD/DXCIVQA	2,200,000	DOIS/DANIDA	IHRIT/IHRD													
Drug supply and policy	Policy development	160,800	SIDA	IHRIT/NC													
	I E C strategies	10,000	SIDA	IHRIT/NC													
	Human resource developMENT	55,000	SIDA	IHRIT/NC													
	Monitoring and evaluation	62,000	ODA/DANIDA/SIDA USAID/UNICEF/DGIS WHO	IHRIT/NC													
	* Drug Supply	10000	GRZ/SIDA/DGIS	DP/NC													
Medical Equipment	Situation analysis for equipment requirements	30,000	GRZ	ME/IHRIT													
	Policy/guidelines development	15,000	GRZ	ME/IHRIT													
	Developing a minimum standar d and specification list	5,000	GRZ	ME/IHRIT													
	capacity building	16,000	GRZ	ME/IHRIT													
	Develop a donation protocol	1,000	GRZ	ME/IHRIT													
	* Rehabit & Replacing Med. Equip.	5,000,000	GRZ/JICA	ME/IHRIT													
TRANSPORT AND COMMUNICATIONS	Development of aminimum standard list of mode of support and communication for each level	30000	GRZ	NC/IHRIT													
	Situation analysis for transport and communiction	50000	IDA	NC/IHRIT													

SUB-COMPONENT	MILESTONE	COST	FINANCING	RESPONSIBLE	NOV.	DEC.	JAN.	FEB.	MAR.	APR.	MAY	JUN.	JUL.	AUG.	SEP.	OCT.	NOV.	DEC.
	Develop a national donation protocal on type and model of trnasport and communiction equipment	5000	GRZ	NC/HRIT														
	Capacity Building	100000	IDA/GRZ	NC/HRIT														
	Development of procurement plans for minimum transport and communication equipment including spareparts	2000000	IDA/GRZ	NC/HRIT														
	Procurement of transport and communication equipment and establishment of data bank	5000000	IDA/GRZ	NC/HRIT														
	Establishment of data bank	7000000	IDA/GRZ	IDA/HRIT														
INFRASTRUCTURE	Development of a data Bank	94,000	IDA/GRZ	PH/P/HRIT														
	Development of norms and standards	40,000	GRZ/IDA	PH-P-HRIT														
	Pilot phase-rehabilitation of 10 health centres	3,079,584	GRZ/IDA	PH/P/HRIT														
	Rehabilitation of regional hospital	18000000																
	Rehabil/Upgrading/Construction of 58 health centres and staff houses	11,757,984	GRZ/IDA	PH/P/HRIT														
	Rehabilitation of central hospital	12000000																
Organisation of the reformed Ministry of Health at all levels	Develop/formalise organo gram, roles, functions and job descriptions at all levels	300,000	GRZ/SIDA	PS														
	Develop workplan and budget		GRZ/SIDA	PS														
	Recruit, select and place staff		GRZ/SIDA	PS														
	delinkage process		GRZ/SIDA	PS														
PARTNERSHIP	Training in participatory methods and skills dev at all levels	300,000	DGIS/USAID/GRZ DANIDA	HRIT/DCB/PCB														
	Development of resource centre at regional and national level	50,000	DGIS/USAID/GRZ	HRIT/DCB-PCB														
	Promotion of innovation in partnerships	1200000	DGIS/GRZ/NORAD/CIDA	HRIT														
FAMS	Establish uniform systems for FAMS	21,000	DANIDA/GRZ	HRIT														
	Training at all levels in FAMS NB: Inclusive of computer and software purchases; systems development	1,017,000	DANIDA/GRZ	HRIT														
MONITORING & EVALUATION	Establish M+E Bureau	30,000	GRZ/USAID/SIDA	M+E/PU														
	Review surveillance system	15,000	SIDA/DAINDA/GRZ	M+E/PU														
	Conduct national health and DHS	300,000	GRZ/SIDA/USAID/EU	M+E/PU/CSO														

SUB-COMPONENT	MILESTONE	COST $	FINANCING	RESPONSIBLE	NOV.	DEC.	JAN.	FEB.	MAR.	APR.	MAY	JUN.	JUL.	AUG.	SEP.	OCT.	NOV.	DEC.
MONNITORING AND EVALUATION (continued)	Implementation of phase two of HMIS	150,000	GRZ/USAID	HRIT/M+E														
	Development of regional and district capacity in research	700,000	GRZ	HRIT/HSR/M+E														
	Compile Annual Report campaign	50000	GRZ	PU														
	Monitoring and evaluation	62,000	ODA/DANIDA/SIDA USAID/UNICEF/DOIS- WHO	HRIT/NC														
Health Financing	Situational analysis	500000	UNICEF/ODA/SIDA/IDA	HFWO														
	Review of resource allocation in view of packages	30000	SIDA/GRZ	HFWG														
	Appointment of budget steering committee		GRZ	PS														
	Operational research	100000	SIDA/GRZ	HFWO														
	* Public Information Campaign	50000	UNICEF/GRZ	HRIT														
	Cost saving																	
BASIC HEALTH PROGRAMMING	Intergrated Plan for bhs	5000	GRZ/DANIDA	BHS														
	Intergrated support visits	700000	GRZ/DANIDA/ USAID/DOIS	DHS/HRIT														
	Intergrated Technical /Pragmatic Guidelines (QA, ICM,	1200000	GRZ/USAID/GTZ	BHS/HRIT														
	Intergrated Logistical + supply system	50000	GRZ/DOIS/ODA	BHS/HRIT/EDP														
	Intergrated procurement plan																	
	Intergrated Training	50000	GRZ/DANIDA/	DHS														
	Special Supplies Ordered Reagents, Vaccine, RPR, Contraceptives	3000000	See Procurement Plan															
CLINICAL SERVICES	Develop a system of monitoring Standards	1000000	GRZ/DANIDA/USIAD	CS/QA														
	Pre-test	30000	GRZ/DANIDA/USIAD	CS/QA														
	Review/set new standards	4000	GRZ/DANIDA/USIAD	CS/QA														
	Implememnts	4000	GRZ/DANIDA/USIAD	CS/QA														
		28712268																
	TOTAL PLEDGE FROM DONORS FOR 1996	32000000																
	BASKET/RECURRENT	14980000																
	SIDA(DRUGS/BASKET FUNDING																	
	NETHERLANDS(DRUGS)																	
	UNICEF(BASKET & VACCINES)																	

(DA/CONTRACEPTIVES)	
WHO (VACCINES & EMERGENCY)	
UNFPA(CONTRACEPTIVES)	
DONOR FUND FOR CAPITAL	17. .0
FINANCING GAP FOR CAPITAL	61592368

Annex 2

Table 1 Estimate of staff requirements based on prototype package Health post and Health Centre level

Staff-requirements	Health Post	Rural Health Centre	Urban Health Centre	Totals
Polyvalent Worker (PHP)	5 PHP x 400 HP = 2000	11 PHP x 400 RHC=4,400	30 UHC x 100= 3,000	9400
Cashiers/Record clerks		2 x 400= 800	1000	1800
Accounts clerks			2 x 200	400

Table 2 Estimate of staff requirements based on prototype package level I hospital

Staff catergory	Numbers required	Total
Executive director	61 districts x 1	61
District Health Specialist	61 districts x 1	61
General Medical Officer	61 districts x 3	183
General Nurses/Midwifes	61 districts x 30	1830
Theatre nurses	61 districts x 6	366
Radigrapher	61 districts x 3	183
Medical Laboratory	61 districts x 10	610
Physiotherapist	61 districts x 2	122
Total		

Table 3 Estimates of staff requirements based on prototype package at level II hospital

Staff catergory	Numbers required	Total
Executive director	1 x 11	11
Deputy director	1 x 11	11
Financial director	1 x 11	11
Board Secretary	1 x 11	11
Intenal Medicine specialist	1 x 11	11
General Surgeon	1 x 11	11
Obsteric and Gynaecology	1 x 11	11
Paeditrician	1 x 11	11
Pathologist	1 x 11	11
Tutors	4 x 11	44
Pharmacist	1 x 11	11
Pharmacy technician	6 x 11	66

Physiotherapist	4 x 11	44
Medical equipment technician	1 x 11	11
Medical laboratory technician	15 x 11	165
Dentist	1 x 11	11
General nurses	40 x 11	440
Theatre nurses	6 x 11	66
Midwives	20 x 11	220
Nutritionist	1 x 11	11
Institutional Managers	1 x 11	11
Clinical officer anaethetist	5 x 11	55
Total		

Table 4 In addition to the staff under level II the following staff will be included under level III hospital

Staff category	Numbers required	Total
Regional Health director	1 x 9	9
Basic health programme experts	4 x 9	36
Health Management Information system	1 x 9	9
Public Administration Experts	3 x 9	27
Accountant	1 x 9	9
Assistant Accountant	2 x9	18

Table 5 District health office staff

Staff catergory	Numbers required	Total
District Director of Health	1 x 61	61
Deputy Director of Health (Programming)	1 x 61	61
Deputy Director of Health (Administration)	1 x 61	61
District Health Information officers	1 x 61	61
District accounting officer	1 x 61	61
Accounting /booking clerks	2 x 61	122
Administrative Officer	1 x 61	61
Purchasing officer/buyer	1 x 61	61
Transport and mantainance officer	1x 61	61
Public health officer	1 x 61	61

Total		

Table 6 Regional Health Office staff

Staff catergory	Numbers required	Total
Regional Health directors	1 x 9	9
Basic Health Programme experts	4 x 9	36
Health Management Information expert	1 x 9	9
Public Administration experts	1 x 9	9
Accountant	1 x 9	9
Assistant Accountant	1 x 9	9
Total		

Table 7 Proposed training activities for 1996

Level	Catergory of staff	Estimated number	End date
Health centre	Public health practioners	138 +(240)	June 1996(Dec 1996)
District Health Office	DDH	400	June 1997
All levels	Management training	?	?
	Accounting officers and stores officers	?	?
Level I, II & III	Hospital institutional managers	?	?
Total			

ANNEX I

Zambia's Proposed Minimum Ppackage of Health Care (Prototype)

Household/Community

- Community-based distribution of Oral Contraceptives
- First line treatment of malaria, diarrhoeal disease (MoH input is training of distributors and provision of IEC, whereas community meets the cost)
- Treatment of injuries first aid
- Screening for anaemia
- Safe Motherhood/FP
- Nutrition Screening of Children

Health Center + outreach (including health post)

- Treatment of ARI with antibiotics
- Treatment of diarrhoeal disease with ORS
- Care for measles
- Treatment of Malaria
- Health education on childhood diseases
- Screening children who consult for the above for nutritional status
- Referral to Level 1 hospital for severe cases
- EPI
- Vitamin A and iodine distribution for children through EPI programme
- Micronutrient distribution for children through EPI programme
- Annual helminth & schistosomiasis treatment at schools/other venues for children 6-14
- IEC on family planning, STDs, alcohol & tobacco for adolescents through school curriculum and out of school adolescents
  Screening for at risk pregnancies (BP, urine dip stick)
- Provision of tetanus toxoid for pregnancy
- Provision of drugs to contract uterus
- Bimanual compression for haemorrhaging
- Antibiotics for delivery
- IEC on perinatal care
- Referral to level 1 hospital for complications
- Passive case detection of TB
- Confirmation of suspected TB with clinical assessment and sputum smear
- 3 weeks impatient care + 21 weeks home-based chemotherapy
- IEC for family planning
- Hormonal injections for family planning

- Simple immunoassay and clinical diagnosis of STDs
- Treatment with antibiotics for of syphilis, gonorrhea & chancroid
- IEC for STD prevention, and identification
- Condom distribution targeting most at risk
- IEC on condom use
- Pain relief, advice and simple treatment for conjunctivitis, skin conditions, burns, poisons
- Treatment of injuries
- Eye care
- Oral health
- Screening for anaemia
- Bandaging and Suturing lacerations
- IUD insertion
- Referral for non-specialized emergency care
- Diabetes care through diet counseling and oral hypoglycemic
- Hypertension management with diet counseling
- Treatment for mild to moderate asthma
- IEC on hygiene
- IEC on alcohol/tobacco
- IEC/Counseling on AIDS
- Epidemiological surveillance for responding to outbreaks

Level I Hospital

- Cesarean section
- Repair of lacerations to uterus
- Surgical drainage of pelvic abscesses
- Manual removal of placenta
- Medical care for preeclampsia
- Blood transfusions
- Intubation
- IUD insertion
- Casting/reduction of simple fractures
- Bandaging/suturing lacerations
- Emergency abdominal surgery
- Pneumothorax for collapsed lung by chest tube insertion
- Hysterectomy? (CEA to be done)
- All refered cases from H.C
- Classification of emergencies
- T.O.P
- Vasectomy
- Tubal ligation
- D and C
- Antopsy

District Office

- Water&food monitoring of potable water, restaurants & food stalls
- Epidemiological surveillance for responding to outbreaks
- Enviromental monitoring and control

REFERENCES

1. Ministry of Health, (1992): National Health Policies and Strategies (Health Reforms) Lusaka.

2. The World Bank, (1993): Better Health in Africa Technical Working Paper No. 7.

3. Kalumba, K., Nangawe, E., Muuka - Kalumba, L., Musowe, V., 1993: Beyond Our Own Interest: Zambia's Health System Reform Agenda into the next Century.

4. Newell, K.W.; King. M.H.; Sulianti Saroso, J., (1975) The Health Care Package; WHO Chronicle, Geneva.

5. The World Bank; (1994) Poverty Assessment For Zambia, Lusaka, Zambia