

PD-ABL-288

ISN 95207

 **BASICS**  
**TRIP REPORT**

**ZAMBIA**  
**EPI ASSESSMENT**

*BASICS is a USAID-Financed Project Administered by The  
Partnership for Child Health Care, Inc.:*



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**ZAMBIA EPI ASSESSMENT**

**April 11 - 23, 1994**

Jean-Jacques Frère

BASICS Technical Directive: 000 ZA-00-014  
USAID Contract Number: HRN-6006-C-00-3031-00

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## **I. BACKGROUND**

The initial purpose of this mission was to participate in a review of the Expanded Program of Immunizations (EPI) in Zambia. USAID has granted 6 million US\$ to UNICEF for supporting EPI in seven African countries, including Zambia. As a result, the review was to be conducted jointly by USAID (Africa Bureau), UNICEF/New York, BASICS, possibly REDSO, UNICEF regional office (ESARO), and WHO/AFRO. In fact, it seems that UNICEF/New York intended to review the funding needs of the EPI as well as elements of sustainability; UNICEF/Lusaka had very little information about UNICEF/NY's intention. Both USAID and BASICS thought that it was essential that technical aspects as well as program issues be reviewed during the exercise. This technical review was thought to be especially important because it is unclear how "vertical" programs will be forced to evolve in the current context of extensive and rapid decentralization and also because two major donors, Rotary and the Japanese International Cooperation Agency (JICA), are significantly reducing their contribution to the Zambian EPI program. Unfortunately, coordination among so many people from different offices and agencies proved difficult and the mission was postponed following further discussions between UNICEF/NY and AID/Africa Bureau. However, it was believed that the technical content of this mission could still be addressed during the scheduled trip to Zambia and that a less formal, but direct collaboration with the UNICEF health officer and representative in Lusaka would still be profitable. Apparently, UNICEF/headquarters (program funding office, not the health cluster) thought otherwise which put UNICEF/Lusaka in a difficult position vis á vis the BASICS representative two days after his arrival in Zambia.

The initial schedule for this mission coincided with an important strategy/planning workshop which was organized by the Government of Zambia and to which all major donors, including the World Bank were represented and participated. That participation included delegates from the Dutch, Danish, and Swedish aid agencies. Although I considered aborting this mission in order to avoid further complications, following a discussion with R. Thomas, Deputy Director USAID Zambia, it was felt that my participation in the series of meetings would be useful. Feedback about the workshop outcomes on health sector policy, strategies, and donors' interest would be provided to the mission prior to my departure from Lusaka. This was all the more appropriate as the USAID mission has a very limited staff and no one from the mission was available to attend these meetings in Siavonga.

## **II. ACTIVITIES**

The revised scope of work included my participation in a series of meetings held in Lusaka on April 11, 12, and 13. The objectives of these meetings were:

1. to present the current status of the implementation of health reforms; and
2. to examine the appropriateness of the strategic plan given on-the-ground realities and how Zambia will bridge the gap between vision and reality. Witness the changes on-the-ground, and compare presentation of reforms to the reality.

Field trips were organized for all donors and I visited one district and one health center in Mumbwa. I also visited the Lusaka University Teaching Hospital. The workshop itself was organized by the Ministry of Health in Siavonga and took place from April 17 to April 22. The main objective was to present the strategic plan and propose strategies for implementation. Debriefing with the USAID mission took place on April 21, prior to my departure from Lusaka.

### **III. THE HEALTH STRATEGIES/PLANNING WORKSHOP**

#### **1. GENERAL ISSUES**

The main purpose of this workshop was to move ahead in the definition of the essential health packages, the resources needed, financing issues, and donor support. Some of these goals were achieved, at least in part, but it was clear that the Zambian reform unit was not as well prepared as some donors would have liked them to be.

Important issues linked to the health sector reforms in Zambia have already been raised by previous observers. These issues pertain to the legal framework needed to implement health reforms, the current health management capacity found at the district level, the level of central government allocation, and the low capacity for health education found at the district level. In addition, the role of central staff in supporting the ex-"vertical" program remains vague. What is expected from existing community health workers is not defined either. The central epidemiology unit is weak and its capacity to respond to outbreaks of cholera, shigella, or measles is questionable.

These problems exemplify the difficulties in implementing decentralization while sustaining achievements obtained during the preceding years through a more vertical approach involving strong donor assistance to the central level. It is premature at this stage to predict whether the relatively good results obtained in terms of immunization coverage and oral rehydration salts (ORS) use will be affected by decentralization. Close monitoring will be necessary during the immediate future and the amount of support to be provided at central level for child survival activities should not be underestimated.

Decentralization is often described as an evolutionary process; in Zambia, it is almost a revolutionary one. Although formidable obstacles remain, the political will is manifest, and the momentum it creates is such that quick and visible results are expected by the donor community as well as by the Zambian authorities. The strategic health plan was based on the 1992 document on health policies. It clarifies a number of issues but it is still a broad statement of intent and much more work will be required to translate these strategies into a plan of action. National objectives were not discussed during this workshop, possibly because sound baseline data are not available.

The roles of district health teams and district health boards have been clarified. The role of the provinces has also been discussed and the need to maintain strong technical skills at the central level has been recognized. The situation remains somehow vague about the community's role,

and what to expect from community health workers (CHWs) is not clear. Non-governmental organizations (NGOs) are responsible for as much as 40 percent of health care in rural Zambia and the best way to have them on-board and to include NGOs in the reform process has yet to be found. Most recognize that the district level will provide the best setting for integrating the NGOs but central level collaboration will also be needed and it is not certain that all the NGOs will embark on this program of reforms and adopt the concept of packages and standard treatment protocols, or are willing to report to the district. Nothing was said about the commercial/private sector's role.

The concept of decentralization has the somewhat naive assumption that the communities will be able to identify their priorities in term of health needs. They might be able to do so, but not without strong direction from health workers who possess the skills needed to work with the community.

## 2. HEALTH PACKAGES

Essential health services will be available at all levels of the system. They will be grouped in health packages for which different levels have been identified: home and community level; health center level; referral levels 1 (district), 2 (regional hospital), and 3 (university teaching hospital in Lusaka). Unfortunately, a very complex process for defining the packages and estimating unit costs has been adopted. The process is based on the current occurrence of diseases observed at facility level. All diseases included in the World Health Organization's (WHO) are included and correspond to "X" number of minutes/per staff member/per year.

There are several weaknesses to this approach. The approach represents an estimate for clinical management only, ignoring other aspects of health care. Also, it does not prioritize health interventions and is based on current activities, not on health needs. A more empirical approach based on rough epidemiological estimates would be far more practical as major health problems in Zambia are well described: diarrheal diseases, acute respiratory infections (ARI), measles, malaria, tuberculosis (TB), cholera, shigella, AIDS, and malnutrition.

It appears that the central authorities are reluctant to "impose" standard packages at the district level for fear that it would undermine the true spirit of decentralization. They also believe that the situation in some districts is so bad that it would be unrealistic to expect the district staff to deliver even the minimal level of essential care.

## 3. INFRASTRUCTURE

A plan for infrastructure renovation has been prepared but, apparently it was not based on a thorough and systematic review of the existing situation. The plan calls for the building of 1450 new health centers which, under the current situation, does not seem realistic. Even if the World Bank decided to support part of this program, the Ministry of Health (MOH) would certainly not be able to address staffing needs and cannot finance the recurrent costs.

#### 4. PERSONNEL

Ideally, each health center should be staffed with five to seven health workers, instead of the current level of two or three workers. Most district medical officers are of foreign nationalities (a new group of 55 Cuban doctors recently arrived and the Dutch have 25 doctors in the districts...) which excludes them from leading the district health management teams. In addition, the shift of responsibilities from the provision of services to the management of district health services will require a different range of capabilities. Managerial and accounting skills are in short supply at the district level and additional recruitment might be necessary; however, this is unlikely due to budgetary constraints. As a result, a considerable amount of management training will have to be delivered at the district level.

#### 5. DRUGS (AND EQUIPMENT)

It is not known whether SIDA, DANIDA, and the Dutch Cooperation will continue to provide the bulk of essential drugs supplies to the districts and the rural health centers. The question of drug procurement was not thoroughly discussed during the workshop although it would through provincial depots or private pharmacies. Will the central level continue to get most of the supplies from one parastatal? Will hard currency be made available by donors and/or will revolving funds be established? Clearly, important aspects of drug supply and management require further thought and planning.

#### 6. VEHICLES

Apparently, the current fleet is rather old and not in good shape; some districts seem to be considerably better off than others and may have four or five functioning vehicles. This situation results from a particular donor's interest and support to vertical programs, not from careful planning or better maintenance. A questionnaire has just been sent to the districts assess the situation in a more precise manner.

#### 7. TRAINING

Neither immediate nor future training needs at the district level are well defined. A training plan will have to be prepared but it is unlikely that the central level will be able to develop such a plan without technical assistance and adequate resources. Even if planning, budgeting, and accounting guidelines have been developed, the current capacity to manage health services at district level remains inadequate, with a few exceptions.

#### 8. TECHNICAL SUPPORT/SUPERVISION

The word "supervision" has been banned from the official vocabulary but everyone agrees that districts will need "guidance." This support is expected to be provided by the province but provincial health teams in the past have not been particularly efficient. The ministry would like

to have public health specialists in each province and expects these specialist to be supported by external technical assistance.

## 9. FUNDING

Aside from the rather vague term of "community participation," little is known about what will come out of the various schemes of community financing.

Prepayment has been proposed for hospitals. User fees might be implemented in rural health centers, but preliminary tests in Lusaka resulted in a 60 percent decrease in utilization of health centers. At hospital level, the amount charged is grossly insufficient to generate significant additional resources (K 1000, \$1.50 per day in the newly renovated maternity of the university teaching hospital).

Moreover, since most people beneath the poverty-level line, very few will be 'eligible' for payment. This is an area where applied research would be extremely useful, as well as the diffusion of experiences conducted in other African countries. A document on Zambian health insurance has been distributed. The central government's allocation to the districts represents 18 percent of the central recurrent health budget. Whether or not this includes drugs (the bulk of which is supplied by external donors ) is not clear. An estimate of US \$2 per capita has been used for district health plans. That amount is unlikely to be sufficient to fund the full package of essential services as it is described in the WDR. In fact, the content of the packages has not yet been described. The general tendency would be in favor of leaving this task of definition to the district management team which, of course, bears considerable risks. For example, disease surveillance and control of cholera and malaria might well be severely crippled in the process.

## 10. OPERATIONS RESEARCH/QUALITY ASSURANCE

A real concern exists at the national level about the need to provide services of an acceptable quality. What is truly meant by acceptable quality is unclear. Research capacity is weak and an area where technical support will be essential. This form of assistance should involve not only case management and the provision of services at household, community, and facility levels, but also the management support activities that decentralization will require.

## 11. LEGAL FRAMEWORK

The lack of an existing legal framework is a matter of serious concern. The problem was raised during a previous mission and although the decentralization bill (or act) has been prepared, it is not due to be submitted to Parliament before June. If passed, it will then have to be ratified. It seems that the Ministry of Finance is quite supportive of this decentralization process but the Ministry of Local Government is said to be less sympathetic. District health boards won't be elected before the middle of next year and meanwhile, the appointment of district health management teams will remain provisional. An additional problem stems from the fact that

approximately 70 percent of the district medical officers are foreigners and therefore are not eligible to become heads of district management teams.

## 12. TIMEFRAME

As I could not attend the last two days of the workshop, I may have missed some information, but my feeling was that both donors and the World Bank were concerned about the lack of preparedness on the Zambian side and that it is difficult to foresee how and when all the elements of the reform are going to be implemented. Additional information should be available when the World Bank team returns to Washington (around May 27, contact person Reiko Nimi, task manager, or Julie McLaughlin from PHN)

## 13. DONOR COORDINATION

Donor coordination is apparently excellent, especially among the Scandinavians who have a long history of involvement in the Zambian health sector. UNICEF also plays a very visible role. WHO has a planning adviser posted in Zambia by the ICO. The WHO representative attended all the meetings and two additional WHO staff members came from Geneva. The Dutch Cooperation was also represented, as well as the British ODA. The World Bank had obviously pushed very hard to get this workshop organized and tried to be relatively humble despite the size of its representation (which included the Division Chief for AF6PH, Roger Grawe). Both the minister and the deputy minister of health were present. The deputy minister spent four days in Siavonga and the Permanent Secretary stayed for the entire week. By contrast USAID, which will soon be the largest or the second largest donor in Health, was not officially represented. The donor community, as well as the Zambian officials (unofficially), expressed their concern about USAID's lack of participation.

## IV. CONCLUSIONS

1. The momentum in favor of decentralization is not reversible and cannot be ignored. Political forces are extremely important in inspiring that process but structural, legal, administrative, and financial impediments appear formidable.
2. The Zambian health system is still strongly hospital-based and district health services are still centered around the district health hospital which drains away a large proportion of the meager resources and tends to serve as a primary facility. Rural health centers are generally neglected and ineffective. In a way, the ultimate decentralization issue remains how to decentralize within the district itself. If the goal is to provide more services to more people, it will be crucial to avoid the creation of a bottleneck at the district level.
3. Much remains to be done in terms of strengthening the district capacity for planning, budgeting, and management of health services. A certain degree of confusion prevails about the role of district health teams: managers versus providers of health services. An accounting system has been developed and seems to function, but the auditing capacity

is absent, even at the central level. A few selected districts have significantly improved their performance since they began receiving direct financial support from donors, but Zambia contains 66 districts!

4. Even if district health plans are prepared in 1994-1995 in a large number of districts, aggregating those plans to form a national health plan will be extremely difficult. This implies that various donors may have to program their assistance without referring to a national health plan.
5. A more detailed and systematic assessment of all equipment, staffing, and training needs at district and health center levels is essential.
6. The contents of the "packages" at community, health center, and hospital levels must be clarified.
7. Close monitoring and flexibility will be needed to sustain the fragile achievements obtained by the "vertical" programs. The provision of technical and managerial support to central and provincial levels will be essential.
8. From a planner's point of view, the major characteristic of the current reform might be "too much, too quickly." Decision makers, driven by their desire to prove their commitment to addressing community needs and to break with years of excessive centralization and patronizing, obviously have a different perception.

## **LIST OF PERSONS CONTACTED**

### **USAID/Lusaka**

Mr. Fred Winch, Director  
Mr. Rudolph Thomas, Deputy Director  
Mr. David Straley, Program Development Officer  
Ms. Pam Straley, HPN

### **HIV/AIDS Prevention Project**

Mr. Joseph Wiseman

### **World Bank**

Reiko Nimi, Task Manager  
Steen Jorgensen, Mission Leader  
Julie McLaughlin, Public Health Specialist

### **UNICEF**

Mr. Mark Sterling, Representative  
Dr. Ahmed Magan, Health Officer  
Pr. Mukelabai, Regional Health Advisor, ESARO  
Ms. Sally Lake

### **WHO**

Dr W.S. Boayue, Representative  
Mr. David Howells, Health Policy Advisor

### **Ministry of Health**

Dr. Charles Mukalenge, District Medical Officer Mumbwa  
Dr. Katema, Director University Teaching Hospital  
Mr. Albert Mulungu, District Facilitator  
Ms. Gertrude Mundia, Donor Coordination  
Mr. Vincent Musowe, Director, Planning Unit  
Dr. Katele Kalumba, Deputy Minister of Health  
Dr. S.L. Nyaywa, Reform Planning Unit  
Dr. Kawaye Kamanga, Permanent Secretary, MOH  
Dr. J.J. Banda, Reform Planning Unit

## **Dutch Cooperation**

Mr. Verheul  
Mr. Kees Kostermans

## **DANIDA**

Mr. Tommy Hemmingsson  
Dr. Heldrups  
Mr. Erik Heydelberg

## **ODA**

Ms. Sue Durston

## **SIDA**

Dr. Arne Thorfjnn  
B. Lading Rasmussen

ANNEX I  
APPRAISAL WORKSHOP AGENDA

11-

**ZAMBIA**  
**NATIONAL HEALTH STRATEGIC PLAN**  
**APPRAISAL WORKSHOP 11 - 22 APRIL 1994**

**PART I: Status report on the Implementation of Health Reforms: Where are we now?**

**Venue: Intercontinental Hotel**

Monday, 11th April

- |                     |   |
|---------------------|---|
| 08.30 - 09.00 Hours | Welcoming Remarks by the Chairman<br>Synopsis of Health Reforms and the Planning Exercise<br>(Dr. K. Kamanga)   |
| 09.00 - 10.30 Hours | Health Reforms: Past Present & Future<br>(Dr. K. Kamanga, Mr. V. Musowe and Dr. S.L. Nyawya)  |
| 10.30 - 11.00 Hours | <b>TEA/COFFEE BREAK</b>   |
| 11.00 - 12.00 Hours | District Capacity Building<br>(Dr. J.J. Banda)<br><br>Chair - Dr. Kawaye Kamanga  |
| 12.00 - 13.00 Hours | District Capacity Building: Management and support activities<br>(Dr. S.L. Nyaywa)<br><br>Chair - Dr. Kawaye Kamanga  |
| 13.00 - 14.30 Hours | <b>LUNCH BREAK</b>  |
| 14.30 - 15.30 Hours | The Challenges and the Resources Available<br><br>The State of Health in Zambia<br>(Dr. S.L. Nyaywa and Dr. R. Chimba)<br><br>Sources of, and Principles for, Public Financing of Health Care<br>in Zambia<br>(V. Musowe, J.J. Banda)<br><br>Chair - Dr. Kawaye Kamanga |
| 15.30 - 16.00 Hours | <b>TEA/COFFEE BREAK</b>   |
| 16.00 - 17.30 Hours | How Does the National Planning Exercise Support<br>Decentralization?<br>(Panel discussion<br>V. Musowe, E. Nangawe, S.L. Nyawya, J.J. Banda)  |

Tuesday, 12th April, 1994

08.30 - 10.30	Introduction to the Diversity in Zambia what you expect in the Districts - organization, special concerns, district plans, accounting systems (J.J. Banda, V. Musowe)
10.30 - 10.45 Hours	<b>TEA/COFFEE BREAK</b>
11.00 - 12.30 Hours	Issues to Be Addressed (Plenary)
12.30 - 1.00	Final Logistics

Close

**Part II:** To examine the appropriateness of the Strategic Plan given on-the-ground realities; to examine how Zambia will bridge the gap between vision and reality. Witness the changes on the ground, and compare presentation of reforms to the on-the-ground reality.

Wednesday, 13 - Friday, 15th April

Venue: Field Sites

Field Visits: Separated into manageable groups to examine different issues of interest to government and donors, in the context of Health Reforms and the Strategic Plan.

**Part III:** Presentation of Strategic Plan: To share the Vision with all participants: Conceptual Framework (the Model) & its significance  
Process & Definition of Packages

Sunday, 17th - Friday, 22nd April:

Venue: Manchichi Bay Lodge, Siavonga

**ZAMBIA**  
**NATIONAL HEALTH STRATEGIC PLAN**  
**APPRAISAL WORKSHOP 17 - 22 APRIL 1994**

**Agenda for Part III:**  
**Presentation of the Plan and Strategies for Implementation**

**Venue: Manchichi Bay Lodge, Siavonga**

**DAY ONE: SUNDAY 17TH**

17.00 - 18.30 Hours      Registration

20.00 Hours              Feedback on field visits (Mrs. G. E. Mundia)

**DAY TWO: MONDAY 18TH**

08.30 - 09.00 Hours      Key note by **Hon. M.C. Sata, MP Minister of Health**

9.00 - 9.30                  Why a Strategic Plan?  
**(Hon Dr. Katele Kalumba and Mr. V. Musowe)**

9.30 - 10.45 Hours      Process for defining Cost Effective Packages of Care and  
Management and Support "Packages"  
**(Dr. J.J. Banda)**

10.45 - 11.00 Hours      **TEA/COFFEE BREAK**

11.00 - 13.00 Hours      Plenary Discussion of approach taken in Zambia

13.00 - 14.30 Hours      **LUNCH BREAK**

14.30 - 16.00 Hours      Presentation of packages

- Household
- Community
- Health Centre
- Primary Referral Hospital
- Secondary Referral Hospital
- Tertiary Referral Hospital

**(Dr. J.J. Banda and Ms. J. Nyoni and C. Mutale, R. Msiska, Dr. S.L. Nyaywa, V. Musowe)**

16.00 - 16.15 Hours      **TEA/COFFEE BREAK**

16.15 - 17.30 Hours      Presentation of Management and Support "Packages"

- Community
- Health Centre
- Hospitals
- DHMT/DHB
- RHM

- Central MOH (including Programme Managers)
- Parastatals
- NGOs

(Ms. J. Nyoni, Mr. V. Musowe, Dr. S. Nyawya)

### **DAY THREE: TUESDAY 19TH**

- 08.00 - 11.00 Hours      Small Group Discussions of Packages
- 11.00 - 11.45 Hours      **TEA/COFFEE BREAK**
- 11.45 - 13.00 Hours      Presentation of Small Group Discussions and Plenary Discussion of Issues
- 13.00 - 14.30 Hours      **LUNCH BREAK**
- 14.30 - 16.00 Hours      What is the Resource Gap between the Existing System and the Vision?  
(Mr. V. Musowe)
- 16.00 - 16.15 Hours      **TEA/COFFEE BREAK**
- 16.15 - 17.30 Hours      Specific Resource Gaps
  - Infrastructure (Mr. F. Chindele)
  - Equipment (Ms. Mundia)
  - Communications (Dr. J.J. Banda)

### **DAY FOUR: WEDNESDAY 20TH**

- 08.30 - 10.45 Hours      Human Resources
  - The gap between the vision and the present situation?
  - Reallocating staff
  - Incentives
  - What will be indicators of progress in Human Resource Development?
(Ms. J. Nyoni with Dr. J.J. Banda)
- 10.45 - 11.00 Hours      **TEA/COFFEE BREAK**
- 11.00 - 13.00 Hours      Institutional Transitions
  - Between levels (from the center to the district)
  - Within the Center (parastatals, regional role, ministerial role, programme managers, national NGOs)
  - Within the districts (linking district planning to national planning, incorporating community partnership, local NGOs)
(Dr. Katele Kalumba, Mr. V. Musowe, Dr. Limbambala, and Dr. J.J. Banda)
- 13.00 - 14.30 Hours      **LUNCH BREAK**

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14.30 - 16.00 Hours	Small Group Discussions
16.00 - 16.15 Hours	<b>TEA/COFFEE BREAK</b>
16.15 - 17.30 Hours	Plenary Presentations of Small Group Discussions

**DAY FIVE: THURSDAY 21TH**

08.30 - 10.45 Hours	How Will the New System Operate?  <ul style="list-style-type: none"> <li>● Assuring adherence to standards (Dr. Limbambala)</li> <li>● Logistics (procurement, distribution, supply, storage, maintenance) (Mr. Nguni, Mrs. Mundia)</li> </ul>
10.45 - 11.00 Hours	<b>TEA/COFFEE BREAK</b>
11.00 - 13.00 Hours	<ul style="list-style-type: none"> <li>● Financing (Hon. Dr. Katela Kalumba, Mr. V. Musowe)</li> <li>● Disbursement (Hon. Dr. Katela Kalumba, Mr. V. Musowe)</li> <li>● Accounting/Auditing (Mr. Miti and Dr. J.J. Banda)</li> </ul>
13.00 - 14.30 Hours	<b>LUNCH BREAK</b>
14.30 - 15.00 Hours	<ul style="list-style-type: none"> <li>● Monitoring, evaluation, reporting and reassessment (Dr. Nyawya and Mr. V. Musowe)</li> </ul>
15.00 - 16.15	Small Group Discussions
16.15 - 16.30	<b>TEA/COFFEE BREAK</b>
16.30 - 17.30 Hours	Plenary Presentations of Small Group Discussions

**DAY SIX: FRIDAY 22ND**

08.30 - 10.30 Hours	Donor Presentations <ul style="list-style-type: none"> <li>● Funding preferences and tentative amounts</li> <li>● Requirements for reporting, accounting, disbursements</li> <li>● Process for reassessment and regular coordination</li> <li>● Timelines (when funds would be available)</li> <li>● What do Donors need from MOH?</li> </ul> (Hon. Dr. Katele Kalumba and Dr. Kawayya Kamanga)
10.30 - 10.45 Hours	<b>TEA/COFFEE BREAK</b>

10.45 - 11.30 Hours	Donor Coordination (Agreements on donor "principles")
11.30 - 12.00 Hours	Conclusions and Recommendations (Dr. Kawaye Kamanga & V. Musowe)
12.00 - 12.30 Hours	Closing Statement by Hon. Katele Kalumba
12.30 Hours	<b>CLOSE</b>
12.30 - 14.00 Hours	<b>LUNCH</b>
14.00 Hours	<b>Departure for Lusaka</b>

ANNEX 2  
KEY NOTE ADDRESS BY THE DEPUTY MINISTER OF HEALTH

**KEY NOTE SPEECH MADE BY HONOURABLE DEPUTY MINISTER OF HEALTH  
DR KATELE KALUMBA AT THE OFFICIAL OPENING OF THE APPRAISAL  
WORKSHOP FOR THE NATIONAL STRATEGIC HEALTH PLAN AT  
MANCHINCHI BAY LODGE - SIAVONGA ON 18TH APRIL, 1994.**

Your Excellencies,  
Dr. Kawaye Kamanga, Permanent Secretary, MoH,  
The World Bank Health Sector Appraisal Mission,  
Executive Directors of Medical Management Boards,  
Senior Consultants at Ministry of Health,  
Members of Strategic Health Plan Task Force,  
Ladies and Gentlemen,

I would like to welcome you all and at the same time thank you most sincerely though belatedly for accepting my Ministry's to join the appraisal process of our National Strategic Plan which started in Lusaka on 11th April, 1994 and runs through until 22nd April, 1994.

My special tribute and warm welcome is accorded to the World Bank Health Sector appraisal mission from Washington and to all representatives of bi-lateral and multi-lateral Development agencies from different capitals of the world for coming all the way to join the appraisal team. We appreciate this gesture of good will and solidarity.

Let me once again seize this opportunity and thank all our cooperating partners in the Health Sector in general and to the health reforms in particular for their continued invaluable support. As cooperating partners in our health enterprise you are stakeholders and as such therefore our success is your success too. Distinguished delegates, allow me to put it more bluntly in the logic of our reform. This exercise that we are engaged in with you all is not about ensuring Zambia's success in health sector alone. We are all "development patients"....too many technological prescriptions, but very few successful cases of recovery...real recovery and not ephemeral. We in Zambia are trying to avoid a Zulu healer's tragedy of the past. In dealing with cases of epilepsy, it is documented by an anthropologist that Zulu healers had a hard time to prove success. One ingenious response to this crisis of medical credibility in those times was to suggest to the patient the following ritual healing. The patient had to wake up early on a June morning, the coldest part of the year in the South, go to a river point known to be infested with crocodiles and lethal snakes. Completely in the nude, he or she was to dive in the river and hold his breath as long as possible. If he came up alive, he would be cured of epilepsy. The anthropologist adds that there are no records to show how many survived the ritual to tell the rest of the story!

Distinguished ladies and gentlemen, we are in this boat together. We do not want to fail and we believe strongly that neither do you! You distinguished excellencies cannot walk away from Zambia's reform effort with the pronouncement: We helped Zambia dive into the river of comprehensive health reforms...and those chaps were courageous but Zambia's infant mortality rate has become worse; its infrastructure remain unfixed; its drug supplies still inadequate; its epidemics uncontrolled etc. There is no taxpayer in the world in Europe, Japan, America or any member country who contributes to the coffers of the multi-lateral

agencies who want to hear that kind of "success" story. Our fate is your fate too. We have gone too far together not to share in the common cause for success...real success and not one measured by the volume of documents we collectively produce. As much as we want to succeed, we want to make you succeed as well. The World Bank needs a success story. Japan, Britain, Denmark, the Netherlands, Sweden, France, the USA, the EC, UNICEF, WHO, UNFPA and all of you I haven't mentioned, we all need a real success story in health reform consistent with a vision of health that moves away from orthodoxy...from more of the same thing. Work with us in this social laboratory, to provide environments that are conducive to health; help our people learn the art of being well; and provide a basic package of health care for all. This is our simple futuristic vision. We want to be able to spend less on drugs, less on expensive technology; less on superspecialists with long credentials whose value is only acknowledged by editors of professional journals. We want cost-effective, quality-assured health, centred around the needs and resource possibilities of the family. This vision we have defined. This vision, we have shared with you. This vision we have come to learn is now being shared by many the world over. Somewhere, it must succeed. That place is here.

Your Excellencies, ladies and gentlemen, as it was earlier indicated at Lusaka meeting, the appraisal process is divided into three parts.

Part one dealt with the status report on the implementation of health reforms: A specific question it attempted to answer was: Where are we now? This took place in Lusaka from 11 - 12th April, 1994 in a workshop setting.

Part two was in the form of organised field visits to the districts. The objective was to examine the appropriateness of the Strategic Health plan given on-the-ground realities; to examine how the nation will bridge the gap between vision and reality; witness the changes on the ground, and compare representation of reforms to-the-ground reality.

Part three which is the major appraisal process is mainly meant to share the National Strategic Health Plan vision with all participants, its conceptual framework, model and its significance.

The cry of my country as indeed that of the old and new Third World of Eastern Europe is that of limited resources. But, I know some, if not all of you, share in the idea that countries such as Zambia should first learn to harness more efficiently, existing resources before they go out with the begging bowl. I agree. Cost-containment, cost-saving measures must be part of our reform strategies. But your excellencies, this diagnosis must be backed by the technical support that allows countries such as Zambia to even begin to establish working systems of cost-management. The reason why we have been unable to manage our costs properly before, is not simply because we believed in Santa Claus, (this may be only partially true in recent past of the unmentioneable Humanist Republic). But we know the truth now. The fact is that we did not invest in those technologies or skills in our health management that would have made asking questions of cost-structures and management an important part of the practice of medicine.

Further, there is no exaggeration, that even under conditions of cost-containment today, our health care system is in such a state that more resource investments are needed to reach a level at which as a system, it could start to behave rationally.

In attempting to deal with these issues, my Ministry has examined various options at its disposal and has concluded on the need to initiate a politically directed technical process aimed at the development of a Strategic Health Plan. Strategic Health Plan offers an opportunity of defining an essential package of care to which every Zambian citizen will have access. Government and private resources will be channelled towards ensuring access to the complete package of care and ensuring the quality of the delivery of this package of care.

The dynamic process of the development of the Strategic Plan marks yet another milestone in the process to reform our national health services in Zambia. The National Health Policies and Strategies among its goals directs the Ministry to develop basic health care packages. Therefore the initiative to develop a Strategic Plan and Basic Packages is Zambian.

Your Excellencies, "Amano mambulwa" so goes a saying in one of our civilized languages! There is a lot in the approach to this exercise of strategic planning that reflects the working philosophy of some of your organizations but we would like to restate, that the logic of what the Plan contains reflects the originality of Zambian reform. I need perhaps to share with you that both the concepts of the strategic Plan, and of a basic package of health services, were defined in MMD's Policy Framework paper! A lot more needs to be accomplished in fact, to capture the total frame articulated in that reform document.

There are several reasons why we in MMD set out in 1990 in Policy Framework Paper, the concept of a package of health care as was published later in the National Policy and Strategies Document.

First, as people are uncertain about the nature of the care they require, it is logical to group procedures to increase the chance of resolving the problem with which they present.

Second, there is growing evidence that single purpose interventions are effective in reducing a particular cause of mortality, but not in reducing overall mortality.

Third, by integrating health care activities, providers can take the opportunity of each contact with the client to provide less demanded, but needed care, such as immunizations or treatment of sexually transmitted diseases among women.

These packages would be delivered at the following levels:

- (i) Household,
- (ii) Community,
- (iii) Health Centre,
- (iv) Primary Referral Hospital,
- (v) Secondary Referral Hospital,
- (vi) Tertiary Referral Hospital.

I am certain that the concept of a package has become a language of some of your own organization. We take that as a coincidence but we are comforted in the thought that it was and remains a valid concept. I share with you all, who express concern at the technical burden this implies in defining a basic package for each level of care, but may I ask you: wouldn't be much easier once this task is completed to define your own involvement in this partnership ? Wouldn't I be justified in saying that for many years we have been asking you to invest in pieces of a jigsaw puzzle whose total picture remained unmatched and undefined, with no end-state, no face of a successful investment?

It is also our conviction that a completed Strategic Plan must remain a living document responsive to the turbulent environment of implementation. On this, I need to reassure you all, that my technical colleagues and I are agreed, that the current state of the Strategic Plan only sets out some but not all the Skeletal structure of the Plan. More work is being done on drug policy issues; on system integration; on linkages between local government and health authorities etc. We need more technical support to actualise all these aspects. More importantly from a policy legitimation stand point, this massive compass design process must be backed by some functioning system of services even if not the perfect kind. Already our people are saying we have been doing too much planning. I am the first to admit that. And in my own empirical assessment of Zambian health reform history, planning outputs have far exceeded services reaching the people. Let us not fail in the same way. 1994 must begin to see basic, quality assured services reaching our people: I mean, better drug supply, more rehabilitation of health centres and district hospitals; better equipment supply; efficient referral systems; better investment of recovered funds in the interest of improved patient care and better incentives for staff; better coordination with other sectors in the control of epidemics, violence in the homes and occupational hazards. Improved attitudes of staff to patient management. These are the things that our reform program must begin to reflect.

Like any other planning conceptual framework, the Strategic Plan has its own weaknesses and strengths. Some of the obvious ones are as follows:-

The framework could be interpreted as adopting centralisation against the main thrust of the reforms.

My reaction to this well intended concern is that, autonomy is not a unilateral declaration of the independence (UDI). Districts were never expected to operate without national direction, goals, specific guidelines or a nationally accepted framework for operation. There is no inherent conflict between a national policy implementation strategy and the strategies of the District's own "street level bureaucrats" who translate a national strategy in a local-level implementation mode consistent with basic values.

Decentralisation is not a misguided missile. There must always be central guidance, that is part of accountability in a parliamentary system. Accountability means individuals and teams responding to well established methods for managing and "accounting" for their decisions.

Furthermore, in every country there are Public Health Concerns which become National Priorities which are overarching and cross all districts and National Institutions. The Strategic Plan provides a framework within which both National Priorities, and local

priorities, can be combined in the operational work of the District, conscious of each district's peculiarities.

There may be some among you who may argue that the development of a specific "package" of services will mean that Donors will be more directed in their efforts by the Ministry of Health and therefore less at liberty to indicate what they would wish to do.

Your Excellencies, my Ministry's position is simple: we want to encourage you as our cooperating partners to buy into our National Strategic Plan. We want your input into the design but then we will discourage parallel vertical programmes which operate outside the National programme that is being designed. We invite you to transcend the temptation that you take only that which you can individually label: "Made in the Republic of Luampungu". The health of a Zambian child who now dies from immunizable diseases, the health of the Zambian mother whose death rate is a national scandal, the AIDS tragedy, all these if we overcome them must be the pride of all the taxpayers in all the countries from whence our core partners come; it must be the pride of all Zambians, in the end, the pride of our new and future world.

Your Excellencies, ladies and gentlemen, the initial cost of this investment plan would be enormous. Zambians must take the lead to finance this investment plan. This is a challenge to all Zambians. Donor community funding should be seen in the context of supplementing the Zambian effort not the other way round.

It is for this reason that my Ministry has been examining various options of financing the health sector. Though revenues generated at the outset may be modest, improvement in cost recovery is an essential part of any health finance reform programme because:

- (i) increased fee revenues can strengthen the Ministry of Health's hand in its annual "budget battle" with Ministry of Finance;
- (ii) retention of fees at the point of collection can be an incentive to hospital and health centre managers to enhance both revenue collections and service quality;
- (iii) purely on equity grounds, patients from higher income households should be required to pay for the health care they receive.

My Ministry has introduced a prepayment insurance scheme in order to move away from the current situation of reliance on user fees whereby the sick are taxed at the very time when their income may be jeopardised. This scheme would require monthly payment by everyone over the age of 5, entitling them to a package of services at the institution of their choice. This is part of a complement of financing modalities we have to try. With proper fine-tuning by our institutions, we shall get a proper mix of public and private financing system. Yes, we are conscious of the need to keep monitoring and evaluating all these interventions for their social impact.

Finally, Your Excellencies, I extend my futuristic invitation to you all. Let us put the Zambian Health jigsaw puzzle together. I want you and I to see a Zambia, in ten years time, that will compare with the best of the middle income countries on key health indicators. Can we all share in that goal?

On this very important note, I wish first to thank my technical colleagues who have kept motivated to continue to translate our National Policies beyond the expectations of all of us, including myself had. Please recall that we all worried about the conceptual capacity in the Ministry when we started. I am pleased to say, there is plenty of it. We have a core group of dedicated men and women who can equal any other expertise anywhere given proper policy guidance and incentive...real incentives!

On this incentives issue, it is my honour and indeed a privilege to officially open this International Appraisal Workshop.

I thank you