



Republic of Zambia

Ministry of Health

ACTION PLANNING HANDBOOK

FOR

DISTRICT HEALTH TEAMS

5th Edition

Ministry of Health
Ndeke House
Haile Sellasie Avenue
P. O. Box 30205
LUSAKA, ZAMBIA

April 2009

Foreword

This Planning Handbook is one of a series that has been developed for Statutory Boards, Training Institutions, Second/Third Level Hospitals, District Health Offices, Health Centres/Health Posts and Communities.

The Handbook seeks to maintain simplicity while at the same time describing the planning process in detail to enable each level produce an action plan that is generic for that level of care, so as to ensure uniformity of the plans. In order to enhance this process the outline and cost guide sheets for the action plan will be provided electronically and will be distributed together with the Handbook.

Previously the planning framework had been well developed for the Health Sector but there were gaps between intentions and practices. To bridge this gap, this Edition provides:

- Some simple guidance on how to implement the aims of the action planning process;
- Results or activity based plans and budgets;
- A mechanism for migration of information from the action plans to the Activity Based Budgeting data base;
- Encouragement on delivery mode planning rather than disease/target group planning, which is more in line with service provision practices;
- A strong monitoring and evaluation framework.

The district and hospital priorities and objectives should be based on a solid analysis of their local health and environmental situations, previous experiences, performance assessments, research results and hospital accreditation results, in line with the Medium Term Expenditure Framework (MTEF) requirements. Individual health centres/posts should conduct the bottleneck analysis to identify bottlenecks to achieving set objectives by individual health centres/posts. They should then carry out a review of the present health situation in the district, taken from the Health Management Information System reports submitted by the health posts and health centres and from the health centre performance assessment results.

Planning and budgeting under the MTEF should be resource based and allocation of resources should be in accordance with local priorities. However, the plans should be results or activity based plans and budgets, have clear and coherent links with both the National Health Strategic Plan and the National Development Plan to ensure that action plans in districts, hospitals, statutory boards and training institutions adequately reflect national priorities and development objectives.

The Provincial Health Offices have been given authority to launch and support the planning process in districts and hospitals each year. The Provincial Health Office should also evaluate the plans and sign Memorandums of Understanding on behalf of the Ministry of Health. It is essential that the consolidated medium term plan and budget for a district is inclusive of, and consistent with, the objectives and activities that may have been formulated for specific projects (such as micro plans and Roll Back Malaria).

Appropriate planning forms the basis of any system. I strongly appeal to each one to remain committed to the planning process as has been the case in the previous years.

Dr. Velepi C. Mtonga
Permanent Secretary
Ministry of Health

Acknowledgements

This Fifth Edition of the District Planning Handbook was made possible through hard work by Ministry of Health staff and representatives of cooperating partners who actively participated in the revision in order to produce an up-to-date Planning Handbook. We are grateful to all of them individually and collectively for their time and commitment in completing this Edition in good time.

Special thanks go to the Directorate of Planning and Policy for taking the initiative to revise the Handbook and representatives of the following DHMTs whose staff participated in the field testing of the Handbook to ensure its finalisation: Katete; Mazabuka; Mwinilunga; Mungwi; Kaoma; Mpongwe; and Samfya. The list of contributors is tabulated at the back of this Handbook.

Finally the Ministry would like to thank USAID through the Health Services and Systems Programme for providing funding for both the review and the printing of this Planning Handbook and also Dr. John Chileshe for undertaking the final editing of the Handbook.

Table of Contents

Page

Foreword.....i

Acknowledgementsii

Table of Contents iii

Abbreviations v

Glossary of Terms viii

1. Introduction 1

 1.1 The Health Reform Vision 1

 1.2 Rationale 1

 1.3 Purpose of this Handbook 2

2. The District Health Management Team and Planning3

 2.1 Roles of the DHMT3

 2.2 Annual Planning Schedule4

3. The Planning Steps Each Year9

 Step 1: Meeting with the Provincial Health Office 9

 Step 2: Meeting with the Health Advisory Committee 9

 Step 3: DHMT Negotiates the Purchase of First Level Referral Service 9

 Step 4: DHMT Provides Planning Updates to Health Centre and Health Post In-Charges..... 9

 Step 5: Meeting with Health Centres, Hospitals, NGOs and Training Institutions 9

 Step 6: Preparation of the District Health Office Plan 16

 Step 7: Production of the Consolidated District Action Plan and Budget 16

 Step 8: Presentation of the District Plan and Budget to the DHAC and the DDCC..... 16

 Step 9: Presentation of the Consolidated District Action Plan and Budget to the PHO 17

 Step 10: Review of the Consolidated District Action Plan and Budget by the PHO 17

4. Monitoring the Implementation of the Plan 18

5. Format of the District Health Action Plan 19

 Part 1: Introduction..... 19

 Part 2: Situation Analysis 20

 Part 3: Main Plan 36

 Part 4: Budget 40

District Planning Handbook

Annexes	51
Annex 1: Outline of the District Health Action Plan	52
Annex 2: Bottleneck Analysis Explained.....	55
Annex 3: High Impact Interventions	57
Annex 4: Planning Guidance for HIV/AIDS	58
Annex 5: Logical Framework Approach.....	60
Annex 5B: A Worked Example of Logical Framework Approach.....	61
Annex 6: Examples of Outputs/Results Areas	64
Annex 7: Quantification Sheets.....	65
Annex 8: Format for Reporting Action Plan Implementation.....	69
Annex 9: Gantt Chart for Summarizing District Action Plan by Month.....	70
Annex 10: Standard Equipment List	71
Annex 11: List of Cost Item Codes for Budget Preparation	88
Annex 12: Consolidated Budget Spreadsheet	95
Annex 13: Costing Sheets	99
Annex 14: List of Contributors	102

Abbreviations

ABB	Activity Based Budgeting
ACT	Artemisinin Based Combination Therapy
AFB	Acid-Fast Bacillus
AFP	Acute Flaccid Paralysis
ANC	Antenatal Care
ART	Anti-Retroviral Treatment
ARVs	Anti-Retroviral Drugs
BCG	<i>Bacillus Calmette-Guérin</i> (TB vaccination)
BTL	Bilateral Tubal Ligation
CBO	Community Based Organisation
CBoH	Central Board of Health
CIP	Capital Investment Plan
CPs	Cooperating Partners
CSO	Central Statistical Office
CTC	Counselling, Testing and Care
DAO	District Accounting Office
DDCC	District Development Coordinating Committee
DHAC	District Health Advisory Committee
DHB	District Health Board
DHIO	District Health Information Office
DHIS	District Health Information System
DHMT	District Health Management Team
DOTS	Directly Observed Treatment Short Course
DPT	Diphtheria, Pertussis, Tetanus
EHT	Environmental Health Technologist/Technician
EMONC	Emergency Obstetric and Newborn Care
ENT	Ear, Nose, Throat
EPI	Expanded Programme of Immunisation
FBO	Faith Based Organisation
FP	Family Planning
GRZ	Government of the Republic of Zambia
HAART	Highly Active Antiretroviral Therapy
HAC	Hospital Advisory Committee
HAHC	Hospital Affiliated Health Centre
HB	Hospital Board
HC	Health Centre
HCC	Health Centre Committee
HCPT	Hospital Core Planning Team
HIS	Hospital Information System
HMIS	Health Management Information System

District Planning Handbook

HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HMT	Hospital Management Team
HPMF	Health Performance Monitoring Framework
HRHSP	Human Resource for Health Strategic Plan
HSSP	Health Services and Systems Programme
IDA	International Dispensary Agency
IEC	Information, Education and Communication
IPF	Indicative Planning Figure
IPT	Intermittent Presumptive Treatment
IRH	Integrated Reproductive Health
IRS	Indoor Residual Spraying
ITGs	Integrated Technical Guidelines
ITN	Insecticide Treated Mosquito Net
IUD	Intra-Uterine Device
LCPs	Local Cooperating Partners
LFA	Logical Framework Approach
MBB	Marginal Budgeting for Bottlenecks
MCH	Maternal Child Health
MDGs	Millennium Development Goals
MoFNP	Ministry of Finance and National Planning
MoH	Ministry of Health
MoV	Means of Verification
MSL	Medical Stores Limited
MTEF	Medium Term Expenditure Framework
MVA	Manual Vacuum Aspiration
NGO	Non-Governmental Organisation
NHC	Neighbourhood Health Committee
NHSP	National Health Strategic Plan
OI	Opportunistic Infection
OPD	Out-Patients Department
OPV	Oral Polio Vaccine
ORT	Oral Rehydration Therapy
PA	Performance Assessment
PEs	Personal Emoluments
PEP	Post-Exposure Prophylaxis
PHC	Primary Health Care
PHO	Provincial Health Office
PLWHAs	Persons Living with HIV/AIDS
PMO	Provincial Medical Office
PMTCT	Prevention of Mother-to-Child Transmission
RPR	Rapid Plasma Reagent

District Planning Handbook

STI	Sexually Transmitted Infection
SWOT	Strengths, Weaknesses, Opportunities and Threats
TB	Tuberculosis
TI	Training Institution
TS	Technical Support
TSS	Technical Support Supervision
UCI	Universal Child Immunisation
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
ZDHS	Zambia Demographic and Health Survey
ZEM	Zambia Enrolled Midwife
ZEN	Zambia Enrolled Nurse

Glossary of Terms

Accreditation	The process by which an institution is objectively judged against pre-established standards in order to provide advice on needed improvements and public acknowledgement.
Activity	A specific action taken to achieve the objective.
Administrative Support	All activities and expenses related to the administration and general running costs not directly allocated to other cost centres, e.g. telephone, communications, salaries, etc.
Bottleneck Analysis	Planning or monitoring exercise to determine where impediments exist to reaching desired goals. These can exist on the levels of availability, accessibility, utilization, continuity and quality. Once bottlenecks are identified, interventions can be chosen to remove the blockage and improve outcomes.
Budget	A quantification of the resources and the associated costs of implementing the plan within a defined time period.
Clinical Care Costs	All costs related to activities associated with patient care.
Clinical Teaching	Teachings done to correlate theory with practice in the practicum setting.
Curative	Actions that reduce or eliminate the impact of illness. They include the early diagnosis and initiation of treatment.
Curriculum	All learning experiences planned to be covered within a specified period of time by learners.
Interventions	Detection and the prompt and effective treatment of illness.
Health Promotion	The process of using information, education and communication and community mobilisation to positively influence the health behaviour of individuals and groups.
Hospital Support to Health Centres	All activities and expenses related to technical support, in-service training, and clinical care provided by hospitals to health centres.
Indicator	An observable measure of the progress made towards achieving an objective.
Inflation	Sustained increase in prices and corresponding fall in the purchasing value of money.
In-Service Training	All activities related to retraining and orientation of existing staff.
Indicative Planning Figure	This is the projected level of funding anticipated for the next year.
Medium Term Expenditure Framework	Planning expenditure framework that provides budgetary information for the next three years for the health sector.
Monitoring	The process of regularly collecting and analysing information about the implementation of a plan to identify problems and take corrective action.

District Planning Handbook

Objective	The desired end result of a set of actions. An objective should state clearly what is to be achieved and must be measurable (to see if it has been achieved).
Plan	The definition of what is to be achieved (objectives), how it is to be achieved (activities), and the resources (people, materials and money) needed for implementation.
Pre-Service Training	The basic course of training which leads to accreditation as a member of a profession.
Prevention	Actions taken to preserve health. Primary prevention is intended to reduce the incidence of disease and injury.
Priority	The most important thing. In planning, a priority might be a problem or a solution (intervention).
Programme	Within the Planning Handbooks, a programme is a classification of activities based upon what those activities are intended to influence. For example, malaria is a programme, therefore all planned activities intended to influence the malaria situation would be classified under the malaria programme.
Rolling Plan	This is a plan of a continuous nature, e.g. the MTEF. The MTEF is a rolling plan with a three-year planning framework, where the planning time is of a continuous nature. The continuity exists because each year a detailed annual plan is prepared for the next year as one year is dropped and another one added, and the three-year timeframe is therefore continuous.
Strategy	A planned approach for achieving an objective. A strategy tells you how the objective will be achieved and provides a guide for the selection of specific activities to be carried out.
Supportive Supervision	The process of monitoring and reviewing achievements with the purpose of providing the necessary supportive guidance and assistance to promote continuous performance and quality improvement.
Technical Support	Clinical or management guidance, advice and assistance provided to other levels in the health system.
Training Institute	A centre in the health sector which provides education and training for health.

1. Introduction

1.1 The Health Reform Vision

The vision of Zambia's health reform is to provide equity of access to cost-effective, quality health care as close to the family as possible. The strategy adopted to achieve this vision emphasises integrated delivery of cost-effective interventions that address the majority of health problems affecting the Zambian population. By decentralising and integrating services, and by shifting emphasis to health centre and community level interventions, costs will be contained while improving accessibility and quality of care.

Consistent with this vision, great emphasis is placed on the work of the district to deliver the Zambian Health Care Package which has been defined for the purpose of improving the overall health status of the Zambian people. Therefore, thoughtful planning and budgeting for these services are essential to make delivery possible and sustainable.

In 2003 the Government decided to shift the public sector planning process to a Medium Term Expenditure Framework (MTEF) with three-year rolling plans. The public sector as a whole and the Ministry of Health in particular, adjusted its annual planning process to meet MTEF objectives, which are to:

- Ensure efficient allocation and management of public resources;
- Develop and maintain fiscal discipline in planning and management of public resources;
- Ensure commitment to budget priorities at national and sector levels;
- Improve accountability for national resources;
- Increase predictability of resources;
- Improve the procurement system.

The Ministry of Finance and National Planning (MoFNP) now provides budget ceilings for 3 years under the MTEF to allow ministries, provinces and spending agencies to develop plans within the available resource envelope. Thereafter, the Ministry of Health provides the strategic focus (derived from the National Development Plan and the National Health Strategic Plan), technical planning guidelines and budget ceilings to all health institutions annually. This information is used alongside other locally generated information from such sources as Health Management Information System (HMIS) and PA reports to prepare action plans.

1.2 Rationale

The last revision of the Planning Handbooks, which incorporated guidelines for planning on HIV/AIDS activities, was undertaken in 2005. Since then, improvements have been recorded in the quality of district and hospital action plans though there is still room for improvement.

A number of planning issues as well as approaches have emerged, making it necessary to undertake a fresh revision to the Planning Handbooks. This revision is aimed at strengthening current planning guidelines to ensure effective planning for HIV/AIDS activities and other key public health programmes. Furthermore, the Ministry of Health has adopted fresh approaches to planning such as Marginal Budgeting for Bottlenecks (MBB) and Health Performance Monitoring Frameworks which place more emphasis on outcomes and outputs rather than inputs and processes. The major purpose of this revision, therefore, is to incorporate these issues and approaches into Planning Handbooks for all levels (district, hospital, health centre, training institution and statutory board). An annex of high impact interventions adopted from the MBB approach and an example of a logical framework template have been inserted into

District Planning Handbook

this Handbook (see Annexes 3 and 5C).

1.3 Purpose of this Handbook

Effective planning is cardinal to the realisation of the objectives of the National Development Plan as well as the National Health Strategic Plan. This Handbook has been prepared to provide planning guidance and information to districts for use in the process of developing action plans.

The District Health Management Team (DHMT) plans should be based on national priorities and an analysis of the local health situation. This forms the basis for the identification of local priorities as well as the development of cost effective interventions which are responsive to the local health needs of the society. The Handbook is periodically revised within the framework of the National Health Strategic Plan when need arises.

The Handbook is not intended to incorporate programmatic or financial guidelines which are subject to more frequent changes such as the:

- Basic Health Care Package;
- Integrated Technical Guidelines;
- Quantification of Medical Supplies Manual;
- Designing and Operating Cost Sharing Schemes for Health Care;
- District Health Financial Planning Guide (updated annually);
- Hospital Financial Planning Guide (updated annually).

2. The District Health Management Team and Planning

2.1 Roles of the DHMT

The major roles of the DHMT include:

- Ensuring that health centres/posts work in close collaboration with their communities and with community representatives, and to facilitate and support community health initiatives;
- Mobilizing and distributing resources (finances, supplies, equipment and human) to health centres/posts and first level referral services;
- Setting performance targets for individual health facilities
- Monitoring and evaluating health care performance in the district in terms of quality and continuity and to take corrective action where necessary;
- Providing/facilitating training for health centres/posts and first level referral hospital staff;
- In health related matters, leading and coordinating the work of all NGOs and other stakeholders in the district, such as agriculture, local government and education whose activities influence outcomes through the District Development Coordinating Committee (DDCC) to ensure a multi-sectoral approach to service delivery;
- Analysing and consolidating district information and providing feedback to health centres/posts;
- Providing effective management of health staff and promoting retention and effective performance;
- Fostering research in health and related fields and ensuring that research results are disseminated and utilized.

In relation to Planning, the DHMT's roles include the following:

- Agreeing with health posts, health centres and hospitals providing first level referral services on priority health problems in the districts and setting general district objectives for the next 3 years, ensuring that each year's targets are reflected;
- Providing each health centre/post and hospital offering first level referral services with details of the projected funding and budgetary ceilings for the next three years;
- Offering guidance and support to health centres/posts and hospitals providing first level referral services in selecting appropriate interventions to achieve the district objectives;
- Assisting health centres/posts and hospitals offering first level referral services to develop their plans and budgets for three years within the budget constraints;
- Consolidating the health centres'/posts' and first level referral hospitals' plans into an overall district medium term plan and budget;
- Facilitating dialogue with the popular structures within the district premises (District Health Advisory Committees, DDCCs, task forces, etc.) on identifying priority health problems to include in action plans;
- Advocating for better prioritisation and planning for interventions that influence health outcomes by collaborating with other line ministries/departments through the DDCC, such as roads, water and sanitation, transport, education, etc.

In relation to Monitoring and Evaluation, the following are the roles of the DHMT:

- Setting performance targets for health facilities;
- Monitoring performance against set targets within and across health facilities;
- Enhancing community participation in monitoring and evaluation;
- Conducting operational research;
- Adjusting plans based on the performance assessment results;
- Undertaking technical support visits to address weaknesses identified within the system.

2.2 Annual Planning Schedule

Table 2.1 provides guidance on when each step in the annual planning process should have been undertaken and completed. The same information is provided in Table 2.2 in form of a Gantt chart. ***The activities presented in the shaded boxes (in Table 2.1 and those presented in bold) are those which directly involve action by the DHMT.*** Each of the activities listed in the schedule is then described in more detail in Section 3.

District Planning Handbook

Table 2.1: Annual Planning Schedule

Activity	Timeline
1. MoH HQ gives PHOs information on financial ceilings, technical planning guidelines and HMIS analysed data for the previous year.	1 st wk. May
2. Provincial Health Office meets with DHMTs and hospitals to review programme guidance and provide other updates (Step 1).	3rd wk. May
3. DHMT meets with the District Health Advisory Committees to review the previous year's experiences and to obtain their inputs to the next year's plan (Step 2).	4th wk. May
4. DHMT meets with hospitals providing first level referral services to negotiate bed purchase and agree on the terms of the Memorandums of Understanding (MoUs) (Step 3).	4th wk. May
5. DHMT brief first level hospitals, health centre/health post in-charges on programme and any planning updates (Step 4).	4th wk. May
6. Health centres meet with community representatives to review achievements and problems and to brief on any updates.	1 st wk. Jun
7. Community representatives meet with community to review experiences, determine priorities and to agree on community actions.	2 nd wk. Jun
8. Community representatives meet with health centre staff to draft community action plan.	3 rd wk. Jun
9. 2 nd and 3 rd level hospitals meet with their Health Advisory Committees to review progress in the first half year and to receive their input to the next year's plan.	2 nd wk. Jun
10. Hospitals form core planning teams which brief their Departmental Heads.	3 rd wk. Jun
11. DHMT meets with health centres, hospitals, health training institutions and NGOs to draft plans (Step 5).	1st wk. Jul
12. Health centres meet with community representatives to provide feedback on the projected budget and final community action plan.	3 rd wk. Jul
13. Core hospital planning team meets Departmental Heads to review next year's departmental allocations and planning launch.	2 nd wk. Jul
14. Hospital departments draft their plans and submit to hospital core planning team.	4 th wk. Jul
15. 2 nd and 3 rd level hospitals present plan to the Hospital Advisory Committee; and first level hospitals submit completed plan to DHMT.	1 st wk. Aug
16. 2 nd and 3 rd level hospitals present their plans to the Provincial Office; first level hospitals present their plans to their DHMT.	2 nd wk. Aug
17. DHMT drafts the district health office plan (training, supervision, advisory committee expenses, epidemic preparedness, etc. (Step 6).	2nd wk. Aug
18. DHMT consolidates district action plan and budget (Step 7).	4th wk. Aug
19. DHMT presents and defends the District Health Plan and budget to the Health Advisory Committee and District Development Committee (Step 8).	1st wk. Sept
20. DHMT submits the District Action Plan to the District Commissioner.	2nd wk. Sept
21. DHMT submits the District Action Plan to the PHO (Step 9).	2nd wk. Sept

District Planning Handbook

Activity	Timeline
22. PHO reviews District, Training Institutions, 2nd and 3rd level hospital plans and institutions revise/finalise their plans and resubmit to PHO (Step 10).	3rd wk. Oct
23. Provinces approve plans, sign MoUs and submit consolidated copies of district, training institutions and 2 nd and 3 rd level hospital plans to MoH.	3 rd wk. Oct
24. MoH HQ consolidates and submits Health Sector plan and budget to MoFNP.	November

Table 2.2: Planning Schedule Gantt Chart

Action	May			June			July			August			September			October			November			
1. MoH HQ gives financial ceilings for the three-year plan to the Provincial Health Office																						
2. PHO meets with DHMTs/hospitals to provide updates																						
3. DHMT meets with DHAC to review past year's experience																						
4. DHMT negotiates purchase of first level referral services																						
5. DHMT briefs H/Cs and HPs on programme/planning updates																						
6. H/Cs meet with NHCs/HCCs																						
7. NHCs/HCCs meet with community members																						
8. NHCs/HCCs meet with H/C to draft community action plans																						
9. 2 nd /3 rd level hospitals meet with their Hospital Boards																						
10. Hospitals form Core Planning Teams																						

District Planning Handbook

Action	May				June				July				August				September				October				November							
24. MoH HQ consolidates and submits Health Sector plan and budget to MoFNP																																

Note: The steps in bold are those for which the DHMT is directly responsible.

3. The Planning Steps Each Year

The following steps are suggested to guide DHMTs in their planning and to help them ensure that key players in implementation are fully involved at the planning stage.

Step 1: Meeting with the Provincial Health Office

During this meeting, the Provincial Health Office (PHO) will brief the Statutory Boards (where they exist), DHMTs, hospitals, and training institutions on the planning process and review any programme updates that have been disseminated by the central level over the last 12 months. The PHO will disseminate national priorities (**adapted to provincial circumstances**) and budget ceilings for the next MTEF. The PHO should also invite representatives from the Provincial HIV/AIDS task forces and other partners supporting public health programmes, such as HIV/AIDS and other key health programmes at provincial level. This allows for strengthened coordination of activities by various partners.

Step 2: Meeting with the Health Advisory Committee

The DHMT should meet with the Health Advisory Committee to brief the members on its meeting with the PHO, to review the previous year's achievements, and to obtain the Board's input to the next three year plan.

Step 3: DHMT Negotiates the Purchase of First Level Referral Service

The DHMT will meet with each of the hospitals from which it intends to purchase first level referral services by the 4th week of May. This negotiation will be the basis on which the purchase is formulated (patient utilisation or flat rate percentage) and the terms of the MoU (covering the specific services to be provided and the expected quality of those services). The district must reflect the total value of 1st level bed purchases under the budget line "1st Level referral services".

Step 4: DHMT Provides Planning Updates to Health Centre and Health Post In-Charges

Following the meeting with the PHO, the DHMT should meet with the in-charges of all their health centres/posts and where applicable training institutions. The DHMT will brief them on any changes to the planning process, national goals and priorities, and to review with them any programmatic updates that have been disseminated by MoH HQ over the previous 12 months. This may not need a special meeting and can be done as part of routine supervision or performance assessment visits.

Step 5: Meeting with Health Centres, Hospitals, NGOs and Training Institutions

The DHMT will call a meeting which should be attended by representatives of all the health centres, health posts, first level hospitals, training institutions (where they exist), NGOs, Council Planning Units and other key stakeholders, such as District HIV/AIDS task forces and Faith Based Organisations (FBOs) in the district to tap their input to the plan and to agree general district objectives.

Health centre and health post representatives should be asked to bring their draft health centre/post action plans drafted earlier, as well as their completed self-assessment forms for the previous year and their performance assessment results for the same period.

Before this meeting, the district should have completed the following preparations:

- Analysis of the HMIS data from the previous year;
- Analysis of the DHMT self-assessment and the health centre performance assessment results for the same period;
- Analysis of research results where this has been done for the same period;

District Planning Handbook

- A complete bottleneck analysis results highlighting blockages to achieving results (*see Annex 2 for a description of the bottleneck analysis*);
- Based on the information analysed, the DHMT should prepare its own assessment of the priority health problems facing the district as identified through recent research, routine information systems and/or bottleneck analysis. This analysis will explore the underlying causes of these problems, to ensure that there is proper understanding of the problem and to determine actions to be taken. Box 3.1 outlines the main elements of a situation analysis. The results of the analysis should be entered in Part 2.1 of the main plan and should form a basis for priority setting.

Box 3.1: Contents of Situation Analysis

Population characteristics

- Demographic information
- Religious, educational and cultural characteristics

Area characteristics and infrastructure

- Geography and topography
- Infrastructure and socio-economic situation
- Public and private sector structures

Policy and political environment

- National and health policies
- Political environment

Health needs

- Medically perceived (HMIS)
- Community perceived

Health services

- Facilities and utilisation
- Service gaps
- Service organisation

Resources

- Financial and personnel
- Buildings, equipment and vehicles
- Drugs and medical supplies

Efficiency, effectiveness, equity and quality of services

- Definition of district objectives for the identified priority health issues for 3 years that will be shared, reviewed and agreed during the meeting, including solutions to the bottlenecks identified, using evidence based interventions (*see Annex 3*). The identified interventions should be entered in Part 3.2 which is the Logical Framework.

Box 3.2: The Logical Framework

The Logical Framework Approach (LFA) is an analytical, presentational and management tool which can help planners and managers to:

- Analyze the existing situation during project preparation
- Establish a logical hierarchy of means by which objectives will be reached
- Identify potential risks
- Establish how outputs and outcomes will be monitored and evaluated
- Present a summary of the project in a standard format
- Monitor and review projects during implementation.

The product of the LFA is a matrix (the Log Frame) which summarizes what the project intends to do and how, what the key assumptions are and how outputs and outcomes will be monitored. More details on the logical framework approach are provided in Annex 4.

- Determination of the total resource envelope based on ceilings provided by MoH HQ, pledges from local donor projects and projections of user fee collections where applicable. The district should then make decisions on how this income is to be distributed between the different service levels and between individual health facilities. (*Worksheet A in Part 5 of the main plan should be used for this step*).

Hospital representatives should be encouraged to attend and participate actively, to agree on the actions that the hospital could take to contribute to the achievement of the district objectives, and to provide assistance to the health centres in the development of their medium term plans and budgets.

The DHMT should run sufficient copies of the Health Post/Health Centre Worksheets B, C and D for use during the meeting.

Part One of the Meeting: Situation analysis and defining objectives

During the first part of this meeting, the DHMT should lead participants in the following activities:

A SWOT Analysis

- Undertake an environmental analysis of both internal and external factors that may have had a bearing on health and also any general changes since the previous year. The team should also make an assessment of the assumptions that were made during the previous planning cycle that may have derailed the implementation of some activities in the plan;
- Review the previous year's performance and results achieved.

B Bottleneck Analysis

- Conduct the bottleneck analysis by individual health centres/posts to identify bottlenecks to achieving set objectives by individual health centres/posts. Enter this information in the bottleneck analysis template provided in Annex 2;
- Review the present health situation in the district, taken from the HMIS reports submitted by the health posts and health centres and from the health centre performance assessment results. (The DHMT should share the district profile with stakeholders for key health indicators to see how they have been performing against the national targets);
- Based on results from the SWOT analysis, bottleneck analysis and analysis of the health situation in the district, agree the priorities and the objectives that the district wishes to focus on in the next three years, and in order of priority (*please refer to Box 3.3 for definition of a good objective*). This should be in line with national goals and priorities and the identified local health problems in

District Planning Handbook

individual districts. However, it is important that districts budget for all the health programmes;

- Agree priority activities based on agreed objectives and these should be high impact interventions (please refer to Annex 3 for some of the examples of high impact interventions) for the coming year.

This part of the meeting will be followed by agreeing and drafting of the general district objectives. These will then be entered into the logical framework provided in **Annex 5**.

Box 3.3: Objectives

An objective states what will be achieved by the end of the period. A good objective is “SMART”, i.e.:

- Specific: It will state an exact and single result to be achieved
- Measurable: Precisely defined and easily quantified. Data is easily available in numerical format to measure how far the objective has been achieved
- Achievable: It will be possible to achieve the objective in the specified time
- Realistic: The resources (money, people and materials) will be available
- Time-bound: It states by when the objective will be achieved

Example of a good objective: “To increase the proportion of fully immunized children in the district

Part two of the meeting: Identifying outputs and high impact interventions

Part Two of the Meeting: Identifying outputs and high impact interventions

In the second part of the meeting, the DHMT will guide health centre/post staff to identify outputs and high impact cost effective interventions to achieve the general district objectives and to determine targets for each year for the next 3 years in relation to the objectives. (*Refer to Annex 6, for examples of outputs and Annex 3 for a list of high impact, evidence based interventions and the ITGs booklet - 3rd Edition, for a wide range of appropriate health interventions*).

At this stage the DHMT will have received the budget ceilings from MoH HQ and will share what is available in support of district medium term plans.

The DHMT will inform each health centre/post, hospital and training institution of their projected service grant allocation based on available MTEF ceilings and will provide guidance on expenditure ceilings for each year as contained in the current year’s District Health Financial Planning Guide.

The DHMT will, where applicable, assist each health centre/post, training institution and first level hospital in projecting its likely fee income (where applicable) for 3 years together with any other sources of support that may be forthcoming.

The total projected allocations and fees represent the total resources that each health centre/post, hospital and training institution should budget for in their plan. Any other known source of income for the coming year should be added at this stage to the appropriate column and year (Table 2.5.1). Based on the projected income levels provided, the DHMT works with health centres and district hospital(s) to define the district budget using the following steps:

Part Three of the Meeting: Costing and budgeting of the plan

1. Defining the scope of the costing exercise

Before undertaking a costing exercise, it is important to define the strategies to be employed in delivering services to the public. For malaria prevention interventions for example, there should be an indication if

emphasis will be placed on distribution of insecticides rather than indoor spraying. It is necessary to make a list of issues and then prioritize them putting aside the less important ones and presented in tabular form.

2. Identification and description of programmes and activities

This guide has adopted the Marginal Budgeting methodology which follows an integrated approach to service delivery and not a disease specific approach. The recommended programmes are community oriented interventions, outreach/disease prevention programmes and clinical care divided between health centre and first level referral services (*please see Annex 3*).

The district should (under these programmes) describe the proposed objectives, main activities, level of operation hierarchical structures, units of “production” and geographical spread of these alternatives and the source of funds. The expected product of this process is a fleshed-out description of the programme with the activity section being the most detailed.

3. Identification of inputs

The next stage is identification of the inputs needed to carry out an activity. The inputs needed to carry out an immunization campaign for example might include staff time, transport costs, subsistence or per diem payments, vaccines and syringes, cold chain equipment, publicity materials, immunization records and staff training (*see Table 3.1*). The District Management Team must carefully identify all the major and relevant items of expenditure needed to carry out activities identified in Step 2. MoH HQ has provided a well designed chart of accounts in Annex 12, detailing and segregating costs in line with designed cost centres. The most common expenditure items include:

Table 3.1: Identification of Inputs

1 Staff allowances	5 Water	9 Travel
2 Drugs/other medical supplies	6 Stationery	10 Seminars and meetings
3 Transport and vehicle running	7 Cleaning materials	11 Bank charges
4 Electricity	8 Repairs	12 Linen

The identification of inputs can be aided by coming up with a checklist like the one provided in Table 3.2 below. Inputs are commonly grouped into two important categories, namely recurrent and capital.

Recurrent inputs are resources that are used up and consumed within a year of purchase (e.g. drugs, educational materials, labour). *Capital goods* are items such as vehicles, equipment and buildings that have a useful life of longer than one year. Capital items are one-off (in the short to medium term) while recurrent items continue to occur as part of the operations of the activity.

4. Developing an activity based cost framework

Each of the cost dimensions (activity, inputs, funding source, level of operation. etc.) can be broken down or subdivided in different ways and with different levels of detail. Table 3.2 illustrates this for each of the dimensions of inputs, activities, level of operation, and source of funds.

District Planning Handbook

Table 3.2: Cost Framework for District Level activities

Programme	Activities	Inputs		Source of Funding	
		Recurrent	Capital	Domestic	Donor
Family and Community Based services	ITNs; IRS; Malaria treatment with Community Drug Kits	Staff costs, supplies, fuel, etc.	Boats, bicycles, motorbikes, buildings and equipment	Govt/fees	Basket, project, etc.
	Complementary and supplementary feeding; Vitamin A	Staff costs, supplies, fuel, etc.	Boats, bicycles, motorbikes, buildings and equipment	Govt/fees	Basket, project, etc.
	Oral rehydration, water treatment and hygiene education	Staff costs, supplies, fuel, etc.	Boats, bicycles, motorbikes, buildings and equipment	Govt/fees	Basket, project, etc.
Schedulable and Outreach Services	Family Planning; Antenatal Care; de-worming, vitamin and iron supplementation in pregnancy, malaria IPT; PMTCT	Staff costs, supplies, fuel, etc.	Boats, bicycles, motorbikes, buildings and equipment	Govt/fees	Basket, project, etc.
	Immunizations; Vitamin A supplementation	Staff costs, supplies, fuel, etc.	Boats, bicycles, motorbikes, buildings and equipment	Govt/fees	Basket, project, etc.
	Condom use, IEC	Staff costs, supplies, fuel, etc.	Boats, bicycles, motorbikes, buildings and equipment	Govt/fees	Basket, project, etc.
Clinical Care (Health centre and hospital in-house care)	Skilled delivery care; Basic emergency obstetric care (B-EOC);	Staff costs, supplies, fuel, etc.	Vehicles, motorbikes, buildings and equipment	Govt/fees	Basket, project, etc.
	Appropriate treatment for malaria (chloroquine or ACT); DOTS for TB	Staff costs, supplies, fuel, etc.	Vehicles, motorbikes, buildings and equipment	Govt/fees	Basket, project, etc.
	Complicated malaria; ART; Management of (pre) eclampsia; Comprehensive emergency obstetric care (C-EOC)	Staff costs, supplies, fuel, etc.	Vehicles, motorbikes, buildings and equipment	Govt/fees	Basket, project, etc.
Admin. and TS	Performance assessment, supervision, utilities, other admin. costs	Staff costs, supplies, fuel, etc.	Vehicles, motorbikes, buildings and equipment	Govt/fees	Basket, project, etc.

It is up to the individual districts to identify the activities under each programme for inclusion in the costed plan. Whatever the details of the categories within each dimension, there are certain points to bear in mind. It is essential that the classification is comprehensive. There must be a “home” for each relevant cost, meaning each item must be placed within a specific cost centre. The classification should also be mutually exclusive. Within any given organizing principle, a particular cost should only have one

“home.”

The end product of this step is a cost framework that identifies the cost dimensions that will be focused on and how much detail and cross-linking of data there will be, as well as a list of key activity categories categorized as either primary, secondary or ancillary activities with a description of what each involves and an indication of how the activities relate to each other and to outcomes.

5. *Determination of input unit costs and quantities*

The next step involves collecting data on unit costs of the various cost items to facilitate expressing the resources identified in money terms. Information for this stage can be obtained from existing budgeting and accounting systems, i.e. books of accounts, payroll, fixed assets register, etc.

The cost of drugs and other medical and laboratory supplies are obtainable primarily from the invoices of suppliers, the medical supplies department and the IDA price list or from pharmacy personnel. Other sources of information include expert opinion from programme officers or commercial firms in the case of specialist equipment costs. Building costs may be obtained from architects and quantity surveyors from the Buildings Department. A price list for selected key inputs will be provided annually by MoH HQ through the technical planning updates.

Having derived the unit costs of various inputs, the next stage will be to determine the quantity of inputs required to undertake the identified activities at the required scale. This determination will take into account the current operational levels as well as the planned scale-up if any. The data can then be collated into the basic tables of the **cost framework**. These tables will reveal the cost of different elements of the programme as well as the programme’s total costs.

In completing the cost framework for the district, the health centre should take note of the following points:

- Refer to the community action plan that they helped the community representatives to complete on Worksheet D. The DHMT can help calculate the cost of each activity and determine whether all these activities can be afforded out of next year’s funds for community based activities;
- Remove lower priority activities from the community action plan if total cost exceeds what is available. If some activities have to be excluded, start a new Worksheet D for the community action plan and enter only those activities that can be afforded, together with the relevant costs;
- Each health centre/post should keep a copy of the original draft community action plan to facilitate feedback to community representatives at a later date;
- Refer to the Basic Health Care Package or the Integrated Technical Guidelines for Frontline Health Workers (Third Edition) and the list of high impact, evidence based interventions for selection of appropriate interventions. Discuss any other ideas they may have which may not be included in the ITG booklet with the DHMT. ***When they have decided what they can do, enter details of the activity and costs on Worksheet D.***
- Refer to the Planning Cost Guide for a detailed discussion on costing.

The DHMT should then lead a discussion of the actions that the DHMT, the first level referral hospital/s and NGOs will take to support the health centres/posts to achieve their objectives. These should cover training, supportive supervision and technical support (such as hospital staff attending health centre/post to run special clinics). The outcome of this meeting should be the first draft of detailed health centre plans and district hospital plan. If health centres/posts cannot complete their plans during the meeting, the DHMT should agree on a date by which they will submit their finalised plans to the District Health Office.

Step 6: Preparation of the District Health Office Plan

Following the meeting described in Step 5 above, the DHMT should then proceed to prepare its plan for the District Health Office in the same way for the same time period. This plan should take into account the agreements reached in Step 5 in relation to the support that the health centres/posts require from the DHMT (technical support, supportive supervision, training, etc.). It should cover DHMT activities related to performance assessment and include a costed plan for drugs and supplies. The District Health Office plan should also include the actions required in support of the preparation of the district medium term plans. Districts should form a core planning team comprising of Manager Planning, District Health Information Officer (DHIO) programme officers and the District Accounting Officer (DAO) to spearhead planning for the District Health Office.

In preparing the District Office Plan, the DHMT should take the following steps:

- Project the income that the District Office is likely to have for next MTEF through the service grant and from other sources such as rent. *Refer to Table 2.5.1 – Summary of income and expenditure;*
- Determine support programmes and activities and calculate all input costs.

The DHMT will refer to the technical planning updates provided by MoH HQ for information on ceilings (Indicative Planning Figures) in order to plan and budget for the stipulated activities.

Step 7: Production of the Consolidated District Action Plan and Budget

Based on the agreed general district objectives, the DHMT now prepares the consolidated district medium term plan and budget. It is essential that the consolidated medium term plan and budget for a district includes and is consistent with the objectives and activities that may have been formulated for specific projects (such as micro plans, multi-sectoral HIV/AIDS plans, and Roll Back Malaria plans). Districts must ensure partner supported programmes are incorporated in the consolidated action plans.

By this point, communities, health centres/posts, first level hospitals and the District Health Office have determined the activities and services to be included in their medium term plan for the next three years. The activities should be costed and summarized on the tables shown in Annexes 1-4 of the outline for the consolidated district medium term plan and budget, guided by these tables. The District Accounting Officer (DAO) completes the tables in Sections 5.6 - 5.10 of the Outline for the District Medium Term Plan. The DAO ensures that the total cost on all these tables is the same as the total cost derived from Annexes 1-4. The figures in the tables are then transferred onto the Consolidated District Budget Spreadsheet, into the appropriate columns. If any of the totals exceed the budgetary ceilings, then the DAO should refer back to the tables and annexes and make the necessary adjustments until the spreadsheet totals tally with the budgetary ceilings.

An outline for the format of the consolidated District Medium Term Plan and Budget is appended to this document as Annex 1 and will also be made available electronically.

The Provincial Health Office will be visiting DHMTs during the development of their consolidated District Medium Term Plans and Budgets to check on progress being made and to provide guidance where necessary. The district may also request technical support from the province (or MoH HQ if necessary) where difficulties are encountered.

Step 8: Presentation of the District Plan and Budget to the DHAC and the DDCC

When complete, the District Medium Term Plan must be presented to the District Health Advisory Committee (DHAC). The DHMT should be prepared to justify its decisions in the committee meeting and

District Planning Handbook

the DHAC should give its approval to the plan and sign the foreword to the plan before it is submitted to the PHO. Thereafter, the district plan should be presented to the DDCC for approval and incorporation into the overall district development plan.

Step 9: Presentation of the Consolidated District Action Plan and Budget to the PHO

The DHMT then submits its consolidated District Medium Term Plan and Budget to the PHO by the 2nd week of September. The action plan should be accompanied by a letter of submission signed by the District Commissioner.

Step 10: Review of the Consolidated District Action Plan and Budget by the PHO

The PHO will review the plan and provide feedback to the DHMT on any adjustments required. Based on the feedback, the DHMT will finalise the consolidated action plan and budget and re-submit the plan to the PHO.

A final version of the action plan should be submitted to the PHO by the 3rd week of October for approval, consolidation and submission to MoH HQ.

Districts, hospitals and training institutions should also submit parliamentary briefs on budget allocations to programmes. These parliamentary briefs are concise statements on variations in budget allocations and expected outputs for each of the budget lines.

4. Monitoring the Implementation of the Plan

The DHMT is required to monitor the implementation of its plan and to report on progress being made towards achieving the district objectives according to the planned activities. To do this, the district should build in a monitoring and evaluation plan within their District Medium Term Plan to facilitate monitoring of the implementation process on a quarterly basis. This information will also be used during the preparation of the annual report. The DHMT is expected to submit quarterly and annual progress reports to the PHO (the HMIS, Income and Expenditure Reports, District Self-assessment Reports) for consolidation and onward submission to MoH HQ once every six months.

At the end of the MTEF period each DHMT will be expected to provide a report on how they have fared and what impact this has had on the expected outcome (the district objectives) and make recommendations for the future. Each quarter, the DHMT, first level hospital, health centres/posts should produce updated quarterly summary action plans and budgets which take into account HMIS reports and the performance reports of the previous quarter. As part of its monitoring responsibility, the DHMT prepares short reports each quarter to identify the progress achieved in implementation. The reports are shared with health centres/posts and first level hospital staff during supervisory visits or meetings.

The questions that need to be answered during monitoring are as follows:

- A. *With reference to the original health centre activity plan and schedule, summarize what was planned for the previous quarter and what is planned for the upcoming quarter. Then answer the following questions:*
 - i) Have the planned activities been implemented at the intended time and by the designated person/s? If not, why?
 - ii) Should activities that have not yet been implemented be rescheduled?
- B. *With reference to the district-wide objectives:*
 - i) Are the implemented activities achieving the desired results (in relation to district-wide objectives)? (*reference should be to the quarterly self-assessment form, updated quarterly summary plan, and performance assessment and accreditation results where possible.*)
- C. *With reference to the planned activities:*
 - i) Given the experience to date, do any of the planned activities need to be adjusted, rescheduled or cancelled?
 - ii) Should any additional activities now be programmed so that the desired results can be achieved?

At the end of the year, the DHMT prepares an annual report (by mid-February of the following year) comparing achievements against the planned activities, identifying major constraints experienced during the year and making recommendations for the future. The annual reports form the basis for producing a full report at the end of the Medium Term Plan period (3 years). It is, therefore, important that the district includes a Gantt chart at the back of the plan showing the implementation calendar for all the activities. This enables them to track the level of implementation.

5. Format of the District Health Action Plan

The following is the format of the District Health Plan.

Table of Contents

District Map

Reflect the district map showing health facilities, roads, rivers and names of neighbouring districts and/or countries to support the district profile.

List of Abbreviations

Foreword by District Commissioner

Acknowledgments

Executive Summary

This section should only be written *after* drafting the whole plan and should provide a brief summary of identified problems and defined priorities. It should summarize what is contained in the whole document. The author is at liberty to leave out what s/he feels less important. What is hoped to be done or achieved should be left out of the main document. Only the summary of what is contained in the main document should appear in the Executive Summary.

Part 1: Introduction

1.1 Overview

- Give a description of where the district is situated, its Zambian and international neighbours, if applicable, its geographic size, rivers, road networks, communications, weather patterns, average rainfall and other special features.
- Describe any special population groups for which special strategies may be required to ensure their access to services.
- Provide a description of services being provided by the district such as laboratory, X-ray, VCT, PMTCT, ART and mortuary.

1.2 Demographic Profile

Table 1.1 requires some analysis, for instance how many pregnancies are expected by year including the population by year. Describe any special population groups for which special strategies may be required to ensure their access to services.

Table 1.1: District Population and Key Health Indicators

Category	Yr n-2		Yr n-1		Yr n	
	Number	%	Number	%	Number	%
Children 0 – 11 Months						
<5 Years						
5 – 14 Years						
Women 15 – 49 Years						
All Adults 15 Years+						
Total Male (All ages)						
Total Female (All ages)						
Total Population [∧]						
Population Growth Rate						
Expected Pregnancies						
Expected Deliveries						
Expected Live Births						

[∧] State whether source is CSO or other source

1.3 Socio-Economic Profile

Brief description of major industries, employment opportunities, main occupations of the population, lifestyles, schools, population movements, levels of wealth/poverty, literacy rates for males and females, women’s status and other factors limiting development.

1.4 Stakeholders, Other Health Providers and Government Departments

Give a brief description about stakeholders, Government Departments and other Health Providers and the type of services/support they are providing.

Table 1.2: Stakeholders in the Health Sector

Organisation	Catchment Area	Programme Focus and Activities

Part 2: Situation Analysis

2.1 Health Status

- Provide details for the top 10 causes of morbidity for Tables 2.1.1 and 2.1.3 and mortality for Tables 2.1.2 and 2.1.4. The list of diseases in the tables should not be pre-populated as they may change by year;
- Write briefly about the top ten by year;
- In Tables 2.1.2 and 2.1.4, list the top 10 according to volumes/number of people dead;
- When calculating the contribution in % for Tables 2.1.2 and 2.1.4, correct to 1 decimal point.

2.1.1 Top Ten Causes of Morbidity (All Ages)

Table 2.1.1

No.	Yr n-1				Yr n-2				Yr n-3			
	Disease	Incidence/1000			Disease	Incidence/1000			Disease	Incidence/1000		
		Male	Female	Total		Male	Female	Total		Male	Female	Total
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												

2.1.2: Top Ten Causes of Mortality (All Ages)

Table 2.1.2

No.	Yr n-1				Yr n-2				Yr n-3			
	Disease	Number dead			Disease	Number dead			Disease	Number dead		
		Male	Female	Total		Male	Female	Total		Male	Female	Total
1												
2												
3												
4												
5												

2.1.3 Top Ten Causes of Morbidity (Under 5s)

Table 2.1.3

No.	Yr n-1				Yr n-2				Yr n-3			
	Disease	Incidence/1000			Disease	Incidence/1000			Disease	Incidence/1000		
		Male	Female	Total		Male	Female	Total		Male	Female	Total
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												

2.1.4 Top Ten Causes of Mortality (Under 5s)

Table 2.1.4

No.	Yr n-1				Yr n-2				Yr n-3			
	Disease	Number dead			Disease	Number dead			Disease	Number dead		
		Male	Female	Total		Male	Female	Total		Male	Female	Total
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												

2.1.5 Top Ten Causes of Morbidity (5+ Years)

Table 2.1.5

No.	Yr n-1				Yr n-2				Yr n-3			
	Disease	Incidence/1000			Disease	Incidence/1000			Disease	Incidence/1000		
		Male	Female	Total		Male	Female	Total		Male	Female	Total
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												

2.1.6 Top Ten Causes of Mortality (5+ Years)

Table 2.1.6

No.	Yr n-1				Yr n-2				Yr n-3			
	Disease	Number dead			Disease	Number dead			Disease	Number dead		
		Male	Female	Total		Male	Female	Total		Male	Female	Total
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												

2.1.7 Nutrition Status of Under 5s

Table 2.1.7

Indicator	Yr n-1			Yr n-2			Yr n-3		
	No <5s	No. Weighed	%	No. <5s	No. Weighed	%	No. <5s	No. Weighed	%
Total number of children weighed out of total < 5s									
No children below lower line (-3 Z scores) 0-23 months									
Vitamin A supplements 6-59 months									
Deworming 12-59 months									

Note: To do this determine the number of <5s weighed during the period under review out of the expected total of <5s in the district. From this number, calculate how many of those were below lower line and the percentage they make.

2.1.8 Notifiable Diseases

In this table provide information on any outbreaks experienced during the year in the key notifiable diseases.

Table 2.1.8

Notifiable Disease	Yr n-1	Yr n-2	Yr n-3
AFP			
Anthrax			
Cholera			
Dysentery			
Measles			
Meningitis			
Neonatal tetanus			
Typhoid			
Yellow fever			
Plague			
Dog bite			
Rabies – confirmed			

2.2 Service Coverage

2.2.1 Child Health Interventions

Provide information on Immunization and Vitamin A coverage.

Table 2.2.1: Immunisation/Vitamin A Coverage

Antigen	N QTR 1 and 2			Yr n-1			Yr n-2			Yr n-3		
	Target	Covered	%	Target	Covered	%	Target	Covered	%	Target	Covered	%
BCG												
OPVO												
OPV1												
OPV2												
OPV3												
DPT+Hib+Hep 1												
DPT+ Hib+Hep 2												
DPT+ Hib+Hep 3												
Measles												
Fully Immunized (0-11 months)												
Vitamin A (6-59 months)												

Note: If the coverage figures appear higher than expected, the district should indicate whether this is due to serving populations which are not included in the Population Table.

2.2.2 Integrated Reproductive Health Interventions

- In Table 2.2.2 provide IRH coverage figures by service for a 3 year period.
- Youths are defined as 10-24 years. Each district should use their own data to come up with their targets for these areas.

Table 2.2.2: Integrated Reproductive Health Coverage by Year (revised)

Service	Yr n-1		Yr n-2		Yr n-3	
	Target	No. attended to	Target	No. attended to	Target	No. attended to
1. Focused Antenatal Care						
First ante-natal attendance						
Average ante-natal visits per pregnant woman						
RPR tested						
RPR reactive						
Partners treated for STIs						
TT protection						
Folic acid and iron						
IPT						
ITNs						
De-worming						

District Planning Handbook

Service	Yr n-1		Yr n-2		Yr n-3	
	Target	No. attended to	Target	No. attended to	Target	No. attended to
2. Deliveries						
Deliveries by tTBAs						
Deliveries by CDEs						
Delivered by skilled provider (Nurse midwife or Doctor)						
Maternal complications						
Post-partum haemorrhage						
Hypertensive Diseases/Eclampsia						
Abortions						
Obstructed Labour						
Infections (Direct)						
Others						
Caesarean section						
Vacuum extraction						
3. Family Planning (FP)						
FP New acceptors						
Pill	65%					
Injectables	15%					
Implants	1%					
Condoms	18%					
IUDs	1%					
BTL (Female Sterilization)						
Vasectomy (Male Sterilization)						
Emergency Contraception						
4. FP Re-attendance						
Pill	65%					
Injectables	15%					
Implants	1%					
Condoms	18%					
IUDs	1%					
BTL (sterilization)						
Vasectomy						
Emergency contraception						
5. Youth Friendly Health Services						
Family Planning						
STIs						
HIV/AIDS						

District Planning Handbook

Service	Yr n-1		Yr n-2		Yr n-3	
	Target	No. attended to	Target	No. attended to	Target	No. attended to
Pregnancy						
6. Post-abortion Care (PAC)						
Manual vacuum aspiration (MVA)						
Dilatage and Curettage (D and C)						

2.2.3 Environmental Health

Table 2.2.3: Environmental Health

Indicator	Yr n-1	Yr n-2	Yr n-3
<u>Water</u>			
% of population with access to safe water supply			
% of population using other sources (shallow wells, streams, etc.)			
<u>Sanitation</u>			
% of population using flush toilets			
% of population using pit latrines			
% of population using bushes/other			
<u>Sources of Energy</u>			
% of population using electricity			
% of population using solar energy			
% of population using charcoal			

Description of inspection of premises and foods, salt testing and water sampling activities.

2.2.4 HIV/AIDS Services

Table 2.2.4 HIV Services

Table 2.2.4a: Proportion of Clients Counselling for HIV Who Took an HIV Test									
Facility	Number of CT Clients								
	Yr n-1			Yr n-2			Yr n-3		
	Counselled	Testing	%	Counselled	Testing	%	Counselled	Testing	%
Total									

Source: HMIS

District Planning Handbook

Table 2.2.4b: Proportion of Clients Taking an HIV Test									
Facility	N-1			N-2			N-3		
	Tested	Positive	%	Tested	Positive	%	Tested	Positive	%
Total									

Source: HMIS

Prevention of Mother-to-Child Transmission of HIV/AIDS

Table 2.2.4c: Proportion of Women Starting ANC who Take an HIV Test by Facility									
Facility	Yr n-1			Yr n-2			Yr n-3		
	ANC 1 st Visit	Tested for HIV	% Tested	ANC 1 st Visit	Tested for HIV	% Tested	ANC 1 st Visit	Tested for HIV	% Tested
Total									

Source: HMIS

Table 2.2.4d: Proportion of Pregnant Women Testing HIV Positive by Facility									
Facility	Yr n-1			Yr n-2			Yr n-3		
	Tested for HIV	Tested Positive	% Positive	Tested for HIV	Tested Positive	% Positive	Tested for HIV	Tested Positive	% Positive
Total									

Source: HMIS

Source: HMIS

2.2.5 Other services

Districts can include any information on programmes not listed above.

2.3 Present Health Facilities/Utilisation Rates

2.3.1 Health Facilities/Neighbourhood Health Committees

In this section, give the utilization rates of facilities by type of ownership. Please indicate the number of *Government and Mission hospitals available in the district as well as beds available in these facilities.*

Table 2.3.1

Type of Facility	Government		Mission		Other (specify)	
	No.	Beds	No.	Beds	No.	Beds
Hospitals/beds						
Stage 1 Health Centres						
Stage 2 Health Centres						
Health Posts						

2.3.2 Utilisation Rates

Table 2.3.2

Year	Total first OPD Attendances	Total Population	Per Capita Attendances
Year ^{N-2}			
Year ^{N-1}			
Current Yr (period)			

2.4 Present Staffing in the District

You are expected to fill in staffing levels as given in Table 2.4.1. Provide a short write-up on health worker availability and distribution pattern.

District Planning Handbook

Table 2.4.1: Staffing Levels by Category of Staff

Category of Staff	Establishment			Existing		
	DHO	Hosp.	H/Cs	DHO	Hosp.	H/Cs
District Medical Officer						
Senior Planning Officer						
Planning Officer						
Senior Human Resource Officer						
Human Resource Development Officer						
District Health Information Officer						
Clinical Care Expert						
Environmental Health Officer						
Senior Environmental Health Technician						
Cold Chain Focal Person						
Maternal and Child Health Coordinator						
TB/Leprosy Focal Person						
District Accounting Officer						
Accounting Officer						
Assistant Accounting Officer						
Typist						
Registry Clerk						
Driver						
Office Orderly						
Stores Officer						
Purchasing Officer						
Personnel Officer						
Security Guard						
Doctor						
Medical Superintendent						
Senior Nursing Officer						
Hospital Administrator						
Nursing Officer						
Night Superintendent						
Registered Nurse						
Registered Midwife						
Senior Enrolled Nurse						
Zambia Enrolled Nurse						
Zambia Enrolled Midwife						

District Planning Handbook

Category of Staff	Establishment			Existing		
	DHO	Hosp.	H/Cs	DHO	Hosp.	H/Cs
Psychiatric Enrolled Nurse						
Environmental Health Technician						
Theatre Nurse						
Principal Clinical Officer						
Senior Clinical Officer						
Clinical Officer						
Laboratory Technician						
Laboratory Assistant						
Pharmacist						
Pharmacy Dispenser						
Dental Therapist						
Radiographer						
Physiotherapist						
X-ray Assistant						
Clerical Officer						
Telephone Operator						
Cleaner						
Helper						
Community Health Worker						
Community Based Birth Attendant						
Traditional Birth Attendant						
Total						

Table 2.4.2: Health Centre Daily Staff Contacts

Year	Average Number of Prof. HC staff	OPD/IP/MCH Contacts	Contacts per staff member per day
Year ^{N-1}			
Year ^{N-2}			
Year ^{N-3}			

Source: HIA1 and HIA2

Table 2.4.3: Attrition by Staff Cadre and Cause for the year N-1 (NEW)

Staff Category	Reason for attrition							TOTALS
	Retired	Resigned	Term Cont.	Dismissed	Deceased	Cont. Expired	Transferred	
Doctor								
Clinical Officer								
Dental Staff								
Administration								
Laboratory Staff								
Medical Social Worker								
Registered Nurse								
Enrolled Nurse								
Registered Midwife								
Enrolled Midwife								
Nutritionist								
Pharmacist								
Pharmacy Staff								
Physiotherapist								
Environmental .Health Technician								
Health Inspector								
Radiographer								
Tutor								
Medical Licentiate								
TOTALS								

Source: Human Resource Data Base

2.5 Health Financing

2.5.1 Summary of Income and Expenditure

- Provide summary information about Income and Expenditure for the 3-year period.

Table 2.5.1

Income		Yr n-1	Yr n-2	Yr n-3	Expenditure	Yr n-1	Yr n-2	Yr n-3
Grants	GRZ				Community			
	Basket				Health Centres			
Total Grants								
Local Revenue					D. Hospitals			
Local Donors					DHMT			
Other Income								
TOTAL INCOME					Total			

Comment on critical items, such as fuel, drugs, capital expenditure and allowances where expenditure is limited by ceilings. Describe any other potential resources in the district, such as revolving funds, micro-projects, charitable institutions, etc. that cannot be classified as district income, but can influence district activities.

2.6 Transport and Communications

2.6.1 Inventory of Current Transport

- Provide information on existing transport and status

Table 2.6.1: Inventory of Current Transport

Make	Type	Vehicle No.	Runner/ Non-Runner	Year Acquired	Amt Spent on Servicing to-date (K)	Where Based

^V Indicate those vehicles currently in the Workshop

2.6.2 Expenditure on Fuel for 3 Previous Years

- Provide details of fuel expenditure by level for the 3-year period.

Table 2.6.2

Level	Cost		
	Yr n-1	Yr n-2	Yr n-3
District health Office			
First Level Hospital			
Health Centre			

2.6.3 Communication Support System

- Provide the status of communication system by institution

Table 2.6.3: Status of Communication Support System by Institution

Name of Institution	Phones				Fax		E-mail		Radios	
	Land		Cell		No.	Status	Available	Status	No.	Status
	No.	Status	No.	Status						

- Land refers to land phone line.
- Fax refers to fax lines.
- Status refers to functional or non-functional.
- If number is '0' i.e. not available, status will be Not Applicable (NA).

2.7 Drugs and Medical Supplies

Write briefly about drugs and logistics/pharmacovigilance. Also include the status of the infrastructure of the pharmacy store and plans (if any) for improvement. Write briefly about status of Cold Chain equipment.

Format of the District Health Action Plan

Table 2.7.1: Expected and Actual Expenditures for Drugs and Medical Supplies

Description of system/s used in the district for drug supply (kit system, purchase from MSL, and local purchase).

Description	Expenditure in previous year			Source of Funds
	Expected/Planned	Actual Received	Value of drugs received	
<i>Total number of Contacts</i>				
Drug Kits – Health Centre				
<i>Total number of active CHWs</i>				
Drug kits – CHW				
Purchase from MSL				
Emergency drugs and supplies (4%)				
Anti-Retro Viral drugs (ARVs)				
Coartem (4 packs)				

2.7.2 Status of Cold Chain Equipment

Table 2.7.2

Name of Facility	Number		Comment
	Units	Status	
Cold Chain Technician available: <input type="checkbox"/> Yes <input type="checkbox"/> No			

Note: Indicate if cold chain trained technician available. Indicate status functioning, that is whether working or not

2.8 Quality of Services

Provide a brief description of key findings from Supervisory visits undertaken during the year (Accreditation, PA, TSS or any other supervisory visits conducted).

Table 2.8.1: First Level Referral Hospitals

Hospital	Accreditation Score		
	1st (Date)	2 nd (Date)	3 rd (Date)
1			
2			
3			

Describe the steps that have been taken since last accreditation survey to improve quality rating. Describe the impact of these assessments on the DHMT decisions concerning purchase of beds.

2.8.2 Health Centres

Some DHMTs have converted their performance results into quality scores for individual health centres. By doing this it provides them with the possibility of tracking changes in health centre performance over time. Those DHMTs doing this should include the scores from the last 3 quarters' performance assessments in a table such as that shown below.

Table 2.8.2

Health Centre	Accreditation Score		
	first (Date)	2 nd (Date)	3rd (Date)
1			
2			
3			

2.9 Research

Present a brief description of any research activities conducted within the district during the period under review, results obtained and follow-up actions that have been taken or need to be taken to build upon these results (including dissemination within or outside the district).

Table 2.9.1

Research/Conducted by	Major Findings	Recommendations for Action
List of questions that the district would like to research on	What needs to be done to conduct the required research	

Part 3: Main Plan

3.1 Progress on Previous Year's Plan

- Provide information on level of implementation and results achieved. Also comment on reasons for failure to achieve expected results.
- Insert a summary of results of SWOT and Bottlenecks analysis in the tables provided below. For the main results of the local analysis of HMIS data and service delivery coverage, please enter this information into the tables provided in Part 3 (Health Status) of this planning guideline.

Bottleneck Analysis, Summary Table

Tracer Intervention: PMTCT; Service Delivery Mode: Population Oriented Scheduled Services							
Coverage Determinants	Indicators	Baseline Coverage (%)	Bottleneck yes/no	Possible Causes of Bottleneck	Proposed Operational Strategies/Solutions	Specific Activities to Be Done	Expected Bottleneck Reduction
Availability essential commodities							
Availability human resources							
Physical accessibility							
Initial utilization							
Timely continuous utilization							
Effective quality							

Note: Please refer to example provided in Annex 2 (Bottleneck analysis) to complete the table. Please provide a summary of key bottlenecks to be addressed.

- Also report on main results of the performance assessment and self assessment reports
- This section together with sections 2 and 3 of the plan outline form the basis for the selection of priority areas for the coming planning period.

3.2 Logical Framework

You have now completed your situation analysis; please complete the Logical Framework template for each of your priorities. The goal and purpose for each of the areas will be provided by MoH HQ. You, therefore, need to enter your agreed district objectives, expected outputs by level of intervention and indicate the interventions (activities) you plan to implement as well targets of key outputs.

Unlike the traditional categorization of health care services, which is often a disease-centered, vertical approach such as TB, HIV/AIDS or malaria programmes, this guide recommends that key results should be organised using the Marginal Budgeting for Bottlenecks methodology around different service delivery mechanisms, namely family and community based interventions, population based schedulable services and individual oriented clinical care services comprising health centre and first level referral clinical care services. This is because in the real world, health services are not delivered as a set of disease specific activities, but as part of service delivery mechanisms, each delivery mechanism contributing towards addressing several health problems.

Table 3.2

Results Chain	Indicators	MoV	NHSP Target	Base Year	Target		
					N+1	N+2	N+3
Goal (impact level)							
Purpose (effect or outcome)							
Objectives (effectiveness)							
Outputs							
1. Family and Community based services							
2. Schedulable and Outreach services							
3. Individual oriented Clinical Services (Health Centre and first level referral)							
4. Admin and Technical Support Services							

A list of interventions under each of the service delivery modes (Family and Community based services, Schedulable and Outreach services, Clinical Services) is provided in Annex 3. For a completed example see Annex 5C.

3.3 Cost Framework for District Level Activities

The list of broad activities against each of the outputs should be inserted in the table below. For the completion of this section, please refer to Annex 3 for a list of high impact interventions. Clinical services should be divided between those provided at the health centre level and those provided at the first level referral care.

Table 3.3

Level	Output	Activity	Timeframe	Responsible Person	Cost		
					Yr n+1	Yr n+2	Yr n+3
<i>Community</i>							
<i>Scheduled and Outreach Services</i>							
<i>Clinical Care Services (Health centre and first level referral services)</i>							
<i>Administrative and Technical Support Services</i>							

3.4 Supportive Supervision

Describe planned schedule of visits to health centres and first level referral hospital/s.

Table 3.4: Supportive Supervision

Performance Assessment				Technical Support Visit			
Institution	Responsible Officer	When	Duration	Institution	Responsible Officer	When	Duration
Team A		Every 6 months	No. Days				No. Days
Team B							

3.5 Summary of DHMT Training Plan

Table 3.5

Training Needed	For Whom	Number to Be Trained	Training Duration	Training Provider	Place of Training	Cost	Source of Funds
Total							

Part 4: Budget

4.1 Projected Income for the Next MTEF

Worksheet A: Distribution of Projected District Income

The new planning process requires that districts produce Medium Term Plans. Therefore, each year, the district is expected to project the total income it is likely to receive the following year in the form of service grants (MTEF ceilings) and other sources (e.g. rent, user fees, direct project funding, etc.). The DHMT then needs to decide on how to divide this total income by cost centre (service level). Finally, the DHMT has to divide the funds allocated for first level hospital services and health centre levels by individual health facility. This Worksheet is intended to help the district to project its total income from fees and other sources and to record its decisions on how these funds should be distributed by level.

When entering the results in Form 1 below, carry out the following steps:

- Based on the ceilings received from MoH HQ for the next MTEF, complete Worksheet A – Form 1.
- Determine the sources of Other Income for the District (such as hiring out of district facilities) and enter these sources as a list in the second row. From this determine how much you expect to receive from “Other Income” in the coming year and enter in the column for “projected funding for next year.”
- Then consider whether there are any factors that may cause an increase or decrease in the income from a particular source next year. Enter the projected income for the coming year in the column for “projected funding for next year”.

Table 4.1.1: Worksheet A Form 1: Projected Grant and Other Income

Source of Income		Amount in Kwacha		
		Yr n+1	Yr n+2	Yr n+3
Projected grant allocation	GRZ			
	Donor			
Fees	Hospital			
	Health Centre			
	DHMT			
Local Donors				
Other income (specify):				
Total projected funds				

4.2 Debt Servicing Plan

The district should provide details of total debt, items owed, the amount owed and to whom this is being owed. Also the district should show how much to be paid each year both the amount and percentage.

Table 4.2.2: Debt Servicing Plan

Items Owed	Amount Owed	To be Paid					
		Yr n+1		Yr n+2		Yr n+3	
		Amount	%\1	Amount	%\1	Amount	% \1
Total							
Total debt as proportion of projected income (debt/income x 100)							

¹ The proportion that the planned repayment represents of the total amount owed.

4.3 Distribution of Projected Income by Cost Centre

The district should determine the proportions (percentages) of the total grant and other income that should be allocated to each cost centre (service level). Districts should remember that the 20% floor for first level referral services is only intended for situations where a hospital is largely providing Primary Health Care (PHC) services. Where a hospital is providing *referral* services, the allocation should approach the 40% ceiling. The method of buying referral services can also be based on actual use (number of referrals) and negotiated with the hospital(s). Whatever the payment method (percentage allocation or payment per referral) the total amount should fall within the range given in the District Health Financial Planning Guide. *The results should be entered in the 2nd column of Form2 below.*

Format of the District Health Action Plan

District Planning Handbook

The district should then calculate the actual amounts to be allocated to each cost centre by adding the total projected income from grants plus other sources (A) by the decided percentages. If the district is purchasing referral services on a per capita basis (referral), the amounts needed are calculated by multiplying the projected number of referrals times the negotiated fee per referral. *These amounts should be entered in the final column of Form 2 below.*

Table 4.3.1: Worksheet A Form 2: Projected Allocations by Cost Centre

Cost Centre	Determined %	Projected Amount for Yr n+1	Projected Amount for Yr n+2	Projected Amount for Yr n+3
District Office (5-15%)				
First Level Referral (20–40%)				
Health Centres (45–60%)				
Community (10-15 %)				
Total	100%			

The projected amount to be allocated for first level referral services then needs to be divided between the individual hospitals available to the district. The aim is to use patient utilisation data to determine the distribution between hospitals. However, given that the hospital HMIS is still in the development stage, this step is currently being done through use of the catchment populations of the health centres which refer to each of the hospitals to derive the appropriate share of the allocation for first level referral services which should go to each of the relevant hospitals. *Decisions should be entered onto Form 3 below.*

Table 4.3.2: Worksheet A Form 3: Distribution of First Level Hospital Allocation by Individual Hospital

Hospital	Catchment Population	Yr n+1	Yr n+2	Yr n+3
Total First Level Services				

The projected amounts allocated for health centre services and community based activities then need to be divided between the individual health centres and hospital OPDs/Hospital Affiliated Health Centres (HAHCs). This distribution should be based upon the proportion of the total district population served by each of the health centres, adjusted for other factors that the district decides should influence the allocations. The projected amount to be allocated to communities should also be divided on the same basis, although decisions on how much goes to individual communities within the health centre catchment area should be made with the Chairperson of the Health Centre Committee based on funds available and priorities between communities. The form at Table 4.3.3 should be used to record the decisions.

Note: When each health centre is notified by the DHMT of its projected allocations for the next MTEF, the distinction between the allocation for the health centre and the allocation for community activities should be made clear.

District Planning Handbook

The DHMT needs to provide guidance to health centres on the fee income they are likely to receive, it should review the fee income for the last 12 months and then project how this may change for each health centre over the MTEF. Changes in fee income may be caused by changes in service charges or changes in service utilisation rates. *The results of this analysis should be entered in Form below.*

4.4 District Budget Spreadsheets

The budget spreadsheets as presented in Annex 12 of this Planning Handbook should be prepared showing the following:

- a) Basket funds (grant received by the District) + Other Income
- b) Fees (revenue + income-in-kind
- c) Consolidated (for all sources of funds).

4.5 Budgets for Allowances and Other Emoluments

(Budget for PEs has been dropped)

4.5.1 Ordinary Allowances

From the consolidated budget spreadsheet (see Annex 12) indicate that these are allowances associated with service delivery including training workshops, such as subsistence, lunch and out of pocket. This must be budgeted for within the district ceiling.

Table 4.5.1: Ordinary Allowances

Allowance	Persons	Days	Rate	Cost
Lunch				
Subsistence				
Other (specify):				
Total for DHMT				
Lunch				
Subsistence				
Other (specify):				
Total for First Level Hospital				
Lunch				
Subsistence				
Other (specify):				
Total for Health Centres/Posts				
Total for All Levels				

Note: The total costs for allowances for each level in the table above (DHMT First Level Hospitals and Health Centres) should be the same as the amounts entered on the Consolidated District Budget Spreadsheet.

4.5.2 Budget for Other Emoluments (formerly Special Allowances)

These are other emoluments such as: settling- in allowances, leave travel benefits, repatriation, funeral grant etc. The budget line for this is at the Provincial Health Office

Table 4.5.2: Budget for Other Emoluments (redesigned)

Allowance	Persons	Days	Rate	Cost
Total for DHMT				
Total for First Level Hospital				
Total for Health Centres/Posts				
Total for All Levels				

Note: Information for completion of this table should be written on the District Consolidated Budget Spreadsheet attached to this Handbook as Annex 12.

4.6 Budget for Transportation and Fuel

Information for completion of this table should be written on the District Consolidated Budget Spreadsheet attached to this Handbook as Annex 12.

Table 4.6.1: Fuel Cost

Level/Activity	Expenditure Yr n	Projected Cost Yr n+1	Projected Cost Yr n+2	Projected Cost Yr n+3
District Health Office				
First Level Hospital Costs				
Health Centre Costs				
Community Costs				
Total Costs				

Note: The total costs for these items for each level in the table above (DHMT, first level hospitals and health centres) should be the same as the amounts entered on the Consolidated District Budget Spreadsheet.

Table 4.6.2: Repairs and Maintenance

	Repairs Required	Service Cost	Maintenance Cost	Total cost
Total DHMT.				
Total First Level Hospital				
Total Health Centre				
Total Community				
Total Costs				

Note: The total costs for these items for each level in the table above (DHMT, first level hospitals and health centres) should be the same as the amounts entered on the Consolidated District Budget Spreadsheet.

Table 4.6.3: Other Transport Costs

Vehicle Hire	Cost
Total District Health Office	
Total first Level Hospital	
Total Costs	

Note: The total costs for these items for each level in the table above (DHMT, first Level Hospitals) should be the same as the amounts entered on the Consolidated District Budget Spreadsheet.

4.7 Equipment and Furniture Maintenance

Table 4.7.1: Equipment and Furniture Maintenance

Priority/Level	Institution	Maintenance Required	Maintenance Cost	Total Cost
Total District Health Office				
Total First Level Hospital				
Total Health Centre				
Total Community				
Total Costs				

Note: The total costs for these items for each level in the table above (DHMT, first level hospitals and health centres) should be the same as the amounts entered on the Consolidated District Budget Spreadsheet.

Table 4.7.2: Buildings and Grounds Maintenance

Priority/Level	Institution	Work and Material Required	Cost
Total District Health Office			
Total First Level Hospital			
Total Health Centre			
Total Costs			

Note: The total costs for these items for each level in the table above (DHMT, first level hospitals and health centres) should be the same as the amounts entered on the Consolidated District Budget Spreadsheet.

4.8 General Charges

Table 4.8.1: General Charges

Item/Level	Qty	Rate	Cost
Electricity Charges			
Water Charges			
Telephone Charges			
Other Charges (specify)			
Total District Office			
Electricity Charges			
Water Charges			
Telephone Charges			
Other Charges (specify)			
Total First Level Hospital			
Electricity Charges			
Water Charges			
Telephone Charges			
Other Charges (specify)			
Total Health Centres			
Total for All Levels			

Note: The total costs for these items for each level in the table above (DHMT, first level hospitals and health centres) should be the same as the amounts entered on the Consolidated District Budget Spreadsheet.

4.9 Budgets for Capital Costs

4.9.1 New Medical Equipment and Furniture

The funds for this will be housed at the central level, however, the DHMTs are expected to budget for this

Table 4.9.1: New Medical Equipment and Furniture

Priority/Level	Institution	Item Required	Cost		
			Yr n+1	Yr n+2	Yr n+3
Total DHMT					
Total First Level Hospital					
Total Health Centre					
Total Costs					

Note: The total costs for these items for each level in the table above (DHMT, first level hospitals and health centres) should be the same as the amounts entered on the Consolidated District Budget Spreadsheet.

4.9.2 New Vehicles

Table 4.9.2: New Vehicles

Priority/Level	Institution	Item Required	Cost		
			Yr n+1	Yr n+2	Yr n+3
Total DHMT					
Total First Level Hospital					
Total Costs					

Note: The total costs for these items for each level in the table above (DHMT, first level hospitals and health centres) should be the same as the amounts entered on the Consolidated District Budget Spreadsheet.

Table 4.9.3: Non-Medical Equipment

Priority/Level	Institution	Items Required	Cost		
			Yr n+1	Yr n+2	Yr n+3
Total District Health Office					
Total first Level Hospital					
Total Health Centre					
Total Costs					

Note: The total costs for these items for each level in the table above (DHMT, first level hospitals and health centres) should be the same as the amounts entered on the Consolidated District Budget Spreadsheet.

4.9.4 Construction of New Buildings

The funds will be held at the Provincial Health Office; however, the DHMTs are expected to plan for new infrastructure based on the Capital Investment Plan.

Table 4.9.4: Construction of New Buildings

Priority/Level	Institution	Item Required	Cost		
			Yr n+1	Yr n+2	Yr n+3
Total DHMT					
Total first Level Hospital					
Total Costs					

Note: The total costs for these items for each level in the table above (DHMT, first level hospitals and health centres) should be the same as the amounts entered on the Consolidated District Budget Spreadsheet.

Annexes

Annex 1: Outline of the District Health Action Plan

Table of Contents

District Map

Foreword by District Commissioner

Acknowledgements

List of Abbreviations

Executive Summary

Part 1: Introduction

1.1 Overview

1.2 Demographic Profile

1.3 Socio-Economic Profile

1.4 Stakeholders, Government Departments and Other Health Providers

Part 2: Situation Analysis

2.1 Health Status

2.1.1 Top Ten Causes of Morbidity (All Ages)

2.1.2 Top Ten Causes of Mortality (All Ages)

2.1.3 Top Ten Causes of Morbidity (Under Fives)

2.1.4 Top Ten Causes of Mortality (Under Fives)

2.1.5 Top Ten Causes of Morbidity (5+ Years)

2.1.6 Top Ten Causes of Mortality (5+ Years)

2.1.7 Nutrition Status of Under 5s

2.1.8 Notifiable Diseases

2.2 Service Coverage

2.2.1 Child Health Interventions

2.2.2 Integrated Reproductive Health Interventions

2.2.3 Environmental Health

2.2.4 HIV/AIDS Services

2.2.5 Other services

2.3 Present Health Facilities/Utilisation Rates

2.3.1 Health Facility/Neighbourhood Health Committees

2.3.2 Utilization Rates

2.4 Present Staffing in the District

2.5 Health Financing

2.5.1 Summary of Income and Expenditure

2.6 Transport and Communications

2.6.1 Inventory of Current transport

2.6.2 Expenditure on Fuel for 3 Previous Years

District Planning Handbook

- 2.6.3 Communication Support System
- 2.7 Drugs and Medical Supplies
 - 2.7.1 Expected and Actual Expenditures for Drugs and Medical Supplies
 - 2.7.2 Status of Cold Chain Equipment
- 2.8 Quality of Services
 - 2.8.1 First Level Referral Hospital
 - 2.8.2 Health Centres
- 2.9 Research

Part 3: Main Plan

- 3.1 Progress on Previous Year's Plan
- 3.2 Logical Framework (*new*)
- 3.3 Cost Framework for District Level Activities
- 3.4 Supportive Supervision
- 3.5 Summary of DHMT Training Plan

Part 4: Budget

- 4.1 Projected Income for the Next MTEF
- 4.2 Debt Servicing Plan
- 4.3 Distribution of Projected Income by Cost Centre
- 4.4 District Budget Spreadsheets
- 4.5 Budgets for Allowances and Other Emoluments
 - 4.5.1 Ordinary Allowances
 - 4.5.2 Budget for Other Emoluments (formerly Special Allowances)
- 4.6 Budget for Transportation and Fuel
 - 4.6.1 Fuel Cost
 - 4.6.2 Repairs and Maintenance
 - 4.6.3 Other Transport Costs
- 4.7 Equipment and Furniture Maintenance
 - 4.7.1 Equipment and Furniture Maintenance
 - 4.7.2 Buildings and Grounds Maintenance
- 4.8 General Charges
- 4.9 Budgets for Capital Costs
 - 4.9.1 New Medical Equipment and Furniture
 - 4.9.2 New Vehicles
 - 4.9.3 Non-Medical Equipment
 - 4.9.4 Construction of New Buildings

District Planning Handbook

Annexes

- Annex 1: Outline for District Health Action Plan (*new*)
- Annex 2: Bottleneck Analysis Explained (*new*)
- Annex 2A: Example of Bottleneck Analysis
- Annex 3: High Impact Interventions (*new*)
- Annex 4: Planning Guidance for HIV/AIDS (*new*)
- Annex 5: Logical Framework Approach
- Annex 5A: Logical Framework Matrix (*new*)
- Annex 5B: A Worked Example of the Logical Framework (*new*)
- Annex 5C: A Worked Example of the Logical Framework – HMIS (continued) (*new*)
- Annex 5D: A Worked Example of the Logical Framework (continued) (*new*)
- Annex 6: Examples of Outputs/Results Areas
- Annex 7: Quantification Sheets
- Annex 7A: Consumption-based Quantification Tool for Calculating Drugs, Contraceptives and Laboratory Supply Requirements
- Annex 7B: Projected Requirements for Medical Supplies
- Annex 7C: Projected Requirements for Health Centre Drug Kits
- Annex 7D: Projected Requirements for Vaccines
- Annex 7E: Projected Contraceptive Requirements
- Annex 7F: Projected Requirements for Non-Medical Supplies
- Annex 7G: Projected Requirements for Food Supplies
- Annex 8: Format for Reporting Action Plan Implementation
- Annex 9: Gantt Chart for Summarizing District Action Plan by Month
- Annex 10: Standard Equipment List
- Annex 10A: Standard Equipment for Health Post
- Annex 10B: Standard Equipment for Health Centre
- Annex 10C: Standard Equipment for First Level Hospital
- Annex 11: List of Cost Item Codes for Budget Preparation
- Annex 12: Consolidated Budget Spreadsheet
- Annex 13: Costing Sheets
- Annex 13A: Guidelines
- Annex 13 B: Activity Sheet
- Annex 13 C: Activity Sheet (continued)
- Annex 14: List of Contributors

Annex 2: Bottleneck Analysis Explained

A bottleneck is an identified constraint to achieving goals and targets. The Marginal Budgeting for Bottlenecks or MBB, which uses the bottleneck analysis, is being rolled out in Zambia through nine pilot districts. This tool focuses on issues which prevent a health system from reaching its goals. The bottleneck analysis uses five implementation issues to identify issues at progressive levels. These are:

1. **Availability of essential commodities and human resources** – assessing the availability of critical health system inputs such as drugs, vaccines and supplies. This information is obtained from stock registers and facility surveys.
2. **Accessibility** – describing the physical access of clients to health services. Accessibility includes outreach services as well as physical and financial accessibility.
3. **Initial Utilization** – describing the first use of a multi-contact service, for example, first antenatal contact or BCG immunization. Initial utilization indicates the members of the target population actually using the services.
4. **Timely, Continuous utilization** – indicating whether patients get the full treatment. This aspect documents the continuity of care and compliance.
5. **Effective Quality** – explaining the quality of care measured by assessing the skills of the health workers. Effective quality means that potential clients are receiving quality care.

These determinants are sequential. Bottlenecks are identified by examining the gaps among the five determinants and finding the weakest link in the service delivery chain. For example, the figures below reveal that the bottlenecks in EPI coverage (seen as drops in coverage) are multiple:

- i. Availability of EPI is low (30%) at districts level with frequent stock outs of basic vaccines;
- ii. Use at household level is insufficient, with mothers not bringing their children in for vaccination (20%);
- iii. Besides this the quality is poor with 2% of children fully vaccinated at 11 months.

The key here is to reduce stock outs, and address the reasons why mothers are not using the immunization services.

Since the bottlenecks affecting scaling-up of interventions at a given level of service delivery are common, it is prudent to choose a representative intervention to act as a tracer for each service delivery mode and do an analysis for the five implementation issues (**Availability** of essential commodities and human resources; **Accessibility**; **Initial Utilization**; **Timely, continuous** utilization; and **Effective Quality**) with regard to existence of bottlenecks, sources of bottlenecks, solutions to remove bottlenecks, specific actions to be taken and the expected bottleneck reduction measured by specific indicators as in the example below.

Annex 2A: Example of Bottleneck Analysis

Tracer Intervention: PMTCT: Service Delivery Mode: Population Oriented Scheduled Services							
Coverage Determinants	Indicators	Baseline Coverage (%)	Bottleneck yes/no	Possible Causes of Bottleneck	Proposed Operational Strategies/Solutions	Specific Activities to Be Undertaken	Expected Bottleneck Reduction
Availability of essential commodities	% facilities with ART available	63%	Yes	Poor forecasting and commodity management	(1) Improve forecasting skills (2) Mid-level managers' training	Conduct workshop for facility staff on forecasting and logistics management	Increase from 63 to 81% by 2010 (50% bottleneck reduction)
Availability of human resources	Availability of trained nurses/midwives in relation to need	20%	Yes	(1) Brain drain (2) Low staff retention (3) Lack of FP-trained nurses (4) Compensation for CHWs	(1) Strengthen staff retention schemes (2) Provide scholarships to nursing training conditioned on bonding	Develop staff recruitment and retention plan Goal: to have 2 trained per facility	30% bottleneck reduction
Physical accessibility	% communities within 8km of health facilities with regular PMTCT services	44%	Yes	(1) Skewed distribution of health facilities in favour of urban areas (2) Inadequate number of PMTCT sites	(1) Construction of health facilities in rural communities (2) Set up more PMTCT sites	Identify sites for construction of health facilities and lobby for financial support from the MoH HQ	25% bottleneck reduction
Initial utilization	% pregnant women receiving PMTCT counselling and being tested	60%	Yes	(1) Not all facilities currently provide PMTCT (2) Inadequate sensitisation (3) Low % of women delivering at facilities (4) Lack of privacy in rural delivery and the time/effort to travel to rural facility	(1) Building mothers' shelters (2) IEC package for PMTCT staff (3) Link PMTCT to immunization visits		40% bottleneck reduction
Timely continuous utilization	% HIV+ pregnant women receiving Nevirapine	39%	No				
Effective quality	% infants born to HIV + mothers receiving Cotrimoxazole prophylaxis	80%	No				

Annex 3: High Impact Interventions

Recent studies and subsequent publications have reconfirmed that around two-thirds of maternal and child mortality can be prevented through existing and proven health and nutrition interventions. Focusing on these activities will mean using the scarce resources available to get the most results. Below is a reduced list of these evidence based, high impact interventions, organized into Community, Primary and Referral level activities. For a full list and further information please refer to the bibliography in “**A User Guide for Marginal Budgeting for Bottleneck Toolkit - An Analytical Costing and Budgeting Approach and Toolkit for Health Service Management in Developing Countries**, UNICEF, June 2006.

Services Delivered by the Community for the Community	PHC and Outreach Activities	Clinical Care
ITNs for under-five children/pregnant women	Family Planning	Skilled delivery care
Supply of safe drinking water	Iron folate	Basic emergency obstetric care (B-EOC)
Latrines	Antenatal Care	Management of neonatal infections at PHC level
Hand washing	Calcium supplementation in pregnancy	Antibiotics
Indoor Residual Spraying (IRS)	Tetanus immunization	Vitamin A - Treatment for measles
Clean delivery and cord care	Deworming in pregnancy	Zinc for diarrhoea management
Breastfeeding	Prevention and treatment of iron deficiency anaemia in pregnancy	Appropriate treatment for malaria (ACT)
Complementary and supplementary feeding	Intermittent Presumptive Treatment (IPT) for pregnant women	Management of complicated malaria (2nd line drug)
Care for orphans	Balanced protein energy supplements for pregnant women	Antibiotics for opportunistic infections, U5 pneumonia, diarrhoea and enteric fever.
ORT	PMTCT	Male circumcision
Zinc	Condom use	ART
Vitamin A	Cotrimoxazole prophylaxis for HIV + mothers, adults, children of HIV + mothers	DOTS for TB
Malaria treatment of children	Immunizations	Detection and management of (pre) eclampsia (Mg Sulphate)
Antibiotics at community level	Post-partum Vitamin A Supplementation	Management of neonatal infections at primary referral level
	Vitamin A supplementation	Comprehensive emergency obstetric care (C-EOC)
		Clinical management of neonatal jaundice
		Universal emergency neonatal care
		Management of first line ART failures
		Management of TB moderate toxicities

Annex 4: Planning Guidance for HIV/AIDS

* Interventions set for planning for HIV/AIDS Services *

Service Delivery Area	Area of Focus (Activity)	Key Indicator
1. Sexually Transmitted Infections (STIs), Diagnosis and Treatment	▶ Screening and treatment of STIs using the Syndromic Management approach	▶ Number of health workers (public and private) trained in Syndromic Management of STIs
	▶ Drugs, reagents and medical supplies	▶ % of patients with STIs at health facilities diagnosed, treated and counselled according to national guidelines
2. Information, Education and Communication (IEC)	▶ Appropriate IEC materials and messages	▶ % of young people aged 15-19, who correctly identify consistent use of condoms to prevent HIV transmission
3. Condom Promotion	▶ Promote accurate and consistent use of male and female condoms to all sexually active individuals	▶ % of young people aged 15-19, who correctly identify consistent use of condoms as a way of preventing sexual transmission of HIV
4. Counselling Testing and Care	▶ Training of Counsellors	▶ Number of clients counselled and tested for HIV at VCT sites ▶ Number of VCT sites established
	▶ Establishment of VCT sites	
	▶ Availability of HIV test kits (applicable to centres conducting tests)	
	▶ Infrastructure and equipment	
	▶ Referral systems	
5. Prevention of Mother to Child Transmission (PMTCT) of HIV	▶ Provide information to the public on PMTCT	▶ Number of sites providing PMTCT ▶ Number of HIV positive mothers receiving adequate prophylaxis (ARVs)
	▶ Availability of HIV/STI screening and treatment facilities	
	▶ Establish or strengthen PMTCT facilities	
	▶ Facilitate access to ARVs for all mothers meeting treatment criteria	
	▶ Provide information to mothers on breast feeding options	
7. Palliative Care	▶ Supportive projects	▶ Number of chronically ill persons enrolled in community HBC and support projects
	▶ Distribution of medicine kits	
8. Anti-retroviral Therapy (ART)	▶ ART scale-up as per national scale-up plan	▶ Number of patients receiving ARVs ▶ % of ART centres having fewer than 14 days ARV stock-out per quarter
	▶ Training health care providers	

District Planning Handbook

Service Delivery Area	Area of Focus (Activity)	Key Indicator
	<ul style="list-style-type: none"> ▶ Drugs (ARVs) (applicable to centres prescribing ARVs) ▶ HIV test kits ▶ Training in monitoring of efficacy and toxicity of ARVs ▶ Adherence support groups ▶ Post-Exposure Prophylaxis (PEP) ▶ Training in ART Information System (reporting) ▶ IEC in positive living ▶ Referral 	
9. TB and HIV (Co-Infection)	<ul style="list-style-type: none"> ▶ Training health workers and non-health workers ▶ Drugs (STI drugs, ARVs, OI drugs, Anti-TB drugs) ▶ VCT, STI screening ▶ Prophylaxis 	<ul style="list-style-type: none"> ▶ Cure rate of 85% ▶ Number of persons accessing first line anti-TB drugs
10. Laboratory	<ul style="list-style-type: none"> ▶ Trained Laboratory Technicians (for centres with Laboratories) ▶ Reagents and equipment 	▶ Number of health facilities with trained Laboratory Technicians
11. HIV and Nutrition	▶ Nutrition interventions at all levels	<ul style="list-style-type: none"> ▶ Number of PLWHA receiving information on nutrition ▶ Number of people with HIV and AIDS receiving micronutrients
12. Management of Opportunistic Infections	<ul style="list-style-type: none"> ▶ Strengthen skills in management of OIs ▶ OI drugs 	
13. Work Place Programmes (absenteeism, loss of productive health workers, high funeral costs and compromised performance)	<ul style="list-style-type: none"> ▶ Counselling, testing and Ccare for health workers ▶ Train peer counsellors at work place ▶ Referral system ▶ ART schemes 	
14. Monitoring and Evaluation	▶ District data management	▶ Number reports submitted timely

Annex 5: Logical Framework Approach

Annex 5A: Logical Framework Matrix

Project Description	Performance Indicators	Means of Verification	Assumption
Goal: A broader development impact at national or sector level to which a project contributes	Measures of the extent to which there is a contribution to the goal – used at evaluation	Sources of information and means to report it	
Purpose: The development outcome expected at the end of the project. All components will contribute to this	Conditions at the end of the project indicating that the purpose has been achieved – used for project completion and evaluation	Sources of information and means to report it	Assumptions concerning the purpose – goal linkage
Component Objectives: The expected outcome of producing each component output	Measures the extent to which component objectives have been achieved – used during review and evaluation	Sources of information and means to report it	Assumptions concerning the component objective – purpose linkage
Outputs: The direct measurable outputs (goods and services) largely under management control	Measures the quantity and quality of outputs and the timing of their delivery – used during monitoring and review	Sources of information and means to report it	Assumptions concerning the output – component objective linkage
Activities: The tasks carried out to deliver identified outputs	Implementation/work plan targets – used during monitoring	Sources of information and means to report it	Assumptions concerning activity – output linkage

Annex 5B: A Worked Example of Logical Framework Approach							
Results Chain	Indicators	Means of verification	NHSP Target	Base Year	Target		
					Yr n+1	Yr n+2	Yr n+3
Goal: To contribute to improved community health on a sustainable basis	Life expectancy	ZDHS/CSO reports					
Purpose: To contribute to the reduction of maternal and child mortality and morbidity in the district	Maternal mortality ratio; Under five mortality rate	ZDHS					
Component 1: Family and Community Based Services							
ITN distribution	% districts with ITNs in relation to need	HMIS Reports					
Indoor residual spraying	% household sprayed	HMIS/ Programme reports					
Community Health Education Sessions	# of sessions held	Annual reports					
Community Treatment of malaria, community treatment of diarrhoea, etc.	% children with fever who are not receiving clinical care but are receiving Anti-malarials at community level	Annual reports					
Component 2: Scheduled and Outreach Services							
Family planning and Antenatal Care Services	% pregnant women who received first ANC in first trimester during their pregnancy	HMIS reports					
PMTCT Services	% HIV+ pregnant women receiving a complete course of ARV prophylaxis to reduce MTCT	HMIS reports					
Immunization Vitamin A Supplementation	Immunisation coverage Coverage of Vitamin A supplementation	HMIS reports					
HIV Services	% of sexually active men reporting the use of a condom at last high risk sexual contact	HIV Service Delivery Surveys					
Component 3: Clinical Care Services							
TB DOTS programme	# of patients on the programme	HMIS					
Health Centre ART services	# of patients on ART	HMIS					
Health Centre skilled deliveries	Proportion of deliveries by skilled labour	HMIS					
Other health centre indoor services (malaria, pneumonia, diarrhoea, etc.)	# Health centre utilisation rate	HMIS					
Skilled deliveries at level 1 referral	Proportion of deliveries by skilled labour	HMIS					
Basic B and C EmONC sites <i>Annexes</i>	% complicated pregnancy treated in quality EOC facility (B-EOC or C-EOC)	HMIS					
Other first level referral services							

Annex 5C: A Worked Example of the Logical Framework – HMIS (continued)

Goal	Measurable Indicators	Means of Verification	Important Assumption
To improve the quality of HMIS data in the district	Increased use of HMIS data in the district	Report from reviews of the district action plan	There will be a change towards the culture of information use by programme managers
Purpose			
<ul style="list-style-type: none"> ▪ Reduced amount of errors in HMIS data ▪ Increase in the use of HMIS data in decision-making 	<ul style="list-style-type: none"> ▪ Proportion of health facilities submitting complete, accurate and timely HMIS reports ▪ Revised action plan as a result of self-assessment 	<ul style="list-style-type: none"> ▪ Data audit reports ▪ Performance assessment reports ▪ Report on the review of the action plan 	Staff trained in data quality assurance will remain in the same positions for some time
Outputs			
# of health workers trained in data management	Proportion of facilities with at least one trained staff	Bi-annual performance assessment reports	There will be health staff already with minimum skills to build on
Structure of reporting and feedback deadlines published	Increase the proportion of facilities that submit complete HMIS reports according to schedule from X% to Y% by the end of Year Y	<ul style="list-style-type: none"> ▪ Data audit reports ▪ Review of HMIS district dataset ▪ District annual report 	The deadlines will be politically accepted
	Increase in the quarterly report completeness from 80%	Review of district databases every quarter	All districts will have working computers
Activities	Inputs	Means of Verification	Important Assumption
<ul style="list-style-type: none"> ▪ Train health workers in data management ▪ Develop a reporting/feedback system ▪ Print/distribute HMIS stationery ▪ Revise the DHIS database to incorporate error-trapping routines 	Resources: <ul style="list-style-type: none"> ▪ lodging ▪ stationery ▪ meals ▪ consultancy fees 	Project expense reports	<ul style="list-style-type: none"> ▪ There will be adequate health staff with minimum requirements ▪ Existence of a budget line from Government to print HMIS materials ▪ New version will be accepted by users

Annex 5D: A Worked Example of the Logical Framework (continued)

Programme Goal(s)	Programme Objectives	Monitoring Objectives	Evaluations Objectives
To improve the quality of HMIS Data	1 To increase the percent of districts that submit complete HMIS reports according to schedule from 76% to 85% by the end of 2009	1.1 To monitor the changes in proportion of districts that submits correct reports within given deadlines on a quarterly basis	To determine whether the percentage of districts reporting according to schedule has increased by 9 percent by December 31, 2009
	2 To redeploy a revised version of the DHIS database in all 72 district health offices by June 2009	2.1 To check each district dataset every quarter for any existence of data errors that the revision was meant to address 2.2 Periodically conduct spot checks to ensure there are no districts that revert to the older version so that they can enter data easily	To determine whether all 72 district have a revised version of the database and are using it correctly by June 2009
	3 Increase quarterly report completeness from 80% to 95% by the end of 2009	3.1 Observe and document variations in completeness as these might be seasonal changes caused by problems of communication/transport	To determine whether quarterly reports from all districts include at least 95 percent of the population in its catchment area
	4 To increase the percentage of quarterly facility reports (in each district) that are correctly entered into the DHIS database from 80% to 100% by the end of 2009	4.1 To develop mechanism for tracking different staff members who might be doing the data entry, so as to separate system problems from human competencies	To determine whether the proportion of correctly entered reports in each district has been rising over time and has reached at least 80 percent in all districts.

Annex 6: Examples of Outputs/Results Areas

- Family planning and reproductive health services:
 - Percentage of pregnant women attending at least one antenatal clinic
 - Proportion of births attended to by skilled health workers
 - Contraceptive prevalence rate
 - Proportion of complicated pregnancies EMOC services
- Child health services:
 - Measles immunization coverage before 12 months of age
 - Full immunization coverage before 12 months of age
 - Proportion of children 6-59 months receiving Vitamin A supplementation
- Access to HIV/AIDS services:
 - Number of clients counselled and tested for HIV at VCT sites
 - Number of VCT sites established
 - Number of sites providing PMTCT
 - Number of HIV positive mothers receiving adequate prophylaxis (ARVs)
- General Clinical Care Services
 - Health centre utilization rate
- Community based health services
 - Number of ITNs distributed
 - Coverage of indoor residual spraying
- Number of hospitals, clinics and outreach posts built or refurbished
- Number of people trained (by gender, programme area, long or short term)
- Number of activities that encompass health promotion principles
- Number of water supply systems established or water sources improved
- Health commodities procured and distributed.

Annex 7: Quantification Sheets

Annex 7A: Consumption-based Quantification Tool for Calculating Drugs, Contraceptives and Laboratory Supply Requirements

VEN	ITEM	Form and strength	Unit size	Total consumption in period	Days out of stock	Month in stock/months test available	Adjusted average monthly consumption	Lead time	Safety stock	Suggested quantity to order	Total upward adjustment	Adjusted order quantity	Stock on hand + stock ordered but not yet received	# months stock on hand or stock ordered	Order quantity	Price	Value of proposed order	% cost (ABC analysis)	Adjusted order quantity	Adjusted value
A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U
				# packs of unit size (column D)	Days	Months	# units of pack size (column D)	Months delivery	# units of pack size (column D)	# units of pack size (column D)	%	# units of pack (column D)	# units of pack size (column D)	Months	# units of pack size (column D)	\$	\$			
				Stock cards/books service Statisticians	Stock cards/books records	12-(F/30.5) (or records)	E/G	Delivery schedules, experience	I x H	(12 x H)+J	See manual	K x (100+L)/100	Stock cards, books	N/H	consider columns M,N and O (M-N)	Price list	P x Q	(R x 100)/total value of all items		T x Q

Columns D, F, M, O, P, R T, U should be in whole numbers, i.e. no decimals

Columns E, G, H, I, J, K, N, S should be to 1 decimal place for drugs and contraceptives and to 3 decimal places for laboratory supplies (where applicable)

Note: Please refer to the manual on quantification on Medical Supplies, June 1998. Once this table has been used of the calculation, please complete the table contained in Annex

Annex 7C: Projected Requirements for Health Centre Drug Kits

Number of kits expected previous year	
Number of kits received previous year	
Total number of HC attendances projected for next MTEF	
Total number of health centre kits required next MTEF	

Note: The above is a temporary measure only. The aim is to move towards a pull-based drug system, where health centres will specify the drugs needed based on past consumption.

Annex 7D: Projected Requirements for Vaccines

Total Number of 1s:

Total Number of Women of Child Bearing Age:)

Immunisation	District Target	Routine	School	Mopping up	Outbreak	Total	Unit Cost	Total Cost		
								Yr n+1	Yr n+2	Yr n+3
BCG 20 dose/vial										
Measles 10 dose/vial										
DPT+Hib+Heb 1 dose/vial										
OPV 20 dose/vial										
TT 10 dose/vial										
Meningitis										
ARV (anti-rabies)										
Yellow Fever										
<i>(if relevant)</i>										

Annex 7E: Projected Contraceptive Requirements

Total Number of Women of Reproductive Age:

FP Acceptors (X %):

Method	%	Persons Using Method	Quantity Needed per User/Yr	Total Needed for year	Unit price	Total Cost		
						Yr n+1	Yr n+2	Yr n+3
Pills	65%							
Injectables	15%							
Implants	1%							
Condoms	18%							
IUD	1%							
Sterilisation	1%				n/a			
Emergency Contraception								
Total	100%							

Annex 7F: Projected Requirements for Non-Medical Supplies

Cost Item	Item Description	Unit Price	Quantity	Total Cost		
				Yr n+1	Yr n+2	Yr n+3

Annex 7G: Projected Requirements for Food Supplies

Cost Item	Item Description	Unit Price	Quantity	Total Cost		
				Yr n+1	Yr n+2	Yr n+3

Annex 8: Format for Reporting Action Plan Implementation

Name of Institution.....Quarter..... Year.....

Programme	Planned Activities	Status	Comment	Expenditure in Kwacha		Challenges / Constraints
				Budget	Actual	
Community Level						
Out Reach and Schedulable Activities						
Health Centre Clinical Care Services						
1 st Level Referral Clinical Care Services						

Note: Use this format to generate the Annual Report

Annex 10: Standard Equipment List

Annex 10A: Standard Equipment for Health Post

Items	Method to Calculate Adequate Quantity for HP with Qualified Staff (CO, Nurse or EHT)	Priority Ranking
Screening Room and Pre-and Postnatal Room		
Ambu bag for adults (resuscitator)	1 per HP	5
Ambu bag for children (resuscitator)	1 per HP	5
Arm circumference tape	1 per HP	4
Autoclave, electrical, small (if electricity available)	1 per HP	5
Autoclave, non-electrical, 39 litres (if no electricity)	1 per HP	5
Bedside screen	2 per HP	4
BP machine, adult	1 per HP	5
Chair for consulting staff	1 per HP	5
Chair for patient	2 per HP	5
Desk for consulting staff	1 per HP	5
Drainage set	1 per HP	5
Dressing set	1 per HP	5
Dressing tray	1 per HP	5
Ear syringe	1 per HP	3
Equipment cabinet	1 per HP	3
Examination couch without leg holders	1 per HP	5
Examination light	1 at HP with electricity or suitable solar energy supply	4
Gallipots, large	2 in addition to sets	3
Gallipots, medium	2 in addition to sets	5
Hospital bed, health centre/health post model	1 for observation	5
Indicator, TST control spot, pac 300	1 per HP	5
Instrument tray, large	1 per HP	3
Instrument tray, medium	1 per HP	5
Instrument trolley	1 per HP	2
Kidney dish, large	1 in addition to sets	3
Kidney dish, medium	1 in addition to sets	5
Otoscope set in case	1 per HP	4
Sterilising drum, small	1 per HP	5

District Planning Handbook

Items	Method to Calculate Adequate Quantity for HP with Qualified Staff (CO, Nurse or EHT)	Priority Ranking
Stethoscope	1 per HP	5
Stove, kerosene, single burner	1 per HP	5
Stretcher, folding type	1 per HP	3
Suction pump, foot operated	1 per HP	5
Suturing set	1 per HP	5
Thermometer jar	1 per HP	3
Thermometer, digital	1 per HP	5
Timer, 60 min	1 per HP	5
Torch, medical, pen-sized	1 per HP	5
Vaginal speculum, large	2 per HP	4
Vaginal speculum, medium	2 per HP	5
Vaginal speculum, small	2 per HP	3
Waste bin with lid	3 per HP	3
Weighing scale, adult	1 per HP	5
Weighing scale, hanging, children	1 per HP	5
Weighing trousers	5 per salter scale (because they are sold this way only)	5
Equipment Specifically for Delivery Room		
Bed pan	2 per HP	3
Bowl, lotion, large	1 per HP	4
Bowl, lotion, medium	2 per HP	5
Bowl, lotion, small	1 per HP	3
Bucket, stainless steel	1 per HP	4
Delivery bed	2 per HP	5
Drip stand	1 per HP	5
Footstool, one-step	2 per HP	4
Stethoscope, foetal, Pinard	1 per HP	5
Vaginal delivery/episiotomy set	2 per HP	5
Wall clock	1 per HP	5
Weighing scale, infant, beam type	1 per HP	5
Equipment Specifically for Ante-/Postnatal Room		
Bedside cabinet (locker), health centre/health post model	1 per bed	3
Hospital bednet, treated	1 per bed	3

District Planning Handbook

Items	Method to Calculate Adequate Quantity for HP with Qualified Staff (CO, Nurse or EHT)	Priority Ranking
Hospital bed, health centre/health post model, with mattress	2 for ante/postnatal room	5
Infant cot bed net, treated	1 per cot	3
Infant cot with mattress	1 per post-natal bed	3
Pharmacy		
20 ml medicine cup	1 per HP	3
Lockable drug cabinet	1 per HP	4
Refrigerator for vaccines	1 per HP	5
Vaccine carrier	1 per HP	5
Vaccine cold box	1 per HP	5
Laboratory equipment		
Glucometer	1 per HP	5
Haemoglobinometer	1 per HP	5
Rapid Diagnostic Test kit for malaria		5
RPR shaker, electric if possible	1 per HP	5
Environmental health equipment		
Bucket for mixing chemicals	3 per HP	5
Food and water sample box	1 per HP	5
Lovibond Comparator	1 per HP	5
Measuring jar	3 per HP	5
Meat inspection kit	1 per HP	5
Personal Protective Equipment	1 per staff involved in EH activities	5
Rodent control apparatus	1 per HP	3
Squirt gun	1 per HP	5
Tape measure	1 per HP	5
Vector control sprayer	1 per HP	5
Water level meter	1 per HP	5
Miscellaneous Equipment		
Camping equipment set	1 per HP	5
Fire extinguisher	1 per HP	2
Health Post solar power supply system for light, cold chain and laboratory	1 per HP	5
Health Post/Health Centre maintenance kit	1 per HP	2
Hurricane lamp	1 per HP	1

Annex 10B: Standard Equipment for Health Centre

Items	Method to Calculate Adequate Quantity	Priority Rating
Equipment and Furniture for OPD and Wards, including Maternity		
Ambu bag for adults (resuscitator)	2 per HC: 1 for OPD/wards + 1 for maternity ward	5
Ambu bag for children (resuscitator)	1 per HC	5
Autoclave, electrical, small	1 at OPD and 1 for wards	5
Autoclave, non-electrical, 39 litres	1 per HC	5
Bed pan	1 per 4 beds	4
Bedside cabinet (locker), health centre/health post model	1 per hospital bed	3
Bedside screen	1 per consulting room and 1 per 4 beds in wards	2
Bowl, lotion, large	2 per HC	4
Bowl, lotion, medium	3 per HC	5
Bowl, lotion, small	2 per HC	3
BP machine, adult	1 per qualified staff, minimum 2	5
Bucket, stainless steel	1 per delivery bed	4
Chair for consulting staff	1 per consulting room, 1 per ward	5
Chair for patient	2 per consulting room + 1 per beds in wards	5
Delivery bed	1 per delivery room	5
Desk for consulting staff	1 per consulting room, 1 per ward	5
Drainage set	1 per HC	5
Dressing set	1 for OPD + 1 for wards	5
Dressing tray, medium	1 for OPD + 1 for wards	5
Drip stand	1 per 4 beds, including couches	5
Ear syringe	1 per HC	3
Equipment cabinet	2 per HC	3
Examination couch without leg holders	1 per consulting room	5
Examination couch, gynaecological	1 per HC	5
Examination light	1 per consulting room at HC with electricity or suitable solar energy supply	2
Foot stool, one-step	1 per delivery bed	4
Gallipots, large	2 per HC as part of sets + 1 as loose item	3
Gallipots, medium	2 per HC as part of sets + 1 as loose item	5
Hospital bed back rest	1 per 4 beds	2 or 3
Hospital bednet, treated	1 per hospital bed	3

District Planning Handbook

Items	Method to Calculate Adequate Quantity	Priority Rating
Hospital bed, health centre/health post model, with mattress	no planning guidelines available	5
Indicator, TST control spot, pac-300	consumable	5
Infant cot bed net, treated	1 per infant cot	3
Infant cot with mattress	1 per post-natal bed	3
Infection prevention trolley	?	?
Instrument tray, large	1 per treatment room	3
Instrument tray, medium	1 per treatment room	5
Kidney dish, large	1 kidney dish per HC as part of sets + 1 as a loose item	3
Kidney dish, medium	1 kidney dish per HC as part of sets + 3 as a loose item	5
Otoscope set in case	1 per consulting room, maximum 2	4
Salter scale	1 per consulting room and 3 for outreach activities	5
Sterilising drum, medium	1 per HC	5
Sterilising drum, small	1 per HC	4
Stethoscope	1 per qualified staff, minimum 2	5
Stethoscope, foetal, Pinard	1 per consulting room + 1 for maternity + 1 for outreach	5
Stove, kerosene, single burner	1 per HC	5
Stretcher, foldable	1 per HC	3
Suction pump, electrical	3 per HC: 1 for OPD/wards + 1 for maternity ward	4
Suction pump, foot -operated	2 per HC: 1 for OPD/wards + 1 for maternity ward	4
Suturing set	1 for OPD + 1 for wards	5
Thermometer jar	1 per consulting room, 1 per ward	3
Thermometer, digital	1 per consulting room, 1 per ward	5
Timer, 60 min	1 for wards and OPD together	5
Torch, medical, pen-sized	2 per HC	5
Trolley, medicine	1 per HC	4
Urinal, male	1 per 4 beds	3
Vaginal delivery/episiotomy set	3-5 per HC	5
Vaginal speculum, large	2 per HC	4
Vaginal speculum, medium	5 per HC	5
Vaginal speculum, small	1 per HC	3
Wall clock	1 for OPD + 1 for maternity ward	5
Waste bin with lid	1 per consulting room, 1 per	3

District Planning Handbook

Items	Method to Calculate Adequate Quantity	Priority Rating
	ward	
Weighing scale, adult	1 per consulting room	5
Weighing scale, infant, beam type	1 for OPD + 1 for maternity ward	5
Weighing trousers	1 set of 5 per salter scale (because they are sold this way)	5
Dental Equipment		
Dental chair	1 per HC with dental therapist	2
Dental syringe	1 per HC with IO trained in dental care	2
Mirror set	1 per HC with IO trained in dental care	2
Molar extraction set	1 per HC with IO trained in dental care	2
Probe set	1 per HC with IO trained in dental care	2
Set of tweezers	1 per HC with IO trained in dental care	2
Upper incisor forceps set	1 per HC with IO trained in dental care	2
Pharmacy Equipment		
20 ml medicine cup	2 per HC	3
Drug cabinet, lockable	1 per HC	4
Refrigerator, domestic	1 per HC	5
Tablet counting tray	1 per HC	3
Cold Chain Equipment		
Refrigerator for vaccines	1 per HC	5
Vaccine carrier	1 per HC	5
Vaccine cold box		5
Laboratory Equipment		
Flammable liquid cabinet	1 per HC with laboratory	3
Autoclave, portable	1 per HC with laboratory technician or microscopist	4
Binocular microscope	1 per HC with laboratory technician or microscopist	5
Glucometer	1 per HC	5
Haemoglobinometer	1 per HC	5
Hand tally counter	1 per HC with laboratory technician or microscopist	3
Centrifuge	1 per HC with laboratory technician or microscopist	4
Rapid Diagnostic Test for malaria	consumable	5
RPR rotator	1 per HC	5

District Planning Handbook

Items	Method to Calculate Adequate Quantity	Priority Rating
Spirit lamp	1 per HC with laboratory technician or microscopist	5
Stool for laboratory worker	1 per laboratory worker	4
Timer	1 per HC with laboratory technician or microscopist	5
Triple beam balance/Analytical balance	1 per HC with laboratory technician or microscopist	5
Water distiller	1 per HC with laboratory technician or microscopist and no water filter; if none is available, the distiller is preferred option	3
Water filter	1 per HC with laboratory technician or microscopist and no water distiller, but water distiller is preferred option	3
Environmental Health Equipment		
Bucket for mixing chemicals	3 per HC	5
Food and water sample box	1 per HC	5
Lovibond Comparator	1 per HC	3
Measuring jar	3 per HC	5
Meat inspection kit	2 per HC	4
Personal Protective Equipment	2 per HC	5
Rodent control apparatus	1 per HC	3
Squirt gun	2 per HC	3
Tape measure	2 per HC	5
Vector control sprayer	1 per HC	5
Water level meter	1 per HC	5
Miscellaneous		
Camping equipment set	2 per Rural HC	2
Fire extinguisher	1 per designated area	1
Health Centre solar power supply system for light, cold chain and laboratory	1 per HC	5
Health Post/health centre maintenance kit	1 per HC	2
Hurricane lamp	1 per ward	1

Annex 10C: Standard Equipment for First Level Hospital

The following list represents the basic minimum requirements for a 40-bed hospital with the following service units: OPD/Casualty; male and female wards; Dispensary; Laboratory; Radiography; Operating Theatre; Dental Unit; Physiotherapy; Kitchen; Laundry and Mortuary.

Standard Equipment and Furniture for First Referral Level Hospitals		
Items	Method to Calculate Adequate Quantity	Priority Rating (assuming qualified staff)
1. Hospital Affiliated Health Centre		
<i>1.1. Medical Equipment and Furniture</i>		
Ambu bag for adults (resuscitator)	2 per HC: 1 for OPD/wards + 1 for maternity ward	5
Ambu bag for children (resuscitator)	1 per HC	5
Autoclave, electric, small	1 per HC with electricity	5
Autoclave, non-electric, small (39 litres)	1 per HC without electricity	5
Bed pan	1 per 4 beds	4
Bedside cabinet (locker), health centre/health post model	1 per bed	3
Bedside screen	1 per consulting room + 1 per ward	4
Bowl, lotion, large	2 per HC	4
Bowl, lotion, medium	3 per HC	5
Bowl, lotion, small	2 per HC	3
BP machine, adult	1 per qualified staff, minimum 2	5
Chair for consulting staff	1 per consulting room + 1 per ward	5
Chair for patient	2 per consulting room	5
Delivery bed	1 per delivery room	5
Delivery/episiotomy set	3-5 per HC	5
Desk for consulting staff	1 per consulting room + 1 per ward	5
Drainage set	1 per HC	5
Dressing set	1 for HAHC OPD + 1 for HAHC wards	5
Dressing tray, medium	1 for HAHC OPD + 1 for HAHC wards	5
Drip stand	1 per 4 beds, including couches	5
Ear syringe	1 per HAHC	3
Equipment cabinet	2 per HC	3
Examination couch without leg holders	1 per consulting room	5
Examination couch, gynaecological	1 per HC	5
Examination light	1 per consulting room at HC with electricity or suitable solar energy supply	4
Footstool, one-step	1 per delivery bed	3
Gallipots, large	2 per HC as part of sets +1 as loose item	3
Gallipots, medium	2 per HC as part of sets + 1 as loose item	5
Hospital bed back rest	1 per 4 beds	3 or 2?
Hospital bednet, treated	1 per hospital bed	3

District Planning Handbook

Hospital bed, health centre/health post model	No standards possible given variety of catchment areas and size of buildings	5
Indicator, TST control spot	1 per HC	5
Infant cot bed net, treated	1 per infant cot	3
Infant cot with mattress	1 per post-natal bed	3
Instrument tray, large	1 per consulting/treatment room	3
Instrument tray, medium	1 per consulting/treatment room	5
Kidney dish, large	1 kidney dish per HC as part of sets + 1 as a loose item	3
Kidney dish, medium	1 kidney dish per HC as part of sets + 3 as a loose item	5
Otoscope set in case	1 per consulting room, maximum of 2	4
Salter scale	1 per consulting room and 3 for outreach activities	5
Sterilising drum, medium	1 per HC	5
Sterilising drum, small	1 per HC	4
Stethoscope, binaural	1 per qualified staff, minimum 2	5
Stethoscope, foetal, Pinard	1 per consulting room + 1 for maternity + 1 for outreach	5
Stretcher, folding type	1 per HC	3
Suction pump, electric	1 per HC with electricity	4
Suction pump, foot operated	1 per HC without electricity	4
Suturing set	1 for HAHC OPD + 1 for HAHC wards	5
Thermometer jar	1 per consulting room + 1 per ward	3
Thermometer, digital	1 per consulting room + 1 per ward	5
Thermometer, mercury type	1 per consulting room + 1 per ward	5
Timer, 60 min	1 per HC	5
Torch, medical, pen-sized	2 per HC	5
Trolley, medicine	1 per HC	5
Urinal, male	1 per 4 beds	3
Vaginal speculum, large	2 per HC	4
Vaginal speculum, medium	5 per HC	5
Vaginal speculum, small	1 per HC	3
Wall clock	1 for OPD and 1 for maternity	3
Waste bin with lid	1 per consulting room + 1 per ward	3
Weighing scale, adult	1 per consulting room	5
Weighing scale, infant, beam type	1 for OPD + 1 for maternity ward	5
Weighing trousers	1 set of 5 per salter scale (because they are sold this way)	5
<i>1.2 Pharmacy Equipment</i>		
20 ml medicine cup	2 per HC	3
Drug cabinet, lockable	1 per HC	4
Refrigerator, domestic	1 per HC	5
Tablet counting tray	1 per HC	3
<i>1.3 Cold Chain Equipment</i>		
Refrigerator for vaccines	1 per HC	5
Vaccine cold box		5
<i>1.4. Environmental Health Equipment</i>		
Bucket for mixing chemicals	3 per HC	5
Food and water sample box	1 per HC	5

District Planning Handbook

Lovibond Comparator	1 per HC	3
Measuring jar	3 per HC	5
Meat inspection kit	2 per HC	4
Personal Protective Equipment	2 per HC	5
Rodent control apparatus	1 per HC	3
Squirt gun	2 per HC	3
Tape measure	2 per HC	5
Vector control sprayer	1 per HC	5
Water level meter	1 per HC	5
<i>1.5 Miscellaneous</i>		
Camping equipment set	2 per Rural HAHC	2
Fire extinguisher	1 per designated area	2
Hurricane lamp	1 per ward	1
2. OPD and Casualty		
<i>2.1. Hospital Equipment</i>		
Stretcher, folding type	1 per ambulance/patient transporting vehicle	4
Wheelchair	2	3
<i>2.2 Office Furniture and Medical Equipment for Screening and Consultation Rooms (nurses, clinical officers, doctors)</i>		
Ambu bag for adults (resuscitator)	1 at casualty and 1 at OPD	5
Ambu bag for children (resuscitator)	1 at casualty and 1 at OPD	5
Bedside screen	1 per consulting room	4
BP machine, adult	1 per consulting room	5
BP machine, child	1 per consulting room	5
Chair for Consulting staff	1 per consulting room	5
Chair for patient	2 per consulting room	5
Chart, vision-testing, Snellen type	1 per consulting room	3
Desk for Consulting staff	1 per consulting room	5
Diagnostic set (otoscope and ophthalmoscope)	1 per consulting room	5
Drip stand	1 at casualty and 1 at OPD	5
Ear syringe	1 per consulting room	3
Equipment cabinet	1 per consulting room	3
Examination couch without leg holders	1 per consulting room	5
Examination couch, gynaecological	1 per consulting room	5
Examination light	1 per consulting room	4
Medicine trolley	1 at casualty and 1 at OPD	5
Patella hammer	1 per consulting room	3
Salter scale	1 per consulting room	5
Stethoscope, binaural	1 per consulting room	5
Stethoscope, foetal, Pinard	1 for entire OPD	5
Suction pump, electric	1 for entire OPD with electricity	4
Suction pump, foot-operated	1 for entire OPD without electricity	4
Thermometer jar	1 per consulting room	3
Thermometer, digital	1 per consulting room	5
Thermometer, mercury type	1 per consulting room	5
Torch, medical, pen-sized	1 per consulting room	5
Vaginal speculum, large	1 per consulting room	4
Vaginal speculum, medium	3 per consulting room	5
Vaginal speculum, small	1 per consulting room	3
Waste bin with lid	1 per consulting room	3
Weighing scale, adult	1 per consulting room	5

District Planning Handbook

Weighing trousers	1 set of 5 per salter scale (because they are sold this way)	5
2.3 Medical Equipment for Dressing and Injection Rooms		
Autoclave, electric, small	1 for entire OPD with electricity	5
Autoclave, non-electric, small (39 litres)	1 for entire OPD without electricity	5
Bowl, lotion, large	1 for entire OPD	4
Bowl, lotion, medium	1 for entire OPD	5
Bowl, lotion, small	1 for entire OPD	3
Drainage set	3 per OPD (one in use, one being sterilised, one spare)	5
Dressing set	3 per OPD (one in use, one being sterilised, one spare)	5
Indicator, TST control spot	1 for entire OPD	5
Instrument tray, medium	1 per consulting/treatment room	5
Sterilising drum, small	1 for entire OPD	5
Suturing set	3 per OPD (one in use, one being sterilised, one spare)	5
Timer, 60 min	1 for entire OPD	5
2.4 Medical Equipment for Observation ward		
Bed pan	1 per 4 beds	4
Bedside cabinet, hospital model	1 per bed	3
Bedside screen	1 per 4 beds	4
Drip stand	1 per 4 beds	5
Hospital bednet, treated	1 per observation bed	3
Hospital bed cradle	1 per 4 beds	3
Hospital bed, hospital model, two-sectioned, with mattress	1 or 2 beds in prototype L1H? Elsewhere depending upon space	5
Over-bed table	1 per bed	4
Oxygen concentrator	1 for the observation ward	4
Sputum mug	1 per 5 beds	3
Suction pump, electric	1 for the observation ward at observation wards with electricity	4
Suction pump, foot operated	1 for the observation ward	4
Urinal, male	1 per 4 beds	4
3. All Wards, except Maternity Ward		
3.1. Nursing Stations		
Chair	4 per nursing station	3
Cupboard, lockable	1 per nursing station	3
Desk	1 per nursing station	3 OR 2?
Equipment cabinet	1 per nursing station	3 OR 2?
Waste bin with lid	1 per nursing station	
3.2 Wards		
Autoclave, electric, small	1 per ward	4
Bed pan	1 per 4 beds	4
Bedside cabinet, hospital model	1 per bed	3
Bedside screen	1 per 4 beds	4
Bowl, lotion, large	2 per ward	4
Bowl, lotion, medium	3 per ward	5
Bowl, lotion, small	2 per ward	3

District Planning Handbook

BP machine, adult	2 per ward	5
BP machine, child	1 per paediatric ward	5
Diagnostic set (otoscope, ophthalmoscope)	2 for all wards together	5
Dressing set	2 per ward (or 3: including one spare set?)	5
Dressing tray, medium	1 per ward	4
Dressing trolley	1 per ward	4
Drip stand	1 per 4 beds	5
Glucometer	1 per ward	5
Hospital bed back rest	1 per 4 hospital beds without head section (HP/HC model)	3 OR 2
Hospital bednet, treated	1 per hospital bed	3
Hospital bed cradle	1 per 5 beds	3 OR 2
Hospital bed elevator	1 per 4 beds	3 OR 2
Hospital bed, hospital model, two-sectioned, with mattress	no official guidelines anymore	5
Indicator, TST control spot	1 set per ward	4
Infant cot	2 per paediatric ward	3
Infant cot bed net, treated	1 per infant cot	3
Instrument tray, large	1 per ward	3
Instrument tray, medium	1 per ward	4
Over-bed table	1 per bed	4
Oxygen concentrator	1 for paediatric ward	4
Oxygen cylinder	1 for paediatric ward	5
Rapid Diagnostic Test kits for malaria	1 per ward	5
Salter scale	1 per paediatric ward	5
Sputum mug	1 per 5 beds	4
Sterilising drum, small	1 per ward	3
Stethoscope, binaural	2 per ward	5
Suction pump, electric	1 for all wards together (hospitals with electricity)	5
Suction pump, foot operated	1 for all wards together	5
Thermometer jar	1 per ward	3
Thermometer, digital	5 per ward	5
Timer, 60 min	1 per ward	4
Traction frame	1 per 20 beds, excluding maternity beds	3 OR 2
Trolley, medicine	1 per ward	5
Urinal, male	1 per 4 beds	4
Weighing scale, adult	1 per adult ward, excluding surgery	4
Weighing trousers	5 per scale/ward	5
3.3. Miscellaneous		
Fire extinguisher	1 per ward	2
Heater, electric	1 per ward	1
4. Equipment for Labour Ward/Maternity		
4.1 Sister' Office		
Chair for consulting staff	2	4
Chair for patient	2	4
Cupboard, lockable	1	4
Desk for consulting staff	1	4
Waste bin with lid	1	3
4.2 First Stage Room		
Bedside screen	2	4

District Planning Handbook

CT machine	1	5
Examination couch, gynaecological	1	5
Examination light	1	5
Foetal heart detector	1	5
Footstool, one-step	1	4
RPR rotator	1	5
Stethoscope, foetal, Pinard	2	5
<i>4.3 Delivery Room</i>		
Bedside screen	2	4
Cabinet, instrument	1	3
Delivery bed	2	5
Drip stand	1	5
Footstool, one-step	1	4
Instrument trolley	2	5
Kick-about bowl	2	5
Neonatal incubator	2	4
Operating stool, revolving	2	4
Resuscitaire	1	5
Set, vaginal delivery /episiotomy	5	5
Suction pump, electric	1	5
Suction pump, foot-operated	1	5
Vacuum aspirator, manual, kit (MVA)	5	5
Vacuum extractor, electrical	2	5
Vacuum extractor, manual	1	4
Wall clock	1	4
Weighing scale, infant, beam type	1	5
<i>4.4 For Recovery Room</i>		
Bed pan	1 per 2 beds	4
Bedside cabinet, hospital model	1 per bed	3
Bedside screen	1	4
Drip stand	1	5
Hospital bed, hospital model, two-sectioned, with mattress	2	5
Infant cot with mattress	1 per bed	4
Over-bed table	1 per bed	4
<i>4.5 For Postnatal Ward</i>		
Bed pan	1 per 2 beds	4
Bed net, long lasting insecticide treated, for hospital bed	1 per bed	5
Bednet, long lasting insecticide treated, for hospital cot	1 per cot	4
Bedside cabinet, hospital model	1 per bed	3
Bedside screen	1 per 5 beds	4
Drip stand	1 per 4 beds; 1 per ward in the prototype of L1H	5
Hospital bed, hospital model, two-sectioned, with mattress	depends, prototype L1H: 10 beds	5
Infant cot with mattress	1 for 4 beds	4
Over-bed table	1 per bed	4
Oxygen concentrator	1	5
Oxygen cylinder	4	5
Phototherapy Unit	1	not rated
<i>4.6 Equipment for Use in Various Parts of Maternity Ward</i>		

District Planning Handbook

Autoclave, electric, medium	1 per ward	4
Bowl, lotion, large	2 per ward	4
Bowl, lotion, medium	2 per ward	5
Bowl, lotion, small	2 per ward	3
BP machine, adult	2 per ward	5
Dressing set	2 per ward	5
Dressing tray, medium	1 per ward	4
Dressing trolley	1 per ward	4
Glucometer	1	3
Indicator, TST control spot	depends on consumption	5
Instrument tray, large	1 per ward	3
Instrument tray, medium	1 per ward	4
Medicine trolley	1 per ward	5
Rapid Diagnostic Test kits for malaria	not done by group	5
Sterilising drum, medium	1 per ward	4
Sterilising drum, small	1 per ward	3
Stethoscope, binaural	2 per ward	5
Thermometer jar	1 per 5 beds	2
Thermometer, digital	1 per 5 beds	5
Timer, 60 min	1 per ward	5
Vaginal speculum, large	2	4
Vaginal speculum, medium	2	5
Vaginal speculum, small	2	3
Weighing scale, infant, beam type	1	4
5. Operating Theatre (the operating unit may consist of one or more operating theatres)		
<i>5.1. Operating Theatre Equipment</i>		
Ambu bag for adults (resuscitator)	1 per operating unit	5
Ambu bag for children (resuscitator)	1 per operating unit	5
Anaesthetic machine	2 per operating unit	5
Bowl, lotion, large	3 per operating table	4
BP machine, adult	2 per operating unit	5
Bucket, stainless steel with cover	4 per operating table	3
Cabinet, dangerous drugs	1 per operating theatre	3
Cabinet, instrument	1 per operating theatre	3
Coagulation Unit	1 per operating unit	4
Defibrillator	1 per hospital	5
Dressing tray, large	4 per operating theatre	5
Dressing tray, medium	6 per operating theatre	4
Dressing tray, small	6 per operating theatre	4
Dressing trolley	1 per operating theatre	5
Drip stand	2 per operating table	5
Ear syringe	1 for all wards (to be kept in minor theatre)	3
Footstool, one-step	2 per operating table	3
Instrument tray, large	8 per operating unit	5
Instrument trolley	1 per operating table	5
Kick-about bowl	3 per operating table	4
Laryngoscope set	5 per hospital	5
Mayo table	2 per operating table	5
Neonatal resuscitaire	1 per hospital operating unit	5
Operating stools, revolving	3 per operating table	4
Operating table	2 per hospital	5

District Planning Handbook

Operating-room light, fixed, ceiling mounted	1 per operating theatre	5
Operating-room light, portable, with stand	2 per hospital	4
Oxygen concentrator	2 per operating unit	3
Oxygen cylinder	4 per operating unit	3
Patient trolley	2 per operating unit	5
Pulse oximeter, separate	not done by group	5
Recovery bed	1 per operating theatre	2
Stand, single bowl	2 per operating table	2
Stethoscope, binaural	2 per hospital operating unit	5
Suction pump, electric	3 (one for surgeon, two for anaesthetist)	5
Ventilator	1 per operating theatre	5
Vital signs monitor, portable	2 per theatre	5
Wall clock	1 per operating theatre	5
X-Ray film viewing box (negatoscope)	1 per operating theatre	3
5.2 Theatre Instrument Sets		
Set, amputation	2	5
Set, bilateral tubal ligation	3 or 5?	3
Set, caesarean section	4 or 10?	5
Set, decapitation	1	3
Set, dilatation and curettage Set (D + C set)	3 or 10?	5
Set, fractures	1	5
Set, general	6?	5
Set, laparotomy	3 or 4?	5
Set, minor surgery	3	5
5.3 Sterilisation Equipment		
Autoclave, electric, 400 litres	1 per operating theatre	5
Bed pan washer	1 per ward	
Sterilising drum, large	2 per operating unit	5
Sterilising drum, medium	2 per operating unit	5
Ultrasonic cleaner	1 per operating theatre	3
6. Dental Unit		
Bench top autoclave	1	2
Dental amalgamator	1	2
Dental chair	1	2
Dental compressor	1	2
Dental film processor or developer	1	2
Dental instrument cabinet	1	1
Dental instrument set	1	2
Dental instrument tray	2	2
Dental light	1	2
Dental light curing unit	1	2
Dental treatment trolley	1	1
Dental treatment unit	1	2
Dental x-ray unit	1	2
Dentist stool	1	2
Ultrasonic dental scaler	1	2
7. Equipment for the Pharmacy		
20 ml medicine cup	?	3
Drug cabinet, lockable	1	4
Graduated glass measure	?	2
Mixer	1	2

District Planning Handbook

Mortar and pestle	2	2
Pharmacy balance	1	2
Pharmacy heavy duty trolley	1	2
Pharmacy refrigerator	1	5
Tablet and capsule counter	1	2
Tablet counting tray	1	2
Vaccine refrigerator	1	5
Water distiller	1	2
Water filter	?	2
8. Equipment for the Medical Laboratory		
<i>8.1. Furniture for Medical Laboratory</i>		
Stool for laboratory worker	1 per laboratory staff, minimum 2	4
Chair for laboratory worker (adm. duties)	1	3
Table for laboratory worker (adm. duties)	1	3
<i>8.2. Laboratory Equipment</i>		
Anaerobic jar	3	5
Analytical balance	1	5
Autoclave for laboratory, medium	1	5
Blood bank refrigerator	1	5
Bunsen burner	1	5
CD4 counting machine	1	5
Centrifuge, medium	1	5
Chemistry analyser	1	5
Differential counter	1	4
Flammable liquid cabinet	1	3
Haematology analyser	1	5
Hot air oven	1	4
Hot plate, controlled temperature	not done by group	5
Incubator for laboratory, medium	1	5
Microhaematocrit centrifuge	1	5
Microscope, binocular	2	5
pH meter	1	3
Refrigerator/freezer for laboratory	2	4
Roller/mixer	1	5
RPR rotator	1	5
Spirit lamp	2	5
Timer	2	5
Voltex for CD4 counting	not done by group	5
Water bath	1	3
Water distiller	1	4
<i>8.3 Miscellaneous</i>		
Cool box for sample referral	1	2
Fire extinguisher	1	2
First aid box	1	2
Voltage stabiliser/UPS on all electric equipment	1 for each electric device	5
Wall clock	1	2
9. Equipment for Medical Imaging Department		
Dryer for manual film processor	1	5
Electrolyte Silver Recovery Kit	1	2
Examination couch	not done by group	not rated
Film hanger (set of five sizes)	4	5
Film processor, automatic	1	4

District Planning Handbook

Film processor, manual	1	5
Lead apron	1 for patient, 1 for staff	5
Lead gloves	1 pair	5
Lead shield or screen, protective	1	5
Marker, actinic	1	5
Safety light holder, darkroom	2	2
Set for Histero-Salpingo Gram	not done by group	not rated
Ultrasound scanner with printer	1	4
X-ray film stationery grid	1	5
X-ray film viewing box (negatoscope)	1	5
X-ray loading bench (film hopper)	1	5
X-ray unit, fixed	1	5
X-ray unit, mobile	1	3
10. Kitchen		
Bain Marie	1	1
Boiling pot	2	2
Cooking pot of 10 litres	1	2
Cooking pot of 20 litres	1	2
Cooking pot of 40 litres	1	2
Fire extinguisher	1	2
Food trolley, basic	1	1
Freezer, domestic, chest model	1	2
Heated Bain Marie Trolley	1	1
Preparation table	2	2
Refrigerator, domestic		2
Stove, domestic, gas (back up)	1	1
Stove, industrial	1	2
Weighing scale , 0-120 kg	1	1
11. Laundry Department		
Ironer, industrial	1	2
Laundry press	1	1
Laundry trolley	4	1
Sewing machine	1	1
Trolley, clean linen	1	2
Tumble dryer	1	2
Washer extractor	2	2
Water heater	1	1
12. Mortuary		
Autopsy saw	1	2
Autopsy scale	1	1
Autopsy set	1	2
Autopsy table	1	2
Body tray	not done by group	not rated
Bowl stand	not done by group	1
Mortuary fridge/unit (4 trays)	1	2
Mortuary trolley	1	2
Organ table	1	2
Waste bag trolley, cart	1	1

Annex 11: List of Cost Item Codes for Budget Preparation

Account Type	Sub-Head	Sub-head Title
2	1	Personal Emoluments
2	2	Use of Goods and Services
2	3	Consumption of Fixed Capital
2	4	Financial Charges
2	5	Social Benefits
2	6	Grants and Other Payments
2	7	Subsidies
2	8	Legal Costs
2	9	Constitutional and Statutory Expenditure
3	1	Non-Financial Assets

Account Type	Sub-Head	Item	Item Title
2	1	1	Salaries
2	1	2	Wages
2	1	3	Allowances
2	1	4	Personnel Related Costs
2	2	1	Office Costs
2	2	2	Building, Repair and Maintenance Costs
2	2	3	Plant, Machinery, Vehicle Running and Maintenance Costs
2	2	4	Other Administrative Operating Costs
2	2	5	Requisites
2	2	6	Services
2	2	7	Travel Expenses
2	2	8	Training
2	2	9	Legal Costs
2	4	3	Other Financial Charges
2	5	1	Social Assistance Benefits
2	6	1	Grants to Grant-Aided Institutions
2	6	2	Grants to Non-Governmental Organizations
2	6	3	Grants to Households
2	6	4	Grants to Institutional Revolving Funds
2	6	5	Other Grants
2	6	6	Transfers to Government Units
2	6	7	Other Payments
2	8	1	Legal Expenses
3	1	1	Fixed Assets

District Planning Handbook

Account Type	Sub-Head	Item	Sub-Item	Sub-Item Title
2	1	1	1	Salaries - Public Service
2	1	2	0	Wages
2	1	3	1	Flexible Allowances
2	1	3	2	Fixed Allowances
2	1	4	1	Housing Costs
2	1	4	2	Statutory Contributions
2	2	1	0	Office Costs
2	2	2	0	Building, Repair and Maintenance Costs
2	2	3	0	Plant, Machinery, Vehicle Running and Maintenance Costs
2	2	4	0	Other Administrative Operating Costs
2	2	5	0	Requisites
2	2	6	0	Services
2	2	7	1	Travel Expenses Within Zambia
2	2	7	2	Travel Expenses Outside Zambia
2	2	8	1	Short-term training and Staff Development within Zambia (<= 6 Months)
2	2	8	2	Short-term training and Staff Development outside Zambia (<= 6 Months)
2	2	8	3	Long-term training and Staff Development within Zambia (> 6 Months)
2	2	8	4	Long-term training and Staff Development outside Zambia (> Months)
2	2	8	5	Registration and Subscriptions (Professional Bodies
2	2	8	6	Medical Costs
2	2	8	7	Other Costs
2	2	9	0	Legal Costs
2	4	3	0	Other Financial Charges
2	5	1	0	Social Assistance Benefits
2	6	1	0	Grants to Grant Aided Institutions
2	6	2	0	Grants to Non-Governmental Organizations
2	6	3	0	Grants to Households
2	6	4	0	Grants to Institutional Revolving Funds
2	6	5	0	Other Grants
2	6	6	0	Transfers to Government Units
2	6	7	0	Other Payments
2	8	1	0	Legal Expenses
3	1	1	1	Buildings and Structures
3	1	1	2	Plant, Machinery and Equipment
3	1	1	3	Office Equipment
3	1	1	5	Other Assets
3	1	1	7	Vehicles and Motor Cycles
3	1	1	8	Specialized Vehicles
3	1	1	9	Intangible Fixed Assets

District Planning Handbook

Account Type	Sub-Head	Item	Sub-Item	Sub-Sub Item	Account Name
2	1	1	1	10	Super Scale
2	1	1	1	20	Salaries Division I
2	1	1	1	30	Salaries Division II
2	1	1	1	40	Salaries Division III
2	1	1	1	50	Contractual Salaries
2	1	1	1	60	Salaries – Locally Engaged Staff
2	1	2	0	10	Wages – Classified Employees
2	1	3	1	10	Retention Allowance
2	1	3	1	20	Special Education Allowance
2	1	3	1	30	Rural Hardship Allowance
2	1	3	1	40	Extra Duty Allowance
2	1	3	1	50	Local Supplementation Allowance
2	1	3	2	1	Cash in Lieu of Leave Division I
2	1	3	2	3	Cash in Lieu of Leave Division II
2	1	3	2	5	Cash in Lieu of Leave Division III
2	1	3	2	7	Cash in Lieu of Leave Teaching Service
2	1	3	2	9	Cash in Lieu of Leave Classified Employees
2	1	3	2	11	Commuted Night Duty Allowance
2	1	3	2	13	Overtime Division II
2	1	3	2	15	Overtime Division III
2	1	3	2	17	Overtime Classified Employees
2	1	3	2	19	Commuted Overtime
2	1	3	2	27	Responsibility Allowance
2	1	3	2	29	Instructor’s Allowance
2	1	3	2	33	Shift Allowance
2	1	3	2	47	Long Service Bonus
2	1	3	2	49	Travelling on Leave
2	1	3	2	59	On Call Allowance
2	1	3	2	67	Transport Allowance
2	1	3	2	69	Risk Allowance
2	1	3	2	71	Housing Allowance
2	1	3	2	75	Contract Gratuity
2	1	3	2	79	Education Allowance
2	1	3	2	83	Extra Accreditation Allowance
2	1	3	2	99	Other Allowances
2	1	4	1	60	House Rentals
2	2	1	0	10	Office Material
2	2	1	0	20	Phone, Fax, Telex, Radio (Charges and Maintenance)
2	2	1	0	30	Internet Charges
2	2	1	0	40	Postal Charges
2	2	1	0	50	Computer and Peripheral Costs
2	2	1	0	60	Maintenance of Office Equipment

District Planning Handbook

Account Type	Sub-Head	Item	Sub-Item	Sub-Sub Item	Account Name
2	2	1	0	70	Machine Spare Parts
2	2	1	0	80	Data Processing Services
2	2	1	0	90	Books, Magazines, Newspapers , Documentation
2	2	1	0	95	Insurance
2	2	2	0	10	Rentals for Buildings
2	2	2	0	20	Water and Sanitation Charges
2	2	2	0	30	Electricity Charges
2	2	2	0	40	Building Maintenance (Maintenance, Consumables)
2	2	2	0	50	Office Furniture and Fittings (Maintenance)
2	2	2	0	60	Insurance for Buildings
2	2	2	0	70	Security and Care Taking Charges
2	2	3	0	10	Petrol, Oil and Lubricants
2	2	3	0	20	Servicing (Other Consumables)
2	2	3	0	30	Spare Parts
2	2	3	0	40	Tyres
2	2	3	0	50	Repairs
2	2	3	0	60	Insurance
2	2	3	0	70	Licenses and Taxes
2	2	3	0	99	Other Costs
2	2	4	0	10	Provisions
2	2	4	0	30	Meal Allowance
2	2	4	0	40	Uniform Allowance
2	2	4	0	50	Repatriation Allowance
2	2	4	0	60	Boards and Committees Allowances
2	2	4	0	99	Other Costs
2	2	5	0	1	Hand Tools and Equipment
2	2	5	0	3	Dental Material
2	2	5	0	5	Protective Wear, Clothing and Uniforms
2	2	5	0	8	Blood Bank Materials
2	2	5	0	10	Drugs, Vaccines
2	2	5	0	13	Drugs for HIV and AIDS
2	2	5	0	15	Medical Supplies (Except Drugs and Vaccines)
2	2	5	0	18	Surgery Materials
2	2	5	0	20	X-ray Materials
2	2	5	0	23	Material and Appliances for the Sick
2	2	5	0	29	Insecticides
2	2	5	0	33	Veterinary Material
2	2	5	0	38	Survey and Mapping
2	2	5	0	40	School Requisites
2	2	5	0	43	Laboratory Material
2	2	5	0	45	Medical Stationery

District Planning Handbook

Account Type	Sub-Head	Item	Sub-Item	Sub-Sub Item	Account Name
2	2	5	0	48	Water Treatment Chemicals
2	2	5	0	99	Other Purchases
2	2	6	0	1	Consultancy, Studies, Fees, Technical Assistance
2	2	6	0	3	Audit Fees
2	2	6	0	4	Accounts and Audit Services Expenses
2	2	6	0	5	Printing
2	2	6	0	8	Advertisement and Publicity
2	2	6	0	10	Technical Equipment Repair and Maintenance
2	2	6	0	13	Transportation
2	2	6	0	18	Official Entertainment
2	2	6	0	20	Public Functions and Ceremonies
2	2	6	0	23	Shows and Exhibits
2	2	6	0	30	Accommodation
2	2	6	0	33	Expenses of Boards and Committees
2	2	6	0	35	Hire of Motor Vehicles
2	2	6	0	40	Insurance - Technical Equipment
2	2	6	0	45	Cultural Promotion
2	2	6	0	48	Census and Statistical Survey Expenses
2	2	6	0	50	Population and Communication
2	2	6	0	53	Welfare and Recreation
2	2	6	0	58	Research and Feasibility Studies
2	2	6	0	60	Labour Day Expenses and Awards
2	2	6	0	63	Hire of Plant and Equipment
2	2	6	0	73	Medical Fees/Charges
2	2	6	0	75	Medical Fees/Charges Abroad
2	2	6	0	78	Conferences, Seminars and Workshops
2	2	6	0	83	Bank Charges
2	2	6	0	99	Other Services
2	2	7	1	10	Road, Rail and Air Fares
2	2	7	1	20	Accommodation Charges
2	2	7	1	30	Allowances
2	2	7	1	40	Kilometre Allowance
2	2	7	1	50	Petrol, Oil and Lubricant
2	2	7	1	60	Airport Charges
2	2	7	2	10	Road, Rail and Air Fares
2	2	7	2	20	Accommodation Charges
2	2	7	2	30	Allowances
2	2	7	2	40	Kilometre Allowance
2	2	7	2	50	Petrol, Oil and Lubricants
2	2	7	2	60	Airport Charges
2	2	7	2	70	Visas
2	2	8	1	10	Training Allowances

District Planning Handbook

Account Type	Sub-Head	Item	Sub-Item	Sub-Sub Item	Account Name
2	2	8	1	20	Training and Education Charges
2	2	8	1	30	Workshops, Seminars and Conferences
2	2	8	1	40	Road, Rail and Air Fares
2	2	8	1	50	Other Expenses
2	2	8	2	10	Training Allowances
2	2	8	2	20	Training and Education Charges
2	2	8	2	30	Workshops, Seminars and Conferences
2	2	8	2	40	Road, Rail and Air Fares
2	2	8	2	50	Other Expenses
2	2	8	3	10	Training Allowances
2	2	8	3	20	Training and Education Charges
2	2	8	3	40	Bursaries Award
2	2	8	3	50	Road, Rail and Air Fares
2	2	8	3	60	Other Expenses
2	2	8	4	10	Training Allowances
2	2	8	4	20	Training and Education Charges
2	2	8	4	30	Bursaries Award
2	2	8	4	40	Road, Rail and Air Fares
2	2	8	4	50	Other Expenses
2	2	8	5	10	Registration
2	2	8	5	20	Subscriptions
2	2	8	6	10	Medical Charges within Zambia
2	2	8	6	20	Medical Charges outside Zambia
2	2	8	7	10	Other Expenses
2	2	9	0	10	Compensation and Awards
2	2	9	0	50	Legal Fees
2	4	3	0	10	Contractual Penalties
2	5	1	0	30	Social Assistance Benefits
2	5	1	0	99	Other Social Benefits
2	6	1	0	10	Grants to Government Agencies
2	6	1	0	20	Grants to Local Authorities
2	6	3	0	20	Scholarships
2	6	2	0	10	Grants to Non-Governmental Organizations
2	6	3	0	50	Medical Treatment outside Zambia (non-employees)
2	6	4	0	10	Grants to Institutional Revolving Funds
2	6	5	0	10	Other Grants
2	6	6	0	10	Funding to Government Units
2	6	7	0	10	Contributions to International Organizations
2	8	1	0	10	Compensation and Awards
2	8	1	0	30	Retrenchee Claims
2	8	1	0	40	Penalties (court cases)
3	1	1	1	1	Residential Buildings

District Planning Handbook

Account Type	Sub-Head	Item	Sub-Item	Sub-Sub Item	Account Name
3	1	1	1	2	Office Buildings
3	1	1	1	3	Fixtures and Fittings
3	1	1	1	5	Colleges
3	1	1	1	7	Hospitals, Clinics and Health Centres
3	1	1	2	3	Air Conditioning Equipment
3	1	1	2	4	Elevators
3	1	1	2	5	Electrical and Electronic Equipment
3	1	1	2	6	Medical Equipment
3	1	1	2	7	Laboratory and Scientific Equipment
3	1	1	2	10	Marine Equipment
3	1	1	2	12	Solar Equipment
3	1	1	2	99	Other Machinery and Equipment
3	1	1	3	1	Computers, Peripherals, Equipment
3	1	1	3	2	Communication Equipment
3	1	1	3	3	Telephone, Fax, Telex, Radio
3	1	1	3	4	Refrigerator, TV, VCR, Cameras, Air Conditioners
3	1	1	3	99	Other Office Equipment
3	1	1	5	1	Office Furniture
3	1	1	5	2	Residential Furniture
3	1	1	5	3	School Furniture
3	1	1	5	4	Hospital Furniture
3	1	1	7	1	Bicycles
3	1	1	7	2	Motor Cycles ? =125cc
3	1	1	7	3	Motor Cycles ? 125cc
3	1	1	7	4	Motor Vehicles ? = 3,500kg
3	1	1	7	5	Motor Vehicles over 3,500 Kg ? = 16,000Kg
3	1	1	7	6	Heavy Duty Vehicles ? 16,000Kg
3	1	1	8	1	Ambulances

Annex 12: Consolidated Budget Spreadsheet

DISTRICT: _____

DISTRICT DIRECTOR OF HEALTH: _____

DISTRICT ACCOUNTANT: _____

PERIOD: JAN - DEC Year _____

(AMOUNTS= x 1,000)

INCOME																				
Grant Funds	<i>GRZ</i>																			
	<i>Basket</i>																			
Local Revenue																				
Local Donors																				
Sub-total																				
MSL Drugs																				
PE's																				
CIP Funds																				
TOTAL INCOME																				

District Planning Handbook

COST ITEMS

Level	Programme	Activities	PERSONNEL COSTS		DRUGS AND SUPPLIES				TRANSPORT			OTHER COSTS					
			Allow's	Other emol	Drugs and vaccines	Medical supplies	Non-Med supplies	Food supplies	Fuel	Spares and maint.	Other costs	furniture	Diag and Grounds	Utilities	Contracting	Medical equip	Non-Med equip
District Health Office	Admin and Technical Support Services	Utilities															
		PA															
		Sup. System															
		Training															
		Other															
	TOTAL																
DISTRICT EXP. % OF TOTAL																	
1st Level Hospital	Admin and Technical Support Services	Admin Support															
		Kitchen															
		Laundry															
		Mortuary															
		Tech Sup to HCs															
	Clinical Care Services	Medicine															
		Gen Surgery															
		Gynae and Obs															
		Paediatrics															
		Psychiatrics															
		Anaesthesia															
		Laboratory															
		X- Ray															
		Pharmacy															
Blood Bank																	
TOTAL																	
First Level Referral (HOSPITAL) EXP. % OF TOTAL																	
Health Centre	Schedulable and Outreach	Family Planning															
		Antenatal Care															

Annex 13: Costing Sheets

Annex 13A: Guidelines

Cat.	Description	Instruction
A	Institution	Ministry of Health
B	Department	Enter Department name, e.g. Public Health or Northern Province
C	Unit Name	Enter unit name, e.g. Malaria Control Centre or Kasama
G	Programme	Enter programme provided for that particular level
K	Activity Name	Enter one particular activity for the programme selected in C
R	Location	List the sub-activities under that activity
S	Inputs	
S1	Funding Source	Enter the code of the source of funding for that particular cost item from the list of funding sources
S2	Funding Type	Enter Grant
S3 -S8	Account type, Sub-head Code, Sub-head Description, Item Code, Item Description, Sub-item Code, Sub-item Description, sub- -sub item code and description	Make reference to guidelines for the use of ABB codes
S9	Unit Cost	Price of each item for the total requirement
S10	Quantity	Number of units required
S11	Total	Product of F9 and F10
Year 2007 and 2008 - Repeat steps F9 to F11		
More Cost Items: Repeat steps F6 to 12 for the other cost items required		
Repeat steps F6 to 12 for the other cost items required		

Annex 13B: Activity Sheet

**MINISTRY OF HEALTH
MEDIUM TERM EXPENDITURE FRAMEWORK 20-- to 20--**

A. Institution: MINISTRY OF HEALTH

A. Department: _____

B. Unit: _____ **D. Cost Centre** _____

E. Objective Code _____ **F. Objective** _____

G. Programme: _____

H. Output Code _____ **I. Output** _____ **J. Target** _____

K. Activity name: _____ **L. ABB Activity Code** _____

O. Responsible Officer _____ **P. Approving Officer** _____

Q. Description

--

R. Sub-Activities

1. Sub-Activity	_____	Level	_____
2. Sub-Activity	_____	Level	_____
3. Sub-Activity	_____	Level	_____
4. Sub-Activity	_____	Level	_____
5. Sub-Activity	_____	Level	_____

Annex 13C: Activity Sheet (continued)

K. Activity

R. Sub-Activity

S. Inputs

S1	S2	S3	S4	S5	S6	S7	S8	S9	S10	S11	S12	S13	S14
Funding Source: (GRZ, EB)	Funding Type (GRZ, Loan or Grant)	Account type	Subhead	Item	Sub item	Sub-sub item	Item Description	Unit Cost	Quantity	No. of days	Total	Internal Funding (Yes/No)	Funds Available (Yes/No)
Sub-activity Total											-		

Annex 14: List of Contributors

No.	Name	Sex	Position	Station
1.	Davies M. Chimfwembe	M	Director - Planning and Policy	Lusaka - MoH HQ
2.	Nicholas Chikwenya	M	Deputy Director - Planning and Policy	Lusaka - MoH HQ
3.	Henry Chewe Kansembe	M	Planning and Costing Specialist	Lusaka - MoH HQ
4.	Kilion Wanchete Ngoma	M	Chief Planner	Lusaka - MoH HQ
5.	Dr Kanyanta Sunkutu	M	HIV/AIDS Advisor	Lusaka - WHO
6.	Samukwepa Chikuni	M	DHIO	Mpongwe DHMT
7.	Manyando Lyamba	M	Manager - Administration	Mpongwe DHMT
8.	Dr. Lyapa Sikazwe	M	District Director of Health	Mpongwe DHMT
9.	Doris Zgambo	F	Ag. MPD/EHO	Katete DHO
10.	Gisela Mutinta Muleya	F	DHIO	Katete DHO
11.	Dismas Mutale	M	MPD	Mungwi DHO
12.	Lescoh Chibuye	M	DHIO	Mungwi DHO
13.	Grace Nanyinza	F	District Director of Health	Mungwi DHO
14.	David Kapole	M	Ag. DDH	Katete DHO
15.	Emmanuel Phiri	M	MPD	Kaoma DHO
16.	Dr. Namasiku Siyumbwa	F	Ag. DDH	Mazabuka DHO
17.	Elias Hakoma Siamatanga	M	MPD	Mazabuka DHO
18.	Monde Chiyabe	F	DAO	Mazabuka DHO
19.	Rhoda Buleze	F	MPD	Samfya DHO
20.	Davies Luchembe	M	DAO	Samfya DHO
21.	Henry Zulu	M	Ag. DDH	Samfya DHO
22.	Mwendabai Muyunda	M	DDH	Kaoma DHO
23.	Masiye Banda	M	DAO	Kaoma DHO
24.	Sikota Lutangu	M	DDH	Kasempa DHO
25.	Nebai Shikelenge	M	MPD	Kasempa DHO
26.	Gideon Michelo	M	DHIO	Kasempa DHO
27.	Emily Moonze	F	HSP Specialist	Lusaka - HSSP
28.	Patrick M. Chewe	M	M and E Specialist	Lusaka - HSSP
29.	Paul S. Chishimba	M	HMIS Specialist	Lusaka - HSSP