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Assessment of the Regulatory Framework for Maternal, Newborn Child Health and Nutrition (MNCH&N) Services in Zambia FINAL REPORT

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Millennium Development Goal Initiative

Accelerating the Reduction of Maternal, Neonatal and Child Mortality

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Acronyms and Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
BEMONC	Basic Emergency Obstetric and Newborn Care
CARMMA	Campaign for Accelerated Reduction of Maternal Mortality
CBOH	Central Board of Health
CBOs	Community Based Organisations
CEMONC	Comprehensive Emergency Obstetric and Newborn Care
CHAZ	Churches Health Association of Zambia
CSO	Central Statistical Office
CSOs	Civil Society Organisations
DHO	District Health Office
DHRA	Department of Human Resources and Administration
DPI	Department of Planning and Information
EMLIP	Essential Medicines Logistics Improvement Programme
EMOC	Emergency Obstetric Care
EU	European Union
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS, TB and Malaria
GRZ	Government of the Republic of Zambia
HC	Health Centre
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HP	Health Post
HQ	Headquarters
HSS	Health System Strengthening
IRH&FP	Integrated Reproductive Health and Family Planning
M&E	Monitoring and Evaluation
MCDMCH	Ministry of Community Development, Mother and Child Health
MCDSS	Ministry of Community Development and Social Services
MCTA	Ministry of Chiefs and Traditional Affairs
MDGi	Millennium Development Goals Initiative
MDGs	Millennium Development Goals
MNCH	Maternal, Newborn and Child Health
MNCH+N	Maternal, Newborn and Child Health and Nutrition
MOH	Ministry of Health
MSL	Medical Stores Limited
MWS	Mother Waiting Shelter
NAC	National AIDS Council
NFNC	National Food and Nutrition Commission
NGO	Non-Governmental Organisations
NHC	Neighbourhood Health Committees
NMCC	National Malaria Control Centre
PF	Patriotic Front
PHO	Provincial Health Office
PMTCT	Prevention of Mother To Child Transmission
PRA	Pharmaceutical Regulatory Authority
RMNCH+N	Reproductive, Maternal, Newborn and Child Health and Nutrition
SAG	Sector Advisory Group
SHN	School Health and Nutrition
SNDP	Sixth National Development Plan
STI	Sexually Transmitted Infections
SWAps	Sector Wide Approaches
TB	Tuberculosis
UN	United Nations
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organisation
ZHWRS	Zambia Health Workers Retention Scheme
ZMRA	Zambia Regulatory Authority

Executive Summary

Many national reports have indicated the decline in both maternal and childhood mortality in Zambia since the Millennium Declaration by the United Nations. The decline has, however, been slower for neonatal mortality. Despite these declines in mortality, Zambia still has significant challenges in achieving both MDG 4 and 5.

In an effort to support achievements of MDGs 4 and 5, the Zambian government working with the EU and the United Nations family in Zambia has embarked on a project aimed at achieving the MDGs based on current national objective by improving community maternal, neonatal and child health (MNCH) and nutrition practices and utilisation of quality MNCH+N services in reducing maternal and childhood morbidity and mortality.

Guided by the framework on strengthening health system to improve MNCH outcomes as developed by Ergo and colleagues in 2011, this report assesses the regulatory framework in order to analyse and understand the national contextual environment with regard to existing health policies, strategies, legislation, financing mechanisms, management structures and devolution of authority for health care delivery in the programme districts of Lusaka and Copperbelt provinces. The resulting report is, therefore, organised in five main parts namely: Background; Enabling Environment and Governance; Enabling Environment for Health Care Delivery; Monitoring and Evaluation Framework; and Conclusion and Recommendations.

Since 1992, the health sector has relied on the National Health Policies and Strategies as mechanisms of supporting health care in Zambia. In 2012, the health sector went further to adopt an overarching National Health Policy that sets clear direction for the development of the sector. This policy development is supported by both the National Health Strategic Plan (2011-2015) and the new Ministry of Community Development, Mother and Child Health Strategic Plan of 2013-2016. Furthermore, both the MOH and the MCDMCH have jointly developed the Roadmap for Accelerating Reduction of Maternal, Newborn and Child Mortality (2013-2016) with the general objective to accelerate the reduction of mortality in order to enable Zambia attain the set MDG goals 4 and 5 by 2015. The recent realignment of the MCDMCH is further intended to optimise synergies with social welfare and community development structures in order to offer integrated services to the communities at the grass-root level.

Despite the highlighted efforts by the Zambian government, the health sector has been operating without a health services delivery legal framework since 2006, except for regulations associated with food and drug safety, health professionals and food and nutrition. Even these regulations are out-dated and are not harmonised with other legal mechanisms within and outside the health sector. For example, while the government has now developed the National Food and Nutrition Strategic Plan (2011-2015), the nutrition governance is still anchored in the Act of 1967 CAP 308 of the laws of Zambia.

Secondly, and even though the national health policy exist to guide both the MOH and the MCDMCH, clarity is still needed on which ministry has the mandate for policy development and implementation monitoring. According to recent government guidelines on the roles and responsibilities by the two ministries, the MOH has responsibility for health policy, standard setting and performance audits. Meanwhile, the MCDMCH has the policy mandate to implement maternal and child health policies since the ministry has a separate cabinet minister responsible for that mandate who should ensure that the policies and strategies under MCDMCH on MNCH are successfully implemented. This further raises the question of which ministry is accountable on the

implementation of policies and strategies related to achieving the goals of the MNCH Roadmap (2013-2016).

In addition to the issues of leadership, policies and regulations, financial and budget mechanisms are critical in ensuring the achievement of MDG goals of 4 and 5; and there are further implications on the overall enabling environment for health care delivery. Even though the government had allocated 11.3% of the 2013 national budget to the health sector and was more than 40% increase from the 2012 budget allocation, the health budget has always been below the Abuja target of 15%. Moreover, the social protection budget allocation that should protect the vulnerable mothers and children in Zambian communities was only 2.8% of the national budget. Even with the 11.3% of the health sector budget, the MOH was allocated 67% while the MCDMCH was allocated 33% that was largely meant for district health care delivery services. By the end of 2013, however, less than one-third of the budget was eventually released to the districts with the highest release being for Northern province at 35%. It is clear from this assessment that despite districts being the core of health care delivery services, they are not receiving sufficient funds even for the minimal of operations especially that over 80% of the allocations to districts also go for payment of personal emoluments.

The second component of the health system is the enabling environment for health care delivery and comprises many difficult elements that include implementation, management, and institutional coordination mechanisms. Over the years, the MOH has developed robust implementation, management and institutional coordination mechanisms that included a well-established health Sector Advisory Group (SAG) and the Sector-wide approaches (SWAps) that included participation of cooperating partners. While coordination mechanisms still needed to be strengthened further within the MOH, the same cannot be said about the MCDMCH that previously could not coordinate adequately the social protection sector advisory group. With the added mandate to coordinate MNCH+N interventions at the district and sub-district levels, the MCDMCH urgently requires a comprehensive capacity building strategy and plan for system strengthening.

The Zambian government has shown commitment to the reduction of maternal, newborn and child mortality by ensuring that the necessary policies, strategies, regulations, guidelines and practices are in place. And while these regulations should be understood as instruments used by government to coerce change in both individual and organisational behaviours in the health delivery system, the challenge has been the enforcement of already existing regulations and providing the necessary incentives as they relate to the life-cycle approach to achieving MNCH outcomes and impact.

Probably two of the major challenges Zambia has had in the implementation of the health sector delivery have been the human resources and supporting infrastructures and related logistics, equipment and supplies. While WHO recommends a proxy ratio of 2 medical doctors and 14.3 nurses per 1,000 population to achieve the health related MDGs, the Zambian ratios of 0.07 and 0.6 per 1,000 population for medical doctors and nurses, respectively, is of extreme concern. As observed in the Ndola district personnel establishment, one of the challenges that worsen health staff shortages relate to unequal distribution of staff especially against remote rural areas of Zambia. Even though staff attrition has not been a major challenge in Zambia, bottleneck analysis within the MNCH Roadmap (2013-2016) found availability of health human resources to be a major challenge in the reduction of under-five mortality and improving maternal health in Zambia. While the health sector has developed strategies, regulations and standards to improve overall performance of health workers, enforcement of the regulations and standards on the performance assessment system has been weak and need strengthening.

Integral to the delivery of health services are the infrastructure and the timely availability of high quality drug and supplies to facilitate at all levels of the health sector. While 46% of rural

households live outside a radius of 5km from a health facility and compared to only 1% for the urban households, the main bottleneck to physical accessibility include insufficient or inappropriate infrastructure, inaccessibility due to geographical features, sparsely distributed populations especially in rural areas, inadequate resources for outreach, and poor scheduling of services leading to missed opportunities. A recent bottleneck analysis on MNCH found inadequate facilities with BEMONC and CEMONC that also included absence of maternity waiting homes. In Zambia, 24% of facilities offered emergency obstetric and newborn care and only 17% of the facilities had mother waiting shelters.

Related to infrastructure is the availability of appropriate health care medical equipment and associated pharmaceutical and medical supplies. Even when Zambia has had a National Drug Policy since 1996, there is currently a critical shortage of key equipment in most hospitals coupled with the ineffective public health supply chain that consists of many players providing diverse services, but often in an uncoordinated manner. The emergence of new programmes, limitations in human resources, weak supply chain management, growing demand on services, and lack of appreciation of the logistics function as a core activity in the health delivery system have negatively affected performance of the national health delivery system.

It is reassuring that within the context of the National Health Policy, National Health Strategic Plan (2011-2015) and the MNCH Roadmap (2013-2016), government is developing the National Supply Chain Strategy for Essential Medicines and Medical Supplies to be approved soon.

Data on MNCH+N drives accountability and oversight, decisions on what health system changes need to be made, and how the system as a whole and each of its parts is functioning. In addition, an important aspect of the information and data elements is to understand whether and how the information collected is used to guide decisions. The recently launched Roadmap (2013-2016) has a comprehensive MNCH+N monitoring and evaluation plan and framework within the context of the life-cycle phases of pre-pregnancy, pregnancy, birth, postnatal, newborn and childhood. The framework has integrated the national level indicators that include family planning, maternal health, neonatal and child health in addition to community-level indicators and both political will and commitment indicators. The framework has further provided for mechanisms to measure progress in MNCH+N plan implementation. The challenge, however, will be in the steps taken and implementation of the transfer and transition in the roles and responsibilities between MOH and MCDMCH. While the MOH had developed one of the most robust M&E systems in the Zambian public service, the same cannot be said about the old Ministry of Community Development and Social Services that has now been given the additional mandate for MNCH+N. Unless a comprehensive and robust capacity building plan is urgently developed and implemented to support the Department of Planning and Information (DPI) in MCDMCH, it will be difficult to measure and further manage MNCH+N interventions, outcomes and impact.

PART 1
BACKGROUND

1.1 Introduction

Zambia aspires to become a prosperous middle income country by 2030. Within the context of the Vision 2030, Zambia developed the Sixth National Development Plan (SNDP 2011-2015) that has now been revised (2013-2016) in line with the Patriotic Front (PF) party manifesto. Human and infrastructure development are the government's strategic focus and priority areas for national development. Although the revised SNDP is guided by principles of accountability, decentralisation and efficient use of resource allocation, it also recognises that high quality and cost effective delivery of services are an important basis for achieving the set objectives of the Plan. Moreover, the plan highlights a number of cross-cutting issues that include governance, HIV and AIDS, food and nutrition, and gender that are necessary in promoting broad based economic growth and development.

Zambia has been categorised as low middle income country largely resulting from recent economic growth of around 7% in 2012 and mostly driven by copper mining that accounts for 80% of foreign exchange earnings. Despite this impressive economic performance, Zambia is yet to achieve gains in social and human development. While poverty remains high with over 60% of its population still living below the poverty datum line, Zambia has significant challenges ahead to attain both Millennium Development Goals (MDGs) 4 and 5. Zambia still experiences both high maternal and childhood mortality indicators. Even though the UNDP's Human Development Report indicates that maternal mortality rates have dropped from 649 deaths per 100,000 live births in 1996 to 470 in 2010, the figure is still high for a country in the lower middle income category. Zambia still has to do more in order to attain the MDG target of 162 deaths per 100,000 live births by 2015. In addition, the under-five mortality rate was 141 per 1000 live births while the MDG target is half of this at 63.6 and to be achieved in less than two years from today. On the other hand, stunting is estimated at 45% among children under the age of five years and has seen little change in nearly a decade.

This observed high rate of poverty despite impressive economic performance continues to affect Zambia's health outcomes, increases morbidity and puts pressure on the country's health delivery system.

1.2 Maternal, Neonatal and Child Health (MNCH) and Nutrition MDG Initiative

In order to support its commitment to achieve the MDGs, UNICEF is working with the government of Zambia, UNFPA and WHO in improving maternal, neonatal and child health and the nutritional status of women and children in selected urban and rural districts (comprising 30% of Zambia's population) within the provinces of Lusaka and Copperbelt through the GRZ-UN-EU MNCH and nutrition MDGi to be implemented during the next three and half years. The project aims at achieving the MDG goals 4 and 5 based on current national objective by improving community maternal and neonatal health (MNH) and nutrition practices and utilisation of quality MNCH&N services in reducing maternal and neonatal morbidity and mortality in Zambia.

As part of assessing the current situation in the project area and priorities in the inception phase to guide policy, planning and prioritising for subsequent year's programme design to strengthen the health system, UNICEF has commissioned this assessment of the regulatory framework in order to analyse and understand the national contextual environment with regard to existing health policies, strategies, legislation, financing mechanisms, management structures and devolution of authority for health care delivery in the 11 programme districts of Lusaka and Copperbelt provinces.

Amongst the terms of reference (TORs) or work assignment include the following:

1. Analyse the adequacy of institutional frameworks governing the design, management, coordination and accountability for RMNCH+N service delivery and quality assurance at the national, provincial, district and sub-district level;

2. Analyse the adequacy of the structure(s) and institutional framework governing the design, implementation and monitoring mechanisms for policies, strategies governing of RMNCH and Nutrition Service Delivery and related legislation;

3. Analyse the implications of current and planned transfer of roles and responsibilities within the context of separation of accountabilities between Ministry of Health and MCDMCH as well as the implications of the upcoming decentralisation plans;

4. Assess the type and functionality of the national, provincial, district and sub-district level coordination, management and oversight structures for RMNCH&N services and the capacity for tracking equitable access of adolescents, women and children to quality and continuity of care;

5. Analyse the adequacy of the financing mechanisms for RMNCH+N services, national budget allocations for health and for RMNCH services, within health and non-health sectors and the level to which they provide sufficient protection from catastrophic health expenditure;

6. Investigate the main bottlenecks impending effective negotiation of adequate funding levels for essential RMNCH+N services and district absorptive capacity for RMNCH funds; and

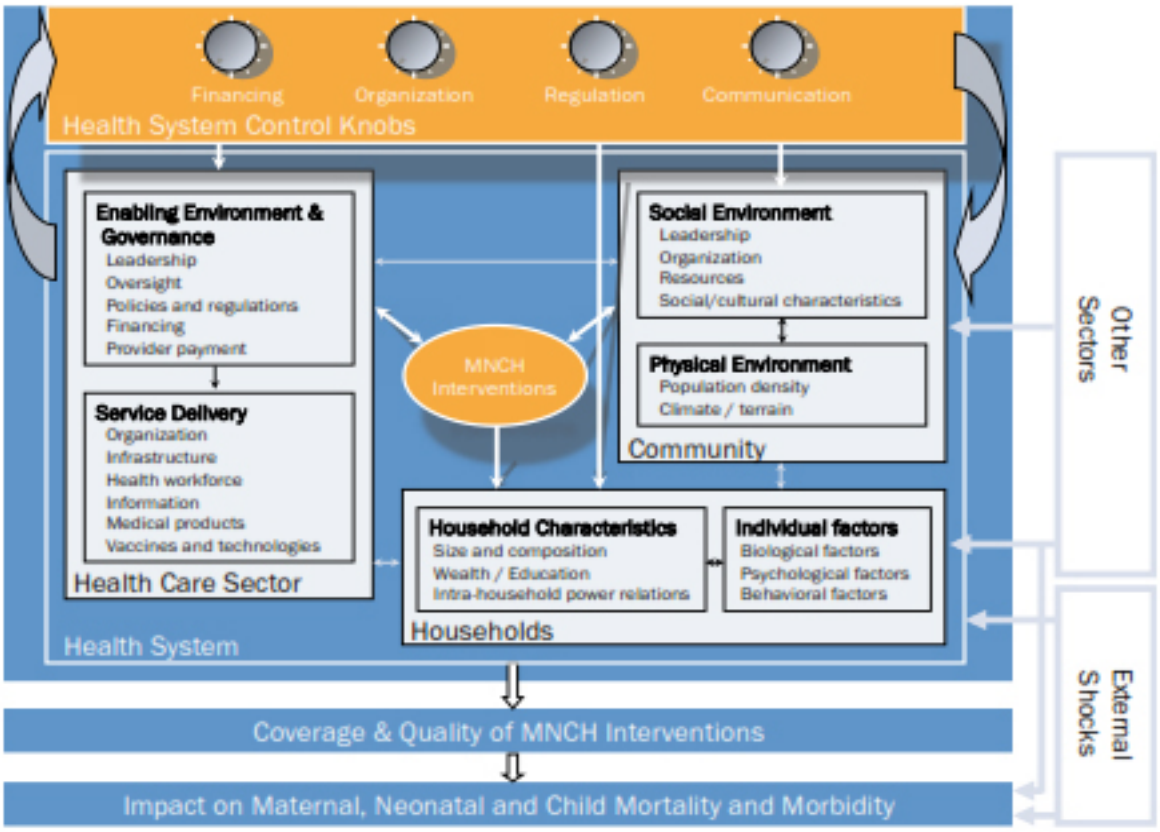
7. Analyse the extent to which existing laws/policies/regulations related to delivery of RMNCH&N services promote increased utilisation of services by beneficiaries, especially among peri-urban populations marginalised and deprived population.

1.3 Maternal, Newborn and Child Health Framework

In order to assess the regulatory framework at all levels within the Zambian healthcare system to support and facilitate fine tuning the design of programme interventions within the MNCH&N context as discussed earlier, this exercise uses a framework on strengthening health system to improve MNCH outcomes as developed by Ergo, Eichler, Koblinsky and Shah (May 2011). The framework presented in Figure 1 has been developed based on a number of earlier frameworks and represents the main components of the health system namely:

- The health care sector, comprising two sub-components: enabling environment and governance; and service delivery;
- The community, with the sub-components physical environment and social environment; and
- The households, which consists of household characteristics and individual factors.

Figure 1: A framework on Strengthening Health Systems to Improve MNCH Outcomes



Source: Ergo, Koblinsky and Shah, May 2011

Each of these components and sub-components, in turn, comprises various interconnected elements of the health system. The sub-component ***enabling environment and governance*** under the ***health care sector*** component, for example, includes the following health system elements: ***leadership***; ***policies and regulations***; ***financing***; and ***provider payment***. MNCH interventions are implemented within the health system. Even though some of the efforts may focus on only a limited number of elements within the health system, it is ultimately the system as a whole—i.e., the combination of the different components and subcomponents, and all the interactions within and between them—that will determine the coverage and quality of MNCH interventions, and therefore the impact on maternal, neonatal and child mortality and morbidity. This is shown at the bottom of the framework. Finally, the four control knobs at the top of the framework allow breaking down health system strengthening (HSS) initiatives and analyzing how these initiatives trigger changes in the health system, whether and how these changes affect the coverage and quality of MNCH interventions, and what the impact is on MNCH morbidity and mortality. The control knobs represent the types of 'tools' available to the different actors—including but not limited to the policymakers—to address weaknesses in the system. These are: financing, organization, regulation and communication. Note that an HSS initiative could very well consist of a combination of several of these tools (Ergo, Eichler, Koblinsky and Shah, 2011).

In summary, the framework indicates that there is a general agreement that well-functioning health systems are needed to reduce maternal, newborn and child mortality and to increase health. As for most interventions in the health sector, the success of maternal, neonatal and child health interventions and programmes is to a large extent determined by the performance of the overall health system in which they are implemented. The framework positions MNCH interventions within the broader health system and presents a structure to organize information and assess how various health systems strengthening (HSS) initiatives might operate within a health system to cause changes that result in improved MNCH.

PART 2
ENABLING ENVIRONMENT AND GOVERNANCE

2.1 Introduction

Using the MNCH framework, the health care sector comprises two subsector components namely: a) Enabling Environment and Governance, and b) Service Delivery.

The assessment and discussion of the policy, strategic, and legal frameworks; and the financing and budgeting mechanism form the enabling environment and governance structures that have implications on the MNCH outcomes and particularly maternal, newborn and child morbidity and mortality. The following sections discuss the Zambian enabling environment and governance within the context of the MNCH Framework earlier presented in Part 1 as part of the background.

2.2 Policy and Strategic Environment

The governance and stewardship of the health sector in Zambia are the responsibility of the Ministry of Health and, since the 2011, the realigned Ministry of Community Development, Mother and Child Health (MCDMCH). Leadership within the health system includes setting priorities and an overall vision and direction for the health system. Moreover, good leadership ensures that policies and regulations are in place for effective, safe service delivery, and that there are appropriate mechanisms in place to ensure accountability (Ergo, Eichler, Koblinsky and Shah, 2011).

In Zambia, most of the health related issues are governed by policies, programmes, schemes, and other approaches. Following independence in 1964 and prior to 1992, the Zambian government used successive national development plans as major policy instruments to guide the provisions of the health care services supported by the Public Health Act CAP 395 of 1930 of the laws of Zambia.

Following the adoption of multiparty democratic system of government in 1991, the government developed and started the implementation of the 1992 National Health Policies and Strategies. Since 1995, Zambia has relied on successive national health strategic plans supported by the National Health Services Act of 1995 that had created the Central Board of Health (CBOH) as a management mechanism of supporting health care services in Zambia until 2006 when the law was repealed, dissolved the CBOH and the management of the health sector reverted to the Ministry of Health. Since then, the health sector has been operating without a health service delivery legal framework, except for regulations associated with food and drug safety, health professionals, and food and nutrition.

In September 2011, the new government established the Ministry of Community Development, Mother and Child Health which assumed the responsibilities of decentralised maternal and child health activities and an increased emphasis on strengthening district level support. In 2012, the government adopted a National Health Policy that sets clear direction for the development of the health sector. The overarching objective of the National Health Policy is ***to reduce the burden of disease, maternal and infant mortality and increase life expectancy through the provision of a continuum of quality effective health care services as close to the family as possible in a competent, clean and caring manner***. The policy is anchored in the Vision 2030 and will be implemented through successive national development plans and national health strategic plans. The policy will particularly be implemented through the National Health Strategic Plan (2011-2015) that elaborates government's health care vision, which promotes access, as close to the home as possible of high quality, cost-effective health services. With the vision of having a ***nation of healthy and productive people***, the strategic plan's overall goal is to improve the health status of people in Zambia through a primary health care approach, equity of access, affordability, cost-effectiveness, accountability, partnerships, decentralisation and leadership. With the development of the National

Health Policy of 2012 and the National Health Strategic Plan (2011-2012) government hopes to develop and/or revise the legislative framework in order to create an enabling environment for health reforms implementation.

On the other hand, the nutrition governance in Zambia is anchored in the National Food and Nutrition Commission Act of 1967 CAP 308 of the Laws of Zambia which gives the National Food and Nutrition Commission (NFNC) the mandate to spearhead and coordinate the food and nutrition sector. The government adopted the National Food and Nutrition Policy in 2006 which has articulated the need for multi-sector approach to food and nutrition issues in the country and streamlined in the national development plans. Indeed, the overarching objective of the nutrition sector within the SNDP (2011-2015) is ***to improve the nutritional status of the Zambian population through quality nutrition services and increased availability, access and utilisation of quality and safe foods***. Recently, the NFNC developed a five-year strategic plan (2011-2015) which aims at better operationalizing the 2006 policy while offering better guidance and synergy to the current plans and programmes in Zambia especially the promotion of "1000 Critical Days" that prevent stunting in children under two years of age and bring added health and productivity to families and the country as whole. It recognises the critical need for approaching many food and nutrition problems through a decentralised approach with major participation from provincial, districts and communities. In 2003, the Government launched the National Decentralisation Policy, which aims at devolving specified functions and authority, with matching resources, to local authorities at district level. Under this environment, the role of the centre would be to provide policy, strategic guidelines, overall coordination, monitoring and evaluation while implementation and supervision of the programmes would be through the local authorities. The Decentralisation Implementation Plan was approved by the Cabinet in late 2009, and the country has been heading towards a full-scale devolution.

Following the launch of the Campaign for Accelerated Reduction of Maternal Mortality (CARMMA) at the ordinary session of the African Union Conference which was held in Addis Ababa, Ethiopia in May 2009, under the theme "***Universal Access to Quality Health Services: Improve Maternal, Neonatal and Child Health***", Zambia officially launched the CARMMA in 2010 under the slogan "***Zambia Cares: No woman should die while giving life***". The CARMMA effort emphasised the need for a multi-sectoral response to reducing maternal deaths and improving safe motherhood.

In line with the government's overall policy framework with respect to the roles of the ministries, the Ministry of Community Development and Social Services was realigned according to Government Gazette Notice No. 183 of 2012 to include the portfolio function on Mother and Child Health. The realignment of the Ministry of Community Development, Mother and Child Health (MCDMCH) has created four service departments namely: Community Development, Social Welfare, Mother and Child Health and Registrar of Non-Governmental Organisations. The four departments are supported by two departments namely Human Resources and Administration; and Planning and Information. The realignment stems from the government priority to implement functional and organisational reforms in the health and social sectors within the overall strategy of increasing efficiency and improving standards in service delivery, especially with regard to reduction of extreme poverty, child morbidity and improve maternal health as highlighted in the United Nations Millennium Development Goals (MDGs) to which Zambia is party. The realignment of the ministry is, therefore, intended to optimise synergies with social welfare and Community development structures in order to offer integrated services to the communities and has reviewed the operational structure of the ministry to cover and enhance sub-district, district, province and national level structures.

Following the realignment of 2012, the MCDMCH has developed a strategic plan (2013-2016) with the main thrust of providing social protection and primary health care for Zambians and sets the

tone for the appropriate policy and legal framework to attain the new mandate. With the vision: ***Pioneers in the provision of integrated social protection and primary health care services***, the ministry's major goal is to reduce extreme poverty and high disease burden by 50% by 2016. Amongst its 12 objectives include two specific objectives on maternal and child health and provision of preventive and curative health services. Specifically, the third objective of the strategic plan is aimed at providing quality maternal and child health services in order to reduce maternal and child mortality and include the following strategies:

a) Mobilize and sensitize communities on Maternal, New born, Child Health and Nutrition services;
b) Scale up the scope and expand the coverage of reproductive health services;
c) Scale up coverage of the expanded programme on immunization, care for the sick child and emergency triage assessment and treatment;
d) Strengthen the implementation of Integrated Management of Childhood Illness strategy; and
e) Scale up young and infant child feeding services.

The fourth objective aims to provide preventive and curative health services in order to reduce the high incidence and prevalence of diseases and include the following strategies:

a) Develop and implement a Behavioral Change Communication mechanism;
b) Strengthen Community health services;
c) Strengthen the preventive health care services;
d) Strengthen and manage curative services for communicable and non-communicable diseases;
e) Strengthen the mechanism for the supply of health commodities; and
f) Strengthen functional referral systems both horizontally and vertically.

Following the development of the MCDMCH strategic plan (2013-2016), Zambia further developed the Roadmap for Accelerating Reduction of Maternal, Newborn and Child Mortality (RARMNCM) 2013-2016 in April 2013. Developed and launched by both ministries (MOH and MCDMCH), the Roadmap's general objective is to accelerate the reduction of maternal, newborn and child mortality rates sufficiently in order to enable Zambia attain the set MDG goals by 2015. Amongst its specific objectives include:

i) Provide skilled attendance during pregnancy, child birth and the postnatal period, at all levels of the health care delivery system;
ii) Strengthen the capacities of individuals, families, communities, line ministries, and the private sector to share responsibility and play their role in efforts to significantly improve maternal, newborn and child health (MNCH) outcomes for universal coverage to attain the set MDG goals.

While recognising that there are known effective interventions for MNCH which if universally scaled up have potential to significantly decrease maternal, newborn and child deaths and that Zambia has adapted and implemented most of these interventions, there has been minimal and limited progress in a number of interventions despite general decline in both maternal and childhood mortality.

Overall, the Zambian Roadmap is premised on an approach that puts emphasis on actions to accelerate progress towards high and equitable coverage of priority maternal, newborn, and child health interventions along the continuum of care within the five phases of the lifecycle:

(a) The pre-pregnancy and adolescent reproductive health needs,
(b) Care and well-being during pregnancy,
(c) The phase of child birth,

(d) Postnatal phase and its special needs,
(e) The needs of the newborn period, and
(f) The childhood phase.

It is also premised on the recognition of the critical role that communities and community based structures can play in providing care to families who do not have easy access to a health facility and in ensuring behaviour change for improved MNCH survival practices.

In June 2012, the Child Survival Call to Action was convened by the governments of Ethiopia, India and the United States, together with UNICEF in order to examine ways to spur progress on child survival and commit countries to lowering child mortality rates to 20 or fewer deaths per 1,000 live births by 2035. This was an important milestone towards the ultimate aim of ending preventable child deaths.

Following Commitment to Child Survival: A Promise Renewed, Zambia was afforded an opportunity to rejuvenate efforts in reducing under-five mortality and to reduce on the divides and disparities in coverage for identified high impact interventions. Amongst these efforts included the development and launch of the Zambia Newborn Health Framework 2013 by the Ministry of Community Development, Mother and Child Health. The main goal of the Newborn Health Framework 2013, is to reduce neonatal morbidity and mortality by providing key high-impact interventions for newborn health care by 2015. The scale-up of newborn health care focuses on the following three strategic objectives that is guiding programming and selection of interventions:

1. To strengthen capacity to improve newborn health care at all levels of the health care delivery system;
2. To increase the availability, access, and utilization of quality newborn health care services; and
3. To empower communities to improve community newborn health care practices and support the continuum of care.

Recognising that two-thirds of newborn deaths could be prevented with high coverage of essential MNCH packages already in policy in Zambia and as long as some specific aspects of newborn care are strengthened, the Newborn Health Care scale-up framework is intended to assist government and partners to determine strategic objectives and priorities for scale-up of newborn health interventions. The guiding principles behind the newborn health care scale-up planning and implementation to ensure effectiveness and sustainability has already been articulated in the Roadmap for accelerating the attainment of the MDGs related to maternal, newborn, and child health in Zambia.

2.3 Legislative Framework

Zambia is party to various international and regional instruments that have had influence in the development of policies on women and children and particularly maternal, newborn and child health. However, international instruments are not self-executing and require legislative implementation to be effective in Zambia as law.

The Zambian constitution, as the supreme law of the country, provides for the care of institutions, procedures, processes and functions of state and government organs, functionaries and institutions. Moreover, the constitution provides for the Directive Principles of State Policy under part nine (9) and Article 112. These principles are guidelines for good governance, accountability and the establishment of policies. Article 2 of the current constitution (1996 as amended in 2006) provides protection for the fundamental rights and freedoms of all Zambians. Moreover, and even

though constitutional development in Zambia spurns over four decades and has always included a Bill of Rights, these fundamental rights are non-justiciable and therefore not legally enforceable. Of relevance are Articles 112 (d), (e), and (f) which stipulate that the state shall endeavour to provide; clean and safe water, adequate medical facilities and decent shelter for all persons and take measures to constantly improve such facilities and amenities. In addition, the constitution allows for the practice of a dual legal system based on both statutory and customary laws. This dual legal system has implications on how the legal framework impacts on the status, welfare and health of both women and children, especially on issues of adolescent reproductive health as related to early childhood marriages and childbearing practices. This is despite recent amendments to the Education Act (2011) that includes the ban on marrying of school-going children. While statutory laws do provide for issues that protect women and children, majority of Zambians still seek legal redress from the local courts that administer customary laws simply because they are less expensive and are easily accessible in most rural areas of Zambia.

Despite the fact that the Right to Life and the Right to Health are protected and guaranteed under Article 12(2) of the Zambian constitution, legislation on health care and health services is almost non-existent. As indicated earlier, and following the repeal of the National Health Services Act of 1995 in 2006, the health sector has been operating without a health service delivery legal framework.

Related to the health service delivery is the issue of nutrition. While the nutrition governance in Zambia is anchored in the National Food and Nutrition Commission Act of 1967 CAP 308 of the laws of Zambia and gives NFNC the mandate to spearhead and coordinate the food and nutrition sector, the School Health and Nutrition (SHN) Policy of 2006 developed by the Ministry of Education based on the 1996 National Education Policy partially aims to foster healthy living, physical coordination and growth of the child. In other words, the SHN programme is the sum total of all health and nutrition activities that go into promoting the physical, social and the mental wellbeing of adolescents and younger children.

With the development and adoption of an overarching National Health Policy in 2012 that sets clear direction for the development of the health sector including the subsequent development of the National Health Strategic Plan (2013-2016), the Ministry of Community Development, Mother and Child Health Strategic Plan (2013-2016), the Roadmap for Accelerating Reduction of Maternal, Newborn and Child Mortality (2013-2016) and the Zambia Newborn Health Framework 2013, the government of Zambia must revise the legislative framework in a multi-sectoral approach in order to create an enabling environment for health reforms implementation targeted and influencing the outcomes and impact of MNCH+N interventions.

2.4 Financing and Budget Mechanisms

The sub-component of ***enabling environment and governance*** under the ***health care sector*** component not only includes leadership, policies and regulations, but also financing and provider payment.

Overall, and according to the HSS framework adopted in this report, the major tools or instruments related to the mobilisation and use of funds are financing method; allocation of funds; rationing; and institutional arrangement for financing. Financing methods include general taxation, social insurance, private insurance, donor funding; community financing and direct out-of-pocket payments by patients. The mix of financing methods will determine the volume of the resource envelope for health, who is in control of available resources and who bears the financial burden.

In addition, how funds are allocated by the population groups or across types of services and how health care is rationed to individuals have important implications in terms of both efficiency and equity. Moreover, funds need to be allocated among prevention, health services, medical training and capital investments. Additionally, funds need to be allocated to the different levels of health care and to geographical areas (Ergo, et al, 2011).

Although the realignment of the MCDMCH took place towards the end of 2011, all programmes on maternal, newborn and child health were still budgeted under the Ministry of Health in 2012. It was only in 2013 when the MCDMCH had a complete budget on all its portfolio functions and responsibilities. In this report, therefore, the 2013 budget is used to analyse and assess the overall financing and budget environment including financing mechanisms for Reproductive Maternal, Newborn and Child Health and Nutrition (RMNCH+N) and related bottlenecks. In some instances, examples are used based on previous patterns of financing mechanisms and the health budget framework in Zambia.

Table 1: 2013 Expenditure by Functions of Government

Function	Allocations (K'Billion)	Percent (%) of Budget
General Public Services	8,441.1	26.2
Defence	2,035.6	6.3
Public Order and Safety	1,347.0	4.2
Economic Affairs	8,897.0	27.6
Environmental Protection	74.2	0.2
Housing and Community Amenities	1,007.8	3.1
Health	3,638.1	11.3
Recreation, Culture and Religion	252.3	0.8
Education	5,626.8	17.5
Social Protection	892.2	2.8
Total	**32,212.2**	**100.0**

Table 1 above presents the budget allocations by sectors for the 2013 national budget. The largest allocation (27.6%) went to economic sector followed by 26.2% allocated to general public services and 17.5% went to education sector. The health sector was allocated K3.6billion and was 11.3% of the 2013 national budget. This represented an increase of 40.7% over the 2012 budget allocation to the health sector. Social protection was allocated 2.8% of the national budget.

Overall, government of Zambia proposed to spend 26.6% of Gross Domestic Product (GDP) in 2013 of which 76.8% was to be financed from domestic revenue and a further 4.6% from cooperating partner grants and the balance of 18.4% from both external and domestic borrowing.

Based on previous financing mechanisms for the health sector, government spending on health accounted for 60% of total public health sector funds while 40% came from external funding by various cooperating partners. The health budget from government allocation has always been below the Abuja target of 15%. Other sources of health care financing include user fees, which until the introduction of the User Fee Removal Policy for rural and peri-urban areas in 2006

represented about 4% of total health care financing (MOH, 2012). For the major hospitals such as University Teaching Hospital (UTH), Ndola and Kitwe Central Hospitals, user fees are a source of flexible financing. In addition, government collects an earmarked 1% tax on interest earnings as contribution to the health basket annually. Although there are some pre-payment arrangements with employer and private insurance schemes, there are no prepayment schemes for majority of Zambians leading to high out of pocket expenditures on health care. However, medical care as a household percentage share on non-food items was amongst the lowest expenditures in 2006 at 1.1% and declined to 0.4% in 2010 possibly resulting from the User Fee Removal policy introduced in 2006[1]. In terms of the 40% external financing the Global Fund to Fight AIDS, TB and Malaria (GFATM) has been a major source of financing for HIV and AIDS, TB and malaria, including areas of health commodities, medicines, human resources, and other inputs. Another major source of external funding particularly for HIV and AIDS and malaria has been the US government, through PEPFAR while the United Nations (UN) family has also supported the health sector by way of technical and financial assistance.

1. CSO, March 2012, Living Conditions Monitoring Survey Report 2006 & 2010.

Table 2 below presents budget allocations and releases to the health sector for 2013.

Table 2: Health Sector Budget Allocation and Releases

	Yellow Book Budget	% of Budget	Released Funds	% of Released Funds
Ministry of health	2,423,328,492.00	66.7	1,859,450,483.00	76.7
Ministry of Community Development, Mother and Child Health	1,213,895,727.00	33.3	354,132,002.00	29.2
Total Health Budget	**3,637,224,219.00**	**100.0**	**2,213,582,485.00**	**60.9**

As earlier discussed, the health sector was allocated K3, 637,224,219.00 which made up 11.3% of the 2013 national budget. Of this amount for the health sector, 67% was allocated to the Ministry of Health while 33% was allocated to the MCDMCH. Table 3 further breaks down the allocation made to the Ministry of Health with over 62% of the allocated budget going to the Ministry of Health Headquarters (HQ) and the lowest allocation (1.1%) going to health training school. Of the budgeted allocation made to the MOH, only 76.7% of the budget was released by the end of 2013. Table 3 below presents the amounts released as a percentage of the budgeted funds by different budget components.

Table 3: Health Sector Budget Allocation and Releases by Level of Institution

Level	Yellow book Budget	Released Funds	% of budget Released
Ministry of Health (HQ)	1,506,726,139.00	1,072,985,216.00	71.2
Provincial Health Offices (PHOs)	143,072,432.00	84,238,729.00	58.9
Second Level Hospitals	357,687,238.00	340,205,718.00	95.1
Third Level Hospitals	388,015,699.00	338,575,786.00	87.3
Training Schools	27,826,983.00	23,445,034.00	84.3
GRAND TOTAL	**2,423,328,492.00**	**1,859,450,483.00**	**76.7**

While 95% of the budget allocation was released to second level hospitals followed by third level hospitals at 87%, only 59% was released to the Provincial Health Offices (PHOs). Table 4 further shows that of the released funds (K1, 859,450,485), the MOH spent 92% with lowest expenditures at HQ and the third level hospitals at 90%.

Table 4: Health Sector Budget Releases and Expenditures by Level of Institution

Level	Released Budget	Expenditure	% of budget pent
Ministry of Health (HQ)	1,072,985,216.00	967,448,949.00	90.2
Provincial Health Offices	84,238,729.00	83,349,292.00	98.9
Second Level Hospitals	340,205,718.00	335,278,445.00	98.6
Third Level Hospitals	338,575,786.00	305,443,226.00	90.2
Training Schools	23,445,034.00	21,437,989.00	91.4
GRAND TOTAL	**1,859,450,483.00**	**1,712,957,902.00**	**92.1**

The highest expenditures were with PHOs and second level hospitals at 99%. During verification visits to some of the institutions in the health sector, it became clear that the 92% expenditure of the released funds was not for lack of absorptive capacity by spending agencies, but due to late release of funds especially towards the end of the year when institutions could not have sufficient time to utilise the funds. In some cases, this was worsened by lengthened procurement processes.

As indicated earlier, only 33% of the 2013 health sector budget went to the MCDMCH. Of this allocation, the ministry HQ was allocated 1% largely for administrative purposes while 99% was allocated to the districts. Of the budgeted district allocations, 17.3% and 16.9% was allocated to Lusaka and Copperbelt provinces while the lowest allocations went to Northern (6.4%) and Luapula (7.9%) provinces, respectively. Of the budgets allocated to the districts only 28.8% was released with Lusaka and Copperbelt provinces having the lowest releases at 25% and 26%, respectively. Highest releases of about one-third were for Northern, Eastern and Luapula provinces at 35%, 33% and 32%, respectively. At the ministry HQ for MCDMCH, only 72% of the budgeted allocations meant for administration was eventually released.

It is clear from the above analysis that while larger budgets were made to the MOH HQ, the ministry also received the largest allocation of the budget at over 62% with the remaining allocation going to PHOs, training school and the second and third level hospitals. Unfortunately, for the districts where health care delivery services take place, less than one-third of the budget gets released as indicated from figures from the MCDMCH.

2.5 Implications of Transfer of Roles and Responsibilities

In 2011, the Ministry of Community Development and Social Services (MCDSS) was realigned to include the Department of Mother and Child Health and the function of cultural development was moved to the Ministry of Chiefs and Traditional Affairs (MCTA). This resulted in the new Ministry of Community Development, Mother and Child Health (MCDMCH). This evolution was necessitated by the need for Zambia to holistically deal with extreme poverty and primary health care issues by using existing community structures in a more integrated and coordinated manner with the goal of providing both social protection primary health care. Table 5 presents a summary of the functions of the Ministry of Health and Ministry of Community Development, Mother and Child Health.

Table 5: Summary of Roles and Responsibilities for Ministries (MOH & MCDMCH)

Ministry of Health responsibilities	Ministry of Community Development, Mother and Child Health responsibilities
• Health policy, standard setting and performance audits • Provision of healthcare at secondary and tertiary levels • Curative services, training of health workers, research and development, disease surveillance and the specialist referral services. • Training facilities affiliated within District Hospitals	• Management of district medical offices, district hospitals, health centres and health posts.(to be retitled to include community) • Community mobilisation, health promotion & health education, maternal and child maternal health services, outreach activities and programmes, prevention and curative services • Will create Provincial Community Medical Offices to support coordination of service delivery

In other words, this realignment stems from government's priority to implement functional and organisational reforms in the health and social sectors within the overall strategy of increasing efficiency and improving standards in service delivery, especially with regard to reduction of extreme poverty, child morbidity and improve maternal health in line with the MDGs. In order to regulate grass root and community structures, the ministry was given an additional mandate to operationalize the Non-Governmental Organisation (NGO) Act No. 16 of 2009.

Following the realignment and government's overall policy framework with respect to the roles of the ministries, Government Gazette Notice No. 183 of 2012 gave the ministry the following portfolio functions:

i) Mother and Child Health;
ii) Adoption Services;
iii) Child Development;
iv) Community Development Policy;
v) Community Development Training;
vi) Disability Affairs Policy;
vii) Food Programme Management;
viii) Group Housing;
ix) Juvenile Correctional Services;
x) Non-Formal Education Skills and Skills Training;
xi) Non-Governmental Organisations;
xii) Probation Services;
xiii) Persons with Disabilities;
xiv) Social Welfare Policy;
xv) Supporting Self-Help Initiatives;
xvi) Welfare Service and Counselling Organisations

In addition to responsibilities for 12 statutory bodies and institutions, the ministry is responsible for the administration of the following pieces of legislations:

i. Persons with Disabilities Act No. 6 of 2012;
ii. Non-Governmental Organisations Act No.16 of 2009;
iii. Probation of Offenders Act CAP 93;
iv. Juveniles Act CAP 53; and
v. Adoptions Act CAP 54.

In order to effectively pursue the above portfolios the ministry now has four service departments namely:

a) Community Development;
b) Social Welfare;
c) Mother and Child Health; and
d) Registrar of Non-Governmental Organisations.

The four departments are supported by two departments namely:

a) Department of Human Resources and Administration; and
b) Department of Planning and Information.

While the realignment has been welcome particularly in integrating community and primary health care delivery services, there are a number of concerns that have been raised and need some policy attention. Firstly, the realignment saw the departure of the Department of Child Development to the Ministry of Gender and Child Development while the Department of Cultural Affairs was realigned with the new Ministry of Chiefs and Traditional Affairs. The transfer of the Child Development mandate has resulted in the duplications and overlap of functions related to child welfare programmes between the two ministries. There is, therefore, need for harmonisation of programmes between the two ministries to ensure that all child related legislations and programmes are placed under one ministry.

The introduction of the Mother and Child Health mandate has placed additional responsibilities on both the Department of Human Resources and Administration (DHRA) and the Department responsible for Planning and Information (DPI). The DHRA has additional responsibility of addressing staff matters related to recruitment of health workers from the centre down to the district and sub-district levels. The DPI will meanwhile be required to establish an integrated management information system to be supported through the establishment of a robust monitoring and evaluation (M&E) system. In addition, DPI is also expected to facilitate the coordination of both the Social Protection and Primary Health Care programmes.

All these responsibilities have also been compounded by the creation of new districts that require both financial and human resources for community development, social welfare and mother and child health at both district and community levels. All these developments are coming at the time when the ministry has had the following challenges in the past as highlighted by the recent Ministry Strategic Plan 2013-2016:

a) Weak Sector Advisory Group (SAG) coordination mechanisms in the social protection sector;
b) Inadequate organisational structures at national, provincial, district and community levels;
c) Lack of transport and fleet management system;
d) Failure to recruit and fill existing staff positions on time;
e) Poor work culture by ministry employees;
f) Lack of a communication strategy;
g) Absence of a management information system and poor record keeping;
h) Inadequate monitoring and evaluation system; and
i) Lack of and out-dated ministerial policies.

PART 3
ENABLING ENVIRONMENT FOR HEALTH CARE DELIVERY

3.1 Introduction

The enabling environment for healthcare delivery comprises many difficult elements that include implementation and management frameworks and both institutional and coordination mechanisms. Other elements include the regulations, guidelines and practices that are derived from government policies and strategies as earlier discussed under enabling environment and governance. Critical within the enabling environment for healthcare delivery especially for MNCH+N interventions and outcomes are the human and financial resources and the infrastructure that should include logistics, equipment and supplies necessary for MNCH+N delivery system especially at the community, household and individual levels which are the sources for healthcare demand system. The healthcare delivery system on the other hand provides the supply system for MNCH+N delivery system.

3.2 Implementation and Management Framework

The first element of the service delivery system as earlier discussed in the framework corresponds broadly to what the organisation control knob tries to change and encompasses the following four characteristics of the healthcare system:

- The mix of organisations providing healthcare services (including private, for profit and community based organisations (CBOs);
- The division of activities among these organisations;
- The interactions among these organisations and their relationship with the rest of the political and economic system; and
- The internal administrative structures of these organisations (Ergo, et al., 2011).

In Zambia, the scope of service delivery comprises promotive, preventive, curative and rehabilitation care that are provided at different levels, from the community level, up to tertiary hospital level care. This hierarchy also determines the structure of the referral system aimed at ensuring continuum of care. The Zambian health sector has a pyramid area based structure, with the provision of basic health services in lower health facilities i.e. Health Posts (HPs) and Health Centres (HCs) covering a limited geographical area, supported by the first, second and third level referral hospitals, through and established referral system.

With the coming of multi-party system of governance in Zambia since 1991, the health sector has been liberalised and embraces diversity in ownership and include: public health sector comprising health facilities and programmes under the MOH, and other government ministries and departments. Faith-based health sector under the coordination of Churches Health Association of Zambia (CHAZ); the private sector, comprising for-and not-for profit health services owned by private investors and Civil Society Organisations (CSOs); and traditional and alternative health service providers, which, however, operate informally and are not regulated or monitored by the MOH and MCDMCH.

Within the government's strategic direction to provide quality and cost effective health services as close to the family as possible, the district health services is the key level in the provision of primary health care services including MNCH+N services to the community aimed at attaining the national health objectives and health related MDGs (MOH, 2011 SP). In order to implement an efficient and effective decentralised system of governance, and ensuring high standards of transparency and accountability at all levels of the health sector, the health centres are managed and supervised by District Health Offices (DHOs) that are in turn supervised by the ten PHOs. The PHOs were previously responsible for coordination, monitoring, technical supportive supervision,

and quality assurance and performance management. At the centre in the MOH, headquarters was responsible for policy guidance and oversight, regulation and defining standards. Like the reporting administrative mechanisms from district through province to the centre, the core health service delivery facilities fall into five categories namely: Health Posts and Health Centres at community level; Level 1 hospitals at district level; Level 2 general hospitals at provincial level and Level 3 tertiary hospitals at national level. The referral system of Zambia also follows the same pattern and hierarchy. The DHOs are the focal point for services delivery, providing supervision, coordination, planning and management support to HPs, HCs and 1st level hospitals.

Before the realignment of the MCDMCH, the PHOs reported to the Ministry of Health HQ that comprised the following specialised directorates: Human Resources and Administration; Planning and Development; Public Health and Research; Clinical Care and Diagnostic Services; Technical Support; and Mobile and Emergency Services. These directorates supported the MOH in its mandate for policy formulation, development, implementation, monitoring and evaluation. In addition, the directorates are supported by health statutory boards that have been established to provide the necessary technical and regulatory support to the core health service delivery facilities. These boards are sub-divided into service delivery and regulatory where service delivery boards are responsible for providing specialised support services while regulatory boards are responsible for enforcing government policies, legislation and regulations related to health.

With the realignment of the MCDMCH, the directorate of Public Health and Research has been transferred to the MCDMCH and a new department of Mother and Child Health created to support government policy development and implementation on MNCH+N interventions. The MCDMCH has taken over the supervision of districts while PHOs provide technical support to the districts while reporting to the MOH.

Currently, the oversight for policy guidance is in both the MOH and the MCDMCH as evidenced with the formulation of the Roadmap that has been signed and endorsed by the two ministers responsible for the two health sector ministries.

3.3. Institutional and Coordination Mechanism

Related to the implementation and management framework are critical issues of mechanisms for institutional coordination in health sector delivery system. Before the realignment of the health sector portfolios in 2012, the MOH has been responsible for the overall coordination and management of the health delivery system in Zambia. The sector had established health sector coordination structures in order to facilitate efficient and effective coordination at various levels from the community, through district and province to the national level. At the national level, the MOH has been responsible for the overall coordination and management using both formal and informal coordination mechanisms. The ministry had established national management units for specific health programmes and included: Reproductive Health Unit; Child Health Unit; National Malaria Control Centre (NMCC); National AIDS Council (NAC); and the National Tuberculosis and Leprosy Control Programme Management Unit. In order to support and coordinate the various programme structures, the ministry also established the Sector Advisory Group (SAG) as a forum for policy dialogue and coordination of health sector partners under the Sector-Wide Approaches (SWAps). Within the SAG include membership of other sector ministries, private sector, faith and civil society organisations. As a way of coordinating the financial resources available to the sector, the MOH has established the SWAp, as a mechanism to coordinate support of various cooperating partners. As part of the SWAp, some donor agencies have agreed to pool funds in a basket to jointly fund agreed upon health plans. On the other hand, there are other partners that continue to support and

fund vertical programmes while government feels that such vertical and parallel programmes often undermine the health system strengthening mechanisms.

At the provincial level, PHOs are responsible for coordinating health service delivery in their respective provinces while DHOs coordinate at district level. At the community level, Neighbourhood Health Committees (NHCs) have been established to facilitate linkages between the communities and the health system at district, province and up to the national level structures as discussed in earlier sections.

3.4 Regulations, Guidelines and Practices

Regulations should be understood as instruments used by the state to coerce change in both individual and organisational behaviours in the health delivery system. In other words, this refers to the full range of legal instruments that include laws, administrative rules, guidelines, and practices by government and often through statutory boards with delegated powers of the state. Beyond health care providers, both private and public, and health financing entities, regulations may also target those who produce inputs for the health system such as pharmaceutical companies and those who educate or train health professionals.

The Zambian regulatory system includes institutions responsible for the following pieces of legislation among others: Medical and Allied Professionals Act, Pharmacy and Poisons Act, Nurses and Midwives Act, Food and Drugs Act, Therapeutic Substances Act, Ionising radiation Act, Termination of Pregnancy Act, Extermination of Mosquitoes Act, Mental Disorders Act, National Food and Nutrition Commission Act, etc. Although regulation does not stop at the enactment of legal instruments, one of the challenges in the Zambian health service delivery system include lack of enforcement and the overall process of identifying, penalising and deterring violators. Moreover, despite that a number of these instruments have been inherited from the British colonial system, harmonization and modernisation of these instruments even within the health sector has been a challenge. For example, while the health sector in Zambia has performed remarkably well in formulation of policies and strategies as discussed in sections 2.2, the sector has not had a legal instrument on health service provision since 2006. Moreover, the legal instruments need to be harmonised with various instruments from other sector ministries and state entities. Another challenge in the Zambian situation is lack of incentives associated with most legal instruments. Often, regulation tends to be more effective when accompanied by appropriate incentives and by efforts to influence individual behaviour and by suitable organisational arrangements. The Zambian government has, however, shown commitment to the reduction of maternal, new born and child mortality by ensuring that the necessary policies, strategic plans, and guidelines are in place and include:

- National Health Policy;
- National Reproductive Health Policy;
- National Child Health Policy;
- National Food and Nutrition Policy;
- National Health Strategic Plans (currently 2011-2015); and
- Adolescent Health Strategic Plan 2011-2015).

On maternal, newborn and child health, policies and strategies have included:

- Roadmap for Accelerating Reduction of Maternal, Newborn and Child Mortality (2013-2016);
- Zambia Newborn Health Framework 2013; and
- Ministry of Community Development, Mother and Child Health Strategic Plan (2013-2016).

Existing Guidelines and Practices have also included:

- Updated family Planning Guidelines;
- Comprehensive Abortion care Guidelines;
- Safe-Motherhood Guidelines;
- Pregnancy, Childbirth, Postpartum and Newborn care Guidelines;
- 2010 National Protocol Guidelines on Integrated Prevention of Mother –to-Child Transmission of HIV; and
- Essential Nutrition Package of Care in the Health Sector; among other tools.

In other words, the health sector is not short of policies, strategies and guidelines, but enforcement of already existing regulations and providing the necessary incentives for both individual and organisational behaviour especially as they relate to maternal, newborn and child health interventions, outcomes and impact.

3.5 Human Resources for Maternal, Newborn and Child Health

It is a well-known fact that human resource for health is the backbone and limbs of the health care delivery system. Human resource crisis in health are prevalent, and for varying reasons, across the globe even though policy makers often do not address health worker shortages until it is too late (Ergo, et al., 2011).

For sub-Saharan Africa, and Zambia in particular, human resources for health issues also include the impact of HIV and AIDS and the subsequent impact on the healthcare delivery system. Amongst the critical issues on human resources for health include the number and distribution of health workers, their skill mix and overall skill set, staff productivity and quality of care provided.

At the time of developing the Human Resources for Health Strategic Plan (2011-2015) in 2011, there were 31,962 health staff employed in the Ministry of Health against an establishment of 56,621 and hence an establishment gap of 44%. In other words, only 56% of the required health staff was employed for the whole country. For the medical doctors and clinical officers, there was a gap of 63% and 68%, respectively. As for the midwives and nurses, there was a gap of 53% each for each category, respectively, while the gap for nutrition staff was at 49%. These gaps in the establishment represent positions that could not be funded by the treasury for recruitment.

WHO recommends a proxy ratio of 2 medical doctors and 14.3 nurses per 1,000 population to achieve the MDGs. For Zambia, however, the ratios for medical doctors and nurses are 0.07 and 0.6 per 1,000 population, respectively, which is of extreme concern. Using a workforce review analysis of the inflows and outflows of existing health workers employed in public health sector, the MOH estimated a shortage of 12,996 health workers against the recommended establishment of 39,360 health workers in 2020; an establishment gap of 67%. One of the challenges that worsen health staff shortages relate to unequal distribution of staff across provinces and districts. Even though health staff increased by 34% between 2005 and 2010, Table 6 below demonstrates the unequal distribution of staff as reflected by clinical staff to 1,000 population in the provinces.

Table 6: Provincial Distribution of Clinical Health Staff in 2010

Province	Population	Clinical Health Staff	Clinical staff per 1,000 Population
Northern	1,759,600	1,191	0.68
Eastern	1,707,731	1,385	0.81
Luapula	958,976	807	0.84
Western	881,524	984	1.12
Central	1,267,803	1,442	1.14
Southern	1,606,793	2,477	1.54
North Western	706,462	1,033	1.46
Copperbelt	1,958,623	3,260	1.66
Lusaka	2,198,996	3,648	1.66
Zambia	**13,046,508**	**16,227**	**1.24**

While Lusaka and Copperbelt provinces had a ratio of 1.66 each, the worst situation was in Northern, Eastern, and Luapula provinces at 0.68, 081 and 0.84, respectively. Even within the discussed provinces, however, there are Intra-provincial variations in terms of staff distribution including establishment gaps. In Chongwe district, for example, there is an establishment gap of 43% while that for registered nurses, registered midwives, and enrolled nurses is 7%, 71% and 45%, respectively. For the enrolled midwives, however, the establishment is fully filled at 34 positions. In Ndola district, the establishment provides for 13 medical doctors but only 4 positions have been filled. On the other hand, enrolled midwives, registered midwives and registered nurses are employed above the establishment by 56%, 61% and 33%, respectively, further demonstrating the unequal health staff distribution patterns. For the enrolled nurses in Ndola, however, there is an establishment gap of 27%.

Further workforce review analysis estimated the total attrition rate of 3.6% as of 2009 indicating that attrition of health staff was not a significant factor in Zambia and could be mitigated through increased training of health workers. The attrition has been predominantly through resignations and has had limited impact on the public health workforce. Even though government with support of cooperating partners successfully increased the annual numbers of graduates from health related training programmes by a 110%, a large gap still remains between the available numbers of health workers and the needs of the sector, in general.

In order to mitigate the impact of staff and encourage their redistribution even to remote areas of Zambia, government instituted various incentives through mechanisms such as Recruitment and Retention allowances, Rural and Remote hardship allowances and the Zambia Health Workers Retention Scheme (ZHWRS). Despite these incentives, the mechanisms have not been sufficient to attract a suitable number of health workers. Another strategy employed by government to mitigate shortage of health staff was the development of a National Community Health Worker Strategy in 2010 that has been running on a pilot basis since June 2011. The strategy aims at providing short term training to untrained volunteer health workers in order to formalise and provide government oversight and standardisation. On the strategy to improve overall performance of health workers in the public health sector, government has developed relevant guidelines, procedures and codes to guide managers in encouraging good performance and handling of officers. However, this has not worked accordingly due to absence of a comprehensive system for recording good performance such as a performance-based reward and remuneration system. Moreover, enforcement of the regulations and standards on the performance assessment systems has been weak and need strengthening.

Overall, the health sector has a comprehensive planning framework that includes human resources issues and runs from the district and provincial levels to the national level. In fact, the health sector is, probably, one of the very few sectors in the Zambian public service with a comprehensive strategy on its human resource.

The above review of the human resources for health situation supports evidence from the bottleneck analysis performed during the preparations for the Roadmap on Accelerating the Reduction of Maternal and Childhood Mortality (2013-2016). The analysis used both child health tracer and maternal health high priority interventions. The root causes for the bottlenecks associated with under-five deaths that prevented the full coverage of interventions included high staff attrition, low human resources retention with high cost and length of training, and health staff attitudes consequent to overworking and under motivation especially for the rural areas of Zambia. In other words, availability of human resources was found to be a major bottleneck in the reduction of under-five mortality and improving maternal health in both rural and urban areas of Zambia. Among the strategies for removing the bottlenecks include efforts of ensuring availability of human resources in MNCH intervention strategies. Moreover, addressing the challenges associated with availability of human resources for health in the scaling-up of implementation of high impact interventions will put the Zambian MNCH+N programme on the right footing for attaining adequate effective coverage and eventually the impact needed.

3.6 Financial Resources for Maternal, Newborn and Child Health

As discussed in section 2.4, availability of financial resources is a major bottleneck in scaling-up MNCH interventions and coverage since it affects issues of human resources availability and motivation and enables availability of logistics, equipment and supplies for MNCH+N.

Table 7 presents the breakdown of the 1% health budget allocated to the MCDMCH headquarters by breakdown of programmes. In terms of the budget allocation, 45% and 15% of the total health budget at HQ was allocated to child and reproductive health, respectively, while only 5% was allocated to nutrition. Even though only 72% of budgeted health allocation was released by the end of 2013, about 46% and 19% of the total released funds went to child health and reproductive health, respectively. Amongst the released funds, unfortunately, only 0.09% went to implement nutrition related activities.

Table 7: MCDMCH HQ Health Sector Budget and Releases by Programme

Programme	Yellow Book budget	% of total budget	Amount Released	% of budget Released
Administration	306,696.00	2.8	152,850.00	3.0
Child Health	4,951,491.00	45.4	3,651,947.00	45.0
Health Service Delivery	360,408.00	3.3	409,386.00	3.0
HIV/STI/TB	1,421,414.00	13.0	946,321.00	13.0
Malaria Control	1,108,402.00	10.0	760,000.00	10.0
Non-Communicable and Tropical Disease	553,641.00	5.0	350,124.00	5.0
Nutrition	562,688.00	5.0	70,000.00	5.0
Reproductive Health	1,630,896.00	15.0	1,517,426.00	15.0
Grand Total	**10,895,636.00**	100.0	**7,858,054.00**	100.0

As indicated earlier, 99% of the MCDMCH health budget of K1, 213,895,727.00 goes to support the districts on various health care delivery services. Table 8 below presents the 2013 budget for the districts of Ndola and Chongwe that are part of the EU-UNICEF MNCH+N programme. Programme budget lines are categorised according to the following:

i) Personal emoluments;
ii) Health Service Delivery (that include: provision of 1st Level Referral Services; Health Centre Clinical Care Services; Community Health Services; and Health Centre Outreach Services); and
iii) Health System Management (that include: Performance Assessment; Technical and Administrative Support; and Utilities and Other Office Costs).

Table 8: 2013 Health Sector Budget for Ndola and Chongwe Districts

Programme	Ndola District	Percentage	Chongwe District	Percentage
Personal Emoluments	30,362,733.41	89.1	10,659,050.68	83.6
Health Service Delivery	3,150,721.86	9.2	1,348,988.19	10.6
First Level Referral Services	741,346.33	2.2	522,227.50	4.1
Health Centre Clinical Service	652,940.31	1.9	285,932.60	2.2
Community Health Services	444,807.78	1.3	216,327.24	1.7
Health Centre Outreach Services	1,311,627.44	3.8	324,500.85	2.5
Health System Management	556,009.75	1.6	739,923.42	5.8
Performance Assessment	24,349.56	0.1	67,986.90	0.5
Technical & Administrative Support	26,139.97	0.1	143,475.81	1.1
Utilities and Other Office Costs	505,520.22	1.5	528,460.71	4.1
Total	34,069,465.02	100.0	12,747,962.29	100.0

The table indicates clearly that more than 80% of the district budgets are going to pay personal emoluments. For Ndola district, this is nearly 90% of the 2013 budget. While 9.2% of the Ndola budget goes to health service delivery category, less than 2% of the budget goes to health system management. The proportions for Chongwe districts are, however, higher at 10.6% and 5.8%, respectively.

In order to assess the amount of resources that go to support MNCH+N activities at the district level, Table 9 presents the 2013 budget for Chongwe district indicating breakdowns by programme.

Table 9: 2013 Health Programme Budget for Chongwe District

Programme	Budget	Percentage
Integrated Reproductive Health and Family Planning	595,579,882	23.8
Child Health and Nutrition	428,513,614	17.1
Malaria	301,101,703	12.0
Tuberculosis	215,001,398	8.6
STI, HIV and AIDS	220,001,646	8.8
Environmental Health	301,003,290	12.0
Mental Health and Epilepsy	62,334,429	2.5
Oral Health Services	198,800,987	7.9
Eye Care Services	99,334,430	4.0
Non-Communicable Diseases	82,410,873	3.3
Total	2,504,082,251	100.0

The highest percentage of the budget in Chongwe district is allocated to Integrated Reproductive Health and Family Planning (IRH&FP) at nearly 24% followed by Child Health and Nutrition at 17%. In other words, the MNCH programme combined is allocated about 41% of the 2013 budget. The lowest allocation is made to Mental Health and Epilepsy at 2.5%. To further assess the 2013 Budget performance in terms of actual expenditures that go to MNCH+N activities, Table 10 presents the expenditures for Ndola district based on the actual releases of funds.

Table 10: 2013 Health Programme Budget Performance for Ndola District

Programme	Budget	Funds Released	Percentage	Donor Funds
Surveillance	31,807	25,278	0.9	
Child Health	290,977	208,367	7.5	73,465
Maternal Health	95,340	44,200	1.6	
PMTCT	1,063,449	752,616	27.1	100,800
Nutrition	270,726.38	206,541	7.4	105,860
Malaria	303,119	93,861	3.4	82,378
Non-Communicable Diseases	11,386	11,386	0.4	
Tuberculosis	226,624	27,041	1.0	
HIV and AIDS	3,900	3,900	0.1	
Pharmacy	127,752	82,662	3.0	
Procurement	1,428,694	1,087,064.71	39.1	
Administration	238,954	234,604	8.4	
Total	**4,093,388.38**	**2,777,520.71**		**362,503**

According to Table 10, Ndola district had budgeted K4,093,388.38[2] and only K2,777,520.71 making 67.9% of the budgeted figure was actually released for expenditure. For the Ndola district expenditures, the largest proportion of 39.1% went to procurement of materials and supplies of which 49.5% were for the first level hospital services followed by fuel expenses at 26.3%. Within the procurement component drugs and laboratory supplies made up only 7%. While the largest programme component went to PMTCT at 27%, Maternal and Child Health components including Nutrition made up 16.5% of the released budget.

2. Please note that this figure differs from the Yellow book approved figure of K3,706,731.61 as it includes other projected incomes coming from Health Centre, Yellow Fever and Medical Fees.

3.7 Logistics, Equipment and Supplies for Maternal, Newborn and Child Health

Integral to the delivery of health services are the infrastructure and the timely availability of high quality drugs and supplies to facilities at all levels of the health sector. The health service delivery infrastructure constitutes the physical capacity and readiness of the buildings, equipment, communication systems and the transport networks. On the supplies side, the stocks of medical products and vaccines should be well managed, affordable to facilities and clients, and appropriately distributed. The availability of pharmaceutical and medical supplies enables health workers to deliver appropriate care and builds the community's trust in the health system (Ergo, et al., 2011). Managing the supply chain is predicated by having the right information at all levels and should include case load and case mix, current stock levels for drugs and supplies, and predictions of future needs. This information, combined with data on the quality of the care delivered, is a key input in ensuring that resources are appropriately utilised.

Although the Zambian government has made great strides in improving health care delivery infrastructure, the country is still far away from meeting the policy objective of ensuring that the population has access to health facilities within a 5km radius. Moreover, health centre structures are not responding to new challenges in health service delivery such as maternal, newborn and child health. Health infrastructure is inadequate in both rural and urban areas. In rural areas, 46% of households live outside a radius of 5km from a health facility compared to 1% in urban areas making it difficult for many people to access the needed services (MOH, 2012). The main bottlenecks to physical accessibility include insufficient or inappropriate infrastructure; inaccessibility due to geographical factors; sparsely distributed population in rural areas; inadequate resources for outreach; and poor scheduling of services leading to missed opportunities.

Recent bottleneck analysis during the preparations of the Roadmap indicates that long distances from the health facility and difficult geographical terrain together with seasonal factors were some of the root causes for the bottlenecks. Other root causes included inadequate facilities with BEMONC and CEMONC, and absence of maternity waiting homes in many districts of Zambia (MCDMCH and MOH, 2013). According to the 2012 List of Health Facilities in Zambia published by the MOH in June 2013, 24% of facilities offered Emergency Obstetric and Newborn Care and only 17% of the facilities had mother waiting shelters (MWS). For the Copperbelt and Lusaka provinces, only 17%, 10% and 5%, 11% had EMOC and MWS, respectively. Moreover, only 63% and 46% of the health institutions offered delivery facilities in Copperbelt and Lusaka provinces. In Masaiti district of Copperbelt province, for example, only 6 sites (26%) and 4 sites (17%) had EMOC and MWS facilities, respectively. For Chongwe district of Lusaka province, only 4 sites (15%) had EMOC facilities and no single mother waiting shelter despite long distances and terrain for that district. For the new Rufunsa district of Lusaka province, there was only one (1) EMOC site and one (1) mother waiting shelter, despite the distances between village settlements and health facilities. In Rufunsa, for example, there are facilities with a distance of 200km from the district health office. In terms of transport logistics and ambulances in particular, patients can only be

transported from health centres to EMOC sites and not from communities to health facilities in all the two programme provinces of Lusaka and Copperbelt.

The quality, efficiency and effectiveness of health service delivery are determined and dependent on the availability of appropriate health care medical equipment. Currently, there is a critical shortage of key equipment in most of the hospitals in Zambia that has hampered provision of quality critical services especially in level 2 and level 3 hospitals. Theatre and anaesthesia, maternity and general bedside nursing equipment are also in dire need of replacement in most of the hospitals. By the end of 2011, for example, there were 7 level 1 hospitals, 38 health centres and 135 health posts that had been constructed by government but could not be commissioned due to lack of equipment among other inputs (MOH, 2012).

Pharmaceuticals and medical supplies are essential components of the health system. Zambia has had a National Drug Policy since 1996 although it is currently under review. This is equally the case for the development of the National Supply Chain Strategy for Essential Medicines and Medical Supplies that is under development. In the past years, the supply of essential drugs and medical supplies have remained erratic in Zambia. The emergence of new programmes, limitations in human resources, weak supply chain management at certain levels, growing demand on services, and lack of appreciation of the logistics functions as a core activity in health delivery system, have negatively affected performance in this area (MOH, 2012). The unsatisfactory access to medicines by the population had partly been attributed to the capacity of in-country supply chains to accurately forecast, procure and deliver essential medicines and health supplies on time to health facilities across a geographically diverse country. The public health supply chain consists of many players who provide diverse services, often in an uncoordinated manner. The MOH and Cooperating Partners undertake procurement, Medical Stores Limited (MSL) does the storage and distribution up to the district while district health offices deliver the supplies to the respective health centres. Meanwhile, quantification and forecasting is performed by different players that include MOH itself, cooperating partners and other implementing agencies and often in an uncoordinated fashion. This observed fragmentation of roles and responsibilities in the supply chain has resulted in supply chain breakdowns and a lack of accountability leading to delays, shortages, and expiries, as no single entity has full control of the end to end supply chain process.

Another challenge has been the irrational use of drugs and medical supplies despite an established National Formulary Committee whose mandate is to ensure adherence to the concept of rational use of medicines and other commodities. While other additional structures such as the Drug and Therapeutic Committees exist at different levels throughout the country, there is notable non-adherence to set standard guidelines. While a regulator through the establishment of the Pharmaceutical Regulatory Authority (PRA) exists, the absence of a National Drug Quality Control Laboratory has greatly affected the monitoring of quality and safety of products circulating on the Zambian market.

In terms of how essential pharmaceuticals and medical supplies affect MNCH+N interventions, the bottleneck analysis pointed to limited storage space and poor distribution of supplies, and lack of supplies procurement planning at the district level. In recent years, the government has taken some reform measures in this area. In September 2012, the MOH provided new policy direction that significantly changed the role of MSL by giving the institution responsibility for the end to end supply chain management of pharmaceuticals and medical supplies in the public health sector. In December 2013, government further officially adopted a hybrid supply system, as an enhancement to the Essential Medicines Logistics Improvement Programme (EMLIP).

At policy, strategic, legal and regulatory levels, government through the MOH will continue with the overall coordination of the supply chain activities, while the legal and regulatory controls are being provided, largely, through the Medicines and Allied Substances Act of 2013 and administered by the Zambia Regulatory Authority (ZMRA). ZMRA currently has the responsibility for product licensing, setting standards for management of medicines and medical supplies and quality assurance.

Within the context of the National Health Policy, National Health Strategic Plan (2011-2015) and the Roadmap for Accelerating Reduction of Maternal, Newborn and Child Mortality (2013-2016) under the MCDMCH, government is developing the national Supply Chain Strategy for Essential Medicines and Medical Supplies to be approved as soon as possible.

PART 4
MONITORING AND EVALUATION FRAMEWORK

4.0. Introduction

The ultimate assessment of the interventions, and of the health system, is the impact on the lives and lifespan of the vulnerable members of the Zambian society. Although the impacts, particularly on maternal and childhood mortality are difficult to measure due to the large sample sizes required and the huge costs associated with national surveys, a comprehensive monitoring and evaluation system is essential for measuring outcome interventions and ultimately the impact on mothers and their children. Data on maternal, newborn and child health and nutrition drives accountability and oversight, decisions on what health system changes need to be made, and how the system as a whole and each of its parts is functioning. Moreover, an important aspect of the information and data element is to understand whether and how the information collected within the health system is used to guide decisions (Ergo, et al., 2011).

4.1 Strengthening Monitoring and Evaluation for Maternal, Newborn and Child Health

The health sector probably has the most comprehensive monitoring and evaluation system within the entire Zambian government system with adequate capacity and institutional mechanisms under the MOH. Unfortunately, this is not the case for the new MCDMCH and great efforts and resources are required to transfer that capability to the new ministry with the overall policy and strategic mandate on maternal, newborn and child health and nutrition. To ensure value for money and in pursuit of result oriented approach, the health delivery sector has been using the following processes in monitoring and evaluating the health sector:

- Quarterly Progress Reports;
- Performance Assessments;
- Joint Annual Reviews;
- Mid-Term Reviews; and
- Final Evaluation of Strategic Plans.

While the mid-term reviews and final evaluations have been used to feed into both the implementation process and the design of future plans, the current M&E system relies largely both on routine through the HMIS and non-routine information sources such as the surveys and the national census of population and housing. One of the challenges of the routine information source, the HMIS, has been the integration of information particularly from private health sector systems.

The recently launched Roadmap for Accelerating Reduction of Maternal, Newborn and Child Mortality (2013-2016) has developed probably the most comprehensive MNCH+N monitoring and evaluation plan and framework within the context of the life cycle phases of pregnancy, birth, postnatal, newborn and childhood. The developed framework has integrated the national level indicators that include family planning, maternal health, neonatal and child health in addition to community-level indicators and both political will and commitment indicators. The framework has also provided for mechanisms to measure progress in MNCH plan implementation. The challenge, however, will be in the steps taken and implementation of the transfer and transition in the roles and responsibilities between the Ministry of Health and the Ministry of Community Development, Mother and Child Health.

PART 4
CONCLUSION AND RECOMMENDATIONS

5.1 Conclusion

Various national reports have indicated the decline in both maternal and childhood mortality in Zambia since the Millennium Declaration by the United Nations. The decline has, however, been slower for neonatal mortality. Despite these declines in mortality, Zambia still has significant challenges in achieving both MDG 4 and 5.

In an effort to support achievements of MDGs 4 and 5, the Zambian government working with the EU and the United Nations family in Zambia has embarked on a project aimed at achieving the MDGs based on current national objective by improving community maternal, neonatal and child health (MNCH) and nutrition practices and utilisation of quality MNCH+N services in reducing maternal and childhood morbidity and mortality.

This report has, therefore, assessed the regulatory framework in order to analyse and understand the national contextual environment with regard to existing health policies, strategies, legislation, financing mechanisms, management structures and devolution of authority for health care delivery in the programme districts of Lusaka and Copperbelt provinces. Guided by the framework on strengthening health system to improve MNCH outcomes as developed by Ergo and colleagues in 2011, the following issues were observed for Zambia.

Over the years and since 1992, the health sector has relied on the National Health Policies and Strategies as mechanisms of supporting health care in Zambia. In 2012, the health sector went further to adopt an overarching National Health Policy that sets clear direction for the development of the sector. This policy development is supported by both the National Health Strategic Plan (2011-2015) and the new Ministry of Community Development, Mother and Child Health Strategic Plan of 2013-2016. Furthermore, both the MOH and the MCDMCH have jointly developed the Roadmap for Accelerating Reduction of Maternal, Newborn and Child Mortality (2013-2016) with the general objective to accelerate the reduction of mortality in order to enable Zambia attain the set MDG goals 4 and 5 by 2015. The recent realignment of the MCDMCH is further intended to optimise synergies with social welfare and community development structures in order to offer integrated services to the communities at the grass-root level.

Despite the highlighted efforts by the Zambian government, the health sector has been operating without a health services delivery legal framework since 2006, except for regulations associated with food and drug safety, health professionals and food and nutrition. Even these regulations are out-dated and are not harmonised with other legal mechanisms within and outside the health sector. For example, while the government has now developed the National Food and Nutrition Strategic Plan (2011-2015), the nutrition governance is still anchored in the Act of 1967 CAP 308 of the laws of Zambia.

Secondly, even though a national health policy exist to guide both the MOH and the MCDMCH, clarity is still needed on which ministry has the mandate for policy development and implementation monitoring. According to recent government guidelines on the roles and responsibilities by the two ministries, the MOH has responsibility for health policy, standard setting and performance audits. Meanwhile, the MCDMCH has the policy mandate to implement maternal and child health policies since the ministry has a separate cabinet minister responsible for that mandate who should ensure that the policies and strategies under MCDMCH on MNCH are successfully implemented. This further raises the question of which ministry is accountable on the implementation of policies and strategies related to achieving the goals of the MNCH Roadmap (2013-2016).

In addition to the issues of leadership, policies and regulations, financial and budget mechanisms are critical in ensuring the achievement of MDG goals of 4 and 5; and there are further implications on the overall enabling environment for health care delivery. Even though the government had

allocated 11.3% of the 2013 national budget to the health sector and was more than 40% increase from the 2012 budget allocation, the health budget has always been below the Abuja target of 15%. Moreover, the social protection budget allocation that should protect the vulnerable mother and children in Zambian communities was only 2.8% of the national budget. Even with the 11.3% of the health sector budget, the MOH was allocated 67% while the MCDMCH was allocated 33% that was largely meant for district health care delivery services. By the end of 2013, however, less than one-third of the budget was eventually released to the districts with the highest release being for Northern province at 35%. It is clear from this assessment that despite districts being the core of health care delivery services, they are not receiving sufficient funds even for the minimal of operations especially that over 80% of the allocations to districts also go for payment of personal emoluments.

The second component of the health system is the enabling environment for health care delivery and comprises many difficult elements that include implementation, management, and institutional coordination mechanisms. Over the years, the MOH has developed robust implementation, management and institutional coordination mechanisms that included a well-established health Sector Advisory Group (SAG) and the Sector-wide approaches (SWAps) that included participation of cooperating partners. While coordination mechanisms still needed to be strengthened further within the MOH, the same cannot be said about the MCDMCH that previously could not coordinate adequately the social protection sector advisory group. With the added mandate to coordinate MNCH interventions at the district and sub-district levels, the MCDMCH urgently requires a comprehensive capacity building strategy and plan for system strengthening.

The Zambian government has shown commitment to the reduction of maternal, newborn and child mortality by ensuring that the necessary policies, strategies, regulations, guidelines and practices are in place. And while these regulations should be understood as instruments used by government to coerce change in both individual and organisational behaviours in the health delivery system, the challenge has been the enforcement of already existing regulations and providing the necessary incentives as they relate to the life-cycle approach to achieving MNCH outcomes and impact.

Probably two of the major challenges Zambia has had in the implementation of the health sector delivery have been the human resources and supporting infrastructures and related logistics, equipment and supplies. While WHO recommends a proxy ratio of 2 medical doctors and 14.3 nurses per 1,000 population to achieve the health related MDGs, the Zambian ratios of 0.07 and 0.6 per 1,000 population for medical doctors and nurses, respectively, is of extreme concern. As observed in the Ndola district personnel establishment, one of the challenges that worsen health staff shortages relate to unequal distribution of staff especially against remote rural areas of Zambia. Even though staff attrition has not been a major challenge in Zambia, bottleneck analysis within the MNCH Roadmap (2013-2016) found availability of health human resources to be a major challenge in the reduction of under-five mortality and improving maternal health in Zambia. While the health sector has developed strategies, regulations and standards to improve overall performance of health workers, enforcement of the regulations and standards on the performance assessment system has been weak and need strengthening.

Integral to the delivery of health services are the infrastructure and the timely availability of high quality drug and supplies to facilitate at all levels of the health sector. While 46% of rural households live outside a radius of 5km from a health facility and compared to only 1% for the urban households, the main bottleneck to physical accessibility include insufficient or inappropriate infrastructure, inaccessibility due to geographical features, sparsely distributed populations especially in rural areas, inadequate resources for outreach, and poor scheduling of services leading to missed opportunities. A recent bottleneck analysis on MNCH found inadequate facilities with BEMONC and CEMONC that also included absence of maternity waiting homes. In Zambia,

24% of facilities offered emergency obstetric and newborn care and only 17% of the facilities had mother waiting shelters.

Related to infrastructure is the availability of appropriate health care medical equipment and associated pharmaceutical and medical supplies. Even though Zambia has had a National Drug Policy since 1996, there is currently a critical shortage of key equipment in most hospitals coupled with the ineffective public health supply chain that consists of many players providing diverse services, but often in an uncoordinated manner. The emergence of new programmes, limitations in human resources, weak supply chain management, growing demand on services, and lack of appreciation of the logistics function as a core activity in the health delivery system have negatively affected performance of the national health delivery system.

It is reassuring that within the context of the National Health Policy, National Health Strategic Plan (2011-2015) and the MNCH Roadmap (2013-2016), government is developing the National Supply Chain Strategy for Essential Medicines and Medical Supplies to be approved soon.

Data on MNCH+N drives accountability and oversight, decisions on what health system changes need to be made, and how the system as a whole and each of its parts is functioning. In addition, an important aspect of the information and data elements is to understand whether and how the information collected is used to guide decisions. The recently launched Roadmap (2013-2016) has a comprehensive MNCH+N monitoring and evaluation plan and framework within the context of the life-cycle phases of pre-pregnancy, pregnancy, birth, postnatal, newborn and childhood. The framework has integrated the national level indicators that include family planning, maternal health, neonatal and child health in addition to community-level indicators and both political will and commitment indicators. The framework has further provided for mechanisms to measure progress in MNCH plan implementation. The challenge, however, will be in the steps taken and implementation of the transfer and transition in the roles and responsibilities between MOH and MCDMCH. While the MOH had developed one of the most robust M&E system in the Zambian public service, the same cannot be said about the old Ministry of Community Development and Social Services that has now been given the additional mandate for MNCH. Unless a comprehensive and robust capacity building plan is urgently developed and implemented to support the DPI in MCDMCH, it will be difficult to measure and further manage MNCH+N interventions, outcomes and impact.

5.2 Recommendations

1. Zambia has developed an overarching National Health Policy, Strategies including a comprehensive MNCH+N Roadmap (2013-2016). There is, however, an urgent requirement for clarity in policy mandate between MOH and MCDMCH to ensure accountability and oversight.

2. Zambia has been operating without a legal framework for health services delivery since 2006. There is urgency in providing an immediate legal environment with updated and harmonised legislations, regulations and guidelines as they relate to the life-cycle approach to MNCH+N interventions.

3. Even though Zambia has developed legislation, regulations and standards relating to MNCH+N interventions and health staff performance frameworks, there is immediate need to ensure that mechanisms are strengthened for enforcement and that the necessary incentives for both individual and organisational behaviour are provided for especially as they relate to MNCH+N interventions.

4. Based on the Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis of the MCDMCH Strategic Plan (2013-2016), the structural inadequacies of the new ministry have been highlighted. It is recommended that a comprehensive capacity building implementation and operational plan based on the new MCDMCH strategic plan and the MNCH+N Roadmap (2013-2016) is urgently developed and adequately funded. This should support both sector coordination and build a robust monitoring and evaluation system.

5. Discussions during the report validation exercise with some of the districts participating in the project point to the immediate requirement to develop synergy between Community and Social Welfare structures and that for Mother and Child Health that currently seem to operate in parallel. In other words, there is a need for horizontal rather than the current observed vertical integration in order to further enhance implementation of both maternal and child health and social protection.

6. The Zambian health sector has developed strategic plans for enhancing both the human and financial resources for the districts and other national structures. Despite these plans, the common challenge of inadequate financial resources and the treasury authority to employ critical health staff according to the establishment has remained a chronic bottleneck. Government and partners need to revisit this challenge that has implications on several other MNCH+N interventions in Zambia and devise a workable mechanism.

7. Related to recommendation 6, there is a need for political will to fully finance district budgets within the context of real fiscal decentralisation and devolution in line with the decentralisation policy of government.

8. With the commendable effort government has recently made in 2012 towards providing new policy direction that significantly changed the role of Medical Stores Limited (MSL) by giving the institution responsibility for the end to end supply chain management of pharmaceuticals and medical supplies in the public health sector, there is immediate need to provide a strategic mechanism by urgently approving the National Supply Chain Strategy for Essential Medicines and Medical Supplies.

9. Lastly, but not least, there is a need for a costed and adequately financed national infrastructure plan within the framework of operationalizing the MNCH+N Roadmap (2013-2016).

REFERENCES

Central Statistical Office, 2012; Living Conditions Monitoring Survey Report 2006 & 2010, Lusaka.

Ergo A, Eichler R, Koblinsky M, and Shah N, 2011: Strengthening Health Systems to Improve Maternal, Neonatal and Child Health Outcomes: A Framework. Washington DC.

Government of Zambia, 2012; Estimates of Revenue and Expenditures (For the Year 1st January 2012 to 31st December 2012), Lusaka.

Government of Zambia, 2013; Estimates of Revenue and Expenditures (For the Year 1st January 2013 to 31st December 2013), Lusaka.

Government of Zambia, 2012; 2013 Budget Address, Lusaka.

Government of Zambia, 2006; Vision 2030: A Prosperous Middle-Income Nation by 2030, Lusaka.

MCDMCH, 2013; Ministry of Community Development, Mother and Child Health Strategic Plan 2013-2016, Lusaka.

MCDMCH, 2013; Chongwe District Community Medical Office MTEF Action Plan 2014-2016, Chongwe.

MCDMCH, 2013; Ndola District Health Management Team: Consolidated Action Plan for 2014-2016, Ndola.

MCDMCH, 2014; Ndola DHO Annual Progress Report, Ndola.

Ministry of Finance, 2013; 2012 Annual Progress Report, Sixth National Development Plan, Lusaka.

Ministry of Health, 2000; Family Planning Counselling Information for Service Providers, Lusaka.

Ministry of Health, undated, CARMMA: Campaign for Accelerated Reduction of Maternal Mortality in Africa, Lusaka.

Ministry of Health, 2009; Essential Nutrition Package of Care in the Health Sector, Lusaka.

Ministry of Health, 2010; 2010 National Protocol Guidelines on Integrated Prevention of Mother-to-Child Transmission of HIV, Lusaka.

Ministry of Health, Undated; Pregnancy, Childbirth, Postpartum and Newborn care Guidelines, Lusaka.

Ministry of Health, 2013; The 2012 List of Health Facilities in Zambia: Preliminary Report, Lusaka.

Ministry of Health, Undated; Maternity Counselling Tool for Safe Motherhood, Lusaka.

Ministry of Health, 2011; Adolescent Health Strategic Plan 2011-2015, Lusaka.

Ministry of Health, 2012; National Health Policy, Lusaka.

Mukelabai Mubita, 2011; An Analysis of Child Related Legislation in Zambia, Bachelor of Laws Dissertation, University of Zambia, Lusaka.

National Food and Nutrition Commission, 2011; National Food and Nutrition Strategic Plan for Zambia 2011-2015, Lusaka.

National Food and Nutrition Commission, 2012, The First 1000 Most Critical Days, Three Year Programme 2013-2015, Lusaka.