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Towards Universal Health Coverage

Zambia's Experience Developing a Roadmap to Support Heath Benefit Package Reform

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Main messages

- Defining a cost-effective, affordable, and implementable health benefits package (HBP) is a requirement for achieving Universal Health Coverage (UHC), and as a result, an HBP should be regularly revised to address evolving country needs.
- From 2020 Zambia began a policy process that relies on data and evidence, and stakeholder consultation and engagement, to revise their HBP.
- To effectively plan for the revision and channel inputs in a fair and effective manner, Center for Global Development (CGD) supported Ministry of Health (MoH) to develop a roadmap to organise the process, i.e., a tool that explicitly maps out the steps, decision points and expertise to conduct a revision, based on CGD's 'what's in what's out' framework.
- This case study presents the roadmap, describing the process that was adopted to develop it and draws early implementation lessons.
- The Zambia roadmap is organised around nine steps from landscape analysis to implementation and future revisions. It is tailored to the Zambian context as it puts emphasis on consultation and engagement as well as implementation (given issues around implementation of the past HBP package).
- Practical guidance on HBP revision processes is limited. We primarily target this resource to decision-makers and technical staff working in low- and middle-income countries (LMICs) to inform their own revision process, by providing clear and detailed information of our experience in Zambia. However, development partners and research groups across the world may find this resource useful to understand the complexity and full requirements of a revision process, and as a result target funding, capacity strengthening efforts, and generation of data and analytics to best support LMICs on their journey to UHC.
- It is worth noting that the implementation of the roadmap has faced a number of challenges as a result of a combination of factors; namely leadership changes within the Ministry of Health, and support from partners, as well as unresolved issues from the outset on funding.

1. Introduction

Universal Health Coverage aims to ensure that everyone has access to good quality health services without suffering financial hardship, through the provision of a full spectrum of "essential, quality health services, from health promotion to prevention, treatment, rehabilitation and palliative care" (Chalkidou et al., 2016). Deciding what constitutes 'essential, quality health services' is a major challenge to all countries embarking on UHC, due to the host of factors to consider (epidemiology, health system design, resource constraints). Ideally essential services should be prioritised from a broader pool of services to form a health benefits package (HBP), using transparent and consistent criteria (WHO, 2021).

Defining a clear, affordable, and implementable HBP is necessary for UHC to become reality. Yet it is a contentious process and requires making extremely tough decisions that will be challenged from all parts of society. Moreover, the prioritisation process requires bringing together a vast amount of information and data, under a decision-making framework that requires leadership, exhaustive stakeholder involvement, coordination, and best governance practices. For those reasons, Bredenkamp et al. (2015) found that countries struggle with developing HBPs that are responsive to their health challenges as well as being financially sustainable.

For the last three decades, Zambia has implemented a series of policies to gradually work towards UHC. As part of this, in 2012, the Government of Zambia developed the National Health Care Package (NHCP) to support UHC in the country. The NHCP covers a wide range of services across the continuum and all levels of care. It is organised into 25 disease control priorities and includes a mix of infectious and non-communicable diseases, as well as medical specialties (Ministry of Health, 2012a). At the time, the plans of creating a social health insurance fund, or more broadly of a pooled funding mechanism, to support the delivery of the NHCP had reached an advanced stage. The aim was to implement the NHCP as a whole, rather than adopting a piecemeal approach by funding individual services (Ministry of Health, 2020a).

Acknowledging the obstacles and weaknesses of the earlier approach of developing, funding and implementing the NHCP as a whole, discussions surrounding the revision of the NHCP were initiated in 2020 (Ministry of Health, 2020a). The aim was to revise the NHCP to address the evolving burden of disease in the country, the changing landscape of health technologies and heath infrastructure, and changes in resources available; and to make use of guidance, data and tools that are now available (at the international level, as well as country level).

To plan the revision process, the Ministry of Health (MOH) worked with partners to develop a roadmap; a tool that explicitly maps out nine steps to revise the NHCP, as well as the corresponding required decision points and partners to each step. This roadmap builds directly on the Center for Global Development (CGD) steps developed as part of the what's in what's out guidance, which has been tailored

to the specificities of the Zambian context. It was developed by a project management team appointed by the MOH and reviewed and validated by the stakeholders across the MOH and its partners. Despite the enthusiasm generated by the process, the roadmap implementation stalled on step 3 because of a lack of funding for supporting the analytical work and changes in leadership within the MOH.

The intention of this case study is to introduce and disseminate the approach taken to develop the roadmap, as well as the roadmap itself, adding to the limited published literature on experiences with HBP revisions in LMICs. Our audience is the decision-makers and technical staff initiating revisions, as well as development partners and academic groups to identify potential areas where they can support this process, mainly through funding, capacity strengthening or production of tools and data. First, we provide a brief discussion of Zambia's efforts towards achieving UHC and an overview of the NHCP and its revision plan. We then present the approach and process underpinning the tool and introduce the roadmap.

2. UHC in Zambia

The health system in Zambia is governed by the National Health Policy (NHP) principle of "equity of access to assured quality, cost-effective and affordable health services, as close to the family as possible" (Ministry of Health, 2012b). Healthcare services are provided by the government, faith-based organisations (FBOs), nongovernmental organisations (NGOs) and the private sector. The Government and donor contributions accounted for about 41 percent and 42 percent of the estimated $59 current health expenditure (CHE) per capita in 2016 (Ministry of Health, 2018). The Zambia CHE per capita in 2016 was below that of the lower-middle income average of $82 and declined from $90 in 2013 (Ministry of Health, 2018). There is a high level of reliance on external funding to support the delivery of health services in Zambia: in the region, only four other countries (the Central African Republic, Malawi, South Sudan and Mozambique) have such high levels of external funding in the health care sector (WHO, 2018). Out of pocket expenditure constitutes about 12 percent of current health expenditure. Moreover, catastrophic medical expenditure was estimated at 6.3 percent in rural areas and 2.6 percent in urban areas in 2014 (Chansa et al., 2018). As a share of total household health expenditure, spending on drugs was the highest category at 42 percent followed by transport and food at 26 percent (Chansa et al., 2018).

There are persistent gaps and barriers in provision of and access to services in Zambia. In 2020, only 40 percent of essential drugs and medical supplies were readily available, only 20 percent of hospitals had completely functional requisite equipment, and the patient-to-doctor ratio was 1 to 6750 (Ministry of Finance and National Planning, 2022) which is below the average for sub-Saharan African countries (World Bank, 2023). The National Health Strategic Plan 2017–2021 identified a $2.4 billion infrastructure gap and additional $2.2 billion on supply chain management

for essential medicines and commodities (Ministry of Health, 2017). Despite significant reductions in communicable diseases, the burden of Malaria, HIV/AIDS, and TB remain high. Furthermore, noncommunicable diseases are becoming increasingly prevalent in Zambia, accounting for 29 percent of overall mortality in 2016 (Ministry of Finance and National Planning, 2022).

Zambia has two HBPs covering a range of services: the National Health Care Package (NHCP)[1] and the National Health Insurance Scheme (NHIS) HBP.[2] The NHCP was launched in 2012 as the essential package of health services for Zambia, building on efforts to develop a package dating back two decades (Luwabelwa et al., 2017; Wright, 2015). The overall objective for the NHCP is to have "a set of standards that will be the cornerstone of health care service delivery at all levels in Zambia (Ministry of Health, 2012a). These standards include services, therapeutics, infrastructure, medical equipment, and availability of trained health workforce. The national health strategic plan and the health financing strategy summaries the NHCP revision objectives as:

1. To focus on health promotion, disease prevention, basic health care, and multi-sector collaboration for community health.
2. To support strategic purchasing through the effective implementation of free primary and reimbursable hospital level packages. The package will support the effective use of government tax revenues to financing primary care targeting the entire population and support reimbursement at hospital level using the National Health Insurance Scheme.
3. To encourage efficiency in resource allocation by supporting the funding of effective, acceptable, and cost-effective interventions at all levels of care.

Services listed in the NHCP span across all levels of care from health posts to specialised units in tertiary and teaching hospitals. Diagnostic, therapeutic, and rehabilitative services are also included (in addition to treatment, promotion, and prevention services). Some health systems strengthening interventions such as equipment maintenance services and supply chain management are also included. Services are categorised in 25 disease control priorities or clinical areas; examples include maternal conditions, tuberculosis/leprosy, AIDS, trauma, and malnutrition.

The NHCP is not delivered as a whole (e.g., through a central pooled funding) but instead some disease control programs of the NHCP are delivered through different sources, including government funding, donor support for vertical programmes and the NHIS. As a result, there remains much confusion over what services that form the HBP are actually implemented and available to patients on the ground (Chi and Regan, 2021).

1 A descriptive table of the NHCP can be found in the appendix.

2 In this note, we do not discuss the NHIS HBP. For more information, please refer to www.nhima.co.zm. The NHIS began its implementation in 2019 and complements the NHCP with a subset of entitlements that are financed through a predictable and dedicated mandatory contributions scheme (MOH, 2019).

3. Developing the roadmap for the NHCP revision

Origins of the roadmap

A sustainable HBP requires ongoing review and revision to ensure that the package of services continually reflects the needs of the populations and efficient use of limited health resources (Chi et al., 2021). The 2012 NHCP was built on previous efforts dating back to 1993, and a revision was necessary to account for several changes (*e.g.,* disease burden, health technology, funding) and to include new evidence and data available to health planners. Moreover, learning from the implementation challenges since its creation, this revision also intended to look at the delivery modalities of the NHCP, not only its list of services. This is in line with growing guidance on HBP emphasizing the need to align different health system functions (*e.g.,* budgeting processes including provider payment, clinical guidelines, procurement) to the content of HBP to ensure its implementation) (Chalkidou et al., 2016).

For the above reasons, the MOH initiated the development of a roadmap to support the revision of the NHCP, with support from CGD. The roadmap is a tool to map out the different steps of the revision process, from inception to adoption. The anticipated benefits of the tool are (i) effective planning and governance of the process, (ii) effective channelling of research, data, evidence and other contributions from local and international partners, and (iii) transparency and legitimacy of the approach taken by the MOH.

Tailoring of an existing CGD framework

While the literature on HBP development is growing (including covering country perspectives such as Uganda (Mohan et al., 2022), Ethiopia (Eregata et al., 2020)), case studies covering practical procedural steps required for whole package revisions in LMICs remains limited. The conceptual framework used to guide this present roadmap was adapted from the CGD *What's In, What's Out* report (Glassman et al., 2017) (referenced as the CGD framework in this note), which outlines the core principles and ten steps towards the development of an explicit HBP. The ten steps refer to the one-off process of developing a HBP de novo, but is organised as a cycle to inform revisions, which would occur periodically. The aim of the framework is not to be 'prescriptive', but to articulate a set of activities and discuss possible arrangements to conduct those in a given country. As stated by the authors of the framework, "there is no single 'correct' way of organizing these functions; their precise nature and locus may vary substantially depending on the political framework, policy choices, and nature of the health system". Evidence-informed decision making is a growing area (Oortwijn et al., 2021; Voorhoeve et al., 2016), but a key strength of the CGD framework is that it is intended to support all steps in the development of a HBP and this current work the only tailoring of the framework to a country context. In addition, the WHO publication 'principles of health benefits packages' (WHO,

2021) was also used to inform some aspects of the roadmap, though this latter does not articulate steps or activities. It is worth noting that a guidance on HBP revisions was released by the Joint Learning Network in December 2022 though it was not available at the time to inform this present work (Joint Learning Network for Universal Health Coverage, 2022).

Literature documenting Ethiopia's HBP revisions was also used to further tailor the process (Eregata et al., 2020). Eregata et al. (2020) provides detailed information on the revision process, methodology, involvement of stakeholders and experts; as well as the new features of the HBP. We summarise some take aways from this resource in Box 1.

BOX 1. Summary of the Ethiopia Experience

Two important principles of the process were (i) the establishment of a transparent and accountable governance structure and (ii) to deliberate evidence and decisions by engaging all relevant stakeholders. A 30-member technical working group (TWG) comprised of senior partners from cooperating partners, stakeholders, and the Ministry of Health lead the governance for the processes. To support the day-today facilitation, a core team with varied experts was identified. The stakeholders extended beyond health experts across disease control programs to women, and youth associations.

A nine stepwise process roadmap was subsequently established. Social value judgments were identified in a set of criteria: disease burden, cost effectiveness, budget impact, financial risk protection, equity, and public and political acceptability. The criteria were used to generate evidence on a set of interventions identified through stakeholder engagement. Using this evidence across interventions, priority packages were modelled. Finally, preceding the dissemination of the final package, fiscal space analysis was used to establish the financial feasibility for the HBP options. The process was guided by principles of acceptability and transparency and ensured that legitimacy of decision making through evidence-informed deliberative processes.

Effective leadership and governance for the revision exercise was a key success takeaway. The established TWG and core group had a clear mandate described in the roadmap. The roadmap defined the scope and goals for the revision and the quality of the evidence to be used. Stakeholders representing different social groups, were included in the decision-making process at all stages. Evidence was generated for seven prioritisation criteria identified and used to prioritise all interventions.

Source: From (Eregata et al., 2020).

Process for developing the roadmap

The revision project management team generated the roadmap as a deliverable to the multi-stakeholder HBP Technical Working Group (HBP TWG). The HBP TWG is a 50-member forum of senior representatives from cooperating partners, academia, civil society groups, local and international NGOs, the private sector (including faith-based health providers), regulatory institutions, public representatives, and other government line ministries. Its role is to provide overall governance of the NHCP revision process and to generate consensus for political and public acceptability (Ministry of Health, 2020b).

To support the HBP TWG function, the MOH, through the planning and budgeting department, appointed the project management team (Ministry of Health, 2020b). The team's role was to support the day-to-day functionality of HBP TWG, including the generation of evidence to support decision making.

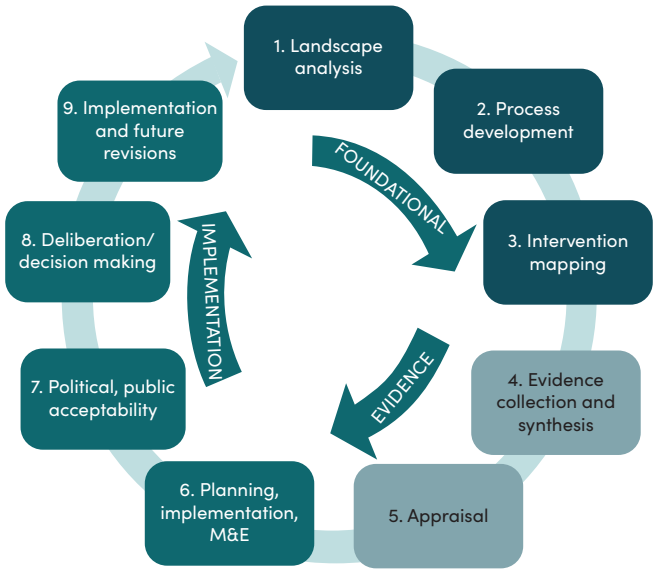
Once developed and reviewed by project management team, the roadmap was circulated to the HBP TWG and global experts on HBP through iDSI for feedback, until deliberative iterations were finalised. The revised version was then internally shared within the planning and budgeting department and across departments within MOH for policy consistency and alignments.

The planning and budgeting department, as chair of the multistakeholder group, held a NHCP validation meeting in November, 2021 (Ministry of Health, 2021a). This meeting was attended by members of the HBP TWG, broader stakeholders and sub-national heads from MOH. The MOH presented the roadmap, highlighting the use of principles of accountability, legitimacy and evidence-informed deliberative processes for its implementation. The presentation also outlined a commitment from the government to implement the revised NHCP through an assured resource envelope and to continually review the package to accommodate new technology through the establishment of a formal HTA institution (Ministry of Health, 2021b). Feedback from the meeting was used to finalise the roadmap. The finalised version was later presented and signed off in an internal MOH high-level meeting, chaired by the permanent secretary. The final roadmap report was disseminated and shared to all stakeholders. In addition, to disseminate it more broadly and share lessons learnt, MOH and CGD has produced this present article.

Overview of the roadmap

The framework in Figure 1 provides an outline of the nine broad steps.

FIGURE 1. Conceptual framework outlining the HBP revision process



It should be noted that the roadmap is cyclical, as illustrated in Figure 1; and as pointed by Glassman et al. (2017), long term plans for continual review and revision are necessary to ensure that the content of the HBP and its implementation address the health needs in the country. Steps will most likely not occur in a sequential manner, *i.e.,* some steps will be carried out at the same time, or it may be that decision-makers decide to go back and forth between two steps (*e.g.,* if in light of new evidence or new economic circumstances, appraisal of interventions may need to be revisited after an initial iteration). The idea of steps is to allow the process to be roughly mapped out and to highlight the interdependency between some of the actions.

The roadmap has maintained the structure of the CGD framework, but some steps were rearranged, and new ones introduced (Figure 1). For instance, given the gaps in implementation in the initial version of the NHCP, an entire step (step 9) was introduced to cover those issues (from financing to human resource staffing); whereas the GCD framework adopts a narrower view of implementation by discussing 'resource allocation and use'. A dedicated step for consultations was created (step 7 'public and political acceptability') to reflect the routine practice in the health sector in Zambia. It is worth noting that consultations should be continuous (across all steps), in addition to this dedicated step once a first version of the revised NHCP has been agreed on.

Figure 2a provide more detailed information about the actions contained within each step.

FIGURE 2a. The detailed 9-step framework for HBP revisions

1. Landscape analysis	2. Process development	3. Intervention mapping	4. Evidence collection and synthesis	5. Appraisal
• Description of existing HBP • Root causes of revisions • Setting goals/objectives (alignment with wider health policies) • Development of approach (incr. vs whole package) • Definition of scope of revisions • Assessment of existing strategic purchasing functions to determine the approach and granularity of the HBP • Communication (including wider public) and engagement on initial plans	• Planning activities and stakeholder involvement (including partners) • Governance process definition • Selecting appraisal criteria and developing process • Agreement on key elements of revision • Discuss and describe the explicit goals of the HBP • Obtain commitment from MoH, MoF and other aligned Government Ministries, to actively support the whole process and its associated workload • Define responsibilities of involved partners along each step of the process • Agree on the frequency of meetings/discussion sessions and overal timeline • Timeline definition • Communication (incl. to wider public)	• Description of intervention structure and definitions • What's covered in the current package • What could be covered in the new package • What is covered by other packages in the country • How does it relate to: disease and health priorities, utilisation, coverage etc. • Identify areas for data collection + information gaps management	• Define the process for the public/stakeholders to nominate candidates for inclusion • Define general appraisal inclusion and exclusion criteria • Primary and secondary data collection • Additional analyses and evidence basis (incl. HTA, HiPTool, Tufts, DCP3, prices, tafriffs etc.) • Synthesis (presented in a format that is suitable for review) • Fiscal Space Analysis	• Define the appraisal method (CEA, ECEA, MCDA) • Define the analytical approach to support decision-making once interventions have been asessed-threshold or budget + league table approach • Stakeholder engagement • Deliberation on individual interventions • Costing + actuarial analysis • Decision-making • Communication (incl. to wider public)

6. Planning, implementation levers and M&E framework	7. Political and public acceptability	8. Deliberation/Decision making	9. Implementation and future revisions
• HR planning • Provider payment mechanisms (PPM) • Procurement • Financing sources • Resource allocation formula • Infrastructure • Information systems	• Engagement, consultation with wider group of stakeholder (incl. general public) • Possibly engagement here with MoF about resourcing • Discuss options in the light of impact on budget, opportunity costs and ethical tradeoffs	• Adjustments to the contents of the HBP to reflect engagement with wider group + conversations with MoF • Final costing/actuarialisation • Decision-making • Dissemination and communication (incl. to general public)	• Implementation/roll out • M&E • Methodological manual for the systematic updating of the HBP • Lessons learned • Planning revisions: adapted process manual and anchor in the normative/legal framework • Links to HTA institutionalisation • Strengthening local capacity

Expansion of the roadmap: decision points and partners/expertise

In addition to the activities under each step, decision points and skills required to execute the steps are enumerated in Figure 2b.

FIGURE 2b. Roadmap expansion

1. Landscape analysis	2. Process development	3. Intervention mapping	4. Evidence collection and synthesis	5. Appraisal
• Scope of revision • Overall goals/aims • Agreement on process	• Appraisal criteria & process • Rough budget envelope • Governance • Rough shape of the package	• 'Remit' of the review • Data collection and analysis needs	• N/A	• The rough first draft of the HBP for review • Corresponding estimated budget
MoH Local research partner HBP & HF consultants	MoH Local research partner HBP & HF consultants	Local research partner HBP & HF consultants MoH review	Local research partner HBP & HF consultants	Independent advisory group MoH Actuarial consultants

6. Planning and implementation levers	7. Political and public acceptability	8. Deliberation/Decision making	9. Implementation and future revisions
• Implementation plans • Links with budgeting • M&E plan (including data collection)	• Agreed areas of revisions from the first draft • Rough budget estimate and resourcing plans	• Final HBP • Final budget estimate and resourcing plan	• Implementation and future revisions
MoH, MoF Local research partner HBP & HF consultants M&E experts	MoH, MoF (and other departments) Local research partner HBP & HF consultants	Independent advisory group MoH, MoF (and other departments) Actuarial consultants	MoH, MoF (and other departments)

Decision points Skills and partners

As a result of the activities outlined in a given step, we expect specific decisions to emerge and that will be referenced and used for decision-making in future steps. For instance, as a result of the first step landscape analysis, goals for the HBP (e.g., health maximisation, financial protection, equity) may be defined. Being clear about the goals will be very important in later steps: for instance, during *evidence collection and synthesis*, the goals will inform what data and evidence will be collected or during *appraisal*, to shape the process such as what criteria should be selected and how they will be weighted. To ease the implementation of the roadmap, a list of 'decision points' was thus developed to ensure that the activities appropriately fed into decision-making.

In addition, to help plan activities, a list of partners/expertise was developed to help identifying partners early and channel their inputs more effectively.

As highlighted above, each step of the roadmap has a list of stakeholders that have concerted to provide technical support (e.g., developing analytics or facilitating workshops). With MOH steering, local and international partners had already been engaged in the delivery of the roadmap. For instance, the MOH was able to mobilise technical and financing resources from UNICEF for the community health package component on the NHCP. However, more partners with diverse capacities and experiences are still needed (*e.g.,* on costing, systematic priority setting or implementation).

4. Conclusion

The intention of this case study was to introduce the process followed in the Zambian context to support countries embarking on the journey to UHC, either developing an HBP de novo or revising an existing one. It is worth noting that the experts working on the roadmap did not conduct a literature review (that would meet academic standards) to define the roadmap and that some of the aspects of the roadmap were informed by informal exchanges, local health systems characteristics and implementation constraints that may be very different in another country. As a result, it does not claim to be directly generalisable to other LMICs. To allow countries to adapt it to their settings, we included background information on the Zambia UHC plans, as well as qualitative information on how the idea of a roadmap was approached and developed. Moreover, as acknowledged previously, the HBP revision process has currently stalled. At the time of writing, only components of steps 1–3 were undertaken, and it is unclear whether or when implementation will resume.

Back at the inception of the process, the political commitment to revising the NHCP and learning from the previous implementation challenges was very strong. The roadmap and revision process were driven by an assigned lead department, which moved quickly to convene an HBP TWG and generate TORs. The lead department also committed to relying on evidence, deliberation and promoting fairness in the revision process. Engagement with stakeholders were also deemed very constructive, especially during the roadmap development process. Finally, other adjacent policy initiatives also aligned with the revision process: for instance, the Ministry of Health was committed to establishing an HTA unit within five years.

In spite of those positive developments, progress on the roadmap was hindered by several elements. First of all, there was a lack of clarity on the funding commitment to delivering a revised version of the HBP; a crucial element that has been highlighted in the decision-points. Without consensus on this matter, the responsibilities for carrying the revision forward, including the roles and responsibilities of donors and other external partners, were not very clear. If the roadmap implementation resumes, there will be a need to review the feasibility of delivering the NHCP using fragmented funding from MOH and NHIS, as well as donors (for vertical programs in the revised NHCP), as was initially envisaged. There will also be a need for concerted consensus from stakeholders on revenue raising, pooling and strategic purchasing, considering the high fragmentation in the financing landscape.

In addition to strong initial leadership and governance, lasting commitment and working structures also need to be put in place. Since the inception of the roadmap, the Ministry of Health experienced multiple changes in leadership; an issue common to many LMICs. Navigating a long-term project through those changes was difficult. An HBP revision based on consultations and evidence-based deliberations will also typically take a long time (in some cases, as Ethiopia, years). Successful engagement of stakeholders across the health system requires expertise and human resources. In Zambia, the lack of commitment of human and financial resources towards supporting the revision process was a big obstacle to the implementation of the roadmap from the inception. There was also a reliance on partners, which themselves experienced funding difficulties and withdraw support at short notice.

Another challenge was the lack of evidence to support effective prioritisation in the country. This was made evident in the landscape analysis and through the intervention mapping stages; both of which pointed to the need to build a better evidence stock to support decision-making. In particular, better evidence on the use of international data in local contexts (such as decision-tools developed by external partners) should be explored further. Costing data was also seen as an obstacle, especially during conversations about resourcing and budgeting of the new HBP. This is a common issue for many countries embarking in such revisions.

Despite those challenges, this piece adds to the literature by introducing the process for developing the roadmap, mainly for technical staff and decision-makers initiating a similar process in their country. By providing clear and detailed information on the Zambian context, as well as an open conversation about the implementation challenges, the intention is to allow other countries to adapt this approach and reflect on how their country's situation may influence the implementation of such a process. We also see some relevance for development partners and academic groups to understand better the complexity and full requirements of conducting such a process at the country level, and to find pathways to support countries undertaking such an important task through either the provision of expertise, funding to local expertise, capacity strengthening or the generation of data and evidence at the global and local levels.

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Appendix: NHCP high-level descriptive table of inclusions

Disease Area	Details
Malaria	• Simple and severe
Lung disease	• Acute Respiratory Infection (ARI) • Pneumonia • Asthma • Chronic Obstructive Pulmonary Disease (COPD) • Interstitial Lung Disease (ILD)
HIV/AIDS	• Opportunistic infections, ARV scale up, PMTCT, Paediatric ARV therapy, Adult ARV therapy Services
Trauma	• Soft tissue • Injuries • Fractures • Head injuries • Haemoperitonium • Haemothorax
Diarrhoea	• Simple • Infectious • Bloody • Non-bloody
Anaemia	• Nutritional • Leukaemias • Lymphomas • Thrombocytopenias • Neutropenias
Maternal conditions	• Pregnancy and delivery • Post natal care
TB/Leprosy	
Cardiovascular diseases	• Cardio-vascular disease (CVD): Hyper-tension • Ischaemic heart disease • Congenital Heart Disease (CHD) • Rheumatic Heart Disease (RHD) • Heart failure
Perinatal care and immunisation programme	• Immediate care and immunization programmes as part of integrated child health
Malnutrition	
Gynaecological conditions	• Pelvic Inflammatory Disease (PID) • Pelvic abscess • Abortion • Infertility

GI conditions	• Gastro Esophogeal Reflux Disease (GERD) • Peptic Ulcer Disease • Inflammatory Bowel Diseases • Liver Diseases • Pancreatic Diseases
Musculo-skeletal conditions	• Joint pains • Arthritis • Auto-immune disorders • Myopathies
Genitourinary conditions (GU)	• STIs • UTIs • Acute Kidney Injury • Chronic Kidney Disease • Glomerular Diseases • Kidney Stones • Prostate Problems
CNS diseases	• Meningitis • Epilepsy • Encephalitis • Strokes • Dementia • Movement disorders • Space Occupying Lesion • Motor Neuron Disease • Acute and Chronic demyelinating diseases • Neuromuscular diseases • Cerebral palsy
Endocrine Disorders	• Diabetes Mellitus • Thyroid Diseases Adrenal Diseases • Pituitary/Hypothalamic diseases • Phaeochromocytoma • Multiple Endocrine Neoplasm Syndrome
Neoplasms/Cancers	• Cervical cancers • Breast cancer • Prostate cancer
Skin infections and conditions	
Dental & Maxillofacial diseases	• Tooth and Gum Infections • Fractures • Ameoloblastoma
Eye Health	• General Eye Conditions • Specialized Eye Conditions

ENT diseases	• Allergic Rhinitis • Otitis Media • Foreign Bodies • Tumours • Deafness • Sinusitis • Neoplasms • Vestibular disorders
Mental illness	• Drug and alcohol related disease • HIV related disease • Schizophrenia • Bipolar disorders • Depression • Mania • Childhood Mental Illness • Personality Disorders
Surgical conditions	• Acute abdomen: Appendicitis, Cholecystitis, Pancreatitis, Intestinal Obstruction, Peritonitis • Hernias • Hemorrhoids • Phymosis • Paraphymosis • Elective Circumcision
Water Safety Issues	
Gender and Health Issues	