

**SECTOR PROGRAMME SUPPORT
TO THE
ZAMBIAN HEALTH SECTOR
2002-2005**

EXECUTIVE SUMMARY:

The Zambian health sector was one of the first sectors in the world in which a Sector Wide Approach (SWAp) was applied. Since its inception in 1991 much progress has been made and many obstacles have been overcome. It seems clear that this approach is the most effective way to improve health services in Zambia and thereby to reduce poverty.

This Assessment Memorandum proposes a continued *Sector Programme Support* to the Zambian health sector for the period 2002-2005 in the order of USD 6 million (SEK 60 million) annually. The Swedish support will be flexible in nature and a main objective will be to continue the process of strengthening the SWAp process itself.

Initially, 70% of the support is proposed to be allocated as budget support to primary health care services at a district level, including medical drugs. The remaining 30% is supposed to be used to support the Central Board of Health Action Plan with particular emphasis on institutional capacity building within key institutions in the health sector.

The support is based on the Zambia National Health Strategic Plan 2001-2005, which has been thoroughly assessed and appraised by a large number of stakeholders. It is technically sound and has overall priorities in line with internationally agreed targets and best practices. In recent years, there has been increased commitment both from the Government and Cooperating Partners to the Health reform process.

Since Sector Programme Support is a long term commitment, very close attention will be paid to the political and economical development in Zambia, which is currently volatile. This memorandum emphasises the external context in which the SWAp takes place as well as a *risk analysis* including a possible *alternative strategy*. It argues that SPS is the only sustainable way of supporting the Zambian health sector and outlines a strategy on how to do this in a difficult political environment.

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ACRONYMS

CBoH	Central Board of Health
CP	Cooperating Partner, i.e. stakeholder in the Health Sector
DDCC	District Development Coordinating Committee
DHB	District Health Board
DHMT	District Health Management Team
FAMS	Financial and Management Information System
GRZ	Government of the Republic of Zambia
ICASA	International Conference on Aids and STD's in Africa
JHAM	Joint Health Appraisal Mission
JIFM	Joint Health Identification and Formulation Mission
JIP	Joint Investment Plan
GDP	Grand National Product
HIPC	Heavily Indebted Poor Countries
MMD	Movement for Multiparty Democracy
MoFED	Ministry of Finance and Economic Development
MoH	Ministry of Health
NHSP	National Health Strategic Plan
PE	Personal Emolument
PRSP	Poverty Reduction Strategy Paper
PSRP	Public Sector Reform Programme
SPS	Sector Programme Support
SRHR	Sexual and Reproductive Health and Rights
SWAp	Sector Wide Approach
ZCCM	Zambia Consolidated Copper Mines

1. INTRODUCTION

1.1 Overview of the Zambian Health Reforms

The Zambian health sector was one of the first sectors in the world in which a *Sector Wide Approach* (SWAp) was applied. The cornerstone of the SWAp is the Zambian Government Health Reform Programme, defined in the *National Health Policies and Strategies*, which was launched in October 1992 shortly after the Movement for Multiparty Democracy (MMD) came to power in the first ever democratic elections held in Zambia.

The overall vision of the reform programme is "*to provide Zambians with equity of access to cost effective, quality health care as close to the family as possible*".

A major objective of the reform is the development of district health systems for providing basic health services in all parts of the country. This required decentralisation of financial and administrative powers to the district level hospitals and district health boards, and by actively involving the communities to participate in the decision making process. In this regard, one of the major achievements of the reform has been the pooling of GRZ and donor funds to support the running costs of the districts (District Basket).

The reform process involved a re-definition of the role of the Ministry of Health as the policy making body in Zambia; and the creation of a *Central Board of Health* (CBoH) as a technical unit to be responsible for the delivery of services and implementation of health reform.¹

This vision of the reforms is elaborated in *National Health Strategic Plans* (NHSP) every 4-5 years. The NHSP is operationalised in annual action plans developed at both central and district levels.

Sweden has supported the health reform process since its inception, and the current support comes to an end in December 2001.

1.2 Purpose and Background of this Assessment Memorandum

The purpose of this Assessment Memorandum is (i) to describe and analyse the context in which the reforms take place in order to assess the long-term sustainability of the reforms; and (ii) to outline/identify areas for possible continuing Sida Sector Programme Support (SPS) for the period 2002-2005.

The assessment is divided into five major sections. The first section will discuss the *main objectives of the health reform programme* from a poverty-, gender-, and rights perspective to assess whether it is congruent with general Sida policy. The following two sections will focus on the *external context* in which the health sector reforms take place, including a *risk assessment* and an *alternative strategy*. The fourth section will

¹ This clear distinction between the Ministry as the policy making body and an independent body responsible for its implementation is to some extent based on the Swedish system.

describe the *health reform context* more in detail, including the institutional framework, the financial and administrative arrangements as well as the implementation capacity within the sector. The final section will describe the main elements of the *proposed Sida support* to the sector, including some “lessons learned” from previous support.

When reading this assessment, particularly the parts on long term sustainability, it is important to bear in mind that Sida has been supporting the Zambian health sector for a very long time. Assessments of the Zambian health reform process, similar to this one, have been done regularly.²

Furthermore, this assessment does not take place in isolation. In the spirit of a true sector wide approach preparatory work has been done jointly with the Ministry of Health and all other major stakeholders in the health sector. In September 1999 an extensive process was initiated with the purpose of laying the foundation of the NHSP for the period 2001-2005, including future support from all external Cooperating Partners (CP's). This process started with the most comprehensive assessment ever made of the Zambian health sector³. This included an assessment of the health situation in Zambia, the health profile of its population as well as the institutional response by all major players within the health sector. The mission looked at cross cutting sectoral issues such as the effects of poverty on increasing ill health, gender, environment, participation, and HIV/AIDS.

This assessment was followed by a large number of consultative meetings with internal and external stakeholders leading to the formulation of the NHSP 2001-2005, formally adopted in December 2000. In February 2001, the NHSP was thoroughly appraised by yet another team of international and national consultants with the main objective of assessing the validity and sustainability of the health sector framework⁴.

Under ideal circumstances the preparatory process of the Swedish health sector support would have followed the development of a Swedish overall *country strategy* for Zambia⁵ but due to various reasons this strategy has been postponed⁶. However, it has been deemed more important to harmonise the Swedish health sector support with other donors' and the Government's, rather than adjusting the preparatory process to the purely bilateral Swedish country strategy process. A Swedish long term

² Mattsson, P-O & Nordström, A. (1999): Bedömningspromemoria för fortsatt stöd till hälsosektorn i Zambia genom Sektorprogramstöd 1999-2001, Sida, Stockholm.

³ This *Joint Identification and Formulation Mission* (JIFM) was carried out in February-March 2000 by a team of 20 well reputed experts under the leadership of Professor Ken Lee, Keele University. See JIFM Report (2000).

⁴ A *Joint Health Appraisal Mission* (JHAM) was carried out in March 2001 by a limited. See JHAM Report (2001).

⁵ *Landstrategi*, i.e. an overall strategy for the development cooperation between Sweden and Zambia for the coming 5 years.

⁶ The extra workload of the Swedish chairmanship of the European Union - spring 2001.

commitment to the health reform process was made in 1999⁷ and there has been no indications to revert from that commitment. Hence, it is hardly likely that the country strategy process will lead to a decision to completely terminate the long term support to the health sector.

2. RELEVANCE OF SECTOR OBJECTIVES AND STRATEGY

2.1 Main Objective of Sida's Support

It is a well known fact that widespread poverty is one of the main developmental problems facing Zambia today.⁸ Zambia is one out of only six developing countries in the world which has a lower Human Development Index today (2000) than ten years ago.⁹ According to official statistics 73% of the population have an income below the nationally defined poverty line. This is an increase with four percent units since 1996.¹⁰

The overall objective of Sida's support to the Zambian health sector is to contribute to *reduce poverty* by improving the health situation for the Zambian population. Using the *basic needs approach to poverty*, which is the most widely used approach to poverty, poverty is *defined* in terms of access to health services, life expectancy, infant mortality rate, contraceptive prevalence rate etc. It even touches on needs such as community participation and the right to influence decisions relating to the health services. Hence, improved health indicators is, *by definition*, reduced poverty, regardless of whether it leads to improved (income-) poverty indicators, such as people living below one-dollar-per-day.¹¹

Since all Swedish support is assumed to take place within the context of the health reform process, it is important to assess the relevance of the overall sector objectives in relation to Swedish development cooperation goals. Particularly important are issues related to poverty and equity but crosscutting issues like gender and democracy/human rights are also important.

This section will analyse the main strategic documents in the reform process, particularly the Zambia National Health Strategic Plan 2001-2005 (NHSP), from the above perspectives, i.e. poverty/equity, gender and from a rights-perspective. Environmental aspects are less relevant in this context but have nevertheless been dealt with by the Joint Identification and Formulation Mission. They will not be assessed further in this memorandum.

⁷ Mattsson, P-O & Nordström, A. (1999), p.18, section 6.7

⁸ For more details on the evolution of poverty in Zambia, using a wide range of definitions and measurements of poverty, see *The Evolution of Poverty in Zambia 1990-2000*, P-O Mattsson (2000).

⁹ UNDP(1999): Human Development Report 2000, New York

¹⁰ Central Statistical Office (1999): Living Conditions Monitoring Survey 1998, Lusaka

¹¹ For an elaboration on the concept of basic needs, see e.g. Mattsson (2000), Streeton (1984) or Des Gaspers(1996).

2.2 Poverty and Equity

The NHSP 2001-2005 reflects *a significant progress at policy level to address poverty and equity issues*.¹² Some of the most important features are (i) the resource allocation formula for the district basket, and (ii) the exemption rules for user-fees.

The resource allocation formula to district uses the basic principle “*money follows patients – not service providers*”, i.e. a population based formula is used. The introduction of this principle in Zambia is generally regarded as an important step towards increasing equity. Furthermore, there is an agreement between CP’s and MoH that 60% of total resources to the health sector should be allocated to primary health care services at a district level.¹³

Regarding user-fees, which is a rather controversial issue, Zambia has opted for a pragmatic and realistic solution. Fees are an important part of revenues at the local level but exemption schemes exist for vulnerable population groups and certain conditions.¹⁴

Apart from the NHSP, the linkages between poverty and health has been analysed in the process of producing a Poverty Reduction Strategy Paper for Zambia (PRSP). The Interim PRSP focus on the progress already made in the reform process regarding overall distribution of resources. The preliminary (not yet published) chapter on health in the PRSP is generally regarded as being of a very high quality¹⁵.

2.3 Gender

Zambia’s Gender Empowerment Measure¹⁶ is low and this gives an indication of the vulnerable position of women especially in the context of education and participation in political and economic decision making. However, in relation to health, Zambia does not show some of the major gender disparities in health outcomes seen in other countries, e.g. in the Indian Sub-continent. Data on children under 5 years of age do not exhibit major differences between boys and girls in morbidity, mortality, nutrition or food intake.¹⁷ However, another “gender related” health indicator such as maternal mortality is one of the highest in the world at 650 per

¹² JHAM (2001), pp.209

¹³ Specified in the Memorandum of Understanding signed in November 1999.

¹⁴ For a more detailed discussion on pros and cons of user fees in a Zambian context, see JHAM, pp.214

¹⁵ A number of interventions are discussed, e.g.: (i) Provision of the Basic Health Package with a series of interventions to support an increased access to health services by the poor, (ii) Management of funds at district level to meet specific district needs using social/poverty indicators as criteria for resource allocation, (iii) Establishment of structures for community participation in decision making at neighbourhood, Health Centre and District levels, (iv) Promotion of integrated nutrition packages for vulnerable groups, (v) Ensuring gender equity in service provision, and (vi) Exemption scheme for under-served groups and chronic clients unable to pay for health care, including HIV/AIDS.

¹⁶ Index introduced by UNDP to measure gender empowerment.

¹⁷ CBoH (1997)

100 000.¹⁸

Zambia has adopted international agreements related to gender equality, equity and empowerment of women and the NHSP has incorporated them into national health policies and programmes. The directions established by the Cairo and Beijing conferences on population and sexual and reproductive health issues are addressed in NHSP as closely inter-related to poverty and socio-economic trends. A particular section of the NHSP is devoted to *Gender and Health* including a series of strategies and expected outputs. In the NHSP the importance of observing differences between men and women in the area of HIV/AIDS is particularly stressed. Particular guidelines for health care providers on “HIV/AIDS and Gender” has recently been developed.¹⁹

However, poverty alleviation and gender mainstreaming should be incorporated as core objectives in a cross cutting manner throughout NHSP and not only as a separate section. The NHSP lacks an overall strategy to mainstream gender in programme design, planning and implementation.

Overall, the issue of gender differences in access to health care and the impact of that on health outcomes does not yet appear to have received the attention required. This fact has been observed as a key concern by Sida and other CP's, for future support.

2.4 A “Rights” Perspective

There are a number of international Covenants which are relevant to the health sector. The International Covenant on Economic, Social and Cultural Rights recognises “*the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*”. The Covenant against Discrimination of Women includes articles on health services related to pregnancy, delivery, adequate nutrition etc. Similar articles are found in the Covenant on Discrimination against Children.²⁰

Two issues are particularly important when applying a “rights” perspective on the health sector; (i) the *overall distribution of resources*, including the issue of equity, discrimination against e.g. women or children, and (ii) the right of the individual to *participate* in decisions regarding the health services.

As eluded to in section 2.2 *Poverty and Equity*, the NHSP is very clear on issues related to poverty, equity and resource distribution.

Concerning participation, it should be noted that the health sector is the sector in which the *decentralisation* process has proceeded the furthest. All resources for primary health care are decentralised to the district level. *District Health Boards*, and their operative arm, *District Health*

¹⁸ UNDP (2000): *Human Development Report 2000*, Table 9, p.189.

¹⁹ For more information, see Benkovic (2001): *Gender Mainstreaming in the Health Sector*, Swedish Embassy, Lusaka.

²⁰ See Swedish Embassy Memorandum – *Democracy and Human Rights in the Swedish Support to the Health Sector in Zambia*, P-O Mattsson, 1999-06-02.

Management Teams, have the full responsibility for the provision of services at the district level. However, from a *participatory* point of view, it is important that the decentralisation process in the health sector moves from being a form of *deconcentration* i.e. allocation of power to "field offices", to the form of *devolution*, defined as the transfer of legally defined elements of political power to the districts. A process is on-going on how to achieve decentralisation in the latter sense, in spite of non commitment from the Government.²¹ If this can be achieved, the health sector could be a model for other sectors.

Another provision in the NHSP to strengthen people's participation is that a large proportion of the user fees that are paid for medical care is returned to the community in form of a health related "project". The idea is that communities should have the possibility to implement health related projects that are directly related to their needs.

Finally, issues related to *good governance*, such as public sector management and controlling corruption, is vital for a successful SWAp. These issues will be discussed in section 4 of in this assessment.

3. ASSESSMENT OF THE EXTERNAL CONTEXT

Continued support to SPS is a decision to participate in a long-term process with objectives agreed by all involved parties. The possibility to pursue a long-term development cooperation within the framework of SPS requires a greater degree of political and economical stability than other short-term contributions to e.g. NGOs. It is therefore important to assess the external context in which the SPS takes place, e.g. the general political and economical situation, the public administration situation, general levels of financial accountability, corruption etc. The external context is relevant not only to the health sector but to all Swedish development cooperation in Zambia. The Swedish Embassy in Lusaka is constantly assessing the external context for possible adjustments to the ongoing development cooperation programmes in all sectors. Hence, the ambition of this assessment memorandum is not (and should not be) to make a comprehensive assessment of the political and economical situation etc. but to briefly summarise the context in which the health reforms take place.

3.1 General Political Situation

From a general point of view, the situation in the area of democratic governance is characterised by a wide gap between the high standards expressed in policy statements, and the lack of implementation.²² The Government's White Paper on democratic governance represented an important step forward towards the strengthening of the democratic

²¹ A major study on Local Governance and Decentralisation in Zambia took place in March 2001. An issue that was looked into was to strengthen links between DHB and District Councils as well as elected (rather than centrally appointed) members in the DHB. See Crook and Manor (2001).

²² For a more in-depth analysis of the political situation in Zambia, see the political analysis done by the Swedish Embassy, e.g. Pedersen (2001)

process and increased respect for human rights, but implementation has been lacking.

2001 is an election year and the last six months have been characterised by high political tension. The ongoing electoral process has revealed a flagrant lack of respect for democratic principles within the ruling party. A particular concern is the harassment of opposition parties, non-governmental organisations with views differing from the powerful minority within the ruling party. The Public Order Act is being used as an instrument to substantially limit freedom of expression and association. The police are increasingly dispersing opposition party and NGO meetings without any reasonable ground.

The media in Zambia enjoy in comparison to other countries on the continent a relatively high degree of freedom. However, the only media reaching the majority of the Zambian population, i.e. radio and television, are with a few exceptions state owned, and subject to government control and censorship. The media, if politically controversial, are selectively harassed.

3.2 Corruption

There are a number of reports²³ indicating that corruption and misuse of power at a very high political level is widespread and there are numerous examples of supposed corruption and/or misuse of public funds in almost all sectors, including the health sector.²⁴

However, despite ambitious policy statements, there seems to be little political will to deal seriously with this problem. A flagrant example of this is that legislation on *Money Laundering* has been tabled for parliament twice since 1998, but has been withdrawn by Cabinet both times without any reasons given. The lack of political will to address the issues of corruption is also made evident by the fact that the Auditor General's reports on irregularities has so far been ignored by the Government.

A description on how corruption is dealt with in the health sector is found in next section of this memorandum.

3.3 Macroeconomic Context

Since MMD came to power in 1991 "Zambia has made substantial progress in implementing an ambitious set of economic reforms, including efforts in the areas of privatisation, deregulation and exchange and trade liberalisation"²⁵. The government has undertaken a number of institutional reforms in social sectors and has put forward a broad strategy for growth

²³ According to the Anti-Corruption Commission, the Commission has over the past nine years investigated 144 political leaders, of which 30 at the time were ministers, without formal charges being brought.

²⁴ There is evidence that there is a link between international criminal organisations and Zambian politicians at a very high level related to the lucrative medical drugs sector. Another example is an audit by Auditor General indicating fraud and mismanagement of funds in connection with ICASA.

²⁵ IMF (2000b), p.1

and poverty reduction. Implementation of these plans have, however, been lacking. During much of the past decade, Zambia's overall macroeconomic performance has been weak, as reflected in the continuous high inflation and poor growth.²⁶

Zambia's debt service was expected to rise sharply in 2001 as a result of payments to the IMF's Enhanced Structural Adjustment Facility (ESAF) falling due. This would have meant an unmanageable debt situation, and following an extraordinary effort by the international community, Zambia gained access to HIPC after a very short qualification period in implementing the economic reform programme. HIPC access means that external debt is no longer an insurmountable development problem as long as conditions are met. These conditions include a continuation of the privatisation programme.²⁷

But debt relief is not the whole picture. Fresh donor assistance to Zambia is already several times more than the debt service. IMF expects that net transfers to Zambia will rise by about \$100 million during 2001 to some 15 percent of GDP.²⁸

3.4 The State Budget and the Issue of Fungibility

Support to a project/programme could be defined as *fungible* if the project/programme would have been implemented even without the external support²⁹. Hence the issue of *fungibility* is particularly important when support is given as SPS. The *external* fungibility issue relates to Government allocation of resources between sectors. What is important is that GRZ budgets and expenditure to the entire health sector does not decrease as a result of increased external (budget) support. The table below shows the expenditure on health as a share of total GRZ expenditure 1996-1999:

Table 1: Share of Social Expenditure 1996-1999

	1996	1997	1998	1999
Education and training	18.0%	18.3%	17.4%	18.5%
Health	13.0%	12.9%	13.1%	13.7%
Total social expenditure	35.8%	34.4%	34.2%	36.4%

Source: World Bank (2000), Table 3, p.13

The combined share of social expenditure increased from 22% in 1991 around 36% in 1999. The health sector is today at its highest level in five years. Knowing that the total State Budget has not increased in real terms during the last few years, the maintained level of expenditure to the health

²⁶ For more detailed information, see Heijden, Henrik van der (2000): *The Ineffectiveness of Economic Policy Reform, Foreign Aid and External Debt Relief in Zambia*

²⁷ See Bengtsson, H. (2001): *Semi-annual Economical Report*, Swedish Embassy, Lusaka.

²⁸ IMF (2000a)

²⁹ For a more elaborate discussion on the concept of fungibility, see Holmqvist, G. (1991): *Promemoria - Om fungibilitet i biståndet*, Sida, Stockholm and/or World Bank (1998): *Assessing Aid – What Works, What Doesn't, and Why?*, Oxford University Press, Oxford.

sector indicates that *there is no external fungibility problem related to the health sector*. GRZ has not reallocated resources from the health sector as a result of large external non-earmarked resource flows to the sector.

The *internal* fungibility issue relates to how MoH resources are (re)allocated *within* the sector as a direct result of external resource flows. The internal fungibility issue will be dealt with in section 5.3.

3.5 Public Administration and Reforms

The Budget Process

The Zambian budget process starts with a submission of estimated needs from the line ministries to the Ministry of Finance and Economic Development (MoFED). MoFED then decides on budget ceilings for each line ministry after which each ministry submits bids on the distribution of expenditure within that ceiling. The final budget is presented in January each year.

A cash budget system, meaning that government can only spend money that it has already collected in revenue, was introduced in 1993. Although the idea is simple in practice, application faces a number of problems, one being to prevent ministries from committing themselves to expenditures in advance of their income. There is, however, evidence that the cash budget system has begun to "bite" – there is an overall balance between income (from MoFED) and Ministry of Health expenditure.³⁰

The current budget process itself seems to work reasonably well and disbursements from MoFED to MoH have been adequate. However, the main issue (which will be dealt with later in this memorandum) is the weak correlation between budgets and disbursements.

The Public Sector Reform Programme

Today, Zambia retains an excessively large and poorly functioning public service. An urgently needed *Public Sector Reform Programme* (PSRP) was announced in November 1993, with the objectives to improve Government's capacity, to effectively manage public expenditures, and to make the Public Service more efficient and responsive to the needs of the country's population.

These objectives were to be met through the restructuring of the public service, management and human resources improvement, and the decentralisation and strengthening of Local Government. The PSRP was not officially adopted until 1997. The implementation of the reforms has been slow, partly because of lack of capacity at central and local levels, but also because of continued central government intervention.

In spite of very limited progress in the PSRP, the health reform program has been able to "move ahead" in some key areas such as *decentralisation* and *delinkage*:

Decentralisation

As outlined in the previous section the health sector is the sector in which

³⁰ For an elaboration of the constraints of a cash budget system see White (1999), pp.40

decentralisation has proceeded the furthest. However, in the absence of a national decentralisation policy, the links between the District Health Boards and the District Councils have been very limited. This limits the opportunities for multi-sectoral responses at district level to issues such as HIV/AIDS. Whilst decentralisation is happening in the health, and other sectors, at a faster pace than decentralisation in Local Government, this creates a very difficult situation at sub-district and at community level.

Delinkage

The change to a decentralised system of management means that public service staff are transferred from a central payroll to being employed directly by boards at the central, district and hospital levels. This transfer is usually referred to as *delinkage*.

Today, District Offices can recruit all categories of staff except medical doctors, district directors and Managers of planning and administration, which are still on the central civil service payroll.

The process of delinkage involves a voluntary separation package being made available to MoH employees in the hospitals and districts. The main concept being that staff who change to direct employment by hospital or district boards, on three year contracts, would be compensated for loss of security by being paid a lump sum. The administration of this scheme has been severely flawed, with inequitable application of the scheme, some staff accepting the sum and leaving the country or working in the private sector and grave shortages of staff in some facilities. Other constraints are “bottlenecks” at the central level in the process of delinkage and “over-employment” against available resources at the district level.

3.6 HIV/AIDS

The Ministry of Health has reported that 20% of Zambians 15 years and older are HIV-positive. The prevalence of HIV in urban areas is twice as high as in rural areas with rates of 28% and 15% respectively. The disastrous impact that HIV/AIDS has, and will continue to have, on all sectors of society has been analysed in a large number of reports. Perhaps the most distressing trend is the drop in life expectancy at birth from 54 years in the mid-eighties to an estimated 37 years in 1998.³¹

Some promising trends have, however, begun to emerge. The HIV-prevalence rate among child bearing women aged 15 to 19 has decreased from 28% in 1993 to 19% in 1998. The reason for this welcome decline has been attributed to behaviour change.

In March 2000 a national institutional framework on how to deal with the HIV/AIDS pandemic was finally adopted. However, the most important institution, the National HIV/AIDS Secretariat, is not yet fully operational.

³¹ See particularly Ministry of Health (2000): Zambia National HIV/AIDS/STD/TB Strategic Framework 2001-2003, MoH, Lusaka.

4. RISK ANALYSIS AND ALTERNATIVE STRATEGY

4.1 Introduction

There is a clear distinction between risks that are relevant in a SWAp environment and risks in a project/programme approach.

Risks related to a “traditional” project/programme would mostly be of technical nature out of which some would be regarded as “killing factors”. In this sense, a risk is a threat to the implementation or the objectives of the project/programme itself, hence if the risk is likely to occur, the project/programme should not be supported.

Support to a SWAp is somewhat different. One of the advantages with working within a sector wide approach is that technical risks can better be dealt with. Since SPS, by definition, is a *process*, stakeholders can make adjustments to “their” support to address new circumstances. The very serious risks associated with HIV/AIDS could, for example, be properly address within the SWAp through major reallocations of resources or shift in priorities. It is not likely that a technical risk would be a killing factor within a SWAp environment.

The risks that are relevant within a SWAp are more related to either political commitment to the SWAp itself or to the external context in which the SWAp takes place. Some of these risks are outlined below:

4.2 Risks Related to Good Governance and Corruption

What is worrying in Zambia is the *direction* in which the Zambian society is moving in the area of democracy & human rights. Even though a worsened good governance situation may not have a direct negative impact on the health sector, a precondition for *any* long term commitment (in any sector) should be that the Government adheres to basic principles of democracy and human rights.

The ongoing political debate has revealed a flagrant lack of respect for democratic principles within the ruling party. If this trend continues it is not only an obstacle to a democratic development but also a potential threat to the stability in the country. This might lead to a situation in which the relations between Zambia and Sweden, including all development cooperation, have to be revisited.

Corruption could be regarded from both a *technical* and *political* perspective. From a technical perspective, corruption is adequately dealt with within the health sector. Working within the framework of a SWAp, means that Sweden and other CP's have an overview of *all* resources, including GRZ, to the health sector. This implies that Sweden may be more aware of mismanagement of funds and corruption than would otherwise have been the case. Within a SWAp environment corruption can be *better* dealt than in a traditional project/project environment and it is getting increasingly difficult for politicians or public servants to misuse funds, regardless of whether it is GRZ funds or CP funds.

The political perspective, meaning the *willingness* from the political elite to seriously deal with corruption, is much more complicated. This perspective

is closely interlinked with democracy, human rights and good governance. As outlined above, the good governance situation is far from satisfactory.

Even though some of these risks may not have a *direct* impact on the health reform process it may lead to hesitance from external CP's to continue with development cooperation with Zambia.

4.3 Macroeconomic Risks

As mentioned in the previous section, Zambia qualified for HIPC in December 2000. However, full assistance from the IMF and the World Bank will be delivered only upon completion of further progress in some specified areas including (i) continued commitment to the IMF-programme and IDA's structural adjustment loans, (ii) the adoption of a full poverty reduction strategy paper (PRSP).

During the first months of 2001 there have been worrying signs as regards the political will to implement crucial structural reforms. There is increasing uncertainty if privatisation of the five remaining large parastatal companies may take place as earlier indicated. This may significantly reduce or nullify the positive impact of HIPC and pull Zambia into deep economic crisis. This may in turn lead to a situation where GRZ budget allocations to the health sector will be severely reduced.

However, previous experience has shown that GRZ is aware of demands from the IMF and the international community so this may change. It is likely that Zambia will be able to negotiate compromises so that further debt reductions may still come about.

There is also a risk that macroeconomic indicators, such as inflation and exchange rate, will deteriorate which will reduce the real value of Government contribution to the health sector.

4.4 National Ownership

Zambia has made considerable efforts to increase and maintain the shares of social expenditure in the domestically financed budget. GRZ resources to the health sector is increasing - In 1999 14% of all GRZ expenditure was to the health sector which is rather good in an international perspective. The combined share of social expenditure increased from 22% in 1991 around 36% in 2000/01. The health sector is today at its highest level in five years. This indicates commitment to the health sector.

Another commonly used indicator is *public expenditure on health as % of GDP*. The table below shows that Zambia spends 2.3% of its GDP on health. This is above the Sub-Saharan African average (1.5%) but less than what many neighbouring countries spend.

Table 2: Public expenditure on health as % of GDP for some selected Countries

Country	Public expenditure on health (% of GDP)
Angola	3,9
Botswana	2,7
Malawi	2,8
Mozambique	2,1
Namibia	3,8
Tanzania	1,3
Zambia	2,3
Zimbabwe	3,1
Average	
Sub-Saharan Africa	1.5
Low income countries	1.3

Source: World Development Report 2000/2001, Table 7

Apart from budget allocations to the sector, there seems to be strong national commitment at a technical level for the reform process. During 1998-99 attempts were made by the sitting Minister of Health to make major deviations from the reforms. However, due to strong commitment from both external CP's and technocrats within the sector, the Minister was not successful. It therefore seems clear that there is a strong general agreement on the main directions of the reforms.

However, key to success is a motivated, performing workforce. If salaries and conditions of service do not improve sufficiently to keep staff motivated and to attract staff to more remote areas, equitable access to quality services will not be achieved. GRZ has included significant salary changes in the 2001 budget whereas condition of service is not addressed equally forceful. The question is whether these initiatives will be sufficient to achieve their objective and whether they can be maintained.

4.5 Commitment from Cooperating Partners

The main external investors in the Zambian reform process are Sida, Netherlands, DFID, Danida, Ireland Aid, USAID, World Bank, EU and Unicef. In addition to these, JICA, GTZ, WHO and UNFPA are marginally involved – at least in the SWAp process.

In November 1999, the Ministry of Health and all (15) collaborating partners signed a *Memorandum of Understanding* (MoU) which outlines the vision of the health sector reform process and sets the guidelines for cooperation between the Ministry and all cooperating partners including working towards common systems for planning, reporting, disbursements, accounting, auditing, procurement etc.

The signing was an important indication of the Ministry's, and CP's willingness to continue the reform process within the context of a sector wide approach.

The joint preparatory process (of which this Assessment Memorandum is a part) is also a sign of a strong commitment from all CP's to work within the framework of a SWAp towards the vision expressed in the NHSP and the MoU.

Another indication of commitment to the reforms within a sector wide approach is cooperating partners' contributions as budget support. In 2000 more than twice as many CP's (10) contributed to the District Basket as in 1997 (only 4)³². Due to the fact that many CP's are now in the process of preparing new programs, there is reason to believe that the strong commitment to the District Basket will continue. The District Basket mechanism is discussed more in detail in section 5.2.

4.6 HIV/AIDS

The impact of HIV/AIDS on the health sector continues to be of much concern given the astronomical costs it will have to bear. Available information on health seeking behaviour suggest that people continue to bypass the primary level health facilities and go to the hospitals. In many hospitals 50-70% of the beds are occupied by HIV/AIDS patients that require expensive treatment of opportunistic infections.

The HIV/AIDS epidemic will very much limit what the health sector can achieve in terms of health status. For example infant mortality rate can at best only be maintained over the plan period, even if health services improve.

If the consequences of HIV/AIDS turn out to be even worse than expected, parts of the NHSP may need to be revisited and a higher proportion of resources has to be allocated to HIV/AIDS. It should, however, be noted that financial resources is not the main issue. There is plenty of earmarked funds available from CPs such as the World Bank and USAID.

Political will within GRZ to implement the HIV/AIDS plan and indeed give HIV/AIDS the priority attention its deserves across sectors still has to be proven.

4.7 Alternative Strategy

To develop an alternative strategy should the risk situations outlined above be materialised is not easy. A very specific strategy saying "if A happens, then B; or, if C does not happen then D" may not even be possible or useful. Previous experiences within the sector has shown that any situation is unique and has to be dealt with within prevailing circumstances. An alternative strategy should rather be an outline of a *process* on how to deal with different situations. Below follows a proposed outline of such a process:

1. The first option should always be to use all available instruments for a (political) dialogue. In this dialogue specific benchmarks related to the actual "risk situation" could be specified, e.g. conditions for future disbursements.
2. If the political dialogue leads nowhere it is vital for future credibility that the action specified if conditions are not met, take place. If this action

³² The following donors contributed to the district basket in 2000/2001 (in descending order with the largest contributor first): Netherlands, Sida, DFID, World Bank, EU, USAID, Danida, Ireland Aid, Unicef and UNFPA.

includes suspension of disbursements to specific areas/activities, these should be carefully selected in order to put maximum pressure on GRZ without damaging the Reform Process too much. It is not possible to specify in detail which activities should be suspended or “protected”, partly because Sida support is not likely to be specified in such detail. However, some priorities could be made regarding the *type* of activities that should be protected or suspended:

Priority	Type of Support
High	The District Basket for primary health care at a district level is the core of the reform process and also an area which clearly addresses the needs for the poor people in Zambia. Suspended funding would have a direct negative impact on the quality of health services.
Medium	Long term institutional capacity building is vital for a successful reform process, but effects will be notable only in a longer perspective.
Medium	Specific support to areas outside the district basket, e.g. support to pilot projects, NGOs and CBOs can often be successful in the short term perspective, but less sustainable and seldom cost-effective in a national context.
Low	Activities to support policy development are important but not vital for the reform process. Furthermore, poor people are not likely to be directly affected

The table above should be interpreted with care. Obviously, all activities are of equal priority since they are all part and parcel of the NHSP. However, if there is a need to put pressure on GRZ by suspending disbursements, “low” priority support (in the table above) should be considered first.

The above strategy/process should be applied adhering to the following principles:

- (i) The main purpose of an alternative strategy should be to protect the long term sustainability of the Zambian Health Reform Process (not to “protect” or maximise Sida’s investment in the sector). Hence, an alternative strategy is not necessarily linked to specific Sida support.
- (ii) An alternative strategy should be a joint effort where all (or as many as possible) CP’s participate. Purely bilateral actions should be avoided for principal reasons but also for being much less effective.
- (iii) An alternative strategy should not include elements of reverting to a traditional project/programme approach, especially at this stage when the SWAp has come a long way. The drawbacks of project support are well-known and the possibilities for Sida and other CP’s to have an impact/influence on the long term objectives/direction of the health reform process will disappear.
- (iv) If an alternative strategy includes to suspend some or all disbursements to the sector, Sweden should remain as a CP in the sector. Even if no disbursements are made during a long period of time, Sweden can be an important partner in the policy dialogue.
- (v) Any alternative strategy should be applied in a transparent way and the reasons should be fully explained and justified, possibly in

advance, to all stakeholders in the sector.

As an illustration of how the above strategy could be used is outlined below:

Auditor General discovers that the Permanent Secretary has mismanaged GRZ funds allocated for Medical Drugs (nb! No Sida funds are involved). All CP's raise the issues jointly with the Ministry, first informally, then formally and demand a full explanation. After several weeks, without action, the issue is raised at higher levels (e.g. Minister of Justice, Ministerial meetings at CP's capitals, and possible with the President). All CP's makes it clear that no disbursements to (some areas) of the sector can be unless full GRZ action is taken.

It is worth mentioning, that an alternative strategy similar to the one outlined above was successfully used in 1999.³³

4.8 Conclusions

The table below tries to summarise the risk analysis outlined in this section using two dimensions; The first dimension is the *probability* of certain scenarios becoming a reality, i.e. whether the risk is identified as low, medium or high. The second dimension is the *impact* that a specific scenario would have on the health sector and the *strategy* to deal with it.

PROBABILTY			IMPACT & STRATEGY
Low	Medium	High	
<ul style="list-style-type: none"> • Drug availability remains insufficient 	<ul style="list-style-type: none"> • Diminishing financial & admin. capacity at district level • Delinkage process not fully implemented 	<ul style="list-style-type: none"> • Increasing impact of HIV/AIDS disease burden 	Low – Could be dealt with within the SWAp
<ul style="list-style-type: none"> • GRZ commitment and enthusiasm faltering • Motivation of health staff lessens 	<ul style="list-style-type: none"> • Weak political will to implement the HIV/-AIDS plan • MoU not implemented 		Medium – Alternative strategy could be applied
<ul style="list-style-type: none"> • Commitment from other CP's to the Reform declining • Decentralisation process halted 	<ul style="list-style-type: none"> • HPIC conditions not met, substantially reduced budget allocations to the health sector 	<ul style="list-style-type: none"> • no political commitment to deal with corruption etc. • deteriorating “democratic” environment 	High – Very difficult to deal with within the sector – possible EXIT

Obviously, the most serious risk is the one with a high probability and a high impact. From the matrix above it can be seen that “no political commitment to deal with corruption” and “deteriorating democratic environment” are such serious risks. If these risks materialise, it might lead to a situation where Sweden would have to suspend all involvement in the health sector until real political will to deal with the situation has been

³³ In 1999 a “new” Minister of Health refused to sign the *Memorandum of Understanding* outlining the very principles of the Sector Wide Approach. Without that commitment it was deemed very difficult to continue supporting the Zambian Health Sector. Sweden, and most other large contributors to the health sector then suspended all disbursements to the District Basket until a satisfactory solution had been found.

shown. This would (of course) apply not only to the health sector but to all Swedish development cooperation with Zambia. Obviously, *combinations* of scenarios, could also lead to the same conclusion.

However, most risks are not reason enough to *abstain* from continue supporting the sector. As outlined above a possible “suspension” could, and *should*, take place within the SWAp, i.e. Sweden should continue supporting the Health Reform Process even without disbursement of funds, until GRZ has addressed the situation properly. Furthermore, a decision to suspend all development cooperation with Zambia would necessarily have to take place in a political context at a very high level.

A part from the risks associated with good governance, most other risks can be properly dealt with within the SWAp or by applying the alternative strategy outlined above.

Finally, what is important in a SWAp environment is not the risk analysis as it looks today. Any SWAp in any country/sector will face difficult and serious obstacles during its long development. Many of the risks outlined above are closely related to the current Government which may look completely different after this years elections. What is more important than the actual risks is the fact that Sida, together with all other CP's, continuously monitors these risks and promptly acts accordingly. The above outlined strategy has proven to be an effective tool to do so.

5. SECTOR CONTEXT - HEALTH REFORMS

5.1 Health Situation Analysis

Achievements Since 1991

At the outset of the health reform process nearly a decade ago, Zambia's disease burden was significantly different than today. The impact of HIV/AIDS on households and communities is now of major significance and consequence. HIV prevalence appears to have stabilised in Zambia, but it is still high at almost 29% in urban areas and 14% in rural areas. As a result of HIV, TB cases have increased almost five fold during the period. The health and survival of women and children in Zambia seems to have stayed the same or somewhat deteriorated in the past decade. The maternal mortality ratio is recorded as 649 per 100,000 live births. Mortality among children under age five has increased over the past fifteen years from 174 per 1000 to 197 per 1000.³⁴ The number of households experiencing chronic illness and death is rising: in 1998, 17% of rural and 12% of urban households had experienced a death³⁵. Estimates of the number of orphans vary from 950,000³⁶ to 1,600,000³⁷.

The above limited number of health indicators well represents the general

³⁴ Six leading killer diseases account for about 80 percent of under-five mortality; malnutrition, diarrhoea, pneumonia, malaria, anaemia and measles.

³⁵ CSO (1998)

³⁶ *ibid*

³⁷ UNDP (1998)

health situation. The underlying causes of the deteriorating health situation are mainly

- the HIV/AIDS epidemic that has brought disruption and change in social networks and support systems and a vastly increased burden of care on the health sector, communities and households; and
- the negative macro economical development leading to increasing poverty levels.

Without the health reform process the situation is likely to have been even worse. However, some positive developments should also be noted:

- Increasingly there is *more capable decentralised authority* to manage health services at the district level (the thrust has been so far on managerial autonomy, professional autonomy and decentralisation of planning, budgeting and financial management).
- *Participatory structures have been created*, but require strengthening to become more effective.
- A shift has occurred in the *share of resources that goes to district level* (including the creation of the district basket financing mechanism).
- The *concept of basic health care package* has been developed although it remains unaffordable in the present economic context.
- Theoretically the purchaser-provider split has occurred, but the provider is not yet fully empowered to effectively provide services, nor fully accountable.

Performance Indicators

A lot of work has been put into defining *performance indicators* for the National Health Strategic Plan. Indicators have been identified in five distinct areas:

- (i) *Outcome/impact Indicators* (e.g. maternal mortality rate, malaria incidence, infant mortality rate, under-5 mortality rates, HIV-zero prevalence rate)
- (ii) *Service Output indicators* (e.g. Fully immunised infants, % of institutional deliveries, FP-CPR among women, TB cure rate).
- (iii) *Support Systems Indicators* (e.g. medical supplies. % of fully staffed rural health centres)
- (iv) *Community Partnership Indicators* (e.g. % of health centres with active Neighbourhood Committees)
- (v) *Financing Indicators* (e.g. % of MoH resources disbursed to the district level, % of CP's funding going into the basket, % of CP's pledges actually disbursed)

The table below shows some selected indicators (identified and agreed by all CPs), the actual value in 2000, and an achievable target for 2005:

Table 3: Selected Performance Indicators for the NHSP 2001-2005

Indicator	Actual (most recent) value (2000)	Achievable targets (2005)
Outcome Indicators:		
- IMR	109	110
- Under-5 MR	197	200
- MMR	649	500
- Annual incidence STD (women)	3%	2%
- Annual incidence STD (men)	7%	4%
- 2-weeks prevalence of diarrhoea (under-fives)	23.5%	20%
Service Indicators:		
- Fully immunised infants	58%	80%
- Average no. ANC visits per ANC user	3.5	4
- % deliveries assisted by trained personnel	47%	60%
- FP – CPR: married women	14%	25%
- FP – CPR: unmarried sexually active women	17.9%	30%
- TB Cure Rate plus Treatment Completion	70%	75%

The table shows that containing the present situation (or slightly improving some indicators) seems to be the best achievable at this moment in time. The projected impact of AIDS and continuing socio-economic problems do not leave much room for unenlightened optimism. Indeed, if attained, these targets can be viewed as major achievements.

5.2 Resource Envelope

The most important component of the health reform process is the resource envelope, including the distribution of resources. This will be analysed in three subsections; The first one (*National Health Accounts*) will describe the total flows to the sector, the second will assess the total resources available for the NHSP, and the last subsection will discuss whether the resources available matches the total needs.

The National Health Accounts

Contributions to the health sector come from various sources, notably government, households, donors and employers. These funds flow to various service providers; public health facilities, private practitioners, private pharmacists, traditional healers etc. The *National Health Accounts* (NHA) is an internationally agreed method of quantifying all financial flows related to the health sector. In Zambia NHA takes place regularly and the quality of the information is high in a regional perspective.³⁸ The NHA reveals a number of important observations³⁹:

- More than 50% of domestically generated health care expenditures take place in the private (non-government) sector, either through the mines, missions, out-of-pocket spending by households or other

³⁸ It could be noted the high quality of the National Health Accounts in Zambia is a direct result of a long term Sida commitment to build institutional capacity at the Department of Economics at the University of Zambia.

³⁹ The total picture of resource flows through the sector can be obtained from the Zambia National Health Accounts (1995-1998). Sida has supported the development of NHA nationally in Zambia, regionally through three workshops where 10 African countries participated and globally, through support to WHO.

(charitable/ foreign) institutions and traditional healers;

- Of the total resources spent on health in Zambia, 38% are estimated to come from households, however, only a limited share of these funds are spent in the public health sector.
- Over the last number of years donors have accounted for approximately 15% of total health care expenditures (all sources) and a much larger (approximately 45-55%) proportion of financing through public services.
- Donors contribute through many channels both in cash and kind (for example medical staff). Such expenditures can be difficult to track and plan for.

Funds available for the National Health Strategic Plan (NHSP)

What is most relevant for this assessment is the *resource envelope* available for the National Health Strategic Plan, implemented mainly through the public health sector. The main funders of these services are GRZ, CPs and households contributing through user fees.

Several attempts have been made to estimate the resource envelope available for implementing the NHSP. Making projections for the entire NHSP period (2001-2005) is difficult due to a lack of reliable data but also due to a swiftly changing economic and political environment. The envelope below is based on that the conditions for HIPC are met, which will have a large positive impact on the availability of resources for health in Zambia⁴⁰:

Table 4: Resource Envelope for the NHSP (mUSD)

Funder	1998	1999	2000	2001	2002	2003	2004	2005
GRZ/MOH	82	82	82	85	61	83	102	116
User fees	1,0	1,6	2,2	0,7	0,6	0,8	0,8	0,8
Cooperating Partners	53	54	54	50	48	52	58	58
Total	137	138	138	136	109	135	160	175
Total per capita	13	13	13	14	12	13	14	15

Source: *Joint Health Appraisal Mission Draft Report, p.57*

The table shows that a total resource envelope of between 12-15 USD per capita per year will be available for the implementation of the NHSP. 50-60% of these are domestic resources, the rest are contributions from cooperating partners.

⁴⁰ Other key assumptions are that:

- funds freed under HIPC increase the proportion of GDP going to the health sector (through the MoH) temporarily but much of the space created under HIPC relate to debts that were not always paid and the space created may then be far smaller than hoped. From 2002 the proportion of GDP for health is assumed to fall back to 2%.
- the Kwacha devalues in 2001 by 15% on its current rate to approx. 4150 Kwacha to 1 USD (rate as per April 2001 approx. 3200 Kwacha to 1 USD). This continues in 2002 before slowly stabilising.
- Donor funding remains relatively constant but reduces in real terms over the period.

The figures above should be interpreted with care. The significant decrease of contributions from CP's between 2002 and 2003 is not likely to be a true reflection of reality. Many CPs are in the process of preparing new agreements and have not yet been able to provide the MoH and CBoH with information regarding their future support. Based on previous experiences, the total contributions from CP's is more likely to remain constant or even increase slightly.

Resources Needed - The Basic Package of Care

Obviously, it is important to compare the total resources available with a needs analysis for the sector. More recent work by WHO⁴¹ suggests that total annual investments of less than USD 60 per capita is likely to be ineffective. Such low levels of investments are able to sustain only minimally functional services, even where efforts to reform and restructure health systems are successful. This is 4-5 times more than what is available in Zambia.

In Zambia a more realistic approach has been applied, using the *Burden of Disease* of the country as a point of departure. With this as a basis a *basic package of care*, i.e. an identification of the goods and services needed to deal with the most urgent health problems, has been developed. Estimates of the costs of providing the package have been done on several occasions, the latest indicates a need of approximately 14 USD per capita *for district level services only*. That corresponds approximately to what is available for the entire sector. Since it is clear that available resources are far from enough, the ongoing discussions on how to adapt the package to fit within the limited resources available is even more important.

5.3 Distribution of Resources within the Sector

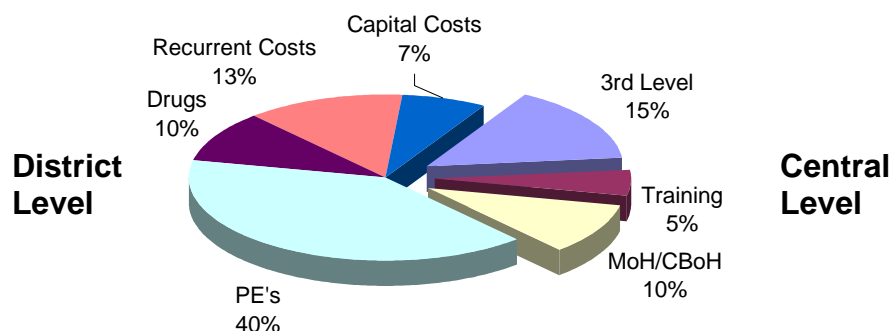
Main principles

Overall distribution of resources is clearly the area which is subject to most discussions between CP's and the MoH. To use the limited resources available in a cost effective way is the top priority for Sida, and many other CP's, in the sector.

There is a joint agreement between the GRZ and CPs to prioritise *primary health care as close to the family as possible*. This means that resources should be shifting from central levels and hospitals to district health services, and commitments to this end are signed in the Memorandum of Understanding between GRZ and the CPs (50% of GRZ resources and 60% of CP resources). A major review of the sector in 2000 made a general, but well justified, suggestion on how the overall resources should be allocated. This suggestion is illustrated in the chart below:⁴²

⁴¹ World Health Report 2000

⁴² Joint Identification and Formulation Mission, January 2000



The review suggested an increase from 60% to 70% to district level, where 40% is PEs, 10% drugs, 13% recurrent costs and 7% capital costs. The remaining 30% to the central level consists of 3rd level hospitals (15%), training (5%) and MoH/CBoH (10%). This allocation formula has then formed the basis for the new NHSP.

The shift of resources started several years ago, as indicated in the table below:

Table 5 Expenditure on Health % share by sub-sector

Level	1995	1996	1997	1998	1999
MOH/CBOH	24	12	8	6	4
2 nd and 3 rd level hospitals	34	44	42	39	38
District grants	40	43	47	52	53
Statutory Boards/Bodies	2	2	2	3	5
Others	0	0	1	-	-
Total	100	100	100	100	100

Source: JFAM, p. 64, Table 3.2.4

From the table it can be seen that a slow shift is taking place. However, there are still practical obstacles such as staff not being shifted to the same extent as funds are, grants not being released in full to district for a variety of reasons, bottlenecks in transfer of funds via MOH etc. These issues are to some extent addressed in the NHSP but are also the focus of continuous discussions between the MOH and the CPs supporting the Health Sector.

Geographical distribution of funds *between districts* is made on the basis of a resource allocation formula that has been adapted over the years and is based on population, fuel prices, disease proneness and banking availability. However, this formula only applies to funds allocated through the District Basket and may not fully account for the difficulties facing the less densely populated districts.

The District Basket

The *District Basket* is currently the mechanism to provide budget support to the health sector. The District Basket finances *all* recurrent costs at a district level in accordance with annual action plans elaborated by the

districts themselves. Both MoH and CPs contribute to the basket.

Of the total resources projected as available to the sector, roughly 25% are estimated to flow to the District Basket. However, the basket is about to be expanded to a *District Health Fund* which will cover new areas such as human resource development, capital investments and possibly medical drugs. The ultimate aim, as expressed in the MoU, is to expand the Basket to cover the entire sector.

The table below shows pledges and contributions to the district basket 2000 and 2001:

Table 6: Pledges and Contributions to the District Basket 2000

	Pledged 2000		Disbursed 2000		Pledged 2001	
	USD	%	USD	%	USD	%
Ministry of Health	6 400 000	27%	1 834 581	10%	6 400 000	22%
Danida	2 113 213	9%	1 045 814	6%	2 200 000	8%
DFID	3 200 000	13%	2 900 000	15%	4 500 000	15%
EU	1 313 000	6%	1 300 000	7%	3 700 000	12%
Ireland Aid	1 000 000	4%	835 428	4%	1 300 000	4%
Netherlands	3 000 000	13%	3 853 282	20%	4 200 000	14%
Sida	3 750 000	16%	3 750 000	20%	3 750 000	13%
UNFPA	-	-	91 000	0.5%	?	
Unicef	500 000	2%	432 697	2%	?	
USAID	2 500 000	11%	1 216 372	6%	2 000 000	7%
World Bank	-	-	1 600 000	8%	1 200 000	4%
	23 776 213	100%	18 859 174	100%	29 250 000	100%

Source: Quarterly District Basket Steering Committee Reports

As can be seen from the table a large number of CPs now contribute to the District Basket. In fact, the number of contributors has more than doubled since 1997. A major reason for this increased confidence in the District Basket has been constantly improving financial reports from the districts. It is generally acknowledged that the District Basket mechanism works well.

Notable from the table above is also that the Ministry of Health did not live up to their pledge in 2000. Since this has been the case for number of years, and repeatedly discussed with MoH, the MoH budgets and disbursements will be dealt with in more detail below.

MoH Budget and Expenditure

Generally speaking, the MoH budget is in overall accordance with the NHSP and the jointly agreed goals. However, more important than the budget, is the actual expenditure patterns. These can be analysed at two levels:

- (i) disbursements from the MoFED to the MoH, and
- (ii) disbursements from the MoH to subsectors within the sector:

The amount released from MoFED for the period 1996-2000 is shown in the table below:

Table 7: MoFED transfers to MoH (Bn Kwacha, nominal values)

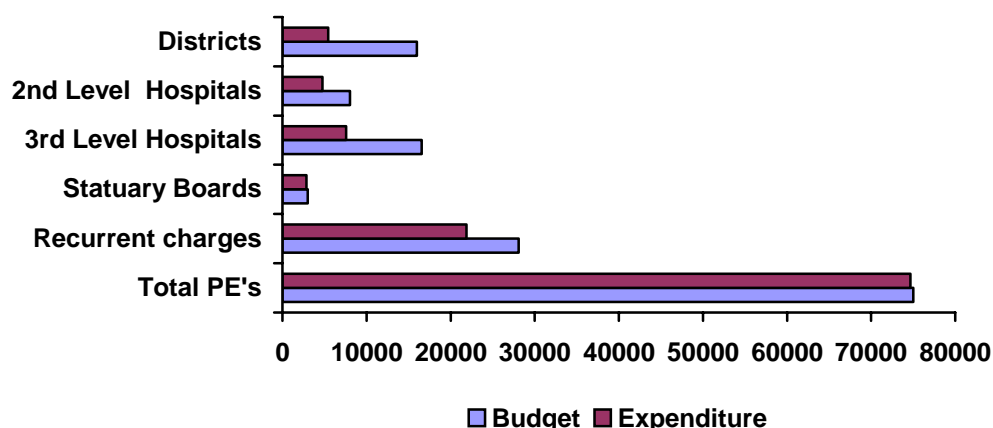
	1996	1997	1998	1999	2000		
	%	%	%	%	Budget	Release	%
Personal Emoluments	165	194	111	110	75,205	78,910	105
Recurrent Departmental Charges	93	105	99	105	31,570	29,319	93
Grants and other payments	95	100	92	105	50,785	35,949	71
Capital Expenditures	74	2	51	121	6,642	3,265	49
TOTAL	109	62	97	106	164,202	147,443	90

Source: MoFED – Macroeconomic Indicators

The table shows that MoFED transfers have been close to the actual budget for the entire period, except 1997. In situations where the full budget has not been released, personal emoluments have been prioritised and capital expenditures (although relatively smaller) have been the heaviest hit.

Even *within* the four main budget lines in the table above, there are differences between budgets and actual disbursements. The Figure below shows the budget and expenditure for some (particularly interesting) budget lines for the year 2000:

Figure 1: Ministry of Health Budget and Expenditure 2000 for some selected budget lines (bn Kw).



The figure shows that the expenditure to the districts is only about a third of the MoH budget while expenditure to statuary boards (including CBoH) and PE's is almost 100%. Could this be interpreted as "non-commitment" to primary health care contrary to the agreed principles? Or, could the low expenditure to the districts be a direct result of large contributions from CPs to the District Basket? In other words, is this a case of *internal fungibility*? While this can not be entirely excluded, the following arguments indicates the contrary:

- (i) A large proportion of the expenditure to PE's (and recurrent charges) is attributed to health care staff at the primary health care level⁴³. Hence MoH contributions to the District Level is much more than its contributions to the basket.

⁴³ In the 2001 budget about 75% of the PE's is allocated to the district and provincial level.

- (ii) The expenditure ratio to 3rd level hospital is almost as bad as the district level, for example, the University Teaching Hospital only received 37% of its budget in 2000. Hence, it seems like the discrepancy between budgets and expenditure is more related to the *type* of expenditure, rather than the level. Salaries (included in PE's) is, for example, almost impossible not to pay and MoH has to bear the full burden (no CP's want to fund salaries)
- (iii) Compared to a few years ago, the situation is improving. Budgets are becoming more realistic, and the proportion actually being disbursed is increasing on all expenditure items. For example, in the budget for 2001 (which has increased both in nominal and real terms), PE's has decreased from 27% to 19%, the proportion devoted to medical drugs has increased from 10% to 16%, and the proportion going to the district basket and grants to district and mission boards has been reduced from 18% to 16%. This could be seen as a step in the right direction.

Even though significant progress has been made in recent years when it comes to presenting and analysing expenditure figures, a lot of work remains to be done. These difficulties do not only relate to the Health Sector but to the public sector in general.

5.4 Institutional Framework for the SWAp

The key document outlining the institutional framework of the SWAp is the *Memorandum of Understanding* (MoU) that was signed in November 1999 by the Ministry of Health and all 15 external CP active in the health sector. The MoU outlines the vision of the health sector reform process and defines the institutional framework for cooperation between the Ministry and all cooperating partners, e.g. on common systems for planning, reporting, disbursements, accounting, auditing, procurement etc. Given the importance of the MoU, this is attached in full to this Memorandum as Annex 2.

The MoU defines two formal fora for consultations between all stakeholders in the sector, biannual *Consultative Meetings* and quarterly *Health Sector Support Steering Committee* (HSSSC) meetings.

The first Consultative meeting of each year primarily reviews the annual report from the previous year from the CBoH and the MOH. The second meeting reviews the Annual Action Plans for the following year and agreements are made on budgets including commitments from all partners. A review of the annual external audit report (in accordance with the general acceptable accounting principles) of the CBoH is also undertaken.

The HSSSC meetings are held quarterly to review progress on Action Plans, accounting/financial reports from the MOH/CBoH and to review the financial flows in relation to the budgets. The HSSSC became operational in April 2001. The ToR for the HSSSC is attached (Annex 3).

Before the HSSSC became operational *District Basket Steering Committee Meetings* (DBSC) were held quarterly. The DBSC consisted of the MoH, the CBoH and all CP's contributing to the basket. These

meetings made decisions on disbursements from the basket based on financial reports from the districts.

On *joint procedures and indicators* the MoU specifies that “Cooperating Partners will work within the GRZ health sector framework as outlined in the NHSP towards agreement on common systems for planning, reporting, disbursement, accounting, auditing and procurement (of all goods and services, including technical assistance) and evaluating the performance of the Health Sector through reviews and appraisals based on jointly agreed monitoring and evaluation indicators”.

5.5 Monitoring and Evaluation

The MoU specifies in detail the requirements for monitoring and evaluation. Some key principles are the following:

- All CP’s agreed to use the MOH/CBOH sector monitoring and evaluation indicators for assessing health status, and service delivery.
- GRZ is responsible for providing and dissemination of information to all CP’s, e.g. quarterly reports from the HSSSC Meetings and Annual Health Report covering performance against annual plans and expenditure against budget of the previous year.
- During the period of the NHSP an independent audit will be organised through the Auditor General.
- GRZ in collaboration with Co-operating Partners, will initiate and support one external evaluation of the performance of the NHSP in the last year of the duration of the NHSP.
- GRZ in consultation with Co-operating Partners, will agree on the timing, Terms Of Reference and composition of all Review Missions.

Sida intends to abide to the MoU and, hence, abstain from any bilateral arrangements on monitoring and evaluation.

5.6 Implementation Capacity

Institutional Capacity at a Central Level including SWAp Management

Implementing health reforms and managing the SWAp are processes that have been ongoing for almost a decade. The implementation capacity of key institutions has varied over the years and has proved to be dependent on the political commitment of the government, and in particular the Minister of Health, to the reforms.

Even though the basic capacity to carry forward the reforms and the SWAp is available, there is a need to strengthen capacity at most levels as an integrated part of the implementation of the NHSP. The important role of the MoH in this area must be underlined which relates to the more intangible issue of trust between the partners. The process so far has shown that an open and constructive dialogue is key to successful management of the SWAp.

At the central level, as much as there is need for capacity building, there is also a need to actually work according to the agreed roles and responsibilities of the different organisations, notably the MoH and the

CBoH. As part of the reforms, the CBoH was established as the implementing arm of the sector, contracting with districts and hospitals and providing services. The MoH was envisaged to transform into a small policymaking entity.

While CBoH's capacity has certainly developed over the years, there are still a number of areas for further capacity strengthening, such as planning, accounting and procurement. In MoH, in particular the planning function may be in need of support and development. The final steps towards a full transformation of the central functions of the MoH and CBoH have not yet been taken, where the CBoH should focus on service delivery and the MoH take on the role of a small policymaking ministry that refrains from handling day-to-day implementation issues.

Financial Administration and Accounting Capacity

At the District level, a Financial and Administrative Management System (FAMS) is in place which covers government recurrent and external resources flowing to the Districts. This is a well functioning system⁴⁴, although it is still under development.

Hospital financial management and accounting systems have not been given the same attention in the reforms as financial management at the district level. However, recently, a comprehensive programme for development of accounting systems at the 2nd and 3rd level hospitals has been introduced, linked to the FAMS.⁴⁵ At the central level, general government accounting systems are followed.

Despite the systems being sound and in place, it must be emphasised that further capacity strengthening in this field is needed as well as coordination between the systems. There is a general shortage of staff with financial management skills in the sector⁴⁶, and in the CBoH, which holds important supervisory functions, there is still a lack of staff working with financial management, partly due to the difficulty of attracting and retaining qualified staff with conditions of service less favourable than in the private sector.

Institutional Capacity in Service Providers

Strengthening of the institutional capacity to manage health services at district level has taken place through training of the DHMTs, and the improved reporting and planning of the districts could perhaps serve as an indicator as to this development. However, the hospitals have until recently largely been left out and will need to be included in management training and institutional capacity building arrangements⁴⁷. It should also be emphasised that efforts in this field need to be continuous for all levels, in order to sustain acquired institutional capacity.

⁴⁴ JHAM, p 85

⁴⁵ JIFM, chapter 9

⁴⁶ JIFM, chapter 7, p 113

⁴⁷ JIFM, p.131

Other Government Systems

In general, sound Government systems for accounting, procurement and auditing do exist and the external audits conducted in the sector by the Auditor General's Office are of high quality. However, the Auditor General's Office suffers from a shortage of staff which leads to audits not being undertaken as frequently as desired.

Perhaps even more crucial is the fact that the general systems in place are not always utilised in the sector; proper tender procedures are not always followed and the recommendations from the Auditor General have, sometimes due to political reasons, not been fully implemented. This is a matter of debate between the MoH/CBoH and the CPs.

Human Resources

Appropriately trained staff at each level of the health system is key to the provision of quality health services. In the Zambian public health sector, there are a number of concerns in relation to human resources⁴⁸. While the overall number of staff may be adequate, the mix between different categories of staff in the sector may not be the appropriate one. There is also a general shortage of certain staff categories, in particular clinical officers, pharmacists, and staff with financial and management skills.

Furthermore, there is a geographical maldistribution of staff where the remote areas are seriously disadvantaged. For example, the staff ratio for medical doctors varies from 1 doctor to 6 600 people in the best served area to 1 doctor to 145 000 people in the most underserved area. For nurses, the ratios vary from 1/3 000 to 1/43 000.

HIV/AIDS puts a heavy burden on staff in the health sector, both in terms of increased workload and stress as well as in terms of staff falling ill or dying. 5% of the qualified workforce is estimated to disappear due to the pandemic on an annual basis, in addition to the staff leaving for other reasons. This, of course, needs to be taken into account when planning for basic education and training.

A 10-year human resource plan has been developed where estimates are made for staff need and availability, and a number of other measures are under way of being introduced in order to come to terms with the staff distribution, mainly through trying to introduce rural incentives through improved salaries and conditions of service. Human resource management will continue to be a key issue in the sector programme.

6. PROPOSED SWEDISH SUPPORT

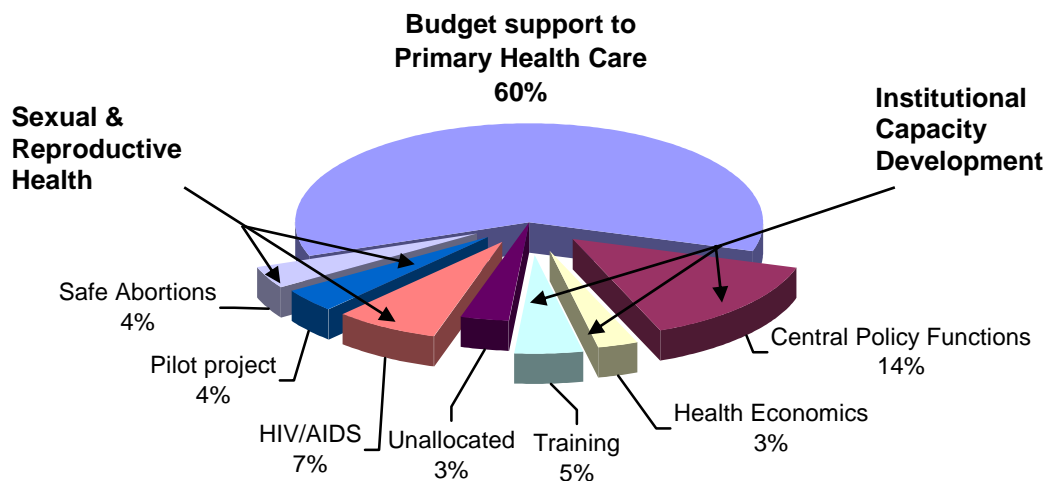
6.1 Previous Sida Support to the Sector

All of the previous Swedish support to the health sector has been an integral part of the SWAp. All activities have been a "selected" from the CBoH's Annual Action Plan and CBoH has also been responsible for contracting arrangements, reporting, budgets, follow-ups etc. Funds have been disbursed to one account at CBoH and CBoH has been responsible

⁴⁸ JIFM, chapter 7, p 111

for any further subcontracting to Zambian institutions or NGOs.

The annual budget for the Swedish support has been around USD 5 million annually (SEK 50 million per year) allocated to three main areas: (i) budget support to primary health care, (ii) institutional capacity development, and (iii) Sexual and reproductive health. This allocation, including division into sub areas, is shown in the chart below:



The chart shows that around 60% of the total budget has been allocated to the *District Basket*, about 20% to *Policy- and Institutional Development* and 15% to the thematic area *Sexual and Reproductive Health*.

Below follows a description of these components including some lessons learned from this support.

1. Budget support

In terms of budget support, Sweden has supported basket funding to the districts since 1994. The District Basket is described in section 5.3 of this report.

2. Policy- and Institutional Development at Key Institutions

One of the main obstacles to a functioning SWAp has been lack of capacity at key institutions at a central level. For this reason about 20% of the Swedish support has been targeted towards capacity building at three (groups of) key health institutions:

(i) Central Policy Functions - CBoH/MoH

Sweden has been supporting the development of health policy, health planning and central management functions at MoH and CBoH for a very long time. The support has mostly been rendered through long-term technical assistance combined with quite substantial financial support for specific activities. This has included the broad framework of health reforms, development of the SWAp institutional framework, the hospital

sector, the pharmaceutical sector, mainstreaming of gender issues, health care financing, development and costing of essential health care packages, developing human resources policies etc. Recently, an increasing proportion of the Swedish support to the sector has been provided as non-earmarked support to the CBoH Action Plan.

(ii) Support to key training institutions

The Sida support to training has been implemented through an *institutional collaboration* arrangement between the Swedish organisation *IHCAR*⁴⁹ and the major training institutions for nurses and midwives in Zambia⁵⁰

The main objective has been to strengthen these institutions and prepare them for a more active role in providing in-service training for health care staff. The working mode has been process-oriented from the outset, aiming more at creating processes and structures for achieving specific objectives and targets set. In implementing the actual work the Swedish counterparts have had the role of “catalysts” or “facilitators”.

A recent evaluation⁵¹ indicates that the training institutions show evidence of human resources development such as tutors trained in problem based learning, computer literacy, MPH training exchange, and developed research proposals. The core institutions have also been computerised and systems for computer maintenance and financial management exist. The achievements will also have an impact on development of the health sector with the development of a training policy, the introduction of problem based learning in the current curricula reviews and the training needs assessment survey leading to a new curriculum for nurses.

(iii) Health Economics

The overall objective of the support to the area of health economics has been to build capacity with the view to make provision of health care delivery services in Zambia equitable and cost effective. This is done through an institutional collaboration programme between Department of Economics at the University of Zambia and a Swedish institute for health economics⁵². The joint activities have included training in health economics, research projects, exchange visits and networking with other national, regional and international organisations. The focus in the collaboration has been on capacity building of the local institution.

According to the above mentioned evaluation, the institutional collaboration in the area of health economics is a story of success.⁵³ Zambia has gone from depending almost entirely on international

⁴⁹ ICHAR – Division of International Health, Department of Public Health Sciences, Karolinska Institute in Stockholm.

⁵⁰ General Nursing Council, the Chainama College, the Department of Post Basic Nursing at the University of Zambia, and the Lusaka Schools of Nursing at the University Teaching Hospital.

⁵¹ InDevelop (2000), p. iv

⁵² IHE – Swedish Institute for Health Economics, University of Lund.

⁵³ InDevelop (2000), p. v

consultants for health economic analysis to having a "powerhouse" in health economics which has been requested to support other countries in the region. Products from this collaboration included a health expenditure review, a macro-economic analysis and an ongoing costing of the essential health care package in Zambia. It should also be noted that also IHE has benefited from the collaboration as the work in Zambia has given a wider perspective on health economic analysis at different income levels

3. Sexual and Reproductive Health and Rights

The third, and last, component which Sida has supported is area of Sexual and Reproductive Health and Rights. About 15% of the total Swedish support to the health sector has been targeted to this area, which has included two sub components:⁵⁴

(i) SRHR Pilot Project targeted towards adolescents

The overall objective of the *Kafue Adolescent Reproductive Health Project* has been to develop strategies for the delivery of Sexual Reproductive Health and Family Life Education information to young people in the project site of Kafue. The project has been implemented by two Zambian NGOs and a Swedish NGO⁵⁵.

The project has evolved from being a pure adolescent reproductive health project into a community based project involving various groups and organisations in the community including local leadership, churches, youth groups, etc. As a pilot, the project has been successful as shown by the sinking number of STD cases reported from health centres. The project has also proved valuable as a "demonstration project" for key Zambian decision makers and MPs as well as visiting delegations from Sweden.

The pilot project as such comes to an end in December 2001. 2001 has therefor been used for *phasing in* the project to be wholly owned by the CBoH, the district administration and the community of Kafue. The inclusion of other strategic partners, such as the Ministry of Health, has assured continuity and shared responsibility for a process that has its end in community participation and ownership. As a first step towards up-scaling, it is envisaged that the project will be replicated in two other districts.

(ii) HIV/AIDS

Sida has been providing support to the area of HIV/AIDS for several years. This assistance has been based on the annual action plans developed by the National AIDS/STD/TB and Leprosy Programme, under CBoH. Four major component can be singled out:

- HIV/AIDS policy development in the health sector including the development of Zambia National HIV/AIDS Strategic Framework.

⁵⁴ Originally a third sub-component, *SRH Policy Development and Post-abortion care*, was included under the SRHR-support but due to internal problems at the implementing organisation (Department of Obstetrics and Gynaecology at the University Teaching Hospital) implementation never started.

⁵⁵ The Swedish Association for Sex Education (RFSU).

- epidemiological surveillance for sentinel-based surveys;
- development of guidelines and implementation of *counselling* services, and
- advocacy and partnership campaigns through media.

Generally speaking, it is clear that the Sida support has played a catalytic role in the development of an institutional framework for HIV/AIDS-activities⁵⁶ required to attract funds from other key donors.

Conclusions

The evaluation eluded to above concludes that *“Institutional development through Sida IC projects has led to significant results in strengthening the institutions/organisations involved. /.../ However, development on organisational and sectoral/ societal level has been more significant in the training and health economics projects than in the adolescent health project. The training institutions and health economics collaborations, have contributed to the health reforms process already, but as regards the adolescent health collaboration institutional impact depends on whether the project turns out to replicable or not”*.⁵⁷

The evaluation also pointed out that a balance between the budget support and other support methods may have to be changed in line with how priorities are set in the strategic health plan and that institutional development activities should be part of a joint process, not being handled in a separate bilateral process.

In summary, the previous support has achieved its objectives. It seems clear that the current model – budget support combined with capacity building at key institutions in the health sector – is a useful point of departure for future Sida support.

6.2 Guiding Principles for Future Sida Support

More important than the *details* of the future Sida support is the *guiding principles* on which it will be based. Some of these principles are *harmonisation, flexibility* and *focus*:

Harmonisation - Strengthening the SWAp

During the programme period the primary objective is to take yet another step towards a “full” Sector Wide Approach. This includes strengthening the existing common systems in place (such as the HSSSC) and continue coordination and harmonisation efforts on procedures such as reporting, disbursement of funds, evaluations, auditing, etc. This may also include winding up some of the existing “bilateral” arrangements.

Flexibility

A cornerstone of any support to a SWAp is to assure a that the total

⁵⁶ The Zambian institutional framework consists of a Council of Ministers, a HIV/AIDS Council and a National HIV/AIDS Secretariat. A National Strategic Framework forms the basis for all activities in the sector.

⁵⁷ InDevelop (2000), Executive Summary, p. viii

resources are allocated in accordance with the agreed principles. This requires a high degree of flexibility from all partners. Hence, the specific focus of Swedish support will *not* be cast in stone for the entire agreement period but agreed with MoH and external CP's on an annual basis. However, no activities should be supported that is not a part of the National Health Strategic Plan and the CBoH Annual Action Plan. The ambition is also that a higher proportion of Swedish support should be provided as non-earmarked support to the CBoH Action Plan.

Focus

In a Sector Programme, the role of cooperating partners changes from project management at a micro level to participation in the overall policy dialogue in the sector. In Zambia, a wide range of policy issues are subject to debate. However, since no CP can be actively involved in all policy discussions, there is a need for Sida to focus on a limited number of policy issues, selected on the basis of comparative advantage and need. The following areas are suggested for Sida priority in the policy dialogue:

- (i) General "coordination" issues and development of the SWAp: Many of the CPs are still in a dual mode and while participating in joint reviews and planning processes, bilateral systems are still maintained. Sida has for a number of years played an important role in trying to move the SWAp process forward, which should be maintained.
- (ii) Certain technical issues, specifically National Health Accounts, decentralisation, hospital reform, adolescent health and gender.
- (iii) Regional cross-cutting issues; there are a number of areas of development and concern in the Zambian health sector that are shared with other countries in the region, for example hospital reforms, development of National Health Accounts and general decentralisation issues.⁵⁸

The above suggested focus areas will be further developed during the latter half of 2001.

This principle of focus should apply also to the financial support, i.e. Sida should try to concentrate on a smaller number of areas.

6.3 Outline of Proposed Support

Timeframe and Volume

It is proposed that the programme period for Swedish support will increase from 3 years to 4 years. One reason for this is to harmonise the Sida support with other donors' and with the National Health Strategic Plan (that covers the period 2001-2005). Another is that three years is a rather short time period for support to a (functioning) SPS. SPS is, by definition, a long term commitment.

⁵⁸ As the Health Advisor for Sida in Zambia is envisaged to have a regional function in addition to the bilateral one, there may be scope for sharing regional experiences and for Sida to play a role in this respect.

It is furthermore proposed that the volume of the Sida support should increase from approximately USD 5 million (SEK 50 million) per year to around USD 6 million (SEK 60 million) i.e. USD 24 million (SEK 240 million) for the entire period⁵⁹. Arguments for this have been eluded to earlier in this assessment and they could be summarised as follows:

- (i) The reform programme and SWAp in Zambia is *technically* sound. Zambia was one of the first countries to embark upon a SWAp, and it is also the first country to “survive” the first period of obstacles. The joint preparatory process, including the two major external assessments of the sector, is a guarantee for the technical, financial and social soundness of the reform programme. Therefore, the proposed Sida support is an effective and sustainable way to improve health services in Zambia, and thereby to reduce poverty.
- (ii) There is an increasing commitment from a large number of external CP's. From a “burden sharing perspective” an increase of the Sida support would be desirable.
- (iii) The absorption capacity in the sector is high. During the last five years emphasis has been put on building capacity, not at least at the district level.
- (iv) Finally, and most importantly, the needs are enormous.

In recent years, the absolute level of the Sida support to the health sector (and to other sectors) has been held back due to negative developments in the area of good governance. If this situation improves, as may well be the case after this year's election, a substantial increase should be seriously considered. In the same vein, there are external factors that might have negative implications for Swedish development cooperation with Zambia at a general level. Hence, the actual budgets and disbursements should be revisited regularly.

Focus on Primary Health Care...

It is proposed the Sida support to primary health care should increase from 60% to 70%. This is based on the recommendations outlined in section 5.2, i.e. that a significant shift in resources should take place over the next five years, towards the delivery of services at the district level. The intention is an allocation of the order of 70% of the total resources available (from GRZ, from CP's and from internally generated funds)⁶⁰.

As outlined in a previous section the District Basket is assumed be expanded to a *Health Service Fund* that will include capital expenditure, human resource development and (in due time) medical drugs.

...and Institutional Capacity Development.

The remaining 30% will be allocated to the CBoH Action Plan, with particular emphasis on *institutional capacity development*. Previous experiences have proved that the combination of budget support and

⁵⁹ In the Agreement between Zambia and Sweden SEK will be used. 1 USD equals approximately 10 SEK.

⁶⁰ JIFM, p.2

support to build capacity at key health institutions at a central level has been a successful. However, attempts shall be made to make a “wider” approach to include the entire *Human Resource Development* sector together with other CPs.

The CBoH Action Plan contains 7 themes and areas for support;

1. Health Systems Structure
2. Health Systems Governance
3. Human Resource
4. Essential Pharmaceutical and Medical Supplies
5. Infrastructure
6. Management Systems
7. Service Production (including District Basket)

The support for institutional capacity building will be an integral part of the CBoH AP and will be further elaborated, together with MoH, CBoH and key CPs, during the next six months. It is foreseen that some of the funds will be provided as non earmarked support to the CBoH AP, and that some funds will continue to support *Zambian-Swedish institutional collaboration* as a means of building capacity in priority areas. The process for consultation for further developing this part of the Swedish support includes a study visit by MoH and CBoH and other relevant institutions to Sweden during the autumn, in order to identify areas where Zambia is interested in drawing upon Swedish expertise.

The Use of the Swedish Resource Base, including Technical Assistance

A move in the health sector towards joint systems for technical assistance (TA); short and long term advisors, consultants and for institutional collaboration, should be supported. However, this transformation has just begun and at present, most development agencies still continue with earmarked support for TA from their own countries. In the interim, it is proposed that the present long term advisor posts in the CBoH will continue, in accordance with the wish of the CBoH.

As mentioned previously in this document, there are a number of institutional capacity building efforts under way through institutional collaboration in various forms. While this collaboration should be seen in a long term perspective, it should be noted that a more holistic approach is required, based on improved coordination with other organisations and moving away from purely bilateral contacts.

During the next phase of the Swedish support to the health sector, it is proposed that these institutional collaborations continue but that the scope is widened and made more flexible, and that Sweden supports efforts made by the relevant institutions for a more joint approach for institutional capacity building.

Concluding Remarks

The above proposed support is, in principle, a continuation of the support that has been ongoing since 1996. It could be outlined as follows:

Summary of Swedish Health Sector Support to Zambia	
<i>Primary Health Care:</i> - Implemented through the District Basket to be developed into a broader <i>Health Service Fund</i>	70% of total
<i>Institutional Capacity Development:</i> - Capacity building through support to the CBoH Action Plan - Support to <i>Institutional Collaboration</i> - Support through Technical Assistance (2 long term posts at CBoH)	30% of total

The proposed focus on budget support and institutional capacity development, has the support of the Ministry and the CBoH. The details will be further developed together with the Ministry and other cooperating partners during the next six months.

Finally, it should be emphasised, that Sida has a very long and solid relationship with the Ministry of Health. It is clear that the Ministry regard Sida as a key cooperating partner in the SWAp process. Over the years, Sida has proven to be a reliable but constructively critical partner in the reform program. A continued support will strengthen this collaboration.

ATTACHMENTS

- National Health Strategic Plan 2001-2005 (Executive Summary)
- Memorandum of Understanding
- Terms of Reference – Health Sector Support Steering Committee
- JIFM – Joint Identification and Formulation Mission (Executive Summary)
- JHAM – Joint Health Appraisal Mission (Summary, Recommendations and Logical Framework of the NHSP)
- Draft Agreement between Sweden and Zambia

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