

FINAL DRAFT

GFATM tracking study
Macroeconomics and sector background paper

ZAMBIA

Prepared for LSHTM
by Sally Lake

January 2004

CONTENTS

Acronyms	iv
Acknowledgements.....	v
Summary of key issues and areas for Phase 2 tracking.....	vi
<u>1 INTRODUCTION.....</u>	<u>1</u>
1.1 BACKGROUND TO THE STUDY	1
1.2 THE COUNTRY MACROECONOMIC AND SECTORAL FINANCING DESK STUDY	1
1.3 STRUCTURE OF THE DOCUMENT	3
<u>2 THE MACROECONOMIC CONTEXT.....</u>	<u>3</u>
2.1 OVERVIEW AND PAST PERFORMANCE.....	3
2.1.1 STRUCTURE OF THE ECONOMY	3
2.1.2 RECENT ECONOMIC PERFORMANCE AND PROSPECTS	4
2.1.3 FISCAL PERFORMANCE	5
2.2 POVERTY AND THE PRSP	6
2.2.1 POVERTY IN ZAMBIA: AN OVERVIEW	6
2.2.2 POVERTY REDUCTION POLICIES AND STRATEGIES.....	6
2.2.3 THE PRSP, HEALTH AND HIV/AIDS	7
2.3 CURRENT ECONOMIC PROGRAMME.....	10
2.4 EXTERNAL FINANCING	11
2.4.1 BUDGET SUPPORT FOR POVERTY REDUCTION	11
2.4.2 FRAMEWORK FOR HARMONIZATION IN PRACTICE.....	12
2.5 ADMINISTRATIVE SETUP	13
2.5.1 ADMINISTRATIVE DECENTRALISATION AND LOCAL GOVERNMENT REFORM	13
2.5.2 FISCAL DECENTRALISATION	13
<u>3 THE GOVERNMENT PLANNING AND BUDGETING FRAMEWORK</u>	<u>14</u>
3.1 PLANNING AND BUDGETING CYCLES.....	14
3.1.1 LONG TERM	14
3.1.2 MEDIUM TERM	14
3.1.3 OPERATIONAL.....	14
3.2 MONITORING AND EVALUATION	15
3.2.1 PERFORMANCE MONITORING	15
3.2.2 FINANCIAL MANAGEMENT.....	15
<u>4 HEALTH SECTOR CONTEXT.....</u>	<u>15</u>
4.1 GENERAL	15
4.2 ADMINISTRATIVE SETUP.....	16
4.2.1 CENTRAL LEVEL STRUCTURES: MINISTRY OF HEALTH AND CENTRAL BOARD OF HEALTH ..	16
4.2.2 DISTRICTS	17
4.3 NATIONAL HEALTH POLICIES AND STRATEGIES	17
4.3.1 HEALTH SYSTEM ORGANISATION.....	18
4.3.2 HEALTH PLANNING, FINANCING, PROCUREMENT AND MANAGEMENT.....	19
4.3.3 THE ZAMBIAN SECTOR-WIDE APPROACH.....	20

4.3.4	GFATM TARGET DISEASES	21
4.4	SECTORAL EXPENDITURE OVERVIEW	25
4.4.1	OVERALL HEALTH SPENDING.....	25
4.4.2	EXTERNAL FUNDING IN THE HEALTH SECTOR	26
4.4.3	PROJECT VERSUS PROGRAMME SUPPORT	27
4.4.4	EXTERNAL FINANCING FOR HIV/AIDS, MALARIA AND TUBERCULOSIS.....	28
5	<u>GFATM AND SPECIFIC ISSUES FOR THE TRACKING STUDY</u>	<u>29</u>
5.1	MACROECONOMIC ISSUES ARISING	29
5.2	SECTORAL ISSUES ARISING.....	29
5.2.1	GENERAL.....	29
5.2.2	HIV/AIDS.....	31
5.2.3	MALARIA.....	32
5.2.4	TUBERCULOSIS	33
6	<u>ANNEXES</u>	<u>36</u>
	Annex A Terms of reference for the macroeconomic desk study.....	36
	Annex B PRSP planning linkages and information systems	38
	Annex C District budget spreadsheet.....	39

List of tables

Table 1 GDP by sector 1999 – 2002 (projected), in 1994 market prices	4
Table 2 Key macroeconomic indicators, 1998-2002	5
Table 3 Overall and extreme poverty in Zambia, in rural and urban areas, 1991 - 1998	6
Table 4 Health sector share of PRSP budget, 2002-04	8
Table 5 HIV/AIDS policy actions in the PRSP	10
Table 6 Malaria Strategic Plan budget (US\$).....	22
Table 7 Possible contributions by selected CPs, 2001-05	27
Table 8 Proportion of grant to be allocated to drugs and supplies, 2002	29
Table 9 Approved HIV/AIDS funding by Principal Recipient, Oct 2003.....	32
Table 10 Approved malaria funding by Principal Recipient, Oct 2003	32
Table 11 Approved tuberculosis funding by Principal Recipient, Oct 2003.....	33

List of figures

Figure 1 MOH expenditure, budgeted and actual, 1990 – 2000 (in 1994 billion Kwacha)	25
---	----

List of boxes

Box 1 Key areas of the NHSP 2001 – 2005 policy framework	18
Box 2 Objectives of the NAC Strategic plan	23

Acronyms

AIDS	acquired immuno-deficiency syndrome
BHCP	Basic Health Care Package
CBOH	Central Board of Health
CCM	Country Coordinating Mechanism
CHAZ	Churches Health Association of Zambia
DANIDA	Danish Agency for Development Assistance
DCI	Development Cooperation Ireland
DGIS	Directorate-General for International Cooperation (Netherlands)
DHS	Demographic and Health Survey
DOTS	Directly Observed Treatment (Short course) for tuberculosis
EIU	Economist Intelligence Unit
ESAF	Enhanced Structural Adjustment Facility
FY	financial year (1 July to 30 June)
GDP	gross domestic product
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
GRZ	Government of the Republic of Zambia
HIP	Harmonization in Practice
HIV	human immunodeficiency virus
HRIT	Health Reform Implementation Team
IFMIS	Integrated Financial Management Information System
IMF	International Monetary Fund
JHAM	Joint Health (pre-)Appraisal Mission (Jan 2001)
JIFM	Joint Identification and Formulation Mission (Feb 2000)
JIFR	Joint Identification and Formulation Report
LCMS	Living Conditions Monitoring Survey
MOFNP	Ministry of Finance and National Planning
MOH	Ministry of Health
MOU	Memorandum of Understanding
MTEF	Medium Term Expenditure Framework
NAC	National HIV/AIDS/STI/TB Council
NGO	non-governmental organisation
NHA	National Health Accounts
NHPS	National Health Policies and Strategies (MOH 1992)
NHSP	National Health Strategic Plan
PER	Public Expenditure Review
PIP	Public Investment Programme
PRGF	Poverty Reduction Growth Facility (IMF)
PRSP	Poverty Reduction Strategy Paper
SP	sulphadoxine pyremethamine
STI	sexually transmitted infection(s)
SWAp	sector-wide approach
TB	tuberculosis
WB	World Bank
WHO	World Health Organisation
ZK	Zambian kwacha

Acknowledgements

This draft paper was commissioned by a team from the Department of Public Health and Policy at the London School of Hygiene and Tropical Medicine as background to an 18-month tracking study of the Global Fund for AIDS, Tuberculosis and Malaria. The study is jointly funded by the Danish Agency for Development Assistance (DANIDA), the UK Department for International Development (DFID), Development Cooperation Ireland (DCI), and the Netherlands Directorate-General for International Cooperation (DGIS).

Assistance in sourcing documents from within Zambia was gratefully received from Denny Kalyalya (Bank of Zambia), Chris Mwikisa (University of Zambia), Anna-Carin Kandimaa (Swedish International Development Agency), and Leo Devillé (Health Research for Action).

Caveats

This document is the draft output of a desk-based study, and as such has been limited by the number and type of documents available to the consultant. Key documents which it has not been possible to obtain include a complete version of the National Health Strategic Plan for 2001 – 2005, and the Strategic Plan for Rolling Back Malaria in Zambia 2001 – 2005. A major gap was the failure to source recent Ministry of Health and Central Board of Health annual plans, or any recent health budget or expenditure data, for government, donor or total sectoral resources. The document was essentially written by October 2003, and there may have been developments which it has not been possible to incorporate since then. These will be included in any update.

Summary of key issues and areas for Phase 2 tracking

Zambia is some way behind other countries in the study, with neither a Medium Term Expenditure Framework, nor established and functioning financial management systems at the national level for tracking sectoral expenditures in relation to budget. Public expenditure management is weak, and macroeconomic performance subject to concern which has resulted in failure to obtain renewed International Monetary Fund support for the country. This has already derailed achievement of the desired Highly Indebted Poor Countries (HIPC) completion point in 2003.

Despite problems with macroeconomic performance, and a relatively high level of public expenditure as a proportion of Gross Domestic Product (GDP), the fiscal deficit is quite low, and there appear to be no expressed concerns at increasing inflows of external aid to support the budget, either as balance of payments or project support.

In a context of such poor government expenditure management that parallel/additional systems have been established to track HIPC funding, the addition of funding from the Global Fund for AIDS, Tuberculosis and Malaria (GFATM) may not result in the same inefficiencies as in other countries, as the degree of harmonization is as yet limited. However, it does represent a move contrary to plans, both generally through the Framework for Harmonization in Practice, and sectorally as it relies on structures and procedures which are inconsistent with the Sector Wide Approach which cooperating partners in the health sector have signed up to.

The interventions outlined in the GFATM proposal go beyond those included in the defined and costed Basic Health Care Package, yet no mention is made of the implications of this for the Zambian health system more generally.

Macroeconomic issues for follow-up

- **GDP growth performance**

Concerns have been raised that predicted GDP growth rates used in the Poverty Reduction Strategy Paper (PRSP) are too optimistic, and this appears to have been borne out to date. Continued monitoring of economic growth is therefore recommended.

- **Conflicting fiscal priorities**

Among past constraints on pro-poor spending, the need to prop up failing parastatals and to improve public sector pay beyond planned levels have been identified in recent years. Failure to deliver on the PRSP will further delay attainment of the HIPC completion point. Actual government expenditures in relation to budget are a measure of commitment to priorities, which to date have favoured health and HIV/AIDS. Follow-up of budget execution is therefore important.

- **Progress with Harmonization**

A Public Expenditure Management and Financial Accountability Review was undertaken in June 2003 which may have implications or recommendations for future aid management within the budget. It would be useful to get hold of this as it may have implications for the way in which GFATM funds are managed in later stages of the support.

- **Inter-sectoral allocations and the additionality of funding**

GFATM funding is intended to be additional to existing funds for target diseases, whether channelled through the health sector or separate HIV/AIDS bodies. Although this is a somewhat unrealistic expectation, given the fungibility of the different financing sources available to government, and is also contradictory to the recent emphasis given to strengthening recipient government leadership in prioritisation and resource allocation, it should be tracked if possible, through analysis of the shares of total and discretionary government spending allocated to the health sector (and to HIV/AIDS where treated separately).

Sector issues for follow-up

- **Overall sectoral allocations**

The poor state of health expenditure data in Zambia has not permitted any discussion of whether GFATM funds are in any sense additional, or indeed whether HIPC funding has added to the health budget since 2001. More complete and up-to-date information should enable some analysis in this area if it can be obtained.

- **Timing and level of GFATM funding flows**

The predictability of aid flows is one of the areas which partners have agreed to strengthen as part of the harmonization effort, and is an acknowledged cause of disruption to implementation of planned activities. This happens both at the macro level, where foreign reserves may need to be drawn down, and at the sector level, where funds may be deviated between activities, or cancelled (as has frequently happened in the past at district level). The extent to which GFATM meets its stated timeframe, as incorporated into sectoral plans, will therefore be of interest, particularly as it is likely to represent a significant share of funding for the target diseases and sector as a whole (see below).

- **GFATM as % of sectoral funding (Health and HIV/AIDS)**

It has not been possible to identify the share of total public (domestic and external) funding to the health sector due to the poor nature of budget and expenditure data. However, the high level of funding approved through GFATM over coming years means that this is likely to be a significant share which it would be of interest to monitor. This will show the extent to which, if at all, other funding is cut back and the GFATM funding ceases to be additional.

- **Incorporation of GFATM funding within sectoral MTEF/budgets/reports**

Although at the time of writing Zambia does not have an MTEF, there is an intention to develop such a tool, and it would be useful to monitor the extent to which GFATM funding is incorporated “on-budget” within either the annual budget or a future MTEF in order to provide a more complete view of sectoral resources. Inclusion of reporting on GFATM expenditures and activities in any sectoral reports is another area which should be tracked, in order to determine the extent to which the funding is being assimilated into existing sectoral planning and management instruments.

- **Balance of funding within the BHCP**

Proposed interventions for GFATM funding to tackle the three target diseases represent only a subset of those included within the Zambian BHCP. In addition, “new” interventions are not

included at all in the most recent costing, eg VCT, TB prophylaxis for HIV positive persons etc. The costs of these (original and “new”) interventions significantly exceed those as included in the original costing. Further analysis would therefore be useful to assess the extent to which other priority interventions identified within the BHCP are funded.

- **Share of funding allocated to district level services**

As the district is seen as the primary level for service delivery, and that decentralisation of both resources and responsibilities to the district level has been a key element of Zambia’s sectoral reform programme, it will be important to track the extent to which GFATM funding reaches health providers at the district level and also, if possible, the extent to which such funding responds to district requests/needs rather than being “pushed” from central level technical programmes.

- **Funding by Principal Recipient**

It would be useful to have more information on the activities to be funded through the allocations to the Churches Health Association of Zambia as opposed to those to be funded through the Central Board of Health. This may just be a safeguard on the part of CHAZ to protect allocations for the same activities undertaken by their institutions and within their catchment areas, but it may be for different activities. Given that the original intention of the reforms was to develop an integrated district health system, and to publicly fund a similar health package as far as possible, it would be interesting to explore why the balance of funding between these PRs is very different to the balance of service provision by government and CHAZ health facilities as a whole.

- **Absorption capacity**

The shortfalls in financial data in Zambia make assessment of absorption capacity rather difficult. However, as GFATM funding is to be tracked separately through parallel reporting systems, the extent to which the health system is able to (effectively) absorb the significant new inflows should be monitored in relation to the planned phasing of funding as given in the proposals.

1 Introduction

1.1 Background to the study

This paper forms part of a series of four country background papers undertaken as a desk study in order to support an 18-month Tracking Study which aims to report recipients' (governments and other country stakeholders) perspectives on the operationalisation of the Global Fund for AIDS, Tuberculosis and Malaria (GFATM) at the country level; and to make recommendations that will contribute to successful future GFATM implementation. The study is jointly funded by the UK Department for International Development (DFID), the Danish Agency for Development Assistance (DANIDA), Development Cooperation Ireland (DCI), and the Netherlands Directorate-General for International Cooperation (DGIS). The study is being undertaken by the London School of Hygiene and Tropical Medicine.

The objectives of the tracking study are as follows:

1. to synthesise government and other country stakeholders' perspectives on CCP (proposal) preparation, functioning of CCMs and implementation processes at the country level;
2. to identify lessons learned and make recommendations on the coordination of the Global Fund and other global health initiatives with existing country-level processes (Sector-Wide Approaches and Poverty Reduction Strategy Papers).

The study will be undertaken through a combination of methods, notably document review, in-country fieldwork, and separately commissioned desk studies on specific areas.

1.2 The country macroeconomic and sectoral financing desk study

The purpose of this background paper is to provide an overview of the macroeconomic and sectoral financing context for the second phase of the more detailed fieldwork, to review the planned inflows through GFATM in relation to aid levels and their potential macroeconomic impact, if any, and to propose areas related to economics and financing which might be tracked during Phase 2 of the main study. Terms of reference are attached at Annex A.

The need for a separate background paper on these issues has arisen in response to growing debate regarding potential trade-offs between the substantial and acknowledged increase in investment in priority sectors such as health if the Millennium Development Goals and others are to be achieved, and the need for sound policies for macroeconomic stability and growth as a basis for long-term development. This debate has been most strongly articulated in Uganda to date, but is of increasing concern more generally among low income countries. In addition, there is some political concern within countries regarding the wisdom of an increasing share of the government budget and Gross Domestic Product (GDP) coming from external resources, both in terms of predictability of revenue flows but also regarding national sovereignty with respect to the policy-making process.

In late 2002, DFID issued a policy paper summarising the macroeconomic effects of aid¹. This was based in part on a paper commissioned on aid and monetary policy in Uganda in order to help clarify the position in which Uganda finds itself, ie of needing to trade off the availability and potentially productive use of additional external assistance to the country, with the adverse macroeconomic effects which such an inflow could produce². These

¹ DFID (2002). *The macroeconomic effects of aid*. Policy paper. London: December 2002

² Adam C, *Uganda: Exchange rate management, monetary policy, and aid*. Paper prepared for the Bank of Uganda with DFID support. Revised version. Oxford: September 2001

primarily involve an appreciation of the exchange rate, resulting in a fall in the demand for exports and increase in imports. Other things being equal, this results in a contraction of the tradable sector of the economy in which it is generally assumed that there is greater long-term scope for productivity gains, and hence a lower long term average growth rate for the economy as a whole. This phenomenon is generally known as “Dutch disease”, after the macroeconomic effects seen following the discovery of natural gas of the Dutch coast.

There is a question mark, however, over this general assumption, with an alternative view suggesting that long term productivity can be enhanced by increased investment in the social sectors. Two key assumptions are necessary for the long term benefits of such investment to be delivered:

- that the increase in public spending on education and health should result in improved health and education outcomes;
- that these improved health and education outcomes should result in increased productivity.

The evidence from the WHO Commission on Macroeconomics and Health (CMH) supports this position, arguing that use of increased aid inflows to purchase non-tradable goods such as health care and education can and should translate into a healthier and more productive workforce, thereby mitigating, at least in part, the effect of such a contraction of the tradable sector of the economy. For example, the impact of girls’ education on future infant mortality rates (IMR) is well known, and lower IMR translates in turn to higher life expectancy and a longer productive life. Higher contraceptive prevalence rates result in smaller, healthier families. Nutritional interventions enhance learning capacity and thus productive potential in later life. In addition, a substantial proportion of aid flows to the health sector is used to purchase imported inputs (eg pharmaceuticals, vehicles) and is therefore exchange rate neutral. GFATM funded interventions could be expected to contribute to such productivity increases through extending life and reducing morbidity.

Unfortunately, the two impacts have different timeframes, with improved health outcomes being a longer term effect, while real exchange rate appreciation has an immediate effect. It is therefore generally recommended that some aid be focussed on measures aimed at improving private sector competitiveness through addressing supply side constraints. In addition, intervention in the financial markets is likely to be necessary in order to prevent domestic inflation due to sudden and excessive increases in the money supply. Such intervention might involve “sterilisation” of excess money through selling Government stocks, which in turn results in increased debt and higher interest rates, again crowding out the private sector. Success in this area therefore depends on the strength of individual country fiscal and monetary policy.

One key indicator of sound macroeconomic policy relates to the size of the fiscal deficit in relation to national income, or GDP, ie the gap between public expenditure and revenues. A distinction is sometimes made between the government deficit which excludes external grant funding, and the overall deficit which includes such grants. This document generally refers to the overall deficit. Any such gap between government incomes and expenditure clearly needs to be financed, with options including the printing of money, issuing of domestic debt, or borrowing from abroad.

There is general acceptance that reducing the fiscal deficit of a country is in itself a good thing, not least as it results in an increased proportion of the overall government resource envelope potentially available for priority poverty-reducing expenditures. Debt service, whether domestic or international, generally has first claim on public resources, and can often lead to a substantial reduction in the pool of funds for “discretionary expenditures”. There is generally less consensus regarding the relative, immediate priority to do so in low

income country governments with both a heavy burden of disease and substantial economic loss arising from HIV/AIDS, tuberculosis and malaria among other conditions.

The potentially large and supposedly additional inflows of funding through GFATM to low income countries has resulted in increased interest both in the broad macroeconomic debate outlined above, but also with respect to the relative advantages or disadvantages, and the potential impacts, within the health sector of different aid mechanisms. In a climate of increased moves towards either general or sectoral budget support, often through a health Sector-Wide Approach (SWAp) to the planning and financing of an agreed sectoral plan and more-or-less integrated package of health services at the operational level, GFATM funding threatens to re-introduce parallel systems and a vertical approach, with subsequent reversals in the efficiency of external support. These background papers therefore aim to explore these issues in the four study countries.

1.3 Structure of the document

The paper is structured as follows. Section 2 provides a snapshot of the current macroeconomic situation, describing the structure of the economy, recent economic developments, and the Poverty Reduction Strategy which currently govern overall macroeconomic policy and inter-sectoral allocation decisions. It goes on to outline current sources of budget support, and recent plans for managing external assistance in Zambia.

Section 3 describes the government budgetary framework, covering the planning and budgeting cycle, and current administrative and financial management arrangements.

Section 4 goes into more detail on health sector planning and financing, and the relationship with HIV/AIDS-related activities. To the extent permitted by the data, overall trends in sector financing are reviewed, and the changing nature of external support is examined. Specific details of financing for activities relating to HIV/AIDS, tuberculosis and malaria are presented where available.

Section 5 pulls out issues specifically related to the GFATM proposals in the country.

2 The macroeconomic context

2.1 Overview and past performance

2.1.1 Structure of the economy

With its rich mineral reserves and relatively urbanised population, Zambia's economic situation and prospects at Independence in 1964 were positive relative to other countries in the region. However, falling copper prices and economic mismanagement through the 1970s and 1980s eroded such advantages leaving the country one of the poorest in sub-Saharan Africa by the time of the first multiparty elections in 1991. Nominal per capita GDP fell from US\$630 in 1980 to US\$ 450 in 1990 and US\$ 300 in 2000³.

Zambia has remained largely dependent on the copper and cobalt mining industries as earners of foreign exchange and as formal employers, although the country has seen a shift in GDP structure over the 1990s. Agriculture doubled its share of GDP, and metal exports

³ World Bank (2002). *Zambia: Country Assistance Evaluation*. Operations Evaluation Department. Washington: 7 November 2002

fell from 90% of merchandise export earnings in the early 1990s to 65% by the end of the decade (World Bank 2002).

Agriculture has traditionally accounted for the largest single contribution to GDP, with the exception of trade, as shown in Table 1. Agriculture-related activities in Zambia provide a livelihood for the majority of the rural population, largely through small and medium-scale farming, but only a fraction (roughly 14%) of arable land is currently under cultivation.

Tourism plays a small but growing role in the Zambian economy, particularly given the problems in neighbouring Zimbabwe, and the country has seen an increase of over 70% in the number of tourists arriving, and an almost similar increase in employment in the sector which was estimated to contribute about 2.5% of GDP in 2002 (EIU 2003).

Table 1 GDP by sector 1999 – 2002 (projected), in 1994 market prices

	1999		2000		2001 provisional		2002 projection	
	ZK m	%	ZK m	%	ZK m	%	ZK m	%
Agriculture, forestry and fishing	423.2	17.5%	429.8	17.2%	418.9	15.9%	427.3	15.6%
Industry	602.5	25.0%	620.1	24.8%	681.4	25.9%	717.5	26.2%
<i>o/w Mining and quarrying</i>	160.2	6.6%	160.4	6.4%	182.9	7.0%	189.5	6.9%
<i>Manufacturing</i>	254.2	10.5%	263.2	10.5%	278.6	10.6%	292.5	10.7%
<i>Construction</i>	116.0	4.8%	123.6	4.9%	137.8	5.2%	148.1	5.4%
Services	1,247.5	51.7%	1,298.8	52.0%	1,362.4	51.8%	1,418.8	51.8%
<i>o/w Wholesale and retail trade</i>	446.2	18.5%	456.6	18.3%	484.2	18.4%	503.6	18.4%
<i>Transport, storage and communications</i>	154.1	6.4%	157.6	6.3%	162.1	6.2%	167.0	6.1%
<i>Financial intermediaries and insurance</i>	206.7	8.6%	205.4	8.2%	205.6	7.8%	209.7	7.6%
<i>Community, social and personal services</i>	193.8	8.0%	192.8	7.7%	204.0	7.8%	208.7	7.6%
less: FISIM	- 118.8	-4.9%	- 121.8	-4.9%	- 124.9	-4.8%	- 128.0	-4.7%
Taxes on products	258.9	10.7%	272.4	10.9%	291.4	11.1%	306.0	11.2%
Total GDP (at market prices)	2,413.3		2,499.7		2,628.9		2,741.5	

Source: from MOFNP 2002a (p 41, Table 4.2)

Note: FISIM not explained, but probably imputed financial services

The dependence of the economy on an increasingly uneconomic mining sector has long been recognised as a problem, and a new plan for diversification was recently launched by the government (see Section 2.3 below).

2.1.2 Recent economic performance and prospects

The government of the Movement for Multiparty Democracy (MMD), which took power in the country's first multiparty elections in 1991, did so with an economic manifesto favouring stabilisation, privatisation and liberalisation in contrast to the years of socialist economic policies under Kenneth Kaunda's United National Independence Party. Key reforms included privatisation of state-owned enterprises, decontrol of agricultural prices and the liberalisation of maize marketing, public sector downsizing, with expenditure being redirected towards the social sectors, removal of exchange controls and floating of the Kwacha, and liberalisation both of trade and the banking sector. However, this transition resulted in an initial contraction of real GDP in the period 1991 – 1995. Subsequently, real annual average GDP growth of 1.4% was achieved, but was still too low either to increase average per capita income or to reduce poverty to any substantial extent. Delays in privatising the increasingly insolvent mining sector, particularly during the late 1990s, have contributed substantially to the weak economic situation.

In March 1999, the MMD government agreed an Enhanced Structural Adjustment Facility (ESAF) with the World Bank and International Monetary Fund (IMF) to cover the three year period to 2001, focusing on financial and economic policies complemented by structural reforms, particularly in the public and banking sectors, together with privatisation and the rehabilitation of infrastructure.

These policies were intended to achieve a constant GDP growth of 4.5% and to reduce inflation to single figures by the end of 2001. However, inflation remained over 20% throughout the period, and although the GDP target was achieved in 2001, it was expected to fall back in 2002 due to ongoing problems in the mining sector (aggravated by a major investor pulling out of its commitment to one of the privatised mines), poor agricultural performance due to the drought, and the knock-on effects of reduced private consumption.

Table 2 Key macroeconomic indicators, 1998-2002

	1998	1999	2000	2001	2002
GDP at market P (ZK bn)	6.4	8.3	10.8	<i>13.0</i>	<i>16.3</i>
GDP (US\$ bn)	3.4	3.5	3.5	3.6	3.8
Real GDP growth	-	1.9	2.0	3.5	4.7
Consumer price inflation (av, %)	24.5	26.8	26.0	21.4	22.2
Foreign exchange reserves (US\$m)	69.4	45.4	244.8	183.4	<i>451.4</i>
External debt	6.9	5.9	5.7	5.7	5.9
Debt service ratio, paid (%)	21.0	16.9	21.2	28.5	43.9
Exchange rate (av, US\$1: ZK)	1,862.1	2,388.0	3,110.8	3,610.9	4,306.9

Note: Figures in italics are EIU estimates, others are actual (no other source given)

Source: Economist Intelligence Unit (2003)

Throughout the 1990s, Zambia's debt service payments exceeded net transfers, and in recent years accounted for approximately 10% of GDP compared with total social sector spending of 5% of GDP (MOFNP 2002a). The country qualified for initial debt relief under the Highly Indebted Poor Countries (HIPC) initiative in December 2000, and the latest data on Zambia's external debt indicates a slight reduction in 2001 over the previous year, at US\$5.67bn⁴ (cited in EIU 2003). This was due largely to bilateral debt deals, and a reduction in use of IMF credit, and the position is believed to have reversed in 2002. In addition, debt service also fell to 2001 due to relief entitlements under the HIPC initiative, but is currently rising as a result of repayments due on the ESAF. Completion point was originally scheduled for 2003 which, if achieved, was expected to reduce the debt stock by two-thirds.

2.1.3 Fiscal performance

Zambia's fiscal performance is generally considered weak, with indiscipline contributing to high inflation as a result of persistent fiscal deficits. Progress in containing the fiscal deficit has been good in recent years since the introduction of the cash budget, although inflation remains a problem.

Tax revenues have been relatively strong as a share of GDP compared with other sub-Saharan African countries, averaging 18.4% over the period 1995 – 2000. However, in the absence of growth in the tax base, further increases are judged difficult (World Bank 2001)

Although there has undoubtedly been some increase in expenditure on pro-poor activities and sectors, the main concern with respect to government spending is the high level of public sector deficits, arising through central and local government, state-owned enterprises (not least within the mining sector), and the Bank of Zambia. This quasi fiscal deficit was estimated to account for more than half of total budgetary spending in the period 1995 – 1997, inclusive of foreign current and capital grants, with the Zambia Consolidated Cooper Mines alone accounting for a third of total spending (World Bank 2001).

Adoption of a cash budget system in 1993, although having contributed to some containment of inflation, is claimed to have *“led to the nearly complete demise of the annual budget as the determinant of government expenditure and guardian of financial discipline and its*

⁴ World Bank (2003) *Global Development Finance*. Cited in EIU 2003, p26

replacement by monthly cash releases determined largely on an ad hoc basis with a minimum of transparency“(Dinh, Adugna and Myers 2002). In the health sector, cash releases for Recurrent Departmental Charges (non-salary, non-capital payments) fluctuated by at least 30% in three-quarters of the months over the period 1995 to 1998, thereby severely disrupting activities.

In 2002, the main fiscal objective had been to reduce the deficit to 3.0% of GDP but this was subsequently revised to 3.3% due to unforeseen increases in expenditures, notably due to the drought which resulted in food imports, maize price support, and a disaster relief programme, together with increased spending on inputs for the 2002/03 agricultural season.

2.2 Poverty and the PRSP

2.2.1 Poverty in Zambia: an overview

Income poverty in Zambia has been defined as the amount of monthly income required to purchase basic food to meet the minimum calorific requirements of a family of six, although it is recognised that this measure is deficient in that it fails to capture other basic needs, and is also based on a modest, predominantly vegetarian food basket. Extreme and overall poverty were defined in the 1998 Living Conditions Monitoring Survey as monthly Adult Equivalent Expenditure per household of less than K32,861 and K47,188 respectively.

Zambia has gone from being one of the most wealthy countries in the sub-Saharan African region in the 1960s, due to its substantial mineral deposits, to having the highest level of income poverty and the fourth highest level of human poverty among Southern African Development Cooperation countries at the end of the 1990s. A number of surveys⁵, using comparable poverty line definitions, have captured the high level of poverty in the country, particularly in rural areas, as shown in Table 3 below.

Table 3 Overall and extreme poverty in Zambia, in rural and urban areas, 1991 - 1998

Year	Zambia		Rural		Urban	
	Overall	Extreme	Overall	Extreme	Overall	Extreme
1991	69.7	58.2	88.0	80.6	48.6	32.3
1993	73.8	60.6	92.2	83.5	44.9	24.4
1996	69.2	53.2	82.8	68.4	46.0	27.3
1998	72.9	57.9	83.1	70.9	56.0	36.2

Source: MOFNP (2002a), Table 2.1, p21

Although widespread, poverty in Zambia is particularly associated with rural residence, small-scale farming activity, larger household size, and female-headed households.

2.2.2 Poverty reduction policies and strategies

The Zambian Poverty Reduction Strategy Paper (PRSP) was approved by Cabinet in May 2002, relatively late compared to other countries in the study. Three key assumptions are spelled out at the start of the document:

1. that the PRSP is not a substitute for structural reforms aimed at achieving the macroeconomic stability necessary for both growth and poverty reduction
2. that the PRSP both serves to “carefully channel the scarce national resources only to meet those goals and objectives that have been agreed upon through the

⁵ The Social Dimensions of Adjustment Priority Surveys of 1991 and 1993, and the Living Conditions Monitoring Surveys of 1996 and 1998, all of which were undertaken through the Central Statistical Office. .

- consultative process that characterised the preparation of the PRSP*”, and that progress with decentralisation is essential to strengthening implementation, monitoring and evaluation;
3. that particular emphasis will be paid to the agricultural sector as the “*engine of income expansion for the poor*”.

As income poverty has been identified as a major constraint to improved social welfare, improved economic growth remains the most important component of government intervention to reduce poverty. Reversal of the stagnation of the past 30 years is necessary, as enhanced economic growth is expected to increase the productivity and incomes of poor people, thus expanding their choices and opportunities. Programmes under the PRSP therefore target both small scale informal operators in agriculture, mining, industry and tourism as well as larger operations.

Infrastructure development, particularly rural roads, and investments in the energy sector are also outlined in the PRSP, in order to support faster diversification within agriculture. One particular area is the proposed shift in focus to cash crops for export, such as coffee, flowers, groundnuts, given limitations of the domestic market.

At the same time, social sector investment is seen as key in producing the necessary human capital to generate the growth, alongside mitigation of the effect of HIV/AIDS which has crippled households and economic production.

2.2.3 The PRSP, Health and HIV/AIDS

Health

Health is affirmed as the most important of the assets and capabilities available to poor people, giving rise to the statement that “*protecting and promoting health care is central to the process of poverty reduction and human development*” (MOFNP 2002a, p82). The poor suffer from worse health status, are less likely to seek care due to the opportunity cost of the time spent, and are more likely to suffer further impoverishment due to ill health. The role of health care as an investment in human capital is clearly acknowledged, and health is thus accorded a high priority in the Zambian PRSP (as seen below).

Nutrition, both in relation to poverty and as a major contributing factor in the high levels of morbidity and mortality within Zambia is given a relatively high profile in the PRSP. Food insecurity is high in the country, at an estimated 70% of the population, and malnutrition levels are defined as ‘critical’ and ‘high’ according to the WHO severity index for stunting, and as ‘serious’ and ‘high’ for underweight prevalence (MOFNP 2002a, p85)⁶.

Health status in Zambia is poor. The 1996 Demographic and Health Survey (DHS) estimated life expectancy at birth at 37 years, while both infant and under-five mortality have risen in recent years, to 109 and 197 per 1,000 live births respectively⁷. HIV prevalence was estimated at 29% in urban areas, and 14% in rural areas, given a national average of 20%.

In accordance with its importance for poverty reduction in the country, the health sector has been allocated the second largest share of the PRSP budget for the period 2002-04, as shown in Table 4 below. The health share includes some expenditures also referred to under the HIV/AIDS section of the PRSP.

⁶ It is not clear from the PRSP what the different ratings refer to, possibly urban/rural differences.

⁷ Cited in MOFNP (2002), p 83

Table 4 Health sector share of PRSP budget, 2002-04

Sector	Cost (\$)	Share
Roads	229,000,000	19.1%
Health	200,150,000	16.7%
Agriculture	173,000,000	14.4%
Education	147,500,000	12.3%
Energy	114,000,000	9.5%
HIV/AIDS	94,600,000	7.9%
Tourism	58,700,000	4.9%
Water and Sanitation	42,400,000	3.5%
Macroeconomic reform/institutions	38,200,000	3.2%
Governance	27,000,000	2.2%
Mining	26,600,000	2.2%
Transport	22,000,000	1.8%
Industry	12,500,000	1.0%
Social Safety Net	9,000,000	0.7%
Environment	3,000,000	0.2%
M&E/statistics	1,500,000	0.1%
Gender	976,500	0.1%
Total	1,200,126,500	

Source: MOFNP (2002a), Table 15.3, p 128

Health sector priorities within the PRSP have been defined according to existing programmes and the National Health Strategic Plan, and are summarised below⁸.

- Basic health care package (BHCP): financing of the defined BHCP is expected to *“drastically reduce both the morbidity and mortality rates in the country and contribute to poverty reduction.”* Emphasis will be given to pro-poor elements of the BHCP, and cost-sharing will be maintained with improvements in exemption mechanisms to *“ensure that user fees are not a barrier to the poor accessing public health services.”*
- Resource allocation: the existing bases for financial and human resource distribution will be reviewed to give more weight to poverty than is currently the case. Strengthening community participation and local accountability will be an important part of this process.
- Governance: Action will be undertaken to strengthening procurement systems in terms of both efficiency and their needs-basis, particularly for drugs, together with improvement of governance structures and stakeholder relationships at all levels, and review/enforcement of health-relevant legislation.
- Access: focus will be given to improving access for vulnerable groups, and populations in under-served and hard-to-reach areas.
- Public health priorities: Although an integrated approach to service delivery will remain the objective, priority will be given to selected BHP interventions related to malaria, HIV/AIDS, tuberculosis and sexually-transmitted infections, reproductive health, child health, epidemic control, and hygiene, water and sanitation.

⁸ MOFNP (2002), pp87-88

- Strengthening support services particularly related to: physical infrastructure and equipment; human resource development; and support systems such as policies and legislation, and improved management practices.
- Nutrition: incorporation of nutrition objectives into broader development programming, institutional capacity development of the National Food and Nutrition Commission, strengthening nutrition care practices, and prevention and control of macro and micronutrient deficiencies.

HIV/AIDS

HIV/AIDS is highlighted as possibly the most important cross-cutting issue within the PRSP, given the role of AIDS in having reversed social and economic gains made since independence.

A number of interventions are proposed within the PRSP, including a number of interventions which are costed under the health sector, and distinguishing between first and second level priority programmes:

1. First priority programmes:

- Reduction of new HIV/AIDS infections in high risk groups such as youths, men, sex workers and prisoners, through a) the implementation of multi-sectoral behaviour change communication campaigns; and b) improvements in free condom distribution;
- Reduction of the socio-economic impact of AIDS, through expansion of access to VCT plus services, community home-based care, and antiretroviral treatment;
- Improving the quality of life of orphans and vulnerable children

2. Second priority programmes:

- Improving STI management and treatment in Zambia to reduce sexually transmitted infections;
- Expansion of access to quality prevention of mother to child transmission;
- Provision of prophylaxis against tuberculosis;
- Provision of drugs for opportunistic infections.

HIV/AIDS has been assigned a specific budget line within the PRSP, with a total allocation of US\$94.6m, or 7.9% of the total, allocated (see Table 4 above). This figure differs slightly from that given in the Appendix 2-12 on HIV/AIDS policy actions which sums to US\$95.8m, broken down as per Table 5 below.

Table 5 HIV/AIDS policy actions in the PRSP

Sector goals/objectives	Policy actions/action plans	Costings (\$) 2002-04	Responsible institutions
To reduce new HIV/AIDS infections	Conduct campaigns through Behavioural Change Communication; the mass media; peer education; drama; outdoor media; and working with community leaders	3,000,000	MOH, CBOH, HIV/AIDS Council
	Enhance condom promotion, regular distribution mechanisms, and the monitoring information system	8,000,000	
	Enhance treatment of STIs; procure STI drugs and commodities; train health workers on syndromic management of STIs; develop and implement a system for monitoring drug resistance; create an MIS system for monitoring the distribution and procurement of STI drugs; train Traditional Healers on early identification, management and referrals, as well as partner notification	Costed in health	
	Enhance prevention of MTCT programme; training of health workers; community sensitisation; provision of supplies including ARVs; and monitoring and evaluation	WNB	
To promote positive and healthy living among asymptomatic HIV+ people	Establish and expand VCT centres; expand access to and improve the quality of VCT services; improve access and/or referral to post-test services; train VCT counsellors; train laboratory technicians; improve or expand facilities; and integrate TB prophylaxis and/or treatment into VCT services	4,800,000	
To improve the quality of life of people living with AIDS	Increase community home-based care; expand sustainable home-based care for PWAs; provide support for their caregivers and children; strengthen linkages between home-based caregivers and private and public health facilities	15,000,000	
	Introduce treatment with ARVs (revolving fund); train health workers; carry out community sensitisation; provide supplies, including ARVs; improve or expand facilities; and monitoring and evaluation	59,000,000	
	Provide treatment for some opportunistic infections	Costed in health	
To improve the quality of life for orphans and vulnerable children (OVCs)	Expand existing programmes (OVCs and widows); provide support to CBOs, FBOs, and other community groups; strengthen the capacity of these groups to care for the most vulnerable community members facilitate networks, exchange visits, and other approaches that facilitate collaboration and mutual learning	5,000,000	
To improve and put in place an efficient monitoring, evaluation, and surveillance system	Undertake surveillance	560,000	
	Undertake operations research	440,000	
TOTAL		95,800,000	

Source: MOFNP (2002a), p174

Note: WNB – within normal budget

2.3 Current economic programme

The budget speech for 2003 outlines macroeconomic policies aimed at achieving the following objectives:

- Real GDP growth of at least 4%
- A reduction in the annual inflation rate to 17.9%
- Building up of international reserves to the equivalent of 1.9 months of imports
- Ensuring food security
- A reduction in poverty levels; and
- Reduction in the budget deficit to 1.55% of GDP (MOFNP 2003).

Policies to achieve these are largely based on the ongoing privatisation and re-investment in the mining sector, together with diversification into cash and export agriculture, as mentioned in Section 2.2.2 above. Agricultural production is expected by GRZ to drive economic growth, although positive performance in the manufacturing, service and tourism industries is also cited in the 2003 Budget Speech. The losses due to propping up non-performing parastatals were expected to be curtailed through increased privatisation and liberalisation of key companies, and to have a direct impact on the recognised need to lower interest rates in order to foster growth.

Debt reduction as a means of freeing up resources for investment in infrastructure and improved social service coverage is also highlighted in the 2003 budget. Total domestic and foreign debt service accounts for 15.8% of the total budget, with 30% expected to be covered by external financing. As a result, GRZ committed itself in the Budget Speech to work towards the HIPC completion point by the end of the year in order to obtain the associated debt relief (MOFNP 2003). However, this has not been achieved.

Concerns had been expressed earlier in the year by observers that the stated economic policy might be compromised, not least in terms of its impact on PRSP outcomes, due to a number of factors. The first is the development and launch of two distinct economic plans since publication of the PRSP: the 2002 – 2005 Transitional National Development Plan in October 2002, and the National Economic Diversification Implementation Plan in May 2003. The latter is aimed at reducing dependency on the mining sector, and although both are consistent with the PRSP to some extent, their launch is felt to have increased uncertainty about policy direction (EIU 2003). In addition, there is some doubt about the next stage of the IMF Poverty Reduction and Growth Facility (PRGF) given the President's opposition to the privatisation of two key loss-making parastatals (the Zambia Electricity Supply Corporation, and the Zambia National Commercial Bank) which is a precondition for the IMF and other donors, and a compromise is therefore under discussion. Finally, there has been a change in Minister of Finance since May 2003, which always brings some uncertainty.

In addition, a large projected overrun in the public sector wage bill and associated allowances has resulted in additional negotiations with the IMF. This overrun is projected at K500bn, ie equivalent to 2.5% of GDP above the original 2003 budget estimate, and is expected to put pressure on domestic prices, interest rates and the exchange rate. It also reduces the resource envelope available for priority poverty-related expenditures as outlined in the PRSP. The government has agreed to reopen discussion with public sector unions, and to simultaneously clean the payroll as a means of limiting growth in this area. A revised macroeconomic framework was to be monitored over the course of 2003 with a view to satisfactory progress providing the basis for the initiation of discussions on a new PRGF (IMF 2003).

The Economist Intelligence Unit forecasts that economic growth will be somewhat lower in 2003 than that given in the Budget Speech, at 2.9%, due largely to lower growth in the service sector, and possible increased oil prices for the manufacturing sector due to sourcing difficulties, together with a higher than forecast budget deficit due to lax fiscal policy. Improved prospects for the maize harvest, and higher copper production are expected to contribute to the slight increase in GDP growth over the EIU estimate for 2002 of 2.8%. Inflation estimates are also queried, with an EIU forecast of 21.5% rather than the 17.9% projected by GRZ. The external balance is however expected to improve through greater production volume and prices for copper, together with a reduction in imported food (EUI 2003).

2.4 External financing

Zambia depends significantly on external financing to meet expenditure plans articulated in the budget. In the 2003 budget, the planned foreign contribution came to 42.7% of expenditures in 2003, slightly up from 2002 when the figure amounted to 39.6%⁹. The 2003 Budget Speech refers to such support being provided through a variety of modalities including project assistance, budget/balance of payment support, and commodity aid. It is difficult, however, to get accurate figures on how the total breaks down between these different modalities and their sources.

2.4.1 Budget support for poverty reduction

In common with other countries in the region, Zambia intends to move progressively towards general budget support as the preferred channel for external resources, for the usual

⁹ MOFNP (2002b) and (2003). *Budget speeches*. It should be noted that for 2002, the figure for total revenues was ZK 5,189 bn while total expenditure came to ZK 5,677 bn. Budgeted foreign funding at ZK 2,247 bn therefore accounted for 43.3% of planned revenues. In 2003, budgeted revenues and expenditures are equal at ZK 6,932 bn.

reasons regarding the potential efficiencies of harmonised practices in support of a common programme of poverty reduction and economic development.

Currently, Zambia potentially benefits from general budget support through the IMF PRGF, although the most recent such facility expired in March 2003, and subsequent negotiation of a new facility are dependent on macroeconomic policy implementation during 2003, as outlined in Section 2.3 above.

World Bank support appears to have been more project-based in Zambia, although reference is made in a recent evaluation document to successive agreements for balance of payments support through adjustment credits during the 1990s. There appear to be no such credits in place at present (according to the World Bank website), possibly due to the recent evaluation having been highly critical of Bank support in the period covering 1996 – 1999, when funding continued at a very high level despite a a climate of *“repeated slippage in IMF-agreed programs, delays in key structural reforms and a halving of net [Overseas Development Assistance] commitments including the withholding of virtually all balance of payments support from the international community”*¹⁰.

It is possible that bilaterals (and possibly the EU) have been providing balance of payments support to Zambia in more recent years, but no data could be found to indicate levels or sources.

Zambia has a floating completion point under the HIPC initiative. This means that completion is dependent on three triggers, namely maintaining macroeconomic stability, implementation of a participatory PRSP for at least one full year, and satisfactory implementation of agreed structural and social reforms¹¹. As the PRSP was approved in March 2002, March 2003 was the earliest point at which completion could be achieved and, as indicated in Section 2.3, the stated target was the end of the year. However, delays in agreement of a new IMF PRGF have resulted in delays in reaching completion and thus the guaranteed release of continued HIPC funding.

2.4.2 Framework for Harmonization in Practice

Zambia is participating in the international Aid Harmonization programme, although progress is at an early stage. This programme was developed following a February 2003 meeting in Rome of aid recipient countries, bilateral and multilateral development organisations, and resulted in publication of the Rome Declaration on Harmonization¹².

Following this meeting, in March 2003 GRZ together with a number of the like-minded donors (notably Denmark, Finland, Ireland, the Netherlands, Norway, Sweden and the UK), developed a common agreement on how to move forward with harmonization, building on positive experiences in the health and education sectors, together with international developments. The resulting Framework for Harmonization in Practice outlines a number of principles to which both government and cooperating partners have agreed to subscribe:

- Leadership coordination and guidance by the government;
- Commitment to civil service reform;
- Public financial management reform;
- Commitment to using the PRSP as the basis for strategic planning and monitoring;

¹⁰ World Bank (2002). *Zambia: Country Assistance Evaluation*. Operations Evaluation Department. Washington: 7 November 2002

¹¹ IMF/IDA (2003). *Heavily Indebted Poor Countries (HIPC) Initiative – status of implementation*. Washington: 14 September 2003.

¹² Available on www.aidharmonization.org

- Commitment to adoption of SWAps and possible move towards direct budget support¹³.

Agreed actions, for which a timeframe has been outlined, include the development and implementation of a formal policy on external aid, preparations for direct budget support, and increasing commitments to SWAps, improvement of aid predictability, and the development of common planning, monitoring and reporting procedures.

2.5 Administrative setup

2.5.1 Administrative decentralisation and Local Government Reform

Zambia has to date achieved a certain level of devolution to the provincial level, with offices established in each of the nine provinces with some administrative and financial responsibility. In some sectors, more rapid decentralisation of responsibilities and/or resources has taken place, resulting in different systems for planning and financial flows within a province. The health sector is one of these, and relevant structures and processes are described further in Section 4.2 below.

As part of a broader Public Sector Reform Programme, initiated in 1997 but moving very slowly, local government at the district level is being strengthened, with the intention of progressively devolving responsibilities and resources for service delivery to the district level. A Decentralisation Policy has been under discussion for several years, and District Development Coordinating Committees (DDCC) have been established in all districts. These link with, and have a coordinating role with respect to community-based organisations within the district, and report to the District Councils. However, at present, the councils have no legal or financial authority over representatives of sector ministries based at district level, resulting in a dual governance structure at that level.

2.5.2 Fiscal decentralisation

The extent to which fiscal decentralisation can be claimed to have taken place in Zambia depends upon the sector. As mentioned above, some sectors (including health) have taken action to remove themselves from the system which prevailed in the early 1990s whereby funding for operational level activities was channelled through the Provincial Permanent Secretary.

Obviously part of the delay in standardising practice among sectors, and in designing a clear system of inter-governmental grants is due to the slow progress with the Decentralisation Act and policy. This has constrained government-wide efforts to improve decentralised fiscal and financial management capacity (World Bank 2001).

One of the medium to long-term recommendations of the 2001 PER is that an inter-governmental fiscal framework should be planned, given the weak current recording and reporting of expenditures at sub-national levels and their relative importance for poverty reduction.

¹³ www.aidharmonization.org

3 The Government planning and budgeting framework

3.1 Planning and budgeting cycles

3.1.1 Long term

Zambia is perhaps unusual in that the process of defining a long term development vision is taking place after publication of the PRSP. As with other countries in the region, the intention is to develop a Vision 2025, through a participatory process, which will “*broadly reflect what Zambians aspire to be by 2025 and options they feel will realistically get them there*” (MOFNP 2002a, p 130).

3.1.2 Medium Term

At the national level, the PRSP is seen as the country’s medium term development framework, serving as both development planning and resource programming tool over a rolling three year period. It is expected that the PRSP will link to other instruments and processes such as the longer-term national development vision, public investment planning, sectoral investment programmes or SWAPs, and the annual budget process at both national and sub-national level.

Medium term development expenditures are programmed through the Public Investment Programme (PIP) which has been in place for several years. The expectation is that this will be synchronised to run concurrently with the PRSP and the proposed Medium Term Expenditure Framework (MTEF) in the future.

Somewhat behind other countries in the region, the development of a Medium Term Expenditure Framework based on the strategies outline in the PRSP has not yet happened, although it is under preparation with MOFNP officials having received training in 2003, and various donors supporting such efforts. The MTEF is seen as the key instrument for translating broad policies into more specific financial and budget priorities, and is expected to cover both government and external resources, although the continued existence of the PIP as a separate instrument suggests that it will be restricted primarily to recurrent expenditures.

At provincial and district level, medium-term development plans and budgets will be prepared, and linked to these higher level instruments.

3.1.3 Operational

The annual budget is the instrument by which PRSP priority expenditures will be effected throughout the programme cycle. A Call Circular is issued by MOFNP each year at start of the budget cycle, setting out budget procedures for the coming financial year. Guidelines for annual work planning by line ministries, provincial administrations and other government institutions are covered in this Call Circular which also provides a tentative budget ceiling.

Individual line ministries take responsibility for developing annual plans of action which set out the activities to be undertaken using budgetary, and in some cases extra-budgetary, resources.

The linkages between the different planning and budgeting cycles and instruments, as envisaged by the PRSP, are shown in Annex B.

3.2 Monitoring and evaluation

3.2.1 Performance monitoring

Progress under the PRSP will be monitored through production on an annual basis of a Progress Report, in line with the general conditions governing PRSPs and HIPC funding.

3.2.2 Financial management

At present, all government spending is subject to Government General Orders and Financial Regulations. These are administered by the Accountant General within MOFNP. However, the recent PER found that systems were generally weak, both in terms of being able to support day-to-day supervision and control of public expenditure, and in terms of annual budget/expenditure monitoring and subsequent trend analysis (World Bank 2001, p xvi).

According to the PRSP, expenditures incurred through HIPC funds are to be monitored through parallel systems at least in the short term. This is seen as necessary in order to ensure accountability, given the weak state of general government public expenditure management and financial management systems. In addition, spending in priority sectors will receive attention through specific tracking studies.

Linked to the development of an MTEF in support of the PRSP, and to the inflow of HIPC funding since 2001, Zambia is also in the process of developing an Integrated Financial Management Information System (IFMIS).

4 Health sector context

4.1 General

Health services in Zambia are provided through a network of public facilities, complemented (largely, although there is still some duplication) by mission facilities in the rural areas and by a growing private sector largely in urban areas. Primary health care in the public sector is provided by health centres, either urban which are intended to service a catchment population of between 30,000 and 50,000, or rural, with a designated catchment area of 29km and an estimated catchment population of 10,000. Some areas also have health posts, which offer a more limited range of services to a smaller population.

Each of the nine provinces has either a 'general' or 'central' hospital, supposedly providing second level referral services, while most of the 72 districts have a first level or 'district' hospital. In provincial centres, first level referral services may be provided by the 'general' hospital facility, while in several rural districts there are also first level referral facilities run by the missions.

Being one of the most urbanised countries in sub-Saharan African, it is perhaps unsurprising that access to health infrastructure is concentrated along the line of rail which links the Copperbelt to Lusaka, the capital, and down through the south of the country to Zimbabwe. No recent figures were available on the proportion of the population within a given distance of a health facility.

Public health services, and ideally others within the district health system, are supposed to provide an agreed range of services, the Basic Health Care Package. This has been progressively defined, redefined and costed over the past decade, but has never fully been financed or implemented. The most recent version estimated the total cost of the package

for the first level (ie up to and including the first level referral facilities) at US\$87.95m resulting in a national average per capita cost of US\$8.55 per year. Of this, 38% is estimated to cover health centre curative care, curative care at hospital level accounts for 36%, preventive programmes provided through health centres and the District Health Office (DHO) for another 25%, and the administrative operating cost of the DHO the final 1%¹⁴.

4.2 Administrative setup

The administrative setup within the health sector has changed a number of times since the initiation of the health reforms in 1992, arguably as much due to politics and personalities as to considerations of efficiency and effectiveness. The sections below describe the current situation and outline some of the key changes over the past decade.

4.2.1 Central level structures: Ministry of Health and Central Board of Health

At the start of the health reform process, a separate, project-type structure was set up to facilitate the reform process through enabling some of the bureaucratic delays and constraints associated with government working to be bypassed. Known as the Health Reform Implementation Team (HRIT), this comprised a relatively small number of MOH staff, together with technical advisors initially from DANIDA, who funded HRIT and were arguably the first partners with large scale bilateral assistance to the reform process, and subsequently from a number of partners.

In 1996, HRIT was transformed into the Central Board of Health (CBOH), in line with the 1995 National Health Services Act, with the following specified roles and responsibilities:

- Supervise, advise and monitor the technical performance of management boards;
- Set financial objectives and the framework of the management boards and co-ordinate the technical capacity;
- Provide technical consultancy to management boards and assist non-Governmental health providers;
- Co-ordinate the technical capacity of management boards;
- Advise the Minister on ways to encourage and promote a social and physical environment conducive to good health and all matters affecting public health
- Advise the Minister on the role of the public and private sector in the provision of health care;
- Do all such things connected to or incidental to the foregoing as the Minister may direct¹⁵.

Following a period of some turbulence, under a previous Minister of Health, during which the CBOH Board was dismissed, the Management Development Division of the Cabinet Office undertook a review of MOH and CBOH, with a view to proposing restructuring. The December 1999 report recommended that the functions of MOH should be restricted to: policy formulation, review and monitoring; legislation (amendment and drafting of new legislation); resource mobilisation (material, finance and human); external relations; performance audit of CBoH as well as statutory bodies; assessing the impact of the health policy; strategic planning; and advocacy. It also found that contrary to the intentions in the 1995 Act, MOH remained highly centralised, and retained a strong hand in some aspects of service delivery, while failing to effectively supervise or monitor board performance at any level.

Currently (as of JHAM 2001), the CBOH comprises four directorates, covering:

¹⁴ MOH/CBOH (2002). *Costing first level basic health care package in Zambia*. Lusaka: January 2002

¹⁵ taken from HERA (2001).

- Technical support services, which includes the nine provinces (thus reversing the move to create four regional offices which were a) too distant from many districts to provide effective support and b) fell outside broader GRZ administrative structures);
- Public health and research;
- Clinical care and diagnostic services; and
- Health services planning.

In addition, four administrative units are responsible for administration, finance, internal audit, and procurement.

4.2.2 Districts

The district has been the focus of the health reform process initiated in 1992, with initial strengthening of District Health Management Teams (DHMT), and subsequent appointment of District Health Boards (DHB) following the passing of the National Health Service Act of 1995. Under the Health Reform Implementation Team, a concerted workshop-based capacity building effort was undertaken to appoint and train DHMTs in new planning and budgeting systems during 1993-94, with more formal training being established in later years.

Districts are responsible for all health services up to first level referral (district hospital), and are mandated to coordinate and oversee the activities of both public and private providers within the geographical remit.

Since 1993, funds have flowed directly to districts from the central level, following the withdrawal of the health sector from the national system of devolution to the provincial level. This was done in recognition of the fact that there was little clarity or logic in the per capita allocations which resulted from the provincial budgetary bargaining process, which relied more on the strength of personality of the Provincial Medical Officer vis-à-vis other Provincial officials. Although viewed as a recentralisation in some respects, as the role of accounting officer reverted to the Permanent Secretary, MOH, absolute funding levels at the district level did see some improvement.

4.3 National health policies and strategies

Zambia embarked on a comprehensive reform of the health system in 1992, with the publication of the document National Health Policies and Strategies: Health Reforms (NHPS), which articulated a vision for the sector of ensuring “*equity of access to cost-effective quality health care as close to the family as possible*”. The reforms have been guided to date by three key principles:

- **leadership**, at all levels, focusing on building capacities of health providers and policy makers;
- **accountability**, both in terms of service quality and finances, and in responsiveness to communities served;
- **partnership**, intended to bring together a positive relationship between and among all partners within the sector.

Affordability has recently been added as a fourth principle, covering both more efficient utilisation of available resources and the mobilisation of additional resources to support the sector (and apparently replacing **sustainability** which was added in the mid-1990s.)

The main strategy for the reform process was a primary health care approach, with focus on the district health system: “*The main core of the health strategy shall be managing for quality through a District Health Management System. The district shall be the basic unit of management where bottom-up planning and implementation initiatives meet the thrust of*

national policies. Therefore, it forms the basic point of reference for the articulation of people's power in health care." (MOH 1992, pp28-29).

Since 1995, the sector has also developed a succession of medium term National Health Strategic Plans (NHSP) which aim to translate sectoral policy into more concrete strategies and activities over a three to five year period. The most recent version was produced in 2000, following a review of the health sector and during a Joint Identification and Formulation Mission (JIFM) commissioned by MOH/CBOH and cooperating partners. The NHSP, which was based in part on the report of that mission, covers the five year period 2001 – 2005¹⁶, with areas of focus given in Box 1 below, largely drawn from the original 1992 policy document.

Box 1 Key areas of the NHSP 2001 – 2005 policy framework

- A goal oriented, financial sound management system for health care
 - Clear accountability and responsibilities at each level
 - A mechanism for regular review of progress
 - Enhancing the role and responsibilities of consumers
 - Providing a minimum set of health services at an affordable cost
 - Strengthening health centres supporting community-based health care
 - Maintaining the role of public hospitals, including specialist and tertiary institutions as defined in the Basic Health care package
 - Integrating private sector strengths and resources
 - Improving quality assurance and effectiveness of interventions
 - Broadening the range of professionally regulated health providers
- (MOH 2000, p2)

This NHSP provided the basis for a 2001 Joint Health (pre) Appraisal Mission (JHAM) commissioned by selected cooperating partners in order to work with the MOH, CBOH and other partners to assess the prevailing situation with respect to reform implementation, and to develop a more detailed draft programme document for a joint sectoral programme of support.

4.3.1 Health system organisation

Arguably the cornerstone of the Zambian health system restructuring is the focus on strengthening the district health system, through sectoral decentralisation. As noted above in Section 2.5, the broader government programme of devolution has been very slow, and the health sector was one of the forerunners in developing new structures and procedures for decentralising authority and resources to lower levels of the administrative system.

There is a dual system of popular and technical structures at district, sub-district and hospital level. Popular structures include Neighbourhood Health Committees (NHC), Health facility Advisory Committees (HAC), District Health Boards, and Hospital Management Boards, while District Health Management Teams and Hospital Management Teams provide technical leadership over specific geographical catchment areas or for designated institutions.

Initially, district health officials reported to one of nine Provincial Medical Officers, but the reforms brought discussion as to the need for such an intermediate level of authority. Following the establishment of the CBOH in 1996, the provincial officers were reorganised into four Regional Officers whose Directors were considered as CBOH staff rather than MOH. Subsequent changes in political leadership in the Ministry, together with concerns

¹⁶ MOH/CBOH (2000). *National Health Strategic Plan 2001 – 2005*. Summary. Lusaka: December 2000

regarding effective support over the new, larger geographical areas, and failure to fully staff and equip Regional Health Offices led to a reversal of this policy in the late 1990s.

4.3.2 Health planning, financing, procurement and management

• Planning and budgeting

Districts have been producing costed annual plans since 1993, though the format has changed slightly and the usefulness of detailed plans in the context of regular resource shortfalls is questionable. Guidelines for planning are updated each year as necessary, separating technical guidelines and administrative or management guidelines, and an example of the format for the annual summary district budget (from 2001) is given in Annex C.

The 2000 JIFM concluded that a review of the district planning process would be beneficial in order to ensure needs-based planning rather than the existing resource-based approach (Vol 1, p23).

At the central level, both MOH and CBOH prepare an annual workplan. In theory, this is based on the medium term strategic plan (NHSP) and should therefore reflect the available resource envelope for the financial year, as calculated from budgetary estimates and pledges from cooperating partners. However, one criticism raised in the report of the JHAM was that for 2001, neither the MOH nor the CBOH plan reflected available resources, and the CBOH action plan was described as *“a wish list where staff and management try to put forward ideas that might interest CPs”* (HERA 2001, p145).

• Health financing

A health financing policy has been in preparation for several years, with initial work undertaken in the mid-1990s. According to the Joint Implementation and Formulation Report (JIFR)¹⁷, this was still not approved at the time of the mission. The thrust of the policy recognises that public funds (both domestic and external) will continue to be the main source of financing for the sector, and that these should be channelled only to priority activities included within the Basic Package at any level. However, it also makes clear individuals' responsibility to contribute to the costs of health care while recognising that ability to pay must be taken into account.

Allocation of non-salary, non-drug public resources has been largely formula-driven since 1994, particularly to district level. Recognising the ad hoc basis on which earlier allocations had been made through Provincial Health Offices, a population based formula was introduced both for GRZ and for donor funds channelled through the basket. This also took into account factors such as variation in costs (proxied by fuel prices), and relative deprivation (proxied by absence of banking and retail fuel outlet services).

In February 2003, a basket fund for hospital services became operational, with funds allocated in a similar manner from a pot at CBOH. It has not been possible to obtain the formula basis.

• Procurement

The issue of procurement and distribution of drugs and supplies has been a major stumbling block over the past few years, with a management contract awarded to a private company for the running of Medical Stores Limited resulting in withdrawal of funding and support by several bilateral partners in the late 1990s. The area continues to be a source of disagreement.

¹⁷ MOH/CBOH (2000?). *Joint Implementation and Formulation Report*.

As a means of circumventing ongoing concerns regarding the management contract, the JHAM proposed the establishment of parallel storage and distribution system for drugs and medical supplies, to be based on an upgrading of the system used by the Church Health Association of Zambia (CHAZ). Government funding could still be channelled to purchase supplies or storage/distribution services through MSL but any funding through the proposed Drug Supply Fund, to be capitalised by cooperating partners, would go to the parallel system. Although inefficient in terms of duplicating functions within the sector, this strategy is viewed as necessary in order to ensure that past bottlenecks be overcome. The JHAM proposed that the situation be reviewed at the expiry of the MSL management contract (October 2003).

- **Management**

Considerable investment has been made in management systems since the start of the reform process in Zambia. Indeed, a common criticism of the reforms over the years has been the emphasis given to such systems development at the (possible) expense of service delivery and outputs.

Zambia has a functioning Health Management Information System (HMIS) at the district level, covering facility, service and some drug utilisation, nutritional status, morbidity and mortality. Extension of HMIS to the hospital level has been long recommended, but progress has been slow. The district HMIS was felt by the JHAM team to be starting to provide data on inter-provincial variations in a number of indicators.

The Financial and Administrative Management System (FAMS) which has evolved over the past years is generally felt to be functioning satisfactorily at district level, but again there have been significant delays in incorporating the secondary and tertiary hospitals, and indeed the central level structures. Quarterly district expenditures are compared with budgets, and this, together with a performance report which outlines progress against planned activities, has formed the basis for future releases from the basket fund.

The consistent failure of the central MOH and CBOH to provide transparent information on budgets and expenditures was one factor in the breakdown of the partnership and trust which characterised early years of the SWAp. According to the JHAM, this is still an area of concern: *"..MOH does not provide information and returns which are standard GRZ requirements as administered by the [MOFNP]."* (p94).

4.3.3 The Zambian Sector-Wide Approach

Zambia, along with Ghana, was one of the first countries to develop a sectoral investment programme, and subsequently a SWAp, with the pooling of cooperating partner funds for district health services ("the district basket"), introduced in 1993, seen as an innovative move towards shared government/donor systems in the sector. By 1998 there were 6 partners contributing to the basket (in theory at least, ie at the budget stage), and a system of joint reviews had been introduced, and agreement that partners would adhere to the priorities outlined in successive versions of the National Health Strategic Plan.

However, from around 1997 there was a period of stagnation in the SWAp progress due to a breakdown in trust and communication between partners, due in part to personalities, and in part to issues around governance and transparency, specifically relating to the awarding of the management contract for Medical Stores Limited (see 4.3.2 above), and continued failure of the MOH to produce expenditure reports.

As a means of rekindling the partnership, a Memorandum of Understanding (MOU) was developed and signed in 1999, outlining clear roles for both government and partners, committing them to support for the new NHSP, and specifying shared responsibility for

achieving sectoral goals. Following this, MOH/CBOH and partners commissioned a Joint Health Identification and Formulation Mission which took place in early 2000 to provide the basis for development of a new Strategic Plan, providing a detailed situation analysis and proposals for strategic priorities over the coming five year period.

The NHPS for 2001 – 2005, though not making much explicit mention of the partnership structures and processes required for further development and strengthening of the SWAp¹⁸, does refer to the intention to broaden the current basket system to encompass sector contributions as a whole.

The JHAM of early 2001 was intended to review the NHSP 2001 – 2005 Plan and to make recommendations regarding taking it forward. The JHAM found that although the MOU had been signed in 1999, “[e]vents or rather lack of events since the MOU was signed ... have cast doubt on MOH’s commitment to the SWAp process and/or its ability to manage it” (HERA 2001, p141). However, a change in leadership following the 2001 election has improved the outlook for the sector.

One of the main proposed structures for the SWAp is the Health Sector Support Steering Committee (HSSSC). This is described in the MOU, and would include representation from all signatories to the MOU. According to the JHAM proposals, the HSSSC would meet quarterly, and have a secretariat in the MOH Directorate of Planning and Policy, with ad hoc technical committees as required. HSSSC would eventually take over the functions of the District Basket Steering Committee (DBSC) which has existed for the past decade to approve releases, and which includes officials both of government and contributing CPs. The DBSC Following the creation of the hospital basket and proposals for other such baskets, JHAM proposed an expansion of the DBSC to a “Basket Funding Committee” until sector programme support evolves to permit a single ‘basket’.

A Mid-Term Review of the NHSP 2001 – 2005 is currently being planned, with discussion of terms of reference taking place at the end of June 2003.

4.3.4 GFATM target diseases

The GFATM diseases are all recognised as major contributors to Zambia’s disease burden and are explicitly included both within the Basic Health Care Package (BHCP), and highlighted as public health priorities in the NHSP 2001 – 2005. Zambia has long had a vertical programme for Malaria, together with separate or combined programmes responsible for HIV/AIDS, TB and STIs, and although the reform programme was intended to strengthen the integration of such programmes, this has never been achieved to the extent originally envisaged at the central level.

- **Malaria**

The National Malaria Control Programme, as in most countries in the region, has adopted the Roll Back Malaria approach as its framework for activity to reduce morbidity and mortality from the disease, with a situation analysis undertaken in 2000, and subsequently a medium term Strategic Plan having been developed for the period 2001 - 2005¹⁹, and adopted by partners in March 2001.

The following key interventions for malaria are identified in the Strategic Plan²⁰:

¹⁸ **Note: this comment is based on the summary only – haven’t seen a full version which may have more info**

¹⁹ MOH/CBOH? Strategic Plan for Rolling Back Malaria in Zambia 2001 – 2005 (henceforward referred to as the Malaria Strategic Plan).

²⁰ Taken from an annex of a WHO document as the full Strategic Plan is not available.

- Case management, moving from chloroquine to the combination therapy artemether-lumefantrine (Co-artem[®]) during 2003, with Sulphadoxine-Pyrimethamine (SP) to be used in the interim;
- Taking the use of Insecticide Treated Mosquito Nets (ITNs) to scale, targeting all pregnant women, 40% of the population living below the poverty line, and 20,000 refugees, and aiming for 3 ITNs per household. A mix of strategies for increasing coverage will build on donor-funded pilots, and include community-based distribution with subsidies for the poorest, social marketing, retail access through the private and commercial sectors, and use of revolving fund schemes;
- Adoption of Intermittent Presumptive Treatment (IPT) in pregnancy, using SP, and incorporated into existing antenatal services;
- Targeted Indoor Residual House Spraying (IRS), to be contracted out to private firms but monitored by districts;
- Environmental Management (EM)²¹;
- Epidemic preparedness, to cover forecasting, early warning system, and appropriate response in epidemic prone areas.

The Annex document gives a total budget for the Strategic Plan²² of **US\$10,867,309**, broken down as shown in Table 6 below, presumably over the five year period of the plan. This does not include US\$8m associated with the introduction of Co-artem[®]. All nets are assumed to be imported, with a 10% distribution and 10% promotion cost.

Table 6 Malaria Strategic Plan budget (US\$)

Product	Budget (US\$)
Case management including laboratory diagnosis	2,158,930
Drug cost with SP + quinine for 2002	2,600,000
ITNs (nets + insecticides + distribution + promotion)	3,960,000
Targeted vector control	522,744
Malaria epidemic prevention and control	414,340
Monitoring and evaluation	338,295
Partnerships	873,000
Total	10,867,309
<i>Drug cost with Co-artem[®] (from 2003)</i>	<i>8,000,000</i>

Source: Annex 1 of ?Malaria Strategic Plan document

The PRSP recognises the importance of malaria in the country's disease burden, particularly among the poor, indicating that the condition will be added to the list of diseases exempt from payment at public health facilities alongside HIV/AIDS, TB and other chronic conditions. This is also referred to in the Malaria Strategic Plan.

• HIV/AIDS

Zambia has long recognised the inter-relationship between HIV/AIDS and tuberculosis, with the linking of the two programmes within the MOH in the 1990s. Currently, strategies and activities related to HIV/AIDS are the remit of two separate bodies, the National HIV/AIDS/STI/TB Programme within the CBOH, and the National HIV/AIDS/STI/TB Council (NAC) which was established in 2000 following an Act of Parliament²³. The respective roles and responsibilities of these two bodies are not altogether clear, and a recent external needs

²¹ No additional information given in the document available.

²² At least, it is assumed that this budget reflects the Strategic Plan.

²³ GRZ (2002). *The National HIV/AIDS/STI/TB Council Act 2002*. Number 10 of 2002 93. Supplement to the Republic of Zambia Government Gazette dated 31st December 2002.

assessment of the NAC was undertaken by Deloitte and Touche in order to clarify these and to propose structures and processes for the Council²⁴.

In 2002, the NAC produced the *National HIV/AIDS/STI/TB Intervention Strategic Plan 2002 – 2005* as the basis for action against these priority health conditions (referred to henceforth as the NAC Strategic Plan). Described as “an attempt to provide an aggressive national war plan to guide an effective national response and fight against this merciless silent and serial killer..”²⁵, the plan has a stated mission to provide national leadership for a coordinated fight against HIV/AIDS, and a twin goal both of reducing HIV/STI transmission among the Zambian population and of reducing the socio-economic impact of HIV/AIDS. The content of the plan is based on a problem analysis, various strategic framework documents, and a draft National HIV/AIDS/STI/TB policy document.

A number of guiding principles are spelled out in the plan: that the national response should be people-centred and culturally sensitive; would prioritise high risk groups and the associated geographical area; and would promote an integrated and multi-sectoral approach. The plan addresses all stages of the disease, through preventing infection, strengthening care and cure, improving management strategies etc. The objectives of the NAC Strategic Plan are reproduced in Box 2, with the document providing suggestions for broad interventions. The translation of these interventions into specific activities is left to the relevant stakeholders.

Box 2 Objectives of the NAC Strategic plan

1. to promote implementation of multi-sectoral behaviour change campaigns and health seeking behaviours;
2. to minimise mother to child transmission of HIV;
3. to make transfusion and use of sharp instruments safe;
4. to improve the quality of life of persons living with HIV/AIDS by encouraging positive living, good nutrition, prevention of opportunistic infections and avoiding high risk behaviour;
5. to provide appropriate care, support and treatment to HIV/AIDS infected persons;
6. to provide improved care and support services for the orphans, vulnerable children and others affects and at risk such as refugees, prisoners, disabled people;
7. to improve HIV/AIDS information management and decision making;
8. to assure impartial, transparent and effective programme operations by improving coordination of multi-sectoral implementation of interventions.

Source: NAC (2002), pp x – xiv

Objective 5 of the strategic plan includes explicit reference to the introduction and expansion of antiretroviral therapy for AIDS patients, in both public and private facilities. Strategies include: the use of standardised combinations of ARVs for eligible persons; development of clinical guidelines; and ensuring uninterrupted and continuous supply of affordable ARV drugs.

Perhaps strangely, given the participatory nature of development of the NAC Strategic Plan (which involved NAC, CBOH and government ministry representatives, NGO stakeholders and cooperating partners) and the inevitable overlap in timing, no explicit mention is made of the Global Fund as a potential funding source. Given the focus in the last objective of improving coordination of HIV/AIDS/STI/TB intervention, this is rather worrying.

The Strategic Plan assigns a cost to each intervention, resulting in a total cost of **US\$558,702,000** over the four year period. Although it is not entirely clear, the assumption is

²⁴ Deloitte and Touche (2003). *The National HIV/AIDS/STD/TB Council: Needs Assessment Study (Final Report)*. Lusaka: February 2003

²⁵ NAC (2002), Foreword p. iv

that these are budget estimates rather than committed and known funds, as GRZ, the private sector, and cooperating partners are all identified as potential funders of the Strategic Plan (NAC 2002, p50). It would have been useful to see the extent of already known and agreed allocations of funds against the various interventions in order to assess the size of the funding gap, and for later comparison with GFATM plans.

- **Tuberculosis**

As mentioned above, the long-standing linkages, and subsequent merging of the HIV/AIDS and TB programmes into one has facilitated integration of interventions to a large extent, with a shared strategic plan covering TB-related interventions (NAC 2002). These include the expansion of access to drugs both for TB prophylaxis for HIV positive Zambians, and for diagnosis and treatment of TB.

Historically, tuberculosis has been supported bilaterally by the Netherlands, with support for both TB and leprosy drugs and technical assistance in particular provided from 1988 to 1997. Following an external review in 1997, a strategic plan was developed, providing recommendations for strengthening TB control in the context of a reforming health system. However, this was effectively not implemented, resulting in a deterioration of reporting systems, service delivery, and the need for procurement of several emergency consignments of drugs, and a standstill in procurement of laboratory supplies. This collapse is reported a well-publicised case study of the potentially damaging impact of reform processes on service delivery²⁶.

A further review of TB care and control was commissioned by the CBOH in 2000²⁷. Among the weaknesses identified were the following:

- central level representation for TB control was “too low and too thin” in relation to the magnitude of the problem nationally;
- Lack of oversight for TB activities at the district level, resulting in loss of focus, and failure to carry out key activities such as reporting and recording, patient follow up and monitoring of treatment outcomes;
- A reduction in technical capacity for TB control at both district and central levels; and
- Lack of technical supervision of TB control activities at either district or peripheral level.

The recent appointment of a specific officer within the CBOH Directorate of Public Health and Research was highlighted as a positive factor, and opportunities were identified through inclusion of TB within the Basic Health Care Package, and as one of the six “thrusts” in the Strategic Plan then under development. Also, cooperating partners had expressed willingness to invest in TB activities as part of the district health care systems and services.

The Strategic Plan for TB care and control²⁸ that was developed following the review clearly situated TB-related activities within the context of a reformed, and decentralised health system, with districts responsible for area-specific situation analysis, problem identification and planning for appropriate activities at community, health centre and hospital level in line with national level guidelines. The CBOH and provincial role is clearly identified in terms of support functions such as monitoring, procurement, and supervision, together with quality control through the Chest Disease Laboratory.

Stated objectives of the Strategic Plan include: detection of at least 70% of estimated annual smear-positive TB cases; ensuring that at least 80% of smear-positive cases enrolled on

²⁶ Bosman (2000). Health sector reform and tuberculosis control: the case of Zambia. *The International Journal of Tuberculosis and Lung Disease*, 4 (7): 606-614

²⁷ CBOH (2000a). *National TB Review*. 2nd – 18th August 2000.

²⁸ CBOH (2000b). *National Tuberculosis Care and Control: Strategic Plan 2001 – 2003*. Central Board of Health. Lusaka: August 2000

short-course chemotherapy complete their treatment; sputum microscopy for 90% of smear-positive patients at the end of treatment; reduction in the defaulter rate by 10%; and ensuring the availability and accessibility of quality efficacious drugs and laboratory supplies. While the plan is costed, no indication is given as to the extent to which it is actually funded.

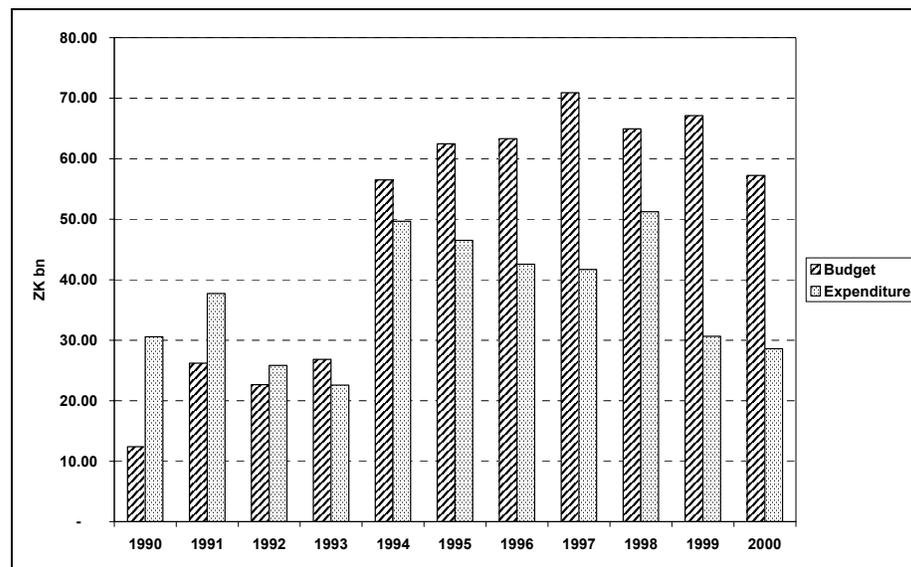
The most recent NHSP goes slightly further in specifying that Directly Observed Treatment - Short-course (DOTS) therapy should be implemented in all districts during the plan period, using innovative methods such as formation of partnerships with community based organisations, although neither the TB strategic plan nor the NHSP summary indicate baseline coverage²⁹. NHSP also implies that procurement of drugs and supplies should be done through CBOH systems, taking note of long lead times, and to ensure a 3 month buffer stock at district level and 6 month stock at central level.

4.4 Sectoral expenditure overview

4.4.1 Overall health spending

The health sector suffers, as does the rest of the Zambian public sector, from an incomplete picture of spending, due largely to the limited reporting of actual expenditures and their deviation from budgeted figures by development partners (World Bank 2001, p60). Figures given in the 2001 PER therefore refer only to government spending <<check>>. Budgeted and actual expenditure for the Ministry of Health for the period 1990 to 2000 is shown in Figure 1 below.

Figure 1 MOH expenditure, budgeted and actual, 1990 – 2000 (in 1994 billion Kwacha)



Source: World Bank (2001), data in Annex 1³⁰

Figure 1 clearly shows the large increase in allocation to the health sector since the start of the reform period, with a substantial leap between 1993 and 1994. This upward trend was largely maintained until 1997 since when there has been stagnation and reduction reflecting

²⁹ NB It appears from the JHAM report that much more detail is given in the full version of the NHSP than the summary, but I have access only to the latter.

³⁰ NB The expenditure data show a different pattern to that given in Figure 7.1 of the PER itself, and I am trying to find out the source/calculation used in the main body of the text. All data has been taken from Annex Tables A1.4 and A1.5 in the PER.

the poor economic situation. The graph also shows the clear shortfall in actual expenditures against budget estimates, attributed at least in part by Dinh et al (2002) to the cash budget system in operation in the country.

The National Health Accounts (NHA) exercise which was undertaken in the late 1990s provides a more comprehensive picture of health expenditure in the country but is now significantly out of date, although work is currently underway to update the information (personal communication, Chief Health Planner). The NHA³¹ found that total health expenditure amounted to around US\$20 per capita per year between 1995 and 1998, the exception being 1997 when it reached almost US\$25 pc. As a percentage of GDP, total health expenditure over the same period was calculated to have risen from 5.2% in 1995 to 6.4% in 1998.

On average, over the NHA period, GRZ contributed 34% of total health expenditure in the country, while donors accounted for 21%. The balance was made up by household out of pocket spending (32%), the mining sector, which ran its own health service for employees, their dependents and in some cases private patients (9%), and others (4%).

The economic and financial appraisal undertaken as part of the Joint Health (pre-)Appraisal Mission (JHAM) indicated that HIPC funding had significantly increased the government budget for the health sector for 2001, by an estimated K94bn to ZK501bn (roughly US\$135m using the exchange rate of US\$1: ZK3,700 prevailing at the time of JHAM). This was equivalent to an increase in the size of the sector as a share of GDP from 1.9% to 3% (HERA, p 59). The JHAM report points out that there were no guarantees that this benefit to the health sector from HIPC funding would be maintained. This concern would seem to have been justified (although no precise figures are available) given public sector salary increases in 2002 which resulted in spending overruns, and failure to achieve targets in poverty-related spending in the same year (EIU 2003, p 25).

Unfortunately, no more recent figures for either budget or expenditure within the health sector were available at the time of preparing this report, and the picture regarding total spending is therefore relatively unclear.

4.4.2 External funding in the health sector

External funding to the health sector has been, and remains, a significant contribution to the resource envelope. However, as with other financing indicators, the availability of accurate and up-to-date information is limited, with the comments below largely taken from the NHA report for 1995-98, and the 2001 JHAM report.

As in other countries, there is a substantial discrepancy between the total amount of external financing to the sector, channelled through NGOs, districts, MOH/CBOH etc, and that which is officially recorded in the budget.

The NHA report indicates that external funding to the health sector rose from 12% in 1995 to 25% by 1998. In real terms, this represented a 126% increase over the period, from ZK14.0bn in 1995 to ZK31.7bn in 1998 (MOH/CBOH 2003, p16). Funds were channelled to MOH headquarters, CBOH, and districts among others.

The JHAM report gives tentative figures for the cooperating partners funding the mission, as given below in Table 7, together with proposing how such funds should be used (eg as contributions to the general Health Service Fund intended to replace the district basket, for

³¹ MOH/CBOH (2003). *Zambia National Health Accounts 1995 – 1998*. Report. Lusaka: 2003

capitalising the Drug Supply Fund etc). The report also refers to funding from the Japanese government but this is determined on an annual basis, and was neither known, nor could it be channelled through the proposed Health Service Fund or other SWAp arrangements. However, it could be used to purchase drugs, supplies and other items which would represent in-kind contributions to the NHSP. Again unfortunately, no more recent data was available to update or to confirm these figures.

Table 7 Possible contributions by selected CPs, 2001-05

Partner	US\$m	Notes
DFID	30.0	
DANIDA	14.8	4 yrs from 2002, amount based on Danish Krona estimate
EU	14.8	4 yrs from 2002, estimate as amount undecided
Annual estimate		
in US\$	13.4	
in ZK	49,580	@ US\$1: ZK 3,700

Source: HERA (2001), pp45-47

Table 7 indicates that a potential US\$13.4m was available from three major CPs to supplement GRZ funding for the health sector over the course of the NHSP, representing a 10% increase on the figure of US\$135m given for the government budget for 2001. Given the substantial contributions by other CPs, through project, programme and commodity support, the total potential resource envelope for the MOH/CBOH may be considered at least 10% higher again, but more details would be required to be able to more accurately quantify this.

4.4.3 Project versus programme support

Programme support in the Zambian health sector is channelled through the various “baskets”, the most long-standing of which is the district basket. In 1998 funding for district health services was contributed by six cooperating partners, each of whom deposited funds in separate holding accounts with the Central Board of Health. These funds then fed a combined District Basket account, enabling some smoothing between partners throughout the financial year due to differing disbursement patterns.

The district basket to date has included only funding largely for non-personnel, non-drugs recurrent expenditure, ie excluding government salary payments and funding for centrally procured items, although some personnel are paid by districts from basket funding, and emergency drug purchases are permitted. Despite these, it has represented a relatively small proportion of total (government) funding going to district health services, a fact which has continued to challenge analysis of the distribution of the total resource envelope by level of care.

The intention, articulated in the MOU, and referenced both in the NHSP 2001 – 2005, and in the report of the JIFM, is to move towards broader sectoral support: “A ‘Basket Fund’ will be established for all monetary support to the Ministry of Health” (MOH para 1.5). As an interim move, the JHAM recommended a broader Health Service Fund which would have three separate components, initially ring-fenced for separate purposes:

- health service delivery recurrent funding, largely for the basic health care package as included in district and hospital annual plans;
- human resources, to cover both pre-service training, funding has often suffered in times of shortfall, and in-service clinical and management training; and
- capital spending, which although included in the basket, has been quite limited.

In addition, a revolving Drug and Supply Fund was proposed, for initial capitalisation by government and CPs, and subsequent replenishment from the Health Service Fund (service delivery component).

The Health Service Fund, together with a separate proposed pooled technical assistance fund, would therefore represent a move towards sectoral programme or budget support in place of existing project funding which has been the norm outside the district basket.

4.4.4 External financing for HIV/AIDS, Malaria and Tuberculosis

Unfortunately, it has not been possible to source much information on external financing for the GFATM diseases beyond that provided in the proposals themselves. The NAC Strategic Plan does not indicate actual, known funding for HIV/AIDS and TB, while we have not yet been able to source comprehensive documents on malaria interventions and their funding in Zambia. The figures below are therefore undoubtedly an underestimate of total available external funding for the key diseases.

The 2000 CBOH review of TB care and control states that there has been no external support for national TB control activities since the ending of the formal Netherlands support in 1997, although it does simultaneously mention emergency supplies of TB drugs received in 1998, 1999 and 2000 due to acute stockouts. No figures are put on these emergency procurements however. The document also refers to limited district specific support, although again without quantification, or clarification as to whether this is included within district basket support or as parallel funding.

In addition, a November 2001 RBM visit to Zambia to discuss implementation of the Malaria Strategic Plan included a roundtable of potential partners, at which the following pledges were apparently made:

- K12bn (US\$4m) from GRZ, including K500m (US\$ 150,000) from HIPC funds, together with the waiving of tariffs and taxes;
- DANIDA, DFID and The Netherlands pledged resources for district level implementation from the common basket. In addition, DFID pledged US\$2m to be used at the discretion of the Government;
- US\$ 20-25m from USAID over a five year period for implementation;
- JICA reconfirmed resources for pipeline goods which are already being procured (no figure given); and
- UNICEF pledged increased financial support in their next funding cycle, together with their procurement services, although they were unable to provide dollar figures³².

To the extent that funding of disease-specific activities at the district level takes place through the district basket, it is virtually impossible to separate out external funding for HIV/AIDS, TB and malaria. External funding of activities at the central level for technical programmes should be easier to solicit but depends on the nature of programme documents. Unfortunately, those available do not provide this information. The Annex document refers to four different means of financing the Malaria Strategic Plan³³: basket funds to districts; direct funds to communities through such channels as the Zambia Social Investment Fund (supported by the World Bank); partner funds to district/sub-district projects; eg through WHO, the USAID-funded Zambia Integrated Health Project, UNICEF, CARE, and JICA; and finally support to the secretarial for partnership including the functioning Inter-Agency Coordinating Committee. No indication is given as to either the relative contributions of each source, or the allocation by activity/geographical area,

³² From Annex III of ???, RBM mission to Zambia, 5-9 November 2001.

³³ As in Section 4.3.4 (footnote 20), it is being assumed that this information relates to the overall Malaria Strategic Plan in the absence of the actual plan itself.

5 GFATM and specific issues for the tracking study

5.1 Macroeconomic issues arising

Government expenditure as a proportion of GDP is relatively high in Zambia, averaging almost 26% during the period 1995-2000. Foreign grants averaged over 8% of GDP during the same period, and total external funding (including loans) accounts for over 42% of planned government expenditure in 2003 (MOFNP 2003). However, no documented evidence of concern regarding these figures was found in the documents reviewed, with more attention being given to the need to get back on track with the IMF and to improve day to day budgetary management through the introduction of a Medium Term Expenditure Framework reflecting strategic priorities as articulated through the PRSP, and of the IFMIS to assist with improved financial management and reporting.

Approved GFATM funding represents a substantial additional inflow to the country, totalling US\$180m over five years, particularly when seen in addition to other sources of funding for Health and HIV/AIDS, eg HIPC funding (which was calculated as raising the Health budget to 3% of GDP in 2001) and the World Bank-funded HIV/AIDS project (ZANARA).

The debate about tradables and the potential impact on the exchange rate does not appear to have been widely raised in Zambia. A substantial proportion of approved funding appears to be allocated towards drugs and supplies, approaching 50% for malaria and HIV/AIDS in the first year, as shown in Table 8 below. Unfortunately it is not possible to determine the proportion over the lifespan of the approved support. The majority of these being imported, this should be exchange rate-neutral. However, given the high value of the total grant, there may be some impact through non-tradables.

Table 8 Proportion of grant to be allocated to drugs and supplies, 2002

Component	Commodities	Total	Commodity %
HIV/AIDS	9,450	19,858	47.6%
Malaria	4,000	8,400	47.6%
Tuberculosis	4,100	12,800	32.0%
Total	17,550	41,058	42.7%

Source: GFATM proposal, 22 March 2002

5.2 Sectoral issues arising

5.2.1 General

The health and HIV/AIDS budget proposed for 2002-04 shown in Table 4 sums to US\$294,750,000, which crudely broken down between financial years amounts to US\$98.25m each year. The total GFATM proposal amounts to US\$180.8m over five years, or roughly US\$36m per year. This represents a potential increase in the health and HIV/AIDS budgets of over a third each year, with significant implications for the inter-sectoral allocation of resources nationally³⁴.

The Zambian BHCP was costed at US\$8.55 (up to district level) in early 2002. However, it should be noted that the interventions included in this costing are significantly out of date,

³⁴ Note: in the absence of any government budget details for the sector or additional information on the subject, the PRSP allocations in Table 4 are assumed equal to the budget allocations for the period. This remains to be checked.

excluding for example the decision to move to Co-artem® as the first line of treatment for malaria, and the addition of VCT and PMTCT as interventions against HIV/AIDS. The BHCP also excludes community-based care for persons living with HIV/AIDS. It is also unclear to what extent the any treatments for opportunistic infections among HIV-infected patients included in the GFATM proposal overlap with those in the BHCP. The BHCP costs are therefore likely to be substantially underestimated given stated priority interventions as included in the proposal, yet have not to date been funded even at the lower level.

The MOU specifies that “[a] minimum of 60 per cent of the total resources (as indicated in the resources envelope) coming from the Co-operating Partners... shall be directed towards district health services.” (MOH 2000). It is not clear to what extent this will be the case with GFATM funding (if indeed GFATM can be seen as a CP), as the proposal is not sufficiently detailed to enable a breakdown of central/hospital/district level activities and spending. However, to the extent that a substantial component of the proposal is for drugs and supplies for the target diseases, it could be argued that these will be deployed at district level and below as they constitute inputs to the Basic Health Care Package at that level, and that the proposal is potentially consistent with this agreed requirement for sectoral funding. More analysis to confirm this would be useful.

It would be useful to know the extent to which districts will be given the authority over planning and budgeting for interventions included in the GFATM proposal, and also to which items will be distributed according to needs identified by districts, ie ‘pulled’ rather than ‘pushed’ by central level technical programmes, through the project-type mode which appears to have been the case in several pilot activities on which the GFATM proposal interventions are based (eg various donor-funded ITN projects, PMTCT, the ProTEST pilot under the National TB Programme etc).

The Churches Health Association of Zambia (CHAZ) is identified as a Principal Recipient for all three components, with responsibility for funding and overseeing implementation of interventions in mission facilities around the country. This begs the question of how public and mission facilities relate within the context of a district health system, as the district health plan was originally intended to be comprehensive of activities supported through public funding, including external funding to the sector such as GFATM.

The Central Board of Health is the primary Principal Recipient for GFATM funding, with a total of US\$50m approved over the first two years of funding (representing 74% of approved funding to date), of which almost US\$8m has already been disbursed. This represents a substantial increase in funding available to the CBOH³⁵, yet the capacity to handle such levels of funding is not yet fully proven and is likely to represent a challenge to CBOH. The economic and financial appraisal undertaken as part of the JHAM pointed to a down-sizing in terms of importance of the Finance function within CBOH as part of the restructuring which took place in 2000.

The proposal indicates that general government rules for financial management will apply, through the Accountant-General’s Office and the Auditor General. However, the health sector has been criticised in the past for failure to adhere to basic principles of financial management (with the exception of district funding) and a lack of transparency in disclosing receipts and uses of funds (see Section 4.3.2). The proposal also refers to development of new formats. This is likely to represent an additional burden on an already stretched government body, and is contrary to the stated intention to harmonize procedures both as part of the broader GRZ HIP effort and through the health SWAp specifically.

³⁵ The 2001 budget for CBOH indicated on the CBOH Action Plan was US\$75m, although this has not been verified in the absence of any official budget data.

The area of procurement, particularly for pharmaceutical products, has long been a problem in the Zambian health sector, and was responsible for much of the stagnation in progress with the SWAp in the mid-1990s. The 2001 PER similarly points to problems in this area: *“Issues of financial management, transparency, and expenditure wastage are serious in many areas such as the procurement of drugs and pharmaceuticals..”* (World Bank 2001, p60). Procurement and distribution systems are among the key areas for which development of a SWAp is expected to bring about more transparent, harmonised, and thus efficient systems, and indeed the same is true on a government-wide scale. GFATM regulations stipulate some conditions regarding procurement, eg of TB drugs through the Green Light Committee of the STOP-TB program.

The proposals indicate that procurement will take place through the CBOH Procurement Unit, but at the time of the JHAM, the role and competency of this relatively new, and potentially under-staffed Unit, was not clear, particularly in relation to MOH activities in the same area, and to broader GRZ procurement systems.

It is quite difficult to separate out those elements of the GFATM proposal which might be considered cross-cutting or contributing to general systems development given the lack of detail within the proposal. Areas mentioned explicitly include Information, Education and Communication, and gender mainstreaming. However, within the three disease components, there are a number of elements which could potentially benefit the broader health system. Examples include:

- a strengthened HMIS (mentioned in relation to STIs, ARVs, and tuberculosis-related indicators);
- enhanced laboratory services (TB and HIV/AIDS),
- basic pre-service training of health workers (TB);
- improving referral systems (TB); and
- strengthening of the national drugs logistics and management systems (TB).

5.2.2 HIV/AIDS

The HIV/AIDS-related interventions outlined in the GFATM proposal are predominantly the remit of the health sector, representing introduction or scaling up of interventions, some of which are already included within the Basic Health Care Package. Unfortunately, due to the incomplete nature of information currently available on existing coverage of and funding for HIV/AIDS-related activities, it is not possible to quantify the potential additional benefits which might be realised by GFATM funding, although it is likely to be significant.

The HIV/AIDS component identifies four Principal Recipients (PR), shown in Table 9 below, along with their respective approved budgets for the first two years. Although the proposal does not go into detail on the particular roles and responsibilities of the different PRs, they are assumed to be handling funds on behalf of their relatively distinct constituent implementing agencies (ie public health facilities, other line ministries and government bodies, mission facilities, and NGOs and community-based organisations respectively). No indication is given of how activities undertaken by these different agencies might come together in comprehensive health or HIV/AIDS plans at the geographical level (ie district, in the case of the health sector).

Table 9 Approved HIV/AIDS funding by Principal Recipient, Oct 2003

Principal Recipient	Agreement signed	2 year funding (US\$)	Disbursed @ 03 Oct 03 (US\$)
Central Board of Health	30-Mar-03	21,214,217	1,692,382
Ministry of Finance and National Planning			
Churches Health Association of Zambia	30-Mar-03	6,614,958	381,585
Zambia National AIDS Network	22-May-03	8,073,013	425,175

Source: GFATM global status report, 3 Oct 03

The proposal includes activities to introduce antiretroviral treatment through the public sector, to supplement treatment already available in the private sector. This has not to date been included within the BHCP, and can be expected to significantly raise the cost of delivering the package (although possibly not at district level as the intervention is planned for central hospitals in the first instance). There are a number of concerns regarding the infrastructural and human resource developments which are necessary in order to deliver ARV treatment, the high cost of treatment relative to other interventions, and the sustainability of such treatment given an overall resource shortfall and the temporary nature of GFATM support which remain to be addressed in the Zambian context.

5.2.3 Malaria

The Malaria Strategic Plan had a total cost of US\$10m (see Section 4.3.4) while the malaria component of the GFATM proposal sums to US\$39m, both over a five year period. This represents an enormous increase in the level of funding to the disease, sufficient to fund the existing planned activities five times over, and representing almost US\$4 per capita (based on the population of 10.2 million referred to in the GFATM proposal (p8).

The source of such a large budget is primarily due to the inclusion of supplies of Co-artem[®] which was referred to in the Malaria Strategic Plan but not included within the US\$10m budget (though it did appear as a cost (see Table 6)). No information is given about the volume of drugs that this will fund over the full proposal period, although 1.375m doses are mentioned in the one year plan.

As with ARVs, the question of sustainability arises once GFATM funding ends, given that these drugs are substantially more expensive than chloroquine which was included in the costing of the BHCP which has failed to attract full funding to date.

Table 10 Approved malaria funding by Principal Recipient, Oct 2003

Principal Recipient	Agreement signed	2 year funding (US\$)	Disbursed @ 03 Oct 03 (US\$)
Central Board of Health	15-Aug-03	17,039,200	4,653,400
Churches Health Association of Zambia	02-Sep-03	852,600	-

Source: GFATM global status report, 3 Oct 03

Table 10 above shows the breakdown between the two Principal Recipients in malaria funding, with the majority funding being channelled through CBOH. It is not clear from the documentation (original proposal of March 2002 and the supplementary document of June 2002) what activities will be funded directly through CHAZ, although reference is made to sales of ITNs at antenatal clinics in CHAZ facilities.

5.2.4 Tuberculosis

The tuberculosis component is clearly linked with existing policy, with the funding requested to enable scaling up of DOTS from 22 to all 72 districts in the country. In addition, the expansion of the ProTEST programme which integrates TB and HIV prevention through VCT activities (presumably into a nationwide service although this is not specified) is envisaged. Table 11 shows the allocation between the two Principal Recipients, the CBOH and CHAZ. Again, as with malaria, it is not immediately clear from the documentation what activities will be funded through CHAZ directly.

Table 11 Approved tuberculosis funding by Principal Recipient, Oct 2003

Principal Recipient	Agreement signed	2 year funding (US\$)	Disbursed @ 03 Oct 03 (US\$)
Central Board of Health	30-Mar-03	12,447,294	1,472,250
Churches Health Association of Zambia	30-Mar-03	2,307,962	62,187

Source: GFATM global status report, 3 Oct 03

The tuberculosis component of the proposal is the only one which explicitly mentions District Health Management Teams, with reference to strengthening of supportive technical TB supervision to and from districts.

The TB component also identifies a number of areas of systems strengthening which would directly benefit TB interventions yet would have a wider impact on the public health system and thus the delivery of the BHCP more generally (see 5.2.1).

References:

- Bosman (2000). Health sector reform and tuberculosis control: the case of Zambia. *The International Journal of Tuberculosis and Lung Disease*, 4 (7): 606-614)
- CBOH (2000a). *National TB Review. 2nd – 18th August 2000*. (Draft?). Central Board of Health. Lusaka: August 2000
- CBOH (2000b). *National tuberculosis care and control: strategic plan 2001 – 2003*. Central Board of Health. Lusaka: August 2000
- CBOH (2001). *Central Board of Health Action Plan 2001*. Lusaka: January 2001
- Deloitte and Touche (2003). *The National HIV/AIDS/STD/TB Council: Needs Assessment Study (Final Report)*. Lusaka: February 2003
- DFID (2002). *The macroeconomic effects of aid*. Policy paper. London: December 2002
- Dinh HT, Aduagna A and Myers B (2002). *The impact of cash budgets on poverty reduction in Zambia: a case study of the conflict between well-intentioned macroeconomic policy and service delivery to the poor*. World Bank, Africa Region, Poverty Reduction and Economic Management Division 1. Washington: October 2002
- EIU (2003a). *Country report: Zambia*. Economist Intelligence unit. London: February 2003
- EIU (2003b). *Country paper: Zambia*. Economist Intelligence Unit. London: June 2003
- GRZ (2002). *The National HIV/AIDS/STI/TB Council Act 2002*. Number 10 of 2002 93. Supplement to the Republic of Zambia Government Gazette dated 31st December 2002.
- HERA (2001). *Joint Health (pre) Appraisal Report*. Final version. Health Research for Action. May 2001
- IMF (2002). *IMF completes review under Zambia's PRGF arrangement and approves US\$44 million*. International Monetary Fund. News Brief No 02/117, November 27, 2002. www.imf.org/
- IMF (2003). *Joint statement by the Government of Zambia and IMF Staff Mission*. International Monetary Fund. Press Release No 03/132. July 31, 2003. (www.imf.org/external/no/sec/pr/2003/pr03132.htm)
- MOFNP (2002a). *Zambia Poverty Reduction Strategy Paper 2002 – 2004*. Lusaka: March 2002
- MOFNP (2002b). *Budget address by the Hon. Emmanuel G Kasonde, MP, Minister of Finance and National Planning delivered to the National Assembly on Friday 1st March 2002*. Lusaka: March 2002
- MOFNP (2003). *Budget address by the Hon. Emmanuel G Kasonde, MP, Minister of Finance and National Planning delivered to the National Assembly on Friday 31st January 2003*. Lusaka: Jan 2003
- MOH (1999). *Memorandum of Understanding [between MOH and Cooperating Partners]*. Lusaka: November 1999

- MOH (2000). *National Health Strategic Plan 2001 – 2005*. Lusaka: December 2000
- MOH/CBOH (2000). Joint Implementation and Formulation Report.
- MOH/CBOH (2002). *Costing first level basic health care package in Zambia*. Lusaka: January 2002
- MOH/CBOH (2003). *Zambia National Health Accounts 1995 – 1998*. Report. Lusaka: 2003
- NAC (2002). *National HIV/AIDS/STI/TB intervention strategic plan 2002 – 2005*. National HIV/AIDS/STI/TB Council. Lusaka: 2002
- Nyaywa S (2003). Questionnaire submitted to IHSD as background to paper presented at post-iHEA session. May 2003.
- World Bank (2001). *Zambia Public Expenditure Review. Public expenditure, growth and poverty: a synthesis*. Report no 22543-ZA. Macroeconomics 1, Southern Africa, Africa Region. Washington: December 2001
- World Bank (2002). *Zambia: Country Assistance Evaluation*. Operations Evaluation Department. World Bank. Washington: 7 November 2002
- Zambia CCM (2002a). *Zambia's proposal to GFATM*. Lusaka: 7 March 2002
- Zambia CCM (2002b). *HIV/AIDS, tuberculosis and malaria action plans in support of the country coordinated proposal*. Lusaka: 22 June 2002

6 Annexes

Annex A Terms of reference for the macroeconomic desk study

General objectives:

- To summarise the macroeconomic and sectoral context (policy and performance) for each of the four countries
- To flag issues of concern relating to macroeconomics and financing for subsequent tracking during the country studies (both general and, where appropriate, country-specific), and to propose means of addressing these

Specific objectives:

- a) To present general macroeconomic issues, as follows:
- To describe country Medium Term Expenditure Frameworks (MTEF), annual budget structures and the pattern of inter-sectoral allocations, in relation to stated country priorities.
 - To synthesise available literature on the impact of aid on macroeconomic variables and performance, and to consider the level and planned use of GFATM inflows at the country level in relation to this information
 - To review available information on country aid inflows in relation to the breakdown between general and sector budget support and project support, their inclusion within MTEF ceilings; and the level, time-scales and modalities of donor commitments to ongoing funding
- b) To present health sector issues, as follows:
- To describe sectoral MTEF and annual budget allocations (to health and other HIV/AIDS activities), and to report recent budgetary performance, comparing planned and actual spending (from MTEF, Public Expenditure Reviews, sectoral budgets, National Health Accounts, etc)
 - To summarise current country health policy priorities (particularly relating to HIV/AIDS, TB and malaria) – as reflected in written policy and strategy statements, and budgetary allocations, comparing these with plans and proposed use of GFATM funds
 - To summarise current financial management (planning, budgeting, procurement, disbursement, accounting and reporting processes) in each country, in relation to SWAp development and the adoption of common (government) procedures
 - To use this information as a baseline for future tracking of the extent to which GFATM processes are integrated with or set up in parallel to existing procedures
 - To summarise trends in health sector financing by type: domestic/external, by level of care, across diseases/programmes (where available)
 - Where information exists, to review country and sector performance in relation to evidence of absorption capacity (percentage of money released that was spent)
 - To analyse existing GFATM proposals in terms of type of support (eg commodity versus systems strengthening; disease specific versus general), and allocations by level of care (e.g. tertiary versus primary or community level interventions)
- c) To propose areas for future tracking, e.g.
- Balance of commodity support versus systems strengthening support

- Extent to which GFATM funding is in fact additional or has substituted for other sources of funding (at the country level, and/or by individual development partners)
- Shifts in the modalities of donor support (between budget, sector, project and GFATM support)
- Degree of integration and/or duplication of new with existing financial management and reporting systems
- GFATM funding as % of total sectoral funding (and implications for financial sustainability)
 - Generally, and for specific high value commodities such as ARVs
- Extent to which GFATM funding alters the intra-sectoral allocation of resources by:
 - level of care
 - geographical area (urban/rural, or more detailed)
 - disease/programme
 - type of input
 - general systems strengthening versus disease-specific activities

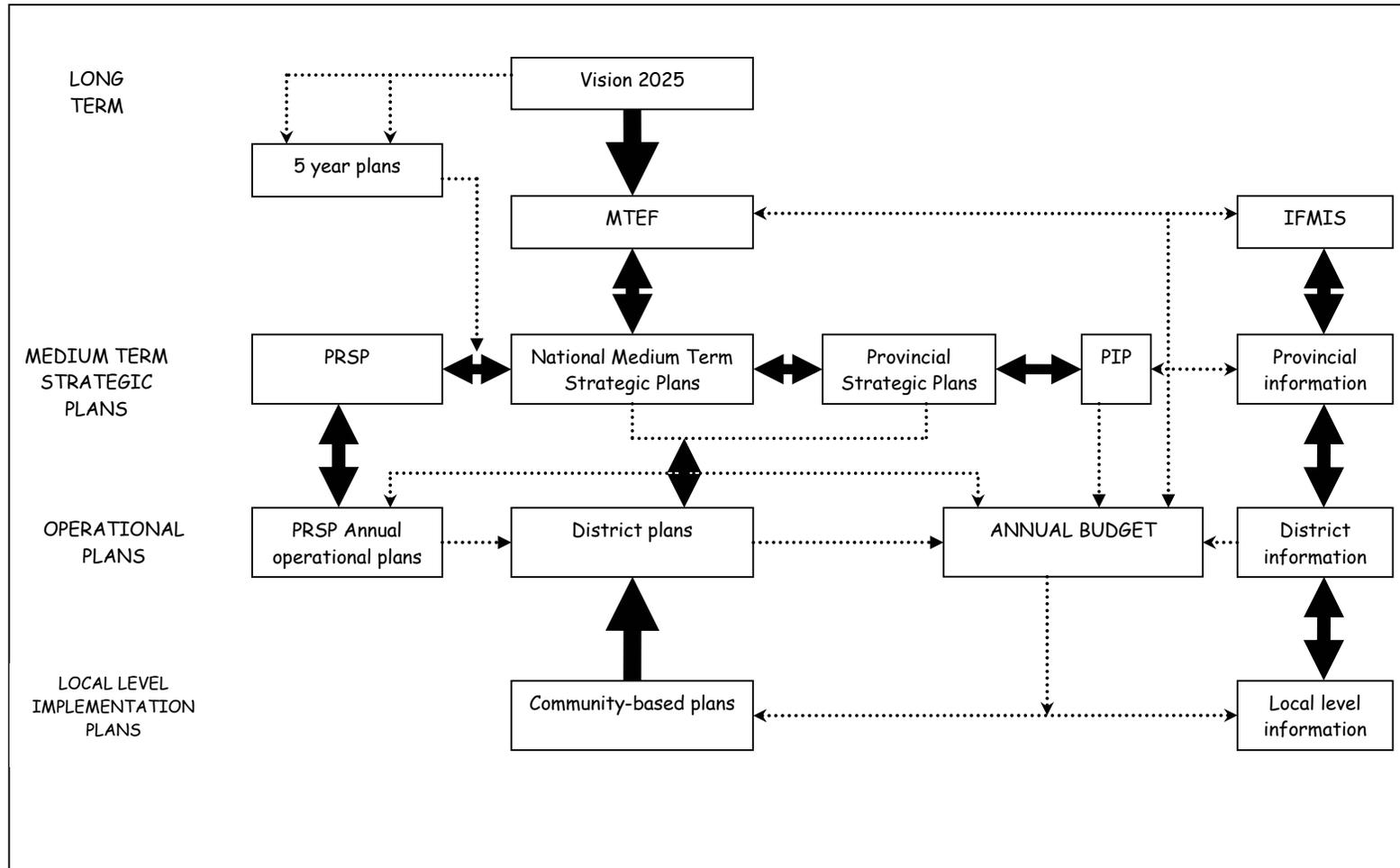
Methodology:

- Participation in meetings of tracking study team:
 - planning of phase 1 field work, January 2003
 - review of findings and planning of next phase of field work, mid 2003
- Desk review of general and available country-specific literature (to be provided, or access to it to be facilitated, by the funders). It should include:
 - General documentation on macroeconomic implications of aid – general and, if possible, sector specific
 - MTEF documentation, with external audit reports, where available
 - Indicative (e.g. 1 and 3 year) health sector basket funding commitments by partners – pooling donors and government
 - Overall general and health sector/HIV-AIDS budgets
 - Breakdown, where available, of non-pooled (e.g. project) support from major donors to health / HIV/AIDS activities
 - Existing and indicative future levels of commitment by donors to general budget support
 - GFATM applications (successful ones for each country, or most recent applications if approval still pending)
 - Key development agency policy documents (general, HIV/AIDS, health, country)
 - National Health Accounts reports
 - Public Expenditure Review reports
 - Sectoral policy documents
 - Current country HIV/AIDS, malaria and TB policies and strategies, where these priorities have been included in GFATM applications
 - Country Financial Accountability Assessments (where available)
 - Available audit reports

Outputs:

Four country-specific reports, including recommendations for issues to be raised and data to be collected in the tracking study field work.

Annex B PRSP planning linkages and information systems



Source: MOFNP (2002), Figure 16.1, p131

*GFATM Tracking Study: Macroeconomics and sectoral background
Zambia*

Annex C District budget spreadsheet

CONSOLIDATED DISTRICT BUDGET SHEET (IN K 1,000)																																													
DISTRICT:		DISTRICT DIRECTOR OF HEALTH: _____								ACCOUNTANT :				PERIOD : JANUARY TO DECEMBER 2001																															
INCOME																		TOTALS																											
GRANTS	910	CBoH																227577																											
OTHER FUNDS	920	MEDICAL FEES																31621																											
REVENUE	930	INTERNALLY GENERATED REVENUE (Fax,Phone charges, Photc account																115692																											
INCOME IN KIND	940																																												
TOTAL INCOME																		374890																											
COST ITEMS																																													
EXPENDITURE		PERSONNEL COSTS																DRUGS AND SUPPLIES				TRANSPORT			OTHER COSTS				CAPITAL				TOTAL PER LEVEL	% PER LEVEL											
		Pers. Emol.	Allowanc es	Special Allow.	Drugs & vaccines	Medical supplies	Non-med supplies	Fuel	Spares/ maint.	other trsp costs	Maint equip furniture	Maint bldg grnds	General charges	Hlth Serv. Contracting	Medical Equipment	Non-med equip/furn	Transport	Building																											
LEVEL	COST CENTRES	310	320	330	410	420	430	510	520	530	610	620	630	640	810	820	830	840																											
DISTRICT	Board expenses	51	1654				250	278		700			1620									4502																							
	Administration	52	5870				3836	888	6000	160			12050			3200						32004																							
	Planning	53	3925				5850	2975		800	2273		731			5000						19681																							
	TOTAL		11449				9936	4141	6000	1660	2273		14401			8200						56187																							
DISTRICT EXP. % OF TOTAL																																											15%		
1ST LEVEL HOSPITAL	Administration	61																																											
	Tech. Support	62	6750					6000														12750																							
	Clinical care	63											96722									96722																							
	In-service traing	64																																											
	Training school	65																																											
	TOTAL		6750					6000					96722									109472																							
HOSP. EXP. % OF TOTAL																																												30%	
HEALTH CENTRE	In - house	71	26488	530	45	293		31667	13172	7157	100	1000	2430	3062			4493	1396	2545			94378																							
	Out - reach	72		41056	730	360	870	12523	14913		842			788							800	72882																							
	In-service traing	73			3764			10475	570		390			1976								17175																							
	TOTAL		26488	41586	4539	653	870	54665	28655	7157	1332	1000	2430	5826			4493	1396	3345			184435																							
HEALTH CENTRE % OF TOTAL																																													49%
	Comm. Initiated	81		755		478	280	10882		5843	99		360	410					420	1223		20750																							
	TOTAL			755		478	280	10882		5843	99		360	410				420	1223		20750																								
HC AND COMMUNITY % OF TOTAL																																													6%
TOTAL EXPENDITURE		26488	53970	11289	1131	1150	75483	38796	14000	3091	3173	5063	20637	96722		12693	1816	4568																											
COST ITEM % OF TOTAL			14.3%		0.3%			10.3%								5%						370844																							