ihp+results

IHP+ 2016 MONITORING ROUND

ZAMBIA REPORT

COUNTRY	ZAMBIA
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1 Process of the 2016 IHP+ Monitoring Round

The IHP+ monitoring exercise has been a very painstaking exercise. There was a lot of enthusiasm at the beginning as the different persons and institutions were invited to participate and they all consented. The Ministry of Health put a team of 4 persons to help with the exercise. I met with 3 of them to get the pre-exercise briefing and they then got into their different schedules and it was very difficult to get them to facilitate anything else.

The DPs, CSOs and Private Sector were invited to participate. The lists of those invited and those who actually participated are available.

The response was rather poor from all the participants. There was a definite lack of enthusiasm. Some DPs found this as a rather repetitive process from the COMPACT preparation exercise they were involved in not in very distant past but did not yield any tangible results. The CSOs and Private Sector consider themselves as not being significantly involved in the Health Sector and thus found little value in responding to the demands being placed on them.

The Ministry of Health was a very willing host of the whole process and facilitated with the invitations to the other respondents to participate in the process. The meeting was the PS was held at the MoH Boardroom. However, there were few challenges in getting the Ministry of Health to effectively lead the process as there seemed to be many more competing demands on the few staff at the Directorate of Planning during the last quarter of the financial year. There was also no central depository where documents relating to the quantitative data could be accessed. There were thus delays in obtaining information from the main stakeholder in this process.

2 Commitment to establish strong health sector strategies which are jointly assessed and strengthen mutual accountability

2.1 EDC Practice 1: Partners support a single national health strategy

The Partners are keen to support a single national health strategy. However, the mechanisms for achieving this need strengthening. The entire cycle from planning, through implementation, to monitoring and evaluation has gaps which need serious attention. Some DPs propose the development of a new Compact aligned with the new national health strategy. The basic principles of inclusivity and stakeholder involvement are already agreed but the processes of implementation for effectiveness remain weak.

- There is a National Health Strategic Plan 2011-2016 whose Planning process was inclusive to some extent. The process is underway for NHSP 2017-2021. The invitation list is said to have been robust though only a limited number stakeholders actually participated. The implementation has been monitored through meetings that are supposed to have been held between the MoH and the stakeholders using different fora such as the Sector Advisory Group meetings, JAR, the Technical Working Group meetings, subcommittee meetings, Troika , Policy Meetings, the Annual Coordination Meetings, etc. The NHSP was formally jointly assessed through a Mid-Term Review done during this period but did not involve the Private Sector. The Permanent Secretary -Health and Members of Parliament participated. There has been no JANS as yet; it was planned for 2016 but got disturbed by the period of Presidential Elections.
- There is a Memorandum of Understanding between the govt and the DPs in the Health sector which contains the basics of the partnership agreement. This is considered adequate by govt for mutual accountability but some DPs feel there is still need for a Compact., There is, therefore, need for dialogue for consensus building.
- At subsector level, there have just been assessments of the projects being supported by DPs with the participation of the MoH. While most of DPs consider these necessary, the govt thinks they are unnecessary in the presence of more robust nationally agreed systems for monitoring these projects.
- The main constraints for joint assessments are said to be the project approach adopted by most of the DPs which provide funds ring-fenced for specific activities and the lack of govt
- leadership. There is need for harmonisation. Zambia uses the sector-wide approach in managing the health sector and therein are many opportunities for alignment of DPs' plans to the NHSP

2.2 EDC Practice 5: Mutual accountability is strengthened

To promote mutual accountability there have been increased consultations on IT based harmonized systems to formulate one system that would be compatible with many other systems already in use eg SMARTCARE/DIHS2/etc. Other mutual accountability processes in place include Joint Annual Reviews, Joint Program visits, Steering Committee meetings, Sector Advisory Group meetings, policy meetings, health troika meetings, and other cooperating partner meetings where DPs participate. Although only 67% of DPs participated in those mutual accountability processes but they think it can be strengthened. In terms of M & E, there is NO detailed M&E framework for the national health sector plan/strategy, apart from the HMIS platform that is being used. 43% of the DPs that provided information declared that the monitoring and results framework of their support was agency project or program specific while 62,5% of them said it is based on an agreed results framework and harmonized M&E

system but different from the national No DP based it solely on the national results framework with indicators and targets identical with the national system's; Some DPs preferred easily disaggregated data. There is need to merge the ICT systems; to promote Data Quality Analysis to validate the systems etc

3 Commitment to improve the financing, predictability and financial management of the health sector

3.1 Practice 2a/b: Health Development Cooperation is more predictable

The planning follows a 3 year rolling plan with an MTEF.

Overall, close to 90% of GOV health sector funding was disbursed against the approved annual budget. Under-disbursements are common and usually arise from inadequate allocation at the treasury. There are no reported areas of over-expenditure but areas of underfunding are many eg funding for drugs, medical supplies, equipment and infrastructure. Constraints include inadequate funding from govt treasury and diminished donor confidence. Opportunities mentioned by the government include the establishment of the social health insurance and an increased support from DPs.

The health development cooperation is less predictable. Only 67% of the DPs reported sharing with the govt the 3 year activity and funding plans. The rest of the DPs have Bi-annual plans while one DP (CDC) gave only a yearly plan and DFID did not report. However, there were discordances with the data provided by the Government, who just mentioned Sweden as having communicated their planned resources for the next 3 years to the MoH. The DPs who reported disbursing funds for govt projects mostly utilised their own implementing partners. UNICEF was committed to supporting the govt systems but disbursed only 18% of funds according to the agreed schedules. The under-disbursement was caused by multiple factors including inefficient or inadequate reporting by the govt depts or implementing agencies thus delaying the disbursements beyond the budget period. Other circumstances of under-disbursements cited included unavailability of funds or enhanced project efficiency thus making significant savings. It could be avoided by efficient communication between the DPs and the govt or implementing agencies to meet the milestones for disbursements and by an efficient M&E that would invoke reactive funding processes in response to the reported achievements.

While all the DPs were glad to share their information with the govt only a few were willing to put their funds through a govt common basket system. The information flow could be improved by more effective engagement between the govt and the DPs in the planning and implementation processes. Regular, joint reviews would be a mechanism that would enhance this, with common reporting processes eg at the SAGs. A comprehensive report was done by the DPs putting together a forward looking budget/commitment from most of the cooperating partners for the years 2016 to 2020. This report is with the Ministry of Finance.

3.2 Practice 2c: Health Aid is on budget

The contributions from individual DPs are reflected only to a limited extent. Most DPs use the project mode of financing and thus keep expenditure off the govt budget. Only 3 DPs reported that their funds are recorded on the national budget. However, there were discordances about the percentage of estimated health sector development co-operation funding scheduled for disbursement to the government that was recorded in the annual budget as grants, revenue or loans, being 22% according to the Government and 68% according to the information provided by DPs. The rest of DPs provide support through implementing partners. These funds were for

specific projects, thus making it easy for them to track and account for the resources. Even then, only 1 DP provided a value of the amount of money thus recorded. This constituted 23% of the reported amount of funds disbursed through the govt systems. However, almost all DPs reported that their funds are known to the govt because they shared their activity plans and budgeted funds with the govt either through the Ministry of Finance or Ministry of Health.

Only 4 of the 9 DPs who responded to the question reported that their resources from their organisations were part of an overall agreed financing framework for the national or subsector strategy. Most of these were targeted at subsector financing eg RMCH, This would be improved if the govt took leadership in the processes of project formulation and/or implementation to ensure value for money and alignment with national priorities. The main constraint mentioned was the lack of capacity of the govt to perform at all levels thus making the DPs have no confidence in the existing systems. The govt needs to build capacity for system strengthening to gain the needed confidence of the DPs. The DPs are willing to render support for capacity building for a robust PFM system that would pass the international tests but the Govt must identity its gaps.

4 Commitment to establish, use and strengthen country systems

4.1 Practice 3: PMF systems are used and strengthened

The PFM system has been formulated and approved by the Ministry of Health but has not been implemented as yet. Financial resources have been the major obstacle in implementation. There is a reform programme in place but perceived to be too slow by the DPs. According to the Government most of the DPs are utilising the project model of funding and thus of accounting systems. There is the need to have a common basket fund from where to draw the budget. The opportunities lie in the possibility of the DPs agreeing on a common platform for funds disbursements.

Most of the DPs reported they do not use the PFM; only UNICEF and WHO said they did. In total only 21% of health sector development cooperation disbursed to the government used national budget executing procedures, and 14% used national reporting and auditing procedures. They noted that the PFM is rather protected thus not easily accessible. The PFM failed a quality assessment thus it has not been recommended for use by the DPs.

Currently there are no efforts towards harmonisation of the processes and DPs use their country or DP specific financial reporting mechanism. The DPs are willing to support capacity building eg through provision of TA for the strengthening of the PFM but there has been no request from govt about that and thus, none has been given. SIDA has a relatively robust HMIS system that is set up at the Ministry of Health and could be adapted to the IFMIS.

4.2 Practice 4: Procurement systems are used and strengthened

There is a government plan for national procurement and supply that allows for global and regional procurement. According to the Government, DPs are using the national procurement and supply system. The presence of well-trained procurement officers in the public sector, the existence of a strong Regulatory Framework and the existence of the supply chain strategy are some of the opportunities to increase the volume of DP funds using the national procurement and supply systems. Zambia has done remarkably well at procurement reforms but there is room for improvement; the introduction of e-procurement system is an opportunity.

Just 38% of DPs reported to use the national procurement system which is said to be frustratingly slow. There is no joint/harmonised procurement system among DPs. Only CDC is

effectively engaged in the Zambian National Procurement Plan though specifically for drug supply procurement.

All the DPs are ready to give support for TA to assist in the process of developing a more robust PSM. e.g. SIDA hired a Procurement Officer to increase capacity for conducting the annual procurement audits, formulate the annual procurement plan etc. There is the need for continued dialogue between Govt and DPs to reach consensus on evidence based practices which could then be adapted for optimal and sufficient utilisation. More inclusive mechanisms must be devised for this to be agreed by all the stakeholders

4.3 Practice 6: Technical support is coordinated and SSC and TrC supports learning

The country has yet to develop a national TA plan for the health sector. Just GAVI, SIDA and WHO reported that they were in the process of supporting the govt effort to develop it. National institutions are involved in the coordination of TA, being consulted or requesting for the TAs and providing the TORs; however the DPs can do the selection on their own. All the DPs provide TA in response to identified gaps in national capacity, agreed between parties. Most of the DPs reported that the TAs were bound by mutually agreed terms between govt and DPs while 40% of them reported that TAs were bound by the agency's regulations. They mentioned the need for better coordination and communication between DPs.
The GOV receives reports on TA delivered to a large extent but their allegiance seems to be more to the funder. There are mechanisms in place to monitor the performance of TA.

Only 63% of the DPs support regional technical cooperation. Some of them explained that there were other organs within their systems which were responsible for this and not necessarily the DPs in the health sector. GAVI gave an example of the type of support given as being through supporting regional meetings where sharing of learnt experiences is done.

There is room for improvement and suggestions given included an urge for better coordination of efforts between the DPs, a call on the national govts to take ownership of the processes and deliberate creation of frameworks that could be utilised for supporting the south-south and triangular collaboration.

5 Commitment to create an enabling environment for CSO and PS to participate in health sector development cooperation

5.1 Practice 7: Engagement of CSO

The DPs are all convinced that there are institutionalised mechanisms established to involve CSO in program development and oversight. Both the Gov and the DPs consider that CSOs participate in most sector governance processes including strategy formulation, implementation and monitoring. They are part of the health sector coordination mechanism and are invited to sign agreements and commit to the SWAP as well as to the Policy, SAG, Annual Review meetings and technical working goups. CoPlanning involves CSOs. These exist at both national and subnational levels. However, only faith-based CSOs were prominently mentioned by the DPs as being included in these processes. Other International NGOs were also said to be included. CSOs have a representative in the DPs group in the sector, as such their views are assumed to be heard and considered in all sector activities.

The DPs reported rendering support to the CSOs to perform their function. While 67% of the DPs reported granting financial resources to the CSOs, only 44% reported giving technical assistance and 37,5% gave support in terms of training. Other DPs including CHAI and the EU reported no direct support to CSOs. Opportunities exist to improve the support provided by DPs. The CSOs are said to be the voice of the communities thus are an important stakeholder eg to communicate with the Donor community or for effective advocacy eg TALC. Enhanced communication is important especially through regular meetings, joint activities eg health sector reviews and community liaison. 71,5% of the DPs reported that they reported their CSO support to the Govt. The DPs do a mapping exercise to review which CSO they are supporting and the type/amount of support.

5.2 Practice 8: Engagement of PS

There is very little PS involvement in govt affairs. There are challenges especially in communication. The private sector are supposed to be part of the health sector coordination mechanism and are invited to sector advisory group meetings, JAR meetings etc. The problem is that there does not seem to be cohesive leadership among them and so it is difficult to get them around the table for most of the meetings. There have been no formalised routes for feedback to PS and the govt has been very slow in facilitating any form of PPP in health. There is need to enhance the channels of communication.

Most of the DPs did not include private sector organisations in their consultations. The few that reported PS involvement (CDC, the EU and JICA) referred to some of the subcontracted functions as engagement. The PS is said to be not well defined and thus has been difficult to involve. The MoH needs to develop and implement a private sector strategy for better engagement to appreciate their functionality and thus formulate ways of cooperating. The private sector must also showcase their capacity eg value addition. The science produced must be translated into policy and/or practice, etc. The DPs pleaded for improved relationships and interaction between PS, DPs and govt. There is also need for increased dialogue between the parties. There is need for better coordination of activities carried out by the private sector players to strengthen this function. PPP must be promoted.

6 Other observations

None

7 Discussion of findings

The results were presented and discussed at a meeting held with the Ministry of Health Senior Management Team on the 17th February 2017. The Director of Planning introduced the presentation, stating that the MoH was committed to the principles of IHP+ and they saw this exercise as an important step towards achieving it as they embark on the National Health Strategic Plan 2017-2021.

The discussion of findings meeting took place finally on the 20th April 2017 but due to some problems with the time scheduled, it lasted only one hour and the CSOs invited could not even participate. Therefore, the Directorate of planning has requested to meet again to go through the questions before organising another meeting and developing the country plan of action.

No new discussion of findings had taken place by 31st of May 2017.

8 Annex 1: list of DPs that were invited and those that participated

Nr	List of DPs active in the health sector	DPs invited to participate in 5th IHP+ Monitoring Round (please add an X if the DP was invited to participate)	DPs that participated (please add an X if the DP participated)
1	CDC	CDC	X
2	Clinton Health Access Initiative	Clinton Health Access Initiative	
3	DFID	DFID	X
4	EU	EU	X
5	Global Fund	Global Fund	
6	Gates Foundation	Gates Foundation	
7	GAVI	GAVI	X
8	JICA	JICA	X
9	PEPFAR	PEPFAR	
10	Save the Children -	Save the Children -	
11	Swedish Aid-SIDA	Swedish Aid-SIDA	X
12	UNAIDS	UNAIDS	X
13	UNDP –	UNDP –	
14	UNFP -	UNFP -	
15	UNFPA	UNFPA	
16	UNICEF	UNICEF	X
17	USAID	USAID	
18	World Bank	World Bank	
19	World Food Program	World Food Program	

9 Annex 2: list of participating CSOs

Nr	List of CSOs active in the health sector	CSO participated in online survey	CSO participated in focus group discussion
1	ActionAid Zambia		
2	Africa Health Care Foundation		
3	AfyaMzuri		
4	Care International.		
5	Caritas		
6	Catholic Relief services (CRS)		
7	CCZ		
8	CHAMP -		
9	Cheshire Homes Society of Zambia		
10	Childfund		
11	CHRE		
12	CHRESO		
13	Churches Health Association of Zambia		
14	CSO-SUN	X	
15	CSPR		
16	CITAM+		
17	CMMB- – Catholic Medical Mission Board	X	
18	Dan Church Aid		
19	DAPP	X	
20	Expanded Churches Response (ECR).		
21	Family Health International		
22	Family Health Trust		
23	FAWEZA		
24	Health Communication Partnership.		
25	Jesuit Centre for Theological reflection (JCTR)		

Nr	List of CSOs active in the health sector	CSO participated in online survey	CSO participated in focus group discussion
26	Network of Zambian People Living with HIV and AIDS.		
27	Oxfam		
28	PANOS		
29	Plan International		
30	Palliative Care Association of Zambia (PCAZ)	X	
31	PPAZ		
32	REPSSI		
33	Safaids		
34	Save the Children		
35	Society for Family Health.		
36	Southern African AIDS Trust.	X	
37	Transparency International Zambia (TIZ)	X	
38	Treatment Advocacy and Literacy Campaign (TALC)		
39	WLSA Zambia		
40	World Vision		
41	World Vision Zambia		
42	YMCA (Men)		
43	Youth Alive Zambia	X	
44	Youth Vision Zambia		
45	YWCA (Women)	X	
46	ZANERELA		
47	Zambia Civic Education Association		
48	Zambia Medical Association		
49	Zambia Redcross Society,	X	
50	Zambia Interfaith NGO (ZINGO)	X	
51	Council of Churches in Zambia (CCZ)		

10 Annex 3: list of participating private sector organisations

Nr	**List of private sector active in the health sector** (as per the definition in the PS tool)	**Private sector organisation participated in focus group discussion** (please add an X if participated)
1	PRUDENTIAL LIFE INSURANCE	X
2	MADISON HEALTH SOLUTION INSURANCE	X
3	METROPOLITIAN ZAMBIA INSURANCE	X
4	ZAMBIA PHARMACEUTICAL BUSINESS FORUM	X
5	GENERAL FACULTY PRACTITIONER - PRESIDENT	X
6	PRIVATE HOSPITAL ASSOCIATION - PRESIDENT	X
7	ZAMBIA UNION OF NURSES ORGANISATION	X
8	ZAMBIA MEDICAL ASSOCIATION	X
9	DEFENSE FORCE MEDICAL SERVICES	X
10	PHARMACEUTICIAL SOCIETY OF ZAMBIA	
11	KCM HOSPITAL	
12	MOPANE COPPER MINE HOSPITAL	
13	LUSAKA EYE HOSPITAL - DIRECTOR	
14	BIET CURE HOSPITAL - DIRECTOR	
15	CLINICAL OFFICER ASSOCIATION	
16	BIO-MEDICAL ASSOCIATION OF ZAMBIA	