Zambia: the role of aid management in sustaining visionary reform

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As part of its ongoing reform of the health sector, Zambia has developed a number of systems and structures to coordinate and manage external resources. With increasing attention being given to the potential for sector-wide approaches (SWAs) to enhance the efficiency and effectiveness of health systems in low-income countries, Zambia provides an interesting case study of how this is emerging in practice over time. The paper outlines the different coordination mechanisms and assesses them in terms of selected criteria of effectiveness, finding that the potential to meet reform objectives is currently not being met. Factors influencing the effectiveness of these mechanisms are identified as falling into categories around personalities and human interaction, the nature of reform processes, and the impact of broader context. The need to maintain dialogue in the face of external constraints and uncertainties is stressed.

Introduction

Zambia is viewed as having embarked upon possibly the most radical and far-reaching reform of the health sector in the sub-Saharan African region, both in terms of the scope of change and the speed of implementation (Mogedal et al., 1995; Oxford Policy Management, 1997). These reforms receive substantial financial and technical support from a variety of donors. Management of such support has received growing international attention over the past years, in recognition of the potential for coordination to reduce inefficiency and inequity in the health sector caused by: duplication of activities, the administrative burden on overstretched ministry officials, and geographical inequalities as a result of targeted assistance, \textit{inter alia} (Buse & Walt, 1996).

Publicity of the early reform successes and the current focus on Zambia as an example of an early candidate for the introduction of a sector-wide approach\(^1\) (SWAp) has ensured continuing interest from external observers both within and outside the region. This paper aims to review existing aid management processes in Zambia, and to assess factors influencing their effectiveness, concluding with some prospects for future success. It is drawn from an externally-funded study undertaken by a national policy analyst which involved an extensive literature review and interviews with major stakeholders in the process, supplemented by experiences of a former long-term expatriate advisor with continued involvement in the sector.

Visionary reform

The package of reforms was introduced following the change of Government in 1991, when the Movement for Multiparty Democracy (MMD) came to power. Economic collapse during the 1980s, due largely to falling world copper prices, severely constrained government expenditure which fell from about 45% of GDP in 1980 to less than 25% in 1994. The health sector was duly affected, with its share of the budget falling by 31% between 1984 and 1991, and by 1992, per capita government health expenditure was less than 30% of its 1982 level (Kamanga, 1995). As a result, the Zambian health sector displayed the familiar symptoms of a deteriorating infrastructure, demoralized staff, migration of professionals to neighbouring countries, and critical shortages of essential supplies (Freund, 1986; Kalumba, 1991; Ministry of Health, 1992; Kalumba, 1997). At the same time, population growth of 3.2% per annum and the re-emergence of malaria and tuberculosis, coupled with the new threat of HIV/AIDS, placed increasing demands upon an already strained health sector.

An internal Ministry of Health (MoH) process of policy review was initiated around 1989. Though it met with political opposition, a core group of reformers continued to debate ideas for restructuring the sector to better meet the needs of the population (Foltz et al., 1997; former MoH official, personal communication). Simultaneously, policy thinking within MoH was creating a vision of a health sector that embodied the principles of leadership, accountability and partnership. This was a direct response to the perceived failings of the previous administration (Kalumba, 1991). Following the election success of MMD in November 1991 and the appointment of a new ministerial team, these two processes were merged, and the resulting document – \textit{National Health Policies and Strategies: Health Reforms} (Ministry of Health, 1992) – was approved by Cabinet in October 1992.

The reform process aims to secure a health system which will ‘ensure equity of access to cost-effective quality health care as...
close to the family as possible' through the adoption of a strategy of decentralization (Ministry of Health, 1992). Key elements of the reform to date have included: separation of policy-making and executive functions at central level; creation of autonomous Boards in districts and larger hospitals; partial devolution of funding to Boards; renewed emphasis on cost-sharing and the development of a comprehensive health financing policy; definition and costing of an essential package of district health services; and initiation of a process of ‘de-linkage’, whereby health workers would no longer be employed through the civil service but rather would apply for direct employment by District and Hospital Boards, with revised terms and conditions of service.

External support

As a low-income country with colonial links to Britain, Zambia has traditionally enjoyed external support throughout her history. In 1983 it was estimated that over 29% of total MoH expenditure came from donors (Kalumba & Freund, 1989). Capital projects in particular relied increasingly on such external financing in the face of domestic economic problems (Freund, 1986). Relations, however, were not always cordial. Following the Kaunda government’s decision to abandon the IMF/World Bank-supported Structural Adjustment Programme in 1987 due to problems in meeting the conditionalities, several bilateral agencies suspended assistance to Zambia, while others reduced their support (Saasa & Carlsson, 1996). A large, planned World Bank–supported Family Health Project was also suspended (former MoH official, personal communication).

However, the transition to a multiparty democracy at the time of the 1991 elections, the adoption of market-oriented economic policies emphasizing liberalization and privatization, and an explicit commitment to furthering the democratic process, all combined to create an enabling environment for renewed or increased external support to the country as a whole. Links with the World Bank and the International Monetary Fund were keenly embraced by the new government, in contrast to the ‘on-off’ stance of the former administration, and the potential for economic recovery was broadly felt. The health sector benefited from the overall increase in confidence after the elections, witnessing expansion in the number of key external players in the sector and revision in the nature and level of their support. Moves towards more untied, non-earmarked donations have been championed by MoH officials, with some pull from mid-level partners whose headquarters have required extensive and continued convincing on the path forward.

Key players in the aid relationship

MOFED

The Ministry of Finance and Economic Development (MOFED) is responsible for the preparation of annual budgets, which are intended to include both internal and external resources. Historically, donor funding has been captured through the capital budgets of each line Ministry, listed as discrete projects in the annual Estimates of Revenue and Expenditure, the so-called ‘Yellow Book’. Due to the different channels of funding adopted by donors within any given sector, i.e. through the line Ministry headquarters, or directly to geographical regions or projects, such support has often been only partially included.

MoH

Until 1996, the Ministry of Health was the overall body responsible for all aspects of the health sector, encompassing policy formulation, financing, and provision of health services. With the creation of the Central Board of Health (CBOH) in 1996, the functions of the Ministry have been restricted to policy development, strategic planning, annual budget negotiation with the Ministry of Finance, and donor coordination and international relations (Musumali, 1997). Plans are currently underway to reduce the size of the staff establishment within the MoH headquarters accordingly, from about 300 to 60 professionals.

The MoH is headed by a Minister, assisted by a Deputy Minister. Although the Ministry has seen four changes of senior Minister since the MMD came into power, significant continuity was ensured by the presence of Dr Katele Kalumba, initially as Deputy Minister and from May 1996 to March 1998 as Minister. This contrasts with other sectoral ministries which have seen a more rapid turnover in leadership.

The Directorate of Planning and Development, created through the upgrading of the former Planning Unit to a full Directorate, plays a key role in health policy, planning and budgeting, overall monitoring of the reform process, and donor coordination. The Director, formerly known as the Chief Health Planner, is generally involved in all bilateral and multilateral negotiations together with the Controlling Officer, the Permanent Secretary. The current Director has headed the Unit/Directorate since 1991. A specific post of donor coordinator was approved in 1994 and has provided stability and continuity within the government–partner relationship.

Major cooperating partners

As already noted, Zambia’s health sector has benefited from significant and growing external support over the past decades. In 1997 and 1998 it was estimated that donor funds made up at least 40% of total public expenditure in the sector (Musumali, 1997; Ministry of Health, 1998).

Multilateral donors

The role of the multilateral agencies, in particular UNICEF and WHO, was critical in the early stages of the reform process. The close personal links between the Country Representatives of WHO and UNICEF and key figures within the MoH, prior to and following the change of government in 1991, facilitated an easy and open relationship, resulting in their participation in internal policy review meetings where representatives of bilateral agencies were not included. Early on they played a role in coordination of external support, with MoH–donor meetings often held in their offices and sometimes co-chaired by the agency Representatives.
The World Bank, though not a continuous presence in Lusaka as were the other multilaterals, briefly enjoyed a self-imposed role of ‘midwife’ to the reform process in 1993/94. The Bank facilitated a comprehensive and coordinated approach to reform through articulation of its position as ‘lender of last resort’, which resulted in the development of the first National Strategic Health Plan in 1994. This served as an implementation plan, operationalizing the 1992 policy document, and enabled gaps in support to be identified and incorporated into the Sector Support Programme funded through a loan from 1995.

The trust between the MoH and the multilateral agencies, and the Ministry perception that they were relatively neutral and objective in their support to the reforms, led to the decision to allow the three agencies to coordinate the first external review of progress with the reform programme in 1996 (see Mahler et al., 1997).

**Bilateral donors**

Zambia plays host to most of the major bilateral agencies. Although many of these had been involved in the Zambian health sector prior to the change of government and implementation of the reforms, some new players have emerged. Arguably the most prominent of these has been DANIDA, whose radical decision in early 1993 to provide direct recurrent budget support to districts in order to reverse the deterioration in the health system speeded up the decentralization process and highlighted the need for integrated planning and accounting systems. That, together with the commitment to support the emerging Health Reform Implementation Team with office space and other logistical support, bought DANIDA a powerful negotiating position.

USAID has also significantly altered the nature and level of its support over recent years. From vertical projects largely concerned with HIV/AIDS and family planning in the early 1990s, USAID assistance has expanded to cover cost-effective child survival interventions, health management information systems, logistics and supply, and health financing, in a move to integrate support into the health reforms. Despite being traditionally viewed as highly constrained by strict agency regulations, future support for the first time will include non-project, sector programme assistance.

Although constrained in many cases by the nature of the requirements of their individual head offices, several of the major bilaterals (notably SIDA, the Netherlands, and Irish Aid) are in the process of reorienting their funding from project aid towards sector support, either on paper or in practice. Recent government proposals envisage partners providing 80% of their assistance in ‘untied’ form (Daura & Mulikelela, 1998).

**The emergence of management processes**

In common with many developing countries, in the past the Zambian health sector was characterized by fragmented, multiple donor-assisted projects. The MoH was not able to effectively manage this fragmentation, and duplication of efforts was common (Kalumba & Musowe, 1996). The need for improved coordination has been explicitly recognized since 1991 as a means of strengthening the overall reform process and thus ultimately the capacity of the health system to meet its objectives.

Processes for managing the external resources flowing into the Zambian health sector fall into two different categories. Firstly, there are instruments which have developed as part of broader policy changes such as decentralization and budgetary reform, but which have also had implications for the handling of aid flows. Secondly, a number of mechanisms have been specifically introduced to coordinate or manage aid.

**The pragmatic development of coordination mechanisms**

**Common planning, budgeting and accounting procedures**

Building on the success of an earlier pilot of decentralized block grant funding at district level (using a new budget format which separated three levels of the district system – administration, hospital care, and primary health care), the opportunity provided by the promised DANIDA funding was seized and a rapid programme of capacity building undertaken for all districts in the country to prepare them for the receipt of such donor funding in mid-1993. Costed district plans were prepared and accounts clerks trained in new bookkeeping systems.

With the subsequent devolution of government non-salary, non-drug recurrent funding to districts in January 1994 however, the administrative burden of maintaining two separate sets of accounts quickly became evident. This prompted a process of consultation between the MoH and a number of key partners as to how individual donor concerns could be met in a unified district planning, accounting and reporting system. A joint MoH/partner working group was established, and a meeting was convened in May 1994, with representatives from the headquarters of key agencies, to discuss individual requirements and processes for merging these. This was followed by an external consultancy to develop procedures and formats for a comprehensive, harmonized Financial and Administrative Management System (FAMS), initially at district level. The original proposals from the consultants, an American private sector company, were deemed too ambitious in terms of the level of detailed information required and in the context of limited staff numbers and capacity at that level. The local process of development and adaptation was re-established, with increased involvement of district and provincial staff, and the system has undergone continuous revision since then.

**Basket funding**

The term ‘basket’ funding in Zambia refers to the co-financing of district health services by a number of donors and government using a single set of procedures. It developed both as part of the process of designing the common budgeting and accounting format (FAMS) and as a means of moving away from predominantly donor-financed vertical programmes at the operational level. Once DANIDA and the government had begun sending resources directly to districts, it became clear that this was the most efficient way of funding district services. The expansion of partnership in the basket has been gradual,
reflecting concerns that FAMS should meet individual donor reporting and accountability requirements, but by 1998 most of the major agencies were contributing, as shown in Table 1.

In order to monitor the release of funds and to ensure that expenditures reflect approved plans, a government-donor Basket Steering Committee has been formed. This committee meets on a quarterly basis to review summary financial and progress reports from districts, and on the basis of these reports, approves donor funding for the next quarter, or details follow-up activities such as audit or monitoring visits accordingly.

The growing support for the basket can be attributed to two factors. Firstly, there is general recognition that this mode of support provides the way forward in terms of achieving the MoH vision, through priority-based, costed district plans supported by government, donors and the population. Secondly, but equally importantly, the Basket Steering Committee offers a forum for broader discussion among MoH, CBOH and donor representatives about reform progress at the operational level. Initially the committee was open both to current and to potential contributors to the basket, with the latter attending as observers. Although at one time there were moves to restrict membership to those making financial contributions to the basket (Kalumba & Musowe, 1996), this has not happened in practice. There have, however, been instances of established partners being explicitly excluded due to temporary suspension of their basket disbursements (donor official, personal communication).

The current and planned flows of funds through the district basket are shown in Figure 1.

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**Table 1. Budgeted district basket grant 1998**

<table>
<thead>
<tr>
<th>Agency</th>
<th>Amount (US$)</th>
<th>%</th>
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<tbody>
<tr>
<td>GRZ</td>
<td>11 885 938</td>
<td>64.4</td>
</tr>
<tr>
<td>DANIDA</td>
<td>1 875 000</td>
<td>10.2</td>
</tr>
<tr>
<td>Netherlands</td>
<td>1 718 750</td>
<td>9.3</td>
</tr>
<tr>
<td>SIDA</td>
<td>1 328 125a</td>
<td>7.2</td>
</tr>
<tr>
<td>EU</td>
<td>869 792</td>
<td>4.7</td>
</tr>
<tr>
<td>Irish Aid</td>
<td>390 625</td>
<td>2.1</td>
</tr>
<tr>
<td>UNICEF</td>
<td>390 625</td>
<td>2.1</td>
</tr>
<tr>
<td>Total</td>
<td>18 458 855</td>
<td>100.0</td>
</tr>
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</table>

Source: CBOH (1998)

* According to SIDA, this figure should be $1 875 000.

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Figure 1. Basket funding flows
In effect, the district basket may be viewed as a partial SWAp, covering only the primary level up to district hospital and management structures, and accounting for an estimated 22% of total planned donor support in 1998 (Daura & Mulikelela, 1998). This contrasts with the experience in Ghana where a smaller number of partners have embraced a ‘genuinely sector-wide programme’ (Cassels & Janovsky, 1998). Intentions remain to create similar ‘baskets’ covering other levels of the system.

Sub-sectoral policy groups

Progress with some key aspects of health service strengthening has been facilitated by the gradual emergence of joint MoH–donor groups, mobilizing around specific issues such as drugs, reproductive health and health financing. One donor official described these as ‘…highly fluid bodies, [which had] never . . . been formally constituted. They have tended to mix elements of technical policy, management and donor coordination.’

Introduction of explicit aid/donor coordination mechanisms

Appointment of desk officers

Since 1994 there has been a designated Donor Coordination Officer within the MoH Planning Unit, although the physical seat of that officer has been at CBOH rather than the Ministry. To date this has been the same person in charge of the World Bank health sector support project, although it is not clear that this has been a deliberate strategy. Responsibility for liaison with specific cooperating partners has also been delegated to other members of the Planning Unit in a bid to reduce the heavy burden of coordination on the Director of Planning and the Coordination Officer, each of whom were estimated to field about 15 calls to partners per day (Musumali, 1997).

National Strategic Health Plan

Building on the framework outlined in the policy document (Ministry of Health, 1992), Zambia has developed a rolling, medium-term implementation plan, which is the basis for annual negotiation with donors and other partners. While the concept of such a plan was initiated in 1994 in response to a concern by the World Bank that there was little justification for its proposed role as ‘lender of last resort’, this has become firmly established as a key Zambian document with substantial time and resources being absorbed in the annual revision process. In 1998, for the first time, the Strategic Plan provided the basis for detailed annual work-plans of the Ministry and Central Board.

Steps leading to the plan involved:

- the undertaking of a critical self-assessment of health needs, and identification of financial, physical and human resources as well as the stakeholders in the reform process;
- proposal of a set of standards for the new health system, on the basis of agreed principles (e.g. equity, affordability);
- development and costing of an essential health care package;
- mobilization of government, donor, and other stakeholders’ resources for the financing of the essential package.

There is some debate as to the extent to which the Strategic Plan is adequately costed and represents a right-sizing of the system, but it is generally accepted by cooperating partners that this plan should serve as the framework for their contributions to the sector. Ideally all external actors should ‘buy in’ to the Strategic Plan as the basis for a SWAp. Although this is not yet the case, the expectation is that as additional pre-requisites are met, in the medium to long term this could happen.

MoH–donor meetings

Regular consultative meetings between the MoH and partners have taken place for a number of years. Since 1994, these have been formalized into biannual events. The first meeting takes place in April each year to review activities and accomplishments during the previous year, while the second meeting, held in October, serves as a planning forum, resulting in operational plans and budgets for the coming year. At this meeting, donor commitments are reviewed as part of the overall budgeting process. These consultative meetings are attended not only by in-country representatives of the various cooperating partners, but also frequently by delegations from the regional or central headquarters of the respective agencies.

An invaluable forum for information exchange, such a sector-wide ‘get together’ has also been developed as a deliberate means of streamlining the previous system whereby individual donor review missions came at will and placed an unacceptable burden on the limited personnel and time of the MoH. Prior to each consultative meeting, a period of about a week is designated for delegation members to make field visits or to hold meetings with MoH/CBOH personnel relevant to their individual interests.

One outcome of such consultative meetings since 1994 has been the development of a ‘joint statement’ whereby the MoH and partners pledge anew their support to the key objectives and processes of reform. In 1998, this has evolved a stage further, with the development of a formal Memorandum of Understanding between MoH, CBOH and cooperating partners, one of the proposed agreements required in the move towards a SWAp (Cassels, 1997).

Informal donor–donor meetings

As in many other countries, informal gatherings of donors occur in Zambia, typically around policy issues of common concern or during times of particular crisis, e.g. following the suspension of aid. A number of issues get discussed ‘over a cup of coffee’, and consensus building among a particular subset of stakeholders is thus enhanced. In the past the Ministry has expressed opposition to such gatherings, rejecting any need to exclude policy-makers in a climate of openness and consultation. However, their continued existence demonstrates both the inevitability of donor–donor communication and the asymmetry of power within the host
country–donor relationship, and also the changed climate in which they are currently operating, in which senior MoH officials welcome the opportunity for partners to present a common position.

Effectiveness: a mixed picture
The effectiveness of efforts to coordinate external resources can be assessed in the narrow terms of the transparency and accountability with which such resources are used. More broadly, it is recognized that aid and its coordination are a means to an end, and that improving the effectiveness with which external resources are managed has the potential to contribute to overall health sector reform objectives, such as improved efficiency and equity (Buse & Walt, 1997). Table 2 assesses some of the mechanisms in terms of these criteria, together with selected others proposed by Buse and Walt (1996).

Efficiency criteria
The potential for improved health system efficiency through reduced duplication of services and harmonization of administrative procedures has already been highlighted. Common budgeting and accounting procedures have directly contributed to the latter, although their influence has been limited by the fact that participation is incomplete, and that the procedures themselves are currently in place for only one part of the health system, the district level. The focus on one level of the health system may actually lead to inefficient intra-sectoral resource allocation decisions. In addition, actual disbursements from partners through the basket have been both irregular and less than budgeted, hampering effective planning at central and operational levels (Daura & Mulikelela, 1998; personal communications, CBOH and donor officials). Although UNICEF was among the first agencies to contribute to the basket, more recently there appears to have been a desire to return to ‘attribution’, i.e. the ability to clearly flag their own support (Daura & Mulikelela, 1998).

Reduced duplication of service provision seems to be more difficult to achieve. Periodic National Immunization Days, which reflect a primarily multilateral policy agenda, provide an example of ongoing duplication of service delivery, diverting significant resources from the strengthening of routine systems. The broader strategy of moving away from vertical programmes towards support to a comprehensive district health plan has encouraged managers to consider the broad range of health problems and possible solutions to them within their own districts, and has achieved some reduction of duplication in management and supervisory structures and in logistics. Such a strategy, while increasing efficiency at the operational level, has resulted in resistance to the overall reform process as vertical programme managers have lost perceived status, influence, and financial and other perks which often accompanied such programmes.

The combination of the Strategic Plan and the biannual consultative meetings is arguably the most effective mechanism in terms of improving efficiency, by providing an overall

<table>
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<th>Table 2. Effectiveness of selected coordination mechanisms</th>
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<tr>
<td><strong>Criterion</strong></td>
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</tr>
<tr>
<td>Efficiency</td>
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<tr>
<td>Equity</td>
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<td>Transparency</td>
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<td>Integration with policy process</td>
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<td>Authority/ adherence</td>
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framework for external support and thereby having the potential to reduce duplication and fragmentation. These mechanisms also benefit from being fully integrated into the national budget cycle and policy-making processes, involving the majority of donor and NGO partners while retaining clear Ministry leadership, and adopting a sector-wide focus. Similarly, the streamlining of the donor review process into the period preceding consultative meetings is generally seen as increasing the day-to-day effectiveness of key MoH and CBOH officials who are less constrained by the demands of donors. In practice, however, the duration and inflexibility of existing donor–MoH agreements, together with wider macro-economic and governance issues, have reduced the extent to which the plan is adhered to, and individual donor missions remain a significant burden on MoH and CBOH officials.

Equity and sustainability

Basket funding has contributed to improved equity through facilitating the geographical allocation of both government and donor resources for the most cost-effective level of the health system, the district, according to a transparent, if crude, population-based formula. This has encompassed not only public health facilities but also the mission sector.\(^5\) Again, however, the limited participation in and scope of the current basket restricts its overall effectiveness in this respect.

In contrast, in the absence of explicit geographical zoning of donor support to minimize potential regional inequalities in resources, a recent decision to permit USAID to target assistance to a range of child survival and management activities in a limited number of districts is likely to enhance inequity. This also contradicts an earlier policy decision to promote nationwide development, which resulted in a refocusing of Dutch support away from selected provinces and emphasis on filling technical gaps towards strengthening national capacity and providing sectoral support, both strategies seen as having higher potential for improving overall sustainability within the sector.

Transparency and accountability

Enhanced transparency and accountability were among the objectives for the development of common procedures and basket funds, reducing districts’ potential to play off differing sources of funds. These are seen as key prerequisites for a SWAp (Cassels, 1997). FAMS has done much to increase the availability of information on those district revenues and expenditures which pass through CBOH, but during 1998 concerns were raised that the MoH had neither met nor revealed its contribution to districts. A climate of mistrust developed resulting in failure to sign the formal Memorandum of Understanding that would strengthen adherence to the principles of sector support.

The development of the Strategic Plan as a medium-term framework that serves as the basis for annual operational planning has passed through two phases. Early on, it was viewed as having been externally imposed, with its annual production absorbing scarce personnel and time for little visible benefit, particularly as the level of ambition expressed did not appear realistic in the face of resource constraints. More recently, translation of the strategic goals into annual plans supported by more rigorous financial analysis has clarified its purpose as outlining the system developments to which partners ‘buy in’.

Factors influencing effectiveness

It is clear from the above section that a number of the effectiveness criteria have a reinforcing effect. The full potential of coordination mechanisms to meet broad objectives of efficiency and equity is hampered by limited participation, adherence and ownership, among other factors. In the section below, influences on effectiveness are reviewed in more detail.

Contextual influences

The context in which the health reforms have taken place and the various mechanisms for management of aid have emerged, has been, until 1998, one of growing confidence and openness. Political support for the reforms at the highest level of the Zambian government has enabled the adoption of innovative and potentially risky strategies, and the reforms have been portrayed as a ‘flagship’ of MMD success. Several of these, such as the devolution of government funding to districts, and the increase in hospital autonomy, have paid off. Others, such as the move towards de-linkage, have created a climate of mistrust and uncertainty among health workers which has yet to be overcome. There is also concern in government that the MoH has moved too fast and without adequate attention to reform in other sectors.

External partners have similarly been supportive over much of the reform period, and there is a genuine feeling of ‘shared ownership’ of the reforms. According to MoH officials, early attempts to coordinate donors failed due to the disparate nature of the agencies, their potentially conflicting agendas, differing procedures etc. (Kalumba & Musowe, 1996). The articulation of a clear and shared vision in the 1992 policy document (Ministry of Health, 1992) resulted in explicit MoH priorities, enabling donor activities and resources to be better directed towards fulfilment of the reform objectives. Strong personalities within the MoH have enabled leadership of the reform process to be clearly associated with Zambians rather than ‘outsiders’, as is the case in many countries. The importance and perceived success of the reforms has enabled some partners to maintain support for the health sector despite political turbulence and the poor macro-economic situation affecting broader programme aid.

More recently, partners and the current Minister have raised concerns regarding the relative concentration on administrative and management procedures and monitoring, to the neglect of output and outcome information (Mahler et al., 1997; Luo 1998). Reports provided through FAMS were limited to the degree of timely achievement of planned activities, rather than providing details of service delivery, utilization, or health status. The development of a Health Management Information System designed to provide such detail is one area where territoriality among external partners created tensions and thus delayed progress.
Key players: capacities and interactions
Perhaps one of the most critical factors in strengthening the management of external resources has been the continuity provided by relative stability among key actors. This has been the case both among Zambian policy-makers and donor representatives. As pointed out by a recent external review team, '[donors] have also gone so far as to maintain continuity of staffing so that those familiar with the Reforms could continue to support the work of the Ministry' (Mahler et al., 1997). Among MoH and CBOH staff, stability has in some cases been facilitated through external funding for the supplementation of salaries for key individuals.

The nature of personal interactions has had a critical influence. Successive Ministers of Health have differed in their relationships with donors, seemingly alternating between more cooperative and conflictive positions. The decision by one partner to make negotiation of a new agreement conditional on the passing of reform legislation resulted in a very different Act to that originally envisaged, reflecting a refusal by the then Minister to be held to ransom. Under a subsequent Minister, donors and technical advisors enjoyed relatively open access on a more informal basis, while recently an uneasy relationship appears to have again developed due in part to uncertainties regarding the momentum of reform efforts. One observer attributed a several month-long suspension of bilateral support during 1998 to 'a simple clash of two strong personalities', as a donor attempted to impose actions on a Ministry keen to maintain its position in the driving seat.

Personalities within donor agencies have also influenced the aid relationship. The presence of certain, highly respected donor representatives has enabled Zambia-based agencies to maintain some autonomy and flexibility with respect to their head offices, thus allowing potentially more risky approaches to external assistance to be tested. In a few cases, such personalities have even succeeded in changing attitudes towards broad sectoral support within their headquarters, using Zambian success as the lever.

The issue of institutional capacity is of major importance in managing external resources (Saasa & Carlson, 1996). The constraints of limited staff numbers in middle management in the MoH have in many cases been overcome through the use of policy-specific working groups, local workshops, and national consensus building meetings. These have both removed pressure to directly employ more staff within the MoH and enhanced collaboration with key stakeholders, including the various cooperating partners. Delays in releasing donor funds from MoH to CBOH for onward disbursement to districts has been attributed to relatively poor financial management capacity within the MoH, which does not have the heavy technical assistance input seen at the CBOH. At district level, developing capacity to effectively manage all resources has been a core component of the reforms, but much work remains to be done.

Variety in processes
The Zambian MoH explicitly adopted an incremental, ‘learning-by-doing’ approach to many aspects of the reform programme. This has been both an acknowledgement of the need for trial and error in an arena where there were few lessons to be learnt from other similar countries, and also in recognition of the need to build consensus and support from various stakeholders. The limited risk in placing a small portion of funds in the district basket has enabled systems to be developed which have increased confidence and raised the interest and willingness to contribute to a larger basket in the form of a SWAp. Similarly, the perceived success of the current Basket Steering Committee has led to the decision to broaden it to encompass all donors and all aspects of the health system, and to rename it the Health Sector Support Steering Committee. This committee is envisaged to meet four times a year, and is viewed as another key move towards the SWAp.

Donors concerned with increasing the visible service delivery outputs of reform have recently expressed the view that more could be done in an incremental fashion. Immediate actions could be taken to address glaring problems such as the shortage of drugs or unclear procedures for managing user-fee revenues. In contrast, there is a feeling that undue time and effort have been spent in first developing ‘perfect’ policies and systems on paper, such as the essential package and financing policy.

The use of both formal and informal processes in policy development and the monitoring of progress have also benefited the reforms. While the Basket Steering Committee and the biannual consultative meetings are formal gatherings, informal donor-only meetings have enabled a common stand to be taken, in order to enhance negotiating positions with the MoH. Similarly, the relatively informal approach adopted by the former Minister enabled more personal relationships to be developed and used in both directions to further particular agendas.

Future prospects
At the end of 1996, observers noted that Zambia had ‘provided a model of how international donors can be brought together in partnership with government to support a locally designed and led reform process’ (Oxford Policy Management, 1997). More recently, as implementation has slowed and the practical implications of such radical policies as de-linkage – job insecurity for health workers, vocal political resistance from unions who may lose members, the capacity requirements of decentralized personnel management – have emerged, sustaining the early momentum is problematic.

MoH priorities are also currently being revisited. According to the current Minister of Health, ‘priorities will shift from the invisible to the visible, from structures to services, and from development to delivery’ (Luo, 1998). This will entail changes in the nature and scope of external resources and consequently in the mechanisms of coordination. It is by no means clear that the structures for such coordination, which have been developed for the central level, will address the issues of multiple partners in service delivery (government, local and international NGOs, private sector) at the operational level.
Further uncertainty may arise over the changing context in which the health reforms are taking place. The Ministry’s original ‘go it alone’ approach to decentralization, which received strong political support at the time, is becoming more contentious as progress continues with broader local government restructuring, and the Public Sector Reform Programme. The need to fit in with newly emerging structures and processes may further hamper progress towards visible impact on the health of Zambians.

Cassels (1997) has argued that a successful SWAp requires a relatively stable macro-economic environment. 1998 saw a drastic decline in the economic fortunes of the country, coupled with governance issues rising to the fore in the broader political arena, both of which had the potential to reduce aid flows to the sector. In practice, broad commitment to the principles of reform and the proposed SWAp meant that health sector donors have attempted to maintain their support. Government revenues and subsequent disbursements have, however, been severely constrained. In such a climate, the need to maintain dialogue, openness and trust between MoH, CBOH and partners, for example in relation to intra-sectoral resource allocation decisions, is essential for continued progress.

**Endnotes**

1 SWAps are designed to avoid the fragmented, donor-driven approaches characteristic of vertical programmes. Their features include a ‘sustained partnership’ between MoH, government, civil society and donors, national leadership, a sector-wide as opposed to sector-specific approach, and a medium-term financing plan into which partners buy in.

2 Potentially inefficient, as found by a case study of HIV/AIDS support systems which facilitate use of common procedures between government and donors, and joint monitoring of system performance against ‘jointly agreed milestones and targets’ (Cassels, 1997). See also the definition given in the opening paper (Walt et al., this issue).

3 Until recently external funding was managed through the National Commission for Development Planning which was merged with the Ministry of Finance in 1996 to create MOFED.

4 The Central Board of Health is the implementing agency of the Ministry. Contracts are signed each year between the MoH and CBOH, and between the CBOH and autonomous Hospital and District Boards.

5 Kalumba had himself been a key player in developing the health strategy of the MMD.

6 Government funding is released unconditionally.

7 The climate of uncertainty created by the change of leadership at the start of the year significantly slowed progress in implementing these plans.

8 Support to other NGOs has tended to remain fragmented and potentially inefficient, as found by a case study of HIV/AIDS support within Lusaka (see Musumali, 1997).

**References**


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