Overseas Development Institute

Mokoro

Sector Budget Support in Practice

Case Study

Health Sector

in

Zambia

November 2009

Overseas Development Institute
111 Westminster Bridge Road
London SE1 7JD
UK

and

Mokoro
87 London Road
Headington
Oxford OX3 9AA
UK

Acknowledgements

The team would like to thank both the EC and DFID in Zambia, in particular Francesca di Mauro and Dyness Kasungami for support in arranging the meetings and providing us with key documents and feedback throughout the study

We would also like to thank all of those in Government and the donor community who gave generously their time and input to the study and to Shakil Sidat who provided invaluable research support.

The opinions expressed and any errors of fact or interpretation are the responsibility of the authors.

Contents

Acknowledgements ... ii
List of Acronyms ... v
Executive summary ... vii
1. Introduction and Study Objectives ... 1
1.1 Methodology ... 1
1.2 Activities Carried Out ... 2
2. Country, Sector and Aid Context ... 3
2.1 Country Context ... 3
2.2 Sector Context ... 6
2.3 Context for External Assistance ... 12
3. The Key Features of SBS and its Effects on the Quality of Partnership ... 17
3.1 The Key Features of SBS Provided ... 17
3.2 Derogations from Country Policies, Systems and Processes ... 24
3.3 The Effects of SBS on the Quality of Partnership in the Sector ... 25
4. Sector Budget Support and its Effects in Practice ... 26
4.1 SBS and its influence on sector policy, planning, budgeting, monitoring and evaluation processes ... 26
4.2 SBS and its Influence on sector procurement, expenditure, accounting and audit processes ... 29
4.3 SBS and its influence on the capacity of sector institutions and systems for service delivery ... 31
4.4 The Influence of SBS on domestic ownership, incentives and accountability in the sector 34
5. The Effectiveness of SBS and the Conditions for Success ... 37
5.1 The Main Outputs of SBS ... 37
5.2 The Sector Outcomes Influenced by SBS ... 38
6. Conclusion ... 39
Bibliography ... 42
Annex 1 – Summary of Findings against Logical Framework ... 44
a) Context in which SBS has been provided ... 45
b) Nature of the SBS Provided ... 46
c) The Effects of SBS in Practice ... 47
d) The Outputs and Outcomes of SBS ... 54
Annex 2 – Country and Sector Data ... 55
a) Core Country Data ... 55
b) Sector Expenditure and Service Delivery Data ... 56
Annex 3 – Sector Aid Data ... 60
Annex 4 – Inventory of Sector Budget Support ... 61
a) Details of Inputs by Type of SBS ... 61
b) Financial Contributions against Budget over Time (US$m) ... 65
c) Details of Conditions relating to Sector Budget Support Over Time ... 65
d) Details of TA and Capacity Building linked to the Provision of Sector Budget Support ... 66
Annex 5 – Institutions visited and Individuals Met ... 67

List of Tables

Table 1: Health Sector Outcomes 6
Table 2: Evolution of Service Delivery Inputs and Outputs over Time 11
Table 3: Mix of on Budget Aid Modalities to the Health Sector over Time 16
Table 4: Budgeted and Actual Disbursements of SBS Programmes (2006-2009) 20
Table 5: SBS practices with positive and negative effects 40

List of Figures

Figure 1: Zambia Real GDP Growth 1980-2008 3
Figure 2: Evolution of Public Expenditure in Health over Time (1995-2006) 9
Figure 3: MOH/CBOH Health Expenditures by Level of Care (%), 1999-2004 10
Figure 4: Health Sector SWAp Coordination Mechanisms 14
Figure 5: On-budget and Off-budget expenditures in health 15
Figure 6: Budget Donor Funding Relative to Public Expenditure in Health from 1995-2006 16
Figure 7: The Spectrum of Sector Budget Support Covered by the Study 18
Figure 8: Diagram of SBS Funding Flows in the Context of Mainstream Budgetary Channels 21
Figure 9: Logical Framework for Assessing Sector Budget Support in Practice 44

List of Boxes

Box 1: Main Study Questions 2
Box 2: Key Components of the Health Sector Reform Process 6
Box 3: Institutional Structure of the GRZ Public Health System 7
Box 4: Earmarking, Traceability and Additionality 19
Box 5: 10th EDF: EC SBS to the Health Sector 32

List of Acronyms

ACM	Annual Consultative Meeting
BHCP	Basic Health Care Package
CBOH	Central Board of Health
CHAZ	Church Association of Zambia
CIDA	Canadian International Development Agency
CPs	Cooperating Partners
DANIDA	Danish International Development Agency
DCI	Development Cooperation Ireland
DFID	Department for International Development
DGIS	Directorate General for International Cooperation
EC	European Community
FAMS	Financial Accounting and Management System
FNDP	Fifth National Development Plan
GAVI	Global Alliance for Vaccine Initiative
GF	Global Fund to Fight AIDs, Tuberculosis and Malaria
GBS	General Budget Support
GHE	Government Health Expenditure
GNI	Gross National Income
GRZ	Government of the Republic of Zambia
HE	Health Expenditure
HIV/AIDS	Human Immunodeficiency Virus
HMIS	Health Management Information System
HRR	Human Resource Retention
HRP	Human Resource Plan
IMHP	International Health Partnership
IMF	International Monetary Fund
JAR	Joint Annual Review
JASZ	Joint Assistance Strategy Zambia
NGO	Non-Governmental Organisation
NHSP	National Health Sector Plan
MoFNP	Ministry of Finance and National Planning
MDG	Millennium Development Goals
M&E	Monitoring and Evaluation
MoH	Ministry of Health
MoU	Memorandum of Understanding
MTEF	Medium Term Expenditure Framework
MTR	Mid-term Review
ODA	Official Development Assistance
ODI	Overseas Development Institute
PAF	Performance Assessment Framework
PEPFA	Presidential Expanded Program for AIDS Response
PEMFA	Public Expenditure Management and Financial Accountability
PFM	Public Financial Management
PRBS	Poverty Reduction Budget Support
PRSP	Poverty Reduction Strategy
RBM	Roll Back Malaria
SBS	Sector Budget Support
SAG	Sector Advisory Group
SBSiP	Sector Budget Support in Practice
SIDA	Swedish International Development Agency
SPA	Strategic Partnership with Africa

SWAp	Sector Wide Approach
THE	Total Health Expenditure
UK	United Kingdom
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNAIDS	Joint United Nations Program on HIV/AIDS
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WB	World Bank
WHIP	Wider Harmonisation in practice
WHO	World Health Organisation

Executive summary

1. This study documents the experience with Sector Budget Support (SBS) in the health sector in Zambia. It forms part of a broader study commissioned by the Strategic Partnership with Africa Task Team on Sector Budget Support which covers ten sector case studies from six different countries. The purpose of the study is to draw together experience of SBS to guide future improvements in policy and practice by partner countries and donors in order maximise the effectiveness of SBS in improving sector outcomes.

Sector Context

2. In Zambia total health expenditure per capita has been high and is on a level nearer to middle-income southern African countries. Despite this, health indicators are no better than Zambia's neighbours such as Malawi, Mozambique and Tanzania who spend less on health care. Although there have been some improvements in service delivery, there has been a mixed picture in terms of improvements in sector outcomes.

3. The health sector underwent a series of institutional reforms in the early 1990s and as part of this process, a sector-wide approach (SWAp) was established which still provides the overarching sector framework. A series of health sector policies have also been developed and a mechanism for donor coordination has been introduced to ensure alignment with key sector policies.

4. The health budget has been increasing and has risen in nominal terms from K415 billion in 2005 to K974 billion in 2008. As a share of the government of Zambia's (GRZ) discretionary budget, it is still below the share targeted in the Abuja Declaration of 15%. The actual annual health spending of GRZ and donors is estimated to have increased from around US$115 million in 2004/5 to more than US$270 million in 2007.[1]

5. However, much of the funding to the health sector is off-budget as the recent advent of vertical funds has changed considerably the funding modalities through which the Ministry of Health (MoH) receives external assistance and has contributed to the fragmentation of health funding. This has also put a strain on the health system, as it increases transaction costs for the MoH as parallel systems are used, it conflicts with the SWAp objective of joint planning and priority setting and attracts qualified staff away from the government health system which further exacerbates staff retention issues.

6. Health service delivery has experienced some improvements, with the coverage of some basic services such as immunisation, antenatal care and supervised deliveries increasing, while some diseases have been tackled more effectively such as tuberculosis. This is thought to have occurred as a result of the activities of vertical funds, focusing on specific interventions and enabling more funds to flow to the districts due to basket funds. The improvement in service delivery has not been consistent across provinces, with Lusaka having better health service indicators than the north and north-western regions. Also rural and poorer households have less access to health services.

7. Until recently, improvements in health sector delivery have not been translated into better outcomes. This is due to the major challenges faced by the sector which include critical shortages of key staff, a disease burden exacerbated by the impact of HIV/AIDs and malaria, inadequate infrastructure and shortages of essential supplies. However, according to the UNDP 2008 assessment there has now been some progress towards meeting the health MDGs. It is likely that Zambia will achieve the Millennium Development Goal (MDG) targets for HIV/AIDS (MDG 6).

[1] MoH (2008) *Mid-term Review of the Zambia National Health Strategic Plan: NHSP 2006-2010.*

There is potential to achieve the targets for child mortality (MDG 4), maternal mortality (MDG 5), and Water and Sanitation (MDG 7), as the supporting environment is ranked as good or fair.

8. There are currently four major official development assistance (ODA) funding modalities which are used in the health sector: basket funding, projects, earmarked on-budget funding and sector budget support (SBS). Prior to 1992, most support to the health sector was project based. With the introduction of the SWAp process in the early 1990s there was a move towards basket funding by cooperating partners (CPs) to support the sector wide approach (SWAp) process. Originally funding was provided for a district basket which was mixed with GRZ resources to finance district grants. The basket mechanism has expanded over recent years and now consists of a set of sub-baskets which cover district, hospital and an expanded basket. As a result, ODA has become increasingly important to the sector as in 1995 funding from CPs comprised 11% of total health expenditure, but by 2006 it had risen to around 41%. However, an increasing amount of this funding is off-budget due to the increase in the activities of vertical funds especially financial support towards HIV/AIDs.

The Nature of Sector Budget Support

9. The EC and DFID are the only CPs who have provided support to the health sector through SBS. The EC has undertaken a pilot SBS program from 2006-2008 and from 2009 is implementing a larger SBS program. DFID earmarked some of its general budget support (GBS) allocation to the health sector from 2006-2007, although from 2008-2010 whilst there is additional funding provided for health within the GBS allocation, it has only broad earmarking to the health sector. This DFID support is considered SBS throughout the study.

10. The EC was previously providing resources to the MoH basket funds, but began SBS in 2006 as a pilot with EUR 10 million allocated to the Health Human Resources Plan (HRP) under the 9th EDF. The intention was to provide support to finance the HR plan to support human resource retention, although the funding was only non-traceable earmarked. A condition of funding was that the MoH had to create a budget line for HR in 2006, but there was no reporting requirements related to this. For the following years (2007 and 2008), several benchmarks had to be met before money was released.

11. The original financing agreement for the EC SBS envisaged a programme of EUR 10 million with annual disbursements of fixed tranches of EUR 3 million and EUR 3.5 million euros, released according to agreed benchmarks in 2006 and 2007 respectively. In 2008 two variable tranches would be disbursed of EUR 2 million and EUR 1.5 million against the achievement of specific targets. In practice this did not occur as the agreement was signed in 2007 rather than 2006, as the GRZ was not able to meet all the benchmarks for the first fixed tranche until this date. There was also some delay by the GRZ in scrutinising the agreement before signature and subsequently from Brussels. This led to a significant delay in the program's start date and as a result, it was agreed that the funds would be disbursed in two equal tranches. The first tranche of EUR 5 million was requested by the MoH in July 2007 and was received by the MoH in December 2007, whilst the second tranche of EUR 5 million was requested, but only EUR 3.57 million was disbursed from Brussels to Ministry of Finance and National Planning (MoFNP) in December 2008, and received by the MoH on 25th March 2009.

12. The second tranche was only EUR 3.57 million as it was judged by EC headquarters that the required targets had not been met. This was despite the fact that the targets for the variable tranches were assessed in country by the MoH, MoFNP, EC and the other health SWAp partners, as part of the normal health sector dialogue. The targets necessary for the release of this funding were judged as met, but were re-assessed by officials in Brussels which not only added to the delay in disbursement, but resulted in a shortfall in the funding which the MoH had expected.

13. Part of DFID GBS funds were earmarked to health and then non-traceably earmarked to assist in financing the elimination of user-fees. DFID committed to give an additional US$5 million for

health to their GBS commitments over five years (2006-2010). Funds were disbursed into the Treasury account in the MoFNP, with a reporting requirement that DFID should be given evidence that the funds had been transferred to the MoH.

14. There were also delays in disbursement for the DFID support earmarked to health from GBS. In 2006 the first year of funding, the first tranche was disbursed to the MoH who then allocated it to the districts. There was a problem which led to delays in disbursement. The money arrived at the districts after their normal grant funding and it came without instructions from the MoH. Some districts knew it was to be used as a substitute for user-fees so used it accordingly, others were not aware so either left it in the bank or spent it on unrelated items.

15. In the 2007 the MoH decided to roll DFID funds into the district grant, with instructions that 4% of the grant should be spent on items that user-fees would have paid for, so districts were free to choose how to spend the funds. There were still problems with the disbursement reaching the MoH in a timely manner from the MoFNP. As the MoH had not received the funding, DFID had to intervene. The MoFNP argued that as the MoH already had sufficient unspent balances available in their own bank accounts they were not eligible for additional funds during budget execution. Due to this under-spending by the MoH 2007, the transaction costs involved in earmarking GBS resources to health and the fact that earmarking did not fit well with the principles of GBS in 2008 DFID decided not to earmark the US$5 million of GBS resources to user-fees. They still continue to give an additional amount of US$5 million to GBS funding, so they consider that they are still providing this funding which is now only very broadly earmarked to the sector as a whole.

16. Although there has been very little SBS, this study is timely as levels of SBS are expected to rise in the near future, as more CPs move to SBS in response to the GRZ's statement that general and sector budget support are its preferred aid modalities.

The Effects of Sector Budget Support

17. The overall conclusion of the study is that SBS in the health sector in Zambia has not had a significant effect in meeting the objectives of partner countries and CPs. This is mainly because SBS has not been extensively implemented in Zambia, so the experience has been very limited, with only small amounts of funding channelled through SBS over a relatively short period of time. Issues related to the design of SBS, delays in disbursements and budget transparency have caused significant problems. As a result, it is unsurprising that the experience of SBS so far has not been very positive, however if these problems are resolved, SBS still has the potential to be effective in supporting the achievement of health sector goals.

18. One of the key elements of SBS in health is that it has not sought to establish parallel systems, but has aligned itself with existing policy and planning mechanisms under the SWAp and has used GRZ PFM and service delivery systems. This has occurred as CPs who sign up to the SWAp are already using a variety of funding modalities, so the financing modality used by CPs has always been separate from the SWAp mechanism itself, but designed to support it. Through SBS using existing systems, it has helped to ensure that these systems are supported.

19. The contribution of SBS is limited but can be seen in the following three areas:

i) SBS has focused through non-traceable earmarking of funding and in the case of the EC through conditions, on issues that need to be addressed to ensure improvements in service delivery and health outcomes. These have either not been receiving sufficient funding such as the Basic Health Care Package (BHCP) or are new initiatives such as user-fee elimination and staff retention that need financing. The EC has given EUR 8.57 million and DFID US$10 million of funds to these initiatives respectively. These initiatives have the potential to strengthen service delivery institutions and shift dialogue and funding in the health sector more towards results. This addresses a criticism, that to date SWAp dialogue has been

focused more on upstream system strengthening, (e.g. sector policies and strategies) than outcomes. This is important given the marginal improvement in health sector outcomes that has occurred over the previous years.

ii) By channelling funds through GRZ systems SBS has increased, albeit by a small amount, funds on-budget. This should by increasing the volume of external funding that is controlled by the MoFNP increase the efficiency of resource allocation overall, as well as accountability. To date this has not occurred in the most efficient manner, as there has been considerable confusion regarding whether funds were additional to the GRZ budget or not. Even though they were included in the GRZ budget they were still tagged as originating from a specific donor in internal systems and the MoH allocated these funds to specific budget lines.

iii) By operating a pilot SBS process in the case of the EC and a limited amount of SBS in the case of DFID, constraints in the PFM system and the way in which it operates have been highlighted. It has also brought to light problems in the design and implementation of SBS and misunderstandings and communication problems between the MoH and the MoFNP. The most important issue that has come to the fore has been the way in which SBS funds were treated as a separate block of funds, rather than as part of government revenues. This led to normal cash management procedures, which should have been used, not being used. This kind of small scale initiative is important, as the first stage in the process of highlighting bottlenecks in PFM systems and attempting to ensure the development of a stronger budget process and a more functional relationship between the MoH and the MoFNP. On the other hand, it is not clear that changes have been made to the design of SBS by donors or improvements to PFM system by GRZ as a result of the experience, which to a certain extent negates the point of a pilot.

20. There are two main reasons why the contribution of SBS to sector systems, processes and service delivery have been less than expected. These are delays in disbursement and budget unpredictability, which are a result of the requirement for traceability without additionality of SBS funds, which was not explicitly resolved during the design phase. Additionality of SBS funds is to a certain extent unimportant as SBS funds from both the EC and DFID had no additionality conditions; therefore it was at the discretion of the MoFNP whether the MoH budget would increase as a result. Given that it is very difficult to prove additionality anyway, particularly when the MTEF process does not function well. What is more important is to ensure that at the very least there is a credible and transparent budget allocation system with an agreement on the level of health sector funding on an annual basis. In addition, budgetary funding supported by SBS should be disbursed via the usual cash management procedures, and should not be based on SBS specific disbursements from CPs. A clear understanding of this was not reached between the central bank, MoFNP and MoH before the move to SBS.

21. As a result, the contribution of SBS to date is rather marginal, not only due to the factors mentioned above, but due to the small scale of SBS funding. There is the potential for SBS to make significant contributions, particularly as the EC is scaling up support and other CPs may move from basket funding to SBS. However, it is important to bear in mind that the effects of SBS on sector systems, processes, and expenditures will remain small in the light of the substantial amount of vertical funding within the health sector. Much of the funds are off-budget and funds that are channelled through the MoH place a considerable burden on the MoH in terms of parallel reporting, implementation, procurement and accounting and auditing requirements.

Conclusions and Recommendations

22. Given that the problems experienced with SBS have been as a result of bad design by donors and weaknesses in GRZ PFM systems, it is recommended that the following steps are undertaken to ensure increased effectiveness of SBS in the future.

- Donors should improve the design of SBS. This means avoiding traceable earmarking of funds as this was a practice that caused derogations from normal budgetary procedures. If a donor wants to focus on specific issues then this should be undertaken through the sector dialogue and non-traceable earmarking. Additional reporting procedures should be avoided so that there are no added transaction costs for the MoH moving to SBS. Any SBS reporting system should be harmonised with the SWAp and those used by the basket funds. Similarly disbursement procedures should be simple and designed to increase predictability.
- Improvements in GRZ PFM systems also need to be made to support SBS. It is important to have a transparent and predictable system for resource allocation in place in the MoFNP in order to build confidence between all stakeholders. As part of this an effective and transparent budget process is needed for the MoH to be able to plan for the medium-term. This implies an MTEF and a budget process which involves line ministries and is not only transparent, but contestable and performance related. The MoFNP should also stop the practice of treating SBS differently in internal systems for budget execution and reducing GRZ budget disbursements to the MoH when SBS funds do not arrive on time.
- There needs to be agreement by all stakeholders on how SBS will operate and how the transfers of funds will be made. This will avoid the misunderstandings that have occurred related to the process for transferring funds between the MoH and the MoFNP. It is not feasible in practice to ensure additionality of SBS funds to the MoH, but it must be made clear for all parties how the process will work.
- Related to this, the transition to SBS should be jointly managed by the MoH, MoFNP and CPs so that trust is not lost between the stakeholders involved and that the MoH still feels that it has ownership of the process. A planned approach to ensure that resources to health are maintained and planned activities are not disrupted due to delays in funding is needed. Particularly, as it is likely that basket funds will be severely depleted as a result of a shift to SBS, which is currently the MoH's only form of accessible and flexible funding that it has control over.
- Lastly, one of the key positive practice lessons from SBS is that it has used sector policy, planning and budgeting processes and been fully aligned with the SWAp process. The use of GRZ systems in the provision of SBS without additional requirements has also ensured that more funds are included within domestic external accountability processes and are subject to parliamentary oversight. Both these practices should be maintained as more CPs move to SBS.

23. If these issues relating to the design and implementation of SBS and associated government systems are addressed, SBS will still only be effective at improving sector outcomes in future, if it is provided on a larger scale. The size of SBS needs to increase not only in absolute terms, but also relative to other aid modalities, in particular vertical funding arrangements.

1. Introduction and Study Objectives

24. This is a case study examining Sector Budget Support in the health sector in Zambia. It forms part of a broader study commissioned by the Strategic Partnership with Africa Task Team on Sector Budget Support (SBS) which covers ten sector case studies from six different countries.

25. The overall purpose of the study is to draw together experience of SBS to guide future improvements in policy and practice by partner countries and donors. The additional objective of this case study is to assess the lessons learnt from experience to date in the health sector and to provide the Government of Zambia (GRZ) and donors with guidance that will help them improve the design and implementation of SBS in future.

1.1 Methodology

26. The case study has been carried out using a methodology (ODI and Mokoro, 2008) which draws from evaluation frameworks of General Budget Support (IDD and Associates, 2006; Lawson and Booth, 2004, Caputo, Lawson and van der Linde, 2007), and the specific requirements of the Terms of Reference for the Assignment. The assessment framework has four levels:

- Level 1 breaks down sector budget support into inputs, both financial and non financial inputs such as dialogue, conditionality and associated technical assistance and capacity.
- Level 2 identifies the immediate effects of SBS inputs on the overall nature of external assistance to the sector.
- Level 3 examines the outputs influenced by SBS in terms of sector policy, budgeting, financial management, institutional capacity, service delivery and accountability systems and processes.
- Level 4 examines the likely influence of SBS on outcomes in the sector, in terms of the achievement of sector policy objectives and service delivery.

27. The assessment framework also recognises the importance of external factors on the effects of SBS, the context within which it is provided, and the existence of feedback loops between and within each of the levels. A diagram of the assessment framework is provided in Annex 1.

28. The primary question posed for the case studies by the terms of reference is as follows:

> *How far has SBS met the objectives of partner countries and donors and what are the good practice lessons that can be used to improve effectiveness in future?*

29. The key purpose of the study is therefore the identification of good practice. Therefore the assessment framework, will be used as the basis for the identification of cases good practice. For the purpose of this study, good practice is defined as:

> *Instances where SBS inputs (level 1), and their influence on the overall nature of external assistance to the sector (level 2), have helped strengthen sector processes (level 3) in areas which have improved, or will plausibly improve, service delivery outcomes (level 4).*

30. The case studies follow four steps in applying the assessment framework:

- The first step involves analysis of the country, sector, and aid environment, in particular evolution of sector systems and service delivery outcomes (i.e. the context from levels 1 to 4).
- The second step involves documenting and assessing the specific nature of SBS provided to the sector, and its effects on the quality of partnership in the sector (level 1).
- The third involves an assessment of the effects of SBS from inputs to outputs (i.e. across Levels 1 to 3). This is carried out along four dimensions:
    - (i) Policy, planning and budgeting processes and monitoring and evaluation systems;

(ii) Sector procurement, expenditure control, accounting and audit processes;
(iii) Sector institutions, their capacity and service delivery systems; and
(iv) Domestic ownership, incentives and accountability (See Figure 4).

- The fourth step involves an assessment of contribution of outputs influenced by SBS compared to improvements in sector outcomes (level 4).

31. The approach involved the collection and review of documentation, holding stakeholder interviews and conducting field visits to service providers. It also involved close collaboration with stakeholders through Country Reference Groups, so that findings could be further interrogated and tested.

32. The structure of this report follows the four steps. Under each of the four steps Main Study Questions (SQs) have been identified, as shown in

Box 1.

Box 1: Main Study Questions

Step 1: Setting the Country, Sector and Aid Context

SQ1.1: What have been the main national trends in poverty, economic performance, governance, and public sector delivery prior to and during the provision of SBS?

SQ1.2: How have sector processes, institutions, accountability and service delivery outcomes evolved prior to and during the provision of SBS?

SQ1.3: What has been the environment for external assistance at the national and sector level?

Step 2: The Key Features of SBS Provided and it's Effects on the Quality of Partnership

SQ2.1: What are the key features of the SBS that has been provided?

SQ2.2: Has SBS contributed positively to the quality of partnership and reduction in transaction costs between development partners, the recipient government and civil society?

Step 3: The Influence of SBS in Practice on the Sector and Lessons Learned

SQ 3.1: What has been the influence of SBS on sector policy, planning, budgeting, monitoring and evaluation processes, and what are the constraints faced and lessons learned in practice?

SQ3.2 What has been the influence of SBS on procurement, expenditure control, accounting and audit systems at the sector level, and what are the constraints faced and lessons learned in practice?

SQ3.3: What has been the influence of SBS on sector institutions, their capacity and systems for service delivery and what are the constraints faced and lessons learned in practice?

SQ3.4: What has been the Influence of SBS on domestic ownership, incentives and accountability in the sector, and what are the constraints faced and lessons learned in practice?

Step 4: The Effectiveness of SBS, and the Conditions for Success

SQ4.1: What are the main contributions that SBS has made to the improvement of sector policy processes, public financial management, sector institutions, service delivery systems and accountability, and what were the conditions for success?

SQ4.2: Have the improvements in sector systems and processes to which SBS has contributed, had a positive influence on sector service delivery outcomes, and are they likely to do so in future?

33. The conclusion will draw out the answers to the primary questions, and examine how the practice of the provision SBS to the health sector can be improved in future.

1.2 Activities Carried Out

34. The field visit to Zambia took place from the 19-30 January 2009. It included meetings with key government officials from the MoH, MoFNP and other institutions such as the University of Zambia.

35. All donors providing SBS to the health sector and basket funding were met, as well as key donors providing support through project modes such as the World Bank or through GBS (DFID).

The consultant leading the study also gave a presentation at the meeting of the MoH and CP's policy committee.

2. Country, Sector and Aid Context

2.1 Country Context

SQ1.1: What have been the main national trends in poverty, economic performance, governance, and public sector delivery prior to and during the provision of SBS?

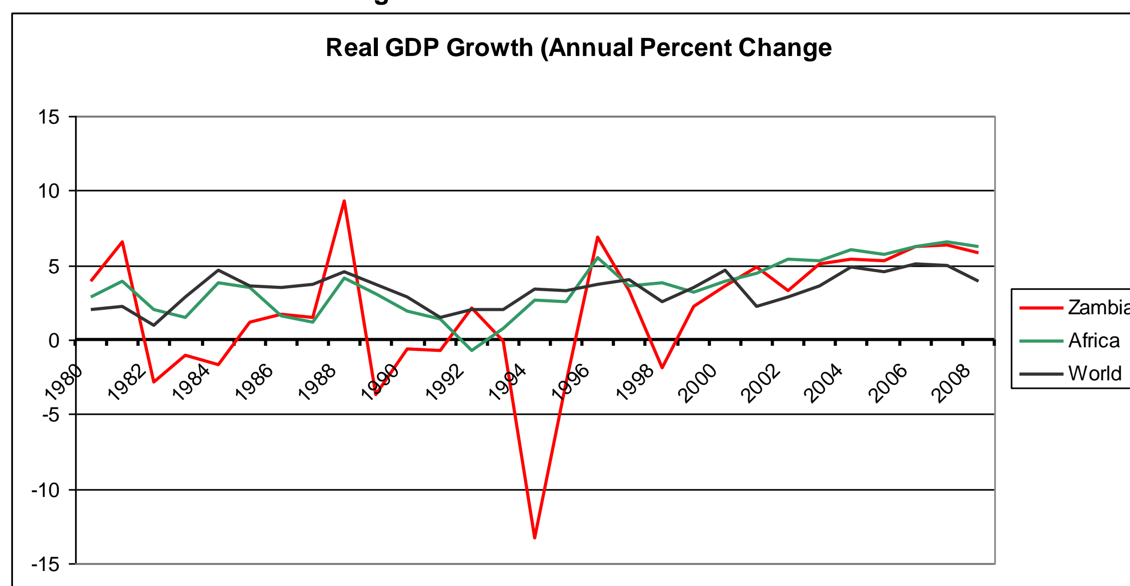
Economic Growth and Poverty Reduction

36. Zambia gained independence in 1964 and at the time was among the wealthiest nations in Africa. The economy is reliant on copper as the main driver of growth and in the mid-1970s, poor economic management as a result of a highly centralised state, coupled with a steep fall in export prices and a rise in fuel prices, turned Zambia into one of the poorest countries in Africa.

37. There was a transition to multi-party democracy in 1991, which led to the introduction of an economic reform program which entailed the removal of exchange rate controls, liberalisation of the trade regime, decontrolling food and agriculture prices and privatisation of state-owned enterprises. After the economic reforms of the early 1990s, Zambia experienced more stable economic growth and as Figure 1 shows, since 2000 GDP has grown on an average of 5.1%.[2]

38. Economic growth is now slowing as a result of the negative global economic outlook. A sharp fall in copper prices in 2008 has decreased copper production, reduced copper exports and growth in sectors linked to copper. This in turn has reduced government tax revenues. A fall in net foreign inflows has also resulted in a depreciation of the Kwacha (IMF 2009).

Figure 1: Zambia Real GDP Growth 1980-2008



Source: World Economic Outlook (October 2008)

39. Zambia received HIPC (Heavily Indebted Poor Country) and Multilateral Debt Relief Initiative (MDRI) status in 2005 and 2006 respectively; this resulted in Zambia's debt being reduced from US$7.2bn to US$0.5bn[3]. However, poverty continues to be at a high level with 64% of the population living below the US$1 a day mark and 68% living under the national poverty line. Rural

[2] Source: World Economic Outlook (October 2008).
[3] Source: Zambia Country Brief, World Bank

poverty is a major problem with 78% of the rural population currently living below the poverty line compared to that of 53% of the urban population[4].

40. The UNDP Human Development Report 2008 gives Zambia 0.453 in the human development index (HDI) with a ranking of 163 out of 179 countries. Zambia has had the greatest fall in HDI among the developing countries with its value in 1995 being lower than it was in 1975.

41. Zambia is on track to achieve some of the MDG goals. There has been progress towards meeting the health MDGs. According to the UNDP 2008 assessment it is likely that Zambia will achieve the MDG targets for HIV/AIDS (MDG 6). There is also potential to achieve the targets for child mortality (MDG 4), maternal mortality (MDG 5), and Water and Sanitation (MDG 7), as the supporting environment is ranked as good or fair.

Political Governance

42. After Zambia gained independence in 1964, its first president Kenneth Kaunda outlawed all parties in 1973. Opposition parties were once again legalized in 1990. Zambia is now a multiparty republic with an Executive President and a parliament consisting of 150 members. Both the parliament and president are elected by popular vote and have a five year term of office.

43. The Movement for Multi-Party Democracy (MMD) candidate Frederick Chiluba won the first general election in 1991, and the party has been in power since. Frederick Chiluba served for 2 terms of office from 1991 to 2001. In 2001, Levy Patrick Mwanawasa was elected in office and served for a full 5-year term. He was re-elected in 2006 and died in office in 2008, leading to a by-election which Rupiah Banda won. President Banda will now finish the remainder of Mwanawasa's term, with general elections likely to be held in 2010.

44. The President appoints the Vice-President, while Cabinet Ministers and Deputy Ministers are selected from Members of Parliament. Permanent Secretaries are also appointed by the President, as are most senior civil servants.

45. A constitutional review began in 2007, which is expected to be completed in 2009. This will look at a number of issues and it is expected that various changes will be implemented relating to public financial management.[5]

46. The National Decentralisation Policy was adopted in 2004 with the aim of establishing a fully decentralised and democratically elected system of governance with transparent policy making and implementation processes. To date progress towards achieving this objective has been slow with public services still delivered through deconcentrated local structures of central government ministries.

Policy, planning and public financial management

47. Vision 2030 is the overarching long term policy framework of the GRZ, with the Fifth National Development Plan providing the medium term plans and policies to achieve the Vision 2030 goal of Zambia reaching middle income status by 2030. A Poverty Reduction Strategy Paper (PRSP) was also developed which covered 2002–2004, whilst at the same time Zambia a Transitional Development Plan had started which ran to 2005. This led to the Fifth National Development Plan from 2006-2010.

---

[4] Source: World Bank Country Assistance Strategy for Zambia 2008-2011, April 8 2008.
[5] It is hoped that this will resolve one important anomaly in the budget cycle, whereby the budget is approved after the first quarter of the budget cycle, as this can only be changed as a result of a constitutional amendment.

48. The Vision 2030 identifies a number of development goals, which include: (a) reaching middle-income status; (b) significantly reducing hunger and poverty; and (c) fostering a competitive and outward-oriented economy. The Fifth National Development Plan aims to realise these goals through focusing on '*broad based wealth and job creation through citizenry participation and technological advancement'.*

49. There have been significant efforts made in recent years to strengthen financial management systems. Weaknesses in public financial management are a result of low GRZ capacity, rather than any desire to subvert the budget process or make it deliberately opaque. An MTEF (green paper) has been in place since 2003, which outlines the medium terms projections for the macroeconomic framework and the fiscal implications. Although this is a step in the right direction there have been some concerns raised about the credibility of the MTEF process.

50. In 2005, the government approved a comprehensive reform of their public financial system, called the Public Expenditure Management and Financial Accountability Program (PEMFA). PEMFA was one of the first donor financed programs in the public finance sector and was aimed at assisting GRZ to improve capacity to mobilise and use public resources and strengthen financial accountability. Combined with the Right-Sizing and Pay Reform and Decentralization, PEMFA is one of the three pillars of the GRZ Public Service Reform Programme (PSRP), focusing on improving the quality of public service delivery.

51. A 2008 PEFA assessment and update noted that there have been improvements in PFM in recent years, most notably that transparency, comprehensiveness and accountability of fiscal management, although further improvements in budget outcomes are needed (MoFNP, 2008). In particular, the credibility of the budget needs to be strengthened, as does the comprehensiveness and transparency of the budget and predictability and control of budget execution, while accounting, recording and reporting and external scrutiny need to be improved as well.

Sub-national government and decentralisation

52. The current administrative structure of local government in Zambia was established through the promulgation in August 1991 of the Constitution of Zambia Act (No.1) and the Local Government Act (No.22). Zambia's administrative divisions comprise 9 provinces (Central, Copperbelt, Eastern, Luapula, Lusaka, Northern, North-Western, Southern, Western) which in turn are made up of 72 local councils (4 city councils, 12 municipal councils and 56 district councils). There are also deconcentrated government departments operating at provincial and district level. The Act of 1991 recognises councils as the primary bodies responsible for development at district level and awards them sixty-three scheduled functions, including the provision of feeder and district roads.

53. With regard to finance, the Act gave councils powers to raise and utilise revenue from their own local sources at their discretion. In addition, councils receive grants from central government, which were intended to be their major source of revenue. These comprise of: (i) grants in lieu of rates on government property (17% of total 2007 allocations); (ii) restructuring grants (24%), intended to clear local government debts, particularly for unremitted pension contributions; (iii) recurrent grants (49%), to cover both service provision and administrative costs, including salaries, and; (iv) capital grants (10%) for capital projects in the local government area (GRZ, 2008a).

54. However, there is a substantial problem of unfunded mandates – i.e. a mismatch between responsibilities and financing such that the majority of councils do not have sufficient funds to meet their statutory obligations. This has been exacerbated by: (i) declining and erratic grant disbursements from central government; (ii) erosion of councils' asset base, and; (iii) redirection of funds intended for local authorities to the control of local politicians through mechanisms such as constituency development funds (Chikulo, 2009). Moves to allocate water and electricity responsibilities to utilities have lessened the burden on local councils but they still have more responsibilities than their financial resources can meet.

2.2 Sector Context

55. This section provides an overview of the health sector context and in particular examines how the sector has evolved.

Health Sector Outcomes

56. Total health expenditure per capita has been high in Zambia and is on a level nearer to its middle-income southern African countries, but despite this, health indicators are no better than Zambia's lower spending neighbours such as Malawi, Mozambique and Tanzania.

57. Trends in health sector outcomes are shown in Table 1 and indicate that there has been an improvement in indicators such as infant mortality, child mortality and maternal mortality, as well as in first antenatal coverage and fully immunized children under five years. The disease burden has increased however, and trends relating to this can be seen Table 4b, Annex 2 which summarises the incidence of major diseases in Zambia. This rise has occurred primarily due to the high prevalence of HIV/AIDS, which has been exacerbated by poverty and the difficult macroeconomic situation in the early 2000s.

Table 1: Health Sector Outcomes

Indicator	Baseline	2002	Sept 2008
Infant Mortality Rate (IMR per 1000)	109 (1996)	95	70 (MDG target 36)
Under –Fives Mortality Rate (U-5 MR per 1000)	197 (1996)	168	119 (MDG target 63)
Maternal Mortality Ratio (MMR per 100,000)	649 (1996)	729	449 (MDG target 162)
Total Fertility Rate (TFR)	6.1 (1996)	5.9	6.2
HIV Sero-prevalence + (%)	19.7 (1999)	16	14
Under-weight Under-Fives (%)	26 (1999)	22	15

The Zambian Health Sector Reform Process

58. Zambia began a public sector reform process in 1991 as part of a process of liberalisation, privatisation and public sector restructuring. Reforms in the health sector began in 1992 in order to achieve the overarching goal of *'equity of access to assured quality, cost-effective and affordable health care as close to the family as possible'*. The reforms stemmed from concerns regarding the fragmented nature of the system, particularly aid delivery which it was felt could potentially undermine the new national health reform agenda. As part of the reforms, institutional restructuring occurred, as well as the introduction of a sector policy on harmonisation in health in 1994, which was later turned into a sector wide approach. The key components of the health reform process are outlined in Box 2.

Box 2: Key Components of the Health Sector Reform Process

- **Decentralisation of the health sector** with delegation of planning, management and decision-making to health services in the districts.
- **Introduction of a basic health care package** with the objective of giving equal access to basic health care.
- **Harmonised support in health** including the introduction of a Swap and funding to a district basket
- **Establishment of mechanisms for participation** including health centre and neighbourhood health committees.
- **Introduction of cost-sharing in health care** as previously health care was free. This decision was reversed in 2006 with the reintroduction of free health care in rural areas.

Source: 'Report of the Mid Term Review of the Zambia National Health Strategic Plan NHSP IV, 2006-101', Lusaka 16 November 2008

Institutional Structure of the Sector

59. A major element of the reforms was decentralisation which aimed to transfer management responsibilities and financial resources from the central level (MoH) to the district level. This involved the development of district health systems to provide a basic "package" of health services. A change in the institutional structure of the health sector supported this process. The first change was to ensure a 'split purchaser/provider model', where the MoH was the purchaser and a newly established Central Board of Health (CBOH) was the provider. The second was to create structures for public involvement and participation in the decision-making process. These included the CBOH, hospital management boards (HMBS), district health boards (DHBs) and neighbourhood health committees and health centre committees. The third was to establish management teams to ensure that services were implemented efficiently and effectively, with management teams created at the hospital and district level.

60. In practice these institutional changes were never thoroughly undertaken and the CBOH was later abolished in 2006 and merged back into the MoH, re-centralising decision-making and reducing participation. Other elements of the reform process such as hospital reforms and devolution of primary health care activities to local authorities have also not made much progress.

61. The providers of health care services in Zambia remain diverse. There are public facilities under the control of the MoH, Ministry of Defence and the Ministry of Home Affairs. Not-for-profit private facilities owned and run by mining companies, and faith-based organisations such as the Churches Association of Zambia (CHAZ) are available. A number of private for profit hospitals, clinics, pharmacies and traditional healers also provide services. The institutional structure of the GRZ health system is outlined in Box 3.

Box 3: Institutional Structure of the GRZ Public Health System

- **Health posts:** These cater for around 500 households in rural areas and 1000 households in urban areas.
- **Health Centres:** These facilities cover urban centres with a catchment area of 30,000 to 50,000 people and rural health centres which service 10,000 people or a catchment area of 29 km.
- **1st Level Hospitals:** Medical, surgical, obstetric and diagnostic services are provided, including clinical services to support referrals from health centres. These facilities are in most of the 72 districts in Zambia
- **2nd Level Hospitals:** These hospitals are located at provincial level and act as referral facilities for the 1st level hospitals. They provide internal medicine, general surgery, paediatrics, obstetrics, gynaecology, dental, psychiatry and intensive care services.
- **3rd Level Hospitals:** There are five of these facilities in Zambia, which act as referral institutions for 2nd level hospitals. They provide similar services to the 2nd level hospitals as well as undertaking training and research.

Source: World Bank 2009

Health Policy Framework

62. The reform process was articulated in the Health Policy Framework of 1991, while a series of four strategic plans have been developed. The current plan is the National Health Strategic Plan IV (NHSP) 2006-2010, which is aligned with the Fifth National Development Plan (FNDP 2006-2010), the successor to the Poverty Reduction Strategy paper (PRSP) 2002-2004 and the National Vision 2030, which articulates Zambia's long-term development objectives. The NHSP IV focuses on attaining strategic national health priorities. These are based on the MDGs and 10 national health priorities which have been grouped into four categories. These are the human resources crisis, public health priority interventions, clinical care and diagnostic service priorities and priority support systems.

Budget formulation, and Execution

63. Implementation of the NHSP IV is undertaken through Annual Action Plans. Program activities outlined in the Action Plan are drawn from the NHSP IV. Planning is a bottom up process with actions plans being prepared at district and provincial level. In addition to the NHSP IV, there is a three year rolling medium term expenditure framework (MTEF) and an annual Activity Based Budget that informs public sector resource allocation to health.

64. Planning and budgeting are well integrated as an institutional process within the MoH and as part of the process for preparing the overall annual budget. The MoH budgets are prepared as part of the process of preparing three year rolling operational plans, which are themselves guided by the budget ceiling allocated by the MoFNP in the MTEF and the annual budget call circular.

65. Planning manuals are developed to support the MoH action plans and the plans themselves are discussed at district, provincial and central levels before they are incorporated into the MoH budget submission.

66. The planning and budgeting process is relatively transparent, as disbursements from the MoFNP to the MoH have been relatively predictable in recent years compared to in the past. The MoFNP releases funds quarterly on the basis of quarterly cash profiles prepared by the MoH. The main problem stems from the budget calendar and the fact that the budget is approved in the first quarter of the new financial year. Thus MoH budget planning occurs before an agreed budget ceiling is allocated and expenditure plans have to be adjusted once these are finalised which, is after the start of the financial year.

Sector Reporting and Monitoring arrangements

67. A Joint Annual Review (JAR) is undertaken annually to assess sector performance. It is a participatory process with the MoH, other line ministries, CPs, non-governmental organisations, civil society organisations, district and provincial level staff taking part in field visits and reviewing issues in-depth. The objective of the JAR is to identify achievements, constraints and challenges in order to improve the performance of the sector.

68. Financial reporting systems which report on implementation of plans are weaker than the processes for the budget. This is a result of accounting systems which are fragmented and overlapping in their functions. The MoH accounting system is different to that of the MoFNP, as it was developed to overcome problems experienced with the MoFNP's system. The Financial, Administration and Management System (FAMS) operated by the MoH comprised a mix of computer models, spreadsheets and manual records. This does not produce the information needed by all stakeholders. It is intended that a government wide IFMIS will be introduced as part of the PFM reforms process. As a result, the capacity to undertake financial reporting is constrained and reporting does not occur on sector performance in any systematic way that is linked to the budget process.

Health Expenditures

69. The GRZ health budget has recently been increasing and has risen in nominal terms from K415 billion in 2005 to K974 billion in 2008. As a share of the GRZ discretionary budget, it is still below the share targeted in the Abuja Declaration of 15%.[6] In 2007 the health budget was 9.6% of

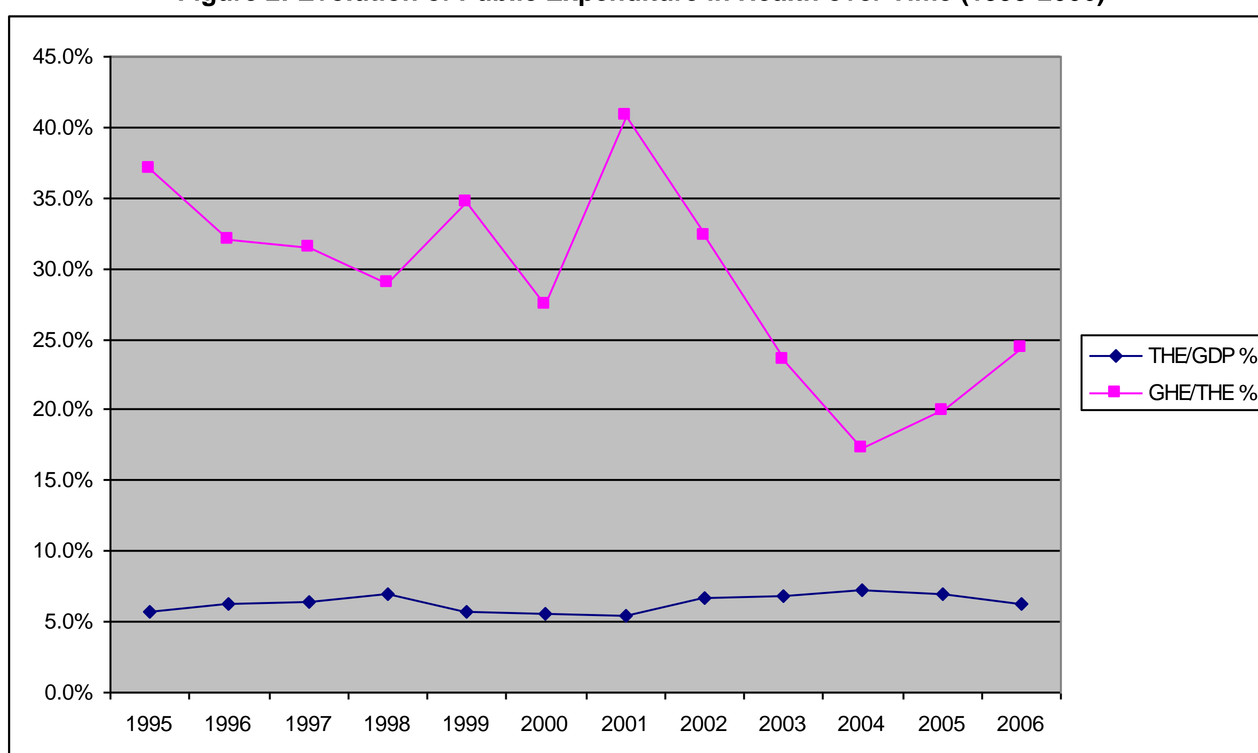
---

[6] At a 2001 health summit in Abuja, Nigeria, member governments of the Organization of African Unity set a target of allocating at least 15 percent of their annual budgets to improvement of the health sector. The WHO Commission on Macroeconomics and Health suggests that US$40 per person is the minimum amount necessary for effective delivery of a basic public health intervention.

the GRZ discretionary budget, a drop from 11.5% in 2005, while in 2008 it rose to 11.2%, while there is a budget allocation for health of 11.9% in the 2009 budget.[7] As a percentage of GDP it dropped from around 2.0% in the 1990s to 1.2% in 2004, but has risen to around 3% in 2008 (the latter based on calculations using 2008 budget allocation figures). This is using a definition of the health budget that includes GRZ resources and those of donors that are channelled through the Ministry of Finance.

70. The actual annual health spending of GRZ and all donors (this figure includes all donors to the health sector – on budget and off-budget) is estimated to have increased from around US$115 million in 2004/5 to more than US$270 million in 2007.[8] This is due to the vertical funds which have brought substantial financial inflows. However, as described in Section 2.3, the majority of these funds remain off budget, and when they are on-budget, they are project based and represent a non-discretionary source of funds for the MoH.

Figure 2: Evolution of Public Expenditure in Health over Time (1995-2006)



Source: Econ/UNZA, MoH/ Sida/IHE National Health Accounts for Zambia 2002 – 2004, July 2006 and SWAp Secretariat data

71. This sum also does not capture expenditure on HIV/AIDs, private sector and household spending. The 2008 Mid-term Review of the NHSP notes that the figure of US$270 million could double if this was included. Taking only GRZ and all donor spending this translates on a per capita basis into an increase in spending from approximately US$10 in 2004 to US$23 in 2007, although this is still below the US$33 recommended by the WHO Commission on Macroeconomics and Health.

72. Even so, the MoH has significant funds that are channelled by donors directly to the Ministry and as Figure 2 shows overall health spending has increased, although the share of GRZ spending

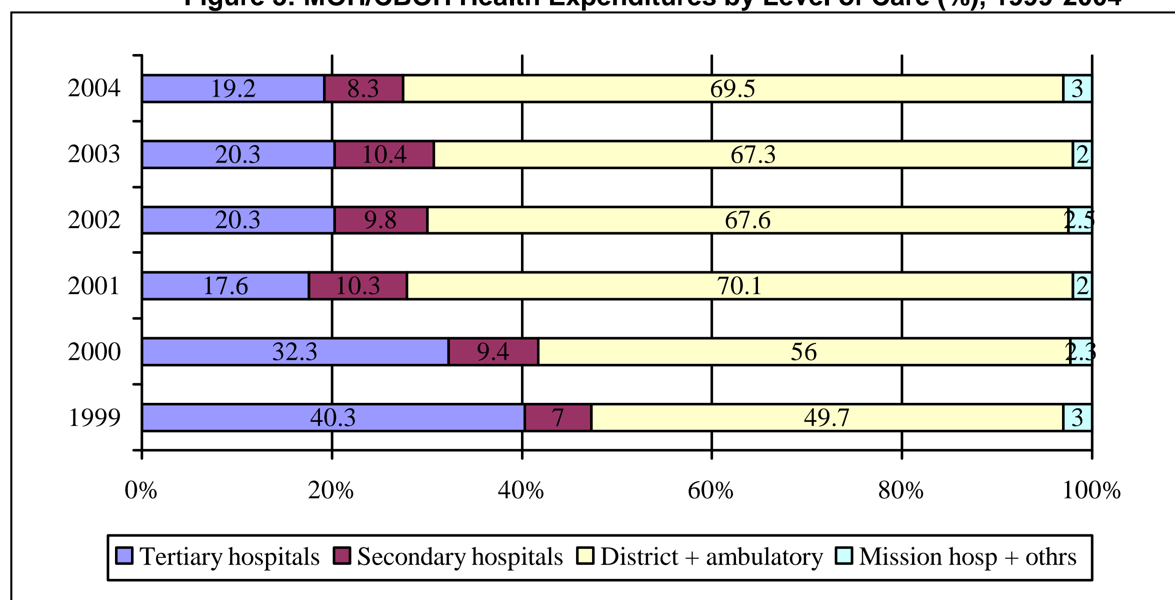
[7] *Source*: MoH (2008) Towards Scaling-up for Better Health: Stock Taking Report for Zambia, Lusaka
[8] MoH (2008) *Mid-term Review of the Zambia National Health Strategic Plan: NHSP 2006-2010.*

has decreased, due to an increase in donor funding (this figure includes all GRZ funding and donor funding channelled through the MoH.

73. However, GRZ health expenditure has decreased from 37% in 2005 to 24.4% in 2006. Table 2b in Annex 2 outlines health expenditure by source and this illustrates how household expenditure is also an important source of health expenditure, as it comprised 27.3% of total health expenditure in 2006, while employers contributed 5.4% of total health expenditure in 2006.

74. Figure 3 illustrates, there has been a significant shift away from resource allocation to tertiary hospitals to district and ambulatory health services.

Figure 3: MOH/CBOH Health Expenditures by Level of Care (%), 1999-2004



World Bank (2009) 'Zambia Health Sector Public Expenditure Review', Africa Region.

75. Health expenditures by service provision for 2006 are outlined in Table 3b in Annex 2 and show that when both GRZ and donor basket funds are included, over half the budget is spent at district level. Wage costs comprise 43.2% of health expenditure, non-wage costs 42.1%, while drugs comprise 6.3% and capital spending 8.4%. Disaggregating these figures on a time series basis indicates that there has been an increasing shift away from expenditure on service provision towards administration. Figures from the World Bank Public Expenditure Review 2009 show that expenditure on administration in health has risen from 14.8% in 2001 to 30.8% in 2004. This is attributed to the separation of the CBOH and MOH which turned out to be expensive, duplicating costs and the number of donor projects which have increased administrative and transaction costs.

Health Service Delivery

76. Health service delivery has experienced some improvements and the MoH has made a considerable effort to put in place a package of basic health services (BHCP) to improve delivery further. As Table 2 shows, the coverage of some basic services such as immunisation, antenatal care and supervised deliveries have improved. Some diseases have been tackled more effectively such as tuberculosis. However, the basic health service package has not been fully implemented yet, but there is evidence that increased funds, that now flow to the districts as a result of the basket funds and the decentralisation process, have led to these improvements in service delivery.

77. The improvements in service delivery have not been consistent across provinces, with Lusaka having the better health service indicators than the North and North-Western regions. Also rural and poorer households have less access to health services.

78. The major constraints faced by the health sector are highlighted in Box 4. One major problem is a lack of human resources. It was estimated in the health sector JAR in 2007 that there was a 40% shortfall in staffing. This shortage of qualified staff is due to low numbers of people being trained by health institutions, high mortality levels among health workers due to HIV/AIDs and the migration of staff to developed countries, which is probably the biggest contributory factor. This has also led to an imbalance of staff between rural and urban areas.

Table 2: Evolution of Service Delivery Inputs and Outputs over Time

Indicator	Baseline	2002	Sept 2008
OUTPUT INDICATORS			
% Births Attended by Skilled Health Workers	32 (1999)	47	47
Tuberculosis Cure Rate (%)	50 (2000)	55	77
% < 1 yr having received measles vaccine	85 (2000)	84	84
% Child Fully Immunized	76 (2000)	82	85
% PW receiving at least 1 ANC visit	81 (2000)	97	94
PROCESS INDICATORS			
Drugs & Vaccines (Stock-ins)	69 (2001)	73	70
Health Centre Staff Work Load (patient contact)	16 (1999)	15.9	17.8
Drug Kits Opened per 1000 Patients	0.73 (1000)	0.75	0.75
INPUT INDICATORS			
Per Capita GRZ+CP Budget for on Health (US$)	17.5 (1999)	19 (2005)	23
Per Capita Annual GRZ Expenditure on Health	6.1 (1999)	7.5 (2005)	12
% of Ministry of Health Budget on PEs	66 (2001)	66	66
Doctor/ Pop Ratio		1:18,100 (2005)	1:14,423
Nurse/Pop Ratio		1:5,144 (2005	1:189

Source: Collated from the 'Report of the Mid Term Review of the Zambia National Health Strategic Plan NHSP IV, 2006-101', Lusaka 16 November 2008 and MOH 'National Health Strategic Plan 2001-2005, Mid Term Review, February 2004.

79. A lot of graduates could not be employed due to restrictions of the IMF instigated wage policy. Wage bill policies implemented from 2003 to 2006 through the Staff Monitored Programme (SMP) were aimed at limiting the overall government wage bill in order to reduce the domestic non-interest expenditures over the medium term. This included a hiring freeze and setting of ceilings on the government wage bill, which contributed to the slowdown of employment in the health sector, and increased migration of health workers due to worsening conditions of service. This freeze has now been lifted and a Health Human Resource (HRH) Strategic plan has been developed to overcome this problem, but implementation has been slow to date.

Box 4: Major Constraints to the Health Sector

The major constraints which the health sector faces are as follows:

- A high disease burden exacerbated by the impact of HIV/AIDS and malaria.
- Critical shortages of qualified health workers
- Shortages of essential drugs and medical supplies and erratic supplies due to a number of constraints including procurement, logistics and management problems.
- Inadequate infrastructure, equipment and transport, particularly in rural areas
- Lack of funding to the sector, which remains below the Abuja Declaration of 15% of the discretionary budget.

Source: MoH (2007) Joint Annual Review for 2007: Main Report

80. Progress towards meeting the health MDGs according to the UNDP 2008 assessment is outlined in Annex 2, Table 5b. It is likely that Zambia will achieve the MDG targets for HIV/AIDS (MDG 6) and there is potential to achieve the targets for child mortality (MDG 4), maternal mortality (MDG 5), and Water and Sanitation (MDG 7), as the supporting environment is ranked as good or fair.

The Contribution of Policies and Expenditures and Services to Sector Outcomes

81. The 2009 Zambia Health Sector Public Expenditure Review notes that '*despite recent improvements in service delivery, overall health status has stagnated and the disease burden has continued to increase'.*[9] However, some improvements in service delivery have been translated into improved sector outcomes in some areas and as noted above in paragraph 80, there has been progress more recently towards meeting the health MDGs. According to the Mid-Term Review of the NHSP IV, this has occurred due to interventions undertaken by the vertical programs which have contributed to improvements in infant mortality and child mortality rates by tackling malaria and HIV/AIDs and targeting de-worming and distribution of Vitamin A. For other indicators such as the reduction in maternal mortality the reason why this had occurred is not clear.

82. In some areas, improvements in outcomes have not been experienced despite better service delivery, mainly because the disease burden has increased as a result of the high prevalence of HIV/AIDs, high poverty levels and the difficult macroeconomic environment of the early 2000s. For example, Zambia's maternal mortality ratio is extremely high, with some of the indirect causes of this resulting from malaria, HIV/AIDS and delays in accessing high facilities.

2.3 Context for External Assistance

SQ1.3: What has been the environment for external assistance at the national and sector level?

Aid levels and modalities

83. ODA comprised 22% of Gross National Product (GNI) in 2002 and had declined to 5.2% in 2006 (UNDP, 2008). The majority of bilateral aid, around 25% in 2007 was directed towards actions relating to debt, the second largest inflows were to health and population at around 23% and the third largest receiver of bilateral aid flows was other social sectors (OECD-DAC 2009).

84. General budget support through the PRBS began in 2005 and in 2006 US$159.6 million was disbursed through this mechanism (UNDP, 2008). There are also pooled funding mechanisms in education, health and in PFM, with SBS occurring only in the road and health sectors.

Aid Coordination Mechanisms

85. In 2002 a Wider Harmonisation and Alignment process in Zambia was launched. This led to the development by the MoFNP of a Framework for Action in March 2003. As a result, a MOU was signed by GRZ and 10 cooperating partners (the Nordic + group, the World Bank, the UN system and Germany) in April 2004. Canada, the EC, France, Italy and Japan signed later. The MOU outlines the principles and procedures which the GRZ and the cooperating partners agree to adhere to in order to increase harmonisation and alignment in order to make aid more effective.

86. This process translated into two main outputs which were the Zambia Aid Policy and Strategy in 2005 and the Joint Assistance Strategy for Zambia (JASZ 2007-2010). The Aid Policy provides a framework for guiding how development aid should support the FNDP, while the JASZ attempts to harmonise aid delivery. This has resulted in a division of labour being agreed between CPs across each sector, with one donor leading and functioning as the focal point between cooperating partners and the GRZ. In the health sector it has been agreed that there will be three lead donors (the Troika), with the lead being shared on a rotational basis annually between SIDA, DFID and WHO for the NHSP IV.

---

[9] 'World Bank (2009) 'Zambia Health Sector Public Expenditure Review', Africa Region.

87. It has also resulted in some donors exiting sectors which are over-subscribed. This has occurred in the health sector as Irish Aid and Danida have both shifted their support to other sectors whilst the Netherlands has become a silent partner channelling its funds through Sida.

88. Budget support is managed through the Poverty Reduction Budget Support Group (PRBS). An MoU was signed between the GRZ and the Netherlands, Norway, DFID, Sweden, the World Bank and the EC in April 2005. The IMF has also been engaged with the process, although it has not signed the MoU and Germany, Finland and the African Development Bank have joined the PRBS group since 2005. The MoU defines the two categories of performance that are important for disbursement. Performance is first measured against the under-lying principles and the second against specific indicators in the PAF.

Health Coordination Mechanism

89. A sector wide approach (SWAp) has been developed between the MoH and cooperating partners since 1994. The objective of the SWAp has been to align and coordinate external assistance to support MoH plans. A Memorandum of Understanding (MOU) was signed in 1999 and 2006 between the GRZ and cooperating partners in the SWAp, which outlines agreed terms and procedures to support NHSP III and NHSP IV respectively, and coordinate external health sector support. A chronology of the key events in the evolution of the health sector is outlined in Table 1b in Annex 2.

90. The progress towards a SWAp has not always been smooth. In the late 1990s the reform process went off track, as it was felt that there had been significant investment in systems development as a result of CP demands to meet fiduciary and good governance standards, but less attention had been directed at improving service delivery. This led to a first MOU being developed in 1999 and a reorientation of the sector reform progress with a renewed emphasis on service delivery as outlined in the NHSP III 2001-2005.

91. A diagram of the health sector coordination mechanism is outlined in Figure 4. The highest level forum for consultation in the health sector is the Annual Consultative Meeting (ACM). The ACM meets yearly and is chaired by the Minister of Health. It is comprised of the senior management of the MoH and the heads of the CP agencies and NGO and private sector partners. The ACM is a forum for joint policy dialogue as well as the body which gives final approval to the NHSP, the five year rolling sector operational plan, the sector MTEF and the Annual Action Plan and budget.

92. The Health Sector Advisory group (SAG) meets biannually and is the body that oversees the implementation of activities in the health sector as outlined in the NHSP and the annual action plans. The SAG is chaired by the Permanent Secretary of the MoH with a similar membership to the ACM, although the Minister of Health and Heads of Missions do not attend. The functions of the group are to review progress on performance indicators and approve disbursements from the common basket.

93. A Monthly Policy Meeting is held to discuss policy issues and strategic and technical recommendations from sub-committees and working groups. The meetings are chaired by the Director of Planning and Development and the quarterly meetings by the Permanent Secretary. The policy meetings are attended by the Directors and seniors managers of the MoH, representatives of the MoFNP, CPs technical heads, and NGOs.

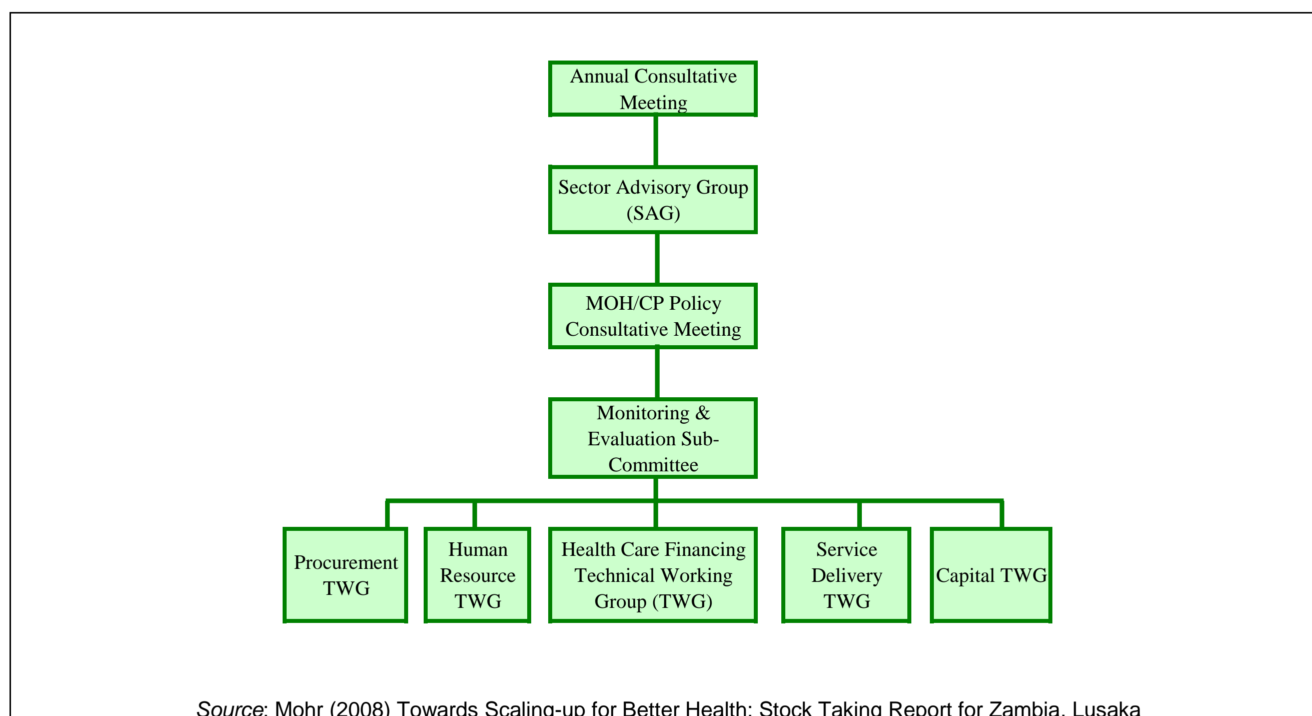
94. The main technical working groups are comprised of:

- Monitoring & Evaluation
- Procurement
- Human Resources
- Health Care Financing

- Service Delivery
- Capital

95. There is also a health CP group meeting which occurs prior to the policy meeting, SAG, and ACM. These meetings provide an opportunity for CPs to reach a common position on issues to be raised at the major SWAp meeting.

Figure 4: Health Sector SWAp Coordination Mechanisms



Source: Mohr (2008) Towards Scaling-up for Better Health: Stock Taking Report for Zambia, Lusaka

96. At the international level the International Health Partnership (IHP) was signed up to by Zambia. This is an international initiative that is attempting to provide a framework for donor alignment and coordination, to operationalise the Paris Declaration and to meet MDGs 4 and 5. Zambia is one of seven developing countries (Burundi, Cambodia, Ethiopia, Kenya, Mozambique and Nepal) and nine international organisations (WHO, WB, GAV, UNFPA, UNAIDS, UNICEF, UNDP and EC), and seven bilateral donors (UK, Norway, Germany, France, Italy, Portugal and Netherlands), plus the Bill and Melinda Gates Foundation and African Development Bank who have signed the IHP global compact. Currently the MoH and CP's in Zambia are looking at how an addendum could be added to the 2006 MOU in order to accommodate the objectives of the IHP.

External support to the health sector

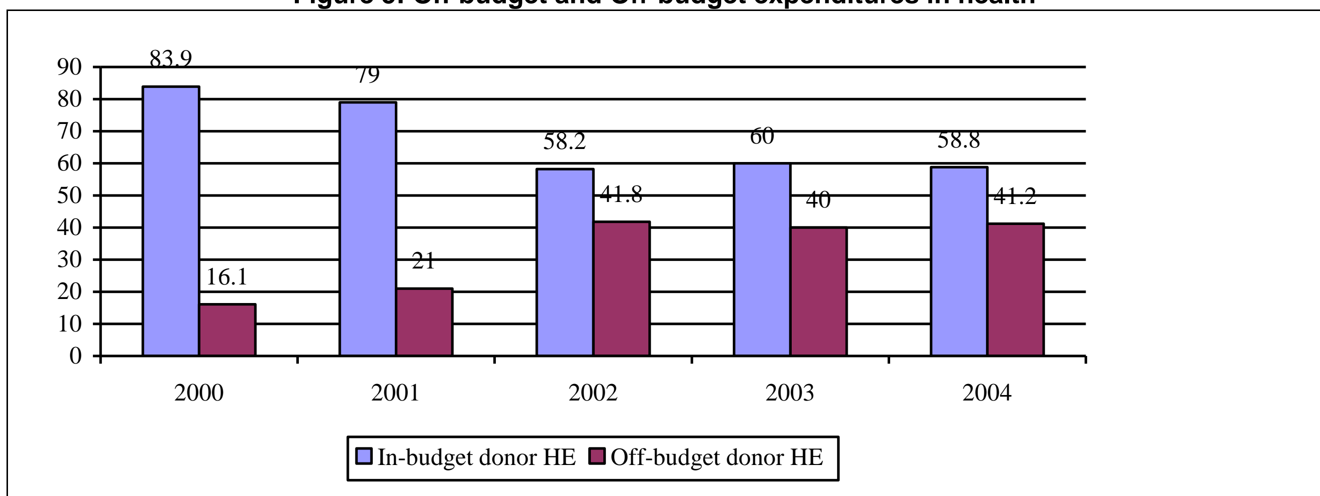
97. ODA has always been important for the health sector budget with over 60% of funding coming from external assistance. There are currently four major ODA funding modalities used in the health sector which are basket funding, projects, earmarked on-budget funds and SBS. Prior to 1992, most support to the health sector was project based. With the introduction of the SWAp process in the early 1990s there was a move towards basket funding by CPs to support the SWAp process. Originally funding was for a district basket which was mixed with GRZ resources to finance district grants. The basket mechanism has expanded over recent years and consists of a set of sub-baskets which cover district, hospital and an expanded basket. More recently in 2006, a human resources basket was introduced, although this is focused on one budget line so is less a 'basket' in the sense of the district and expanded baskets where the MoH can choose how to allocate

funding. Resources from each basket are mixed with GRZ funds and use GRZ financial, procurement, reporting and auditing systems, although most CPs who are basket funders have earmarked their contribution to a particular sub-basket or baskets.

98. The advent in recent years of vertical funds such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (GF); Roll Back malaria (RBM); Stop TB; the Global Alliance for Vaccine Initiative (GAVI); the US Governments Presidential Expanded Program for AIDS Response (PEPFAR) and the Gates Foundation (MACEPA) have changed considerably the funding modalities through which the MoH receives external assistance. These programs have brought large amounts of funds which are either off-budget and not channelled through the MoH or are formulated as projects which use their own procurement and fiduciary systems, with many providing support in kind or funding directly to facilities. This type of funding has put a strain on the health system as it increases transaction costs for the MoH as parallel systems are used. It conflicts with the SWAp objective of joint planning and priority setting and attracts qualified staff away from the government health system which further exacerbates staff retention issues. It also increases the degree of fragmentation in health sector funding, as the importance of basket funding has declined. However, it should be noted that the use of multiple baskets has meant that a common funding modality has never been achieved through this mechanism.

99. The large amount of health resources that are controlled by donors and are off-budget clearly has significant implications. As Figure 5 illustrates, in 2000 around 84% of donor health expenditure was on-budget, by 2004 this figure had fallen to 59% with an estimated 41% of donor expenditure off-budget. This makes implementing a coherent health sector policy difficult as funding of activities and implementation has become increasingly fragmented.

Figure 5: On-budget and Off-budget expenditures in health



World Bank (2009), 'Zambia Health Sector Public Expenditure Review'.

100. In terms of on-budget funding, Table 3 shows how the share of basket funding has declined over time and project funding has increased as a share of the budget. The total amount of health sector support provided through basket funding has declined from 54% in 1997 to 39% in 2005. This picture is also out of date as DCI and Danida have left the sector due to the JASZ process which streamlined the number of donors in each sector and the EU and DFID now provide funds to health through SBS and GBS respectively. This has led to a reduction in financing through the basket in recent years, and in 2009 there are only six donors providing funding through the basket funding mechanism. These are SIDA and the RNE (the latter is a silent partner who funds through SIDA), CIDA, the UNFPA, the World Bank and USAID. A more detailed table outlining the individual CP's and their contributions to each health sector basket can be found in Annex B Table 6b.

Table 3: Mix of on Budget Aid Modalities to the Health Sector over Time

	1997	2000	2001	2002	2003	2004	2005
GRZ Budget	32%	23%	38%	28%	19%	18%	25%
Basket funds	54%	63%	47%	57%	51%	33%	39%
Projects	14%	14%	14%	16%	29%	49%	35%
Of which global funds comprised					*40%*	*97%*	*67%*
Total MoH Budget	100%	100%	100%	100%	100%	100%	100%

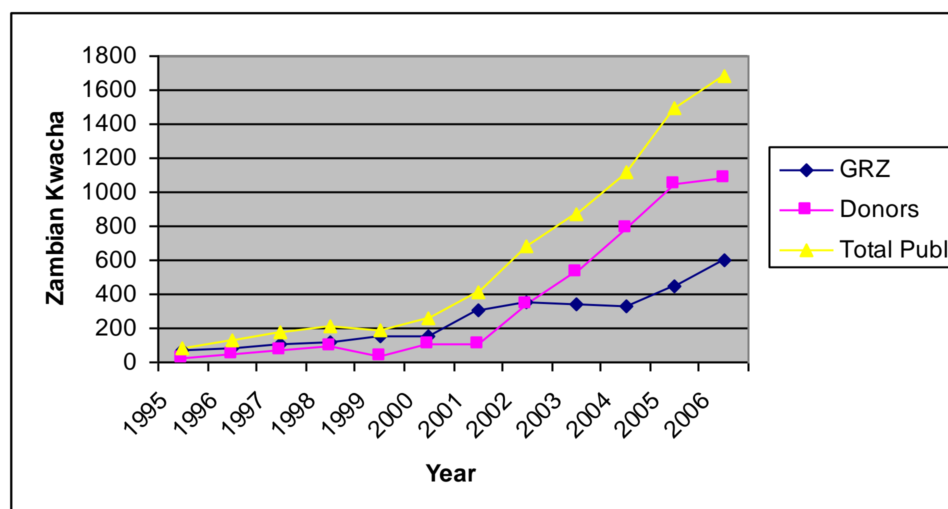
* These figures differ to those in figure 6 as the latter includes other

101. SBS and GBS earmarked to health began in 2006 and in this year SBS and earmarked GBS to health comprised around 6% of total MoH expenditure and around 8 % in 2007[10].

102. Overall, donors contribute a significant amount of the health budget as Figure 6 below shows. It is estimated that including all donor funding, donors contributed in 2007 the following shares of the budget to each area.[11]

- Service delivery 72%
- District health services 62%
- Human resource training 55%
- National health system management 47%
- Drug management 41%

Figure 6: Budget Donor Funding Relative to Public Expenditure in Health from 1995-2006



Source: Econ/UNZA, MoH/ Sida/IHE National Health Accounts for Zambia 2002 – 2004, July 2006 and SWAp Secretariat ; MoH National Health Accounts for Zambia 2005 – 2006

[10] Data supplied by the SWAp Secretariat MoH from NHA.
[11] MoH (2008), *Mid-term Review of the Zambia National Health Strategic Plan: NHSP 2006-2010.*

3. The Key Features of SBS and its Effects on the Quality of Partnership

3.1 The Key Features of SBS Provided

SQ2.1: What are the key features of the SBS that has been provided?

103. This section outlines the types of SBS provided in the health sector and assesses the level of predictability of SBS funding; financial management arrangements; earmarking and conditionality.

Types of SBS in the health sector in Zambia

104. The SBSIP study defines Sector Budget Support as those aid programmes where:[12]

- *Aid uses the normal channel used for government's own-funded expenditures. Aid is disbursed to the government's finance ministry (or "treasury"), from where it goes, via regular government procedures, to the ministries, departments or agencies (MDAs) responsible for budget execution.*
- *The dialogue and conditions associated with the aid should be predominately focused on a single sector.*

105. The EC and DFID are the only CPs who have provided support to the health sector which meets the criteria outlined above. The EC has undertaken a pilot SBS program from 2006-2008 and from 2009 is implementing a larger SBS program. DFID earmarked some of its GBS allocation to the health sector from 2006-2007, although from 2008 there is additional funding provided for health within the GBS allocation, but with no earmarking. For the purposes of this study DFID support is considered as SBS from 2006-2007, but no longer falls within the study definition of SBS after this date. Although there has been very little SBS, this study is timely as levels of SBS are expected to rise in the near future, as more CPs move to SBS in response to the GRZ's statement that general and sector budget support are its preferred aid modalities and as donor headquarters encourage country offices to use SBS as their default aid modality[13].

106. In terms of the studies spectrum of SBS as outlined in Figure 7 below, the EC's support is non-traceably earmarked to HR retention, with conditions focusing on this sub sector, but dialogue covers the whole of the sector which means that it can be classified at point 1 on the spectrum. For DFID, funding is also non-traceably earmarked, in this case to use-fee removal with conditionality focused on the GBS PAF and dialogue encompassing the whole sector. This would suggest that it would be at point 2 on the SBS spectrum.

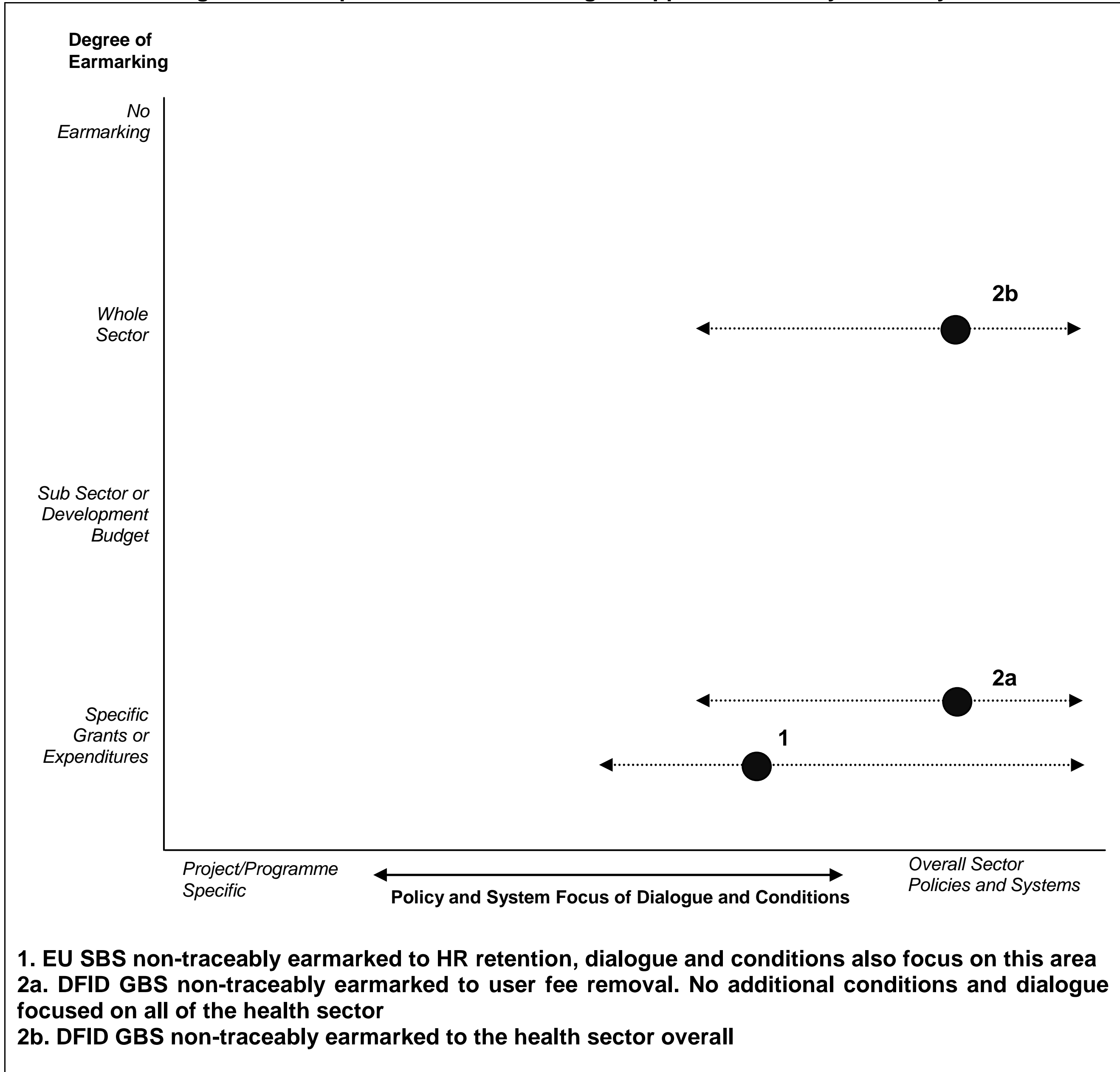
The evolution of SBS and its objectives

107. The EC was previously providing resources to the MoH basket funds, but began SBS in 2006 as a pilot with EUR 10 million allocated to the Health Human Resources Plan under the 9th EDF. The intention was to provide support to finance the HR plan to support human resource retention, although the funding was only non-traceably earmarked.

[12] See SBSIP Inception report p.7.

[13] Sida for example is moving towards SBS as its default aid modality (ODI & Mokoro (2009) Sector Budget Support in Practice: Donor Headquarter Accountability Requirements).

Figure 7: The Spectrum of Sector Budget Support Covered by the Study



108. The move to SBS by the EC as outlined in the financing agreement was stated as being because:

- Budget support is particularly effective at supporting recurrent costs such as human resource development.
- SBS is an effective instrument for strengthening sector dialogue, especially around areas such as health care financing, financial management and accountability of domestic resources.
- Budget support harmonises cooperating partner support behind national poverty reducing strategies

109. In the tenth EDF which began in 2009, health became a focal sector for the EC. The SBS program was scaled up to EUR 57 million and became sector wide, rather than just focusing on HR. The objective is to achieve the MDGs related to health and other priority interventions. Specifically support is being directed at:

- Improvement of equitable access to health services;
- Funding and support to the Basic Health Care Package (BHCP);
- Support towards addressing the human resource crisis;
- Development of nutrition programs.

110. There is a three year SBS programme underway, followed by a two year program which will be either SBS or direct support to the MoH depending on the experience of the first phase. This was designed as a fall-back position in case there were problems with disbursements through SBS.

111. DFID shifted funding from basket funding to supporting the health sector through general budget support in 2006. They chose this route over SBS as they realised through the JASZ process that the health sector was oversubscribed with donors and felt that providing support through GBS would lower transaction costs for the GRZ. Also improving outcomes in health is not just a function of supporting health, as many of the issues are cross-cutting, so providing support to the overall GRZ budget means that the GRZ can consider all these elements holistically and allocate budgetary resources accordingly. As the relationship between the MoH and MoFNP was weak, another benefit that DFID expected was that the budget process would be strengthened as the MoH would have to argue for its budget allocations based on needs and results, focusing the MoH on these issues and increasing engagement with the MoFNP

Box 4: Earmarking, Traceability and Additionality

Earmarking is a requirement that all or a portion of a certain source of revenue, such as a particular donor grant or tax, be devoted to a specific public expenditure. The *extent* of earmarking can vary. It involves the *ex ante* assignment of funds to a particular purpose and can range from the very broad and general to the narrow and specific.

Traceability refers to whether donor funds are separately attributable to a specific use. Funds are either traceable, or not:

(i) **Traceable**, whereby allocation, disbursement and spending of funds is via specified and separately identifiable budget lines. This bypasses the normal procedure by which revenue is pooled with all other revenue in a general fund and then allocated among various government spending programmes. *De facto*, a traceable aid instrument must involve a degree of earmarking, although this may be very broad - this is often referred to as *real earmarking*.

(ii) **Non traceable**, whereby external funding is not identifiable by separate budget lines. If earmarked, the allocation of funds is justified against budget allocations to pre-agreed institutions or budget lines, and is pooled with other government revenues in the general fund. When non traceable SBS is accompanied by earmarking - this is often referred to as *notional earmarking*.

These two dimension combine to form three main types of SBS funding:

	Earmarked	**Un-earmarked**
Non Traceable	Non-traceable Earmarked SBS	Un-earmarked SBS
Traceable	Traceable Earmarked SBS	

Additionality refers to requirements from the donor that the provision of external funding earmarked to a set of expenditures leads to an increase in total expenditure allocations to those expenditures. Additionality attempts to address the problem of fungibility, which arises because government resources can be substituted for aid resources. If aid finances any activity that the recipient would otherwise have financed itself, the resources that the recipient would have spent on that activity become available to finance something else.

Source: SBSIP Literature Review

112. DFID funds were non-traceably earmarked to assist in financing the elimination of user-fees. A rough calculation was carried out of how much the elimination of user-fees would cost and DFID committed to give an additional US$5 million to their GBS commitments over five years (2006-2010). This was to be distributed to districts in proportion to the amount of user-fees they usually collected. Funds were disbursed into the Treasury account in the MoFNP, with the only reporting requirement being that DFID should be given evidence that the funds had been transferred to the MoH. This was required as in the first year of support DFID funds were disbursed after the budget had been finalised and DFID wanted to ensure that these funds were additional.

113. From 2008 the specific earmarking was dropped in favour of broad earmarking to the health sector overall, with no associated requirements to provide evidence of fund transfer.

The level of SBS funding and its predictability

114. Predictability has been the main problem with SBS. The timing of commitments and disbursements for the EC and DFID are outlined in Table 4. There were considerable delays in EC disbursements from year to year which led to a three year program being changed into two years, while delays in DFID disbursements were within year. There were also delays in the MoFNP disbursing to the MoH.

115. The overall result was that the MoH delayed or did not implement planned activities, as they did not receive this additional funding on time, which had a consequent impact on the implementation of sector plans, particular those related to the HR plan.

Table 4: Budgeted and Actual Disbursements of SBS Programmes (2006-2009)

		2006	**2007**	**2008**	**Total**
EC SBS (Euro million)	Committed Disbursed	3.0 0.0	2.0 5.0	5.0 3.57	10.00 8.57
		2005/6	**2006/7**	**2007/8**	**Total**
DFID GBS (US$)	Committed Disbursed	5.0 5.0	5.0 5.0	5.0 5.0	15.0 15.0

* EC figures were supplied by the EC. DFID commitments and disbursements were drawn from conversations with the MoH and DFID but have not been verified by DFID.

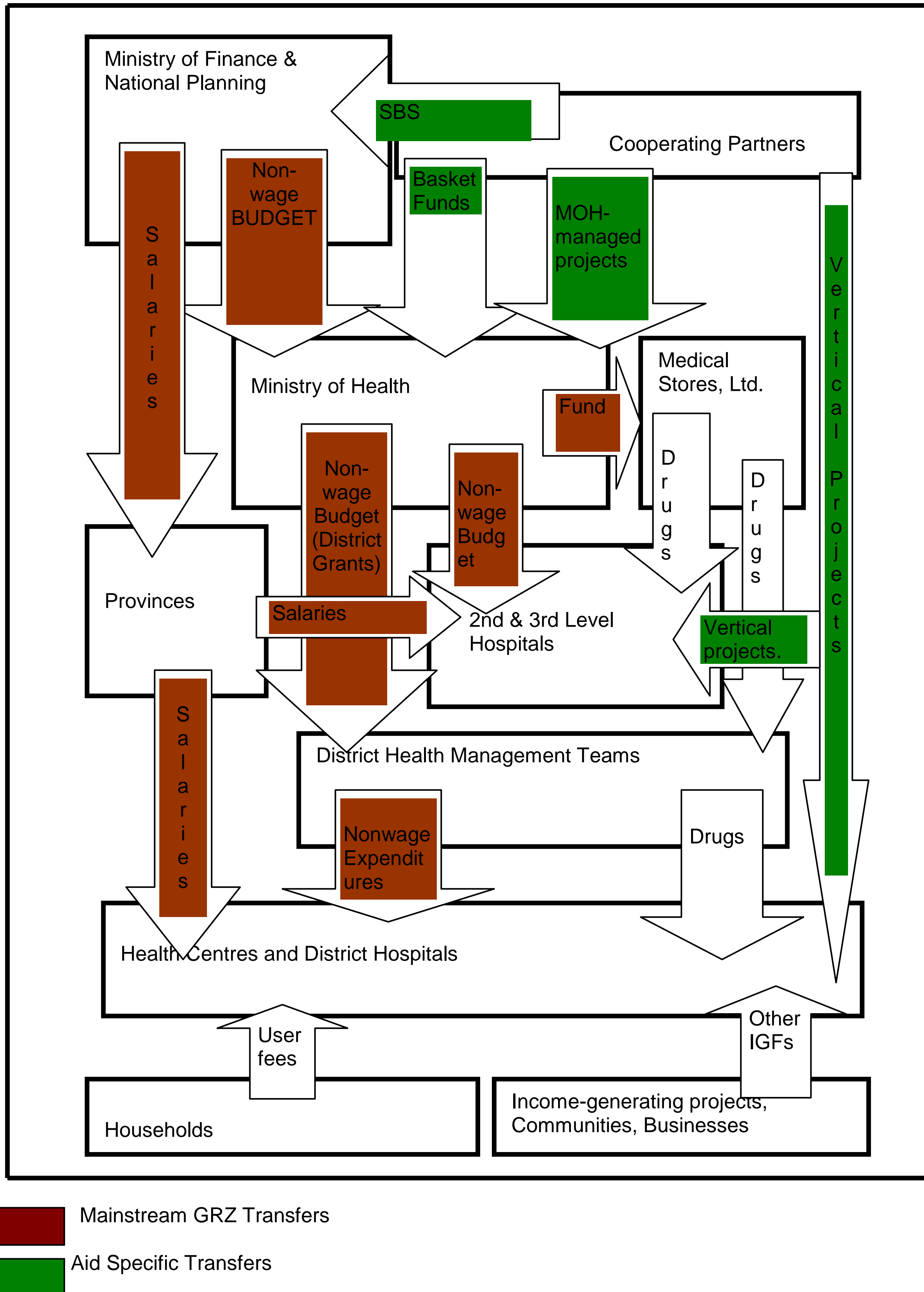
Earmarking, additionality and financial management arrangements

116. Both the EC and DFID used GRZ financial management procedures. Funds were transferred to the Bank of Zambia and then disbursed to the MoH by the MoFNP using normal government disbursement channels. Figure 8 below gives an overview of how GRZ and CP funds flow from the MoFNP to the MoH and the districts.

117. There were no additional procedures that were required in terms of accounting, auditing and procurement. There was an additional reporting requirement for DFID funds, as the MoFNP had to provide evidence that funds had been transferred to the MoH, while the EC required a report from the MoH outlining progress towards meeting benchmarks and indicators for disbursement of each tranche.

118. Both CPs non-traceable earmarked their funding to specific areas in health, with DFID non-traceable earmarking their support to the elimination of user-fees for the first two years, while the EC non-traceable earmarked their resources to human resource retention. There were no additionality requirements specified by either CP.

Figure 8: Diagram of SBS Funding Flows in the Context of Mainstream Budgetary Channels



119. The combination of non-traceable earmarking plus no additionality requirements has been a source of misunderstanding between the MoH and the MoFNP, as the MoH still expected the

SBS funds to be disbursed in addition to the resources that were allocated through the GRZ budget, whereas the MoFNP saw them as part of the GRZ budget. As there were no additionality requirements there was no reason why these funds should have been additional to the normal MoFNP budget allocation, as this was at the discretion of the MoFNP. In practice, this issue was not resolved and as noted above, the MoH delayed activities until SBS funds were received as it took the earmarking literally and only spent SBS resources on the activities specified by the CPs. It was not prepared to spend GRZ funds, even though GRZ and SBS funds were fungible.

120. The issue from the MoFNP side was that although SBS funds are included as part of the GRZ budget and as such are not identifiable. They are treated separately within internal budget execution systems and if DFID or EC funds are not disbursed on time, then MoFNP sometimes reduces the GRZ budget disbursements with the justification that this part was supposed to be financed by the donor and they haven't received it yet.

121. These problems stemmed from ambiguity in design which had not been thought through by either donor. This was compounded by DFID requiring evidence that funds were transferred to the MoH which means that in practice they wanted traceability of their GBS funds allocated to health. This is a clear derogation to normal budget procedures, which does not make sense in the circumstances given that DFID had not stated any requirement for additionality. It seems that DFID had expected the funds to be additional, as they had worked out what the likely funding gap would be from the abolition of user-fees, but without additionality requirements, non-traceable earmarking to user-fee abolition does not make much sense, nor does the need for traceability. This suggests that DFID had not thought through where their funding would flow from and how this would work given their objectives. Therefore the problem was one of shortcomings in the design.

Conditionality and Dialogue

122. For the SBS provided by the EC there were conditionality requirements for the disbursement of the fixed and variable tranches. These can be seen in Annex 4 and were mainly related to the HR strategic plan and the adoption of the NHSP IV. There were problems with meeting the specified benchmarks and indicators, as delays in the approval of the NHSP IV and the creation of a budget line in the GRZ budget related to human resources held up the first fixed tranche. The indicators for the variable tranche, had a financial weight attached to them, so that if the indicator was fully achieved, all the funding available to that indicator would be disbursed, but if the indicator was only partially met, only some of the funding would be disbursed. In the case of the variable tranche, as noted above, although the indicators were judged to be fully met by the SWAp group, this was disputed by the EC headquarters and the amount given to the MoH was reduced.

123. This system used by the EC is completely different to that used by the donors who fund the baskets. For the basket funds, donors disburse on satisfactory receipt of a financial report which is produced biannually. Head office requirements was the reason given by the EC as to why they have instituted a parallel system reporting system and the fact that they wanted to shift sector dialogue away from its present focus on systems to outcomes, so indicators related to this was chosen to be used for tranche disbursement.

124. There were no conditions specific to health for the DFID support, as the funding was disbursed according to PRBS procedures. These rely on monitoring the performance assessment framework (PAF) which has four indicators related to health (see paragraph 130). DFID used the PAF to monitor progress rather than interpreting conditionality in a rigid way, so as long as the overall PRBS progressed and none of the underlying principles were violated, the allocation to health would continue.

125. SBS dialogue was not undertaken through any parallel mechanism, but through the established SWAp framework. Dialogue was not focused on the specific areas that the SBS

funding was non-traceable earmarked to, but was based on the whole sector and the areas outlined in the NHSP IV.

Links to TA and Capacity Building

126. There are is very little capacity building activity in the SWAp that SBS is linked to. In addition to SBS, the EC gave support through a project to develop the health management information system (HMIS) system. This was funded from 2006-2008 and was a EUR 4 million project, implemented through a project implementation unit in the MoFNP. This was complementary to the EC's SBS as it assisted in providing the information needed on health sector inputs, outputs and outcomes which underpin the indicators for SBS.

127. SBS has also been supported through significant work that had been undertaken to improve PFM systems through PRBS, and the move to SBS can be seen as both complementing and reinforcing this. The PEMFA programme is key to this process and is aimed at assisting GRZ to improve capacity to mobilise and use public resources and strengthen financial accountability. It began in 2004 and DFID and the EC are among the CPs supporting it as well as the Netherlands, Ireland, Denmark, Norway, Sweden, World Bank, Finland, Germany and the UN. It has thirteen components which cover a range of issues such as financial management systems, improved fiscal policy and economic planning and strengthened audit and oversight.

Harmonisation and Links to Other Aid Modalities

128. There is a strong link between the SBS in health and GBS through the PRBS, as both the EC and DFID perceived that providing resources to health through GRZ systems would support the strengthening of PFM. One of the overarching objectives of PRBS is improving the efficiency of the PFM system and the capacity of line ministries to engage with the MoFNP. PRBS began in 2005 when a group of bilateral and multilateral CPs signed a MoU outlining the general principles underpinning GBS. The CPs involved in PRBS are DFID, the EC, Finland, Germany, Netherlands, Norway, Sweden, the World Bank and the African Development Bank. The areas focused on are health; education, agriculture, HIV/AIDS, PFM, Public sector Reform, Domestic revenue, financial sector development, public service pension funds, private sector development and infrastructure.

129. At the same time as funding user-fee elimination, DFID has been providing support to an HIV/AIDS project which runs from 2003-2009. This is separate and not strongly linked to their sector support and DFID will also get catalytic funding of £11 million over three years for maternal health and human resources, which is aimed at encouraging further harmonisation and alignment in health to undo bottlenecks in the health sector. This funding will either be channelled through SBS, go to the MoH direct or through NGOs, but the mechanism is yet to be decided.

130. Health has been a sector that has been included within the GBS PAF and in the 2008-2010 PAF there were four indicators related to it. These are:

- Percentage of institutional deliveries;
- Percentage of fully immunised children under one year of age in the worst performing districts;
- Utilisation of PHC facilities;
- Percentage of MoH releases to district levels.

131. SBS and the health SWAp are also explicitly interlinked as SBS is aligned with SWAp policy and planning processes and there are no separate processes for SBS dialogue as these occur through the SWAp framework.

Conclusions on the design and its implications on the lack of predictability of SBS

132. There have been significant problems with the design of SBS that have had a negative impact on predictability of funding. The lack of financial management requirements and thinking through how funds would be transferred and how the process would fit with existing budgetary systems, led to confusion about how funds would be transferred and whether they would be additional.

133. DFID's insistence on traceability was a derogation from normal budgetary procedures, but this as well as non-traceable earmarking, did not make any sense without additionality requirements. This flaw in design then compounded problems with disbursement, as it created the expectation of additionality, while it was not clear how funds would be transferred to the MoH.

134. The EC's choice of design using tranche based conditionality, also led to disbursement delays, due to failure to meet conditions and the level of funding being reduced at headquarter. There were additional problems in the case of the EC due to delays in signing of the original agreements and administrative delays at EC headquarters.

3.2 Derogations from Country Policies, Systems and Processes

SQ2.2: To what extent have SBS inputs derogated from country policies, systems and processes, and are these a result of country specific concerns and/or headquarter requirements?

135. The design of EC SBS to the health sector has been aligned with sector policies and uses GRZ systems, but has derogated from health sector processes by requiring additional conditionality mechanisms. There is a matrix of indicators in the NHSP IV which are used to monitor progress in the sector by CPs who contribute to the basket funds. All that is required from CPs such as SIDA, UNFPA and CIDA are that the MoH produces a bi-annual report which monitors these indicators. Basket fund contributors then disburse once this report has been released. The EC system requires a separate report to be produced on the EC sub-set of indicators and a complicated system is in place as described in paragraph 122 above, where resources are allocated to each target and disbursed depending on the extent to which they have been achieved. The final decision on achievement of these targets is then made in Brussels taking ownership out of the hands of the MoH and SWAp partners.

136. This system responds to the EC's corporate policy on SBS which proscribes a system based on fixed and variable tranches, which gives the EC little flexibility in terms of how it designs SBS. The EC is however able to give support through SBS, as headquarters require a shift in the composition of aid programmes to more sector and budget support. It is also not now allowed to earmark SBS, hence the un-earmarked nature of the second phase of SBS.

137. In contrast, DFID was able to channel health sector funds through PRBS without any additional conditionality, as DFID guidelines on conditionality state that rather than using conditions, benchmarks towards progress should be used and a long term view should be taken. This means that PAF indicators are not used as conditions, but to monitor progress. Also, DFID support used GRZ systems and processes, the only deviation being that a letter was required from the MoFNP to show that funds had been transferred to the MoH, which led to the corresponding problems as described in paragraph 121.

138. The extent to which CPs are able to move to SBS is also restrained by corporate accountability policies, despite the GRZ giving a clear signal that it would prefer SBS or GBS. Currently of the CPs that use basket funds it seems that SIDA and the RNE (who is a silent partner and funds through SIDA) will shift to SBS, if the conditions are right and disbursement problems are resolved, as their new corporate strategy asks country offices to use SBS as their default aid modality. CIDA will probably not move away from basket funding, as there is currently no clarity from CIDA headquarters on when SBS should be used and their program is also under review so

they are unable to make a decision yet. Others such as USAID will be unable to move to SBS as pooled funding is not allowed under USAID rules, but USAID was able to fund the health basket as it began doing this before these rules were introduced.

139. It is unlikely that those CPs who are using project modalities in health, particularly the vertical funds will move to SBS, given that they have not been able to pool funds through basket funding due to corporate accountability requirements.

3.3 The Effects of SBS on the Quality of Partnership in the Sector

SQ2.2: Has SBS contributed positively to the quality of partnership and reduction in transaction costs between development partners, the recipient government and civil society?

140. Sector dialogue is separate from the funding mechanism used by CPs in the heath sector, so it can be argued that the move to SBS by the EC and the DFID earmarking of GBS made no difference to the quality of the partnership in terms of the dialogue and interactions between the MoH and CPs. The SWAp process and the mechanisms through which this operates are independent of CP funding, so DFID and the EC continued to participate in the sector processes for dialogue and adhere to the NHSP IV. DFID for example is one of the troika for health and is the CP focal point for health in 2009, despite all its funding being through the GBS.

141. On the other hand, there is a perception on the part of the MoH that the move to SBS is a negative step by CPs and is resulting in the fragmentation of basket funding which they consider has worked well. The MoH perceives that it has experienced a reduction in funding as a result of DFID and the EC moving away from basket funding which went directly to the MoH, although in practice overall funding to the health sector has increased. From the MoH point of view, SBS has created considerable problems due to late disbursement of funds from the MoFNP, which has increased transaction costs, as the MoH have spent time trying to resolve the issue and have had to delay implementation of activities as a result. In addition, although the MoH receives a large amount of external funding, most of this is not discretionary, but the baskets funds can be used flexibly, particularly the expanded basket. This is a significant concern for the MoH given that it is likely that other CPs may follow suit and shift basket funding to SBS.

142. The EC's use of a fixed and floating tranche system is also seen as burdensome by the MoH with several officials expressing the view that it is 'immoral' to request that benchmarks and targets be met before the funds are given to the Ministry. The process is also lengthy causing delays to the funding which is further exacerbated by officials in Brussels then reducing the assessment of indicators, so less funding is received. This has made funding unpredictable and has increased transaction costs for the MoH.

143. Finally there is also an issue of sustainability of basket funding and a lack of clarity as to which CPs will make the transition to SBS. This has created uncertainty for the MoH as various CPs have expressed interest in exploring a possible move to SBS, but it is not clear to what extent there will be a shift and whether this is just a transition in the move to GBS. As the experience of SBS has been disruptive for the MoH so far, in terms of causing delays in implementation of activities, this uncertainty is a concern for the MoH.

4. Sector Budget Support and its Effects in Practice

4.1 SBS and its influence on sector policy, planning, budgeting, monitoring and evaluation processes

SQ 3.1: What has been the influence of SBS on Sector Policy, Planning, Budgeting, Monitoring and Evaluation Processes, and what are the constraints faced and lessons learned in practice?

SBS Alignment with and contribution to policy and planning processes

144. Policy and planning processes are well established in the health sector with the HNDP IV providing the policy and planning framework which all CPs are encouraged to align with. It is also the basis for dialogue between stakeholders.

145. The EC's support through SBS is aligned with these sector policy and planning processes. SBS funding supports the Health Sector Human Resources Strategic Plan and its implementation is non-traceable earmarked to the retention of health workers. Resolving the human resource crisis is one of the 10 national health priorities and is a key area that needs to be addressed in order for the health sector to function effectively. By aligning with existing sector policies and plans, the EC have helped to reinforce the SWAp process and through SBS have been able to give support that wouldn't have been possible by using basket funding. Basket funds can only be used for operational costs, not for paying wages, whereas the EC support can be used to make additional payments to staff to encourage staff retention.

146. The EC is also providing complementary support to SBS through financing of the Health Management Information System (HMIS). This provides data on indicators and targets in health which assists the MoH and CPs with the overall planning of activities and monitoring of results. The next phase of EC support that began in 2009 under the 10th EDF is also be aligned with health sector priorities, through supporting the drive to attain the MDGs. Assistance will be given through non-earmarked discretionary financing non-traceably labelled to specific policy measures outlined in the NHSP IV.

147. DFID support has been non-traceably earmarked to financing the elimination of user-fees in health, which is another key health sector policy priority and therefore the support is fully aligned with government and sector priorities.

148. The provision of SBS has not changed the nature of dialogue within the sector as it is still undertaken through the SWAp consultation mechanisms and given that the SBS objectives of both the EC and DFID are priority issues under the NHSP IV, this has not altered the content of dialogue, but supported existing structures and focused on existing issues.

149. In the future this may change as the EC has stated that part of the objective of SBS under the 10th EDF, is to shift the nature of dialogue more towards results. Given that a criticism of the SWAp dialogue has been that it has focused more on systems rather than outcomes and results, this may have a potentially positive impact.

150. Overall, given that there are well-established procedures for alignment with health sector policy and planning processes that are already used by those CPs in the SWAp, SBS has not influenced these processes, but rather aligned with them which, is appropriate in the circumstances.

SBS alignment with and contribution to budgeting, monitoring and reporting processes

151. SBS has been aligned with GRZ budgeting processes as funding provided by DFID and the EC were pooled with GRZ funds and considered as part of the overall GRZ budget by the MoFNP.

The funding was included within the MoFNP MTEF allocations, and included within the health sector budget allocation. This should have helped with bringing funds on budget and strengthening the efficiency of the budget allocation process.

152. The MoH allocated SBS funds separately in the health budget and allocated the funding to specific budget lines. Interestingly the EC is still listed as contributing to basket funds, as EC SBS funds are allocated to the HR basket. This was the budget line that the EC stipulated had to be established as a condition of their SBS. This funding is therefore included within the health sector budget which is approved by Parliament, but it is not stated as being SBS. At the MoH level it is treated in the budget process as direct donor funding, even though it is part of the GRZ budget.

153. This has caused problems with the late approval of the budget (as outlined in paragraph 119) has resulted in MoH delaying implementation of activities that SBS funds had been allocated to. This is not a problem of SBS per se, but a result of a failure to explain to the MoH how the change in funding would make a difference to how disbursements were made and how funding could be used differently.

154. Monitoring and reporting processes are well established in the health sector and there are well defined procedures for those involved in the SWAp and basket funds. For the CPs that fund the basket, the MoH produces a separate report biannually which most basket funders have used to satisfy their own reporting requirements (some such as USAID have additional ones). The move to SBS by the EC means that the MoH now has to produce an additional report outlining progress towards meeting the targets and benchmarks outlined in the EC financing agreement. Although the assessment of whether these have been met is undertaken through a joint process at the Health Sector Advisory group meetings, it still means an additional procedure for the MoH. The benchmarks and targets are a sub-set of the matrix of monitoring and evaluation indicators and targets which are laid out in the NHSP IV and reviewed through a joint review process between CPs and MoH annually. A separate report has to be produced for the EC as the level of funding depends on the degree to which indicators have been met. The SWAp donors are monitoring progress, whereas the EC has to assign a percentage to which each indicator has been met and levels of funding are decided accordingly.

155. DFID disburses according to the PRBS agreement which is linked to an assessment of the PAF (see paragraph 130). The only derogation was DFID's requirement for evidence that SBS funds had been transferred to health, but on the whole, DFID SBS is aligned with existing monitoring and reporting procedures.

SBS influence on resource allocation

156. Resource allocation has been subject to a number of distortions in the health sector, due to the variation in funding mechanisms used by CPs. The main distortion arises from vertical funds which result in serious distortions in funding priorities, as resources are often not in line with sector priorities and they are rigidly earmarked to specific programs. The basket funds have been a move in the right direction, but even these have been earmarked to various sub-baskets, with the aim of a single consolidated sector wide basket that consists of discretionary funding, remaining elusive. Most basket funders have also operated parallel projects at the same as contributing to the baskets.

157. Although overall external funding to the health sector has increased, most of this is off-budget and non-discretionary, although it should be noted that GRZ funding has recently increased. SBS has led to a reduction in donor funding as DFID was contributing approx US$9m in 2005 to the expanded health basket which was in practice completely discretionary as there was no earmarking. The DFID allocation to health in 2006 through SBS was US$5 million which constituted a decrease in overall funding. DFID funding in 2005 was 25% of the total health basket funds.

158. The EC was contributing around US$2.5 million to the district basket in 2005 which goes directly to districts. In 2006 there was no funding to health as the expected SBS funding was not disbursed, although in 2007 it was US$5 million which was greater than planned, but in 2008 was less than the amount committed and not received by the MoH until March 2009 (see Table 4). Again this has had a negative impact on health sector resource allocation, particularly due to the unpredictability of disbursements and the fact that in 2006 no funds were received by the MoH.

159. The lack of additionality requirements also means that it is difficult to judge the impact of SBS on overall resources. In nominal terms the GRZ budget allocation to the health sector has risen, but whether this is due to SBS it is not possible to tell, as the MoFNP MTEF is not a very reliable indicator of future resource allocations. This also makes it difficult for the MoH to engage in medium to long term planning, which means a credible MTEF will be important if more resources are channelled through SBS.

160. The main impact is probably on the composition of expenditure as by focusing on HR retention and user-fee elimination there has been an increase in expenditure on these issues. For example the MoH's allocation to the districts has still remained at a higher level than before DFID gave funds for user-fee elimination, suggesting funds are still being allocated to this, even though DFID is not earmarking funding to health anymore.

161. It can be argued that SBS has improved resource allocation at the central level as the MoFNP did not transfer what the MoH perceived to be SBS funds, as they argued that the MoH already had sufficient resources in their own bank accounts. This was part of a recent change in regulations where the MoFNP decided that they would not give additional resources to line ministries who already had sufficient funds, as the MoFNP was finding that it had to borrow when these ministries were depositing their additional cash in bank accounts. This move on the part of MoFNP should have helped in increasing the efficiency of resource allocation to government institutions.

162. Overall, the change to SBS has presented problems for sector resource allocation, but much of this was due to a lack of clarity from the MoFNP in terms of the level of the MoH GRZ budget allocations and how SBS would affect these. Non-traceable earmarking through SBS has had some impact on intra-sector resource allocation as DFID funds were used to provide additional resources to the district level to mitigate the effect of user-fee elimination. EC funds have been used to implement the human resources plan and as noted earlier, unlike other CPs funding are able to be used to supplement salaries this is important for increasing staff retention. The EC's next phase of support is focusing among other things on the BHCP which to date has not been successfully implemented, as it has not been adequately funded. This could have a positive impact on sector resource allocation in the future.

Lessons learned

163. Several areas where SBS has had a positive influence on policy, planning, budgeting, reporting and monitoring in the health sector have been observed. In summary:

- Using existing mechanisms for sector planning, dialogue and reporting is a good practice that reduces transaction costs for the MoH and reinforces the SWAp as the overarching framework in health, through alignment with its practices and processes.
- Ensuring that SBS funds are non-traceably earmarked to priority areas or those that are under-funded has played an important role in intra-sectoral resource allocation through ensuring that SBS in these areas are highlighted and dialogue is focused on key sector priorities.

164. There are a number of lessons learned that would strengthen the benefits of SBS if implemented:

- Additional reporting procedures should be avoided so that there are not added transaction costs for the GRZ from moving to SBS. Any SBS reporting system should be harmonised with the SWAp and those used by the basket funds.
- It is important to have a transparent and predictable system for resource allocation in place in the MoFNP in order to build confidence between all stakeholders. As part of this an effective annual budget process, with reliable budget ceilings is important for the MoH to be able to plan for the medium-term, while the MoH needs reassurance from the MoFNP that a shift of basket funders to SBS will not affect the overall resources allocated to health.
- It is also important to ensure that funding to health is not reduced as a result of more CPs moving to SBS and that activities planned under the NHSP IV can still be implemented. This is implies an orderly transition with the MoH working with CPs and the MoFNP to ensure that this occurs and that all stakeholders are aware of what changes will result.

4.2 SBS and its Influence on sector procurement, expenditure, accounting and audit processes

SQ3.2	What has been the influence of SBS on procurement, expenditure control, accounting and audit systems at the sector level, and what are the constraints faced and lessons learned in practice?

SBS support to national PFM systems

165. The SBS provided by the EC uses national procurement, expenditure, accounting and audit systems. The funds are transferred to the Bank of Zambia and then to the MoFNP, where there are no additional processes undertaken or derogations from national procedures in terms of the transfer of funds to the MoH. The funding is treated as part of the GRZ budget. Auditing is also undertaken by the Office of the Auditor General as part of the established process of auditing the GRZ budget, so it is not possible to track SBS funds. DFID funds were provided through GBS and a report had to be provided by the MoFNP to DFID to confirm that funds had been released to the MoH to ensure traceability. This was a major derogation from normal GRZ budgetary procedures and caused significant problems.

166. There have been negative influences on PFM and particularly expenditure control systems from SBS for a number of reasons. First, the EC SBS due to late disbursements by the EC headquarters, disrupted budget planning and expenditure for both the MoFNP and MoH. The amounts involved were reasonably small (See Table 4), but given the EC has now scaled up its SBS program any delays are likely to have a greater impact. The same issues were experienced with DFID's support.

167. Second, there were problems with the GRZ PFM system which led to delays in SBS disbursements as outlined earlier. Despite SBS having no conditions attached in terms of ring-fencing or additionality, these funds were still perceived as separate to the GRZ budget in some instances (but not all) by the MoFNP and also by the MoH. This lack of clarity led to the perception by the MoH that SBS funds were not been disbursed predictably as significant delays occurred between the time the funds were transferred to the MoFNP and disbursed to the MoH. For example, DFID funds for 2007 became available to the MoFNP in October 2007 but were not released to the MoH until April 2008. This occurred because the MoFNP were not using their normal budgetary cash management procedures, when in practice they could have done. In this case, late disbursements would have not made any difference as the MoFNP would make up the shortfall as it is part of their overall budget.

168. Third, the processes for transfer of SBS funding had also not been fully worked out as according to the MoFNP the Bank of Zambia would transfer funds to the MoFNP, which would only state which CP it came from. This means that if the funds stated it was from DFID for the PRBS, it would not be known that part of this was the US$5 million earmarked allocation to health. Added to

this, the notification would go to the finance department in the MoFNP, not the planning department who would be more likely to know what each transfer was for. This suggests a need for prior agreement as to what instructions CPs need to give the Bank of Zambia when transferring funds and what the process is for notifying the correct departments (i.e. planning) in the MoFNP and giving information about when funds will be transferred to the MoH and which accounts they will go to.

169. On the other hand, it should be noted that basket funds are often not transferred by CPs on time either, which is a problem as MoH sometimes has to borrow money from the GRZ budget to cover the shortfall.

170. In the past there have been problems with GRZ budget execution and reporting, but in the last few years' predictability of funding to the MoH has generally been good. The MoFNP releases funds based on quarterly cash profiles developed by the MoH. The release of funds by the MoH to the provinces, districts and other facilities is reported to be reasonably smooth too. The PEFA assessment also notes that average variance between actual expenditure and the original budget is between 2005-2007, just over 5% on average, compared to 14% on average from 2002-2004. The reason for this is that revenue receipts have been high relative to budgeted amounts due to the buoyant economic situation. If this changes due to slower economic growth, cash shortages maybe more common in the future, strengthening the need to agree on how SBS funds will be treated within the budget and transferred using GRZ systems.

171. There is also another significant problem that has the potential to be an issue on the expenditure side if a larger shift to SBS occurs. The budget year starts at the beginning of the calendar year, but the budget is not presented to Parliament until January or February and only approved two months later. This means that a Presidential Provisional Warrant is used to authorise spending retrospectively between January and March and can only be undertaken on a fractional basis of the previous year's budget. This means that capital expenditure cannot go ahead which makes procurement difficult as effectively this has to take place within the next nine months. Ministries are allowed to start the procurement process, but not award contracts until after the budget is approved. The budget cycle is fixed by the constitution which makes amendment difficult, although it is currently being reviewed. This means that more SBS is likely to exacerbate this problem, if it is not resolved in the near future, as other external funds such as basket funds are not subject to these restraints.

172. Overall, SBS has not had an impact on procurement, expenditure control, accounting and auditing systems, primarily because the basket funds use GRZ systems, which means that there has been little change at sector level. To date the switch to SBS has been marginal, which means it would be unlikely to have any impact anyway. System wide problems with PFM such as a non-transparent budget allocation process and a lack of communication between the MoF and line ministries have been exacerbated by SBS which means that SBS is likely to cause greater problems if these are not resolved before it is scaled up.

Lessons learned

173. The following are examples of positive influence which can be drawn from the SBS experience in the health sector in Zambia:

- The use of GRZ PFM systems including procurement, expenditure control, accounting and auditing have been important to ensure that there are no additional transaction costs for the GRZ and through this areas in PFM systems that need to be strengthened have been highlighted.
- In addition, this demonstrates the importance of operating a pilot SBS approach in order to learn where the bottlenecks exist in PFM systems and the changes that are needed for SBS to operate effectively before it is scaled-up.

174. There are a number of lessons learned that would strengthen the benefits of SBS if implemented:

- There needs to be clarity at the beginning of the SBS process as to how SBS will operate, whether funds will be additional to the GRZ budget and how transfers of funds will be made. This was not made clear and as a result there were misunderstandings that related to the processes for transferring funds between the MoH and the MoFNP.
- The transition to SBS implies a change in the mindset for the MoH from viewing SBS funds as basket funds that come through the MoFNP, to seeing them as being incorporated into the GRZ budget allocation for health. It was not necessary to use specific funds from SBS for activities that they were non-traceably earmarked too, so the MoH could have avoided delays in implementation of these activities by using GRZ funds. The MoFNP needs to treat SBS funds differently too, rather than seeing them as separate blocks of SBS funds that fund the GRZ budget, they need to treat them as normal revenue and as part of the overall budget, using normal budget execution procedures.

4.3 SBS and its influence on the capacity of sector institutions and systems for service delivery

SQ3.3: What has been the influence of SBS on sector institutions, their capacity and systems for service delivery, and what are the constraints faced and lessons learned in practice?

Use of government systems for funding institutions and service delivery

175. SBS has used government systems for funding institutions and service delivery. It is also been aligned with the SWAp agreement that has its self been instrumental in shifting significant resources towards district and primary health care. As Figure 3 illustrated, there has been a significant shift away from resource allocation to tertiary hospitals to district and ambulatory health services. The 1999 and 2006 MoUs reinforce this by stating that a minimum of 60% of total resources from CPs should go to this sub-sector and a minimum of 50% from resources from GRZ should be directed towards district health services.

176. DFID GBS funding earmarked for health was allocated by the MoH as additional funding to the districts. Although this support entirely used GRZ guidelines, systems and supports the decentralisation process, there were some significant problems in the first and second years of support which resulted in delays in disbursement to districts of the funds that they expected to use to cover funding gaps caused by the elimination of user-fees. This is likely to have impacted negatively on service delivery (see paragraph 14 and 15).

177. Similarly, the EC SBS funds are non-traceably earmarked for HR retention. There was a condition for the release of the first fixed tranche that a budget line related to HR was included within the GRZ national budget. Although EC funds are non-traceably earmarked it does seem that the MoH allocates EC funding to the HR budget line and resources are then allocated using GRZ systems.

Support to institutional capacity building, dialogue, TA and Conditionality

178. Given that human resource constraints seriously undermine sector service delivery, the EC SBS focus on assisting in institutional capacity building through the HRH strategic plan, should in theory have a positive impact on institutional capacity building. It is too soon to tell any affect that it may have had, as late disbursement of funds and the fact that the MoH took the non-traceable earmarking literally means that implementation of activities has been delayed (see paragraphs 11 and 12).

179. However, as the mid-term review of the NHSP IV notes, the scale up of the retention scheme in conjunction with the provision of adequate supplies and equipment is likely to have a positive impact on staff retention and health outcomes.

180. The 10th EDF SBS that the EC is just beginning is intended to have an impact on service delivery and institutional capacity building. The main aim is to expand social services and assist in attaining the MDGs and other priority interventions. The objectives are outlined in Box 5.

Box 5: 10th EDF: EC SBS to the Health Sector

- Improvement of equitable access to health services in the context of the Governments policy on free basic health and in collaboration with local authorities.
- Funding and support for the Basic Health Care Package (BHCP) targeting assistance to:
    - systems development for the effective and efficient distribution of standards, guidelines, logistics and supplies for the implementation and coordination of essential clinical services
    - strengthening the provision of the essential package of care especially at district level
    - strengthening the referral level.
- Support towards addressing the human resource crisis focusing on the following:
    - recruitment of core health workers and their retention also through improvement of conditions of service
    - addressing the systemic challenges related to operationalisation of the Human Resources Strategic Plan
    - development of the capacity of health providers through pre-service and in-service training of health workers in essential clinical services
    - capacity building in training institutions
- Development of nutrition programs.

Source: EC (2008) Zambia – European Community Country Strategy Paper and National Indicative Programme for the period 2008-2013.

181. Support provided by the EC to strengthen the HMIS has assisted in strengthening the capacity of the MoH to collect and generate useful information to guide sector policies and activities. This is complementary to the EC SBS support, but also underpins SBS and SWAp implementation.

182. Issues of institutional capacity and service delivery in health are also addressed through PRBS dialogue, as many health outcomes are affected by actions implemented in other sectors, rather than in just the health sector itself. The PRBS also supports broader reforms which should assist SBS to work more effectively and enhance capacity building in health through PEMFA, which is instituting reforms of PFM, public procurement and public service management. Through channelling SBS funding through GRZ systems this helps to discover where the bottlenecks are in the PFM and budget systems at both central and sector level, which means that ways can then be found to resolve them. In this way, the institutional capacity building that is occurring at sector level in health is complemented by actions at the central level through PRBS.

183. Dialogue on service delivery issues does not occur separately for SBS and is undertaken as part of the SWAp processes for dialogue. Thus, SBS has not shifted the dialogue to highlight specific issues that need addressing, but has responded to problems that have emerged as part of the dialogue and incorporated these as part of the SBS program. In particular, there has been an emphasis on non-traceable earmarking of funds and focusing conditions on areas that have not been receiving sufficient funding such as the BHCP and new initiatives of user-fee elimination and staff retention that need financing. These have the potential to have a strong impact on service delivery.

184. In terms of conditionality, there was no conditionality attached to DFID GBS support earmarked to health. The EC's SBS (2006-2008) used conditionality taken from the HR for Health Strategic Resources Log-frame and the National Development Plan, which reinforced the need for

institutional strengthening and capacity building in the area of HR. Particular benchmarks related to tranche disbursements were:

- Development and implementation at central and provincial level of an HR information system to ensure that human resources planning is coordinated across the health sector and is based on best available data.
- Agreed and formalised mechanisms for selective incentives for health workers in underserved areas and for prioritised professional profiles.
- Improvements in the ratio of health professional population/staff (enrolled nurses); no districts in Zambia presenting a ratio above 7000.
- Progress on the MoH payroll of staff currently paid from grants and user-fees at district levels.

185. These benchmarks were judged to be partially met so it can be assumed that SBS in this case had some positive impact on institutional capacity building and will continue to do so in the next phase of EC SBS support.

186. There has been no specific TA provided to support SBS from either DFID or the EC.

Contribution to increased funds for service delivery and increased capacity for service delivery institutions

187. SBS has not resulted in any significant additional funds for service delivery as the EC previously financed the district basket fund and DFID the expanded basket. The basket fund also used GRZ systems and was focused on service delivery at district level. Given that DFID's earmarked GBS funding to health was less than previously given by DFID through the basket funds, this will have led to a decrease in funding available. The EC gave approximately the same amount through basket funds as through SBS in their first phase of support and in the current phase have scaled up funding. Although this will have increased funds available for service delivery, the amounts involved are very small and will have been outweighed by CPs leaving the health sector as part of the JASZ process.

188. The main contribution related to funding is that the EC funds are more flexible and can be used for paying wages, whereas the basket funds could not be. This should have a positive impact as EC support can be used for topping up salaries which helps in supporting staff retention schemes. Therefore, SBS from the EC should in principle have increased the capacity of service delivery institutions as the focus on human resource retention and the BHCP in EDF 10 should strengthen service delivery through increasing staff numbers and delivery of basic services. This is pushing forward key areas that have been constraints for improving health care services and outcomes, but it is too soon to see any specific results in these areas. This is due to the fact that delays in EC SBS have meant that planned activities have not been implemented as planned.

189. There is also evidence that the abolition of user-fees for the rural population has resulted in a substantial increase in attendance at health facilities. DFID calculated how much was received each year from user-fees and how much the expansion of the health services would cost as a result of the policy and allocated this amount to health from GBS each year. This was estimated to be US$5 million. The NHSP IV's aim of improving service delivery has been based on improving access to and utilisation of health services through providing free health care. DFID's GBS earmarked to fund the elimination of user-fees in health will have played a role in achieving this policy.

190. On the other hand, the increase in attendance at health facilities due to the abolition of user-fees in rural areas has put more pressure on staff at these facilities, so in this way is negating some of the impact of the EC support to increase staff numbers and delivery of basic services.

Lessons learned

191. The following are examples of positive influence which can be drawn from the SBS experience of supporting service delivery and capacity building in the health sector in Zambia:

- The use of government systems by SBS to fund service delivery without adding additional procedures or derogations has been an important element of EC SBS design. This is supportive of the decentralisation process and should reinforce institutional capacity at sector and district level.
- The focus of SBS has been to target support on areas of the HNSP IV which to date have been under-funded and which should in principle have a strong impact on service delivery. Given the need to improve health outcomes and progress towards the MDGs this is a very useful approach.
- There is valuable contribution from allowing funds to be used in more flexible ways. The EC's SBS funding of salaries has enabled progress to be made on MoH staff retention plans which could not have occurred under basket funding.

192. There is one important lesson learned that would if implemented strengthen the benefits of SBS:

- There is a need to identify the funding channel for service delivery that SBS will be funding in the design phase and to ensure that there are appropriate instructions for the use of that funding. This was not done for the first year of DFID SBS.

4.4 The Influence of SBS on domestic ownership, incentives and accountability in the sector

SQ3.4: What has been the Influence of SBS on domestic ownership, incentives and accountability in the sector, and what are the constraints faced and lessons learned in practice?

SBS as a modality

193. There is a high degree of ownership by the MoH of the SWAp process and also of the basket funds. The SWAp ensures a high degree of alignment with MoH policy and helps in the coordination of external funding, while basket funds are seen as flexible resources that the MoH has access to that have a reasonable level of predictability. In contrast vertical funding and projects are not perceived by the MoH to be owned as they operate parallel systems to those of government and often result in highly unpredictable funding. GRZ budget funds are also perceived to be less predictable by MoH, so basket funds are their preferred modality.

194. The shift to SBS is perceived by many respondents in the MoH as decreasing their level of ownership as resources were shifted away from the direct control of the MoH to the MoFNP. This is because the MoH has had no control over the amount of SBS funding received and the timing of disbursements has been extremely delayed.

195. There is a feeling that the MoH has put a lot of effort in to establishing the SWAp and the basket funds and that the move to SBS has the potential to undermine this. The concern amongst most MoH officials interviewed is that as more basket funders, particularly those who were instrumental in its establishment migrate to SBS this will result in more fragmentation of health sector support and a reduction in sector funding. Although there has not been a reduction in sector funding in the past couple of years, there has been a reduction in basket funds which has affected the MoH's direct funding.

196. As there are already monitoring frameworks agreed for the disbursements of basket funds, the inclusion of additional systems for the disbursement of EC SBS is seen to undermine

ownership by the MoH, particularly as even after the SWAp group agrees that targets are met, these may then be changed in Brussels. Due to a lack of additionality, there is a perception by the MoH that the allocated budget for health will probably remain the same regardless of whether the benchmarks and indicators are met or not for SBS, thus limiting incentives to achieve them. Furthermore, delays in SBS funding have resulted in planned activities not occurring due to a lack of financing or being implemented late which has acted as a disincentive for officials at the MoH and at district level.

197. All of the above is a result of a misunderstanding regarding the nature of SBS. As SBS was treated as a separate channel of funding in the first years of SBS, this has led to the impression that it is prone to delays in disbursement and funding to health has fallen, even though in practice funding from the state budget has risen. If normal budgetary channels and cash management procedures had been followed, which in practice they should have been, then this perception would not have arisen.

198. On the other hand, the MoFNP perceives that the shift to SBS has been a very positive move. As the MoH has a lot of off-budget funds, moving donor funds on-budget and through the treasury system has strengthened the ability of the MoFNP to allocate budget funds efficiently. In fact, this has been one of the issues of dispute regarding SBS when the MoFNP who has refused to transfer funds from SBS to the MoH when it has been aware that the ministry already has sufficient funds in its bank account to fund current activities. In this instance SBS has helped the MoFNP to strengthen its cash management procedures.

Government Ownership, Incentives and Accountability

199. Health sector policy is already strongly owned within the health sector through the SWAp process, which means that SBS has not had any influence on policy but has reinforced it through aligning with existing policy frameworks.

200. SBS has by channelling funding through the treasury contributed to the strengthening of national accountability systems. As SBS funds follow normal GRZ procedures this means that more CP funds are subject to oversight by the Parliament (Public Accounts Committee) and the Office of the Auditor General, which increases the proportion of resources over which Parliament has discretionary power. This is clearly an advantage of SBS over basket funding and projects. It also compliments the reforms that are being undertaken through PEMFA that aim to strengthen accountability within PFM.

201. There is a high degree of accountability within the MoH as considerable progress has been made during the NHSP IV to develop national policies, establish a legal framework for support to the health sector and develop guidelines for resource allocation. The development of a new MoU for the SWAp in 2006 outlines the obligations of both the MoH and CPs in giving support and a number of management and organisational reforms have been undertaken to support the decentralisation of health service planning and provision to district level. The MoH attempts to ensure a reasonable level of accountability to CPs, as efforts are made to be transparent by reporting regularly and improving financial reporting and monitoring and evaluation. These aspects are all related to the SWAp and other processes rather than SBS.

202. One of the objectives of SBS was to strengthen the relationship between the MoFNP and the MoH to ensure better accountability and a stronger relationship between two institutions to establish a more effective budget process. Through SBS there was an expectation that a more contestable budget process would emerge with the MoH arguing its case for budget allocations and the MoFNP taking a holistic view on the overall budget and allocating resources accordingly. Previously this could not happen as all CP funding was going directly to the MoH and the MoFNP was often not aware of all the resources that the health sector has available to it.

203. To date there is not much evidence of this occurring, budget processes are still opaque in terms of the method by which the MoH is allocated resources in the budget with a contestable budget mechanism still not yet developed. This means that health is not able to argue for a larger budget allocation based on sector performance, as this is not taken into consideration. Rather budget ceilings tend to be allocated on a historical and incremental basis. Conversely, so much health sector funding is still off budget, it is difficult for the MoFNP to know the full sector resource envelope available for health in order to allocate budget resources accordingly. Communication still seems to be an issue between the MoH and the MoFNP, with a lack of information on SBS disbursements causing considerable frustration for the MoH. In the case of DFID's GBS allocation to health, DFID had to step in to chase up the funds and find out where they were. Also, the MoFNP reportedly does not attend SAG meetings which in theory it should, as the link between the MoH and the MoFNP, these would be another forum in which to raise issues of this nature.

Lessons learned

204. The following are examples of positive influence which can be drawn from the SBS experience in the health sector in Zambia:

- The use of GRZ systems in the provision of SBS without additional requirements which has ensured that more funds are included within domestic accountability processes and are subject to parliamentary oversight.

205. There are a number of lessons learned that would strengthen the benefits of SBS if implemented:

- Stronger accountability has not occurred between the MoH and MoFNP. Although using SBS was perceived to be a way to bring this about, if a transparent budget allocation and disbursement systems are not in place, then this undermines MoH ownership of the budget and planning process.
- There is a need for better understanding of budget processes and PFM systems by donors. If this had been the case in Zambia, then some of the design issues with SBS would have been avoided. If analysis shows that budgetary processes and PFM systems are not at the required level for SBS to work then consideration should be given to strengthening these systems first or using other aid modalities.
- It is important that the transition to SBS is jointly managed by the MoH, MoFNP and CPs so that trust is not lost between the stakeholders involved whilst also ensuring that the MoH still feels that it has ownership of the process. Crucial to this is having a good design with all stakeholders being clear about their roles.

5. The Effectiveness of SBS and the Conditions for Success

5.1 The Main Outputs of SBS

SQ4.1: What are the main contributions that SBS has made to the improvement of sector policy processes, public financial management, sector institutions, service delivery systems and accountability?

206. Sector policy processes and service delivery systems are well-established in the health sector in Zambia due to the SWAp process that was already in existence long before the start of SBS. Given this, it is unsurprising that there has been little contribution made by SBS to the improvement of sector policy processes, PFM, sector institutions and accountability. Particularly as SBS has been very limited and has consisted of the EC undertaking a small pilot from 2006-2008 that non-traceable earmarked funds to human resource retention and DFID earmarking US$5 million annually from PRBS funds for two years, before including it un-earmarked within the overall PRSB allocation.

207. An important element of SBS in health is that it has not sought to establish parallel systems, but has aligned itself with existing policy and planning mechanisms under the SWAp and has used GRZ PFM and service delivery systems. This has occurred as CPs who sign up to the SWAp are already using a variety of funding modalities and in this way, the financing modality used by CPs has always been separate from the SWAp mechanism itself. Through SBS using existing systems, it has helped to ensure that these systems are supported, which is important in the face of the process of fragmentation that is occurring in the health sector due to the large increase in vertical funds.

208. The contribution of SBS is limited but can be seen in the following three areas:

i) SBS has focused through non-traceable earmarking of funding and in the case of the EC through conditions, on issues that need to be addressed to ensure improvements in service delivery and health outcomes. These have either not been receiving sufficient funding such as the BHCP or are new initiatives such as user-fee elimination and staff retention that need financing. The EC has given EUR 8.57 million and DFID US$10 million of funds to these initiatives respectively. These initiatives have the potential to strengthen service delivery institutions and have the possibility to shift dialogue and funding in the health sector more towards results. This addresses a criticism that to date SWAp dialogue has been focused more on upstream system strengthening than on outcomes. This is important given the marginal improvement in health sector outcomes that have occurred over the previous years.

ii) Through channelling funds through GRZ systems SBS has increased the amount of funds on-budget, albeit by a small amount. This should by increasing the volume of external funding that is controlled by the MoFNP increase the efficiency of resource allocation overall, as well as accountability. To date this has not occurred in the most efficient manner, as there has been considerable confusion regarding whether funds were additional to the GRZ budget or not.

iii) Through operating a pilot SBS process in the case of the EC and a limited amount of SBS in the case of DFID, constraints in the way SBS has been handled have been highlighted. This was the aim of the EC support which has been scaled up in EDF 10. It has brought to light problems in the design and implementation of SBS and misunderstandings and communication problems between the MoH and the MoFNP. The most important issue that has come to the fore has been the way that SBS funds were treated as a separate block of funds, rather than as part of government revenues, which means normal cash management procedures which should have been used were not. This kind of small scale initiative is important, as the first stage in the process of

highlighting bottlenecks in PFM systems and attempting to ensure the development of a stronger budget process and a more functional relationship between the MoH and the MoFNP.

209. There are two main reasons why the contribution of SBS to sector systems, processes and service delivery has been less than expected. These are delays in disbursement and budget unpredictability, which are a result of the requirement for traceability and additionality of SBS funds which was not explicitly resolved during the design phase. Additionality of SBS funds is to a certain extent unimportant as SBS funds from both the EC and DFID had no additionality conditions; therefore it was at the discretion of the MoFNP whether the MoH budget would increase as a result. Given that it is very difficult to prove additionality anyway, particularly when the MTEF process does not function well, what is more important is to ensure that there is a credible and transparent budget allocation system with an agreement on the level of health sector funding. In addition, budgetary funding supported by SBS should be disbursed via the usual cash management procedures, and not be based on SBS specific disbursements from CPs. A clear understanding of this was not reached between the central bank, MoFNP, MoH and districts before the move to SBS.

210. As a result the contribution of SBS to date is rather marginal, not only due to the factors mentioned above, but due to the small scale of SBS funding. There is the potential for SBS to make significant contributions, particularly as the EC is scaling up support and other CPs may move from basket funding to SBS. However, it is important to bear in mind that the effects of SBS on sector systems, processes, and expenditures will remain small in the light of the substantial amount of vertical funding that the health sector receives. Much is off-budget and funds that are channelled through the MoH place a considerable burden on the MoH in terms of parallel reporting, implementation, procurement and accounting and auditing requirements. There is also only likely to be a small number of CPs that move to SBS, due to the limitations that most other CPs have placed on them due to headquarters accountability requirements.

5.2 The Sector Outcomes Influenced by SBS

SQ4.2: Have the improvements in sector systems and processes to which SBS has contributed, had a positive influence on sector service delivery outcomes, and are they likely to do so in future?

211. At this stage it is too early to assess the extent to which SBS has contributed positively to service delivery outcomes. As noted above, this is because it has been too recent and delayed in its implementation, although the policies that SBS have supported should make a positive contribution to service delivery in the future, through financing the expansion of services through supporting user-fee abolition and schemes to support human resource retention. Currently it is too early to tell whether this has been achieved, although there is some preliminary evidence that user-fee elimination has increased utilisation of health facilities.

212. However, if the main constraints outlined in this report are addressed – delays in disbursement and transparency and predictability in budget formulation and budget execution – SBS has the potential to have a positive impact on service delivery and has an advantage over basket funds. This is because SBS is non-traceable funding which is channelled through the GRZ budget and is more flexible, so can be used to address funding issues that the MoH considers a priority. This contrasts with basket funding, which in nearly all cases is earmarked to specific baskets or budget lines. This will facilitated greater allocative efficiency of the health budget and reduce transaction costs for the MoH. The greater this shift, the greater these benefits would be.

6. Conclusion

Primary Study Question:	How far has SBS met the objectives of partner countries and donors and what are the good practice lessons that can be used to improve effectiveness in future?

213. The overall conclusion of the study is that SBS in the health sector in Zambia has not had a significant effect in meeting the objectives of partner countries and CPs. This is mainly because SBS has not been extensively implemented in Zambia, so the experience has been very limited, with only small amounts of funding channelled through SBS. Issues related to the design of SBS, delays in disbursements and budget transparency, have caused significant problems. As a result, it is unsurprising that the experience of SBS so far has not been very positive, however if these problems are resolved, SBS still has the potential to be effective in supporting the achievement of health sector goals.

214. The perception of the MoH is that their ownership has been undermined by SBS, as it has resulted in a shift away from direct support through basket funds under the control of the MoH, to channelling funding through the MoFNP. The MoH view is that SBS has resulted in less funds being received as disbursements from the MoFNP have been delayed. This has led to delays in implementation of activities that the MoH had planned to implement using SBS funding. This has occurred as a result of stakeholders failing to agree and make clear how the shift to SBS would change the budgetary process and the extent to which the funds would be additional or not to the GRZ budget allocations.

215. For the MoFNP there have been significant benefits from SBS as more funds are being channelled through the Treasury and are being included as part of the GRZ budget which strengthens the planning and budgeting process. It also allows for a more efficient allocation of budget resources, giving the MoFNP more discretion in resource allocation.

216. From the point of view of the CPs involved, the process has been frustrating, but has also been a learning experience which has highlighted useful issues in terms of how the budget process works. DFID had originally planned to earmark GBS funds to health for five years, but gave this up after two years as a result of the transaction costs caused by earmarking, under-spending by the MoH in 2007 and the fact that earmarking conflicted with the principles of GBS. DFID decided not to earmark funds to health, although the funds are still part of the GBS allocation. Although the EC experienced significant problems with the predictability of the timing and level of their SBS funding, these were perceived as initial start-up problems which have been overcome to a certain extent and in the current phase of support, SBS has been scaled-up but without any non-traceable earmarking.

217. Despite these problems which to a certain extent are only to be expected given the experimental nature of the support, SBS has made a contribution through aligning support with existing sector processes, supporting existing GRZ institutions and accountability mechanisms, as well as ensuring that more funds are on-budget. There is also potential for SBS to be more effective in the future due to the focus on areas that are important for service delivery and achieving results. On the other hand, it is likely that any contribution is likely to remain small when taken in the context of the sector as a whole, given that few CPs are likely to shift to SBS and a large amount of external funding will remain off-budget or be undertaken through projects.

Lessons learned and recommendations for improvement

218. This report has documented a number of practices which have had positive effects on sector systems, and a number with negative effects. These are summarised in Table 5 below.

Table 5: SBS practices with positive and negative effects

Domain	Practice with positive effects	Practice with negative effects
Sector policy, planning, budgeting, monitoring and evaluation	• Use of existing mechanisms for sector planning, dialogue and reporting reduces transaction costs and reinforces the SWAp as the overarching framework in health, through alignment with its practices and processes. Ensuring that SBS funds are non-traceably earmarked to priority areas or those that are under-funded has played an important role in intra-sectoral resource allocation through ensuring that SBS funds are focused on key sector priorities.	• Additional reporting and assessment procedures used by the EC (system of fixed and floating tranches). • The DFID practice of requiring traceability which caused major problems with disbursement, but which was not needed as no additionality/traceable earmarking was specified. A budget calendar where the budget is approved in the new financial year, yields unpredictable annual budget allocations. This led to confusion on levels and timing of SBS/GRZ disbursements.
Procurement, expenditure, accounting and audit processes	• The use of GRZ PFM systems including procurement, expenditure control, accounting and auditing. • Operating a pilot SBS approach in order to test SBS design, learn where the bottlenecks exist in PFM systems and the changes that are needed for SBS to operate effectively before it is scaled-up.	• Lack of clarity at the beginning of the SBS process as to how SBS will operate, whether funds will be additional to the GRZ budget and how transfers of funds will be made. • The MoH perceiving SBS funds as the same as basket funds. • The MoFNP treating SBS funds as separate and not using normal budget and cash management procedures.
Capacity of sector institutions and systems for service delivery	• The use of government systems by SBS to fund service delivery without adding additional procedures or derogations. • The focus on areas of the NHSP IV which to date have been under-funded and which should in principle have a strong impact on service delivery. • Allowing funds to be used in fully flexible ways.	• There is a need to identify the funding channel for service delivery that SBS will be funding in the design phase and to ensure that there are appropriate instructions for the use of that funding. This was not done for the first year of DFID SBS.
Domestic ownership, incentives and accountability	• The use of GRZ systems in the provision of SBS without additional requirements which has ensured that more funds are included within domestic external accountability processes and are subject to parliamentary oversight.	• Lack of accountability and effective communication between the MoH and MoFNP which been exacerbated by SBS undermining MoH ownership of the budget and planning process. The transition to SBS has not been jointly managed by the MoH, MoFNP and CPs so that trust has been lost between the stakeholders involved. Good design is a crucial element of this.

219. Given that the problems that have been experienced with SBS have been as a result of bad design by donors and weaknesses in GRZ PFM systems, it is recommended that the following steps are undertaken to ensure increased effectiveness of SBS in the future.

- Donors should improve the design of SBS. This means avoiding traceable earmarking of funds as this was a practice which has caused derogations from normal budgetary procedures. If a donor wants to focus on specific issues then this should be undertaken through the sector dialogue and non-traceable earmarking. Additional reporting procedures should be avoided so that there are not added transaction costs for the MoH from moving to SBS. Any SBS reporting system should be harmonised with the SWAp and those used by the basket funds. Similarly disbursement procedures should be simple and be designed to increase predictability.
- Improvements in GRZ PFM systems also need to be made to support SBS. It is important to have a transparent and predictable system for resource allocation in place in the MoFNP

in order to build confidence between all stakeholders. As part of this an effective and transparent budget process is needed for the MoH to be able to plan for the medium-term. This implies an MTEF and a budget process which involves line ministries and is not only transparent, but contestable and performance related. The MoFNP should also stop the practice of treating SBS differently in internal execution systems and reducing GRZ budget disbursements to the MoH when SBS funds do not arrive on time.

- There needs to be an agreement by all stakeholders on how SBS will operate and how transfers of funds will be made. This will avoid misunderstandings that have occurred related to the process for transferring funds between the MoH and the MoFNP. It is not feasible in practice to ensure additionality of SBS funds to the MoH, but it must be made clear for all parties how the process will work.
- Related to this, the transition to SBS should be jointly managed by the MoH, MoFNP and CPs so that trust is not lost between the stakeholders involved and that the MoH still feels that it has ownership of the process. A planned approach to ensure that resources to health are maintained and planned activities are not disrupted due to delays in funding is needed. Particularly, as it is likely that basket funds will be severely depleted as a result of a shift to SBS, which is currently the MoH's only form of accessible and flexible funding that it has control over.
- Lastly, one of the key positive practices of SBS in the Zambia Health Sector that it has used sector policy, planning and budgeting processes and been fully aligned with the SWAp process. The use of GRZ systems in the provision of SBS without additional requirements has also ensured that more funds are included within domestic external accountability processes and are subject to parliamentary oversight. Both these practices should be maintained as more CPs move to SBS.

220. If these issues relating to the design and implementation of SBS and associated government systems are addressed, SBS still will only be effective at improving sector outcomes in future, if it is provided on a larger scale. The size of SBS needs to increase not only in absolute terms, but also relative to other aid modalities, in particular vertical funding arrangements.

Bibliography

Bossert, T., Chitah, M. B., Bowser, D. (2003) 'Decentralization in Zambia: resource allocation and district performance', Health Policy and Planning; Vol. 18(4), P.357-369

Chansa, C., Sundewall, J., McIntyre, D., Thomson, G., Forsberg, B. C., (2008) Exploring SWAp's contribution to the efficient allocation and use of resources in the health sector in Zambia, Health Policy and Planning, Vol.23, P.244-251

CIDA (2006), Canada's contribution to the Implementation of the Zambia national Health Strategic Plan

CIDA (2008), Canada's contribution to the Pooled Fund for Technical Assistance at the Zambian Ministry of Health

CSO (2007a) Zambia Demographic and Health Survey.

CSO (2007b), The Monthly Newsletter, December 2007

CSO (2008), The Monthly Newsletter, December 2008

DFID (2004) ' Zambia Country Assistance Plan 04/05 - 06/07', May 2004

DFID (2007), Zambian Health Sector Support Mapping Report, January 2007

EC (2008), Country Strategy Paper and National Indicative Programme for the Period 2008-2013,

EC (2008), Public Financial Management Annual Monitoring Report for 2007, Zambia

European Court of Auditors, (2008), EC Development assistance to Health Services in Sub-Saharan Africa together with Commission's replies. November 2008

GRZ (2006), The Vision, December 2006

GRZ(2008)The Public Procurement Bill, 2008

Handley (2009), "Sector Budget Support In Practice: Literature Review", Overseas Development Institute, London.

HLSP Institute, Performance Monitoring Frameworks in the Health Sector - Zambia Country Notes.

IDD and Associates (2006) Evaluation of General Budget Support Synthesis Report, May 2006

IMF (2007), Zambia: Poverty Reduction Strategy Paper, August 2007

IMF (2008), Zambia: 2007 Article IV Consultation - Zambia Selected Issues, January 2008.

IMF (2008), Zambia: 2007 Article IV Consultation - Zambia Statistical Appendix, January 2008.

IMF (2008), Zambia: 2007 Article IV Consultation, January 2008.

IMF (2009) Statement at the Conclusion of an IMF Staff Mission to Zambia, Press Release No. 09/55, March 4, 2009

MOFNP (2005), Zambia Aid Policy and Strategy.

MOFNP (2006), Fifth National Development Plan 2006-2010, June 2006

MOFNP (2006), PEMFA 2005 Annual Progress Report, March 2006

MOFNP (2007), PEMFA 2006 Annual Progress Report, January 2007

MOFNP (2008a), PEMFA 2007 Annual Progress Report, February 2008

MOFNP (2008b), Poverty Reduction Budget Support (PRBS) Programme Joint Annual Review, June 2008.

MOFNP (2009), Budget Address by Honourable Dr. Situmbeko Musokotwane, MP, January 2009

MOFNP (2009), Budget Address by Honourable Ng'andu P. Magande, MP, January 2009

MOH (2000), National Health Strategic Plan, 2001-2005,

MOH (2004), Institutional and Organisation Appraisal, May 2004.

MOH (2004), National Health Strategic Plan (2001-2005) Mid Term Review Report, February 2004.

MOH (2005) ' National Health Strategic Plan, 2006-2010' December 2005

MOH (2005), Health Care Financing in Zambia: A Study of the Possible Policy Options for Implementation, June 2005

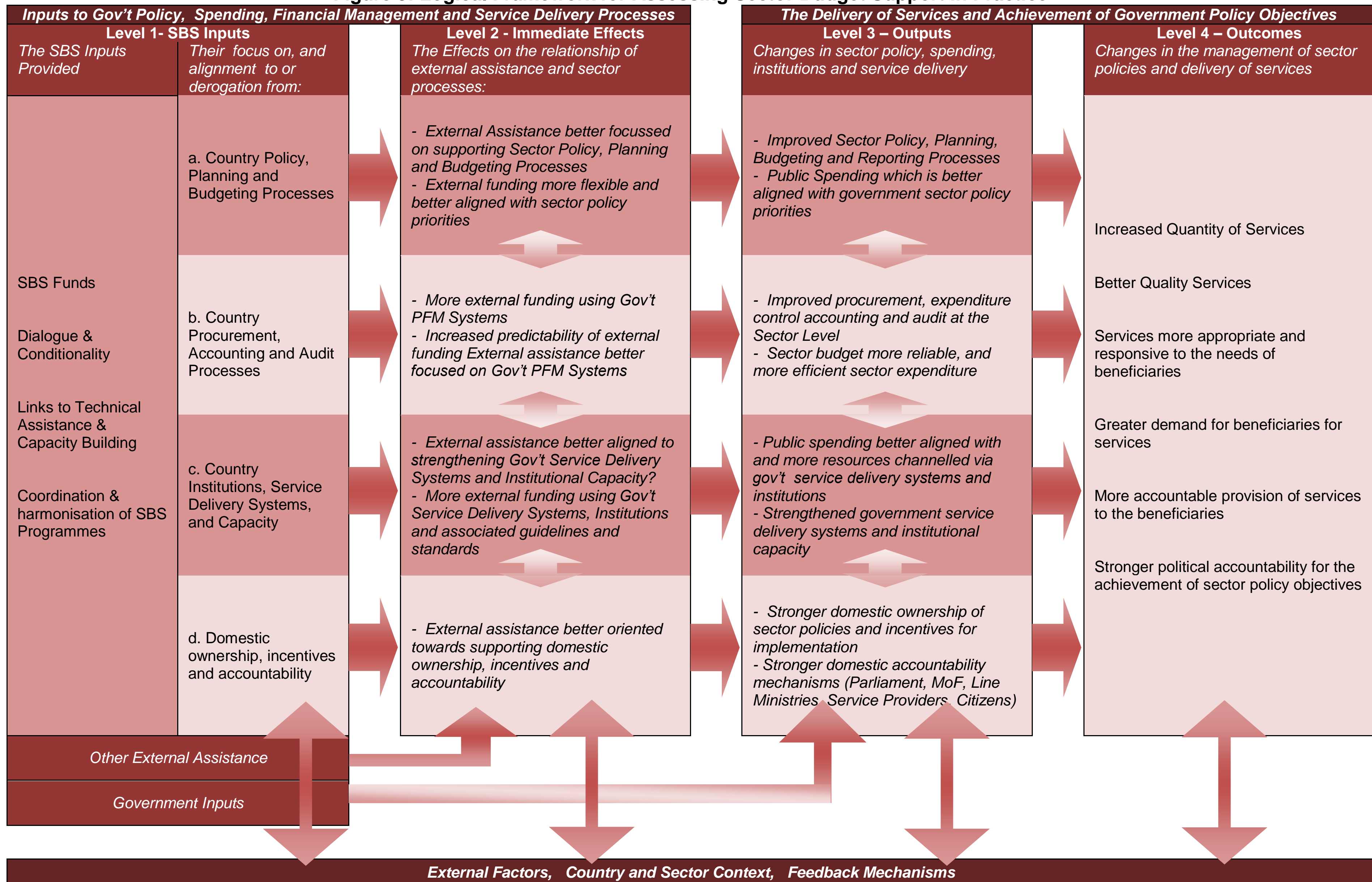
MOH (2005), Human Resources for Health Strategic Plan (2006 - 2010), December 2005

MOH (2006), 'Draft National Health Care Financing Policy', February 2006

MOH (2006), National Health Accounts for Zambia 2002 - 2004, July 2006.
MOH (2006), Structure, composition and Terms of Reference for Various Committees and Technical Working Groups in the Health Sector, October 2006
MOH (2007), Roadmap for Implementation of the International Health Partnership, October 2007
MOH (2008) 'Joint Annual Review for 2007, Main Report', April 2008
MOH (2008), Lusaka Final Report - IHP+/HHA, March 2008
MOH (2008), Towards Scaling up for Better Health: Stock-Tacking Report for Zambia, February 2008
MOH (2008), National Health Accounts for Zambia 2005 – 2006, March 2009
OECD (2008), Zambia Paris Report,
Partnership for Health Reform (2000), Analyzing the Process of Health Financing Reform in South Africa and Zambia: Zambia Country Report, April 2000
MoH (2008), Mid Term Review of the Zambia National Health Strategic Plan, November 2008
MoH (2007), Joint Assistance Strategy for Zambia (JASZ) 2007-2010, April 2007.
Republic of Zambia (1991), National Health Policies and Strategies (Health Reforms).
Republic of Zambia (2005), Memorandum of Understanding between Ministry of Health and Cooperating Partners. November 2005
Republic of Zambia (2008), Public Expenditure Management and Financial Accountability (PEMFA) Programme, November 2008.
Republic of Zambia (2008), Zambia Public Financial Management Performance Report and Performance Indicators, 2008 Assessment and Update, June 2008
Republic of Zambia (2009), Performance Assessment Framework 2008-2010, January 2009
SIDA (2001), Sector Programme Support to the Zambian Health Sector 2002-2005, April 2001
SIDA (2003), Mapping of Sector Wide Approaches in Health, June 2003.
SIDA (2006), Agreement regarding the support to the National Health Strategic Plan
SIDA (2007), Discussion on moving from basket funding to sector budget support for the National Health Sector Strategic Plan - Minutes, (December 2005)
SIDA (2008), On the feasibility of a possible move to Sector Budget Support (SBS) to The Ministry of Health in Zambia, December 2008.
SIDA, Specific Agreement between Sweden and the Government of the Republic of Zambia on Support to the Health Sector 2006-2011.
Swedish Embassy (2008), Health SBS Meeting Minutes: 10 January 2008,
UASID (2004), Supporting the Decentralized Delivery of Health Services: USAID and the District Basket in Zambia, July 2004.
UNDP (2008) Zambia Millennium Development Goals, Progress Report 2008
World Bank (2008), A proposed Credit for a Second Economic Management and Growth Credit, April 2008

Annex 1 – Summary of Findings against Logical Framework

Figure 9: Logical Framework for Assessing Sector Budget Support in Practice



a) Context in which SBS has been provided

	Country context	Sector context	Aid management context
Zambia health (2006-) "Late comer": Focus on specific policies in pre-existing framework and SWAp Pre-existing and continued basket funding, starting very early 1993	Policy: Vision 2030 (Zambia as middle-income country); 5th National Development Plan (NDP) 2006-2011 (integrating PRSP process). Significant donor influence on many policies. Growth: Following 1991 transition to multi-party democracy and ensuing macro-economic reforms, stable growth from 2000 (average 5.1% annually); High vulnerability to commodities' world market. Poverty reduction: Continued high income poverty level (68%; 78% rural) (2005) Institutional context (unitary country): Decentralisation Policy 2004: Slow progress; Most service delivery has remained deconcentrated; Significant unfunded mandates for district LGs. Long history of CSR (1993-), starting from "one of the most bloated bureaucracy" in Africa; Little progress; New start (2006) but large-scale retrenchment not politically feasible; Low salaries, graft/ corruption, brain drain in health and education PFM: Significant relatively recent PFM reform efforts; Comprehensive reform programme (2005), one pillar in Public Sector Reform Programme (with Right-Sizing & Pay Reform and Decentralisation). PEFA 2008: progress though more needed including budget credibility (unreliable MTEF), comprehensiveness and transparency, predictability and control of budget execution, accounting, monitoring and reporting, and external scrutiny.	Policy/plan/M&E: Reform (1992-): decentralisation, basic health care package, harmonised support (SWAp, district basket fund), facility-level participation mechanisms, cost-sharing (reversed since then; SBS funding fee user reduction). Mixed track record of implementation including reversal of earlier institutional restructuring actions and of cost-sharing policy. Service delivery has remained fragmented. Yet, large (pre-SBS) reorientation of spending on basic services (e.g. 1999-2004), thanks to district basket fund. Policy Framework 1991; 4th National Health Strategic Plan aligned with 5th NDP, MDGs, and 10 national health priorities. Bottom-up sector planning/budgeting process in place and linked to overall annual budget process, within 3-year operational plans linked to MTEF. Participatory JARs, though weak and de-linked financial and performance reporting (MOH accounting differs from Finance Ministry's system) Spending level: Budget (government + donor aid through Finance Ministry) doubled in nominal terms (2005-2008), but fluctuating as budget and GDP share. More than doubled (2004/5-2007) if including off-budget vertical funding. Thus increasing envelope but not discretion. Sector results: Progress in service delivery though uneven across provinces; Low capacity (40% staff shortfall, staff migration, HIV/AIDS); Mixed progress in sector outcomes, although recent improvements in some indicators, mostly linked to	General aid trend: ODA/GNI = 17.3% (2005); 10.2% (2007) Harmonisation and Alignment process since 2002 ➔ Zambia Aid Policy and Strategy (2005); Joint Assistance Strategy for Zambia 2007-2010, with donor division of labour. GBS in place since 2005, with joint Performance Assessment Framework (including WB); pooled funding mechanisms in education, health and PFM; SBS only in roads and health. Aid to health sector Health & population 2nd largest aid beneficiary "sector" after debt. SWAp (1994), MOU (1999-2006) including focus on service delivery (as opposed to previous Development Partner-driven focus on fiduciary and good governance standards), elaborate dialogue structure. Health ODA (basket funding since SWAp, projects, earmarked on-budget funds SBS) = 60% sector funding; Recent large increase in off-budget vertical funding controlled by donors (thus, 84% aid was on-budget in 2000, down to 59% in 2004). SBS = additional modality.

	Country context	Sector context	Aid management context
		vertical programmes targeting specific areas and basket funds channelling funds to districts.	

b) Nature of the SBS Provided

	Types:	Timescale:	Donors:
Zambia Health	SBS for HR Retention	2006-2008	EC
	SBS for User Fee Elimination	2006-2007	DFID

	Funds and Financial Management	Dialogue and Conditions	T/A and Capacity Building	Links to other Aid
Zambia Health	Funding Level: Low in absolute terms and relative to other aid - approx US$15m per annum. Switch from basket funding. Earmarking: Non-traceably earmarked to human resource retention and user fee compensation. There were no explicit additionality requirements from either donor, but DFID traceability requirement required this. Tracking: SBS funded expenditures not separately identifiable in the government budget, although DFID required evidence that funds were transferred to the Ministry of Health, in practice requiring traceability. In 2008 this requirement was dropped. Cash Management: EC funding used normal government cash management procedures. DFID traceability meant funds transferred separately, and led to confusion.	Dialogue Structures: Dialogue undertaken in the context of the SWAP structures. Conditionality Framework: EC SBS included particular accountability requirements for the disbursement of fixed and variable tranches. DFID SBS linked to GBS conditions, with no additional ones beyond traceability requirements. Focus: Dialogue focused overall, however EC conditions focused on HR issues. Derogations: EC conditionality different from the other donors participating in the SWAP. NB: DFID used GBS rather than SWAP conditions.	Part of SBS Instruments: There is no T/A and capacity building provided as part of SBS. Links to other initiatives: EC provided TA in parallel project, which complemented SBS.	Links to Project Funding in the sector: Main link to other projects is through the SWAP. DFID provides support through an HIV/AIDS project but there are no strong links to its SBS. Links to GBS: Strong link to GBS as both EC and DFID provided it. DFID SBS associated with PRBS, which includes health conditions.

	Funds and Financial Management	Dialogue and Conditions	T/A and Capacity Building	Links to other Aid
	Use of Other Gov't FM Systems: Uses government procurement, accounting and audit systems in full. Derogations: Relate to the DFID traceability requirement.			
	Other important design features			
	HR Retention Budget Line: EC required the creation of a budget line for HR retention, but not that EC funds were channelled to it. Confusion over design: The combination of non-traceable earmarking plus no additionality requirements has been a source of misunderstanding between the health and finance ministries, as the health ministry expected the funds to be disbursed in addition to the resources that were allocated through the government budget, whereas the finance ministry saw them as part of the government budget. This issue was not resolved, and the MoH delayed activities until SBS funds were received as it took earmarking literally.			
	Effects of SBS on the Quality of Partnership			
	Quality of Dialogue: Sector dialogue has not changed significantly as a result of the shift to SBS, as it was already well-established in the context of the SWAP, however the confusion over the design has led to some tension in the partnership. The MoH perceives that it has experienced a reduction of funding as a result of the shift from basket funding to SBS, although overall health funding has, in fact, increased. The confusion over disbursement of funds has added to the negative impression of SBS in the health ministry. Arguably, however, the shift to SBS has, rightly, brought the finance ministry into the picture, along with its legitimate role in resource allocation and budget management. Transactions Costs: There is concern that the shift to SBS has unnecessarily fragmented donor funding, which is considered to have worked well. The EC use of a fixed and floating tranche is seen as burdensome by the health ministry. The process of tranche approval is lengthy, leading to uncertainty.			

c) The Effects of SBS in Practice

i) Policy, Planning, Budgeting, Monitoring, Evaluation and Expenditure

	Inputs	Effects	Outputs
	SBS funding is on budget, is aligned with government policies and is reported on using government systems. Focus (TA/CD, dialogue, conditions) on sector policy, planning, budgeting, monitoring and evaluation processes?	External funding more flexible and better aligned with sector policies overall; assistance better focused on supporting sector	SBS contribution to: ▪ Public spending is better aligned with government sector policies. ▪ Improved Sector policy, planning, budgeting and reporting Processes

	Inputs *Derogations: why, justified, temporary?*	Effects policy, planning and budgeting processes. *Effects of derogations*	Outputs *How do derogations affect outputs?*
Zambia Health	**Contextual factors:** Sector policy and monitoring processes were well established in the context of the SWAP. Distortion in sector resource allocation, in particular as a result of vertical funds, and earmarking within basket funds. There have been increases in off budget, non-discretionary aid.		
	Policy and Planning Processes: EC SBS was specifically provided in support of the Health Sector Human Resources Strategic Plan, and was non-traceably earmarked to its implementation. DFID support was non-traceably earmarked towards the elimination of user-fees, another key priority. Policy and planning processes are well established, and EC and DFID SBS used these existing structures as the basis for dialogue. The areas of focus of the two SBS instrument also meant they were areas of focus in the dialogue as well. In future the EC plans to shift the nature of dialogue towards results.	SBS has focused the attention of the overall dialogue on two priority areas of the health strategic plan.	The use of dialogue structures and the focus of key priority areas of the health strategy has helped reinforce the SWAP process; and its focus on policy implementation. A future focus on results by the EC may address shortcomings in the SWAP, where the predominant focus is on systems.
	Budgeting, Monitoring and Reporting Processes: SBS has been aligned with GRZ budgeting processes as funding provided by DFID and the EC were pooled with GRZ funds and considered as part of the overall GRZ budget by the MoFNP. The funding was included within the MoFNP MTEF allocations. However, the MoH allocated SBS funds separately in the health budget to specific budget lines, treating it as direct donor funding, even though it actually already formed part of the GRZ budget. Monitoring and reporting processes are well established in the health sector. However, additional reporting requirements were required under the EC SBS tranche request process, all though the indicators	SBS has helped focus attention on overall resource allocation in the sector, and used existing SWAP processes. SBS did result in additional reporting requirements for external funding, and confusion over how to treat it in the budget.	The inclusion of SBS in overall GRZ funding should help with bringing funds on budget and strengthening the efficiency of budget allocation. However a failure to explain to the MoH how SBS funds would be treated led to confusion. When it came to budget execution, and the funds were delayed, they did not implement activities. Both the EC and DFID take advantage of existing SWAP structures, which helps reinforce them, although EC SBS reporting requirements add an additional administrative burden.

	Inputs	Effects	Outputs
	and targets do represent a subset of health strategy indicators. DFID uses GBS reporting requirements which are also consistent with the health strategy.		
	Resource Allocation DFID SBS represented a reduction in resources from previous contributions to the health basket. EC SBS allocations have been erratic, but of a similar scale to their contributions to the health basket. As mentioned above EC support was non-traceably earmarked to HR retention, and DFID support to user fee elimination. There were no additionality requirements associated with either SBS instrument, yet DFID required traceability. A condition related to EC support was the creation of an HR retention budget line, whilst the dialogue focused on resource allocation to HR retention and user fee elimination.	SBS has marginally contributed to making external funding more flexible and through non-traceable earmarking facilitated more balanced aligned with sector policies overall. There was an absence of additionality requirements associated with SBS.	The main impact of SBS is probably on the composition of expenditure as by focusing on HR retention and user-fee elimination – it is reasonable to assume both dialogue about these line items and non-traceable earmarking had an effect on this. The change to SBS has presented some problems for sector resource allocation, due to a lack of clarity from the MoF on the level of MoH resource allocations and how SBS would affect them. The absence of additionality requirements added to this lack of clarity, especially in the context of DFID traceability requirements.

ii) Procurement, Accounting and Audit

	Inputs	Effects	Outputs
	SBS funding uses government expenditure control, accounting and audit processes. Focus (TA/CD, dialogue, conditions) on strengthening government expenditure control, accounting and audit processes at the sector level? *Derogations: why, justified, temporary?*	External funding uses government FM systems and is more predictable; assistance better focussed on gov't FM systems. *Effects of derogations*	SBS contribution to: ▪ Improved sector procurement, expenditure control, accounting and audit at the sector level; ▪ Sector budget more reliable and sector expenditure more efficient. *How do derogations affect outputs?*
Zambia Health	**Contextual factors:** Increasingly reliable budget execution; problems in slow execution of domestic development budget.		
	SBS uses national procurement expenditure accounting	SBS has resulted in	As overall budget disbursements in Zambia are relatively

	Inputs	Effects	Outputs
	and audit systems. EC and DFID SBS differed in their use of government budget disbursement procedures. The EC used the government systems in full and so was not traceable. DFID required a report from the finance ministry that funds had been released to the MoH to ensure traceability, however the transfer mechanism was not fully worked out. EC SBS was disbursed late due to delays in approval at headquarters, whilst DFID support was disbursed early in the financial year.	little change to the share of external funding using government systems as the level of SBS was low and it represented a shift from basket funding which was already using many government systems. There was little focus on PFM in SBS dialogue, and no associated TA/Capacity building.	reliable, the use of cash management systems for EC funds was relatively smooth. However, the late disbursement of EC SBS puts a strain on the finance ministry's cash management – although relatively small, as EC support is scaled up this may present problems in future. The fact that DFID's disbursement process was not fully worked out led to confusion during budget execution. There was unclear communication between the central bank and finance ministry, and the funds were released separately to the MoH instead of as part of government's normal cash management procedures. There use of government systems does reveal problems, such as the late execution of the investment budget. However, overall SBS has not had an impact on procurement, expenditure control an, accounting and auditing systems, primarily because the basket already used those systems and the shift to SBS has thus far been marginal.

iii) Capacity of Sector Institutions and Systems for Service Delivery

	Inputs	Effects	Outputs
	SBS use of Gvt mainstream funding mechanisms and sce delivery institutions (structures, guidelines, stds) Focus (TA/CD, dialogue, conditions) on devt and strengthening of mainstream sce delivery institutions? Derogations: why, justified, temporary?	SBS contribution to focus aid (funds and other inputs) on sce delivery systems & capacity	SBS contribution to: ▪ Increased **total** funds flows through mainstream govt channels for sce delivery, & used within regular institutional sce delivery framework ▪ Stronger sce delivery systems and institutions How do derogations affect outputs
Zambia Health	**Contextual factors:** Decentralisation policy (2004) slowly implemented (public services mainly provided by sector de-concentrated structures); Right-Sizing and Pay reform ongoing (2005); Unstable institutional and organisational sector framework; Diversity of health service providers; Increasing and increasingly fragmented sector resource envelope: large donor funding (including through basket funds), significant increase in (mostly off-budget and non-discretionary) vertical funding; Re-orientation of spending on district health services, with resulting improvements in service delivery inputs and outputs; SWAp in place since 1994; Lack of human resources is the most significant issue faced by the sector.		
	SBS funding has been small in the total sector	The identification of HR	SBS helps implement policies with significant potential to

	Inputs	Effects	Outputs
	spending (6-8%)[14], but focused on key policy priorities which should have a direct impact on service delivery inputs and outputs, and for which funding was needed. The objective was to use GRZ mainstream funding mechanisms and service delivery institutions. However, with regard to DFID SBS, an unclear design and MOH's being used to basket funding modalities[15] led to confusion at central level and major delays in transfers to district level in the first year. With regard to EC SBS there were difficulties around the EC conditionality framework, which (as usual for EC budget support operations) is based on a split tranche design with disbursement of the variable tranche linked to HQ-assessed performance on agreed result indicators. In one instance where there was divergence of views between local stakeholders and HQ, which led to delay and cut in SBS funding. In parallel to SBS the EC provided TA support to the development of an HMIS, aimed to strengthen the capacity of the sector to monitor inputs, outputs and outcomes.	retention and elimination of user-fees as priorities to enhance service delivery took place through the SWAp process (not SBS specific). Also, basket funding was focused on service delivery prior to SBS introduction, but it was limited in how it could tackle these two issues. SBS focus on them was/is therefore useful. However, there was insufficient consultation in EC and DFID shift from basket funding to SBS. This created misunderstandings and, due to the ensuing delays in funding and the lack of clarity and of medium term predictability in GOZ budget allocation processes, a perception by MOH that it had lost resources and that further shifts from basket funding would be detrimental for the sector.	improve service delivery (raising access to health care through the elimination of user-fees; improving sector institutions' capacity to provide quality health care through HR retention). Considering the small size of SBS thus far, the systemic capacity effects of SBS funding would have been small but useful. However, these effects were undermined by the lack of predictability and delays in SBS funding. In turn, this meant that activities were delayed or not implemented, with a negative impact on the effects that they might have (and therefore SBS) on actual service delivery. But this is not due to the nature of SBS. In the case of DFID SBS for the elimination of user-fees, insufficiently clear design and mis-understandings could have been cleared. DFID has switched to GBS instead, but in so far as GOZ continues to compensate districts for the elimination of user-fees from its own resources (domestic + GBS), SBS may have given the impetus needed for GRZ to pursue with the implementation of this policy. With regard to the EC SBS there seemed to have been insufficient attention to the shift in capacity that the result-oriented conditionality framework requires compared to the well-established basket funding procedures. This, however, does not detract from the intrinsic value of focusing on the HR retention policy. There is a lack of joint work on aid modalities (design of instruments including clear identification of funding channel, but also whether and how to manage further transition of aid flows from basket funding to SBS).

[14] Here also including DFID "health GBS"
[15] i.e. earmarking, additionality and separate cash management.

iv) Domestic Ownership, Incentives, and Accountability

	Inputs	Effects	Outputs
	How do SBS inputs support ▪ Stronger ownership of policies and incentives to implement them? ▪ Stronger domestic accountability[16]/ avoid parallel requirements & biasing accountability to donors?	SBS contribution on improving aid influence on ownership, incentives and domestic accountability	SBS influence on ownership, incentives & domestic accountability (stronger sense of responsibility & demand for performance etc.)
	Derogations to domestic systems: why, justified, temporary	Effects of SBS derogations	
Zambia Health	**Contextual factors:** Decentralisation policy (2004) slowly implemented (public services mainly provided by sector de-concentrated structures); Right-Sizing and Pay reform ongoing (2005); Unstable institutional and organisational sector framework; Diversity of health service providers; Increasing and increasingly fragmented sector resource envelope: large donor funding (including through basket funds), significant increase in (mostly off-budget and non-discretionary) vertical funding; Re-orientation of spending on district health services, with resulting improvements in service delivery inputs and outputs; SWAp in place since 1994; Lack of human resources is the most significant issue faced by the sector.		
	SBS funding, albeit small in the total sector spending (6-8%)[17], focused on policies (HR retention, user fee elimination) which had been identified as key priorities by GOZ. SBS programmes were designed to use GOZ mainstream systems in most respects. However, with regard to the elimination of user-fees (DFID SBS), an unclear design and MOH's being used to basket funding modalities created difficulties between MOH and MOF.	The SWAp partnership has survived ups and downs since its outset in 1994, and policy ownership appeared to be relatively strong in the sector before the introduction of SBS. However, SBS has the potential to further strengthen policy ownership through providing funding for policies which other sector aid could not support. In addition, being aligned with GRZ systems better than other aid funding, SBS should in principle have improved (albeit marginally because of its small size thus far) the way aid in the sector interacts with GRZ incentives and accountability processes. In practice, there was insufficient attention to SBS design which had negative consequences at the output level.	Focusing on important policies, SBS has the potential to strengthen GOZ ownership of them, and of their implementation at local levels. Using GOZ systems SBS should also strengthen domestic accountability processes (systemic effects). The focus on HR retention should in principle help address staff incentive issues. However, these effects have not been tangible thus far, due to the confusion which followed the poorly managed introduction of SBS, and delays in implementation. The difficulties that SBS (un-earmarked and which should have been merged with GOZ funds) caused in practice illustrate how basket funding (earmarked and managed separately in terms of cash flows

[16] Understood as accountability to parliament, of sector spending agencies to Min Finance, of sce providers to sector ministry/LG, of sce providers to citizens, of LGs to sector ministries (within respective mandates)
[17] Here also including DFID "health GBS"

	Inputs	Effects	Outputs
	With regard to HR retention there were also difficulties around the EC conditionality framework, which (as usual for EC budget support operations) is based on a split tranche design with disbursement of the variable tranche linked to HQ-assessed performance on agreed result indicators. In one instance where there was divergence of views between local stakeholders and HQ, which led to delay and cut in SBS funding.	There was also insufficient joint donor and donor/GOZ work on sector aid management issues (relevance of and possible complementarities between aid modalities) with several potentially negative effects. First, there is a discrepancy between the basket funding accountability requirements and the EC SBS conditionality framework which, if not resolved, will confuse GOZ in its accountability to sector donors. Second, the poorly prepared introduction of SBS in replacement of basket funding, and the difficulties faced in this process, left MOH fearing that further shift of aid flows from basket funding to SBS would be detrimental to the sector. Donors themselves don't seem to be clear in their views at the moment. This is likely to weaken MOH ownership of the SWAp (and it could lead to un-helpfully polarized discussions over merits and demerits of basket funding vs. SBS).	hence implementation of the earmarked activities) skew line agencies' incentives and incite them to stay clear from the mainstream government accountability processes, including the budget process. There are indications that there would be room to improve the MTEF/ budget process in terms of credibility and medium-term predictability. It also seems that there was a pre-existing lack of trust on MOH's side. The lack of joint preparation of the SBS programmes and the unclear design of DFID SBS aggravated this lack of trust. With regard to the EC SBS for HR retention, it is not clear that conditionality as it is designed and implemented is the best way to strengthen domestic accountability processes around results as is intended. Interference of EC HQ in locally managed assessment processes is unhelpful. Moreover, for the SBS focus on results to be really effective in terms of domestic incentives and accountability, stakeholders such as MOF and Parliament should have been involved in the design and/or implementation of the conditionality framework. It is not clear that this has been the case.

d) The Outputs and Outcomes of SBS

	Main SBS Outputs Influencing Outcomes	**Outcomes Influenced by SBS**
	Changes in sector policy, spending, institutions, service delivery systems and accountability influencing sector outcomes	Changes in the implementation of sector policies and delivery of services influenced by SBS
Zambia Health	SBS is very recent, and was preceded by a SWAP, therefore the outputs of SBS, thus far have been limited. Through non-traceable earmarking and conditions SBS has helped focus on one under-funded area (human resources) and a new policy initiative (user fee elimination). This has the potential to strengthen service delivery institutions and shift funding towards results as opposed to systems development. However, the scale of SBS was small – in absolute terms, and relative to overall sector funding, which limited the scale of these effects. Through channelling funds through GRZ systems, SBS has increased, albeit by a small amount, the volume of external funding that is controlled by the finance ministry, and has increased the efficiency of resource allocation overall, although this has not been done in the most efficient manner due to confusion over additionality and traceability, which were not resolved during design. SBS outputs have not been as great as might have been expected, because of this confusion, which resulted in delays in disbursement. The use of small-scale SBS has highlighted weaknesses in the PFM system, and the original design, which increases the likelihood of them being addressed, which will improve sector PFM in future.	It is too early to assess the extent to which SBS has contributed to sector outcomes, although the policies that SBS have supported should make a positive contribution to service delivery outcomes in the future. There is some preliminary evidence that user fee-elimination has increased utilisation of health facilities. If delays in disbursement of SBS, and weaknesses in government systems highlighted by SBS (such as transparency and predictability in budget formulation and execution) are addressed, SBS has the potential to have a positive impact on service delivery.

Annex 2 – Country and Sector Data

a) Core Country Data

Zambia	1990	1995	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	SSA (2007)
Exports of goods and services (% of GDP)	36	36	27	27	27	28	28	29	38	34	38	42	**34**
GDP growth (annual %)	- -	3 -	2	2	4	5	3	6	5	5	6	6	**6**
GNI per capita, Atlas method (current US$)	430	340	310	310	300	310	320	360	410	500	630	770	**951**
GNI per capita, PPP (current international $)	820	770	810	830	870	920	940	1,010	1,030	1,080	1,140	1,190	**1,869**
Gross capital formation (% of GDP)	17	16	16	16	17	19	22	25	24	23	23	24	**22**
Inflation, GDP deflator (annual %)	106	38	19	21	30	24	21	20	21	18	13	9	**6**
GDP (current US$m)	3,288	3,478	3,237	3,131	3,238	3,637	3,716	4,374	5,525	7,349	10,886	11,363	**847,438**
Official development assistance and official aid (% GDP)	14	58	11	20	25	15	21	17	20	16	13	9	**4**
Official development assistance and official aid (current US$m)	475	2,031	348	623	795	551	794	755	1,128	1,165	1,426	1,045	**35,362**
Revenue, excluding grants (% of GDP)	20	20	18	19	-	20	18	17	18	17	17	18	-
Total debt service (% of exports of goods, services and income)	15	-	21	16	21	17	20	42	22	11	4	2	**5**
Fertility rate, total (births per woman)	6	6	-	-	6	-	6	-	-	5	5	5	**5**
Population growth (annual %)	3	3	2	2	2	2	2	2	2	2	2	2	**2**
Population, total (m)	8	9	10	10	10	11	11	11	11	11	12	12	**800**
Income share held by lowest 20%	-	-	3	-	-	-	-	6	4	-	-	-	-
Poverty headcount ratio at national poverty line (% of population)	-	-	73	-	-	-	-	-	68	-	-	-	-
Agriculture, value added (% of GDP)	21	18	21	24	22	22	22	23	23	22	21	22	**15**
Primary completion rate, total (% of relevant age group)	-	-	65	63	60	-	60	-	71	83	84	88	-
Ratio of girls to boys in primary and secondary education (%)	-	-	91	90	91	91	91	-	93	93	-	96	-
Births attended by skilled health staff (% of total)	-	-	-	47	-	-	43	-	-	-	-	-	**45**
Contraceptive prevalence (% of women ages 15-49)	-	-	-	22	-	-	34	-	-	-	-	-	**23**
Immunization, measles (% of children ages 12-23 months)	90	86	85	85	85	84	84	84	85	85	85	85	**73**
Life expectancy at birth, total (years)	48	43	-	-	40	-	39	-	-	41	42	42	**51**
Malnutrition prevalence, weight for age (% of children under 5)	-	-	-	-	-	-	23	-	-	-	-	-	**27**
Mortality rate, under-5 (per 1,000)	163	178	-	-	178	-	-	-	-	174	-	170	**146**
Prevalence of HIV, total (% of population ages 15-49)	9	16	16	16	16	15	15	15	15	15	15	15	**5**
Roads, paved (% of total roads)	17	-	-	-	-	22	-	-	-	-	-	-	-
Improved sanitation facilities, urban (% of urban population with acces	49	51	-	-	53	-	-	-	-	-	55	-	-
Improved water source (% of population with access)	50	53	-	-	54	-	-	-	-	-	58	-	-

Source: World Bank Website – Africa Quick Query (2009)

b) Sector Expenditure and Service Delivery Data

Table 1b: Chronology of the Zambian Health Sector

Year	Key Events
1991	MMD Health Policy Framework paper
1992	Cabinet approved 1991 Health Policies & Strategies (Health Sector Reform) Paper
1992	Autonomous Hospital Boards established based on 1985 Medical Services Act
1993	➢ Public Service Reform Program launched ➢ National Decentralization Policy approved by GRZ ➢ Health Reform Implementation Team established ➢ Creation of the District Health Boards under the National Health Services Act ➢ District Basket became operational with DANIDA - later increased to 5 CPs
1994	➢ NHSP 1995-1998 developed ➢ Financial & Accounting Management System (FAMS) introduced ➢ HMIS introduced
1995/96	➢ Basic Health Care Package defined ➢ National Health Services Act legitimizes District Health Boards ➢ CBoH established with 4 Regional Offices replacing the 9 Provincial Offices ➢ CP funding shifted to CBoH
1995-2000	➢ Fragile period for the sector reform program and the SWAp partnership
1997	➢ NHSP 1998 – 2000 developed ➢ Medical Stores Ltd put under external management contract
1998	➢ Re-establishment of the National Malaria Control Centre ➢ Cabinet approves National Drugs Policy & National Laboratory Policy
1999	➢ Cabinet approves Reproductive Health Policy ➢ Regional Health Offices scrapped and the 9 Provincial Health Offices reinstated ➢ Restructuring of the CBoH ➢ 24 November - First SWAp MOU signed between GRZ and 13 CPs
2000	➢ Joint Identification & Formulation Mission ➢ NHSP 2001-2005 formulated
2003	➢ Basket expanded to include Secondary and Tertiary Hospitals, CBoH and MOH HQ ➢ MTEF adopted by GRZ ➢ MTR of NHSP 2001-2005 conducted ➢ SWAp Code of Conduct drafted
2004	➢ Institutional & Organizational Appraisal of the Health Sector conducted ➢ Health SWAp coordination mechanism re-organized ➢ Basket further expanded to include Statutory Bodies, Training Institutions and Laboratories
2005	➢ Health Services Act repealed thereby abolishing CBoH, Provincial & District Health Offices ➢ GRZ indicated its preference for General Budget Support ➢ EU moves to General Budget Support ➢ DANIDA and Irish Aid migrate away from health; DGIS (silent partner) continues support through SIDA ➢ MOU between GRZ MOH and CPs revised ➢ Introduction of Wider Harmonization in Practice (WHIP)
2006	➢ January – HE the President announces the abolition of User-Fees in all rural public health care delivery facilities; April – new user fee policy came into effect ➢ 4th National Health Strategic Plan (2006 - 2010) launched ➢ Restructuring of MOH ➢ Drug Budget Line established ➢ First Joint Annual Review and report ➢ March - CBoH formally dissolved and merged with MOH ➢ MOU for Wider Harmonization in Practice signed between GRZ and CPs
2006	➢ DFID moves to earmarked budget support to target user fee elimination (the earmarking is dropped by 2008)
2006	➢ EC moves to SBS with earmarking to HR

Source: Adapted from Neupane, R. & H. Njie (2007) Zambian Health Sector Support Mapping Report, DFID Health Sector Resource Centre

Table 2b. Trends in Health Expenditures (ZK Billion) by Source, 1995-2004

Years	GRZ	Donors	Private				Total
			Employers	Households	Other Private	All Private	
1995	65.3	19.0	26.6	58.8	2.9	88.3	172.7
1996	80.6	43.4	33.4	81.6	3.9	118.9	243.0
1997	108.8	72.9	40.1	101.7	4.5	146.3	328.0
1998	120.9	95.1	57.8	130.9	9.0	197.7	413.8
1999	149.0	37.9	50.3	178.4	8.2	236.8	423.7
2000	155.2	101.1	59.2	223.8	23.6	306.5	562.8
2001	304.1	104.3	54.7	248.2	10.0	312.9	721.2
2002	350.2	336.2	62.5	308.9	24.7	396.1	1,082.4
2003	337.3	528.4	89.8	399.6	34.4	523.7	1,389.5
2004	332.8	790.1	128.9	528.9	79.9	737.7	1,860.6
2005	450.4	1,041.9	121.6	613.8	26.2	?	2,258.8
2006	598.7	1,081.3	132.5	668.7	35.3	?	2,453.6

Source: 'World Bank (2008) 'Zambia Health Sector Public Expenditure Review', Africa Region and figures for 2005-2006 supplied by the SWAp secretariat.
** Note that for 2005 and 2006 there were no figures supplied for all private so the overall total is slightly lower than it should be in practice.*

Table: 3b: Health sector expenditure (GRZ and basket funds)

	GRZ + Basket Funds					
	Wage	**Non-wage**	**Drugs**	**Capital**	**Total**	**% of total**
MoH HQ	4.8	67.4	29.1	0.3	101.6	14.9%
3rd level hospitals	62.2	20.4	2.9	17.5	103	15.1%
2nd level hospitals	44.7	21.5	2.8	-	69	10.1%
Districts	178.1	123.8	8.4	36.9	347.2	51.0%
Training institutions	4.1	16	-	2.8	22.9	3.4%
Grants & other payments	-	37.4	-	-	37.4	5.5%
Total	293.9	286.5	43.1	57.5	681.1	100.0%
% of total	43.2%	42.1%	6.3%	8.4%		0.0%

Source: MoH Zambia Public Expenditure Tracking and Quality of Service Survey in the Health Sector.

Table 4 b: Summary Statistics on the Major Diseases, 2000-05

Disease	Indicator	2000	2002	2004	2005
Malaria	Incidence/1,000	316	388	383	373
	Cases	3,591,621	4,101,169	4,328,485	
	Deaths	8,952	9,021	8,289	
Respiratory infection, non-pneumonia	Incidence/1,000	119	148	153	161
	Cases	1,340,283	1,565,430	1,726,597	
	Deaths	1,269	1,057	1,436	
Respiratory infection, pneumonia	Incidence/1,000	35	45	44	42
	Cases	402,643	475,389	494,040	
	Deaths	4,254	4,484	4,186	
Diarrhoea, non-blood	Incidence/1,000	65	80	75	75
	Cases	739,055	846,336	843,423	
	Deaths	2,795	2,996	2,725	
Eye infections	Incidence/1,000	47	43	40	40
	Cases	471,743	451,346	448,280	
	Deaths	72	8	5	
Trauma	Incidence/1,000	34	42	46	46
	Cases	390,869	447,278	525,039	
	Deaths	646	787	833	
Skin infections	Incidence/1,000	28	37	42	42
	Cases	309,758	393,384	472,746	
	Deaths	135	126	125	
Ear, nose, throat infections	Incidence/1,000	21	25	23	24
	Cases	238,403	260,058	259,877	
	Deaths	49	31	34	

Source: 'World Bank (2008) 'Zambia Health Sector Public Expenditure Review', Africa Region.

Table 5 b: UNDP Assessment of Progress in the Health MDGs 2008

GOALS AND TARGETS	Will Target be met?				Supportive environment			
	2008	2007	2005	2003	2008	2007	2005	2003
MDG 4: Child Mortality Target 5: Reduce by three quarters, between 1990 and 2015, the under-five mortality rate	Potentially	Potentially	Potentially	Likely	Strong	Good/fair	Good/fair	Good/fair
MDG 5: Maternal Mortality Target 6: Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio	Potentially	Unlikely	Unlikely	Unlikely	Strong	Weak/weak but improving	Weak/weak but improving	Good/fair
MDG 6: HIV/AIDS Target 7: have halted by 2015, and begun to reverse, the spread of HIV/AIDS	Likely	Potentially	Likely	Potentially	Good/fair	Good/fair	Good/fair	Good/fair
MDG 6: Malaria & other major diseases Target 8: Have halted by 2015, and begun to reverse, the incidence of malaria and other major diseases	Potentially	Potentially	Potentially	Potentially	Good/fair	Good/fair	Good/fair	Good/fair
MDG 7: Water & sanitation Target 10: Halve, by 2015, the proportion of people without sustainable access to safe drinking water	Potentially	Potentially	Potentially	Potentially	Good/fair	Good/fair	Good/fair	Weak/weak but improving

Source: UNDP (2008) Zambia Millennium Development Goals, Progress Report, 2008.

Annex 3 – Sector Aid Data

Table 6b: Donor Funding to the Health Sector through Basket Funds

	1997	2000	2001	2002	2003	2004	2005
District Basket							
SIDA	1,091,919	4,562,500	3,821,900	5,442,163	3,895,598	7,203,374	4,025,636
Danida	1,040,870	1,045,814	2,443,326	3,915,118	2,966,511	2,926,945	2,626,675
UNICEF	214,051	291,689	-	-	-	-	-
DGIS	46,920	3,853,283	4,106,710	7,825,396	-	-	-
DCI	-	1,315,428	1,689,787	2,272,878	2,993,095	2,233,511	2,819,686
DFID	-	3,685,714	-	2,393,070	-	-	-
USAID	-	1,000,256	354,287	-	-	-	-
EU	-	-	1,065,172	-	2,287,622	1,237,268	2,520,000
UNFPA	-	-	100,000	300,000	100,000	100,000	99,353
CIDA	-	-	-	82,152	106,004	-	-
UNDP	-	-	-	120,880	-	-	-
World Bank	-	-	-	-	1,429,608	-	-
Total District Basket	**2,393,760**	**15,754,684**	**13,581,182**	**22,351,657**	**13,778,438**	**13,701,098**	**12,091,350**
Expanded Basket							
DFID	-	-	-	-	7,857,470	-	9,240,050
DGIS	-	-	-	-	10,024,476	10,578,000	13,031,857
Total expanded Basket					**17,881,946**	**10,578,000**	**22,271,907**
Hospital Basket							
SIDA	-	-	-	-	1,921,955	2,572,608	1,439,577
DCI	-	-	-	-	176,555	360,137	841,798
Total Hospital basket					**2,098,510**	**2,932,745**	**2,281,375**
Total Basket Funds	**2,393,760**	**15,754,684**	**13,581,182**	**22,351,657**	**33,758,894**	**27,211,843**	**36,644,632**
Basket funds as % MoH Budget	**54%**	**63%**	**47%**	**57%**	**51%**	**33%**	**39%**

Annex 4 – Inventory of Sector Budget Support

a) Details of Inputs by Type of SBS

This table provides a detailed description of SBS inputs provided in the country.

SBS Input	***EC Support to HR Retention***	***DFID Support to User Fee Elimination***
(i) SBS Programmes and their Objective		
Programmes Included (state donor an dates)	EC support under 9th EDF (2006-2008)	DFID (2006-2007) through earmarking of GBS
What Were the Objectives of SBS Operations and how has this evolved over time?	Support to HR retention scheme in EDF 9. EDF 10 will be broader and focus on MDG attainment	To strengthen the relationship between the MoH and the MoFNP To support the elimination of user-fees in health
(ii) Level of Funding and Arrangements for Predictability		
Trends in the size of SBS agreements over time. (relate to table in part c of the inventory)	Euro 10 million over three years 2006-2008. Euro 59 million 2009-2013.	US$5 million in 2006 and 2007 earmarked to health and non-traceable earmarked to user-fee elimination. This was then rolled into GBS in 2008 without any earmarking
Mechanism and timing communication of amounts for the next financial year and the medium term and their reliability in practice. (relate to table in part c of the inventory)	Outlined in financing agreement. Unreliable in practice	Five year funding program. Disbursements reliable from year to year, but not in-year. After two years eliminated earmarking to health.
No. and timing of tranches within the financial year and their predictability in practice.	2006 and 2007 one tranche per year 2008 two tranches. Unreliable as disbursements not until 2007 and last two tranches rolled into one and not received until 2009	1 tranche which was predictably disbursed to the MoFNP, but not to MoH.
(iii) Earmarking, Additionality and Disbursement Channels		
Overall level of discretion/degree of earmarking of SBS (i.e. location on y axis of spectrum of SBS)	Non-traceable earmarking to HR retention. No evidence needed of expenditure	Completely discretionary
Route of channelling funds to treasury and thereafter to sector institutions (describe diagram in section b of inventory)	Bank of Zambia to MoFNP to MoH	To Bank of Zambia, MoFNP then MoH and districts
Requirements for additionality of funds to sector budgets / programmes within the sector, if any.	None	None
Specific arrangements for earmarking of	Condition to include budget line for HR retention, but no	MoFNP has to show to DFID that funds have been

SBS Input	*EC Support to HR Retention*	*DFID Support to User Fee Elimination*
funds to specific programmes in the budget and during budget execution.	reporting on if monies spent on this	disbursed to the MoH.
(iv) Conditionality and Dialogue		
Overall Focus of Dialogue and Conditionality (location on x axis of spectrum of SBS)	HR Retention issues	All of the health sector
Nature of Underlying MoU/Agreement (this may be agreement specific or joint)	Agreement EC and MoH	Have not been able to get a copy of this.
Nature and types of condition relating to the sector	*2006 Fixed Tranche* • Creation in GRZ budget of budget item devoted to human resources for health strategic plan • Formal adoption of the National Development Plan *2007 Tranche* • Development & implementation at central & provincial level of an HR information system • Indicators for M&E of the HR plan developed • Agreed & formalised mechanisms for selective incentives for health workers *2008 Tranche* • Improvement in health professional staff • Progress in implementation on the MoH payroll of staff paid from grants & user-fees at district/facility level.	*Indicator HEA 1.*Percentage of Institutional Deliveries Target: 2006 45%, 2007 47%, 2008 50% *Indicator HEA 2.*Percentage of fully immunised children under one year of age in 20 worst performing districts Target: 2006 65%, 2007 70%, 2008 73% *Indicator HEA 3* Utilisation rate of PHC facilities Target: 2006 0.5, 2007 0.55, 2008 0.6 *Indicator HEA 4.*Percentage Ministry of Health releases to district level Target: 2006 57%, 2007 59%, 2008 60%
Conditions outside the sector	*General Conditions* • PEM sufficiently transparent, accountable & effective • Existence of well defined macro-economic or sectoral policies	PRBS Conditions
The nature of Performance indicators monitored, and the source of performance indicators	• Improvement in ratio of health professional population/staff (enrolled nurses); no districts in Zambia presenting a ratio above 7000.	None
Accountability requirements for SBS programmes	None	None
Existence of any performance assessment framework or equivalent, and description of	Framework for the assessment of fixed and variable tranches as described above	PRBS PAF

SBS Input	*EC Support to HR Retention*	*DFID Support to User Fee Elimination*
its structure and content.		
Process for reviewing adherence to conditions	Undertaken by the SWAp CPs and the MoH	As part of PAF process
Linking of conditions to the triggering of release of funds	A financial weight is attached to each target for variable tranche release. Disbursement is according to progress towards achieving the target. For fixed tranches disbursement is upon achievement.	None
Mechanisms/Fora for dialogue with respect to SBS	Dialogue is undertaken through the established SWAp mechanism	Normal SWAp processes
(v) Links to TA and Capacity Building		
Overall focus of TA/Capacity Building Linked to SBS	• Focused on HMIS and providing information on health results and indicators	• None
Is the provision of technical assistance and capacity building delivered as an explicit part of the SBS programme? If yes, describe.	• No	• N/A
Is the provision of TA/Capacity building in other programmes/provided by other donors explicitly linked to the provision of SBS?	• No	• No
Are there TA/Capacity Building conditions built into the SBS programme? If yes, describe.	• No	• No
(vi) Coordination with other SBS programmes and other aid modalities *e.g. common calendar, joint missions, common set of indicators, pooling of funds, delegated cooperation or silent partnership, Joint diagnostic and performance reviews*		
What provisions are there for coordinating the provision of SBS and its associated dialogue and conditionality amongst DPs providing SBS?	• Yes, among SWAp donors where dialogue is joint. Conditionality is separate but is assessed jointly with SWAp partners	• No
What provisions are there for coordinating the provision of SBS inputs with General Budget Support?	• None formally, although the EC is a GBS funder.	• It is undertaken through GBS
What provisions are there for coordinating	• Yes, through the SWAp and adherence of SBS to	• All part of the SWAp process

SBS Input	***EC Support to HR Retention***	***DFID Support to User Fee Elimination***
the provision of SBS with project and other forms of aid to the sector?	health sector policy frameworks	
(vii) SBS as a transition mechanism		
Have donors providing project/basket funding shifted their support to SBS? What was the justification for doing so?	• The EC has moved from basket funding to SBS and DFID moved from basket funding to GBS with an earmarked allocation to health. The justification was to put health sector support on budget and to ensure a more coherent budget negotiation and allocation process through encouraging strengthened links between the MoH and MoFNP	• Not as yet, they are looking carefully at the DFID/EU experience first
Have donors shifted from the provision of SBS to general budget support? What was the justification for doing so?	• DFID moved from SBS to GBS as SBS support was already through an earmarked GBS allocation. This proved difficult to manage as the MoH did not receive predictable funding and there was no additionality condition which meant that it was easier to eliminate earmarking and let the MoFNP decide on the MoH's budget allocation.	• Yes, for DFID it has been part of a total transition to GBS with no specific health funding. The justification was streamlining of the number of CPs involved in health
(viii) Influence of HQ requirements on the design of SBS instruments		
Degree to which the design of SBS has been influenced by donor HQ requirements	• The system of fixed and variable tranches was a requirement of the EC headquarters	• Influenced by HQ lack of requirements

b) Financial Contributions against Budget over Time (US$m)

This table below sets out SBS disbursements against the amount budgeted for in the national budget and the total committed in the BS agreement.

Programme Name	***Donor***	***Start date***	***Loan/ Grant***	***Earmarking***	***Total Agreement***	***2006***	***2007***	***2008***
EDF 9 Health	EC	*2006*	Grant	*none*	10 m euro	*3m committed* *0 disbursed*	*2m committed* *5 m disbursed*	*5m committed* *3.57 m disbursed*
GBS allocated to health	*DFID*	*2005/6*	*Grant*	*none*	*US $20 m*	*5m committed* *5m disbursed*	*5m committed* *5m disbursed*	*5m committed* *5m disbursed*

c) Details of Conditions relating to Sector Budget Support Over Time

This table sets out the specific conditions (e.g. policy actions, performance targets) associated with SBS agreed each year, mapped onto the four themes in the assessment framework.

Timing	***Policy, planning and budgeting***	***Procurement, Expenditure, Accounting and Audit***	***Institutions, service delivery systems, and capacity;***	***Accountability***	***Due Process and other Conditions***
EC					
2006	• Creation in GRZ budget of budget item devoted to human resources for health strategic plan • Formal adoption of the National Development Plan.				
2007	• Development & implementation at central & provincial level of an HR information system • Indicators for M&E of the HR plan developed		• Agreed & formalised mechanisms for selective incentives for health workers		

2008		Progress in implementation on the MoH payroll of staff paid from grants & user-fees at district/facility level.	• Improvement in health professional staff recruitment.		
DFID					
2006-2008		*Indicator HEA 4.*Percentage Ministry of Health releases to district level Target: 2006 57%, 2007 59%, 2008 60%.	*Indicator HEA 1.*Percentage of Institutional Deliveries Target: 2006 45%, 2007 47%, 2008 50% *Indicator HEA* 2.Percentage of fully immunised children under one year of age in 20 worst performing districts Target: 2006 65%, 2007 70%, 2008 73% *Indicator HEA 3* Utilisation rate of PHC facilities Target: 2006 0.5, 2007 0.55, 2008 0.6.		

d) Details of TA and Capacity Building linked to the Provision of Sector Budget Support

This table sets out the details of any TA and Capacity building provided to the sector which is linked to the provision of SBS, mapped onto the four themes of the assessment framework.

Timing	***Policy, planning and budgeting***	***Procurement, Expenditure, Accounting and Audit***	***Institutions, service delivery systems, and capacity;***	***Accountability***	***Other***
			HMIS Strengthening (EC)		

Annex 5 – Institutions visited and Individuals Met

Institution	Name	Position
European Commission	Alessandro Zanotta	Advisor
	Francesca Di Mauro Ph.D	Counsellor
	Jurgen Kettner	Seconded Secretary
	Paul Kalinda	Health Advisor
	Benoist Bazin	Section Head
	Eric Beaunie	Head of Co-operation
Ministry of Health	Vincent Luhana	Senior Accountant
	Dr. C. Simoonga	Deputy Director - M&E
	Alex Chikwese	
	Nicholas Chikwenya	Deputy Director, Health Planning & Budgeting
	Steve Mtonga	Financial Specialist
	Vincent Musowe	Advisor
	Roy Maswenyeho	Principle Accountant, Donor
	Davies Chiimfwembe	Director of Policy and Planning
	R Chitengu	Principle Planning
HSSP	Brighton Bwacha	Deputy Chief of Party
UNFPA	Duah Owusu-Sarfo	Resident Representative
	Sara Bvulani Malumo	National Programme Officer - RH
CIDA	Laurie Rodgers	First Secretary
WHO	Solomon Kagulula	Management Processes
DFID	Alan Whitworth	
	Clare Harris	Economist
	Dyness Kasungami	Advisor
	Angela Spilsbury	Advisor
	Gregory	
UNZA	Bonah Chitah	Lecturer
German Embassy	D Dempf	3rd Secretary
Swedish Embassy	Audrey Mwendapole	Health Officer
	Christina Larsson	First Secretary
Danish Embassy	Annelise Boysen	Counsellor
Ministry of Finance	Monde Sitwala	Assistant Director ETC
	Dr. Thomas Krimmel	Dev. Co-operation Advisor
	Temwani Chihana	EDF Projects Coordinator
World Bank	R. Sunkutu	PHN Specialist
USAID	Randy Kolstad	PHN Director