



GAVI Health System Strengthening Support Evaluation

RFP-0006-08

Zambia Case Study

Final Version – August 2009
David Lewis & Kawaye Kamanga

Submitted by

HLSP
5-23 Old Street, London,
EC1V 9HL, UK

T +44 (0)20 7253 5064

F +44 (0)20 7251 4404

E enquiries@hlsp.org

www.hlsp.org

Group Disclaimer

This document has been prepared for the titled project or named part thereof and should not be relied upon or used for any other project without an independent check being carried out as to its suitability and prior written authority of HLSP being obtained. HLSP accepts no responsibility or liability for the consequences of this document being used for a purpose other than the purposes for which it was commissioned. Any person using or relying on the document for such other purpose agrees, and will by such use or reliance be taken to confirm his agreement, to indemnify HLSP for all loss or damage resulting there from. HLSP accepts no responsibility or liability for this document to any party other than the person by whom it was commissioned.

To the extent that this report is based on information supplied by other parties, HLSP accepts no liability for any loss or damage suffered by the client, whether contractual or tortious, stemming from any conclusions based on data supplied by parties other than HLSP and used by HLSP in preparing this report.

Table of Contents

- List of Acronyms 3**
- Summary of key findings, conclusions and recommendations..... 4**
- 1. Scope, Approach and Methodology.....13**
 - 1.1 Background.....13
 - 1.2 Brief conceptual framework of the Evaluation13
 - 1.3 Approach to the Country Case studies.....15
 - 1.4 Acknowledgements.....16
- 2 Snapshot of the Zambian health system17**
 - 2.1 Progress towards MDGs.....17
 - 2.2 The response from the health system20
- 3. The GAVI HSS proposal – inputs, outputs and progress to date.....23**
 - 3.1 HSS proposal design23
 - 3.2 HSS application and approval processes.....26
 - 3.3 HSS Start up measures28
 - 3.4 Progress to date and Annual Progress Reporting (APR) on HSS.....30
 - 3.5 End of HSS Assessment.....32
 - 3.6. Support systems for GAVI HSS34
 - 3.6.1 Technical support for proposal design and approval.....34
 - 3.6.2 Technical support to the APR35
 - 3.6.3 Technical support for HSS implementation.....36
- 4. Alignment of HSS with GAVI principles.....37**
 - 4.1 Country Driven37
 - 4.2 Is GAVI HSS aligned?.....37
 - 4.2.1 Alignment with broader development and health policies.....37
 - 4.2.2 Alignment with budget and reporting cycles.....38
 - 4.3 Is GAVI HSS Harmonised?38
 - 4.4 Is GAVI HSS funding Predictable?.....39
 - 4.5 Is GAVI HSS Accountable, Inclusive and Collaborative?.....39
 - 4.6 Does GAVI HSS have a Catalytic Effect?40
 - 4.7 Is GAVI HSS Results Oriented?.....41
 - 4.8 GAVI HSS Sustainability Issues.....41
 - 4.9 Does HSS funding help Improved Equity42
- Annex 1 – List of people met43**
- Annex 2 – List of Key Documents Reviewed.....44**
- Annex 3 Typology of areas for HSS support.....45**

List of Acronyms

AIDS	Acquired Immune Deficiency Syndrome
CBA	Community based agents
CHAZ	Churches Health Association of Zambia
CHW	Community health worker
c-MYP	Costed-Multi Year Plan
CP	Cooperating Partner
DFID	Department for International Development
DPT-Hep b+Hib	Diphtheria-Pertussis Tetanus, hepatitis B and Haemophilus influenzae vaccine
EPI	Expanded program on Immunisation
EU	European Union
GAVI	Global Alliance for Vaccines and Immunisation
GRZ	Government of the Republic of Zambia
ICC	Inter-agency Coordinating Committee
IGA	Income Generating Activities
ISS	Immunisation Support Services
HSS	Health system Strengthening
HSSP	Health Systems Support Program
HRHSP	Human Resource for Health Strategic Plan
HIV	Human Immune Deficiency Virus
MDGs	Millennium development Goals
MoH	Ministry of Health
MoFNP	Ministry of Finance and National Planning
MTEF	Medium Term Expenditure Framework
NHC	Neighbourhood Health Committees
NHSP	National Health Strategic Plan
NIDs	National Immunisation days
RED	Reaching Every District
UNICEF	United Nations Children's Emergency Fund
USAID	US Agency for International Development
WHO	World Health Organisation

Summary of key findings, conclusions and recommendations

Background, approach and limitations

Our findings in Zambia have been limited to the HSS proposal design and application processes, to the early implementation measures and to progress achieved as per the APR reports. It would have been useful –as originally intended- to complement these findings from our relatively short visit to Zambia with the more detailed data from the ongoing Zambia HSS Tracker Study. The Tracker Study –undertaken by a research group made up of JSI/InDevelop-IPM is partnering with the Economics Department of the University of Zambia to undertake a detailed assessment of the GAVI HSS funded activities in Zambia (and in 5 other countries). Unfortunately, the timings of the Tracker Study and of this evaluation are different and results from the former were not yet available to these evaluators at the time of conducting the analysis of country results. We were also unsuccessful in our repeated attempts to meet or talk to the team from the Economics Department at the University of Zambia.

At the planning stage of the evaluation it proved very difficult to make contact with in-country contacts in the MoH provided by the GAVI Secretariat. It later transpired that an on-going investigation into the possible misuse of funds in the MoH had resulted in a number of officials being unavailable. The head of the Child Health Unit had been on official business outside Lusaka when the consultants made their initial approach and, understandably, it was difficult to contact her. When the consultants did make contact with the Child Health Unit in the MoH, it provided an excellent level of support to the mission, for which we are most grateful.

Nonetheless, the consultants were able to meet with a reasonably wide range of officials from the MoH and partner organisations and are of the opinion that sufficient information was gathered to be able to fulfil most of the requirements of the evaluation. All meetings took place in Lusaka. The possibility of making a field visit to a site where GAVI HSS activities were being implemented was considered. However, the nearest location was 500km from Lusaka and, given the time required, and the short duration of the mission, the decision was taken not to go-ahead with a field visit.

Overview of progress to date

The HSS programme in Zambia is at an early stage. Implementation began in earnest towards the middle of 2008. The programme is moving in the right direction and good progress is being made in implementing the agreed programme of work in the twelve intervention districts. In total, \$US 2.7 million was spent during 2008 on drilling boreholes, purchasing bicycles, motor cycles, vehicles, radio communications equipment and solar panels, mobile phones, stationary and to establish neighbourhood health committee incentive grants.

The evaluation team were impressed with the innovative approach to HSS adopted in Zambia. The focus on supporting non-salary incentives to improve recruitment and retention rates in poorly served rural districts has the potential to provide sustainable benefits such as health service utilisation and linked health outcomes.

Whilst the evaluation team found much that was positive about the HSS programme in Zambia, there were several aspects of the programme that it was felt needed greater attention. The M&E framework needs strengthening as it does not adequately reflect the interventions being supported through the HSS grant. Also, the HSS section in the APR needs to incorporate a much more detailed reporting of progress at the district level. This should be combined with more disaggregated national indicators to the district level in order to allow a more accurate picture of progress achieved.

Significant efforts and resources have been invested in Zambia's health reforms over the last 17 years, and good progress has been made in some areas, notably on improving immunisation rates and reducing infant and child mortality. However, the health sector has continued to face significant obstacles and challenges, which have continued to adversely affect performance and made it difficult for the sector to provide basic health care services to all, as defined by the Basic Health Care Package (BHCP).

HSS proposal design

A document review highlighted the severe human resource crisis that Zambia is experiencing and which is negatively affecting the delivery of health services including the Expanded Program on Immunization (EPI). Over the past few years, the Ministry of Health has seen a massive exodus of health workers, especially nurses to the domestic private sector and abroad, primarily due to the low level of wages and benefits in the civil service.

A decision was made to focus the GAVI HSS proposal on providing non-salary staff incentives in 12 remote, poorly performing districts. These incentives include: the provision of transport and communications equipment; improved staff housing; solar power and boreholes for accessible, clean water supplies. Additionally, limited funding is also being provided to support Income Generating Activities (IGAs) to allow communities to provide some support for CHWs to encourage them to remain active.

HSS application and approval processes

The proposal development process began in September 2006 when the MoH put together a small Task Force led by two national consultants to write the GAVI HSS submission for Zambia. There was considerable technical support from a range of partners including: WHO, UNICEF, USAID, CIDA and the Churches Health Association of Zambia (the main CSO representative in the process). The proposal was submitted to GAVI in May 2007.

The MoH and partner staff interviewed thought that the proposal writing process had been thorough and rigorous. The availability of high quality national consultants to undertake most of the research and proposal writing had been a significant bonus.

HSS Start up Measures

The same systems and procedures that already applied to other GAVI grants were used for the HSS grant. Such systems and procedures already had accounting and financial management arrangements in place within the MoH.

The initial disbursement of \$US 2,344,500 into the MoH GAVI account was made on the 12th October 2007, but detailed planning with the selected districts for the implementation of the HSS funding did not begin until May 2008.

Problems with procurement at the central and district levels have created some problems and delays. Tender boards do not always operate efficiently and often require the guidance of a superior board before reaching a decision.

The HSS proposal provided for the establishment of revolving funds to support income generating activities in each of the 12 districts. US\$ 24,000 were allocated to establish the funds but no provision was made for any technical support to the communities involved to help them establish basic operating procedures to manage the funds.

Annual Progress Reporting (APR) on HSS

Specifically in relation to the HSS section in the 2008 Zambia APR, the consultants found the following:

- HSS Activities. There were brief descriptions of the HSS activities undertaken with no district breakdown included.
- Financial reporting. There was almost no detailed reporting of how the money had been spent at the district level
- Result indicators. The choice of indicators did not seem entirely appropriate given the focus of the intervention on non-salary incentives. The reporting against indicators should be done on a district basis. Using aggregate national indicators does not provide sufficient information to be able to effectively assess impact in the 12 intervention districts.

There is little detailed guidance provided either in the GAVI Handbook, the revised HSS guidelines or on the proforma APR on how data should be reported and presented. The section on reporting in the GAVI Handbook is focussed almost exclusively on ISS. ***It is recommended*** that HSS proposal guidelines are improved and contain more detailed information on developing appropriate M&E frameworks and reporting arrangements

It will be very difficult for the IRC when reviewing the 2008 APR to make a reasonable assessment of progress being made in Zambia due to the lack of detailed data on activities in the report. There are also some concerns as to whether or not the six outcome indicators identified in the original HSS proposal will provide an effective framework for measuring outcomes and impact.

If GAVI is to be a responsible source of funding for HSS interventions, it needs to be confident that activities that it is supporting are being implemented as agreed, and that its resources are not being diverted for other uses. In order to do this, it is important to have a monitoring framework in place with a set of indicators that will capture fully or in large part, the progress being made in implementing the agreed programme of work.

Serious attention needs to be given to ensuring that the monitoring framework for HSS work is appropriate at the time of proposal development. Subsequent progress reports should be generated through a process that closely follows the agreed framework and uses the highest quality data available. ***It is recommended*** that more attention given to constructing an appropriate results framework at the time of proposal development

Given, the significant levels of funding involved in some countries, consideration should be given by GAVI to not only supporting the development of proposals (\$US50K) but also to providing greater support to the on-going monitoring and reporting of implementation. ***It is recommended*** that greater levels of support to implementation and reporting are provided.

There is also the opportunity for other partners such as WHO or UNICEF to support the monitoring process more intensively.

Ideally, the GAVI HSS reporting should not be undertaken in a stand alone way, as is the current GAVI requirement, but should be incorporated into joint sector monitoring efforts wherever possible. Where there is a Joint Annual Review or performance assessment undertaken, potentially the GAVI HSS monitoring could be included as part of that exercise. ***It is recommended*** that GAVI HSS reporting should be included as a part of sector monitoring arrangements

Ensuring effective governance arrangements and solid financial management systems is vital for GAVI to be a responsible funder of HSS. Due to an investigation into the possible misuse of funds involving 27 billion Kwacha (\$US5.4 million approx.) by officials from the planning, HR and accounts sections of the Ministry it did not prove possible to interview a number of key officials involved in proposal design and management of the GAVI HSS funding during the consultants' mission in Zambia. At the time of writing, 23 MoH officials had been suspended for six months pending an investigation of serious allegations

Given, the seniority and number of MoH officials under investigation and the serious concerns raised regarding the operation of the basket fund, there must be legitimate concerns about the management of the GAVI HSS resources (and other GAVI funds) by the MoH, given that these are channelled through the common funding arrangements.

End of HSS Assessment

Immunisation coverage rates in Zambia are already high, making the probability of anything more than small improvements unlikely. The current set of indicators is very focused on immunisation making it unlikely that the current monitoring framework will be able to effectively capture other important improvements to the health system produced through the HSS funding. In the poorly or least performing HSS project districts, we may have to wait for the evaluation in 2012 to see whether the HSS funding has had some impact in those particular districts (assuming the M&E framework is able to capture it.)

The focus being given to supporting non-salary interventions in Zambia is a novel and innovative approach which has been well thought through and targeted appropriately. If it is successful, there will be some very useful lessons that emerge. It is important that those lessons are to be comprehensively captured and reported. To do this effectively, it will be important to undertake a well designed study. If this is to happen, then thought needs to be given to how best to do this, and the earlier the better. ***It is recommended*** that where GAVI HSS supports novel or innovative interventions that resources be included to undertake any necessary operations research

Support systems for GAVI HSS

Due to difficulties in interviewing senior MoH officials involved the development of the HSS proposal during the week that the consultants were in Zambia it was not possible to determine if MoH stakeholders thought that the support received from WHO, UNICEF and other partners was adequate.

The consultants are of the view that the process did produce a strong proposal that addresses a number of the major obstacles to posting and retaining health staff in rural areas. The decision to focus the HSS funding in only 12 of the 72 districts in order to try and maximise impact was logical and sensible. However, given the magnitude of the work that needs to be done, coupled with the modest amount of funding available from GAVI (\$6,604,638 over 5 years), a focus on even fewer districts may have been prudent.

The consultants are of the view that the M&E framework could have been further strengthened to better reflect the innovative approach to HSS adopted in the proposal.

Technical support for HSS implementation

The WHO and UNICEF were heavily involved in the design stage of the HSS proposal. WHO sent a draft of the proposal to the its regional office and requested comments/suggestions. However, after the implementation of the HSS proposal began there is very little evidence of any on-going structured support being provided by either organisation to the MoH to assist with specifically with the process.

During discussions with bilateral partners it was clear that in the main, they had little knowledge of the detail of the HSS work and some were unhappy with the standard of the APR reporting, they felt pressured to sign-off in order not to hold-up the submission of the report which may have delayed the release of future tranches of funding. The MoH

commented that the EPI technical working group includes many cooperating partners who could provide additional support but their attendance can be erratic.

Is GAVI HSS Country Driven?

The GAVI HSS proposal was clearly country driven by a group of MoH, WHO and UNICEF official supported by two national consultants. The proposal was well researched and focused on responding to the current human resources crisis within the Zambia health sector.

Is GAVI HSS aligned?

The focus of the HSS proposal on supporting non-salary interventions aimed at encouraging more health staff to work and live in rural areas is clearly well aligned with national health priorities and with key objectives of the national health plan. The focus of the HSS proposal on 12 poorly performing rural districts has also given it a strong poverty focus.

While aligned with country plans the HSS implementation, monitoring and reporting arrangements are clearly not aligned with country systems, particularly in a country like Zambia where standard review and reporting procedures have been in existence over many years as part of the health SWAp.

Is GAVI HSS Harmonised?

The GAVI HSS support is largely harmonised with the existing financial arrangements. Disbursements are made from the separate GAVI \$US account into the MoH basket fund for onward transfer to districts or for expenditure at the national level. The basket is subject to established financial management and reporting arrangements.

Is GAVI HSS funding predictable?

The GAVI HSS funds have been disbursed on time according to the agreed schedule. The Funds are readily available and accessible. In comparison with other funding sources, there is less bureaucracy required for the disbursement of funds from the GAVI HSS grant which is appreciated by the MoH.

Is GAVI HSS accountable, inclusive and collaborative?

The GAVI proposal was developed in a collaborative way to address a range of HRH issues that are impacting significantly on the health sector in Zambia. Unlike in some other countries, the proposal was not framed in a way that focused it specifically on helping to deliver and strengthen the EPI programme.

Knowledge of the GAVI HSS support was extremely variable amongst partners interviewed during the consultants' mission to Zambia. Some, such as WHO and UNICEF had a detailed knowledge of what was happening and how the funds were being deployed. Bilateral partners who had been less involved with the design of the HSS programme were relatively unformed about how the HSS work was proceeding.

This raises some question about the extent to which reporting of HSS implementation is effective through the existing committee structures within the MoH. In theory information sharing is done at technical working group and at the ICC level.

The problems with data presentation in the HSS Section of the 2008 APR (mentioned earlier in this report) also raise some important questions regarding the accountability (to other sector partners) of the current HSS reporting arrangements.

Effective reporting provides the basis for accountability, inclusiveness and collaboration. Without information it is very difficult for stakeholders to know if what is happening is taking place in a timely and effective way. Also without adequate reporting it is very difficult for other partners to be able to adjust their work programmes to take account of what GAVI HSS is doing.

The standard of HSS reporting and the lack of knowledge among some partners as to the scope and extent of the GAVI support to this area indicate that there may problems with some aspects of accountability, inclusiveness and collaboration in relation to the programme.

It is recommended that the MoH and its partners look at the current GAVI HSS management and reporting arrangements to determine if there are alternatives that could provide improved accountability and transparency.

Does GAVI HSS have a Catalytic Effect?

The work being funded by GAVI HSS in Zambia to support non-salary interventions is innovative. It builds on work done by a USAID supported health strengthening project in one district of Zambia. If the interventions in the 12 selected districts are successful, then a useful model for increasing recruitment and retention rates of key frontline health staff in remote, underserved areas will have been established. This would have the potential to be rolled-out to other districts in Zambia and potentially to other countries. If this proves to be the case, then the HSS funding could be said to have been catalytic.

If this is to happen, then the results of the Zambia programme are going to need much greater visibility. This will require a well planned study to be undertaken measuring the interventions and their impacts. Significantly better monitoring and reporting systems would need to be put in place.

Is GAVI HSS Results Oriented?

If the GAVI HSS funding in Zambia is to be results orientated there will need to be improved reporting of progress. Without reasonably detailed and accurate reporting mechanisms it will be very difficult to give a real “results focus” to the work.

GAVI HSS sustainability issues

The focus of the HSS proposal on providing non-salary incentives in rural districts is potentially very sustainable. A key point made by one of the partner organisations was that an intervention focused on providing non-salary incentives, is intrinsically more sustainable than say providing salary supplements directly to staff. Investments in boreholes, improved staff housing and solar power will potentially continue to deliver benefits for many years at very little additional cost.

Does HSS funding help improved equity?

The selection of the 12 districts to be supported with GAVI HSS funding was made on the basis of their under performance. The 12 districts selected are in areas where there are enormous challenges in providing health services. Almost by definition, selecting these districts on the basis of objective performance data will have given the HSS support a strong poverty and equity focus.

1. Scope, Approach and Methodology

1.1 Background

This report contains the findings of the case study conducted in Zambia during June 2009 as part of the GAVI HSS Evaluation Study. This is one of 11 In-depth case studies that have been conducted in the following countries, all of them recipients of GAVI HSS grants: Burundi, Cambodia, Democratic Republic of Congo (DRC), Ethiopia, Kyrgyzstan, Liberia, Nepal, Pakistan, Rwanda, Vietnam and Zambia. An additional 10 countries were also studied that did not involve country visits but just review of available documentation combined with email/phone interviews by the study team. These countries were Bhutan, Honduras, Georgia, Ghana, Kenya, Nicaragua, Nigeria, Sierra Leone, Sri Lanka and Yemen.

Other issues relating to the overall study methodology (evaluation framework, key questions, study components, guidelines for data collection, sampling method, etcetera) are publicly available documents that can be requested from HLSP. To keep this report short these broader methodological issues will not be discussed here.

1.2 Brief conceptual framework of the Evaluation

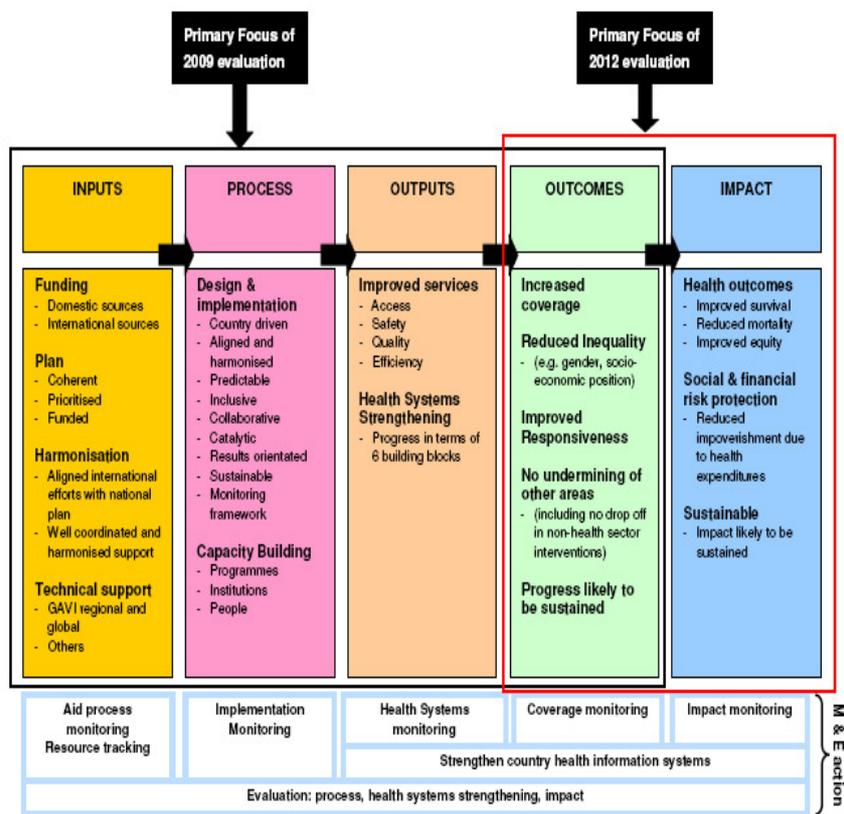
This evaluation is being conducted to inform three areas of decision making:

1. The Board decision in 2010 about whether or not to increase the funding available to the GAVI HSS window
2. How to improve current and future implementation. (This is valid even if the window is not expanded, because there are considerable sums of money which have been awarded but not yet disbursed.)
3. To enhance the quality of the 2012 evaluation.

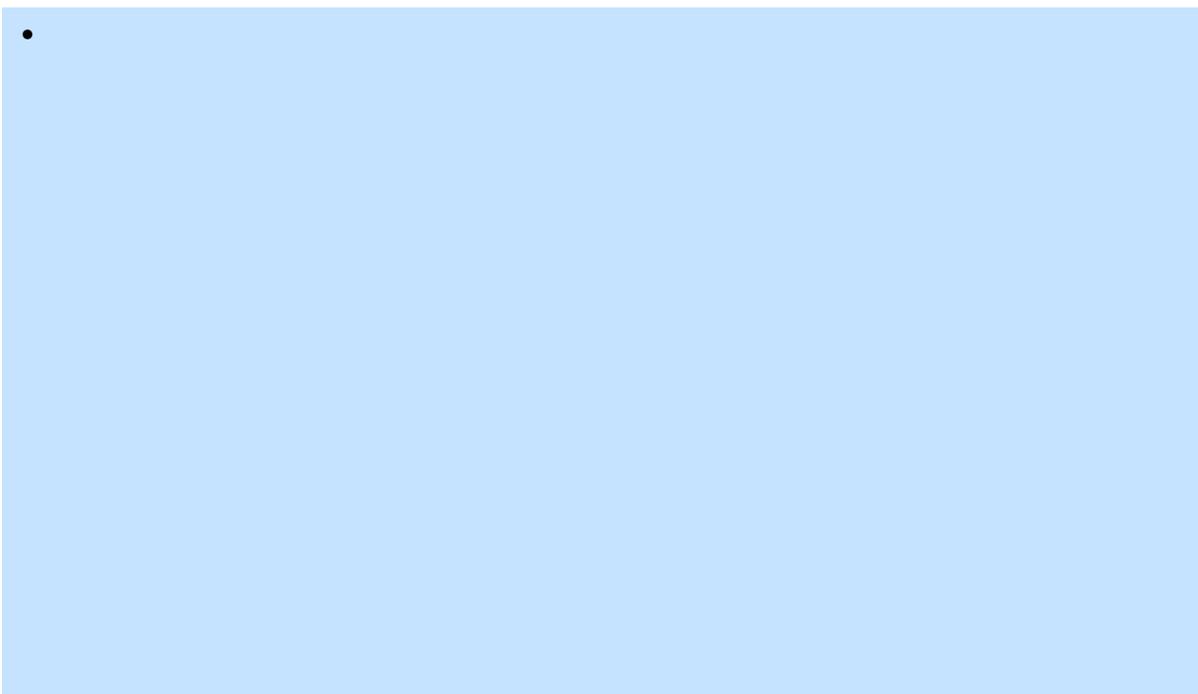
It is important to note given the little time elapsed since the first HSS applications were approved in 2006 that this evaluation –the first one ever conducted on the GAVI HSS component- will focus primarily on issues linked to: proposal design; approval and review processes; early start up measures; nature of inputs, processes and outputs involved in grant implementation and annual performance review; and assessment of activity and outputs achieved to date. The study will also reflect on the nature and quality of global, regional and

national technical support systems delivered by a range of stakeholders in support of HSS grants. The conceptual framework for this evaluation is shown in Figure 1.

Figure 1: The conceptual framework - logical progression from inputs to impact



Our priority questions have been summarised in Box 1 below.



1.3 Approach to the Country Case studies

All 11 countries included for in-depth review underwent at least one country visit by the HLSP country lead consultant helped by one or more national consultants or national research institutions depending on the circumstances.¹ In the case of 6 countries (DRC, Ethiopia, Kyrgyzstan, Nepal, Vietnam and Zambia) the HSS evaluation team were potentially able to count on the invaluable support and previous work of another study team conducting the GAVI HSS Tracking Study in those countries. The Tracking Study -led by the JSI/InDevelop-IPM covers very similar areas (albeit from a different angle) to those aimed for in our HSS Evaluation study, so it was highly synergistic for us to be able to use the Tracking Study guidelines and their extensive network of contacts and country knowledge for the purposes of our own evaluation study. To all members of the Tracking Study team including their country collaborators we wish to express our most sincere thanks and appreciation for their generous collaboration.

In Zambia as in other countries, the country case studies were triggered by a letter from the Executive Secretary of the GAVI Alliance Secretariat addressed to the Minister of Health and copied to the main stakeholders involved in follow up or implementation of GAVI grants at national or regional level, including the so-called “Focal Points” based at either the World Health Organisation (WHO) or UNICEF. It was later found that several people copied in such letters were no longer in post and that new stakeholders had been missed, which is why this study has recommended the GAVI Alliance Secretariat to review and update the list of country contacts on an annual basis. This will not only help other eventual study teams but will improve effective communications between the GAVI Alliance and the countries, particularly as the GAVI Alliance is not formally present in countries.

Once the letters had been sent the Country Lead Consultants began the process of documentation (see list of documents reviewed in Annex 2), they approached potential country researchers to work with them and they began preparing the country visits with country and regional stakeholders. In the case of Zambia, the country visit took place between the 1st and the 5th of June 2009. A list of people met for this evaluation is included in Annex 1.

¹ The main circumstances that determined the kind of support required by the HLSP Country Lead consultants included the size of the country, the size and complexity of the HSS grants, whether the grants were targeting any specific geographical areas, etcetera.

It was hoped that the relatively short duration of this visit would be sufficient given that Zambia is part of the JSI Tracking Study and that at least some of the required information should have been already collected. An evaluation of the GAVI HSS funded activities taking place in Zambia is being undertaken by a team from the Economics Department at the University of Zambia led by Professor Dick Jonsson. This should provide a great deal of useful information on the practical implementation of activities in the chosen districts. Unfortunately, despite repeated attempts by the evaluation team, it proved impossible to make contact with Prof. Jonsson and his team.

At the planning stage of the evaluation it proved very difficult to make contact with in-country contacts provided by the GAVI Secretariat. It later transpired that an investigation into the possible misuse of funds in the MoH had meant that a number of senior officials were unavailable. The head of the Child Health Unit had been on official business outside Lusaka when the consultants made their initial approaches, and understandably was difficult to contact. When the consultants did make contact with the Child Health Unit, it provided an excellent level of support to the mission for which we are most grateful.

Despite the previously mentioned problems, the consultants were able to meet with a reasonably wide range of officials from the MoH and donor organisations. Sufficient information was gathered to be able to fulfil most of the requirements of the evaluation. All meetings took place in Lusaka. The possibility of making a field visit to a site where GAVI HSS activities were being implemented was considered. However, the nearest location was 500km from Lusaka and given the time required, and the short duration of the mission, the decision was taken not to go-ahead with a visit.

Review this after receiving feed back from Zambia and Evaluation team on this draft

During the visit to Zambia it was agreed with the Dr V. Mukonka, the MoH Director of Public Health & Research that a draft report of the evaluation would be shared with the MoH in due course. Dr Mukonka also asked the question of how the wider issues raised by the evaluation would be shared and discussed between countries and the GAVI Secretariat and at what point?

1.4 Acknowledgements

We would like to thank the Ministry of Health in Zambia and particularly the Child Health Unit for the support received during this evaluation study. Thanks are also expressed to WHO and UNICEF, DFID, USAID and Rotary International. The full list of people met for this study is included in Annex 1.

2 Snapshot of the Zambian health system

2.1 Progress towards MDGs

Zambia's Fifth National Development Plan 2006 – 2010 identified that wealth creation through sustained economic growth constitutes the most important element in poverty reduction and, consequently, a very high premium is being placed on growth-stimulating interventions. The Government also recognises that redistributive policies do matter for reducing poverty and that *growth* and *equity* are not necessarily in conflict. It is resolved to approach poverty reduction through the 'broad-based growth' approach. In this context, the Government, together with civil society, have placed priority attention on those sectors that both maximise growth stimulation as well as on those, such as agriculture, education and health, which best address the plight of the poor.

From 1992 onwards, Zambia has implemented significant Health Sector Reforms, whose purpose is to *"..provide the people of Zambia with equity of access to cost-effective, quality healthcare as close to the family as possible..."*. The current National Health Strategic Plan ("NHSP" or "plan") is the fourth in the series of the strategic plans implemented since 1992. The theme of the current NHSP (2006 – 2010) is *"...Towards the Attainment of the Millennium Development Goals (MDGs) and National Health Priorities..."*.

The plan was prepared at the time when Zambia faced significant changes and challenges, including: a high disease burden compounded by the HIV/AIDS epidemic; critical shortages of health personnel; deteriorating health infrastructure; significant legal reforms; on-going restructuring of the health sector; a weak economy; and inadequate funding of the health sector. All these factors have significant implications on the organisation and management of the health sector.

The NHSP (2006 – 2010) prioritises those interventions and systems that have the potential to make a significant impact on health service delivery to improve the health status of Zambians. It focuses mainly on 12 national health priorities. These include 7 public health interventions and 5 health systems strengthening interventions which facilitate the efficient and effective management of the health sector, and without which, implementation of the public health priorities would not be possible. These priorities were selected on the basis of the health related MDGs and other national health priorities, and are presented in Table 1 below.

Table 1: National Health Priorities

S/N	Intervention/System	Objective/Main Targets
A.	Human Resource Crisis	
1.	Human Resources:	To provide a well motivated, committed and skilled professional workforce who will deliver cost effective quality health care services as close to the family as possible.
B.	Public Health Priorities	
2.	Integrated Child Health and Nutrition:	To reduce Under-5 MR by 20%, from the current level of 168 per 1,000 live births to 134 by 2010, and significantly improve nutrition.
3.	Integrated Reproductive Health:	To increase access to integrated reproductive health and family planning services that reduce the Maternal Mortality Ratio (MMR) by one quarter, from 729 per 100,000 live births to 547 by 2010.
4.	HIV/AIDS, STIs and Blood Safety:	To halt and begin to reverse the spread of HIV/AIDS and STIs by increasing access to quality HIV/AIDS, STI and blood safety interventions.
4.	Tuberculosis (TB):	To halt and begin to reverse the spread of TB through effective interventions.
5.	Malaria:	To halt and reverse the incidence of malaria by 75% and mortality due to malaria in children under five by 20%.
6.	Epidemics Control and Public Health Surveillance	To significantly improve public health surveillance and control of epidemics, so as to reduce morbidity and mortality associated with epidemics.
7.	Environmental Health and Food Safety:	To promote and improve hygiene and universal access to safe and adequate water, food safety and acceptable sanitation, with the aim of reducing the incidence of water and food borne diseases.
C	Support Systems Priorities	
9.	Essential Drugs and Medical Supplies:	To ensure availability of adequate, quality, efficacious, safe and affordable essential drugs and medical supplies at all levels, through effective procurement management and cooperation with pharmaceutical companies.

10.	Infrastructure and Equipment:	To significantly improve on the availability, distribution and condition of essential infrastructure and equipment so as to improve equity of access to essential health services.
11.	Systems Strengthening: (M&E, HMIS, FAMS, Procurement and R&D)	To strengthen existing operational systems, financing mechanisms and governance arrangements for efficient and effective delivery of health services.
12.	Health Systems Governance: (Governance and Health Care Financing)	To provide a comprehensive policy and legal framework and systems for effective coordination, implementation and monitoring of health services.

Source: 2006 – 2010 National Health Strategic Plan

Despite some improvements (i.e. immunisation coverage rates, infant mortality etc.), the disease burden has continued to increase, health care delivery has continued to be constrained due to lack of adequate human, material and financial resources, and performance against the Millennium Development Goals (MDGs) has not been satisfactory. The high disease burden in Zambia is compounded by several factors, including the impact of the HIV/AIDS epidemic, high poverty levels and the poor macroeconomic situation. Notwithstanding discrete and sustained improvements in most indicators, it is unlikely that Zambia will meet most of the MDG targets by 2015².

Table 2 - Progress as per successive DHS surveys

	1992	1996	2001/2	2007
Infant mortality	107	109	95	70
Under-five mortality	191	197	168	119
Maternal mortality	-	649	-	591
Deliveries with skilled attendant (%)	50	47	43	46
Contraceptive Prevalence Rate (%)	15	26	34	41
Total fertility rate	6.5	6.1	5.9	6.2

Source: www.measuredhs.com

² National Health Strategic Plan: 2007 - 2010

Progress has been made in some areas. The trends in reducing infant mortality over the last 15 years have been positive with a 35 per cent reduction over the 15 year period 1992 – 2007. However, the maternal mortality rate remains very high at a reported 591 maternal deaths per 100,000 live births in 2007. The total fertility rate has decreased only slightly since 1992 despite a substantial increase in the reported contraceptive prevalence rate from 15 per cent to 41 per cent. The slight decline in the number of births attended by skilled health staff is evidence of the severe challenges faced in a large, sparsely populated country like Zambia in getting adequate obstetric care to all sectors of the population.

Some progress has been made in child health, with a steep increase in the proportion of sick children receiving treatment. But much more remains to be done to assure integrated management of childhood illness (including malnutrition and related complications) at facility and community level. There is considerable room for progress in ante-natal care (taking advantage that a high proportion of women receive one AN check up in the first 3 months of pregnancy) and in raising the quantity and quality of delivery care.

2.2 The response from the health system

Significant efforts and resources have been invested in Zambia's health reforms over the last 17 years, and good progress has been made in some areas. However, the health sector has continued to face significant obstacles and challenges, which have continued to adversely affect performance and made it difficult for the sector to provide basic health care services to all, as defined by the Basic Health Care Package (BHCP). The major constraints include³:

- A high disease burden, compounded by the impact of HIV/AIDS and malaria, which are responsible for majority of morbidity and mortality;
- Critical shortages of qualified health workers at all the levels of health service delivery;
- Continued shortages and erratic supply of essential drugs and medical supplies, due to a range of challenges including procurement and logistics management problems;
- Inadequate and poor state of essential infrastructure, equipment and transport, particularly in rural areas.

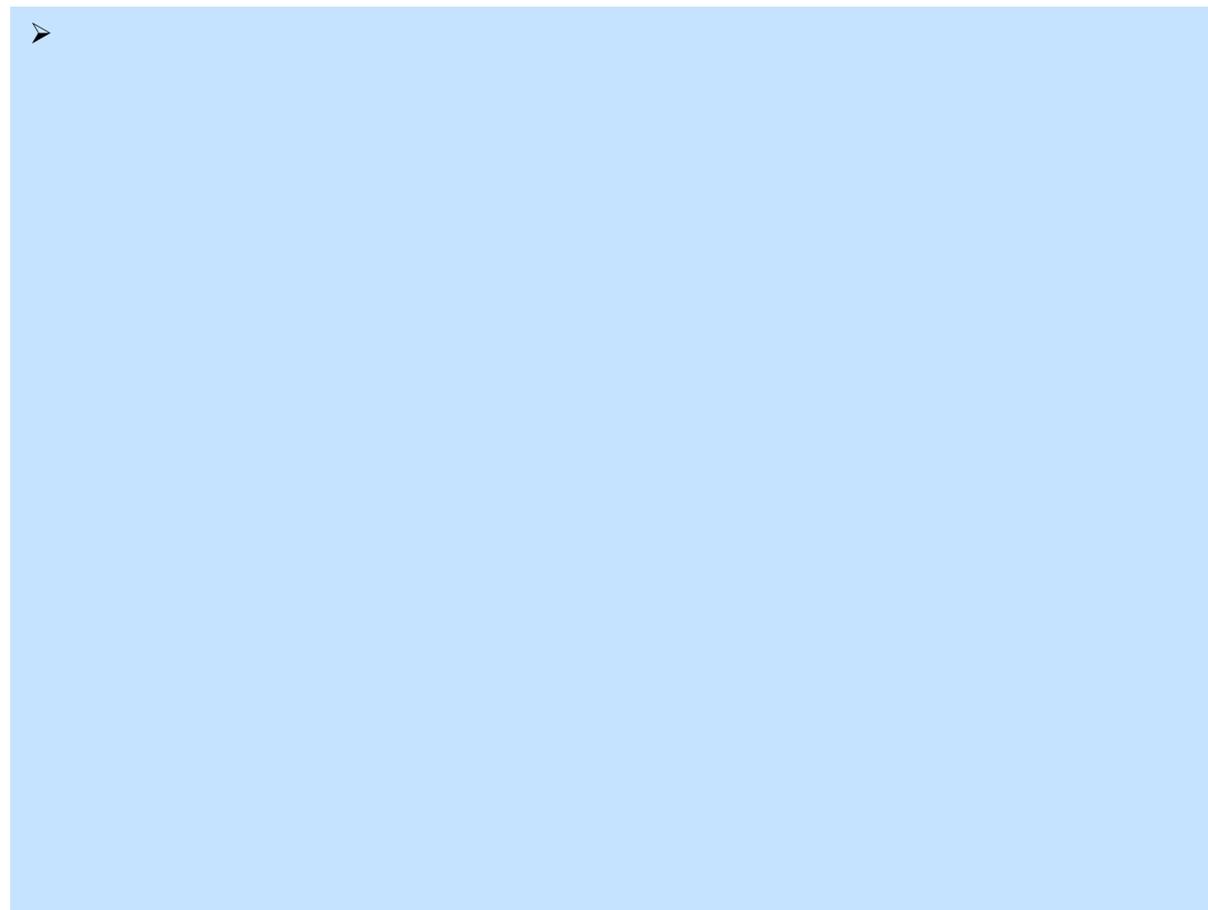
Despite the significant support from CPs and improvements in Government budgetary allocations and execution, funding to the health sector has continued to be inadequate and below the 15% of discretionary budget recommended by the Abuja Declaration.

Challenges in improving the health situation in Zambia have been exacerbated by the poor social-economic conditions, characterised by a weak economy, high unemployment and the

³ Zambia, MoH, Joint Annual Review 2007

high prevalence of poverty among the population, particularly among the rural population and vulnerable groups.

However, there has been significant recent progress in a number of key areas including the rehabilitation of infrastructure, the recruitment and deployment of staff to serve in rural areas and in reducing the prevalence of malaria and improving the TB cure rate.



Coverage of key health interventions, particularly in the maternal, reproductive and sexual health areas remain quite low in spite of long standing efforts to improve access. There are large health inequalities between higher and lower socio-economic groups and also urban and rural populations in Zambia. The high disease burden in Zambia is compounded by several factors, including the impact of the HIV/AIDS epidemic, high poverty levels and poor macroeconomic situation.

Coordination Arrangements

Different coordinating mechanisms have been established in order to strengthen partnerships through the SWAp and through coordination of health interventions. The overall aim of the coordination is to foster the realisation of the health sector vision. The health partnerships at the centre operate through Joint Coordinating Mechanisms. These are

closely linked consultative/coordination structures comprising of; (1) Annual Consultative Meeting (ACM); (2) Sector Advisory Group (SAG); (3) the MOH/CP Consultative Policy Meeting; (4) Technical Working Groups/Sub-Committees; and (5) Health CP Group Meeting. In addition, the Joint Annual Review (JAR) is conducted each year to assess the performance of the sector.

The Global Fund operates through the Country Coordinating Mechanism (CCM). The MOH and the CPs signed a MOU in 2006 to confirm and reaffirm their commitment to the health sector and to the implementation of the entire duration of the NHSP 2006- 2010. A number of donors are not part of the CP Dialogue forum. There seems to be consensus among the CPs that: (1) the Global Fund recipients should be part of the CP meeting and that: (2) GAVI and the GFTAM should also sign the MOU

The establishment and maintenance of strong partnerships for health with all of the key stakeholders has been one of the key principles on which the Zambian health sector reforms are based. The Ministry of Health (MOH) has established and continued to broaden and strengthen partnerships with all the key stakeholders in health, including the local communities, faith-based institutions, private sector, civil society, line ministries and the international community, at all the levels of health service delivery.

These partners have continued to significantly impact on health service delivery through various means, including direct participation in the delivery of health services, and the provision of financial, technical and logistical support to the health sector. According to the MoH records, in 2007, the international cooperating partners (CPs) contributed a total of US\$90.8 million to the health sector basket (pool fund), representing 40.5% of the total MoH basket (MoH Financial Report 2007, 3rd April 2008 SAG Meeting), under the existing Sector Wide Approach (SWAP) arrangement.

In spite of moves to increase Sector Budget Support Mechanisms, project-type aid remains the dominant instrument for health aid delivery. The UK provides General Budget Support to Zambia. Only the EU is involved in providing Sector Budget support whilst Sweden and a number of other bilateral donors contribute to the health sector basket fund. Unusually, USAID also make a modest contribution to the fund in Zambia.

3. The GAVI HSS proposal – inputs, outputs and progress to date

This section will review the main issues surrounding the GAVI HSS design and application processes and will attempt to summarise progress to date. It concludes with a reference to the issues that ought to be covered in the assessment of the HSS grant at completion in 2010. On purpose this section will be mainly descriptive, while the assessment of the meaning of these findings in relation to GAVI principles and to the questions of the evaluation study will be done in section 4 in order to avoid repetition.

3.1 HSS proposal design

When developing to proposal, The GAVI HSS Task Force undertook a review of key health sector documents including:

- The Health Sector strategic Plan 2006 – 2010
- Multi-year immunisation plan
- Sector Human Resources Plan
- HMIS data

The document review highlighted the severe human resource crisis that Zambia is experiencing and which is negatively affecting the delivery of health services including the Expanded Program on Immunization (EPI). Over the past few years, the Ministry of Health has seen a massive exodus of health workers, especially nurses to the domestic private sector and abroad, primarily due to the low level of wages and benefits in the civil service. The median salary level of health workers in Zambia is one of the lowest in the region. The staff attrition rates are high.

Ministry of Health documents indicated that there is an almost 50 per cent shortfall in the numbers of some key cadres of health professionals. In 2004, the MoH had 16,732 established posts for nurses across the country but only 8,706 nurses in-post. There were 3,781 posts established for clinical officers with only 2,620 actually in post.

The human resource crisis experienced by the health sector has been compounded by high death rates of health workers mainly due to HIV/AIDS. This has led to a situation where 50 percent of rural health centres in the country are run by unqualified staff and community health workers. Very few facilities have the full complement of established staff. The low staffing levels in health facilities have compromised the quality of health service delivery and led to low utilisation of these services by the communities they serve. The inadequacy of appropriate transport is another

challenge in a country where the majority of people live a long distance from their nearest health facility.

In 2005 the Ministry of Health, supported by JICA conducted a Health Facility Census to identify the state of health infrastructure (including staff housing), the availability of a clean water supply, solar power, radio communication, and transport (motor vehicles or motor bikes). The development of this data base enabled the infrastructure requirements for each facility to be identified. It was found that transport was not only inadequate but in some cases inappropriate for the particular geographical location.

Qualified health staff are reluctant to be posted to distant rural facilities where there may not be the equipment needed for them to do their jobs, where housing may be inadequate, where there may be a lack of clean water and electric light and where there is inadequate transportation available. All these factors combine to create severe shortages of trained health staff in rural areas.

Based on this analysis combined with an assessment of the resources that were likely to be available both from government and cooperating partners, a decision was made to focus the GAVI HSS proposal on providing non-salary staff incentives in remote, poorly performing districts.

In total, twelve districts have been selected for GAVI Health Systems Strengthening support from a total of 72 districts nationwide. The criteria for the selection of these districts were as follows:

- Districts with the lowest coverage for Measles and DPT 3
- Districts with the highest proportion of unimmunised children for measles
- Geographical location (remoteness)

The districts selected were:

1. Eastern Province: Chama, Chipata, Lundazi and Petauke
2. Luapula Province: Mwense and Samfya
3. Northern Province: Kaputa and Nakonde
4. Western Province: Kalabo, Lukulu and Sesheke
5. Copperbelt Province: Lufwanyama

The interventions to be funded are included in Table 3. below.

Table 3: Zambia GAVI HSS Intervention Areas

Health Workforce – mobilisation, distribution and motivation of health workers at the district level and below		
Implementation of a performance improvement scheme	<p>To enhance performance it is proposed that districts that have improved their performance in providing health care (including immunization). Prizes will be given annually to the best performing district. Improvements in performance will be confirmed by an independent body.</p> <p>Other awards to be given annually include “the prize of the most improved district” for the district that has improved immunization coverage by 10%. 12 shields will be given to the best health centre and 12 Neighbourhood Health Committee in each of the selected districts.</p>	\$US20,000
Improving Communications - Radios, Cellular telephones etc.	120 radios, 83 handsets of cellular phones and stationery provided to 5 NHCs in 12 districts	\$US675,480
Performance based incentive grants to Neighbourhood Health Committees	All NHCs will be encouraged to develop project proposals that are beneficial to communities that they serve. The projects should provide a means of income generating (IGA) for the NHC. The proposal will be reviewed by a committee of experts constituted at the DHO. A revolving grant of \$US2000 USD will be established in each of the 12 districts and be disbursed to successful NHCs.	\$US24,000
Transportation	<p>To provide high quality health services in rural areas, transport is essential for outreach, referral, supportive supervision and distribution of logistics and supplies.</p> <p>Twelve, 4x4 motor vehicles, 4 speed boats, 215 motorcycles for health centres and 1000 bicycles for community health workers will be acquired with GAVI HSS funds.</p>	\$US1,520,000
Renovation of health centres and staff housing units	<p>In 2005/6 JICA carried out a health facility census of all health infrastructure across Zambia.</p> <p>Many of the health centres and staff houses are very old and in urgent need of rehabilitation and maintenance. The renovation of these facilities should result in a better living and working environment for health workers.</p>	\$US2,396,138
Installation of solar powered lighting systems in health	One of the many reasons why health workers do not want to work in rural areas are the poor working conditions. The lack of power and light in health	\$US1,291,500

centres and staff houses	centres and staff housing is a major contributing factor. GAVI funds are being requested to install solar power in 92 health centres and 234 staff housing units for health workers.	
Improved water supply	A clean safe water supply is essential for the effective functioning of a health centre and for an adequate quality of life for its staff and the neighbouring community. At present, most rural health centres have no clean water or have an inadequate water supply. Clean water supply will be provided through the sinking of 122 boreholes at rural health centres in 12 districts.	\$US671,000
	Grand total (\$US)	\$US6,598,118

Source: GAVI HSS Proposal

The non-salary interventions chosen for funding with the GAVI HSS resources address a range of issues identified in numerous reports and research on the Zambian health system as contributing substantially to poor health service performance, particularly in remote, rural districts. The developers of the GAVI HSS proposal made a sensible decision to focus the funding in only 12 of the 72 districts in Zambia. This decision was taken despite significant pressure to implement the programme more widely within Zambia.

As part of the JSI Tracking Study, a detailed assessment of the implementation of the GAVI HSS activities at district level is being undertaken by Professor Jonsson of the Department of Economics, University of Zambia. This should provide a useful baseline at the district level for the GAVI HSS impact evaluation planned for 2012. Unfortunately, it was not possible for the evaluation team to meet with Prof. Jonsson during its mission to Zambia.

3.2 HSS application and approval processes

The proposal development process began in September 2006 when the MoH put together a small Task Force led by two national consultants to write the GAVI HSS submission for Zambia. There was considerable technical support provided from a range of partners including: WHO, UNICEF, USAID, CIDA and the Churches Health Association of Zambia (the main CSO representative in the process). Within the MoH itself, the Department of Planning and the Child Health Unit were the lead members of the Task Force. The Task

Force reported to the Interagency Coordination Committee for Immunisation (ICC) which in turn reported to the Health Sector Advisory Group (HSAG).

The \$US 50k made available by GAVI to pay for consultants to help with proposal design was not used. It was thought that these funds could only be used only for the employment of international consultants, and that there were significant advantages in using high quality national consultants who would have a better understanding of the local context.

There were several meetings of the Inter agency Coordinating Committee between January and May 2007 to review and refine the proposal. After approval by the ICC, the proposal was sent to the Health Sector Advisory Group, the peak health sector coordination body for final sign-off by the MoH and donors. The proposal was submitted to GAVI in May 2007.



Feedback was received from the GAVI Secretariat in May 2007 indicating that the proposal had been approved, subject to some improvements being made in the indicator set.

The following box summarises the key dates involved in the Zambia GAVI HSS proposal preparation and approval:

Box 3. Key dates in the Zambia HSS proposal

Sept 2006	ICC establishes Task Force to develop proposal (2 national consultants recruited to work on proposal)
Jan - April 2007	ICC reviews and debates HSS proposal
??	HSS proposal submitted to the monthly cooperating partners' meeting (a sub group of the SAG) for endorsement
May 2007	HSS Proposal submitted to GAVI
June 2007	Proposal approved with clarifications by IRC
July 2007	MoH sends clarifications
26 July 2007	Approval decision by GAVI Board
12 Oct 2007	First disbursement of \$2,344,500
29 April 2008	Second disbursement of \$573,000

The MoH and partner staff interviewed thought that the proposal writing process had been thorough and rigorous. The availability of high quality national consultants to undertake most of the research and proposal writing had been a significant bonus. Partner organisations contributed a considerable amount of time and technical support to help ensure that a high quality product was developed.

In general, it was thought that the input in terms of time and effort had be reasonable when set against the potential benefits of the GAVI HSS funding made available to Zambia and the flexibility with which they can be used, which is unlike some of the other Global Health Funds.

3.3 HSS Start-up measures

GAVI HSS money is deposited in the GAVI \$US account held by the MoH. The funds are managed through the existing MoH financial management mechanisms by the Permanent Secretary at the Ministry of Health. According to the HSS proposal, the mechanism for disbursement of the GAVI HSS funds is through the MoH basket fund. When funds are required, a transfer is authorised from the separate GAVI \$US account into the basket account which is denominated in Kwacha. Funds are then disbursed from the basket fund account to districts or to fund the purchase of goods and services at the central level according to standard GoZ financial operating procedures.

Unfortunately, due to an unfolding investigation relating to the possible misuse of MoH funds by officials from the planning, HR and accounts sections of the Ministry, it did not prove possible to interview key officials involved in the financial management of the GAVI HSS funds during the visit to Zambia. In total, 23 MoH officials have been suspended for six

months pending an investigation of serious allegations involving 27 billion Kwacha (\$US5.4 million approx.). Round 8, Global Fund money is apparently involved and the GF has now frozen its funds until the extent of the misuse can be determined. Sweden and Holland have also suspended their support to the basket fund until investigations are complete and the necessary corrective measures taken to prevent a re-occurrence of the problem.

The Auditor General is in the process of carrying out a forensic audit of the accounts involved. This should shed some light on the extent of the fraud and the level of involvement of the MoH officials concerned. Given, the seniority and numbers of MoH officials apparently implicated in the fraud, and the serious questions raised regarding the operation of the basket fund, there must be legitimate concerns about the management of the GAVI HSS resources (and other GAVI funds) by the MoH.

The same systems and procedures that applied to other grants made through other GAVI windows were used for the HSS grant. Such systems and procedures already had accounting and financial management arrangements in place within the MoH.

Whilst the initial disbursement of \$US2,344,500 into the MoH GAVI account was made on the 12th October 2007, detailed planning for the implementation of the HSS funding did not begin until May 2008. Some central procurement of major items was initiated earlier in the year which enabled the programme to go forward. Meetings were held with the management teams in order to develop, costed, implementation plans for each of the 12 districts based on the overall allocations contained in the HSS proposal.

Despite the somewhat late initiation of detailed planning for the implementation of the HSS programme, good progress was made in 2008. In total, \$US 2.7 million was spent on drilling boreholes, purchasing bicycles, motors cycles, vehicles, radio communications equipment and solar panels, mobile phones, stationary and on the establishment of neighbourhood health committee incentive grants in twelve districts.

Tenders were required for the purchase of vehicles, motorcycles, communications equipment. These were organised at the central level and the vehicles and equipment was then distributed to districts. However, the sinking of boreholes and the provision of hand pumps required districts to undertake their own tendering exercises at the district level. This has created some problems and delays as the central and district tender boards do not always operate efficiently and often require the guidance of a superior board before reaching a decision. This has slowed things down considerably in some districts. There are problems

with delays and long tendering processes at all levels of the Zambian public procurement system.

In one or two cases, the transfer of funds to districts has proved problematic and this has taken far longer than originally anticipated. By the end of 2008, 11 of the 12 districts had sunk their boreholes although fewer were drilled than originally anticipated due to unanticipated cost escalations.

The average cost of a borehole and hand pump purchased with GAVI HSS funds worked out at just over \$US5,000. In casual conversation with a representative of a CSO, the consultant was told that an average bore hole and hand pump in Zambia should cost around \$US3,500. There may be some issues around value for money that need to be explored, or it could equally well be, that in the difficult, remote districts where the HSS funding is being used, costs are simply higher than in more accessible areas.

The HSS proposal provided for the establishment of revolving funds to support income generating activities in the each of the 12 districts. \$US 24,000 were allocated to establish the funds but no provision was made for any technical support to the communities involved to help them establish basic operating procedures to manage the funds. This may prove to be an unfortunate oversight which could hinder the effective operation of the funds and reduce their impact.

3.4 Progress to date and Annual Progress Reporting (APR) on HSS

In this section we discuss issues linked to the quality of APR reporting on HSS and to the relevance and alignment of APR HSS reporting in the context of the Zambia's established health reporting and accountability mechanisms.

In May 2008 the MOH submitted the first GAVI APR report for 2007 including information on the HSS window. At this stage very little had been done and the report covered that amply. The evaluation team was provided with a copy of the GAVI APR covering calendar year 2008 which had been submitted to GAVI on the 15th of May 2009.

Specifically in relation to the HSS section of the Zambia 2008 APR the consultants found the following:

- HSS Activities. There were brief descriptions of the HSS activities undertaken with no district breakdown included.

- Financial reporting. There was no detailed reporting of how the money had been spent at the district level
- Result indicators. The choice of indicators did not seem entirely appropriate given the focus of the intervention on non-salary incentives. The reporting against indicators should be done on a district basis. Using aggregate national indicators does not provide sufficient information to be able to effectively assess impact in the 12 intervention districts.

There is little detailed guidance provided either in the GAVI Handbook, the revised HSS guidelines or on the proforma APR on how data should be reported and presented. The section on reporting in the GAVI Handbook is focussed almost exclusively on ISS.

It is recommended that HSS proposal guidelines are improved and contain more detailed guidance on developing appropriate M&E frameworks, reporting arrangements and the level of data decomposition and detail required.

It will be very difficult for the IRC when reviewing the 2008 APR to make a reasonable assessment of progress being made in Zambia due to the lack of detailed data on activities in the report. There are also some concerns as to whether or not the six outcome indicators identified in the original HSS proposal will provide an effective framework for measuring outcomes and impact.

If GAVI is to be a responsible source of funding of HSS work, it needs to be reasonably confident that activities that it has committed itself to supporting are being implemented as agreed, and that its resources are not being diverted for other uses. In order to do this, it is important to have a monitoring framework in place with a set of indicators that will capture fully or in part, progress being made in implementing the agreed programme of work. Equally, the data used to generate the indicators should be appropriate, come from a reliable and verifiable source or sources, with the capability to check on the accuracy and validity of the data provided.

There are always going to be problems and risks associated in ensuring the collection and reliability of data. However, serious attention needs to be given to ensuring that the monitoring framework for HSS work is appropriate at the time of proposal development. Subsequent progress reports should be generated through a process that closely follows the agreed framework and uses the highest quality data available. The IRC has previously noted that the monitoring and reporting of HSS work has been weak in a large number of countries.

Given, the significant levels of funding involved in some countries, consideration should be given by GAVI to not only supporting the development of proposals (\$50K) but also to providing greater support to the on-going monitoring and reporting of implementation. There is also the opportunity for other partners such as WHO or UNICEF to provide great input to the monitoring process.

Ideally, the GAVI HSS reporting should not be undertaken in a stand alone way, but should be incorporated in joint sector monitoring efforts if possible. Where there is a Joint Annual Review or performance assessment undertaken, potentially the GAVI HSS monitoring could be included as part of that exercise. The specifics of this would need to be thought through and agree with other sector partners.

Applying effective governance arrangements and credible monitoring and reporting systems to health investments serve a number of vital purposes. Firstly, they help to ensure that agreed programmes of work are delivered in the ways that were originally intended; secondly they provide a means of tracking progress effectively and enable sensible course changes to be made when these are necessary; and thirdly, they help to deter, that generally small number of individuals who would like to try and divert resources to the own, nefarious ends. The probability of being found out or caught by effective monitoring systems can have the effect of focusing minds and strongly deterring those who would do wrong.

3.5 End of HSS Assessment

Immunisation coverage rates in Zambia are already high making the probability of anything more than small improvements unlikely. The current set of indicators is very focused on immunisation making it unlikely that the current monitoring framework will be able to effectively highlight other important improvements to the health system produced through the HSS funding. In the poorly or least performing HSS project districts; we may have to wait for the evaluation in 2012 to see whether the HSS funding has had some impact in those particular districts

Indicators

The 6 indicators identified in the HSS proposal were:

- national DPT3 coverage
- Number / % of districts achieving $\geq 80\%$ DPT3 coverage
- Under 5 mortality rate

- National measles coverage
- Vitamin A supplementation rate
- Antenatal care, 2nd visit rate

However, the main focus of the GAVI HSS strengthening work in Zambia is on providing non-salary incentives to encourage trained health workers and CHWs to work in difficult, rural areas. Whilst it is useful to have some indicators which demonstrate how effectively the immunisation system is functioning, it would also be useful to have some more specific indicators which could indicate the impact HSS funding is having in achieving its particular objectives. For example, it would be useful to know how many of the facilities in the intervention areas have trained health staff, how many communities have active CHWs, what are the turnover rates for CHWs. In addition, it would be useful to look at the impact the GAVI HSS funding is having on the numbers of being women attended by a trained provider during delivery etc. Given the significant investment in infrastructure it would be useful to undertake a survey to measure the improvements made in the intervention districts.

Clearly, rather than looking at aggregate national averages, indicators need to be reported on by intervention district and then compared with the baseline picture for that district.

The focus given to supporting non-salary interventions in Zambia is a novel approach which has been well thought through and targeted appropriately. If it is successful, there will be some very useful lessons that emerge. It is important that those lessons are to be comprehensively captured and reported. To do this effectively, it will be important to undertake a well designed study, to ensure that this is achieved in rigorous and scientific way. If this is to happen, then thought needs to be given to how best to do this, and the earlier the better. The JSI Tracking Study which undertook field work in the twelve intervention districts should capture much useful baseline information.

There are a number of important issues and questions that should be addressed in relation to establishing the ToRs for the 2012 evaluation. These include:

- Is there evidence that the recruitment and retention of trained health workers and CHWs in the selected districts has improved?
- What have been the effects on health service provision outreach etc.
- Is there greater user satisfaction action with the health system?
- Are there any other factors beyond the GAVI HSS support to which improvements could be attributed?

- Have health outcomes improved?

3.6. Support systems for GAVI HSS

Technical support provided by various agencies can be divided into support provided: (a) at proposal design and approval stage; (b) at APR; (c) for HSS proposal implementation. These are briefly reviewed now in the case of Zambia. Please refer to the typology of HSS support systems in Annex 3.

3.6.1 Technical support for proposal design and approval

The MoH Planning Unit and the Child Health Unit led in the design of the HSS proposal. Discussions began in 2007 and proposal writing in 2007. Two independent consultants were employed to undertake the bulk of proposal writing. The evaluation team were able to meet with one of these consultants who is now employed by UNICEF as its EPI officer and were impressed with his competence and grasp of the issues that emerged from the analysis undertaken at the time of proposal development.

Other partners involved in the development of the HSS proposal included: WHO, UNICEF, USAID and the Churches Health Association of Zambia. Proposal development was discussed with partners at numerous meetings of the ICC and also at a the bi-weekly meetings of an MNCH technical working group.

Due to difficulties in interviewing senior MoH officials involved the development of the HSS proposal during the week that the consultants were in Zambia it is was not possible to determine if MoH stakeholders thought that the support received from WHO, UNICEF and other partners was adequate. The consultants are of the view that the process did produce a strong proposal that addresses a number of the major obstacles to posting and retaining health staff in rural areas. The decision to focus the HSS funding in only 12 of the 72 districts in order to try and maximise impact was logical and sensible. However, given the magnitude of the work that needs to be done, coupled with the modest amount of funding available from GAVI (\$6,604,638 over 5 years), a focus on even fewer districts may have been prudent.

The consultants are of the view that the M&E framework could have been further strengthened to better reflect the innovative approach to HSS adopted in the proposal.

3.6.2 Technical support to the APR

It is clear from a review of the HSS section of the 2008 APR for the reasons described previously, that there is room for considerable improvement in the presentation of data in the HSS section of the APR. Data collection and analysis is fairly basic, and there is insufficient decomposition of the data in order to give an accurate picture of what is happening at the district level and below. However, the current situation in the MoH and particularly in the Planning Unit, may have contributed to the problems with the HSS section of the 2008 APR. It was the consultants' impression that the Child Health Unit had taken the lead in the development of the HSS section of the 2008 APR. The focus and experience of the personnel working in the CHU is not necessarily in the HSS area.

During discussions with bilateral partners it was clear that in the main, they had little knowledge of the detail of the HSS work and some were unhappy with the standard of the APR reporting, they felt pressured to sign-off in order not to hold-up the submission of the report which may have delayed the release of the next tranche of funding. The MoH commented that the EPI technical working group includes many cooperating partners who could provide additional support but their attendance can be erratic.

There is clearly room for the greater involvement of WHO, UNICEF and other partners to support the production of the HSS section of the APR. However, given the limited time of the consultants in-country and the challenging circumstances of their visit, it is hard to make firm conclusions regarding the quality and relevance of technical support provided to the MOH during the preparation of the 2008 APR.

***It is recommended** that the MoH and its partners review the way in which the APR is developed and identify ways in which partners can provide greater support to this process.*

***It is recommended** that greater consultation amongst partners be undertaken during the development of the APR as a means of improving information exchange and coordination. This should help to improve the quality of the document.*

***It is recommended** that GAVI look at ways of using existing sector reporting mechanisms to include HSS work.*

3.6.3 Technical support for HSS implementation

The WHO and UNICEF were heavily involved in the design stages of the HSS proposal. WHO sent a draft of the proposal to the its regional office and requested comments/suggestions.

However, after the implementation of the HSS proposal began there is very little evidence of any on-going structured support being provided by either organisation to the MoH to assist with specifically with the process. Partners are involved in providing supervision at the district level and WHO for example, has three staff dedicated to supporting immunisation.

The interventions supported in Zambia under GAVI HSS are fairly straightforward and in the main would require simply an effective administrative system at the national and district level to organise tenders and manage the repairs of staff housing for example. The work with communities in supporting income generating activities are more complex and require expertise in areas that WHO and UNICEF may be unaccustomed to supporting in Zambia. Finding ways of providing this support is important and should be a priority.

4. Alignment of HSS with GAVI principles

This section will attempt to analyse the extent to which the Zambia HSS grant adapts to the following GAVI principles, some of which have been slightly modified to accommodate specific questions being asked in this evaluation such as the concepts of accountability and additionality of GAVI HSS funding:

- Country driven
- Aligned with national plans and M&E
- Harmonised
- Predictable funding (inc financial management and disbursement)
- Inclusive and collaborative processes (accountability has been added)
- Catalytic effect
- Results orientated – How are results measured?
- Sustainable – what is being funded? What will happen when there is no HSS money?

4.1 Country Driven

The GAVI HSS proposal was clearly country driven and its development supported by a group of MoH, WHO and UNICEF officials supported by two national consultants. The proposal was well researched and focused on responding to the current human resources crisis within the Zambia health sector.

4.2 Is GAVI HSS aligned?

In this section we consider several dimensions of alignment as discussed in the evaluation study guidelines: alignment with broader development policies such as the PRSP and the national health plans and priorities; alignment with planning and reporting systems; alignment with budget and financial management systems.

4.2.1 Alignment with broader development and health policies

In his introduction to the Zambia National Health Strategic Plan 2006 – 2010 the then Minister of Health, Silvio Masebo commented:

The plan will therefore focus at achieving the national health priorities, which will include: resolving the human resource crisis; addressing national public health priorities, including the MDGs; and ensuring that priority support systems and services receive the necessary support.

The NHSP 2006 – 2010 went on to say in relation to the human resources crisis:

Currently, the health sector in Zambia is experiencing a human resource crisis, which is significantly undermining its capacity to provide even the basic health care services to the people. The already inadequate health systems in Zambia have suffered further deteriorations due to high staff attrition rates attributed to the migration of health professions and HIV/AIDS related deaths. Consequently, the BHCP is unevenly and barely provided and trends in vital statistics such as life expectancy, maternal, infant and child mortality point to a rapid deterioration in the nation's health status.

The focus of the HSS proposal on supporting non-salary interventions aimed at encouraging more health staff to work and live in rural areas is clearly well aligned with national health priorities and with key objectives of the national health plan.

The focus of the HSS proposal on 12 poorly performing rural districts has also given it a strong poverty focus.

4.2.2 Alignment with budget and reporting cycles

Due to the unavailability of officials in the planning and finance sections during the consultants' visit information contained in this section of the report is not as comprehensive as we would have liked.

There is an established reporting system in Zambia where the nine provinces and 72 districts provide reports on a quarterly basis to the MoH. Reporting to the ICC is through the EPI at the national level.

In terms of alignment with budget and financial management procedures, GAVI HSS money, as with all of the GAVI to the MoH funding is "on plan" and "on budget". It features in instruments such as the Medium Term Expenditure Framework (MTEF) for health

4.3 Is GAVI HSS Harmonised?

The GAVI plans are integrated with district plans and complement the 5th National Health Strategic Plan. The health sector SWAp under the broad guidance of the Zambia Aid Policy and Strategy (2005) and the Joint Assistance Strategy for Zambia (JASZ) continues to be receptive to foreign assistance. The various plans and programmes are informed by the Vision 2030, the Fifth National Development Plan (2006-2010) and the National Health

Strategic Plan (2006- 2010). These are consistent with the MDGs and other global agendas. The Launch of the Aid Policy in February 2008 was a major milestone in defining Zambia's aid architecture

The GAVI HSS support is largely harmonised with the existing financial arrangements. Disbursements are made from the separate GAVI \$US account into the MoH basket fund for onward transfer to districts or for expenditure at the national level. The basket is subject to established financial management and reporting arrangements.

Due to the ongoing problems within the MoH it proved difficult to establish how effective these mechanisms are and how good they are at providing specific information on GAVI HSS activities.

4.4 Is GAVI HSS funding Predictable?

The GAVI HSS funds have been disbursed on time according to the agreed schedule (see Table 4 below). The first disbursement of funds was made in July 2007. The second disbursement was made in July 2008 for the period up to December 2009. The Funds are readily available and accessible. In comparison with other funding sources, there is less bureaucracy required for the disbursement of funds from the GAVI HSS grant which is appreciated by the MoH.

Table 4. GAVI HSS Funds: Receipts and Disbursal

	Year	
	2007	2008
\$US		
Amount of Funds Approved	2,344,500	573,000
Date Funds Sent	12/10/2007	29/04/2008
Amount Spent	0	1,869,740
Balance	2,344,500	1,047,760
Amount Requested	573,000	730,885

4.5 Is GAVI HSS Accountable, Inclusive and Collaborative?

The GAVI proposal was developed in a collaborative way to address a range of HRH issues that are evidently impacting significantly on the health sector in Zambia. Unlike in some other countries, the proposal was not framed in a way that focused it specifically on helping to deliver and strengthen the EPI programme. This is an advantage as it enables the HSS funding to be used for what it is intended for: more broadly strengthening health systems. If

successful, the interventions supported will have a significant impact on improving the delivery and quality of health service delivery in the 12 districts selected.

Knowledge of the GAVI HSS support was extremely variable amongst partners interviewed during the consultants' mission to Zambia. Some, such as WHO and UNICEF had a detailed knowledge of what was happening and how the funds were being deployed. Bilateral partners who had been less involved with the design of the HSS programme were relatively uniformed about how implementation was proceeding. Approval and sign-off of the GAVI HSS proposal was by the ICC and Sector Advisory Group. Other committees also involved managing and monitoring the HSS programme include the Child Health Technical Working Group and the EPI Technical Working Group.

This raises some question about the extent to which reporting of HSS implementation is effective through the existing committee structures within the MoH. The standard of the 2008 APR (mentioned earlier in this report) also raises some important questions regarding the effectiveness of the current HSS reporting arrangements.

Effective reporting provides the basis for accountability, inclusiveness and collaboration. Without information it is very difficult for stakeholders to know if what is happening is taking place in a timely and effective way. Also without adequate reporting it is very difficult for other partners to be able to adjust their work programmes to take account of what GAVI HSS is doing.

The quality of reporting and the lack of knowledge among some partners as to the scope and extent of the GAVI HSS support indicate that there may problems with accountability, inclusiveness and aspects of collaboration.

Recommendation: the MoH and its partners look at the current management and reporting of the GAVI HSS funding to determine if there are alternatives that could provided for greater accountability, reporting and management.

4.6 Does GAVI HSS have a Catalytic Effect?

The work being supported by GAVI HSS in Zambia is innovative and different. It builds on work done by a USAID supported health strengthening project in one district of Zambia. If the interventions in the 12 selected districts are successful then a useful model will have been

established that can be rolled-out to other districts and potentially other countries. If this is the case then the HSS funding could be said to have been catalytic.

The intervention results are going to need much greater visibility which will require a well designed study of outcomes and impacts. Better reporting systems will also need to be introduced to capture the data required.

4.7 Is GAVI HSS Results Oriented?

If the GAVI HSS funding in Zambia is to be results orientated there will need to be much better reporting of progress. Without reasonably detailed and accurate reporting mechanisms it will be very difficult to give a real “results focus” to the work. As discussed previously, if this is to happen, then a stronger M&E framework that more effectively reflects the nature of the interventions being supported will be required. This will require the active support of partners such as WHO and UNICEF if it is to be achieved.

In order not to impose undue additional demands on hard pressed staff at the national and district levels, ways should be sought to incorporate the GAVI reporting requirements into the existing sector reporting system.

4.8 GAVI HSS Sustainability Issues

The focus of the HSS proposal on providing non-salary incentives in rural districts is potentially very sustainable. A key point made by one of the partner organisations was that an intervention focused on providing non-salary incentives, is intrinsically more sustainable than say providing salary supplements directly to staff. Investments in boreholes, improved staff housing and solar power will potentially continue to deliver benefits for many years at very little additional cost.

Other features of the HSS support such as the provision of vehicles and communications equipment have shorter lives and will require maintenance and replacement within a relatively short period of time. However, these are all important ingredients of effective health districts and vital to their successful operation.

In total, two thirds (\$US 4.35 million) of the \$US 6.6 million GAVI HSS grant is being spent on renovating staff housing, providing solar power and on drilling boreholes. These will all become lasting and highly sustainable interventions. There is an economic case to be made

for the sustainability of this GAVI HSS programme which is however, outside the scope of this evaluation.

4.9 Does HSS funding help Improved Equity

The selection of the 12 districts to be supported with GAVI HSS funding was made on the basis of their lack of performance. The health indicators used to identify the districts' performance included:

- DPT3 coverage
- HR situation
- Maternal health indicators
- Availability of transportation

The 12 districts selected are all remote districts where there are enormous challenges in providing health services. Almost by definition, selecting these districts on the basis of objective performance data will have given the HSS support a strong poverty and equity focus.

It is unlikely that the resources required to fund the HSS interventions in the 12 selected districts could have been found elsewhere. In this sense the funding has been additional.

Annex 1 – List of people met

Name	<u>Organisation</u>
Mrs M. Siame	MoH, CHU-IMCI
Mrs J. Simwinga	MoH, CHU-EPI
Mr F. Mutumbisha	MoH, CHU-Longistician
Mrs E. Kamiji	MoH, CHU-EPI
Mrs M.K. Mulenga	MoH, CHU-Longistician
Mr D. Cheembo	MoH, CHU-Longistician
Dr P. Kalesha-Masumbu	MoH, CHU-Child Health Specialist
Mary Kaoma	HSSP, EPI/IMCI
Dr Oliver Lulembo	USAID, PMI/CTO
P. Randy Kolstad	PHN-Director
Dr Dave Barbar	President, Rotary International
Mrs Rhoda Mpembamoto	MoF, Health Desk Officer
Dr Mukonka	MoH, Director Public Health & Research
Mr Kansembe	MoH, Asst. Director Planning & Development
Dr O. Babaniyi	WHO Representative
Mr Flint Zulu	UNICEF, EPI Plus Officer
Mr Festus Lubinga	JICA, Program Officer
Mr Ippei Matsuhisa	JICA, Representative

Annex 2 – List of Key Documents Reviewed

Zambia, 5th National Development Plan, 2006 – 2010

Zambia, National Health Strategic Plan, July 2006

Zambia, Demographic & Health Survey, 2007

Zambia, APR, 2009

Government of Zambia, MoH budget, 2008

Zambia, HRH Strategic Plan, November 2005

MoH detailed Action Plan, 2008

WHO Zambia factsheet

Zambia Joint Annual Review, 2007

Zambia cMYP, 2006

Zambia cMYP Costing & Finance Tool

Annex 3 Typology of areas for HSS support.

Key stages in the HSS 'funding cycle'.	Support available	Responsible for support
Information about HSS funding and processes	Policies; broad 'rules of the game'	GAVI Secretariat
	Guidelines for applications	GAVI Secretariat, HSS Task Team
	Communication with countries re funding rounds, proposal guidance, dates and deadlines	GAVI Secretariat
Proposal development	Financial support for TA (\$50k max) TA	TA provided by UNICEF, WHO, other national or international providers
Pre –application review	TA to check compliance, internal consistency etc.	WHO
Pre application peer review	Regional support, inter-country exchanges, tutorials, learning from experience, etc.	WHO HSS Focal Points
Submission of proposal and formal IRC review	<i>Internal process</i>	IRC-HSS
IRC recommendations	<i>Internal process</i>	IRC-HSS
Decision on proposals	<i>Internal process</i>	GAVI Board; IFFIm Board
Countries informed	Information to countries on decision, conditions, amendments, etc; and steps to obtain first tranche funding	GAVI Secretariat
Funding	Finances transferred to country	GAVI Washington office
Implementation	TA (if budgeted)	UNICEF, WHO, other national or international providers
M & E	TA (if budgeted)	Defined in proposal, e.g. National Committee.
APR pre review	Validation of APR	HSCC / ICC
APR consideration	Feedback to countries	IRC-Monitoring