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NGOs AS PARTNERS IN HEALTH CARE, ZAMBIA.

by

DIS
Centre for Partnership in Development

Evaluation report:

NGOs as partners in health care

ZAMBIA

A REVIEW OF SUSTAINABILITY

WITH SPECIAL REFERENCE TO STRATEGIES FOR NORAD SUPPORT

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ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
CDD	Control of Diarrheal Disease
CHW	Community Health Worker
CINI	Children in Distress
CMAZ	Church Medical Association of Zambia
CMO	Chief Medical Office
DHMT	District Health Management Team
DMO	District Medical Office
FCM	Family Christ Mission
FHT	Family Health Trust
FLMZ	Family Life Movement of Zambia
FNDP	Fourth National Development Plan
FP	Family Planning
GO	Government
GPA	Global Programme on AIDS
GRZ	Government of the Republic of Zambia
HIV	Human Immune Virus
IEC	Information Education Communication
IFFLP	International Federation Family Life Promotion
MCH	Mother and Child Health
MOE	Ministry of Education.
MOH	Ministry of Health
NCD	National Commission for Development
NGO	Non Governmental Organisations
NORAD	Norwegian Agency for Developmental Cooperation
NPHEP	Northern Province Health Education Project on
NVS	Norwegian Voluntary Service.
PHC	Primary Health Care
RHC	Rural Health Centre
SAP	Social Action Programme.
TBA	Traditional Birth Attendance
TNDP	Third National Development Plan.
UCI	Universal Child Immunization.
UHC	Urban Health Centre.
UNDP	United Nation Development Programme
UTH	University Teaching Hospital.
ZCSD	Zambian Council for Social Development
ZRC	Zambia Red Cross
ZRHC	Zonal Rural Health Centre

EXECUTIVE SUMMARY

Background

NORAD is currently reviewing their overall strategy for health sector support in programme countries ("Hovedsamarbeidsland"). As part of such a review, DiS (Centre for Partnership in Development) was commissioned to undertake a study of NORAD´s support to the health sector in Zambia through Non Governmental Organisations (NGOs).

The aim of the study was to contribute to working out an overall strategy on health sector support in the country programme. In addition, the study should focus on NGOs as a channel for support, and their capacity and competence as implementers in the health sector. The study should more specifically look into NORAD´s criteria for NGO funding, government (GO) policy regarding co-operation with NGOs, the present level of NGO activities, how coordination is addressed, and long term sustainability of the NGOs´ efforts.

After agreeing on a study design where sustainability was the central theme, the field work was undertaken during a four week period February-March 1992 by a team of four members. Thirty organizations/projects were reviewed mainly in the North, South and Lusaka Urban area. The selection of projects to visit was done by choosing one key project for NORAD support in these provinces, and seeking as wide and representative coverage of NGOs in the neighbouring districts as was possible within the short time frame available. Thirteen of the organizations/projects which received NORAD funding were given an additional questionnaire and subjected to a more in depth study.

Based on the findings of these studies, interviews with key informants, observations and review of the literature, a wide range of topics emerged. The scope of the study and reporting was subsequently expanded in order to make it relevant to a broader evaluation process of Norwegian development assistance through NGOs, and a new contract was agreed upon between the Ministry of Foreign Affairs, Oslo and DiS. The first report was completed September 1992. This latest edition has been somewhat changed, including a more comprehensive executive summary and some further elaboration on issues arising in the interface between the public and the private sector.

In the first section of the report, three themes have been looked into in some detail i.e. *contextual factors, activity profile and organizational capacity* . These factors have been put into a framework for discussing *sustainability* of the NGOs/projects. The second section focuses on the relationship between NGO and NORAD as a donor with sustainability still as a central theme. In the last section, 11 case studies of NORAD supported NGOs are presented. Lessons from these case studies have been incorporated into the two first sections.

Contextual factors - activity profile - organizational capacity

Regarding *contextual factors*, the report presents in some detail changes having taken place in Zambia since independence in 1964, and how these changes have affected different sectors of society and in particular the socio-economic situation and the health condition of the people, and government policy and priorities addressing these challenges. Some major issues are a fast growing population (3.5% per year), rapid urbanisation, an increasing debt burden with subsequent economic structural adjustment, falling prices for export commodities resulting in less government spending in the health sector, and a rising cost of living and unemployment with an increasing infant mortality rate and rate of malnutrition among children. Adding to these problems, the country faces a serious AIDS epidemic, especially in the urban areas, which increasingly will represent a strain on the health and social services, and in addition will have major consequences for manpower in the health sector and for the country´s economy generally.

These factors have weakened government capacity to respond to health needs and resulted in severe setbacks in public health care in most areas. The poor and other vulnerable groups in need of health care provision are increasingly the ones to suffer. Increased privatisation and the general introduction of user charges may now threaten to marginalize these groups to an even greater extent.

In meeting these problems, the Government of the Republic of Zambia (GRZ) is cooperating with the private, non profitable sector for providing health care and is partly funding them, seconding manpower and in other ways facilitating their work.

The Primary Health Care (PHC) approach was adopted as the main basis for health policy in 1981. Decentralization with focus on a district health service consisting of a district hospital, health centres and health posts, and active support to Community Health Workers (CHWs) and Traditional Birth Attendances (TBAs), have subsequently been central issues in the government health policy. The will and capacity to prioritize PHC and decentralization may be questioned, however, as changes have taken place rather slowly.

As a result of democratization and a new government in 1991, certain policy issues also affecting the health sector are presently addressed with some vigour: Decentralization and the proposed autonomous District Health Councils, will have implication for the development of the district health service if the reform is carried through. As a result of a weak budgetary situation, emphasis will be put on the provision of a basic "health service package" focusing on maternal and child health services including family planning, adequate treatment and control of diseases and preparedness to face epidemics. Cost sharing and the private/public mix in health are other issues discussed. The government policy on these issues represent important challenges which should lead to further discussion of NGO roles in health care provision, as well as new strategies for donor support.

The international donor community has in the past few years responded to the problems facing the country by a Social Adjustment Programme (SAP) where some additional funds are forthcoming in the health sector both for GO and NGOs.

The NGO/project *activities* reviewed cover four fields: health services, family planning, AIDS and various development efforts contributing to health. (When NORAD supports such activities, they are in budgetary terms covered by the NGO and AIDS vote). The major NGO involvement is through organizations responsible for delivery of health service, mainly through long established work by church related organizations to the rural population in underserved areas.

The NGO sector covers work in the district health service with a fairly even distribution between larger health centres and hospital facilities. The service rendered are "traditional" curative and preventive with a training component in some centres. They tend to be

somewhat more extensive and sophisticated than those by corresponding government facilities; even to the extent that a government district hospital at times refers patients to a mission health centre. The NGO sector has generally not been very strong in primary health care development. When it comes to community participation and local control of activities, the NGO sector does not seem to be any closer to the "grass-roots" than the government facilities. No in depth studies comparing the two have been conducted, however.

There is an obvious need for looking at how government and NGOs function as a whole. NGOs cannot take over the role of the government, and need a functioning public health system to be able to contribute effectively in a complementary way. The report gives examples of lack of coordination and too little attention to complementarity between the GO and NGO sector. Even though the NGOs in general, and church-related organisations in particular, work successfully and in line with government health policies, there are problems because of inappropriate location, size and care level for services, as well as the patchy coverage which is often found. NGOs have followed their own strategies and priorities when developing infrastructure and services. On the other side, the public sector has not had the capacity to guide, distribute and co-ordinate inputs.

Since appr. 1985, a number of new NGOs addressing the challenges of the HIV/AIDS epidemic have been established. These organizations cover work related to preventing the spread of HIV, and to a lesser extent, the social consequences of the AIDS epidemic. Zambian NGOs have been exceptionally innovative and effective in this work.

GRZ has increasingly acknowledged the need for a population policy, but family planning is still only practiced by less than 10% of the population. Some NGOs are specifically working on this issue, and the report presents one case study (PPAZ) where fast expansion of activities resulted in organizational problems and an end to NORAD support.

Regarding organizations which are working in the broader field of community development, this NGO sector is rather small in Zambia, and the report does not to any extent discuss their activities.

The third element discussed, is that of *organizational capacity*. In the NGO context this refers to their ability to mobilize resources (funds, manpower) and to undertake and sustain activities. Other elements are organizational structure, management, and the capacity to adjust to new needs and solve problems.

Many church related organizations are in a process of transferring leadership to nationals, and the organizational implications of such a move is discussed. These organizations face an increasingly difficult funding and manpower situation, and their organizational capacity is constantly stretched as they are trying to meet an ever increasing demand for services. New NGOs working on the AIDS issue, face a different capacity problem. As funds have been forthcoming fairly easily from donors (AIDS in Africa has received much public attention in the West), these NGOs have grown at a pace that has resulted in imbalance between the activity level and their managerial capacity.

A problem that is especially faced by organizations providing health services, is their difficulties in securing long term running (recurrent) cost as opposed to funding for capital investment and costs meeting ad hoc needs. All investments also have implications for recurrent costs. The simplistic view that capital funding should be preferred for the sake of sustainability therefore needs to be further differentiated. As it now is, donor criteria to a large extent determine access to funds, and lead to imbalances and inappropriate investment.

A special feature on the NGO scene in Zambia, is the efforts made to coordinate their activities through umbrella organizations. The report presents four coordinating bodies which are also NGOs in their own right. All NGOs reviewed were members of one or

more umbrella organization. The principal NGO working on coordination in health service delivery, is the Church Medical Association of Zambia (CMAZ).which also provides a link to donors and the GRZ on funding and reporting. Umbrella organizations can represent an important potential for strengthening the organizational capacity of each member organization, particularly when it comes to resource mobilisation and access to specialised skills and systems. This would however require that members would accept some measure of coordination and collaboration. And that the umbrella organisation itself would have sufficient capacity to take up an expanded role in ways that its members would accept and utilize. These are important challenges for NGOs and their umbrella organizations in Zambia in the years to come.

Sustainability

At the end of the first section of the report, sustainability is addressed in relation to the findings in the review. The following definition on sustainability is used:

> *"An operation can roughly be considered sustainable if there is a match between activities and capacity to maintain them in a given context over a period of time."*

Sustainability is therefore discussed in a much broader perspective than only in economic terms. It is argued that in health care the choice of target group and the range and level of activities or services to provide (including technology and size) will to a large extent determine required resources and capacity, and thereby also sustainability in a given context.

The variable that can best be controlled is therefore the activity profile. Donors and NGOs must to a greater extent address the consequence of their choices of activities and services, and ensure that they are viable in the actual context and conducive to ensuring equitable provision of a basic health care package in a given area. Appropriate organisational capacity then needs to be ensured, both in the public and the private system, to support and sustain such services long term.

The following are some of the most critical issues identified in terms of sustainability:

Context :

NGOs need to recognize they are partners with and supplements to the GO health services, and should neither compete nor in other ways undermine the role of GO in service provision.

GO policies should clarify the commitments of the public sector in terms of financing and services to be provided, and on what terms NGOs are invited to participate in service provision.

NGOs should play a more central role in taking an assigned responsibility for producing a comprehensive "package" at the district level. A fragmented approach will need to be replaced by a broader attention to issues such as resource allocation in relation to equity and access to basic health care for all in accordance with the PHC ideology.

GO and NGOs should ideally play complementarity roles. One role for NGOs is that of experimentation and to produce models related to current issues such as affordable packages of services, addressing the issue of cost sharing and finding ways to improve on community participation in the health sector. The ways NGOs have addressed the AIDS issue is a good example of such an experimental, innovative role.

Activities

In the current situation in Zambia, NGOs should attempt to consolidate their activities and services and put greater emphasis on quality control and collaboration with the public sector.

There is a need for caution in expecting NGOs to take on an even higher care load in the system (such as expanding into new areas or increasing volume or level of services) as their economy and capacity already appear to be overstretched. Only if their capacity can be strengthened in a viable way (management, staff, systems), should one encourage a wider scope for their activities.

The NGO activities in the AIDS sector have been innovative and effective. As the epidemic is relentlessly progressing, there will still be a need for a high level of activity by GO and NGOs in this field for many years. Experiences should be critically assessed and actively shared and networking will continue to be an important activity.

Family planning activities will continue to be an important field of work for NGOs as birth spacing have important implication for maternal mortality and morbidity and child survival and development. The public sector does not yet have sufficient ability to ensure availability of FP services.

Capacity

The most critical sustainability factor in the organizations studied, was related to organizational capacity; NGOs providing services were constantly overstretching their capacity due to increasing demand for services, while NGOs working with AIDS problems grew too rapidly due to easy access to funds.

Constrained access to national key personnel (heavy national shortage), poor continuity in staffing and weak management systems are important features of current organizational capacity for most of the NGOs. Most of the church related projects depend upon expatriate leadership. NGOs are therefore in need of assistance in strengthening their overall organizational capacity, if quality and continuity of the current level of services shall be maintained.

There is a continuing dependence on external funding, with strong external influence. In order to improve sustainability, there is the need for a clearer planning framework in terms of access to resources. Long term donor commitment will make it more possible to match activities with resources, plan for longer periods and retain competent staff. The present practice of short term project funding makes the NGOs very vulnerable.

Almost all donors prefer to support capital cost and avoid as much as possible funding recurrent expenditure. This practice has been more pronounced in the NGO sector dealing with health services than in the one dealing with AIDS. The consequences of such a policy is roughly the same as that of avoiding long term commitment in funding.

The possible role of "intermediaries" such as. CMAZ is discussed as one mean of strengthening organizational capacity through monitoring of NGOs, provision of training and other means of organizational support.

In *conclusion*, the central issue to address is the sustainability of the whole district health system, rather than individual NGO projects on their own.

NGOs in Zambia do supplement national resources for health by mobilizing some additional sources of income, but mainly through the international donor community. They have some comparative advantages over the public sector in terms of service continuity and service standards, which can be utilized to strengthen district health systems.

When NGOs are supported in the health sector, donors do however also need to assess the performance of the public sector and to what extent it is able to undertake its critical functions of policy, coordination and resource allocation, in order to produce a well balanced private/public mix.

One sided NGO support in the current context of a weak public sector, might have serious consequences in terms of equity, both at local and national level. In Zambia, the recent move towards more decentralisation to the district level may aggravate this problem, if not deliberate steps are taken to strengthen the managerial capacity of the public system to take on the new responsibilities.

NORAD´s current practice as a donor to NGOs in the health sector

NORAD´s support to NGOs in the health sector represent close to one third of the total NGO vote. In addition there is a separate AIDS vote and a WID vote. NORAD is a major donor for NGOs in the field of health. In 1992, the first Country Plan for NORADs support to local NGOs in Zambia was developed as a strategic basis for future assistance. Up to this time (Feb. 1992), only general criteria for project funding through NGOs were applied.

Being seen as agents for target group oriented approaches at the grass root level, with the ability to mobilize people as agents for their own development and for democratization, NGO assistance have been used to complement and fill gaps in the overall NORAD Country Programme. NORAD has not been involved in bilateral support to the health sector in Zambia.

Through the selected case studies, NORAD´s cooperation with NGOs in the health sector has been studied. A number of positive results have been achieved:

In the health service sector, NGOs have provided a much appreciated high quality service in areas which otherwise would have been underserved. The support to an AIDS coordinator in CMAZ, has contributed to better incorporation of AIDS activities into the existing service system.

The support to NGOs working principally in the AIDS sector, has been flexible and productive. The NGOs have produced a range of innovative initiatives especially related to preventing the spread of the virus. The future challenge will be to see how these experiences are evaluated, improved upon and further spread e.g. to the government health sector.

However, a number of problems and critical issues relevant for future cooperation, have also been brought up.

In order to reach the desired level of assistance, NORAD has had to relate to a fairly high number of projects and organizations, and in several cases initiated funding relatonships by approaching "promising" NGOs to explore how they could be supported.

Even though most of the NGOs supported already were performing better than the parallell GO services, they were supported to increase standards and volume through capital investments without addressing the possible imbalances arising in the district health system.

As a result of such a fragmented approach, the NGO sector in health has at times been supported at the expense of necessary development in the GO sector. This is now an area that require specific attention, particularly in the new context of policy reform.

There has been a notion that only services which directly touch the target group of poor and marginalized should be supported. Therefore NORAD has for instance avoided funding accommodation for staff. There is no reason to believe that a hospital bed or a ward is closer to the target group than staff housing in the same facility. What should matter is continuity, appropriateness and access for the poor. Staff accommodation may in some instances be a better investment to improve continuity and quality than more beds.

NORAD funding has in most cases not improved sustainability, as it has raised the activity level and thereby the load, without addressing corresponding needs in organizational capacity. Insisting on investment rather than recurrent funding has also weakened sustainability.

A lack of consistency in policy has been observed e.g. it has been easier for NGOs working on AIDS than on health services to secure funding for recurrent cost. NGOs are not properly aware of NORAD´s funding policy.

Low capacity has resulted in insufficient monitoring and poor continuity in contact. NORAD has not had the capability and resources to support NGOs through policy dialogue and comprehensive review and discussion of issues and needs relating to sustainability. An important example is the experience with PPAZ, leading up to termination of support.

Future donor support to the NGO sector. Comments to the NORAD Country Plan.

The Country Plan effort for outlining strategies for future NORAD support to NGOs in Zambia, represent an important step forward. Chapter 11 in the report discusses some consequences of the review findings as they relate to the Plan.

NORAD assistance to local NGOs has been managed without the necessary capacity, competence and continuity in the NORAD system. Development assistance to the private not for profit sector does raise its own peculiar issues and challenges which need some level of special expertise.

If NORAD should decide not to expand its own capacity in dealing with NGO support, strategies and processes should be tailored to a high volume of support with limited administrative and professional involvement. This could be done by contracting partners who could take on roles as co-managers, or by reducing the number of organisations/projects which receive support.

One way of achieving this in the health sector without reducing the volume of assistance, would be through work with intermediaries such as CMAZ. The umbrella organization(s) would need more support to take on a task of closer

monitoring and promotion of institutional development in the individual organizations.

To achieve the aim of improving PHC to defined target groups, as stated in the Country Plan, it appears that in Zambia this needs to be done through a district focus, with the aim of addressing the overall need for capacity building for appropriate and sustainable PHC both in the public and the NGO sector. To continue support the way NGOs have been supported up to present, is not likely to be an effective approach to improve PHC in the current context. PHC cannot be achieved in a sustainable way by the NGO sector alone.

It is therefore important to review positions as to channels for health sector support, and see if there are ways to open up for approaches focusing the private/public mix at the district level. This could be done through support to District Health Councils/Boards, once these are operational.

NORAD should assess funding needs in relation to how likely they are to contribute to ensuring effective and viable provision of basic health care within a district. For this, it is necessary to be able to play on a wider range of options than capital costs, health education and training. A basic care perspective will be more constructive than seeking some sort of balance between preventive and curative interventions, as proposed in the plan.

Innovation is now much needed in the health sector. NORAD should consider using their flexible and somewhat "risky" approach in the AIDS sector also to promote service development. Institutional capacity building and approaches to community involvement and action for health should be given high priority. When the AIDS and the NGO votes are put together, there is a need to take special care that the flexibility that is currently a feature of the AIDS vote is not lost for the sake of administrative ease.

The move towards more long term funding agreements with NGOs rather than short term project funding proposed in the Country Plan is affirmed.

In training and capacity building efforts, one should seek to avoid strategies that further strengthen the strong external support agency influence on the NGO sector.

INTRODUCTION

Background

NORAD, Oslo is currently reviewing their overall strategy for health sector support in program countries ("Hovedsamarbeidsland"). As part of such a review, DiS (Centre for Partnership in Development) was engaged by NORAD, Oslo to make a design for a review of the NGO sector as partners in health care in Zambia, focusing on the potential of NGOs as a channel for increased Norwegian assistance, and on criteria for support.

The design was presented to NORAD in January 1992 with sustainability as the central theme. A method development component was originally included as part of the design. Because of financial constraints, the design had to be adjusted to make it more limited in scope. This had implications for the in-depth part of the field work, and also meant that it was not possible to conclude the field work with a workshop for discussing and analysing findings together with a wider group of Zambian professionals and NGO representatives.

Methods

Methods included observation, interviews, document review and the use of structured questionnaires for NGOs at national level and for selected projects. A separate questionnaire was used for projects which had received support from NORAD. The questionnaires were filled in by the respondents together with the team members during visits to organisations and projects.

The field work was undertaken in the period 17.02 - 13.3. 1992, and included interviews with organisations and resource people at central level in Lusaka, and project visits to Northern and Southern Province. The selection of projects to visit was done by choosing one key project for NORAD support in both provinces, and seeking as wide and representative coverage of NGOs that was possible within the short time frame available in the neighbouring districts.

All together 17 organisations were contacted, and 15 projects were visited. Brief case studies were made of 11 projects/organisations which had received or were applying for NORAD support.

Reporting

After completion of the field work, a contract was made between DiS and the Ministry of Foreign Affairs, Oslo to produce an expanded version of the report, to constitute a country case study related to a major evaluation of Norwegian NGO assistance.

The report is based on official documentation, reports and other written material collected from a range of organisations involved in health and NGO activities in Zambia, in addition to the information collected through interviews, questionnaires and observation.

The report is presented in three sections.

Section I with a general discussion of NGOs in health care in Zambia
Section II with a focus on Norwegian support to NGOs
Section III with the material from the case studies

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A draft report was prepared in June 1992, and circulated for comments to the main parties. These comments were taken into account in the production of the first report to NORAD, dated September 1992.

This latest edition has been further edited by S. Møgedal and P. Jareg, and a more comprehensive executive summary has been written.

SECTION I

THE ROLE OF NGOs IN HEALTH

1. THE HEALTH SECTOR IN ZAMBIA; GENERAL ISSUES AND TRENDS

1.1 The Context

Zambia is a nation that is rather sparsely populated, yet with one of the highest growth rates (3.2% pa) and fertility rates in the world. Contraceptive prevalence rate is estimated to be less than 10%.

The population has grown from 3.5 mill 1967 to 8.09 mill in the 1990 census. The national average population density in 1980 was 8 persons pr sq.m, which raised to 10.8 in 1990. The provinces in the Copperbelt and along the "line of rail" have the highest densities, while Luapula and provinces in the north and west have densities substantially below national average.

Zambian economy has been very dependent on copper, with copper mining contributing to over 30% of Zambia´s GDP and over 95% of foreign exchange earnings. The mines have also represented the second largest employer after the government. The world economic recession and the low copper prices in the seventies and eighties affected Zambian economy dramatically, leading to a significant deterioration of living standards, particularly among the poorest. The implications for the delivery of social services have been serious, with deteriorating quality of education and reduced availability of essential health services.

The country is also the most urbanized south of Sahara. It is estimated that more than 50% of the population now live in urban areas, and that 42% of these live below the poverty line. The urban annual growth rate is very high (6%), leading to squatter problems in the urban centres, and severe unemployment and underemployment in urban areas. It is estimated that currently approximately 1/3 of all families in Zambia are headed by a woman.

The total expenditures on health have declined to a level where the capacity of the system to deliver adequate services have been seriously undermined. Infrastructure and equipment are run down, and the medical transport and supply system is seriously affected. Rising food prices, inflation and unemployment hit women, children and the poorest segments of society the most.

In this situation malnutrition is on the increase, from a national figure of 6.1% underweight in the under five age group (weight for age) in 1980 to 23% in 1990%. Women and children in urban marginal groups are particularly at risk. It is expected that malnutrition will continue to rise, and cause an increase in morbidity and mortality.

This picture is aggravated by the impact of the HIV-AIDS epidemic, both in terms of mortality figures, economy and the load on the health care system. The first AIDS cases in Zambia were diagnosed in 1985. By the end of 1991 appr. 23.000 cases of AIDS and ARC (AIDS Related Complex) have been reported. The true figure is probably much higher. The proportion of ARC/AIDS cases among hospital admissions have increased from 13 % in 1986 to 35% in 1989. Among pregnant women in urban areas, studies indicate that 30% are HIV-positive, and among clients with sexually transmitted diseases (STD), more than 50 % are infected. The figures are lower in rural areas, but the whole country is affected by the epidemic. These figures put Zambia among the countries in the world worst hit by the AIDS-epidemic, and the impact of the epidemic is gradually being noticed in many sectors of the society.

In 1980 the Zambian government reformed its local administrative system. The reforms involved the transfer of increased authority to district councils. The process of decentralisation has however been slow, and the district councils have generally not been able to take on the expected role in planning, coordination and implementation of services and local development efforts. Main constraints have been insufficient resource allocations, the rather centralised economic system and failure to raise local funds.

In September 1990 it was announced that a multiparty system would be introduced. The election in 1991 brought a new government to power, and the "Third Republic" with a new constitution was established. An important consequence is that the previous party structure linked to the various levels of government has been dismantled, and that representatives in the district councils are now locally elected. The new government is committed to implement a policy for local government where the district level is given more authority and political power.

1.2 Health Policy Development

Since independence in 1964, Zambian health sector policy has been governed by three main principles:

- health care should be free to all citizens
- the coverage and quality of health services should be improved
- basic health services should integrate public and personal health care efforts

The Third Development Plan (TNDP, 1979-83) continued to stress increased coverage and improved quality, with an aim to have a health unit within 12 km distance for 80% of the population by 1990. The plan made commitment to basic services for the most vulnerable, and gave priority to expansion in such rural areas where no care was yet available. The importance of integrated care was also stressed in the plan, and strategies were outlined for Zambianisation and more decentralisation.

The Primary Health Care approach was adopted as the main basis for health policy in 1981, after a National Primary Health Care Conference in 1980. This lead to the introduction of Community Health Workers in the periphery of the health system, and to increased emphasis on popular participation and intersectoral collaboration in planning documents. Changes were however few and slow in terms of practical implementation.

The TNDP turned out to be overambitious in relation to the economic realities for the sector. Only a little more than 20% of the planned investment was actually spent. It did however make some progress in the area of management; health management teams at the provincial, districts and rural health centre levels were formed, MOH functions were partially decentralised and district health planning was initiated. By 1990 75% coverage with some kind of health facility was achieved.

The failing national economy led to major restructuring efforts by the IMF supported Structural Adjustment Programme 1983-87. The programme had heavy political and social consequences, including also decreased spending in the health sector. After a brief period of an Interim National Development Plan for economic recovery independent of IMF (1987-88), the country is moved into a second phase of Economic Recovery with its Fourth National Development Plan (FNDP, 1989 - 93).

The FNDP introduced cost recovery strategies in the health services, and thereby made a significant move away from the commitment to free care. Other policy directions for the health sector established by previous plans were retained. More emphasis was however given to integrated interventions in the area of MCH/FP and to nutrition.

In spite of an emphasis on rehabilitating existing infrastructure, the FNDP included plans for upgrading 165 health centres and building 233 new health centres, thereby seeking an increase in coverage of health units to 85% of the population within 15 km from their homes by 1993. Top priority was given to staff housing.

A special "Social Action Programme (SAP)" (1991-94) was designed to support the structural adjustment process, by seeking to arrest the deterioration of social and economic infrastructure and alleviate the adverse effects for the poorest and most vulnerable groups. Although the overall commitment to the FNDP was not carried forward, the SAP programme was continued by the new government that came to power after the 1991 election, with a focus on quality and access to basic social services (health, education, water), income generation and employment and on household food security.

Both government line ministries, NGO's and the private sector are seen as potential implementing agencies for SAP. In health, the first priority has been rehabilitation of existing District Hospitals and Rural Health Centres for ensuring adequate Primary Health Care. Second priority is given to disease control intervention, where this may be critically affected by the financial constraints.

In spite of the rapidly growing population, GRZ has until recently given little policy attention to population management. Since 1989 population issues have however been higher on the agenda and gained growing political support. A National Population Policy has been formulated which include as main strategic elements:

- integrating population factors in overall development planning,
- emphasis on intensified PHC with integrated FP and mother and child health
- strengthening key institutions
- establishing a National Population Council
- improved collection and use of information on population
- family life education in schools
- strategies for reducing rural urban migration
- strengthening status of women/women's role in development.

The new leadership in the Ministry of Health after the 1991 elections and change of government, has reviewed the health sector plans, and is in the process of bringing out a new document on health policy.

The new policy affirms the principle of cost-sharing but does at the same time reaffirm the governments commitment to equity in health. A broad concept for health is being used in policy objectives and strategies, including also the importance of supportive environments for health. The policy also stresses that consumers have both responsibilities and rights.

The policy shift is described as primarily a management reform, through

- effective leadership
- improved accountability
- strengthened "partnership" with families, communities and NGO's

The role of public hospitals as a government responsibility is maintained, but the policy also opens up for a stronger role of the private sector. An emphasis on better integrated use of local resources include an expressed desire for improved cooperation with traditional healers.

1.3 The Health Services

Much has been achieved in the past in terms of basic infrastructure development and training of manpower. According to UNICEF State of the Worlds Children 1990, 75% of people have access to health services and 59% (40% rural, 76% urban) access to safe water (1985-87). These figures may according to UNICEF be too high.

The immunisation coverage has increased steadily over the last years in spite of major economic constraints in the health sector at large, due to extensive external funding and intensified efforts. Whereas coverage with basic immunisations was as low as 37% in 1984, 83% of one-year old children were fully immunized with DPT in 1988. Mortality figures were declining, but are now again showing an increasing trend. The infant mortality rate was listed as 121 per 1000 in 1965 and dropped to an estimated 76 per 1000 nationally in 1989. Preliminary figures from the recent Demographic and Health Survey (April 1991) show a clear rise, with an IMR of 108 per 1000.

In spite of the achieved reduction in infant and child mortality during the seventies and eighties, there was not a similar decline in maternal mortality, which has been stable at approx. 2 pr. 1000 live births (maternal deaths are notifiable in Zambia). Antenatal care coverage appears to be high, but important inadequacies in obstetric care were pointed out by the MOH Family Health Programme Rapid Evaluation in 1989. 50-60 % of the population continue to deliver at home (in Northern Province 72.5%).

The 1988 Contraceptive Prevalence survey showed that use of family planning is still low, but knowledge about family planning fairly high. Total prevalence for all methods was 10%, for modern methods 4.5%. 60% women interviewed had heard about FP. The pill is the most used method (65% of acceptors), followed by condom (28%). Use of IUD is very low. High drop out rates are seen as a major problem.

There is still great variation between various parts of the country, both when it comes to health status indicators, service accessability and actual coverage. This reflects a heavy *concentration of services* to Lusaka, the Copperbelt and the Central Province and a strong *urban bias* in the distribution of health facilities. The private for profit sector contributes further to this inequality. Approximately 100 private surgeries operate mainly in urban areas, where they provide outpatient services to private clients. The declining quality of governmental basic urban health services has however given rise to concern over the last years, aggravated by the increase in the population of urban poor.

In spite of a small decline in the ratio of beds pr. 1000 population (from 3.6 in 1981 to 3.2 in 1987), the current bed ratio is still among the highest in Africa. The urban bias is demonstrated by a bed ratio for the rural population at 1.7/1000 whereas the urban bed ratio is 5.8/1000.

Also a *curative as well as an academic bias* continues to be evident in the health system. The PHC policy has not gained strong support by professionals, who still prefer academic careers and curative specialities to involvement in rural health services.

Basic training programmes have been slow to adjust curricula to accommodate appropriate training for PHC. This means that health workers are charged with new types of responsibilities for which they have very limited knowledge, skills and experience. Training for leadership in PHC has therefore been identified as a priority activity.

The current *coverage* of health units leaves about 1/3 of the rural population without access within 12-15 km from their homes. The demand for services has grown more than expansion/availability of services. Poorly maintained health units and transport systems,

irregular supplies and shortage of personnel hamper service quality and continuity, and adds to the problem of services availability. Increased demand in spite of generally reduced quality is thought to reflect greater awareness among people.

The quality of epidemiological data recorded by the health services reporting system are considered to be inadequate, and the development of improved health information systems has been identified as a priority.

The various components of the comprehensive *PHC strategy* are somewhat *out of balance* with each other, due to different access to external funding. As a heavily externally supported programme, the Universal Child Immunisation programme can for instance be said to be far ahead of other PHC activities.

The real value of the drug budget for the health units have been on the decrease (in 1986 it was 1/4 of 1983 level), and there have been major interruptions in drug supplies and shortages of drugs. Since the introduction of drug kits during 1987-88 this situation has however been considerably improved.

Personnel development has been uneven, with staffing shortages for some categories of staff and surplus of others.

The doctor/population ratio has shown a sharp fall the last decade. From 1 doctor pr. 11 380 population in 1965, it raised to 1 pr. 7150 in 1984 (figures from World Devt. Report 1991), but has since fallen again to approx. 1 pr. 13 500 in 1991(estimate based on a 1991 figure of 621 doctors in posts and an estimated population of 8.5 mill). The current ratio for doctors is below average for low income countries world wide.

The falling ratio is not only due to the population increase, but also to an actual reduction in the number of doctors in the country. Unsatisfactory working conditions have caused an exodus of doctors to neighbouring countries from the early part of the eighties. Nearly 400 physicians resigned from government services between `81 and `85. This, combined with reduced training capacity, has resulted in a situation where more than 1/4 of the positions for doctors are vacant and less than 1/4 of all doctors actually working in Zambia are nationals. The situation is aggravated by the actual distribution of doctors, with a drain from public to private and industry-related services, and a concentration to provinces around the line of rail. The situation in the northern province at the time of the review illustrates this: only three out of a total of 25 doctors were Zambian. 12 were junior doctors from Cuba, and the rest of various other nationalities.

One of the targets of the new Health Policy is to develop improved working conditions for doctors, in order to retain them in the country and attract doctors who have left to return.

The situation when it comes to nurses is complex. Whereas there currently is an oversupply of Enrolled Nurses, there is a shortage of Registered Nurses, particularly evident in the rural areas, where staff turn over is highest. There is also a shortage of nurses with specialist training.

Clinical Officers, Pharmacists and Laboratory Technicians are other categories health professionals which generally are in short supply.

In addition to low training capacity for some categories of staff, it has been hard to keep staff in posts in rural areas. Poor housing and inadequate education opportunities for children are seen to be the most important factors contributing to this situation. Improving staff morale and motivation has therefore been identified as an important area of emphasis in the current health sector strategy.

1.4 The Organisation of Health Care

Zambia is administratively divided in 9 Provinces and 58 Districts, which also form the structural basis for the organisation of health care.

Most reviews of health care in Zambia have pointed out the weak organizational capacity of the system at large, and particularly at the central and district levels. At all levels there is generally said to be poor planning capacity, poor supervisory capacity and poor quality of health information. The inadequate staffing is aggravated by a high turn over of senior staff.

Since the local government reform in 1980, the district has been identified as the administrative focal point for management and implementation of public services and local development. Although decentralisation to the district level also has been adopted as an important strategy for health planning and implementation, the system has in practice remained rather centralised.

A Department of Medical Services is responsible for all Primary Health Care programmes, which include UCI, CDD, Maternal and Family Health etc. A PHC coordination unit within the MOH is charged with the task to support PHC development in Zambia, with an emphasis on networking and sharing learning experiences, and on exploring the potential of innovative strategies such as community based health care.

The provincial level has acted as representatives of the central MOH, with delegated authority for policy implementation, control, supervision and advice functions. The role of the provincial level is now being adjusted to become more advisory, as part of the renewed efforts towards more effective decentralisation to the district level.

The PHC policy of 1981 introduced the concept of the PHC Unit (a Rural Health Centre and all the Community Health Workers (CHW's) within their catchment area) and the Zonal Health Centre (a large Rural Health Centre with supervisory functions for other PHC Units in their zone). The CHW is according to policy selected by the local community, trained by MOH, expected to serve as a volunteer or be paid by the community, accountable to the community and supervised and guided by health centre staff. According to the plans, there should be one CHW for a population of about 500. Up to 1986, 3387 CHWs were trained, of these 2510 were active and 20% had dropped out. The high attrition rate is contributed to lack of support, low credibility and insufficient resources. The FNDP makes provision for training 2850 new CHWs. The PHC Policy also introduced committee structures for local and intersectoral participation in decisionmaking, including advisory committees and management committees at the various levels.

In spite of the policy, the process of adjusting and developing the health system along these lines did however not take off to any significant degree during the eighties. Limited management capacity within the health system itself, low motivation for utilizing the potential of the structure and limited knowledge and commitment to principles and practices of PHC have been listed as factors contributing to this situation. PHC management and implementation has in the later years been supported in a major way by Swedish SIDA and by Dutch development assistance, as well as by UNICEF and WHO.

Most districts do have a District Hospital (100-200 beds), which function as referral centres for Rural Health Centres (6-20 beds) and carry the responsibility for coordinated implementation of the Primary Health Care activities in the district. Rural Health Centres can be small (serving 2500-5000) or large (serving 5000-10000). A Zonal Health Centre, where these exist, may serve larger populations, up to 30 000 or more.

The health service organisation has been under review by the new government. The emerging direction seems to be to establish a stronger intersectoral policy base for health at the central level (a National Multisectoral Council on Health Strategy with the MOH as executive) and more autonomous District Health Councils. The mechanism for providing central grants for health activities in the districts within the new decentralised structure, has not yet been clearly defined. In three pilot districts, planning, budgeting and accounting within the health sector has been decentralised, with the DMO as "controlling officer". The role of the MOH will more and more be to support the districts in operationalization of policy and to control/audit performance and quality.

Priority will now be given to capacity building at the district level; building local skills in planning and management and shaping attitudes. The zonal system will be further developed with Zonal Rural Health Centres given clear responsibilities for supervision and management of health care in the zone on behalf of the District Health Management Team.

Popular representation will be strengthened through the establishment of Area Health Boards under the District Health Councils. Autonomus Hospital Boards are also seen as desirable. Three districts have been selected for piloting the new approaches in health care management, and other nine districts will be added in the near future.

The District Health Councils are being charged to operate "Mandatory Health Programmes" to ensure balance in and commitment to the broad PHC principles. In this context the National Health Policy (First Draft) speaks about a basic level health service "package", including:

- maternal and child health services including family planning
- adequate treatment and control of disease
- epidemic preparedness

Essential drugs and equipment are seen as integral elements of the basic package. The donor community is invited to establish long term relationships with a focus at the district level to help ensure the provision of this basic package, yet in such a way that the district can sustain essential services also when donors withdraw. Resources for additional activities (over and above the basic service package) may be accepted with less emphasis on local sustainability.

1.5 Financing Health Care

Up to the early eighties, Zambia's allocations to the health sector compared very favourably with other countries in the region, as can be illustrated by an expenditure for health in 1981 which represented 6.1% of total government expenditure. Since then, the real value of expenditure for health has declined substantially. Per capita expenditure for health (adjusted for devaluation) was in 1985 only 48% of the 1974 level.

External donor financing has represented an increasing proportion of the overall allocations to health during the last decade. The total value of aid-funded activities in 1987 (excluding supplemented posts, NGO activities, scholarships etc.) was according to UNDP ZK 32 million, against MOH expenditure of ZK 188 million (17 % external assistance).

Of the total expenditure for health, a high proportion (40% in 1985) has consistently been allocated to urban/provincial hospital care and less than half of this (about 15 % of total expenditure in 1985) to rural health centres. Most of the current allocations in the health budget are spent on salaries and food.

Overall per capita recurrent expenditure for health has gone steadily down since mid-eighties and capital expenditure has virtually stopped. With no room for additional recurrent expenditure, there is also no room for new investment/expansion which will have implications in terms of recurrent costs. This situation has had serious consequences for the status of health infrastructure, for continuity and quality of services and for PHC development.

Even within the policy context of free health care, the Medical Services Act of 1985 opened for an introduction of a fee system in medical facilities. The FNDP went further, and stated that there is a need for community contributions to health care.

The provision for charging a small registration fee has been implemented in a rather ad hoc manner. Where they were charged, registration fees varied greatly between different provinces and institutions. A complicating factor was that fees charged in MOH institutions had to be sent on to the province level, instead of being kept as local income for use according to local needs and decisions. The rapid inflation and lack of incentives for staff to collect charges have also undermined the introduction of this practice.

Reduction in the employment rate and price increases for consumer goods have at the same time reduced the public's general ability to pay for services.

A new policy on health sector financing has been outlined by a Working Group established in early 1992 seeking to restructure, review and explore financing mechanisms for the health sector. The strategies being discussed include the possible introduction of compulsory health insurance schemes, user fees, private sector investment incentives, donor funding, chronic care cost, cost-quality comparisons and community financing alternatives.

The general position in the MOH is that there is a need to enhance efficiency and raise the quality of care before consumer charges should be implemented. MCH/FP have been identified as priority services which should continue to be given free of charge.

2. NON GOVERNMENTAL ORGANISATIONS AS PARTNERS IN HEALTH CARE

2.1 Policies for NGO collaboration in health

The private sector involved in health in Zambia include private industrial companies, private for profit care and voluntary not for profit organisations. Whereas health care operated by the industry has played a very important role in the Zambian health care system, private for profit health care has been limited to very low scale individual private practice in urban centres.

The church-related institutions have played a very significant role in health services delivery since long before independence. The GRZ has generally encouraged the active involvement of NGOs in nation building, and has contributed to the recurrent expenditure of social services provided by NGOs on the condition that they be in line with government policies and plans. NGO's are seen to offer services to people where government have not been able to do it, particularly in rural areas. The government has repeatedly invited NGOs to continue this service, and also to increase number of health facilities in the rural areas of Zambia.

At the time of independence, policy in mission hospitals was to charge fees, however with provision for subsidised or free care for those unable to pay. Based on the government policy declaration of free health care, and the government grant to mission facilities, the fee structure was abandoned, and all care was given free of charge. Up to the early eighties, the standard in mission care under these new economic circumstances was fairly well maintained. The situation has however deteriorated significantly after 1985 due to the economic situation in the country.

In the period `64-`66 the government took over management and ownership of five church health facilities. Two of these were later again taken over by the church. Again in the last two years there has been a few facilities handed over to government management (total of three in the period 1990-91). Handing over church facilities to government does not therefore seem to be a very active option for neither church nor government.

The PHC strategy for Zambia developed in 1980/81, expected NGOs to play a full part in PHC delivery. NGOs were asked to draw up plans for their participation and forward copies to MOH. Improved communication and cooperation between NGOs and government were seen as a necessary consequence of the strategy. A full fledged national PHC effort did however not take off. Support for PHC activities has mainly been given by donors directly to the NGOs. Funding has however been less predictable than what has been the case for curative care. Actual collaboration between mission and government at the level of implementation has varied considerably, from district to district and over the years. Low capacity for planning and coordination in the system at large may be an important reason for this situation.

Church related health care, organised under Churches Medical Association of Zambia (CMAZ) has increasingly been seen by the government as a "parastatal" function, with a separate identity and yet with a defined task on behalf of the government. In a speech to the CMAZ Annual Council in 1987 the MOH representative underlined "the desire of the party and its government to integrate fully church administered institutions in the health care delivery system". This has meant commitment from government to provide grants and personnel, and at the same time an obligation for the CMAZ institutions to comply with government instructions and regulations as an integral part of the service delivery system.

The actual basis for resource allocation from the government, such as agreement on the approved number of beds, staffing lists, flow of funds, authority in personnel management etc. has been areas of ongoing discussion through the years at the central level. Most of the NGO facilities have more actual beds than the approved number. In 1988 steps were taken to adjust the criteria for allocation to incorporate both approved and actual number of beds, as well as daily average patient attendance and inpatient days. So far, the approved bed number still continues to be the main criteria. The negotiations are undertaken between the MOH and the CMAZ, on behalf of its member institutions. Direct approaches from member institutions to MOH for separate negotiations have been discouraged.

The new health policy which is under development affirms and strengthen the role of the private sector in health services delivery. "Private, parastatal cooperative hospitals and clinics are to be encouraged, and legislation should be reviewed to facilitate this". It is understood that this also include private for profit health care as a potential partner in health provision. The potential additional loss of scarce trained staff to the private sector is not discussed.

The concept of "partners in health care" is often used by the MOH about the private sector. One also talks about a special category of "co-partners" who are the partners willing to accompany the MOH in its efforts, even through periods of major resource constraints.

CMAZ is seen as such a co-partner with the government and is also referred to as a parastatal organisation.

The stress on the district level in the new policy means that the district may increasingly become the most critical unit in terms of coordination between government and various types of private sector care. Local dialogue and appropriate mechanisms for coordination between government and NGOs at the district level will therefore be essential.

The need for improved accountability to the public, also by the private sector in health care, is increasingly becoming an issue. With the intended process of decentralisation, the MOH anticipates to take up a stronger role in monitoring the performance and quality of the services in the districts, including the private sector.

The NGOs are invited to contribute towards the implementation of a comprehensive, integrated PHC programme in Zambia. Increased participation in CHW and TBA training is also called for. It is hoped that NGOs through their own external networks can raise external funding for such activities.

The HIV/AIDS epidemic made it necessary to develop specific policies and strategies for action, including also for the role of NGOs. In general, this involved a stronger central coordination and control, both in terms of fund raising, information systems and project implementation. NGOs are actively encouraged to involve themselves in AIDS activities within this framework. The NGOs have organised themselves in a "AIDS NGO Network Coordinating Committee, both to exchange information and ideas, and to liase with MOH.

Also for the implementation of the National Population Policy are NGOs seen as important partners with government. It is stated that "due recognition and support shall be given to their work, expertise, experience and resource capabilities". It is however also stressed that "appropriate guidance shall be provided to NGOs to ensure that their activities respond to the priority problems of the local communities and the nation as a whole.

22 Overview of ongoing NGO activities

The NGO sector in Zambia appears generally to be less diverse than in many other African countries. This particularly applies to health, where church related organisations are by far the largest and most experienced group. Non-church NGO's have generally a much shorter history, and have focused their work around special concerns such as women, family planning and AIDS.

Based on the main areas of activity, NGO's involved in health related work can be grouped in:

- Organisations mainly concerned with health service delivery
- Organisations mainly concerned with family planning
- Organisations mainly concerned with AIDS
- Organisations concerned with various development efforts contributing to health

There are however obvious overlaps between all the four categories, with some organisations being involved in a broad range of areas.

It is a general impression, based on the material from this review, that NGOs in the last three categories are more "Zambian", more diverse in approach and more creative in strategy development than the traditional health services delivery organisations. The health service delivery organisations operate very closely with the governmental system, and their

main contribution is increased volume, coverage and quality of basic health services following a standard pattern.

An important feature of the NGO scene in Zambia is the existence of several umbrella organisations and mechanisms for NGO coordination. Among these are the Churches Medical Association of Zambia (CMAZ), the Non Governmental Organisations Coordinating Committee (Women´s development), the AIDS NGO network Coordinating Committee and the Zambian Council for Social Development.

2.2.1. Health Service Delivery

a) Church related organisations

Church related organisations are responsible for a large volume of health care in the country. In rural areas, up to 40% of all the health services actually provided are said to be church related.

All church related health care providers are members of the Christian Medical Association of Zambia (CMAZ), which is a registered trust established to liason with government and to coordinate and support church related health activities. CMAZ is regarded as a "parastatal" organisation, defined as a close partner to government in carrying out national policies in health care. The organisation therefore receives block grants from the government according to the volume of services (calculated on the basis of approved number of beds), yet has retained managerial autonomy for the umbrella organisation as well as the member projects.

The distribution of health facilities between government, "mission" (not only CMAZ) and industry (mines) according to MOH 1990 figures are shown in table 2.1 below

Table 2.1 Government and "mission" facilities, 1990 (as registered by MOH)

	Government	Industry	"Mission"	Total
Hospitals	43 (52%)	10 (12%)	29 (36%)	82 (100%)
Hospital beds	8339 (60%)	1602 (12%)	3965 (28%)	13906 (100%)
RHCs	630 (90%)		70 (10%)	709 (100%)
RHC beds	6064 (79%)		1587 (21%)	7651 (100%)

The above figures include some RHCs listed under mission which are not member institutions of CMAZ. Urban health centres has not been included in the table above, as mission has virtually no input with this kind of facility.

In 1991, 32 hospitals and 54 RHCs were listed under CMAZ. This means that some of the "large RHCs" may have changed status to hospitals.

According to the MOH statistics of 1990, altogether 70 RHCs (out of 709 RHCs) were listed under "mission". 53 of these RHCs had beds. The bed average for mission RHCs is significantly higher than for government owned facilities. Of all the mission RHC's the average bed number is calculated to be 23, compared with 8.5 as all country average. 16 RHCs out of the 53 with beds had 40 beds or more, the highest being 90 beds. The distinction between hospitals and large rural health centres is somewhat unclear, but said to be based on a recognized status related to care level rather than bed number; in practise whether there are operation theatre facilities or not.

Mission facilities are generally located outside the "line of rail" areas. The strongest presence, based on the proportion of mission hospital beds to all available hospital beds in the provinces, is in the Northwestern province where 62% of all hospital beds are operated by mission. No mission hospital is in operation in the Central province. In the Copperbelt and Lusaka the proportion of hospital care provided by mission is very low, and also quite low in Northern.

Table 2.2 Mission hospital beds(in percent of all available hospital beds)

	Mission % of total hospital beds	Total mission hospital beds
Northwestern	62 %	869
Western	46 %	615
Southern	45 %	748
Central		0
Lusaka	9 %	160
Copperbelt	7 %	242
Eastern	45 %	619
Northern	14 %	170
Luapula	51 %	425

The church related facilities are generally located in underserved areas. Some overlap appear to exist between mission and government when it comes to hospital services. Approximately 1/3 of the missions hospitals are formally designated District Hospitals, and carries out regular district hospital functions on behalf of the government. The rest provide additional hospital services in districts where there also are other government district hospitals in operation. In several of the cases observed, the relationship between mission and government showed signs of strain, because mission facilities are generally better equipped and have access to additional resources through the external church network. Independent of the assigned role in the system, mission hospital carelevel is often above what governmental district hospitals are able to do within their resource constraints.

The mission RHCs are also generally larger and better equipped than government RHCs. Sometimes even the mission RHCs act as referral centres for government district hospitals. However, little real overlap appear to exist between government and mission at the RHC level. Some of the mission RHCs have also been given the function as zonal health centres, with supervisory responsibilities. The following table shows the proportion of mission RHCs in the various provinces, based on bednumbers:

Table 2.3 Mission RHC beds(in percent of all available RHC beds)

	Mission % of total RHC beds	Total mission beds
Northwestern	26 %	995
Western	8 %	630
Southern	37 %	955
Central	7 %	559
Lusaka	24 %	127
Copperbelt	61 %	344
Eastern	25 %	733
Northern	26 %	1178
Luapula	17 %	728

Looking at table 2.2 and table 2.3 together, is appears that in most provinces (Northern, Western , Southern, Eastern, and Luapula) mission is responsible for a higher proportion of hospital beds than RHC beds as compared to government and industry. This is completely reversed in Copperbelt where more than half of all RHC beds belong to mission and very low proportion of hospital beds. A similar tendency can be noted in Northern.

The CMAZ related agencies has been developing some new health infrastructure in the later years, although not very actively. 3 new RHCs were established by CMAZ in 1987, 4 in 1988 and 3 in 89. This is in line with the national plan priority to expand NGO services in uncovered rural areas.

Mission hospitals also have had an important role in training of nurses and midwives, and will likely be asked to contribute more to the training of MDs, as well as registered nurses and clinical officers in the years to come.

b) Flying Doctors Service

The ZFDS has its headquarters in Ndola and serves as a complementary effort to the MOH services, with the main focus on delivery of PHC services (preventive and curative) to remote and inaccessable areas. The ZFDS also provides outreach specialist services and assists in the evacuation of emergency cases and transport of referred cases.

It is a non governmental organization, listed by the MOH as another parastatal. As such it receives considerable funding from the government. The FNDP made provisions both to assist the ZFDS to replace the fleet as well as for contributions to the running costs.

The ZFDS operates in support of selected RHCs and by supervising specially established health posts. The health posts are staffed by VHWs who have been given a 6-month training in Ndola (ZFDS-HQ). ZFDS is also the implementing agency for an Integrated FP, Nutrition and Parasite Control Project.

c) Self-help groups

A considerable amount of local community initiatives, so called self- help groups, operate more or less on an ad hoc basis for different purposes according to felt need. A typical self-help project would be to construct a RHC in a community, staff houses, additional wards, repairs etc., either in support of an established GRZ Health Unit or with the view to have a new established and approved.

In general, these self-help groups do not have any responsibility to the running of the projects. Self-help groups may approach different donor agencies directly for funds outside the regular GRZ agreements for development assistance. As such they therefore acts as an additional resource mobilizing agent for the government.

The strength of these groups is primarily that the community gains experience in acting together to improve their own situation, and that they function as pressure groups for increased distribution in areas with poor access. There are however also clear weaknesses in the system when it comes to the capacity for planning and implementation of such schemes.

d) Lions and Rotary Clubs. Red Cross

These international NGOs are well established in Zambia, and contributes locally in various ways to health services delivery through fund-raising and volunteer efforts in support of both government and mission projects. There are also examples of specific projects operated by these NGOs themselves, although in Zambia more in response to the AIDS epidemic than in regular service delivery.

2.2.2. AIDS care and prevention

Since the AIDS epidemic became known in Zambia, NGOs have been involved in AIDS programmes, and have taken innovative initiatives in developing projects addressing the epidemic. Foreign donors have supported these programmes, and NORAD has been one of the leading agencies in this work.

"World famous" NGO programmes on AIDS in Zambia are first of all the AIDS programme at Chikanata Hospital, which has been used as a model in various places around in the world (one example: on two occasions have Chikankata-staff been in Norway to present their programmes in AIDS Seminars). Secondly the Anti-AIDS Clubs involving school-children and youth, and thirdly the Copperbelt Health Education Project (CHEP), which started from a nutrition group in 1987-88, with emphasis on health education targeted to various groups, and facilitation of training programmes. These three projects have very different approaches and services, which illustrates some of the magnitude and the creativity of AIDS projects in Zambia.

The majority of the AIDS programmes in Zambia are involved with home care programmes, in various forms, the programmes mostly fall under the hospitals or rural health centres. Information programmes are also being integrated in many organisations, and counsellor training is also done. In a Directory worked out by the NGO AIDS Coordinating Committee, more than 40 organizations and projects are listed.

Many of the NGOs receive support for AIDS activities from external donors, and support is also given from WHO through the National AIDS Control Programme. Vertical home care programmes for AIDS patients supported by mobile health personnel are increasingly being questioned in terms of cost and sustainability.

2.2.3. Family Planning

NGOs are encouraged by the Zambia`s National Population Policy to participate in family planning activities. Two major NGOs are dominating this area, that is the Planned Parenthood Association of Zambia (PPAZ) and the Family Life Movement. PPAZ is affiliated to International Planned Parenthood Federation (IPPF), whereas the Family Life Movement is a member of the International federation for Family Life Promotion and bases its work on scientific natural FP techniques.

PPAZ has played a major role in implementation of the National Population Policy, in terms of procurement of contraceptives, training service delivery and awareness raising.

The Makeni Ecumenical Centre, a Christian education centre and service agency with a campus and three settlement villages, run a specialized family planning clinic, mobile FP services and small scale CBD (community based distribution) programmes, claiming to have a high number of new acceptors each month.

Most NGOs involved in health promotion do also incorporate family planning. Services are also provided by a small number of private doctors and some contraceptives sold in some pharmacies in the main towns.

2.2.4. Various NGO efforts contributing to health

In addition to the above mentioned organizations directly involved in health related activities, there is a range local organisations and groups which deals with concerns that have implications for health. Among these are the organisations with a strong target group orientation, such as the disabled, children and youth. There are also organisations representing professional interest groups, organizations with a main concern for the empowerment of women and organisations involved in broad community development.

A number of NGOs are involved in various village settlement projects. Nutrition groups are in action throughout the country, organized in different ways and mainly as women´s groups, involved in nutrition education and feeding of malnourished children. Some nutrition centres are established as well. These are usually established by more formally organized womens groups.

A general impression is that there are few health related NGOs in Zambia with strong experience in and commitment to community based action. This impression was confirmed in the discussions with the PHC coordinating Unit in the MOH, where it was stated that as a whole there are few examples of community based health and development projects in the country.

3. POLICIES AND TRENDS FOR FINANCING THE NGO SECTOR

3.1 Government contributions

Government contributions are mainly provided for health service delivery organisations. Some of the other organisations do indirectly get government support, as use of staff is integrated with government services (such as the Breastfeeding Association).

3.1.1 Overall policies for grant in aid

Keeping within the policy of free health care to all citizens, GRZ has regularly made annual budget allocations to the church/mission health facilities registered as members of the CMAZ. The government contributions include a "bed" grant, allocated on the basis of the number of approved beds in the health facility, drug kits for rural health centres, trainee grants for operating training schools for health workers (ZEN/ZEM) and the secondment of personnel with salaries and benefits.

In addition, PHC grants are allocated according to specific roles, responsibilities and activities of each facility. Those hospitals which have a district hospital status are in principle provided with funding, vehicles and equipment by MOH to carry out responsibility in PHC as any other government district hospital. Where a mission rural health centre is recognized as a zonal centre, it is entitled to specific funding equivalent to what is available to government zonal RHCs. For special vertical programmes like the Universal Child Immunisation programme (UCI), mission facilities are reimbursed through the channels of the Provincial Medical Officer. When complications arise, CMAZ at the central level have needed to facilitate negotiations for reimbursement.

A common understanding both in the CMAZ and in MOH has been that the intended level of grant in aid for health service provision through CMAZ member institutions is to meet 75% of the running costs, with the churches themselves responsible for the remaining 25%. There is however no written agreements to this effect, and actual allocations are negotiated annually based on rates related to the number of "approved beds". According to information from CMAZ, the proportion of grant allocation has been showing a declining trend the last years.

The criteria for and volume of the grant allocations have been recurring themes in the negotiations between CMAZ and MOH through the years. In the eighties, the proportion of the national health budget allocated to CMAZ dropped. (figures which are given indicates that the CMAZ allocation represented approx. 11% of the national health budget in 1978, about 6% in 1987 and close to 7% in 1989). When one also considers that the overall budget for health dropped from about 8% of the national budget to 5% in the same period, it is evident that the government´s capacity for following up previous commitments to the NGO health activities has been decreasing in the period since the mid-eighties.

In spite of a rise in actual figures, as illustrated by the table below, the government funding for CMAZ institutions has not kept up with inflation. The real value of the bed and drug grant is therefore in effect gradually reduced.

Table 3.1 Actual figures, grant to CMAZ

1986	1987	1988	1989
K 15 mill	K 22 mill	K 30 mill	K 33 mill

The government grant allocated to the institutions under CMAZ amounted to 7% of the total MOH budget in 1989 (ODA review).

Total budget excluding capital:			zk 583 073 730
Grant allocations to church sector:	zk	33 000 000	
Seconded personnel	zk	7 680 000	
Total to CMAZ	zk	40 680 000	
(7% of total MOH expenditure)			

In dealing with the issues arising out of the grant in aid system, the MOH has shown considerable flexibility within their own constrained framework for problem solving and policy adjustment, both in terms of personnel, drugs and other grant provisions.

In July 1986, the MOH policy on funding for church health facilities changed to paying quarterly block sums to all institutions instead of monthly allocations. The main reason was to reduce the workload in the MOH. An important implication was however that overspending could not any more be offset by MOH, as previously on occasions had been the case.

From 1989 some additional allocations were made for rehabilitation of church facility infrastructure. Otherwise main capital expenditure and expenditure for maintenance of physical facilities has generally had to be met through external grants. Decrease in overall government support has led to a very tight economic situation for most of the facilities. It has been found increasingly difficult to match the financing gap with external grants.

There have also been a number of practical problems with the grant in aid system, such as timely transfer of funds and the governments financial ability to match budgeted expenditure. Grant-aided personnel has at times been affected by government announcements of salary increases which have not been followed up with increases in

actual grant allocations. Understandably this has put the NGO institutions in a difficult position.

The new government has stated that the CMAZ member institutions which operates in accordance with the government policy framework for health services delivery in the future will receive the same amount of bed grant and seconded personnel as the governments own institutions.

3.1.2 "Bed grant"

In some CMAZ institutions, the discrepancy between the actual number of beds and the approved number of beds is large (up to additional 50% of approved beds), in other institutions the approved number and the actual number is the same.

The bed grant should cover expenditure for wages to unskilled staff, food, maintenance, fuel, drugs (in the hospitals - the RHC are provided by a drug kit) and stationary.

Looking at the health facilities which were visited during the review, the government grant covers between 63% and 95 % of the total income, as shown in the table, next page. In these figures however, it must be noted that for most of the institutions (apart from Monze where a separate study is done), miscellaneous income through informal donations and in-kind contributions has not been consistently valued.

Table 3.2 Government grant as % of total expenditure (1990)

	Government grant as % of total expenditure	Total income	Total expenditure	No of beds
Chilonga Hosp	87%	5 608 218	5 641 549	240
Monze DH	66%	6 696 624	6 759 836	250
Zimba hospital RHC´s	91%	2 974 565	2 612 159	77
Chilibula RHC	63%	3 037 181	4 713 477	58
Chivuna RHC	85%	1 075 168	883 836	22
Chikuni RHC	95%	1 633 822	1 629 529	99

The figures illustrate that the bednumber alone is not a meaningful criteria for relating to cost of care. Also that statement of accounts are not easily comparable between the institutions. Looking at the above figures it appears that cost pr bed is generally higher in the RHCs (average 38 400 pr bed) as compared to the hospitals (average 25 300). We do not believe that this gives a true picture.

3.1.3 Personnel

In addition to the bed grant, most of the projects are provided with governmental seconded staff. "Established posts" are agreed staff lists for essential skilled staff which in principle should be seconded by the government. Unskilled staff are employed locally and paid from the regular bed grant. The actual number of seconded staff in posts in each institution depends on availability and on the provision of staff houses.

3.2 Local income

The economic pressures have forced the government to reconsider the policy of free health care, and to look for ways in which new sources of funds can be mobilized. The Medical Services Act introduced the possibility for charging fees in 1985.

The erosion of the government grant made it necessary for the CMAZ facilities to seek to raise local income through user charges and contributions. The Annual Council of the CMAZ in 1989 resolved to recommend a list of hospital fees to the MOH which could be made applicable to all people in Zambia and that the money collected should be kept by the collecting institution for local use. The structure of the fee system was an OPD registration fee of zk 10.- and admission fee of zk 50.- Delivery fee was set to zk 75.-

All CMAZ facilities are now supposed to have a fee schedule in operation with fees for registration, consultation and course of treatment. The implementation of fees has however varied from institution to institution. It has been a problem that practise has been different between mission and government, which has caused complaints and local dissatisfaction. Some institutions have tried to introduce fees but stopped charging due to negative reactions from users. It seems as if most of the health services delivery institutions are now awaiting new policy statements from the new government through CMAZ before making further adjustments of the fees.

All the health institutions visited during this review had introduced fees, some had also raised the fee since the initial introduction. Monze had raised the fees from the initial level, and the contribution to the running costs of the project was 14% (of total income). At Chilibula where the fees have not been raised, they contribute to only 2,7% of the income. Ongoing studies look at how attendances are affected by charges. There are indications that the use drops considerably initially but then stabilizes at a slightly lower level than before the fees. Further work is required to find out more about the impact of introduction of fees on attendance e.g. who are effected? Do those in real need still come? Some argue that introduction of fees prevent people in need to use the health services. Others that reasonable fees prevent those that use health services without real need.

Not infrequently mission health services receive some local donations from various parties, including assistance from "self help groups" and advisory committees who sometimes help to raise local funds in situations of major crisis. Only one of the health services delivery projects visited supplemented other income with specific income generating activities (Mbaya).

Membership fees is a way of raising income for some of the other health care related organisations (PPAZ, Makeni, Breastfeeding Association of Zambia). Some of these organisations also sell items like T-shirts for a small profit (PPAZ), or rent out buildings/offices (Red Cross).

3.3 External Financing

Common for most of the external financing relationships is that support is based on a project funding approach rather than a block grant. Most such projects represent defined elements of the overall institutional activities, and are designed to match the funding priorities and needs of the funding agencies. Most of the NGOs have support from more than one external partner. Two to three sources of funding appears to be common, five sources or more not uncommon.

3.3.1 External NGO support networks

Many of the organizations have mother/sister organizations in the first world which they have close or less close relationship with. The Churches in Zambia have their links with the "global" church through sister churches and wider international church networks and structures. The mother/sister churches in the "north" would contribute with professional personnel and with funds. International sisterorganisations are also important features for a number of non-church NGOs, such as Red Cross, Lions and Rotary Clubs, Breastfeeding Association and PPAZ.

Besides project focused support from sister organisations and other NGO funding partners, donations of medicines and supplies via the CMAZ represent an important source of support in kind to the health services organisations. Such donations have been kept up at a fairly high level. The contributed supply is distributed by CMAZ to member institutions. The need for a improved storage and distribution system has been discussed but has been hard to find funding for. The import of drugs for the church related health work has in periods been questioned by the MOH, and CMAZ has been challenged to take part in local drug production.

With the encouragement of government, approaches have been made to various donors for funding PHC programmes. In order to give substance to such applications, the CMAZ has sought to collect information about PHC activities being undertaken, as well as plans for further PHC involvement from the various member institutions. This has however been an uphill struggle so far.

> *Less willingness of funding partners to support projects within the health sector is lately experienced by the Zambian churches as well as non-church organisations. This goes hand in hand with a general decline in expatriate staff from the same organizations. The decreased flow of funds from the traditional sister organisations has been seen to reflect an overall decreasing trend in official aid allocations to NGOs for this kind of work in developing countries.*

Most of the organisations and projects therefore generally express that their financial situation has deteriorated, and many have started to be more active than before in seeking financial support from a variety of sources.

3.3.2 National donorsupported programmes which include NGOs

In the April 1990 meeting of the Consultative Group for Zambia, a Social Action Plan (SAP) was presented to alleviate some of the negative effects of the structural adjustment process under the Economic Recovery Programme. It was based on strategies laid out in the Fourth National Development Plan (see 3.2).

SAP was proposed as a time-bound, prioritized and targeted programme in the social sector, designed to address the needs of the poorest and most vulnerable groups. It has been regarded as a crucial step in the re-ordering of the expenditure priorities of the government for targeting them towards the needs of the poorest of the poor to improve the availability of social services and employment opportunities. The current government has adopted and affirmed the SAP as a strategy to address the urgent problems and needs within the social sector. SAP consists of 6 areas of action of which health and water and sanitation is of primary interest in this context.

A National Steering Committee with representatives from NCDP, the line ministries, donor community and NGOs, is established. The six sectoral Working groups for each area of action are chaired by Permanent Secretaries in relevant ministries. In the health working group the lead donor is currently the Dutch Development Aid and the deputy lead donor SIDA. This reflects their relative importance and contribution in the health sector in Zambia. In addition UNICEF, CMAZ and EEC have representatives in the working group.

Within the health sector, the work plan consists of two different strategies. A short term, Emergency Health Programme (14 mill US$) for urgent implementation mostly in 1992. However, the time might be extended. A long term strategy relates to the implementation of the new health policy. In this long term plan 1/2 bill zk has been allocated for rehabilitation of RHC and District Hospitals, 1,5 mill US$ for investments in equipment included solar refrigeration (paid by UNICEF) and 200 mill zk for a cholera control programme. Lusaka Urban Maternity Programme will be supported with 120 mill zk over 2 years.

A Microprojects Unit (MPU) operates as a component within the SAP framework. It represents a coordinated continuation of the former EEC Microprojects, with the EEC and the World Bank Social Recovery programme as the main funding agencies. Microprojects unit has already a administrative and professional staff through the EEC microprojects and WB. The WB has budgeted US$ 20 mill and the EEC ECU 12 million. This represents a total budget of US$ 42.2 mill. over 5 years an average of almost US$ 7 mill. a year. Some of the funds are made available as grant, some as loan.

There is also an AIDS support programme within this framework (mainly EEC funds). Considerable amount of money will be made available for AIDS education projects run by NGOs. The Family Health Trust and Kara Councelling have until now received most of its funds from NORAD. MPU will most probably give financial support to these organizations and is specifically interested in supporting an extension of the study implemented in the suburb areas of Lusaka.

SAP and MPU do not discriminate between NGOs and GRZ institutions. Many NGOs have received financial support through these programmes. Most of these are church related NGOs involved in delivering health services. In line with the focus on decentralized planning, the projects to be supported by the MPU should be endorsed by the District Councils and Provincial Planning Units.

Priority areas are infrastructure improvement such as rehabilitation of Health Centres, Child Care Centres and Shelters. New constructions are generally discouraged, exceptions are staff houses and new premises to replace temporary structures. MPU does also support services such as preventive health care and nutrition programmes (construction, equipment, seed or fertilizer supplies). However, they will not fund long-term recurrent costs. Only basic health care equipment is funded e.g. beds and beddings. Other equipment is not funded. Vehicles are not considered.

3.3.3 Multilateral donors supporting NGOs

UNICEF in Zambia is strongly involved in programme collaboration for PHC. Components include Maternal health/Safe Motherhood, Universal Child Immunisation, Control of Diarrhoeal Diseases, Nutrition in PHC. The UNICEF Country Programme also include district PHC strengthening in collaboration with WHO and institutional strengthening and management
Direct support to NGOs is limited. NGOs receive their support mainly through the governmental system such as in the UCI- programme (vaccines, syringes, paraffin, fridge sterilizer etc.). Some limited PHC activities run by the churches are funded by UNICEF

through CMAZ. Three of the projects included in our study had received additional contributions from UNICEF. Breastfeeding Association of Zambia, Family Life Movement (US$ 20 000) and Chilubula RHC. All contributions were towards Mother and Child Health activities. One of UNICEF´s strength is said to be on networking, helping NGOs to get together for common discussions and policy development.

UNICEF prefers to work with institutions rather than many small organizations. They are collaborating with University of Zambia on studies within the area of UNICEF mandate and has committed themselves to support the PHC coordinator at CMAZ. The support includes salary, vehicle and various running costs connected to the functioning of the position.

UNFPA supports a five year comprehensive population programme (1988-92) in the amount of $10 million, geared to integrate population concerns into the national planning and social service delivery system, with a focus on human resource development, institutional development and strengthening inter-sectoral coordination. Activities include basic data collection and analysis, population dynamics, formulation and evaluation of population policies and programmes, maternal health and family planning, population information, education and communication and population and development.

Trade unions has been included as partners in family life education activities. Family life services for women and youth is also supported as elements of rural development programmes, some of these operated by NGOs. Apart from this, there is no particular focus on NGO collaboration in the current UNFPA country programme.

3.3.4 Bilateral Donors supporting NGOs

SIDA is one of the major donors to the health sector in Zambia and as such is playing a major role in the development of the health services in the country. SIDA is involved in the following programme:

- construction and upgrading of rural health centres
- primary health care training (CHW , TBA)
- transport support
- health planning including health information
- nutrition surveillance
- essential drugs programme
- AIDS (financial and technical support)

SIDA supports NGOs indirectly through the above mentioned programmes esp. through the EDP programme. SIDA does not have a similar programme to the NORAD system for support of local NGOs. They do support Swedish NGOs through a NGO vote administered in Sweden.

SIDA has however, an agreement with the government that funds allocated to AIDS are also available to NGOs. These funds can only be made available if the MOH gives NGO projects priority. No NGO has received financial support through this channel so far.

ODA has not supported NGOs health sector activities to any considerable extent. The review of Zambia health and population sector in 1989 proposed that ODA adopt a strategy for health sector assistance focusing on training assistance designed to approve the supply of skilled health personnel and the management of resources and provision of manpower, rather than support for any particular primary health care activity.

Only one project included in our study has received financial support from ODA. Chilubula RHC in the Northern Province has received through an Integrated Rural Development Programme in 3 districts in Northern Province which in its current phase (3) is focusing on health sector development. The main aim of the programme is to strengthen the institutional capacity of the District Councils and the Provincial Administration in the Northern Province.

DMDC Dutch Aid is heavily involved in the health sector, especially in policy development and PHC, and is the lead donor agency in the health working group under SAP. The head of the PHC unit in the Ministry of Health is a Tanzanian doctor recruited and paid by the Dutch. Together with SIDA the Netherlands are currently supporting the EDP programme. They provide health manpower especially doctors. In the Northern Province, 75% of the doctors are Dutch. Some of the doctors in the Church hospitals are also Dutch. In the Western Province, Dutch Aid has been involved in the development of PHC with a PHC coordinator. Only one of the organizations included in our field study has received financial support from the Netherlands.

Other bilateral donor agencies supporting NGOs in the health sector include NORAD, CIDA and DANIDA.

NORADs NGO-vote is one of the biggest in the donor community, and is discussed in detail in section II in this report.

CIDA is mentioned as a donor agency for special projects by two of the NGOs which are included in the field study. Both are churches running hospitals and Rural Health Clinics. Similar to most of the other donor agencies, CIDA´s financial support is limited to capital costs.

DANIDA does also fund NGOs involved in the health sector, but their role seems minor compared to NORAD and CIDA.

3.3.5 General trends, external financing.

All donors underscore the need for institutional development, but are not willing to commit themselves to a long-term cooperation with NGOs for this purpose. They all look for "strong" and experienced NGOs to make sure that the funds provided are used efficiently. Small and indigenous NGOs seem to have more difficulty in getting support.

The Health Working Group related to SAP plays an important role in the development of health policies and priorities in the country and SAP criteria for funding has a very strong influence on current health development. Faced with the enormous task of rehabilitation, effective coordination is very much required. *There is however a clear need for caution to avoid adverse effects of strong donor control.*

Although there is a great number of donor agencies, the policies and priorities developed and/or practiced by the various bilateral donors seem to be astonishing similar. The general trend is that they are more willing to fund capital costs on ad hoc basis rather than running/recurrent costs. The reason given in general, is that projects which are limited to capital costs are easier to monitor than running costs. It is also said that they create less dependency.

4. MECHANISMS FOR NGO-COORDINATION

4.1 Churches Medical Association of Zambia (CMAZ)

Almost all the church related institutions that provide health services in Zambia are members of this organisation, established to promote the highest level of patient care through cooperation between members and facilitate cooperation between the MOH and the church related agencies.

The CMAZ is not a policy making agency, but undertakes administrative and advisory functions on behalf of the member institutions.

The main functions include:

- resource mobilisation from the MOH and external support agencies
- representing member institutions in relation to government
- coordination of training programmes between government and church related institutions
- policy coordination for church related institutions
- professional support and service functions for member institutions

CMAZ receives donations of drugs and medical supplies from various donors on behalf of the member institutions, which are allocated to the institutions on the basis of size and work load. It provides administrative support to members such as to obtain work permits, deployment of trained personnel etc. It receives government grant from the MOH which are allocated to member institutions.

It is the church health institutions which are the main members of CMAZ. The churches are "Constituent members" with representation and voting rights at the Annual Council level along with member institutions. To be responsible for the work, an Executive Committee is elected. Advisory committees have also been established; AIDS committee, PHC committee, Finance committee and Drug committee.

The CMAZ has established a small secretariat with a General Secretary and some support staff. Until the present time, the capacity of the secretariat has been rather limited, particularly in terms of professional staff. This situation is currently changing in a very significant way. In 1989 an AIDS Coordinator was employed and in March 1992 a PHC Coordinator . A Planning and Development Officer and a Pharmacist is also in the process of being recruited. This is a result of long term discussions and planning within CMAZ, which has made it possible to agree on an expanded role and to raise the funds required.

With a stronger professional capacity in the secretariat, the CMAZ will have the opportunity to play a stronger role as a supportive body to the member institutions. Although most of the institutions now do welcome a stronger function of the CMAZ, in the years passed there have been different opinions expressed among the members as to how much the CMAZ should take initiative on its own beyond service functions such as securing drugs and resources.

The current administration feel that the role should now go beyond programme planning and evaluation and policy coordination to also include issues related to health services organization and institution building, in partnership with the member institutions.

Membership subscription, rentals of office building and residential property and service charges contributes to the administration costs of the secretariat. However, CMAZ depends heavily on donor agency funding for its different activities. This dependency on external funding will increase as the role now expands. NORAD is currently funding the AIDS

Coordinator and UNICEF is funding the PHC Coordinator. Other regular donor agencies include Miseror, Memisa Medicus Mundi and Christian Aid.

CMAZ is represented in various bodies and forums where policies and coordination is occurring, such as the National PHC Coordinating Committee and the Health Working Group for SAP activities. They also take part in the Aids NGO network coordinating committee, Medical Stores Board of Directors and the NGO forum.

A Joint Working Committee between CMAZ and the MOH has been in operation and been instrumental in negotiations between the two parties through the years. CMAZ records show that the frequency of meetings has fluctuated and that the committees ability to function as a problem solving and negotiating mechanism has varied greatly. Some years there have hardly been meetings at all, whereas other years the Committee has met up to three times. The function and usefulness of the Committee appears to be very dependent on personal relationships and the leadership in the MOH at any given time.

The CMAZ has been able to play a significant role in mobilizing church-related institutions for AIDS activities. A total of 60 among the CMAZ member institutions now have AIDS activities as an integral part of their programme, 10 of these work with home based care approaches.

It is obvious that CMAZ has been well placed as a strategic coordinating mechanism, both for the member organizations and the MOH. Its effectiveness will continue to depend on the importance and authority given to it by its main client groups; the government, the member institutions and the donors. Currently it appears that the NGO forum established as a lobby group in relation to the SAP (see below), has taken on much of the policy development and resource mobilisation work. This may have temporary reduced the importance given to the Joint CMAZ/MOH Working Committee.

The need for professional support for institution building in the various CMAZ member institution is clearly there. Similarly for assistance in developing more creative PHC approaches and exploring different service models and models for district level cooperation between NGOs and government. The PHC unit in MOH is also looking towards CMAZ as a partner for developing models for PHC approaches in the country. Much will however depend on the availability of long term support, as these functions need to be developed over time.

The decentralisation to district level, with the district as the main unit for planning, coordination and resource allocation, does present new challenges to the role and function of a central coordinating mechanism like CMAZ. So far little has been done in strategy development for this new situation.

4.2 NGO forum:

NGO forum is an informal forum for different organizations involved in health. The following organizations are members:

- World Vision (currently chairing the forum)
- OXFAM
- Africa
- Red Cross
- PPAZ
- NGO- CC (see below)
- YMCA
- Family Health Trust
- DAPP
- CMAZ

Its main purpose is to act as a lobby group. One of the main current issues are the NGOs role within the framework of the Social Action Programme. SAP started out as an effort to identify critical needs during the structural adjustment process and mobilize and coordinate donor inputs towards alleviating hardship for the most vulnerable. Donor representatives have had a strong role in the SAP all the way through from design to implementation.

During the design of the programme, the NGO community was to a very limited extent involved. As the programme was being made operational, there was a clear need for the NGOs to come on to the scene as real partners. The establishment of this forum has therefore been a response to this need.

It is said that the forum is currently *the* important coordinating group of NGOs in the country, acting both as a pressure group for input in policy and strategy development and as a mechanism for coordinating resources and energies, so that the NGOs can be contributing to the implementation process in the most effective way.

4.3 NGO- Coordinating Committee (NGO-CC)

The NGO Coordinating Committee is an organization which was formed after the UN decade for women conference to coordinate activities of women´s development being carried out by NGOs. The organization has got a membership of 2 international and 29 Zambian NGOs. Non-Zambian NGOs may be admitted as Associate members.

It has international links to the UNIP Women´s League, and is relating to the government through the National Commission for Development Planning (NCPD) were it serves on one of the Committees. Among the member organisations, some are involved in women´s health such as the Family Life Movement, PPAZ, Breastfeeding Association of Zambia and the Nurses Association.

The main objective of the organization is to strengthen the links between member NGOs throughout Zambia through training, seminars, dissemination of information, and to be a voice and pressure group for member organizations.

An important function is to lobby for equal representation in different sectors of society and in organisations. The NGO CC is a member of the Zambian Council for Social Development (ZCSD). An aim is now to move into organisational development and human resource development in the member organisations, so that they can become more and more autonomous in their own operations.

An Annual General Conference approves plans and budgets and elects an Executive Committee. The NGO CC shares information between the member organisations through a newsletter, but have problems in getting adequate feed back from their organisations. The organisations on their side feel that NGO CC does not do the coordinating job effectively, it should improve on the conducting of workshops and meetings and should assist member organisations in getting funds (Workshop Lusaka 2-3 June 1990) .

NGO CC has a sub committee on health related matters. Through this committee and in addition to regular activities, NGO CC has involved itself operationally in the prevention of AIDS/HIV and participates in the AIDS NGO- network. They do feel that as a coordinating body, they should not be operational in AIDS, but felt forced to enter as few of their member organizations at the time were ready to get involved. The responsibility will now be handed over to the Girl Guides, a member organisation of the committee, in the near future.

4.4 Zambia Council for Social Development (ZCSD)

The council was established in 1954, but has since gone through several periods of reconstruction and change in functions and emphasis. The secretariat currently consists of three people; including the Executive Secretary and a women´s issues officer. The total budget for 1991 was 5 mill. kw.

It represents the broadest coordinating body/umbrella organization for all NGOs in Zambia, and has 72 member organizations. Other coordinating bodies have more sectoral or group interest, such as health, AIDS, agriculture, church organisations, women etc.

In recent years the organisation has been faced with major policy discussions and financial and managerial set-backs. ZCSD has in the past been receiving funds from abroad - among others from OXFAM, NOVIB and UNDP. Funds have been used for own activities as well as for the activities of member organizations. ZCSD has in the past for instance operated different social development programmes, such as through a "self help assistance fund" (SHAF) which provided financial assistance to Rural Health Centres.

External support is however now largely withdrawn. According to ZSCD, "the international partners wanted to direct change in the organisation based on their influence and power as funders". This has however caused an active discussion in the organisation of how one can move towards more self-sustaining activities for social change.

Northern NGOs are criticized for the way they use development jargon like "partnership", "sustainable development", and "institutional building", but appears not to take the consequence in terms of the way they work together with organisations in the south.

ZCSD sees itself as the leading forum in Zambia where these issues are raised, to "reclaim institutional sovereignty". The southern NGOs must discover their strength and the resources they represent in themselves. Only northern NGOs that are willing to see their collaboration in this perspective should be invited to become partners in the struggle for social development.

The whole constitution is currently tabled for discussion. The policy direction that is pursued is sharpening the focus on being the main coordinating/umbrella organization between the NGO- community and the government, and leaving out operational activities. However, educational and supportive activities might be continued. It will not serve as a channel for funds in future and is looking for means to support its own activities without having to depend on foreign donor agencies. The new political environment of Zambia, has also made it important for the ZSCD to review its relationship to the government.

4.5 The Zambian AIDS NGO Network Coordinating Committee.

This network was formally established after a conference for NGOs working with AIDS in 1990. On the same occasion the committee was appointed, and a "clearing house" or a secretariat was also appointed. Family Health Trust is currently the clearing house. A newsletter is produced regularly.

The committee is responsible for the annual AIDS conference held in connection with the World AIDS Day on December 1st. Members of the network meet monthly to exchange informations and ideas.

By the end of 1991 the committee published a Directory of NGO AIDS-related activities in Zambia, "intended to be a resource and networking tool". More than 40 organizations and projects are listed and briefly presented. Some of the organizations are only working with AIDS-related activities, others have AIDS activities integrated with other work.

4.6 Concluding remarks

More or less all the registered NGOs in Zambia belong to one or more of the above coordinating bodies. This does represent an important feature of the NGO scene in the country. At the same time it appears that there are different expectations to these bodies from the various members, particularly regarding the level of initiative and authority in coordination, and as to what kind of role they should have in fund raising.

Whereas therefore coordinating bodies are already in place, most of the organisations contacted during the field work noted that the capacity of these organisations should be strengthened (in one way or another).

The benefit of this kind of cooperation and coordination is obvious. The risk of "streamlining" the NGO effort too much, and the risk of increased vulnerability to the influence of donor agencies are however aspects which need careful consideration. Both the benefit and the risk is demonstrated through the SAP effort. Through cooperation the NGO`s have been able to make their voice heard. Because of the availability of funds, many NGOs may however also be attracted to steer their activities to conform with the SAP criteria for support.

The critical reflection which takes place within some of these NGO bodies such as ZCSD therefore appears to be of major importance at this stage of NGO development in Zambia, also in light of the changes that have taken place on the political scene.

The new leadership in the MOH has identified the need for a better donor coordination in the health sector, both in general and in relation to NGOs. There is a plan to establish a forum where GRZ, NGOs and the donor agencies can exchange ideas and together develop a "programme type of thinking". MOH will also soon develop a donor coordination document which will address the need and means of coordination in the health sector.

See also 7.4 on government`s role in coordination.

5. REVIEW OF SELECTED NGO'S

During a three week field period, selected organisations and projects were visited with the view to get an understanding of major issues related to sustainability. In some cases were visits could not be arranged, a questionnaire was completed by the organisation.

The projects/organisations were selected to give an overview of NGO activity in 3 provinces: Northern, Southern, and Lusaka Urban. Information was gathered from 15 national organisations, 15 local projects, and 2 umbrella organisations using a semi-structured interview schedule or completed questionnaires.

An attempt was made to include both church based and non-church NGOs. Projects for seven of the 15 organisations were included at the local level. The national organisation for 11 of the 15 projects was included in the sample.

The following summary of findings therefore first of all presents what we see as a fairly representative picture of NGO's related to health in the Northern and Southern provinces. It also seeks to give a national picture of NGO activity within the limitation of this material, by bringing in a broader range of organisations operating at national level. The major national level organisations involved in health related activities are included here.

5.1 Types of NGO's

5.1.1 Organisations and projects

Organisations vary in size and complexity ranging from Africare which is involved in constructing facilities to Family Life Movement of Zambia which provides pregnancy counselling and family life education in 4 government run clinics to the Roman Catholic Church which is responsible for 13 hospitals, 27 rural health centres (RHCs) and innumerable health posts.

Table 5.1 Organisations and projects

ORGANISATIONS	PROJECTS
United Church of Zambia	Masuka RHC
Church of the Prov. of Central Africa (Council of Churches, Zambia)	Makeni FP Clinic
Pilgrim Wesleyan	Zimba Mission Hospital
Salvation Army	Ibwe RHC
Roman Catholic Church (Catholic Secretariat)	Chikuni RHC Chilubula RHC Chivuna RHC Monze District Hospital Our Lady´s Hospital. (Chilonga)
PPAZ	PPAZ- Southern Region
Zambian Red Cross	Red Cross-Livingstone
	Mbaya Musuma CHC (Family in Christ Miss) Namvianga RHC (Church of Christ) Sikalonga RHC (Brethren in Christ Church) Northern Prov. Health Educ. Project on AIDS (Lions Club)
Reformed Church in Zambia Evangelical Church of Zambia Zambian Union of 7th Day Adventists Church Breast Feeding Association of Zambia Family Health Trust Family Life Movement of Zambia Kara Counselling & Training Trust Ltd. Africare	
CMAZ NGOCC Zambian Council for Social Development	

Aside from the umbrella organisations described in Chapter 4, the Review included 14 Protestant (4 national organisations together with one of their local projects, 3 other churches at national level, and 3 local church projects at local level), 6 Roman Catholic organisations (national level, 2 hospitals, 3 RHCs), and 10 non-church related projects (including 2 at both national and local level). One mission operated district designated hospital is included in the sample.

The projects in the sample included 3 hospitals, 8 rural health centres (7 RHCs + 1 CHC without RHC status), 1 family planning clinic, and 3 Zambian branches of international organisations involved in a range of AIDS and family planning activities.

Only the church-related run permanent health facilities e.g. RHCs and hospitals. The Zambian Red Cross- Livingstone run some mobile clinics as well as community based water & sanitation projects.

5.1.2 Institutional affiliation

Half of the 18 *organisations* (including umbrella organisations) are church related. Two of the organisations are international organisations; 8 are Zambian with international sister organisations (such as the Roman Catholic Church, Planned Parenthood Association of Zambia); and 8 are Zambian organisations with no direct international sister organisation relationship.

Table 5.2 Institutional affiliation

	Church related	**Non-church related**
Zambian	• Reformed Church in Zambia • United Church of Zambia • CMAZ	• Breast Feeding Association of Zambia • Family Health Trust • Kara Counselling & Training Trust Ltd. • NGOCC • Zambia Council for Social Development
Zambian with International sister organisations	• Roman Catholic Church • Church of the Prov. of Centr. Africa • Evangelical Church of Zambia • Pilgrim Wesleyan Church • Zambian Union of 7th Day Adventists	• Planned Parenthood Association of Zambia • Zambian Red Cross Society • Family Life Movement of Zambia
International	• Salvation Army, Zambia & Malawi territory	• Africare

Twelve of the *projects* included in our sample are church related; 3 are not (IPPF, Lions Club, and Red Cross). All the church-related organisations involved in health included in the sample, apart from the Family in Christ Mission which is a small independent Christian group, belong to the CMAZ umbrella. Other umbrella bodies where churches involved in health care participate include the Council of Churches in Zambia, Evangelical Fellowship of Zambia, the ZCSD, the Family Life Movement and the NGO AIDS CC.

The non-church organisations all belong to NGOCC, ZCSD, NGO Forum , and the NGO AIDS CC.

Table 5.3 Project affiliations

Church related projects	**Non-church related projects**
• Chikuni RHC (R. Catholic Sisterhood) • Chilubula RHC (R. Catholic Sisterhood) • Chivuna RHC (R. Catholic Sisterhood) • Our Lady´s Hospital, Chilonga (R. Catholic) • Monze District Hospital (R. Catholic Sisterhood) • Makeni Family Planning Clinic (Ecumenical) • Masuka RHC (United Church of Zambia) • Namvianga RHC (Church of Christ) • Sikalonga RHC (Brethren in Christ Church) • Zimba Mission Hospital (Pilgrim Wesleyan) • Ibwe RHC (Salvation Army) • Mbaya Musuma Community Health Centre (Family in Christ Mission)	• Northern Prov. Health Educ. Project on AIDS (Lions Club) • PPAZ- Southern Region (Planned Parenthood Assoc. of Zambia) • Red Cross. Livingstone (Red Cross)

When looking at the material, we have found it most useful to organise the organisations/ projects in 3 categories:

- Church related Protestant;
  (7 organisations, 1 hospital, 4 RHCs, 1 CHC, 1 FP Clinic)
- Church related Roman Catholic;
  (1 organisation, 2 hospitals, 3 RHCs)
- Non-church related
  (7 organisations, 3 various FP/AIDS projects)

CMAZ, NGO CC and ZCSD are organisations which cannot be grouped according to these categories, and is not included in the summary of findings below.

The reason for using two church categories is that the Roman Catholic church appears to have a more unified structure, with its own Catholic Secretariat in addition to the CMAZ, as compared to the Protestant group which here represent a much wider variety of small and large churches as well as independent groups.

5.2 Values, strategies and approaches

5.2.1 Objectives

As could be expected, the church related organisations/ projects related their work in the health sector to the overall purpose of the church's mission; to share the Gospel by word and service. There is no difference here between the Catholic and non-Catholic group.

The locally based church projects´general organisational and specific health objectives were also largely the same: to provide preventive & curative services, promote PHC, promote FP, and provide basic health service coverage. Two hospitals see training health care workers as a significant part of their work.

There is some indication in the sample that some organisations feel that there is tension or at least the potentional of conflict between their general objectives and specific health objectives. For some church based organisations, there may be competition for funds and

staff to be used for preaching the Gospel, building congregations and providing health services.

The non-church related organisations in our sample all have specific areas of concern within the health sector e.g. AIDS, family planning, and breast feeding promotion. Preventive activities are seen as an integral part of work in these areas. The Zambian Red Cross also does considerable community based water and sanitation work, and sees itself primarily as an emergency relief organisation which during times of peace, supplements public services. Africare is mainly involved in construction of health related infrastructure (health centres, water wells and latrines).

5.2.2 Target groups

The 15 projects were asked whether they targeted their work to specific groups. Women, mothers and children were named as the main target groups (children, 5; mothers, 4; women, 2; out of school youth, 1). This is reflected in the emphasis placed on MCH/FP activities for all the organisations and projects.

More generally rural people are named as the target group, which is reflected by the large number of rural health centres in the sample. The non-church organisations listed have activities in urban health centres nearly as often as in rural health centres which reflect their specific goals e.g. AIDS, breast feed promotion.

Seven of the church based national organisations and 5 of the non-church based organisations noted that working with local communities was an important aspect of their work or that they had close connections at the grassroots.

5.2.3 Strategies

Specific questions were asked about community participation and intersectoral collaboration in the local project interviews.

<u>Community Participation</u>

Twelve of the local projects said that community participation is a stated objective in their projects and 11 that it is also a current project strategy. Chilubula RHC wants to plan for community participation in the future.

4 out of 5 of the Catholic projects have community participation as both an objective and a strategy. For 2 this means that local people are included in planning procedures, in one project also in monitoring procedures. One of the projects have community participation in different labour operations. Three of the Catholic units involve the community through village health committees, but not through representation on project committees or boards. Chilonga Hospital only includes local people on an advisory committee in advising positions.

Among the 7 non-Catholic projects, 5 include local people in planning procedures, monitoring procedures, and labour. 4 projects involve the community through village health committees, and 3 have the community represented on project committees or boards. Zimba Hospital also involves the community in fund raising. Ibwe RHC, which is one of the units which does not have community participation as a stated objective or strategy, does however make use of voluntary local labour. Ibwe RHC involves the community in an advisory committee.

The non-church NGO projects said that community participation is both an objective and a strategy for their work in planning, monitoring procedures, and participating in different labour operations with no comments on how this is done. Only Red Cross Livingstone involves the community through village health committees and through representation on project boards. PPAZ wrote that they try to involve the community more, that they do not do enough today. Again, one senses that although community participation is a stated objective, little is done in practice to involve the community.

Based on the above, it may be concluded that although in their general and specific objectives, the groups aim to promote PHC, promote community based education health care and education, and mobilize the community, there are limited opportunities for local community residents to be involved in the management of health services. Participation is mostly at a level of *contribution* (contributing labour and advice), and only very limited *collaboration* in decisionmaking and implementation.

Training of Community Health Workers, and enabling local Village Health Committees where this takes place, represent activities with the potential for higher level of participation. These have however little influence on the services provided at a higher level (such as RHC).

It was not possible to identify real community based action in relation to the sample projects, if this be defined as initiated and implemented by the community itself.

Intersectoral collaboration

Thirteen of the 15 projects said that they collaborated with other sectors or departments. Schools (educational institutions), water & sanitation projects/boards, local churches, and development committees were among the most frequently listed groups.

Very little was said about the purpose of collaboration. The sense is that the health projects realised that to be effective they need to work with other sectors, especially education, for getting across information.

5.3 Activity profile

5.3.1 Location, size, volume and role

Location

Five of the 15 organisations answered the question about the geographical areas in which they mainly operate (one of which was the Catholic Church which answered "all over the country".) Eastern, Southern, Western, & Northern Provinces were named.

The Evangelical Church of Zambia was allocated the area by the government. Africare responds to requests for support. The Breastfeeding Assoc. of Zambia works in Lusaka because people tend to think and act modern by bottle feeding whereas in rural areas, breast feeding is traditional and bottle feeding costs money.

The Church of the Province of Central Africa said that the Anglican church started in the Eastern Prov. as a reason for being there. Makeni FP clinic (the local project) says that they are in Lusaka rural & urban and Kabwe rural because this is where the farmers/settlers come from and can go through an agricultural course with the idea that contraceptives are available in their local areas when they return.

The non-Catholic church based projects had a clear idea of the catchment area each served. But the reasons for establishing themselves where they were, were in most cases not necessarily (health) needs based.

The Roman Catholic local units gave considerable details of the catchment areas they covered, and pointed to a wide variety of reasons for why they were in the area including being requested by local people, started by the Bishop, and seeing a local need for services.

Among the non-church related projects, the NPHEP was started specifically in Northern Province to serve that province, initiated by an expatriate and a local medical doctor. In the case of PPAZ, it was noted that IPPF has had an influence on the question of location.

The following table (5.6) presents a list of the areas where the organisations and projects included in this study have activities.

Table 5.6 Project location

Province	Organisations	Projects
Central	1	
Copperbelt		
Eastern	5	
Luapula		
Lusaka	5	1
Northern		3
North-West	2	
Southern	4	11
Western	2	1
All over	4	2

Size

The size of the health service projects included in the sample based on beds registered in the 1990 MOH register are:

Table 5.7 Project size

	Roman Catholic		Protestant	
Hospitals	Monze Chilonga	225 170	Zimba	62
RHCs	Chikuni Chilubula Chivuna	75 58 20	Masuku Ibwe Mbaya Namvianga Sikalonga	23 4+1 deliv. 70 (no beds) 45

We have found it difficult to compare the organisations in size. The church based organisations gave their size in terms of members (which for the Catholic Church is 2,000,000) and congregations. The non- church organisations often did not describe themselves in terms of members. The 2 which are comparable to the churches are PPAZ (with more than 10,000 members) and the Zambia Red Cross (30,000 members).

Volume

All the projects were able to provide some statistics on the volume of their work in terms of out-patients, in-patients, acceptors, beds, deliveries, people exposed to IEC (Informative Education Communication) programme, or number of projects (with the exception of the Red Cross-Livingstone branch which runs mobile clinics and community based water & sanitation programmes).

Client contacts ranged from 668 out-patients at Ibwe RHC (Salvation Army) to 37,062 out-patients seen at Zimba Mission Hospital (Pilgrim Wesleyan). Generally utilization is high, and capacity stretched.

Even within the CMAZ member institutions, service statistics are not structured in a uniform way. This makes any effort to make comparisons between projects very difficult. What can be stated is that all units appear to be heavily utilized, both in terms of bed occupancy and in terms of outpatient attendance. Some of the projects have also made excellent contributions to UCI programme coverage.

In a situation where there are heavy resource constraints in public services, it is reasonable to believe that the high utilization of NGO facilities reflect use beyond the population within the defined (or not defined) catchment area for the RHC or hospital. The pressure on services is therefore built up because of nonfunctioning services in neighbouring areas.

Health Service Role

Eight of the 12 church based health services facilities list curative and preventive work as their main contributions, with an emphasis on the curative side. PHC is listed but there is a sense that it is the first line curative work that they are mainly referring to. The two Catholic hospitals do not emphasise their curative role, but note their role in training, PHC, and AIDS.

The main contributions of the other local projects relate to their specialist activities e.g. family planning, AIDS.

All the projects see their activities as corresponding with government policies and as with the organisations, some see themselves as extensions of the government. Chikuni RHC notes that there are no government health services in the areas covered. Masuku RHC notes that `sometimes we get programmes to carry out, like outbreaks. PPAZ notes that they divide services with the government: PPAZ motivates, government provides services. NPHEP sees their work as complementary to the government's.

3 of the 12 health services projects in the sample are located in areas where there also are government services. Chilubula RHC and Makeni FP clinic actually do state that there is a sense of competition with the government services. The third, Chivuna RHC, felt that they work hand-in-hand with the government.

Eight of the health service units and the Red Cross, Livingstone sees themselves as providing services which the government does not provide, emphasising particularly that they provide a more caring service.

Several of the national organisations noted that NGO's are providing services which might be sensitive for the government to provide. Examples noted were the introduction of fees for services, and relief work among famine hit people. Similarly it was noted by several that AIDS was a bit sensitive, including HIV statistics and HIV testing, and that they avoid

public statements which could cause embarrassment. There has apparently also been a conflict over the suppression of information about cholera.

5.3.2 Types and range of services

The organisations/projects were asked about the type of services and activities provided. Although not all forms are comparable, the following is an indication of the services provided by the sample projects/organisations:

8	Organisations provide	24 hospitals	3	Projects provide	3 hospitals
6	"	41 RHCs	10	" "	10 RHCs
No	"	UHCs	1	" "	2 UHCs

The information on clinics and health posts is incomplete as some of the hospitals or RHCs are responsible for these smaller units but have not listed them.

The church based projects/ organisations are often facility based i.e. are responsible for the running of hospitals, RHCs, and associated clinics and health posts. A wide range of services are offered at these facilities with a particular emphasis on curative, preventive, and MCH/FP. In addition, supplemental feeding programmes, community nutrition training programmes, CHW/TBA training programmes, and AIDS programmes are often available. Water/sanitation programmes, rehabilitation services/programmes, and community development initiatives are less frequently included in the range of activities.

The non-church based organisations/projects are not health unit based. These organisations/projects operate with a much smaller spectrum of activities, but often offer services which supplement existing services at government or church run facilities. AIDS programmes represent the prominent activity in this group, followed by MCH/FP.

There do not appear to be many differences in the pattern of services offered by all the church based health services providing organisations/projects. The one striking difference is that the Catholic Church makes less mention of broader community development efforts as part of their health services. A possible reason could be that these churches organise community development activities separately, rather than linked to health care. Another possibility is that they actually do less community development. One assumes that also the nature of family planning services differs between the Catholic and non-Catholic facilities.

As we have not collected information from the same number of government facilities, it is not possible to compare the range of activities provided by NGO RHC's and Govt. RHC's. Based on the information available, it does however appear as the church related health services do include the full range of services that the government pattern prescribes. At the same time it also appear as the church related services offer *little in addition* to the prescribed government pattern. It is more in the continuity of services, the volume and the quality, that NGO's represent something that is different.

AIDS activities, nutrition programmes and water and sanitation activities (where these exist), may be an exception from the above statement. Our impression is that such activities are found more in NGO projects than in government services. This may show that the NGO's do have greater flexibility, thereby representing an important potential for responding and adjusting to local needs as they may arise.

The national organisations and the local projects were asked to rate their performance in relation to the government. All in the sample consistently rated themselves as better or at least equal to the government in terms of being innovative, flexible, responsive to community needs, able to target services/activities to special groups, able to involve the

community in planning, needs assessment and monitoring of programmes. The only exceptions were Nambianga RHC which noted that they do not have a board or forum to meet community leaders, United Church which viewed their lack of transport as hampering their innovativeness, and the national office of Pilgrim Wesleyan Church which thought that the government is better able to target special groups because it has more resources to carry out research and compile data.

Three factors were given which in the NGOs´ assessments enabled them to perform better than the government. Their small size facilitated greater flexibility in decision making and better accountability. (Although in family planning, Chikuni RHC, a Catholic -run unit noted that missionaries may be less flexible.) Staff motivation was higher. The United Church noted that their medical personnel are very much more willing to work in the rural area where the government personnel are reluctant to work. (Although the headquarters had only Zambian staff, the local project visited did not answer that part of the questionnaire which asks about expatriate staff.) A closer working relationship with local communities is also given as a strength.

5.4 Working Relationships with the Government

5.4.1 Government grant

Six organisations (all church related) and 4 projects said they received a government grant which ranged from an estimated 10% to 100% of their health sector funding. In several of the health services projects, staff were not clear about the grant policy, and to what extent a grant was actually received (four of the organisations and 6 projects were not able to give an answer).

Generally, the government grant is only allocated to partners in regular health services provision. The non-church organisations and projects included in the sample did not receive government grants.

Seven church based organisations noted that their grants had changed, 5 of these noting an improvement. The United Church of Zambia (for which the government grant makes up 75% of their health service funding) said that their grant had been increased by 200% in 1991. The Reformed Church, whose government grant makes up 66% of their funding, said that "the demanded (was) given".

The Salvation Army and Zambian Union of the 7th Day Adventists Church noted that they do not always receive the grants ("due to inflation govt. did not manage to release money). Pilgrim Wesleyan noted that although there was an increase in 1991, it did not reflect what should be their true "Bed & Drug" allocation. Others noted that the increase did not keep up with inflation.

Four of the projects said that the funding had not changed (one implying that it was so little that it made no difference). Two said that the grant had increased, 3 that it had decreased, 2 that it had increased but not kept up with inflation, and 4 that the question was inappropriate or not answered.

5.4.2 Registration

All the organisations in the sample were registered NGO's in Zambia (Family in Christ Mission only locally as the Mbaya Musuma Community Health Centre). A number were registered more than one place. The MOH was the ministry most often mentioned as the

place for additional registration. Six projects listed a local place as their place of registration.

Registered	Organisations	Projects
Register of societies	12	1
Special Act	5	1
Additional reg. in any govt. ministry	9	6
Other	1	6

Eight of the organisations and 7 projects believe that the current Government arrangements for the registration of NGO & Mission are adequate. Two of the church affiliated organisations, 2 non-church related organisations, both umbrella organisations, and 2 church affiliated projects think that the arrangements of registration could be improved. None believe that the arrangements are unnecessary and 3 organisation and 6 projects either answered "Don´t know" or made other comments.

5.4.2 Influence of the organisation/project on the central government or local authority

The interview schedule asked a series of questions aimed at finding out what influence, if any, the organisation/ project had on health service policy and provision.

Nearly all the organisations & projects believe that they enjoy a good informal working relationship with the Government. Eight organisations (including NGO CC) and 9 projects are members of at least one committee relevant to the work of the organisation/project at the appropriate central or local level. Six organisations and 9 projects indicated that they are consulted on health policy issues (3 more answered "Sometimes" indicating a desire for greater consultation).

Ten of the organisations (including the 2 umbrella organisations) and 8 of the projects feel that they have some influence on Government policy-making. Four of the organisations and 5 of the projects feel that they do not. The interesting finding is that while most of those who do not feel they have any influence wish that they had, The Catholic Church would not "like to have the opportunity" but prefers to work through CMAZ; Africare does not want influence; and Mbaya Musuma Community Health Centre "would NOT like the opportunity."

5.4.3 Government influence on the organisation/projects

A similar set of questions were asked aimed at finding out how, if at all the Government influenced the organisations and projects. Nearly all the organisations and projects see the Government as influencing their health policy making. Notably the Catholic Church at the national level says that this is not the case, whereas the 5 Catholic projects all say that the Government influences through their national programmes, prescription policies, training regulations, fee arrangements, and the need to follow plans and policies.

The influence of the Government is felt in the need to work within the framework of health care as established by the Government - the projects articulate this in more detail than the organisations. The Zambian Union of 7th Day Adventists Church states that they "would like more freedom." Six of the sample said that the Government is a member of a planning or advisory committee, or on the Board.

Four in the sample noted that the Government influences their work by being a resource for funding (or the lack of it) and personnel.

5.4.4 Government view

The NGOs are nearly unanimous in their belief that the Government appreciates their activities. A few are saying that the Government is highly appreciative.

Some projects have doubt, as expressed by the following comments:

- "It is difficult to say. Govt. know we exist, but we rarely get visitors from Govt offices; and there is no direct support link. Even DMO hasn't been to the RHC for some time";
- "Appreciates (us) at the top level but local health officials are difficult";
- "Government appreciates but does not support".

5.4.5 Government takeover

Given that the organisations and projects see themselves as being better at providing health services than the government, it is not surprising that most say that they do NOT wish for the Government to take over their services.

The three organisations which said that they would like the Government to take over their services indicated at the same time that what they really wanted was greater support in specific areas where they have limited capacity:

- PPAZ would like the government to undertake the distribution of contraceptives as they lack vehicles and noted that plans for handover are underway.
- Africare would like the Government to take-over the maintenance of water wells and annual repairs of RHCs and equipment.
- The Church of the Province of Central Africa would like the Government to take-over one clinic. (No further comment).

Only one of the health projects, a Protestant church RHC, would like the Government to take over services as "the Church gives so little. But the service may be not so good."

5.4.6 Reporting, supervision and support services

Reporting

Five of the organisations do not report at all the Government. Ten of the organisations (including the two umbrella organisations) report annually while three report quarterly.

Reporting is through the CMAZ, the hospital, the MOH, or mother organisation. Reports include "statistics," annual reports, financial reports, projected plans (sometimes from the international organisation, organisation. (Answers here were very vague).

All the projects make written monthly returns, usually to the DMO. The content of reports range from activity levels, attendance figures & reasons for attendance, staff returns, to financial information.

Supervision

The projects were asked whether local health authorities supervise the project and its activities. Although it appears that there is a system of visits, it does not seem to be implemented consistently.

11 of the 12 church affiliated projects all said that they were supervised through visits by the DMO/PMO more or less regularly. About the frequency and nature of supervision the following comments were made:

- "last time the RHC was visited was in 1990 when there was a cholera epidemic".
- "only if MOH requires certain information".
- "transport problems limit the visits"
- "reports are discussed and read but we do not receive many visits".
- "we are supposed to be supervised but last year had only one visit and that was regarding staffing".

Support services

The projects were asked whether they share any support services such as supplies or training with governmental health services in the area. Only one of the projects said that they did not. Drugs, training, medical supplies, staff, and in one case - transport - were listed as shared support.

5.5 Relationship with external support agencies

5.5.1 Church related health services organisations and projects

Churches are all part of international church movements. The church based organisations vary in the degree to which the parent churches influence policy and planning. The Salvation Army and Zambian Union of 7th Day Adventists Church specifically noted that they follow policy established elsewhere. Both of these belong to international church organisations.

Approval of plans and budgets is usually required by the parent church; reporting is regular and can be extensive. A major area of influence/support for all the church based organisation is in the form of personnel who are usually expatriates.

10 of the 12 church based projects said that they do not relate directly with external support agencies apart from their own parent church/organisation. Those projects which note that they relate directly to funding agencies are: Makeni FP clinic and Chilubula RHC.

Makeni says that they receive major contributions to FP work from Pathfinder, which provides guidelines, approves plans and budgets, receives reports, exchanges information and assists in establishing other international networks in for example Community Based Distribution. Makeni has also a range of other activities funded through church networks and through government contributions. Chilubula notes that it and its international partners cooperate in all areas (without further comment).

5.5.2 Non-church organisations

Africare (90% budget from affiliated overseas organisation) , PPAZ (60-80% from IPPF) and FLMZ (80% of funding from IFFLP) are all heavily dependent on their international main partner financially.

Africare answered the questions relating to policy planning, approval of plans & budgets, reporting, funding raising personnel in terms of its head office in Washington DC, which maintains a close watch on Africare´s activities.

PPAZ follows the policies and procedures established by HQ but report to donors involved in specific activities.

FLMZ notes that international partner accept policy and plans for the organisation but do not ratify or reject; approve appropriate plans and budgets (presumably those which they fund), receive appropriate reports, and occasionally send in short-term advisors or consultants.

The Family Health Trust, which is funded 50% by NORAD and also a significant and increasing part by EEC note that their international partners have no influence on policy and planning and only approve plans and budgets for those activities they are involved in. Yet before formally applying to NORAD, they had discussed their proposal in detail.

The Breast Feeding Assoc. of Zambia (funded by UNICEF, IBFAN, and by membership subscriptions) and Kara Counselling (funded almost 100% by NORAD) reported no influence of the external agency on policy and planning (although Kara Counselling does have close informal contacts with the NORAD AIDS co-ordinator).

NPHEP (owned by Lions) notes that its international partners are WHO and NORAD which to a certain extent influence policy and planning procedures, give final approval of plans and budgets which have been worked out by the office team, receive regular reports, and have provided a co-ordinator who has been responsible for personnel recruitment.

5.5.3 Development of future relationships with international partners

Among those organisations and projects which commented, most would like to strengthen the co-operation/links with international partners over the next 5-10 years.

However, the reasons for wanting to strengthen links differed considerably. Pilgrim Wesleyan feels that to improve the quality of care they offer, they need greater financial support and that they have not fully investigated donor possibilities. At the same time Zimba Hospital, a project of Pilgrim Weslyan, stress nationalisation as a goal and that the international organisations would become brother organisations rather than fostering organisations.

The United Church of Zambia would like to strengthen links between medical work, agriculture and education, and feels a need for more consultation and visits, while Masuku RHC (their local project) would like a direct link with a donor because at present their contacts are through the Synod which does not give any feedback from external donors and which they feel is not sufficient in facilitating communication.

The Church of the Province of Central Africa would like to be more independent of international partners, but recognising this as unrealistic, sees them as remaining the same. However, they note that donors should be more careful as they are dealing with small projects.

The Evangelical Church of Zambia notes that co-operation should be changed with a shift from service and provision to training. Their Zambian doctors feel uncomfortable as foreign nurses have much better conditions.

The Zambia Red Cross feels the need for more support, given the difficult economic climate in the country.

The FLMZ feels networking would benefit if a regional office were established and the Salvation Army would like to see more regional conferences and exchange within the region. The Breast Feeding Association would like to establish international links. NPHEP would like to see more co-operation with WHO and NORAD and between them and needs more feedback.

Finally, the Zambian Council for Social Development notes that international partners are not really partners but are still in a patronage role which needs to be broken.

6. ORGANISATIONAL CAPACITY AND CAPABILITY

In order for NGOs to mobilize support and undertake and sustain activities and services, the organisation needs a certain capacity and capability, in terms of available personnel with the necessary skills, access to essential infomation and appropriate structures and workprocesses.

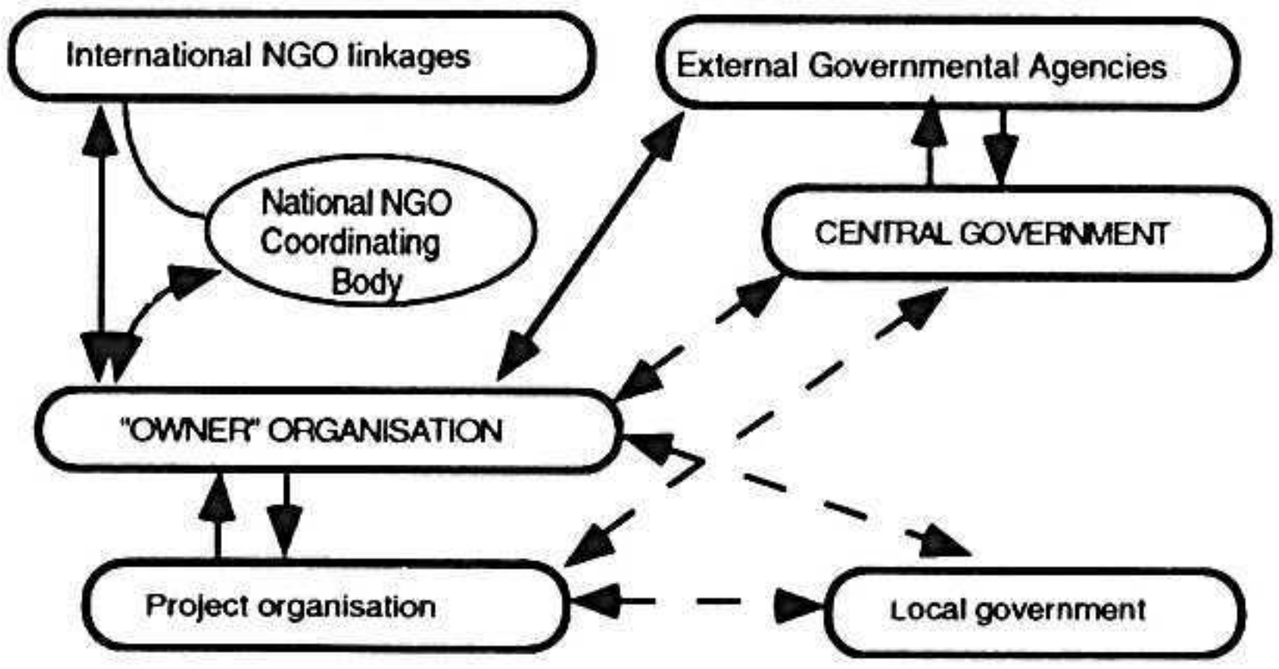
The organisation needs to be sufficiently predictable, so that it is given confidence by supporters as well as clients or target groups.

In the following we will try to outline some general features of the organisational systems and some main constraints in capacity and capability for NGOs in Zambia, based on those organisations we have visited.

6.1 Organisational systems

In relation to NGO projects we may talk about several levels of organisation. The "project organisation" is directly involved with action in relation to the target groups. This may or may not be separated from the formally established and registered NGO that is responsible for the project. The two parts together can be understood to constitute an organisational system, which will vary in complexity according to the nature of NGO and the type of activities they have defined for their work. When an external NGO is operating either through a local NGO or directly with a project, this becomes another part within the organisational system that adds to the complexity:

Fig. 6.1 Organisational systems and linkages



An aim for development assistance is that it should provide opportunities for people to organise themselves to achieve desired changes to improve their own life situation. An important part of this process is to learn how organisations can be built and utilised in this way. In order for that to happen, rights to ownership, responsibility for and management of personnel and finance and the professional leadership of activities should be firmly rooted in a local, viable organisational structure.

Some activities and services may have a temporary nature (relief, campaigns, support for transferring skills etc.) other may be withdrawn after a period of time because sufficient benefit will be self-sustained or the target group will at least not be harmed by negative effects. When it is a question of delivering essential services however, the organisational system needs to have the ability to sustain these services over time, or ensure a transfer of responsibility to another organisation which has the necessary capacity and capability.

External organisations will normally have only a temporary contribution to the total capacity and capability of these systems, and need to constantly monitor their role to ensure that they contribute to sustainability. The various types of organisations will need different types of capacity and capability, according to their organisational relationships, aims and activities and the context in which they work.

The organisational system of the Roman Catholic health services projects can be used to illustrate some of these challenges:

a) national level
The National Secretariate of the Zambia Episcopal Conference has various departments e.g. for Development and relief. However, it does not have a health department. The Bishop of Livingstone Diocese is elected as Director of Health Affairs with responsibility for the health work within the church. The implementation of church projects/institutions is the responsibility of the various Dioceses. In practice it seems as if each Diocese is running its programmes autonomously and do not perceive that the church has a common policy.

b) diocesan level
The Diocese has transferred the day to day management to socalled "Managing Agencies". The Managing Agencies are all Sister Congregations, either Zambian or with a base abroad.

c) project level
The Sisterhood managing agencies represent an important element in the project organisation. The organizational set-up within the projects vary. A Board of Management may or may not be constituted. Project staff consists of staff recruited and paid by the church and staff assigned and paid by the government. The project organisation will often have high degree of autonomy in terms of decisions regarding care level and work strategies, less in terms of personnel.

The external linkages of the church, and its collaboration with CMAZ is not shown in the above presentation.

The Roman Catholic church organisational system for health care delivery in Zambia needs to sustain essential services established at a high care level and with great volume. It is essential in this system that the project organisation (here the health facility level) be developed to be able to relate effectively to the rest of the involved organisational groups and to the government organisation, and take responsibility for resource management.

A very critical factor for capacity in this set up appears to be the Sisterhood "Managing Agencies". Many of these have been external sisterhoods. Now transfer is increasingly sought to indigenous sisterhoods, who however still in a sense remain "external" to the project they are assigned to manage. The sisterhoods need to make available professional and managerial skills to the projects. Their capacity for building up such skills therefore becomes a very essential element of sustainability. The situation can be illustrated by an example:

> One of the Zambian sisterhoods consists of 102 sisters in total. Many of these are retired. The sisterhood has 4 registered nurses and 7 enrolled nurses, 3 of these are midwifes. 4 sisters are currently training as nurses. For a long time it has been difficult to recruit new novices. There is therefore a limited potential to train more health professionals. The sisterhood is operating 3 RHCs and has now entered into a 240 bedded hospital with the perspectives of assuming the responsibility within short time.

If project operations will continue to depend on the sisterhoods as a managing agency, it appears important to address how they can be assisted to strengthen their capacity with the kind of personnel that have the skills and experiences required.

The non-Catholic groups are even more vulnerable, as they are dependent on recruiting individuals who will move into leadership in their institutions, without the backing of a broader "home base" like the sisterhoods have. At the moment, most personnel in leadership positions are expatriate. Government staff on secondment are "transient" and will therefore not be able to represent a stability in the organisation. It may be that for these institutions, the church as owner organisations need to take up a much stronger role in management, in order to provide the necessary organisational stability, and not be totally dependent on individuals.

> *Some of the non-church organisations visited had very unstable organisational structures, with person based leadership, little formalised accountability and little real participation by the target groups.*

Even some of the larger organisations seemed to be vulnerable and in need of consolidation of organisational structures.

6.2 Financial Management Systems

Access to and management of essential resources such as finance and personnel are major determinants of sustainability. How resources are mobilized and used, who contributes and on what conditions therefore represent important areas to explore.

- ***The resource network***

All the church related organizations are connected to an international network through CMAZ as well as their bilateral church relationships, and receive donations both through CMAZ and directly. Designated funds such as for PHC work and AIDS is made available to CMAZ from a number of sources and distributed to the different member agencies.

The larger the network of potential contributors, the easier it is likely to be for the institution to mobilise resources for its work. Some of the members have a network of their own to donor agencies, collaborating external NGOs and the international community in addition to the CMAZ.

Some organisations are very dependent on one major external partner, both for financial support and in some instances also for professional advice and management support.

Local NGOs appear to have very limited experience with and knowledge of the wider resource network, both in terms of its potential and its limitations. They are thereby vulnerable when it comes to approaches for generating support, as well as for manipulation by the external agency.

Adequate knowledge about such external support systems and how they operate is essential, both within the project or in a local "owner" organisation.

- ***Expatriates as channels for resource mobilization***

International organisations appear often to link project support to the presence of staff from their own organisations. Where there is an expatriate worker, it is also more commitment from the support organization to provide funds for "making things work".

Expatriates do generally have strong personal links to their home countries and the organisations or churches that have recruited them. These links provides additional opportunity for mobilising resources through personal appeal, opportunities which will not in the same way be available to Zambians who may replace them in the same positions.

In most cases the salary of the expatriate worker represents an in-built support to the operating budget. Additional funds towards mobility and some specific activities are also often provided to ensure that the worker have appropriate working tools and conditions. When such staff is replaced by nationals, the project or national organisation is usually expected to pay both the salary and the associated costs themselves.

The expatriates are also often occupying key positions with responsibility for mobilising resources and maintaining contact with donors. These factors do in many situations make resource mobilisation dependent on the expatriate, and can preempt the national staff from gaining experience and routine for taking over such roles.

- ***Administration of financial resources***

In the projects, adequate accounting systems for financial control are generally in place. There are a number of examples however, that inadequate accounting has led to shortfalls in some donor funded projects.

Much less emphasis has been put on setting up systems that can be used for management purposes, such as cost analysis and control and for resource allocation and forward planning. The way budgets and statements are made, it is also very hard to compare figures between institutions, even within the CMAZ network. There is for instance varying practise as to how donations in kind are accounted for, and also the contributed value of expatriate personnel.

Two hospitals, Chilonga and Monze (see case descriptions, section III), are currently working on economic management issues. Monze has ongoing research: "Study of economic Aspects of Adult Illness" which includes costing of hospital services, cost of

AIDS counselling and Home Based care, study of the hospital inpatients, and a community survey with the objective of gathering general data about use of health services and in what ways persons who use the hospital differ from the general population in the district. The hospital intends to use the results of the research for planning and management purposes. Chilonga hospital has had an ongoing analysis of high expenses items and have used the results to guide the use of items towards more cost-effective items.

Some organisations and projects maintain external accounts for hard currency, in case there is need for purchases abroad. In church related projects, these accounts are linked up to having expatriates, and therefore represent a practise which is not easily localised.

6.3. Planning Systems

Some of the major non-church organisations are utilising medium term planning systems with inputs from several levels, and with yearly reviews and adjustments. Zambia Red Cross has for instance a three year plan related to every activity area. At branch level these are reflected in project plans rather than sector activity plans. PPAZ develops three year plans at national level. IPPF has developed a format for planning which is used.

The Kasama Archdiocese has recently taken the initiative for a more comprehensive review of its own role in the whole Northern Province. The report outlines proposals for main strategic directions. The coming year will show how the church is able to apply the findings to their actual work.

Annual plans seem to be a routine procedure in most of the projects. The uncertainty of the level and timing of the government block grants have in the past upset budgeting and planning. In government hospitals the PHC vote tends to suffer, since its operation is less of an emergency than ambulance services and administration. Mission do however tend to create alternate funding and resources to enable continued functioning.

Members of CMAZ would in connection with annual budgeting routines also develop annual plans. Some of the members in CMAZ consider CMAZ Annual Council meeting as the main forum for planning. Until present CMAZ planning has mainly been linked to the financial support from the Government and the budget and financial report cycle. There has been a problem with availability of data for planning purposes. CMAZ is still in the process of analysing a 1990 survey.

The recent appointments of co-ordinators with different areas of responsibility (AIDS, PHC, Development and Planning) is now making it possible for CMAZ to become more of a resource for member institutions on planning.

> *Whereas most of the church related organisations have made general policy statement, very few of the health services projects appear to have invested efforts in making comprehensive long term plans for their work.*

Planning has mostly been related to project applications to external support agencies or partner organisations abroad.

- ***Coordinated planning MOH/NGO***

Where the NGO is running a Zonal Rural Health Centre, the in-charge of the institution is a member of the DHMT, giving both the District Authorities and the NGO opportunity to co-ordinate their initiatives and activities and to use resources in an appropriate manner.

Most of the NGOs health facilities are included in a MOH supervisory system, which also follows targets and outputs for various activities. MOH uses seminars at district level to inform and discuss recent policies and implementation routines (e.g. distribution system for drug-kit etc.)

Every institution and organisation reports its activities to MOH. This is done through the appropriate level usually the district with copies to other levels (PMO, HQ). There are complaints that there is little feed back and interaction on such reporting.

The plans for the future implies NGO participation in the District Health Councils where now district planning and prioritising is supposed to take place. This opens up a possibility for improvement in co-ordination.

- ***Community participation in planning***

According to general procedures in Zambia, Advisory Committees should be established at different levels and for a variety of activities. For the health services this means Village Advisory Committees, Hospital Advisory Committees etc.

Some of these committees are said to be functioning and meaningfully involved . However, the general pattern appears to be that the committees are more like public relations groups rather than actually part of a regular planning process and a system for accountability to the community.

However, there are good examples on how they have been active in more ad hoc problem solving, such as in times of sudden financial difficulties.

Membership organisations like PPAZ and Red Cross have established planning systems that involve members at the local level.

6.4 Personnel management

- **Staff availability**

Generally there is a shortage of some categories trained staff in the country, which obviously has a bearing on staff availability for NGO services.

Church related health care is very much depending on government secondment of professional staff. There is a list of approved posts for secondment for each registered institution, negotiated by CMAZ on behalf of the members. According to CMAZ, the establishments fall far below the standard pattern for government hospitals/RHCs. One important factor in this is that staff lists are based on the formally approved number of beds, whereas the actual number generally is much higher.

Actual secondment of professional staff depends on availability as well as on appropriate accommodation. Registered nurses are in very short supply, also nurse midwives in some regions.

Doctors are particularly hard to have assigned, as the government gives priority to their own institutions, knowing that NGOs have other alternatives, like missionaries or short term volunteers.

In mission hospitals one member of the management team is the Hospital Administrator. This is a post so far without a parallel in the government system, and therefore filled with staff recruited and paid by the church.

- ***Non Paid Volunteers***

Some organisations have a very small number of regular staff, but a large number of volunteers. These are usually professional people, nurses, teachers, social workers and army people. They collaborate closely with the health personnel at the health units and work within the institutions (counselling, family planning education etc.) In the work of the Family Health trust, also medical doctors and lawyers are involved on a voluntary basis.

- ***Expatriate staff***

In the church health programmes long term involvement of expatriates, like previously missionaries that stayed for 10-15 years or more, is not very common any longer. Expatriates still do play a key role in planning activities, and in development of projects and proposals for funding. Non-church organisations are less dependent on expatriate staff.

Missionaries continue to be central in nursing, both in terms of training, quality assurance and administration. Expatriate nurses seem however to play less significant roles in general management of health care projects and programmes.

Because of the limited availability of national staff, expatriate volunteers that come for periods of 2 years or so are currently very important for health services operations. This kind of personnel seem to be fairly easy to mobilise and recruit. Almost all of those who are currently working as volunteers are professionals such as pharmacists, administrators and doctors.

> *In essence it is currently the staff in leadership positions which also carry the identity of the organisation, because most other staff belong to the government system. As most leadership posts still are filled with expatriates, this has a lot of bearing on identity.*

- ***Management of staff***

All categories of government seconded staff are posted by the Permanent Secretary of the Ministry of Health (there is no information yet as to whether decentralisation will have any consequence for personnel posting and transfer). Staff are paid directly through the Ministry of Finance, including overtime and non practising allowance.

Transfer can be initiated by the institution as well as the government, without a set pattern of how long time they spend in each assignment. The institution has the right to supervise and discipline seconded staff, but few incentives or disincentives to apply in terms of promotion, recognition etc. The MOH is currently designing an incentive package which will also relate to the seconded personnel, including career incentives for those in rural areas and a specialisation programme with training blocks in universities while maintaining the job.

A main motivation for staff in church related hospitals is often job satisfaction and the work environment, with more adequate infrastructure, better functioning equipment and better supplies as compared to government.

CMAZ has attempted to achieve parity in salaries and conditions of service between government and mission institutions, whereas one of the health project which is not organised under CMAZ commented that their pay salaries which are much higher than government.

For other projects and organisations, there is considerable variation in pay for staff: some pay higher salaries and others pay lower salaries than government. The fact that projects with a high level of external donor support do not easily get funds for personnel costs makes it difficult to recruit and keep competent Zambian staff.

- ***Staff development***

Most of the health service delivery projects/organisations do not have a staff development plan nor in service training programmes. Most of them rely on the MOH e.g. at district level for seminars and courses. However, some of the projects do provide training for some of the personnel, for instance by arranging for counter-part training of a Zambian by an expatriate. Individual initiatives are often supported and even stimulated.

Organisations involved in AIDS and those which have many volunteers seem to be more concerned about providing regular training, both of volunteers and of their own staff.

6.5 Decisionmaking and leadership

In church-related health institutions, decision making appears very closely linked to three key leadership posts, usually staffed by expatriates: The matron, the administrator and the doctor. Very few of the institutions have been able to develop structures and processes for decision making which builds capacity among local staff.

Strong individual leadership, and informal decision making appears to play an important part in most of the non governmental organisations which have been contacted as part of this review.

In contrast to the governmental system which in practise has been rather centralised, church related health institutions has had more or less local autonomy. This, combined with the mismatch that often exist between the governmental and the church health system, does make co-ordinated management of health care in a district quite difficult.

> *Knowing the very difficult times the country has gone through over the last decade, and how this has affected everybody, including the NGOs, it must be stated that problem solving and the ability to "survive" in a rapidly changing context is a strength of the NGO community.*

7. CRITICAL FACTORS FOR SUSTAINABILITY

7.1 A framework for discussing sustainability

An operation can roughly be considered sustainable if there is a *match between activities and capacity to maintain them in a given context over a period of time.*

If therefore a project is undertaking activities of such a nature that they need to be maintained over time, it also will need a project organisation which is sufficiently stable to be predictable, and that is able to mobilise resources (money, information and personnel) and deal with problems and new challenges as they arise.

For health care this can be interpreted as follows:

> *A health service is sustainable when operated by an organisation with a long term ability to mobilise and allocate sufficient resources (manpower, technology, information and finance) for activities that meet individual or public health needs and demands.*

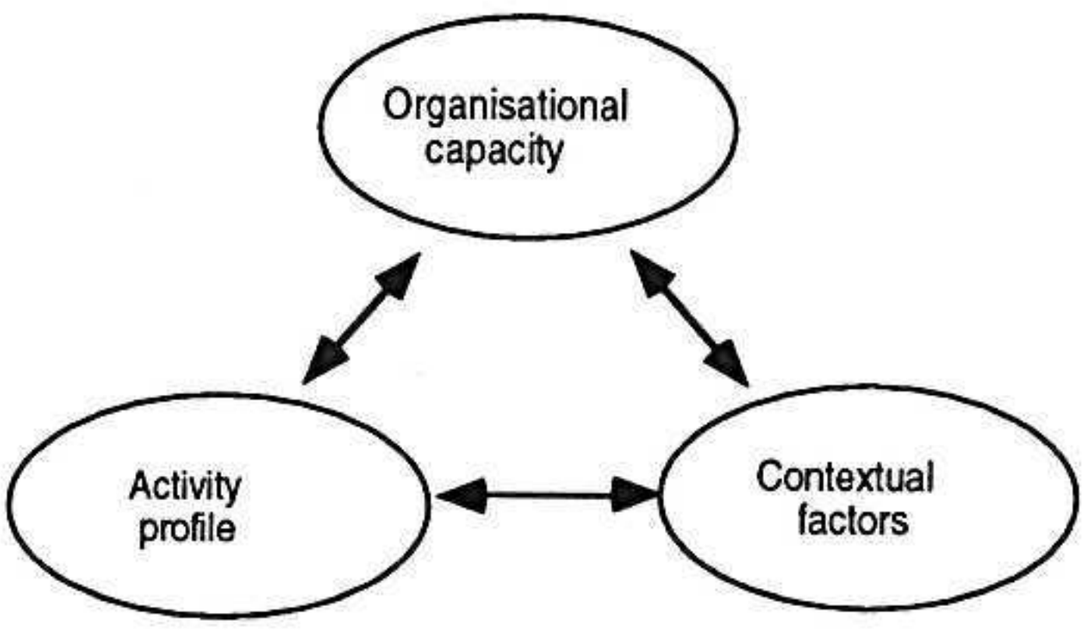
This definition does not in itself say anything about the type and level of care, as long as there is a need or demand and available resources. Long term could for instance mean "as long as there is a demand" or more ideologically "as long as there is a major public health need". All services are not necessarily desirable services, even if there is a demand and available resources. The concept of sustainability therefore has to be put into a value framework, which may be different for different types of organisations.

For national health systems the concept of sustainability, when used this way, will likely have to bring in the equity issue. Private not for profit health care tend to want to be need oriented rather than demand oriented, and to look for ways of meeting needs for special groups such as the poorest, the rural population, etc. This has major consequences for sustainability, because it limits the kind of resources that can be mobilised locally.

In the case of church based health care, additional limitations is related to the nature of the project organisation, as it is often seen mandatory with organisations and personnel that can identify with the Christian motivation for work in the health sector.

Conceptually, the question of sustainability can be grouped in three major "clusters" of factors:

Figure 7.1 Factors related to sustainability



These factors interact with each other in different ways. All the three groups of factors may change or can be manipulated, with consequence for the other two, if sustainability should be maintained.

> *It is primarily the organisations potential for producing certain desired activities which should be sustained. If important contextual factors change, the need and demand for the activities may change, or the basic conditions that the organisations has worked under may change. An important element of sustainability is therefore the capacity to cope with these kind of changes.*

For health care important factors to include could for example be:

I. Contextual factors

Govt. policy framework for health care, and for cooperation with NGOs;
Socio-economic conditions
Geographical factors
Health needs/demands
Availability of other services etc.

II. Factors related to activity/service profile

Range of services and level of care
Volume and differentiation of services
Utilisation of services
Technology
Work procedures and practices
Quality standards
etc.

III. Factors related to organisational capacity and ownership

Ability to mobilize essential resources (personnel, finances, other)
Ability to manage essential resources (planning, resource allocation, monitoring)
Organisational structure and relationships to environment
Legitimacy/predictability
Decisionmaking and leadership processes
Ability to solve problems and respond adequately to new needs

7.2 Contextual factors

The fact that the new government is committed to maintain a bed grant to CMAZ hospitals, and also to seek to continue to second personnel for church related private not for profit health services, represents important aspects of the current level of sustainability of these activities.

Major contextual factors which should be carefully monitored to assess the implications for future sustainability include:

- the general economic crisis in the country,
- introduction of multiparty democracy and the new policy of decentralised management of local development,

- the introduction of costsharing for health services and
- the openness for the "for profit" privatisation of services.
- the AIDS epidemic

We consider the likely influence of these factors on the sustainability of NGO health care projects and programmes to be:

- The need for the NGO to carry an increased share of cost for care (including recurrent expenditure), that is it needs to be mobilised from other sources than government. This put pressure on the NGO external funding partners to raise their level of contribution in a period of time when the strategy of most donors is to withdraw, and at least not fund running costs. It also means increased pressure on a barely introduced cost sharing system, and the risk of denying access to the main target group which is the poor.

- The increased demand for care due to HIV/AIDS, TB etc. and thereby increased load on a system already under strain, both in terms of quality, quantity and finance

- The socio-economic and demographic consequences of AIDS, including reduction of the work force and the strain on household economy

- The increased competition for scarce personnel which may be a consequence of privatisation, including the need for increased incentives to work for the NGO sector, which will again raise salary expenses and thereby cost of care.

- The need for increased attention to complementarity to governmental health systems at the district level, including the need to monitor consequences of stronger local influence on resource allocation in relation to equity and access to basic health care for all

7.3 Factors related to activity profile

The present volume of services provided by the NGO sector is generally very high, which means that NGOs represent an important part of the overall service delivery system.

Assessing activity profile in relation to national policies for health services delivery, it appears that NGOs tend to have gone above the level which is consistent with what the government sees itself able to provide, both in terms of volume and care level. Technology is also in many institutions well above what is aimed for in the government sector. This means that there is a very high overall financing load on the NGO sector.

We have not been able to look at questions of efficiency in the NGO sector. We do however expect that the efficiency in expatriate operated church facilities already is fairly high, and that therefore it may not be a whole lot to gain on improving economy by measures to increase efficiency.

The current direction by government policy is to make districts accountable for the provision of a "basic service package", available to all. It is hard to say whether this directive will have to compete with resources for maintaining higher level services which are already established, or whether they will be provided in addition.

For church related health care one would however expect that the projects and institutions will be under increased pressure to develop the primary health care component of their work more actively. This will again likely add to the overall financing burden, unless the responsibility for costs is carried by the government or long term donors.

In terms of future direction for improved sustainability, not many very promising options appear to be available. One could consider:

- To reduce volume and care level, and trim activities down to what is aimed for the governmental sector. This is likely to be a rather unpopular option, and can also mean withdrawal of service from people who have now come to depend on churches health care.

- To specialise in delivering services which are "marketable", that is become more oriented towards secondary care for those who can pay. In this case church health care will have to seriously consider this option in relation to their value framework and see whether they can live with the consequences.

The consequence of this situation must be that one should be extremely careful with expanding or raising the care level of the individual health units of the NGO sector, and rather look for ways of consolidation.

This does not mean that one should not rehabilitate the NGO health institutions, but that all NGO health activities need to be assessed in relation to the overall district capacity to provide health care, the balance in the system and the long term financing capability of the NGO.

NGOs and their funding partners should above all seek to avoid duplication of services, or situations where the public responsibility for health care is being undermined by the NGO activity.

Strategies which assist in co-ordinating resources at the district level to ensure both adequate public responsibility for basic health care and maximal use of NGOs as a resource in the district health system as a whole, should be actively pursued. NGOs can play important roles in model development for accessible and affordable basic health care, and in the development of equitable models for cost sharing in health systems.

7.4 Factors related to organisational capacity

We have not been able to identify any major contextual factors which hinder NGOs as such to operate.

Both general policies and health sector policies are seen conducive to NGO participation. With the emerging multiparty democracy, the potential for NGOs to have a role in democratisation and nation building may even grow stronger.

The problems are rather in terms of matching capacity with the level of activity that is established. Most of the organisations with a few exceptions appear overstretched and very vulnerable. The focus for NGO development in Zambia has been more on the production of services and activities that on the need for ensuring sufficient long term capacity in the organisation to sustain services.

The organisations are vulnerable in most of the main functions previously listed under 7.1 (III, Organisational capacity and ownership). It is not just a question of access to funds

and other resources, but very much also a question of resource management, work processes and relationships to main actors like the government and the local community.

In most of the institutions, leadership continues to be linked to expatriate staff. Most organisations have coped with the current activity load through developing increased dependency on external support agencies, not just in terms of finance but also in terms of competence, legitimacy and "appended" management systems. With a strong donor influence, management functions which serve to meet the funding needs have been given priority by all the involved parties (owner, management and donor).

The relationship between the church-related health institutions and the government also raise special challenges in terms of sustainable organisational capacity. With the government controlling more than 50% of personnel and finances, and a large proportion of staff with their primary loyalty to government, management at the institutional level becomes a rather tricky matter.

The way the institutions often have operated in a more or less autonomous way in relation to the church structures, they have been extremely dependent on strong imported leadership which provide the link of confidence with the church. Strengthening organisational capacity in this situation may have to mean decreasing autonomy of the projects and strengthening the church organisations in their responsibility for management and accountability to community and government and the church constituency. This will probably also have to mean that the churches will have an even stronger need for CMAZ as an advisory body in such matters.

The need for building managerial capacity is a common factor for most of the organisations that have been included in this review. This should be seen as a main challenge for funding partners, and should lead to a re-examination of funding processes and priorities.

The reluctance to fund recurrent expenditure should not lead to a situation where activities continuously expand and the organisations get more and more overstretched. This is the time to see institutional capacity building as a development project in itself.

Also for NGOs in Zambia, and particularly in health services delivery, mobilisation of funds and personnel are obviously critical issues. In the current context, it is not likely that NGOs will be able to maintain the current level of involvement without continued and long term external support. A main issue in this situation is how dependable collaborative relationships can become, and to what extent a climate for partnership can be developed where it is possible to honestly face very difficult adjustments and work out strategies to ensure that critical service functions are being maintained.

Long term predictable funding relationships with a few partners are more likely to achieve this climate, than ad hoc short term project funding from many.

8. CONCLUSIONS, NGOS POTENTIAL FOR AN EXPANDED ROLE IN HEALTH

8.1 The situation

The current situation for provision of health care in Zambia gives reason for strong concern. NGOs carry the responsibility for a substantial part of the services actually provided, and are generally able to provide better quality care than the government. NGOs operate as a "parastatal" with government funding for 50-75% of service delivery cost. As an effort to counteract the consequences of the structural adjustment programme, special programmes for rehabilitating and supporting essential services have been initiated, which also include NGOs. In the light of the severity of the problem for the government sector, questions are being raised as to whether NGOs can carry a larger load.

In developing appropriate responses to the AIDS epidemic, new NGOs have been created and many of the already established NGOs have taken a very active part. Approaches have been innovative, and efforts have been made to co-ordinate resources for more effective action. Efforts to better cope with the AIDS epidemic is increasingly being built into regular social services and development planning. The increasing care load on the health system and communities is being very strongly felt in many areas.

In family planning NGOs have also been at the forefront, both in terms of awareness creation but also for service delivery and counselling. Acceptance of a National Population Policy has the last few years led to increasing commitment to family planning service delivery in the regular health system. The continued need for personal interaction and counselling, and the need to facilitate that a growing demand is matched with services, calls for continued attention by NGOs.

8.2 What kind of expanded role?

- **To increase coverage ?**

Government plans count on NGOs to assist in increasing coverage, that is start new activities in areas where services do not yet exist. This may be an important function, given a situation where NGOs can raise capital funds and find personnel, and where there is provision for running costs.

In the current situation, additional capacity in terms of personnel and finances for running costs does however not appear to be the strength of the church-related NGOs which are already involved. Rather, their capacity seems already overstretched. They largely depend on government for secondment of trained personnel, and barely manage to cope with the current financing load related to their present involvement. In spite of considerable support from the GRZ towards operating expenditure, there continues to be heavy dependency on external resources in terms of finances, personnel, decision making and leadership.

We have not seen any signs that the load currently being carried by NGOs can be transferred to government or independent community organisations, or otherwise phased out without harmful effects. One could seek to consolidate the work, may be reduce the institution based emphasis and create new balances of priorities in the areas currently served. This would however not necessarily release capacity for new areas, in terms of personnel and leadership, nor would it meet the financing needs required for new base facilities.

It is therefore hard to see how the NGOs that now have experience in health care delivery can pick up the challenge and go to new, uncovered areas, unless they are able to drop some of their current commitments.

The conclusion is therefore that the currently involved NGOs do not appear to have a strong potential for contributing to increased coverage in underserved areas.

- **To increase volume and care level?**

NGOs in health services delivery have already established a volume and level for services which goes beyond and is somewhat out of balance with the intended governmental district health services system.

An expanded role of the NGOs in terms of increasing volume and care level where they presently work and as partners with government in health care provision, would mean increasing the imbalances in the system.

With a possible trend towards increased privatisation of health care, some of the hospitals might in the future decide to develop into private institutions totally based on paying patients, without a bond to the district health priorities of the government. That could also mean developing some specialities to become third line referral services. At this stage it however appears too early to discuss such an option further.

Rehabilitation of infrastructure to consolidate current work and sustain basic quality continues to be a need also for NGO facilities. Such rehabilitation should however be done in a way where size and care level is made more appropriate to the system, that generally means consolidation of appropriate care level and avoiding increase in bed numbers. For consolidation of the work, staff houses are needed in many of the places.

The currently involved NGOs do have the potential for increasing volume and care level in their present areas of operation, but this should not be pursued as this would cause increasing imbalances in the system. Rather their facilities should be rehabilitated in a way where they meet appropriate government standards, including staff housing.

- **To get more involved in the delivery of a "basic care package"?**

The new policies gives emphasis to the delivery of a "basic care package" which contains preventive and curative services made accessible for all. It also stresses a primary health care ideology that will mobilise for community involvement and support.

NGOs have not so far demonstrated any special competence and creativity in this form of health care development in Zambia, although they are committed to the process and involved in the same way as government and to the extent funding makes it possible.

Given a situation where District Health Councils are able to follow the intention of the new national health policy, and where NGOs are invited and willing to be real partners at district level, this is an area where NGOs definitely could have an expanded role. Such expanded involvement in primary health care would however require funding by the

District (and the Districts funding partners) and that the District also has the final responsibility for maintaining such services also in the future, by the help of the churches as far as they are able and willing to go.

The currently involved NGOs do have a potential as partners to government at the district level for ensuring the delivery of a "basic care package", not through an autonomous operation but as real partners to the District Health Councils.

- **District health planning and management**

It is still somewhat unclear what role will be given to District Health Councils in co-ordinating NGO activities. It is stated that they are invited to become members of the Councils. Funds for health will in the future go through the Councils, but as for the church-related institutions this will probably not apply to the regular bed grants etc. It is also not clear what kind of authority will be given to the districts for personnel management.

Planning and management capacity is stated to be weak in the governmental system at large, and also in the local government. NGOs themselves do also seem to be generally weak in this area. One therefore is facing a formidable challenge, to make this new system work. Monze Hospital (Roman Catholic) is currently part of piloting the decentralisation effort, and their experience should be followed closely.

CMAZ is as a co-ordinating body developing its professional strength in planning and primary health care development, and could be made a resource for district management support in partnership with member institutions. How this should be worked out need to be planned carefully together with MOH. Such an initiative is likely to need substantial funding.

In conclusion we would argue that using NGOs as partners with MOH in capacity building at district level represent a possibility for an expanded role of NGOs that should be actively explored.

- **What role in family planning?**

NGOs have had an important role in family planning so far, which should be continued and could be expanded. As the main organisation has needed a time to consolidate, the rate of expansion would have to be carefully matched with capacity.

NGOs in Family Planning should be actively encouraged and supported for an expanded role through institutional capacity building and long term support.

- **AIDS**

In AIDS the NGOs have shown that they have great contributions to make, and that they are able to collaborate very constructively also with the government.

It is important not to overstretch their capacity, and ensure support for appropriate organisational capacity building as well as taking care to work within a realistic framework for what resources will be available to cope with this severe problem in the years to come.

NGOs should continue to be supported in their AIDS related activities in such a way that creativity and the ability for situation oriented responses is maintained.

8.3 The governments role

The relationship between the GRZ and the NGOs generally appear to have been characterised by formalised communication through co-ordinating mechanisms, an in practise often "non-interference" type coexistence. In health service delivery government and NGOs have taken a more active line of collaboration, as government has coopted the NGOs as partners.

From the MOH point of view it has been a problem that most of the NGOs are "donor driven", with strong external influence in decision making. It is recognised that NGOs have important lessons to share, but the scale of operation is often too limited for general application of such experiences. One therefore need to look at what is the optimal arena for NGO activities in terms of the relevance of their piloting efforts.

In spite of the efforts to make NGO activities function as an integral part of overall health services in the country, the MOH has found it hard to monitor these activities. Evaluations have been undertaken by the NGOs themselves, but are not regularly made available to the MOH.

It is reason to question whether the GRZ has the capacity to co-ordinate and monitor the large NGO sector and ensure that policies are followed and that activities sustainable. With the increased autonomy at the district level, and the move towards more privatisation, monitoring and co-ordination may become even more complex. It will be increasingly important to find ways where the various agents do not compete in a destructive manner.

For the appropriate function of a large NGO sector as partners in health development, the government needs to fill the role of being the co-ordinator. The support to NGOs therefore need to be matched with sufficient capacity in the government system itself, both centrally and at the district level.

8.4 Donors role

The MOH sees the need of a better donor co-ordination both in general and towards NGOs. It is planning to establish a forum where GRZ, NGOs and the donor agencies can exchange ideas and develop a "programme type of thinking". MOH will soon develop a donor co-ordination document which will address the need and means of co-ordination.

A main problem is rigidity in aid policies of donor organisations, that all donors tend to follow the same trends, and that they look for organisations which can efficiently use their money rather than risk long term partnership for developing good organisations.

> *In the current situation in Zambia, we are not able to advice on any ways to expanding NGOs role in health, which will avoid the need for long term external funding. It is in this context that donors should review the time perspective for support to NGOs, and develop criterias and approaches which in a better way will give attention to sustainable functions and sustainable organisations.*

SECTION II

NORAD SUPPORT TO NGOs IN THE HEALTH SECTOR

9. OVERVIEW OF NORAD SUPPORT TO NGOS IN THE HEALTH SECTOR

In this chapter, as in the rest of this report, NORAD support to Norwegian organisations working in Zambia is not included.

Support to local NGOs is given through three different votes; the NGO vote, the AIDS vote and the Women in Development (WID) vote. The part of the review that looked specifically at current NORAD support to local NGOs, focused on available current information on the NGO vote. Among the current files on the NGO vote available in NORAD Lusaka, were also some of the projects related to AIDS. This caused some confusion in data collection and means that the figures below need to be interpreted with this limitation in mind.

9.1 A profile of NORAD allocations to NGOs in health related work (NGO vote)

The Annual Report of NORAD 1991 shows that the NGO Vote in 1991 had a total allocation of NOK 10 120 193.- . Altogether 1009 applications were received, which were distributed as follows:

Table 9.1, NGO vote 1991

	Number of applications	% of total applications
Education	450	44.6
Health	84	8.3
Community Development	337	33.4
Other	138	13.7
Total	1009	

The same report also gives the figures for actual number of projects and allocations in 1990 and 1991.

Table 9.2, Sector allocations, NGO vote

	Number of projects approved		% of total applications approved		% of resource allocations, NGO vote	
	1991	**1990**	**1991**	**1990**	**1991**	**1990**
Education	46	165	44.7%	57%	23.4%	47.4%
Health	14	46	13.6%	16%	34%	31.1%
Community Development	31	50	30.1%	18%	19.8%	13.2%
Other	12	25	11.6%	9%	22.8%	8.3%
Total	103	286				

This information shows that the applications from the health sector are few compared to other kinds of projects, that the "approval rate" is higher than for other sectors (approximately 16% of applications approved as compared to around 10% generally for other sectors) and that the money allocated pr health project is higher. This may indicate a situation where there are exceptionally good health projects, or where the representation actively seek out health projects in order to fill a certain "quota".

In order to get an overview of current health related projects funded through the Lusaka office, the team looked through the available files. It was decided for practical purposes that only the `active files´ would be reviewed, as it was not possible to get access to all files for a given time period. The active files were said to include those organisations and projects which currently receive funding, or where final reports/statements have not yet been received. Thus, an organisation receiving funding from 1988 up to 1990 and not since, would not be included, provided statements were received. The information in the active files do not tally completely with that given by the organisations/projects visited by the team, who filled in a special questionnaire. This could only to some extent be explained by the separation between the AIDS vote, the WID vote and the NGO vote. Even though therefore the picture based on a review of files can only be very partial, it gives some indication of the profile of the NORAD NGO involvement related to the health sector.

All the allocations through the years the projects have been active are included in table 9.3 below, and grouped according to region. No clear geographical areas of concentration are evident from this distribution, although the provinces where NORAD has a strong bilateral presence all belong in the group of provinces with allocations above 1 million NOK for NGO health activities. Among all provinces, Western Province is clearly the one with highest allocations of this kind.

Table 9.3 Regional distribution,
"Active Health-Related Projects" in the Health Sector

Region	Amount in NOK	Total number of activities
Lusaka	1,450,817	20
Luapula	184,064	8
Eastern	523,400	7
Western	2,399,500	14
Northwestern	461,100	2
Northern	1,036,640	15
Central	571,900	7
Southern	1,270,040	16
Copperbelt	1,937,671	14
National	1,887.020	15

These allocations were given to a range of different organisations, as shown in table 9.4. It can be noted that also government projects have been supported through the NGO vote, routed through groups defined as NGOs, including "self-help" groups.

Table 9.4 Project organisations

Project organisations	Amount in NOK	Total number of activities
Church related organisations	2,603,611	29
Government: Rotary	531,617	4
Self-help	951,200	14
Other	435,864	6
Family Planning: FLMZ	186,520	10
PPAZ	1,700,500	5
AIDS:Rotary	659,200	3
Kara Counselling	147,000	1
Kitwe Nutrition	365,900	5
Lions Club	423,540	10
Maloza Theatre Group	402,000	10
Others	257,100	4
Cheshire Homes (Rehabilitation)	2,576,100	13

Using the same available information for allocations in the period, the types of projects funded is shown in table 9.5. The table demonstrates that there may be a preference for funding RHCs as compared to hospitals (however obviously depending on the applications received), and that rehabilitation activities represent a very important share of the total allocations considered to be health related. (The fact that support to AIDS appear here, reflects that some of the NGO vote has also been allocated for AIDS).

Table 9.5 Project type

	Amount in NOK	Total number of activities
Hospital	1,484,357	20
RHC	2,441,835	30
Clinics	660,300	7
AIDS	1,997,640	29
Family Planning	1,887,020	15
Nutrition	35,000	1
Rehabilitation	2,576,100	13
Dental	178,800	1

In spite of an overall impression both among applicants and donor representatives that NORAD is not very keen to fund recurring costs, such project costs still represent a large proportion of the overall actual allocations (31%), as is demonstrated by table 9.6, relating funding to types of activities or inputs. It could be that the AIDS projects included contribute a fairly high proportion of this total allocation for recurrent costs under the NGO vote (see also comment above). *NORAD Lusaka has generally been much more open for funding recurrent costs when it comes to AIDS projects as compared with general NGO projects.*

Table 9.6 Activity type

	Amount in NOK	Total number of activities
Building: New	3,927,300	29
Building: Renovated	1,398,200	9
Building: Buy	147,000	1
Equipment: New	1,395,997	22
Equipment: Renovation	78,571	3
Vehicle: New	232,900	9
Vehicle: Used/Renovated	597,100	2
Running costs: *ad hoc*	1,111,384	30
Running costs: regular	2,360,900	10

9.2 NORAD support to AIDS programmes

To Zambia, NORAD funds for AIDS have gone through WHO and through local NGOs, very little has been channelled through Norwegian NGOs. For 1991 the support to local NGOs amounted NOK 5.5 million. In addition, a research cooperation between the Tropical Disease Research Centre, Ndola and the Institute of Public Health, Oslo is funded. In 1991 two Norwegian volunteer were also working with AIDS, and some of the funds channelled through the NGO vote is also spent on AIDS related activities.

There are four main NGOs/umbrellas receiving most of the NORAD AIDS vote. More than 4.5 mill NOK are going to CMAZ (as a channel for member institutions), Family Health Trust (including Anti-AIDS project, teacher's education on AIDS, home care), Copperbelt Health Education Project and Kara Counselling.

While the NGO support vote has been somewhat restrictive in supporting running expenses and given priority to capital costs, the opposite sometimes seem to have been the case with the AIDS vote. It will therefore be a challenge for NORAD and those receiving support to reconcile funding policies, as the AIDS support according to the new NORAD NGO Country Plan will be integrated into the NGO vote in the future. The AIDS vote shall be "reserved" for new innovative initiatives.

9.3 The interaction between the projects and the donor

Altogether 13 organisations which had received NORAD funds, were visited during the review process to collect information on the process of interaction with NORAD as a donor through the use of a separate questionnaire. There is an obvious need to approach the answers to this part of the questionnaire with caution, as it is unlikely that the groups receiving NORAD funds would answer in anything but positive way.

The questionnaires were completed by 13 organisations including:

- 6 non-church related *organisations:*
  Africare, Family Health Trust, FLMZ, Kara Counselling, PPAZ, and Zambian Red Cross
- 2 umbrella *organisations:*
  CMAZ and NGOCC
- 1 non-Catholic church *project:*
  Family in Christ Mission
- 3 Roman Catholic *projects*:
  Chilubula RHC upgrading, Chikuni HC, Monze District Hospital
- 1 non-church based *project:*
  NPHEP

The organisations which received the largest amount of funds were CMAZ (NOK 7550,000), Chilubula RHC upgrading (4,511,160), and Monze DH (NOK 2,848,000).

9.3.1 What does NORAD fund?

Eight of the organisations/projects said that they were aware of the principles that guide NORAD in their assessment of application for funds, naming:

- not funding running costs,
- interest in funding capital costs at the local level
- the potential for project sustainability.

Africare is aware of NORAD´s interest in self-help contributions from the community and in projects which help women and children. The FLMZ believes that NORAD will not finance capital costs `like a building.´ Family Health Trust and NPHEP believe that NORAD will not fund running costs.

Two of the five organisations/projects which said that they were not aware of the principles underlying NORAD´s funding, were still able to point out that they thought NORAD had an interest in FP, in rural areas and income generating projects. NORAD was also thought to be innovative in its thinking about AIDS projects.

Some projects seemed to find NORAD´s criteria unclear. One thought that principles for funding changed with the responsible person in Lusaka, while another thought NORAD had special rapport with a few organisations.

Eight of the organisations/projects said that at no time had there been activities which they would have liked to apply for NORAD for support but decided not to. Two mentioned that they did not apply to NORAD for either running costs or staff housing. Kara Counselling said that other funding possibilities arose.

Six of the organisations/projects had applied to NORAD earlier and been refused funding listing a handmill development project which was too research oriented and did not have sufficient direct benefits, refusal to top up a workshop sponsorship, investment in a building in Lusaka, staff housing, a vehicle, and an ambulance project which was `forgotten´ by the project officer.

9.3.2 Advice on how to apply for NORAD funds

The organisations/projects were asked whether they received any advice or guidance when applying for funds with regard to strategies and activities, formulation of the application, or components of a programme for which one could apply. Not many of the groups appear to have received advice. One limitation of the data is that the question does not indicate the source of the advice e.g. NORAD itself or other informal contacts outside NORAD.

NGO CC received advice in all aspects of the application procedure as did CMAZ and PPAZ. NGO CC is given as the source of advice for FLMZ. Kara Counselling and Family Health Trust had informal discussions with NORAD.

9.3.3 Why NORAD?

The 13 organisations/projects were asked why they had applied to NORAD. It appears that it was NORAD that approached three of the health projects and asked if they needed support.

Most of the others seemed to believe that their activities fit in with some of NORAD´s priorities, especially those related to AIDS, regarding which Kara Counselling says NORAD is considered flexible and innovative. Family Health Trust, FLMZ, PPAZ, Zambia Red Cross and Family in Christ Mission had heard informally that an approach to NORAD might prove fruitful.

9.3.4 How does NORAD follow the progress of implementation?

All the groups said that they report to NORAD. But the frequency of reporting varies. Zambia Red Cross said that NORAD does not monitor - that the organisation sends reports and guidelines for the vehicle and gets no feedback. NORAD also visits but again with varying frequency. There is a sense that the organisations would appreciate more feedback.

9.3.5 Effectiveness of NORAD funding

The 13 groups were asked what would have happened if their funding from NORAD had not been approved. Three said that they would have approached other donors; 5 that they activity would not have been started, completed, continued; and 3 that they would have been delayed.

The groups were further asked what benefits they thought the funding had to the project/programme and to the target groups. Four groups were not able to say how the funding benefited the project/programme. Two gave very general answers e.g. `meet aims & objectives,´ `More effective.´ Six gave specific answers all related to the request for the funding. Kara Counselling which received NOK 1.8 mil over three years for general running expenses said that they would like to look into the cost effectiveness.

Regarding target groups, 7 groups did not answer the question and when answered, the definition of target groups were general such as "Beneficiaries are the communities which receive FLMZ services"

9.3.6 Importance of NORAD funding for strategies, innovative initiatives, range of activities, & strengthening PHC

In terms of fostering innovative initiatives, NORAD funding were not seen to assist in innovative initiatives for 4 of the groups. Five other named initiatives of a rather general nature e.g. `brought in new staff,´ `presence of a MD-manager who brought in new ideas,´ `building of seminar & counselling rooms in some of our institutions, ´ `been able to establish an ongoing programme for research & establish a permanent structure.´

Some groups named specific innovations which had been enabled by the NORAD funding, e.g. allowed a project to do something USAID disagreed with, helped provide caravan-mobile AIDS education and develop methods of communication.

Similarly, in terms of whether NORAD funding strengthened PHC, 6 groups did not answer, 1 organisation was clear that the funding did not enhance PHC, and the remaining organisations´ answers were in terms of naming specific activities such as: poster information, condom distribution, strengthened FP efforts which are part of PHC, further co-operation with hospitals, providing room which could be used by the PHC team and health education, and integrating AIDS care & prevention in PHC.

9.3.7 Other donors

For none of the 13 organisations/projects is NORAD the sole funder. A wide range of international organisations and bilateral donors have also funded activities for these 13 groups. In some cases e.g. Africare, and Chikuni Health Centre the NORAD funding complements other project activities or funds components of a larger activity, and in other cases such as PPAZ, FLMZ, and CMAZ, it provided for activities which otherwise would not be funded.

This matches well the information from the active files on NORAD funding (see previous paragraph, 9.1) where 24 of the 116 activities funded were only part of the cost of the funding. Particularly in building, 11 allocations for a total of NOK 2,013,700 for new buildings and 5 allocations for NOK 1,170,200 for renovating buildings were part of larger projects. Fourteen of the allocations to RHCs were components of larger activities.

Given the wide variety of donors involved, one could expect conflicting donor agency policies and priorities to arise. This did not seem to be the case. Where donors have specific areas on

interest, the organisations & projects apply to them for specific activities. But not all donors have specific guidelines.

Africare said that except for USAID and UNDP which have clear policy directions, the donor agencies have very little influence. The reluctance to fund running costs is seen to have a limiting effect on adequate & appropriate staff recruitment.

The emphasis on funding capital investments in the Chilubula RHC upgrading has limited their funding applications to such projects which do not increase running costs. Chikuni HC and Zambia Red Cross say that they make local assessments and then look for a donor with interests to match. NORAD is not seen as an agency which has detailed requirements for funding although NPHEP believes that NORAD prioritises AIDS activities.

10. ISSUES ARISING FROM FIELD VISITS TO CURRENT PROJECTS

A total of 11 projects which receive or have applied for NORAD support were visited during the field work, for brief case studies. Details from the case-studies are presented in section III of this report.

The case studies bring out a number of issues and observations in relation to NORAD funding policies and approaches to NGO support in Zambia, which are summarized and discussed below.

10.1 Some main features

- **Health services: NORAD on the shopping market**

As discussed in the previous section, the functional relationship between government and NGO institutions in health care delivery in Zambia appears to be a very critical issue, particularly in terms of district level health development. This situation makes it necessary to look at the consequences of supporting the NGO sector for the district health system as a whole.

In Zambia, NORAD has chosen not to support the health sector through their regular, bilateral country programme. Health is however seen as a priority area for support through the NGO vote. In the new NGO Country Plan the aim is that 50% of the NGO vote should be for health. In addition to seeing health as an area of priority in its own right, NORAD Lusaka may have been under some pressure to raise the proportion of funds for health in the NGO vote, to compensate for the lack of involvement in health on a bilateral basis. Several of our project cases indicate that NORAD has wanted to expand in health on the NGO side (such as for instance Monze and Chilubula), with a history where NORAD itself has taken the initiative for establishing funding relationships. Both of the two projects given here as examples are major ones, with NORAD support primarily allocated for hospital infrastructure development.

All the NGO health services projects visited were in one way or another health facilities which operate on a level "above" what is deemed feasible for government health care development. By choosing to support the facilities within the health system which already are the best functioning, the funding agency therefore may contribute to imbalances which can be very hard to rectify. Given that NORAD for the time being has made the decision to only support the health sector through NGOs, an important question is therefore how one takes precautions to avoid such imbalances.

In a situation where applications for assistance to the health sector appear to be fewer than what is the case with other sectors (table 9.1 and 9.2), a "shopping market" approach for "good partners" may make it possible to increase the volume of support without too much administrative load for NORAD. On the other side, such an approach could easily lead to a choice of partners that, just because they are well organised and therefore attractive, also have access to other funding options. This may again aggravate imbalances in the district health system, and thereby undermine the government system rather than complement it.

With CMAZ as a well organised co-ordinating body for most of the NGO activities in health services delivery in the country, one could question why NORAD up to present has not made more active use of the opportunity for a more co-ordinated approach to funding the NGO health sector. CMAZ could be a partner for discussing how the health sector development through the church network could best be supported, as well as for effective channelling of such support. This kind of an approach would also likely be more effective in terms of the absorptive capacity in the system, and thereby a good alternative to the current practice of shopping around and picking up bits and pieces of requests (see also 11.3).

> *Support to NGOs for health care provision in a context like the one we find in Zambia, can only represent a supplementary strategy for assisting the health sector, if the aim is to make health services available to all, affordable within the national context, and accessible and acceptable to those that are most in need. For the NGO sector to be effective and appropriate in its contributions, there need to be a public commitment to basic health care, and a structure for governmental health services with sufficient capacity to guide, co-ordinate and distribute inputs.*

- **AIDS: Continuing need for diverse and flexible responses**

A number of innovations and broad mobilisation for dealing with AIDS has been achieved in Zambia. NORAD has been active in stimulating initiatives and making available support, both through WHO and NGOs. A strength has been the flexibility in funding arrangements, and that everybody somehow started "from scratch", being forced to sit down and analyse and design strategies for action. The special capacity in NORAD set aside for dealing with AIDS has obviously also been a contributing factor to a rather impressive programme.

The experience shows that there is considerable potential in the NGO sector, both for the development of Zambian interest groups and issue oriented organisations, and in terms of new and creative responses from established NGOs with their various histories and commitments and relationships. Yet one could also question whether there has been too much money available for a while, leading to approaches which may not be sustainable long term.

The case studies demonstrate that one is now into the phase of consolidating initiatives and have to face the issues of sustainability in various ways:

> The NPHEP has established a "facilitating mechanism" outside the regular government system, yet with the purpose of mobilising and supporting the government system, and thereby demonstrate an approach which could be accepted as temporary. Once the external support is not any more available, maintaining such a mechanism may not be the most viable strategy, and one would have to come up with basically new alternatives.

The FHT on the other side needs to face the issue of long term organisational development, as they have taken on responsibility for services and support systems which cannot be withdrawn in the foreseeable future without harmful effects. Funding agencies need to respond to this situation in a way that takes appropriate institutional capacity building seriously and involves longer term commitments.

Through the support to CMAZ, NORAD has contributed to stimulate a major response in almost all church institutions. This is a good example of strategic choice and willingness in the funding agency to think in terms of institutional capacity building combined with funding options for project activities with a commitment for several years.

The apparent success of the AIDS programmes may well be due to the availability of funding and flexibility in approaches, the gravity of the problem and the commonly shared mandate to address the problem by both government, NGOs and international donors. Future NORAD support in Zambia would do well take note of these elements and apply them as far as possible to funding strategies.

- **Family Planning: A relationship not maintained**

Norway rank population policy and family planning as priority issues in developmental assistance. In Zambia, this concern has only the last years been supported by official policy.

PPAZ is the NGO in Zambia that has spearheaded family planning activities, and mobilised support through an extensive membership network. The organisation was supported substantially by NORAD in the period 1985-88. From 1989 the funding was withheld due to unsatisfactory reporting and weaknesses in the management system. Apart from a report from a NORAD appointed consultant undertaking a brief review of administrative information on ongoing PPAZ projects, there is limited formal documentation in the NORAD Lusaka office as to the actual decisions taken about terminating collaboration.

As to the extent of our knowledge, and based on information from the two sides during the field work, there has been no follow up, contacts or interaction between PPAZ and NORAD the last few years.

We find this surprising, because NORAD has shown active initiative in relation to other kinds of NGO projects, and also because IPPF, an international organisation for which Norway is the largest funding partner, has continued its support to PPAZ and found reason to assist the organisation in management development. Rather than be guided by strategic choices, NORAD Lusaka appears to have chosen to pick organisations and projects which already can demonstrate sufficient management capacity (at least the ability to respond to NORADs own reporting needs), and where there is no "known risk".

As it now is, the PPAZ appears to be back on its feet, and it should be considered whether relationships should be re-established. If decided to do so, NORAD should however stay in close communication with other partners like IPPF.

We believe that by withholding support and remaining passive, NORAD Lusaka has lost out on participation in a constructive management development process, which may turn out to be of major importance in Zambia in the years to come.

10.2 Notes on special issues

- **What does it mean to be close to the target group?**

One of the main arguments for assistance to NGOs in development work is their assumed closeness to the target group, often specified as the rural poor and marginalised, with a special emphasis on women.

As to Zambia, we have made the following observations:

- There is a definite need to include the urban poor in the above target group for assistance.
- There is no reason to believe that a hospital bed or ward is closer to the target group than staff housing in the same health facility. What matters is the *services* the facility is able to provide and sustain, and *who* are served. The cases demonstrate that there has been a rather simplistic application of the target group concept in assessing funding requests, and that this has most probably served to limit service availability for the target group, by for instance not having staff to provide services.
- By supporting hospital level services rather than primary health care development, access for the poor is not likely to have been improved.
- In a situation where NGO institutions has introduced user fees, access for the poor is even made worse, although the institutions may come closer to financial sustainability.

We were not able to visit the "self help" groups during the field programme, and may have found initiatives in this category which really responded to local needs and involved the target group in meaningful ways. In the projects visited, none (apart from smaller AIDS initiatives) showed any obvious strength in terms of being "closer to the target group than government".

We assume that the extensive church networks through their congregations have broad contacts with the target groups. It may be that these contacts are utilised for social development in less formal ways, and that therefore we were not able to identify it.

- **Comprehensiveness or fragmentation?**

There is need to critically assess the effects of funding capital items such as vehicles and buildings (e.g., wards), also in relation to adjacent government operations and services at the zonal or district level. Are government services strengthened by the provision of equipment and structures or do such funding priorities hamper consolidation and strengthening of government services (increased referrals to missions, low government staff moral, loss of credibility by users, etc.)? Are there specific government assistance required during this period of re-adjustment for a more balanced, basic, health package for the majority?

In a few health projects, NORAD has contributed to extensive planning (Monze and Chilubula). Monze is a district hospital with broad interaction with the system at large and a number of funding partners. The hospital has therefore had sufficient capacity to come up with plans as requested. The plans that relate to the NORAD involvement however only deal with the physical facilities, and not with the wider role of the hospital in the district health system. Planning and management systems for comprehensive health development continue to be noted as a weakness in Monze, in spite of all the attention to quality care. A similar situation applies to Chilubula, where there has been extensive planning exercises undertaken by NORAD-appointed consultants, however without proper attention to the health service functions beyond the hospital fence.

In most of the other projects visited, NORAD funding has been based on project descriptions defining a capital investment or activity components. This approach contributes to

fragmentation and imbalances, both within the larger programme that is supported and the way its relates to its environment and clients. Some items or activities are always more marketable than others, yet in most cases single activities can not function in separation from the rest. In this regard, the example of Mbaya can be mentioned, where funding a truck for income generation is easy, but where the appropriateness of the services for which income is generated can be questioned.

> *Ad hoc funding of items and components is often attractive from a funding agency perspective, but generally cause a lot of difficulty for project operations. Because of the difficulty in obtaining funds, NGOs still tend to adapt their operations and requests to what is "marketable".*

- **What about recurring expenditure?**

Criteria for NORAD funding (rural, community based, capital costs, funding periods, etc.) is not clear to NGOs in Zambia. Part of the confusion has been due to NORAD´s flexibility in funding AIDS programmes.

In spite of the policy not to fund recurring expenditure, various types of running costs represent a large proportion of actual grants. Where expatriate personnel is provided to fill regular functions (volunteers, consultants) this in effect is also a contribution to meet recurring expenditure.

Each capital investment brings a recurrent cost along. In a sense therefore the argument to prefer to give grants towards capital cost is not based on a rationale that this is less risky in terms of creating dependency. Vehicles need to be grounded and services in buildings curtailed if there is no money to pay staff.

We would therefore suggest that it is the viability of the institution/organisation and its programme functions that need to be studied very carefully in assessing all funding applications, whether one applies for operating expenditure or capital investments.

The preference for capital investment project can therefore not primarily be based on a sustainability argument, but is rather a question of convenience for the funding agency. It is usually easier to describe, control and monitor capital projects, therefore they tend to be more acceptable.

Institutional capacity building is emerging as the main challenge is in all the cases studied.

If this should be taken seriously, NORAD in its funding criteria need to go beyond the simple recurrent/capital discussion and work on introducing some techniques for analysing viability of initiatives within a more comprehensive framework. Key questions in assessing all funding applications should therefore be:

- What consequence will this initiative have for the institutional capacity?
- To what extent will it build capacity?
- To what extent will it represent an added strain on capacity?
- Under what conditions will the initiative be viable?

- **What kind of partnership (influence)**

Where NORAD itself has taken initiative to establish collaboration with NGOs, it is likely to be a partnership which gives the donor fairly high influence. Directly or indirectly such influence is exercised in all projects because of the selection criteria which are applied in the process. Among our cases, the AIDS projects demonstrate how such influence can be exercised in a very constructive way, whereas Chilubula and PPAZ can be used to demonstrate risks.

An important feature of the AIDS co-operation is the apparent "negotiating power" of the partner NGO, such as FHT, CMAZ and Red Cross. NORAD and the NGOs are partners with a common challenge and aim.

In Chilubula, NORAD has more or less taken management responsibility for "its own project", by hiring and placing a consultant in an NGO, with a terms of reference which makes him accountable to NORAD.

With PPAZ, what started out as a promising long term partnership was abruptly ended by NORAD and not followed up further . One could use this as an example for how a contractual relationship ideally should operate: if one of the partners do not fulfil obligations the contract should be terminated. Yet, it could be that in an institution building process like this, one should seek to spot the problems as they arise, rather than wait until they take on such dimensions as were seen here.

A review of NORAD project files indicate inadequate monitoring and ongoing dialogue regarding the projects they fund. This may easily lead to situations where more formal evaluations are used to justify cessation of funding as well as to differing expectations between NORAD and those they fund. We would argue that NORAD should not have more major partners for NGO funding than what they are able to keep up a constructive dialogue with. If NORAD itself does not have such capacity, "intermediate partners" should be found (such as for instance co-ordinating agencies).

Flexibility will be needed from NORAD so that good NGOs (such as Family Heath Trust and Kara Counselling) do not suddenly lose their support for running expenses, and have to close their work because of the time frame for NORAD support. Careful planning will be required, preferably in a co-operation between the NGOs and NORAD.

> *The cases strongly reflect the need to consider longer time perspective for NGO collaboration. Short term funding create additional load on the organisation and a very difficult planning environment. Short term ad hoc funding can therefore in itself be a major constraint to sustainable initiatives.*

- **Sustainability is more than access to money**

Our cases strongly suggest that complex problems are aggravated by the way funding agencies including NORAD tend to limit the discussion of sustainability to the question of local income generation. In addition, the question has a lot to do with the sustainability of the organisation in terms of its context, its culture and its capacity. Important observations include:

- In Mbaya income generation is a thriving activity, but the organisation is not at all in a situation where its structure, culture or work processes match the volume and nature of services provided.
- In NPHEP the possibility of creating a new NGO is being discussed. Yet in the context where the organisation is operating, and with its purpose, its very strength may actually

be to remain a temporary "facilitating mechanism" rather than a full fledged NGO with its own organisational needs.

- For PPAZ, institutional capacity appropriate to current policy context for family planning and the ability of the formal health system to provide services is the most critical challenge in the years to come. Funds are likely to be generally available for family planning as long as the organisation can manage, innovate and respond.

The fact that funding agencies including NORAD tends to affirm already "good" organisations and avoid those that "could become good" appears as a major problem. The "good ones" run the risk of becoming inflated with short term money from many sources, and in a spiral where they need to become more sensitive and adaptable to funding agencies than to the needs the interaction with the people they serve.

10.3 Special challenges in health services projects

The health services projects are in a special situation where they are associated partners in a governmental health system, yet organisationally independent and generally with access to resources in addition to the regular government grant. This situation was discussed in detail in the first section of this report. Here we will seek to apply this discussion to the specific challenges to NORAD funding policies for these types of projects.

- **The need to consider a District Focus**

Given the current government policies to give more political and administrative power to the district level also for health development, the need to find models for a better functional integration of NGO services within the government system is obvious. NORAD´s funding of projects need to take this factor into account. Just a formal acceptance of an NGO activity by the district government should not be seen as sufficient in this regard.

Health activities, particularly at the peripheries/rural areas appear to operate within institutions in a self-sufficient, isolated manner, with obligatory routine reporting to the district level. There appears to be a lack or difficulty in exchange of information, experiences and even resources at the district level, between NGOs and with government. NORAD support should seek to facilitate improvements rather than aggravate this communication and co-ordination problem.

With a stronger general commitment to the policy of Primary Health Care Development in the country, this should have some consequence for NORAD support to health institutions (training of community health workers, upgrading of premises, planning and management capability support, logistics support such as vehicles, petrol, volunteers, doctors, upgrading level and type of care?).

If at all possible, NORAD should adopt a district focused strategy if it is decided to pursue health sector support through funding of infrastructure development or health facility rehabilitation, and balance efforts between NGOs and government.

May be a NGO, as part of its NORAD supported rehabilitation programme also could be made responsible for managing rehabilitation support for a neighbouring government facility? Even better would be to work through the new District Health Boards.

- **Recruitment and retention of personnel**

The lack of personnel willing and able to work in rural areas and even in mission hospitals is a major hindrance to sustained provision of services. An opening up for private for profit types of health care may cause additional strain on scarce personnel resources. The majority of key staff in mission hospitals are still non-Zambians. Inadequate incentives and lack of housing were mentioned as preventing recruitment of Zambian personnel. Funding for adequate housing in conjunction with government plans on improvement of health infrastructures may in the short-term contribute to availing Zambian staff in both government and mission health institutions.

- **Training**

Opportunities for up-grading skills for both health professionals and non-professionals working in health is not systematised, but remains a prerogative of individual institutions. While the more innovative programmes in AIDS provide for informal skills improvement and are able to obtain flexible funding from donors, much less attention appears to be paid to such staff development in regular health services.

There appears to be large training gaps for appropriate PHC approaches at the district level, as well as for management roles in health care.

With the NORAD emphasis on NGOs in health care, there may be a need to explore possible roles of mission hospitals and CMAZ in such training programmes, with a scope that also could include neighbouring government facilities.

Training as a budget item in donor funding of projects to meet appropriate training needs in different contexts in a flexible way needs further consideration.

- **CMAZ as a major channel for support to health services development**

Rather than shopping around and maintaining an agency approach to ad hoc NGO funding in the health sector, NORAD may in the future want to consider CMAZ as a main partner agency for such support , and thereby enter into a long term agreement and dialogue. This is also consistent with the strategies for future NGO assistance laid out in the NORAD NGO Country Plan, where a main concern is the need to reduce the number of funding partners.

This kind of approach would make it possible to channel a larger amount to health and direct it to critical needs such as PHC development, training and staff development, modelling of community based approaches and support for management development at the district level. CMAZ would need to develop their professional resource base in a systematic way, and make it available to support the development of functioning models for district health care, the way that is envisaged in the new MOH strategy.

Provided CMAZ is interested in taking up this kind of a role, such an approach (which in principle is similar to the support given to AIDS through CMAZ) could be a major contribution to health sector development in Zambia at this very crucial time, without NORAD having to enter into the governmental health sector directly.

11. SUMMARY REMARKS ON NORAD´S POLICIES AND PRACTICES

In this chapter we will mainly relate our remarks to the new NORAD NGO Country Plan for Zambia, dated February 1992, and summarize our recommendations based on the findings of the review. In this we would also want to acknowledge the significant progress that is made in this Plan effort towards establishing a clearer NGO strategy for NORAD in Zambia.

In the following we will limit our comments to what is relevant for the health sector.

11.1 NORAD´s capacity for funding NGO projects

NORAD is taking particular interest in funding NGOs, both Norwegian NGOs and local NGOs operating in one of the main partner countries for development assistance. Apart from the more general remarks, this report only deals with the NORAD support to local NGOs operating in the area of health in Zambia.

NORAD as an agency has generally only rather limited capacity for dealing with NGO support, considering the amount of money available in the NGO vote. The capacity problem has in the past been aggravated by the style of operation, and by NORADs limited ability to build competence in NGO support into the organisation at large. One of the Assistant Resident Representatives is usually charged with this responsibility, supervising one or more locally recruited professional staff. Often the NORAD person assigned to NGO support has little previous experience in this area of work

As the responsibility for operating the NGO vote as part of NORADs total development programme in Zambia increasingly have been delegated to the NORAD representation in Lusaka, the need for available basic competence in NGO support has also increased. As the Norwegian staff always will be temporary, the competence and continuity will very much have to depend on the locally recruited, more permanent personnel. Management systems and personnel policies that enable local personnel to take on such critical roles are therefore essential.

The available information on NORAD support to NGOs in the health sector in Zambia affirms that the capacity up to present has not matched work style and volume. This is demonstrated by NORAD being slow to give feed back and follow up to the NGOs with whom they collaborate, and that projects are supported which do not appear properly assessed and monitored.

It appears also to be a problem with continuity in the work processes and relationships to the NGOs. Information has not been systematised in order to make it easily available when staff are changed, and NGOs tend to feel that much depends on the person in charge at any given time.

Accepting these basic operational conditions for NORAD´s involvement in NGO support which cannot easily be changed, it is important to find strategies and processes that would allow a high volume of support with very limited administrative and professional involvement from NORAD´s side, and to ensure a process where the most critical concerns are being identified and dealt with. The Country Plan seeks to improve this situation by reducing the number of contracts through identifying partner organisations that are able to take on larger responsibilities. Similarly to enter into longer term contracts, establishing a data base and changing procedures for financial control and for purchases from abroad. These appear to be important steps in the right direction.

It can be argued that development assistance through NGOs represents a separate "professional" area of expertise which as yet has not been sufficiently recognised in the NORAD system.

11.2 WHY funding through NGOs

- **General aims**

NGOs are primarily seen to be agents for target group oriented approaches at the grass root level, with the ability to mobilise people as agents for their own development and for democratisation.

According to general NORAD strategies, the NGO vote should be related to other activities in the total NORAD Development Programme in a planned manner, and should be of a complementary nature. NGO support is, according to the Country Plan, intended to fill specific gaps in areas where the country programmes are in operation, or otherwise make a contribution to areas and sectors that other NORAD activities do not cover.

The health sector is chosen for NGO support in order to be complementary to the country programme, as there is no bilateral involvement in health. Specifically, the Country Plan objective for health reads: "to support activities that aim at improving primary health services to NORAD/NGO defined target groups".

- **Discussion**

Although accepting the validity of the general aims, it is important to note that based on the findings of this review the health related projects operated by NGOs in Zambia show little evidence of being more target group oriented than governmental health programmes.

There are only few examples of NGOs that apply community based participatory strategies to their health care efforts. Some local participation in committees related to health facilities may serve to mobilise consumers to more active involvement in decision making. NGO activities are not more accessible or available to the most vulnerable groups, nor do they show particular flexibility or creativity in their response to local needs.

NGOs definitely provide vital health services in some areas where government are not able to provide coverage. Yet, the services supported so far are very similar to what the government itself is seeking to do, probably even with less involvement in what is commonly understood as a broad primary health care strategy. Current NGO services represent mainly a combination of first and second level care, with a curative bias.

In the NGO Country Plan, support to NGOs in health aims at improving primary health services to defined target groups. It is not clear whether the current NGO activities that receive NORAD support are seen as fulfilling such an aim, or whether the intention for the future is a shift in direction compared with present practise.

We believe in the aim stated, but do feel that currently the NGO sector in health is less active in pursuing such an aim compared with governmental policy. If primary services or primary care is the concern, this can only be sustainable if NGOs work closer with governmental efforts.

- **Options to consider**

The Country Plan points out what is also affirmed by this review, that in spite of all constraints, health facilities operated by mission are already generally in a far better condition than those run by the government. This means that there is a need to be cautious with an approach where NORAD by policy sees the NGO side as an alternative strategy for strengthening the health sector in Zambia. As part of the total NORAD Development Programme in Zambia, one may therefore have to seriously consider opening up for parallel support to some of the government facilities in most critical need, in those districts where heavy support is given to NGO infrastructure development and rehabilitation (see also below).

We have in previous discussion shown that there are major problems with a one-sided emphasis on NGO support in relation to the overall health sector development context in Zambia, if a sustainable primary health care effort is the aim.

> *In order to ensure complementarity and balance in the sector, a main aim for Norwegian support should be to enable NGOs to become more active partners with government in district health systems development, and more creative in mobilising local participation.*

11.3 WHAT should be funded through NGOs

- **Plan priorities**

The Country Plan suggests that 50% of the NGO vote should be allocated to health activities (including AIDS). It is proposed that assistance to the loosely organised "selfhelp groups" be phased out. Priorities listed are capital costs, construction and renovation of physical structures, provision of water and sanitation, clinic equipment (investments), training and health education. What is meant with health education is not specified, apart from that it relates to AIDS. Recurrent costs, transport and staff houses are not excluded, but placed lowest on the priority list.

It is a stated intention that there should be a balance between allocations for preventive and curative services. The plan gives no further definition or content to these concepts, which could be interpreted in a range of different ways. An important criteria in the plan is that applications should carry the recommendation from local/provincial authorities, and only such projects will be supported that provide services where the government cannot. Particular attention will be made to assess whether the organisation will be able to meet future running costs.

- **Discussion**

Based on arguments given in previous chapters, we believe that this section of the Country Plan should be thoroughly reviewed, in order to be more consistent with the aims stated for NGO support to health, and with the context in which NGO operations take place.

We agree that the previous support made available to loosely knit "self help groups" should be discontinued, in light of the major administrative load. However, it is important not to loose the possibility that this represented for support to specific components within the government system. The Plan indicates that in special cases NGOs could take on such specific, local government support projects. Yet it is important to bear in mind the dynamics within the district health system once authority becomes more decentralised to the district level. It may not be the best thing to let NGOs play a "executing agency" role towards government in this situation.

We do not believe that it is sound policy to give capital costs highest priority in order to improve primary services at this stage of NGO health sector development in Zambia. The critical factor is much more on the recurrent and the organisational development side. In addition, capital costs are also given priority by SAP and the MPU, including both NGOs and government facilities, which means that there is no obvious strategic need for NORAD to insist on such a priority in order to fill a gap. If there is a need to include such projects in order to reach the desired level of health sector support, it may be better to fund SAP projects, rather than work with the same criteria within an alternative funding system. We have previously presented arguments for why staff quarters at the present stage of development within the NGO sector may be a top priority to ensure appropriate function.

It is obviously important to ensure that the organisation will be able to meet future running costs for any service it has started to provide which cannot be withdrawn without harmful effects. This is true regardless of whether one decides to support activities and functions or capital costs. We do however believe that NORAD should pay much greater attention to the organisational and managerial capacity, and not limit its concern to financial sustainability alone.

We affirm the opening in the Country Plan for making available funds for training purposes, and the concern for appropriate recommendations from and avoiding overlap with government. As previously also underlined, one need to move beyond acceptance of a presence to commitment to collaboration and mutual support.

- **Options to consider**

The AIDS vote is now being brought together with the NGO vote in the future Country Plan strategy. One of the most significant features of the NORAD supported AIDS projects is precisely the flexibility in the funding instrument. This should not be lost for the sake of administrative ease.

Generally, NGO support should risk to be daring and creative, rather than follow prescriptions. Even with a limited administrative capacity, this could be done through selecting some organisations where a relationship of trust and dialogue could be nurtured, as has already been demonstrated in the case of AIDS support.

> *Rather than be focused on capital versus recurrent funding, we propose that NORAD consider institutional capacity building for appropriate and sustainable primary health care development as a major priority.*

This will mean that one would need to go beyond blue print checklists, and have the ability to assess funding requests in light of their merits and the context and potential of each organisation and project.

11.4 HOW should the funding process operate

- **The process as outlined in the plan**

Besides the formal procedures the plan stress the need for *improved co-ordination*, both between the various modes for NORAD assistance and between the different donors, in order to avoid duplication of efforts and ensure a target group focus on the NGO part. A closer relationship between NORAD Lusaka and Norwegian NGOs is also called for.

Some *geographical concentration* for better interaction with local partners and active use of the presence of Norwegian volunteers for project visits is proposed as a main strategy, to be applied flexibly. Collaboration with local and provincial authorities is stressed.

The use of *"intermediaries"* as channels for NGO support is briefly mentioned as a strategy and a major concern is to reduce the number of projects and rather increase their comprehensiveness.

A strategy for mobilising the NGO potential for *development at grass roots level* through seminars and courses for NGO representatives or even a "school" for NGOs in collaboration with other donors is also being discussed.

- **Discussion**

It is very understandable that NORAD wants to avoid having too different criterias for support to NGOs working with AIDS and other NGOs in health related activities. Today, examples may be seen of NGOs applying and receiving support from various NORAD votes and handled by several NORAD officers, which does not seem very efficient.

We also affirm the need to reduce the number of project agreements, although we are not sure that this should mean that individual projects supported should necessarily all be large and comprehensive. Use of more substantial thematic support or programme support to national level organisations, may achieve the same. The possibility of making much more active use of the presence of CMAZ and other umbrella organisations has already been mentioned.

The role of "intermediaries" need to be further defined, if they themselves are not meant to carry the responsibility for project operations in relation to NORAD. To whom should they be accountable and where should their loyalty go? Do they represent NORAD as a control agency or management support to the implementing NGO or both? To what extent will there be role conflicts?

The plan indicates a move towards more long term funding agreements, but does not spell out what kind of conditions or contractual arrangements one will be looking for. We have previously argued that closer partnership with fewer organisations over longer periods of time may be a good direction for the future.

As to the role of NVS participants as "funding agency representatives", we would want to stress the caution that is also mentioned in the Country Plan. Volunteers do not work in a neutral and homogeneous environment, but are appointed with their loyalty to a specific job in a specific context and cultural setting. It is no reason to believe that they will have the necessary insight in NGO support issues or have a well informed and balanced overview of the NGO setting in their area, just because they live and work there. Mixing roles as working colleagues and control agents with influence over funding may well put themselves as well as other partners in difficult situations, even if one does not intend to do so.

We would finally issue a warning for getting operationally involved in the proposed training of NGOs as an external funding agency, both as a matter of principle and because of NORADs very limited capacity for NGO support. Such initiatives should preferably be carried by one or several of the co-ordinating or umbrella organisations in the country.

- **Options to consider**

The plan's opening for support to government via NGOs "adoption" of certain construction projects may be a possible option to consider further. *A better alternative from a health professional point of view would be to provide support for district health development through selected District Health Councils/Boards once these are operational.* Such support might possibly be channelled through SAP or MPU, or alternatively be negotiated directly as a special allocation for health development in the district, including both government and NGOs.

The possibility of assisting CMAZ to develop to become a strategic partner for district primary health care management support should be seriously considered.

Use of Norwegian NGOs as partners for Zambian NGOs in institutional capacity building and management development support where this can be in the interest of both parties may well be worth considering.

NORAD should be open for support to "NGO mobilising" and training initiatives through some locally established mechanism that has the necessary continuity, capacity and competence, or could link up with resource groups on NGO development in the region (such as for instance in Zimbabwe or Kenya), but should not get operationally involved. One should avoid strategies that further strengthen the strong external support agency influence on the NGOs.

Improved planning and monitoring systems which involve dialogue between the partners and relate to the most critical issues regarding institutional sustainability should be developed. Limiting the concern for appropriate monitoring to a "at least once" project visits and a system of administrative routines that only meets the funding agencies need for proper control will be less than satisfactory.

We suggest that NORAD should seriously consider to make longer term commitments to a few organisations at the national level rather than offering ad hoc projects for a larger group, even if they are concentrated to certain provinces.

SECTION III

CASE STUDIES, SELECTED NORAD SUPPORTED PROJECTS

Under the NGO vote:

Under the AIDS vote:

12. REVIEW OF SELECTED PROJECTS WITH NORAD SUPPORT

12.1 Under the NGO Vote

A. MONZE DISTRICT HOSPITAL

A1. General description

Monze Mission Hospital is located in Monze town in the Southern Province. It was founded by the Diocese of Monze in 1964 at the time Zambia achieved independence. The managing agency has been the Holy Rosary Sisters since its establishment.

The hospital was assigned the status of District Hospital for Monze District in 1973, and supervises the implementation of primary health care in the district through 13 RHCs and 2 UHCs. In practice the hospital combines the functions of a district hospital (second level care) and a general hospital (third level care), with specialised services in gyn/obst and orthopaedic surgery.

The hospital caters for a population of about 157 000 and covers an area of 6687 square metres. Approximately 200 - 250 patients (new cases) are seen at OPD, and on the average 20 patients are admitted daily.

The role of Monze Hospital will be important in the future, as Monze district has been selected as one of the three trial projects for district based planning, budgeting and accounting.

A 2. Discussion

The mission hospital represents the key health institution in the district, with clearly designated roles and responsibilities within the governmental health system. There has been some signs of innovation and interest in community based health care approaches, as demonstrated by the AIDS programme and the workshop on "Training for Transformation". The district has also an extensive network of CHWs and TBAs who appear reasonably well integrated within the total health care approach.

While there is considerable strength in service delivery, there appears to be limited experiences available for the development of sustainable and effective planning and management systems.

The Sisters are planning to hand over the management of the hospital to a Zambian Sister Organisation within three years. While the hand over period of 3 years is short, the success of the transfer of management will depend on the capacity of the future managing agency, the role of the current sister organisation (advisers etc.) and the commitment and role that the diocese and the new Bishop will play.

NORAD support has been following a project-component approach, with an initial emphasis on up-grading of facilities for AIDS care. The fact that funding could be switched to female ward improvement demonstrates appropriate flexibility on the side of the funding agency.

While the hospital development plan has made it possible to see the NORAD funded component in a larger hospital physical development perspective, such a project should preferably be assessed in relation to appropriate care level/function and district priorities

as a whole, to ensure co-ordination and balance between front line services and hospital care in the district.

In a situation where the hospital already has the double bed capacity of a regular government district hospital, where the hospital is overloaded by primary care functions and where management is obviously vulnerable, one could well have argued that hospital construction/renovation is a questionable priority. The concern for primary facilities for urban health care, raised in the 1991 evaluation is an example of a competing need in the category of "construction projects" and the need for staff and systems development might well have been addressed as mandatory concern along with any hospital renovation. Without such a perspective, fragmented project funding can easily lead to imbalances in function.

B. CHILUBULA RURAL HEALTH CENTRE

B1. General Description

Chilubula Rural Health Centre is situated in Kasama District, 33 km west of Kasama Town and has 58 beds. It is in Chilubula Parish in the Diocese of Kasama in the Northern Province. The Health Centre, formerly called Fidelis Hospital was built in 1965 by a foreign Catholic mission, the White Fathers and the White Sisters of Africa and is now owned and run by the Diocese of Kasama. The Zambian Congregation Sisters of the Child Jesus are the managing agency since 1983.

The centre began operating as a Zonal Rural Health Centre from 1990. According to the district plans, the RHC is responsible for implementation of PHC through supervision, training, distribution of supplies, etc. The centre supervises about 13 rural health centres as well as implements UCI in 9 out-reach centres.

The district sees Chilibula playing a leading role in the future in community based health care and community development through inter-sectoral action and through mobilising and supporting CHWs. In addition, Chilubula will continue in its present role of implementation UCI in rural health centres and health posts.

B 2. Discussion

In general, the NORAD support to Chilubula has many good features, such as developing a phased long term plan, ensuring technical support for its implementation, and combining training and construction.

If the motivation for involvement in Chilubula was to improve health service function in the area, and should represent an alternative to supporting the GRZ system, it is hard to understand why not more emphasis was given in the plans to role definition for such an expanded RHC in the system, and to develop functional linkages within the health system, rather than looking at what could be done to improve curative care.

We therefore note the following observations:

- the choice of Chilubula for upgrading to a zonal RHC appears questionable because of its location so close to Kasama. It must however also be born in mind that this location for a zonal RHC was approved by Kasama District Council already in 1984

- the heavy emphasis in the support package on institutional curative care (clinical skills improvement, maternity ward, theatre and x-ray) was questionable in a situation where the role as a zonal RHC calls for balanced development of well integrated functions, including the supervisory and support functions for PHC

- the way a NORAD consultant was hired full time and actually placed in the project for implementation of the support package for several years, with unclear reporting lines and with accountability to NORAD rather than to the project management could also be questioned. If such professional support was needed, why could not such a person be hired by the institution and the salary be included in the support package? Steps have recently been taken by NORAD Lusaka to change the conditions of employment so that the person is now formally employed by the Diocese.

The Kasama Diocese made arrangement for a comprehensive review of its role in health care in the whole Northern Province early 1992. The report (Medicus Mundi, Belgium February 1992), points out that in the NORAD supported project in Chilubula "there seems to have been no clear idea about the specific role of the upgraded structure within the district health system" and that "the concept of a fragmented health service delivery has influenced the architectural plan".

The conclusions of the report stress the need for looking at ways to improve the performance of the health services within the new framework of district focused primary health care development, giving emphasis to management, organisation and supervision and to appropriate quality and scope of curative care. The present infrastructure should not be further expanded, but be made fully operational.

The construction of theatre and X-ray department has now been postponed. This appears to be a very sensible decision by project management. NORAD should as far as possible seek to benefit from the review done by Medicus Mundi, and redirect its future support to some of the priority areas outlined in its recommendations.

C. CHILONGA HOSPITAL

C1. General Description

Our Lady Mission Hospital was started as a RHC by the mission in 1956, recruited a doctor in 1956. The hospital also offered training for clinical medical assistance in 1962 and later trained nurses. MCH services began in 1967. The hospital has maintained a constant supply of doctors from Germany, Denmark and other countries. as well as having seconded government nurses.

The hospital is presently well equipped, with x-ray department, surgery etc. and augments the services provided by the Mpika District Hospital which is operated by the government. All cases needing additional medical or surgical treatment are referred to this hospital.

C2. Discussion

The situation of Chilonga Mission Hospital illustrates both the potential and the risks in relation to NGOs role as health service providers. The additional access to personnel and resources, as well as motivated leadership with strong expatriate support, makes it possible to offer good quality services. This invites increased demand, and leads to the need to cope with increased pressure while sustaining quality.

For neighbouring Mpika district hospital, with much less access to additional resources and less flexibility in management, Chilonga´s excellence may easily undermine Mpika´s role and even motivation to improve. For adequate functioning, Mpika needs a major rehaul, both for medical and non medical equipment, supplies and facilities.

Any assessment of funding request to hospital care in Mpika District therefore needs to take this situation into consideration. Assistance for a new ward at Chilonga will most likely be easy to approve, administer and implement, with reasonable assurance of good results in terms of improved performance. At the same time such assistance will continue to increase the gap between Mpika and Chilonga, and likely even undermine the chance of Mpika to take on its assigned role. The two hospital functions must therefore be reviewed together, and responsible decisions made as to what level of care should be provided where, if sustainable care should be achieved.

D. MBAYA MUSUMA COMMUNITY HEALTH CENTRE

D1. General Description

Mbaya Musuma Community Health Centre is run by Family in Christ Mission, an organisation created by a family for the purpose of working with the needy people in Tonga land. The head of the family is originally from the area, and has returned with his family from Lesotho after having been away for 20 years. The family belongs to a Full Gospel Pentecostal Church.

The family arrived in Zambia in 1987 without money and without backing from a church or organisation and started simple curative services, referring more serious cases to various local health institutions.

With financial support from donor agencies such as World Vision and EEC micro projects, they were able to construct a health centre. A part of the house where the couple is living, will in future be used as a centre for terminal patients (mainly AIDS victims).

The Health Centre has now 70 beds and consists of an OPD department, a delivery room, a labour room and a small isolation ward, a children's ward, a males ward, a female ward and a nursery which combines with orphans accommodation. In addition to the health centre there is a workshop, an office, a trading store, store rooms, a grind mill and staff houses and a visitors accommodation block. Two staff houses are currently being constructed.

All these premises are built on what is called community land made available by the local traditional authorities. The project has no intention of buying the land. However, the organisation does not have any written agreement about the use of the land either.

The project serves 6 communities with approx. 20 000 people. In addition to the above mentioned health centre, FCM is responsible for other clinics in the area, with 4-8 beds each.

D2. Discussion

This is a project demonstrating what can be achieved by an individual "gründer", with vision, creativity, faith and adequate financial support. Like most of these kinds of projects, the development process has been rather directive. Until recently the development of the programme has depended entirely on the family's ideas about the needs of the community.

The idea of income-generating activities to develop "self-reliance" is not new. Many projects have tried and many have found it difficult to succeed. In this case it seems as if this approach actually has gone a long way to become successful. Income generated from the different projects are actually fed into the running costs.

So far, the income generating activities have been entirely dependent on investments from donor agencies, and the personal abilities of the director. His role in planning, in management and implementation appears at this stage to be a rather critical element of the self-reliance strategy. It may however well be that it is possible now to move in the direction of stronger community ownership and control.

The care received by the people coming to the health centre is most certainly quite acceptable. However, the field visit team noted that a "charity profile" was heavily present. Nobody should pay, and people should be met with assistance to every problem they presented.

Administration and management of the health activities appears to represent a weak area in the current set up. The records were not in order, and it was difficult to get an overview of the activities. There are few efforts to supervise and support the different units and make them accountable to the project management. Reports are given directly to the district authorities and not to the main centre. The management of the Health Centre seems also to depend on the supervision of the FCM leader who would even give advice on treatment etc.

Plans for the near future, including extension of both installations and activities, appear too ambitious compared to the organisational set-up and the stage of operation. Rather one should consider a consolidation phase to give the organisation a chance to establish itself, and to develop a more sustainable management and personnel development system.

The vision of the community gradually taking over is interesting, but needs to be translated into realistic strategies. A centre of this dimension (if the future plans are to be implemented, the size of the project will increase considerably), demands an organisational capacity that is not automatically present in the community. It also needs a very different co-ordination with other health care efforts in the district.

NORAD should therefore in the future not contribute to the extension of the project activities, but should seek a way for supporting the consolidation of activities and the development of a more sustainable organisational and managerial structure. Sustainability is not just a question of generating financial resources, but also a question of a stable and predictable organisation.

E. PLANNED PARENTHOOD ASSOCIATION OF ZAMBIA (PPAZ).

E 1. General description

The Planned Parenthood Association of Zambia (PPAZ) was started by a group of women in Ndola as the Family Planning and Welfare Association of Zambia in 1972, with a branch opening in Livingstone in 1975.

PPAZ provides family planning information and services. It became an associate member of International Planned Parenthood Federation (IPPF) in 1978, and a full member in 1983. In 1989 IPPF provided approximately 50% of the total external support to the organisation.

The organisation operates nation-wide, with more than 10.000 volunteers in the whole country. 30 people are employed in the headquarters in Lusaka, and 32 people employed in regional and branch offices. PPAZ has no expatriate staff.

E2. Discussion

The concept of Family Planning is now recognised by the government, and the government also acknowledges the efforts done in this area by NGOs. PPAZ should in a special way be recognised for its very important role in bringing the concern for population management on the official policy agenda in Zambia. Being a Zambian NGO adds to its strength in this regard.

PPAZ has however had a period of too rapid growth, which they were not fully able to cope with. The restructuring with the introduction of a regional level of management, will enable improved monitoring and supervision of branch activities.

It appears that PPAZ is rather dependent on IPPF for all their operations. IPPF operates both as a fire brigade or a trouble shooter, and in the role of donor agency/control. A major question is therefore what kind of autonomy PPAZ really has as a Zambian organisation and how it is able to develop and take on more responsibility. Whether it is good or bad for an organisation to have an external agency come and put things in order when there is a crisis, is not easy to answer. Much will depend upon what ownership PPAZ itself has to the introduced changes and whether competence and capacity is being built into the organisation through active participation in the management development processes.

Norway is the biggest single funding agency of IPPF international. The funds donated to IPPF are not targeted to specific programmes or countries. Representatives for the Ministry of Foreign Affairs attend donor meetings, where general policies and plans are outlined. Whereas in this case NORAD Lusaka has noted PPAZ as a risk organisation, IPPF remained and stood by PPAZ, and sought to guide it through troubled waters. Norwegian foreign aid policies and procedures can thereby accommodate a situation where an abrupt withdrawal of Norwegian funds is found necessary locally, while at the same time the resulting gap in support to the same organisation is filled in by an international agency largely supported by Norwegian funds!

We have noted the following additional observations:

- One could question why all the donors had to do their own reviews of PPAZ in the period 1987-89, rather than pool resources to find ways to overcome some of the apparent problems.

- One could also question how NORAD in their own documents were able to stress the effective management of PPAZ in 1987, when the same year the Coopers and Lybrand study pointed out several areas of critical management weaknesses in the organisation?

- As population management and family planning represents areas that are given high priority in Norwegian aid policies, it is somewhat surprising that NORAD has taken such a passive role in its relation to PPAZ, rather than wanting to see the organisation get back on its feet and actively nurturing relationships.

IPPF is now of the opinion that PPAZ has improved considerably in their administrative systems. PPAZs role and strategy which currently is being reformulated, will likely reflect the rapidly changing political and policy context in Zambia. This time may therefore be an important point for reopening dialogue between NORAD and PPAZ, in order to see whether the time is now right for renewed collaboration.

F . FAMILY LIFE MOVEMENT OF ZAMBIA (FLMZ)

F 1. General description

The organisation started operating in 1981, and is linked to the International Federation for Family Life Promotion (IFFLP), which supports them financially and with personnel training. They currently operate 5 provinces, Southern, Lusaka, Central, Copperbelt and Northern.

The main aim of the FLMZ is to promote Family Life Education with a specific objective of promoting the Scientific Natural Family Planning (SNFP) method. The organisation has the following objectives:

- To work for healthy and happy family life as one of the foundations of integral human development.
- To provide leadership, guidance and education in the fields of family life in general and natural family planning in particular.
- To promote family life and marriage enrichment programmes.
- To promote respect for human life at every stage of its development from conception to death.
- To provide animation and education concerning responsible parenthood and fertility control by natural methods.

These objectives are accomplished through training couples in the use of SNFP, marriage preparation and counselling, education of youth, pregnancy counselling and distribution of publications and books.

F 2. Discussion

Natural Family Planning promotion is clearly relevant and important in a country with high population growth and a Catholic majority.

FLMZ seem to be generally well administered. The methods they are advocating have the benefit that supplies of contraceptives are not required, which enhances sustainability. However, their local support base still seem quite weak, with few members and not that many acceptors.

Based on our limited information, the NORAD support to the organisation appears quite appropriate. Given a situation where there are few NGOs with a special interest in family planning, and where FLMZ is recognised for making a valuable contribution, it might be reason for NORAD to consider a stronger commitment with a longer perspective for funding institutional development, rather than continue to provide scattered ad hoc funding for bit by bit requests. Such an approach would however require a planned effort at institutional analysis and organisational development by FLMZ itself.

If NORAD re-establish contact with PPAZ, it might even be possible to assist in improving the communication between the FLMZ and PPAZ as two main NGOs with a strong focus on family planning.

12.2 Under the AIDS Vote

G. ZAMBIA RED CROSS SOCIETY

G 1. General description

The Red Cross opened in the then North Rhodesia in 1950, and in 1966 an independent Zambia Red Cross was established. The branch in Livingstone was opened in 1979. 10.000 adults are members in ZRC, and app.. 30.000 youths. In the whole country there are 53 branches and member groups.

There are mostly Zambian staff working in the organisation. One expatriate is working with a project for street-children in Lusaka, one is working with various projects in Western province, and one expatriate works as a voluntary health adviser in Lusaka. There are 17 persons employed in the head office and currently 5 provincial officers. Approximately 3000 of the volunteers are nurses while the rest are teachers, army people and social workers.

There is one employee in Livingstone branch which also operates a hostel.

The aims and objectives for the ZRC are:

- To furnish aid to the sick and wounded in times of war and peace.
- To organise relief services to all disaster victims of both natural and man-made disasters.
- To assist the authorities in improvement of health services and the prevention of disease.
- To perform all the duties which evolve upon a national society in accordance with the provisions of the Geneva convention and their additional protocols.

Community participation is stated as a basic strategy in the work. All the activities of ZRC are guided by the seven Red Cross principles: Humanity, impartiality, neutrality, independence, voluntary service, unity and universality.

G 2. Discussion

Both on visiting the headquarters and the Livingstone Branch, one was struck by how efficient and well-functioning the organisation seemed. The field work did not give room for observing project activities, but people met had a clear sense of direction for their work and seemed competent and knowledgeable.

ZRC has a large number of volunteers doing a lot of good work without salary. The organisation seem to cope well with the challenge, and the emphasis on training and follow up assists in affirming volunteers as important to the organisation.

As for NORAD support, the programme in Livingstone fits well with the criteria used for the AIDS vote and the organisation should be well placed for both ad hoc and more long term project based funding arrangements, as it appears to have the capacity to deal with such funding. Clearer communication between NORAD and the organisation may lead to better proposals for future collaboration.

H. FAMILY HEALTH TRUST (FHT)

H 1. General Description

FHT is a well-known Zambian NGO for AIDS-work and the secretariat acts as a clearing house for the NGO AIDS Co-ordinating Committee. It is an umbrella organisation started in 1987, upon the initiative of professionals in Zambia for promoting family health, in view of the AIDS epidemic.

FHT is co-operating with the government. In addition they try to attract innovative initiatives and support them through administrative and professional assistance. In this way they serve as an organisational base for various projects not addressed by other NGOs.

The main objective of the Family Health Trust is "to contribute to the NGO response to the impact of HIV/AIDS in Zambia". They have 3 specific objectives:

1) Education for prevention of the spread of AIDS
2) Care and counselling for people living with AIDS (PWA).
3) Support for support-groups for PWA.

FHT aims to be flexible in order to respond to new needs and innovations, and to assist groups or initiatives related to AIDS activities. The projects operate independently, but with supervision and monitoring from the head office which also has the main responsibility of securing funds for the activities.

H 2. Discussion

FHT can be termed as an indigenous Zambian NGO, with competent and dedicated professionals and with the ability to recruit volunteers for the organisation although the organisation is structurally small.

FHT is a well-known NGO both inside Zambia and also internationally among people involved in AIDS-work. The fact that rather different programmes are under the same administrative umbrella has also given the organisation fame. Through the umbrella system they are able to utilise the resources better through close co-operation, and duplication of services and equipment is avoided. The FHT is also increasingly becoming an advisor and catalyst for others that want to start programmes.

The trust system may in a given situation be vulnerable, especially as many of the current Board members are centrally placed politicians. With the active involvement of a number of competent volunteers, it may be necessary to review how they to a higher extent can have influence in the organisation.

FHT´s working through local community groups, ensures competence without extensive additional costs. For the foreseeable future FHT will however continue to be very dependent on donors.

NORAD has been the biggest donor to the FHT. There is no doubt that substantial support to this organisation under the AIDS vote is appropriate. What may be worth considering is however the nature of the support that is given, particularly in terms of the limitations of year by year applications and further discussion on how the issue of recurrent expenditure best can be approached.

There should be a way to discuss such expenditure as a part of appropriately planned institutional development efforts, rather than as a "yes or no" question.

I. NORTHERN PROVINCE HEALTH EDUCATION PROJECT ON AIDS (NPHEP).

11. General Description

The project started in 1988 on the initiative of an expatriate spouse in collaboration with local health personnel. It has built its own project organisation, and is run by the NPHEP Team. The project team consists of one co-ordinator, and seconded government staff who are all Zambians. Lions Club Kasama was instrumental in starting the project, but has now a very limited role.

A 6 months pilot project was started in Kasama District with the general objective of "giving simple and clear information on AIDS to the general public". Target groups for the pilot phase were schools, police, prisoners and prison workers, and local chiefs. The methods used were lectures on AIDS and follow up of participants through questionnaires. Posters were put up around in the district, and materials on AIDS distributed. The pilot phase was supported by NORAD and WHO/MOH. An evaluation after the first 6 months recommended the continuation of the project on a regular basis.

The project uses various means of communications such as quizzes, songs, focus group discussions and drama. They work closely with the District AIDS Co-ordinator in each district.

12. Discussion

On the whole the project demonstrates creativity and the fact that it is possible to mobilise for a common response to critical needs, given somebody that takes initiative and adequate support.

The project has also shown ability to adjust and refine methodology and approaches for IEC. Limiting activities to IEC means that the project is not involved in counselling or home based care efforts, apart from linking training efforts with the Psycho Social counsellor at the Hospital, who is also a team member. It may therefore be important to keep track of the balance between resources for IEC and resources for counselling and home based care in the Province.

The organisation's ability to be an "outside agency" as well as bring together key government staff, has allowed for more creativity also within the government system, as well as better combined use of resources. This very strength of the organisation may however also be its dilemma. The current ad hoc nature, with an expatriate co-ordinator, only part-time government staff involvement and no formal structure apart from a loose attachment to Lions Club, means that NPHEP in reality functions not as an NGO but as a facilitating mechanism to enable the government system to meet the challenges of the AIDS epidemic with more flexibility, creativity and resources.

Two different alternatives for organising the project in the future is currently being discussed. One is to develop as an independent NGO with full-time staff. The other is to develop as a government programme. From what is said above, any of these two alternatives may turn out to mean loosing the main potential as facilitating mechanism. If it becomes another governmental committee there is no reason to believe that the flexibility will remain. If it becomes a NGO, it will need to develop its own identity and project organisation, and require more funding and institutional development.

In our opinion the current model can not be made sustainable (here: operate without external support), although some of the activities may well be sustained within the government system or by other actors even if the NPHEP as such is phased out. As the activities are of a kind that can be discontinued without "harmful effects"(in the sense that nobody will loose jobs and nobody's basic services will be disrupted), we would however suggest that the concern for sustainability of this project organisation may not be such an important issue in this particular situation. The main issue is how to mobilise the potential of the government system in the best possible way, given some additional external resources over a period of time.

Given that government personnel can continue to be available as present, that general donor support will be continued and that an expatriate volunteer or a Zambian replacement will continue to be funded for a period of several years to come, there is likely no major risk in keeping the NPHEP mechanism the way it currently works. If any of these conditions are not met, maintaining the activities will be difficult. Establishing a NGO will require even more in terms of external support, and will bring in new risks.

The NPHEP has the ambition of covering the whole Northern province. To reach out to the whole province from a project base in Kasama will take a lot of resources, and probably require strengthening of the organisation, that is establishing a NGO. On the other hand, it may not be impossible to disseminate the "model" and encourage and support similar ad hoc facilitating mechanism in other districts, for instance by enabling the District AIDS co-ordinator to take the role as the main facilitator.

J. KARA COUNSELLING AND TRAINING TRUST LTD.

J1. General description

Kara Counselling Project was started in 1989, registered under Companies Act as a trust.

The main objective of Kara is to carry out AIDS prevention and to provide support to people living with HIV and AIDS, through Information, Education and Communication activities (IEC) and counselling. A specific objective is to address personal and family problems in relation to HIV/AIDS.

A support organisation called PALS (Positive And Living Squad), is established under Kara Counselling which has 20-30 members. They operate from a house centrally placed in Lusaka, but plan to re-locate in a facility donated by NORAD.

J2 Discussion

The project complements the health sector in counselling and education. Their approach of using Persons With Aids in their work, and working so closely with them, adds to their relevance, as do also their telephone hot-line.

On a personal level it also seems that the Kara counselling has been of substantial help and support for HIV-infected individuals. It seems however, that the group being reached by this programme are mostly young single persons. The typical HIV-infected persons in Zambia are probably married and with children, and they don't seem to have found Kara as a place to get help and support.

The character of Kara as a "Social Welfare bureau" that supports individuals may become an increasing burden to the work. If Kara in addition to the current network of PWA comes in contact with large numbers of PWAs with families and children, the demands on resources will be overwhelming.

Kara should be praised for innovation and creativity, and for an approach where the beneficiaries are very much involved in the development of the activities and strategies. However, to develop a sustainable foundation will take time, and in the meantime it seems that the project is quite dependent on a strong leadership and substantial support. Kara is aware that the NORAD funds may decrease, and are establishing contact in the donor community to secure other funds, while they are also concerned with income generating activities.

Establishing a broader support base to reduce dependency on NORAD funding is obviously an important strategy. With the need for strengthening the organisation (management and organisational development), it would however be important for an organisation like this to have funding partners who were willing to "walk with them" some miles. As a Norwegian volunteer will be added to the team, it appears to be too early for NORAD to talk about decreasing the support at this stage. Rather it should be a question of establishing collaboration with other potential funding partners to ensure support for a sound organisational development effort.

K. CHURCHES MEDICAL ASSOCIATION OF ZAMBIA (CMAZ).

K 1. General Description

For information about this association, see chapter 5. In this connection the emphasis will be laid on the support and co-operation CMAZ has had with NORAD in connection to the AIDS Control Programme.

A CMAZ AIDS Advisory Committee was formed in 1987 at the CMAZ Annual Council and a concept of home based care and prevention (and hospital intervention where required) for the church administered health institutions was developed. A project proposal was thereafter submitted to various donors for funding.

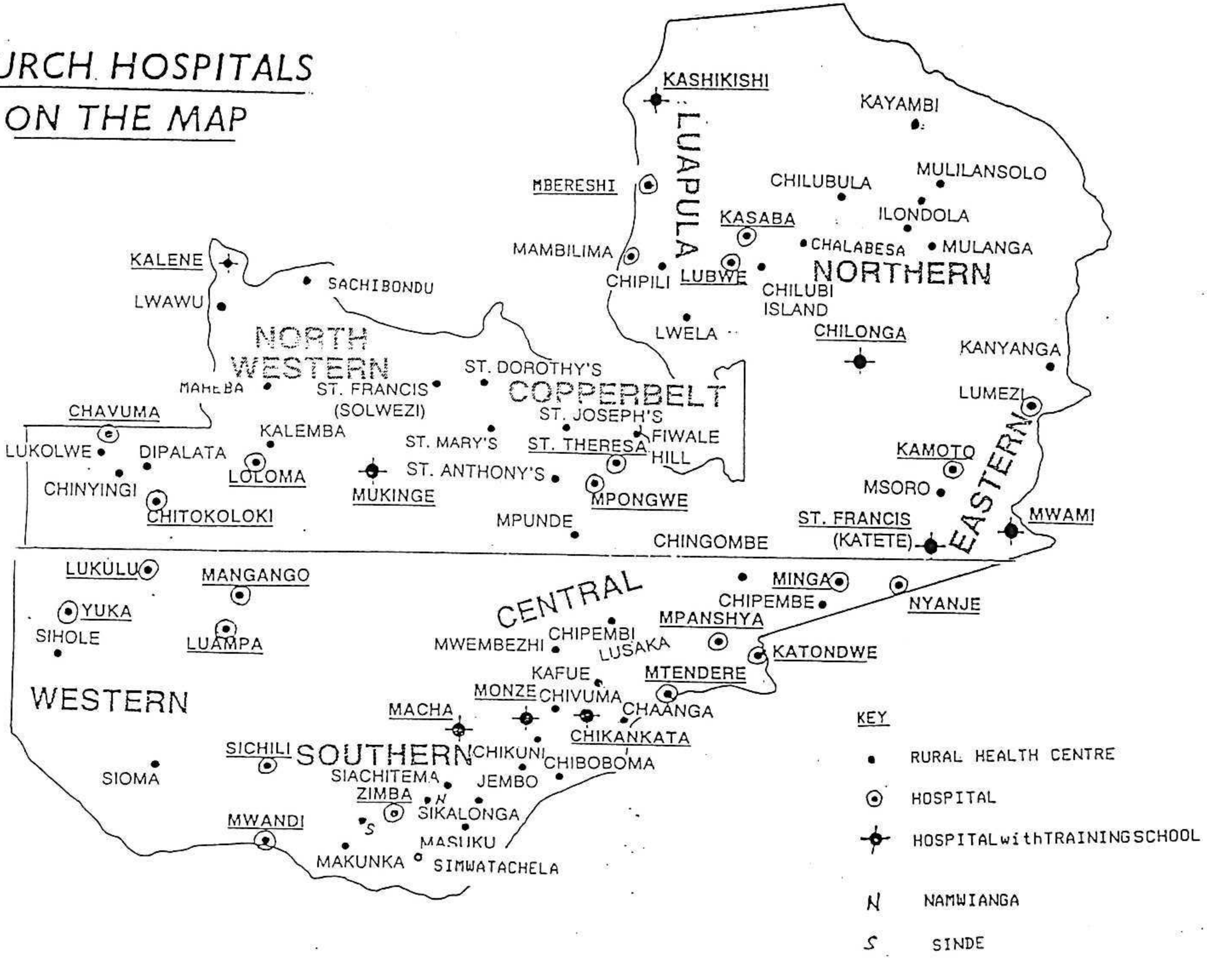
About 50 of the CMAZ institutions now have an AIDS-programme (most often home-based), and receive funds through NORAD, WHO and other donors.

K 2. Discussion

The AIDS programme under CMAZ seems to have important impact on member institutions. As many of these institutions are spread in rural areas and don't easily get in contact with others, it seems like a good approach to have an AIDS Co-ordinator at CMAZ to gather and share information, and also to be a channel for funds for projects. This arrangement secures a professional knowledge and competence on AIDS in CMAZ, as an important resource base for the members, thus strengthening the role of CMAZ.

This is an arrangement which also benefits NORAD, as CMAZ has much better knowledge about the situation in the institutions than NORAD could possibly have, and can manage and monitor the funds and thereby reduce the administrative load on NORAD.

CHURCH HOSPITALS ON THE MAP



LIST OF CONTACTS IN ZAMBIA

Africare	McDonald HOMER, Resident Representative
Breast Feeding Association of Zambia	Alice S. MUNALULA, Chairperson
Catholic Secretariat and Church	Rev. Father I. C. BANTUNGWA, ZEC Secretary General Raymond MPEZELE, Catholic Bishop Director of Health Affairs
Chikuni Health Centre	Eileen DURACK, Sister-in-charge
Chilubula Rural Health Centre	Dr. B.M.BOTI,, MD, Manager
Chivuna Rural Health Centre	SR. Beatrice MALAMBO, R/N/RM
Church Medical Association of Zambia	Mrs. HAIMBE, General Secretary Karen SICHINGA, AIDS Coordinator
Church of the Province of Central Africa	Pierre J. DIL, Vicar General Diocese of Lusaka, Chairman Makeni Ecumenical Centre
Evangelical Church of Zambia	Paul MUSUSU, Dep. Bishop
Family Health Trust	Elizabeth MATAKA, Executive Director
Family Life Movement of Zambia	Raymond MUCHINDU, Assistant Director
Ibwe Rural Health Centre	Mrs. L.T. Jennifer MULIYA
Kara Counselling & Training Trust Ltd.	Michael T. KELLY, Director Wingstone ZULU
Makeni Familyn Planning Project	Alice CHANZA, Dep. Project Coordinator
Masuku Rural Health Centre	Godwin KOBOMBO, Clinical Officer
Microproject Unit	Mary Barton
MOH	Dr. Kalumbo, Deputy Minister Mr. Mzowe, Head of Planning Unit Dr. Patel, Head of Epidemiologi Unit Dr. E. Nangawe, PHC-unit
Monze District Hospital	Hospital Administrator CMO/DMO
Namvianga Rural Health Centre	Gertrude PHIRI, Nurse-in-charge
NGO CC	

NORAD	Bjarne Garden, ass. repr. Unni Knutsen, NGO vote resp. Alf Paulsen, NVS Birgitta Soccorsi, Aids, WID vote
Northern Province Health Education Project on AIDS	Godfredah C. MUGALA, Provincial AIDS Coordinator Liv Inger Nerhagen, NVS Mr MWENYA Mr CHITALIMA
Our Lady Hospital	Dr. Djure SIZCAMA, Med. Superintendent SR. S. WAPAKWENDA, Nursing Officer Sr. M. Josephine GUINEY, ADMINISTRATOR
P.M.O. Kasama	Dr. Christopher SIMUTAVE
Pilgrim Wesleyan Church	Rev. William F. PEED, Mission Director
PPU - Kasama	Oluf MARTINS
Reformed Church in Zambia	Foston D. SAKALA, Moderator General
Salvation Army	Lt. Colonel Thomas KAGORO, Chief Secretary
SAP	Capt. MOHN Mr. Richard DELGANO
SIDA	Margaret Tullberg, health sector resp.
Sikalonga Rural Health Centre	Josias LUNGU
United Church of Zambia	Joseph A. SIMWINGA, Medical Secretary
UNICEF	Dr. SINYANGWE
WHO	Mrs. LESIKEL, Aids-coord.
Zambia Red Cross Society	Chipo Lungo MIS, Secretary General
Zambia Red Cross Society, Livingstone Branch	Mr. P.H. MULEYA, Branch Vice President Mr. D. CHANDA, Provincial Field Officer Mrs. Nellie NCHIMUNYA, Branch Field Officer
Zambian Council for Social Development	
Zambian Union of 7th Day Adventists Church	Charles WICAL, Medical Director Pastor CHIMOGA, Executive Secretary
Zimba Mission Hospital	Storer W. EMMETT, Medical Officer

PROJECT DESIGN
REVIEW OF NORADS HEALTH SECTOR SUPPORT THROUGH NGOS IN ZAMBIA

1. Background

Water and sanitation have been chosen as the main areas of Norwegian development cooperation with Zambia within the country program.

As potential areas for a supplementary strategy to the country programme, support to "The Social Action Plan", with focus on primary health and education through NGOs, Norwegian Volunteer Service and multi-bi, was identified the NORAD Zambia country programme 1991.

The NGO vote in Zambia is considered to be a part of the state to state development cooperation, but not a negotiated part of the programme and should, according to NGO country plan (draft), be related to other NORAD activities in a planned manner and should have a defined role as complementary to other NORAD activities.

NORAD Health Department is currently assessing the entire health sector support in "Hovedsamarbeidsland". The aim is to elaborate a comprehensive strategy for health sector support in each country where support channelled through special allocations (Norwegian Volunteer Service, multi-bi and the NGO-vote) and through the country programme are coordinated and play a complementary role.

In order to develop such an overall strategy for Norwegian support to the health sector in Zambia, NORAD Health Department has taken an initiative to a study of the support through the NGO vote in Zambia.

2. Objective and main focus

The overall aim of the study/review is to contribute to the above mentioned overall strategy for Norwegian support to the health sector in Zambia.

The study intends to achieve a better understanding of the scope for channelling NORAD funds through the NGO sector and should contribute to the development of guide-lines for future support and ways and means of cooperation with NGOs.

The study/review will therefore focus on

1. NORADs current support to NGOs in Zambia in relation to NORAD´s general policy for health sector support.

2. the *capacity and competence of NGOs* when it comes to the implementation of primary health care *in accordance with national guide-lines and priorities*, and their actual role in the implementation of these.

In this study we understand NGOs as:

> *the part of the private sector that could be characterised as "non-governmental, non-profit", in other words "voluntary" organizations with activity within the health sector - hereafter called NGOs. Consequently health services and programmes provided by the industrial sector, mainly concentrated in the Copperbelt are not included.*

The focus of the study is the role of NGOs in providing Primary Health Care in Zambia which according to WHOs definition, includes MCH/FP, AIDS and Water and Sanitation. The district level (DHMT/District Hospital) is considered as the organisational basis for PHC and responsible for the implementation of the PHC services in the district.

The change of government which took place at the end of 1991, represented considerable political changes in Zambia. It is therefore possible that "The Social Action Plan", as it was presented in 1990, no longer represent actual priorities within the national health strategy. Therefore, it is possible that the review, to a certain extent, will be detached from "The Social Action Plan", and rather examine the role of private organisations within the framework of actual national health policy and priorities within the health sector in a broader sense.

3. Mains issues and questions

The following issues relate to the objective and focus of the study and will be included in the study:

1. NORADs current support to NGOs in the health sector
   Which criteria seem to have guided the current support to NGOs involved in the health sector in Zambia?
   Has the projects been implemented according to project proposal?
   How does support to a component relate to the entire project?

   How has the current support related to NORADs general policy on health sector support and to the role allocated to NGOs by Government policy?

2. Government policies
   What role does the Government policy and practice give NGOs within the health sector?

3. NGOs perception of their role
   How do NGOs perceive and define their own work in relation to government health services, policies and plans?
   What role(s) do they themselves, wish to play ?

4. NGOs activities:
   What is actually being done by the NGOs within the health sector (activities, priorities, performance)
   What determines the scale and the nature of involvement? (types and volume of activities)
   What are the strengths and limitations of the NGOs in contributing to the implementation of National policies and plans?

5. Co-ordination and support

What type of relations have been established between

- NGOs and the governmental sector
- NGOs themselves
- NGOs and external support agencies

6. Long-term sustainability of NGOs efforts in the health sector

What is the actual organisational capacity of the NGOs?
What factors seem to be the most critical for their capacity?
What are the realistic potentials for organisational development?
What potential do the different types of NGOs have as a channel for increased support to the health sector in future?

4. Method and implementation

4.1. Development of method and tools for fieldwork

Methods for analysing "sustainability"

Although the role and potential of NGOS within the health sector has been the object of great attention and interest in several countries (SIDA, ODA-Leeds, OECD), there is a need to continue to develop an instrument/tool for analyzing "sustainability". Time will be used in this assignment to develop methods and to analytic work as far as this question of sustainablity is concerned.

Development of questionnaires for basic information on NGOs
one for distribution to *national NGOs headquarters* working in the health sector and another questionnaire that will be used for *collecting information at project level according to selection of relevant projects.*

Development of a questionnaire for collecting information about the NORAD supported projects

4.2. Fieldwork in Zambia

Distribution of questionnaires and follow-up visits with interviews

The fieldwork will include implementation of the questionnaires to national NGOs and some selected projects. Some selected Norad supported projects will be included in this survey. An additional questionnaire will be distributed to these. The questionnaire will be distributed to the most important National NGOs involved in the health sector. The projects to be included will be selected according to agreed criteria and in cooperation with the NGOs.

In-depth study

The fieldwork will also include an "in depth" study of selected and representative organizations/projects. One currently supported NORAD project will possibly be included. These will be selected after discussion with representatives for the NGOs and CMAZ and other relevant people.

Interviews with

- Senior officials in the Zambian Ministry of Health
  (Planning Unit, Health Systems Research, PHC secretariat)

- Department of Economic and Technical Cooperation (NCDP)
  NGO-unit
- Other UN agencies: PHC desk, UNICEF
- Other main donor agencies:
  The Dutch Embassy (Dr. Smedberg), DANIDA, SIDA, ODA
- Umbrella organizations such as
  CMAZ and Zambia Episcopal Conference, Catholic Secretariate
- National NGOs

Review of project documents at NORAD, Zambia.

Workshop
A workshop for the purpose of discussing main issues and factors critical for the sustainability of NGOs efforts in the health sector will be conducted at the end of the field work if resource people are available.

5. The review team

The DiS team will consist of the following members:

Sissel Hodne Steen
Magaret Kaseje
Anne Skjelmerud
Mr. G.M. Ssenkoloto
Ivar Evensmo
Sigrun Møgedal

REFERENCES

Chr. Michelsens Institutt Avd. for Samfunnsvitenskap og Utvikling	Zambia, Landstudie og vurdering av norsk utviklingshjelp 1986
Consultative Group for Zambia	Republic of Zambia, Social Action Programme for 1990-93 April 1990
Dr. Bart Criel, Unit of Research and Training in Public Health	Evaluation of the Monze district hospital Monze district, Southern Province, Republic of Zambia
Freddy Moends, Medicus mundi	Mission report. Health interventions in Kasama Archdiocese, Zambia, Jan. - Feb. 1992
Government of Republic of Zambia	Fourth National Development Plan
Government of the republic of Zambia, Ministry of Health	Health by the people implementing primary health care in Zambia, The Planning Unit Jan. 1981
Government of Zambia	The Social action programme 1991-94 Policy working paper
Health Information Unit, Ministry of Health, Zambia	Health Facilities in Zambia 1990 Republic of Zambia, 1990
International planned parenthood federation.	Overall programme evaluation of the planned parenthood association of Zambia (PPAZ) Evaluation & Management audit department
International planned parenthood federation.	Management review of Planned parenthood association of Zambia, 1991
Lea Moua, HEDEC	Health and social sectors in Zambia A review of available information and preliminary problem analysis, HEDEC Health Development Cooperation group/National Board of Health, Finland Oct. 1990
Ministry of Health Family Health Programme, Republic of Zambia	Rapid evaluation of maternal health and family planning (rem-Zambia) 1989
Paul J Freund, University of Zambia	Health care in a declining economy: The case of Zambia. Soc. Sci. Med. Vol. 23 No. 9. pp. 875-888, 1986

Republic of Zambia	Zambia´s national population policy, Office of the president, Lusaka
Roy K. Saviye	Churches Medical Association of Zambia, Record of Approved Minutes 1985-89 CMAZ, 1990
S. Dahlgren et al.	No short cuts to health. 1989/3 An evaluation of SIDA Health Sector Support to Zambia 1979-1988 SIDA, 1989
Sara Bennett, Manengu Musambo	Bamako Initiative Technical report. Report on Community financing and district management strengthening in Zambia. Ministry of Health and UNICEF, Sept. 1990
Stephanie Simmonds et al. ODA	Health and Population Sector Review April 1989 British Development Division in Southern Africa
United nations children´s fund	Economic and Social Council, Country programme recommendation* Zambia, Feb.. 1991

EVALUATION REPORTS

1.85 LO's (Norwegian Trade Union) Development Assistance
2.85 Rural Water Supply Reconstruction and Development Programme - DDF, Zimbabwe
3.85 Opplæringsstøtteordningen
4.85 REDD BARNA Development Efforts - Ethiopia and Sri Lanka
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