THE TRENDS AND CHARACTERISTICS OF DONOR FUNDING PATTERNS OF NATIONAL TUBERCULOSIS, MALARIA AND HIV PROGRAMS IN ZAMBIA

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A mini-thesis submitted in partial fulfillment of the requirements for the degree of Masters in Public Health at the School of Public Health, University of the Western Cape

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Key Words

Donors, Recipients, Funding, Tuberculosis, Malaria, HIV/AIDS, Modalities, Sustainability Predictability, Conditionality

ABSTRACT

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Introduction

Tuberculosis, malaria and HIV put enormous socio-economic and demographic strain on several African countries, as they are among the largest contributors to morbidity and mortality. There are tools and strategies to manage and control these diseases. But many countries lack local resources to implement these interventions due to weak economies and policy constraints.

While substantial external funding is required to support the interventions, such donor funding has often led to problems. Recipient countries lack capacity to distribute donor funds and use these funds effectively. There are problems of poor donor co-ordination, duplication, lack of alignment with host national programs and inadequate local control of these donor funded programmes.

Zambia, being one of the largest recipients of external funding, is facing some of these challenges. Therefore an assessment of the various challenges posed by donor funded allocations is considered useful.

Aims

The study aims to assess the characteristics of donor funding for national tuberculosis, malaria and HIV programmes to Zambia over an 8 year period in order to inform it's more effective and efficient utilization.

Methodology

A descriptive study design was employed utilizing quantitative as well as qualitative research methodology. Donor reports and documents over the period 2000-2007 were reviewed.

The study population was all donors known to have funded the three disease programs. Sub samples of the largest funders among different types of donors were purposely sampled; and key recipients were purposely sampled to provide comprehensive coverage of all types of recipients.

Donor funding data were collected and analyzed from reports and document of donors and the recipient country. The questionnaire further elicited funding data as well as characteristics of funding, namely predictability, sustainability, modality, conditionality and ownership. In-depth

interviews were conducted with recipients to gain a deeper understanding of questionnaire findings. The study was conducted in Lusaka, capital of Zambia where most of the donors and recipients offices are.

Results

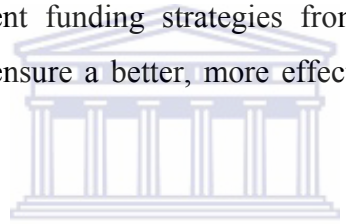
For the period of the study, only 26.5% of funding promised, flowed through the study recipients, while the rest of funds went to other recipients. The donor funding from 2003 to 2007 increased by 1,485%; there was a decline in real funding from 2005 to 2006 attributed to 'Dutch Disease', the impact of (local currency) appreciation caused by a range of internal and external factors. Donor allocations of funding between 2000 and 2007 were TB (4%), malaria (7%), and HIV (89%). During the same period bilaterals were the largest funders (71%), foundations (22%), multilateral non-UN (6%) and multilateral UN (1%). In the same period foundations funded 82.86% of all funding to TB, 87.03% to malaria, while bilaterals funded 79.23% to HIV. Between 2000 and 2007 PEPFAR was the largest funder (63%), followed by others (14%), Global Fund (11%), DFID (7%) and World Bank (5%).

On donor fund flows, the Health Ministry was the most preferred recipient (82%), followed by NGOs (54%), while the group of Multi-lateral Non-UN funded the least number of recipients (33%). Donor funding interest was highest for training (91%), followed by infrastructure and procurement (55%), while bilaterals had the highest specified areas of interest in funding (80%). Health Ministry was the most preferred mode of funding (73%), followed by Health Ministry Agent, and NGO (55%), while Multilateral Non-UN showed least preference in funding modality. Transparency& accountability, and effective & efficient implementation of programs were the most commonly imposed conditionalities by donors (36%), while Multilateral Non UN and foundations imposed 40% of all conditionalities. 50% of donors' programs were affected by the IMF conditionality of restricting public spending in the recipient country. 91% of the donors disbursed 81-100% of funding committed, while foundations had the most flexible disbursing time frame. Majority of donors preferred a four year funding commitment time frame (54%). 63% of the donors shared running costs with the recipients.

Recommendations

- Zambia must enact rules and regulations, to capture all donor fund inflows to Zambia.
- There should be a strong donor fund monitoring system to systematically and regularly track all fund inflows into Zambia by way of tracking expenditure. National Health Accounts must be adopted as a gold standard.
- Donor funding to Zambia should be cushioned from local exchange rate fluctuations by fixing exchange rates for the donor funds

- There must be a consultation process between Donors in Zambia and Zambia from the onset to determine which programs to fund, taking into consideration that the objective is to support the sector with one investment plan only
- Donors in Zambia's commitment to disbursement of funds should address benchmarks/conditionality of funding and the sustainability of programs, prior to the funding. The donors should disburse funding based on one set of recipient country reports.
- Zambia should re-look at the new Aid Policy, and allow Donors in Zambia to fund the health sector by moving to General Budget Support in a systematic and coordinated way.
- The IMF should urgently review its conditionality of maintaining the GDP: PE (Gross Domestic Product: Personal Emolument) ratio by including an exceptionality for the health sector as it is labor intensive
- Domestic resources must scale up health budgets to critical areas, while donor funds to Zambia must be channeled to non critical areas.
- There must be periodic evaluations of the impact of the donor funding to Zambia so as to improve programs; re-orient funding strategies from highly vertical to mixed vertical-horizontal programs; and ensure a better, more effective and efficient utilization of donor funds.



DECLARATION

I declare that *The Trends and Characteristics of Donor Funding Patterns of National Tuberculosis, Malaria and HIV Programs in Zambia* is my own work, that it has not been submitted for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged by complete references.

Full name Akbar Yusuf Badat

Date .....

Signed .....

Dedication

Dedicated to His Excellency, the late Dr. Levy Patrick Mwanawasa, S.C. (1948-2008) President of Republic of Zambia, a friend and a former colleague in Parliament; whose untimely death, while on duty, left Zambia in a state of mourning and grief; a dedicated, hardworking and honest leader; strived to lead a corrupt free society; upheld democratic principles and strict rule of Law; worked tirelessly to uplift the standard of Zambians, from abject poverty to a relatively prosperous Country; whose Presidential Mission Statement is admired by millions of Zambians both at home and abroad:

"I will provide continuity with change
In the interest of our Nation
Zambia, and the common good,
sacrificing all and expecting
little in return,
I wholeheartedly commit myself
with God's help and guidance,
to serve Zambia and
Zambians to the best of my ability with loyalty,
honor and integrity
with all my heart and strength,
with love and Justice,
with consideration and compassion,
with commitment and dedication and in
collaboration with all stakeholders,
women and men of goodwill,
to give fresh hope to our people,
to create opportunities for all and bring honor,
dignity and prosperous to our Country,
through honest selfless hard work
above and beyond the normal call of duty"

May His Soul Rest In Peace

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My Medical Practice staff and patients who showed understanding and patience during my absences

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DEFINITIONS

Commitment: Funds set aside to cover costs for a program which spans over a period of time

Conditionality: A set of conditions imposed on recipients which are linked to the funding provided by the donors

Disbursements: Funds that are actually disbursed

Donor Funding: Aid given by government and economic agencies to support the social, economic and political development of developing countries

Dutch Disease: The impact of (local currency) appreciation caused by a range of external factors.

FBO: Is an organization affiliated with a religious denomination

General Budget Support: Aid to governments that is not earmarked to specific projects or expenditure items

HIV/AIDS: A viral infection caused by unprotected sex, blood contamination, and mother-to-child transmission, commonly affecting sexually active people, and persons exposed to the virus.

Joint Disbursement Mechanism: Donors funding the basket agree to disburse funding at the same time based on one set of recipient country reports

Malaria: A parasitic infection caused by a Plasmodium species which is transmitted by a bite of Anopheles mosquito, known to affect predominantly the hematological system, commonly seen in young children and expectant mothers and people often exposed the vector

Modalities: A mechanism used by donor to fund directly or indirectly a recipient country

NGO: Is a non-governmental group, non-profit making, organized around a common interest

Ownership: Is effective leadership by a recipient country over its policies, strategies, and priorities, and systematic coordination of these for the benefit of its people

Predictability: The funding that follows at a mutually agreed pace and time frame

Recipients: Any organization, institution, or country which receives donor funding

Sector Budget Support (SBS): All donors funding are taken fully into account in the recipient governments planning and budget process, and are transferred into recipient government accounts and blended with domestic resources to be spent according to national procedures.

Sector-Wide Approach (SWAp): All donors funding for the sector that supports a single sector policy and expenditure program under government leadership, adopting common approaches across the sector and progressing towards relying on government procedures for funds

Sustainability: The continuation of benefits after major assistance from a donor has been completed

Tuberculosis: A bacterial infection caused by Mycobacterium Tuberculosis, known to affect predominantly the lungs, commonly seen in immune compromised, socially deprived, and overcrowded environment

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LIST OF ABBREVIATIONS

AAA	Accra Agenda for Action
AfDB	African Development Bank
AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral (drug)
Ausaid	Australian Aid
CCM	Country Co-coordinating Mechanism
CDC	Centers for (Infectious) Disease Control
CGD	Centre for Global Development
CHAZ	Churches Health Association of Zambia
CIDA	Canadian International Development Agency
DAH	Development Assistance for Health
DANIDA	Danish International Development Agency
DCI	Development Cooperation Ireland
DFID	Department for International Development (United Kingdom, UK)
DOTS	Daily observed therapy, short course
EU	European Union
FBO	Faith-Based Organization
FNDP	Fifth National Development Plan
FDA	Food and Drug Administration
GAVI	Global Alliance for Vaccines and Immunization
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GHP	Global Health Partnership
GHI	Global Health Initiative
HIPC	Highly Indebted Poor Country
HQ	Headquarters
HIV	Human Immunodeficiency Virus
ILO	International Labor Organization
IHSD	Institute for Health Sector Development
IMF	International Monetary Fund
IPT	Intermittent Preventive Treatment
IRS	Indoor Residual Spraying
ITN	Insecticide Treated Nets
JICA	Japanese International Cooperation Agency
MAP	Multi Country AIDS Program
MACEPA	Malaria Control and Evaluation Partnership in Africa
MDG	Millennium Development Goal
MDR-TB	Multi-drug-Resistant Tuberculosis
NAC	National AIDS Council

NGO	Non Governmental Organization
NORAD	Norwegian Agency for Development Co-operation
ODA	Official Development Assistance
OECD	Organization for Economic Co-operation and Development
PE	Personal Emoluments
PEPFAR	The President's Emergency Plan for AIDS Relief
RBM	Roll Back Malaria
RNE	Royal Netherlands Embassy
SFH	Society for Family Health
SIDA	Swedish International Development Cooperation Authority
SSA	Sub Saharan Africa
SWAp	Sector-Wide Approach
TB	Tuberculosis
UN	United Nations
UNAIDS	The Joint United Nations programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
US	United States
WB	The World Bank
WFP	World Food Program
WHO	The World Health Organization
ZANARA	Zambia National Response to HIV/AIDS
ZMK	Zambian Kwacha
ZNAN	Zambia National AIDS Network

Chapter 1

INTRODUCTION

1. Overview

Tuberculosis, malaria and HIV/AIDS are ravaging the African continent putting enormous socio-economic and demographic strain on many countries. Together they account for 25% of Africa's global disease burden (Atim 2006). Various effective interventions are available to reduce morbidity and mortality from the three diseases. There is a demand for substantial resources for successful interventions. Such resources are presently supplied, in many countries, predominantly by external donors.

Tuberculosis, malaria and HIV/AIDS are major contributors to morbidity and mortality in Africa. Tuberculosis cases are increasing in Africa, fuelled by the HIV pandemic, with more than 80% of patients living in Sub-Saharan Africa (SSA) and Asia (WHO 2006). Malaria in Africa accounts for 60% of cases worldwide, while 80% of deaths attributed to malaria are in SSA. (UNICEF/WHO 2005). One tenth of the world's population lives in SSA, yet it is a home to almost 64% of all people living with HIV. Further, in SSA 2.7 million become infected yearly with HIV, with 2.0 million adult people dying of AIDS (UNAIDS 2006).

A number of interventions exist to tackle the three diseases. Daily observed treatment (short course) (DOTS) is the cornerstone of tuberculosis management, and with streamlining of TB/HIV activities there is mainstreaming of DOTS-Plus to diagnose and treat Multi-drug-Resistant Tuberculosis (MDR-TB) effectively. New diagnostics, drugs and vaccines are emerging interventions. Malaria has been managed with various anti-malarial, and prevention strategies like Insecticide Treated Nets (ITN) and Intermittent Preventive Treatment (IPT) in expectant mothers. There have been recent developments in rapid diagnostic tests, new disease management protocols and anti-malarial combinations. Various combinations of Anti-Retroviral Therapy (ARV's), new diagnostic equipment for monitoring of patients, and the aftercare of patients and communities, are strategies currently in use to manage HIV/AIDS. Much research is occurring in the development of

microbicides and vaccines. There is a huge cost to Africa in implementing the current and evolving interventions.

The estimated cost of supporting malaria interventions is around US $3.2 billion per year for 82 countries with the highest burden of malaria (US $1.9 billion for Africa and US $1.2 billion elsewhere) (UNICEF/WHO 2005). According to WHO (2006) the estimated cost of tuberculosis control was US $ 1.6 billion in 22 high burden countries in 2006, increasing to US $2.0 billion for all 74 countries that provided financial data. For HIV control, the estimated cost is US $14.9 billion in 2006, US $18.1 billion in 2007 and US $22.1 billion in 2008 (UNAIDS 2006).

There is increasing recognition of several challenges posed by the nature of current donor funding. It is different now from what it was throughout the twentieth century in two respects: selective and comprehensive models are being implemented in parallel in aid-recipient countries; and the array of actors at global and country levels is broader and their relationships are less clear (Brugha 2008). While the funds provided by donors have helped in combating diseases, there is an ongoing debate about funding arrangements.

Zambia, once a middle income country, is richly endowed with natural resources, being the third largest copper producer in the world. When the world copper price tumbled in 1970's, there was a devastating effect on Zambia's economy. Government expenditure drastically fell from 45% of Gross Domestic Product (GDP) in 1980 to less than 25% in 1994, while the health sector budget was reduced by 31% between 1984 and 1991 (Lake & Musumali, 1999). Zambia which had always enjoyed donor assistance further resorted to external resources to finance development, and for balance of payment support, culminating in heavy debt to donors by 1991. Zambia obtained some relief under the Highly Indebted Poor Country (HIPC) initiative but still has debt repayment obligations (McKinley & Weeks 2006).

With a declining economy, rise in poverty levels, run down health infrastructure, brain drain of medical personnel, and the transition from state to free economy with dire social consequences, Zambia faced serious health challenges amongst them a rise in tuberculosis, malaria and HIV/AIDS cases. The tuberculosis notification rate increased from 105 per 1000 population in 1985 to 545 in 2002; the malaria incidence rate tripled from 121 per 1,000 population in 1976 to 383 in 2004;

while the 2001-2002 Zambia Demographic and Health Survey found the HIV prevalence rate in the general population to be 16%, being one of the worst affected in SSA (MOH 2005).

As Zambia faced scarce local resources for effective health spending, from 2000 there was a significant increase in funding from new donors coming on the scene. These donors were responding to a desperate need in affected countries to accelerate the scale up of the fight against tuberculosis, malaria and HIV/AIDS, by urgent top-down finance. The new donors were: the Global Fund to Fight AIDS Tuberculosis and Malaria (GFATM), the (United States) President's Emergency Plan for AIDS Relief (PEPFAR), the World Bank Multi Country AIDS Program (MAP), and a number of bilateral donors. Zambia was so overwhelmed by donor funding that the external resources for health as a percentage of total health expenditure on health rose from 17.8% in 2000, to 26.02% in 2002, 34.0% in 2004, and 37.2% in 2006 (WHO 2008).

1.2 Problem Statement

The Zambian government support for the health budget has been declining in real terms during the period 2005-2008. The health budget as a percentage of total Government of Republic of Zambia (GRZ) budget declined from 11.5% in 2005 to 10.3% in 2006, 9.6% in 2007 and then increased to 11.2% in 2008 (MOH 2008b). The health sector is now donor dependent, with the domestic revenue for HIV interventions in Zambia accounting for only 6% of HIV/AIDS program budgets (MOH 2008a).

There is no central data bank for donor funding, nor rules or procedures to capture all donor inflows. Further, there are limited studies to identify all the donors and the funding trends for the three diseases. This study will establish the donors and assess the donor funding trends for the three diseases over an eight year period.

Zambia has weak health systems which are being overwhelmed by large amounts of donor funds earmarked for disease specific functions. This has caused serious distortions of health budgets and clouded priority setting. Further, nearly all donors require that there should be separate plans and budgets despite the Health Ministry having one sector strategic plan. Zambia now has more than five separate plans and budgets for the major donors contributing to the fight against TB, malaria,

HIV/AIDS and Childhood Illnesses (MOH 2007). There are increased transaction costs, exacerbated administrative inefficiencies, inefficiencies in service delivery through duplication, and misplaced priorities as donor preferences prevail over national health priorities.

Further, the donors have not focused on building strong sustainable health systems. In Zambia only 10% of all donor support for health goes directly to Health Ministry (MOH 2007). The Health Ministry is not even aware about these resources and how they are channeled nor is it given an opportunity to influence the allocation of these resources to priority areas based on the fundamental principles of equity. The Health Ministry has acknowledged practical problems in compiling updated and current National Health Accounts (NHA) (MOH 2006).

Appendix I provide an illustration of the range of potential problems which have been identified with donor funding, such as predictability, sustainability, modality and conditionality. This study will further identify: weaknesses in utilization and disbursement of funds, inadequacies in the monitoring of funds, policy overlaps, policy gaps, and help identify donor synergies for the three diseases over an eight year period.

1.3 Justification of Study

Zambia was chosen for the study: as it is a SSA country; donor funding will continue to remain one of the main health financing sources in years to come (MOFNP 2006b); tuberculosis, malaria, and HIV/AIDS are still the top five causes of death in Zambia and shall continue to pose significant challenges (MOFNP 2008a); Zambia has the potential to meet the health Millennium Development Goals (MDG) by 2015 but much work still remains to be done (MOFNP 2008c); both Zambia and the donors have now recognized that external resources should be better disbursed, planned, utilized, monitored and have their impact enhanced (MOFNP 2005b); and, there is always a continuous need to review, improve, and strengthen its health policy and implementation framework as the situation is dynamic, and evolving over time.

The above justify the undertaking of this study to determine the flow of donor funds to national tuberculosis, malaria and HIV programs in Zambia between 2000 and 2007 and to analyze problems associated with the funding so as to inform more effective and efficient utilization of the funding.

Chapter 2

LITERATURE REVIEW

The chapter begins by looking at the significance of donor funding. It is followed by literature on donor funding trends, characteristics of donor funding and the various challenges associated with donor funding. Finally, Zambian studies on donor funding are examined.

2.1 Significance of Donor Funding

Additional donor funding, estimated to be $25 billion a year, will be required to meet the health Millennium Development Goals (Gottret & Schieber 2006). According to the same authors, the Commission on Macroeconomics and Health of the World Health Organization estimated that an additional $40 billion to $50 billion will be needed annually until 2015 to scale up coverage to address malaria, tuberculosis, HIV/AIDS, childhood mortality, and maternal mortality. Tuberculosis, malaria and HIV are key public health challenges that will require continued donor funding now and in the coming years, to achieve the Millennium Development Goals (MDG's) of halving prevalence of the three diseases by 2015 (UN Millennium Project 2005).

2.2 Donor Funding Trends

Donor funding for health to SSA increased from US $2.6 billion in 1990 to more than US $10 billion in 2003 (Atim 2006). According to the same author, this is due to entry of new funders, the Global Health Partnerships (GHP's) like GFATM, Global Alliance for Vaccines and Immunization (GAVI), Roll Back Malaria (RBM), and the PEPFAR.

Disease-specific donor funding patterns have also shown an upward trend. Donor funding for tuberculosis rose between 1999 and 2003 reaching a record US $405 million in 2004, GFATM being a major funder (Stop TB Partnership 2005). Malaria had an increase in donor funding between 1999 and 2004 with SSA receiving more than 75% of this increase since 2001 and GFATM being a major funder (Martin et al 2005). The funding pledges for HIV doubled between 2002 and 2004 to over US $6 billion, with 72% allocated to 25 countries mostly in Africa and the

Caribbean. The funding is mainly attributed to GFATM and Organization for Economic Co-operation and Development (OECD) countries that have increased bilateral funding although this is dominated by PEPFAR (Lewis 2005).

There have been variations in donor funding priorities. Shiffmann (2006) in a study of 42 donors funding 20 high burden communicable diseases between 1996 to 2003 found a link between direct funding of the three diseases and their burden in the industrialized world. HIV/AIDS having a high burden in industrialized countries received greatest donor attention. According to the same author, tuberculosis is better funded than malaria with donor interest possibly reflecting an industrialized country burden of tuberculosis 25 times greater than malaria although the burden of tuberculosis is 57% lower than malaria in developing countries.

Trends in donor funding are also affected by predictability (and sustainability) of donor funding. .According to Hecht & Shah (2006) in Comoros and Eritrea where year-to-year changes in donor funding amount to about a fifth of all public spending for health, the fluctuation in donor funding was so great that coherent national planning of health programs was almost impossible. In Ghana disbursement uncertainties by donors caused difficulties in short and medium term planning, a situation where government identified GHP funded proposals as part of its national strategies, leading to distortions when GFATM applications were not approved (High Level Forum on Health MDG's 2005a).

Donor funding is adding significant resources to already existing resource inflows. According to Pearson (2004) the GHPs accounted for at least 50% in health spending in the 13 countries under study while in Ethiopia, Liberia and Malawi they accounted for 100% of health spending. Buse et al (2004) have pointed out that GHPs, PEPFAR and Multi Country AIDS Program (MAP) are likely to double the level of resources for health in around ten countries and significantly increase resources in many others. Recipient countries are unlikely to be able to meet ongoing costs once the funding ends after the 5-year period. Further, the recipient country spending patterns could be distorted by these health initiatives with an ongoing need to sustain activities and services provided by them rather than support recipient country priorities.

According to Cali & te Velde (2007), the adverse impact of a sudden inflow of large amounts of foreign exchange on the national economy was the appreciation of the real exchange rate and the decline in export competitiveness. Such countries suffered from 'Dutch Disease', a term derived from the Netherlands, when natural gas was discovered in the North Sea in the 1960's, which induced an expansion in public current expenditure and an appreciation of the currency, which resulted in reduced Dutch export competitiveness (Mukungu et al 2007).

Further, the Global Health Initiatives (GHI's) have impacted on the recipient country health systems. In a 10 country study from completed and on-going research by Global HIV/AIDS Initiative (GHIN), there was a major problem of shortages of staff to meet the growth in services, with an imbalance between public and non-governmental sectors (GHIN 2008). While training and motivation were key factors in delivery of HIV/AIDS programs, the effect of this on non-HIV patients still needs to be assessed.

2.3 Characteristics of Donor Funding

The mechanism used by donors to fund directly or indirectly the recipient country is a key characteristic of donor funding. Buse et al (1999) in a study of Malawi, Mozambique, South Africa, Zambia, Bangladesh and Cambodia found that Malawi had few aid co-ordination and management instruments while Mozambique had developed multiple instruments over time. One of the instruments, Sector-Wide Approach (SWAp) was not available or was still an emerging concept at the time of this study.

An IHSD (2003) study on the status of SWAp's in eleven countries concluded that Ghana, Tanzania, Mozambique, Senegal and Bangladesh began SWAp in 1997, and later Zambia and Mali. Uganda and Burkina Faso launched it in 2000 and 2002 respectively while Cambodia and Malawi were in the process. In the same study, different partner agencies played a different role in the SWAp. DFID, the Netherlands, NORAD, and WB played a leading role in SWAp while DANIDA, DCI, UNICEF, WHO, EU, SIDA and UNFPA were supportive. Bilaterals like Spain, Italy and France were not involved in the SWAp. Further, there was a major concern by most countries that Global Health Initiatives like GAVI and GFATM were outside the SWAp. In some countries, MAP, Clinton Fund and PEPFAR are also mentioned as being outside the SWAp.

Bernstein and Sessions (2007) analyzed disbursement policies of key donor funders. The GFATM disburses funds directly to Principal Recipients following Board approval. The disbursement is in advance of program activities, further funding being released periodically. The PEPFAR which is a 5-year US bilateral government program to 15 core recipient countries disburses funds to recipient organizations following yearly congressional budgetary cycles. There is advance payment depending on the funding agreement. The World Bank (WB) MAP as a financial institution disburses grants or credits in 3-5 year cycles to a recipient government account provided there is in place a high level HIV/AIDS country coordinating body with broad participation.

On conditionality, Carter et al (2004) have explored the effects of International Monetary Fund (IMF) conditionality on public health sector spending. As inflation rates are affected by money introduced into the domestic economy, the IMF conditionality requiring low income countries to maintain low inflation rates reduces public spending. Further, the conditionality of reducing the budget deficit has affected public sector spending. One of the IMF's conditions to Senegal was for it to reduce the budget deficit from 4% of GDP to 3.5% of GDP over a three-year period, but if that 0.5% of GDP was used to increase spending on health rather than for paying off the deficit, the national health budget could have been doubled for each year of the 3-year loan program (Carter et al 2004).

The World Bank funding has a series of intricate procedural requirements for program implementation on assumption that such procedures ensure accountability and reduce misuse of money, but actually it's becoming a bottleneck in the smooth flow of funds (Bernstein et al 2007).

Radelet (2004) noted that the GFATM has performance-based funding where benchmarks are set by recipients themselves in their proposals, but reduces or redirects funding to programs that do not meet the benchmarks. In a study by Shakow (2006), the Global Fund refused to approve releases due to failure to meet required measures of performance (Senegal), and suspended grants due to inadequate fiduciary performance (Uganda). But, performance-based funding has problems in countries where there is an inability to implement projects quickly due to lack of capacity (e.g. small Caribbean nations). Rivers (2008) in a White Paper to re-enforce effectiveness of GFATM identified that some of the Global Fund rules for grant implementers are too burdensome, or they are enforced in too rigid a manner, with transaction costs of dealing with Global Fund becoming too high.

According to the Government Accountability Office (2007) it's the limited capacity in recipient countries that have negatively affected performance. There are weaknesses in financial, procurement and monitoring and evaluation systems.

PEPFAR which promotes the ABC model (Abstain, Be faithful, or use Condoms) recommends that 20% of funds must be spent on prevention, of which 33% must be spent on abstinence-until marriage activities (Government Accountability Office 2006). According to this survey, of United States teams in 15 target countries and five other countries which receive PEPFAR funding, the requirements for abstinence and faithfulness spending presented challenges to their ability to respond to local prevention needs. A number of focus countries had to reduce spending on prevention of Mother-to-Child HIV transmission in order to meet the requirements (Government Accountability Office 2006).

Case studies on Mali, Mozambique, Papua New Guinea and Tanzania to look at national structures and co-ordination instruments as well as the related efforts of health development partners and donors, showed growing harmonization and alignment between governments, bilateral and multilateral agencies (GFATM 2005). In the McKinsey study, field research was conducted in 20 countries on issues that recipient countries struggle with when working with GHP's individually and collectively (Bill and Melinda Gates Foundation, 2005). The study discovered that recipient countries that worked well with GHP's had certain defining characteristics. Vietnam, Zambia and Tanzania where policies are set at national level and action plans are determined at district level in accordance with national priorities, were better able to fit GHP resources into their health activities. This is an example of clearly established roles of central and district governments. In the same study, in Vietnam, Bangladesh, Kyrgyz Republic, China, Tanzania and Ghana, the GHP funding supported execution of the existing health strategy with no distortion of existing priorities. These countries had strong and integrated health plans (Bill and Melinda Gates Foundation, 2005).

2.4 Challenges Associated with Donor Funding

A number of challenges with regard to donor funding have been highlighted by different authors. The medium to long term role of donors in recipient countries remains unclear. PEPFAR is an emergency response to HIV/AIDS (Carpenter et al 2007). The GFATM is a funding mechanism with unique challenges (Dhaliwal 2006). The WB MAP initiatives are not clearly defined (Shakow 2006). The GHP's and Foundations' role in coming years is yet to be defined (Buse et al 2006).

The projections indicate that needs based on demand during 2008-2010 would be US $4 billion in 2008, US$ 5 billion in 2009 and US$ 6 billion in 2010, bringing the total figure for the period to US$ 15 billion (GFATM 2007a). On average donors disburse only two thirds of aid committed, and in low income countries' the ratio of aid commitment to disbursements is only 50% (High Level Forum on Health MDG's 2005b). The gap between commitments and disbursements is widening without solutions in sight. There is also uncertainty over future funding levels for malaria (Martin et al 2005), and tuberculosis (Stop TB Partnership 2005). The disbursement patterns as against commitments are raising predictability questions.

PEPFAR addresses the issue of sustainability of their programs from a different perspective as it is changing the paradigm for development from 'donor-recipient mentality' to an 'ethic of partnership'. It addresses the specifics of sustainability by emphasizing that 25% of its resources are devoted to building of capacity of public and private institutions, building infrastructure, training and support of workforce, and enhancing capacity for health systems (PEPFAR 2007b). But the report is silent on financial sustainability in the coming years.

There have been different modalities of funding to recipient countries (Lake & Musumali 1999) with no mechanism to track resource flows at country level (CGD 2005). Some GHP's are not supporting country financing mechanisms (Bill & Melinda Gates Foundation 2005). The role of Country Coordinating Mechanisms (CCM) other than receiving Global Fund proposals is unclear, especially on disbursements (Bernstein & Sessions 2007, Dhaliwal 2006, LSHTM 2005). The WB channels funds through government ministries and NGO bodies (Shakow 2006) while PEPFAR funds recipients through its agencies (Bernstein & Sessions 2007) with consequences like duplication, improper co-ordination and lack of alignment with host national programs.

Each donor sets their own conditions which are expected to be followed by a recipient country within a specified time frame to access funding. Developing countries are still repaying debts despite the HIPC initiative which was meant to be a substantial debt write off (Carter et al). What is not clear is whether there are still restrictions on public spending due to IMF conditionality or not. There are other conditionalities pertaining to specific institutions whose reasons are not established. The WB insists on country co-ordinating bodies with broad participation (NAC) (Shakow 2006). Its role is in conflict with Global Fund initiated CCM's (Bernstein & Sessions 2007). There are PEPFAR conditionalities on using only FDA approved ARVs, rigid budget allocations for treatment, care, prevention and orphans and vulnerable children, and fixed

percentage allocations to be spent on prevention not in line with local needs (Carter et al 2007, Bernstein & Session 2007, Government Accountability Office, 2006).

On ownership, the challenge for recipient countries is to secure ownership by developing capacity to identify problems, set priorities, and establish accountable systems, while the challenge for donors are to be accountable by providing support to national plans and policies by aligning with them and harmonizing with each other (UNAIDS 2005).

The implementation vision for national ownership of country programmes is uneven (UNAIDS 2005). The "Three Ones" principle of One Country Level Action Framework, One National Coordinating Authority and One Country Level Monitoring and Evaluation System, is not being applied and this has posed serious challenges to service delivery, and substantial donor resources remain unutilized. Due to a lack of clearly defined ownership there are parallel and duplicative processes from multiple GHP's (Bill & Melinda Gates Foundation, 2005) with difficulties in persuading donors to pool funds.

2.5 Studies in Zambia

There have been limited studies on the donor funding and the problems associated with it.

A sustainability analysis of Zambia's main HIV/AIDS services over a five-year time horizon was assessed (MOH 2008a). The study team used the HIV/AIDS Program Sustainability Analysis Tool (HAPSAT) and three primary conclusions were drawn: Zambia is heavily donor dependent on funding for HIV/AIDS services, whereby in 2007 only 6% of funding came from domestic sources; human resources for health pose a major constraint in sustaining or expanding services in coming years; and, to scale up HIV/AIDS services to moderate or full coverage levels over the long term, significant financial and human resources need to be mobilized.

Bernstein et al (2007) examined the flow of resources from three of the world's largest donors GFATM, PEPFAR and World Bank MAP to three countries where the programs were active: Zambia, Uganda and Mozambique. GFATM did well on tailoring programs and sharing data; PEPFAR performed well on making the money move and on collecting data; while World Bank stood out for its long term commitments to working with government, strengthening systems, and building local recipients' capacity.

The funding by donors to various sectors of the economy is being streamlined following the launch of Zambia's Aid Policy and Strategy (MOFNP 2005b). It aims to have a clear, systematic, predictable, and well coordinated approach to acquisition, utilization, management, monitoring, and evaluation of impact of donor assistance. The Finance Ministry will rely on the health sector to provide leadership on Aid Harmonization through its experiences on SWAp over years and attain a full SWAp so that these experiences can be replicated in other sectors (MOH 2007). The Health Ministry wishes to see a full SWAp where donors will support one sector plan; disburse resources into one expanded basket to support that sector plan; implement activities through the government led public health care system; and provide funds in a flexible and predictable way where the Ministry is given leverage to allocate resources and ceases to earmark aid to specific interventions (MOH 2008b).

According to Action for Global Health (2008), a case study on donor coordination and general budget support in Zambia brought out three concerns regarding funding directly to the Zambian Government through general budget support: The money the Finance Ministry allocates to the Health Ministry may not be enough to meet challenging health needs such as HIV AIDS; it takes time for money and improvements in services to reach health workers and patients in communities; and the ability of local community organizations to provide essential health services is weakened as it becomes difficult to access funds.

On one of the major problems Zambia is facing is a serious human resource shortage. A study conducted by the Global HIV/AIDS Initiative (GHIN) found that while there was a small increase in staff delivering HIV services, there were considerable variations between facilities, and in some cases decreases were noted (GHIN 2008). The research found also that health staff workloads had increased since the inception of Global Health Initiative HIV/AIDS programs. Further, the study revealed that workers in Zambia received incentives for HIV/AIDS related services, as opposed to staff for non-HIV services.

This research attempts to address some of the challenges associated with donor funding. It is therefore worthwhile to determine the trends in donor funding and assess the characteristics of the donor funding in a broader perspective. This is why the study is important.

Chapter 3

RESEARCH DESIGN AND METHODOLOGY

This chapter describes the aim and objectives of the study, and the research design, definitions, and methodology utilized in the study. It then describes how data were analyzed, and then lists limitations of the study. The chapter concludes with the ethical considerations.

3.1 Research Aim

The study aims to assess the characteristics of donor funding for national tuberculosis, malaria and HIV programmes to Zambia over an 8 year period in order to inform it's more effective and efficient utilization.

3.2 Research Objectives

(i) To determine the flow and duration of donor funding for the period 2000 to 2007 for national tuberculosis, malaria and HIV programs in Zambia

(ii) To establish the predictability and sustainability of donor funding for the national tuberculosis, malaria and HIV programs in Zambia

(iii) To investigate the modalities of funding by various donors supporting tuberculosis, malaria and HIV programs in Zambia

(iv) To investigate the terms and conditions imposed by donors on Zambia when funding tuberculosis, malaria and HIV programs

3.3 Research Design

The study is a descriptive study using both quantitative and qualitative methods sequentially. The study aims to measure and describes the trend as well as assesses the characteristics of donor funding using quantitative methods initially. This was followed by a qualitative approach to

explore the opinions, perceptions and experiences of key recipients of donor funding and obtain an in-depth understanding of the subject.

The donors funding Zambia for TB/malaria and HIV provide different amounts and with various interests, while the majority of recipients receiving the funding have different levels of structures, staff, and programs and capacity to expend funds.

The range of benefits that such a mixed-method approach offers has been conceptualized by a number of authors. Tashakkori and Teddlie (1998), Knodel (1997) and Obermeyer (1997) demonstrate that combining quantitative and qualitative methods in a study results in a more powerful design than either used alone. The mixed method increases the researcher's understanding of findings.

However, the Mixed-Method approach could pose some problems. Different sources may yield different or even contradictory information. While results from one method do not invalidate the results of the other, it is logical to consider the differences in the context in which they emerge.

3.4 Study Population

The study population includes donor agencies operating in Zambia and various departments and divisions of the Zambian Government as well as various other national level stakeholders.

The study population for the donors includes those known to have funded programs addressing any or all of the three diseases in Zambia from 2000 to 2007. These are in four categories

Multilateral donors (non-UN): WB, EU, AfDB, and GAVI Alliance; Multilateral donors (UN): UNDP, WHO, UNFPA, UNICEF, and UNAIDS; Bilateral donors: PEPFAR, DFID, CDC, CIDA DANIDA, RNE, SIDA, DCI, JICA, NORAD, and AusAid; Foundations: Global Fund, Bill & Melinda Gates Foundation, Clinton Foundation HIV/AIDS Initiative, Soros Foundation and Metclife Foundation.

The study population for recipients was those major recipients known to have received donor funding for the three diseases in Zambia from 2000 to 2007. These include: government (health), government (finance and other ministries excluding health), NGO's, and Faith Based Organizations. These are Ministries of Health, and Finance and National Planning (a key World Bank and Global

Fund recipient), Zambia National AIDS Network (ZNAN) and Churches Health Association of Zambia (CHAZ).

3.5 Sampling Size and Sampling Procedure

The study population consisted of only 25 donors. To choose cases typical of the study population, to allow for selection of donors who were major donors in each of the four categories identified, to reduce sample and response bias, and to fulfill the purpose of the study, subsamples of 3 donors representing highest funders from each of the four categories were purposely sampled. The sample size was 12 donors (48% of the study population).

To explore perceptions, opinions, experiences of recipients, and to obtain an in-depth understanding of the subject, a participant from the four major recipients was purposely selected for interview. Participants were selected for their ability to provide rich information.

3.6 Study Setting

The study was conducted in Lusaka, the capital of Zambia. The vast majority of donors and all key recipients are based here.

3.7 Data Collection

Questionnaire

The semi-structured questionnaire was based on relevant discussion with various stakeholders and a review of literature (Appendix II). Its quality was optimized by having the questionnaire peer-reviewed by academic members of staff at the University of Zambia and Public Health Practitioners. It was pre-tested on donors who were not part of the study. Following pre-test a few questions, particularly ones which pre-test donors felt were sensitive and the few open-ended questions were re-evaluated.

A research assistant was initially trained for data collection, but because of the high profile status of donor interviewees who were at the level of Country Managers, Country Program Managers, Grant

Specialists, and Monitoring and Evaluation Specialists, the researcher conducted the interviews himself while the assistant was given various other tasks tasks that did not require interaction with donors.

Following the initial approach by the researcher to donors to conduct research, all donors requested an official application to conduct a questionnaire interview addressed to respective Heads of Mission and Country Managers. The Participant Information Sheet from the University of The Western Cape and a letter of support from the Zambian Government were communicated to the donors together with the application. There were delays in donors responding to the research request due to respective donor administrative procedures/bureaucracy. But the final response was 92%.

Following formal appointment procedures, all interviews were conducted at the respective donor offices. There was a pre-interview introduction with an explanation given of the study and its potential advantages. Interviews were held in a cordial atmosphere. Confidentiality was assured by having no personal identification of the participant, and the use of a pseudonym. All participants signed the Informed Consent Form without reservation, and all participants requested the interviews to be conducted without any audio-recording.

Questions were read out one at a time and answers recorded in a logical sequence. Questions were asked in the same way, though explanations sometimes differed due to the nature of different donors funding. Completed questionnaires were reviewed at the place of interview and corrected immediately if unclear.

Coding was done by the interviewer on computer following the interviews. Every variable with a measured characteristic had a code set. The qualitative questions in the interview were allocated codes according to the theme in response to the interview question. The coding was checked before data analysis.

In-depth Interview

Due to the sensitivity and complexity of the subject matter an in-depth interview schedule was prepared using a written set of flexibly worded questions as a conversation guide (see Appendix III).

Open questions pre-tested on participants who were not part of the study were used. Few questions were re-evaluated. The research assistant was also trained in qualitative data collection, but because of high profile status of recipient interviewees, who were at the level of Directors in Government Ministries, and senior technical staff in other major recipient organizations, the research assistant was given various other tasks that did not require interaction with recipients.

Following an approach by the researcher to recipients for permission to conduct research, all major recipients requested an official request to conduct an in-depth interview to be addressed to the respective Permanent Secretaries in Government and Heads of recipient organizations. The Participant Information Sheet from the University of The Western Cape, and a letter of support from the Zambian Government were communicated to the recipients together with the request. Again, there were delays in recipients responding to the research request due to respective recipient administrative procedures/bureaucracy. But ultimately the response was 100%.

Following formal appointment procedures, all in-depth interviews were conducted at the respective recipient's offices. An informal chat set the stage for a relaxed atmosphere with the participant. A clear explanation was made of the study to each participant and why the participant had been chosen. All participants agreed to sign the Informed Consent Form and confidentiality was assured by ensuring anonymity of the participant. All participants requested their interviews to be conducted without audio-recording.

The interviews were conducted slowly but did not exceed an hour. Detailed notes were manually recorded.

The interview began with a clear description of the direction the researcher wanted to take. An easy and non-threatening question allowed the participant feel secure. The participant was encouraged to play a more active role in determining the flow of discussion. The main questions related to the themes of the research problem. As the interview progressed with each participant, there was greater openness and detail provided. Delicate and sensitive questions were put last.

When some participants expressed discomfort with sensitive topics, the researcher reminded them

of the confidentiality of the information. All interviews ended on a cordial note and all interviewees assured the researcher they would maintain contact.

Most recipients could not supply the data on donor funding received for TB, malaria and HIV at the time of interview. They requested the interviewer to return for this; this has been a challenge in respect of some recipients.

Documents

Document sources consisted of the Ministry of Health Strategic Plans, available Ministry of Health Annual Reports, Ministry of Finance and National Planning Aid policy and yearly Economic Reports, available reports of donors funding the three diseases, daily newspaper reports from Zambia, and documents located through search engines on the internet.

3.8 Data Analysis

Quantitative Data

Data cleaning procedures were instituted, coding was re-checked, inconsistencies and extreme values in data were identified and corrected to eliminate errors.

Donor funding data obtained from the donors for funding trends were assessed for missing data observations, and, after standardizing the currency, compartmentalized for disease specific funding. The data were then plotted for the period against disease specific funding, and funding for other areas of the health sector for completeness. Extreme patterns in data presented were identified.

Simple numerical analysis was performed to obtain general trends, identify various disease-specific funding patterns, and the role of the various donors in the funding pattern that emerged. Data Analysis was conducted by the researcher with the assistance of a statistician. Data were captured for analysis by using Epi Info Version 6.

Data were analyzed by investigating the distribution of scores for each variable and determining

whether scores on different variables were related to each other. A frequency distribution was created by tables and graphs where a variable was plotted against its frequency. Because of small sample size, non-parametric tests were used.

Qualitative data

The qualitative data were analyzed using the Qualitative Content Analysis Method. The analysis of data by the researcher began at the time data were being collected thus allowing the researcher to collect further data in a more meaningful way to answer research questions. The researcher enlisted an independent researcher to re-analyze the raw data to offset any subjective bias of the researcher.

All answers were written to the interview questions and transcribed logically in full. With a highlighter, all descriptions relevant to the study topic were marked. A further distinct unit of meaning was marked on these highlighted areas.

Most of the text was coded, coding consistency re-checked to avoid inconsistencies and human error. Conclusions were drawn from coded data.

3. 9 Triangulation

Methods triangulation was used. Conclusions were drawn from synthesizing results from different data source.

3.10 Study Limitations

The non-response of PEPFAR, being the largest funder ever to TB/malaria and HIV programs in Zambia, was a major limitation of the study. Data concerning this donor were obtained from literature, secondary data and the recipients. It is possible that this donor may dispute some of the data collected from recipients. It was also not possible to triangulate the information collected about these donor from secondary sources.

Due to the sensitivity of the research, all donors and recipients requested a formal letter to be sent to heads of missions and organizations, and respective Permanent Secretaries and Heads of recipient organizations. The interviewees were not Chief Executives of the donor and recipient agencies, except for Bill and Melinda Gates Foundation and Clinton Foundation. This process could have affected the quality of data and nature of response from the delegated officials as they might have felt constrained to project a good image of their employers.

Since interviews were conducted at participants' work places, there could have been some reluctance to answer some questions properly in this environment, due to time constraint and disruptions from routine office operations such as telephone calls and other clients.

Most participants could not give donor funding data for TB/malaria and HIV funding to Zambia at the time of the interview. They requested the interviewer to return; administrative procedures and bureaucracy slowed down the inflow of data and delayed data analysis.

A few donors gave answers that coincided with stated policies but this did not reflect actual practice as reported by recipients. This was manifested by their inability to give a complete picture of their funding data and funding practices. In one case the interviewer was referred to a recipient to obtain funding data.

3.11 Reliability, validity and generalisability

The reliability was enhanced by using a semi- structured questionnaire which was administered in a uniform way. Further, reliability of response is likely to have been enhanced by the age, educational qualifications and experience of all the participants

.

The questionnaire was constructed from discussion with various stakeholders and the literature review, and it was peer reviewed by academics and experts in the field. Content validity was assured by pre-testing the questionnaire. Validity of the research was further enhanced by the study being conducted with confidentiality guaranteed, the study explained prior to interview, the option of non-participation offered, and interviews being held in privacy in a collegial atmosphere. Validity was further assured as the researcher was the interviewer, thus easily able to respond to questions in instances where clarity was needed or if further probes were required. To increase

research validity, an independent researcher was given the raw data to analyze, areas of differences identified, discussed and results synchronized.

Most importantly, triangulation of data sources was used to increase the validity of results. With the use of two methods the researcher aimed to obtain a more comprehensive and reliable response than one used alone.

Finally, the researcher documented a simple listing of events from research protocol, interview schedule and notes, data collection procedures, the codes, and how they relate to one another, to track the process that led to the conclusions.

The results cannot be generalized as the sample size was 12 (48%) out of a total of 26 donors.

3.12 Ethical Considerations

Written permission in principle was obtained from the Ministry of Health to conduct the study. The Zambia Health Research Ethics Committee and University of the Western Cape Higher Degrees Committee gave Ethical Clearance to conduct the study. A Participant Information Sheet was given in advance requesting their participation and assurances of confidentiality (Appendix IV). The consent of participants was sought and Consent Forms were given to willing participants to sign (Appendix V). Due to the sensitivity of the research pseudonyms were used for participants. All the records will be kept and safeguarded, and will be used for future publications.

Chapter 4

RESULTS

The following chapter presents the results of the study, highlighting the donor funding trends and analyzing the various problems associated with it.

The chapter begins by looking at the various donors and recipients who participated, and then describes the key results of the study. Results from all data collection methods were analyzed. Triangulation of data was effected by synthesizing results from the different data sources and comparing them. Both similarities and differences were observed in the findings.

4.1 Description of Participants

The distribution of the donors interviewed for the study (Table 1) was as follows:

Eleven of the 12 donors responded representing a 92% response rate. They included the WB, EU and AfDB from Multilateral donors (non-UN); UNDP, WHO and UNAIDS from Multilateral donors (UN); DFID and SIDA from Bilateral donors; Global Fund, Bill & Melinda Gates and Clinton Foundation HIV/AIDS Initiative from Foundations. There was a non-response from PEPFAR, a key bilateral, and highest donor funder for TB/malaria and HIV programs in Zambia.

Table 1. Donors Interviewed for the study

Donor	n	(%)
Multilateral, Non UN	3	(27.3)
Multilateral, UN	3	(27.3)
Bilateral	2	(18.2)
Foundation	3	(27.3)
Total	**11**	**(100.0)**

All four major recipients responded, with a response rate of 100%. These were: the Ministry of Health (health sector); the Ministry of Finance and National Planning (representing the Ministry itself and other Ministries excluding the health sector); ZNAN (NGO's) and CHAZ (FBO).

4.2 Donor Funding Trends

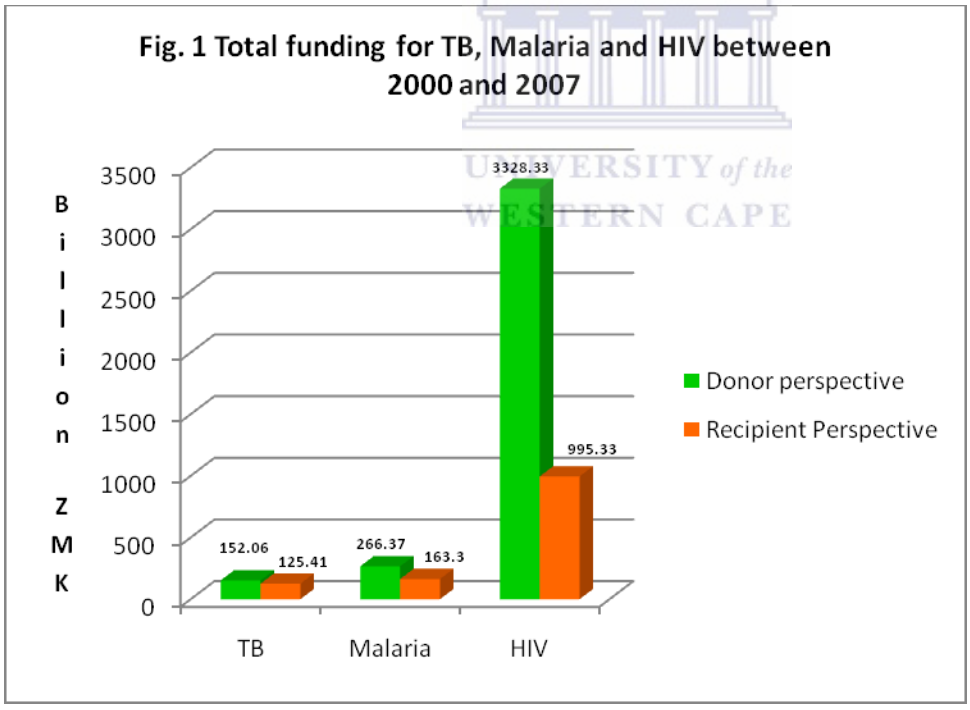
4.2.1 Volume of donor funding for the period 2000 to 2007

Donor perspective

The study revealed that the total donor funding for the period 2000 to 2007 for TB, malaria and HIV was ZMK 3,747.05 billion[1,2] of which tuberculosis was funded ZMK 152.06 billion (4%), Malaria ZMK266.37 billion (7%) and HIV ZMK3,328.62 billion (89%) (Fig. 1).

Recipient perspective

The study revealed that the total donor funding received by major recipients in the period 2000 to 2007 for TB, malaria and HIV was ZMK 996.33 billion[3]. TB donor funding received was ZMK 125.41 billion (12.59%), malaria ZMK 163.30 billion (16.42%), while HIV received the highest donor funding ZMK 995.33 billion (70.99%).

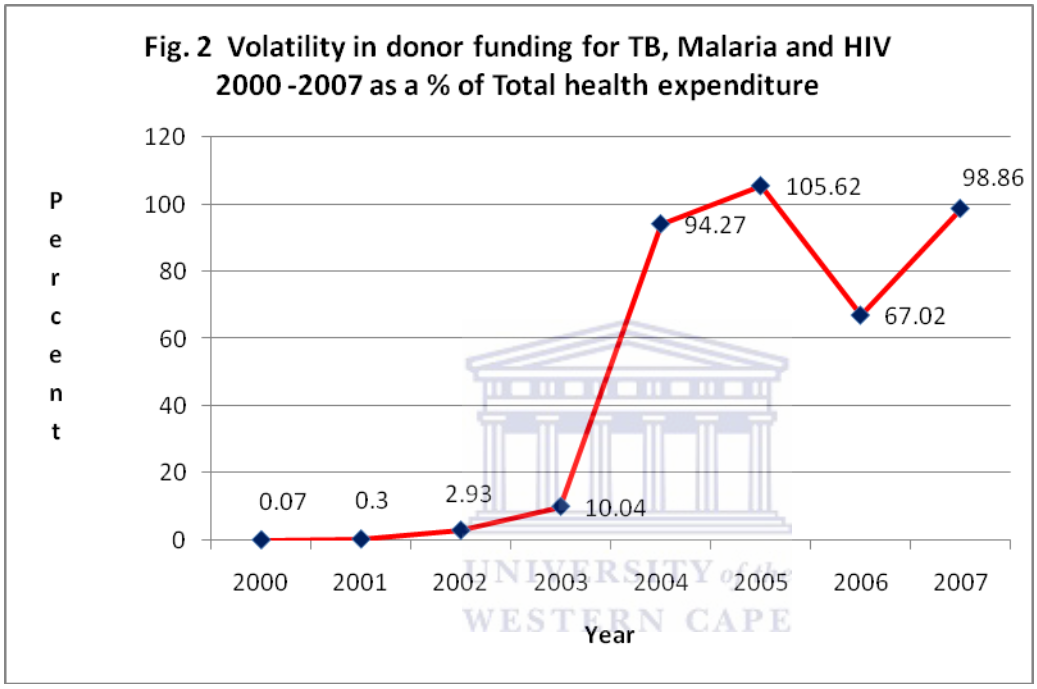


For the purpose of this study:
1 Used the Bank of Zambia Annual average exchange rate US$ to ZMK (Refer APPENDIX VIII)
2 Inclusive of PEPFAR Funding. As PEPFAR was non-response to the study, funding data source was Annual Reports to Congress. Refer PEPFAR (2005), PEPFAR (2006), PEPFAR (2007) & PEPFAR (2008). Also, it should be noted that PEPFAR does not provide disbursements data disaggregated by country. PEPFAR do not publicly release expenditure data for their recipients (Bernstein & Sessions 2007).
Note, further that only 45% of PEPFAR money allocated reaches Zambia (MOH 2008c)
3 Inclusive of PEPFAR funding data from study Recipients only

From the funding data obtained, the four major recipients received only 26.5% of the entire donor funding pledged during period 2000 to 2007 for the three diseases, while the rest of funds went to other recipients.

4.2.2 Volatility in the TB, Malaria and HIV donor funding between 2000 and 2007[4][5]

The volatility in donor funding for TB, malaria and HIV is shown in Fig. 2. In 2004, 2005 and 2007 the funding was almost the same as the total health expenditure of the Zambian Health Ministry.



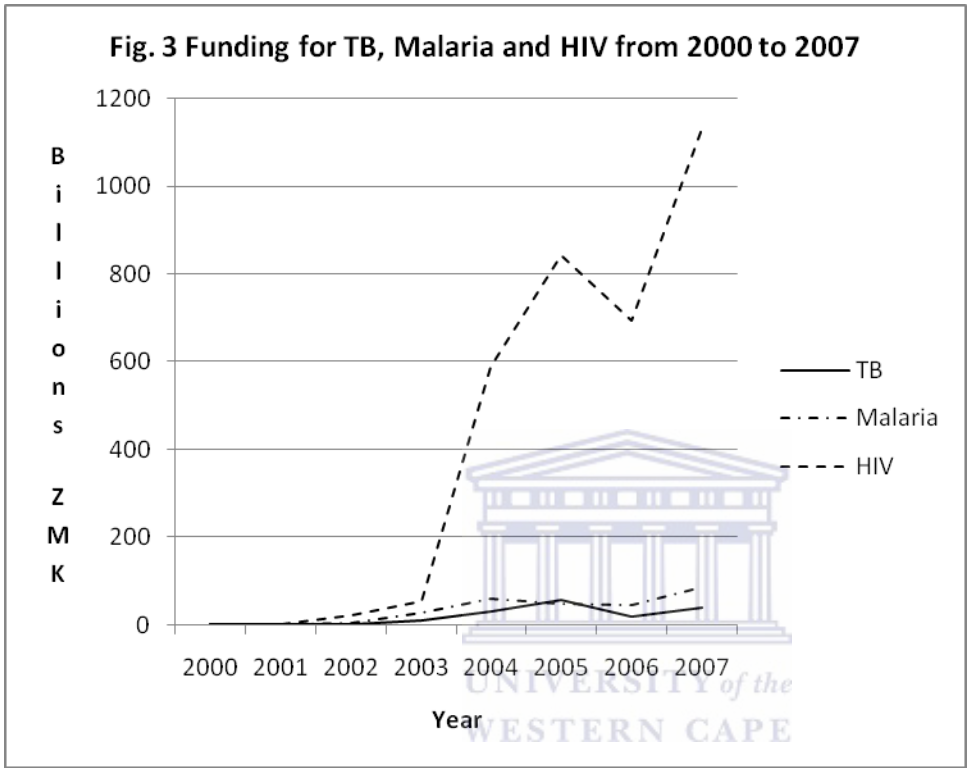
4.2.3 Donor funding trends

Donor perspective

The donor funding trends for TB, malaria and HIV between 2000 and 2007 reveal that there was low level donor funding till 2003 when a surge in donor funding was observed following the entry of the Global Fund in 2003 followed by PEPFAR in 2004 on the funding scene (Fig 3). There was an increase in the donor funding for all the three diseases from ZMK 84.71billion in 2003 to ZMK 1,257.81billion in 2007 representing an increase of 1,485%.

4 The TB, malaria and HIV donor funding is the total funding between 2000 and 2007 from the donor perspective
5 Total health expenditure is the yearly health expenditure plus the supplementary expenditure from the Budget Yellow Book (Estimates of Revenue & Expenditure for the Years 2001-2008, Lusaka: MOFNP)

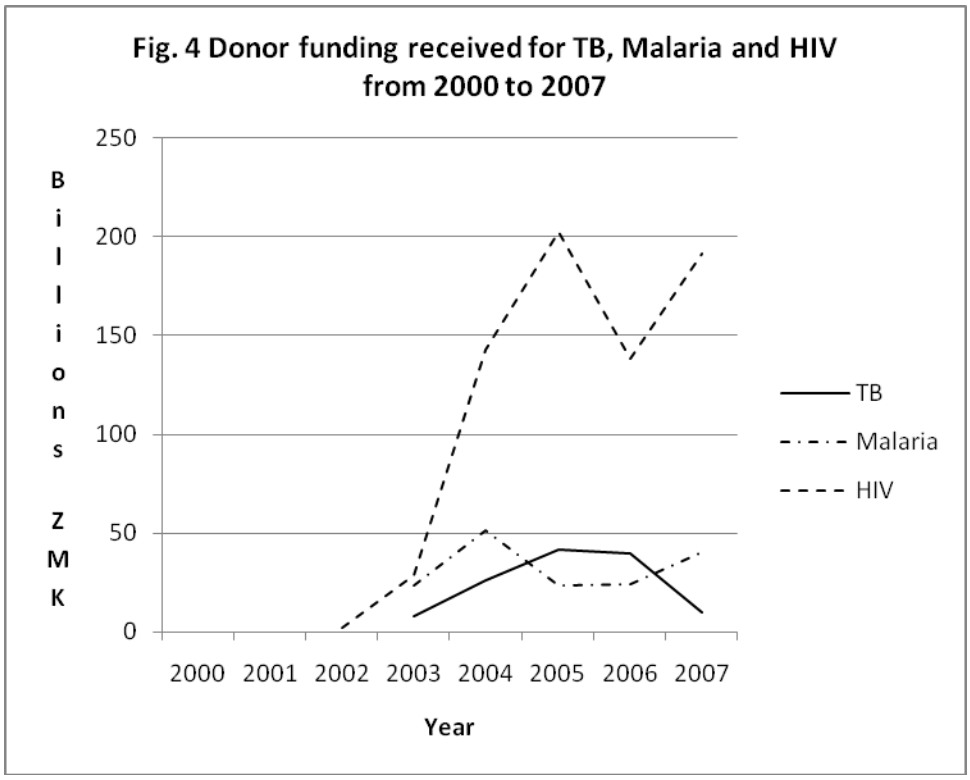
The TB funding increased from ZMK 7.66 billion in 2003 to ZMK 39. 25 billion in 2007; malaria funding increased from ZMK 25.64 billion in 2003 to ZMK 86.19 billion in 2007;and HIV funding increased from ZMK 51.41 billion in 2003 to ZMK 1,132.37 billion in 2007; representing an increase in disease specific funding from 2003 to 2007 by 512.40% (for TB), 336.15% (for malaria) and 2,202.62% for HIV.



There was a marked decline in funding for all the three diseases in the year 2006, with TB funding declining by 296.97% from 2005 to 2006, malaria declining by 109.76% from 2005 to 2006, and HIV funding declining by 121.89% from 2005 to 2006; attributed mainly to 'Dutch Disease', the impact of (local currency) appreciation caused by a range of internal and external factors.

Recipient perspective

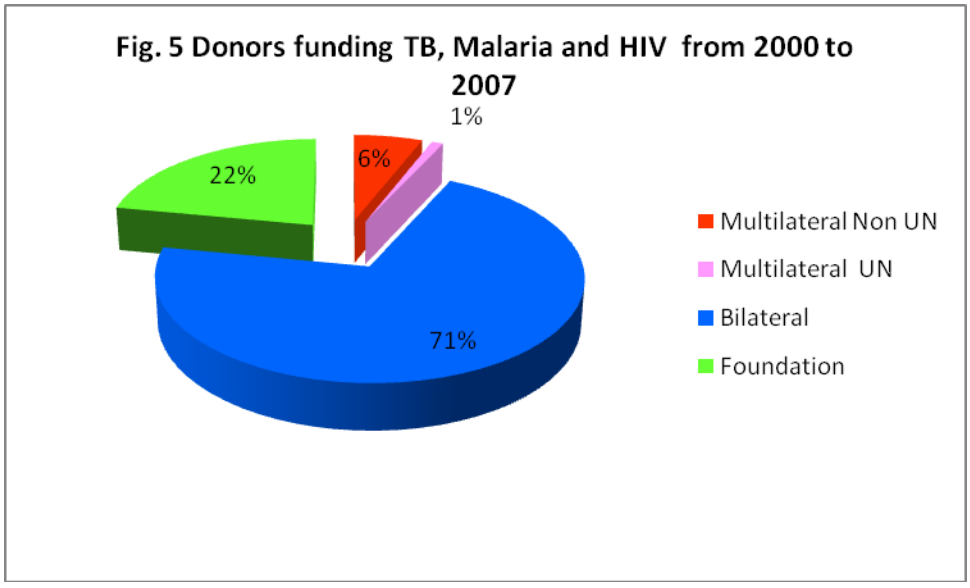
The patterns of donor funds received by recipients for the three diseases TB, malaria and HIV between 2000 and 2007 (Fig 4) is consistent with the donor funding trend data obtained from donor perspective, except for TB which showed a decline in funding in 2007 from the recipients perspective.



4.2.4 Distribution of funding by donor/recipient category

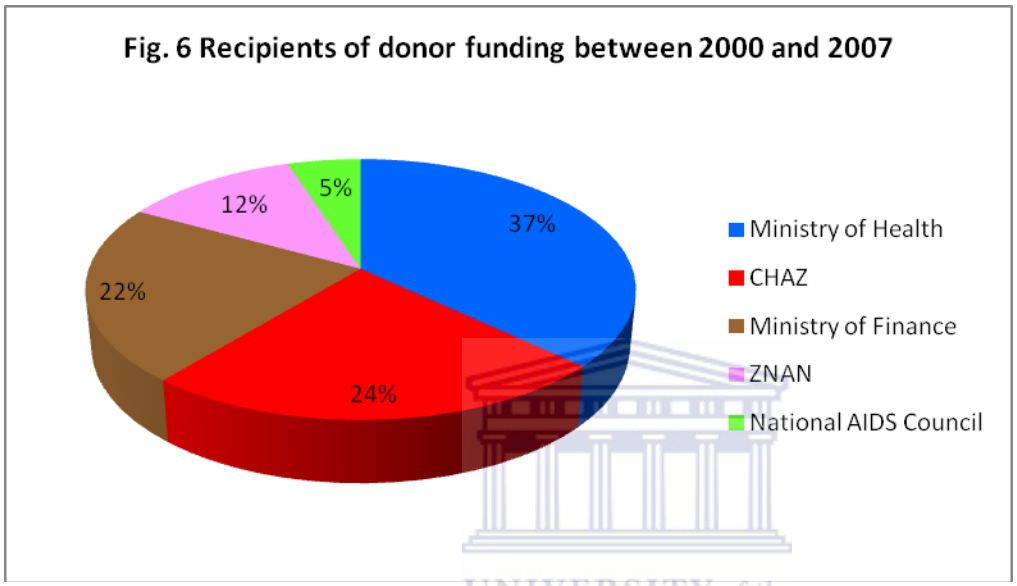
Donor perspective

The proportion of donor funding by category (Fig 5), illustrates that between 2000 and 2007 the bilaterals were the largest funders contributing to ZMK 2,670.72 billion (71%), followed byfoundations ZMK 805.53 billion (22%), multi-lateral donors (non-UN) ZMK 234.35 billion (6%), while the multi-lateral (UN) funded ZMK K36.44 billion (1%).



Recipient perspective

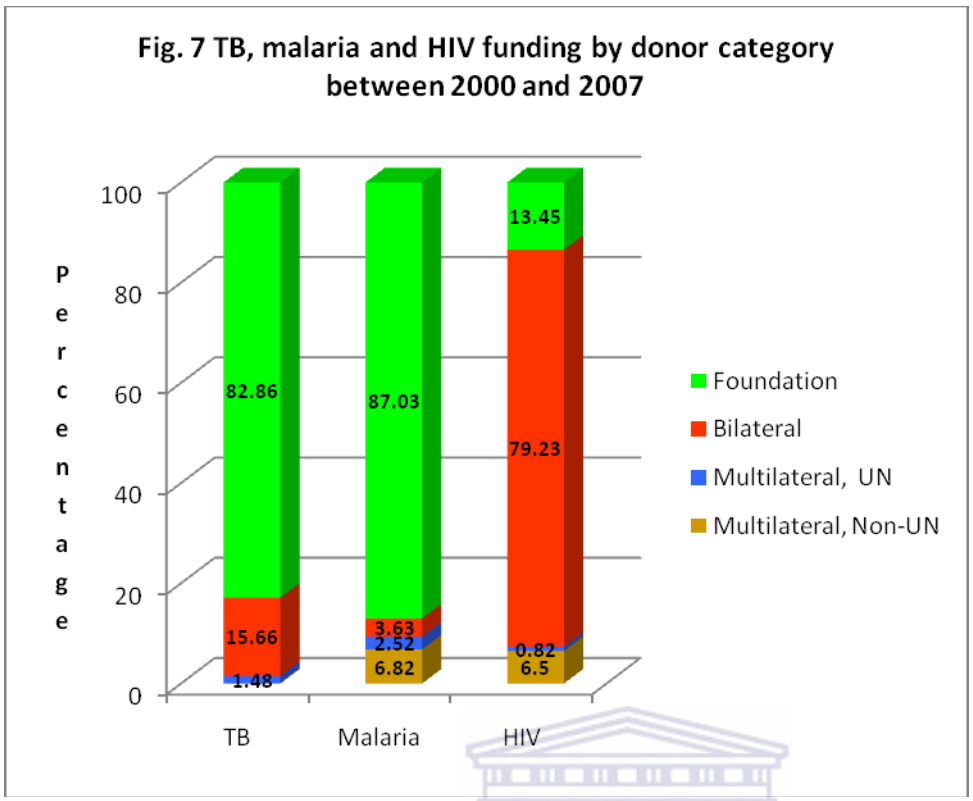
Of the four major recipients, the Ministry of Health received the largest share of donor funding for the period 2000 and 2007 (Fig 6) amounting to ZMK 364.27 billion (37%); followed by CHAZ ZMK 241.07 billion (24%); Ministry of Finance and National Planning received ZMK 220.93 billion (22%); ZNAN ZMK 118.20 billion (12%), while the Ministry of Health agent, the National AIDS Council received the least funding of ZMK 50.86 billion (5%).



4.2.5 Distribution of disease specific funding by donor category

Donor perspective

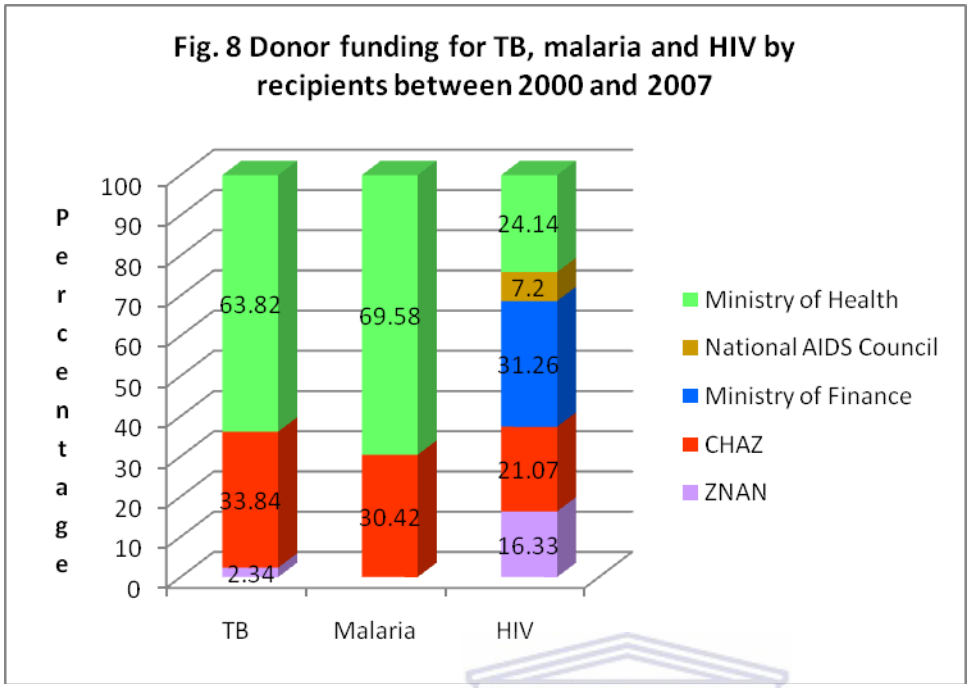
The proportion of disease specific funding by different donor category between 2000 and 2007 (Fig 7) reveal that foundations funded TB K126.01 billion (82.86%), bilaterals funded ZMK 23.8 billion (15.66%), whilst the multilateral (UN) funded TB ZMK 2.25 billion (1.48%). An almost similar disease specific funding pattern emerged for malaria funding by different donor category for the period 2000 to 2007;foundations funded ZMK 231.83 billion (87.03%), Multi-lateral (non-UN) ZMK 18.19 billion (6.82%), followed by bilateral ZMK 9.67 billion (3.63%), while Multi-lateral (UN) funded malaria ZMK 6.68 billion (2.52%).



The HIV funding pattern by donor category was markedly different, with bilateral funding being ZMK 2,637.25 billion (79.23%); followed by foundations ZMK 447.7 billion (13.45%); Multi-lateral (non-UN) ZMK 216.16 billion (6.5%), with multi-lateral (UN) at the tail-end with ZMK 27.51 billion (0.82%).

Recipient perspective

The proportion of disease specific donor funding received by type of recipients between 2000 and 2007 (Fig 8) illustrates that the Ministry of Health received the highest amount of TB funding i.e. ZMK 80.04 billion (63.82%), followed by CHAZ ZMK 42.45 billion (33.84%), while ZNAN received ZMK 2.92 billion (2.34%). A similar disease specific funding pattern for malaria emerged, with Ministry of Health receiving ZMK 113.62 billion (69.58%), while CHAZ received ZMK 49.68 billion (30.42%).

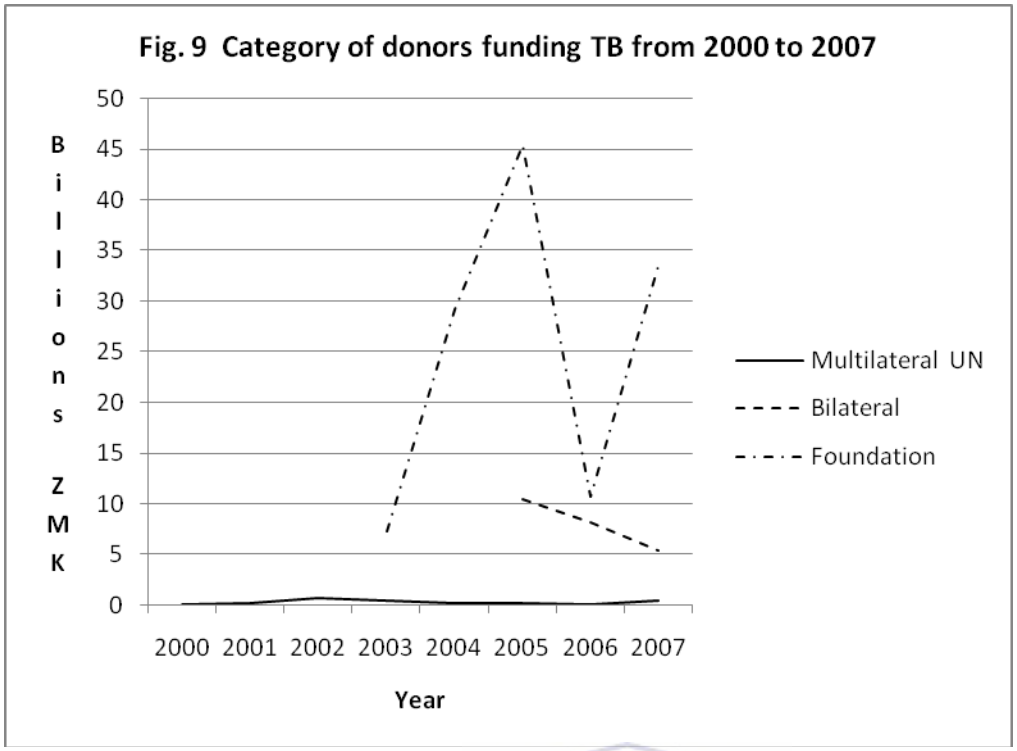


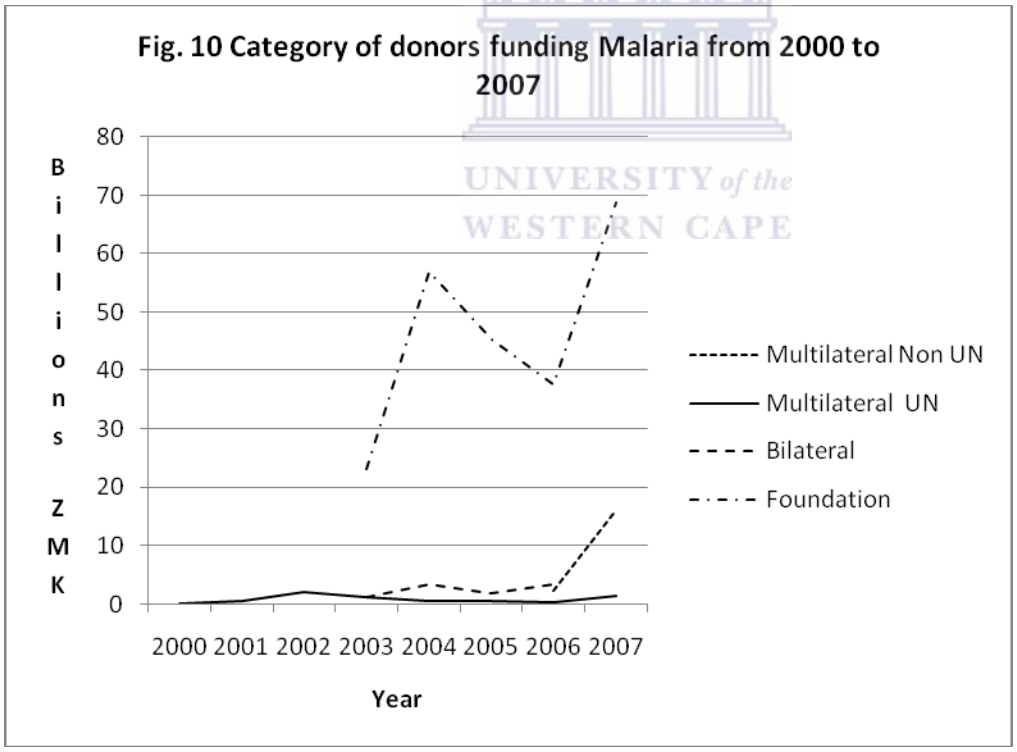
The Ministry of Finance and National Planning received the highest amount of HIV funding, ZMK 220.93 billion (31.26%), followed by Ministry of Health ZMK 170.61 billion (24.14%); CHAZ received ZMK 148.94 billion (21.07%); ZNAN ZMK 115.28 billion (16.33%), while National AIDS Council received only ZMK 50.86 billion (7.2%) of HIV funding.

4.2.6 Donor preferences for disease specific funding

Individual disease donor funding patterns, between 2000 and 2007 by various donor categories reveal the following.

Tuberculosis received consistent funding throughout the period of study (Fig 9). Global Fund has been a key TB funder from 2003 reaching a peak in 2005, with a decline in 2006, followed by a rise thereafter. DFID is a recent funder from 2005 with funding declining to 2007. The multi-lateral (UN) contribution to TB funding was consistent throughout, but at a very low level.

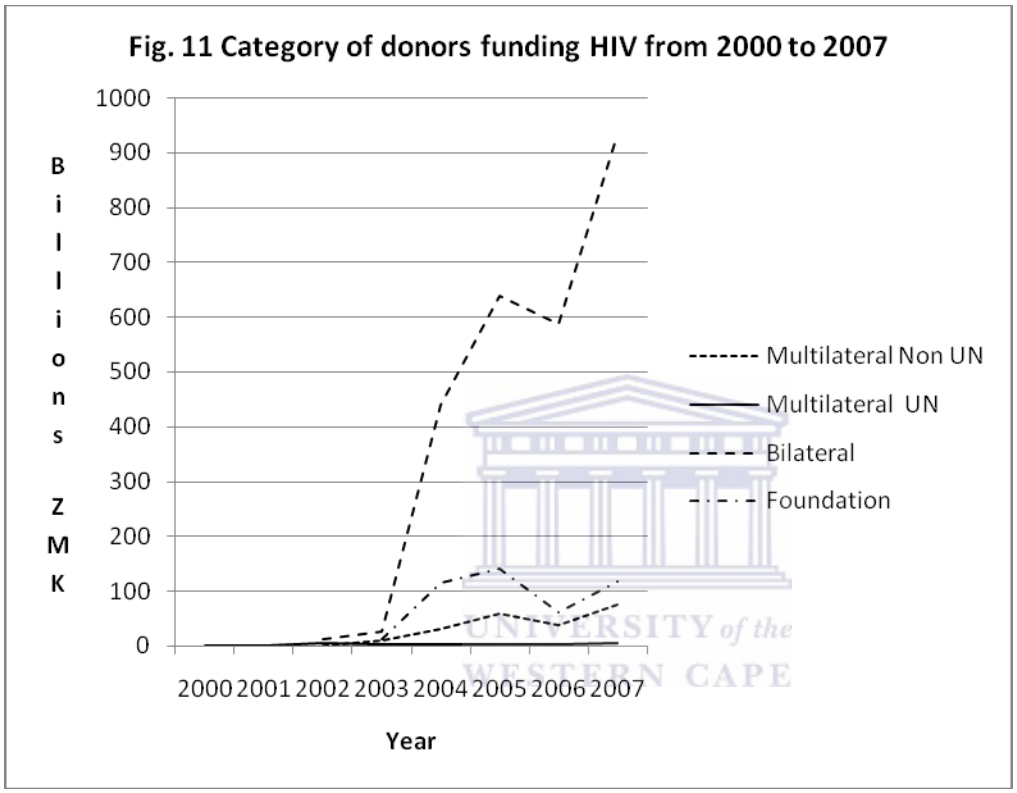




All categories of donors funded malaria between 2000 and 2007 (Fig 10). The funding trend for foundations (Global Fund and MACEPA) and multi-laterals (UN) in funding malaria was almost the same as tuberculosis. The bilateral (DFID) funded malaria from 2003 to 2006 only. The multi-

laterals (non-UN) including World Bank were very late malaria funders though significant.

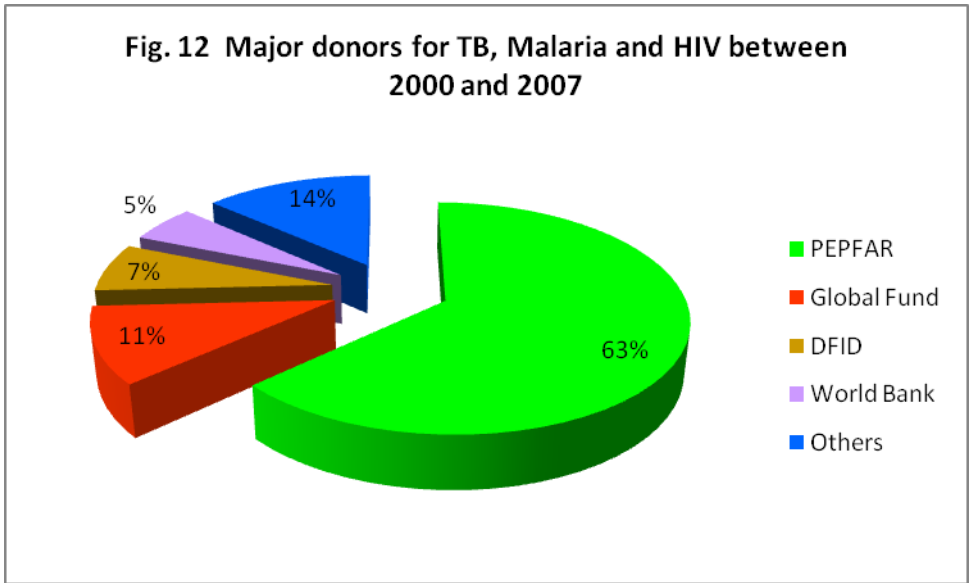
HIV was significantly funded by all donor categories (except multilateral UN) between 2000 and 2007 (Fig 11). The donor funding for HIV rose overwhelmingly from 2003, following the entry of bilaterals (DFID, SIDA then PEPFAR) followed by foundations (Global Fund and Clinton Foundation much later), multilateral (non-UN) (World Bank with minimal ADB funding), and then multilateral (UN). There was a drop in HIV funding in 2006.



4.2.7 Major donors for TB, Malaria and HIV between 2000 and 2007

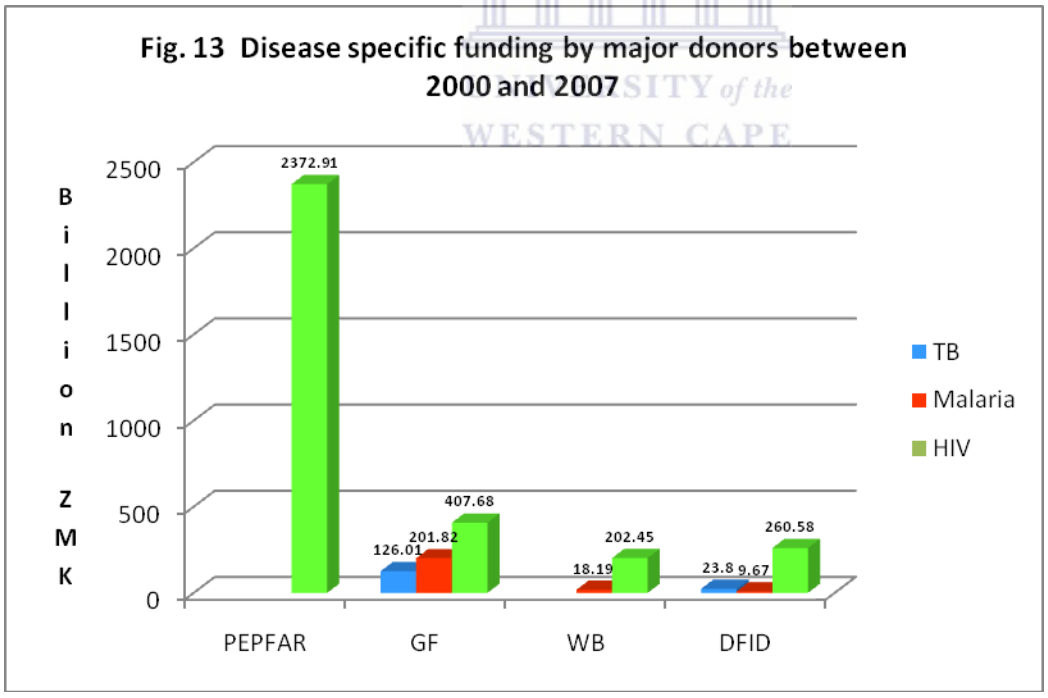
From the analysis of donor funding, the top four donor funders[6] between 2000 and 2007 were PEPFAR (63%), Global Fund (11%), DFID (7%) and World Bank (5%) (Fig 12).

6 It should be noted that Zambia has a large number of bilateral donors funding the health sector and disease specific funders. Further, there is a spectrum of UN agencies funding as well. The study only looked at top three funders in the four categories: Multilateral non UN, and UN, Bilateral and Foundation



4.2.8 Disease specific funding by major donors between 2000 and 2007

Between 2000 and 2007, PEPFAR[7] funded HIV only. Global Fund funded TB, malaria and HIV, the World Bank HIV and malaria, while DFID funded all the three diseases (Fig. 13).



7 PEPFAR was a non-respondent to the study, funding data source was Annual Reports to Congress, Refer PEPFAR (2005), PEPFAR (2006), PEPFAR (2007) & PEPFAR (2008). Also, it should be noted that PEPFAR does not provide disbursements data disaggregated by country. PEPFAR do not publicly release expenditure data for their recipients (Bernstein & Sessions 2007). Note, further that only 45% of PEPFAR money allocated reaches Zambia (MOH 2008c)

4.2.9 Flow of donor funds

The results from the donor interviews show that the Health Ministry was the most preferred recipient (82%), followed by NGOs (54%). Multi-lateral Non-UN funded the least number of recipients (33%), while bilaterals funded most recipients (60%) (Table 2).

Table 2. Donors Funding Recipients

Donor Category	Numbers of Donors per Category	Donors by recipient institution					Expected Frequency	Observed Frequency	Percent (%) of total	pvalue
		MOH	MOH Agent	NGO	MOF	Others				
Multi. Non UN	3	2	0	1	2	0	15	5	**33**	0.2
Multi. UN	3	2	2	2	1	1	15	8	**53**	0.8
Bilateral	2	2	2	1	0	1	10	6	**60**	0.2
Foundation	3	3	0	2	1	2	15	8	**53**	0.14
Total	11	9	4	6	4	4				
Percent (%) of total	**100**	**82**	**36**	**54**	**36**	**36**				
pvalue		0.9	0.14	0.8	0.4	0.4				

Results of interviews with recipients revealed that 15 donors funded National Aids Council, 9 Ministry of Health, 7 ZNAN, 2 Ministry of Finance and National Planning and 2 CHAZ (Table 3).

Table 3 Recipients Receiving Donor Funding

Recipient	Source of Donor Funding	
Ministry of Health	Multilateral (non-UN) Multilateral (UN) Bilateral Foundation	World Bank WHO, UNAIDS CIDA, USAID Global Fund, MACEPA, SFH, Novartis
National AIDS Council	Multilateral (non-UN) Multilateral (UN) Bilateral Foundation	ADB, World Bank UNAIDS/UNDP, ILO UNFPA, WFP, UNICEF Norad, SIDA, RNE, DFID, CDC, Irish Aid, USAID Global Fund
Ministry of Finance & National Planning	Multilateral (non-UN) Foundation	World Bank Global Fund
ZNAN	Bilateral Foundation	Irish Aid, DANNIDA, Netherlands, NORAD, DFID Global Fund, Open Society Institute
CHAZ	Bilateral Foundation	Netherlands, Irish Aid Global Fund, Dan Church Aid

The results from recipients' interviews on the flow of funds showed that half of the recipients had difficulties in establishing the exact amounts of fund inflows and, often, the mode of dispending funds: '***the ODA data management unit at the Ministry is at its infancy', 'the only available data for ODA is from 2004 onwards which is not complete and not broken into disease specific funding'*** and ***'some donors fund the recipients directly from the source', 'others receive funds in the country and are managed from their country offices', 'a number of donors fund organizations and communities where our Ministry cannot monitor'.***

One recipient said ***'We cater for over 135 member institutions around the country', 'and donor funding caters for a number of sub-recipients'.***

4.2.10 Utilization of donor funds

The results from the donor interviews show that donor funding interest was highest for training of health manpower (91%), followed by infrastructure and procurement (55%). Bilaterals had the broadest range of areas of interest in funding (80%), followed by Multilateral Non UN. Multilateral UN had the least specified area of interest in funding (33%) (Table 4).

Table 4. Donors Funding Area of Interest

Donor Category	Number of Donors per Category	Donors by funding area of interest					Expe. Freq	Obse. Freq	Percent (%) of total	pvalue
		Un earmarked	Manpower Training	Infra structure	Procure	Other				
Multi. Non UN	3	0	3	3	2	2	15	10	**67**	0.06
Multi. UN	3	1	3	1	0	0	15	5	**33**	0.06
Bilateral	2	2	2	1	2	1	10	8	**80**	0.4
Foundation	3	1	2	1	2	2	15	8	**53**	0.8
Total	11	4	10	6	6	5				
Percent (%) of total	**100**	**36**	**91**	**55**	**55**	**45**				
pvalue		0.4	0.9	0.4	0.4	0.4				

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The results from the recipient interviews indicated that the use of donor funds by the major recipients varied depending on particular recipient needs and donor interest.

Invariably all major recipients used donor funding to procure drugs, medical equipment, accessories, and vehicles. When recipients were asked about procurement, ***'we procure an assortment of ARV's, malaria drugs and TB drugs, various medical drugs and equipment and mosquito nets', 'our Ministry procures ARV's, mosquito nets, and vehicles' 'the organization procures ARV's, 'ours cater for the entire country so we procure various drugs, mosquito nets, vehicles, boats and even bicycles'***.

Half of the major recipients used donor funding to strengthen administration and setting up of various programs, ***'we invest some donor funding in getting the administrative system strengthened to enable a reasonable delivery of those services'*** and ***'some programs are set up from scratch like PMTCT programs'***. Some recipients' used donor funds for a specific target area only, like community-based programs ***'we fund and manage palliative care and orphans and vulnerable children programs as one of our core functions'***, salary supplementation ***'for these HIV programs to succeed our Ministry is offering salary supplementation to attract good staff'***, and health promotion campaigns, ***'though not much, our organization believes prevention is better than cure, and we do have vigorous prevention campaigns put in place'.***

While the usage of donor funding depended somewhat on the recipients needs, there were some reservations in this regard. When probed in-depth one recipient said: ***'The donors are not interested in building new structures like hospitals. Nor do they wish donor funds to be used in motivating health staff with better salaries. Their scope of usage of donor funds should take into account these two teething problems we are facing as a country'***. Another recipient echoed a similar sentiment: '***The restriction in the usage of donor funds actually becomes counter-productive especially when we need to do variations in the program due to arising needs. Our hands are tied and the program then fails to meet the aspirations of what it was intended to serve'***.

4.3 Predictability of Donor Funds

The results from the donor interviews show that 91% of the donors disbursed 81-100% of funding committed, while only 18% of donors disbursed 61-80% of funding committed. Amongst donors, foundations had the most flexible disbursing time frame (66%) (Table 5).

Table 5 Donor Disbursement of Committed Funds

Donor Category	Numbers of Donors per Category	Donor disbursement of committed funds		Expected Frequency	Observed Frequency	Percent (%) of total	pvalue
		61-80%	81-100%				
Multilateral Non UN	3	1	2	6	3	**50**	0.45
Multilateral UN	3	0	3	6	3	**50**	0.03
Bilateral	2	0	2	4	2	**50**	0.08
Foundation	3	1	3	6	4	**66**	0.1
Total	11	2	10				
Percent (%) of total	**100**	**18**	**91**				
pvalue		0.45	0.91				

The results from the recipient interviews on donor funds being disbursed as per commitment showed that all major recipients were of the view that donor funding was disbursed as committed, but with strong reservations.

All recipients gave bureaucracy and late submission of reports from recipients as the reasons for the donors not disbursing funding they committed. With bureaucracy the recipients said: ***'we have to do one paperwork after another'***, '***we have to do the application process very meticulously ensuring all those procedures for funding are met'***, '***donors have the habit of referring all problems overseas***' and '***by the time funding request is approved, we notice its paperwork after paperwork'***.

On late submission of reports the recipients said: ***'the annual Ministry reports, audit reports, funding reports have all to be submitted in time'***, ***'the audit reports of our Ministry is needed whose deadline we just cannot fulfill', 'the sub-recipients to our organization do not submit progress and audit reports in time'*** and ***'the perceived delay in us handing in the various reports they request for'***.

Half of the recipients cited local administrative problems from recipients: ***'there is some delays in our Ministry coordinating donor issues'*** and ***'we do not have the necessary local manpower to manage big inflow of funds'*** Individual problems cited by each recipient were, conditionalities not

being met by recipients ***'once agreed benchmarks not met',*** lack of capacity to absorb resources ***'the slowness by our system in taking all that external funding',*** mistrust from donors ***'we locals do not have the capacity to deliver'***, communication breakdown ***'the slowness in getting back to us after we have funding approved',*** systems change in donor countries ***'once the donors change their system, effect is felt by us'***, and political ***'touch one donor, all other donors get together against us',*** were individual problems cited by each recipient.

When the recipients were probed in-depth on the disbursement problems with donors, a major Government recipient, expressed the following:
'Donors like referring issues to their headquarters. I have experienced bureaucracy even in the donor set-ups. Donors like to sympathize with each other whereby if you touch one, you have touched all'.

Another major Government recipient attributed the problems in funding disbursement to both recipients and donors:
'Both we the recipients and the donors are to blame for these disbursement problems. We just submit reports late. We can't absorb resources at a pace the donors want. Our audit process is equally long. The procurement process is not at a pace a donor wishes to see. On the other hand, almost all donors seek their headquarters' approval'.

The third recipient had different reasons for disbursements not made as per commitment: ***'I have been dealing with these donors. They are very rigid on their grant cycle. Despite submission of reports, which we do, funding is not guaranteed. Also communication lacks from them on when they will fund'***. A fourth recipient was of the view that lack of trust by donors' impeded release of donor funds as per commitment.

4.4 Sustainability of Donor Funds

The results from the donor interviews show that the majority of donors preferred a four year funding commitment time frame (54%), while only 18% preferred one year time frame (pvalue 0.05). From the various donor categories, there was no donor variation in funding commitment time frame (Table 6).

Table 6 Donors Funding Commitment Time Frame

Donor Category	Numbers of Donors per Category	Donors by funding as per commitment time frame					Expected Frequency	Observed Frequency	Percent (%) of total	pvalue
		One year	Two years	Three years	Four years	Six year HIV, three years Funding mechanism				
Multi. Non UN	3	0	1	0	2	0	15	3	**20**	0.15
Multil. UN	3	2	0	1	0	0	15	3	**20**	0.15
Bilateral	2	0	0	0	2	0	10	2	**20**	0.04
Foundation	3	0	0	0	2	1	15	3	**20**	0.15
Total	11	2	1	1	6	1				
Percent (%) of total	**100**	**18**	**9**	**9**	**54**	**9**				
pvalue		0.05	0.26	0.26	0.45	0.26				

On the other hand, the results from the donor interviews further show that 63% of the donors shared running costs with the recipients, while 36% of the donors had their running costs borne by the recipient government. From the various donor categories, there was no donor variation in taking care of the running costs (Table 7).

Table 7. Bearer of Running Costs

Donor Category	Numbers of Donors per Category	Donors whose running cost are taken care of by;		Expected Frequency	Observed Frequency	Percent (%) of total	pvalue
		Recipient government	Both donor and recipient government				
Multilateral Non UN	3	1	2	6	3	**50**	0.4
Multilateral UN	3	1	2	6	3	**50**	0.4
Bilateral	2	1	1	4	2	**50**	1
Foundation	3	1	2	6	3	**50**	0.4
Total	11	4	7				
Percent (%) of total	**100**	**36**	**63**				
pvalue		1	0.9				

The results from recipient interviews on sharing the running costs with donors showed that half of the recipients, that are wholly dependent on donors said: '***Of the donor funds 15% is factored for program implementation. In other instances running costs are provided in kind like vehicles and computers'***, ***'programs are not built on sustainable indicators, so once donors leave this is a real challenge'*** and ***'running costs are budgeted within the allocation, as on our own we can't survive' 'the government has to take the responsibility or will just have to look for alternative donors'***.

The other recipients who are major Government Ministries had a different view altogether. The Health Ministry said it will reduce donor dependence as expressed by: ***'Government committed to increase grants and ensuring 60% of resources gets to Districts', ' look towards the future by building more donor partnerships', 'government taking over major programs like ARV roll out, vaccines, TB drug purchases'.*** The Ministry of Finance and National Planning shared similar sentiments but with a slightly different view on reducing donor dependence as expressed by: ***'We just have to raise domestic revenue', 'reduce donor funding to the national budget', 'restrict donors to capital projects while operational costs are funded by the treasury', 'depends on how programs are structured, but we share program costs, or donors take responsibility, and we take over once they leave'***.

4.5 <u>Modality of Donor Funding</u>

The results of the donor interviews show that the Health Ministry was the most preferred mode of funding (73%), followed by Health Ministry Agent, and NGO (55%). The Multilateral Non-UN showed least preference in funding modality (Table 8).

Table 8 Donor Funding Recipient Through Various Modalities

Donor Category	Number of Donors per Category	Donors by funding modality					Expe. Freq	Obse. Freq	Percent (%) of total	pvalue
		Direct Budget Support	SWAp	Health Ministry	MOH Agent	NGO				
Multi. Non UN	3	2	1	3	2	1	15	9	**60**	0.4
Multi. UN	3	0	0	2	0	2	15	4	**27**	0.08
Bilateral	2	1	1	0	2	1	10	5	**50**	0.4
Foundation	3	0	0	3	2	2	15	7	**47**	0.05
Total	11	3	2	8	6	6				
Percent (%) of total	**100**	**27**	**18**	**73**	**55**	**55**				
pvalue		0.18	0.4	0.3	0.45	0.82				

The majority of donors preferred funding the recipient country through the Health Ministry, followed by funding the National AIDS Council & the NGO's. SWAp and direct budget support were not preferred modes of funding.

The results from recipient interviews on how the donor funds are received showed that all recipients were funded by foundations: ***'the Global Fund, Bill and Melinda Gates, and Clinton Foundation fund us directly'***, ***'the Global Fund funds us directly as well'***, ***'our organization actually is a major recipient and dependent on Global Fund'***, and ***'bilaterals and foundations both fund us and it is direct'***.

Half of the recipients said they received funding directly from bilateral donors: ***'bilateral fund our organization directly'*** and ***'we received funding from bilateral donors known as Joint Finance Arrangement'*** while the same number of recipients received donor funding through direct budget support: ***'donors are now funding our Ministry as direct budget support'*** and ***'once donors fund the Finance Ministry as direct budget support, we then receive that money as funding from the budget, but actually there is donor component in there'.***

One recipient received donor funding in various forms: as sector support to health ***'we receive***

money meant for Health Ministry, which is then channeled to that Ministry', direct project support ***'our Ministry actually is in-charge of Finance and it plans, executes the budget'***, and direct technical assistance ***'some donor assistance we receive is in form of technical expertise'.*** One recipient received funding through SWAp ***'since 2001 SWAp has been the key funding mechanism put in place'***.

A major government recipient, the Health Ministry interviewee was probed in-depth on its relations with the donors as expressed in the following:

'Initially there was lot of goodwill from bilateral donors. Following the abolition of Central Board of Health in 2006, an autonomous body was created with the full backing of donors to minimize dependence on the civil service, and the launch of Zambia's Aid Policy where as much as possible donors had to strive for Direct Budget Support than sector support, a number of donors have shifted donor funding to the Central Treasury causing reduction in donor funding to our Ministry by 40%'.

Further probing revealed that Sector Support to the Health Ministry still works better and in the eventuality of this not being possible this Ministry: ***'wished to have a framework to monitor health funds from donors by tagging health donor funds at the Ministry of Finance'.***

The other major Government recipient, the Ministry of Finance and National Planning, made it explicitly clear that it is now seriously working on alignment and harmonization of donor funding. The Finance Ministry expressed the following view: ***'We want a Central Budget, easy to account and implement, should have one vision and work towards it, with the need for Health Ministry to approach us and tell us their needs'.*** Upon further probing that the Ministry of Health has lost funding of up to 40% due to a switch of donors from SWAp sector funding to General Budget Support, the Finance Ministry expressed the following: ***'other Ministries are competing for resources as well, so we shall fund only where there is a real need'.***

On further probing the Finance Ministry on whether it is really committed to the Abuja Declaration on funding the Ministry of Health 15% of the Government Budget, the interviewee expressed in the following direct quotation: ***'we are committed to Abuja Declaration but have not yet attained 15%, further it is hard to classify a sector like health especially when it transgresses into other sectors, and actually the sector support type funding marginalizes smaller Ministries'.***

4.6 Donor Conditionality

From the results of the donor interviews, transparency and accountability, and effective and efficient implementation of programs were the conditionalities donors preferred most (36%). From the various donor categories, the Multilateral Non UN and foundation had the highest conditionality preferences (40%). 50% of donors' programs were affected by the IMF conditionality of restricting public spending in the recipient country (Table 9).

Table 9. Funding Donor Conditionality

Donor Category	Number of Donors per Category	Donors by funding conditionality					Expe. Freq	Obse. Freq	Percent (%) of total	Pvalue
		Trans-parency and account.	Effect. and effic. imple. of prog.	Manage. of national economy	Indirec. linked to cond.,	Good Gover.				
Multi. Non UN	3	1	1	1	2	1	15	6	**40**	0.82
Multil. UN	3	0	0	0	0	0	15	0	**0**	0
Bilateral	2	1	1	0	0	1	10	3	**30**	0.5
Foundation	3	2	2	1	0	1	15	6	**40**	0.42
Total	11	4	4	2	2	3				
Percent (%) of total	**100**	**36**	**36**	**18**	**18**	**27**				
pvalue		0.45	0.45	0.45	0.05	0.7				

The results of the donor interviews on a specific IMF conditionality revealed that 50% of donors' programs were affected by the IMF conditionality of restricting public spending in the recipient country (Table 10).

Table 10. Donors Affected by IMF Conditionality of Restricting Public Spending in Recipient Countries

	Yes		No		Total	
	n	(%)	n	(%)	n	%
Multilateral, Non UN	2	(40.0)	1	(20.0)	**3**	**(30.0)**
Multilateral, UN	0	(0)	2	(40.0)	**2**	**(20.0)**
Bilateral	2	(40.0)	0	(0)	**2**	**(20.0)**
Foundation	1	(20.0)	2	(40.0)	**3**	**(30.0)**
Total	**5**	**(100.0)**	**5**	**(100.0)**	**10**	**(100.0)**

X^2=4.7 p=0.2

The results from recipient interviews on donor conditionality showed that half of the recipients were affected by the following conditionalities: donor reporting format ***'have to follow donor rules, different donors having different reporting systems'***, '***there are reporting conditionalities, like reviews and assessments from one of the donors, the other donors want us to follow their format of reporting which is tedious'***; frequent audits required by donors, ***'more time is spent in fulfilling audits than our programs', 'our organization has to be audited regularly and it's really time consuming'***; the IMF conditionality of restricting personal emoluments to the GDP fixed ratio, ***'the GDP: PE has definitely affected the human resource staffing in the health sector'***, ***'the IMF conditionality has resulted in less spending for health worker'***; and recipient governance issues ***'donors want to look at set targets like figures rather than overall impact of programs', 'the donors are critical on adverse governance issues, and this has affected our programs though in very few instances'***

Procurement and technical assistance from the host country, financing modalities, and donor emphasis on program conception were individual conditionalities that affected various individual recipients: ***'there is donor rigidity especially on procurement and technical assistance, some donors want these strictly from their countries', 'there are donors who still talk project language instead of strengthening health systems'*** and ***'we have observed, that donors emphasise only on 'adding on' to existing programs yet they do not want to start a new program'.***

The Health Ministry was probed further on the IMF conditionality of GDP: PE ratio that has affected the health sector adversely and expressed the following as evidenced by direct quotation: ***'IMF conditionality of GDP: PE ratio has caused freezing of employment of health staff, with no increase in salaries for staff, dealing a further blow to the health sector'.*** When probing further

on the fact that there are no written rules to the effect that could be shown to the researcher, the interviewee expressed the following: ***'there is freeze on employing and paying well the medical staff, a fact which is known and can be proved with the donors and others'.***

But it was evident that the Finance Ministry's views on the IMF conditionality were at total variance with their health counterparts as evidenced by the following:

'Conditionalities are good for the country, they are set targets and benchmarks which are for the sake of good governance and we must adhere to. The medical staff cannot be employed further because we just do not have the resources, so once enough resources are available the civil service will be rewarded and more will be employed'.

The rigidity of donors on procurement practices was also further probed with the Health Ministry, and the views are expressed in the following:

'Procurement practices of some donors have brought problems, we are told to purchase from pre-determined foreign sources. Further, there are bureaucracies in the procurement of some donor items which is so stringent that it actually delays programs, and there is no reasoning behind the notion that procuring from donor countries is most cost-efficient'.

Chapter 5

DISCUSSION

This chapter discusses the results found in the study. The chapter analyses and details the findings of the trends and flow of funds, donor preferences in funding recipients and diseases. Where relevant, these are compared to relevant literature. Then key funding characteristics are analyzed, and discussed and where possible compared to the literature. The chapter ends with a brief comment on aid effectiveness.

The trends of donor funds

From the study, there was an increase in the donor funding for all the three diseases from ZMK 84.71billion in 2003 to ZMK 1,257.81billion in 2007 representing an increase of 1,485% (Fig 3). The overwhelming fund flow into Zambia followed the entry of the Global Fund in 2003 and PEPFAR in 2004. As a percentage of total health expenditure, the total funding received in 2000 was 0.07% in 2000, 10.04% in 2003, 105.62% in 2005 and 98.86% in 2007 (Fig. 2). The funding pattern in the study agrees with findings from studies by Atim (2006) and Hecht & Shah (2006).

There was an upward trend in funding from 2000, followed by a drop from 2005 to 2006 by 296.97% (TB), 109.76% (malaria) and 121.89% (HIV). The drop in funding was due to a dramatic appreciation of the Zambia currency (Kwacha) which started in the second half of 2005 (Cali & te Velde 2007). Some of the factors attributed to the appreciation of the Kwacha were: Zambia had a debt write off following a successful HIPC completion point; the increase in non-traditional exports (NTE); high inflow of donor aid, and a marked rise in copper prices. Zambia thus suffered from 'Dutch Disease' (Mukungu et al 2007). For the donor funders, there was a fall in ODA value resulting from exchange losses from mid-2005 to mid-2006.

Relying heavily on donor assistance, Zambia is confronting the challenges associated with the volatility of donor funding. Consequently, this has had important implications for sustainability of programs which require consistent funding over the long-term to finance recurrent expenditure. A

MOH (2008a) report has ably demonstrated the volatility of funding Zambia has faced from 2000 to2005 for HIV funding when looking at external assistance as a percentage of total health expenditure. The overwhelming funding Zambia has received has also raised the question of whether it can be used effectively. The donor flows have increased the risk of appreciation of the exchange rate, Dutch Disease, and reduced government's capacity to generate local revenue due to aid dependency. Also, a situation where a greater part of the donor funding not channeled through national budget aid could result in corruption as donor priorities are substituted for country priorities, with vertical programs that are relatively separate from the national health system.

The Zambia Aid Policy and Strategy, a key policy document has acknowledged that despite significant amounts of external resource inflows into the country, the intended impact has remained marginal (MOFNP 2005b). This has been attributed to weak institutions within the Government for effective resource management, inadequate and often unclear procedures regarding how best to mobilize, receive, plan/budget and manage external resources, and weak Government accountability systems due mainly due to weaknesses in oversight institutions and mechanisms as well as frail legal frameworks.

Further, Saasa (2005) has pointed out that the Zambia Government has placed a lot of faith in the donors in what is required and how best it could be attained. Zambia has stood out in the developing world for following external prescriptions religiously. Evidence suggests that because of absence of sufficient will and technical/managerial skill to guide donor activities; weak institutional structures, low analytical capacity, and lack of policy clarity, the government finds it difficult to voice its concerns and offer better solutions.

Flow of donor funds

The study showed that flow of donor funds to the recipients is a complex process. The results from the donor interview show that the Health Ministry was the most preferred recipient (82%), followed by NGO (54%) (Table 2). Further, according to the study, Multi-lateral Non-UN donors were the most selective funders, funding only 33% of the recipients, while bilaterals were the most non-selective, funding 60% of the recipients.

On the other hand, from the recipient perspective the number of donors funding which were captured by our study was over 25 (Table 3). In reality, the exact number of donors funding TB/malaria/HIV is not known.

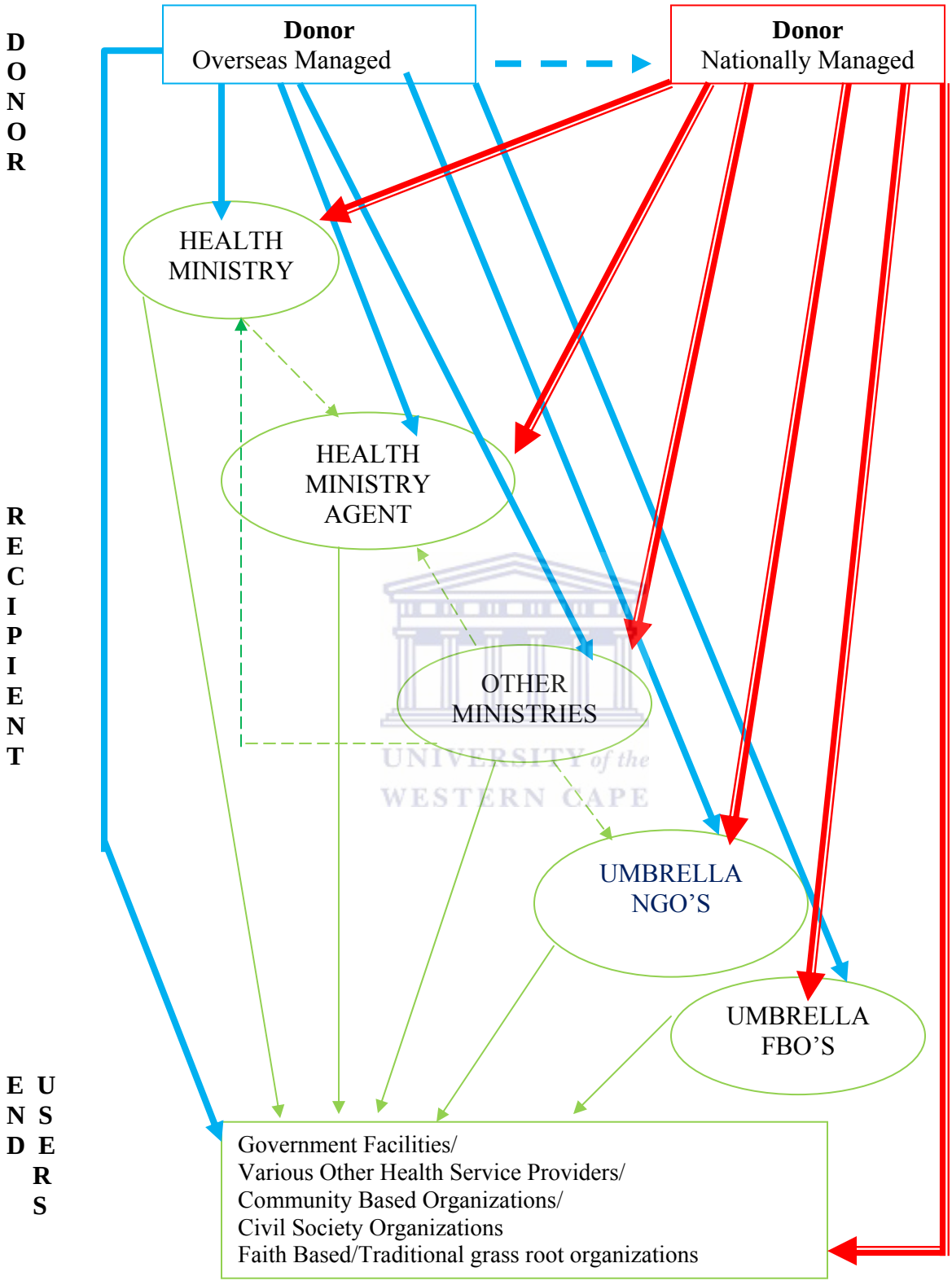
The flow of funds from many donors to the recipients could be attributed to a variety of reasons. The National Aids Council received donor funding from an array of UN agencies, bilateral donors, the multi-lateral banks, and the Global Fund, as it was instituted as an autonomous body overseeing the policy implementation of HIV/AIDS in Zambia. The Health Ministry received funding directly from Global Fund to cater for all government institutions in the Republic; from MACEPA for malaria programs; from the Clinton Foundation for procurement of ARV's; from the UN agencies WHO and UNAIDS for technical expertise; and the World Bank and USAID for HIV programs under the Health Ministry. The Finance Ministry received from the World Bank and the Global Fund for HIV programs for other government Ministries; CHAZ and the umbrella NGO received direct bilateral and foundation funding.

There has also been flow of donor funds horizontally, from PEPFAR to CDC and CIDRZ, from global donor funders to donors within the country, and flow of the donor funds received between various recipients. In some instances the recipients fund a number of sub-recipients (Figure 14).

The study revealed that there's no mechanism to monitor the flow of donor funding to tuberculosis, malaria and HIV programs in Zambia, from the time of approval from the donor source to the receipt by the very end-user.

Capturing the total flow of funds into the country to the last Kwacha is the hallmark of ensuring transparency and accountability. Also, the judicious and realistic monitoring of external fund flows gauges the recipient countries' capacity to decide how best it can decide on resource use it sees most beneficial. Further, it enables the recipient country to plan its current national budget and make future projections for up to 10 years to guarantee sustainability. But how best to achieve the monitoring of flow of funds is a challenge. Flow of funds data could possibly be obtained from national budget figures (estimation of funds planned and available), funding commitment data, funding disbursement data, and the National Health Accounts (NHA).

Fig. 14 The Flow of Donor Funds for TB/malaria/HIV



According to Mills & Powell-Jackson (2007) the NHA is the most accurate assessment of the financial situation of the health system. There has been refinement of NHA to develop methods to track disease specific expenditures. But in areas of weak government public expenditure management and information system, NHA can't do much. Further, there is a danger of stand alone disease accounts only. Further, the direct budget support modality of funding, which is now advocated by the new Aid Policy, poses a challenge to health resource tracking as funds cannot be identified as supporting a particular program or disease.

In Zambia the Health Ministry has pointed out that the exercise of compiling the NHA is a demanding undertaking in that it requires all known sources of funding in the country to provide data on their current financing status, and that because of problems associated with the exercise, no NHA compiled can have a specific reference point less than a year (MOH 2006). A 1992-2002 NHA on financial flows into the health sector as a whole was only published in 2006. Currently, the combined Health Ministry and University of Zambia team are upgrading the NHA accounts 2002 to 2004 up to 2006, and further investigating disease specific NHA sub-funding. The NHA accounts are in draft form (verbal communication, UNZA NHA team).

Donor preferences in funding diseases and recipients

For the study period 2000 to 2007, the four major recipients received only 26.5% of the total funding for TB/malaria and HIV. The donors in the study funded TB 4%, malaria 7%, and HIV 89%, while the recipients in the study received for TB 12.59%, malaria 16.42%, and HIV 70.99% of funding (Fig 1).

A very interesting observation was that the bilaterals had the broadest range of interest in funding (80%), followed by Multilateral Non UN. Multilateral UN had the least area of interest in funding (33%) (Table 4). While the recipients had various uses of funding, the donor funding interest was highest for training (91%), followed by infrastructure and procurement (55%), and with only 36% for unearmarked funding.

The HIV funds are lower from the recipient perspective than the donor perspective because the study could not ascertain any significant funding received, especially from PEPFAR, through any of

the major recipients. The Health Ministry is not even aware of how these PEPFAR resources are channeled nor is it given an opportunity to influence allocation (verbal communication, Health Ministry). The donor preference to fund HIV accords with findings in a study by Shiffman (2006). But the donor preference on funding malaria over TB differed with the findings of the study by the same author who reported that TB received greater attention than malaria since TB had a higher burden in industrialized countries. Malaria receiving higher funding than TB in the study could be attributed to two reasons. There were foundations which funded malaria (87.03%) and which were not selective in choosing diseases that needed to be funded (Fig 7). Also, MACEPA specifically funded malaria. Further, Zambia received a large Malaria Booster loan from the World Bank**.**

TB and malaria in the period of study were predominantly funded by foundations, 82.86% and 87.03% respectively, while HIV was predominantly funded by bliaterals, 79.23% (Fig 7). The donor preferences could be attributed to the background of the funders, TB being funded by Global Fund, while malaria by Global Fund and MACEPA. The Global Fund's core business is to fund TB/malaria/HIV, and one of its original intentions was to fund the global battle against all the three diseases that together kill more than 6 million people per year around the world (Radelet 2004). According to Fritz (2008), the Bill & Melinda Gates Foundation (MACEPA) is a philanthropic organization spending 60% of its world charitable dollars on public health issues, the same as that spent by WHO, if not more.

DFID funded TB and malaria because its highest priority is in helping the poor and emphasizes Basic Health Needs assistance to poor countries based on humanitarian considerations (FASID 2005). The World Bank was the second highest funder of malaria after foundations. The World Bank is focusing on disease interventions following its formulation of the Health, Nutrition and Population strategy in 1998, which emphasized HIV/AIDS prevention, malaria eradication and reform of the health systems, to meet the needs of the poor (FASID 2005).

HIV was mainly funded by PEPFAR, Global Fund, World Bank and DFID, of which PEPFAR took the lead. PEPFAR's interest in funding has been diverse; from perceiving AIDS as a 'security issue' due to its impact on various institutions and citizens, to an economic interest where it is seen as big business, to the view that AIDS relief is a religious obligation to help the suffering and has been equated to other US policies like the Marshall Plan and Peace Corps (Dietrich 2007).

PEPFAR's entry into funding HIV has undoubtedly had a major impact on the HIV situation in Zambia, with an increase in numbers of patients on ARVs, care and support, OVC programs, HIV counseling and testing, community outreach programs and condom distribution (PEPFAR 2008).

Another interesting feature observed regarding donor preferences in funding diseases was the marginalization of the Health Ministry in the management and treatment of HIV. From the donor funding captured by this study, the Health Ministry between 2000 and 2007 was granted only 24.14% of the funding for HIV. The Zambian public health sector had made initial gains through health sector reforms by reversing backward trends in health service delivery (Bossert & Chitah 2001) and also had problems which could have been improved on (Berman & Bossert 2000). Following the entry of high donor funders from 2003, there has been no funding specifically marked for other priority areas like health systems strengthening. The donors actually imposed a conditionality that the funding should go to these selected interventions only instead of overall health system wide strengthening (MOH 2007).

One of the negative consequences of the massive funding with verticalization of programs is a serious depletion of health workers, further weakening the very system meant to carry health programs in the country. Either there was an overwhelming inflow of resources without consideration of the recipient country's' capacity; the donors wanted to manage the programs themselves; or donors felt that it would be much easier to do business with other recipients.

Predictability of donor funds

The predictability of funding has been linked to sustainability and the donor conditionality of the funding. For funding to be predictable, there should be both donor and recipient responsibilities. Sustainability of donor funded programs depends on the predictability of funding. Predictable levels of funding allow recipients to plan for medium to long term objectives, and allow the recipients to orderly and systematically scale up government efforts to specifically address bottlenecks. The longer the funding commitment time frame, the more likely are recipients to be assured of funding of programs over a period of time. The greater the dependence on donor funds, the more vulnerable the donor programs are to the certainty of donor funds. Thus, if funding is not predictable, there is a question of sustainability, while donor conditionality has to a great extent affected predictability of funding.

Though 91% of donors in the study said funding was 81-100% disbursed as committed (Table 5), from the recipient perspective invariably all were of the view that donor funds were not disbursed as per commitment.

The study showed an interesting relationship between predictability of funding and the various donors. A closer look will be taken at the Global Fund and the World Bank HIV funding disimbursement to Zambia. The Global Fund funding disbursement is based in two portions, where an initial release is made, and then a further release approximately 2 years later, based on detailed reports on progress made towards programmatic targets that are outlined in the grant agreement (Bernstein & Sessions 2007). As for the Global Fund Round 1 funding, the two government recipient organizations did not fare well compared to the disbursement rates with NGO recipient organizations (Table 11). This lends credence to the Global Fund view that dual-track financing, in which both public sector and NGO entities are chosen as recipient organizations, will lead to increased "absorption capacity" and "accelerated implementation and performance of grants" (Bernstein et al 2007).

Table 11. Round 1 Global Fund Disbursement to Zambia for HIV (US $) 8

Principal Recipient	Phase 1 Grant Amount	Phase 1 End date	Phase 2 Grant Amount	Phase 2 End date	Amount Disbursed	Percentage of Grant Amount
MOH	21,214,271	07/2005	19.670,657	07/2008	26.857.291	66%
MOFNP	(Grant Amount 6,395,758)			3,057,134		48%
CHAZ	6,614,958	07/2005	16,225,653	07/2008	21,959,088	100%
ZNAN	8,073,013	07/2005	12,131,468	07/2008	19,388,949	96%

(Source: GFATM 2008)

For Global Fund Round funding, where the phase 2 of funding is expected to end in October 2010, the disbursement as at September 2008 was less than 50% for all recipients (Table 12). The Health Ministry had received only a paltry 9% of the total pledged funding of US$ 116 million as at September, 2008. A closer look at "Conditions Precedent", benchmarks recipients have to fulfill, reveal that the Health Ministry had to fulfill certain conditions like employing a Finance Manager,

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selection of procurement agents, providing annual breakdown of partners' commitments to national HIV/AIDS program prior or after review, and end December 2007 audit to be presented by April 2009.

Table 12. Round 4 Global fund disbursement to Zambia for HIV (US $) 9

Principal Recipient	Phase 1 Grant Amount	Phase 1 End date	Phase 2 Grant Amount	Phase 2 End date	Amount Disbursed as at 08/2008	Percentage of Grant Amount
MOH	11,091,640	11/2007	105,036,921	10/2010	10,698,939	9%
MOFNP	2,376,376	10/2007	13,390,383	03/2011	7,382,073	47%
CHAZ	8,487,920	09/2007	62,912,103	10/2010	28,994,054	41%
ZNAN	4,814,840	10/2007	28,208,555	06/2010	12,624,105	38%

(Source: GFATM 2008)

According to Rivers (2008), disimbursement difficulties are one of the key Global Fund problems that need to be improved upon. The author has recommended Health Systems strengthening, simplifying processes for extending or expanding grants, and improving the application process. According to GAO (2007) limited capacity in recipient countries negatively affected performance and the study has recommended a more streamlined funding mechanism, developing a risk assessment framework that includes an early alert and response system for poorly performing grants; and, improving technical capacity at local level.

The World Bank ZANARA Project began in 2003 (Table 13) and ended in August 2008 under the Multi-Country AIDS Program whose aim was to increase access to HIV/AIDS prevention, care and treatment programs with emphasis on vulnerable groups with a specific development objective of each country project drawn from the national strategic plan (Mullen 2005). The World Bank funding has conditions which become a bottleneck in the smooth flow of funds (Bernstein et al 2007). ZANARA funding had been tied down to procurement conditionality whereby the release of funds was linked to fulfilling some of conditions**.** A World Bank review report reveals the inability of ZANARA to reach all targets despite 80% of the funds disbursed, without a mention of how the Bank intends to continue with the unaccomplished work (World Bank 2007, 2008).

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Table 13. World Bank (ZANARA) Funding to Zambia (Commitments and Payments: 2003-2006) (US$) 10

Source of Funds	2003	2004	2005	2006
IDA Grant ($)	1,575,505	6,188,024	12,673,450	10,752,639
IDA (% of total financing)	80%	97%	88%	89%
GRZ Counterpart Funds ($)	367,559	209,122	1,162,791	600,985
GRZ (% of total financing)	19%	3%	8%	5%
STARZ/DFID (S)			523,280	546,009
STARZ (%of total financing)	0%	0%	4%	5%
Others-Exchange differences ($)	28,233	-36,712	25,590	158,155
Total Financing (Commitment) ($)	1,971,297	6,360,434	14,385,111	12,057,788
Total Payments ($)	1,373,700	6,792,397	13,010,671	14,178,153
Disbursement rate (Payments as % % of allocation)	70%	107%	90%	118%

(Source NAC 2008)

From the conduct of these major funders, it's evident that predictability of funding is one of the challenges Zambia is still facing.

Sustainability of donor funds

Sustainability is the capacity of a recipient country to generate sufficient local funding, over a period of time, to fund full costs of the donor funded programs. This entails both a donor funding commitment over a reasonable period of time, and the recipient country's commitment to expand local funding over that period to substitute for the donor funding. Currently, there is little chance that recipient countries can meet ongoing costs if donor funding for current programs end while there is scaling up of the programs. There is also a real risk that recipient spending patterns will be dictated by funders and in fact recipients will have to sustain activities provided by donors rather than address other pressing national issues. To have sustainable programs, there is a serious need for both donor and recipients to share responsibilities, especially if the funding cycle for some donors comes to an end in the period 2008 to 2010.

According to the study, 63% of the donors shared running costs with the recipients, while 36% of donors' running costs were borne by recipient government. From the donor category, there was no donor variation in taking care of the running costs (Table 7).

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The Zambian government's domestic health funding budget on the contrary portrays a very different picture of the government's commitment. According to MOH (2008b), the trends in budgetary allocations to health indicate that Government health budget is increasing only in nominal terms, from ZMK 415 billion in 2005 to ZMK 557 billion in 2006, ZMK 830 billion in 2007 and ZMK 974 billion in 2008. As a proportion of the national budget, the health budget has actually been static over this period of time. Actually, the health budget as a percentage of total GRZ discretionary budgets declined from 11.5% in 2005 to 10.3% in 2006, 9.6% in 2007 and then increased to 11.2% in 2008 reflecting an annual average of 10.7% of the total budget over the period 2005 to 2008.

The demand for HIV management and prevention services will be increasing in coming years as more HIV positive individuals, and AIDS patients are identified and managed. From the HAPSAT study, it's evident that Zambia will require continued funding commitments for the years 2009-2011, as domestic revenue accounts for only about 6 per cent of HIV/AIDS program budgets (MOH 2008a). In fact, the Zambian government has acknowledged that donor finding will still be required for managing HIV in the next 5 years (MOFNP 2006b).

Currently, Zambia has accrued debt relief from HIPC write-off which can be channeled to social sector spending; the copper prices have skyrocketed with a huge windfall-tax from copper producers; there's massive inflow of Foreign Direct Investment. Will government increase its health budget to incrementally fund HIV in the next five years; or will government look for other cost-sharing initiatives like private-public partnerships, and insurance schemes? The government's increased commitment to fund HIV, in view of a dramatic surge in the economy remains to be seen. PEPFAR, the Global Fund and the World Bank have been major players in HIV donor funding (Fig. 7). PEPFAR currently has been the highest funder to Zambia (Table 14).

Table 14. PEPFAR HIV Allocation For the Period 2004 to 2007 (US$) 11

	Country Managed Programs	Central Programs	Total
2004	57,933,801	23,852,837	81,786,638
2005	102,745,140	27,343,465	130,088,605
2006	108,914,000	30,108,153	149,022,153
2007	184,811,047	31,201,733	216,012,780

(Source PEPFAR 2005, PEPFAR 2006 PEPFAR 2007, PEPFAR 2008)

Zambia has received generous PEPFAR funding which has undoubtedly had a positive impact on managing the AIDS pandemic in Zambia. According to the provisional figures of the 2007 Zambia Demographic and Health Survey, the national HIV prevalence rate among adults aged 15 to 49 years has declined from 15.6% in 2001/2002 to 14.3% in 2007 (MOFNP 2008c). Table 15 shows the impact of PEPFAR in treating HIV/AIDS in selected African countries.

Table 15. Impact of PEPFAR in Selected Focus Countries

Country	Provided treatment by July 2004 (direct U.S. support)	Provided treatment by end September 2004	Receiving treatment end September 2005	Receiving treatment end September 2006	Receiving treatment end September 2007	Target for FY 2008
Botswana		32,839	37,300	67,500	90,500	33,000
Mozambique		5,133	16,200	34,200	78,200	110,000
Namibia	2,500	4,000	14,300	26,300	43,700	23,000
South Africa	3,700	12,253	93,000	210,300	329,000	500,000
Tanzania	100	1,518	14,700	44,300	96,700	150,000
Zambia	1,500	13,636	36,000	71,500	122,700	120,000

(Source: AVERT. org 2008)

But PEPFAR has no long term funding strategic plan. The Congress legislates the way PEPFAR allocates its funding following the submission of yearly Country Operational Plans prepared by its local field staff (Bernstein et al 2007); further, the funding is channeled outside government system, and while local PEPFAR staffs are encouraged to share information with the host government, there's no system or guidance on how to go about this. Thus PEPFAR falls short of creating a public health or clinical care infrastructure. If the program ends, as it will someday, its staff will pack and go home (Klag 2008). PEPFAR addresses the issue of sustainability of their programs from a different perspective, it emphasizes that 25% of its resources are devoted to certain programs but is silent on financial sustainability in the coming years.

Recently, a re-authorization Bill was signed by ex-President George Bush that reauthorizes PEPFAR through to the year 2013. It allocates US$48 billion; over half of program aid to go towards HIV/AIDS treatment and care; creating a link between HIV/AIDS and nutrition; setting a target of recruiting 140,000 health workers, US$5 billion for malaria; US$4 billion for TB, amongst others (KFF 2008b). Further, the US Congress House Speaker Nancy Pelosi praised the Bill for

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taking the global fight against TB, malaria and HIV from "emergency phase to the sustainability phase". Questions that remain answered are the criteria that will be used to increase funding to the 15 PEPFAR focus countries, the way PEPFAR will ensure recruitment of highly skilled and semi-skilled manpower between 2008 and 2013, and whether PEPFAR will genuinely re-align its programs within the host countries' national development and health plans.

It is crucial that the sustainability of donor funded programs be considered before a program is introduced rather than after, as is the case now.

Modality of funding

There are broad ranges of mechanisms used to coordinate aid and countries develop different instruments over time. Buse et al analyzed changing practice of aid coordination in a number of countries and found that aid is context-dependent and subject to continuing changes. Zambia has not escaped from this finding, receiving aid in various forms; direct budget support, SWAp, project support, direct donor-recipient funding, and technical assistance. But SWAp in the health sector has been identified as the preferred business model (MOH 2008b).

The results of the donor interviews show that there was high donor preference for health sector support (73%), followed by Health Ministry Agent, and NGO (55%). Direct Budget Support is not yet the preferred mode of funding (27%), while SWAp had the least donor preference. The Multilateral Non-UN showed least preference in funding modality (Table 8), while Multilateral UN showed highest preference in funding modality.

While the NGO's and FBO's were recipients which received funding direct from donors and foundations (Figure 14), the study found an important development in the funding modalities to the two major Government recipients. Since 1999, the Health Ministry had adopted the SWAp as a funding modality. It received funding to the sector from donors.

It is interesting to look at the mode of funding to Zambia by PEPFAR, Global Fund, World Bank and DFID. PEPFAR and the Global Fund completely by-passed the SWAp. In some countries the Global Fund funded through the SWAp (Bill & Melinda Gates Foundation 2005). The World Bank funded directly through the Finance Ministry where the HIV ZANARA project was based, while the

malaria funding was to the Health Ministry for channeling to National Malaria Control Center**.** DFID funded through the SWAp, then resorted to General Budget Support, and are now contemplating getting back to SWAp**.**

It is obvious that the policy shift from SWAp to General Budget Support in the new Aid Policy has a bearing on the Health Ministry in the coming years. The Health Ministry wishes to see a full SWAp where donors will support one sector plan; disburse resources into one expanded basket to support that sector plan; implement activities through the government led public health care system; provide funds in a flexible and predictable way where the Health Ministry is given leverage to allocate resources; and cease to earmark aid to specific interventions (MOH 2008b). The donors prefer SWAp whether funded through sector budget support, pooled funding or project modality (MOFNP 2007b).

What is important is a gradual shift from SWAp to Sector Budget Support to General Budget Support, to enable the process to stand the test of time.

Donor Conditionality

The concept of 'donor conditionality' is now taking a backstage in donor-recipient relations as donors have realized that 'conditionality does not work' (Collier et al 1997). A recipient country which has good policies and institutions to deliver will use the funding in a better way than one which does not, as withholding aid does not change a recipient's performance, further aggravating the recipients' progress. Meanwhile, taxpayers in donor countries want to see how their funds are used and whether they are used for the intended purpose. Donors can only assess recipient performance by formulating some indicators to fulfill. While most donors have shifted to indicator-based funding, the Breton Woods institutions still work on the concept of conditionality as a method for recipients to perform better.

In the study, transparency and accountability, and effective and efficient implementation of programs were the conditionality donors preferred most (36%). From the various donor categories, the Multilateral Non UN and foundations had the highest conditionality preferences (40%) (Table 9). 50% of donors' programs were affected by the IMF conditionality of restricting public spending

in the recipient country (Table 10). Conditionality has affected Zambia at macro and sectoral level.

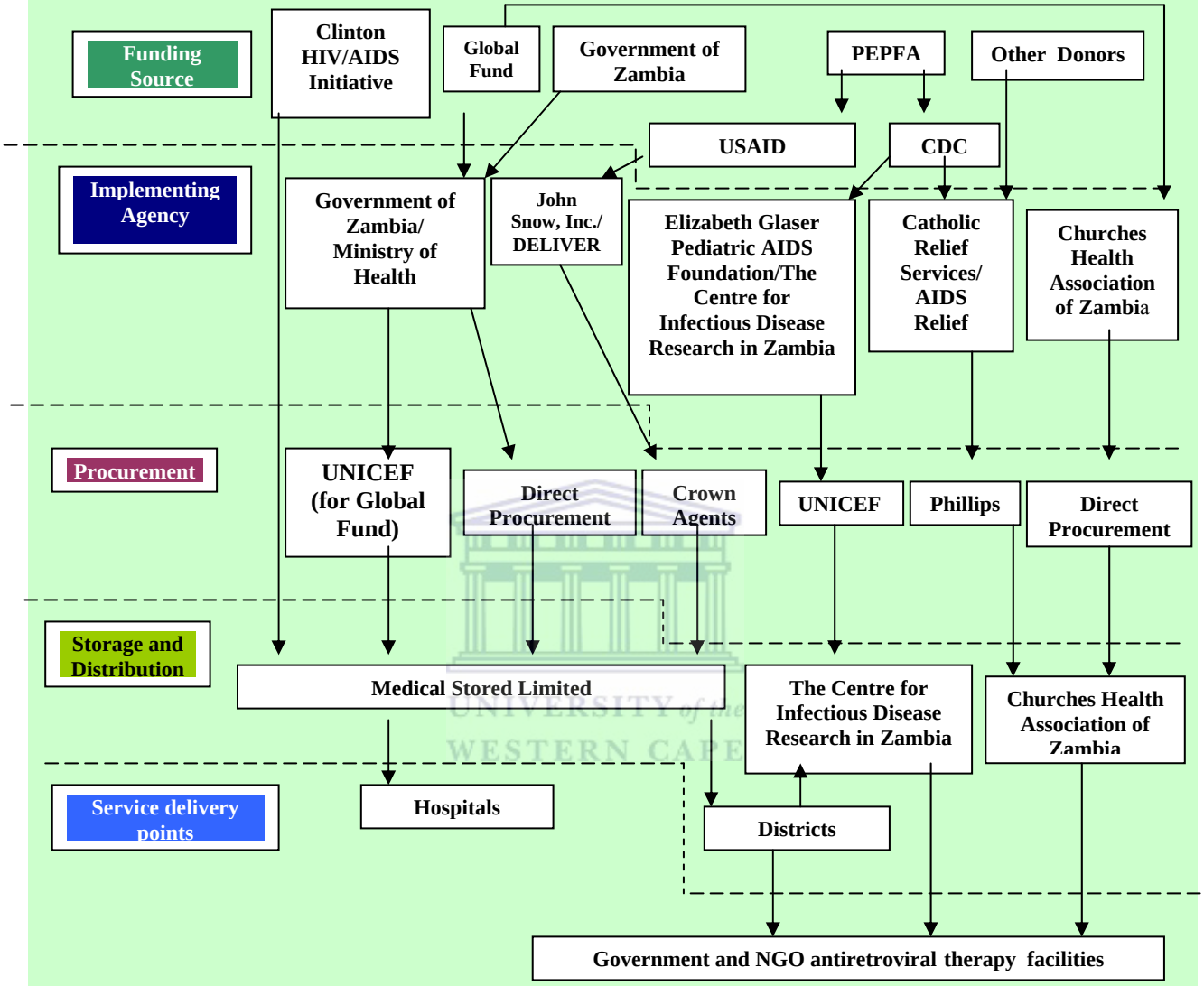
At the macro level, the IMF conditionality of GDP: PE impacted on the health sector and the TB/malaria/HIV programs. The IMF often points out that it does not limit expenditure for specific health sectors (including health) and that expenditure on health staff are exempted from budget ceilings. It also states that it offers support to mitigate macroeconomic effects of increased aid flows, and even calls for more aid at sustainable levels in meetings. It also calls for improved resource allocation (Wemos 2006). In case studies in Ghana, Kenya, Uganda, and Zambia it is reported that, although the IMF does not explicitly set limits on health spending, its overall targets do limit resources available for health and health staff (Wemos 2006). Zambia already has a human resource crisis in the health sector emanating from migration to neighboring countries for better conditions of service; limited training facilities due to lack of capacity to train and expand; and, the HIV/AIDS pandemic ravaging the country (Banda et al 2005).

At the sectoral level, the study looked at the conduct of two major donors, PEPFAR and the Global Fund. PEPFAR initially specified that drugs purchased from its money had to be approved by US Foods and Drug Administration, and not WHO pre-qualification. Subsequently the policy changed and FDA began to share its files with WHO and had its list of drugs added to WHO's list of approved drugs. PEPFAR began to purchase generic drugs and Fixed Drug Combinations so that by end of December 2007 the FDA approved 57 generic ARVs which are cheaper, 8 Fixed Drug Combinations (FDC) which has a beneficial effect on adherence, and 14 pediatric formulations (AVERT.org 2008). Though generic competitions have reduced the price of 1st line ARVs from US $10,000 per patient per year to the current level of US $130, this is not the case for new and future ARV's which remain under patent protection (Stop Aids Campaign 2007).

According to a study by Bernstein et al (2008), an assessment by John Snow Inc. in Zambia revealed at least seven different logistics systems used by governments, donors and others in procuring ARV's (Fig. 15). PEPFAR hired DELIVER to consolidate the systems, but it does not address how PEPFAR was conducting procurement. The same study reveals that the Zambian Health Ministry complained about non-availability of PEPFAR procurement plans and processes to them, and PEPFAR resisted their request to be part of the procurement process.

The Global Fund also has questionable procurement process. The 'long lasting insecticidal nets' have been adopted as a priority intervention against malaria. To establish guidelines for safety and

Fig. 15 **The Antiretroviral Supply Chain System for Zambia**



Note: CDC is the U.S Centres for Disease Control. Since 2005, this picture has changed somewhat. For example, the implementing agency Government of Zambia/Ministry of Health now uses Crown Agents for procurement rather than UNICEF and direct procurement; USAID now uses SCMS as the implementing agency and for procurement; and Catholic Relief Services/AIDS Relief procurement through Phillips goes to Medical Stores Limited for storage and distribution rather than to the Churches Health Association of Zambia.

(Source: Bernstein et al 2008)

efficacy, the World Health Organization Pesticide Evaluation Scheme (WHOPES) reviews and recommends new 'long lasting insecticide net' technologies following field studies on netting material and chemical used (WHO 2007). WHOPES's recommendation has become a 'gold standard' because donors almost exclusively purchase WHOPES recommended nets (Table 16).

Ideally Global fund should prequalify suppliers of long lasting insecticide nets but in reality this is not being followed. Verstergaard actually has the sole monopoly in supplying mosquito nets PermaNet to Global Fund funded programs worldwide, thus monopolizing the lucrative mosquito

Table 16. WHO Recommended Long-lasting Insecticidal Mosquito Nets as at December, 2007

Product Name	Product Type	Status of WHO Recommendation
Duranet ®	Alpha-cypermethrin incorporated into polyethylene	Interim
Netprotect ®	Deltamethrin Incorporated into polyethylene	Interim
Olyset ®	Permethrin Incorporated into Polyethylene	Full
PermaNet 2.0 ®	Deltamethrin coated on polyester	Interim
Interceptor ®	Alpha-cypermethrin coated on polyester	Interim

(Source WHO 2007)

net business (personal communication, Health Ministry). Since Vestergaard has no other competitor, there is no value for money.

The study initiated by Global Fund on the organizational effectiveness and efficiency as part of its five-year evaluation, identified procurement as one key area that needs improvement (GFATM 2007b). It calls for strengthening of the Procurement Unit at the Global Fund and authorizes it to work with partners and look for innovative ways to assist countries with procurement, particularly those with weak procurement systems where training is needed. It now remains to be seen how the Global Fund will improve on procurement procedures since there appears to be a contradiction in its theory and practice.

PEPFAR's funding to recipients is based on funding legislated by congress. 55% is allocated for treatment, 10% Orphans and Vulnerable Children, 15% care, and 20% prevention. Of the 20% prevention allocation, 50% of it is for sexual transmission. Regardless of whether 50% of the targets are met, countries are required to spend 66% of their sexual transmission funding on Abstinence/be faithful (AB) programs. According to Bernstein et al (2007) a comparative study of PEPFAR allocations to Mozambique, Uganda and Zambia found a strikingly similarity in funding despite the epidemiological difference among the three countries (Table 17). Global earmarks are driving the funding allocation regardless of country specific epidemiology and health systems capacity.

Two key United States based studies identified restrictive funding earmarks as a problem as it restricts PEPFAR's ability to tailor its activities in each country to the local epidemic, and have recommended a more country based approach in allocating funds (GAO 2008, IOM 2007).

Table 17. PEPFAR allocations FY 2007 to selected countries

	Prevention	Care	Treatment	Others
Mozambique	23.6%	24.4%	38.3%	13.7%
Uganda	18.4%	29.9%	38.9%	12.8%
Zambia	20.7%	28.1%	39.2%	11.9%

(Source: Bernstein et al 2007)

Following the passing of the PEPFAR re-authorization bill in mid-2008, some of the measures include a provision that more than half of program aid goes towards HIV treatment and cure. It over turns an existing law that requires one-third (50% of 66%) of prevention funds be spent on AB programs, and instead requires a report to Congress if countries do not spend half of the prevention money on such a program (KFF 2008b). The re-authorized bill has not removed the restrictive funding earmark, and as a result it will restrict PEPFAR country teams' ability to work with local organizations to allocate resources to areas where they are most needed.

The Health Ministry currently has five separate plans and budgets for major health partners (MOH 2007). These add to high transaction costs. The disbursement of funds should ideally be triggered by a Joint Disbursement Mechanism, whereby the Health Ministry Financial Report, the HMIS and the Health Ministry Strategic Plan, are pre-requisite documents for donors to preview. The Global Fund, World Bank, and PEPFAR always demand more reports and in-depth proposals which actually impacts on program implementation. The Global Funds conditionality on proposals has hurt the Health Ministry to the extent that the yearly funding is only released in the third or the fourth quarter of that year rather than the first quarter (personal communication). Naturally this derails program implementation, and adds on high transaction costs.

Conditionality at both macro and sectoral level has affected TB/malaria/HIV programs directly and indirectly, and has to be addressed at the two levels.

Aid Effectiveness

How effective is the aid to recipient countries? According to Addison et al (2005) aid increases public expenditure, and together with aid's positive impact on growth implies that aid works to reduce poverty, and that poverty would be higher in the absence of aid. Reduced poverty levels reduce TB/malaria/HIV and vice-versa (APPENDIX VI & VII). On the other hand Eberlei (2005) notes that aid is always focused on the elite in developing countries; with it there are donor-driven policies; and with traditional aid modalities there are structural problems like weak donor coordination, small and isolated bilateral projects, rapid proliferation of aid agencies with own procedures, and off-budget aid difficult to plan and monitor.

There have been various international efforts in the last 16 years to make aid effective (APPENDIX IX) in which Zambia has been an active participant. Key high level meetings have been the 2002 International Conference on Financing for Development in Monterrey, Mexico; the 2003 Rome High Level Forum on Harmonization; the 2005 Paris High Level Forum; and the 2008 Third Accra High Level Forum on Aid Effectiveness.

Zambia participated in the 2006 and 2008 Paris Monitoring Surveys (OECD 2007, OECD 2008). A comparison of the results for both surveys on aid effectiveness show a mixed picture. There were improvements in the use of country procurement systems from 46% in 2006 to 74% in 2008, in aid on budget from 52% in 2006 to 74% in 2008, and aid predictability from 50% in 2006 to 86% in 2008. Indicators relating to harmonization and alignment showed only slight improvement.

High level meetings and resolutions on aid effectiveness are not enough. In reality much remains to be done if Zambia is to successfully attain most of the MDG's. Zambia's Health Minister at a recent workshop on the International Health Partnership and related Initiatives (IHP+) and harmonization for health in Africa said, ***'despite huge external support Africa has received, most countries continued to show little progress towards the attainment of health-related Millennium Development Goals (MDG's)'*** (Times Reporter 2008). Subsequently, the Pan-African Parliamentary President said ***'Zambia is among the African countries that are unlikely to attain the MDG's four and five (on health) by the year 2015 due to poor health service delivery*** (Nyondo 2008).

The challenge of transforming donor funding into an effective and efficient instrument for Zambia to achieve its MDG's is an onerous task which involves the concerted efforts of both the donors and the recipients to fulfill a basic moral, legal and social responsibility to its citizens: to account and be accountable.

Chapter 6

CONCLUSION AND RECOMMENDATIONS

This study has analyzed a large volume of data that has provided an insight into the flow and the various characteristics associated with the donor funding, over an 8-year study period. Based on the data from the interviewee and document sources, triangulated with key in-depth interviews, the study makes the following conclusions:

Conclusions:

- Currently, there are a number of donors funding TB, malaria and HIV in Zambia, funding various recipients. There is no central data bank for the donor funding, nor are there any rules or regulations to capture donor inflows.
- There is no mechanism to systematically and regularly monitor all donors funding expenditure. The National Health Accounts are prepared on an ad-hoc basis, rather than a matter of policy.
- There is no mechanism to cushion the donors, and the program, from the effects of local exchange rate fluctuations caused by various internal and external factors
- There is no consultation process from the onset, between the donor and the recipient, in determining what, how and when to fund programs. Consultation in some instances takes place as a matter of formality only.
- The donors don't seriously engage the recipient on the benchmark/conditionality of funding prior to the funding. Recipients in some instances learn of the benchmark/conditionality only after the program is on-going.
- There have not been enough local stakeholder consultations on the New Aid Policy. The New Aid Policy has not clearly and categorically spelled out the movement of the health sector to General Budget Support from SWAp.

- The IMF conditionality of GDP: PE ratio has seriously affected the employing of health personnel. Despite denial of the conditionality from the donor, recipients and other donors have acknowledged its existence, and serious negative consequence to the health sector.

Recommendations

- The Zambian government must as a matter of procedure, enact immediately rules and regulations, to capture all data on donor funding inflows.
- Zambia should have a strong donor fund monitoring system as a matter of policy to systematically and regularly track all fund flows by way of tracking expenditure. National Health Accounts must be adopted as a gold standard.
- Zambia should cushion the donor funding from local exchange rate fluctuations. Zambia should fix rates for donor funds to protect the funding from losing value and keep the programs on course.
- The Donors in Zambia must engage Zambia from the onset, as part of the consultation process, in determining which donors fund what programs, taking into consideration that the objective is to support the sector with one investment plan only
- The Donors in Zambia should ensure a very high commitment for disbursement of funds, by seriously engaging Zambia and addressing the benchmarks/conditionality of funding, and the sustainability of programs, prior to the funding. The Donors in Zambia should subscribe to a Joint Disbursement Mechanism.
- Zambia should have a re-look at the new Aid Policy, and allow Donors in Zambia to fund the health sector by moving to General Budget Support from SWAp, through Sector Budget Support, then to General Budget Support, as an evolving process
- The IMF should urgently review its conditionality of maintaining the GDP: PE ratio, and have an exceptionality for the Health Sector as it is labor intensive
- The Donors in Zambia and Zambia must periodically evaluate the impact of the massive funding on diseases and further improve the programs; and re-orient future funding strategy from highly vertical to mixed vertical-horizontal programs, to ensure a better, more effective and efficient utilization of donor funds.

- Ultimately, Zambia must seriously scale up health budgets to critical areas from domestic resources, and channel donor funds to non critical areas to ensure sustainability, predictability, minimize conditionality issues, lessen donor dependency, and genuinely fulfill the various donor-recipient covenants that both have signed.

Finally, the findings from one-off studies may not represent the nature and effects of some donors, especially the new entrants like the Global Fund, and PEPFAR. According to Brugha (2008), empirical cross-country studies including policy analysis are needed to track, assess and obtain a pluralistic perspective on their effect on national policy making as these new entrants evolve and adapt their approaches in coming years.

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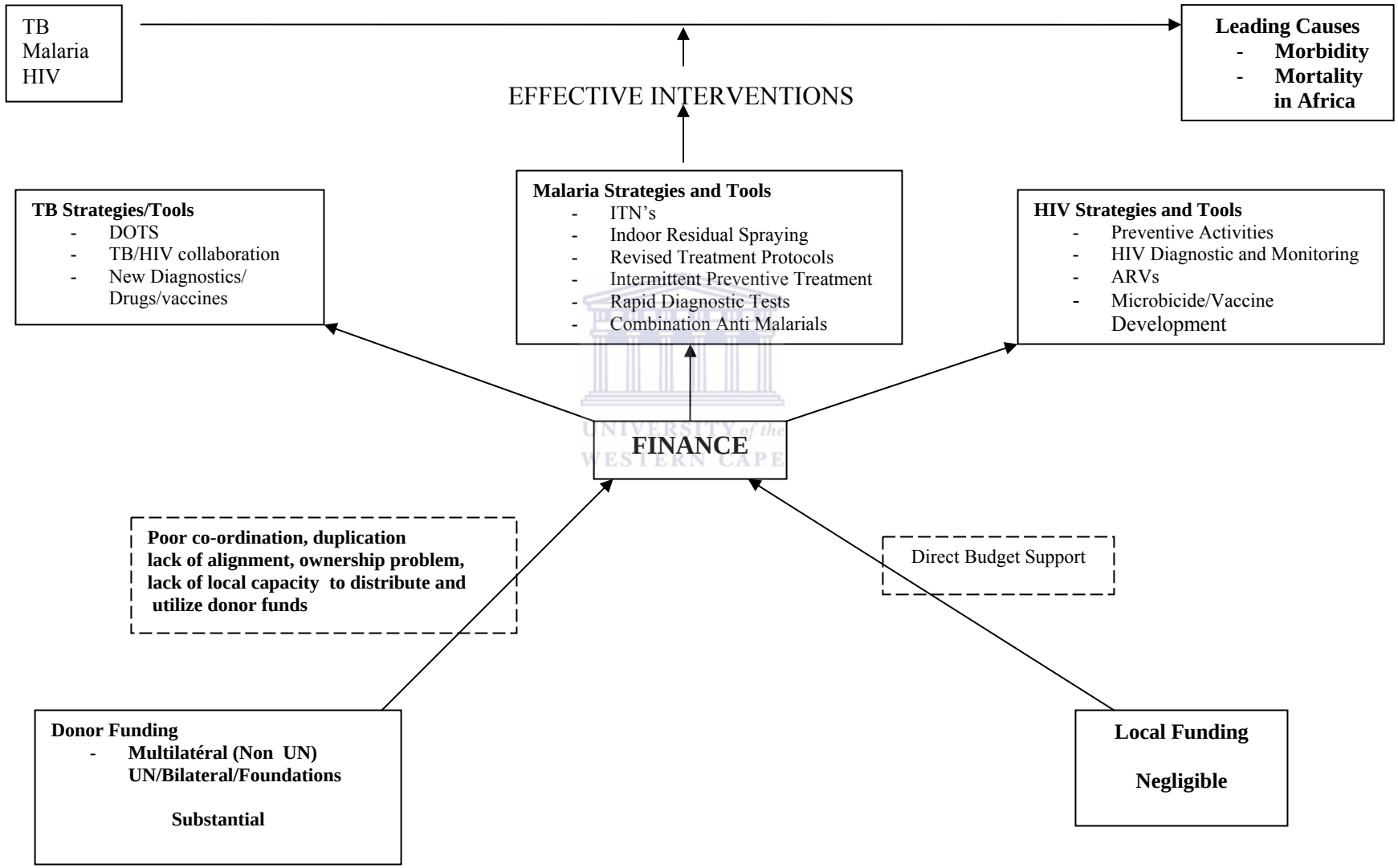
APPENDIX I

Problem Analysis for Donor Funding of National Tuberculosis/Malaria/HIV Programs in Zambia



APPENDIX II

Donor Questionnaire for Donor Funding of National Tuberculosis/Malaria/HIV Programs in Zambia

INSTRUCTIONS TO THE INTERVIEWER

a. No name to appear on the questionnaire

b. Explain purpose of study and obtain written consent before commencement of interview.

c. Information given by respondent is considered confidential.

RESPONDENT INFORMATION

1. Interview date/Place:_____

2. Organization (Specify: Multilateral (Non UN)/Multilateral (UN) Bilateral/Foundation

_____

3. Organization/Institution/Ministry Funded (in Recipient Country) _____

4. Contact Details: Address, telephone, Fax, e-mail _____

_____

_____

5. What allocations have you provided for tuberculosis/malaria/HIV programs in the past eight years?

	2000	2001	2002	2003	2004	2005	2006	2007	Total
a) Tuberculosis									
b) Malaria									
c) HIV									

DONOR FUNDING

6. The allocations have been provided to cater for which of the following areas:-

(Please tick, multiple answers possible)

a) Funding mechanism only ☐

b) Training local manpower ☐

c) Building Infrastructure ☐

d) Procurement facility ☐

e) Any other ☐

7. What is the percentage of disbursement, of the funding committed? (Please tick)

a) 1 – 20% ☐

b) 21 – 40% ☐

c) 41 – 60% ☐

d) 61 – 80% ☐

e) 81 – 100% ☐

8. What is your funding commitment time frame (please tick)

a) One year ☐

b) Two years ☐

c) Three years ☐

d) Four years ☐

e) Five years and more ☐

MODALITY OF FUNDING

9. Who are bearing the running costs of existing national tuberculosis/malaria/HIV programs being funded by you (please tick)

   a) Recipient government ☐
   b) Donor ☐
   c) Other donors ☐
   d) Both donors and recipient government ☐

10. Through which mechanism do you fund the recipient country (please tick, multiple answers possible)

   a) Direct budget support ☐
   b) SWAp ☐
   c) Different recipient country line Ministry ☐
   d) Recipient country Agents ☐
   e) NGO/community ☐

11. Do you have mechanisms to track resource flows into the recipient country (please tick)

   a) Yes ☐
   b) No ☐
   c) Don't know ☐

12. What mechanisms are put in place to not derail the programs once the funding proposals are not approved?

_____

_____

_____

CONDITIONALITY

13. Is your funding linked to following donor conditions (please tick) ☐

   a) Transparency and accountability of donor funds ☐
   b) Efficient and effective implementation of the programs ☐
   c) Management of national economy in recipient country ☐
   d) Good governance in the recipient country ☐
   e) Not linked to any conditionalities ☐

14. Is the IMF conditionality of restricting public spending in recipient country affecting your national programs? (Please tick)

   a) Yes ☐
   b) No ☐
   c) Don't know ☐

15. When conditionalities are set, do you discuss, negotiate, and agree with recipient country these conditionalities (please tick)

   a) Yes ☐
   b) No ☐
   c) Don't know ☐

16. If No to question 15 above, explain why

_____

_____

_____

_____

OWNERSHIP

17.	Are you subscribing to (please tick)	***Yes***	***No***
a)	One Country level Action Framework	☐	☐
b)	One National Co-coordinating Authority	☐	☐
c)	One Country Level Monitoring & Evaluation System	☐	☐

18. Are your programs aligned to recipient countries national development priorities (please tick)

a) Yes

b) No

c) Don't know

Thank you for taking part

APPENDIX III

Recipient In-depth Interview Schedule for Donor Funding of National Tuberculosis/Malaria/HIV Programs in Zambia

INSTRUCTIONS TO THE INTERVIEWER

a. No name to appear on the Interview Schedule

b. Explain purpose of study and obtain written consent before commencement of interview

c. Information given by respondent is considered confidential

RESPONDENT INFORMATION

1 Interview date/Place:_____

2. Organsiation (Specify: Ministry/NGO/Faith Based Organization):_____

_____

3 Donor funding the Recipient (Specify: Multilateral (Non UN)/Multilateral UN/Bilateral/Foundation):_____

_____

4. Contact Details: Address, telephone, Fax, e-mail_____

_____

_____

5. Can we begin by asking if you receive donor funding regularly for implementing tuberculosis/malaria/HIV programs

If yes, then note:

a) For how long have you been receiving funding?

b) How much have you received?

c) Which donor funds have you received?

d) What is the intended use of donor funding?

e) Is the funding disbursed as per commitment?

6. If you don't receive donor funding regularly,

a) What could be possible problems?

b) Is the problem lying with yourselves or donor conditions?

c) If the problem is with you, what are possible reasons?

7. How do you receive funding from the donors?

a) Through central government budget

b) Through Health Ministry

c) Through donor agents in country

d) Through NGOs

8. Once you receive funding (3) do you bear the running costs of the programs as well?

9. Do you track donor resources that flow to your programs?

10. If you track resources (5), how are you going to sustain programs once donor funding runs out?

11. Are you tied down to any donor conditionalities which affects your program?

12. If you are tied down to donor conditionalities (7) at what stage of program planning and implementation have you been engaged?

13.. Are you subscribing to: the "Three Ones Principles"?

a) One country Level Action framework

b) One National Coordinating Authority

c) One Country Level Monitoring and Evaluation System.

14. If you are subscribing to (9), which donors have your come across who could have had difficulties in subscribing to 'Three Ones Principles'?

15. Do the donor fund programs which are aligned to national development priorities?

16. If they are not aligned to national development priorities (11), what could be other reason(s) for donor funding the national TB/Malaria/HIV programs?

17. The donors funding these national TB/Malaria/HIV program, some view it as help to developing countries, others see it as a dependency syndrome. How do you see donors? (Probe on donor mentality)

Thank you for your time

.

APPENDIX IV

Participant Information Sheet

UNIVERSITY OF THE WESTERN CAPE
School of Public Health

Private Bag X17 ● **BELLVILLE** ● 7535 ● South Africa
Tel: 021- 959 2809, Fax: 021- 959 2872

September 2007

Dear Participant,

Kindly please accept my sincere thanks for taking your time to read about this research. A description of the research study is being given and your potential involvement. The research is being conducted for a Mini-Theses fulfillment of my Master's Degree in Public Health. If you need further clarity, or anything you might not have understood, please don't hesitate to contact me or my Supervisor whose details are at the end of this memo.

TITLE OF RESEARCH
The Trends & Characteristics of Donor Funding Patterns of National Tuberculosis, Malaria and HIV programs in Zambia.

PURPOSE OF STUDY
The study is trying to determine the donor funding allocations, and assess the characteristics of funding for the three diseases. With your participation a better understanding will be obtained of the donor funding trends, and various problems generated by donor funding like predictability, sustainability, modality, conditionality and ownership of the tuberculosis, malaria and HIV programs.

DESCRIPTION OF THE STUDY AND YOUR INVOLVEMENT
The study will include Questionnaire interviews with donors funding the diseases' programs and Indepth Interviews with recipients receiving donor funding. Your knowledge and experiences will be instrumental in having successful interviews.

CONFIDENTIALITY
Your name will be kept confidential throughout the research. I'll personally handle all records of your participation, inclusive of signed Consent Form which I'll need from you should you agree to participate in this research study. All records will be locked away at all times and destroyed after the research has been completed.

VOLUNTARY PARTICIPATION AND WITHDRAWAL
Your participation in this research is entirely voluntary. If you participate, you are free to withdraw at any stage. You may also choose not to answer specific questions asked during the interviews. If you wish to not discuss a certain item, do feel free to let me know.

BENEFITS AND COST

You may not benefit directly from the study. But the information and knowledge I'll gather from you the participant may help both the recipients and the donors funding the tuberculosis, malaria and HIV programs. As the research is based purely on existing practises, you'll gain indirectly by having an opportunity to shape the future of funding. There's no cost for participating in the study other than the time you're giving for the interviews.

INFORMED CONSENT

Before the Interview, I'll need your signed Consent Form to participate in this study. The Consent Form is herewith enclosed for you to go through and decide whether you would like to participate in this study or not.

QUESTIONS

If there's any clarity needed, or anything you wish to know more about, please contact me:

Name	:	Akbar Yusuf Badat
Student Number	:	2520610
Cell	:	260 97 7 773265 or 260 96 6 773265
E-mail	:	aybadat@gmail.com
Fax	:	260 21 1 312618

I am accountable to Prof. David Sanders, my Supervisor at the UWC. His contact details are:

Cell	:	27 82 202 3316
E-mail	:	dsanders@uwc.ac.za
Tel	:	27 21 671 7553 or 27 21 959 2402
Fax	:	27 21 959 2872
Web	:	www.uwc.ac.za/comhealth/soph

APPENDIX V

Record of Informed Consent to Conduct an Interview

UNIVERSITY OF THE WESTERN CAPE
School of Public Health

Private Bag X17 ● **BELLVILLE** ● 7535 ● South Africa
Tel: 021- 959 2809, Fax: 021- 959 2872

Date:
Interviewer: Akbar Yusuf Badat
UWC Student No: 2520610
Tel: 260 97 7 773265 or 260 96 6 773265 Fax : 260 21 1 312618
E-mail: aybadat@gmail.com
Institution :
Interviewee's pseudonym:
Place at which the interview was conducted:

Thank you for agreeing to allow me to interview you. What follows is an explanation of the purpose and process of this interview. You are asked to give your written consent before commencement of the interview.

1. Information about the interviewer

I am a graduate student at the SOPH, University of the Western Cape. As part of my Masters in Public Health, I am required to write a Mini-Thesis. I will be focusing on Trends & Characteristics of Donor Funding Pattern of National Tuberculosis, Malaria and HIV Programs in Zambia. I am accountable to Prof. David Sanders (my Supervisor) who is contactable at 27 21 671 7553 or Cell 27 82 202 3316 or c/o SOPH Fax: 021 959 2872 or by e-mail at dsanders@uwc.ac.za.

2. Purpose and contents of interview

As the study is trying to determine the donor funding allocations, and assess the characteristics of funding for the three diseases, with your participation a better understanding will be obtained of funding trends and various problems generated by donor funding. The information and knowledge I'll gather from you may help both the recipients and donors funding the three diseases. There'll be an opportunity to shape the future of funding.

3. Interview Process

Following the explanation of the study, and after your signing of this Consent Form, I'll be myself collecting the data in a one-to-one Questionnaire Interview. I'll get back to you in the eventuality of gaps and further data requirement.

4. Anonymity of contributors

At all times, I will keep the source of the information confidential and refer to you or your words by a pseudonym or invented name which I would like you to choose. See name above. I shall keep any other records of your participation locked away at all times, and destroy them after the data has been collected.

5. Things that may affect your willingness to participate

The interview may touch on issues which could be sensitive. If there's anything that you would prefer not to discuss, please feel free to say so. I'll not be offended and there will be no negative consequences if you would prefer not to answer a question. I would appreciate your guidance should I ask anything which you see as intrusive.

CONTINUED

6. **Agreement**

6.1 **Interviewee's Agreement** (The respondent will be asked to give her/his written consent before commencement of the interview).

6.2 **Interviewer's agreement**
I shall keep the contents of the above research interview confidential in the sense that the pseudonym noted above will be used in all documents which refer to the interview. The contents will be used for the purpose referred to above, but may be used for published or unpublished research at a later stage without further consent. Any change from this agreement will be renegotiated with you.

Signed:
Date:
Place:

APPENDIX VI

Selected Comparative Country Statistics on TB/Malaria and HIV

Indicator	Date/Date Range	Data Type	Data				
			Canada	India	Mexico	South Africa	Zambia
HIV/AIDS							
People Living with HIV/AIDS	2007	#	73,000	2,400,000	200,000	5,700,000	**1,100,000**
Adults living with HIV/AIDS	2007	#	73,000	2,300,000	200,000	5,400,000	**980,000**
Adult HIV/AIDS Prevalence Rate	2007	%	0.4%	0.3%	0.3%	18.1%	**15.2%**
AIDS deaths	2007	#	<500	NA	11,000	350,000	**56,000**
ARV Treatment	Dec 2007	#	NA	158,000	43,000	460,000	**151,000**
ARV Coverage Rate	Dec 2007	%	NA	NA	57%	28%	**46%**
TB							
New TB Cases	2006	#	1,678	1,932,852	22,473	453,929	**64,632**
People living with TB	2006	#	1,277	3,444,685	26,711	482,036	**66,383**
TB Prevalence Rate	2006	Rate per 100,000	4	299	25	998	**568**
TB Deaths	2006	#	167	325,172	2,128	105,179	**11,875**
DOTS Coverage	2006	%	100%	100%	100%	100%	**100%**
HIV Prevalence in Incident TB Cases	2006	%	6%	1%	1%	44%	**37%**
Malaria							
Malaria Cases	Data From Most Recent Year Available	#	NE	1,781,336 (2003)	3,819 (2003)	13,446 (2003)	**2,010,185 (2001)**
Malaria Case Rate	Data From Most Recent Year Available	Rate per 1,000	NE	1.67 (2003)	0.04 (2003)	0.30 (2003)	**190.18 (2001)**
Malaria Deaths	Data From Most Recent Year Available	#	NE	990 (2003)	0 (2003)	141 (2003)	**5,763 (2001)**

(Source: KFF 2008a)

APPENDIX VII

Selected Comparative Country Statistics on Health Finance, Demography and Economy

Indicator	Date/Date Range	Data Type	Data				
			Canada	India	Mexico	South Africa	Zambia
Programs, Funding, & Financing							
Health Expenditure Per Capital	2003	$	$2,989	$82	$582	$669	**$51**
Total Expenditure on Health	2004	%	9.8%	5.0%	6.5%	8.6%	**6.3%**
Government Health Expenditure as Percent of Total Health	2004	%	69.8%	17.3%	46.4%	40.4%	**54.7%**
External Resources for Health	2004	%	0.0%	0.5%	0.3%	0.5%	**36.3%**
Demography & Population							
Population	2007	#	33,390,141	1,129,866,154	108,700,891	43,997,828	**11,477,477**
Death Rate	2007	Rate per 1,000	7.86	6.58	4.76	22.45	**21.46**
Infant Mortality Rate	2007	Rate per 1,000	4.63	34.61	19.63	59.44	**100.71**
Under-Five Mortality Rate	2005	Rate per 1,000	6	74	27	68	**182**
Life Expectancy – Male	2005	#	78	62	72	50	**40**
Life Expectancy – Female	2005	#	83	64	77	52	**40**
Population Growth Rate	2007	%	0.87%	1.61%	1.15%	-0.46%	**1.66%**
Income & The Economy							
GDP Per Capita	Data From Most Recent Year Available	$	$35,600.00 (2006 est.)	$3,800.00 (2006 est.)	$10,700.00 (2006 est.)	$13,300.00 (2006 est.)	**$1,000.00 (2006 est.)**
Population Below $1 a Day	Data From Most Recent Year Available	%	NA	34.7% (1999-2000)	4.5% (2002)	10.7% (2000)	**75.8% (2002-2003)**
Country Income Classification	As of July 2007	Text	High income	Low income	Upper middle Income	Upper Middle Income	**Low Income**
External Country Debt	2005	$	NA	$123,123.0	$167,228.0	$30,632.0	$5,668.0
HIPC Eligible	As of July 2007	Text	No	No	No	No	**Yes**

(Source: KFF 2008a)

APPENDIX VIII

The Bank of Zambia Annual Average Exchange Rate

A United States Dollar (US$) to the Zambian Kwacha (ZMK)

2000	K3,110.84
2001	K3,610.93
2002	K4,306.93
2003	K4,732.97
2004	K4,778.89
2005	K4,463.49
2006	K3,602.52
2007	K4,002.52

(Source: Bank of Zambia)

APPENDIX IX

Timeline - Various International Forums on Aid Effectiveness

2002 *The International Conference on Financing for Development in Monterrey, Mexico, - The Monterrey Consensus*.

- Developing countries: to strengthen commitments to policies and institutions that stimulates growth, reduce poverty and achieve the MDG's.
- Developed countries to provide more and better aid, as well as improved trade and debt policies

2003 *The Rome High Level Forum on Harmonization.*

- Donors committed to align development assistance with partners' strategies and improve systems, harmonize donors' policies and procedures, and implement principles of good practice in development cooperation

2005 *The Paris High Level Forum endorsed the Paris Declaration on Aid Effectiveness*, commits signatories to specific actions (with targets set for 2010) that promote the effective use of aid funds:

- Ownership, 75% of countries with operational development strategies
- Alignment, strengthened national financial management, strengthened national procurement more likely through government systems, coordination of support of having donor pooled technical assistance and avoidance of parallel implementation
- Harmonization, common arrangements, procedures, and program-based approaches, shared analysis, joint missions and reviews
- Managing for results, results oriented frameworks
- Mutual accountability, assessment of programs

September 2008 *The Third High Level Forum on Aid Effectiveness, Accra, endorses Accra Agenda for Action (AAA).* AAA includes specific timelines some new plans, committing to meet the targets set in Paris Declaration and Accra High Level Forum by year 2010. Areas of focus

- Predictability, the donors will provide 3 to 5 years forward information on their planned aid
- Country Systems, partner country systems will be used to deliver aid as first option, rather than donor systems
- Conditionality, a switch from prescriptive conditions on how and when to conditions based on developing countries own development objectives' and
- Untying, donors will relax restriction that prevent developing countries from buying goods and services from whomever and wherever they can get the best quality at lowest prices.

(Source Accra HLF 2008, OECD 2005)

APPENDIX X

TIME FRAME

Month	Output	Time Taken
April 2007	Permission granted to conduct study by Government of the Republic of Zambia	
August/October Week 3	Preparations and refining research protocol for submission to Higher Degrees Committee (UWC	120 hours
October Week 4 2007	Approval of Research Protocol by UWC HDC	
January Week 1 2008	Preparation for application for approval of the proposed research by Zambia Research Ethics Committee	20 hours
February Week 4 2008	Approval of Research Protocol by Zambia Research Ethics Committee	05 hours
	Training of Research Assistant	10 hours
March Week 2 2008	Initial Contacts and personal delivery of Official Communication/Participant Information Sheet/Government Approval (donors)	50 hours
March Week 4/ April Week 3 2008	Collection of data (donors)	100 hours
April Week 4 2008	Initial and personal delivery of official communication/Participant Information Sheet/Government Approval (Recipients)	20 hours
May Week 3/ June Week 2 2008	Collection of data (Recipients)	50 hours
June Week 3/ Week 4 2008	Collection of remaining funding data, collating funding data	70 hours
July 2008	Data Entry and Data Analysis	70 hours
August 2008	Writing of Draft Research Report	70 hours
September/October Week 1	Writing of final Thesis for Submission for examination 15th October, 2008	30 hours
October 15th 2008	**Final Version of Mini-Thesis October 15th 2008**	**Total 615 Hours**