Planning and budgeting for Primary Health Care in Zambia: A policy analysis

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Executive summary

The work presented in this policy brief was prompted by a request from the Zambian parliamentary committee on Health, Community Welfare and Social Development. The parliamentarians had wanted to know why despite all the funding to the health sector, there were no 'visible' gains to speak of from the on-going health reforms. The stated mission of the Zambian health reforms is to provide equity in access to cost-effective quality health care as close to the family as possible for all Zambians, by establishing appropriate leadership, accountability and partnerships at all levels of the health system. The bottom-up policy implementation framework was adopted to ensure the attainment of the desired equity goals. In response to this need for information and answer, the CHESSORE team discussed with and searched for a suitable method to help respond to the request. The policy analysis approach was recommended and chosen as a research tool to use. This policy analysis study was designed and implemented in two phases.

During the first phase the research team collected views and perception from district health managers in four districts, selected to represent an equity gradient from the most advantaged (Lusaka), Chingola (Urban and industrial), Choma (mix of rural-urban and agricultural) and to the least advantaged (Chama) in the country. The District Health Mangers (DHMs) gave as their top three problems in planning and budgeting for health services as (a) inadequate funding, (b) poor population census figures (on which the per capita funding was based), and (c) staff / skill shortages in the health system to effectively implement policies.

Using the issues raised by DHMs as tracers, the views and perceptions of other stakeholders were sought with respect to policy implementation of the bottom-up approach to planning and budgeting for primary health care (PHC) services. The study focused on how decisions were made at each stage and how the different interests by different implementing actors affected the outcomes from the process in each of the above four equity gauge districts. The discussion interviews were focused to examine policy implementation in terms of policy context, content, process and the role of actors in all these areas, using the Watt-Gilson (1994) policy analysis triangle. Individual discussion interviews were conducted with two officials at the central level, five at the district level, 28 at the health centre level and 47 at the community level.

The findings in this study show that despite the policy intentions, planning and budgeting for PHC in Zambia is still a top-down process. Nearly half way through fieldwork activities, it became clear that issues of power in and around policy implementation of planning and budgeting for PHC services played a key role in understanding implementation outcomes from the policy. The culture of civil service framework was used in implementation, making it difficult for most implementing actors to feed into and benefit from the intended benefits of a bottom-up approach. The findings also emphasise the need to dig beneath the surface and ascertain what really takes place behind public policy pronouncements. The introduction of a bottom-up approach in priority setting for primary health care in Zambia was intended to be a more beneficial approach for a resource constrained health system. In reality, the process has been characterised by varied interests and used for different purposes, thereby making it difficult to achieve the intended goals. This study exemplifies the use and value of a policy analysis approach to better understand policy and policy implementation in the health sector and other public sectors.

1. Introduction

Since 1992, Zambia has embarked on a far-reaching health reform programme to try to reverse the stagnation, dilapidation and shortages of resources in the health system (MoH, 1992). Decentralised management of health services and a set of financing reforms were introduced as a way to ensure equity and accountability (MoH/ CBoH, 2001; CBoH, 2004). Guided by the three pillars (leadership, accountability and partnerships (with community participation) at all levels) in the implementation of the health reform process, the government introduced a bottom-up approach for priority setting of primary health care service (PHC) provision.

This bottom-up approach was intended to be more beneficial for a resource constrained health system. In reality, the process has been characterised by varied interests and used for different purposes, making it difficult to achieve the intended goals. For this reason, the Parliamentary Committee on Health in the Zambian parliament asked our research team to undertake a study to help them understand what was really happening with all the money that had so far been spent on the health reforms. The link with the Parliamentary Committee on Health was developed from the activities of the Equity Gauge Zambia (EGZ) to which CHESSORE provides technical support.

The EGZ operates in four Zambian districts, purposefully sampled to represent:
- a most rural and least developed district;
- a district with rural-urban characteristics;
- a district in an industrial and mining town; and
- Lusaka, the capital city with the best socioeconomic advantages of all Zambian districts.

This view allows us to see how the socioeconomic status of a district influences or is influenced by policy implementation to achieve the health reform vision of “equity of access to cost-effective quality health care as close to the family as possible, for all Zambians.”

The main objective of the Zambian Equity Gauge was to ensure that issues of equity in health and health service delivery were considered and equitably taken into account at the policy, planning and implementation levels. The Equity Gauge feeds its findings to:
- policy managers at national level;
- implementers at district level in the four districts;
- members of parliament of the Committee on Health, Community Development and Social Welfare;
- the general public through newsletters and holding of special events; and
- the Zambia Medical Association.

With an equity focus in mind, this study took place in the four Equity Gauge districts: Chama (the poorest), Choma (semi rural, semi urban), Chingola (urban, light industrial and mining) and Lusaka (the capital city and most advantaged socio-economically). The study thereby examined how policy implementation had progressed across districts with vastly different socioeconomic characteristics and capacity to implement.

The study followed through the process of budgeting for PHC services at national, district and health centre levels. It focused on how decisions were made at each stage and how different interests by different implementing actors affected the outcomes in each district.

1.1 Public policy processes

Public policy making is an important way of distributing resources and services consciously and purposively. Usually, policy making is done by politicians and policy makers at the top (whether as guidelines, statutes, executive decisions or court rulings). The intentions and contents of these policies are then implemented at lower levels by civil servants, professionals and other individuals or groups to produce or deliver the intended outcomes. This is referred to as the top-down approach to policy process implementation (Hill et al, 2002). In this approach, socioeconomic conditions and legal instruments are used to constrain the behavior of actors to bring about desired outcomes. Though this approach to policy implementation has its merits, a drawback is that it does not fully take it account the realities on the ground and tends to be based on a number of assumptions. In addition, this policy-setting framework is faulted for being unresponsive to the interests of implementing actors on the ground.

An alternative to this approach is the bottom-up approach to policy making, which rests on the belief that we "need to understand what is happening from the bottom end of a policy system in order to have better public policies and better policy implementation outcomes". In this regard, policy making is thought of as a dynamic process whereby the realities and choices/ preferences made at the grassroots are systematically fed up to align public policies with programme components, and with the concerns, perspectives and strategies of all major categories of implementing actors on the ground.

The bottom-up approach to policy process implementation is partly based on the notion that high level of consensus among policy implementation actors makes a high degree of desired change possible, thereby overcoming the main difficulties that often characterise policy implementation. However, this too is not a foolproof approach. The process may be put under pressure from the various interests of the different actors. Unchecked, these interests may in some cases conflict with, dominate and even distort the original policy intentions, thereby making it impossible to achieve the intended objectives.

1.2. Public health policy in Zambia

The Ministry of Health (MoH) (1992) put out guidelines that define a priority health problem to be one that either causes a high level of morbidity or affects the most vulnerable groups in the community (women and children). In order to realise the goal of providing high quality, accessible health care at the community level, close to the family, to address the most common illnesses and public health needs, the MoH (1992) decreed: 'health care services and other interventions must be selected and organised carefully to achieve the greatest possible benefits within the constraint of limited funding and other resources.' In this regard the strategy adopted prioritises 'delivering an essential health care package of cost-effective interventions at the "frontline" level,' i.e. at the health centres, health posts and local communities.

The guidelines anticipate variations in priority setting and advise that each district must determine which activities to implement and at which level to implement them. Three levels for intervention are recognised:

- the health centre (in-house level);
- health centre outreach activities; and
- community initiated activities to support related activities by community volunteers to promote the utilisation of antenatal care (ANC) services.

Using these guidelines and with a focus on these three levels, PHC priority setting with plans and budgets are made for each district in Zambia annually, guided by the MoH's national health strategic plan.

This study was undertaken to evaluate how the policy was implemented and what factors account for the observed outcomes of policy implementation. The study was undertaken in four districts where an equity gauge approach is underway to try to mobilise community participation for equity in health and health care. Lessons from this study were intended to provide knowledge on how the concept of community participation in health is implemented and how improvements to this policy could be effected in these four equity gauge districts. In addition, the outcomes from this work were intended to provide parliamentarians on health committee with an understanding of how policy was implemented and how this implementation results in the observed health outcomes.

The findings of this study were intended to lay open and generate useful data about the policy process of the Zambian health reforms. Specifically, the findings will help enhance the role members of the Parliamentary Committee on Health could play to improve leadership and accountability in planning and budgeting for PHC, as follows:

1. Zambian parliamentarians of the Health Portfolio Committee could use the data to undertake an informed audit for each financial year of the health budget in terms of:
   - resource allocation patterns
   - expected results
   - what actually transpires (implementation and service delivery).
2. Members of Parliament will be offered an opportunity to understand how the health policy process is operationalised, thereby enabling them to contribute to informed debate in parliament and better scrutiny of the health budget before it is approved.
3. By laying bear the key actors, content, context and micro-processes in the health policy process, it might make it easier for the various stakeholders at all levels to take up and play their useful role(s) as contained in the policy document.
4. It is envisaged that with everyone playing their prescribed useful roles (as described in the Zambian Health Reform document (MoH,1992)) in the health policy process, the equity concepts outlined in the policy document may be pursued in a sustained manner with the potential to make outcomes more readily realised.

2. The research objectives and questions

Focussing on the way the previously ended planning and budgeting exercise was undertaken, this research sought to answer the following questions:

Q1 What is the budget process in the Zambian health services?

Q2 What are the major three common problems faced by the actors in the budget process at district level?

Q3 How do the actors, the policy content, the context and the micro-processes interact in the three common problems faced above?

Q4 How do the three key health budget problems impact on PHC programme outputs in the target districts (using malaria control and immunisation programmes as tracers of PHC activities)?

Q5 What current strengths and weaknesses in the health budget process have influenced PHC service outcomes?

The study thus sought to examine the participation, accountability and outcomes in health planning and budgeting for PHC services. This broad objective was examined by focusing on the policy process of the PHC as the tracer health programme in the Zambian health services from 2003 to 2004. The specific objectives were to:

- understand the planning and budgeting process in the health service;
- identify three common problems faced in the budget process at district level;

- use the policy process analytical framework to help understand how the interaction between the actors, policy content, policy context and the micro-processes impacts on the three common problems identified above;
- examine the impact of the problems faced in the health budget process on service outputs in the PHC programmes, using malaria control and immunisation coverage as tracer health programmes; and
- get some consensus on what was actually happening at the different levels in the planning and budgeting process for PHC programmes, with a view to identifying the strengths and weaknesses in PHC service provision in Zambia.

With time and as circumstances dictated, the plan to study the problems identified by focusing on malaria and immunisation programmes was dropped and replaced with merely examining how the planning and budgeting process for the (then current) 2004 priority setting exercise was implemented.

Fieldwork commenced after completion of the priority setting exercise at district level. A fresh memory from those that had participated was thought useful for greater objectivity on views expressed. Additionally, after implementing work in the first two districts during the Phase Two data collection exercise, the issue of power and power relations in the implementation of the bottom-up approach became more evident; these were widespread across the different districts and levels of the health system. It was then decided to make a greater focus on power and power relations in the PHC planning and budgeting process. To aid with this task, additional tools were adapted and used to capture this information. Thus a sixth specific objective to this study was added to reflect a core analytical angle to be used for understanding how actors related to each to each other in the implementation process. The focus for analysis was changed so as *to understand power and the power relations among actors in the decision making processes for planning and budgeting for PHC at each level in the system.*

3. The methods

This study was undertaken in two phases. Phase 1 was used to get a sense of what district health managers (DHMs) thought were their main problems affecting PHC planning and budgeting. The identified problems were ranked and scored to come up with the top three that were commonly mentioned by officials from the four sampled Equity Gauge districts. These problems were later used as tracers to assess the process for PHC budgeting and planning among all stakeholders in the health system, from national level to the health centre and community level representatives.

While acknowledging the problems experienced as highlighted by DHMs, the policy analysis approach nonetheless sought to understand how policy was implemented and why practice differed from policy intentions/ goals. Among the questions asked:
- Why was this so when the policy was intended to make things better?
- What led to this scenario and what can we learn from this?

This policy process analysis approach was intended to help us understand this situation with a view to learn from it. To this end, the following methodological approaches were used: a number of stakeholders were interviewed and several documents reviewed and assessed in the process of this research work, as outlined below.

A preliminary analysis of the issues raised and emerging from fieldwork suggested implementation failure resulted from use of power in and around the implementation process and from conflicting interests between various actors during these planning and budgeting sessions. Unequal distribution and use of power by stakeholders in support of

their desired goals (Lukes, 1974; Parsons, 2003) appeared to be entrenched, resulting in lack of leadership and accountability in the budgeting process, and thereby revealing that unequal partnerships underlie some of the poor outcomes from PHC plans and budgets. During Phase Two of the study, various tools and techniques were developed to follow through issues in the implementation of the bottom-up PHC planning and budgeting.

3.1. Sampling, study populations and sources of data

The findings presented are based on individual discussion interviews with implementers at the district health offices (6), staff in-charges at health facilities (7), other health facility staff (13), members of governance structures in health at health centres (16), community health workers (6), members of the neighbourhood health committees (4), community leaders and other key informants in the community who participate in governance activities at local health centres (5). Available documents relating to the implementation of the bottom-up approach to priority setting for PHC were reviewed, including policy documents on community participation in health and on guidelines for planning and budgeting at the district, health centre and community levels. Records of district planning meetings conducted to verify how decisions were made were generally not available.

The study largely used qualitative approaches to examine the priority setting process for PHC activities at district and health centre levels. Interviews were conducted with DHMs, health centre in-charges, other health workers at health facilities (environmental health technicians, care providers, and classified daily employees (CDEs), as well as a number of key informants in the community (who comprised of members of the local health centre committees, community health workers, members of neighbourhood health committees and local community leaders with perceived influence on health issues in the catchment areas (traditional rulers, councilors, businesspersons, and others).

A total of 92 respondents were interviewed for their recollections and views on the process of setting health priorities for PHC activities to overcome local health problems. The study was undertaken in four districts and the priority setting process was reviewed at ten health centres (see *Table 2*).

Table 2a: Stakeholders interviewed at district, health centre and community levels

Wealth ranking	District	District health office	Health centre		Community stakeholders
			Facilities	Staff	
1st	Lusaka	1	4	11	16
2nd	Chingola	2	2	6	14
3rd	Choma	1	2	8	10
4th	Chama	1	2	3	7
Totals		**5**	**10**	**28**	**47**

Table 2b: Categories of respondents

Level of respondent	Designation of respondents	Number interviewed
Central level	National health managers	2
District level	District health managers	5
Health Centre level	In-charges (or acting)	10
	Trained health workers	16
	Untrained health workers CDEs)	2
Community level	HCC chairpersons	8
	Other HCC members	31
	Key informants	8

The wealth ranking used was based on the proportion of households interviewed and classified as belonging to quintiles 1 (poorest) to 5 (least poor) as developed for Zambia by the World Bank. This ranking also correlates with previous findings from a baseline survey (2003) of a sampled population of almost 1,000 respondents from each district undertaken by the Zambian Equity Gauge (also see *Table 8*).

3.2. Study sites

The findings presented in this study come from case studies from four districts: Chama (Eastern province, Kambombo and Tembwe RHCs), Chingola (Copperbelt province, Chawama UHC and Muchinshi RHC), Choma (Southern province, Mbabala and Township RHCs) and Lusaka (Lusaka province, Chawama, Chipata, Chelstone and Kaunda Square UHCs). Overall, two health centres were studied in each district, except for Lusaka where four health facilities were studied.

The four districts were selected by convenience in that an Equity Gauge approach to understanding issues of equity in health and health care are being undertaken in these districts. The districts were chosen to reflect the richest and most urbanised district – Lusaka, the capital city and the poorest district (Chama district was randomly selected from a list of five districts grouped in this category, i.e. being rural in nature and having no grid electricity, banking services, fuel stations, having poor road and physical infrastructure and highest poverty levels). These districts comprise the four equity gauge districts and reflect a mix of socioeconomic characteristics that characterise the 72 Zambian districts. Therefore, the information obtained would be applicable to almost every district in Zambia. The selection of facilities was guided by a previous EQUINET study that showed the health centre committees at the selected facilities to be either well performing or poor performing. Therefore, the knowledge gained from this study could build on earlier research work and provide a background from which to understand or validate outcomes.

3.3. Tools and techniques used

Data was collected from individual discussions following guidelines, group discussions, participatory research action techniques (SARAR approaches[1]) and a review of available documents and records. The study was first undertaken in Lusaka and Choma. After examining issues from six health centres, general implementation patterns and problems emerged. It was then decided that while collecting similar information and using the same tools, a special focus was needed on key issues relating to how power was acquired and used by different stakeholders, so as to understand what was really taking place. This was applied in the third district and issues that emerged pointed to different (and generally low levels) of stakeholder commitment. So when the study reached the fourth district (Chingola), the SARAR research tool (World Bank, 1995) was added to gauge the level of commitment to the budgeting process by stakeholders at different levels.

[1] *Self-esteem*, *associative strength*, *resourcefulness*, *action planning* and *responsibility for follow-through* (SARAR) are five attributes/ abilities thought to be critical to achieve full and committed participation in development. SARAR is a participatory training approach, which builds on local knowledge and strengthens local capacity to assess, prioritise, plan, create, organise and evaluate. It is a philosophy and practical approach to adult education, which seeks to optimise people's capacity to assess, prioritise, plan, self organise, take initiatives and shoulder management responsibilities.

Using the SARAR approach, brief presentations were interspersed with hands-on activities, with most work done in small groups. Participants drew their personal visions of participation in the PHC budgeting process at their level on large sheets of paper, and presented and discussed them with one another. Participants were thereby able to reflect, using examples, on what actually happened and what they thought was needed to change the status quo. The tools enriched the understanding of participants' personal experiences and brought out examples and realism to views expressed, even for those expressed in other districts where such PRA tools were not applied. The SARAR tools also allowed for ranking of consensus views on an issue, thereby validating the prevalent normative procedures followed in budgeting sessions.

3.4. Data analysis

Data analysis was based on the Walt and Gilson (1994) analytical framework. The framework proposes a triangular relationship between the policy content, context and processes. At the centre of this triangular relationship are the actors who:

- interpret the policy contents; and
- are influenced by the prevailing context and underlying socio-economic processes that influence the policy and policy implementation environment.

Using this framework the policy content in PHC planning and budgeting was reviewed. The policy context was assessed and actors to be involved in the policy implementation identified. The process of policy implementation was then examined in relation to the three key issues identified by DHMs, focusing data analysis on:

- policy implementation procedures; and
- power and the power relations exercised during the implementation process.

As it became clear that the exercise of power was largely from top to bottom, special effort was made in order to understand why it was difficult for stakeholders to influence changes from the bottom. Finally, the procedures followed during the budget process were assessed for extent of stakeholder commitment using the SARAR research tool.

The main data analysis problem was lack of documentation of the process followed. Notes and minutes of proceedings were not available to give a clear impression of who was present, what issues were discussed and how priority setting was done. At each level, the research team relied on personal recollections. Thus the analysis relied heavily on stakeholder consensus of what transpired during the PHC priority setting meetings.

4. Findings

The study began with Phase One activities that took into account the perspective of stakeholders on why there were generally poor outcomes from the PHC planning and budgeting process. In this process, DHMs identified several problems that hindered progress and improvement in attaining the desired goals of the ongoing health reforms.

4.1. Findings from the Phase 1

After ranking and scoring all the possible issues encountered/ raised by the DHMs for poor outcomes from PHC planning and budgeting in their districts, three major problems were identified:

- low and unrealistic indicative planning figure (IPF)[2] handed down to them by central level officials;
- the wrong population statistics figures used to determine funds to be made available to each district; and

[2] The indicative planning figure is the projected level of funding anticipated for the following year.

- the poor human resource problems faced that contributed to overworked, under skilled (untrained), and low performing health personnel.

Each of these problems often compounded the effects of the other, making the PHC goals difficult, if not impossible to attain.

4.2. Findings from the Phase 2

Health centre staff, in-charges, community representatives, key informants in the community and others agreed that the problems identified by DHMs greatly contributed to the poor outcomes from PHC programmes in their areas. Generally low population census figures meant that the health system was under-budgeted and resources were inadequate to make any significant impact. In addition, increasing poverty levels meant people migrated to areas (or districts) with 'greener' pastures and better employment outcomes. One DHM estimated the population was 40% higher than official census figures; some health centres experienced discrepancies as high as 57% (see *Table 1*).

Table 1: Observed discrepancies between census and actual head count population catchment figures of a sampled health centre

Clinic catchment population profile and formula		Census figures	Head counts
Total catchment population		**14,752**	**23,182**
Children	0-11 months (4%)	590	927
	1-5 Years (16%)	2,360	3,709
Child bearing Age (22%)		3,245	5,100
Children below 15 years (48.8%)		7,228	11,313
Expected pregnancies (5.4%)		797	1,252
Expected births (5.2%)		797	1,205
Disparity between census and head count figures: 57.1%			

In addition to the already low health budgets, low population statistics meant lower IPFs and correspondingly lower actual budgetary allocations. All stakeholders agreed that available money was simply insufficient to deal with the many district level health needs. In addition, irregular budgetary remittances to districts, coupled with the unexpected budget cuts meant health workers were unable to make and implement coherent plans to bring about the desired outcomes.

Staff shortages in the health system meant there were less health workers; these health workers were overworked and had no incentives to undertake the additional roles that the health reforms imposed on them. These additional responsibilities required additional skills for health workers, many of whom had not been trained. High attrition rates of staff have led to a situation where those previously trained are no longer in the system; those replacing them remain untrained in the additional skills required or are ill-equipped to understand the roles expected of them even if they underwent training. The inability to recruit trained health workers has led to use of untrained health professionals who undertake clinical duties and management roles at health facilities. Therefore, many available health workers were unable to grasp the meaning and concepts in the health reform process. Coupled with the poor conditions of service, many health workers operated on traditional business as usual, responding to top-down bureaucratic management style rather than the desired participatory bottom-up policy implementation.

The final outcome from these shortcomings were that the resources available to health have been decreasing over time, the desired PHC targets were not being reached, the disease burden (as reflected by morbidity and mortality statistics) has been increasing – with frequent and regular occurrence of disease epidemic outbreaks. The desired improvements in infrastructure and quality of clinical care services have become difficult,

if not impossible to attain in the current policy and implementation framework. Although many of the issues DHMS complained of were confirmed, these were by no means the real issues affecting PHC planning and budgeting. It became clear from initial interviews with stakeholders that there were deeper underlying issues to the observed poor planning and budgeting for PHC services. During Phase Two, these issues were then used as tracers to understand how the process of PHC planning and budgeting was implemented. The issues raised were grouped to reflect the policy content, context, and implementation process and the actors and their interpretation of these policy components. The findings, in *6.3* to *6.7* below, are presented in the Walt and Gilson (1994) analytical framework, followed by a review of the power relations affecting budgeting for PHC services.

4.3. The policy context

The Zambian health system is operating in a severely resource constrained setting due to the poor performance of the economy. Realising these limitations the government thought decentralisation of power was a way to target resources to health issues prioritised on the ground, at each level in the health system. In this way, it was assumed that the maximum possible benefits could be realised from the limited resources available. Thus, instead of top-down implementation, a bottom-up approach to policy implementation was adopted.

At each level, stakeholders should be identified and mobilised to play the desired roles and responsibilities in planning and budgeting for PHC services. The guidelines define planning as a process that sets out what is to be achieved (objectives), how it is to be achieved (activities), and the resources (people, materials and money) needed for implementation (CBoH, 1998). The guidelines further stipulate that planning should be based on a reasoned review and analysis of available information, reflect team effort, and draw on shared expertise and judgements of participants. The stakeholders (actors) should be drawn from all sectors (government, NGOs, community, CBOs, private sector, etc). With this done then the stakeholders should, in an atmosphere of partnership:

- assess their local health needs;
- set their health priorities guided by the basic health care package;
- select desired interventions;
- select and assign activities to be undertaken; and
- cost the needed input and incorporate this into annual action plans and budget.

This partnership approach is intended to guide and direct resources to solve needy health problems at local level, ensure accountability and the effective and transparent use of the meagre health resources. These roles and responsibilities of the partnership are played out in a series of events commonly referred to as the annual budgeting process for PHC (CBoH, 2001 & 2004). This paper uses the budgeting process as a way to follow through policy implementation, progress and outcomes from this policy change.

4.4. The policy content on planning and budgeting for PHC

The key elements of the reforming health services in Zambia incorporate the concept of decentralised management of health services as a way to make the health services relevant to local health priorities. Through this policy, the district has become the unit of planning and budgeting for health; while the health system is brought closer to the communities they serve through the creation of structures for leadership, accountability and partnerships at all levels in health service provision.

The planning and budgeting process ideally starts with a signal from the Central Board of Health (CBoH) to districts after providing district health officials with planning guidelines and ceilings. During this phase the CBoH puts out spending ceilings for the various

activities and cost centres. In addition, the CBoH gives the district health authorities an IPF around which to plan and budget activities for the coming financial year. Based on a time scale set by the CBoH and the roles and responsibilities prescribed for the different actors at different levels (see *Appendix 1*) the process should result in health centre staff and community representatives providing feedback on the District Health Management Team (DHMT)-approved projected budget and final community action plan.

4.5. Actors and stakeholders involved in PHC budgeting and planning

The guidelines provide for a multi-sectoral involvement of stakeholders from government, NGOs, CBOs, the private sector and any other identified stakeholders at each level. These stakeholders (see *Table 3*) were key actors in the PHC budgeting process in the four districts during the 2004 budget cycle. At the district level, annual orientation meetings for planning and budgeting, DHMT officials, health centre in-charges, health centre committee (HCC) chairpersons and representatives of invited non-governmental organizations (NGOs) were involved. At the health centre level the key stakeholders involved were the health centre in-charges, HCC chairpersons, HCC members and some health workers (usually the environmental health technicians (EHTs)). EHTs are the health cadre generally assigned to work with HCC members on preventive health issues in the community.

Involvement of donors and NGOs was least in rural districts and highest in Lusaka. Health worker involvement beyond the health centre in-charges was least in districts outside Lusaka. One reason for this was that the health centres in Lusaka had recently been upgraded under a DFID programme to serve as mini-hospitals, with a medical officer, a surgical capacity, an in-patient admission capacity, and provision for mini-departments with own unit heads. The unit heads were thus involved in planning and budgeting, more or less as stipulated for hospitals. Staffing at Lusaka health centres was also very high, while in the other districts, staffing patterns were inadequate; in some cases untrained staff served as in-charges when a trained health worker left the station for duty, long leave or other causes such as in-service training courses out of station.

Table 3: Stakeholders invited to participate in the 2003/4 PHC budgeting process

Stakeholders	**Urban, industrial districts, capital**	**Urban, industrial districts, mining**	**Semi-rural district**	**Rural, most poor district**
	Lusaka	**Chingola**	**Choma**	**Chama**
DHMT officials	√	√	√	√
Facility-in-charges	√	√	√	√
Unit Heads	√	**X**	**X**	**X**
HCCs	√	√	√	√
NHCs[+]	√	√	√	√
CHWs*	√	√	√	**X**
Donors/ NGOs	√	**X**	√	**X**
Total donor/ NGO partners invited	5+	0	1	0

√ = Stakeholder is involved; X = Stakeholder NOT Involved
*Community Health Worker; [+]Neighbourhood Health Committees

The Zambian health reforms have incorporated the need for community participation in planning and budgeting for PHC. This requirement is part of the guidelines and procedures for planning and budgeting at each level in the health system, from community to district level. To differing extents and depending on opportunities available,

a range of stakeholders were involved in the 2004 planning cycle in each of the four districts where the study was undertaken (see *Table 3*).

Aware that planning and budgeting meetings required the involvement of different stakeholders with different backgrounds and skills, the MoH produced some criteria to guide action and consensus among stakeholders. In this regard, the guidelines stipulated that funds be allocated to enable DHMs and health centre in-charges to mobilise and train community groups and stakeholders to effectively participate in this process.

Table 4: Stakeholder adherence to priority setting guidelines

Attribute for decision making	DHMT	HC in-charge	HCC representatives	Community
Decisions should be based on current information	Have national HMIS* data/ information	DHMT guidelines + HC statistics	Based on HCC needs + own perceptions	Based on own perception of disease factors
Planning should include both objective and subjective decision making to be based on:				
Reasoned review of available information	3 day meetings; DHMT sets up objective criteria to guide process	1 day meetings; some subjective and objective criteria	1 day meetings; subjective criteria	Half-day meetings; subjective criteria
Reasoned analysis of available information	Information analysed at higher level and brought down for endorsement	Information analysed at higher level and brought down for endorsement	Information analysed at higher level and brought down for endorsement	Information analysed by HCC/ NHC representatives
Planning should be a team effort guided by use of participatory skills by health workers	Participatory approaches not applied or known	Participatory approaches not applied or known	Participatory approaches not applied or known.	Participatory approaches not applied.
Planning should draw on the following input of participants from various sectors and levels (NGOs, government, community, etc)				
Shared expertise	Unequal stakeholder expertise	Unequal stakeholder expertise	Unequal stakeholder expertise	Lack training and expertise for decision-making
Shared judgement	No mechanism for consensus	No mechanism for consensus	No mechanism for consensus	No consensus building tools
Health and demographic assessment guidelines	No evidence of their use seen.	Not used, not available	Not used, not available	Not used, not available

*Health Management Information System.

Apart from holding district and health centre meetings, no funds were used to mobilise and train community stakeholders for effective participation in planning and budgeting, as outlined in guidelines. Similarly, no participatory skills were reported used in coming up with agreed priority health issues for inclusion in health budgets. Complaints of lack of involvement or unfair exclusion of planned priorities by other stakeholders support this view, in the absence of official records of minutes at planning and budgeting meetings. The guidelines outlined in the official booklets and *Table 4* appeared not followed by those charged with the responsibility of convening and guiding deliberations at such meetings. The lack of participatory skills and adherence to set guidelines opens the process to abuse and use of informal mechanisms to exclude views and interests of less powerful stakeholders, especially those at community level.

The tendency was for participants to listen to their senior officials and then take the guidelines given as the way forward for planning and budgeting purposes. Throughout the interviews undertaken, no respondents mentioned a process of priority setting where different views were solicited and a selection process used to arrive at consensus of top health priorities for inclusion in the budget.

The cumulative effect resulting from the lack of consensus procedures distorted policy intentions and implementation, making attainment of set objectives difficult. In addition, the distortion in policy implementation was also a reflection of the uneven distribution and exercise of power between the actors in the partnership. Several factors contributed to these uneven power relations in the budgeting process, as discussed below.

4.6. Power and power relations in priority-setting and budgeting

The process for stakeholder involvement made it difficult for weaker stakeholders to have an input into the health centre budgets. To the extent that some stakeholders were able to have their priorities incorporated into a health budget (and exclude incorporation of priorities from other stakeholders) meant that such stakeholders had more power. Similarly, to the extent that some stakeholder groups were unable to get their prioritised items onto the common health budgets (within the limited and scarce resources/ finances) meant they had less power. The planning process involved stakeholder competition for inclusion of desired health priorities onto scarce resources. Such a competition required gaining and using power. The interaction between stakeholders involved in the planning and budgeting process was seen from the angle of acquisition and power used to get prioritised health issues onto the budget.

A review of how the budgeting process was undertaken showed an unequal distribution of power between the various actors, as can be seen from the success achieved by each group of stakeholders in terms of decisions made during the process. Stakeholders at different levels possessed different levels of power (see *Table 5*).

All stakeholders interviewed agreed that available resources for PHC services were inadequate and that the remittances were irregular and less than planned for in the budgets. Despite this, none of the stakeholders had the courage to inform higher authorities of this or to take action to influence the allocated PHC budgets. All stakeholders interviewed at district level felt themselves powerless to influence the amount of funding coming to them for PHC activities. Using an arbitrary scale (see *Table 5*) it became clear that the national level had more power than the bottom level, despite the popular policy pronouncement of bottom-up planning and budgeting.

Where and how distortions in policy implementation occurred

Dislocation in policy implementation was known to all stakeholders at national, district, health centre and community levels. There is no shared vision from the health reform policy and each level holds different expectations. The concept and policy of health reforms is understood differently by different people at each level, leading to different expectations from the programme.

Such a situation made leadership, accountability and partnership difficult to attain. At national level, and according to the constitution, accountability for public funds in health is the responsibility of the Parliamentary Committee on Health, Community Development and Social Welfare. This committee has not had the time, space and necessary resources required to grasp health policy and budget issues due factors such as the short life of the committee, high membership turnover and the high turnover rates of committee members after each national parliamentary election. Thus national health budgets were routinely made and passed for expenditure without due attention to outcomes.

Table 5: An analysis of power present at each level in the budgeting process

Manifestation of power in decisions made in the budgeting process in relation to	Level of stakeholder/ decision making							
	National		District		Health centre		Community / representatives	
Ability to influence the IPF	Yes		Some		None		None	
Ability to make input into national BHCP*	Yes		None		None		None	
Ability to make input in the preparation of planning & budgeting guidelines	Yes		Some		None		None	
Ability to make input into PHC priority setting at District level orientation meeting	Yes		Yes		Some		None	
Ability to incorporate prioritised health issues into district budget	Yes		Yes		Some		None	
Ability to influence input into PHC priority setting at Health Centre level orientation meeting	Some		Some		Yes		None	
Ability to influence input of prioritised health issues into health centre budget	Some		Yes		Yes		None	
Ability to influence input into PHC priority setting at community level	Some		Some		Some		Some	
Ability to influence input of prioritised health issues in community health budget	Yes		Yes		Yes		None	
Overall power (Yes)	6/9	100	4/9	89	3/9	67	0/9	11%
Overall potential power (Some)	3/9	%	4/9	%	3/9	%	1/9	

* Basic Health Care Package: minimum set of (preventive, promotive and curative) interventions needed to effectively and efficiently manage leading causes of morbidity and mortality.

The lack of accountability on the national health budget meant that policy implementers did not have to worry and prioritise outcomes from the budget expenditure incurred, as long as the system was maintained. Thus although plans and budgets were made, supervision and adherence to these was not a priority. Funds were allocated at central level to suit current health system interests and in response to situations as they arose. Thus, for example, it was easier for central level to shift expenditure to address the needs of striking health workers and pass on the deficit to districts, without worrying about whether or not budgeted activities achieved the desired outcomes. In return, central level had no incentive to hold district health officials accountable for their plans and budget. This attitude also manifested itself down the line of policy implementation. Thus at each level, it was considered normal to spend funds on an ad-hoc basis with no need to stick to budgetary allocations contained in action plans, as long as it could be explained.
In such a scenario, those who wielded the most power made the most decisions on how and where health resources were used. Available resources were used to serve the needs and interests held by the most powerful rather that the needs and interests of the partnership at each level in the health system. In this regard, power rested in the health system; the higher the level in the health system, the more power was wielded.

How actors/ stakeholders acquired or lost power

In this paper, power is viewed as the extent to which actor(s) A have successful control over actor(s) B to secure B's compliance. Power is also viewed as securing compliance through the threat of sanctions. These notions of power embrace and are rooted in:

- *coercion*: a threat of deprivation;
- *influence*: change without threats of deprivation;
- *authority*: opponent recognises the rationale as legitimate or reasonable (or arrived at using legitimate and reasonable procedures) in terms of own values;
- *force*: stripping of choice between compliance and non-compliance;
- *manipulation*: compliance in the absence of the complier's comprehension of the nature of the demand on them; and
- *resistance:* actively or passively ignoring/ refusing to act accordingly; or even consciously subverting policy implementation, usually to push for change(s).

The budgeting process as discussed by various interviewees guided the extent to which each of these attributes were used to acquire power by each stakeholder group.

The power relations in the partnership arrangements for PHC action planning were built on the traditions of a civil service bureaucracy. In this regard, the national, district and health centre levels were related through delegated authority as a form of power. Compliance by the lower level was thus mandatory and expected. Policy implementation followed this chain of command. The selective application of laid-down consensus guidelines has resulted in decision making being exercised by a few, thereby giving such individuals more power and influence over other stakeholders.

Box 1: Stakeholder views on Bottlenecks to bottom-up policy implementation

"The existing channels of communication in our civil service structures do not permit us go to beyond the DHMT (who already know our problems and predicament) for whatever reason we may have and no matter how pressing such a problem could be".

"There are these 'standing regulations' that all the serving civil servants must be complied with. You face a disciplinary charge if you breach protocol procedures and no one is interested in wasting their time responding to disciplinary charges especially in a situation where you will be accused of breaching regulations purposefully".

"We have never tried to advise higher authority before (on the situation at grassroots level) and we have no deliberate intention to by pass our DHMT and go directly to the provincial health office or the ministry headquarters. We feel we have nothing to lose if we complied with the existing structural guidelines regarding channels of communication. This is how our government has structured its reporting structures. We are being governed by (civil service) general orders. Our corresponding role is compliance, which is all we can do. If you don't, then you are perceived a wrong person, and a misfit. All we are expected to do at the bottom is merely provide compliance because that is how communication channels have been designed in our government system".

At district level, the district health office should initiate the formation of partnerships in health, as well as to plan, encourage, motivate stakeholders and supervise implementation activities. Discussions held with stakeholders reveal no such role for the DHMT.The lower levels expressed difficulties liaising with their DHMT for fear of negative repercussions. Community representatives that tried to approach the DHMT recalled being unwelcome and being threatened with some kind of punishment for their initiative.

The DHMT has authority among stakeholders in the process in that they are a legitimate body through which health programmes are implemented and through which information

from national level is brought to lower levels. Their authority is recognised as being derived from government authority. As such, they carry influence and some force to push through decisions. However, in addition to these sources of power, the DHMT selectively passed on information to lower levels to ensure their views and interests in the budgeting process are carried through. This manipulation of information weakens the roles and participation of other stakeholders, who only see their roles as compliance rather than discussions to reach consensus for rational implementation of policy (see *Table 6*).

Table 6: Mechanisms to get or lose power in PHC planning and budgeting

Mechanism for getting power	District Health Office level	Health Centre level	Community level
Coercion	√	√	**X**
Influence	√	√	√
Authority	√	√	**X**
Force	√	√	**X**
Manipulation	√	√	**X**

Similarly, with varying degrees, health workers were a conduit through which information and policy on partnerships are transmitted to other stakeholders and can be manipulated to ensure compliance and 'easy' acceptance. Compliance at health centres was ensured by threat of sanctions/ punitive measures. Several community respondents reported staying on partnership committees, which they knew were 'toothless' and unproductive, for fear of being singled out for dissent and punishment. Professional roles played by health workers gave them authority and influence, summed up by the expression that health workers were "our Gods on earth since they looked after our lives". Several community respondents reported a strong alliance to protect mutual interests between DHMs and health centre staff. This alliance was a force community representatives felt powerless to overcome in order to take through community health interests.

Community-level stakeholders were the least powerful and had the least opportunities to acquire power. They frequently lost power in the partnerships as other stakeholders increased their power. For a start, most community representatives lacked legitimacy. A recent study showed that HCCs and their members were known to at most 20% of their catchment populations (Ngulube et al, 2004). Most HCC members did not know the legal status of their existence and functions. Unsure of their mandate, responsibilities and roles, most community representatives owed their allegiance to health workers they worked with, not the communities they served, leaving them powerless to represent and intercede on communities' behalf.

Community representatives also lacked the professional recognition to undertake some of the roles they played in health promotion. Their lack of skills and knowledge of the health system made it difficult for them to articulate community health interests, let alone to convince health workers to accept their views. Lack of knowledge about policy made community representatives powerless to do much besides what health workers wanted.

The bureaucratic framework in which the reforms are implemented is intimidating for community representatives, who said in group discussions: "We are also intimidated by these people because whenever we complain they always tell us that we should remember that we are just volunteers. The bureaucratic channels prevent us from being effective agents for the community. For one to meet the intended person in the bureaucratic set up, you have to see several other people who would first ask you intimidating questions which would put off your desire to do what you came for." Communities and community representatives had no corresponding capacity to manipulate, coerce or force anything onto the health system. Thus community

representatives were powerless (and maybe worthless) in the eyes of both health workers and the communities they served.

How power and individual preferences influenced observed outcomes

The policy of partnerships in PHC planning and budgeting had brought with it not only new partners, but also new roles and responsibilities (see *Table 7*). However, rather than use these new roles and responsibilities as tools to ensure common responsibilities and agendas in PHC priority setting through mutually beneficial give and take transaction, each of the stakeholder group sought to maximise the interests they represent and, if possible, also use the roles and responsibilities exercised to serve local self interests. This appeared to be the case at each level assessed.

At national level, the government recently stated that it did not prioritise the attainment of outcomes from the process. Thus the government may have had their own interests to be served from the process. This remains unknown at the moment. At the level of the DHMT, district health officials were clearly aware of shortcomings in the budget process and even sought an alliance with health centre in-charges to prevent being held accountable by local stakeholders. Though not concerned with whether or not set PHC targets were set, the process went on as though everything was normal.

The inadequate funding and lack of accountability enabled officials to use the money for 'feasible' programmes as they saw fit. These served the local self-interests as long as health worker key concerns were addressed. The same context prevailed for health centre in-charges.

At community level, the closeness to the health system, the lack of supervision and monitoring by the health system and the prestige they enjoyed for doing so made the community representatives put self-interest before those for ensuring the attainment of desired PHC outcomes. They thus requested community initiated projects that brought benefits to them first rather than undertake assigned roles.

Table 7: Perception and manifestation of power and authority in budgeting

Perceptions and manifestation of power	Level of stakeholder/ decision making			
	National	District	Health centre	Community/ HCC/ CHWs
Perception of fulfilling a set political agenda (backed by a bureaucracy)	Yes	Yes	Yes	Possibly
Perception of providing additional income/ support to the health system	Yes	Yes	Yes	Yes
Perception to fulfill government/ donor conditionality	Yes	Possibly	Possibly	Possibly
Providing social/ personal prestige or higher social standing	Yes	Yes	Yes	Yes
Providing personal (material/ financial) gains	Yes	Yes	Yes	Yes
Perception of genuinely focusing on improving PHC services	Yes	Maybe	Maybe	No
Perception as an annual "business-as-usual" routine exercise	Yes	Yes	Yes	Yes
Perception as a potential tool to improve PHC priority setting	Maybe	No	No	No

4.7. Equity considerations

Attaining equity was at the core of the health reform initiative. Realising that money was not enough to go round, the focus was on getting additional health benefits by adopting a partnership approach at all levels, thereby tapping on the contribution and comparative advantage from each stakeholder. This approach was supplemented by basing resource allocation (RA) on a defined RA formula to ensure that each level and each facility got at least some of the national budget. The RA formula went further by recognising that some districts were disadvantaged and the cost of delivering care in these areas was higher than in socio-economically advantaged areas. Thus on a per capita basis, the RA formula was weighted in favour of disadvantaged areas to deliver a measure of equity in services. This allocation would help similar levels of service to be delivered to all areas while providing disadvantaged districts with the potential to make up for lost development in previous years. The extent and effects on set equity goals from the RA formula used for the 2004 budget on the four districts are shown in *Table 8*.

Table 8: Equity in resource allocation and health outcomes between four districts

Expenditure attribute	Annual Expenditure on PHC (2004)			
	LUSAKA DHMT	CHINGOLA DHMT	CHOMA DHMT	CHAMA DHMT
Population (2000 census)	1,103,413	177,445	203,305	75,685
Per capita (PHC) allocated	ZMK 6,668.09	ZMK 1,254.35	ZMK 1,511.59	ZMK 1,154.99
Per capita (PHC) - US$	$1.40	$0.26	$0.32	$0.24
Poverty Level (2004)				
(%) Poor by asset ranking	1%	35%	42%	79%
Households on <US$1/pp	85%	92%	96%	99%
Health Burden (2004)				
Had worsened health	14.1%	17.5%	23.4%	17.7%
Morbidity (last 12 months)	66.2%	61.3%	72.2%	69.1%
Drinking water not safe	34.6%	59.9%	64.7%	71.3%
Malaria a serious problem	87.5%	87.6%	97.6%	98.7%
Allocated to district (2004)				
First referral	$98,984.97	$15,655.57	$18,027.88	$6,841.92
Child health	$75,813.78	$11,990.79	$13,807.77	$3,165.16
DHO functions	$1,310,157.84	$7,433.56	$12,254.31	$3,248.67
HIV/AIDS	$22,147.02	$3,502.80	$5,039.11	$1,530.82
Malaria	$20,149.32	$3,186.84	$6,042.73	$1,392.74
Maternal health	$12,861.96	$2,034.26	$2,342.52	$889.03
Tuberculosis	$ 8,355.63	$1,321.54	$344.24	$577.55
Water and sanitation	$10,957.45	$1,733.04	$3,740.77	$757.39

To help ensure fair RA to health and for improving health outcomes, a Memorandum of Understanding (MOU) was signed between the donor community and the Zambian government for a commitment to allocate 70% of resources to PHC services (CBoH, 2003). In addition, the government signed international agreements to progressively increase the proportion of the national health budget to 15%.

In the 2004 budget, the national health budget comprised 8.64% of the health budget, down from 11.56% in 2003 (Ministry of Finance and National Planning, 2003 & 2004). The proportion of the 2004 health budget spent on implementing the prescribed PHC

programmes was 3% (US$0.43 per capita of the overall US$14.53 per capita health expenditure. An equivalent of US$4.73 per capita (32%) was budgeted for salaries and US$9.40 per capita (65%) was budgeted for capital expenditure, of which the donor community controlled the largest share. Thus, PHC allocations were much less than intended by the MOU with the donor community. It follows from this that the equity pronouncements in the national policy were not matched by practice. Advantaged districts like Lusaka got much higher per capita allocations than disadvantaged rural districts like Chama and Choma.

5. Discussion and policy implications

That the health reforms in Zambia had not produced the desired results in the first ten years of implementation is no longer in question. A lot of resources and effort went into implementing this health reform agenda. So, why did it fail to deliver results as planned? What went wrong, at what level and why? To answer these questions, the implementation process of the Zambian health reforms will be assessed by different levels.

5.1. Political stewardship

For a start, the policy was largely conceived from the top, initially as a political party manifesto, thereafter translated into government policy by incorporating existing procedures, frameworks and infrastructure. The policy itself was not 'uniformly' understood both in the party hierarchy and in the government establishment (Kalumba, 1999), which resulted in inconsistent focus and changing interpretations. Thus, in the first ten years (1991-2001) of implementation, no less than eight ministers were appointed to the health portfolio.

Box 2: Stakeholder views on partisan interests in health reforms

"We are aware that partnerships have been frustrating and difficult to implement. Perhaps what is needed is to introduce a system where by (politically) neutral and committed local stakeholders can be selected to constitute the various community leadership and accountability structures", a view from the donor perspective

"We are aware that funds for community partnership activities are not reaching the intended levels for implementation. What we have now started to do is to monitor reports from districts on how such funds are used", a perspective from central level managers.

"Actually all these things concerning the budget are decided upon by the CBoH and are given to us for implementation only; ….. They tell us that they use various weighting factors including the CSO population figure, the socio-economic status of the district as underlying points to help them come up with different IPFs for the various districts. And according to the figure that we have been given, we also do the same to our health centers. After the briefing, they go back to their stations where they also conduct their health center budgets with various stakeholders at the health center level. The in-charges call for the HCC meeting first, and after briefing them on the guidelines, the HCC representatives also inform their NHCs to identify and prioritize various health needs to be included in the action plan for the health center which will finally reflect the health center budget. So, you can see that our district health budget begins right from the community", a view from district health management.

"When you try to by-pass the health centre in-charge and present your views to district health office for solutions, you are accused of being a trouble maker, admonished and threatened with arrest for 'subverting' the government political agenda", a view from community stakeholders

"As area councillor from the opposition, I am heavily sidelined by the HCC. They have brought a lot of politics. They think and say that all programmes in this area must be initiated and run by the ruling party without looking at their abilities to perform. The HCC members here have closed up against me. They don't consider me as their civic leader. I have always been open but they don't want me to associate with them just because I am not from the ruling party", a view from a local councilor.

The health reforms were also introduced in the context of a newly introduced multi-party system of government. Without much re-examination, the policies may have been introduced in the hope that they were some kind of a 'magic wand' to quickly turn around the declining health services and get political mileage over the opposition. Rather than work to accommodate the health reforms idea, the reforms were introduced on an existing civil service structure (at MoH headquarters) and where necessary created parallel administrative structures (such as the health reform implementation team (HRIT)) in an effort to bypass the civil service bureaucracy. The HRIT gave rise to CBoH and a new administrative structure in health, after the Health Services Act bill of 1995 (MoH, 1995). The transition from HRIT to CBoH did not pass without disagreement. The contents of the 1995 Services Act were a watered down version of an earlier proposed Health Services Act (1995).

5.2. Within the Health system

Following the sudden change of government and system of government, the civil service opted to bring on board new ideas from their new political masters rather than risk a confrontation. Rather than incorporate reforms in the civil service structures and function, new structures and systems were created, so as not to upset the current civil service structures in government and other ministries not undergoing reforms. In a way, the new structures operated 'outside' of the civil service, based on a different work culture.

Policy implementers and CBOH level

Recent revelations from the Zambian government explained that the MoH had spent resources for the last ten years on trying to sustain a costly bureaucracy that duplicated the roles and functions. This gave rise to a bloated and costly central level structure that was less efficient with incoherently organised and unaccountable to stakeholders at different levels (Mwanawasa, 2004; Miti, 2005).

DHMT level

A lot of responsibilities and roles were expected from district level activities. However, all the expectations from the health reform process with the rather 'blurred' political stewardship of the reform had left implementation in the hands of the civil service, who thus used bureaucratic means to try to attain set goals; somewhat contrary to the requirements of bottom-up planning and partnership implementation. In using this framework, partners were considered to be 'outsiders' and were not needed. In a bureaucratic system, one tends to follow procedures and any discussions must follow established channels and procedures.

The district health office did not receive enough resources to support the many intended PHC goals. This was seen through steadily declining allocations to the national health budget from a high of 14% in the mid-90s to around 9% by 2004. This decline further compounded the effects of a bloated bureaucracy so that by 2004, out of the national health budget per capita allocation of US$14.80, not more than US$0.45 per capita was allocated to PHC programmes. District health officials therefore informed health centre officials 'not to prepare big budgets for our 2004 action plans'and 'not to budget for what was ideal but for what was practically realistic or attainable'. The prevailing perception on budgeting was to think of budgets to be "like a dream, and that not all dreams come true".

Thus the efforts of the district health officials switched from being results oriented to merely support health centre staff in creating an atmosphere that 'all is well', and DHMs merely implemented what they thought feasible and practical with available resources.

Health centre level

The health centre managers were expected to budget for three kinds of activities, namely, curative, promotive and preventive activities at health centre, during outreach activities in the community and for community partnership initiated activities. Due to lack of resources, the health centre prioritised health centre activities and a few outreach activities. Health centre staff similarly switched their roles from delivering desired PHC improvements to maintaining the status quo by fitting realistic activities within available resources, and managing the critical observation raised from their partnerships.

5.3. Community level

At the lower level (community level), most of those holding critical views were reportedly either punished (and sidelined), coerced and intimidated (with sanctions on services) or threatened with dismissal from the committee (and hence loss of personal 'benefits'), or manipulated (by giving selective information/ facts or denial).

Box 3: Stakeholder views on self interest in policy implementation

"Considering that all of them want to live and enjoy the benefits and privileges that go along with these structures (and the positions they hold), no one will ever make an attempt to dare such a highly risky move (to question and advise higher authority). When we ask them about why planned and budgeted for community based activities are not being implemented, all we are tired of listening to, is 'the sister in- charge has told us wait because the government hasn't got bla! bla! bla! Or they don't even say anything. What we want is the timely implementation of the planned activities meant for the communities, after all, we hear that there is money meant for community based activities. If such funds are not available, then our question is simple that demands a simple answer. Why then do they have to waste time on this non-starter and a futile exercise?" views from a key informant in the community

"Again the issue of the amount allocated to us is very little; hence our dreams are shattered upon hearing the figure (on which) to plan from. For the 2004 activities we were told to budget on about K300, 000.00 (US$ 63.16). Now what can you budget on this amount? We were all frustrated but we had to do the planning (anyway) so as not to sour the existing relationships which are there. We ended up planning for petty issues", an observation from a participating health worker interviewed from a sampled health centre.

Despite sensing that all was not well in the performance of partnerships, community stakeholders nonetheless valued their association. The community appreciated being requested to have a say on health issues and valued the knowledge they got from health promotion activities. Communities valued the partnerships from the point of view that any form of association with their health system was better than no association at all. In addition, the culture of top-down implementation to which people were accustomed was such that it did not matter whether or not the association was productive to the extent desired. As a traditional ruler who was also a former HCC chairperson said:

> *One important area that was left hanging was the operational extent and limitations of the selected HCC members. They told us to work well with the health centre in-charge and in the event of finding an operational problem in the community; we could report it to or resolve the problem with the health centre in-charge. Our background is such that when government has sent us their officers to explain about new policy changes (which appear to be) somewhat to our advantage, our role as a community is to comply and not to*

be antagonistic. Even the Holy Bible says that in order to be a good citizen, one must be loyal to and obey the state. It is often this spirit of blind loyalty that has continued to 'kill' us in terms of community development.

Whatever, the contribution of the above factors to the inadequate functioning of the partnerships for PHC action planning, the bottom-up partnership approaches adopted for health reforms seem not to have taken into account traditional factors, such as the underlying culture of not questioning one's elders, superiors or appointed responsible officials. With respect to health, the doctor-patient relationship still holds firm in Zambia. In traditional parlance there is the saying that "you cannot question what a traditional healer tells you". In addition, the relationship between government and its people is based on unquestioning compliance and loyalty from citizens.

5.4. Trends and perceptions on community participation in acquiring and using power for PHC district-level planning and budgeting

To start with, the health reforms policy was introduced in the framework of a radical shift in process of political change. The need and activities to initiate the health reform process in Zambia followed the Alma Alta declaration, and was implemented in an incremental process to build on earlier achievements and taking lessons on board. The new health reform policy was brought in as part of political change in 1991 and has been seen and implemented as such by all stakeholders – such that any alternative points of view were perceived as being antagonistic to the political status quo.

Thus, the health reform process was 'owned' by the political establishment. The high level of donor funding for the health reforms was perceived as an endorsement of the correctness and potential for quick positive results from the process. These perceptions raised political stakes and expectations from the health reforms to such a level that the ruling political party claimed ownership and systematically discouraged the involvement of other political parties. This contributed to making any critical constructive comments in implementation difficult; stakeholders then expected to receive policy and implementation directives through the ruling political party hierarchy. This meant that a coherent understanding and implementation of the health reform policy rested with the political establishment. It was assumed that the health reform policy framework was understood similarly by all ruling party policy makers. This was sadly not the case, as was evidenced by the frequent shifts in implementation focus by successive ministers of health. In ten years from 1991 to 2001, eight different ministers were appointed to the MoH. Politicians come and go and political direction is subject to frequent change.

The high political associations and expectations from the health reform policy made take-up of policy and implementation by the civil service partial and cautious lest they be seen to be anti-establishment. The take up and interpretation was selective to suit the political environment of the day while at the same time incorporating local interests to the extent possible. To avoid being seen as antagonistic, health managers waited for and implemented directives from the top and avoided initiating and introducing alternative views on policy (see *Box 1*). Thus, a civil service framework was used to implement what should have been a partnership approach to policy implementation.

Thus, the primary obligation of health managers and policy implementers at lower levels was to be seen to support government policy within the available resources and political climate. Policy and implementation were interpreted to suit this understanding, not necessarily whether or not the desired goals were attained or attainable. The recent statement by the permanent secretary in the MoH that the health reforms implementation did not prioritise the achievement of outcomes from the policy, affirms this (Miti, 2005).

If the attainment of desired outcomes was not a priority, then it follows that the method of implementation was not a priority concern for supervisors. The priority was how "problem-free" the policy was interpreted and implemented within the available resources and policy environment. This led to a situation where supervisory roles and responsibilities were not adhered to and selectively implemented to suit the desired policy context. Thus, a key feature in policy implementation was the selective release of needed information and selective interpretation of policy to suit the interests of policy as perceived by actors in a particular stewardship role. The selective release of information and interpretation of policy was used to get and exercise power to serve the interests of the particular level of actors at that level (Mogensen et al, 2001; Likwa et al, 1998). This perception also came out clearly in this study (see *Box 2*).

At the district and health centre levels, the lack of focus on outcomes by central level officials meant planning and budgeting did not receive the desired attention and support. Both district and health centre in-charges complained that the system was such that it did not matter how much and when the budgeted funds were disbursed to districts and health centres. Thus plans were not adhered to and available resources were diverted to address immediate needs to keep the system functioning. This made PHC planning and budgeting a meaningless and a frustrating exercise. Thus participation in planning and budgeting fulfilled a procedural requirement, not the expected, desired outcomes.

The occurrence of epidemics also prevented district health authorities from implementing planned activities, as resources were diverted to control of epidemics. Nearly all districts are epidemic-prone. But when epidemics occurred, the district health office was expected to respond to this, no matter the cost, without additional financial support from the centre. The realisation that no additional support can be expected from the centre beyond whatever came through has led to a situation where plans and budgets were made so as to receive funds to run health programmes in reaction to prevailing circumstances rather than for implementing planned activities for desired outcomes.

The prevailing scenario led to a situation where participation for the desired leadership and accountability roles from the community were aligned with partisan interests. The perception from the community and health workers was that the health reforms could best be implemented and safeguarded by community members from the ruling party. In order to effect this perception in a multi-party setting any dissent was seen and interpreted to be anti-policy and anti-establishment. The ideas of those clearly identified as belonging to opposition parties were neither needed nor sought. Influential and respected community leaders (such as councillors) were thereby excluded from participating in policy implementation. Thus, the major objective and interest from stakeholder participants at community level was to support the policy framework within the available resources for the desired political objectives (see *Box 3*).

Lack of training and skills to understand and implement the desired action plans was a major factor in poor performance from the health budgets made. Perhaps, apart from the CBoH officials, no one from the districts, health centres and community level were clear on how the IPF was derived. Population figures were thought to be a key consideration, but no one agreed on what the correct population figures were. Head count figures were known, but no one was allowed to use them. This scenario resulted in a situation where budgetary allocations at district and health centre levels were made without legitimate guidelines either from the top or jointly worked out through the partnership. This situation left decision-making on how much to allocate to which cost centre in the hands of the few powerful actors, usually the supervisors at district or health centre level. In the absence of clearly laid out allocation formulae and lack of transparency and accountability, the allocation of funds was done without following the laid down priority setting criteria to guide the attainment of desired goals (see *Table 4*).

6. Next steps and reflections

The research team now plans to disseminate these findings to stakeholders for their information and comment on the way forward. A dissemination workshop will be held in Lusaka for officials from the MoH, CBoH, district directors of health, district health board chairpersons, district coordinators and chairpersons of the Equity Gauge, and district chapters and chairpersons of HCCs from the sampled health centres. The Zambia Medical Association (ZMA) has requested dissemination of this work so they may be better informed on what transpires during the PHC budget process.

Impressions on value of policy analysis as an analytical approach

The policy process analysis approach has made quite an impression on our research team and our research capacity. It opened us to what should be the obvious in that there are systems or policies (good or bad) through which things happen – but the reality is that the differences in understanding, interpretation, interests and so forth can and do manifest to alter the outcomes. In our part of the world, there is always the 'belief' that all is well simply because government policy says so.

Secondly, the findings from this work have brought home the reality that things happen and there are people to move things. But the way in which things happen is just as important as whether or not adequate resources are made available. The other side of the coin being that issues of resources are better looked at with an understanding of the policy and the process by which the particular policy is implemented.

Differences in approach may be masked and become muffled as stakeholders try to give and take. Where consensus/ common agreement/ common understanding is lacking, these things may manifest in and affect policy implementation. Hence, a policy process analysis can reveal a lot in terms of how and why a particular policy was adopted; and thus give an indication of the power dynamics in negotiating and implementing particular policies. This understanding can inform timely corrective action in future.

Indirectly, this policy process work has helped us to understand how bureaucracy is practiced and used to serve the interests of the powers-that-be at each level of the health system. The sad realisation from this work has been the knowledge that the seemingly good intentions in the health reforms merely appear to serve the interests of individuals rather than for the intended collective good.

The policy process analysis is a useful tool if one of the goals is to empower people to claim and help make a difference. This can help all involved make informed decisions on how best to work together. Since the conclusion of this project work, findings and issues coming from this work have been presented to health workers at district and central levels. The issues raised were appreciated and described as revealing. During a discussion session following another seminar presentation, an observation was made that while the policy delegated authority to lower levels, implementation practices showed that stakeholders resorted to using more informal power in order to get things moving their way. Further dissemination sessions are planned, after the final report presentation. These will hopefully help stakeholders understand why all should be involved in a meaningful way if the aim is to come up with meaningful results from the health reform programme.

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Equity in health *implies addressing differences in health status that are unnecessary, avoidable and unfair. In southern Africa, these typically relate to disparities across racial groups, rural/urban status, socio-economic status, gender, age and geographical region. EQUINET is primarily concerned with equity motivated interventions that seek to allocate resources preferentially to those with the worst health status (vertical equity). EQUINET seeks to understand and influence the redistribution of social and economic resources for equity oriented interventions, EQUINET also seeks to understand and inform the power and ability people (and social groups) have to make choices over health inputs and their capacity to use these choices towards health.*

EQUINET implements work in a number of areas identified as central to health equity in the region:

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- Health rights as a driving force for health equity
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- Public-private mix and subsidies in health systems
- Distribution and migration of health personnel
- Equity oriented health systems responses to HIV/AIDS and treatment access
- Governance and participation in health systems
- Monitoring health equity and supporting evidence led policy

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