

JULY 2016

Public-Private Partnerships for Women's Health in Zambia

Lessons for U.S. Policy

A Report of the
CSIS TASK FORCE ON WOMEN'S AND FAMILY HEALTH

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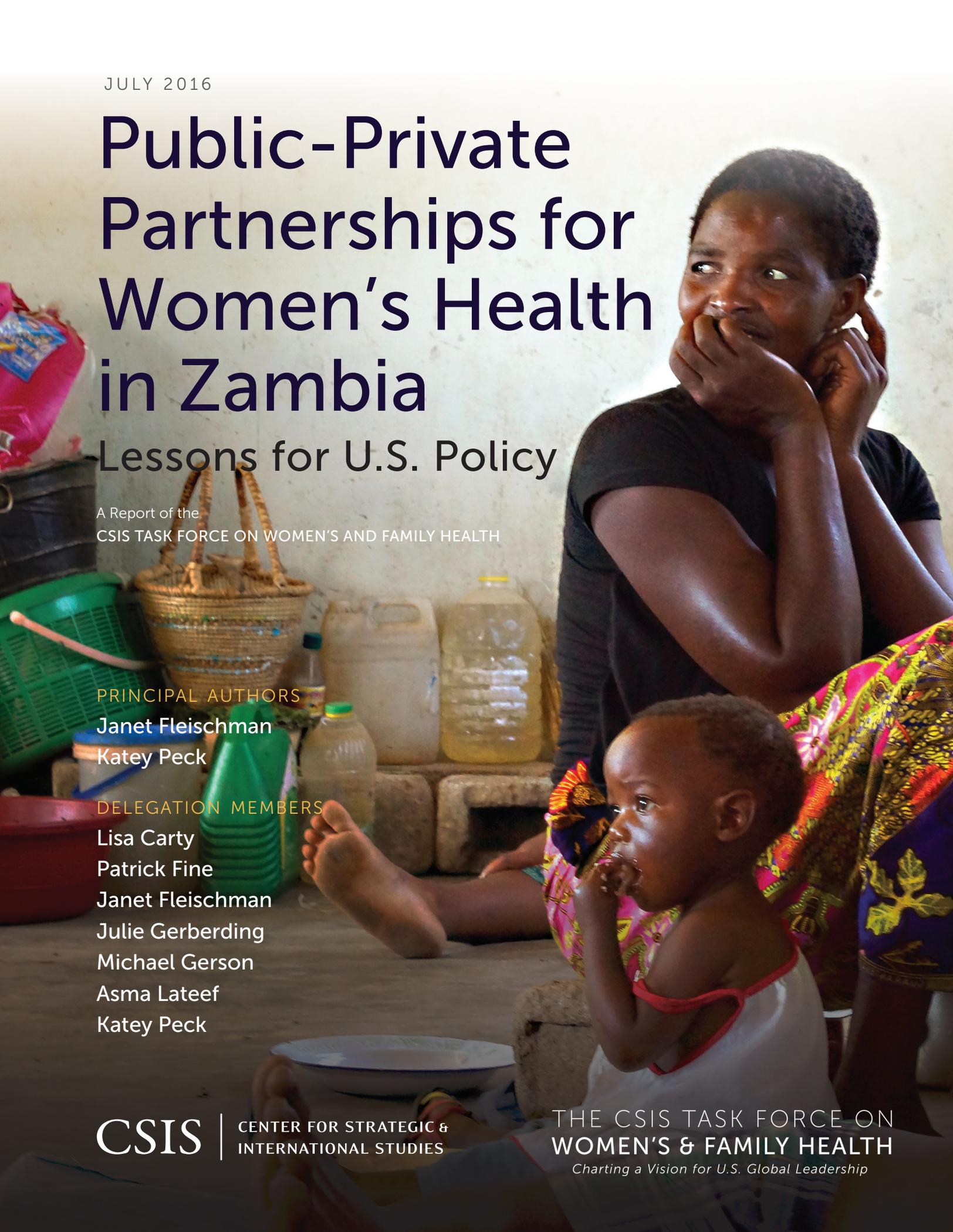
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THE CSIS TASK FORCE ON
WOMEN'S & FAMILY HEALTH

Charting a Vision for U.S. Global Leadership



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Acknowledgments

This report was made possible by the generous support of the Bill & Melinda Gates Foundation. The authors would like to acknowledge the assistance and insights provided by the U.S. government's interagency team in Zambia, the Zambian Ministry of Health, the nongovernmental organizations working on women's health, and the many Zambian women, girls, and healthcare workers who shared their perspectives with us.

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Executive Summary

Zambia is a lower-middle-income country struggling with critical health challenges, including high rates of maternal and neonatal mortality, malnutrition, cervical cancer, and a severe HIV/AIDS epidemic that disproportionately affects adolescent girls and young women. The United States is the largest donor to the health sector in Zambia,² largely through the President's Emergency Plan for AIDS Relief (PEPFAR).³ Over the past five years, the United States has also helped establish several public-private partnerships (PPPs) aimed at advancing the health of women and families. These PPPs provide lessons about the potential impact of these approaches, the challenges inherent in such partnerships, and the importance of PEPFAR support. With future U.S. global health funding likely to be flat-lined, this is an important moment to assess how partnerships with the private sector can amplify the impact of U.S. investments in women's and family health. The lessons from the U.S. engagement in the PPPs in Zambia are valuable for other such initiatives.

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² Over the last decade, the United States has accounted for the largest share of health funding to Zambia, and its share has increased in recent years, rising from 42 percent in 2006 to 63 percent in 2014. The second-largest donor in 2014 was the Global Fund (16 percent), followed by the United Kingdom (8 percent). See "Zambia Funding Analysis," March 2016, received directly from the Kaiser Family Foundation.

³ PEPFAR's Country Operational Plan (COP) for 2016 for Zambia is \$359 million.

This report is based on an April 2016 visit to Zambia by a delegation of the CSIS Task Force on Women’s and Family Health.⁴ Zambia was chosen because it is the site of several PPPs in women’s health, and the delegation examined U.S. investments through three such partnerships: Saving Mothers Giving Life (SMGL), Pink Ribbon Red Ribbon (PRRR), and DREAMS (Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe).⁵ The delegation sought to understand these partnerships in Zambia within the context of U.S. support for women’s and family health,⁶ which represent the core of functional health systems. Zambia is the site of these PPPs for a number of reasons, including that it is a generally reliable and stable partner in health and development efforts. Despite recent economic challenges and concerns around the upcoming Zambian presidential elections in August 2016, the Zambian government expresses a commitment to advancing health programs, and clearly values U.S. support.

Figure 1. U.S. Health Funding as a Share of Total Foreign Assistance for Zambia, FY 2006–FY 2015



NOTES: Includes funding from USAID and the State Department; country-specific funding amounts from other agencies, such as the CDC, are not available. FY 2013 includes the effects of sequestration.
 SOURCE: Kaiser Family Foundation analysis of data from the U.S. Foreign Assistance Dashboard, www.foreignassistance.gov.



⁴ The members of the delegation were (organizations listed for identification purposes only; the views expressed in this report are those of the authors): Lisa Carty, director, UNAIDS US Liaison Office; Patrick Fine, CEO, FHI360; Janet Fleishman, senior associate, CSIS Global Health Policy Center; Julie Gerberding, executive vice president of strategic communications, global public policy, and population health, Merck & Co., Inc.; Michael Gerson, senior adviser, ONE Campaign; Asma Lateef, director, Bread for the World Institute; and Katey Peck, program manager and research associate, CSIS Global Health Policy Center.

⁵ Saving Mothers, Giving Life was launched in 2012 to reduce maternal mortality; Pink Ribbon Red Ribbon was launched in late 2011 to prevent and treat cervical and breast cancer; and DREAMS was launched in December 2014 to reduce HIV incidence in adolescent girls and young women.

⁶ We have defined women’s and family health as family planning and reproductive health; maternal, newborn, and child health; immunizations; and nutrition.

To understand the lessons of the PPPs in Zambia, the delegation focused on a few overarching questions: What has been the impact and value-added of these PPPs? What do they tell us about how to build effective, dynamic PPPs where all partners are actively committed and engaged? Given how indispensable PEPFAR funding has been for each of these PPPs, what are the implications for program scale-up and sustainability? And finally, can such PPPs usefully contribute to the longer-term support necessary to advance women's and family health, even as they strive to produce "quick wins" to meet annual targets and demonstrate impact?

The delegation found that U.S. support for these PPPs has been critical, and that they have achieved valuable successes and hold important promise; however, the full potential of these partnerships has yet to be fully realized. From the outset, these initiatives should be strategically coordinated with the national government and other development partners to plan for scale and sustainability, which has proven challenging in the past. These PPPs were designed with ambitious goals and timelines to show quick results and achieve early impact, yet they do not replace the need for longer-term support for public health systems from other development partners and the national government. The delegation saw clearly the importance of PEPFAR's resources for each of the PPPs, as well as the constraints this imposes on where and how the programs can operate. It also observed missed opportunities for more integrated services within the health space and across development sectors, which will require the United States to move away from vertical, siloed approaches and toward more comprehensive funding mechanisms, a departure from how the U.S. government operates. Finally, growing economic inequality, urban-rural disparities, and dampened export markets could reverse recent gains in Zambia and pose a challenge to the health status of women and families.

Recommendations

The challenges of women's and family health in Zambia compel the United States and its partners in the government, the private sector, and the other donors to be strategic in how they allocate resources and design programs. Given the overwhelming importance of its health investments in Zambia, the United States has a critical role to play in improving health outcomes for women and children, including through PPPs. The PPPs in Zambia have highlighted critical health needs, and can be a tool to motivate action in important but neglected areas; accordingly, the delegation found that engagement in PPPs will remain an important tool for U.S. policy. To find new ways to build sustainable and scalable programs in this area, the United States should consider the following policy options:

- **U.S. engagement in PPPs in Zambia holds great potential for amplifying the reach, effectiveness, and sustainability of U.S. support for women's and family health and is going to remain an important tool in U.S. policy approaches. The United States should designate a director-level position charged with coordination of PPPs in health and development across the interagency process to strengthen their performance, ensure sustainability of financing and personnel, and apply lessons learned to current and future PPPs. This higher level of oversight should be designed**

to bring greater accountability to these initiatives and lay the groundwork for expansion and scale downstream.

The three key U.S. government-supported PPPs in Zambia have made a positive contribution to saving lives and raising awareness about certain health issues, particularly around maternal mortality, cervical cancer, and HIV, and lessons can be learned about establishing more effective and impactful partnerships. When designing new partnerships or adapting existing ones, the United States and its partners should focus on key elements to ensure that the comparative advantages of the various partners are put to best use: 1) clear expectations and a common vision among the partners, 2) the establishment of an inclusive and active governing structure; 3) an intentional planning process that reflects the priorities of all the partners, especially the local community and national health authorities; 4) early planning for achieving scale and sustainability; 5) an ability to adapt and adjust ways of working to account for lessons learned; and 6) political leadership in support of a country-owned and led strategy.

Since Zambia has been such a focus of U.S. government-supported PPP activity, the U.S. government should strengthen the interagency mechanisms at the country level and at headquarters to guide future partnerships, to conduct a more systematic evaluation of how these initiatives could work in better synergy, and to identify what lessons might be relevant for future U.S.-supported PPPs in Zambia and beyond. This process should help ensure that there is cross-fertilization among these PPPs to build on shared learning and best practices.

- **Ambitious goals and timelines in these PPPs can drive progress but should be accompanied by plans for scale and sustainability from the outset, with a particular focus on building local capacity. Otherwise the United States and its partners risk facing a tradeoff between quick wins and programmatic sustainability.**

The ambitious goals and timelines of the PPPs in Zambia have driven faster implementation and impact than is typically possible, propelled by high-level U.S. leadership. These accomplishments are critical to demonstrate feasibility and build support at the country level and within the U.S. government. Creating incentives for urgent action can force more discipline, foster a more serious management culture, and heighten focus on results. However, if plans for expansion and sustainability are not built into the initial program design, they risk being one-off initiatives.

The relatively short time frames for results in these PPPs also present challenges for building local capacity and systems to take over programs when the donors leave. For longer-term sustainability and scale, the United States should use its role in the PPPs to strengthen the capacity of national ministries and provincial and district governments to coordinate and manage the resources for women's health more effectively. This includes strengthening the government's capacity to collect and use health data and to coordinate the various partners' activities at the provincial and district level.

- **Given the centrality of PEPFAR to these PPPs, the U.S. interagency team in Zambia should work with the Zambian health officials and other donors to identify and**

mitigate any adverse effects of the changes in PEPFAR strategy on maternal and child health and family planning services.

PEPFAR support for PPPs adds value to U.S. government health programming and should be continued in new and strategic ways. Where changes in PEPFAR strategy might disrupt other service delivery, the United States should coordinate with the government and other development partners to address any gaps. For example, where data indicate disruptions in services at sites previously supported by PEPFAR, the U.S. country team in Zambia, notably PEPFAR and the U.S. Agency for International Development (USAID), should provide transitional funding to address gaps and coordinate with the government and other donors to support maternal and child health, nutrition, and family planning services.

- **The United States should expand integrated services to advance women’s and family health, and the U.S. chief of mission in Zambia should ensure that the appropriate authority and resources are aligned to implement and measure outcomes effectively in maternal and child health, family planning, and nutrition. To that end, the U.S. country team in Zambia should publish a comprehensive and coordinated plan for women’s and family health and report publicly on its implementation.**

Each of the three PPPs has reinforced the importance of integrated services in effectively and efficiently reaching women and families with essential health services. U.S. support for greater integration of services within health (including family planning, maternal and child health, and HIV) and across sectors (including education, nutrition, agriculture, and energy) will require a programmatic and structural shift in U.S. approaches to service delivery and to funding in Zambia, but could improve the impact of existing resources across multiple sectors.

The Chief of Mission should create an interagency working group on women’s and family health to advance a comprehensive, integrated approach in Zambia. The working group should ensure that PEPFAR, USAID, and the Centers for Disease Control and Prevention (CDC) authorize their implementing partners to provide integrated services and to develop program indicators that are output oriented, integrated, and multisectoral. The interagency working group would facilitate joint planning between PEPFAR and other U.S. health and development programs, leading to the creation of a comprehensive plan for women’s and family health that spans the different agencies and encompasses different U.S. funding streams. Such integration will also require leveraging the other presidential health and development initiatives in Zambia—Power Africa, Feed the Future, and the President’s Malaria Initiative (PMI)—both to recognize the importance of women’s and family health in order to achieve their goals, and to address these areas through a multisector response.

Going forward, the U.S. government agencies should work with Congress to identify new resources to strengthen U.S. support for women’s and family health and to inspire new champions for these issues in the administration and Congress.

Key Findings and Observations

1. PPPs are complicated, but can help drive impact.

The term “public-private partnership” (PPP) in health covers a wide range of programs, financing, and in-kind services/donations. PPPs can involve local and/or international private-sector companies, nongovernmental organizations, as well as alliances among public and private donors. Accordingly, PPPs can be quite diverse, ranging from those reflecting shared value for commercial business, to those with either the U.S. government or a private foundation as cofounder.

Private-sector engagement in health has evolved, moving from philanthropy to corporate social responsibility to a shared value proposition⁷ that engages the private sector in ways that add value to its core business interests and goes beyond in-kind donations. While PPPs hold great potential for amplifying the reach, effectiveness, and sustainability of U.S. global health programs, we heard that the significant promise of PPPs has yet to be fully realized in Zambia.

The three principal U.S.-supported PPPs in women’s health—Saving Mothers Giving Life (SMGL), Pink Ribbon Red Ribbon (PRRR), and DREAMS—illustrate both the challenges and opportunities inherent to these initiatives: transaction costs of negotiating and governing a coalition of partners can be high; it may be difficult to hold partners accountable for meeting their commitments; the national government may feel little sense of ownership or commitment if it was not involved in forming the PPP; and they are dependent on existing U.S. government platforms.⁸ Zambia’s experience with these partnerships underscores the importance of finding common interests and shared value between public and private partners to achieve success and sustainability, the importance of local engagement, and the need for flexibility to learn and course-correct.

Examples of private-sector involvement in Zambia demonstrate the added value that such partnerships can bring. For instance, Merck’s contribution to PRRR involved a donation of 210,000 doses of their GARDASIL[®] HPV vaccine to jumpstart the HPV vaccination demonstration projects among adolescent girls, which has led to Zambia’s plan to submit an application to Gavi in September 2016 for a nationwide rollout of the vaccine. Since PEPFAR financing does not cover vaccines, this was an important contribution to cervical cancer prevention efforts. “Let industry help with innovation,” a USAID representative told us. A private-sector official also noted that in-kind donations can be the start of a partnership, but that the goal is to move beyond donations to make investments relevant to the company’s shareholders and employees by creating sustainable health markets. If the Gavi application is approved, this could be a useful lesson; through a PPP, a private-sector partner made a

⁷ Shared value is a strategy focused on companies creating measurable business value by identifying and addressing social problems that intersect with their business.

⁸ SMGL was designed in 2011 through frequent meetings between CDC, USAID, and the Zambian Ministry of Health, and drew from Zambia’s National Maternal and Child Health Road Map, as well as the Zambian adaptation of the Campaign to Accelerate the Reduction of Maternal Mortality in Africa (CARMMA). See Margaret E. Kruk, Sandro Galea, et al., “External Evaluation of Saving Mothers Giving Life,” SMGL, March 2013, <http://www.savingmothersgivinglife.org/docs/SMGL-Columbia-Interim-Report.pdf>.

product donation at an early stage, which will then be scaled up by Gavi, the Vaccine Alliance.

A different kind of engagement can be seen in private-sector contributions to SMGL in Zambia.⁹ Merck for Mothers, together with the Bill & Melinda Gates Foundation and ELMA Philanthropies, is supporting entrepreneurial models for 24 maternity waiting homes, aimed at making them economically sustainable.¹⁰ As construction of these waiting homes was not included in USAID's program,¹¹ Merck for Mothers filled this gap, although some observers have questioned whether this maternity waiting home project made best use of the private partners' expertise.¹² Another private partner in SMGL is Project C.U.R.E., which is upgrading SMGL facilities by conducting needs assessments and providing donated medical supplies and equipment, valued at over \$4 million.¹³ Given the considerable needs in this area, these supplies are valuable contributions to the program.

Despite a clear desire to engage the private sector in Zambia, these initiatives have had only mixed success in gaining participation from international private-sector partners, and even less engaging local private businesses. One stakeholder noted that the private contributions were "marginal" compared to the public resources; another explained that in order for these partnerships to realize their potential, private investment needed to go beyond corporate social responsibility to advance corporate interests. A distinct shortcoming of PPPs in Zambia is the lack of engagement by the local business community.¹⁴ While this relates to the underdeveloped state of the private sector in Zambia, including private health providers, it also reflects that these PPPs remain primarily donor-led constructs. Some observers suggested that American industry leaders could help engage Zambian industry in PPPs, rather than just relying on outreach from public health professionals.

⁹ In SMGL in Uganda, where Merck for Mothers is known as MSD for Ugandan Mothers (MUM), it works more directly with private-sector health delivery. Through a partnership with Population Services International and its local affiliate, the program has worked to improve private delivery of health services in 30 districts. See Merck for Mothers, "Uganda Fact Sheet," http://merckformothers.com/our-work/uganda/fact_sheet.html.

¹⁰ As USAID is not usually involved in constructing buildings due to limitations under the Foreign Assistance Act, the Department of Defense (DoD) and Peace Corps are helping with the construction and the Lafarge cement company has donated cement for the buildings under SMGL.

¹¹ DoD has been involved in some construction and renovation of maternity waiting homes and labor/delivery wards for SMGL.

¹² According to Merck for Mothers, it decided to focus on building maternity waiting homes to improve community ownership and introduce more entrepreneurial approaches to their management. The goal is to encourage more women to use the shelters so that they can give birth with a skilled health provider in a facility, reducing their risk for complications. See more at Merck for Mothers, "How Maternity Homes Can Make Childbirth Safer for Women in Zambia," http://merckformothers.com/our-work/from_the_field/zambia_priya_agrawal.html#sthash.KjSYk7Vm.dpuf.

¹³ See Project CURE, "Countries," <https://projectcure.org/countries/af>.

¹⁴ One exception is the Lafarge Foundation in Zambia, which is part of the Lafarge Group, a global supplier of building materials, and focuses on corporate and social responsibility in Zambia. It is donating 3,000 bags of cement to build the maternity waiting homes for SMGL, in cooperation with DoD.

ink Ribbon Red Ribbon*

Pink Ribbon Red Ribbon (PRRR) was launched in September 2011 by the George W. Bush Institute as a partnership with PEPFAR, Susan G. Komen, and UNAIDS and has since grown to include other private partners including Merck. PRRR's goals are to reduce deaths from cervical cancer by 25 percent, achieve 80 percent coverage of HPV vaccination, screen at least 80 percent of target populations and treat those with lesions, increase awareness about breast and cervical cancer, and create innovative approaches to service delivery and laboratory and data systems that can be sustained and scaled up. Zambia was the first PRRR country, and benefited from several high-profile visits by President George W. Bush and Mrs. Laura Bush. PRRR has received the bulk of its funding from PEPFAR (\$7 million) and has screened nearly 170,000 women in Zambia for cervical cancer since December 2011. With support from Merck, PRRR in Zambia launched a demonstration HPV vaccination program to reach 70,000 girls. PRRR now also operates in Botswana, Ethiopia, Namibia, and Tanzania. There are plans in place to transition the program (fiscally and operationally) to the Zambian government by 2019.

*Pink Ribbon Red Ribbon, "Fact Sheet," March 2016, received directly from PRRR.

Saving Mothers Giving Life*

Saving Mothers Giving Life (SMGL) was announced by former Secretary of State Hillary Clinton in June 2012, with the ambitious goal of reducing maternal mortality by 50 percent in one year in selected districts of Zambia and Uganda. In Zambia, the program was built on the government's roadmap for maternal and newborn health. Now nearing the end of its five-year program, SMGL has achieved measurable success in Zambia, contributing to a 53 percent reduction in institutional maternal mortality in its original target areas. Although designed as a PPP, the program has functioned largely as bilateral assistance between the United States and Zambia (with \$15 million in funding from PEPFAR), with add-on contributions from private-sector companies and organizations. The U.S. government (through USAID, CDC, PEPFAR, Department of Defense, and Peace Corps) leads implementation and monitoring and evaluation activities, Merck for Mothers is developing entrepreneurial models for maternity waiting homes, American College of Obstetricians and Gynecologists provides scientific, technical, and clinical expertise around uterine balloon tamponade, and Project C.U.R.E. leads efforts to upgrade SMGL facility infrastructure and donates medical supplies and equipment. Given its initial success in Uganda and Zambia, SMGL has recently expanded to Nigeria, which accounts for 14 percent of maternal deaths and 25 percent of newborn deaths globally. The initiative will work to strengthen maternal health services in Cross River State over the next 2.5 years.

*USAID, "SMGL Zambia Summary Brief," March 2016, received directly from USAID.

DREAMS*

DREAMS (which stands for Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe) was launched by Ambassador Deborah Birx on World AIDS Day 2014 as a PPP between PEPFAR, the Bill & Melinda Gates Foundation, and the Nike Foundation (now the Girl Effect), later joined by Johnson & Johnson, ViiV Healthcare, and Gilead Sciences. Its goals are to reduce new HIV infections among adolescent girls and young women aged 15–24 by 25 percent in two years and by 40 percent by the end of 2017 in DREAMS target areas. To address the structural drivers of HIV infection, the program will provide a core package of interventions: adolescent-friendly health services (post-violence care, HIV testing and counseling, and sexual education including condom promotion and expansion of the contraceptive method mix); social protection for adolescent girls and young women (education subsidies, post-violence care, socioeconomic support); targeting male sex partners (antiretroviral therapy; voluntary male medical circumcision; and condoms to males in their sexual networks, community-based gender norms); and community strengthening (parent/caregiver programs and school-based HIV, violence, gender education).

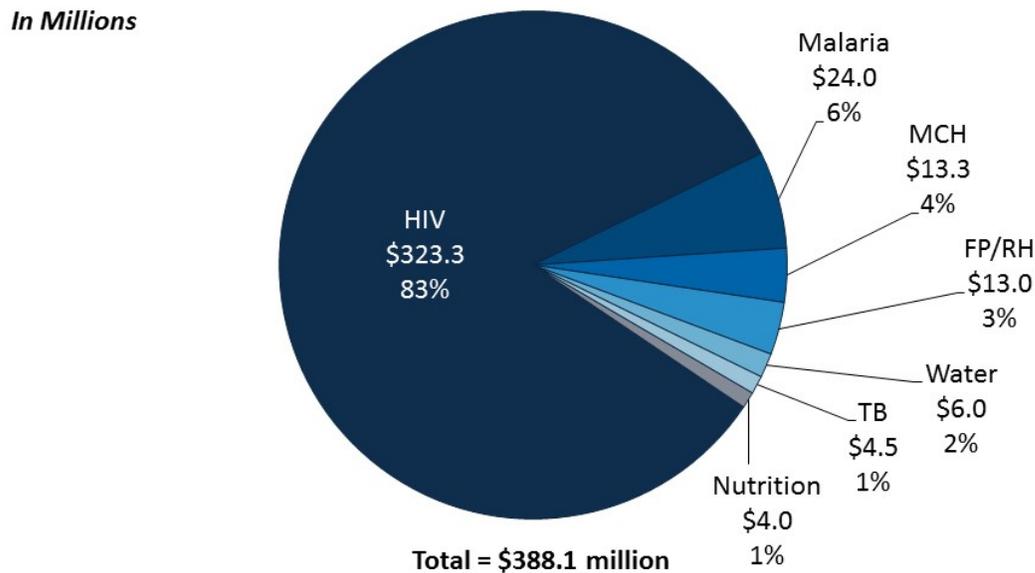
*CHANGE, "Fact Sheet: The DREAMS Initiative," November 2015

http://www.genderhealth.org/files/uploads/change/publications/Finalized_DREAMS_Partnership_FC.pdf
PEPFAR, "Zambia: DREAMS Overview," <http://www.pepfar.gov/documents/organization/253962.pdf>.

A U.S. government representative put things in a more positive light by noting, “even if they [the private-sector partners] don’t bring much in the way of resources, it is useful to have their brands associated with the effort.” While this recognizes the value of association with corporate “branding,” at least for a U.S. audience, it falls short of the significant added value that partners seek. Others noted the high transaction costs associated with cultivating and servicing PPPs; indeed, the management and operation of the SMGL and PRRR partnerships were described as a time-consuming effort, which depend heavily on PEPFAR financial, programmatic, and human resources.

2. PEPFAR’s support has been key to each of the PPPs, which will require ongoing efforts to minimize disruptions caused by changes in U.S. strategy.

Figure 2. U.S. Global Health Funding for Zambia, by sector, FY 2015



NOTES: Includes funding from USAID and the State Department; country-specific funding amounts from other agencies, such as the CDC, are not available.

SOURCE: Kaiser Family Foundation analysis of data from the U.S. Foreign Assistance Dashboard, www.foreignassistance.gov.



As the main U.S. health intervention in Zambia, PEPFAR has been the key underwriter of each of the PPPs. SMGL, PRRR, and DREAMS all build on programs already put in place by PEPFAR and, to a much lesser extent, USAID’s Maternal Newborn and Child Health (MNCH) program, which enabled these initiatives to launch more quickly. Yet the difference in resources is stark—PEPFAR support to Zambia has been over \$300 million a year for the last several years, while MNCH and family planning funding have each been about \$13 million annually (see funding chart below).

Working through existing partners¹⁵ has also meant the programs are almost exclusively focused on PEPFAR priority areas,¹⁶ raising concerns about 1) the urban-rural divide in access to care, since PEPFAR is now targeting higher-population urban areas where HIV burden is higher, and 2) equity in access to health services. We heard repeatedly that districts with highest HIV burden and highest maternal mortality often do not overlap, and as one U.S. government implementing partner told us, “Rural women suffer disproportionately.”¹⁷ Since the HIV burden is not as high in some of the areas with the greatest needs in maternal and child health and family planning, those will not be areas with ongoing PEPFAR support.¹⁸

This all comes at a time when PEPFAR is shifting its model to focus resources to saturate priority “hotspot” districts, known as PEPFAR 3.0 or the PEPFAR pivot.¹⁹ The goal of the pivot is to more efficiently use resources to achieve HIV epidemic control through primarily biomedical treatment and prevention approaches.²⁰ In Zambia’s PEPFAR Country Operational Plan (COP 2016), which was just approved, PEPFAR is shifting available resources to saturate services in 46 priority districts, maintaining services with flat-lined funding in 15 sustained districts, and providing ARVs, supply chain, and surveillance in 21 centrally supported districts. As many of the nonpriority districts still experience high HIV prevalence (up to 5 percent) the pivot presents both an opportunity and what one U.S. government official called “a philosophical gamble.”

U.S. officials acknowledged that the pivot has been “taxing.” It is provoking hard discussions around resource allocation and a new level of engagement between PEPFAR and the Zambian government, with a concerted effort to manage the transition and to coordinate with the provincial and district health officials to mitigate gaps in services in the areas where PEPFAR is reducing its footprint.²¹ Nevertheless, the Ministry of Health faces harsh realities, given that the pivot means that PEPFAR no longer directly supports service provision in some districts with as high as 5 percent HIV prevalence, a level unimaginable in other countries,

¹⁵ According to USAID, in most cases, funds were added to existing agreements/programs. Activities were also built into newly initiated projects.

¹⁶ SMGL is not as affected by the pivot because its funding has been outside of the COP process and considered “special” funding for MCH. SMGL sites that are not in PEPFAR priority districts will be maintained, except for two small districts that will be covered with MCH funds.

¹⁷ Interview in Lusaka, April 20, 2016.

¹⁸ According to the U.S. interagency team in Zambia, these are areas where the local government will have to step up to ensure optimal health care continues for the population, working with or without other bilateral partners.

¹⁹ In late 2014, PEPFAR announced a shift in its approach—what many refer to as the PEPFAR pivot—which will allow PEPFAR to focus its resources on the areas of highest HIV burden. In describing the new approach, PEPFAR documents state: “To reach the Joint United Nations Programme on HIV/AIDS’ (UNAIDS) ambitious 90-90-90 global goals: 90 percent of people with HIV diagnosed, 90 percent of them on ART and 90 percent of them virally suppressed by 2020—we have to shift the way we do business. We can best control the epidemic by pivoting to a data-driven approach that strategically targets geographic areas and populations where we can achieve the most impact for our investments.” See PEPFAR, “PEPFAR 3.0—Controlling the Epidemic: Delivering on the Promise of an AIDS-free Generation,” December 2014, <http://www.pepfar.gov/documents/organization/234744.pdf>.

²⁰ By targeting achievement of 81 percent antiretroviral therapy (ART) coverage in high-burden districts, PEPFAR aims to break the epidemic. The other key piece of the pivot beyond the geographic shifts is the programmatic shifts toward “core” activities and away from “noncore”—which is also affecting the ability to leverage or synergize with non-HIV activities. See PEPFAR, “PEPFAR: 2015 Annual Report to Congress,” 15, <http://www.pepfar.gov/documents/organization/239006.pdf>.

²¹ The pivot was received positively by PS Mwaba because of potential for epidemic control in certain hotspots. It should be noted that while PEPFAR is reducing support in some of these areas, U.S. government will support ongoing surveillance activities, ARVs, and supply chain countrywide.

with the potential for disruptions in health outcomes and services, equipment maintenance, and data management systems. A representative of the Ministry of Finance expressed concerns about the pivot, asking, “Who’s going to pick up the slack as PEPFAR funds are moved out?” However, the permanent secretary for the Ministry of Health, Dr. Peter Mwaba, was more sanguine, noting that this was part of a strategy to achieve epidemic control and that the government would try to increase its contributions in those areas. “We can’t leave the population to perish,”²² he told us. In an acknowledgement of the U.S. budget realities, he then added, “If America is broke, where will Zambia be?”²³

While PEPFAR is refocusing on treatment in high-burden locations, DREAMS is expanding programming beyond PEPFAR’s biomedical model to shift the paradigm on HIV prevention for adolescent girls and young women in Zambia. (See section 4 for more information about DREAMS.)

3. Ambitious targets and timeframes in PPPs can lead to quick wins but can be difficult to scale and sustain.

We heard from a number of senior U.S. government officials closely involved with SMGL, PRRR, and DREAMS that ambitious targets and timelines can provide the incentive to work differently. One explained that SMGL “was perfectly played to us” in that it had “outrageous deadlines, a big chunk of money” and “allowed us to be creative.”²⁴ Referring to the ambitious targets in SMGL and DREAMS, a CDC official said: “It forced us to do what we wouldn’t otherwise have done.”²⁵ In aiming for a 50 percent reduction in maternal deaths in one year under SMGL, the pressure to show quick results encouraged what was described as an “unusual” degree of collaboration among the different U.S. government agencies and with implementing partners.²⁶

Yet it was repeatedly acknowledged that proving the model and taking it to scale are different endeavors. While SMGL led to a remarkable reduction in maternal mortality in its target areas, it was expensive to implement.²⁷ Similarly, DREAMS has significant resources to implement its ambitious goals around reducing new HIV infections among adolescent girls and young women, but it is unclear what will happen after the initial two-year timeframe comes to a close in December 2017.²⁸ Many noted that quick wins, especially within these high-profile initiatives, are key to sustaining interest and resources, and SMGL was described as a catalyst that has helped to encourage focus and coordination among the donor partners (see section 7).

However, the short timeframe for PPPs was also described as a barrier to sustainability and scalability. In terms of the planning process, the short start-up times for all three initiatives

²² Interview with Permanent Secretary Mwaba, Lusaka, April 20, 2016.

²³ Ibid.

²⁴ Interview in Lusaka, April 22, 2016.

²⁵ Interview in Livingstone, April 17, 2016.

²⁶ Interview in Lusaka, April 22, 2016.

²⁷ Kruk and Galea, “External Evaluation of Saving Mothers Giving Life: Final Report.”

²⁸ If the results of DREAMS are positive, the expectation is that the DREAMS programming would be incorporated into the PEPFAR Country Operational Plan (COP).

meant that the programs came together quickly and did not involve all of the partners at the concept stage, with many joining after the fact. This can pose challenges for coordination, making best use of the respective partners' resources and skills, and planning for the long term.

Another challenge associated with the tight timeframes is the need for rapid disbursement of funds. The short time horizon for SMGL, and now for DREAMS, has meant that the U.S. government has had to channel money through existing implementing partners. We heard concerns that especially for initiatives meant to address neglected issues or harder-to-reach populations, existing PEPFAR implementing partners may not always be the best equipped or positioned for these particular tasks.²⁹

Short timeframes also make it difficult to build local and institutional capacity (including technical, administrative, funding, and accountability measures) that will function after donors and partners have left. Some of the biggest outstanding challenges under SMGL and PRRR, voiced by both the government of Zambia and its partners, are around insufficient infrastructure and human resources for health, particularly in rural areas. As these are areas that typically attract less donor funding, this poses a huge challenge for sustainability unless the PPP is part of a broader government plan that addresses these gaps. One partner estimated that the country needs twice as many health staff to meet the current demand for services. Another mentioned that "the whole system is propped up on volunteers,"³⁰ a significant issue given the important role played by community health workers in general and by the Safe Motherhood Action Groups (SMAGs) in SMGL.³¹ It was widely asserted that using donor funds to pay public health officers or build hospitals does not make for sustainable development, and that without expanded personnel and infrastructure, it is difficult to scale these partnerships beyond a few districts or provinces. The permanent secretary of health further noted that if you look at partner support, "Americans will rehab a building but not build a new one,"³² underscoring the importance of coordination with the government and other donors.

Finally, there are challenges around replicating these PPPs, as partners—including the U.S. government—have different motivations behind their participation. SMGL provides a somewhat cautionary tale, where the partners involved in Zambia did not agree to expand to neighboring countries—notably Malawi—as was initially expected. This highlights the diverse motivations of the different partners for working in particular countries, and the dangers of relying so heavily on the U.S. government; sources in the U.S. government report that the U.S. Embassy in Malawi opposed launching SMGL there, due to insufficient staffing for

²⁹ In February 2016, the DREAMS Innovation Challenge was announced as an \$85 million program to stimulate new thinking around critical challenges, develop high-impact approaches, and engage new partners. For more information, see PEPFAR et al., "DREAMS Innovation Challenge," <http://www.pepfar.gov/documents/organization/247602.pdf>.

³⁰ Interview with Mike Welsh, FHI360 country director, Lusaka, April 19, 2016.

³¹ SMAGs are community-based volunteer groups that work to link communities and health facilities. Their aim is to reduce delays at the household level about seeking maternal care at health facilities. SMAG members provide information on safe motherhood to their communities; encourage pregnant women to go for antenatal care, delivery, and postnatal care in a health facility; identify maternal and newborn complications during pregnancy, delivery, and the postnatal period; and refer cases with maternal and newborn problems to the health facilities.

³² Interview in Lusaka, April 20, 2016.

oversight. Since SMGL is so reliant on U.S. funding and PEPFAR platforms, SMGL did not move forward in Malawi. By contrast, PRRR has now expanded to four other countries in sub-Saharan Africa, each reflecting a different constellation of partners;³³ for PRRR, the partners have engaged in countries where they have a specific interest, and the programs are not always as reliant on the U.S. government.

4. Adolescent girls and young women represent a key population in Zambia's HIV/AIDS epidemic.

In Zambia, more than 1 in 10 young women will become infected with HIV by the age of 24.³⁴ The country faces high rates of teenage pregnancy (nearly 30 percent of girls will become pregnant by 19) and gender-based violence (over 40 percent of 20- to 24-year-olds have experienced physical violence since age 15), and low rates of secondary school enrollment for adolescent girls (41 percent).³⁵ The evidence makes clear that HIV and sexual/reproductive health services for adolescents are failing to meet their needs, and family planning remains very low among unmarried women ages 15–19, despite the high rate of unplanned pregnancies.³⁶ We heard that in many ways adolescent girls and young women represent a neglected population, and have “fallen through the cracks” in terms of the national HIV response.

Zambia is 1 of 10 countries that is implementing DREAMS,³⁷ and will target roughly 170,000 girls in three districts (Lusaka, Ndola, and Chingola), focusing on 21 “DREAMS zones” with high rates of HIV prevalence. Of this population, the partnership will seek to reach 64,000 identified vulnerable girls with a comprehensive, integrated package of services.³⁸ In recognizing that the structural drivers of the HIV epidemic must be addressed for adolescent girls and young women to protect themselves and negotiate sexual encounters, this initiative goes beyond the biomedical realm to include social protection, parent caregiver programs, school block grants, comprehensive sexuality education support, education, and links to health services through the safe spaces model.³⁹ Effectively carrying out this initiative also requires a unique coalition of diverse partners that differs from how PEPFAR has worked in the past.

³³ PRRR is now operating in Botswana, Ethiopia, Namibia, and Tanzania, as well as Zambia.

³⁴ Central Statistical Office (Zambia), Ministry of Health (Zambia), and ICF International. “Zambia Demographic and Health Survey 2013–14,” March 2015, <https://www.dhsprogram.com/pubs/pdf/FR304/FR304.pdf>.

³⁵ PEPFAR, “DREAMS Overview: Zambia,” <http://www.pepfar.gov/documents/organization/253962.pdf>.

³⁶ Republic of Zambia and National AIDS Council, “Zambia Country Report, Monitoring the Declaration of Commitment on HIV and AIDS and the Universal Access,” March 2014, http://www.unaids.org/sites/default/files/country/documents/ZMB_narrative_report_2014.pdf.

³⁷ See Janet Fleischman and Katherine Peck, *Addressing HIV Risk in Adolescent Girls and Young Women* (Washington, DC: CSIS, 2015), http://csis.org/files/publication/150410_Fleischman_HIVAdolescentGirls_Web.pdf

³⁸ PEPFAR, USAID, CDC, and Peace Corps, “DREAMS: Preventing HIV in Adolescent Girls and Young Women (AGYW),” presentation for CSIS DREAMS Meeting, Lusaka, April 20, 2016.

³⁹ Interventions include condom promotion and provision, HIV testing and counseling, post-violence care, social asset building, community mobilization and norms change, school-based HIV and violence prevention, parenting/caregiver programs, cash transfers, educational subsidies, and combination socioeconomic approaches.

The DREAMS partnership in Zambia is supported by PEPFAR, the Bill & Melinda Gates Foundation, and Johnson & Johnson,⁴⁰ and plans to try to engage other private partners, especially from the local private sector. Zambia's National AIDS Council is helping to coordinate DREAMS, and other government ministries, UN agencies, and PEPFAR implementing partners are involved. DREAMS will undoubtedly face challenges in coordination and referrals, identifying and addressing gaps, strengthening multisectoral systems, and measuring impact. When asked why PEPFAR has launched this ambitiously multisectoral program, a PEPFAR official responded that it is because "we are still looking for an answer . . . how is it that we reach these young women?"⁴¹

There are many barriers in reaching adolescent girls and young women, including the complexities of addressing gender-based violence and changing community norms around harmful practices such as early marriage; provider bias/attitudes, especially around contraceptives; and behavior change among young women and their male partners. DREAMS in Zambia will provide family planning methods beyond condoms to young women ages 20–24, but there is clearly a need to expand access to modern contraceptives for adolescent girls. Similarly, DREAMS will have to expand programs designed to keep girls in school, and to highlight the intersection between education and health outcomes. Another issue is how to effectively engage male partners. In addition to the \$16 million budget for DREAMS Zambia, PEPFAR is providing supplemental funding—roughly \$20.7 million for test and start programs targeting men and about \$3 million for voluntary medical male circumcision. This additional \$23.7 million targets the male partners in DREAMS areas, and is higher than the amount that will be spent on girl-focused activities.

One particular challenge for the Zambian government will involve the introduction of pre-exposure prophylaxis (PrEP).⁴² Zambia has not yet approved PrEP for adolescent girls and young women, although the DREAMS program supports PrEP in other countries.⁴³ As the technology develops and an injectable, long-acting version becomes available, this is likely to present the government and the country with stark ethical questions—will they oppose providing a proven method to prevent infection in girls and young women at high risk, due to societal concerns about sex and promiscuity?

5. Zambia's burden of cervical cancer requires focused attention.

According to PRRR, Zambia has the second-highest prevalence and highest mortality from cervical cancer in the world.⁴⁴ In part due to high rates of HIV among women of reproductive

⁴⁰ In Zambia, the U.S. government will lead implementation through its implementing partners, the Bill & Melinda Gates Foundation will oversee the monitoring and evaluation and implementation science component, and Johnson & Johnson is creating a communication strategy to support targeting AGYW based on identified typology.

⁴¹ Interview in Lusaka, April 22, 2016.

⁴² PrEP is an HIV prevention strategy that uses antiretroviral drugs taken in a daily pill for people who do not have HIV but who are at high risk of infection. When taken consistently, PrEP has been shown to reduce the risk of HIV infection in people who are at high risk by up to 92 percent. See CDC, "Pre-Exposure Prophylaxis (PrEP)," July 5, 2016, <http://www.cdc.gov/hiv/risk/prep/>.

⁴³ DREAMS is the first time that PEPFAR is directly funding PrEP, because it holds significant promise as an HIV prevention tool that women and girls can control themselves.

⁴⁴ PRRR, "Zambia," <http://pinkribbonredribbon.org/where-we-work/zambia/>.

age,⁴⁵ it is the most common cancer among Zambian women. PRRR has been successful in expanding access to cervical cancer screening and treatment, and supporting a Gavi demonstration project for the HPV vaccine.⁴⁶ Working with the Zambian Ministry of Health, PRRR has also contributed importantly to Zambia's efforts to develop a national cervical cancer strategy, create a national cancer registry, better track and link women to care, and help pilot mobile screening facilities.⁴⁷

However, significant challenges remain for PRRR. These include limited technologies for screening, how to most effectively reach women at highest risk, and limited capacity to treat women with more advanced cancer due to lack of pathology laboratories and only one doctor in Zambia (an American) trained in gynecological oncology. At our site visits we heard that overall, screening rates for cervical cancer are low, especially compared to the observed burden, and that the percentage of women who tested positive was also low.⁴⁸ PRRR programs are carried out at government facilities through government healthcare providers, built on the PEPFAR platform, with the support of PRRR's implementing partners. PRRR is currently engaged in active discussions with the Zambian government on how to transition PRRR financial support and operations to the Zambian government by 2019.

6. Integration of services is essential but requires a shift in U.S. mechanisms/approaches.

These PPPs have reinforced the view that integration of services is essential to more effectively and efficiently meet the health needs of women and children. A subject of global debate for decades, Zambian health officials are keenly aware of the need to provide more integrated and comprehensive services, but are constrained by donor-funded vertical projects, as well as their own budgetary and human resource limitations. We heard this at every level of the Zambian health system: a good partner enables integration of programs. Yet, according to one provincial health official, "the central government talks integration, but funders pick vertical areas."⁴⁹

Integration across health programs as well as across sectors—including nutrition and education—requires flexibility in funding, which is particularly difficult in the context of U.S. foreign assistance. In Zambia, as in many other developing countries that have received significant PEPFAR or PMI assistance, there is an inherent tension between the ability to

⁴⁵ HIV-infected women who are also infected with specific types of human papilloma virus (HPV) are substantially more susceptible to cervical cancer than HIV-negative women.

⁴⁶ PRRR worked to expand the number of clinics providing cervical cancer screening from about 14 to over 40, with sites in each province. The program has also established referrals to 25 LEEP clinics (for removing abnormal cells from the cervix), and trained over 150 healthcare workers in screen and treat procedures. These services and health providers are all part of the government health system.

⁴⁷ PRRR has advocated that cervical cancer, technically a noncommunicable disease but one that is caused by an infectious disease (HPV), is worthy of significant additional attention since investing in prevention can reap huge rewards in terms of lives saved and costs averted with late-stage treatment. As a leading killer of women in their reproductive years, with a growing disease burden, there is a need to recognize the missed opportunities to integrate cervical cancer services across the spectrum of sexual and reproductive health services.

⁴⁸ It should be noted that Zambia is a leader in Africa for cervical cancer screening, although the provision of cervical cancer services is still hampered by lack of funding.

⁴⁹ Interview in Southern Province, April 18, 2016.

measure discrete, quantifiable targets associated with a single disease and more comprehensive, integrated approaches that are more difficult to disaggregate and measure. There is no doubt that single-focus initiatives such as PEPFAR, PMI, and Gavi have achieved great successes, but there are many missed opportunities to provide more “health for the money” with integrated services.

The barriers to advancing women’s and family health do not lend themselves to a vertical approach, but require strong, integrated, primary health systems. As SMGL has shown, reducing maternal mortality requires effective linkages between the health facility and the community; supply chains, labs, blood supply, and surveillance systems; skilled providers and appropriate staffing, training, and mentorship; and transportation and communication systems. Its success relied on harnessing the PEPFAR and MCH platforms. Similarly, PRRR highlights the need for cervical cancer screening and treatment to be integrated as part of a package of comprehensive care including reproductive health and HIV services. And DREAMS recognizes that preventing HIV in girls and young women requires a more integrated, holistic, and multisectoral strategy.

The experience of SMGL in particular has highlighted the importance of an integrated package of comprehensive care. While renewed energy and resources around SMGL led to a first round of successful outcomes, it has also helped to expose some important gaps in MNCH services. As the SMGL model expands to new districts, it will require working to systemize processes and expand its scope beyond the 48 hours around labor and delivery. For example, expanding programs to deal with maternal nutrition, including anemia (which causes 20 percent of maternal deaths), as well as voluntary family planning (which if used effectively could prevent an estimated 30 percent of maternal deaths in Zambia), and neonatal health (which did not receive as much focus in the first stage of the SMGL partnership). SMGL will also have to tackle the outstanding challenges surrounding transportation, which in rural areas remains the predominant obstacle to accessing emergency services.

USAID health official in Zambia acknowledge that the success of SMGL highlights the need to roll out an integrated package of reproductive, maternal, and child health services across the country, including family planning, nutrition, and neonatal health. Similarly, PRRR has evolved from its initial focus on integration of cervical cancer screening/treatment and HIV to a broader vision to integrate with women’s health services. The limitations in reaching the targeted number of women with screening and treatment through fixed clinics has pushed the program to provide more outreach and mobile services in urban and rural areas.

Most of U.S. funding for health in Zambia is through presidential initiatives.⁵⁰ The challenge for the U.S. interagency team in Zambia is how to leverage and integrate these resources for maximum benefit. This will include finding ways to take full advantage of Power Africa⁵¹ and

⁵⁰ In addition to the \$326 million for PEPFAR in 2015, PMI was \$24 million in 2015.

⁵¹ President Obama launched Power Africa to bring together experts, the private sector, and governments to increase the number of people in Africa with access to power. See USAID, “Power Africa,” <https://www.usaid.gov/powerafrica>. Feed the Future is the U.S. government’s hunger and food security initiative, focused on 19 countries including Zambia. See “Feed the Future—Country Partners,” <https://feedthefuture.gov/about#Country%20Partners>.

Feed the Future investments,⁵² integrate nutrition into MCH programs and coordinate with food security and agriculture programs, and intentionally incorporate maternal and child health, cervical cancer screening, and family planning into PEPFAR. As Permanent Secretary for Health Dr. Peter Mwaba explained, “Very few things don’t require an intersectoral way. Health should see linkages; it cannot stand alone.”⁵³

Integration requires a change in U.S. government mechanisms and tools, and ultimately a shift in mindsets away from siloed approaches toward more comprehensive funding mechanisms. This means focusing on and measuring outcomes not just inputs, and building in the flexibility to holistically address some of the drivers of maternal mortality, such as nutrition, women’s economic empowerment, and education.

7. Sustaining health programs in the midst of economic crisis will require more than PPPs.

The impact of Zambia’s gloomy macroeconomic forecast on domestic resource mobilization for health casts a shadow over the short-term outlook for health financing.⁵⁴ Given that the growing inequities between rich and poor, rural and urban in Zambia are likely to become more acute as the economy worsens, these issues will further challenge the health sector.⁵⁵

Permanent Secretary Mwaba explained that a major priority in the next five years for the Ministry of Health is to create a social health insurance scheme as the preeminent solution for Zambia’s long-term health financing challenges.⁵⁶ While at present fewer than 30 percent of Zambians have some form of health insurance, there are plans to create a system that will allow people to pay comparable to their income. In addition, a growing middle class means

⁵² While Feed the Future does not have a health component it has a strong nutrition component. This means that particularly in rural areas, coordinating and leveraging resources across global health investments and Feed the Future can help improve nutrition and health outcomes.

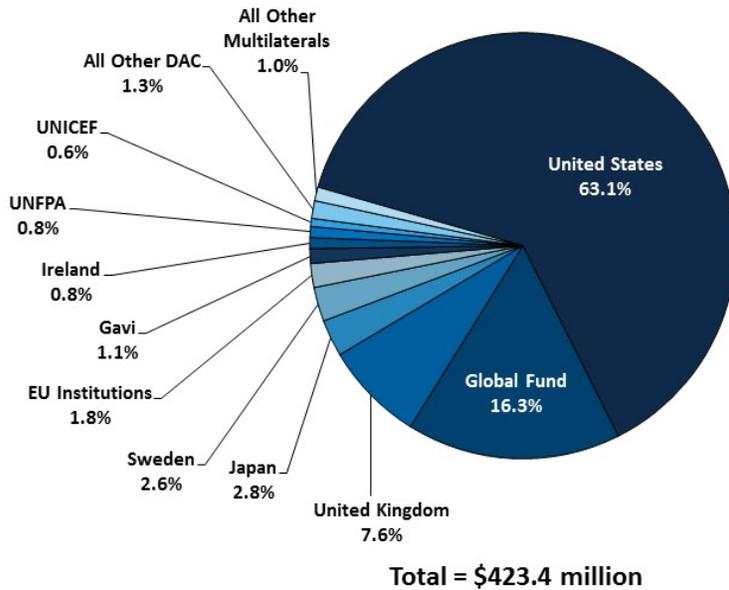
⁵³ Interview with Permanent Secretary Peter Mwaba, Lusaka, April 20, 2016.

⁵⁴ In the last year, declining demand for copper caused the value of the kwacha to drop by roughly 50 percent, and the volatility of the exchange rate has reportedly made it challenging to service the external debt. The government has financed large off-budget subsidies for electricity and staple foods, and in the last year had to realign health spending in order to meet payroll and purchase essential commodities. As a result, funds have been shifted away from some operational activities, hiring and filling vacancies has been frozen, and budgeted resources have not reached facilities at lower levels of the health system, particularly in rural areas.

⁵⁵ While Zambia experienced record economic growth over the last decade and is now classified as a lower-middle-income country, stakeholders voiced real concerns about prospects for growth over the long term and rising income inequalities. While the government has taken on greater responsibility for health care financing, the enthusiasm for domestic resource mobilization expressed last July at the UN-sponsored Financing for Development Conference in Ethiopia may be misplaced, given recent performance in emerging markets, especially those relying on a single export (copper comprises 70 percent of Zambia’s export revenue) and are susceptible to shocks in the global economy. Development policy needs to continue to demand domestic resource mobilization but also be realistic about where and how much governments will be able to contribute.

⁵⁶ Interview with Permanent Secretary Mwaba, Lusaka, April 20, 2016.

Figure 3. Top 10 Donors for Health ODA in Zambia, 2014



NOTES: Amounts in gross US\$ disbursements. Health ODA combines data from three OECD CRS sub-sectors: (1) Health; (2) Population Policies/Programs and Reproductive Health (includes HIV/AIDS & STDs); and (3) Other Social Infrastructure and Services—Social Mitigation of HIV/AIDS.

SOURCE: Kaiser Family Foundation analysis of data obtained via online query of the OECD Development Assistance Committee (DAC) Database and Creditor Reporting System (CRS), February 22, 2016.



that there is potential for market segmentation and demand for private services, which could help to diversify models of care.

Private health care delivery in Zambia is minimal, although there is a strong network of faith-based organizations delivering health services in Zambia. Given the small footprint of the private sector, and of private-sector partners in health, it was widely recognized that PPPs are not the solution to financial sustainability for health programs in Zambia, and there is a need for sustained investments in public health. However, there are important questions around how donor partners can help to incentivize greater private-sector engagement in Zambia and support the growth of private-sector health care, and how international private-sector partners can collaborate with local private-sector partners to build interest in health investments.

In Zambia, bilateral donors are working to replicate and scale up the SMGL model, although without expanding the PPP itself. Based on the successful proof of concept demonstrated in SMGL’s first phase, other donors, including Swedish SIDA, the World Bank, and the EU, are now working to scale up a package of reproductive, maternal, and child health interventions in additional districts across Zambia. The goal is to expand the SMGL model by adding reproductive health/family planning and nutrition, an important gap in SMGL’s initial design.

The current donor approach to delivering health aid is meeting some important needs but is also failing to address a number of critical elements, such as staffing, infrastructure, and systems strengthening. In fact, most external support to Zambia is off-budget. While this support is often delivered in close partnership with the Ministry of Health, the donor sets the priorities, and programs are implemented through a mix of nongovernmental organizations and the payment of special incentives to government personnel. This creates parallel programs and systems that can be difficult to sustain once external funds end.

Direct financing, with rigorous policy agreements that ensure external funds are additive to ongoing efforts and not displacing domestic resources, could expand the resource base available to address critical infrastructure, staffing, technology, and management shortcomings. However, more direct financing of national programs is constrained by the lack of transparency and the Zambian government's poor track record in managing funds effectively and preventing mismanagement and corruption. Poor public-sector management has led a number of Zambia's international donors to withdraw support,⁵⁷ making Zambia even more dependent on the United States.⁵⁸

The different approaches to U.S. government funding in Zambia highlight the challenges of working directly with government as opposed to through partners, both of which have implications for sustainability. For example, CDC is providing some \$50 million per year in direct support to provinces and districts, as well as the central government, to address specific resource gaps, build human capacity, and support systems strengthening. In contrast, USAID typically avoids financing recurrent costs both because of statutory limitations and because it does not want U.S. assistance to substitute for domestic resources or create dependency. In many countries, these differences result in U.S. interagency competition, which has been much less evident in Zambia, due to past and present leadership at the Embassy and within the U.S. country team. Nevertheless, there is a clear need for a more coherent U.S. position on operating models for managing foreign assistance that address issues of sustainability, dependency, and ownership.

Swedish SIDA, one of Zambia's remaining bilateral health partners, has recently revived the use of direct budget support for health programs.⁵⁹ It plans to provide \$50 million over five years to expand the continuum of reproductive, maternal, and child health and nutrition services covered by Saving Mothers Giving Life, including a greater focus on sexual and reproductive health and adolescent health in districts not covered by SMGL. SIDA's model of

⁵⁷ For various reasons, including financial concerns, the Netherlands, Denmark, Norway, and Canada have left Zambia; the United Kingdom's Department for International Development (DFID) and Swedish International Development Cooperation Agency (SIDA) have scaled down their health programs.

⁵⁸ CDC and USAID use different approaches to implement the programs they support. As an agency in the Department of Health and Human Services, CDC is not directly governed by the Foreign Assistance Act, as is USAID. Also, the two agencies have different perspectives on how to address development challenges, with USAID typically advocating a longer-term, systems-strengthening approach that prioritizes building capacity and sustainability, and CDC more often stressing a biomedical approach that prioritizes immediate medical needs. Because CDC is not subject to the same statutory program and financial compliance requirements as USAID, it has more latitude to disburse funds through government-to-government mechanisms such as hiring to fill gaps (which some see as topping up salaries) of Ministry of Health positions or supporting meeting, something the FAA prohibits USAID from doing.

⁵⁹ The Swedes supported an earlier SWAp that collapsed in 2009 due to financial irregularities.

MNCH/reproductive health funding will reward districts for meeting service performance metrics and holds the Ministry of Health accountable for channeling the funds to the districts. The program is intended to be performance based by conditioning 15 percent of annual funding on five major reproductive, maternal, and child health indicators, and another 15 percent on budget execution. The United States is interested in collaborating with SIDA, and SIDA is hopeful that other European donors (EU, DFID) may join in a SWAP, but this is not certain.⁶⁰

Conclusion

Zambia's recent experience offers important lessons for U.S. engagement on women's and family health, including how public-private partnerships can work to advance health outcomes. While SMGL, PRRR, and DREAMS have shown the potential to drive impact, the full promise of these initiatives has not yet been realized in Zambia, and the U.S. government and its partners should work to apply the lessons learned from how these partnerships have unfolded.

As the largest donor to health in Zambia, the United States should ensure that its investments work to support integrated provision of reproductive, maternal, and child health and nutrition services while strengthening the measurement systems needed to track progress and secure funding. The U.S. government is well placed to continue its catalytic role in women's and family health in Zambia, but should also continue to support the government of Zambia to build the capacity needed to sustain the gains achieved by PPPs. A high-level U.S. Embassy official in Zambia explained the need for a longer-term perspective: "Zambia is a success story, but with fragile progress . . . we need to take the long term view—we've achieved enormous successes, but we're not over the hump yet."⁶¹

⁶⁰ The Swedes themselves noted that their assessment of the Zambian government's financial management found very weak internal controls in the Ministry of Finance, leading them to vest management responsibility for their direct budget support with the Ministry of Health. According to the Embassy of Sweden, the funds will not be disbursed through the Ministry of Finance, they will be on-budget. The Ministry of Finance stated that it did not support line ministries acting as the lead managers of direct budget support. While the objective of ensuring funding goes directly to the districts is laudable, the approach could cause confusion if it undermines the Zambian government's financial management systems, which is the rationale for providing direct budget support in the first place.

⁶¹ Interview in Lusaka, April 22, 2016.

Appendix: Trip Agenda

Sunday, April 17, 2016: Livingstone

Working dinner: overview of U.S. investments in women's and family health in Zambia, with a focus on SMGL, PRRR, and DREAMS. Participants: Tamu Daniels, Acting PEPFAR Coordinator; Melanie Luick-Martins, Health Office Director, USAID; Jim McAuley, CDC Country Director; Masuka Musumali, Family Planning, Maternal Neonatal and Child Health Advisor, USAID; Heidi O'Bra, Social Protection Division Chief, USAID; Heather Robinson, Peace Corps Director; Fatma Soud, Epidemiologist, CDC; Patricia Ulaya, Department of Defense PEPFAR Program Assistant.

Monday, April 18, 2016: Livingstone

Courtesy call: District Commissioner's Office in Livingstone.

Site visit: Maramba clinic.

Site visit: Mosi-oa-Tunya clinic.

Working lunch: discussion with Peace Corps volunteers about SMGL activities and opportunities in Southern Province.

Site visit: Livingstone General Hospital, presentation by Livingstone Provincial Ministry of Health.

Meeting: discussion with SMGL partners. Participants: Jhpiego and Systems for Better Health.

Working dinner: discussion with District and Provincial Medical Officers about involvement in SMGL.

Tuesday, April 19, 2016: Kalomo and Zimba Districts in Southern Province and Lusaka

Site visit: Namwianga Rural Health Center.

Site visit: Kalomo District Hospital.

Site visit: Zimba Mission Hospital.

Working dinner: discussion of role of PPPs in advancing health of women and children. Participants: Allison Spensley, Consultant, Senior Advisor for Africa and Global Health, Bill & Melinda Gates Foundation; Mike Welsh, FHI360 Country Director.

Wednesday, April 20, 2016: Lusaka

Meeting: overview of DREAMS partnership from U.S. government staff and Zambian National AIDS Council. Participants: CDC; PEPFAR; USAID; Dr. Jabbin Mulwanda, Director General, National AIDS Council.

Meeting: opportunities and challenges in women's and family health in Zambia. Participants: Dr. Peter Mwaba, Permanent Secretary for Health, Ministry of Health.

Meeting: advancing maternal and child health in Zambia. Participants: Dr. Caroline Phiri, Director of Maternal and Child Health, Zambia Ministry of Health.

Working Lunch: implementing the DREAMS partnership. Participants: Catholic Medical Missions Board, Marie Stopes Zambia, Pact, Population Council, World Vision, Zambian Community HIV Prevention Project.

Site visit: N'gombe DREAMS Zone.

Working dinner: overview of UN engagement on women's and family health. Participants: UNDP, UNICEF, UNFPA.

Thursday, April 21, 2016: Lusaka

Working Breakfast: discussion of PRRR program. Participants: Dr. Elizabeth Chizema, MOH Director of Disease Surveillance, Control, and Research; Dr. Kennedy Lishimpi, Director of Clinical Care and Diagnostic Services, Ministry of Health Zambia; Dr. Susan Citonje Msadabwe, Director of Cancer Diseases Hospital Lusaka; Jo Musonda, Country Director for Project Concern International.

Meeting: discussion of nutrition challenges in Zambia. Participants: Civil Society for Poverty Reduction, Concern World Wide, Harvest Plus, Heifer International, National Food and Nutrition Commission, Nutrition Association of Zambia, Scaling Up Nutrition Zambia, Population Council.

Meeting: domestic and international resource mobilization for women's and family health. Participants: Pamela Kabamba, Permanent Secretary of Budget and Economic Affairs, Ministry of Finance; Ministry of Finance staff.

Working lunch: perspectives from implementing partners in women's health in Zambia. Participants: Abt, BRITE, FHI360, Jhpiego, John Snow Inc., PATH.

Working dinner: opportunities for collaboration in women's and family health among international donors. Participants: EU, UNAIDS, DFID, CDC, Embassy of Sweden, the World Bank, CHAI, USAID.

Friday, April 22, 2016: Lusaka

Meeting: out brief discussion with U.S. government interagency staff. Participants: USAID, PEPFAR, CDC, DoD, Peace Corps.

Meeting: out brief discussion with DCM David Young. Participants: Melanie Luick-Martins, Health Office Director, USAID; Jim McAuley, CDC Director; Kristie Mikus, Deputy CDC Director; Heidi O’Bra, Social Protection Division Chief, USAID; Mike Yates, USAID Mission Director; David Young, DCM.

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