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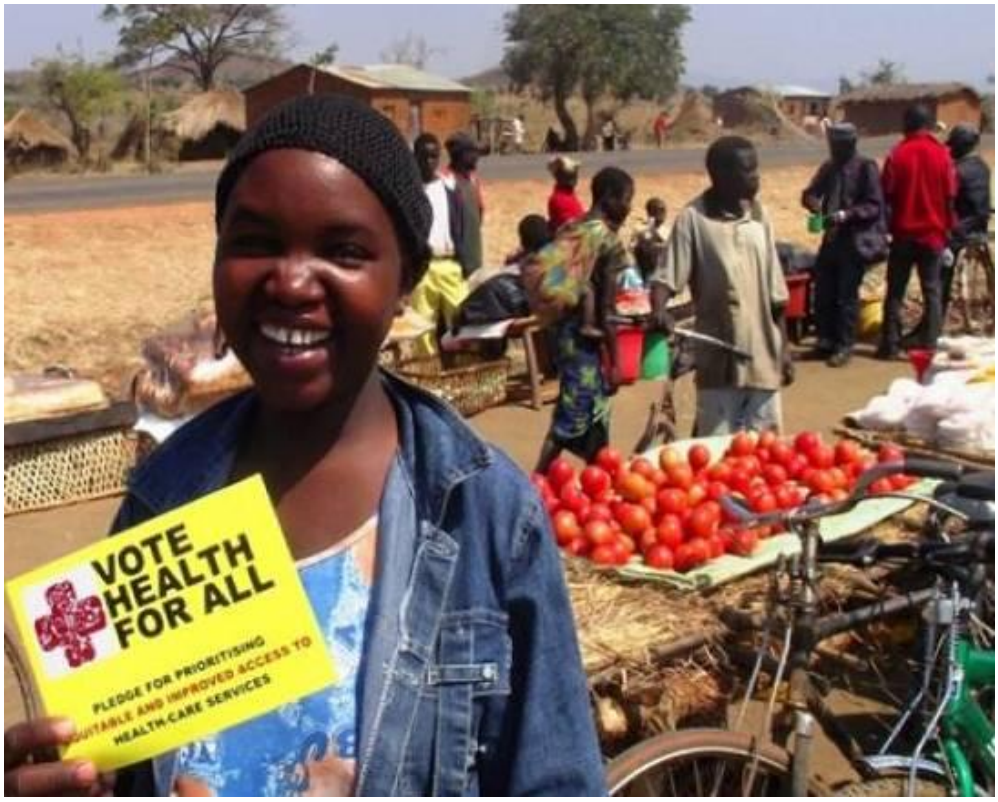
CITIZEN VOICE IN ZAMBIA

Evaluation of the 'Vote Health for All' campaign

Effectiveness Review Series 2013/14



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CHRISPIN CHOMBA
OXFAM GB

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ABBREVIATIONS

CSHF	Civil Society Health Forum
CSO	Central Statistical Office
CSOs	Civil Society Organisations
FP	Family Planning
GPF	Global Performance Framework
HIV	Human Immunodeficiency Virus
MMD	Movement for Multi Party Democracy
MP	Member of Parliament
NHSP	National Health Strategic Plan
NAREP	National Restoration Party
OGB	Oxfam Great Britain
PAC	Post Abortion Care
PF	Patriotic Front
PMTCT	Prevention of Mother to Child Transmission of HIV
RH	Reproductive Health
SNDP	Sixth National Development Plan
SRHR	Sexual Reproductive Health and Rights
TALC	Treatment Advocacy Literacy Campaign
UNDP	United Party for National Development
ZED	Zambians for Empowerment and Development
ZDHS	Zambia Demographic and Health Survey

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1 EXECUTIVE SUMMARY

The parliamentary and presidential elections in Zambia in September 2011 were identified as a key moment to press for change in access to health care in the country. Notably, and learning from other election-related campaigns in Malawi, Nigeria and Liberia, Oxfam and its partners used the opportunity to mount the campaign 'Vote Health for All' to improve access to health care for all Zambians. Among many health issues that the campaign focused on was increased commitment to health budgetary allocation in line with the 15% Abuja Declaration and increased access to health services through abolition of user fees in urban areas.

Oxfam worked with partners to deliver its 'Vote Health for All' campaign, and implemented campaign activities at constituency and national level. The campaign mobilised thousands of community members to engage with the democratic process and express their views on health provision in the country. At constituency level, partners organised a series of 'town hall' styled meet-your-leaders meetings – bringing constituents together with parliamentary candidates to discuss their concerns on health. During these meetings, candidates from various political parties were invited to make a public pledge to extend and improve health care if elected. Over 50 aspiring MPs, councillors and chiefs signed the pledge, many of whom were elected and five became ministers in the new government.

As per Oxfam Great Britain's (OGB) Global Performance Framework (GPF), samples of mature projects are randomly selected each year and their effectiveness rigorously assessed. The 'Vote Health for All' project was thus selected to be assessed for its effectiveness in its contribution towards:

- **Outcome 1:** Increased budgetary allocation to health to at least 15% of the country's national budget in line with the Abuja Declaration
- **Outcome 2:** Abolition of user fees in all public urban health facilities.

Specifically, the Evaluator engaged a form of system mapping. This method involved identifying various key players, activities, outputs and outcomes in the campaign that were expected to change or effect change, and then identifying ways of measuring or capturing whether and how those changes have occurred.

The Evaluator began the data collection process after an induction meeting with Oxfam to familiarise himself with the campaign and the logic model, and then moved into reconstructing of a theory of change for the campaign, which was then shared with Oxfam. Outcomes that the campaign influenced were agreed upon and interviews with key stakeholders, including ministers, members of parliament, CSO representatives and technocrats were conducted. This was coupled with a rigorous review of documents, which included national budgets, presidential speeches, government directives, budget speeches, budget analysis documents, national strategic frameworks, and global and national documents among others. Data analysis used trend analysis, causal-linking processes, and comparative analysis followed by outcome rating and grade distribution using the Likert scale and conclusions.

Since the year 2011, there has been a significant increase in national budgetary allocation to health in line with the Abuja Declaration. Although the Government has not yet reached the 15% Abuja target; it is highly likely to achieve this by 2016. This can be deduced from increased budgetary allocation to health vis-à-vis the political commitment from current leadership; some of them who were part of the 'Vote Health for All' campaign. The most probable explanations for increased commitment to increased budget allocation to health are, in order of effect, availability of funds from global and regional sources, the well articulated PF manifesto with a particular clause on increasing funding to health in line with the Abuja commitment and the commitment of ruling party leaders and the 'Vote

Health for All' campaign. This is evident from available documentation and through interviews with key stakeholders. Ruling out all other explanations for movement towards the realisation of increased national budgetary allocation to health, the 'Vote Health for All' campaign contribution towards this outcome is about 16%.

One of the target outcomes of the 'Vote Health for All' campaign was abolition of medical user fees in Zambia. User fees have since been abolished in all public health facilities, irrespective of whether they are in urban or rural districts. This was achieved just some months after the 2011 general elections. The main influencing factor on the abolition of user fees is the increased funding allocation to the health budget followed by the PF manifesto, which was targeted at improving access to quality health services. Commitment to increased funding to health was partly influenced by the 'Vote Health for All' campaign and there is evidence that the campaign itself had a direct influence on the abolition of user fees. The percentage contribution of the 'Vote Health for All' campaign is about 20%; which is significant given the other factors that influenced the outcome.

It is thus concluded that the campaign was effective in influencing the targeted outcomes. Some of the success factors of the campaign were as follows:

- Targeting of influential leaders some of whom became Ministers after the 2011 elections
- Crucial timing as the campaign came at critical time when political leaders needed votes and thus they needed to be identified with the people,
- Strategic targeting of a coalition of CSOs, community and political leaders who could make change happen.

In moving forward a campaign of this nature it would be more effective if follow up mechanisms of the outcomes were strengthened. Such a campaign should also include accountability of constituency and area members of parliament with strong feedback mechanisms to community members and political leaders, ensuring sustainability with a clear exit strategy. Strengthening of partner coordination for future campaigns should factor in rival intervention partner mapping at the inception of the campaign.

Summary of findings:

Outcome	Rating	Short commentary
Increased budgetary allocation to health to at least 15% of the country's national budget in line with the Abuja Declaration.	**3.5**	Although the Government has not yet reached the 15% Abuja Declaration target, It is highly likely to achieve this target by 2016. This can be deduced from increased budgetary allocation to health due to the political commitment from the current leadership. This commitment is also referenced in various Government documents. The main contribution to this outcome was the availability of funds in national budget, coupled with Maputo Plan of Action and Millennium Development Goal commitments, and Patriotic Front's commitments as detailed in its manifesto, but there is evidence that intervention made an important contribution.
Abolition of user fees in all public urban health facilities.	**4**	The main influencing factor to achieving the outcome is an increased allocation to the health budget, followed by the PF manifesto, which was targeted at improving access to quality services. Commitment to increased funding to health was partly influenced by the 'Vote Health for All' campaign, although there is evidence that the campaign itself had a direct influence on abolition of user fees.

Scoring key: Specific contribution of intervention

5	Outcome realised in full Evidence that intervention made a crucial contribution
4	Outcome realised in part & evidence that intervention made a crucial contribution Outcome realised in full & evidence that intervention made an important contribution
3	Outcome realised in part & evidence that intervention made an important contribution
2	Outcome realised in part & evidence that intervention made some contribution Outcome realised to a small degree & evidence that intervention made an important contribution
1	Outcome realised, to any degree, but no evidence that the intervention made any contribution

2 INTRODUCTION

Like many African countries Zambia faces significant health challenges, most of which are related to poor budgetary allocation to health – very few sub-Saharan African countries have reached the Abuja Declaration of 15% GDP allocation to health. The health care system is severely underfunded and poorly organised. This has resulted in a critical shortage of personnel while those available are overworked; in some cases the doctor:population ratio is 1:17,589. Because of this situation the health sector is characterised by a sever brain drain. According to the 2011–2015 National Health Strategic Plan, the country is also faced with a high burden of Maternal, Neonatal and Child Health (MNCH) problems, and a growing problem of Non-Communicable Diseases (NCDs), including mental health, cancers, sickle cell anaemia, diabetes mellitus, hypertension and heart disease, chronic respiratory disease, blindness and eye refractive defects, and oral health problems. The country is also faced with the high burden of the HIV and AIDS epidemic, which has had significant impact on morbidity and mortality levels across the country, with one in every 10 children dying before the age of 5 and 14.3% of the adult population living with HIV and AIDS (ZDHS 2009). While health provision had been made free in rural areas of the country, clinics and hospitals in urban areas were still charging user fees, preventing many of the poorest people from accessing health care. There is a chronic shortage of health workers, and being out of stock of essential medicines and drugs is commonplace in many clinics across the country.

Coupled with low funding to health, is the existence of user fees, introduced in the 1990s. This move was widely promoted by the World Bank and IMF as a condition for the country to settle debts and borrow more money. In addition the Government of Zambia introduced a medical levy in 2003, which entailed additional fees for patients. Unfortunately, as the World Health Organization (WHO) notes, although user fees contribute only minimally to health budgets (less than 5%), they result in a sharp decrease in access to health services for the majority of poor people.[1] Oxfam (2006) noted that young women and girls in rural areas were particular victims of user fees as their families were unwilling to pay for their treatment. Realising these challenges, in 2006 the Ministry of Health in Zambia, through its commitment to improving the quality of life for all Zambians, decentralised the health system as a means of addressing the health problems of individuals and communities through Primary Health Care (PHC) and abolished user fees in rural health centres. Medical levies however continued and the charging of user fees in urban set-ups still continued, thus affecting access to health services.

Theparliamentary and presidential elections in Zambia in September 2011 were identified as a key moment to press for change in access to healthcare in the country. Notably, and learning from other election-related campaigns in Malawi, Nigeria and Liberia, Oxfam and its partners used the opportunity to mount a campaign dubbed ‘Vote Health for All’ to improve access to health care for all Zambians. Among many health issues that the campaign focused on was advocacy towards increased commitment to health budgetary allocation in line with 15% Abuja Declaration and increased access to health services through the abolition of user fees in urban areas.

Oxfam worked with partners to deliver its ‘Vote Health for All’ campaign, and implemented campaign activities at constituency and national level. The campaign mobilised thousands of community members to engage with the democratic process and express their views on health provision in the country. At constituency level, partners organised a series of ‘town hall’ styled meet-your-leaders meetings – bringing constituents together with parliamentary candidates to discuss their concerns on health. During these meetings, candidates were invited to make a public pledge to extend and improve health care if elected. Over 50 aspiring MPs, councillors and chiefs signed the pledge, many of whom were elected and five became ministers in the new government. To spice up the campaign local artists and musicians helped spread the key messages and profile of the campaign across communities through song, drama and poetry. At national level, the campaign was launched at a

major concert in the capital city, Lusaka, featuring an award-winning musician, Maiko Zulu. The campaign's partners also published a policy report that attracted significant interest from journalists and policy makers, organised a press conference with the presidential candidates, and undertook further media work to expose the huge challenges to expanding health provision in Zambia, and the steps the new governments needed to take.

As per Oxfam Great Britain's (OGB) Global Performance Framework (GPF), samples of mature projects are being randomly selected each year and their effectiveness rigorously assessed. The 'Vote Health for All' project was selected in this way under the 'Policy Influencing' and 'Citizen Voice' thematic areas for equitable and improved access to health-care services in Zambia.

Through process tracking, the project effectiveness was assessed based on two specific campaign outcomes.

- **Outcome 1:** Increased budgetary allocation to health to at least 15% of country's national budget in line with the Abuja Declaration.
- **Outcome 2:** Abolition of user fees in all public urban health facilities.

Although the campaign had more than the above stated outcomes, given the limited time and resources for the exercise only the above were selected. The selection of the outcomes for the evaluation was agreed after consultation between the Evaluator, Oxfam and the implementing partners. Implementing partners were requested to identify at least two outcomes that the campaign could claim to have influenced. In identifying the stated outcomes, guidance was provided using the programme logic model in chapter 5. Partners were asked about what had changed, how the change had come about, who was involved in ensuring change and when the change occurred.

3 PROCESS DESIGN

3.1 PROCESS TRACING

As part of Oxfam GB Global Performance Framework, samples of closing or sufficiently mature projects under seven outcome areas are randomly selected each year and their effectiveness rigorously assessed. These are referred to as Effectiveness Reviews. The evaluation designs for Effectiveness Reviews carried out of interventions selected under the 'citizen voice' and 'policy influence' thematic areas are informed by Oxfam GB's process tracing protocol, a qualitative research approach used by case study researchers to investigate causal inference. Policy Influence and Citizen Voice interventions will be working to achieve specific intermediary and final outcomes.

The Evaluator employed a form of system mapping, identifying various key players, activities, outputs and outcomes in the campaign intended to change, and then identifying ways of measuring or capturing whether and how those changes occurred. The Evaluator's first task was to identify the scope of the intervention, including the outcomes, or changes it sought to achieve, and the activities undertaken intended to bring these about. The Evaluator then designed a data collection matrix to gather evidence of the extent to which the intervention's key targeted outcomes have materialised; investigate the causal mechanisms responsible, i.e. how the observed outcome change came about; and, in light of an evidenced understanding of competing explanations, draw conclusions about the significance of the intervention's contribution. As such, the purpose of the evaluation was to shortlist one or more evidenced explanations for the outcome in question; rule out alternative, competing explanations incompatible with the evidence; and estimate the level of influence each intervention had on bringing about the change in question.

The following eight steps form the core of the research exercise's protocol.

1. Undertake a process of (re)constructing the intervention's theory of change, in order to clearly define the intervention being evaluated – what is it trying to change (outcomes), how it is working to effect these changes (strategies/streams of activities) and what assumptions is it making about how it will contribute to these changes (key assumptions)?
2. Work with relevant stakeholders to identify two final outcomes considered by stakeholders to be the most significant for the evaluation to focus on (central to the intervention's theory of change, and useful for learning/forward planning).
3. Systematically assess and document what was done under the intervention to achieve the selected targeted outcomes.
4. Identify and evidence the extent to which the selected outcomes have actually materialised, as well as any relevant unintended outcomes.
5. Undertake 'process induction' to identify salient plausible causal explanations for the evidenced outcomes.
6. Gather required data and use 'process verification' to assess the extent to which each of the explanations identified in Step 5 are supported, or not supported, by the available evidence.
7. Write a narrative analytical report to document the above research processes and findings.
8. Summarise aspects of the above narrative analysis by allocating project/campaign 'contribution scores' for each of the targeted and/or associated outcomes. This is not expected to provide a precise measure of contribution, but rather a sense of how much the campaign was likely responsible for observed change(s).

3.2 DATA COLLECTION STRATEGY

Variables	Method	Tool	Sample	Location	Sampling	Sample size	Data Analysis
Conduct in-depth interviews with Oxfam campaign programme-implementing staff	Key informant interviews	In-depth Interview guides, checklists	Executive Directors and Programme Managers of implementing organisations	Lusaka and Kitwe	Purposive	13	Qualitative analysis by themes
Conduct in-depth interviews with non-Oxfam but similar activists during the campaign period	Key informant interviews	In-depth Interview guides, check lists	Executive Directors and Programme Managers of implementing organisations	Lusaka and Kitwe	Purposive	5	Qualitative analysis by themes
Conduct in-depth interviews with Ministers who were part of the campaign	Key informant interviews	In-depth Interview guides, checklists	Ministers, political leader representatives and MPs from ruling and opposition parties	Lusaka and Kafue, Chibombo, Kabwe, Mfulira	Purposive	10	Qualitative analysis by themes
Conduct in-depth interviews with Oxfam project staff members	Key informant interviews	In-depth Interview guides, checklists	M&E Coordinator, Campaign Manager (Moved to ZNBC) and Programmes Manager	Lusaka	Purposive	3	Qualitative analysis by themes
Conduct desk review of the existing national policies, budgets, yellow books, ministerial and presidential policy directives, parliamentary debates, reports, strategic plans	Review actual documents and online review	Checklist of documents and case studies reviewed	As many as appropriate	Lusaka	Purposive	As many as appropriate	Qualitative analysis by themes

3.3 DATA COLLECTION PROCEDURES

The consultant began the data collection process after an induction meeting with Oxfam to familiarise themselves with the campaign and the logic model, and then moved into reconstructing of a theory of change for the campaign, which was then shared with the client. The next step involved a consultative process of agreeing on outcomes that the evaluation should focus on, once this was agreed, the consultant and client agreed upon the list of potential respondents. Introductory letters were prepared by Oxfam and were delivered to the identified respondents to schedule for an appropriate date of interview. Interviews took forms of face-to-face, breakfast meetings and in some cases phone interviews. The burdens of participation (including time demands) were explained to participants. No one was penalised for non-participation. The consultant also collected data in a consistent manner. Review of relevant materials for evidence took varied forms, which included several visits to the national assembly building, and online reviews of evidence.

Peer debriefing: The evaluation offered opportunities for peer debriefing, both within Oxfam GB and Oxfam Zambia. These findings can also be used for the purpose of increasing another key measure of quality – trustworthiness of data.

Member checking: As data was collected and analysed, there was continuous checking with participants to ensure that their thoughts, opinions and experiences were captured accurately and that the interpretations that researchers make of data are correct.

3.4 LIMITATIONS

The following were some of the limitations of the evaluation.

- The targeted respondents were occupied with a number of high-level responsibilities both at national, constituency and organisational level, making scheduling appointments for the interviews difficult in some cases.
- There are a number of contributing factors to the intended outcomes, some of which cannot be assessed with regard to their influence on the outcomes.
- The campaign did not have systematic follow-up mechanisms for the causal outcomes in the post-election period thus making it time consuming and difficult to link the campaign one hundred percent to the outcomes.
- The outcomes did not have specific target end dates and thus achievement can be on-going.

4 EVALUATION DESIGN

Zambia is characterised by many health challenges, ranging from dire to severe, as most of the country's citizens are under-served by the health delivery systems. While this situation is more evidenced in rural areas it also negatively impacts many people in urban areas. During the period of the campaign the following were notable challenges.

Morbidity and mortality of under-fives

Forty-five percent of Zambian children suffer from chronic malnutrition (as measured by low height for age or stunting) and almost one in five are underweight. UNICEF estimates that malnutrition underlies some 52% of all under-five deaths in Zambia.[2] Beyond the inadequate access to food of adequate quantity and quality, these high chronic malnutrition levels are due to poor environmental, economic, and social conditions, particularly a lack of access to clean water, poor levels of hygiene, and poor knowledge pertaining to maternal health, especially during pregnancy.

Under-five mortality rates still remain an area of great concern. They currently stand at 119[3] deaths per 1,000 children, which implies critical issues in the quality of and access to health care. A study conducted by the Ministry of Health and University of Zambia notes two issues in particular. Firstly, a third of urban and rural health clinics experience delays in receiving drugs and evidence of drug diversion 'can be inferred' in a quarter of the facilities receiving drug kits. Essential drugs are widely unavailable and about half of hospitals and rural health clinics reported having expired drugs

Staffing, vacancy rates and infrastructure

The vacancy rate for health staff is as high as 33.5% and this scenario is accompanied by a heavy and rapid staff turnover, especially at rural health clinics, which has become absolutely untenable.[4] Only 47% of the births in these facilities are attended to by skilled personnel. The doctor to population ratio stands at 1:17,589[5] while the nurse/midwife to population ratio stands at 7:10,000.[6]

The public health sector in Zambia is estimated to operate at half the expected number of health workers, and many of the more remote rural health centres do not have any qualified personnel, relying only on Classified Daily Employees (CDEs) to provide health care to the population. Yet it is a known fact that improving the quality and availability of health care services will require increasing the quantity and quality of the health workforce, ensuring availability and efficient use of essential health commodities, upgrading equipment and health information management systems, and improving the construction, distribution, and maintenance of health infrastructure

The Abuja Declaration

Zambia is a signatory to the Abuja Declaration of 2005. Up until now it has failed to meet the commitment to spend a minimum 15% of its annual national budget on health expenditure. Besides this, Zambia's huge dependence on donors has been exposed as a major and worrisome sign. A large reliance on such funding implies a government that is unable to meet its own planning and implementation of health plans.

This point is especially distressing because investing in health systems in Zambia is an opportunity to drive economic development and growth forward, move Zambia closer to achieving the objectives of the national poverty reduction strategy, meet the Millenium Development Goal (MDG) targets, and ensure social and political stability by saving millions of lives and preventing lifelong disabilities.

HIV/AIDS pandemic

The prevalence of HIV/AIDS remains one of the critical health issues in the country. Although infection rates can generally be adjudged to have fallen, the issues of HIV/AIDS still remain a very large and active health flash-point. As at September 2010 some 300,000 people, 23,000 of whom are children, were on anti-retro viral drugs,[7] this represents 89% of the total number of people with HIV in need of treatment. Added to this is the number of HIV infected pregnant women who received anti-viral treatment (ART), under the prevention of mother to child transmission, that is continually on the rise. Unfortunately, 93% of the budget for AIDS treatment comes from external sources and much of the provision of treatment is outside the government-run health service.[8] Thus, unless ART can be brought into the mainstream government-provided health-care system and significant efficiencies (in terms of cost per person) made there is the very real possibility that progress in treatment provision will stagnate or slip backwards.

User fees

A policy to remove user fees in both rural and urban areas is a means to increase access to care rather than an end in itself. It should therefore be implemented alongside a package of measures that address longer-term health to manage inequality of health outcomes in the community by moving towards universal coverage and social protection

Reform that involves community participation

A need has been felt to foster more inclusive health system leadership with community participation and based upon improved knowledge management and sound evidence[9] as a means to improve the entire health delivery system.

Civil Society organisations in Zambia, working in the area of health had identified the 2011 Zambian tripartite elections (electing president, National Assembly and Local Councillors) as an opportunity uniquely suited to a campaign to ensure that key health issues were made a priority. This was based on evidence from other successfully conducted campaigns in various African countries including, most recently Malawi. Some of the lessons learnt in the campaigns of other countries were used to help shape the Zambian campaign. In February 2011 various civil society organisations met to develop a campaign strategy[10] that would sensitise the electorate and those seeking to be voted into power to the important health issues that required reform. Building on the work of Fair Play for Africa, the forum agreed to collaborate under the Fair Play for Africa campaign brand but localised for Zambia – around the common goal of increasing investment in health care for the benefit of all Zambians. It themed the campaign ‘Vote Health for All’.

About the ‘Vote Health for All’ campaign

Objectives

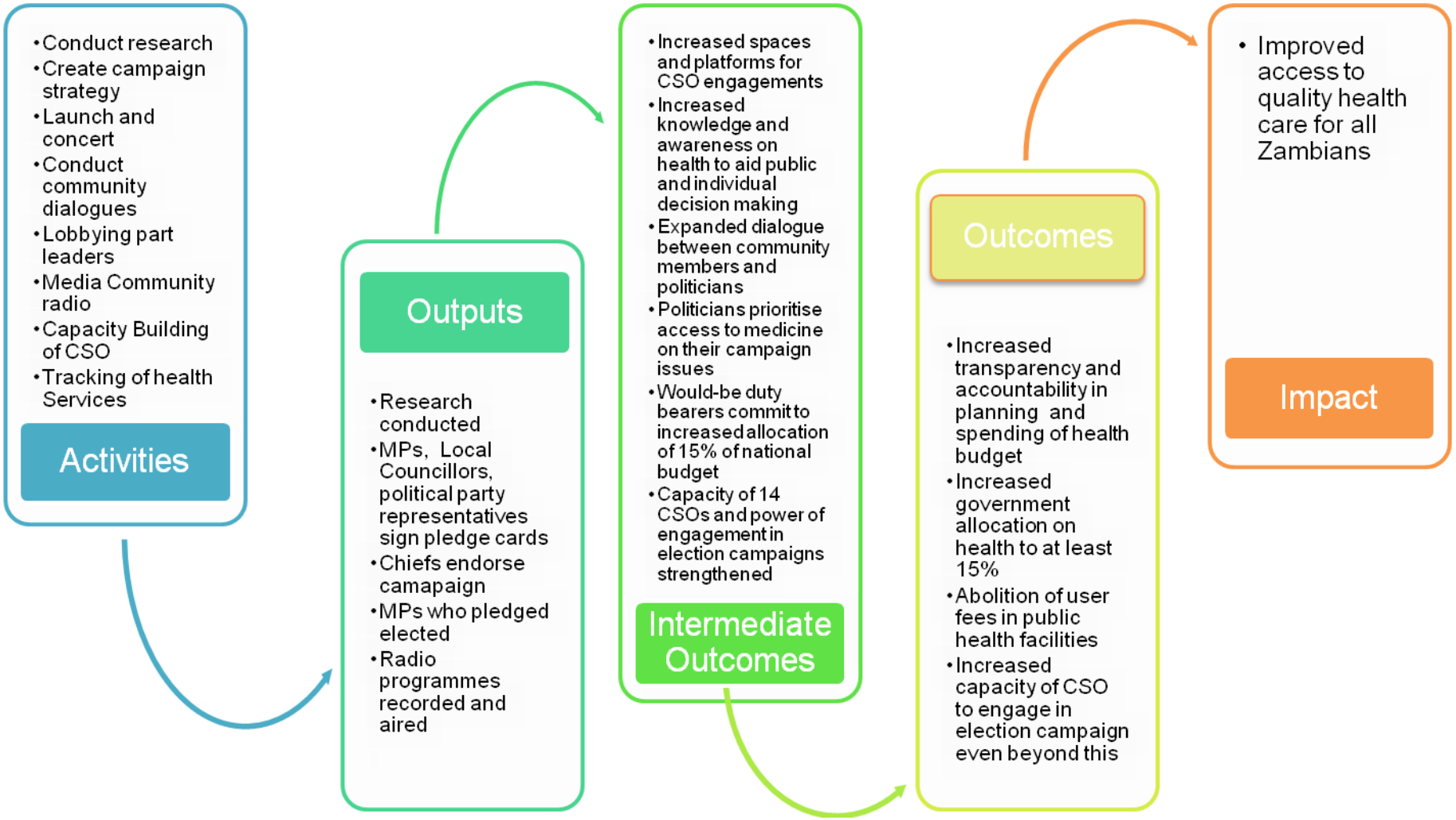
The objectives of the campaign were:

- to strengthen community level advocacy by working with the communities to increase their knowledge and expand their dialogue with their politicians and provide a platform for their voices to be carried to national level;
- to make health services, especially access to medicines, as one of the top three election issues in 2011;
- to make politicians and political parties pledge to increase resources for health with an emphasis on the 15% Abuja target as a minimum, not a ceiling, and increased per capita health spending; and
- to build the capacity of CSOs to engage with politicians and duty bearers regarding policies and provision of quality healthcare services.

Expected outcomes[11]

- The government of Zambia entrenches the practice of transparency and accountability in planning and spending of the health budget.
- The government commits to increasing the health budget to at least 15% in accordance with its commitment to the Abuja Declaration
- Equitable access to medicines and no drug shortages at all levels of health facility.
- Health is included in the Constitution's Bill of Rights as one of the fundamental human rights
- Adequate trained staff in health centres allocated to ensure quality service.
- User fees are abolished in urban areas.

5 PROGRAMME LOGIC MODEL



6 CAMPAIGN THEORY OF CHANGE

7 FINDINGS

7.1 OUTCOME 1

Outcome 1: Increased health budget to at least 15% in accordance with government commitment to the Abuja Declaration.

The above is the first outcome which the campaign was anticipated to influence, through government commitment. It is clear from the PF's 2006 and revised 2011 manifestos that PF was committed to increasing the health budget allocation once voted into office. The following extract from the PF 2011 manifesto bears witness to this.

Article 20 of the 2006 PF manifesto on Health Policy states:

> *'The current health care system is characterised by a critical shortage of personnel such as doctors, clinical officers, nurses and others. The few staff available is overworked, de-motivated and poorly remunerated. The unfavourable conditions of service have, over the years, accelerated the brain – drain of essential health personnel to other countries, thus leaving the country even more starved of essential health personnel. The infrastructure lacks maintenance and there is a critical lack of basic equipment and medicines especially in the rural areas. In the area of HIV/AIDS, most rural areas remain isolated from health care and cannot access treatment including ARVs.*
>
> *This severely deficient, inequitable, and inadequate health care delivery system has been unable to cope with the country's health demands especially in times of major epidemics such as cholera. The upshot of these declining health standards has been the dramatic increase in the levels of mortality, particularly infant and maternal mortality.*
>
> *Recognising this scenario, the PF government will:*
>
> • Increase the budgetary allocation from the current level to about 20% of GDP'

Similarly the 2011 PF manifesto[12] clearly better targeted increased allocation to health budget allocation as evidenced from the extract below:

> *Futhermore under the MMD governance the budget for health services has been a paltry 6% of the total annual national budget. This has resulted in poor and insufficient provision of essential health care; an inadequate, overworked, poorly remunerated and de-motivated human resource; a massive brain drain; frequent shortages of essential medicines whose procurement is riddled with gross irregularities; dilapidated health infrastructure; discriminatory financing mechanisms of the health sector; manual and outdated health information system; and an organizational structure ill fitted to deal with the critical and worsening health challenges.*
>
> *Recognizing the grave state of the current health services provision in Zambia, the PF government shall:*
>
> ***Health Services Financing***
>
> • *Increase the budgetary allocation from the current levels to at least 15% of the national budget in accordance with the Abuja protocols and ensure actual releases;*

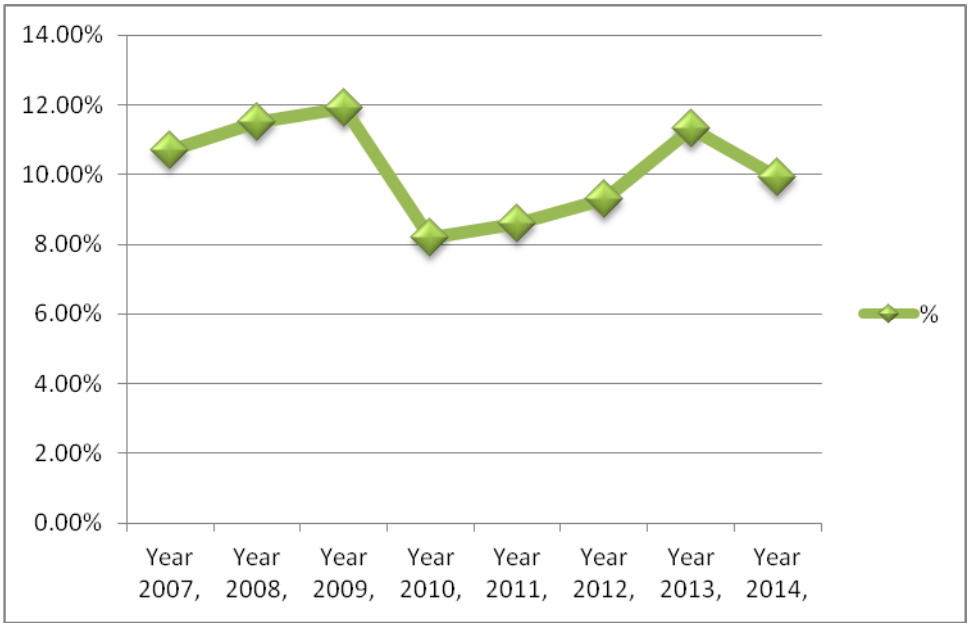
Has the outcome been achieved?

In his first speech to parliament following the 2011 election, the president echoed the directives of increasing budgetary allocation to health to address several challenges that were facing the health sector.

> *'…Our health service delivery system is presently characterised by insufficient provision of health care due to inadequate, over worked and poorly remunerated and de-motivated human resource, shortages of essential drugs, dilapidated health infrastructure, including a lack of staff accommodation among others.*
>
> *In view of the grave state of affairs in the health sector, the PF government will address obstacles to the provision of health care services. This will include increasing budgetary allocation to the sector, improving the work culture and intensifying the construction and rehabilitation of health infrastructure such as hospitals, clinics and Health Centres'*

Analysis of the national budget allocation to health after 2011 shows a significant increase, although it is still below the Abuja target of 15%. In the budget year 2012 the allocation to health was 9.3% compared to 8.6% and 8.2% of the previous two years. In 2013 the percentage increased to 11.3% but fell to 9.9% in 2014. Further analysis, in Figure 2, of the percentage increment in budget allocation to shows an encouraging trend of increased health allocation in national budget, a progressive move in meeting the Abuja commitment.

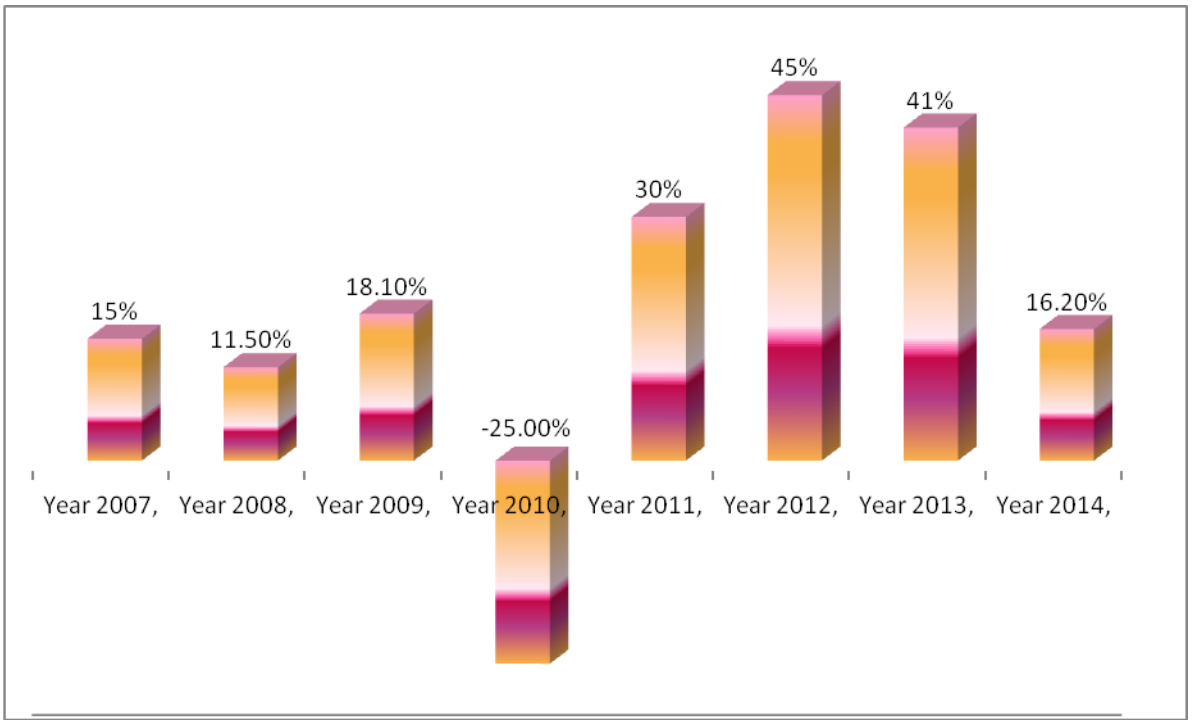
Figure 1: % Budgetary allocation to health



Source: Computed from National budget of respective years

The trend analysis of the increased allocation to health in national budgets shows that the years since 2011 have recorded almost double and in some years more than double the budget allocation to health. Figure 2 below indicates that while the year 2010 recorded a 25% decrease in budget allocation to health compared to the year 2009 which had recorded 18% increase compared to the previous year, the percentage increase of 2011 and subsequent years have been doubling. Since the new government took office there has been a significant increase in overall budget compared to previous years before. The years before was characterised by reduced funding from partners such as Global fund due to previous mismanagement of global funds allocated to health.

Figure 2: Trend % yearly increase in budget allocation



The evidence presented above is further supported by the budgetary speech in 2012 by the Minister of Finance. Below is an extract:

> 'Today, I am making a commitment to the Zambian people that the budgetary allocation to the health sector will progressively increase in line with the Abuja Protocol. Mr Speaker, in 2012, I have increased the allocation to the health function by 45.0 percent to K2,579.9 billion.' Honourable Chikwanda, 2012

> *'…Mr Speaker, with regard to health, I have proposed an allocation of K3.6 trillion or 11.3 percent of the 2013 Budget. This represents an increase of K1.0 trillion or 40.7 percent over the 2012 allocation.'* Honourable Chikwanda, 2013

7.1.1 Causal stories – How did the change come about?

Understanding the causal evidence

Causal factor 1: Funding to the National Budget

There are a number of influencing factors to increased allocation to health as per the Abuja Declaration with a major influencing factor being the availability of resources and competing demands by various sectors of society. Most of the funding towards health is donor funding and as such it plays a greater role in influencing budgetary allocations. Over 30%[13] of the total national budget, especially allocation to health, comes through as donor support. Therefore, it fluctuates with the amount of donor support. In years where there is reduced donor support, expenditure to health reduces. It increases with increased donor support. For example, in 2010 when donor support was withheld, budget allocation to health reduced by 25%, whereas in the subsequent year, when donor support was

increased, budget allocation increased by about 30%. See Figure 2. This was also evidenced in the then Minister of Finance's budget presentation to parliament when he noted the following:

> *'Mr Speaker, the impact of the global crisis on Zambia has had a negative effect on our fiscal operations. Domestic revenues are projected to underperform by K692.4 billion or 6.5% by the end of the year. The withholding of sector and general budget support by some Cooperating Partners has further weakened our fiscal position. In order to safeguard key programmes in the roads, education and health sectors. In order to safeguard key programmes in the roads, education and health sectors, the Government has increased domestic borrowing, while simultaneously reducing domestic expenditures in lower priority areas.'* Dr Musokotwane, Former Minister of Health, 2010, Budget Presentation

This is further supported through the interview with his predecessor Dr Brian Chituwo who acknowledged the following during the interview specifically for this report

> *'As you may know most of our budget to health depends on donors and thus what goes into the budget to health is largely controlled by what is available. Other sectors are also competing for what is available and you can only give what you have and not what you don't have, even if you have all the commitments.'* Dr Chituwo during an in-depth interview for the evaluation, 2014

Countering causal story 1

Funding alone not enough to achieve the outcome!!

> *'While agreeing that donor support is key influence to budgetary allocation to every sector of the economy, this alone is not enough for equitable distribution of resources to the most need sectors such as health. In fact it does not even reflect commitment towards achieving the commitment of 15% allocation to health as per the Maputo plan of Action signed in 2006.'* Honourable Hamududu, UPND MP, 2014

The years preceding 2006 had seen minimal increase in budget allocation to health, even with available donor support prior to global crisis and before the global fund withdrew its support to Ministry of health in August 2009. It is evident that in the years 2007, 2008, 2009 the percentage increase in health budget allocation was not more than 6%[14] and had not reached the 15% target. However between 2011 and 2014, there has been about 40% average increase in the health budget and hence the need to explore other explanations for this change. Causal factors can be understood from the quote below. It recognises that availability of budget funds influences allocation to health. However, along with this and sometimes as a pre-requisite to receiving external funds for health is government commitment to regional and global protocols and goals, such as the Millennium Development Goals and the Maputo plan of action, which in themselves influences to some extent increased budget allocation to health. Since committing to the Abuja Declaration in 2001, WHO (2013) reports that very few African countries are on track to meet both the Abuja target and several MDGs.

Donors Lose faith in Zambian Health Ministry

Ann Danaiya Usher, 2010

The Global Fund to Fight AIDS, Tuberculosis and Malaria has lost trust in Zambia's Ministry of Health to manage public sector grants. Ann Danaiya Usher reports.

The Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) has dropped the Ministry of Health in Zambia as a principal recipient of current public sector grants as a result of financial irregularities and continued concern that Zambian authorities are not moving fast enough to improve control systems. The Fund's decision comes at a time when $US millions in aid to Zambia from several other donors have been suspended in connection with corruption in the health and roads sectors.

Causal story 2: Political party manifesto and leadership

Political parties need leadership and a well-articulated manifesto. Honourable MP and Cabinet Minister, Mwaliteta (2014) explains that:

'The government can have all the money but without a well-articulated manifesto which responds to the health needs of the people, very little commitment will be paid towards people's and to funding towards health. The manifesto was developed based on the needs of people and was in line with the republican constitution which supports their social and basic rights. We are simply honouring our manifesto which is a working tool.'

The 2011 PF manifesto has clear clauses about increased health budgetary allocation to health to at least 15% as per the Maputo Plan of Action (MPoA)[15]. Comparative analysis of the PF manifesto against other political parties shows that while other political parties have general statement on increasing access to health services and funding towards health, only the PF manifesto has a specific budget target allocation in line with the Abuja target.

Honourable Professor Luo, Former Minister of Health, now Minister of Chiefs and Traditional affairs, noted that the

'PF Manifesto was largely influenced by the President's own experiences and people like herself who, both have been Ministers of health and are aware of the sufferings of Zambian people and the need to provide. We cannot also rule out the role of the first lady who in her every day to day interaction with patients knows their suffering. The PF has people like myself who are exposed to various global and regional commitments to health and the fact that the PF manifesto was informed by the University think tank of intellectuals who are also exposed to government commitments. I also know that some of my colleagues have been interacting with some civil society organisations working around MPoA before we developed the final constitution.'

The 2011–2015 National Health Strategic Plan also provides evidence to the above, as seen in this extract.

> *The NHSP 2011–15 has been developed within the context of the overall national development agenda, and forms an integral part of the Sixth National Development Plan 2011 to 2015 (SNDP) and the Vision 2030 strategy, which aims at transforming Zambia into a prosperous middle-income nation by 2030. The plan is also linked to multi-sector strategic frameworks, with relevance to health, including the National Multi-Sectoral HIV and AIDS Policy and strategic framework, National Food and Nutrition Policy, and the National Youth, Sport and Child Development Policy.*
>
> *At regional and international levels, the plan is linked to various relevant policies and strategic frameworks, including the MDGs, the Roll Back Malaria (RBM) strategy, the Stop TB strategy, the Abuja and Maputo Declarations on health, the Accra Agenda for Action of 2008, the Paris Declaration on Aid Effectiveness of 2005, the International Health Partnerships and related initiatives (IHP+), and other policy pronouncements and resolutions of the World Health Assembly (WHA), as far as they are signed and ratified by Zambia.*

Countering causal story 2

While having a well-articulated manifesto and high profile individuals helps focus efforts on a target, a manifesto alone, even where resources are available, does not guarantee increased funding to health. For instance, Zambia has been signatory to the 2001 Abuja Declarations and MDGs commitment. In addition it has even taken steps to develop operational tools, such as the CAMMAR, vision 2030, strategic plans and policies, but this did not immediately result in significant increased budgetary allocation to health.

> *'Without the voices of the people themselves budgets and manifestos mean nothing. Thus the advocacy role and monitoring of implementation is key and can only be achieved if community members begin to hold their representatives accountable towards their commitments'.*
> Honourable Hamududu, MP UPND 2014

Causal story 3: Civil society roles

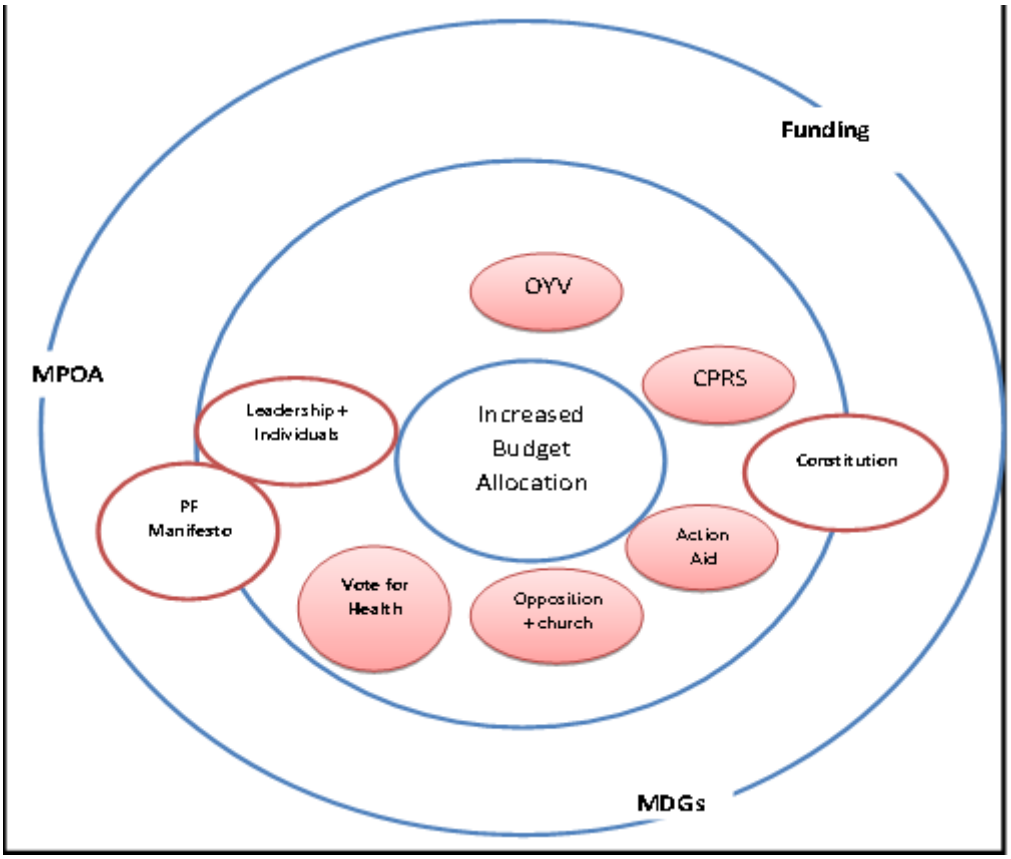
The civil society organisations that were conducting activities at the same time as the Vote for Health campaign included: Operations Young Vote (OYV), Jesuit Centre for Theological Reflection (JCTR), Action AID, Caritas Zambia, Civil Society for Poverty Reduction (CSPR), and the church mother bodies such as the Catholics and Evangelical fellowship of Zambia.

However, analysis of activities that each of these were conducting shows no link to the specific outcome on increased commitment as they had different focus areas. For instance, Action Aid had their focus on land rights and governance; JCTR through its campaign 'Active Citizenship' focused on mobilising communities to hold their leaders accountable for the promotion of social rights; Caritas Zambia similarly focused on governance issues, while the church mother bodies such as the Catholics and Evangelical fellowship of Zambia and CSPR had their campaigns focused on social and economic empowerment and human rights. OYV conducted a campaign called 'Follow your vote', this involved mobilising the country's youth to have a dialogue with aspiring candidates asking them to make commitments towards youth empowerment once they were in office. It also involved the formation of a youth manifesto, which ideally articulated the needs of young people especially ensuring that they are involved in governance. This tool was not specific to the Abuja Declaration or increased funding to health, although it highlighted the reproductive needs of the young people. The OYV Executive Director, Mr Guess Nyirenda, 2014, noted that while the campaign managed to ensure that political party manifestos bought into the youth manifesto, very little has materialised in addressing youth needs.

'Most of the CSO aligned themselves with the PF manifesto prior to elections and focused on the social needs and not necessarily on increasing commitment towards budgetary allocation to health. After the elections many of these CSOs have failed to reposition themselves, and a few that are active are focusing more on good governance and issues of the constitution and subsidies.' Dr Fredrick Mutesa, ZED President 2014

Thus the contribution of civil society to the outcome could only have been indirect and negligible.

Figure 3: Understanding causal factors



Causal Story 4: 'Vote Health for All' campaign

A vote to influence the health outcome.

Notably the 'Vote Health for All' campaign was the only campaign that had a clear focus on getting government commitment for increased health budget allocation in line with the Abuja Declaration. It managed to gather thousands of community members around health issues through partners and made leaders pledge to honour their commitments. Interviews with various stakeholders and policy makers including ministers who participated in the campaign, show a significant influence of the campaign on the outcome. Below is evidence gathered to support the campaign contribution to increased funding to health.

'Yes I remember that campaign very well. I also remember some of the organisations that organised it such as TALC, WILSA and Oxfam...I can't remember others off the top of my head. I was one of the leaders that signed the commitment. I was representing PF at that forum, and I signed because it was in line with our PF manifesto on this aspect and thus signing the commitment for increased funding was for us re-affirming our commitment to the people of Zambia of fulfilling our manifesto promises, so we took that exercise very importantly. As you know the President sent me to represent the party and I reported back to him that we have pledged to honour our PF promise through that pledge which he welcomed and we have honoured our promise. In my view, I think that we need proper tabulation of health allocation, as I believe that we have actually gone past the 15% target in that health is not just through Ministry of Health alone but other Ministries with health components, such as Ministry of Gender, Ministry Community Development, Mother and Child Health, etc. I think the campaign played a role in reminding us of our commitments.' Hon. Prof. Luo, MP, Minister of Chiefs and Traditional affairs, 2014

'I remember the vote for Health Campaign and I participated in pledging and in some of the activities. For instance I was on one radio programme organised by one organisation, [2410; 'Your right to Health']. The commitment towards increased funding was in the PF manifesto but the campaign helped us to be thinking about it as we made pledges to our communities and we knew that if we don't deliver on the promise we will be held responsible in 2016. So we are committed to increased funding and we are on the right path, in my constituency a lot has changed including new health facilities because of increased funding.' Hon. Jean Kapata, MP, Minister of Environment and Tourism, Chairperson of PF committee on health in 2011, 2014

It is interesting to see that the campaign left a mental impression on all MPs and ministers who participated in it, as all of those interviewed in this evaluation were able to vividly remember it and were alert to the fact that if the commitment was not fulfilled it might be used against them in the next election year.

7.1.2 Conclusion

Given the evidence above it can be concluded that although the government has not yet reached the 15% Abuja Declaration target, it is highly likely to achieve this target in by 2016. This can be deduced from increased budgetary allocation to health vis-à-vis the political commitment from the current leadership; some of whom were part of the 'Vote Health for All' campaign as also evidenced by various government instruments, such as the National Health policy 2013, Vision 2030, Decentralisation Policy, National Health Strategic Plan 2011–2015 and the Sixth National Development Plan 2011–2015, which have made reference to the commitment.

Using the construction and deconstruction methodology, it is established that the most probable explanation for increased commitment towards increased budget allocation to health are, in order of effect, availability of funds vis-à-vis global and regional commitments, well articulated PF manifesto with particular clause on increasing funding to health in line with the Abuja commitment and the 'Vote Health for All' campaign. This is evident from available documentation and through interviews with key stakeholders.

On a scale of 1–5, the likelihood of achieving the outcome is 3.5 and the contribution of the campaign to the likelihood, after taking into consideration all other confounding factors, is 0.8[1] out of 5 representing 16% contribution to the outcome.

Table1: Percentage estimates - contribution to target of 15% budget allocation to health

Influences	Estimated contribution to outcome - %
Available funds towards national budget + MPoA and MDGs commitments	62
PF manifesto + individuals' commitment	20
'Vote Health for All' campaign	16
Other indirect contribution	2

Contribution Score for Outcome 1

Outcome	Rating	Short commentary
Increased budgetary allocation to health to at least 15% of country national budget in line with the Abuja Declaration	**3.5**	Although the government has not yet reached the 15% Abuja Declaration target, it is highly likely to achieve this target by 2016. This can be deduced from increased budgetary allocation to health vis-à-vis the political commitment from the current leadership. The commitment is also referenced in various government documents. The main contribution to this outcome was the availability of funds in national budget, coupled with Maputo Plan of Action and Millenium Development Goal commitments, and Patriotic Front's commitments as detailed in its manifesto, but there is evidence that intervention made an important contribution.

Scoring key: Specific contribution of intervention

5	Outcome realised in full Evidence that intervention made a crucial contribution
4	Outcome realised in part & evidence that intervention made a crucial contribution Outcome realised in full & evidence that intervention made an important contribution
3	Outcome realised in part & evidence that intervention made an important contribution
2	Outcome realised in part & evidence that intervention made some contribution Outcome realised to a small degree & evidence that intervention made an important contribution
1	Outcome realised, to any degree, but no evidence that the intervention made any contribution

Based on the evidence and gradating criteria above, **Outcome 1 is scored as 3.5 in that outcome has been realised to a large extent and the intervention made very important and significant contribution**.

7.2 OUTCOME 2

Outcome 2: Ensuring increased access to quality health services through abolition of user fees in urban areas.

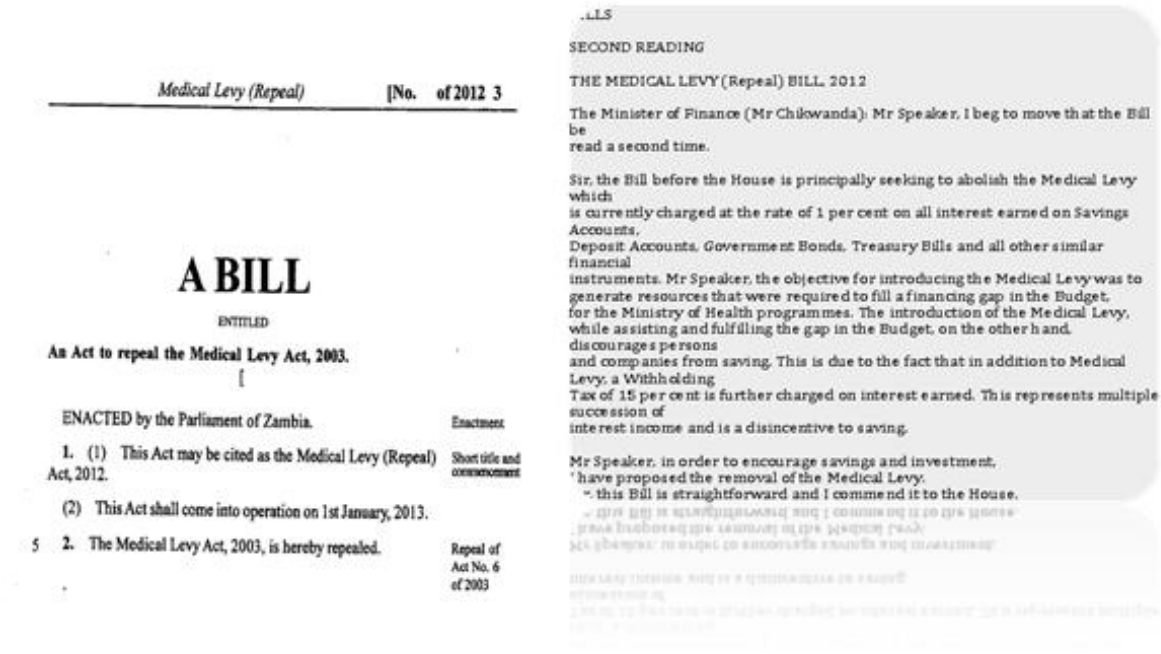
Outcome 2 is related to Outcome 1. The momentum to remove user fees in health facilities can be traced back to the year 2006 when a policy to abolish user fees for health services for all rural facilities was introduced. This was during the MMD government. Although user fees were scrapped for all rural facilities, the policy did not cover urban areas where the majority of the population live, with the result that urban communities had limited access to quality health services. Analysis of all political party manifestos[16] shows that all the four major parties are committed to increasing access to quality health services, however only the PF manifesto specifically makes reference to the abolition of user fees all health facilities. See the extract below from the PF manifesto on health policy.[17]

> *'Furthermore under the MMD government the budget for health services has been a paltry 6% of the total annual national budget. This has resulted in poor and insufficient provision of essential health care; an inadequate, overworked, poorly renumerated and de-motivated human resource; a massive brain drain; frequent shortages of essential medicines whose procurement is riddled with gross irregularities; dilapidated health infrastructure; discriminatory financing mechanisms of the health sector; manual and outdated health information system; and an organizational structure ill fitted to deal with the critical and worsening health challenges.*
>
> *Recognising the grave state of the current health services provision in Zambia, the PF government shall:*
>
> - *Abolish user fees and co-payments at all levels*
> - *Promote basic health care based on need and not ability to pay*

In line with the PF manifesto and the 'Vote Health for All' campaign, just few weeks later, upon taking office, the new government announced the abolition of the user fees at all levels of service provision in public health institutions. Policy analysts wondered whether

> *'this was to fulfil their campaign slogan of "more money in your pocket" or to achieve equity of health for all'.*[18]

This was followed by the enactment of the new repeal act number 11 of 2012 through parliament that repealed the 2003 Medical Levy Act and came into effect in 2013.



Medical Levy (Repeal) [No. of 2012 3

A BILL

ENTITLED

An Act to repeal the Medical Levy Act, 2003.

[

ENACTED by the Parliament of Zambia. Enactment

1. (1) This Act may be cited as the Medical Levy (Repeal) Act, 2012. Short title and commencement

(2) This Act shall come into operation on 1st January, 2013.

2. The Medical Levy Act, 2003, is hereby repealed. Repeal of Act No. 6 of 2003

.LS

SECOND READING

THE MEDICAL LEVY (Repeal) BILL, 2012

The Minister of Finance (Mr Chikwanda): Mr Speaker, I beg to move that the Bill be read a second time.

Sir, the Bill before the House is principally seeking to abolish the Medical Levy which is currently charged at the rate of 1 per cent on all interest earned on Savings Accounts, Deposit Accounts, Government Bonds, Treasury Bills and all other similar financial instruments. Mr Speaker, the objective for introducing the Medical Levy was to generate resources that were required to fill a financing gap in the Budget, for the Ministry of Health programmes. The introduction of the Medical Levy, while assisting and fulfilling the gap in the Budget, on the other hand, discourages persons and companies from saving. This is due to the fact that in addition to Medical Levy, a Withholding Tax of 15 per cent is further charged on interest earned. This represents multiple succession of interest income and is a disincentive to saving.

Mr Speaker, in order to encourage savings and investment, I have proposed the removal of the Medical Levy.

Sir, this Bill is straightforward and I commend it to the House.

Further, the abolition of user fees and the repeal of the medical levy was backed by the national health policy of 2013, which gives the following guidance under Health Care Financing: 'The policy recognises that overall, the current resource envelope is far below the minimum required for the delivery of an optimum package of care despite significant increases in the flow of funds to the health sector.

Objective

To ensure adequate and sustainable financing of the health sector in order to provide quality, cost effective health services.

Policy Measures

Government shall:

- (i) Ensure that Primary Health Care services at all levels are funded from general tax revenue and provided free of charge to all citizens[19]
- (ii) Ensure that Hospital services (district, general and tertiary) shall be funded partially from tax revenue and partially from a mandatory Social Health Insurance (SHI) fund and other medical aid schemes. Determine the benefit package and contributions to existing health insurance schemes and through actuary valuations taking into consideration, among other things the value of protection, cost effective analysis, epidemiological profile and administrative expenses.'

7.2.1 Causal Stories

Understanding the causal evidence

Causal story 1: Increased funding to National Budget

There are a number of influencing factors on the abolition of user fees in urban health facilities. One obvious one is the link between increased budget allocations to health and abolition of the user fees. Since 2011 the budget allocation to health has been doubling from the previous year, and this is one reason why removing user fees has been possible. Significantly, the Minister of Finance, Mr Chikwanda, accredited the abolition of user fees to increased budget. See the following extract from his budget speech of 2012.

> *'Mr Speaker, health care provision cannot only be judged in terms of resource allocation, but also by improving access and health outcomes. In order to increase access to health services, the Government will remove all financial barriers to accessing health services by abolishing all user fees for primary care services not only in rural but also in urban areas. [Part of the reason for doubling the budget was to cushion the effects of removing the user fees.]'*

In the recent past, there have been various debates about the need to raise more domestic revenue in light of the steady drop in the external donor support to the national budget and also the failure of the tax system to raise sufficient revenue.

The introduction of user fees was in fact necessitated by the dwindling of the economy in the 1990s, which led to government's inability to finance the provision of free health care services over time. This was worsened by the Structural Adjustment Programmes (SAPs), which were changes dictated by IMF and the World Bank. This meant reforming of the economy. A major tenet of the health reforms was the cost-sharing policy, which saw Zambia introducing user fees for health services in all public health facilities at all levels of care. Patients were now required to pay at the point of using health services. However the consequences of that move included the lowering of the utilisation of services and denied more people, especially the poor, access to health care. In 2006, after reaching the IPIC completion point, user fees were done away with at primary health care in rural areas. There were more resources allocated to health in the years after the IPIC completion point, hence the move to remove user fees in rural health facilities. Studies show that after the removal of user fees utilisation and access to health services increased by almost 55%.[20]

There is therefore an apparent correlation between increased allocation of budget to health and the abolition of user fees, which in turn results in increased utilisation of health services, while the reverse is also true. Therefore the increased funding to health played a significant if not a major part in influencing the abolition of user fees. However, it is also true that availability of funds to health, although necessary for, does not always result in the abolition of user fees. It is therefore necessary but not sufficient for the removal of user fees. So what are the other factors?

Causal story 2: PF manifesto

The drive to honour campaign promises.

The 2011 PF manifesto has clear clauses about increasing access to health services through the abolition of user fees. This is in contrast to other political parties' manifestos that only have general statements on increasing access to health services, but no specific mention of abolishing user fees.

As discussed under Outcome 1, the PF manifesto had a significant bearing on ensuring that more resources were channelled into the Ministry of Health basket, which indirectly influenced user fees.

'Our manifesto is pro poor as such we are share in the suffering of the poor. We know from our constituencies that the majority of the people cannot afford if charged fees as such our manifesto clearly states that we remove user fees. With increased number of health facilities and removal of user fees ensures that they receive the services.' Hon Esther Banda, MP, Deputy Minister of Gender 2014

Having clauses in political manifestos, however, does not necessarily translate into action or implementation. It is necessary for other key stakeholders and civil society to monitor that manifesto clauses are not just campaign statements. Manifestos are developed and implemented by human beings who constantly have to be reminded of their promises.

Causal story 3: Civil society roles

The civil society organisations conducting activities related to increased access to health are many including: PPAZ, YVZ, SAfAIDS, UNICEF, UNFPA, PANOS, Operations Young Vote (OYV), Jesuit Centre for Theological Reflection (JCTR), Action AID, Caritas Zambia, Civil Society for Poverty Reduction (CSPR) and the church mother bodies such as the Catholics and Evangelical fellowship of Zambia.

However analysis of the activities that each of these was conducting show that only the 'Vote Health for All' campaign partners and Action AID had undertaken specific activities on advocacy towards the abolition of user fees with the future parliamentarians. Other were either focusing on information provision on services related to their targeted audience, providing actual services, promoting right to services or providing referrals to services. These are not, therefore, considered to be counter campaigns.

Thus, only Action AID and CSPR were further assessed on specific activities that they were conducting. However, during the period of implementation, CSPR had not undertaken specific activities on the abolition of user fees in urban areas.

'We were very instrumental in the abolition of the user fees for rural health facilities, but this was in 2005 and 2006. We held a number of dialogue meetings and advocacy sensitisation meetings with communities and MPs. We still think this has had some impact to some extent even on the removal of user fees for urban health centres.' Mr Soul Banda, Action Aid, Director of Programmes, 2014

Thus the contribution of the CSPR to the outcome in question could only have been indirect and negligible.

Causal story 4: 'Vote Health for All' campaign

It is clear from the analysis that while a number of civil society organisations who were not in the campaign focused on advocacy and activity around increased access to services, only the 'Vote Health for All' campaign and CSPR (although this was in 2006) worked with future leaders specifically, and particularly made them commit to abolition of user fees once they were voted into office.

'I personally think that the role of the campaign came at a right time and especially a right government was getting into office. The campaign and a similar agenda as us and in a way helped us to sell the manifesto agenda to our people, the NGOs [in the campaign] spoke the same language as us but it is ourselves who were making commitments. We even shared these commitments among ourselves as MPs and with our counsellors, so this helped to implement our commitment. I personally still work with the civil society [ZAMSOF] in my constituency. I had promised during the campaign to secure an ambulance to a health facility and I have just done that, and I will be going to back with them [ZAMSOF].' Hon. Mwiliteta, MP, Cabinet Minister, 2014

'This issue of social contract should be done also in 2016. You made us pledge to our people and we have delivered, now you are our mouthpiece in the next campaign period, tell them what we have done. I still work with NGOs, like these that were on this project because they represent people who I represent but no other NGOs like….[mentioned names].' Hon. Jean Kapata, MP, Minister of Environment and Tourism, Chairperson of PF committee on health 2011, 2014

'I think why the campaign worked was because abolition of the user fees was a popular issue and appealing to the majority of poor people than anything else.' Hon. Hamududu, MP, UPND

7.2.2 Conclusion

It is evident that the outcome has been achieved (100%) and was achieved just some months after the general election, while the commitments were still fresh. The main influencing factor to achieving the outcome is increased allocation to the health budget followed by the PF manifesto, which was targeted to improving access of quality services. Commitment to increased funding to health was partly influenced by the 'Vote Health for All' campaign, although there is evidence that the campaign itself also had a direct influence on abolition of user fees. The 'Vote Health for All' campaign was one of a kind, targeting leaders to make specific commitments with key clear messages. This is substantiated by the testimonies of the targeted leaders themselves and from implementing partners.

On a scale of 1–5, the likelihood of achieving the outcome is 5 and the contribution of the campaign to the likelihood, after taking into consideration all other confounding factors, is 1.0[1] out of 5, representing a 20 % contribution to the outcome.

Table 2: Percentage estimate - contribution to abolition of urban health care fees

Influences	**Estimated contribution to outcome - %**
Available Funds towards national budget + MPoA and MDGs commitments	40
PF manifesto + individual commitment	35
'Vote Health for All' campaign	20
Other indirect contribution	5

Grading of Outcome 2

Outcome	Rating	Short commentary
Abolition of user fees in all public urban health facilities	**4**	The main influencing factor to achieving the outcome is increased allocation to the health budget, followed by the PF manifesto, which was targeted to improving access of quality services. Commitment to increased funding to health was partly influenced by the 'Vote Health for All' campaign, although there is evidence that the campaign itself had a direct influence on abolition of user fees.

Scoring key: Specific contribution of intervention

5	Outcome realised in full Evidence that intervention made a crucial contribution
4	Outcome realised in part & evidence that intervention made a crucial contribution Outcome realised in full & evidence that intervention made an important contribution
3	Outcome realised in part & evidence that intervention made an important contribution
2	Outcome realised in part & evidence that intervention made some contribution Outcome realised to a small degree & evidence that intervention made an important contribution
1	Outcome realised, to any degree, but no evidence that the intervention made any contribution

Based on the evidence and gradating criteria above, Outcome 2 is scored as 5 in that outcome has been realised in full and the intervention made very important and significant contribution.

8 PROGRAMME LEARNING CONSIDERATIONS

8.1 LESSONS

Targeting influential leaders, even if it's only one leader

From the findings of this evaluation, it is clear that targeting influential leaders in the country is a strategic and effective tool to achieving the advocacy outcomes. The campaign targeted leaders, such as Professor Kandu Luo, who has been Minister of Health, a civil society leader, advocate and activist and became a minister in the new government, she also understands international and regional commitments towards improving health. She and other key individual political leaders are able to influence change. The key is to ensure their timely engagement with the evidence. Similarly the inclusion of influential individual community leaders, such as Chief Mumena, played a critical role in influencing the outcomes.

Timing is crucial

The campaign came at critical time when political leaders needed votes and thus they needed to identify with the people. The campaign was also launched at the time when calls for increased funding and improved access to health services resonated very well with the needs of the people. Thus it helped in ensuring that the political party manifestos were aligned to the critical needs of the people. The campaign was also timely being launched before an election, when the eventual winners would be anxious to fulfil their campaign promises. There is a high likelihood that the outcomes would have been different if the campaign had come at a different time.

Targeting is key

The campaign targeted a coalition of CSOs, community members, and community and political leaders who would be in a position to make change. For instance the likely highest holders of office such as party presidents and representatives of political party health committees, were strategically targeted. This played a positive part in influencing the campaign outcomes.

8.2 KEY RECOMMENDATIONS

Strengthen follow up mechanism of the outcomes: some of the advocacy outcomes are long term and a campaign of this nature can be sustained if there is a clear follow-up mechanism of the anticipated outcomes. As things currently stand, there is seemingly weak or no clear follow-up mechanism for the campaign outcomes. This can be improved through a strengthening of the organisation M&E system. There is also a need to ensure that communities and political leaders provide feedback on whether or not the commitment made by political leaders has been achieved or not so that they can hold the leaders accountable.

Campaign to include accountability of constituency and area MPs: While this campaign targeted high-level national commitments, it is imperative that at a lower level, such as constituency and ward level, leaders are also held accountable. Thus a need for future campaigns to ensure that civic leaders are also held accountable. There is also a need to carefully consider working with losing

aspiring candidates and opposition party members who also made commitments during the 2011 campaign.

Ensuring sustainability with a clear exit strategy: A campaign of this nature should have a sustainability plan with clear exit strategy. This is particularly important given that this campaign involved a number of key stakeholders and different CSOs who can play a critical sustainability role even after the campaign cycle ends if they were clear about the exit plan.

Strengthen partner coordination: The campaign involved a lot of CSOs and one of the challenges faced was coordination and ensuring that each organisation played an effective role. Future campaigns of this nature should ensure effective coordination with clear roles defined for each of the organisations involved.

Mapping out rival interventions: There is need for clear mapping of similar campaigns/intervention occurring concurrently with Oxfam campaigns, so that areas of influence can be established right at the inception of the campaign. This would also be of importance to inform an evaluation of this nature.

9 CONCLUSION

It is clear that although the government has not yet reached the 15% Abuja Declaration target, it is highly likely to do so by 2016. This can be deduced from increased budgetary allocation to health vis-à-vis the political commitment from the current leadership; some of whom were part of the 'Vote Health for All' campaign. The most probable explanation for commitment to increased budget allocation to health are, in order of effect, availability of funds vis-à-vis global and regional commitments, well articulated, PF manifesto with a specific clause on increasing funding to health in line with the Abuja commitment and the 'Vote Health for All' campaign. This is evident from available documentation and through interviews with key stakeholders. Ruling out all other confounding explanations for the realisation of increased national budgetary allocation to health, the 'Vote Health for All' campaign contribution towards this outcome is about 16%.

One of the target outcomes of the 'Vote Health for All' campaign was abolition of medical user fees in Zambia. User fees have since been abolished in all public health facilities irrespective of urban or rural districts. This was achieved just some months after the 2011 general elections. The main influencing factor on the abolishing of user fees is increased allocation to health budget. This is followed by the PF manifesto, which was targeted to improving access of quality services. Commitment to increased funding to health was partly influenced by the 'Vote Health for All' campaign, and there is also evidence that the campaign itself had a direct influence on the abolition of user fees. The percentage contribution of the 'Vote Health for All' campaign is about 20%; which is a significant contribution given the other factors that influenced the outcome.

It is thus concluded that the campaign was effective in influencing the targeted outcomes as elaborated above. Some of the success factors of the campaign were: targeting of influential leaders some of whom became Ministers after the 2011 elections, crucial timing as the campaign came at critical time when political leaders needed votes and thus they needed to be identified with the people. Targeting of a coalition of CSOs, community and political leaders who would make a change proved to be strategic in achieving the target outcomes.

In moving forward, a campaign of this nature would be more effective if follow-up mechanisms of the outcomes is strengthened. Such a campaign should include accountability of constituency and area MPs with strong feedback mechanisms to community members and political leaders, ensuring sustainability with a clear exit strategy. The strengthening of partner coordination in future campaigns should factor in mapping of rival intervention partners at the inception of the campaign.

APPENDIX 1 - DOCUMENTATION REVIEWED

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APPENDIX 2 LIST OF INFORMANTS

Name	Organisation	Title
Hon. Mwaliteta	National Assembly	Cabinet Minister, MP
Hon. Chituwo	National Assembly	Vice President MMD, MP, former Minister of Health
Hon. Mukanga	National Assembly	Cabinet Minister, MP
Hon. Ester Banda	National Assembly	Deputy Cabinet Minister, MP
Hon Jean Kapata	National Assembly	Cabinet Minister, MP
Hon. Hamududu	National Assembly	MP, UNPD
Hon. Nkandu Luo	Ministry of Chiefs and Traditional Affairs	Cabinet Minister, MP, former Minister of Health
Geoffrey Chungu	JCTR	Head of Programme
Fr. Joe Kakoma	Caritus Zambia	Head of Programme
Mr Nyirenda	Operations Young Vote	Executive Director
Mr Kabaso	Civil Society for Poverty Reduction	Executive Director
Dr Love Mutesa	ZDE	Party President
Reverend Kamaga	NAREP	National Secretary
Henry Kabwe	Media Rights Network	Programme Manager
Mr Kabaso Geshom	ZAMSOF	Executive Director
Mr Mwanza	TALC	Executive Director
Mr Amos Mwale	YVZ	Executive Director
Tamara Simavwa	SAfAIDS	Programme Manager
Mr Soul Banda	Action Aid	Programme Manager
Mr Ayami Yusufu	Zingo	Executive Director
Sr Matilda Mubanga	ZEC	Programmes Coordinator
Mr Justine Mushoke	2410	Executive Director
Dr Katema	Ministry of Information and Broadcasting	Cabinet Minister, MP
Lucy Munthali	Sightsavers	Programme Officer
Namuchana Mushabathi	Wilsa	Programme officer
Makani Muzete	PANOS	Head of Communication
Berry Lwando	ZNBC	Director of Programmes

APPENDIX 3 DATA COLLECTION INSTRUMENTS

1. In-depth Interview Schedule for Political Leaders

1. To begin with, kindly share with me what does your manifesto stipulate on health, including funding and increasing access of health services for all people?

2. Kindly elaborate the processes that your party took to develop your manifesto. For instance share with me global and national frameworks that might have influenced your manifestos. Could it also be the citizens' needs? How did you determine the citizens' needs?

3. Did you work with any CSOs in developing your manifestos, what were some of the CSOs and what were their roles? To what extent were the community members involved in influencing your manifesto priorities?

4. I am going to ask your view on some of the changes that that might have occurred since the new government came into office after the 2011 elections. Do you think there has been increased funding towards health, especially in line with the Abuja Declaration, and do think user fees have been removed? If so what do you think are the factors/organisations/individuals that might have contributed towards that?

5. Prior to the elections, do you remember making a commitment to improving the health of the citizens? Specifically what were these commitments? Specifically share with me whether you/your political party made any commitment to funding for health in line with the Abuja Declaration of 15% and the abolition of user fees.

6. Taking you back to 2011, do you remember organisations/campaigns that worked with you/your political party in ensuring commitment to increased funding towards health in line with the Abuja Declaration of 15% and the abolition of user fees? Kindly mention the organisations that worked with you and specific activities they undertook.

7. How would you rate the contribution of the organisation/campaigns in question 1 to the realisation of the outcomes of increased funding and abolition of medical user fees? In your own view, do you think the outcome would have occurred without these organisations and their activities that you were involved in? Kindly elaborate.

8. Finally, what organisations do you still work with in ensuring that your election commitments are being fulfilled?

2. In-depth Interview Schedule for CSO

1. To begin with, kindly share with me the goal, mission, vision and areas of focus for your organisation.

2. Prior to the 2011 election, did your organisation work with political leaders/parties to ensure that their manifestos reflect the needs of the people? If so, how?

3. Before the 2011 campaign, did your organisation specifically work with political leaders in ensuring that their manifestos had clauses about increased funding for health in line with the Abuja Declaration and increasing access of health services for all people?

4. During the campaign period of the 2011 elections, kindly elaborate if any of your activities targeted politicians to ensure that they owned some of the election promises. Specifically what were these promises?

5. Kindly tell me what processes your party took to develop your manifesto. For instance share with me global and national frameworks that might have influenced your manifestos. Could it also be the citizens' needs? How did you determine the citizens' needs?

6. I am going to ask your view on some of the changes that that might have occurred since the new government that came into office after the 2011 elections. Do you think there has been increased funding towards health especially in line with the Abuja Declaration, and do think user fees have been removed? If so what do you think are factors/organisations/individuals that might have contributed towards this?

7. How would you rate the contribution of your organisation and its activities to the realisation of the outcomes of increased funding and abolition of medical user fees? In your own view, do you think the outcome would have occurred without your organisation and their activities that you were involved in? Kindly elaborate.

8. Finally, does your organisation still work with political and national leaders in ensuring that election commitments are being fulfilled?

NOTES

1 According to the ZDHS (2009) about 70% of Zambians are poor and the most affected are girls and women.

2 UNICEF Zambia Situation Analysis 2008, p10. Stunting implies long-term under-nutrition and poor health and is measured as 2 z-scores below the international reference of weight for age. Underweight is a measure of low weight for age (also against an international standard).

3 Source – The infant mortality data is from 2002, Zambia Demographic Health Survey, 2001/02 as reported in the CSO Bulletin, Nov 2007. The child mortality rate is from 2004 data , from the UNDP Human Development Report for Zambia (2007). 2007 data is from the CSO bulletin, May 2008.

4 Ministry of Health (MoH) and University of Zambia, 'Zambia public expenditure tracking and quality of service delivery survey in the health sector', 2008, pp. 73–76

5 National Health Strategic Plan 2011–2015

6 Scorecard Research. Africa Public Health Information Services. 2009–2010

7 President's address, September 2010

8 Unicef Zambia Situation Analysis 2008, pp.38–39

9 WHO, The World Health Report 2008 Primary Health Care (now more than ever), Geneva, World Health Organisation, 2008.

10 ZARAN, ZARAN, TALC, Media Network on Child Rights, National AIDS Alliance, ZINGO, Association for Aid and Relief Japan, Sightsavers, WLSA, Civil Society Health Forum Secretariat, SAFAIDS, 24-10, Oxfam GB

11 Only the two specific outcomes; bullet #2 and #6 are the centre of the effective evaluation

12 Analysis of other political party manifestos showed that they did not have clear budgetary allocation targets and did not refer to the Abuja declaration

13 2012 Budget allocations

14 Refer to Figure 1 and 2

15 The Maputo Plan of Action (Maputo PoA) for the Operationalisation of the Continental Policy Framework for Sexual and Reproductive Health and Rights is Africa's policy framework for universal access to comprehensive sexual and reproductive health services. It is the outcome of a special session of the African Union Conference of Ministers of Health, who met in Maputo, Mozambique in September 2006. It focuses on the family planning and reproductive health (FP/RH) priorities for Africa in the context of achieving both the International Conference on Population and Development (ICPD) goals and the Millennium Development Goals (MDGs) - http://www.ppdafrica.org/docs/policy/maputo-e.pdf

16 MMD, UPND, NAREP and PF

17 Most of the PF aspiring candidates were part of the 'Vote Health for All' campaign together with other opposition parties

18 Zambia Institute for policy Analysis and Research, November–December 2011: Bi-monthly publication.

19 National Health Policy 2013

20 Carasso, B et al. (2010) 'Evaluating the impact of abolishing user fees in Zambia – summary of findings.' LSHTM, UZAM, UCT, MoH

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Oxfam GB, Oxfam House, John Smith Drive, Cowley, Oxford, OX4 2JY, UK.

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