Sida Evaluation 06/06

Institutional Capacity Building of Health Economics in Zambia

The Purchaser-Provider Model and Institutional Collaboration in Zambia

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Department for Democracy and Social Development

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Sida Evaluation 06/06
Commissioned by Sida, Department for Democracy and Social Development

Date of Final Report: December 2005
Printed by Edita Communication AB, 2006
Art. no. Sida26403en
ISBN 91-586-8368-2
ISSN 1401—0402

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Content

Executive Summary

Since 1995, the Department of Economics (DoE) at University of Zambia and the Swedish Institute for Health Economics (IHE) have been collaborating in health economics research and health policy analysis under the Sida support to *Institutional Capacity Development in Health Economics trough Institutional Collaboration*. This support is linked to, and channelled through, the Ministry of Health/Centre Board of Health (MoH/CBoH).

The main purpose of the evaluation is to describe and assess the effects of the support on the capacity development in health economics in general and in particular at the DoE. But the most important purpose of the evaluation, from the evaluators' point of view, is the learning process of the evaluation, a learning process in which the stakeholders get the opportunity to learn about and develop the ongoing project. This process of learning is closely linked to the method used. The results will lead to a decision on suggested improvements, in terms of the content and format of the support to DoE (and MoH), to assist Sida in its preparation of a new agreement. The evaluation took place between August and October 2005, and interviews were undertaken in Zambia (Lusaka) and Sweden (Lund). The data collected were summarised in an unevaluated paper, which was used at the evaluation seminar held in Lusaka and Lund.

The Sida support has resulted in several health economics studies of whom some have been published in a book; participation in regional health economics workshops etc. The support has also included funding for training in health economics on Master level at Health Economics Unit (HEU) at University of Cape Town (UCT) from both DoE and MoH/CBoH, and contributed to training of a PhD at DoE. Within the framework of the Sida support approximately eight individuals have been funded so far; four from DoE, and four from MoH/CBoH. The Sida support has also improved IHE's knowledge and capacity in the area of health economics in the Zambian context.

The capacity has increased at several levels at both DoE and MoH/CBoH. MoH/CBoH experiences an increased demand of health economics evidence based studies within the health sector in order to use the information for developing new policies. DoE, on the other hand, values the link to the health sector and sees it as necessary that their research and studies are demanded and used. The strengthen capacity of policy-relevant research are to a great extent a result of the model used, a *purchaser* (MoH/CBoH) – *provider* (DoE) model. There are however some

embedded problems within the model which DoE and MoH/CBoH have to face before renewing the contract, problems of DoE dependency of the Ministry and their inability to further develop the academic skills needed.

The strengthened capacity at DoE has changed the needs at the department, and by that their ambitions and abilities. Therefore this report analysis the collaborative relationship between IHE and DoE, not only in terms of what it has contributed with, but also in the light of the definition of institutional collaboration as a method of accomplishing capacity. One alternative way of developing academic capacity of health economics that are acknowledged in this report is capacity development through the regional network HEPNet (Health Economics and Policy Network). The current situation shows that the regional capacity has not been used at DoE, and the main explanation of the unused capacity is based on internal communication failures at the department.

In conclusion, the methods used so far in developing capacity of health economics at DoE have been successful, but along with increased capacity the models (purchaser-provider model and institutional collaboration) needs to be developed and combined with other methods and models. There is important to try to find ways to increase the critical mass of health economists in a much faster speed than before and that will need a different organisational setup at DoE. One such suggested setup (pointed out by the stakeholders) is the creation of a separate health economics unit within the DoE. The evaluator concludes that such a unit might solve the problem of dependency of MoH/CBoH (and Sida as the only funder), but that it doesn't in itself solve problems of academic independence, critical mass and internal communication difficulties.

Recommendations in brief:

DoE:

- Create an attractive working environment in order to keep and attract health economists. This could be done in three steps:
- Create a better communication with, and play an active role in the further development of, HEPNet. Make sure that the members of the staff at DoE take the first step in establishing better contact with the network instead of waiting for HEPNet to make the first move.

MoH:

- Expanding the negotiation space, i.e. improving the mutuality and exchange when the work plan is decided. This implies that the MoH needs to regard DoE more as a collaborative partner, not only as a provider.
- Trying to open up for more academic-relevant issues of question, so that the policy-relevant research more easily can be transformed into an academic interesting article for DoE.

Sida:

- A formalised demand of dissemination of the research carried out through the support. The studies should give training in how to write articles. This would increase the academic quality of the studies and increase the quality of the methodology used.
- More time given to each separate study and by that more money, in order to make sure that the academic level of the policy-relevant research can be developed. This activity should be stated in the work

plan. One alternative way of release funs for the research on a more general basis could be by core funding DoE.

- Find a way to support the development of PhD's at DoE.
- Strengthening of the local Master program at DoE in order to increase the capacity in general at the department, for example by bursaries to the local Master program.
- One way of strengthening the academic research environment at DoE and the local Master program is by contracting a secondment of a senior researcher.

List of Abbreviation

CBoH	Centre Board of Health, Zambia
DoE	Department of Economics at University of Zambia
HEPNet	Health Economics and Policy Network in Sub-Saharan Africa
HEU	Health Economics Unit at University of Cape Town, South Africa
IHE	Swedish Institute for Health Economics in Lund, Sweden
iHEA	International Health Economics Association
KI	Karolinska Institute
MoH	Ministry of Health, Zambia
Sida	Swedish International Development Aid
SSA	Sub-Saharan Africa
UCT	University of Cape Town, South Africa
UNZA	University of Zambia

1. Introduction

Since 1995 Sida has supported capacity development of health economics in Zambia. The main objective of the support is to strengthen the capacity of health economics and policy with special regard to the Department of Economics (DoE) at University of Zambia (UNZA) in order to increase the capacity of the health sector in Zambia as a whole. The capacity at DoE is developed through an institutional collaboration with the Swedish Institute for Health Economics (IHE) in Lund, a collaboration where exchange of experiences and skills from two different socio-cultural worlds of health economics meets.

In order to make the capacity widespread in the country, in order to broaden the policy horizon, the Sida support to DoE is channelled through the Ministry of Health/Central Board of Health (MoH/CBoH) by a purchaser-provider model where MoH/CBoH purchase policy-relevant studies from DoE who provides the research.

The support has so far multiplied the capacity of health economics in terms of trained individuals, studies carried out etc. The support has changed the competence in the area of health economics in Zambia, and since it has changed it is time to evaluate whether the support should continue as today or if the changed capacity also has changed the needs. The evaluation will, except summarising the outcomes of the support so far, acknowledge some issues worth highlighting in order to continue to strength, build and develop capacity of health economics in Zambia, with special regard to DoE.

1.1. Purpose of the evaluation

The purpose of this report is to evaluate Sida's support to institutional capacity development of health economics in Zambia trough institutional collaboration (Appendix A). One of the main objectives of the evaluation is to describe and assess the effects of the support on the capacity development in health economics in general and in particular at the Department of Economics (DoE) at University of Zambia (UNZA).

Another aim is to describe and assesses the strengths and weaknesses with the current organisational setup, especially by looking at the institutional aspects of the relationship between DoE and MoH/CBoH and between DoE and IHE. This is done by identification of critical factors that limit and/or promote capacity development at the DoE. This includes a review of the flow of funds, indicating strengths and weaknesses in the current funding set up.

A third aim, is to describe and assess how the current support use and take advantage of regional activities in health economics, with special focus on the Health Economics and Policy Network in Sub-Saharan Africa (HEPNet). The evaluation will acknowledge the degree of institutionalisation, and identify critical factors for improved networking moving from sharing of information towards regional capacity development at DoE.

Finally the last aim is the process of learning of the evaluation, a learning process whereby the stakeholders get the opportunity to learn and develop the ongoing project. This process is closely linked to the method used.

1.2. The evaluation method

The evaluation method builds on a model that is based on active participation of the stakeholders in the evaluated project. This approach entails that the involved parties, at a start-up meeting, get the chance to highlight questions of importance that ought to be acknowledged by the evaluators. The aim is to make the stakeholders and involved parties more engaged in the evaluation process and interested in its outcomes. Another important part is when the involved parties, using their contextual knowledge and experience, get the opportunity to reflect and contribute to analysis of the collected data, results and other material. This is done at a so-called evaluation seminar.

The method used is not only a process of giving stakeholders influence over the outcomes of the evaluation; it is also an opportunity to learn. An opportunity to learn what other members of the project think, how they perceive issues that are raised, but also a chance to use this newly gained knowledge in a productive way and to move forward. Past experiences shows that individuals involved in the project, using this method, are more likely to interpret the materials and findings in ways that are understood by the majority of the project members. They are part of the socio-cultural context, a context that is not necessarily shared by the evaluators. This participant evaluation model also facilitates the process of change that is often a necessary next step for most projects.

1.2.1. The evaluation

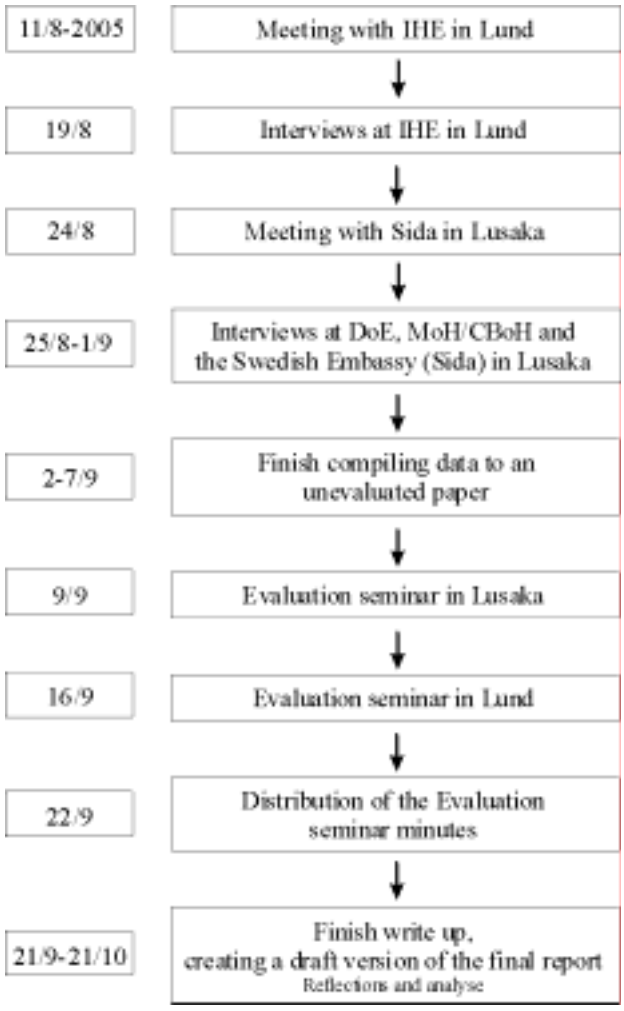
The following evaluation is first of all a qualitative analysis of the process, perceived outcomes and effects of the support at different levels. But it also includes a quantitative review of actual deliverables as well as a financial review. On account of a tight time-schedule for the evaluation no regular start-up meeting with the involved parties was held. Instead an information meeting at IHE in Lund on the 11th of August was held, a meeting where the support was contextualised. A similar meeting was also held at the Swedish Embassy/Sida in Lusaka on the 24th of August.

Interviews were conducted at IHE in Lund (Sweden); and at MoH/CBoH, the Swedish Embassy/Sida and DoE at UNZA in Lusaka (Zambia), between the 19th of august and the 1st of September. The interviews lasted between 30 minutes to 1 hour and 30 minutes and all, except one, were taped. A total number of 16 persons were interviewed, two from MoH, four from CBoH, six from DoE at UNZA, three from IHE and one from Sida. From each institution the head of department was interviewed. Data collecting also included a review of relevant documents such as proposed work plans, progress reports, financial reports etc.

The collected data was summarised in an unevaluated paper (Appendix B) in order to give an input at the evaluation seminar. Preferably

representatives from all involved parties and stakeholders participate at the same seminar, but unfortunately this could not be arranged. Therefore one evaluation seminar was held in Lusaka (9th of September) and another in Lund (16th of September). At the seminar some common issues of importance of the Sida support were discussed. The results and discussions from the evaluation seminar as a whole can be viewed in Appendix C.

After the evaluation seminar the data collected, documents and minutes from the evaluation seminar, were analysed, summarised and put into a broader framework presented in this report.



1.3. Outline of the report

After a sum of the outcomes, funding setup of the support etc. in CHAPTER 2, the three following chapters acknowledges different relations and links within the Sida support.

In CHAPTER 3 the purchaser-provider model that decides MoH/CBoH and DoE relation are explained in order to highlight the outcomes and values of the model. The links and enclosed roles that are embedded in the model will also be discussed.

In CHAPTER 4 the institutional collaboration between IHE and DoE are summarised, where the values of the collaborative relations are highlighted in its own context, but also in the context of what an institutional collaboration actually is.

Before the conclusion, one alternative way of developing academic capacity of health economics is discussed in CHAPTER 5 – the importance of using regional capacity. Reasons of why the regional capacity hasn't been used are discussed in the light of difficulties in communication structures within the DoE.

In CHAPTER 6, conclusions, two issues to acknowledge of further development of the support are discussed. Issues that are analysed are; how to speed up the development of a critical mass of health economists; and what to acknowledge in the future support to capacity development of health economics in Zambia.

2. Capacity development of health economics at DoE and MoH/CBoH

2.1. Background

Since 1995, the Department of Economics at University of Zambia (DoE) and the Swedish Institute for Health Economics (IHE) have been collaborating in health economics research and health policy analysis under the Sida support to *Institutional Capacity Development in Health Economics trough Institutional Collaboration*. This support is linked to, and channelled through, the Ministry of Health/Centre Board of Health[1] (MoH/CBoH), where MoH/CBoH's demands of research decide the agenda for what studies to be carried out. (cf. Sida 1995; Progress Report 2005)

The overall objectives of the Sida support is to build and develop capacity in the area of health economics in the Zambian context with the view to make provision of health care services in Zambia equitable and cost effective. The more specific object is to develop capacity at DoE to provide MoH/CBoH and other partners with quality analytical work in this area. Consequently, the mandate of the support is in two closely related areas; firstly, the project conducts health policy analysis and health economics research; secondly, it facilitates and undertakes capacity development activities (cf. Sida 1995; Progress Report 2005).

2.2. The work process

The formal arrangement of the collaboration is based on a three-year basis where an overall work plan is agreed upon each year (the current contract period is between 2002 and 2005). In brief the MoH/CBoH is seen as the purchaser and the DoE and IHE in conjunction is the provider of research outputs (cf. Sida 1995; Sida 2002)[2].

The work process emanates from MoH/CBoH, the *purchaser*, identifying the issues that they want to further develop. This is done through a process within MoH/CBoH, where different levels and functions of the Ministry get the opportunity to participate, i.e. the Health Sector Committee and a number of Technical Working Groups specialised in different areas. After the issues have been identified MoH/CBoH starts to

[1] As a part of the Zambian Health Reform CBoH was initiated in 1995. CBoH was the implementing unit and MoH were the once focusing on policy development and supervision. In the near future this constellation will change. In this report the two will be referred to as one in order to not get involved in the political process of organisational setup of the health sector in Zambia.

[2] When no reference is given the outcomes is based on collected data from the interviews and completed information by e-mail.

discuss and negotiate with DoE (and IHE), by putting forward and clarifying the needs in terms of health economics research. The discussions end up in an agreed research agenda for the up-coming year (cf. Sida 1995; Sida 2002).

After the research agenda has been set, DoE, the *provider*, together with IHE develops proposals to meet the research questions raised by MoH/CBoH. Proposals that visualise how IHE and DoE could tackle and carry out the studies and what the expected outcomes of the proposed research projects ought to be. It also includes a yearly work plan. The proposals are then submitted to MoH/CBoH. After reviewing and approving the proposals, the MoH/CBoH transfer a part of the agreed funding to the DoE (the other part is paid after completed work). IHE, on the other hand, is paid directly by Sida (cf. Sida 1995; Sida 2002).

In general the work process includes at least one visit of the IHE team to Lusaka, and normally, at least, one visit of the DoE team to Lund. The process of collaboration includes data collecting, discussions, writhing proposals and other texts, conceptualising and analysing the findings etc. The DoE normally takes a greater part of collection of data, and usually, the IHE to a greater extent contributes to the process of developing the conceptual framework and methodology used. Sometimes, the process also includes other parties, such as officers from MoH/CBoH, and experts with project specific knowledge, such as medical doctors specialised in Malaria.

2.3. Outcomes and developed capacity

Capacity development is about supporting and strengthening people and organisations ability to change and develop in their own context. Capacity development is both about building and developing the capacity of researchers to do research and about developing researchers' capacity to carry out policy relevant research and to communicate the findings effectively to policy and decision makers. Expanding policy capacities focuses particularly on improving researchers' capacity to carry out and create use for policy relevant research. Essentially, broadening policy horizons is about the means and relationships that transform research into knowledge which policy makers can use to change policy (Carden & Neilson 2005)3.

In terms of capacity development the Sida support has resulted in strengthened competence in several areas. It has increased the in-house capacity at MoH, IHE and DoE; it has made a contribution to the building of a critical mass of health economists in Zambia; and it has resulted in several policy-relevant studies, a few publications and other capacity developing related activities such as training workshops etc.

2.3.1. Conducted studies and related activities

During the Sida support period 1995–2005 DoE has completed more than fifteen health economics research projects, half of them with personnel from IHE as co-authors, and one research project conducted together with the Karolinska Institute, KI (DoE/UNZA 2005; Sesha-

[3] In this report, capacity development will be used instead of capacity building, this despite that most Sida documents use the latter definition. Capacity building is often described as something built by an outsider, often by installing new technical systems or by providing new knowledge. Using the definition of capacity building, there is also a risk that the support becomes centred on supply instead of demand when using the concept of capacity building. In the case of a wider-reaching process of change the time perspective also tends to be unrealistically short from the perspective of capacity building, which reduces the opportunities for sustainable development. Capacity development, on the other hand, is about providing the opportunity for a characteristic to grow and develop from inside, from the grass root level (Schultz 2005; Sida 2000).

mani et.al. 2002). Most of the research projects has been finished within a year, and has resulted in a written report. Other research projects consists of several studies conducted over several years, as for example the *Costing of a Basic Health Care Package for the 1st, 2nd and 3rd Levels of Referral in Zambia* which resulted in four separate reports. One report for each level (1st, 2nd and 3rd) and a 4th report that updated the whole research before it was consolidated. Another example of a research study that has extended over a longer period is the *National Health Account*. It was initiated in 1997 and has since then been updated every year (cf. DoE/UNZA 2005; Progress Report 2005; Seshamani et.al. 2002). Irrespective of the dimension or the time spent on the research, the studies are considered to have significantly improved the quality of the policy decisions at MoH/CBoH.

At the time of evaluation, three different research projects were running:

- Cost Effectiveness Analysis of Malaria Treatment
- Health Care Financing in Zambia: Paying the Provider.
- Financial Sustainability of HIV/AIDS programmes in Zambia.

Besides carrying out health economics studies the Sida support has also included the hosting of dissemination workshops of study findings; publishing of a book containing the studies conducted between year 1995 and 2000 (Seshamani et. al. 2002); participation in regional health economics workshops; exchange visits with IHE in Lund; networking with other national, regional and international organisations; and to some extent participation in international research conferences, such as the iHEA conference. Together these activities not only contributed to the development of the staff at DoE on a professional level (by strengthened their skills in policy-relevant health economics research), but they have also developed capacity on a personal level (see chapter 4). Finally, but not the least important outcome, the Sida support also has included funding for training in health economics on Master and PhD level (cf. Progress Report 2003; 2005).

2.3.2. The development of a critical mass of health economists at DoE and MoH/CBoH

One important indicator of capacity development is the creation of a critical mass. Within the framework of the Sida support approximately eight individuals have been, or are at the time of evaluation, funded to be trained health economists at Master level at Health Economics Unit (HEU) at University of Cape Town (UCT). Four of these were sent from DoE, and four from MoH/CBoH (of whom most were sent during the last years). In addition, the Sida support has also supported one of the Master students at DoE to PhD level, the departments first PhD specialised in health economics.

The capacity at DoE has also been used to further disseminate health economics among the Zambian students by developing two courses at undergraduate level. The courses are regarded as a helpful tool at MoH/CBoH since it serves in developing their present and presumptive staffs understanding of the subject on a broader basis, to develop capacity in terms of policy understanding, health economics and planning.

2.3.3. Increased in-house capacity at DoE, MoH/CBoH and IHE

When the Sida support started in 1995 there were no health economists at DoE. Consequently, the responsibility of carrying out reliable studies that could be used by MoH/CBoH was to a great extent relying on IHE. But, ten years of collaboration and so called "on the job training" has increased the capacity of carrying out policy-relevant research at DoE. And by that, MoH/CBoH has recognised DoE as a competent local partner. Today DoE are able to carry out studies for MoH/CBoH without the assistance of IHE, and they are also recognised as a Zambian health institution who the MoH/CBoH invites to participate in health related working groups etc. The DoE has, as a side-effect of the support, also gained attention as health economists from international organisations such as WHO. Other signs of developed capacity of health economics are the increased interest of DoE's courses in health economics at an undergraduate level. The health economics courses are one of the most popular and each class facilitates around 90 students.

Just as with the DoE, MoH/CBoH had no staff specialised in health economics when the Sida support begun. During the years, as the capacity has grown, MoH/CBoH's interest of health economics research has increased. And with an increased knowledge of the subject their receptiveness and ability to adopt and criticise the study outcomes, even in the more academic parts has been developed. It has also strengthened MoH/CBoH ability to formulate what kind of studies MoH/CBoH needs, what demands they can have on the implementation of and what to expect of the research. As a result of the improved capacity at MoH/CBoH the quality of the policy decisions and reports are considered to have increased, and that they have moved from being more or less based on presumptions to become more evidenced based.

At IHE, the capacity has mainly been developed in terms of health economics in the field of so-called developing countries. The Sida support has improved IHE's knowledge and capacity in the area of health economics in the Zambian context. The institutional collaboration with DoE is said to have opened up a new market in other non-western countries for IHE and as a side-effect it has resulted in new assignments with organisations such as WHO and the World Bank. The collaboration has also contributed to a PhD at IHE, since the PhD used collected material from one of the Zambian studies (Hjortsberg, C. 2004. *Health care utilisation in a developing country – the case of Zambia*. Nationekonomiska institutionen: Lund).

2.4. Funding setup

Sida releases funds to MoH/CBoH on a yearly basis. In turn, and according to the settled annual work plan, MoH/CBoH transfer a part of the agreed amount to DoE in the beginning of each year, while the other part is paid after completed work. IHE is paid directly by Sida, according to the same annual work plan. Other activities that have strengthen the capacity within the framework of the Sida support, such as the training of DoE and MoH/CBoH staff in health economics is also funded and released trough MoH/CBoH (cf. Sida 2002).

2.4.1 Financial review

With the current agreement (2002–2005) Sida has allocated a total amount of 10 000 000 SEK to the support, 2 500 000 SEK each year. Of the total amount approximately 30% has been allocated to IHE, and 70% to DoE and MoH/CBoH.

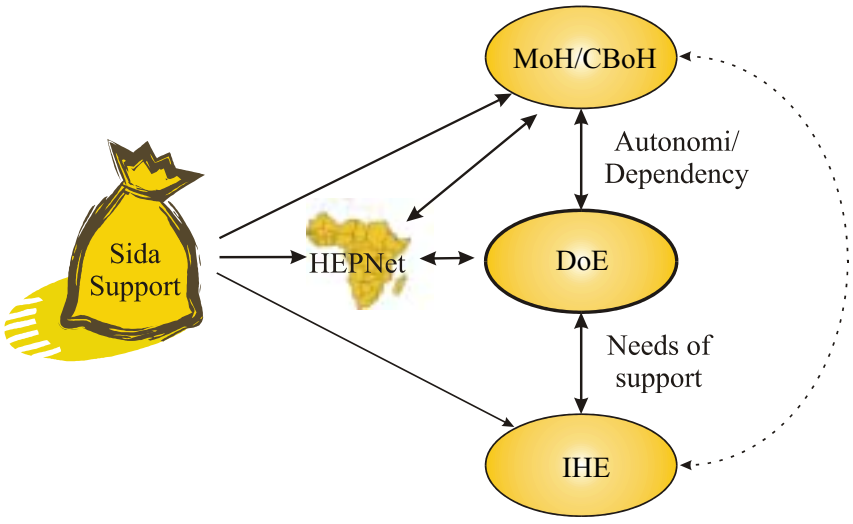
The total disbursement is (2005 estimated):

Year	SEK
2002	1 111 340
2003	2 039 903
2004	3 154 572
2005	3 000 000
Total	9 305 815

2.5. The structure of the Sida support – links and collaborative relations

The structure of the Sida support implies different institutional links and relationships; between MoH/CBoH and DoE; between IHE and DoE and between IHE and MoH/CBoH (with Sida as the common funder). These links have embedded strengths as well as weaknesses. In many aspects they serve as helpful tools in the development of capacity of health economics in Zambia (with special regard to DoE). In other aspects the current links and relationships, especially within the framework of time and capacity that developed during the last ten years, could be perceived as counteract the further development (see chapter 3 and 4).

The relations integrated in the Sida support; between DoE and MoH/CBoH; between IHE and DoE; between MoH/CBoH and IHE, varies in levels of face-to-face interaction, interference, in levels of tight bonds and institutional linkages. As a consequence the different linkages also face different kinds and levels of difficulties. In general, working together in different collaborative efforts, involves interaction between different systems of meaning and types of bias. Interactions that, for example occur at different levels – between different socio-cultural borders, between different economical and political systems, between different disciplines such as between academic aims and policy oriented goals. The difference of collaborative models within the Sida support also creates altered difficulties to acknowledge and reconsider. In brief the link between DoE and MoH/CBoH has to acknowledge the difficulty of how to balance between autonomy and dependency, while the relational link between IHE and DoE has to recognise the needs at DoE and ask whether the collaboration is enough in order to further develop the capacity of health economics at DoE (Fig.1).



In this report the link between MoH/CBoH and DoE and the collaborative relation between IHE and DoE will be highlighted. The former partnership is described and decided by the model of *purchaser* and *provider*, while the foundation of the latter relationship between IHE and DoE rests upon *institutional collaboration*. IHE and MoH/CBoH are also linked, but their interconnection is basically channelled through DoE, and the link could therefore be seen as of secondary interest where IHE meets MoH/CBoH as experts assisting the department. In this report this link won't be further discussed. Worth mentioning though is that this relation does not exclude that personal relationships are established between individuals at IHE and MoH/CBoH, and therefore developed into other side-outcomes.

Finally, the link of other collaborative parties of health economics within the Sub-Sahara African (SSA) region, with special regard to the network Health Economics and Policy Network (HEPNet), will be discussed and analysed. HEPNet will be acknowledged in the light of being an academic tool of capacity development and therefore the focus will lie on the relation between HEPNet and DoE, even though MoH/CBoH also are members of the network.

3. Academic independence and policy relevance
– the link between MoH/CBoH and DoE in Zambia–

The link between DoE and MoH/CBoH can be described in terms of *purchaser* and *provider*, a relation where DoE carry out the requested studies on commission from MoH/CBoH. In this context, the relation is more frequent today than it was in the initial faze of the Sida support. Today the DoE are invited to participate in all health related technical working groups at the MoH/CBoH, a participation which gives DoE an insight of what's going on in the health sector in the Zambian society. At the same time the interest and receptiveness of research at MoH/CBoH has increased, as well as their ability to adopt and criticise the study outcomes. The support has created a deepen communication between the parties, a dialogue about the requested studies, its questions at issue, disposition, expected outcomes etc. DoE' ability to carry out good quality policy-relevant research of health economics has increased, a fact that also has been recognised by MoH/CBoH. As policy makers they have recognised the quality of the research carried out by DoE and regard them today as a competent partner to turn to when health economics is needed. The strengthened capacity of health economics at DoE in terms of policy-relevant research is visible in the fact that they today even carry out studies for MoH/CBoH without the assistance of IHE.

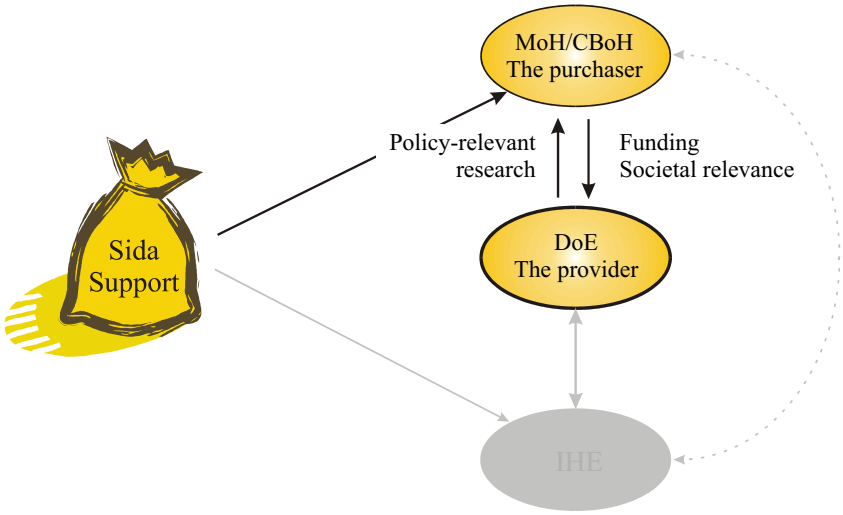
In other words, the capacity has, at both the Ministry and the Department, increased at several levels, and as a consequence, they both regard the link between policy makers and researchers as a necessary prerequisite for further development of the health economics sector. MoH/CBoH experiences an increased demand of health economics evidence based studies within the health sector in order to use the information for developing new policies. DoE, on the other hand, values the link to the health sector and sees it as necessary in that their research and studies are demanded and used. The collaborative link also helps DoE to focus 'relevant' research, research that do not just stay within the walls of the University.

Although the positive outcomes of the purchaser-provider model are multiple, the model possesses some embedded problems. This is even more visible when the provider is an academic institution, an institution where the academic capacity needs to be developed and strengthened in parallel with the skills of policy-relevant research. Issues about independent academic research in combination with commissioned research are therefore a recurrent theme in the meeting between academic research and policy.

3.1 The Purchaser-Provider Model

The purchaser-provider model could be viewed as an attempt to introduce businesslike relations between units in the public sector who produce and units who purchase, as a way of moving towards market oriented means of performance. This businesslike relation within the public sector implies that economic means of control is in favour of rules and policies. The model opens up for a market-like situation where other producing units, within or outside the public sector, could be invited to leave an offer on services on demand and by that the competition are increased. Increased competitions within the public sector are supposed to improve the efficiency.

With this kind of marketisation it is important to create and maintain clear roles between the units since it is within these roles that agreements of expected service and compensation are established and fulfilled. These roles are defined as *purchaser* and *provider*. If the *provider* negotiates an agreement that results in a high financial outcome in relation to the amount of work it implies the (providers') unit is considered to be more efficient. And as a consequence the units economical frames are usually strengthened which also improves the freedom of action. If the opposite occur, that the *purchaser* obtain an agreement that gives more than the economic contribution implies, the purchaser is regarded as a good purchaser. The model entails, in other words (implicit or explicit) to both the provider and the purchaser to protect the own units' interest without considering the full picture (Forsell & Jansson 2000).



The model has awakened a lot of attention in the health sector in Sweden since it is seen to increase the efficiency, but also since it improves the purchasers influence. In comparison with other funding models traditionally used in the public sector the purchaser-provider model clarifies what actually is ordered (Brinkmo 2004). The model helps MoH/CBoH to really get what they want, within an agreed time and at an agreed cost. It also assures that DoE stays within the agreed contract frames of the research so that it meets the needs of MoH/CBoH (Fig.2).

To a large extent, the increased purchasers influence is about framing the providers' freedom of action, frames that, as illustrated above, have its advantages. Exactly how tight the frames should be are decided at negotiations between the parties, but the question is – can these frames be too tight? Is there any risk that the purchasers influence can be too big, where the providers alternatives at the negotiating table are too

limited? This dilemma is acknowledged by the providers (by DoE and their partner IHE) and it is important to take into consideration in the link between DoE and MoH/CBoH since DoE only have one purchaser (with funds from Sida). Further more, the purchaser (MoH/CBoH) have, in this case, proportionately autonomously been able to decide how the money should be spent, such as how much to apply on studies of health economics and how much to put on capacity development of staff at both DoE and MoH/CBoH.

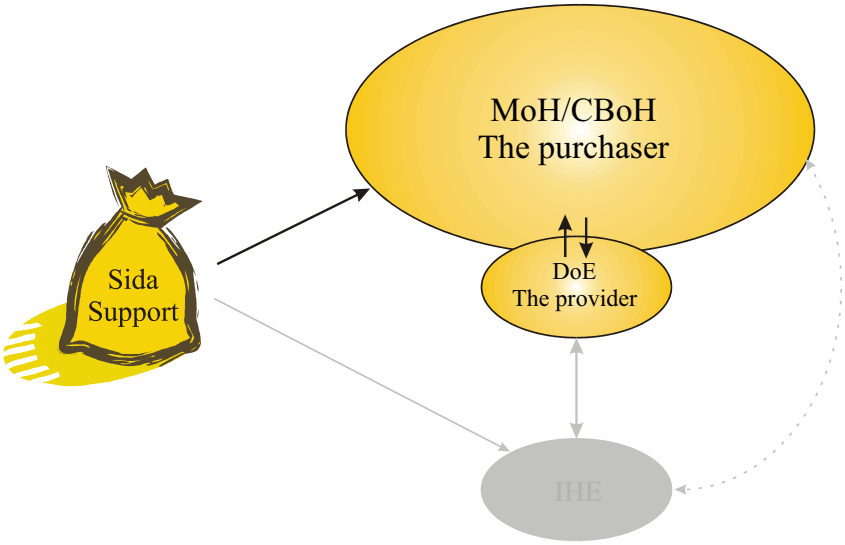
The power structures embedded in the link between DoE and MoH/CBoH highlights two other important issues embedded in the model. First of all is the question of how much power a purchaser with earmark support from Sida should have, or ought to have, towards its provider (3.2). Secondly, it raises the question of academic independence at DoE, an issue that also points at questions of quality, capacity and sustainability (3.3).

3.2. Funding setup as a structure of power

As pointed out earlier, the funds from Sida to DoE is channelled though MoH/CBoH in a purchaser-provider arrangement. MoH/CBoH purchase studies within the area of health economics that they see as useful, and DoE are expected to carry out the research agreed upon, and get paid after the studies are done. Simplified, it is MoH/CBoH that decides both what to be done and what economic space to give DoE for the assignment. The Sida support has also been used to strengthen the capacity in other ways, such as sending staff from both DoE and MoH/CBoH to obtain a Master degree of health economics at Health Economics Unit (HEU) in Cape Town (as well as one PhD at DoE). However, even in these cases it is MoH/CBoH that is the fund holder and by that decides how to distribute the funds.

> The MoH/CBoH is the leader in this collaboration; we decide what the money that goes through the collaboration (Sida support) should be spent on. We are the leader because we are the beneficiaries.
>
> – MoH/CBoH

In a long term perspective, the purchaser-provider model ought to presuppose relatively equal partners. If not, the risk is that one partner, in its ambition to strengthen the own institutions capacity, increases its capacity on behalf of the other partner. The risk with the model is that one partner develops an unhealthy dependency of the other partner. In a longer perspective this implies that the institution that is under a disadvantage threats to be drained on resources and competence since the space to maintain and develop capacity has decreased (Fig.3).



The current funding setup has a tendency to give MoH/CBoH an important advantage over DoE, even though MoH/CBoH and DoE (and their partner IHE) have common discussions before the frames of the agreement been settled. There are situations where such a discussion with DoE has led to some changes in MoH/CBoH's perception of the direction of the research. But, as pointed out earlier, it is clear that with the current funding setup MoH/CBoH have relatively great power to decide the condition of the partnership, and that it limits DoE possibilities to be met with sympathy of other questions at issue, alternative approaches and accomplishments etc. The embedded dependency of the model gets stronger when the financial space, the salaries and other privileges, outside the support is proportionately small which makes the Sida support an attractive opportunity. The collaboration with an external partner such as IHE is one way for DoE to maintain, at least a small, distance to MoH/CBoH.

> Sometimes I feel that we have been treated as an annex to the ministry. – DoE

The above mentioned embedded aspects of the purchaser-provider model opens up for the question of whether the current setup and its link between MoH/CBoH and DoE counteract the academic capacity development at the department. it also raises the question of how a balance between the two can be created so that the policy-relevant research continues to be strengthening at the same time as high academic credential[4] at DoE develops.

3.3. Academic independence and policy relevance

The specific object of the Sida support is to develop capacity at DoE to provide MoH/CBoH and other partners with quality analytical work in the area if health economics, and in the light of the later, at least seen from a short perspective, the support has been successful. But, capacity development is not just about developing researchers capacity to carry out policy-relevant research and to communicate the findings effectively

[4] With academic credential we use the definition of Dr. Knut Ödegaarrd at IHE. A person with high academic credential is described as a person whose knowledge is respected, that has a high position in society and is part of the public debate (Evaluation Seminar at IHE, Lund, 16/09/05).

to policy and decision makers. It is also about developing the capacity of researchers to do research. So, what capacity has actuality been built and developed at DoE?

The relation between science and policy making institutions are often regarded as problematic. One aspect that makes the link between research and policy difficult is that there is an inadequate supply of policy-relevant research as a result of limited communication between researchers and policy makers. Another aspect is that there is a flawed or low demand for research, that policy makers actually ignore the policy-relevant research that already exists, or that they may be incapable of absorbing and using research (Stone and Maxwell 2005). The strengths of the Sida support and its construction lies in these aspects, aspects that many other attempts of making research vital for policy makers and *vice versa* experience as failures. The Sida support has contributed to an increased access and susceptibility of useful research.

An assumption in analysis of policy-relevant and academic research is that capacity on an academic level already is developed. But what happens, as in the case of DoE, when the capacity is too small? How does one then maintain and create a balance between dependency and independency, between policy-relevant and academic knowledge? Independent academic research presuppose independent researchers and institutions, which often are met by more or less permissive economic resources, and an adequate mass of good quality researchers. At DoE there are a total of eight persons whose assignment, except health economics, is to meet the need of teaching and research throughout the whole of Zambia in the discipline of economics. When the support started in 1995 there were no health economists at DoE at all. Since then four individuals has gained a Master and one PhD within the frames of the support. But today, ten years later, there are only two of these health economists left at the department, one with a Master and one with a PhD. With only one health economist at PhD level the developed capacity is rather scarce.

> While we have trained health economists at the department I have been disappointed that they don't return after graduation. If people don't return, the department can't build the capacity that is needed. They can't build up a core team of public health specialist that could undertake teaching and therefore strengthen the teaching a little bit more and be responsible for research. Today we only got Felix (the person with PhD), and he could easily get lost. If he gets a tempting offer he might move away.
>
> – MoH/CBoH

At the same time as the critical mass of health economists at DoE are scarce, the 'pool of health economists' at MoH/CBoH is rapidly increasing. In short there will be five health economists at MoH/CBoH, in comparison with DoE's two. In the long run this is an unfortunate development since the capacity needed at a university department such as DoE is different from the needs at a Ministry. DoE are thought to fill the needs of health economics in Zambia, not only by the learning of the conceptual world of health economics, but also as educators and developers of the academic knowledge of the subject. Therefore the need to build and develop academic capacity at DoE in terms of academic independence, critical mass of health economists, integrity, international acknowledgment etc (so that the availability of policy-relevant research in the

long perspective can be filled) is huge. This aim, however, are felt to be difficult to achieve within the current arrangement of the Sida support. And the ambition to develop capacity is even harder to achieve as the pressure increases at DoE as the competence and susceptibility at MoH/CBoH improves, and by that an increased demand of policy-relevant health economics research. Simplified, even the positive signs of achieved capacity development of health economics at MoH/CBoH can be felt to be negative if the pressure of a few individuals gets too big, which highlights the importance of speeding up the development of a critical mass of health economists.

In sum, the capacity of health economic skills has, during the last ten years, increased at both DoE and MoH/CBoH in several ways. As the capacity of policy-relevant health economic research skills at DoE has been strengthen, and by that the quality of the research produced, MoH/CBoH, as policy makers, have recognised the quality of the research. The Ministry has become more accepting of the findings and is able to see how to use the knowledge for developing new policies. However, in line with the increased capacity at DoE the academic ambitions are getting stronger. The staff at the department is no longer satisfied with just working on demand of MoH/CBoH, they want to get published in academic journals, attend international conferences etc. These dreams of strengthening and entering the international academic arena of health economics clashes to some extent with the embedded dilemmas of the model used in the Sida support between MoH/CBoH and DoE – the purchaser-provider model.

4. Institutional collaboration as a vehicle of capacity development
– the collaborative relationship between IHE and DoE at UNZA –

The characteristics of most support programmes are that they appear as short-lived historical episodes. The Sida support to institutional capacity development through institutional collaboration has so far lasted over 10 years and in this respect the institutional collaboration between DoE and the IHE is an exception. Since the initial faze the support has provided MoH and CBoH with quality analytical work in the area of health economics, resulted in several studies and projects, workshops etc. It has also, as a side-effect, generated a broaden market for both IHE and DoE, and worked as a door-opener for the international arena.

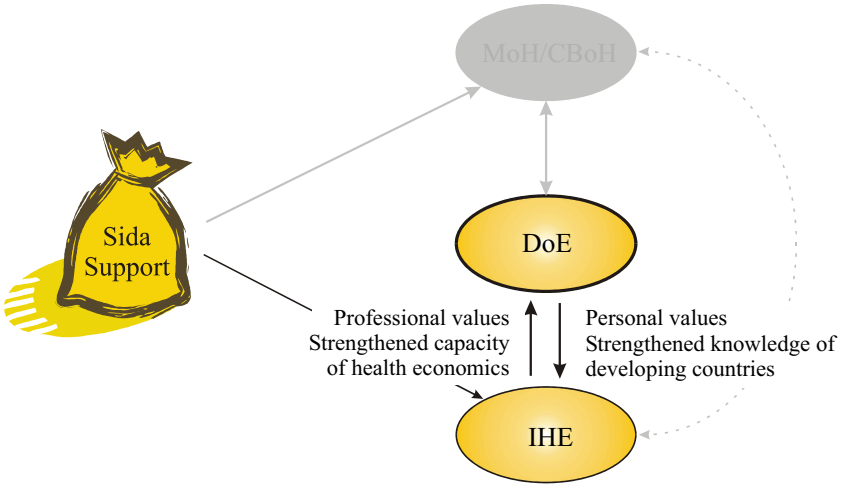
The collaborative relationship between IHE and DoE have both strengths and weaknesses – it is perceived as a helpful tool to develop capacity of health economics, but, on the other hand, since the capacity has increased, it is in some aspects also perceived as counteract the further development. One issue that, on the evaluation seminar at the Swedish Embassy in Lusaka, was acknowledged was that IHE was not sufficient as capacity developers for DoE since they are not a University institution, i.e. an institution that can contribute both with academic research *and* training. However, the strengths of the collaboration, seen both from the view of actual outcomes such as finalised policy-relevant research, and from the involved parties' experience of the collaboration, are multiple. To create a sustainable, long term collaborative relationship between parties situated in different continents and with different socio-cultural, political and economical contexts is not an easy task. Collaborations are, generally speaking, quite easy to initiate, but much harder to sustain, and it is therefore important to acknowledge what creates a long-term collaboration, what makes it vital and sustainable.

4.1. Values of the collaboration

Within the institutional collaboration and its collaborative relations between IHE and DoE three levels of values can be identified. First, there are the values on a professional level, a level that includes growth and strengthened capacity of health economics skills and methods. Secondly there are infrastructural values, values that include access to libraries at IHE, technical equipment, access to books and journals. Thirdly, are the values on a more personal level. Values that help individuals to build and develop an identity as a health economist, that creates personal relationships that go beyond the collaboration, and so forth. Together these values and strengths of the collaboration have

improved "…the collaborative parties' knowledge and capacity in the area of Health Economics in the Zambian context…" (Sida 1995:1). In other words, the capacity of health economics has in many respects increased at both IHE and DoE, but, what are the components that have contributed to the collaboration's vitality?

One major ingredient of the institutional collaboration is the trust building (cf. Erlandsson & Gunnarsson 2005). During the years of collaboration; relationships on both a professional and personal level has been built between staff at IHE and staff at DoE. The collaboration has contributed to widen the perspective of health economics in terms of experiences from a different context and it has created individual contacts between health economics colleagues, relationships that sometimes been transformed into friendship. Values that emerge from feelings of trust created within the collaborative relationship.



However, the values of the collaboration were expressed slightly different at the DoE and at IHE, even though they both unmask the importance of the individuals involved in the projects and studies. Aspect of informal relations, creation of colleagues, friendships and growth on an individual private level were seen as a recurrent outcome, and maybe even the most important value, of the collaboration at IHE. Words used to describe the collaboration were 'mutual respect' and 'understanding'. It was also emphasised that the institutional collaboration with DoE were regarded as and treated differently from other assignments and (consultant) work at IHE. Being in a collaboration in this context, and in comparison with the other assignments at IHE, meant flexibility, less deadlines and time pressure.

> One important thing to mention is the personal contacts that we get and that we have managed to maintain. Even though these persons leave […] the contact is kept by e-mail. […] That doesn't happen when you are doing other consultant assignments. The difference is that we are colleagues that work together during a long period of time. This is not consulting, it is something else. We become friends and they trust us.
>
> – IHE

> The collaboration has given me the opportunity to develop academically. It has given me economical support and it has given me the capacity to behave like a health economist
>
> – DoE

At DoE the personal values was more integrated with the professional values. Increased capacity of health economics at the department were perceived and experienced as an individual chance to develop professional, but also to create a stronger identity as health economists.

The perception of where the main emphasis of the collaboration values lies is highly contextual. Since the Sida support consists of several parts that IHE are not involved in, the question of personal values is complex and more difficult to separate at DoE. The institutional relationship with IHE is only one component of a much wider programme that except the link to IHE includes collaboration with other international institutions, training of staff etc. For IHE, on the other hand, the collaboration is quite easy to isolate from other work done at the institution since it differs in how the work is planned and carried out, but also the contextual difference. Another aspect that affects the way the collaboration is perceived emerges from the context of the work environment. At IHE the criteria of the individuals working in the collaboration are, besides that they are well-educated health economists, that they have a special interest in working in developing countries. At DoE, as a University Department of Economics, the voluntarily grounds of choosing to be part of the collaboration is more doubtful. Since the collaboration is an important source of income, both for the department as a whole and for the individuals *per se*, the assumption is that there is staff involved at the DoE that wouldn't necessarily choose health economics as a topic.

Although some difference of how to perceive, express and experience the personal values of the collaboration were visible, the fundament were shared. A fundament based on trust. The different ways of reflecting over the most important values of the collaboration is dependent on the context, but without an individual openness and a personal engagement in the relationship trust and reliance wouldn't have been created and the collaboration wouldn't have been vital after such a long time.

4.2. What is an institutional collaboration?

As pointed out above, to sustain and make a collaboration vital, both professional and personal engagement and enthusiasm is necessary. But the Sida support is by definition going to an *institutional* collaboration, what's the meaning of that and, in terms of institutional collaboration, has the support been successful?

In general it could be held that the term collaboration, if based on equality and voluntarily basis, implies different levels of shared behaviours, values and goals (cf. Powell 1991). Sida's rather vague definition of institutional collaboration leaves the issues of what it contains unanswered, even though it do state that it should be based on mutual competence and institutional capacity strengthening in both collaborative institutions, i.e. both at DoE and at IHE.

> Institutional Collaboration (IC) represents a new mode of cooperation in the health sector between Zambia and Sweden. IC is based on mutual interest and aims at development of mutual competence and institutional capacity strengthening with improved continuity in the dialog and development process between the collaborating partners (Sida 1995:1).

Working in collaboration in different contexts where the goal of the collaboration is based on capacity development given from one of the collaborative parties (IHE) to the other (DoE) raises the question of mutuality (but not necessarily in-equality). The fundament of the current collaboration rests upon IHE giving and sharing their knowledge and experience of health economics issues where they work as a supporting partner to DoE. In this regard it could be seen as a relationship between a client and consultant, between a student and a supervisor. But as the name implies, the institutional collaboration is, by both parties, perceived as something more than a consultant service which goes beyond the linear relation of consultancy. A consultancy are focused on the assignment, when the assignment is done, the 'relationship' is over. The collaborative relationship between IHE and DoE, on the other hand, contains ingredients of collaborative art such as shared responsibility of carrying out fieldwork (data collection), discussions, writhing proposals and other texts, conceptualising and analysing the findings etc.

The collaborative relation between IHE and DoE are described as an equal relation based on shared responsibility between colleagues. But it is also described, on a more institutional level, as a relation where IHE assists the staff at DoE in carrying out policy research, as a relation where IHE define equal partners as a partnership where "IHE doesn't have any interest of 'run over' DoE" (Evaluation Seminar at IHE, Lund, 16/09/05). The fundament of the collaborative relation lies on IHE's role as an expert of health economics that shares its experience and knowledge by 'learning by doing'. Since is hasn't been part of the current arrangement, IHE's ambition are *not* to market their brand by publications in academic journals etc.

> Many of the studies that we have done in Zambia have been studies that we wouldn't publish in Sweden, but this assignment has been different. It is also true that we never, looking back, had the ambition that the studies done within the framework of this collaboration should be published.
>
> – IHE

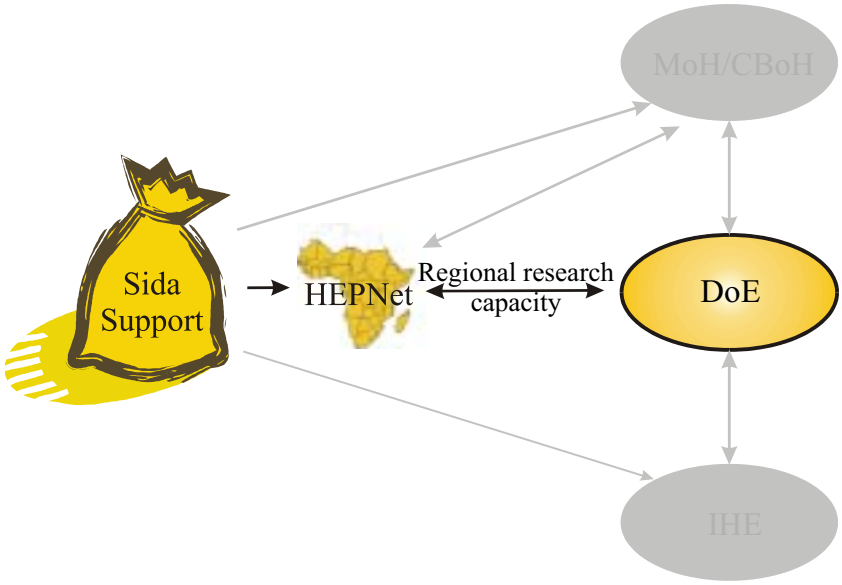
As visualised in chapter 3, the collaboration so far, the method of 'learning by doing' policy-relevant research at DoE, have developed capacity to a certain level. The method and collaborative effort have so far increased the capacity at DoE where the skills and knowledge of health economics have been multiplied, but seen as an institutional collaboration (in Sida's definition), the question must be asked – is the collaboration between the two institutions a collaboration between two mutual competences? And, is institutional collaboration in Sida's definition of mutual competence and institutional capacity strengthening, really what DoE needed in 1995, and still needs, in order to further develop capacity of health economics? In conclusion it could be stated that it is not mutual strength and competence that is the first priority in capacity development of a university institution where a new discipline is too be developed and built from scratch, and where the capacity as a whole is weak. Institutional collaboration in the meaning of Sida's definition might today be what DoE need, since their capacity has been strengthened which implies that they might be able to take another role. But when the collaboration started, an institutional collaboration in Sida's definition, was not what DoE needed, or even were able to participate in. As a consequence, the collaborative parties have, as showed above, been pragmatic

in the interpretation of the concept. Therefore, the collaboration has, and still does, contribute to capacity development of health economics at DoE (and at MoH/CBoH), although the mutuality of competence at the two institutions is unbalanced.

5. Communication as the hub of co-operations

– Regional development of health economics in Sub-Saharan Africa –

One way of developing the academic level of research at DoE is by using and taking advantage of the regional capacity. One such source of regional academic capacity of health economics is the Health Economics & Policy Network in Africa (HEPNet), a network where for example peer review of research in progress can create contexts within which researchers have the opportunity to learn from others. The advantage of using regional capacity is the sharing of knowledge and experiences within more or less equalcontexts.



DoE is a member of HEPNet where the academic capacity is vital, but, as will be highlighted below, the involvement and commitment of the DoE is scarce. The evaluation of *Sida support to health economics capacity through HEU-UCT* (Erlandsson & Gunnarsson 2005), as well as this evaluation, shows that difficulties in the communication structures within DoE are one factor that make the commitment and involvement in HEPNet more or less invisible. At the same time, the communication between IHE and DoE works. This raises the question of what underlying factors decides and contributes to a vital and active partnership.

5.1. Health Economics & Policy Network in Africa, HEPNet

HEPNet is an African health economics and policy network with one of its main goal to create a critical mass of health economists working with relevant topics within the field. Another aim is to strengthen the linkage between research institutions and health policy makers, i.e. to make sure that health economics are the basis for health policy decisions.

The first sketches of a possible structure of a regional network were actually discussed in Zambia, at a two-day workshop in Kaufe Gorge, in August 1999. At the workshop five countries (Zambia, Uganda, Zimbabwe, Tanzania and South Africa), Sida and Alliance for Health Policy and Systems Research participated. This workshop resulted in the formation of HEPNet in the year 2000 (cf. HEPNet 2004). Both MoH / CBoH and DoE in Zambia were identified as members of the network[5].

By using the capacity of health and policy economics within the network, DoE could be able to get training, both by more frequently using the network's bursaries for Master students at the Health Economics Unit (HEU) at University of Cape Town (UCT) and by attendance on the HEPNet initiated workshops. The network also supports participation at the International Health Economics Conference (iHEA) by paying the fees for those members who get their research abstract accepted, and peer-review (and supervision) is given by seniors at HEU and Centre for Health Policy (CHP). But, most of all, the network could contribute to the capacity development of the academic level at DoE.

5.2. Awareness of HEPNet as a regional tool to develop capacity at DoE and MoH/CBoH

It is quite easy to initiate a network co-operation, but it is much more of a challenge to sustain it. Usually it takes several years to build up and consolidate a meaningful network, and it is often hard to keep the enthusiasm and activity up. It is then important to have active members that contribute to the co-operation – without it, it is not possible to sustain the network. The evaluation of *Sida support to health economics capacity through HEU-UCT* (Erlandsson & Gunnarsson 2005), as well as this evaluation, shows that the DoE at UNZA are struggling with internal communicational difficulties, which has resulted in a very low awareness and knowledge about what HEPNet is, what it can do and how to approach it.

The lack of a well-functioned communication structure[6] within DoE leads to two opposing descriptions of the institution's involvement in HEPNet. Two different perceptions of the involvement in HEPNet illustrated below, where the spokesman (at DoE) of HEPNet paints one image and the other members of the department paint another.

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[5] Sine both the purchaser-provider model and the institutional collaboration mainly have focused on policy-relevant research and by that to some extent ignored the academic level, the focus on HEPNet in this chapter will lie on the networks' academic capacity and therefore only reconsider DoE. For further reading about MoH and CBoH relation to HEPNet see Appendix B.

[6] Communication takes a central position in all co-operative efforts and includes communication on different levels, and it is therefore important to clarify what issues of communication that will be discussed. Within HEPNet, as well as other networks and collaborative efforts, a distinction between information structure and communication structure could be made. The information structure refers to questions of how the information is organised, such as what languages are used in writing, on workshops and seminars, if written or electronic documents are used etc. Communication structure, on the other hand, refers to the exchange and flow of information within the network/collaboration and institution, i.e. how the different actors are connected by links and collaborative relationships (Berggren & Elfving 2004). When discussing communication, the evaluators will refer to the communication structure.

Spokesman	Other members at the department
Here at our institution I think that HEPNet is one of the major activities that we are looking forward to this year and at this department there's a full awareness of HEPNet.	As an institution you don't know much about it, just that you're a member. It's difficult to learn more since you don't know how to go about finding information, or what the network can do for you or what you can do for the network. We have never had a meeting where HEPNet has been discussed at this department. HEPNet is pushed aside and only a few individuals who have come close know anything about it, while others actually don't have any idea about it.

Although the internal communication structure at DoE, to some extent, explains the lack of involvement in HEPNet, on both individual and institutional level, other issues also contributes to the overall picture of the network. A picture that contains images of a network based on individual enthusiasts and free-riders[7] as a consequence of an inadequate institutionalisation process within HEPNet (as a whole and on an in-country basis).

Even though the knowledge of HEPNet varies, from "not knowing what it is" to being aware of the constellation, those who know what it is can see its potential and wishes to be included in the network.

5.3. Communication structure within the institutional collaboration between IHE and DoE; and DoE and HEPNet

One of the most crucial factors that are influential in the success of collaborations between organisations is communication, since it is the cement that binds organisations, and a medium for exchanging ideas that builds trust and so forth (cf. Knoke 1991). As pointed out earlier, the relation within a network (and collaboration) relies on trust, without trust the involvement most probably will be less. One important factor in building trust, or at least to help preventing misunderstandings, is to meet face-to-face. This is one crucial reason of why the knowledge of the institutional collaboration is high, while the knowledge of HEPNet at DoE is minimal. IHE meets DoE face-to-face several times a year, while there is only one person at DoE that has attended HEPNet activities over the last years. One conclusion is that it is not enough with infrastructural values by dissemination of information *per se*; there can not be any exchange of information without communication (cf. Hård af Segerstad 1983).

However, distribution and dissemination of information is crucial for every collaboration and network regardless of the topics in focus and the fundament of networks. At the point of the evaluation of HEPNet (February–March 2005), internal communication difficulties at DoE was acknowledged, and as a consequence the involvement in HEPNet was undetectable. But at the same time the communication structure within

[7] *Enthusiasts* within a network context are individuals who are very involved and have the ability to involve others. The enthusiasts are of great importance for the survival of networks and collaborations, but one problem that can occur is if these enthusiasts don't get the right support from colleagues and management within the institution (Erlandsson & Gunnarsson 2005). Another, often reoccurring problem within networks (and social movements) is the problem of *free-riders*, i.e. individuals that choose not to contribute to the networking activities. By taking a "free-ride" they can profit from the work of others without bringing anything to the work process themselves (Berggren & Elfving 2004:28).

the institutional collaboration between IHE and DoE was well-organised. The most obvious difference in organising the two collaborations is in terms of institutionalisation. Institutionalisation can be seen partly in the way the different institutions act and relate to the collaborative partners and network, and partly in more formally stated agreements between the member institutions. Within HEPNet a majority of the member institutions have not integrated the network in the in agenda, in opposition to the institutional collaboration where the institutionalisation process are well developed at both IHE and DoE. This can be visualised through the way the information are disseminated at the member institutions.

The communication structure within the institutional collaboration between IHE and DoE are organised through a coordinator. Each project and study consists of one coordinator at DoE and one at IHE, where the coordinator takes responsibility for the specific study. This includes that the coordinator passes information about how the projects are proceeding to the members directly involved in the specific project. However, within DoE there are no general structures of communication, which indicates that if the coordinator does not pass the information to members of staff not directly involved there will not be shared knowledge about the researches and studies on an institutional level. This lack of formalised communication structure is one reason why HEPNet are not part of the agenda at DoE. In this respect, it shows that an institution with internal communication problems still can be a good partner in collaborations, but this normally requests some kind of formal agreement, and that representative of the institutions meet regularly, face-to-face, to develop trust, reliance and commitment. These face-to-face meetings and formalised structures of communication are vital between IHE and DoE, but not between HEPNet and DoE.

Although the internal dissemination and communication structure on the department as a whole, as a working place, has been limited there are some recent changes in the communication structure. At the DoE the responsibility of dissemination of information within the projects, as pointed out earlier, used to solemnly rest upon the coordinator, but since March/April 2005 there have been a changed meeting structure. A formal structure where each member of staff are obligated to participate, where minutes are taken and issues from previous meetings are reviewed. In what way this will change the active involvement in HEPNet or not is still to be seen.

Simplified, the internal communication difficulties at DoE have resulted in a more or less non existing involvement in the network, a participation that has been limited to one person at the department. But the involvement in networks also presupposes time available, and since time is valuable at a department overloaded by work, it demands that the network must be prioritised. Another aspect that might have contributed to the minimal awareness of what HEPNet actually can do is that the capacity of the academic skills of health economics at the DoE used to be low.

Strengths of HEPNet lies in the academic capacity of health economics and policy research, and the network has to a great extent been directed by academic values, even though it is supposed to strengthen the policy-relevant values as well. This should not be seen as a critique, and instead be regarded as a cornerstone in what the region needs, as well as DoE in Zambia, in order to further develop the capacity of health economics. When the network were initiated in 1999, the DoE were

probably not able to be an equal partner in terms of health economics experience, but today when the capacity has been strengthen the roles have changed. DoE ought to be able to use HEPNet as a tool of capacity development of health economics and policy, but also be able to share own experiences of, for example, what has been learned and achieved through the institutional collaboration with IHE. Another experience to share is the success of integrating policy-relevant research at both the Ministry and at the department in Zambia. In the future HEPNet could, in other words, serve as a vehicle of development of academic skills of health economics and policy capacity at DoE.

6. Conclusions

As pointed out in this report, the increased capacity of health economics at DoE has developed and strengthened the academic ambitions, ambitions that to some extent clashes with the embedded dilemmas of the purchaser-provider model, but perhaps also with the model of institutional collaboration. The link between MoH/CBoH and DoE is clearly a business relation, while the relation between DoE and IHE are based on collaborative grounds of trust and reliance. But isn't the institutional collaboration also to a large extent a business relation between three parties – between IHE, DoE and Sida? Even though there is some flexibility embedded in the relation between the collaborative parties, the frames are strictly regulated by Sida and IHE according to the present contract. An example of this is that even though there is an obvious need of developing academic capacity at DoE, IHE's academic capacity haven't been used since it is not part of the current arrangement with Sida. In this respect the institutional collaboration differs from 'clearer' collaborations such as HEPNet.

With changed capacity at DoE the demands and needs have changed, but the methods of developing capacity has stayed the same over the last ten years. The limitations of the methods used shows that there is a need to create a greater flexibility in the setup. A need to develop flexibility in the organisational setup that follows the development of DoE, instead of making DoE restricted to the methods used. As one consequence of the static elements embedded in the models the building of a critical mass has been very slow.

6.1. Critical mass at DoE/UNZA

Developing health economics and policy in Zambia with special regards to the DoE (and MoH/CBoH) entails a need to create a critical mass of good quality health economists. This includes individuals with skills both on a high academic level and skills to carry out policy-relevant research. As pointed out earlier, a total of nine have been (or are about to be) educated in health economics at University of Cape Town. Five of those have, or will, return to MoH/CBoH, but only two have returned to DoE (one on PhD level). In creation of a critical mass at an University institution, it is crucial to build a stable ground of several individuals on a PhD level in order to, for example, supervise Master students. It still seems to be difficult to recruit and keep health economist at DoE, and seen from a perspective of ten years, the process of developing a critical mass of health economists at the department has been slow.

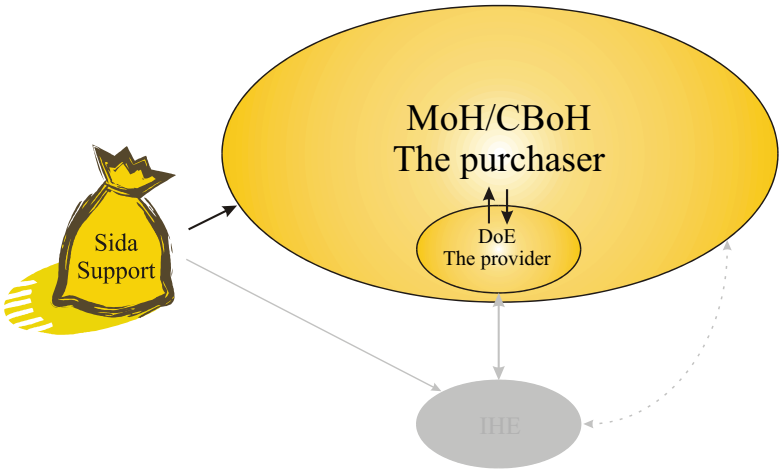
One often recited view is that the graduated Master students choose not to come back to the institution since they can get better-paid jobs in the country. This implies that the capacity stays in Zambia, but it doesn't help DoE in developing a strong base to rest upon. However, one interpretation of the evaluation seminar in Lusaka is that it's not only a matter of salaries and other privileges; it is also a matter of numbers of health economists in the country. The critical mass of health economists doesn't exist.

In the context of the Sida support it is important to acknowledge the whole critical mass at DoE, that is the capacity of both economics and health economics. Even if there only are two who are trained health economists at the department, there are a total number of eight economists at DoE, where two are seniors. They have all participated in the collaboration with IHE and carried out policy research for MoH/CBoH and by that developed capacity of health economics. In other words, to develop capacity at DoE is much more than capacity of health economics. Simplified, one way forward could be to increase the support to the local Master programme which would make the local training available and by that speed-up the capacity development of both economics and health economics. It might also result in an increased academic capacity and by that transform to an attractive work environment which would draw educated economists and health economists to the department. However, even if the local Master program would be strengthened the questions of how to increase the speed and how to create an environment where the educated health economists want to return are still to be acknowledged.

6.2. Organisational setup

Both models used to develop capacity of health economics in Zambia have contributed to a strengthened capacity at DoE in multiple ways, and to a great extent the successful improvement lies within the models used. The institutional collaboration has assisted in building and creating health economists at DoE, where the process of learning to do policy-relevant research has been developed with help from the knowledgebase at IHE. On the other hand, the purchaser-provider model has created a depth to the studies carried out, where the model assures that the research will be acknowledged and used. Together the models have helped to develop individuals with an increased self-esteem as professional health economists. However, lately, the models have contributed to the creation of an academic vacuum. The purchaser-provider model with it's embedded problematic of dependency and the institutional collaboration with its insufficient capacity to cover the needs at DoE. The third collaborative link, HEPNet, could be an alternative tool and complement in strengthening and filling this academic vacuum.

As discussed earlier in chapter 3 there are some embedded difficulties with the purchaser-provider model, and there is a tendency that the link between MoH and DoE will develop to be more unbalanced than it is today. The risk is that if the Sida support continues as today, the MoH will further increase its ability to purchase and negotiate which will lead to an even greater pressure on DoE. With an increased pressure the DoE dependency on MoH will augment, at the same time as more staff at MoH will be gaining skills of health economics at HEU. If this tendency is to come true, if the DoE will be apprehended as more or less an annex to the MoH/CBoH, one might have to ask whose capacity is really developed.



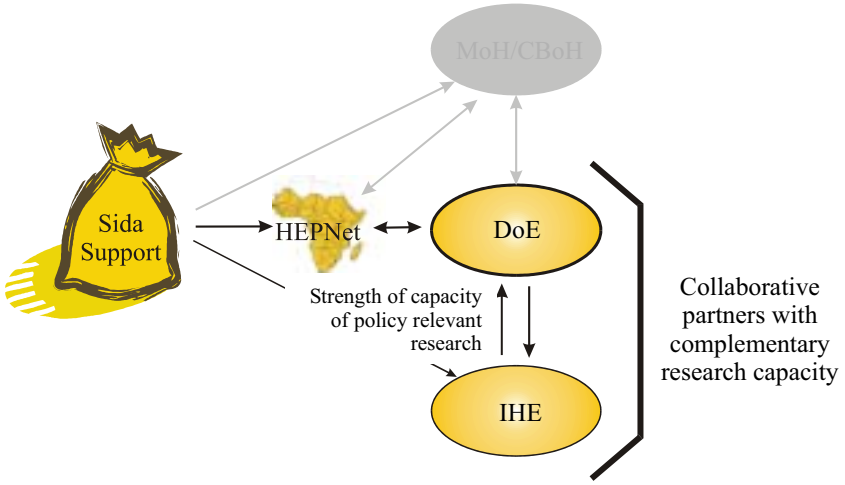
One way of relinquish this scenario could be, as discussed by the stakeholders, to develop a separate unit for health economics. A separate unit for health economics would clarify the roles between the Ministry and the department, and open up for other funders and purchasers. In other words, the dependency would decrease as a result of other purchasers and funders entering the arena.

Another effect of a separate health economic unit, acknowledged on the evaluation seminars, could be strengthened and developed academic skills of health economics research at DoE. The unit are planned to concentrate on research in health economics, policy analysis, consultancies and training (Minutes from the meeting with UNZA and GNC 15/9/05), which would imply a greater survey of the health economics situation as a result of the clear division of work. A separate unit would clarify the role of health economics within the department, where an institutional arrangement to manage health economics programmes would be and where the division of work between health economics and economics would be pronounced. It would make the individual choice of specialisation of health economics easier and clearer, and would hopefully assure that health economics are not at the expense of other economic topics. This also implies legibility towards the surrounding of what skills and expertise to expect, which thereby makes it easier to attract external partners, and by that increase the academic independence. A unit might help further development of academic skills at DoE, but there is nothing preventing such a development today, with or without a separate unit of health economics, even though such a unit probably would help.

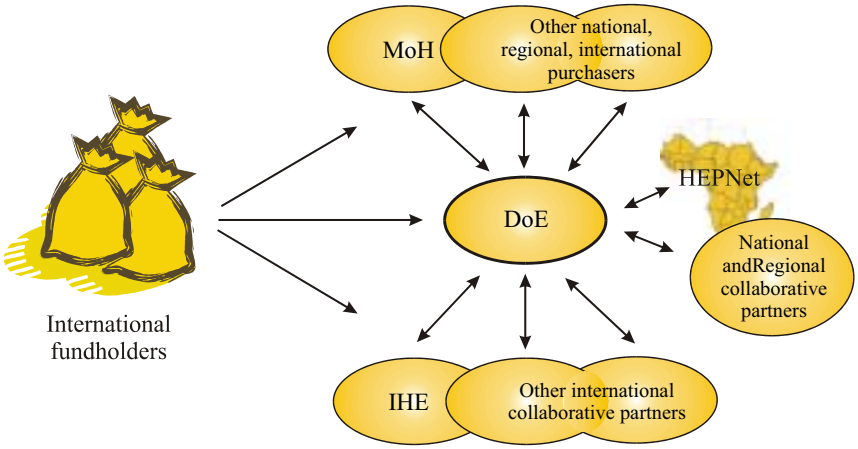
However, in developing a separate unit for health economics there are several issues to acknowledge and a few aspects from the experience of the current Sida support to learn from. A common failure is, not at least from the funders side where the actual contract is formalised, that definitions is negligent. Blur definitions can lead to different expectations and behaviours as a result of taking for granted that the perceptions are shared. This confusion of definitions is seen in the title of the support, *Institutional capacity building in health economics in Zambia through institutional collaboration*, where the immediate impression is that the main objective is to create a collaboration between IHE and DoE where the other parts of the support plays side-roles (even though the focus of the support has varied over time).

One of the reasons why the purchaser-provider model has been so popular is because of its simplicity and clarity, i.e. the model and its embedded roles are difficult to misunderstand. The roles are clear as well

as the transactions. But this is not the case with other types of partnership such as with the institutional collaboration, or with a network constellation such as HEPNet. It is therefore important to make sure that the central definitions is shared, or at least that it has been discussed, put on the agenda and formulated. An example is the definition of institutional collaboration, a definition that, as showed in chapter 4.2. does not necessary meet the needs of capacity development at DoE, but moreover, it creates confusion when analysing the outcomes of the support. The definition of institutional collaboration could be seen as a partnership that excludes other partners and similar relationships at DoE. This way of percept the concept may prevent further development of the collaboration if not acknowledged and discussed (Fig.7).
However, there can also be risks of being to clear, as with the purchaser-



provider model where the clarity leads to a static and linear relation, a linearity that might not fit with the way the stakeholders and participants think about it. The two methods used in strengthening of capacity of health economics at DoE (and the health sector in Zambia) – the purchaser-provider model and the concept of institutional collaboration – needs to, even though they have been successful, be discussed and acknowledged by the involved parties. By not taking for granted that the understanding and perception of central definitions are shared future misunderstandings can be precluded and than the purchaser-provider model and institutional collaboration could be developed and combined with other methods, and collaborative parties, in further strengthening capacity (Fig.8).



Finally, a separate unit for health economics could help to solve several of the difficulties faced so far in the ambition to develop and strengthen capacity in Zambia, but it will not solve the underlying problem of creating a critical mass of health economists. Irrespective of a unit or no unit, the communication structure within the Department of Economics must continue to develop further.

6.3. Recommendations

The Sida support has so far successfully developed capacity of health economics in the health sector of Zambia, even though there are some limitations. The evaluators' recommendations of further development and strengthening of the capacity, in order to increase the speed and create a greater flexibility, are:

DoE:

It is important to acknowledge the active role that DoE actually can take control over at this very moment without any changes in the support, even though the resources are scarce and understaffed. This could be:

- Create an attractive working environment in order to keep and attract health economists. This could be done in three steps:
  1. Create an open atmosphere by continuing to develop the communication structure of formalised meetings at least once a month,

  So that;

  2. the capacity within the department can be used in order to develop staff, by for example internal peer-reviewing of studies where the staff learns from each other and where the seniors can contribute with their knowledge.

  When this has been developed;

  3. marketing activities towards health economists could take place. To spread the word of DoE as a creative and developing work environment.
- Create a better communication with, and play an active role in the further development of, HEPNet. Make sure that the members of the staff at DoE take the first step in establishing better contact with the network instead of waiting for HEPNet to make the first move.

MoH:

Since the capacity within the Ministry has been increased, they are able to support DoE in developing the academic sides of the research. Without a well-grounded academic base at the DoE, the Ministry will not, in the long run, find the capacity at the department and they will therefore go back to where they started – with external consultants. Within the frames of the current purchaser-provider model MoH could support DoE in developing their academic skills by:

- Expanding the negotiation space, i.e. improving the mutuality and exchange when the work plan is decided. This implies that the MoH needs to regard DoE more as a collaborative partner, not only as a provider.
- Trying to open up for more academic-relevant issues of question, so that the policy-relevant research more easily can be transformed into an academic interesting article for DoE.

Sida:

In general it could be said that it is important to acknowledge that Sida's power of the supported project are limited to the role of a funder. In other words it is crucial that Sida doesn't interfere with on-going projects (a fact that doesn't exclude that Sida have formalised demands). And since the capacity of health economics in the health sector of Zambia has increased, the demands ought to change as well. Recommendations of changed demands to consider are:

- A formalised demand of dissemination of the research carried out through the support. The studies should give training in how to write articles. This would increase the academic quality of the studies and increase the quality of the methodology used.
- More time given to each separate study and by that more money, in order to make sure that the academic level of the policy-relevant research can be developed. This activity should be stated in the work plan. One alternative way of release funs for the research on a more general basis could be by core funding DoE.
- Find a way to support the development of PhD's at DoE.
- Strengthening of the local Master program at DoE in order to increase the capacity in general at the department, for example by bursaries to the local Master program.
- One way of strengthening the academic research environment at DoE and the local Master program is by contracting a secondment of a senior researcher.
- A more general recommendation to Sida is to clarify the meaning of methods and concepts used.
- Finally, the evaluators recommend that a mechanism of evaluating the support on a more regular basis, for example between the contract periods, is developed. This should contain meetings where all stakeholders get the opportunity to discuss concepts and developed capacity in order to decrease possible misunderstandings, but also in order to make the support more flexible and in line with the current need.

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Interviews, questionnaire and meetings

Ministry of Health – Lusaka:
Dr. Davies Chimpfwembe, Director Planning and Development
Dr. Felix V. Phiri, Assistant Director Planning and Budgeting
N. Chikwenya, Principal Planner

Central Board of Health – Lusaka:
Dr. B. U. Chirwa, Director General
B. Mukosha Chitah, Health Economist
K. Ngoma, Health Financial Specialist
R. Maswenyeho, Chief Accountant

Department of Economics, University of Zambia – Lusaka:
Prof. M. Ndulo, Head of Department
Prof. V. Seshamani, Senior Lecturer
Dr. F. Masiye, Lecturer
C. Cheelo, Lecturer
D. Mudenda, Lecturer
J. Sundewall, Bilateral Associate Expert
P. Mambwe, former Head of Department (PhD student)
C. Mwikisa, former Head of Department at DoE (WHO, AFRO)

The Swedish Institute for Health Economics – Lund:
Dr. A. Anell, Director, Associate professor
Dr. K. Ödegaard, Senior Project Manager
O. Ghatneker, Senior Project Manager
Dr. C. Hjortberg, Senior Project Manager

Sida – Lusaka:
P. Eriksson, Second Secretary/Regional Advisor, Social Development

E-mail information

Data delivered through e-mails from C. Cheelo and Dr. F. Masaiye (DoE); D. Chimpfwembe (MoH); B. Chitah (CBoH) and K. Ödegaard (IHE).

Appendix A
– Terms of Reference

Terms of Reference for the Evaluation of Support to institutional capacity building in health economics in Zambia through institutional collaboration

1. Background

Sida's support to the development of institutional capacity in the areas of health economics has been implemented through an institutional collaboration arrangement between the Swedish institute of Health Economics and the University of Zambia, UNZA, Department of Economics. Furthermore, close links were established with the Ministry of Health and the Central Board of Health throughout the support period to link the research work to the policy marking process.

The specific objective of the support is to build and develop capacity at Department of Economics, UNZA to provide MoH and other partners with quality analytical work in the area of Health Economics.

The overall objective of the support is to build capacity in the area of health economics with the view to make provision of health care delivery services in Zambia equitable and cost effective.

The joint activities have included training in health economics, research projects, exchange visits and networking with other national, regional and international organisations. However, the focus in the collaboration has been on capacity building of the local institution.

According to an evaluation undertaken in December 2000 Zambia has thanks to the support developed in house capacity in the area of health economics. Zambia has gone from depending almost entirely on international consultants for health economics analysis to be self-sustaining. The output from this collaboration includes studies such as health expenditure reviews, macro-economic analyses, a costing of the essential health care package in Zambia, a health financing study, and NHA reviews.

2. Purpose and Scope of the Evaluation

The support to institutional capacity building in health economics in Zambia has been going on for about 10 years. The current support is part of the health sector support agreement, which is coming to an end in December 2005. An evaluation of the support was done in 2000.

In light of a more general review of Sida's support to the development of health economics in SSA and the anticipated expanded Swedish health support to Zambia moving towards budget support, it is highly

relevant and necessary to evaluate the organizational set up of the present support to UNZA.

The findings and recommendations will be used as a foundation for a continued support to the development of health economics in Zambia and in the region. The interested parties are Sida/the Swedish Embassy, Department of Economics at UNZA, MoH Zambia and IHE.

3. The Assignment (issues to be covered in the evaluation)

The focus of this evaluation is on the organisational set up of the support, and the implications of it for capacity development at Department of Economics at UNZA. The evaluation should *describe* and *assess* the strengths and weaknesses of the current support with regard to the organisational design, including collaboration between UNZA and MoH, collaboration between UNZA and IHE, and the links to existing regional activities i e HEPNet. The evaluation should also describe the output of the support, without evaluating the relevance in terms of the usefulness for the health reform process in Zambia. A separate evaluation will be carried out to look at this particular aspect of the support. Finally the evaluation should describe the flow of funds, and give a financial review of the support including the total cost of the support (not a financial audit), identifying strengths and weaknesses with regard to financial incentives in the current administrative set up.

The evaluation should first of all describe and assess the effects of the support on the capacity development in general and in health economics in particular at the department of economics at UNZA. The evaluation should also suggest alternative ways of organising the support taking into account both the need for developing long term research capacity at the department and the need for applied research and consultancy services for the MoH in Zambia and other institutions.

Secondly the evaluation should describe and assess strengths and weaknesses with the current organisational design looking at the relationship between UNZA and MoH, and the relationship between UNZA and IHE. The evaluation should especially look at institutional aspects of these relationships identifying critical factors limiting and/or promoting capacity development at department of economics at UNZA. The evaluation should also suggest alternative ways of designing the support for improved capacity development and continued sector relevance.

Thirdly the evaluation should describe and assess how the current support use and take advantage of regional activities in health economics, i e HEPNet. The evaluation should especially look at how department of UNZA is involved in networking with other institutions, the degree of institutionalisation, and identify critical factors for improved networking moving from information sharing towards regional capacity development.

4. Methodology, Evaluation Team and Time Schedule

The evaluation of the support to development of institutional capacity is an organisational assessment and review. The evaluation should look at the process of the project; the context within which the support is given, how it has developed, how the different actors interact and support each other or counteract each other. The evaluation should look at the flow of funds and the incentive structure for the involved parties. The focus should be on how capacity in the area of health economics has been developed at the department of economics at UNZA.

The evaluation should also look at the management and implementation of the project, at all levels (the Swedish Embassy, IHE, MoH, UNZA and other relevant partners), including a financial review.

A review should be done of relevant documents as well as interviews with relevant individuals in Sweden and in Zambia.

The evaluation should have a qualitative approach analysing organisational and institutional outcome and effects of the support first of all at the Department of Economics at UNZA in terms of capacity building in general and capacity in health economics in particular, but also in a more general sense at Ministry of Health in Zambia, IHE in Sweden, and HEPNet. The evaluation should also review actual deliverables and the cost of the support.

The evaluation should also suggest improvements in terms of the organisational design of the support or alternative ways of support taking into account institutional, bilateral and regional aspects of the support, to assist Sida in its preparation for a new agreement.

The evaluator should visit and spend time at UNZA, the Swedish Embassy, and Ministry of Health in Lusaka, and IHE in Lund. The evaluator should make interviews with relevant individuals at these institutions.

The evaluator should be familiar with techniques of evaluating processes of change in institutions, how academic institutions work and operate, and preferably with the concept of institutional collaboration.

The evaluation should start in August and be ready by October. A specific timetable is presented below:

1/8–12/8:	Preparation in Sweden including a briefing in Stockholm with PE.
15/8–19/8:	Interviews in Sweden
22/8–2/9:	Interviews in Lusaka
5/9–16/9:	Analysis and write up of report
10/10–14/10:	Presentation of final draft at planned Health Economics meeting in Kampala, Uganda.
21/10:	Final draft submitted to the Embassy.

The Swedish Embassy in Lusaka, UNZA, MoH and IHE will make all relevant documentation available to the evaluator. The Swedish Embassy will also assist as much as possible to set up meetings with relevant individuals; however, it is the ultimate responsibility of the evaluator to arrange for meetings with relevant institutions and individuals.

Sida will call to an initial briefing meeting with the evaluator in Stockholm where a detailed plan for meetings and travels will be discussed and agreed upon and when relevant documents will be handed over to the evaluator.

5. Reporting

The reporting of a final draft report with conclusions and main findings will be submitted to the Swedish Embassy no later that the 21st of October 2005. A draft for discussion will be submitted and presented at a planned health economics meeting in Kampala in mid October.

The evaluation report shall be written in English and should not exceed 40 pages, excluding annexes. Format and outline of the report shall follow the guidelines in *Sida Evaluation Report – a Standardised Format* (see Annex 1). The draft report shall be submitted to Sida electronically and in 5 hardcopies (air-/surface mailed or delivered) no later than

October 21, 2005. Within 3 weeks after receiving Sida's comments on the draft report, a final version shall be submitted to Sida, again electronically and in 5 hardcopies. The evaluation report must be presented in a way that enables publication without further editing. Subject to decision by Sida, the report will be published in the series *Sida Evaluations*.

The evaluation assignment includes the completion of *Sida Evaluations Data Work Sheet* (Annex 2), including an *Evaluation Abstract* (final section, G) as defined and required by DAC. The completed Data Worksheet shall be submitted to Sida along with the final version of the report. Failing a completed Data Worksheet, the report cannot be processed.

Appendix B

– Compile of the interviews

1. The Evaluation

1.1. Data collected

The following paper is a compile of interviews conducted at IHE in Lund, Sweden, and at MoH, CBoH, Swedish Embassy/Sida and DoE at UNZA between the 19th of august and the 1 of September. The interviews lasted between 30 minutes to 1 hour and 30 minutes and all, except one, where taped. A total number of 16 persons were interviewed, two from Ministry of Health (MoH), four from Central Board of Health (CBoH), six from Department of Economics (DoE) at University of Zambia (UNZA), three from the Swedish Institute for Health Economics (IHE) and one representative from Sida. As a representation from each institution the head of department was interviewed.

1.2. Purpose of this compile

This *unevaluated* paper is *not* the evaluation report. It is Your voices that we have organised in a way so that we can work with it on the seminar. The structure used is our interpretation of some common issues raised during the interviews, of course as a result of the questions that we raised and we have therefore set out the guidelines for what to dig deeper into. We would appreciate if You took Your time and read through this paper before the seminar on the 9th of September.

After the evaluation seminar – where you get the opportunity to analyse the findings – we will go back to Sweden and finalise the report. This is when we put our summarised findings, analyse and recommendations into a report.

2. Background

Since 1995, the Department of Economics, University of Zambia and the Swedish Institute for Health Economics have been collaborating in health policy analysis and health economics research under the Sida support to Institutional Capacity Development in Health Economics trough Institutional Collaboration. A support that is linked to, and channelled through, the MoH and the CBoH. The agreement is that their demands of research decide the agenda for what studies to be carried out.

The overall objectives of the Institutional Collaboration is to improve the knowledge and capacities of collaborating partners in the area of health economics in the Zambian context by contributing towards the equitable and cost effective provision of health care services in Zambia.

The joint activities have included training in health economics, research projects, exchange visits and networking with other nation, regional and international organisations. The focus in the collaboration has been on capacity development of the local institution, and the present projects undertaken year 2005 is:

- Cost Effectiveness Analysis of Malaria Treatment
- Health Care Financing in Zambia: Paying the Provider.
- Financial Sustainability of HIV/AIDS programmes in Zambia.

The mandate of the support is in two closely related areas:

- On the one hand, the project conducts health policy analysis and health economics research.
- On the other hand, it facilitates and undertakes capacity development activities.

The initial faze of the collaboration are described as a result of a process where established contact between Dr. K. Ödegaard (IHE) and Prof. V. Seshamani (DoE), who happened to be at the same meeting in Livingstone, were of crucial importance. This meeting and relationship eventually emerged into a long lasting institutional collaboration.

> It all started with a visit from a delegation from Zambia, a delegation of three individuals that were travelling through the whole Sweden in order to investigate the possibilities of identifying a partner to be engaged in an institutional collaboration. The delegation chooses a quite large group of Swedish institutions and companies that were invited to a big meeting in Livingstone. The purpose of the meeting was to discuss the institutional collaboration, what it was and what it should contain. In creating a long-term collaboration, the wish was to move away from having people positioned at MoH as well as a wish to stop the use of short-time consultants. /…/ Since Knut (Ödegaard) had been working in Zambia before, he knew at least one scientist at the Department of Economics. In that way we could show that we had a relevant partner to collaborate with. Both the ministry and Sida felt that this was a good ground to build upon. – Dr. A. Anell, Head of Department, IHE

> I could honestly say that I was the one that brought the whole thing here, because I was there at the meeting in Livingstone just to see how institutional collaboration could be initiated with the Swedish support. At the end of that meeting they wanted to identify institutions both within here and within Sweden. And I strongly put on a case for our department to be the main collaborator. That time I was invited as an individual participator, not as a representative from the department. – Prof. V. Seshamani, DoE.

2.1. The collaboration and the work process

The formal arrangement of the collaboration was based on a three year contract where an overall work plan is agreed upon each year. The previ-

ous contract period was between 2002 and 2005. In brief the MoH/CBoH was described as the purchaser and the DoE and IHE are the providers of research outputs:

> The MoH is the leader in this collaboration; we decide what the money that goes through the collaboration should be spent on. We are the leader because we are the beneficiaries. – MoH/CBoH

The process described was that MoH/CBoH identifies the issues that they want to be further developed. This was done through a process where different levels and functions of the Ministry get the opportunity to participate. After the issues have been identified the MoH/CBoH starts to negotiate with the DoE and IHE.

> We have structures that strengthen this kind of collaboration at different levels where we have the health sector committee, then we have different technical working groups below that. We have different technical working groups, we have one on health care financial, on human resource, on resource allocation etc. These are the once that come up with the issue that are needed to be tackled within the health sector. Then we go to the university and tell them that "this is the things we feel that need to be dealt with". – MoH/CBoH

> MoH and CBoH are very involved and they identify what the research issues are so it is very policy oriented. So we meet and they say what they want to be researched and we meet with IHE and then we agree of how to proceed. Then we, IHE and DoE, agree on an agenda and we produce a report. – DoE

The collaboration process continues with that DoE and IHE together work on an agenda based on the consultation with the ministry. A proposal that explains their perceptions on the questions raised, how they should be tackled and carried out. Sida mainly comes in to provide funding, to UNZA through the MoH and CBoH, and to IHE directly. The funding to DoE is partly paid after submitting the yearly work plan, partly after completed work.

> Normally towards in the end of every year we sit down with the MoH and CBoH, they tell us what their needs are in terms of health economics research for the coming year. So we then talk about what they want and then agree on how our capacity can meet their needs. Then, in December, we reach an agreement. At that time there is normally a visit of a team from IHE, usually Knut and Anders. We talk to the director general and other people at the Ministry. We agree on a research agenda for the next year. From there on we develop proposals for each of those projects – how we will do the work, what could be the expected outcomes, and what are the responsibilities of UNZA, IHE and then other partner if needed. We write down the proposal, submit it to the CBoH and the ministry. They review it, give us the funding and then we start to do the work. Most of it involves data collection, UNZA mainly does the collection of the data, but of course IHE are involved in the conceptual framework, the development of the methodology. Once we have done the data collection and so on, normally IHE comes down (for) 1–2 weeks fieldwork, and usually we also go to them for maybe a week or two, put down our analysis and findings. – DoE

At both IHE and DoE the projects have a coordinator that assures that the process is moving in the right direction. The projects are said to always consist of two persons form each institution in order to reduce the risk of project failures.

> When we take on a project we have a coordinator from this side (DoE) and there will also be a coordinator from theirs (IHE), and there will be other members on the team. So on one project I can be a coordinator and in another I can simply be a member of a team. So that is how we have gone about and basically we put the responsibility on the coordinator from both sides. So if someone in the team is not doing their job or they are not doing things on time, it is up to the coordinator to make sure that things are expedited. In that sense it has been working well. – DoE

In general the work process includes at least one visit of the IHE team to Lusaka, and normally, at least, one visit of the DoE team to Lund. The process of collaboration includes data collecting, discussions, writhing proposals and other texts, conceptualising and analysing the findings etc. The DoE normally takes a greater part of collecting the data, and the IHE usually contributes to the development of different modules to a greater extent. The work process could also include other parties, such as officers from the CBoH, MoH, and experts with project specific knowledge.

> I have done both fieldworks, analysing data, coming up with the reports with IHE and DoE. – CBoH

2.1.1. Examples of the work process within specific projects

Costing of Basic Health Care Package

> At IHE we worked on the modules in order to make the figures right, but the disposition, how the patients should go and so forth, we did together with the DoE, because that we couldn't possibly know. Then we wrote a report, we (IHE) wrote the main part of the methods – how the calculation, the computer program Excel, is structured. UNZA contributed to the background of the data collection. Conclusions and the discussions were written together here in Lund, at least in the first report. They came here. We don't have the exact knowledge about the context, but they do. Anyhow, it is not waterproof shots between the different tasks. They know the background and therefore know how to express themselves, know what terminology to use in order to communicate with the MoH and CBoH. The ambition is that the main parts should be worked on together. – IHE

Health Care Financing in Zambia: Paying the Provider

> Anna from IHE came down to UNZA and during this period we shared notes, discussed different project relevant issues and decided who would write what. IHE helped us during this time to collect data, but the main part was collected by the staff at DoE. – DoE

3. Reflections on Capacity created through the collaboration at the institutions, August/September 2005

Capacity Development is about supporting and improving people and the contributions of organisations as well as their ability to change and develop in their context, in this case at both (regional) national and institutional level. One important indicator of capacity development is

the creation of a critical mass. Within the framework of the institutional collaboration the respondents mentioned the improved numbers of individuals trained with skills in health economics since the collaboration started 10 years ago. A training that has mainly been carried out at the Health Economics Unit (HEU) at the University of Cape Town with funding released from the budget of the collaboration.

> If we look at how many health economics we had before and how many we have now there have been some major changes due to the collaboration. – MoH/CBoH

> Over the years a number of lectures have been sent to Cape Town in order to build their skills in health economics and through that pool of health economics we are now able to pour skills of health economics in terms of undertaking our activities. So the collaboration in this respect has been very helpful to the ministry, not only because the capacity at the university has expanded, but also because capacity at the ministry have been built. So even within the ministry there is this pool of health economists that has been built through the same collaboration, at the same time as the University of Zambia. When the Ministry today needs consultancy, we don't have to go outside the country in order to get people with that competence. We can simply find it locally at the university. – MoH/CBoH

3.1. Department of Economics

At the DoE improved capacity development of health economics were described and measured in the context of more trained staff in the area of health economics; that the capacity been increased by 100% as a result of one graduated PhD as a result of the institutional collaboration. Other outcomes of the Sida support that was emphasised were the fact that DoE lately been able to carry out research on their own.

> IHE are quite experienced in health economics, so it was over the year's very benefitary for UNZA to participate because then we got the skills that they have and now we can bet for out own projects and get our own funding and things like that. – DoE

> When we started Knut was very important as a person to push the collaboration forward, but today I see it more as a giving and taking in respect of what shall be done and how. I guess that it is a sign of a strengthening of capacity at DoE, not only as a result of this collaboration. They have also sent people to be trained in Cape Town. An indication on the strengthened capacity is that we're not involved in everything that DoE carry out anymore. – IHE

> I think it (the collaboration) has helped us (at the MoH/CBoH) build capacity in terms of policy understanding, health economics and planning, cause we are now producing students at UNZA that have a good understanding of these issues. They have a module at the university and they actually trained lectures, one at PhD level through the collaboration. – MoH/CBoH

Other issues mentioned as a development of capacity was the increased interest in health economics issues in general at the University, but also increased attention from other international organisations such as WHO. As a result of the collaboration a few articles had been published in international journals, a book had been edited and two courses in health economics had been possible to develop at the Department, the respondents described.

> I think we have produced results in terms of policy device, in terms of publications, where members of the staff have been published in international journals. I think Pamela has the most publications from the projects, about 4–5 in international health economics journals. We have a book and we are working on another one. And the classes for health economics are big, I think there are 80–90 students. People have been trained through the program, through the University of Cape Town, I think we are about 5 or 6 now. Even Felix was trained through the institutional collaboration, which was 0 first, so the impact is big, even though it is not, by far, enough. – DoE

> The positive things that have come out of this collaboration are many. For example we have been able to train people in the field of health economics. it is not only the increased number of people but also the lever of skills developed within individuals. We are now talking about internationally recognised individuals, seminar presentations and even consultancies. Even WHO wrote and asked for our help to do a report from southern Africa. That is a consequence of this collaboration. We are the only department in this field in the whole country. – DoE

> If you came here 10 years ago you would not find even one person at MoH who was specifically qualified in health economics. But today you have even people on the ground, in other parts of Zambia that have undergone at least some training in health economics. And I would say that this is one of our main side-outputs, apart from the research – that we have been able to put health economics as part of our curricula and we have been able to offer that on a continuous basis without a break over the past 5–6 years. – DoE

3.2. Ministry of Health/Central Board of Health

The increased number of trained health economics at the MoH and CBoH were seen as a direct consequence of the institutional collaboration, this since the funding from Sida emerged in that several officers were trained at HEU in South Africa.

> The last years we also supported people from the MoH and the CBoH to study at HEU under the institutional collaboration support. Quite a few have been sent to do their Masters in Cape Town. There's one here, and one other is finishing in October, two within the MoH, and five that was sent from the University and Felix of course. – MoH/CBoH

As a result of the improved capacity of health economists the perception was that the quality of the policy decisions and reports had increased, and had moved from being presumptions to become more evidenced based.

> Nowadays the policies and decisions at the MoH are evidence based where you in the past could just close your mind not knowing what was happening outside the public sector. – MoH/CBoH

> In the past you could just define the figures and have rough estimates on the budget. Now we are able to clearly cost the interventions and therefore when mobilising the resources and when implementing again we are able to track our costs and at the end of it look at the impact by interventions. – MoH/CBoH

It was also indicated that the capacity development of staff at the MoH and CBoH had changed the level of involvement in the projects. Their participation, both physical by direct involvement and by reviewing, were described as increased.

> In terms of performance, those who have been trained from the Ministry have showed some major change. Their input have been very much improved, so we feel that even in terms of their own personal development it is quite helpful, as well as for the national development where it is extremely helpful. The other area that has been improved is the area of undertaking studies and reviews. – MoH/CBoH

> The formal agreement was that the ministry would ask for a research and then we would do what they requested. Over the years I think it has changed quite a bit because a lot of the time we interact with them, many times we can influence what we are going to look at and they have become more pro-active, more receptive to research so they are willing to listen. They have become more flexible. They really rely on empirical findings when making their decisions. They try as much as possible to keep it that way and keep away from political decisions. This is very different from other ministries like ministry of land, ministry of education and other locations. The research base is very weak at the other ministries so you don't really know how they make their policy decision. Which is very different from MoH. They actually understand a lot of the outputs, a lot of the things you do, they have the competence to understand. Probably they just don't have the time to actually do it in terms of the research, but they actually have the competence to understand. Even in more academic parts of the studies they can criticise and review stuff. – DoE

3.3. The Swedish institute for Health Economics

Even at the IHE the overall impression were that the capacity had developed in terms of health economics in the field of so called developing countries. The collaboration had also opened up a new market in other non-western countries for IHE. As a side-effect, the collaboration has also produced a PhD at the institute.

> I remember one of the first meetings with the Deputy ministry. I told him that"we know health economics, but we don't have any experience of work in developing countries. He just said, "no problem, because that's an experience that we have. It is the experience of health economics that we want". Today we have attained capacity in other fields that we wouldn't have gained if it wasn't for this specific collaboration. Today we have other projects in developing countries with for example WHO and the World Bank, as a result of the work in Zambia. And not to forget, Catharina wrote her PhD using collected data from Zambia. – IHE

> I think that they (IHE) have built a reputation internationally that they are also specialised, not only in European or western health systems, that they are able to do a health economics accounting from low income countries, to do financial issues on low-income countries and so on. I think they benefited quite a lot as well. – DoE

3.4. How to create a critical mass of health economics at DoE

Developing health economics and policy in Zambia with special regards to the DoE (and MoH/CBoH) entails a need to create a critical mass of

good quality individuals and institutions with an understanding of the importance of the subject. The issue of how to sustain the capacity in terms of educated/trained staff were emphasised by represents from all collaborative parties, but more frequently at the MoH and CBoH.

> That is the downside to capacity building, you have a lot of people to have the skills to do the work and they are being attracted by people from outside because the general conditions of the university are not that good. – DoE

> Health economics is a new area so the number of people that have been trained is still very small so we don't have the critical mass to deal with that. Similar with the MoH and CBoH, we need further capacity building in terms of people here that are dealing with health economics issues. MoH/CBoH

> I think my concern has been that we haven't found a way to return the people that we trained and therefore continue to be very thin on the ground, at least the economic department. The ministry and CBoH don't have that problem though. Perhaps a change in the way the program operates within the economics department would help preventing that. While we have trained health economists at the department I have been disappointed when the number leaving has been so high. We need to work on some mechanism that would allow them to return so that they don't get educated through the department but then don't return there. For me it means that it prevents the department to build that capacity that is needed. – MoH/CBoH

4. Values of the collaboration – institutional links, strengths and weaknesses

The structure of the institutional collaboration implies three different institutional links and collaborative relationships. These links are perceived both as strength and as a weakness – in some aspects it is perceived as a helpful tool to develop capacity of health economics; in other aspects it is perceived as counteract the further development.

4.1. DoE and MoH/CBoH

The collaborative relationship between DoE and MoH/CBoH are as previously mentioned a relation between a purchaser and a provider. This relation include that the purchaser can decide what will be done without compromising. The interviews however, showed that there was some flexibility built within this decision making process.

> In general we are the once who determined what should be done. There have been times when the Ministry changed approach during a project as a result of a dialogue with DoE. For example we originally felt that there was a need to do a cost sharing study and our approach was that we only go out there, collect the information, find out how things are happening and then it come out in a report. Through interacting with DoE they said "why don't we try a different approach? We sort of have a pilot where we in a number of districts remove the user-fees and in other district we let it continue. This pilot could be run for, let's say, two years. During this process there will be collection of data and so forth, and in the end we will be able to review it and see what the results are." So that was the universities suggestion to our request. We discussed it at the Ministry and decided to go along with it. – MoH/CBoH

> The Ministry say that they think very high of us (DoE) and the

importance of research in the decision-making. So that is the key. And I don't think UNZA should be an isolated NGO doing health economics research capacity building without a close link with the government, because at the end of the day they are the beneficiaries of whatever we do. – DoE

As part of the changed capacity of trained health economists at both the MoH/CBoH and the DoE the staff from the DoE expressed a feeling of being recognised as important players on the arena of health economics.

I think the link between MoH/CBoH and DoE has been improved a lot as a result of the institutional collaboration. Before the department was not recognised as a health institution so we wouldn't be invited to for example a technical working meeting or policy meeting, but in the past year we are always being invited. We are on their mailing lists and whenever anything is happening in the health sector they will let us know. That tells me that at least we have been recognised as an active player in the health sector, because they are always asking us to sit in on different committees. – DoE

4.2. MoH/CBoH and IHE

The institutional link between MoH/CBoH and IHE are mainly described as a second-hand relationship where IHE appears as partners and colleagues that accompanies DoE.

It has always been the MoH and the CBoH that have decided what we should do, even though we give suggestions. Today the DoE know the agenda at the MoH and CBoH, they know what is happening, not only what they want to have done but also what is more or less prioritised. That is a huge difference from when we started. At that time there were no connection between the DoE and the Ministry. – IHE

The people that have come to us (MoH/CBoH) aren't always the same people. They have a reserve of experts at IHE. It is a flexible team that comes in depending of the sort of problem or challenges we are dealing with. We have a pool of experts in Sweden, a local team that we have developed to deal with hands-on, and then together we can work on strategic planning for the future, long range. – MoH/CBoH

I think by large the way this has been constructed has been a good model where IHE are not coming directly and doing the work, but they are working through UNZA. So it is local capacity that has been built, but at the same time, because it is a major resource in Sweden, we can tap from that resource in various aspects. – MoH/CBoH

4.3. IHE and DoE

The collaborative relation between IHE and DoE are in brief described as an equal relation based on shared responsibility between colleagues.

We work on the same level, it is not us telling them what to do. We might have the capacity because we have done it before, we might have the information of how to do it right, but we always work on the same level. – IHE

It is pretty much shared responsibility between UNZA and IHE. But because we are on the ground most of the time we do much more of things to do with interviews, data collection and things like that. I think that in terms of time UNZA put in more time, but they (IHE) have a very critical role to play, a role they have played very well.

They are also more in touch with the latest development, methodologies, they have more access to resources, connection to electronic resources, and they have better computer facilities and things like that. So they come in quite handy when we sit down and do the analysis. And they are bigger in terms of establishment than we are. The mayor difference from the sort of collaboration we have with IHE and others are that we have a sort of confidence in each other, there is so much trust and they believe that we make good contribution. We also believe they make a very important contribution to the collaboration. So it is more or less on an equal basis. So when we are producing an article, journal publication, they say "okay, you'll be the first author, we'll be second". So they are quite fair. – DoE

I do believe that DoE enjoys working with us. I am aware of that for them it is also a matter of money. It is important for them to have this kind of collaboration in that respect, but I think there is other to it as well. Our working environment at IHE is quite informal; something that we try to create at DoE as well and I think they appreciate that. – IHE

There are studies that come straight from here (DoE) where we write the full proposal and then share it with IHE and they provide some inputs. There are some that we do as joint effort. They fly down from IHE and we sit down for probably a period of a week and come up with things like health care financing. It depends, a few studies comes from there (IHE), it is written up and sold from there, we look at it, brief it up if you like, send it back and eventually we get a document that we think is appropriate and then they fly down and all those documents work as a work plan. – DoE

One way of describing the relation between us (IHE) and DoE is to say that we are like a team working towards the same goal – to satisfy the MoH and CBoH. There are some from IHE and some from DoE. The seniors from DoE and the seniors from IHE have a clear role in leading the projects telling the other members of the team what to do, as well as the juniors at both departments are those who actually do the practical work. – IHE

4.3.1. Values of having a collaboration

Another issue raised during the interviews was the values of not doing a pure consultant work, but instead be involved in a long-term collaboration. Values emphasised were the flexibility and less deadlines and time pressure.

The long-term effort makes it possible to be flexible, which would be impossible otherwise. It is not the whole world if someone drops off for example. You don't have the extreme deadlines that you have in other projects. It gets delayed a month doesn't usually matter that much. – IHE

It has been collaboration because I think that to a large extent they need us as much as we need them. In that respect I think that was a mutual arrangement. For instance there are a lot of things that they are getting involved with in Zambia that we have a lot of expertise in because we are locally based in Zambia. But maybe from the point of view that they only do what are asked for them to do in Zambia, from that point of view it could be seen as consultancy. Unlike what we do, in certain cases we do academic work they always go were the de-

mand is for their services. In that respect I suppose it is a consultancy. They are a consultancy unit so to speak, but in terms of the way we are related it is mainly as collaborative partners. – DoE

4.4. Difficulties within collaborations

Working together involves interaction between different realities systems of meaning and types of bias. This occurs at different levels – between different socio-cultural borders, between different economical and political systems, between different disciplines such as between academic aims and policy oriented goals, for example.

The relations within this collaboration; between DoE and MoH/CBoH; between MoH and IHE and between IHE and DoE, varied in levels of face-to-face interaction, interference, in levels of tight bonds and institutional linkages. As a consequence the different linkages were facing different kinds and levels of difficulties.

4.4.1. DoE and MoH/CBoH

Delays and work load

As a consequence of the high pressure on the staff at DoE and an increased demand of health economics research and skills at the MoH/CBoH, two different pictures were painted. One where the MoH/CBoH described a situation where projects were not carried out in time and to a full satisfaction and another where the staff at the DoE described the delays as partly a result of MoH/CBoH lack of time. However the understandings of the work load from both sides were also emphasised.

> The academic staff at UNZA is most of their time preparing for lectures, advising and counselling students and marking remarks, so they don't have so much time over to follow up and assure that things are completed. When the courses at the DoE starts you'll find that you almost never get the studies in time because they are constrained with time. – MoH/CBoH

> Of course there are incidents when the Ministry thought that we've not done as well as they expected. And sometimes that is because during the time of research there's a need to have regular interferes, so if you running out of track as a researcher and as an individual you are put on the right track quickly. But if that doesn't happen you'll find that in the end of the year when they are reviewing what has been done, and maybe find that perhaps 30–40% of what has been done is things that they perhaps didn't want. Policy makers are confronted with complex problems and as a researcher I have to narrow down to very specific parameters. So I got out of focus and I needed guidance from them to say "no this is the core issue, address it!". But when I didn't get that guidance, as with this case, this is what happened. – DoE

> The link between MoH/CBoH and DoE are very strong and I think that we over the years have proven ourselves as reliable provider of research outputs. We have this undergraduate course which provides a lot of officers at the Ministry with skills of health economics. There is always work for us that the Ministry wants us to do and they are in general our main client. The work load has been to such an extent that we hardly find any time to do studies for other people, other institutions. The ministry are always coming up with things for us to do, we just finished a study on health care financing while that study were finishing they said they wanted us to do a study on health insurances and another experiment on health care financing. So there

were two studies born out of one. The problem is that we are a small department and we don't want to narrow ourselves too much. – DoE

Academical versus hands-on (policy making) knowledge

A concern raised by the DoE was the wishes to further develop the academic skills, an aim that, when the demand were high, were felt to be difficult to achieve within the current framework of the institutional collaboration, i.e. with the current institutional link to the MoH/CBoH.

> Sometimes I feel that we have been treated as an annex to the ministry. – DoE

> It is obvious that in line with increased capacity at DoE the academic ambitions are getting stronger. They are no longer satisfied with just working for the MoH, they want to get published, attend international conferences etc. – IHE

The quality of the research had also an impact on how IHE measured the research reports in comparison to their other projects.

> Many of the studies that we have done in Zambia have been studies that we wouldn't publish in Sweden, but this assignment has been different. It is also true that we never, looking back, had the ambition that the studies done within the framework of this collaboration should be published. – IHE

4.4.2. IHE – DoE

The difficulties that were highlighted between IHE and DoE were consequences of physical facts, such as infrastructural factors; technical equipment and the far distance between Lusaka and Lund.

> There has been times when staffing at the DoE has been very limited. And of course, the distance makes it from time to time difficult, and it makes it more important to plan in slightly different ways than with other projects. There have been delays as a result of e-mail not working at the University, but most of the staff do have an own mail as well and normally they are better to use. The institutional collaboration has despite this survived, so it can't be that bad. – IHE

4.5. Other values

Except capacity development on different levels, other values on a more personal level were highlighted as a result of the collaboration, especially from IHE. The values emphasised were that it gives a broaden perspective, personal contacts, and creates trust.

> It is quite personal enriched to work with developing countries in that sense that you get a perspective on limited resources and on the values of having well-functioned institutions. By using this knowledge you can get a deeper understanding on how the health care function in Sweden and other wealthier countries works, why it works and not. – IHE

> Over the period of time we have become more informal because we have gotten to know each other through this bilateral visits from here to Lund and from there to here I have get to know all the main staff at IHE and they also know me. So you know, we do this in a much more informal way than it would have been 10 years ago, even 5–6 years ago. This is a very important point to make because things doesn't need to happen that way. – DoE

> We have built a lot of relations and trust among ourselves /…/ – DoE

One important thing to mention is the personal contacts that we get and that we have managed to maintain. Even though these persons leave, like Chris who left UNZA, the contact is kept by e-mail. We keep in touch because he is a health economics in the world. That doesn't happen when you are doing other consultant assignments. The difference is that we are colleagues that work together during a long period of time. This is not consulting, it is something else. We become friends and they trust us. – IHE

> On a private level it has given me a lot since it has given me a perspective on the work I carry out in Sweden. It gives me more satisfaction to work with questions and issues that make a bigger difference. – IHE

The collaboration was also seen as a door-opener for the global arena and that it give experience and the self-confidence to identify as a health economist.

> I have learned a lot from this collaboration and it has also developed into other projects and international contacts. – IHE
>
> The collaboration has given me the opportunity to develop academically. It has given me economical support and it has given me the capacity to behave like a health economist – DoE
>
> It has made my work quite easy and interesting. I also gained valuable relationships with lectures that I wouldn't have got in ordinary life. That is really valuable for me. – MoH/CBoH
>
> We live in a global world and every time different people are dealing with challenges you always have best practises from different countries. So the nature of this collaboration also provides opportunities, not only for in-country, but also multilateral arrangement, which for us are good. – MoH/CBoH
>
> One great effect of the collaboration is the exposure to the international arena. Our lectures at the University have been availed to attend conferences; recently it was in Spain at the IHEA. It is good for them, because then they get updated on, what is happening on the globe in the field of health economics. – MoH/CBoH

Other effects of the collaboration between IHE and DoE at UNZA that were emphasised were improved technical equipment, access to books and journals and IHE's library.

> The collaboration has greatly improved the infrastructure in this department – computers and things like that have benefited greatly from this collaboration. - DoE

5. Funding setup

5.1. Current arrangement and how it has been transformed

On an annual basis a work plan is carried out. In brief, the annual work plan is divided into various levels. The main one determines the activities, the interventions in the health sector during the year. The activities in the collaboration are divided in two parts, one that is funded through CBoH to cover DoE activities, the other part funds directly by Sida to cover IHE activities. The funds are released on a yearly basis.

In the beginning of the institutional collaboration the arrangement was that a meeting should be held each quarter, an arrangement that lately transformed into seminal annual meetings instead. The quarterly arrangement were perceived as slowing down the work process, but are still – in a confusing way – remaining.

You sit in quarter 2, you are dealing with quarter 1 and then you decide, because of what is happened in quarter 1, funding flows or does not flow in quarter 3. – Chief Accountant, CBoH

I don't want it to be organised like that in the future. I want to have it basket funded so that they just get the funds and then they can report on a seminal annual basis or on an annual basis it doesn't matter. But the funding should not be that we agree on "yes this quarter you have done this and that so then you will get funds for that and what are your plans for the next quarter". – Sida

5.2. Thoughts about alternatives and changes in the setup

The current funding arrangement has been important for Sida so far, but that is something that we have to review now – if we should sort of continue with this split between purchaser-provider split, if we should continue that or if we should have some core funding (to the unit), if that should be core funded, at lest to certain extent. But I still think there still needs to be this sort of research projects or consultancies and so on so they get full funding. But maybe 50% could be core funded. – Sida

The thoughts about the funding arrangement were in general divided in two positions, one that was fully satisfied (MoH/CBoH) and those who wanted a slightly different setup (DoE). A majority though expressed the importance of keeping the link between policy making (MoH/CBoH) and academic research (DoE).

We (CBoH) find it most valuable because then UNZA knows who their immediate client is, who's the owner of the program. If the money would be channelled directly to the university it would certainly change our relationship. UNZA is a University and as a University institution they are involved in research. They may be interested in pure research questions, but this arrangement finds a compromise between development and work through the University, and putting into practice the challenges the health sector is facings. With the current arrangement we are in control and therefore we can direct the work that goes on. – MoH/CBoH

The money coming through CBoH gives them some kind of responsibility to be interested in what's going on. If it came directly from Sida they might feel that they don't care about the research. Perhaps that kind of construction helps CBoH and MoH to be concerned about our research. – DoE

To fund everyone directly, that would obviously be the ideal, but then the Ministry also want their own involvement in this, and I think that is a key channel. If they get the money and give us the money they feel that they are responsible in a way that makes them interested in making this collaboration succeed. But if you keep them outside even if you have these regular meetings, they won't know how much money is spent, so that might have some negative effects. – DoE

It is always that aspect that the DoE's dependency of the Ministry can be to strong, that they become a consultant or even an annex to the MoH rather than an independent research consultant. That is something to acknowledge in the future, because that was not what we had on mind when this collaboration started. – IHE

6. The Health Economics and Policy Network in Africa – HEPNet

One focus of the evaluation is to "describe and assess how the current support use and take advantage of regional activities in health economics, i.e. HEPNet" (ToR 2005). Therefore questions of how the linkage between the regional network and the institutional collaboration has been so far were highlighted during the interviews.

6.1. What is HEPNet?

HEPNet is an African health economics and policy network with one of its main goal to create a critical mass of health economics working with relevant topics within the field. Another aim is to strengthen the linkage between research institutions and health policy makers, i.e. to make sure that health economics are the basis for health policy decisions.

HEPNet's goals and objectives are to contribute to health sector development in the Sub-Sahara African region by:

- Undertaking networking activities between member institutions and with international organisations active within the region in the area of Health Economics
- Strengthening, promoting and increasing the scope for Capacity Building in Health Economics & Policy
- Strengthening, promoting and increasing the scope for Health Economics & Policy research.

6.2. Involvement in HEPNet activities and awareness within the different institutions

The knowledge of HEPNet varied from "not knowing what it is" to being aware of the constellation, identifying the need, see its potential and wishes to be included in the network.

At DoE the awareness of HEPNet had been taken up on the agenda as a difficult task to overcome. Concerns were raised of problems of distributing information about the activities and potentials within the network. The impression was that the network was too individualised at all levels of the organisation, but also at the DoE itself. There were several comments on how the representative of HEPNet didn't pass on the information about the activities. This was explained by lack of institutionalisation at the department and a result of internal communication difficulties.

> I think the problem was that the representative going (on HEPNet activities) was just attending the meetings, was not passing on the information.
>
> There have been problems the way HEPNet worked over the last 6–7 years. The main activities have taken place at the secretariat and the institutions that are around the university of Cape Town has participated minimally in HEPNet activities and I think our last annual meeting last year was hammering on that point so I hope that it will be a change. The presence of HEPNet must be more within the countries rather than between individual members that attend meetings. But this year we are supposed to do some in-country activities.
>
> I think it would have been useful to know about HEPNet earlier because we are a small department and we try to publish things, but our orientation has mainly been research for policy because it has

been going to CBoH and the ministry, forming policy decisions and things like that. But some of that work you could transform to articles for journals and things like that. But then you need links to distribute it widely and we didn't know about these links such as the network. I think HEPNet would be useful in things like peer reviewing work to a wider audience than just the department, sitting internally here and trying to criticising and so on.

Many countries in the region have had similar reforms, everybody is interested about cost-sharing, about user-fees and so many issues. If you take about 20 issues, we have at least 15 issues that are common to most of us. So obviously it is important to have a kind of network of institutions to start with. HEPNet is now operating in a very small way and I am not directly involved in that but I am being to understand that there are some politics there that the institutions are more or less similar to individuals.

IHE's knowledge of the network was limited and in general the only knowledge about the network was that they had a connection to the Master program at the Health Economics Unit (HEU) at University of Cape Town.

We don't have any bond at all with HEPNet and except the fact that students are sent to HEU, I can't see any other linkage. My impression is that it is rather a club than a network.

My contact with HEPNet is limited to a few individuals that I met in Lusaka since they happened to be there while I was visiting. My understanding is that UNZA has more contacts than we at IHE have.

I haven't had any contact at all, but my impression is that Felix Masyie has worked as a natural contact since he used to study there (at HEU).

At CBoH the knowledge were highly limited. Only one out of three respondents had heard about the network before.

– *Link to HEPNet?*
– Link to…?
– *HEPNet*
– HEP?

At the MoH however the awareness of HEPNet were high and the respondents expressed that they had been involved in the HEPNet activities.

We have a lot of members that have attended HEPNet meetings, and that gives us a chance to look what other people are doing, because sometimes a person that doesn't get out of his parents home he always think his mother is the best cook, but the moment you get out and taste food in let's say Sweden you say that "no, my mother is not a good cook". This exchange of information through HEPNet has actually helped a lot. Sometimes when you are stuck you send a question to HEPNet and somebody will just respond. It really helps.

7. Dissemination of information within each institution

Reasons mentioned of why the involvement in HEPNet were limited were, as mentioned above, the lack of internal communication and institutional structural ways of disseminate information. Within the Institutional Collaboration, the arrangement is that each project consists of one coordinator at DoE and one at IHE, a coordinator who is responsible for the specific project. But how does the information pass to not-involved members of the staff?

7.1. DoE

At the DoE the responsibility of dissemination of information within the projects at the department used to rest upon the coordinator, but since March/April 2005 there has been a changed meeting structure. A formal structure where each member of staff are obligated to participate, where minutes are taken and issues from previous meetings are reviewed.

> The dissemination of information at the DoE was a little bit problematic when it started. Somehow it depends on the personalities in the department. If you communicate everything to everyone then it is easy for you to coordinate, but if the communication is limited, which was the case before, the only person who would know what was happening was the head of the department, the coordinator and the person doing the study. Everybody else at the department wouldn't know. But after implementing the committee we actually sit every two month and we take part of everybody's progress in their studies. Everybody has to present an update and make notes about what's been going on, we make minutes and from the previous minutes we pick up things that were gaps on the previous meeting. So today everybody knows what everyone else is doing. – DoE

7.2. MoH/CBoH

At the Moh and CBoH dissemination meetings are held in order to inform non-active staff of the outcomes of different projects within the health sector.

> Each time a draft report has been made a dissemination meeting is called and everybody is invited. And there we disseminate the findings and if there are any comments that they want to make, observations that is done. From there is where the final report is done. So during the dissemination meeting definitely they know. That is done on every major project. – CBoH

> Since last year we at the ministry have started to have, together with other research partners, a dissemination work shop meeting where we look at all issues, all the studies that have been done in the health sector. It should be that linkage so that the studies don't stay alone and the plan is to have this once a year. – MoH

7.3. IHE

At the IHE the information of the different projects to staff not directly involved were disseminated at internal meetings and to some individuals when expert and specific knowledge was needed.

> The staffs that are not involved in the collaboration do get involved when the yearly visits from Zambia at IHE. And we also disseminate information of all projects at IHE, including this, at our internal staff meetings. I would say that everyone is familiar with the collaboration, but I am not sure about the specific projects. – IHE

We work in developing countries so if someone from the institute with a specific expert knowledge is needed they do get directly involved in the project. Otherwise our time is to limited that it is hard to find time to take part in others projects. But to some extent I would say that the whole institution is involved in the collaboration. – IHE

We do have internal days when we inform each other. – IHE

8. Future challenges – changing support demands

The following issues were emphasised as a requests and thoughts about a further development of the Institutional Collaboration.

The institutional link between DoE and MoH/CBoH – loosen up the dependency

I think it is important to try to formulate the role DoE play against the Ministry so that a healthy distance can emerge, so that the independence can be maintained, the integrity. However, it is important to make sure that the distance doesn't get that far that the Ministry loose their interest in asking the DoE to do assignments for them. So that the DoE sails away on its own route doing things that they think are more academic relevant, but that lacks linkages to what is happening within the health sector. It is a quite hard nut to crack, but probably one that needs to be dealt with. – IHE

I think (the link to the Ministry) is positive and very important because I don't want to be irrelevant as a researcher. The motivation for this collaboration was that there must be a link between policy and health economics. I think it is important to keep it that way. (But,) I don't think we would like to be a research department of the Ministry so that a 100% of what we do is just what they want. We also want some degree of autonomy and flexibility. I think that is a key for us. We want a situation where we are allowed to develop our skills in this field, but at the same time meet the demand at the Ministry and its partners. So once again, flexibility both in terms of how much they demand on us and how much room they give us to pursue our own interest and also our own interest with potential partners. Because if someone else, like UNDP, would come to UNZA in order to work with us we must be flexible. – DoE

Developing the academic skills at DoE

One issue within the department was that it was only the senior lectures that were being published, but we, the juniors, were not able to publish because we were not having that experience. But as a part of the collaboration some of us were given some supervision by people from IHE, skills like – how to write a report, how to write articles for publications and things like that. And we have slowly started to publish ourselves. That was a good spin off. It is very important in terms of the University because that is how you get your promotion. – DoE

My wish is to develop academic relevant studies, not only policy relevant, and I wish to be published in academic relevant journals which could be combined with the policy assignment – DoE

Critical mass of health economist – few PhD's

I think we need to get 1–2 more with PhD level so that we have a fallback situation. Right now there is only one and that is quite risky because if he leaves we have a problem. – MoH/CBoH

Applied knowledge

DoE greatest need is in applied knowledge/…/ I would say that we really need a lot of capacity building in the area of undertaking studies, reviews, assessments and so forth, both within the ministry and even building the local capacity through the University of Zambia. – MoH/CBoH

Extension of the Institutional Collaboration

The institutional collaboration that we got is, in terms of the linkages, a little bit limited. It would be better to extend it and look at other health economics, like for example the University of York and London School of Hygiene. In terms of exchange of information it would be better to have access to what other people have done and to benefit from them. As I can see it we can still have the physical collaboration with IHE, but in terms of getting information and circulation of information it should be expanded. – MoH/CBoH

No extension of the Institutional Collaboration

One issue that has been raised is whether or not we should widen this collaboration or not by bringing in more institutions, both from Zambia and Sweden and even from outside. My own idea is that "let's not upset the apple-cart" when this is performing quite well. So my idea is that, yes we could have more institutions, more brains and probably you could get more ideas and so forth, but it could also be a case of too many cooks spoiling the pot. /…/ And even between the two of us (IHE and DoE) there are sometimes problems to find time and it would also be more expensive. So for me the value added would not be so significant. So my own idea is to make this framework to continue, it can continue to strengthen the way it already has been doing perhaps in an even more pronounced way than before. – DoE

Exchange visits/program

I think the collaboration can go further in the area of visits, in exchanged visits. I know that when IHE usually comes to UNZA they come to finalise the report. They don't just come to exchange visits, to share notes, learn what people are doing. When they come here it is strictly business and they have very limited time. Their eyes are on the computer – they are doing the report. Similarly if we go the eyes are strictly on the computer – to finish the report. So maybe exchanging visits once a year to spend a week and see what is happening in the field. It is important. They only go out in the field when it is a project to collect data. They really should see how things work under a normal day. I feel that a lot of information can be filtered through that way. Similarly another year a team could go to Sweden and see how the systems work there. It could also add some value I suppose. Even at a local level we need to acknowledge that. The DoE come to our office quite often but they rarely go out on the field to see what is happening except to collect data. – MoH/CBoH

We are also interested in sending people to Lund to study, not only to South Africa. What we could do is to sometimes send people from here to Lund, because Sweden has got a different standard of education compared to South Africa. So that means that we can also go in to the Swedish system. – MoH/CBoH

More equipment

> I think that capacity should not only go by training lectures, I think it should also include books, cause I don't think they have enough books in health economics. Compared with what you see in other academic institutions dealing with economics I think that maybe books and journals should be looked at. And also update those journals. – MoH/CBoH

8.1. Suggested organisational setup

A majority of the interviewed mentioned a wish to create a health economic unit, as a way forward, a way that might solve some of the work load and the feeling of being caught in the middle – between teaching and health economics research. These are some of the thoughts.

> One way forward is to make sure that the DoE gets a little bit independent, and that would indicate a change in the finances because if you make it a little bit independent it means that you need have some core funding in it. If it was an independent unit within the department you would still do the same thing, a unit with perhaps 1–3 persons that would do research but also teach a little bit. If they wouldn't teach we would have a problem within the University. The University would fight it and say; "Why don't you go to the research institute where they only do research?" – DoE

> As I see it now, I see a health economics unit as one possible way forward. As I see the problem now is that they are torn between the different health projects that they are doing and other work that is not health. If one could make sure that there is some core funding for this kind of work that we want to see. At least those who are within that specific department, or unit, they know that they can concentrate on that. This is still something that needs to be discussed though. – Sida

> For me it is important to create a situation where we are able to fuel the capacity at the University on a little bit more formal manner, such as through a unit or research institute. Then at least we would be more hopeful to assure that the gains are sustained in terms of retention. And that we within that unit can build some level that even if Sida withdraws they can have developed other linkages through the University. If they develop that capacity then they would be able to write proposals that would receive funding from other resources and allow them to play an even greater role in the shaping of the public health policy. – MoH/CBoH

> One of the major things, especially in terms of capacity building, is if we could create a separate autonomous centre of health economics research were we would be able to do a number of things. Besides doing the research we would be able to engage ourselves in training programmes, advocacy programmes and so many other areas./…/ To kick-start the thing you must have somebody that is fairly high-fling, someone that is quite well-known in that area, who will – let's say for at least the initial 3–5 years – be a director. /…/ So you need someone who is known, someone who is senior, someone who will be able to steer that centre and then once he has put to a level where it is known and can take off on a steady path, then of course someone else can take over. So it is not a question of just creating a centre in the sake of creating it, but it is to create it after giving it a lot of thought to all these various aspects. – DoE

8.1.1. Thoughts about IHE:s future role and DoE needs

Although a majority of the respondents wanted to continue to work closely with IHE, and that the overall impression were that the collaboration had been successful, there were thoughts about the future of the collaboration that included changes of IHE's role. This was partly expressed as a result of DoE changed needs as a consequence of the increased capacity development of health economics at the department. The role of IHE within a future collaboration is, in this respect, important to acknowledge. Some of the thoughts were:

Continue to use IHE's experience – the experience of running a unit

> It would be useful to have at least one staff from IHE, because they have a lot of experience in health economics as well as administrative and financial issues around working in a unit. Since they have been a unit for quite some time. So that experience would be useful. So in that respect they will even in a unit be important. Over the years we have built a lot of relations and trust among ourselves, so we know how they work and it would be easy to draw their skills in areas where we need complementary skills and areas where we find that we don't have enough manpower to do certain things. It would be useful to continue to collaborate with them and to always drawn their services, because they have generally been very reliable in terms of working with us. As long as they just take their time to put in their share of the work. – DoE

A need of strengthening the teaching at DoE

> For the future I think we like to see IHE continue to strengthen the research capacity, but I also see other demands. IHE have not taken much time on the teaching side and that's where we also thought that maybe it could have been strengthen the partnership. I think they have to strengthen their role – find a way to assist in the research skills of young students, applied research. – MoH/CBoH

> IHE have the experience of the African environment and African health system so that is a major plus for them, but perhaps the downside is that they are not a teaching department so they can not contribute. And capacity is both research and teaching. We are running a module in health economics on both Masters and undergraduate level, which we hope that we can expand to a number of courses. It is very popular among the students as been growing over the years. So we are teaching that but IHE have no contribution to make on that specific aspect on this program. So some people say "why don't we get another partner that is teacher oriented?", but again it is where you balance because if you choose another department in Sweden they might not be so oriented towards our conditions. – DoE

Expansion

> I don't think IHE's role should change. IHE is a research centre that are collaborating with an academical department, DoE. As a research centre they can only go that far. It's only when you have an academic institution versus another academic institution you will be able to be at the same level. Therefore it might be important to create a link with a academic unit so when you go to Lund, when issues are being discussed or when IHE's team come here, there are somebody

from the academic department who can engage our academical department, that can give our university knowledge that is passed on to the students. – MoH/CBoH

One scenario is that our role (IHE) will remain as it is today, we can continue to collaborate as it works today, but there could also be changed roles. On the other hand, I am not sure that Sida would be interested in giving support to us then. Another scenario is that other parties than IHE get involved, maybe that MoH/CBoH get the opportunity to choose. One can imagine that Sida buys different research environments and that we then have to compete to get the job. – IHE

I think it is important to broaden the collaboration and not have this close, or almost closed, collaboration with IHE, because that makes it very difficult for others to come and it always become competition. If you add on to what they are doing they will always look upon it as competing projects. – Sida

Reduced role for IHE in the future?

I think that our (IHE) role in the long-run will get less and less. There are several solutions, but I am not sure that we will continue to work the way we do today. The aim was to transfer health economics capacity and when we feel that the capacity is there, when there is stability, and then our mission is completed. It is very satisfying to experience a collaboration that moves forward and that it is not stuck in any support-trap. I can feel that they can do it themselves today. I think it is very fun to work with them, but I do feel that my role in the collaboration have been reduced in terms of importance. – IHE

In the beginning IHE helped us a lot, they even teach some members the staff that didn't have any knowledge of health economics, so some of our staff went to IHE to spend time there. But that has slowly changed. I think the future role is just that they are partner in research. – DoE

9. Important issues to discuss

The seminar on the 9th of September will contain several work shops. During the workshops we will, among other issues, discuss and reflect upon the below mentioned questions that have been arisen through the interviews with You.

- Where is DoE today in terms of capacity? What kind of capacity is important to develop in the future? Has DoE's needs in order to further develop capacity changed during the last years?
- What strengths and weaknesses can be identified within the institutional links between DoE and IHE, and between DoE and MoH/CBoH in terms of capacity development? In what way should they change/develop in the future? How do other partners fit into these frameworks?

Appendix C

– Evaluation seminars

9th of September 2005, The Swedish Embassy, Lusaka

Agenda

09:15–09:30	Introduction
09:30–10:30	Workshop 1
10:30–11:00	Workshop 2
11:10–11:30	Presentation
11:30–13:00	Workshop 3

Participants:
Mr. P Eriksson, Sida
Prof. Ndulo, Head of department, DoE
Dr. F. Masiye, DoE
Mr. J. Sundevall, DoE
Mr. M. Nkosi, DoE
Mr. G. Pollen, DoE
Mr. D. Mudenda, DoE (workshop 3)
Mr. B. Chita, CBoH (workshop 1 and 2)

Introduction
Presentation of the values of the participation method used

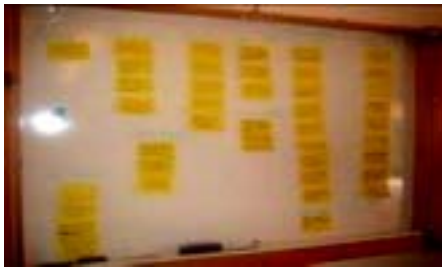
Using the specific participation model gives the opportunities to:

- Meet involved parties and stakeholders
- Reflect upon the findings
- Proceed and together find a way forward
- Learn – both an opportunity for the involved parties to learn as well as for the evaluator.

The following workshops conversations and brainstorming activities has its staring-point in the compile of interviews with involved parties from Department of Economics (DoE), Ministry of Health (MoH), Central Board of Health (CBoH), the Swedish institute for health economics (IHE) and Sida.

Workshop 1 – The needs at DoE to develop capacity of health economics

Methods used:
All participants were asked to write down keywords on different stickers. The stickers were organised under different themes on the blackboard, a themeatisation that were decided by the participants together.



The main team was to identify the needs of DoE in order to further develop capacity of health economics. The following questions were used as a guideline:

- What kind of capacity is crucial to develop in the future?
- How, and is it possible, to hurry a sustainable capacity development at DoE?

  Capacity development in terms of:
  - A critical mass of good quality health economists
  - Academic knowledge and skills (to carry out research, publish articles etc)
  - Applied knowledge
- Other needs?

Needs identified:

- Capacity to produce policy related research
- Academic Independence (raise funding for research, publishing, peer-review of health economic work)
- Health Economics Unit (health economic focused resource centre, clear institutional arrangement to manage health economics programmes, division of work between health economics and economics, a certain amount of independence, capacity management – financing, planning and retention)
- Local Master programme (support to local master programme at UNZA to make local training available and speed-up capacity building)
- Local Undergraduate (improve student participation in health economics research projects; strengthening teaching)
- Human resource capacity development (more staff qualified in health economics – at all levels, recruitment of human resource, training, increased numbers of scholarships)
- Other resources (computers etc.)
- Institutional collaboration (links to regional networks such as HEP-Net; links to international contacts; exchange visits for professional exposure; improved institutional collaborations i. e. HEU, IHEA etc; international collaborations with research institutions; secondment of

external fellows on regular basis to help in specific areas)

- Core funding/steady flow of funds (for general capacity building not necessarily tied to study demands at MoH; support to teaching and research)
- Incentive structure (improved financial needs such as remuneration for members of staff, helps staff retention; retention of existing staff through a number of incentives; bonding of students who are given scholarships e.g. MoH/CBoH approach)

Workshop 2 – Institutional links and collaborative relations

Methods used:
The participants were divided in two groups; one who discussed the institutional link between DoE and MoH/CBoH; another who discussed the collaborative relation between DoE and IHE. The thoughts were later presented.

Group 1 – Institutional link between DoE and MoH/CBoH
The main question was to discuss how the work should be arranged in the future so that both academic and policy-making (applied) knowledge can develop in terms of quality. The following questions were used as a guideline:

- What strengths and weaknesses can be identified within the institutional link between DoE and MoH/CBoH in terms of capacity development?
- Developing and limiting factors in the collaboration
- Changed need of support
- Economical set-up
- In what way ought the link to change/develop in the future?
- Other purchaser as well?

The following issues related to the link between DoE and MoH/CBoH were identified:

- How to distance the dependence from the MoH/CBoH but still keep it policy relevant
- Core funding – the need and to separate it from the project funding, which also could be seen as the solution
- A broader group of stakeholders, not only the MoH (and Sida)
- It has been to much focus on policy and applied relevance. It is important to get a better balance
- Systems to monitor progress of academic work/research and how that is done

Health Economic Unit

- What would a separate unit do? Important to identify/separate work, but also a need to make a timetable
- Benefits of this change should be identified; both for DoE and MoH
- Make sure that the work within the Unit doesn't take more than 30–40% of the work load
- Find other funders

Group 2 – Collaborative relation between DoE and IHE

The main question was to discuss if IHE are able to satisfy DoE's future needs in order to develop a sustainable capacity of good quality health economists. The following questions were used as a guideline:

- What strengths and weaknesses can be identified within the institutional link between DoE and IHE in terms of capacity development?
- Developing and limiting factors in the collaboration
- Changed need of support
- Other collaborative parties?
- What could these collaborative parties bring that IHE can't?

The following collaborative relation needs were identified, where research (policy and other) and teaching were separated:

Strengths:

- The international links – international experience brought in.

Weaknesses:

- Publication activities have been focusing on consultant research.
- Major weaknesses in the structures, not in the links.

Developing factors:

- In terms of teaching the needs have not been satisfied.

Limiting factors:

- The numbers of staff at both DoE and at IHE

Changed need of support:

- Change of support – i.e. bring in experts of teaching capacity to further post-graduate training, could be brought in by other partners – teaching element.

Other collaborative parties:

- Exposure to other universities, an exposure that IHE not necessarily have or are willing to bring in.

Workshop 3 – What is crucial to develop/change

Methods used:
Together with the evaluators the above identified needs were concretised – what, how, when and who?

What?	How?	When /who?
Human resource: – Quality	– Peer-review mechanism quality of staff	
– Speed it up	– Having more bursaries for local training – A review of the incentive structure for teaching staff – Further develop the thoughts of a separate unit – Collaboration with other teaching institutions	
– Further development	– Peer-review mechanism quality of staff	
– Sustained		
Training for Master	– Having more bursaries for local training A review of the incentive structure for teaching staff	
Broaden the base – other stakeholders	– Marketing/information activities – Equipment support including IT/technical support, books, journals, software etc.	
Find a balance between academic and policy	– Peer-review mechanism quality of staff	
Move away from a single project mode	– Funding through the health budget/basket	Pär Eriksson, Sida – before the meeting on the 15th of September 2005

Evaluation seminar 16th of September 2005, The Swedish Institute for Health Economics, IHE, Lund

Agenda:
09:30–09:45 Introduction
09:45–10:30 Workshop 1
10:30–11:45 Workshop 2
11:45–13:00 Workshop 3

Participants:
Dr. K. Ödegaard
Dr. A. Anell
Mr. O. Ghatnekar

Workshop 1 – The needs at DoE to develop capacity of health economics

Methods used:
All participants were asked to write down keywords on different stickers. The stickers were organised under different themes on the blackboard, a themeatisation that were decided by the participants together.

The main team was to identify the needs of DoE in order to further develop capacity of health economics. The following questions were used as a guideline:

- What kind of capacity is crucial to develop in the future?
- How, and is it possible, to hurry a sustainable capacity development at DoE?

  Capacity development in terms of:
  - A critical mass of good quality health economists
  - Academic knowledge and skills (to carry out research, publish articles etc)
  - Applied knowledge
- Other needs?

Needs identified:

		High academic credential*/integrity		
Organisation/ Coordination	Academic knowledge/ Critical mass	Applied research		Independent research
– administration	– No. of PhD	MoH/CBoH		– Other sources of research funding
	– Senior guidance			– Regional/global research

* A person with high academic credential was described as a person whose knowledge is respected, that has a high position in society and is part of the public debate.

Workshop 2 – Collaborative relations

Methods used:
The participants discussed the collaborative relation between DoE and IHE.

The main question was to discuss if IHE are able to satisfy DoE's future needs in order to develop a sustainable capacity of good quality health economists. The following questions were used as a guideline:

– What strengths and weaknesses can be identified within the institutional link between DoE and IHE in terms of capacity development?
– Developing and limiting factors in the collaboration
– Changed need of support
– Other collaborative parties?
– What could these collaborative parties bring that IHE can't?

Strengths:

+ A long term collaboration building of relations mutual respect and understanding, flexibility
+ No time difference
+ Equal partners (IHE doesn't have any interest of "run over")
+ IHE knows health economics and has staff that are interested of working in developing countries
+ The institutional collaboration creates attractive employer both in Lusaka and in Lund
+ Sida as a funder/long term interest

Weaknesses:

- Individuals/staff occupied by other things (IHE and UNZA)
- Only one funder
- Staff turnover and critical mass at UNZA (not only negative though)
- The communication (e-mail) is not always working
- Institutionalisation of competence/capacity at UNZA (better communication and trademark/brand)

Future needs:

– A continuous need of a long-term external support (academic, commission, institutional collaboration)
– Institutionalisation (easy start)
  – improved coordination
  – trademark/brand
  – "attractiveness"
– Other sources of funding/financial support
– Developed communication
  – MoH
  – Other stakeholders in Zambia
– Collaboration with other Swedish resources

Workshop 3 – What is crucial to develop/change

Methods used:

After a brief presentation of what factors that are crucial to develop/change identified at the seminar the 9th of September, the above identified needs were concretised – what, how, and who?

Evaluators short summary of the seminar the 9th of September:

Peer-review	– academic quality of staff – quality of studies	– Balance between policy and academia
Institutional Collaboration	– Exposure to the international arena – Exchange visits – Senior guidance/resource person	– Publications – Academic quality – Funding for research
Teaching	– Experts of teaching capacity to further post-graduate training – Training for local masters/undergraduates	– More time for staff to do research – Quality of staff – A faster capacity development of health economists at DoE

IHE identified the following crucial issues:

What?	How?	Who?
Peer review		IHE – ok
Institutional collaboration		IHE – ok
Teaching		IHE, no role in teaching
Institutional collaboration/ Peer-review		
	There are two choices: 1. That DoE continues to find the institutional collaboration with IHE or another institution interesting ("Marry" another organisation) or 2. To work in separate project with different institutions, for example KI, IHE etc.	DoE must be the once that decide which form to collaborate
Institutionalisation = Health Economics Unit		
Improved coordination	An unit where one staff work as a coordinator on half time	
Brand/"attractiveness"	Senior person with a "profile" (academic credential) that are recruited external	
Improved/developed communication	Develop contact with other stakeholders for example by health economics networks, yearly conferences like the one IHE have in Lund etc.	IHE can share their own experiences and way of creating a broad network, but the implementation must be locally

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