Swedish Zambian Health Partnership

- A case analysis of a potential Public Private Development Partnership

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Abstract
The Zambian Ministry of Health has started an ambitious health reform program. The program includes new ways of cooperation including enhancing partnerships with the private sector in order to improve the nation’s health and move towards the health related Millennium Development Goals (MDGs) of the Millennium Declaration, which the nation has adopted. At the same time the Swedish Government is increasing private sector participation in its international development cooperation strategies, which is quite a new concept in Sweden. This thesis analyzes this new concept called Public Private Development Partnerships (PPDPs) in development cooperation, by looking at an ongoing project between Swedish and Zambian actors. The thesis discusses the advantages and drawbacks of PPDPs as well as trying to assess factors such as efficiency and conflict of interest. The thesis is doing so by using a qualitative research design based on interviews with topic guides, to lead the interviews, combined with notes from field studies in Zambia during the Swedish Health Delegation in February 2013. The interviews were conducted during formal meetings at the ministries as well as in less formal settings during hospital tours. The thesis is further grounded in analysis of governmental development plans and case study research. The result of the study shows that the Swedish Zambian Health Partnership is likely to be efficiently delivered as a PPDP if implemented with the Saving Mothers Giving Life Public Private Partnership already in place. It is however difficult to thoroughly evaluate the efficiency of PPDPs in development cooperation since no comprehensive comparison is available. In order to thoroughly assess the efficiency of PPDPs there is a need for academic research to further analyze the potentials, limitations and effects of these partnerships. Nevertheless, PPDPs contribute to cooperation between different actors, which is seen as an important component of efficiency in humanitarian action.
List of Acronyms

CSO – Civil Society Organization

CSR – Corporate Social Responsibility

MCH – Mother and Child Health

MDG – Millennium Development Goal

MFA – Ministry of Foreign Affairs

MoH – Ministry of Health

MoU – Memorandum of Understanding

NGO – Non Governmental Organization

PPP – Public Private Partnership

PPDP – Public Private Development Partnership

SMGL – Saving Mothers Giving Life

UN – United Nations

UNDP – United Nations Development Programme

UNFPA - United Nations Populations Fund

UNICEF – United Nations Children’s Fund

WHO – World Health Organization
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Preface

My interest in health and health rights reaches far back. Growing up with two parents working as gynecologists in Sweden and internationally involved through WHO, research and educational field trips, formed an early attention of mine. My curiosity in the field increased during my Master Program in International Humanitarian Action and increased even further when I joined my mother and other participants from the Swedish Society of Obstetrics and Gynecology on an educational field trip to Tanzania in January 2012. During the field trip, focusing on reproductive health challenges, I decided to write my master thesis within the field. I found Tanzania’s high number of maternal deaths and the difficulties in reaching Millennium Development Goal 5 particularly striking since most of the deaths are preventable but yet surprisingly little seems to be done in trying to alter the picture. As a young woman with an academic background in management this was unacceptable to me.

My interest in the African region developed further during the fall of 2012 when I conducted my internship at the Africa Department at the Swedish Ministry of Foreign Affairs. One of my supervisors was in charge of the Zambia portfolio and my other supervisor was responsible for Sub Saharan trade relations. I found a perfect mix between my interest in health challenges and the areas of my two supervisors during an event hosted by Swecare in September 2012 focusing on health challenges in Africa and the role the Swedish private sector could play. Later when I was informed of a Swedish Health Delegation to Zambia in February 2013, organized by Swecare, The Ministry of Foreign Affairs and The Ministry of Health and Social Affairs, I approached Swecare with a request of targeting my master thesis towards their ongoing Sida project of increasing cooperation and trade within health between Sweden and developing nations. I wanted to analyze advantages and drawbacks of implementing a Public Private Development Partnership between the Swedish private sector and the Zambian Ministry of Health with the goal of increasing access to maternal health services. Swecare appreciated my approach and put large value in the analysis. The concept for my thesis was also appreciated at the Ministry of Foreign Affairs, since it is quite a new concept in Sweden to integrate the private sector in developing cooperation and not much research has been done on the subject yet. Hence, the idea for my thesis was formed.
Acknowledgements

I would like to thank the many actors involved in the process of this master thesis. It is the variety of actors and their expertise, which makes this thesis unique. I am particularly thankful for the great cooperation with Swecare, The Ministry of Foreign Affairs (including the Swedish Embassy in Lusaka), Sida, Saving Mothers Giving Life, and the private sector involved. I am also beyond thankful for the valuable inputs received at the Zambian ministries and hospitals visited during the delegation trip.

I would like to thank Swecare Foundation for all the assistance provided throughout my thesis including providing me with the opportunity to take part in the Swedish Health Delegation to Zambia, which has served as a foundation for this thesis.

A special thanks also goes to my supervisor Dr. Brian Palmer as well as my assistant supervisor Professor Elisabeth Darj for their knowledge, guidance and support.

A big thank you to my sister for her excellent academic support during this journey.

Finally, a heartfelt thank you to my parents whose extensive medical expertise has guided me along the way. I am very thankful to my mum who spurred my interest in maternal health challenges during our trip to Tanzania last year. I am also very thankful for my father’s extensive commitments in the field of maternal health, which has inspired me along the way.

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Helena Samsioe
1. Introduction

The introductory chapter describes the background to the research problem and presents the aim, objective and the research questions. Thereafter the relevance for the field of Humanitarian Action is presented followed by the justifications and limitations. Lastly the disposition text provides an overview of the following chapters of the thesis.

According to the Constitution of the World Health Organization “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being.” Access to health care is classified as an international human right, which the national and international community should work towards together. Yet a large number of the world’s population live without access to health care services. Zambia, a lower middle-income country in the Sub-Saharan region, is one of the nations struggling with universal access to health care and has a long way to go before reaching the health goals of the United Nation’s Millennium Declaration adopted by the nation. Particularly Millennium Development Goal (MDG) 5, to decrease the maternal mortality ratio by three quarters from 1990-2015 and achieve universal access to reproductive health, is far from being achieved. The MDG 5 goal for Zambia is set to 162 maternal deaths per 100 000, which means a further reduction of 429 deaths per 100,000 has to be achieved by 2015. Unless change is applied the nation will continue to lose the life of many women. The losses are not only of a public health concern but also cause large social and economical burden.

According to UNDP (United Nations Development Programme), in order to achieve MDG 5, necessary investment in terms of training, oversight and incentives for midwives should be provided in conjunction with improved access to and monitoring of rural health posts, and curbing unsafe home-based birthing practices. 90 percent of the complications that lead to maternal deaths can be avoided when women in need have access to quality prevention, diagnostic, and treatment service.

In 2011 the World Bank classified Zambia as a lower middle-income country but it is important to keep in mind that Zambia's economic growth has not translated into significant poverty reduction. Large inequalities exist and there is particularly a need for improved access to health care in rural areas. The hope is for new forms of cooperation to enhance such an access. The Zambian Government is looking for increased international private sector engagement to improve the current health situation, which is in line with current Swedish
Governmental strategies aiming towards increased private sector engagement in its international development strategies. The concept is new to Swedish Zambian Development Cooperation and in Swedish international development strategies overall. Perhaps private sector engagement can improve the current health challenge in Zambia but the challenge ahead is complex.

1.1 Background and Statement of Problem

Swedish foreign aid has for decades been targeting the health sector in Zambia. Improvements have been made but not enough. According to Gunilla Carlsson, the Swedish Minister for International Development Cooperation, we should be able to do better with the domestic and international resources that are being spent today. The Swedish private sector entails highly qualified products and services within the health care sector. According to the Minister there is currently an unused potential in the private sector that could improve people’s health.

Zambia has experienced fast economic development and current economic growth is presently around 6.5% and is expected to remain or perhaps even increase in the following years. This gives the Zambian Government an increased opportunity to tackle existing health challenges. The Zambian Government is now giving priority to the health sector with increased spending and the goal of increased health care access and health quality for all Zambians. The Zambian government plans to find new ways to tackle the many health challenges including how to meet the health related Millennium Development Goals by 2015. The Zambian government is looking for increased private sector participation in order to achieve its goals. One of the goals outlined by the Zambian Ministry of Health in the Zambian Medium Term Expenditure Framework 2013-2015 is to establish 650 prefabricated health posts. This master thesis will focus on how such an establishment could occur by using a Private Public Development Partnership and the advantages and drawbacks of such a partnership. The Swedish Zambian Health Partnership is an ongoing project aiming at establishing a Public Private Development Partnership (PPDP) between the Zambian government and the Swedish Private sector. The goal of the PPDP project is to establish remote health posts in Zambia as an attempt to increase access to health care in rural areas and hence move towards the fulfillment of the health related MDGs. Since MDG 5 has been a particularly hard challenge for Zambia (including many other developing nations) the Swedish Zambian Health Partnership will focus particularly on how to move towards this goal through the establishment of remote health posts.
1.2 Aim, objective and research questions

The aim of this study is to examine the advantages and drawbacks of implementing the Swedish Zambian Health Partnership, presented in this thesis, as a Public Private Development Partnership. The study will investigate if it is possible to conclude whether Public Private Development Partnerships in humanitarian action create new efficiencies as well as investigating whether Public Private Development Partnerships lead to conflicts of interest.

Main research question:

- What are the advantages and drawbacks of implementing the Swedish Zambian Health Partnership, presented in this thesis, as a Public Private Development Partnership?

The sub-questions were chosen to include factors regarding the form of Public Private Development Partnership cooperation and the pros and cons involved of such cooperation in Humanitarian Action. The following sub-questions have been chosen in order to serve the purpose of this thesis:

Sub-questions:

- Is it possible to conclude whether Public Private Development Partnerships in humanitarian action create new efficiencies?
- Could Public Private Development Partnerships lead to conflicts of interest?

1.3 Justifications and relevance to the field of Humanitarian Action

Zambia is suffering from a high rate of maternal deaths largely due to lack of access to appropriate maternal health services. With a maternal mortality ratio of 591 per 100 000 the maternal deaths cause a significant public health problem. Unless change is applied Zambia will continue to lose the life of many women. Lives that many times could have been saved if access to health services was improved. The losses are not only of a public health concern but also cause large social and economical burden.

We are now approaching 2015, the “Millennium Development Goal deadline” and MDG 5 seems to be the goal which is furthest away from achievement. Hence, the Zambian Government wants to accelerate efforts towards MDG 5. Sweden is currently developing new
international development cooperation strategies for some of its bilateral partnerships, which shall include more cooperation with the private sector. The initiative is quite new in Sweden and hence this study can serve as an analysis of the advantages and drawbacks of increased private sector engagement and as a contribution to research on how to use Public Private Development Partnerships as a mean for change in international humanitarian action.

1.4 Limitations

The limitations and ethical dilemmas of the research setup includes difficulties in comparativeness, difficulties in being objective, difficult to assess the informers objectives, difficulties in following and analyzing an ongoing case, addressing some of the key concerns and to receive the information needed.

One of the most difficult limitations of this thesis was to compare the PPDP strategy to other development approaches. Due to the lack of thorough research on the potentials, limitations and effects of PPPs and PPDPs it is difficult to assess if PPDPs are more or less effective than for instance traditional foreign aid initiatives unless both of the approaches are applied simultaneously to a situation and the evaluation could attempt to clarify which strategy has been more effective. It also created somewhat of an ethical dilemma since different methodologies ranked success differently depending on if economical success was seen as more of a success than for instance improved conditions for target group. However, in order to be able to perform a measurement of success, the current PPP by Saving Mothers Giving Life, where the Swedish Zambian Health Partnership presented in this thesis, strives to be a part of, has been evaluated using the most suitable framework by McConnell. But since a thorough comparison would be difficult to be carried out in this case, that has not been the main purpose. Instead the purpose of this thesis has aimed at showing the significance of cooperation between the different actors with the approach of “one can not do everything but together we can do something”. This thesis does not aim at picking one “ultimate” form of development cooperation but instead to discuss opportunities for a broader approach in a changing world. Critics may argue that the private sector does not belong in development cooperation but nevertheless private sector companies have been present in many developing countries long before foreign aid initiatives and might also remain long after the foreign aid initiatives have left. So no matter your own personal opinion or political ideology, the private sector is part of development cooperation, and in mine opinion it is therefore reasonable, and
necessary, to discuss how to involve their capacity, as efficiently and suitable as possible, in today’s work of humanitarian action. Not as a single actor, but as part of a larger movement. After all foreign aid initiatives are present in order to create situations where it should no longer be needed and hence other forms of cooperation need to be explored. Therefore I believe the debate need to focus not so much on whether private sector participation is suitable in development cooperation in general, but instead focus more on how it can be implemented successfully and when it is a suitable form to be used and when it is not. As for this thesis the PPDP form was evaluated as appropriate after meetings with the Zambian Governmental Officials and hence the analysis focuses on how to implement it as successfully as possible taking both the drawbacks and advantages into account.

At times during the thesis writing I have found it difficult being objective. To follow the private sector initiative presented in this thesis has resulted at times in me being “carried away” by all the opportunities for change that I believe this PPDP could bring about, if implemented with carefully selected partners as presented. In my opinion it has great potentials but nevertheless I have also been exposed to the challenges and met with critics ethically concerned regarding private sector involvement in development cooperation due to conflict of interest, so all in all I believe I have been able to maintain an objective perspective.

In a way it has also been difficult to follow an actual ongoing case. There have been limitations surrounding the possible PPDP, which will be addressed later in this thesis. It has at times been very time consuming to follow an actual case since many changes have been made and I myself have been part of discussions between Sida, the private sector, the Swedish Embassy, Saving Mothers Giving Life, Swecare etc. There is no “set answer” to the Swedish Zambian Health Partnership presented in this thesis since the process is still ongoing and the process of establishing a PPDP reaches far beyond the time set for this thesis writing.

At times it has been hard to access information. For instance it was difficult to receive detailed information regarding the Chinese-Zambian health post partnership during our field trip in Zambia and it was also difficult to know at times if you received correct information since it was important for many of the informers to stick to official political guidelines. However, I believe this has also been one of the great challenges to adapt to the constantly changing factors, surrounding oneself with several different actors and not knowing what the end result will look like. A situation very similar to Humanitarian Action work in the field I
would say.

1.5 Disposition

The thesis is divided into three parts. The first part is the introduction and it consists of two chapters, a general introduction and a chapter on method and material.

The second part, the main part, consists of three chapters. The first of these, the third chapter, presents the concept of Public Private Partnerships. The fourth chapter presents the actual case and discusses the selection, process and set-up. The fifth chapter presents an overview of Swedish Zambian Development Cooperation in a historical, current and futuristic perspective.

The third and last part is the conclusion, which consists of two parts. The first part consists of a summary and discussion of the result from the analytical chapters. The second part reflects upon the findings and the contribution as well as providing suggestions for future research.
2. Method and material

This chapter presents the methodology and the material chosen to serve this thesis’s purpose. Firstly a motivation of the research approach is presented in this chapter. Secondly it outlines and explains the perspective applied. This is followed by a presentation of the choice of case and collaboration partners as well as research collection methods. Lastly the chapter concludes with reflections on the research process.

In order to reach the aim of this study a qualitative research design, based on interviews with topic guides, to lead the interviews, combined with notes from field studies in Zambia, was used. Interviews with 19 key actors were made representing the Zambian public sector, the Ministry of Health (3 actors), the Ministry of Community Development, Mother and Child Health (2 actors) and public hospitals (6 actors), as well as the Swedish private sector (3 actors) and the Swedish public sector in form of the Ministry of Foreign Affairs (2 actors) and Sida (3 actors). The information in Zambia was received during formal meetings at the ministries as well as in less formal settings during hospital tours and during the Swedish Zambian Health Expo. The interviews in Sweden were carried out at the Ministry of Foreign Affairs, Sida and at Swecare as well as over the phone. The interviews were carried out in a two months timeframe lasting for approximately one hour each in order to gain the perspective of the key actors as well as surrounding relevant key information. I believe the contact persons established during my internship at the Swedish Ministry of Foreign Affairs served me well in reaching out to the formal decision makers. Due to the professional positions attained by the actors whom I interviewed the information received is regarded as trustworthy even though the informers most likely wouldn’t have disagreed to official political protocols. It also remains to see if the well-formulated political agendas are applicable to reality.

The needs and wants from the Zambian Government within the health sector correlates to a current Sida project focusing on increasing cooperation and trade within the health care sector between Zambia and Sweden. Swecare has been asked to carry out this pilot project and this master thesis will consist of an analysis of a practical case within that project and discuss the advantages of drawbacks of Public Private Development Partnerships (PPDPs). The practical case consists of aiming to establish a PPDP between the Zambian Government and the Swedish private sector in order to establish remote health posts in Zambia as an attempt to
increase health care access.

The Swedish Government, through its international development program, emphasizes on the following areas; maternal health, rural areas, female empowerment, innovation, sustainable development and increased cooperation with new actors including the private sector.

The Zambian Government, through it’s Ministry of Health, puts a large focus on how to increase access to health services and is asking for assistance by bringing in International capacity through PPPs.

The companies chosen for this analysis have been chosen in order to contribute to the need of remote health posts in Zambia in line with the two governmental approaches above. The chosen companies for the case match the above criteria and show an interest in establishing a PPDP with the Zambian Government (see chapter 4 for further discussion regarding the selected companies).

Essential supportive materials in order to carry out this research include governmental health and development programs, UN guidelines, World Bank reports, academic and journal publications in the field of maternal health and development.

2.1 Research field - the case, data collection methods and access

The first step in the process of gathering material was started during the fall of 2012 when I was working with the Zambian context at the Ministry of Foreign Affairs and had access to important documents for my research including the Swedish Bilateral Development Strategy for Zambia. This step was followed by a more in depth study of the Zambian material focusing on current health initiatives by the Zambian Government and establishing a draft of the Swedish Zambian Health Partnership Project in cooperation with the involved companies and actors.

In the beginning of February I took part in a week-long Swedish Health Care Delegation to Zambia, organized by the Ministry of Health and Social Affairs, the Ministry of Foreign Affairs and Swecare. The delegation served as a foundation for my research where the possibility for the Swedish Zambian Health Partnership Project was evaluated. Even though the time in Zambia was short I gained valuable information and was able to meet with several key actors, politicians as well as medical doctors, which added to my previous field trip in
Tanzania last year with the Swedish Gynecologist Society focusing on reproductive health challenges in Sub Saharan Africa. Most of the delegation trip was spent in the urban area of Lusaka due to the location of the ministries and governmental officials. This was estimated to serve the purpose of my thesis well but it was valuable to see the more rural areas surrounding Livingstone as well. I believe my previous field trip in Tanzania also serves as a good indicator to how health care in rural areas differ from the urban areas. It was also valuable to visit both public and private hospitals. The different types of hospitals visited in Tanzania and in Zambia gave me a thorough understanding of the local health care and the differentiations within.

The delegation trip in Zambia was very fruitful for my research. We had meetings with key actors including the Ministry of Health, The Ministry of Community Development, Mother and Child Health, the Ministry of Finance, The Zambian Development Agency, The Swedish Embassy, The University Teaching Hospital, The Cancer Diseases Hospital, Fairview Hospital, Livingstone General Hospital and the regional office for the Ministry of Health in the Southern Province. The meetings were very successful with open discussions where all actors participated and asked targeted questions. The main discussion involved future forms of cooperation between Sweden and Zambia where increased Public Private Partnerships were sought for by the ministries. Main focus on the discussion hence was on how to successfully create Public Private Partnerships in Zambia and what the Ministries and the hospitals particularly were looking for. I was able to follow the general discussions with the ministries and the hospitals and also to ask specific questions related to my thesis. During the delegation trip Swecare hosted the Swedish Zambian Health Conference and Expo, a full day seminar with about 200 participants including the above mentioned key actors and the Zambian First Lady. The Conference added additionally to my research and provided me with the opportunity to engage in longer discussions and interviews for my thesis.

The schedule during the delegation trip was very busy with meetings and field visits at the hospitals from early morning to late at night which made it difficult for me to find time for extra interviews, however it was not estimated as needed since the scheduled meetings provided me with essential information and also gave me access to meet with high level officials which would have been very difficult on your own. It was a tiring, but mostly inspiring, week. At the end of the week in Livingstone, during our last dinner, outside by the river at the David Livingstone Safari Lodge, I had the opportunity to receive “summing up”
information from several of the companies that took part in the delegation as well as a longer interview with Adam Lagerstedt, Regional HIV and AIDS team at the Swedish Embassy and former advisory to the Zambian Ministry of Health.

After the field visit in Zambia, a follow up and monitoring process followed, including completing the project plan draft in accordance to the information received during the delegation as well as adding to the sought after competences through relevant companies. I also had a follow up meeting with Sida as well as Swecare and the private sector coordinator at ProCamp AB to establish how to take the project further. A meeting with additional potential partners took place on April 10th and preparations for the Zambia Delegation visit, by the Zambian Ministry of Health, to Stockholm end of May 2013 were initiated.

The following months entailed detailed discussions as well as qualitative analysis of the material and conclusions for the future could thereafter be drawn. Political procedures and discussions are currently ongoing in order to establish if the Swedish Zambian Health Partnership will be implemented as a PPDP.

2.2 Applying theoretical framework

The lack of research on the potentials, limitations and effects of PPPs and PPDPs in developing cooperation (and overall), particularly when it comes to rigorous methodologies for assessing the impacts of PPPs and PPDPs on service delivery, poverty reduction and political participation, made it difficult to choose a successful previously implemented research method and apply. It would also not be possible to evaluate the efficiency of the Swedish Zambian Health Partnership presented in this thesis since it has not yet been implemented. In order to be able to perform a measurement of success, the current health PPP by Saving Mothers Giving Life in Zambia, which the Swedish Zambian Health Partnership presented in this thesis, strives to be a part of, has been evaluated using the “Three Main Dimensions of Policy Success” (McConnell, 2010:46).

McConnell’s framework of success was chosen due to the fact that it ensures that success not only includes technical matters but also an integrated sense of what matters across a range of lenses from the political (eg. preserving policy goals and instruments), through the program (eg. creating benefit for target groups) to the process (eg. sustaining the broad values and direction of government). McConnell’s framework of success has been defined as the most
useful measurement of PPPs in the study “Theorizing Public Private Partnership Success: A Market-Based Alternative to Government?” by Hodge and Greve (2011), even though the authors conclude there is no ultimate measurement of PPPs and no single view of success providing a meta-framework.

As previously stated since a thorough comparison would be more or less impossible to be carried out in this case, that has not been the main purpose. Instead the purpose of this thesis has aimed at showing the significance of cooperation between the different actors.

2.3 Reflections on the research process

During my time as an intern at the Africa Department at the Swedish MFA I was able to access policy strategies for the Swedish development cooperation with Zambia. Post my internship through Swecare I was able to access policy strategies made by the Zambian Ministry of Health as well as a thorough consultancy report made on the Zambian Health Sector by GEO consulting. These formal documents served as fundamentals for my research and would have been difficult to access in another position.

My position as researcher for Swecare during the Zambia delegation trip made it possible for me to attend all the policy meetings with the key personnel identified. This put me in a unique situation and with a great ability to access information which most likely would have been impossible as a student traveling alone. However, some policy material related to this thesis is classified and some topics regarded as sensitive such as corruption, budgets, and cooperation with the Chinese. This resulted in me choosing a careful approach when conducting the interviews i.e. the adoption of a more informal discussion where the key actors could lead the discussion themselves assisted by some key inputs from my side (see appendix 8 for more information). I was able to approach some of the key participants directly with my questions and some information was received more indirectly through participation in the formal meetings at the ministries and hospitals in Zambia. The majority of the participants were confirmed while in Zambia while three had been confirmed via e-mail beforehand.

Regarding my meetings with the Swedish actors, I had pre-departure meetings as well as post departure meetings with both the private and the public sector in order to capture both expectations and results. I also had post delegation follow ups via e-mail with the Sida staff at
the Swedish Embassy in Lusaka as well as with the Director of Livingstone General Hospital and the Zambian Development Agency, which gave me assistance during my research process.
3. Presentation of Public Private Partnerships

This chapter presents an overview of Public Private Partnerships. It gives the reader an understanding of the concept as well as an historical background. It also discusses the advantages and drawbacks surrounding the concept.

Public Private Partnership (PPP) is a commonly discussed way to accomplish public tasks by bringing in private enterprises. This assumes that the public sector could delegate the whole issue or parts of the issue to one or several private companies. The public demand is partly or fully met by the private providers. Contracts between the public and the private sector regulate the compensation of services. The term Public Private Partnership is used widely and with a variety of arrangements. The US National Council for Public Private Partnership define PPP as:

“a contractual agreement between a public agency (federal, state, or local) and a private sector entity. Through this agreement, the skills and assets of each sector (public and private) are shared in delivering a service or facility for the use of the general public. In addition to the sharing of resources, each party shares in the risks and rewards potential in the delivery of the service and/or facility.”

Following the definition brought forward in “Partnerships for women’s health: Striving for best practice within the UN Global Compact”, by Timmermann and Kruesmann, the objective of a PPP is to combine public responsibility with private efficiency. The definition of a PPP is however many times seen as controversial, which perhaps is one of the outcomes of the widely used term as well as questions regarding the suitability of private sector involvement in development cooperation. These questions arise from unclearness regarding what the PPPs actually cover and questions regarding whose interest and objectives are being promoted in the name of PPPs. Another important question relates to the actual impact of PPPs on sustainable development. As pointed out by the United Nations Research Institute for Social Development (UNRISD) this important factor is sometimes overlooked:

“Whereas the donor discourse tends to emphasizes on the potentials of PPPs to create win-win situations, it has largely ignored insights from previous academic work in this area (Utting 2000) that attempted to examine when, how, where and why PPPs are likely to support or undermine public policy goals. More critical academic work has emphasized the limitations of PPPs in relation to possible co-optation of NGOs, the state and UN agencies; a weakening of efforts to hold transnational corporations accountable for their actions; the development of an internal culture of censorship in non-profit and UN organizations; and the lack of effective monitoring and enforcement mechanisms to ensure that PPPs promote public, and not just private, interests.”

The UNRISD reaches the conclusion that, in academic terms, our knowledge of the potentials,
limitations and actual impacts of partnerships in the post-WSSD (World Summit on Sustainable Development 2002) period is still limited. As pointed out by Bendell and Murphy (1999:60) you can pick the pros or the cons depending on your agenda:

“Those who wish to prosecute business can present a catalogue of environmental disasters, human rights abuses, worker health and safety violations etc. Those who wish to defend the role of partnership can present a growing array of policy statements, environmental and social projects, civil regulation schemes and other fledging initiatives…we cannot deliver a fair verdict at this time and there is a need to collect more evidence for a fair trial.”

Witte and Reinicke (2005:85) argue there is a lack of comparable case studies and other data and hence sum up our further state of knowledge about the potential, limitations and effectives of PPPs as follows:

“Current research on partnerships suffers from a lack of comparable case studies and other data. Resources should be made available to facilitate such applied research work in order to improve the systematic understanding of where, when and under what circumstances partnerships are likely to deliver.”

Boardman and Vinning (2010) argue “no government has performed normatively appropriate analyses of P3” (as PPPs are called in Canada).

The lack of thorough research combined with the wide variety of PPPs make it difficult to come to a general conclusion regarding PPPs in development cooperation so it is of importance to evaluate each case thoroughly on a case by case basis. Today one can say that the role of PPPs in development cooperation is controversial just as the role of globalization. The role of PPPs in development cooperation has developed alongside with globalization and the increased western political focus on the aid for trade movement focusing on the role of trade in development. Prior to the 1980’s direct cooperation with the private sector in development cooperation was limited to the US, and to a lesser extent, Canada, the UK, Germany and a few other countries. At the beginning of the 1990s, UNFPA (United Nations Populations Fund), began to study the role of the private sector in meeting contraceptive requirements and the UNFPA’s Procurement Unit became a major actor in the area of procuring contraceptives for developing countries and the international interest for private sector cooperation was formed. Cooperation with the private sector is believed to increase in the future and continuing dialogue between the private sector, governments and international organizations will help to ensure that this sector responds to demonstrated needs and provides services of quality.
Advantages of Public Private Partnerships include access for all beneficiaries, high efficiency, private capital investment, competition orientation, sophisticated technology, efficient financial investment and that ethical norms are controlled by public authorities and private competitors. Disadvantages include profit orientation may affect service priority, investment returns may dominate and equality of access may still have to be publicly guaranteed. Access for all beneficiaries can be guaranteed only as long as public authorities supervise the PPP or if the public authority is determined as a predominant part of it.

**Public Private Development Partnerships**

This thesis have chosen a more narrow definition of PPP, namely the Swedish International Development Cooperation Agency’s (Sida’s) Public Private Development Partnership, in order to strive to create a more sustainable “win-win situation” for both the private sector and the developing nation involved. The Sida PPDP was chosen in order to fulfill this requirement. In a Public Private Development Partnership (PPDP), the public and private sectors make a joint investment in a project implemented by a third non-profit party, such as a local ministry, agency or a locally established civil society organization with a clear focus on development. The driver of the project is the partnering company, or a cluster of companies. Sida’s PPDPs aim to engage the private sector in proactively committing to developing countries through investments, trade, technology transfer and problem-solving. In order for a PPDP to be accepted by Sida it has to create conditions for people living in poverty to improve their lives. The development partnerships mainly focus on collaboration with large companies and cover initiatives in which private and public actors share a common interest in creating opportunities and achieving development goals. Even though the Sida objective and the private sector objective differ, win-win situations can be created where projects are commercially driven but at the same time generates significant improvements for people in poverty.

The name “Public Private Development Partnership” was established at Sida in January 2013 and replaced the former name of “Public Private Partnership” in order to emphasize on the importance of development in such a cooperation. The private sector will normally be required to provide the main investment (minimum 50 % of total cost) associated with a project and the Sida funding should be seen as complementary. The principle is based on the private partners and Sida jointly financing a project that is implemented by a third non-profit
party in which the resources are pooled. The financial support is channeled through a local partner, such as a local ministry or locally established organization, that has the ownership of the project and is never directed to an individual business. In the case of Tetra Pak, the first PPDP Program under Sida implemented in 2011, a school milk program in Zambia has been established by using World Food Program as the partner where the Sida financing is channeled through. However, the financing could be funneled through a Ministry as well. Nevertheless, it is key to include the relevant ministry in the partnership regardless, since it is a key implementer on the local market. In the case of Tetra Pak’s PPDP in Zambia the PPDP is set up with The Ministry of Livestock and Fisheries Development. The goal of the Tetra Pak PPDP in Zambia is to show how school milk can be a tool to help develop the entire dairy value chain including small holder production, processing and consumption of milk to combat malnutrition and to improve the nutritional and educational status of Zambian school children.

A one year pilot school milk program targeting 13,000 children in basic education was proposed to Sida and accepted for co-funding. Regardless of the setup frequent evaluations (per quarter or every six months) will be made of the PPDP by Sida in order to make sure the project is fulfilling its objectives. According to Sida the evaluations made of the Tetra Pak PPDP Program in Zambia so far shows that on the days were Tetra Pak milk is delivered in schools the attendance among students increase especially among girls and hence create a local “win”, both due to increased school attendance and increased nutrition. The project is implemented during a five-year plan and the “win” for Tetra Pak is created by good global image building and possibly gained market shares on the Zambian market. Factors such as personal commitment to a specific cause, by the founders of a company, might also add to the company’s CSR initiatives.

Sida supports PPDPs such as pilot projects, technical assistance, training and capacity building, investments in facilities linked to a business venture, market support and other problem solving initiatives. According to Sida’s PPDP principles:

“Sida welcomes PPDP initiatives emerging from the business sector which, together with a local partner, address local development constraints. A company, cluster or a consortium in harness with local partners are the drivers of the projects. Projects are aligned with national poverty reduction strategies and priorities as well as the Swedish country strategies. Sida’s support aims at adding value to private investments from a development perspective. Systemic weaknesses and constraints in developing markets might be related to a lack of critical physical infrastructure or constraints in the value chain, such as poor knowledge among farmers preventing them from
delivering products of sufficient quality for processing or export. Private investments can, for instance, have a positive impact for people living in poverty if the company, the partner country in question and Sida establish a program directed at specific parts of the value chain (as an example, a value chain is the process from the cotton seed to the garment we buy in a shop). Sida could co-finance support to small farmers (agriculture, organisation, management, etc.) to enable the farmers to participate in new markets that emerge from a private investment.”

**Lessons from previously conducted Public Private Partnerships**

Even though each country, situation and PPP is unique and should be treated as such it is of value to learn from lessons from previous conducted PPPs within maternal health before implementing the Swedish Zambian Health PPDP. A valid example from the field is the German Women Health Initiative (WHI) aiming at contributing to the improvement of women’s and girls’ reproductive and maternal health care in India. The major underlying idea of the project was to treat women with a new technology, such as endoscopy, which guarantees excellent medical care and also implies that patients will recover more speedily. The project idea was developed in August/September 2004 between on the one hand, Karl Storz (KS) and TIMA (Transition Integration Management Agency) and, on the other, the United Nations University (UNU). It comprised a business model and an assessment approach aiming at responding to the several challenges involved. An interim review, conducted in 2006 by GTZ, provided, among others, the following results:

“Six Endoscopy Training Centres had been set up with the help of Indian endoscopy specialists. The training courses had begun but with a delay of about six months. Because of the delay the annual target of 240 doctors trained in all six centres had not yet been reached. The trend however was considered to be positive. By January 2007, some 200 doctors had been trained and about 130 registrations were pending. Monitoring data relating to 2000 treated patients had also been collected by January 2007. Up until then the majority of the patients had been treated within the centres. In summary three key factors that have contributed to the project’s success are:

1. cooperation with strong partners that are independent, well known and accepted locally;
2. unequivocal validation of the project conducted by the doctors involved;
3. the careful selection of doctors and trainers and trainees."

Recommendations from the WHI include that development cooperation projects and programs are implemented according to the policy priorities of the partner country.
Ultimately, therefore, the Indian government itself determines whether health PPPs are promoted or not. Also successful PPPs primarily depend on the interest and innovative capacity of the private sector involved. Finally, it is crucial to remember that the poor are the main target group of development cooperation and therefore it is of importance that the PPPs are designed with their needs in mind. The WHI illustrates that public private partnership organizations must work together with governments to ensure activities are mutually beneficial and to ensure efficient cooperation overall. In sum, it was established that for the PPP to be successful and sustainable, a glocal design as well as implementation involving all major stakeholders, particularly close cooperation between the private and public sector, was required. It was also established that

“the need for transparency must be accepted by the partners and provided by engaging with civil society. It is also important to maintain a loyal and (as much as possible) permanent project staff with a joint project mediator/coordinator in order to ensure continuous and smooth inter-partner communication. Thus, the overall project know-how and knowledge that are essential for the efficiency of transactions, for progress and for the success of the project will be guaranteed throughout the partnership. The winners will be the partners also – most of all – the women, their health and their human rights.”

Another PPDP which can guide the Swedish Zambian Health PPDP is the UNDP/World Bank/WHO (World Health Organization) Special Program for Research and Training in Tropical Diseases (TDR). The program, which was established from a health analysis conducted by the WHO in developing countries of the tropics in the mid 1970s, had two interrelated objectives which was research and development on one hand and training and strengthening on the other hand. The research and development objective focused on developing safe, acceptable and affordable methods of prevention, diagnosis, treatment and control of the TDR’s target diseases. The training and strengthening objective focused on strengthening the capability of developing disease-endemic countries to undertake the research required to develop new technologies for control of these diseases. During the Program it was clear that the TDR could not achieve some of its specific goals, especially the development of new drugs, without collaboration with the private sector. Because of controversies between the public and the private sector the cooperation with the private sector was initially closely guarded and monitored by the Joint Coordinating Board, the governing body of the Program. The results of the PPDP have been positive. Not only have new products emerged but there are evidence that several of the targeted diseases are now in the process of being eliminated.
by carefully designed public private partnerships.

I also believe the maternal health PPDP in Tanzania shares some common grounds with the proposal of the Swedish Zambian Health PPDP, which could be useful to learn from, not least regarding set-up, since few maternal health PPDPs have been carried out.

The maternal health project in Tanzania started seven years ago and is a joint effort between the Tanzanian government, World Lung Foundation (WLF) as implementers, and Bloomberg Philanthropies. New donors since include Sida (since 2012), H B Agerup Foundation and Merck & Co. According to the World Lung Foundation:

“The model being implemented in Tanzania takes a comprehensive approach – it has contributed bricks and mortar to build and renovate facilities to enable adequate infrastructure at rural health centers; it continues to train non-doctor health workers to learn how to do surgeries and carry out complicated deliveries; and works closely with the government to see to it that there are adequate and appropriate tools for patient care. The result is that life-saving skills are available at local health centers in rural regions. To date, the project has upgraded and equipped 12 health centers and four district hospitals to provide comprehensive emergency obstetric care, including cesarean sections, to surrounding, rural communities. Continuous project monitoring and support is on-going in Kigoma, Morogoro and Pwani regions.”

Ericsson was part of the project during 2012 and responsible for providing and evaluating the impact of implementing a collaboration tool for clinicians in the selected rural health centers, where the clinicians can share education material, view real-time presentations and have discussions with experts. Ericsson’s role in the project was successfully carried out according to both Ericsson and Sida as well as the clinical workers. According to the responsible Sida officer the maternal health PPDP in Tanzania has shown positive results so far, including increased telemedicine operations among the health centers involved. Sida will continue to support the PPDP until 2014 as part of a broader ongoing project in line with the current strategy for development cooperation between Sweden and Tanzania. According to the responsible Sida officer it is too early to measure the results but the indications so far are positive with the increased possibility for communication from the rural health centers.

In order to achieve a best practice PPP according to the principles of the UN Global Compact there is a blueprint to follow which emphasizes on the importance of transparency through independent monitoring, effectiveness, sustainability, self-learning process and up-scalability. Following the UN guidelines will be helpful for the Swedish Zambian Health Partnership and as previously stated I believe the Swedish Zambian Health PPDP will gain a lot by learning
from previously conducted strategies. Not least is it of importance to look at factors that have not been successful such as what caused the delays, and hence the higher costs and not achieved target on time, for the WHI PPDP presented above. Another important factor to consider before entering into a PPDP as previously discussed is that of the “win win” component. The “win win” component can be very difficult to establish before entering into the PPDP but it is of crucial importance to evaluate the goal and capacity including financial resources of the private sector before entering an agreement. If not done carefully you will increase the risk of the private sector withdrawing prior to the project deadline due to for instance financial difficulties. This was for instance discovered in Liberia in March 2013 where the private sector company Vattenfall was accused of withdrawing from a agricultural project too early due to financial difficulties and hence leaving the targeted region and its inhabitants and workers in a worse condition than prior to the project implementation. Hence, the sustainability aspect, including future financing, of the PPDP is crucial to be planned for prior to implementation.
4. Presentation of the Swedish-Zambian Health PPDP

This chapter presents the Swedish Zambian Health Partnership. It gives the reader a background of the ongoing project as well as a thorough description of the content including reasoning behind the chosen partners and concept.

Until now there has been no Swedish health PPDP set up in Zambia. The Swedish Zambian Health Partnership has been set up to follow the Sida guidelines for Public Private Development Partnerships as presented above. To increase health in remote rural areas is a complex challenge. Many times the rural populations can not afford or do not have time to travel the long distances required in order to receive proper health care. The failure in reaching out to rural communities is one of the major factors behind several health challenges today including the current failure by many developing nations in reaching MDG 5.

According to the midwife at Livingstone General Hospital’s maternal ward there are about 50 deliveries per week at the maternal ward, which are referrals from southern province clinics if a problem has been detected. According to the Zambian Ministry of Health 61 % of the deliveries in the Southern Province of Zambia are made by skilled personnel and 78 % are institutional deliveries. However, this number differs depending on the source. According to UNICEF (The United Nations Children’s Fund) the statistics for Zambia as a whole shows a different picture and the Southern Province is not likely to show a more positive trend than the country norm. According to UNICEF only 47 % of the deliveries in Zambia are attended by skilled workers at a health institution and 53 % deliver at home. In the Kalomo District of the Southern Province institutional deliveries are estimated to 32 % and 11 % of the deliveries are made by skilled personnel. As an attempt to address the problem and increase access to health care in rural areas, with a specific focus on primary and maternal health, the Swedish Zambian health partnership was formed.

The Swedish Zambian Health PPDP aims to be 50 % financed by the private sector and 50 % financed by Sida in order to fulfill the requirements of a Sida PPDP. If Sida will not be part of the Swedish Zambian Health Partnership, and SMGL will be the main partner, the triple financing module will be used dividing the costs by three among the Swedish private sector, SMGL and the Zambian MoH.
The Swedish Zambian Health PPDP aims at being carried out in cooperation with the Zambian Ministry of Health and the Saving Mothers Giving Life partnership, which will be further described in section 3.4. SMGL will initially be responsible for operation of the remote medical clinics and gradually transfer over responsibility to local capacities in line with the educational programs provided. The Zambian Ministry of Health is considered a key actor in the Swedish Zambian Health PPDP but due to the corruption scandal within the Zambian Ministry of Health in 2009, where Swedish Foreign Aid was proven to have been misused, the ministry serves as a cooperation partner only at this stage and the financing will be channeled through a selected organization.

The Swedish Zambian Health PPDP aims at providing a district (district to be determined in cooperation with SMGL) in the Southern Province of Zambia with a remote health post package consisting of one primary health unit and one maternal health unit. Possibly a child health unit and a HIV unit will be added to the concept. The remote health clinic is equipped with Remote Patient Monitoring via Wireless Mesh Infrastructure which can connect to a regional, national or international hospital, in order to minimize number of hospital visits for the patients, to detect vital sign problems and to better utilize the many times scarce human resources. Other components of the package include electronic health record systems, medical diagnostic testing, cervical cancer examinations and infection control. The maternal health unit primarily offers prenatal/antenatal care but could also assist in deliveries. At the primary health unit primarily conditions such as infections, cuts and wounds will be treated. For more information regarding the content of the remote medical station see Appendix 5.

The package also includes an educational platform where health education will be provided as well as home based solutions to improve health through solar energy technology innovations. A maternal kit is also planned on being provided to pregnant mothers. Another important component of the package includes local participation where local capacities will be trained in the health post delivery, manufacturing and maintenance. There is also a local procurement aspect of 12 months when local partners are encouraged to take over operations if manageable. There is a possibility for the remote medical stations to be manufactured at the local site and hence create additional local job opportunities.

The Swedish Zambian Health Partnership has taken into account factors affecting health professionals’ decision to migrate including the wish to work in better managed health
systems, the wish to continue education or training, the wish to work in a more conducive working environment and the wish to receive better or more realistic remuneration\textsuperscript{43}. The Swedish Zambian Health Partnership offers housing for staff which many times is limited in the rural areas. The staff housing is considered to be of quite a high local standard e.g. with access to clean water and Internet, and hence should serve as a mean to increase the staff’s willingness to work and live in rural areas, which today is lacking as we were informed during our visit to the Zambian Ministry of Health. Through the remote patient monitoring the quality of care given will also increase and hence serve as another attractive component for doctors and nurses to return to the rural areas. Apart from staff housing the Swedish Zambian Health Partnership could also provide maternal waiting homes where the pregnant women can be housed while awaiting delivery. Maternal waiting homes are currently lacking in Zambia today and increase the difficulties in delivering at a clinic.

As a trial one health post will be donated to Saving Mothers Giving Life/the Zambian MoH and placed in the xxx district (to be defined) in the Southern Province of Zambia with remote patient monitoring access connected to a regional hospital (possibilities for international connection as well). Discussion and reflection regarding the selected area and the set up is currently being negotiated. If partnership with SMGL is signed, initial operation is in first hand planned on being implemented in line with ongoing SMGL initiatives and will be transferred to local capacities in line with current educational efforts.

In order to create a successful and sustainable PPDP, the partners of the PPDP have been chosen carefully with large emphasis being placed on quality products/services, capacity, innovation, development commitment, local involvement and sustainability. With assistance from Swecare, I identified the following companies, selected due to their fulfillment of above criteria’s, their specific interventions suitable for remote medical clinics as well as their interest for the Zambian market:

ProCamp - is a remote filed hospital provider and will serve as the private sector coordinator. ProCamp offers high quality field hospitals with integrated solutions for clean water, energy and Internet, designed and manufactured for remote areas.

Aventyn –is a Health IT company which provides eHealth/mobile health solutions to connect patients to a remote medical station locally. With electronic health record and remote patient
monitoring features this system will also facilitate secure data exchange between the local remote medical station and a regional/central hospital. Together with education providers Aventyn has developed academic as well as hands-on training programs to support the local eHealth operation.

Cavidi – Provides medical personnel with medical diagnostic tests, particularly with a focus on the ability to measure the quantity level of the HIV virus in an HIV positive patient.

Gynius – Provides the Gynocular, which will enable doctors, nurses, and midwives to perform high-quality cervical examinations immediately.

Solvatten – Provides safe and warm water which improves general health as well as addresses the water challenge. Solvatten could also assist in educational trainings regarding water safety.

Peepoople – Provides hygienic sanitation solutions and could assist in educational trainings regarding sanitation.

HiNation – Increases the access to power hence improving general health including charging solutions for the remote patient monitoring module.

SCA – Provides maternal kits which possibly could be sponsored to the remote medical clinic as a CSR initiative.

Other potential partners include: Tengbom, Sweco, Health Solutions, White, Helseplan Consultancy Group, Elekta, Hemocue, Ericsson, Philips and Karolinska Hospital.

Project Cure – a partner of the Saving Mothers Giving Life Initiative – could add to the content of the ProCamp package by providing customized medical supplies, medical equipment, and related program services, if partnership with SMGL will be signed.

As previously mentioned the remote medical units will be accompanied by an educational platform in order to enhance basic health and sanitation information in the area. Solvatten, HiNation, Peepoople are some of the potential partners part of the educational platform. The companies will also assist in education regarding their products/services and infection control techniques in order to enhance local sustainability.

The remote health post package will be designed in a flexible manner, ranging from basic
needs to more high end solutions, in order to best suit the local needs and the demands at any particular place i.e. in some cases health care in the area is lacking completely and in some cases there might be a need to strengthen what is already there. The remote health post package will be designed to do just that. However, in the case of the Zambia implementation in the rural areas, a basic need approach will be used, since the needs are identified accordingly. The exact level, performance and content is currently being drafted together with SMGL and the Zambian Ministry of Health, in order to implement a package appropriate to the local needs and wants.
5. Swedish-Zambian Development Cooperation

This chapter gives an overview of Swedish-Zambian Development Cooperation and compares past strategies to the ones of today. It also discusses future forms of cooperation beyond foreign aid as well as bringing up stereotypes common when discussing an African country.

The role of the private sector in development cooperation is relatively new in Sweden and is driven forward by the current Swedish Government in line with the adoption of Policy for Global Development in 2003, which sees a need for cooperation among sectors in development cooperation. The current Government is reallocating Swedish developing strategies according to the developments achieved in the developing nations. Some nations, such as South Africa, Botswana and Namibia, have experienced positive development and is evaluated to be post the need of traditional foreign aid strategies and hence new developing strategies are being established through so called Partner Driven Cooperation, where the goal is to create three beneficiaries i.e. the inhabitants in the developing nations, the actors in the developing nations and the actors in Sweden.

In the case of Zambia Partner Driven Cooperation is not estimated as suitable as main cooperation strategy, at least not yet, and instead a long term developing strategy based on foreign aid is currently underlining Swedish Zambian bilateral relations which reach far back to the 1960’s when Zambia became independent. However, PPDPs could be seen as a part of the Swedish developing cooperation strategy with Zambia.

According to the Swedish Ambassador to Zambia, Mrs. Lena Nordström, international foreign aid today amounts to 4.6 % of the Zambian Governmental budget. In 2000 international foreign aid was estimated to 30 % of the Zambian Governmental budget. The transition means that Zambia is looking for new types of international cooperation and does not want to be limited to foreign aid nor dependent on it. The new Swedish Development Strategy for Cooperation with Zambia is to be announced during 2013. The strategy has embraced the new reality and taken into account business for development as a component for future development and relations with Zambia.

Sweden has come a long way in developing health rights and is said to have a comparative advantage within Sexual and Reproductive Health & Rights, Children's Rights and
HIV/AIDS\textsuperscript{45}. Among the MDGs goal 4 and 5 are set as priority for Zambia for the new Swedish governmental strategy and not as much focus on HIV as we have previously seen in Zambia. The HIV prevalence has decreased and many actors work in the field of HIV in Zambia but maternal health is a sector with less improvement. The Zambian Government is now asking for new types of cooperation and an increase of Public Private Partnerships. The public sector in Zambia is not strong enough by itself yet and need the international private sector capacity in order to advance.

As witnessed several times during our time in Zambia the Zambian Government is looking for development beyond foreign aid. This clear strategy of theirs is said to be one of the main reasons for why it got elected in 2011 when a strong young population demanded a more independent development than the one based on international donors. The current Zambian Government is responding to these demands and has started a process towards tax reforms in the mining sector where currently billions of dollars are leaving the country through illicit financial flows by large corporations. The exact amount transferred out of the country is unknown but according to Savior Mwambwa, Secretary General at Centre for Trade and Development Policy in Zambia, it is estimated to be as much as ten times higher than the total foreign aid amount from all international donors combined. In Angola it is estimated that Statoil pays taxes to an amount equal to the Norwegian foreign aid to Sub Saharan Africa combined. If similar tax reforms can be implemented in Zambia there is no longer a need for foreign financial aid. It is time for the western world to realize this unfortunate pattern and increase its work towards enhancing Zambia’s capacity, as well as other developing nations capacities, to establish stronger tax reform structures including country by country reporting where the companies are obligated to pay taxes in the country of extraction. Sweden has begun working towards strengthening systems for implementation of country by country reporting but it is a challenging task and much work remains if the pattern is to be changed. However, if the western world sincerely wants to achieve non foreign aid dependency this is the area where lots can and should be done.

The western world also needs to realize that Africa is not one country but a continent with several diverse countries within. The western world associates Africa as one and with poverty, starvation, epidemics and conflicts. Of course these are still large challenges for several African countries but there is so much more going on including seven out of ten fastest growing economies residing in Sub Saharan Africa according to the International
Monetary Fund. One of them being Zambia. In 2012 Zambia became the ninth sub-Saharan African country outside South Africa to sell debt to overseas investors. Zambia has made a positive debut on the international bond market with a high interest from investors much due to the country being Africa’s largest exporter of copper and its political stability. With this being said Zambia is not without risk one of them being the extreme exposure to copper prices and even though the economy is growing rapidly it is from a low starting point. It is also crucial to remember that economic growth does not necessarily mean development or inclusive economic growth, which constitutes a large challenge in Zambia today. However, the last decade’s positive economic growth is a sign of that something is changing and a need for the world to cope with it. In Sweden, the Swedish Institute is working towards an updated picture of African countries in Sweden, which they see as an important mandate of theirs. The Swedish Institute has estimated that the average Swede usually has a perception regarding African countries that perhaps would have been accurate twenty years ago but little or no information regarding today’s reality.

To sum up we see a need both among the average Swede, Swedish companies and policy makers to wake up to the reality of a “new Africa”. Several African countries are moving towards better investment climates and PPPs are only one of several “new forms” of development cooperation. For example Sida could support projects through warrants as in the case of a maternal health project conducted by the Gates Foundation. It is important to realize that developing cooperation could and should look different depending on context. It is important to evaluate our historical forms of cooperation according to the progress seen in several African countries in order to ensure they match today’s reality. And there is a need for fresh ideas on development partnership in order to do so as stated in the Millennium Declaration:

”as the development landscape becomes more complex with new actors, new challenges and new funding streams the importance of partnerships is growing. It is clear that the MDGs cannot be reached without full participation from all members of society (governments, parliamentarians, civil society, private sector) working towards a common agenda. Smarter partnerships aim to maximise the impact of every partner’s input. From public-private partnerships to South-South co-operation, these alliances have shown how to leverage the greatest possible development impact from all development resources, including aid. Efforts to bring in new actors, and promote innovation and mutual accountability have proven their effectiveness in delivering results.”
Several trends show the growing importance of partnerships with the business sector in development cooperation. In particular, the foreign direct investment (FDI) flowing into developing countries have increased remarkably in the past 15 years. According to the United Nations Conference on Trade and Development (UNCTAD), FDI into developing countries amounted to more than US $334 billion in 2005, which surpassed official development assistance (ODA) in 2005 by more than a factor of three and became the most important source of capital inflow into developing countries. According to Sida FDI into Zambia has increased times twenty since 1995 and foreign aid decreased by a factor of three, however there is a challenge in making sure the entire population of Zambia gains from the FDI, which has currently not been the case.

Sweden is a large donor of foreign aid in Sub Saharan Africa and to some countries that foreign aid is still essential while some countries are in the need of other type of international assistance as discussed above. It will be interesting to see what Swedish relations, both economical and political, to the region will look like post traditional foreign aid. After all Sweden is many times associated with foreign aid in the Sub Saharan African countries and with little else. There is a need for Sweden to establish broader relations in the region if Swedish African cooperation is to continue at a high level. Currently China and several other international actors are actively enrolled in many sectors on the African continent. The Chinese agenda for Africa is debated and if Sweden wants to be part of a positive movement for the African continent it is time to evaluate current methods and embrace the future.
6. The Swedish Zambian Health Partnership - Results and Findings

This chapter discusses the results and findings of The Swedish Zambian Health Partnership. It gives an understanding to the selected area as well as it outlines suitable local partners and form of partnership. Lastly it displays the results from applying the selected theoretical framework.

The selection of the Southern Province of Zambia as a suitable pilot for the remote medical post project, was made after our visit to the Zambian Ministry of Health, the Ministry of Community Development, Mother and Child Health, and to the different hospitals in Lusaka as well as Livingstone. During these visits it was confirmed to the delegation that maternal health and health in general is a huge challenge to Zambia especially in the rural areas and that Livingstone General Hospital is a regional hospital covering a large rural area (the Southern Province) with several health challenges, including a high maternal mortality ratio, and with the ambition to increase its capacity tremendously. Based on these national and regional facts as well as the ambitions of Livingstone General Hospital, the Southern Province was chosen in conjunction with Dr. Mzaza Nthele, Head of clinical care at Livingstone General Hospital. Dr. Nthele identified the Southern Province with high maternal mortality and where the outcome of implementing the remote medical posts would be obvious.

The goal of the remote medical post project is to by November 2013 have a donated module in place in the Southern Province of Zambia. The concept will be presented during the visit of the Zambian Ministry of Health end of May 2013. The donated module will serve as a trial to see if it can meet the local wants and needs. If so the hope is to integrate these modules in the work of SMGL and the Zambian Ministry of Health and the Zambian Ministry of Community Development, Mother and Child Health, to a subsidized cost through the Sida PPDP program. The selection of a PPDP solution to deliver the Swedish Zambian Health Partnership is estimated to be in line with Zambian Government initiatives looking for increased capacity through the international private sector as well as in line with the current shift to a more positive view from Sida regarding private sector cooperation in development cooperation.

Due to the 2009 corruption scandals within the Zambian Ministry of Health, the Center for Disease Control, world leading health provider and a partner to SMGL in Zambia, has been identified as a possible venue for which financing could go through since SMGL is not set up as a unit which financing can be channeled through.
Assessing the Swedish Zambian Health Partnership as a PPDP

As previously discussed the form of Private Public Partnership is not always suitable and/or desired and therefore has to be evaluated on a case-by-case basis. The background information when entering into this thesis emphasized on the wants from both the Zambian Government and the Swedish Government to increase cooperation with the private sector to tackle global health challenges. Information which was confirmed both during my meetings with the Swedish MFA and Sida as well as during meetings with the Zambian Government. The main discussions in Zambia during the delegation involved future forms of cooperation between Sweden and Zambia where increased Public Private Partnerships were sought for by the ministries. Main focus on the discussion was on how to successfully create Public Private Partnerships in Zambia and what the Ministries and the hospitals particularly were looking for. No doubt the communicable diseases including HIV still had large focus but also non-communicable diseases, particularly cervical cancer, were gaining more grounds due to increased awareness through recent implemented testing. Improved maternal and child health was also high on the agenda with the aim to move towards MDG 5 and 4. Common for all was the need to improve health management systems and how to tackle the lack of skilled medical personnel. The Zambian Ministries and hospitals reached out for PPP solutions within these areas to improve current solutions and the Swedish Zambian Health Partnership was estimated to be in line with these needs and wants. However, the advantages and drawbacks of implementing the Swedish Zambian Health Partnership need to be taken into consideration.

An important question to address in order to establish the suitability of any type of a PPP structure is if it is feasible for the project to be delivered under a PPP structure, both from a Zambian public sector and a Swedish private sector point of view. When choosing the Sida PPDP structure, as in the case of the Swedish Zambian Health PPDP, there is a subsidiary cost to the Zambian public sector initially even though the hope for the project is to in the future create a local sustainability where costs as well as full responsibility could be transferred to the Zambian public sector when estimated as possible. So at this stage there is a need to estimate that the project corresponds to the Sida requirements of a PPDP i.e. creating the win win situation as elaborated on in previous sections. The win for the local population is in the form of increased health and is estimated as immediate when access to professional care is established (see Appendix 1) as soon as the first remote medical post is in operation.
but the win for the private sector also need to be determined. According to Farquharson E et al there are three key questions to be asked when determine if it is possible for the private sector to deliver the project efficiently and cost-effectively and what is affordable:

- Who will pay for the project and how (affordability)?
- What are the risks inherent in the project, and how should these be dealt with (risk allocation)?
- Will the resulting project be able to raise the required debt financing (bankability) and attract contractors and other equity investors?

One of the most crucial aspects to the PPDP setup, as mentioned above, is affordability. If the project is not affordable there is little sense in going through with it. Affordability is here understood in a broad sense using the reasoning by Farquharson E et al and examines the level and structure of the project’s overall revenue requirements in relation to the capacity of the users, the public authority, or both to pay for the service. This requires building up a picture of the expected operating and maintenance costs of the project, together with the levels of cash flow required to repay the loans and provide a return to investors. To reach affordability the private sector has two alternative financial models, which can be viewed in Appendix 2. If the Swedish Zambian Health PPDP receives 50% financing from Sida and/or financing from Sweden Partnership, the Swedish Zambian Health Partnership is deemed as affordable. An alternative financial model for the Swedish Zambian Health PPDP being discussed is 1/3 Swedish private sector investment, 1/3 SMGL investment and 1/3 Zambian MoH investment. Without the financing options outlined above the project will face financial difficulties unless other forms of cooperation is found, or more private sector actors get involved as part of the package. Return on investment for the private sector in the Swedish Zambian Health Partnership will most likely succeed if cooperation with SMGL is established in the sense of SMGL purchasing the remote medical stations as part of their operations. However, this crucial factor is yet to be determined.

In addition to assessing the affordability of the project the risks involved in the project also need to be identified. Risk identification could be a complex task as described by Farquharson E et al:

“Risk identification is a comprehensive exercise concerning matters and contingent events that are both internal and external to the project itself: it involves analyzing all phases of a project, notably project preparation,
setting up of the project vehicle, funding, design, construction, commissioning, and operation, together with risks associated with legacy assets and services that might be transferred into the project following signature of the contract.”

For the Swedish Zambian Health PPDP there are several risks involved including financing, set-up, cost efficiency, corruption, replication by other actors etc. Risk allocation among the actors involved is important in order to share risk. If approved as a Sida PPDP, the Swedish Zambian Health PPDP, is estimated to share the risk equally 50 % by private sector and 50 % by Sida. If the Swedish Zambian Health PPDP does not get approved as a Sida PPDP I believe the project will have a harder time to succeed both financially and functionality wise since the cooperation with Sida means access to a higher capacity in the field. The cooperation with Sida also increases the chance of a successful partnership with SMGL. However, financial risks beyond a Sida PPDP also need to be taken into account in order to ensure future sustainability. Refer to Appendix 3 and 4 for further elaboration on the risks involved in form of a risk register and a SWOT analysis where the strengths for the projects are analyzed as greater than the risks even though there is a marginal difference.

The last question to bear in mind in order to establish if the project is affordable for the private sector is that of bankability i.e. if the resulting project will be able to raise the required debt financing and if the project will attract contractors and other equity investors. At this stage this is one of the main outstanding questions for the Swedish Zambian Health PPDP but results from actors such as Swedpartnership will determine the outcome.

Above we have been discussing the could perspective of a PPDP, but we also need to address whether the Swedish Zambian Health project should be delivered as a PPDP. PPDP solutions with their capacity of the different actors are suitable in complex situations such as the maternal health challenge facing Zambia. Through a UN perspective the private sector is considered to be the main driver of economic development and shapes the globalization process through changing patterns of production, investment and trade. A vibrant private sector with its combined strengths and linkages between large, medium and small enterprises is therefore seen as essential in fostering a dynamic economic development, increasing productivity, maintaining competitiveness, transferring and spreading innovative technologies and contributing to entrepreneurship development and, consequently, poverty alleviation.

Timmermann and Kruesmann sum up the role of the private sector as crucial:

“In particular, small and medium sized enterprises (SMEs) play a
crucial role in this process because they foster economic cohesion by linking up with larger enterprises (often in the context of partnership for development), by serving niche markets and by contributing to the development of productive capacities. Furthermore, these businesses contribute to social cohesion by reducing development gaps and disparities, thus spreading the benefits of economic growth to disadvantaged population groups, including women – as specifically provided for in Millennium Development Goal 3 (promote gender equality and empower women) – and underdeveloped regions.

Timmermann and Kruesmann also discuss overall incentives for the private sector to become involved in the achievement of the MDGs which include advocacy, expansion, image, lobbying and to lower costs. Timmermann and Kruesmann argue that there is an opportunity for each and every private sector entity to engage with the international community in supporting the MDGs. However, to achieve this there is a need to go beyond the scope of individual actors and to push forward forms of cooperation between the public and private sectors and civil society, and thereby complement each other’s development resources and competences. In this sense, public private and other multi-stakeholder partnerships have a long tradition within the UN system because they can be an elemental force in strengthening societies throughout the world.

An important prerequisite for making such partnerships with the private sector sustainable and for endowing them with credibility is the concept of Corporate Social Responsibility, a concept which seems to be growing in the past decade with its radical change in the private sector’s relationship with both the state and the civil society, leading to the private sector taking an increasingly role in development cooperation. It is also crucial to address questions regarding power and control to make sure the “win-win” component does not turn into a “win-lose” situation where the private sector has reached its profits without a local win. As a response to the latter, in an attempt to avoid the unfavorable outcome, the PPDP definition of partnership was formed by Sida as previously discussed in this chapter. Sida chose the new definition of PPDP since the general definition of PPPs was seen as too wide including partnerships not focusing on the development component. Much of the critique applicable to general PPPs is hence not applicable to PPDPs if monitored and regulated properly in accordance to purpose.

Some projects are more suitable than others to be delivered as PPDPs. Health care is subject to public responsibility. The supply of necessary health care infrastructure, as well as the guarantee of equal access to health care providers, is incumbent on public institutions.
However, public institutions can ask the private sector for assistance to fulfill these duties and responsibilities. Many times the public institutions by themselves are not able to establish the health care facilities needed to service the entire population. During our time in Zambia this was stated repeatedly by Government officials and the public hospital directors. Hence, the Swedish Zambian Health Project was estimated to be efficiently delivered as a PPDP, using the capacity of the Swedish private sector, with its management skills, expertise and technology innovations, combined with the Zambian public sector knowhow.

It is however crucial to remember that PPPs are a comparatively new instrument in development cooperation and there are still many areas where state interventions are first and foremost needed and hence the PPP model is not always to be preferred. It is important to keep in mind that major challenges within the use of PPPs in development cooperation remain such as the need for improved project monitoring and impact assessment as well as the mainstreaming of partnership projects. These challenges were essential when choosing suitable model for the Swedish Zambian Health Partnership and hence the Sida PPDP model was chosen in order to take above considerations into account and limit the risks of such. Until 2005 roughly 6 per cent of all PPPs (or 108 in total) were carried out in the health sector, mostly within HIV/AIDS, and with a financial value of around € 170 million. PPP projects addressing primarily women’s health have been rare but are estimated to have a great potential. Possible areas of cooperation are believed to include medication and reproductive health supplies and materials, as well as social insurance. It is important to learn from the previous PPPs within maternal health, discussed in section 3.1, in order to implement the Swedish Zambian Health PPDP as successfully as possible.

The Swedish Zambian Health PPDP proposal is projected to meet the Sida requirements for PPDPs hence creating a win win situation for the developing nation as well as the private sector involved. During my interviews at Sida I realized that former negative views surrounding PPDPs are increasingly abandoned since the PPDP setup in many cases have proved successful in increasing local sustainability and improving everyday life in developing nations and not just financially convenient for the private sector. However, the informers mentioned the importance of each PPDP being carefully analyzed by Sida in order to make sure the development component is evident and if it is not the PPDP will receive no support from Sida.

The timing of the Swedish Zambian Health PPDP is estimated to be just about right with the
Government of Zambia encouraging the Private Sector to enter into Public Private Partnerships (PPPs) with the Ministry of Health to meet their wants and needs. However, it was quite obvious during our delegation visit that the PPP concept is new in Zambia even though it can be said to have been used before it is new as a concept and formal structure is being set up. The Zambian Government is very keen on increasing the numbers of PPPs and many times refer to PPPs as the “future problem solver”, but there is little knowledge regarding the set-up and the process could be quite complex. It was noticed during our visit in Zambia that the PPPs generally seem to take about one year until established and occasionally the whole PPP submission process needs to be restarted. This leaves the private sector with quite vague guiding and many initiatives must be taken by the private sector itself. There are also risks involved in a vague setup including currency fluctuations where currently local bids were only allowed in the local currency of Kwacha. However, we were informed by the MoH that international bids could be submitted in US dollars. Another financial risk lies in the sustainability of the project, i.e. if the aim is to not be dependent on foreign aid in the future, then alternative financing has to be ensured which is one of the most difficult tasks ahead.

Nevertheless, as previously mentioned, the Zambian Government seems to look upon PPPs as the future problem solver in many areas and hence formal structure is currently being improved. Up until now the Ministry of Finance through its PPP unit together with the National Planning unit has been responsible for all types of PPPs but the overall responsibility is now being moved to the Zambian Development Agency. According to Adam Lagerstedt and Emil Lidén at the Swedish Embassy the move is positive since the Zambian Development Agency is believed to cope with the responsibility efficiently. A coordination desk for PPPs is still to remain within the MoH.

It was noted during our visits that larger companies tend to easier pull off the PPDP structure financially since financial profits are usually not made directly. The PPDP process is regarded as long and complex by the private sector which also makes it more difficult for smaller companies to set aside resources for a longer period of time. However the role of Swecare, as a facilitator and a possible “package solution”, where companies can work together, is anticipated to have a positive impact on the setup of the PPDP not least since it provides smaller companies with an opportunity that might have been hard to achieve by themselves, both financially, resource wise, knowledge wise and as regards to contacts.

In order to meet local demands and ensure local sustainability the Zambian Ministry of Health
should be a key actor in the Swedish Zambian Health PPDP but the most suitable type of involvement by the MoH needs to be discussed with the ministry and the other partners involved. According to Sida since the MoH is a key actor it has to be part of the PPDP, but due to the corruption scandal in 2009, financing through an external part is most likely to be preferred even though changes through the new government (since 2011) has been made. Upon my return from Zambia I conducted a second interview at Sida and found out that late 2012 a Sida PPDP within maternal health had been established in Tanzania. The Zambian health PPDP aims to implement proper structures from the PPDP in Tanzania if found suitable.

**Cooperation with Saving Mothers Giving Life**

According to the information received at Livingstone General Hospital and the ministries in Zambia, discussed in section 3.3, I researched the Southern Province of Zambia in detail upon my return from Zambia. I found that there is currently a Public Private Partnership carried forward by Saving Mothers Giving Life (SMGL) in the Southern Province, which seems to be unique in using this setup. SMGL aims to reduce maternal and child deaths significantly by using the PPP method including the American Government, the Norwegian Government, the Zambian Government, Merck, Every Mother Counts, Project Cure and the American College of Obstetricians and Gynecologists. Saving Mothers Giving Life is rapidly implementing the Maternal and Newborn Health Roadmap (2007-2014) outlined by the Zambian Government, and supporting advocacy efforts through the government's Campaign to Accelerate the Reduction of Maternal Mortality in Africa– Zambia (CARMMA- Z). These plans build upon the existing PEPFAR (The U.S. President's Emergency Plan for AIDS Relief) and maternal and child health structures and experience.

Saving Mothers Giving Life is a five-year effort which began 2012 with selected districts in Uganda and Zambia, which are among the countries with the highest maternal mortality ratios in the world. These two countries also have the political will and commitment to reduce maternal mortality in a significant way. In Zambia, the initiative focuses on the districts of Lundazi, Nyimba, Kalomo, and Mansa. The SMGL initiative follows the U.S. Global Health Initiative (GHI) and a natural outgrowth of President Obama and Secretary Clinton's overall work on improving the lives of women and children across the globe. The SMGL initiative focuses on research which has shown that mothers' lives cannot be saved by any one
intervention alone. Dramatically reducing maternal mortality will require a broad approach, significant resources and expertise. That's why in order to strengthen local healthcare systems and provide comprehensive, integrated and timely maternal care, Saving Mothers, Giving Life programs will build on the success of other global health and national platforms already in place, such as:

The U.S. President's Emergency Plan for AIDS Relief (PEPFAR)'s HIV/AIDS efforts
USAID's maternal and child health programs
The UN Secretary General's "Every Woman, Every Child" campaign

A cornerstone of the Saving Mothers, Giving Life effort is the global partnership where respective strengths, experience, methodologies, and resources will be coordinated or pooled in order to reduce maternal mortality in a significant way. These cornerstones above match the Swedish governmental strategy, for MDG 5 as well as including private sector involvement on a higher level. When I learned about the SMGL initiative I recommended the Swedish private sector coordinator at ProCamp to use the SMGL as a cooperation platform in order to reduce risks of “inventing the wheel twice” and together instead be able to make a greater impact. The suggestion was very much appreciated and confirmed from SMGL’s side as well after I made contact to the Director Celina Schocken who was very positive to cooperation. Ms. Schocken suggested a partnership between SMGL, Sida and the ProCamp Program and for a Memorandum of understanding (MoU) to be signed between the partners to document the partnership. The MoU will serve as a document describing the multilateral agreement between the parties and indicating a convergence of will between the parties and a common line of action. The MoU in itself is not legally binding but will include a model for the program where each partner funds activities directly that correspond to the activities they agreed upon. It will also include which districts to work in, how to collaborate and share tools, data and information, and come up with activities to do jointly. Hence, the Swedish Zambian Health PPDP aims at being carried out in cooperation with SMGL and the exact districts and task allocations to be decided jointly, to maximize impact. As of writing no MoU has been signed yet since the legal structure of SMGL, with Merck, as the legal entity, makes the signing of an agreement more complex. So far the supply and demand details have only been listed in a less formal e-mail agreement. As of writing there is also a discussion within the Swedish Government regarding possible Swedish participation through foreign aid to SMGL to be determined within the new Swedish strategy for development cooperation with
Zambia.

If the Swedish Zambian Health Partnership will be implemented as per above it is estimated to reach the Sida PPDP requirements. The project plan for the Swedish Zambian Health Partnership was submitted to Sida in March 2013 and is currently awaiting official procedures. A decision regarding Sida’s participation in the Swedish Zambian Health Partnership is estimated to take place during 2013 when the Swedish government officially has decided on the strategy for development cooperation with Zambia. If the strategy, with its focus on MDG 4 and 5, will be accepted by the Swedish Government, Sida will be evaluating PPDPs within these fields since the PPDPs preferably should add to or be linked to the Swedish foreign aid projects. The Swedish Zambian Health Partnership as presented in this thesis is estimated to fall within this category, however official procedures will decide on the way forward and decide which projects will be established through Sida’s PPDP structure. Official procedures will also determine whether Sweden, through foreign aid, will be supporting SMGL or other initiatives within MDG 4 and 5.

**Applying the theoretical framework of the “Three Main Dimensions of Policy Success”**

When applying the theoretical framework of the “Three Main Dimensions of Policy Success” by McConnell to the field we are able to make a measurement of the success of the Saving Mothers Giving Life PPP so far, even though, as previously discussed, there is no ultimate method for measuring the success of PPPs, since most methods are not integrated and defines success differently. However, since the “Three Main Dimensions of Policy Success” by McConnell has been defined as most accurate for measuring PPP success in an integrated approach this is the framework used. By using this framework one finds that the Saving Mothers Giving Life PPP qualifies as a “success” in every criteria of the framework by applying the findings by the external interim evaluation by Colombia University:

*Preserving policy goals and instruments:* Yes. Established together with the MoH.

*Conferring legitimacy:* Yes. Working together with the Zambian MoH and local clinics.

*Building a sustainable coalition:* Yes. Educating local personnel.

*Symbolizing innovation and influence:* Yes. Adopting innovative technique and influence mothers.

*Meeting objectives:* Yes. Maternal complications in facilities decreased from 10.8 % to 9.2%
even though numbers of patients increased dramatically.

*Producing desired outcomes*: Yes. The number of pregnant women delivering in facilities has increased by nearly 50% in the targeted districts.

*Creating benefit for target groups*: Yes. Increased health and increased socioeconomical factors.

*Meeting policy domain criteria*: Yes. Program in line with local established policies.

*Enhancing electoral prospects/reputation of governments and leaders*: Yes. Shows positive results in form of improved maternal health.

*Controlling the policy agenda and easing the business of governing*: Yes. Enables measurable results.

*Sustaining the broad values and direction of government*: Yes. The Saving Mothers Giving Life initiative is in line with Governmental health initiatives.

**Possibilities for implementation**

If a governmental decision regarding focus on MDG 4 and 5 will be taken as well as a Sida decision regarding cooperation with SMGL, the Swedish Zambian Health project presented in this project should be able to be implemented as a Sida PPDP. The Swedish Zambian Health Partnership however is not limited to the Sida PPDP setup and will look for other suitable setups and partners, such as cooperation with SMGL only, if not chosen to be included by Sida. At the Swedish Ministry of Foreign Affairs The Swedish Zambian Health Partnership is evaluated as positive but there are many crucial aspects to ensure before implementation is possible including how to integrate the e-health solution most efficiently, how to pick the right partners and how to integrate the partnership in a larger spectrum. During my interviews at the MFA it was emphasized on the importance of a “system and service” approach in Zambia and not only a product approach. The PPDP solution was seen as positive but with the reminder that all projects do not fit the PPDP model and should not be implemented accordingly. However, the ProCamp package with its development, infrastructure and management approach was estimated to do so. Zambia was also estimated as a market where PPDPs could be successful and the demand for such forms of cooperation has increased over the past 15 years. There are however still many challenges surrounding the PPDP arrangements including the “maturity” of both the Swedish private sector and the Zambian
public sector and how to most successfully move from traditional foreign aid initiatives to partner driven cooperation when the time is ready. It will be interesting to follow the neighbor countries of South Africa, Botswana and Namibia on this journey where Swedish foreign aid is phased out during 2013.

As a conclusion to this chapter it is important to emphasize on the fact that the Swedish Zambian Health Partnership in itself is limited. Single actors on their own in development cooperation will be less successful and will face narrow limits with regard to their impact on global development and health problems. Solutions of multifaceted problems of global dimensions must be approached with a multi-stakeholder approach\textsuperscript{67}. However, all actors of society, state as well as non-state, could contribute to solutions according to their obligations, abilities and self-interest. The watershed for the credibility of all societal actors will be their willingness to make resources available and to cooperate in a creative way so that the MDGs can be met and the right to health fulfilled\textsuperscript{68}.
7. Conclusion

This is the final chapter of the thesis where the conclusion, summary and the discussion of the findings are being presented. The chapter concludes with a recommendation section followed by contribution and suggestions

7.1 Summary and discussion of the findings

Even though there are drawbacks of PPDPs in development cooperation, including the risk of conflict of interest as well as affordability concerns, the result of the study shows that the Swedish Zambian Health Partnership is likely to be efficiently delivered as a PPDP if implemented with the Saving Mothers Giving Life PPP already in place. It is however difficult to thoroughly evaluate the efficiency of PPDPs in development cooperation since no comprehensive comparison is available. Nevertheless, PPDPs contribute to cooperation between different actors, which is seen as an important component of efficiency in humanitarian action.

In order to decrease the risks of conflict of interest it is important to distinguish between general PPPs and PPDPs, where the latter involves more of a development aspect and hence less risk of creating conflicts of interest. As previously discussed in this thesis, a successful PPDP involves carefully selected partners and education, as witnessed during previous PPDP setups. Some key observations made during our delegation trip in Zambia and during this master thesis process involves the set-up of the PPDP, the Human Resources available and the costs involved. A summary of these key observations, including drawbacks and advantages, is presented below.

I believe The ProCamp project has great potential to be delivered as a PPDP if it manages to include the identified partners and ensure SMGL as a driver in co-operation with the Zambian MoH. If successfully done a win-win situation could be formed. The purpose of the health posts will be met i.e. to increase access to health services and hence create a local “win”. At the same time the Swedish private sector will be provided with a future potential business partner and hence create their “win”. This is however not necessarily an easy task. For smaller companies the PPDP setup can be expensive and hence larger companies tend to be using it since they can afford a longer period of little or no financial return on investment i.e. creating a Corporate Social Responsibility effort. When several parties are involved it could be more
difficult to ensure the PPDP set up is aiming towards the same goal. At the same time if not enough partners or the correct ones are involved, the aim of the PPDP might not be fulfilled. Important to remember in the PPDP setup is also the fact that from both the Swedish and the Zambian Public Sector side the PPDP set-up is quite complex today and take a long time to establish even though formal structures to facilitate the process are being implemented. However, a PPDP structure is to be recommended in order for its ability to manage complex situations.

One of the largest advantages of the Swedish Zambian Health PPDP is its ability to answer to the local needs and wants by the Zambian Government which is asking for increased private sector involvement through PPPs. The Swedish Zambian Health Partnership will also answer to the local goal of establishing 650 prefabricated health posts outlined by the Zambian Ministry of Health in the Zambian Medium Term Expenditure Framework 2013-2015. The Swedish Zambian Health Partnership is also responding to the wish of the Zambian MoH to increase E-health solutions through its remote patient monitoring, via a regional, national or international hospital, which is an efficient way to increase quality of care in local areas where medical staff and expertise is scarce. The Swedish Zambian Health PPDP will also provide solutions for electronic health records, which will increase possibilities for vital health data to be saved, which still is a crucial problem in Zambia and many developing nations. Other advantages of the PPDP include the capacity of the private sector to improve conditions where the Zambian public sector does not possess the capability. The capacity of the Swedish private sector in combination with the expertise and resources from Sida and SMGL as well as the local know how by the Zambian public sector should be able to improve the lives of many mothers. The outcome of the project should show that a clear impact in reducing maternal deaths have been made, which the interim report of the SMGL initiative is already showing. At the same time other health challenges such as MDG 4 should also improve through the implementations.

As previously discussed the PPDP set up is also to be preferred over PPPs in a development perspective with its aim of a sustainable “win-win” component for both the private sector and the developing nation involved. As stated above the Swedish Zambian Health PPDP proposal is projected to meet the Sida requirements for PPDPs. According to my interviews at Sida it is believed that the successfully implemented PPDPs with the private sector increase the possibilities for local sustainability. After all foreign aid is there to support and build up local
sustainability. And even though challenges within PPPs remain, and should be taken into account, PPPs are instruments that have given new impetus to cooperation between the private sector and development policy.

Apart from the difficulties surrounding the PPDP setup another huge challenge lies in the lack of human resources. The lack of medical staff, especially in the rural areas, was striking during our visit to the hospitals in Zambia. If there are not enough skilled personnel to operate the remote health posts their purpose will not be met. During our visit to the University Teaching Hospital in Lusaka we could see clear cases of “product dumping” i.e. companies that have delivered their products but not ensured the personnel were able to operate them or if the machines were in need of maintenance. It was devastating to see x-rays and a brachytherapy machine, which could enhance everyday operations for medical doctors and patients, just standing in the corners, turned off with piles of dust. This clearly emphasized on the importance of delivering a “package” where education is part. Hence, the ProCamp idea of including an educational platform is a great step in the right direction but a very large and complex step to ensure it actually works in practice. However, if implemented successfully in current strategies by SMGL and Sida I believe the idea might bear more fruit. The private sector is most likely best of to do what they do best and aid organizations to do what they do best, nevertheless, I believe we can make a larger impact if the different actors cooperate in certain issues instead of inventing the wheel twice. I would also like to stress the limitations of one PPDP in itself, but if implemented properly with other relevant activities within the field, larger progress can be made. This is the hope for the private sector partnering up with Sida and Saving Mothers Giving Life.

I would also like to make some reflections regarding costs. Swedish products are usually of high quality but Swedish products are usually also expensive which is a drawback. The case of ProCamp is no different. During our time in Zambia the Chinese presence was impossible to not notice with a large amount of Chinese made medical supplies and machinery in the hospitals visited, but the quality or non-quality provided by the Chinese seemed to be a sensitive subject to discuss. It was also difficult to receive information regarding the Chinese involvement regarding the health posts provided to the Zambian MoH. There were speculations however regarding non-monetary transfers and instead service transfers on a bilateral level.

To sum up the ProCamp project is a step in the right direction and the PPDP establishment
looks promising if carefully considering the above drawbacks and advantages. Nevertheless, it is important to remember that by itself it is limited. However, by implementing the ProCamp project into current existing efforts by the Saving Mothers Giving Life organization already taking place in Zambia the project ought to have a much bigger impact. SMGL has a natural role in the project and has therefore been chosen as a key implementer together with the Zambian Ministry of Health and the Zambian Ministry of Community Development, Mother and Child Health, which are the key ministries and already onboard the SMGL initiative.

Finally, looking at statistics for conducted PPPs within maternal health we see a low number of commitments within the field. The private sector doesn’t seem to find the maternal health sector as profitable compared to other health sectors with “pill solutions” and hence so far been hesitating to be involved in maternal health PPPs since the economical return on investment is estimated as less obvious. In my opinion it is therefore of extra importance to support PPDPs who actually do take up the fight for the survival of mothers. We can choose to do nothing or we can choose to do something. The Swedish Zambian Health PPDP is a response to the latter.

**7.2 Recommendation**

My recommendation to the Swedish Zambian Health PPDP is to continue to prefer cooperation to competition when that is estimated as possible. Too often within Humanitarian Action you face the “inventing the wheel twice” syndrome, which very much is hindering ultimate impact. I also believe the Swedish Zambian Health Partnership is much stronger together as a “package” than by single interventions and hence create a comparative advantage with its ability to provide integrated solutions.

I also recommend for the different actors to limit their focus to what they do best i.e. the private sector can increase quality, resources and capacity which links to the larger efforts done by aid organizations. I see a risk in the ProCamp package trying to take on too big of a role which I believe will serve the project negatively. However, I believe in current implementation efforts in line with the ongoing initiatives by the Zambian MoH such as the SMGL initiative, where the ProCamp expertise can add on to. One actor cannot do it all but together we can do something.

Another recommendation to the Swedish Zambian Health PPDP through the work of SMGL
and Sida, is to focus on how to increase gender equity. This is an important underlying aspect to many of today’s humanitarian challenges including maternal deaths. In order to improve the gender equity, sustainability and efficiency of MCH services, there is an urgent need to pay greater attention to the multiple ways in which gender roles and relations affect maternal and child health, both in policy and in practice. Policies must aim to improve maternity rights, increase girls’ access to education, improve women’s equitable access to productive resources, and encourage men’s increased contribution to reproductive work, including caring for children.

It is also important to remember that gender equality is not only a problem in developing nations but very much in the western world as well. Europe and the United States very much experience gender inequalities as well which affect maternal health. It is my recommendation to the global health society to focus on these challenges more, especially on how to be able to work towards safe abortions in the western world as well. As Richard Horton, editor-in-chief of the Lancet, brought forward during the Conference on Global Health Beyond 2015 in Stockholm – how can we work towards increased safe abortions in developing nations if there are powers in the western world, in this case US politicians part of the Obama Administration, who refuse to take action on global health agendas if the word abortion is being mentioned? According to Horton abortion is a key question that has to be dealt with in order to be able to achieve increased maternal health worldwide. If we are unable to deal with the issue of abortion then we are not doing enough to reach increased global health.

7.3 Contribution and suggestions for future research

If the Swedish Zambian Health PPDP will be successfully implemented into the SMGL initiative it will create a measurable case where progress, or lack of such, could be measured and used for future evaluations of PPDPs as a tool in development cooperation. After all there are many discussions regarding the need for cooperation between different sectors in development cooperation but we need more concrete examples. The Sida PPDPs are new initiatives, both for the Swedish private sector and for the Swedish public sector, hence there are few concrete examples to refer to when discussing Swedish private sector involvement, apart from CSR initiatives, in development cooperation. This thesis serves as a concrete example of how a PPDP could be established as well as it gives useful guidance along the way.
A few years from now when more long term results can be measured it will be interesting for future research to analyze more thoroughly the PPDPs undertaken by Sida in order to gain information regarding their efficiency for all partners involved. It will also be interesting to measure the sustainability of the projects and how financials in the future could be solved on a “post foreign aid” basis. There is also a need for future research to analyze further where Sweden holds a comparative advantage when cooperating and trading with developing nations in order to establish in what areas PPDPs between the Swedish public and private sector are most successfully established and in what areas other type of cooperation is better suited.

In general there is a need for research to analyze further the potentials, limitations and effects of PPPs. In particular as stated by the UNRISD there seems to be an emerging academic and policy consensus on the need to develop more rigorous methodologies for assessing the impacts of PPPs on service delivery, poverty reduction and political participation. I also believe there is a crucial need for future research to separate PPDPs from traditional PPPs.

In the field of maternal health, I recommend for more research to be done outside of the traditional developing nations and look at the western world as well where we see quite a scary trend in decreased reproductive health services such as in Malta and the United States. I also recommend for more research to be conducted on gender inequalities affecting maternal health worldwide since today there are surprisingly few studies examining the influence of gender on maternal health and health services.

Finally I would like to say a few words on the way forward. There might be great public and private practical initiatives, such as the one presented in this thesis, but the maternal health situation worldwide will not change to the better unless underlying causes such as gender inequality is dealt with. The tricky part ahead is not to figure out why women are dying nor how we can prevent it from happening. Instead the challenge ahead lies in making sure that actions to save the lives of mothers are seen as worthwhile. As stated by the past president of the International Federation of Obstetricians and Gynecologists "Women are not dying of diseases we can't treat.... They are dying because societies have yet to make the decision that their lives are worth saving.”
Endnotes

1 http://www.swecare.com/ - Swecare is a platform where academia, public and private sector work towards enhanced export and internationalization of Swedish health care and life science. Swecare was founded in 1978 by the Swedish government along with the health care industry as a semi-governmental non-profit organization.


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Interviews in Sweden

Ericsson
Kositany Margaret, Sub-Sahara Africa Director for Sustainability and Corporate Responsibility, Interview conducted via e-mail 130308

Ministry of Foreign Affairs
Nordström Anders, Global Health Ambassador, Swedish Ministry of Foreign Affairs, Interview conducted at The Ministry of Foreign Affairs 130315
Ultvedt Inger, Ambassador Africa Department, Swedish Ministry of Foreign Affairs, Interview conducted during the Zambia Delegation trip 130205

Sida
Erichs Peter, Sida, Interview via phone 130424
Stridsman Maria, Sida, Business for Development Unit, Interview conducted at Sida130131
Rosendahl Anna, Sida, Business for Development Unit, Interview conducted at Sida 130213

Swecare Foundation
Helling Maria, CEO Swecare, Interview conducted at Swecare 130108

The Swedish private sector actors, part of the ProCamp Package – Several interviews conducted at Swecare and via phone between 130116-130522

Interviews in Zambia

Interviews and meetings conducted with the following institutions and actors throughout the delegation week 130202-130210. The names of the actors have been kept anonymously.

Crown Agents, Lusaka
Fairview Hospital, Lusaka
Livingstone General Hospital, Livingstone
The Cancer Diseases Hospital, Lusaka
The Swedish Embassy, Lusaka
The Swedish private sector actors
The University Teaching Hospital, Lusaka
The Zambian Ministry of Community Development, Mother and Child Health, Lusaka
The Zambian Ministry of Finance, Lusaka

The Zambian Ministry of Health, Lusaka and Livingstone

Zambia Development Agency, Lusaka
Appendix 1 - Estimated local benefit of the Zambian Swedish Health Partnership

SMGL Statistics
Saving Mothers Giving Life Program Update Report of March 2013 indicates that Saving Mothers Giving Life’s set of interventions, launched in June 2012, are making an impact in selected districts in Uganda and Zambia:

The number of pregnant women delivering in facilities has increased by nearly 50% in the targeted districts in both Uganda and Zambia.

The percentage of pregnant women who had their fourth antenatal care visit has doubled in Ugandan target districts since Saving Mothers Giving Life’s launch. All of the facilities in targeted districts in Uganda providing Caesarean sections are now able to provide safe blood for women that are hemorrhaging.

Over 300 new doctors, nurses, midwives, and technical officers have been added to the health workforce in both Uganda and Zambia, providing both basic and comprehensive emergency obstetric as well as HIV care. (Source: Saving Mothers Giving Life Program Update March 2013)

Sri Lanka Statistics
The figure below shows the decline in maternal deaths when trained assistance was made accessible in Sri Lanka. As one can see, when trained assistance was made accessible, maternal deaths dropped immediately and significantly. The hope for the Swedish Zambian Health Partnership is to, in co-operation with partners, achieve a similar reduction.

Appendix 2 - Financial model

Depending on content and health care service level, a Remote Medical Station by the ProCamp package providers, will cost between xxx and xxx (financial figures not yet open to public) including 12 months of supply and operation.

Possible Sida PPDP financial model:

50 % Sida (cost to be shared with the Zambian MoH when estimated as possible)

50 % Shared among the Swedish private sector actors (cost to be shared with the Zambian MoH when estimated as possible)

Alternative financial model if a Sida PPDP is not established:

1/3 Swedish private sector investment

1/3 Saving Mothers Giving Life investment

1/3 Zambian Ministry of Health investment

The 1/3-model above was presented to the Swedish MFA by one of the Swedish private sector actors in March 2013 and was estimated as possible to implement.

The first Remote Medical Station is to be donated by the Swedish Private Sector with the hope of additional paid units to be ordered by The Zambian MoH and/or SMGL or other relevant actors.
Appendix 3 - Risk Register for the Swedish Zambian Health Partnership

**Political risk = Low.** Zambia enjoys quite a stable political and economical situation.

**Security and local tensions = Low.** Zambia is considered as peaceful and local tensions relatively rare.

**Risk in set-up = High.** It is crucial to team up with suitable partners and to share the risk among the different partners.

**Financial risk = High.** The Swedish Zambian Health Partnership is dependent on external funding in order for the project to succeed.

**Commercial risk = High.** There are several providers for remote medical clinics and to a lower price even though it also reflects in lower quality and less of a package deal. Especially competition from the Chinese is estimated as significant. The risk of replication by other actors is also estimated as high.

**Corruption = High.** The corruption in Zambia is still high even though it has decreased. The corruption scandal within the Zambian MoH in 2009 needs to be taken into account.

According to the above risk register one could estimate the Swedish Zambian Health Partnership as a high-risk project. It is therefore crucial to continue to carefully plan the project preparation, the setting up of the project, the funding and partnership set-up, the design, construction, commissioning, and operation in order to reduce the risks. It is also crucial to ensure long-term financial abilities post a possible Sida PPDP.
Appendix 4 – SWOT

One of the most frequently used analytical business models before entering a new market is the SWOT model. The SWOT model analyzes potential strengths, weaknesses, opportunities and threats. The SWOT model for the Swedish Zambian Health Partnership is presented below:

<table>
<thead>
<tr>
<th>Internal</th>
<th>External</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strengths:</strong></td>
<td><strong>Opportunities:</strong></td>
</tr>
<tr>
<td>• The project has a unique setup in its comprehensive and flexible approach</td>
<td>• The project is in line with current political initiatives, both Zambian, Swedish and international</td>
</tr>
<tr>
<td>• The project has the capability of reaching remote areas</td>
<td>• The project has scaling-up capacities both geographically and thematically</td>
</tr>
<tr>
<td>• The project has the capability of tackle several health challenges</td>
<td></td>
</tr>
<tr>
<td>• The project is using innovative and high quality techniques</td>
<td></td>
</tr>
<tr>
<td><strong>Weaknesses:</strong></td>
<td><strong>Threats:</strong></td>
</tr>
<tr>
<td>• Operational and financial difficulties in carrying project without external support hence limiting sustainability</td>
<td>• Not receiving external funding</td>
</tr>
<tr>
<td>• The project might be considered too expensive for end users</td>
<td>• Replication of project by other actors possible and not difficult</td>
</tr>
<tr>
<td></td>
<td>• Other actors offering similar product to lower price</td>
</tr>
</tbody>
</table>

Typically for one to enter a new market the strengths and opportunities shall outweigh the weaknesses and threats which one could say is the case for the Swedish Zambian Health Partnership. However, since it is not a clear case it is recommended to continue with caution and place large emphasis on planning before implementation.
Appendix 5 - Content of remote medical station

The Remote Medical Station can be provided as a generic primary care unit or be fitted as a specialized primary care unit, e.g. providing specialized care for maternal/ prenatal or HIV. Procamp will dynamically adjust the equipment and supplies in delivered station based on the needs in every case.

The Remote Medical Station consists of a patient room, residential room, kitchen and storage to a total surface of 80 m². All material for a fully operational unit fits in a single 40-foot ISO container. Procamp can deliver the basic Station and utility infrastructure within 100 days from order, and have a basic Remote Medical Station operational within 10 days from arrival of the transport container at site.

The detailed information regarding the content of the remote medical station/s is as of date confidential in order to minimize the risk of replication by other actors. For more information contact the ProCamp package coordinator Mr. Michael Lemmel: Michael.lemmel@procampab.com
Appendix 6 - Interview questions Swedish public sector

1. What is your opinion regarding Public Private Development Partnerships in development cooperation?

2. Do you believe Zambia is in need of/ready for Swedish private sector assistance? If no – why is that and what type of development would you argue suits the country better? If yes – In what sectors do you see a need for Swedish private sector assistance and how? Could a PPDP assist in the maternal health sector?

3. (Explaining the ProCamp project). Do you believe in the ProCamp project? What are the pros and cons from your perspective?

4. Please share some thoughts regarding the development agenda post 2015 and the role of maternal health

5. Additional thoughts and comments

Thank you very much for taking time out of your busy schedule and for contributing to my master thesis research. It was very much appreciated.
Appendix 7 – Interview questions Swedish private sector

1. Why are you interested in expanding your activities to Zambia?

2. How could your company contribute to the country’s fight against maternal deaths?

3. What is your opinion regarding Public Private Development Partnerships in development cooperation?

4. Is it possible from your point of view to create a win-win situation and how?

5. Additional thoughts and comments

Thank you very much for taking time out of your busy schedule and for contributing to my master thesis research. It was very much appreciated.
Appendix 8 – Interview questions Zambian Public Sector

Explaining the purpose of the Swedish Delegation to Zambia and the theme for my master thesis. Awaiting comments and thoughts.

Depending on the time available to ask questions the questions below were prioritized as in ranking 1-5. In some of the meetings there was no time for specific questions but comments to my research were made post my introduction.

1. Is Zambia looking for Public Private Development Partnerships within maternal health? If no – please elaborate. If yes – how could they assist?
2. Explaining the ProCamp project. Is such a project sought for and would it fit within current efforts by the Zambian public sector?
3. Could a successful PPDP within maternal health be set-up?
4. Please share some thoughts and comments regarding the development agenda post 2015 and the role of maternal health
5. Additional thoughts and comments

Thank you very much for taking time out of your busy schedule and for contributing to my master thesis research. It was very much appreciated.
Appendix 9 – Pictures from the Swedish Delegation in Zambia

Above: Poster at the Ministry of Finance in Lusaka
Below: Tender box for Public Private Partnerships at the Ministry of Finance Lusaka
Above: The Swedish Delegation visits The Ministry of Community Development, Mother and Child Health in Lusaka

Below: The Swedish Zambian Health Conference and Expo held in Lusaka
Above: Meeting at the Ministry of Health in Lusaka

Below: Meeting at the University Teaching Hospital in Lusaka
Above: Tour at The University Teaching Hospital in Lusaka

Below: Tour at The Cancer Diseases Hospital in Lusaka
Above: Tour at Fairview Hospital in Lusaka

Below: Many supplies Chinese made at the Zambian hospitals
Above: Entering the Southern Provincial Health Office of the Ministry of Health in Livingstone
Below: Meeting at the Southern Provincial Health Office of the Ministry of Health in Livingstone
Below: Tour at Livingstone General Hospital
Below: Tour at Livingstone General Hospital continued
“When a woman dies, the nation dies with her”

~ Professor Elwyn Chomba, Permanent Secretary, Ministry of Community Development, Mother and Child Health, Zambia