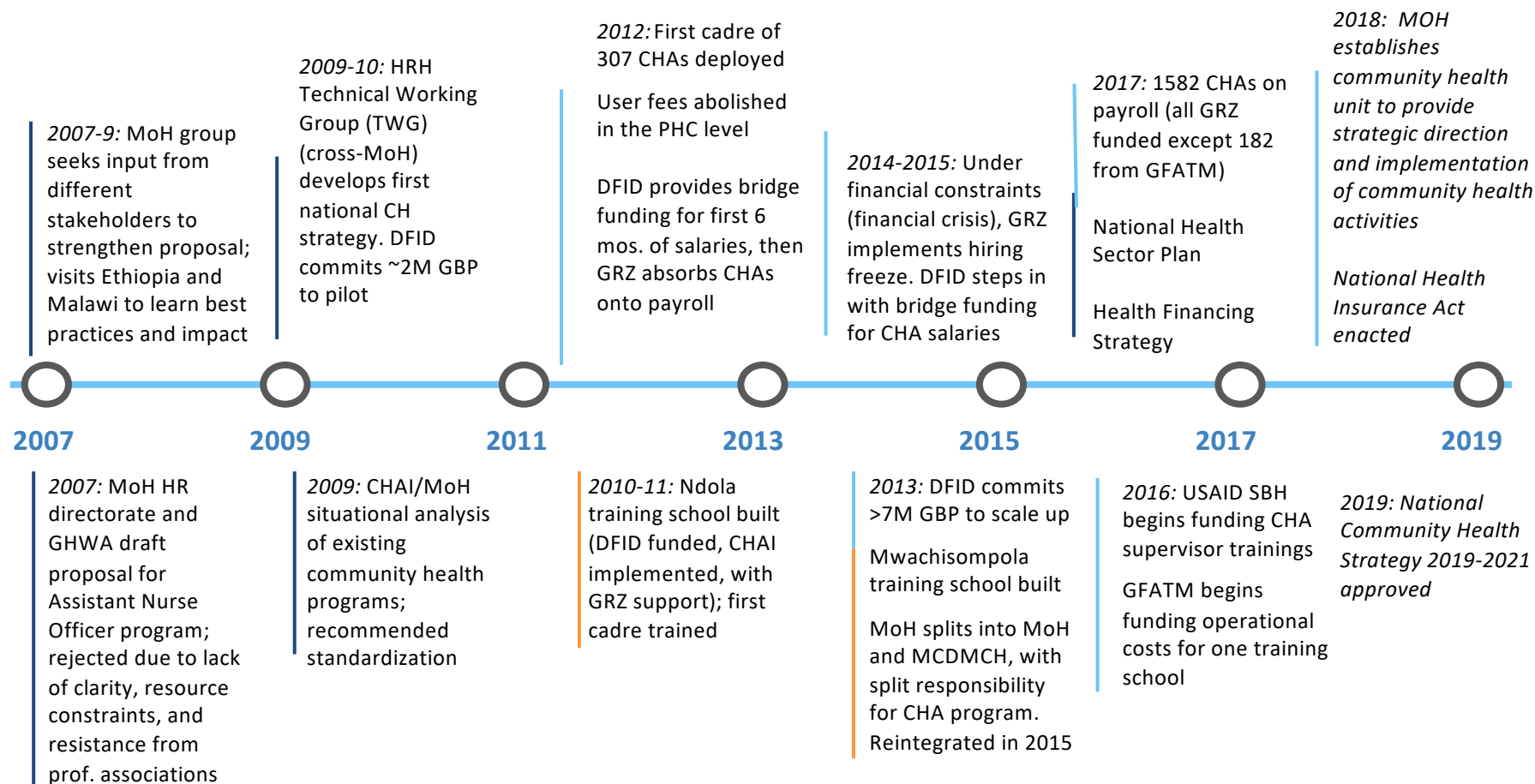


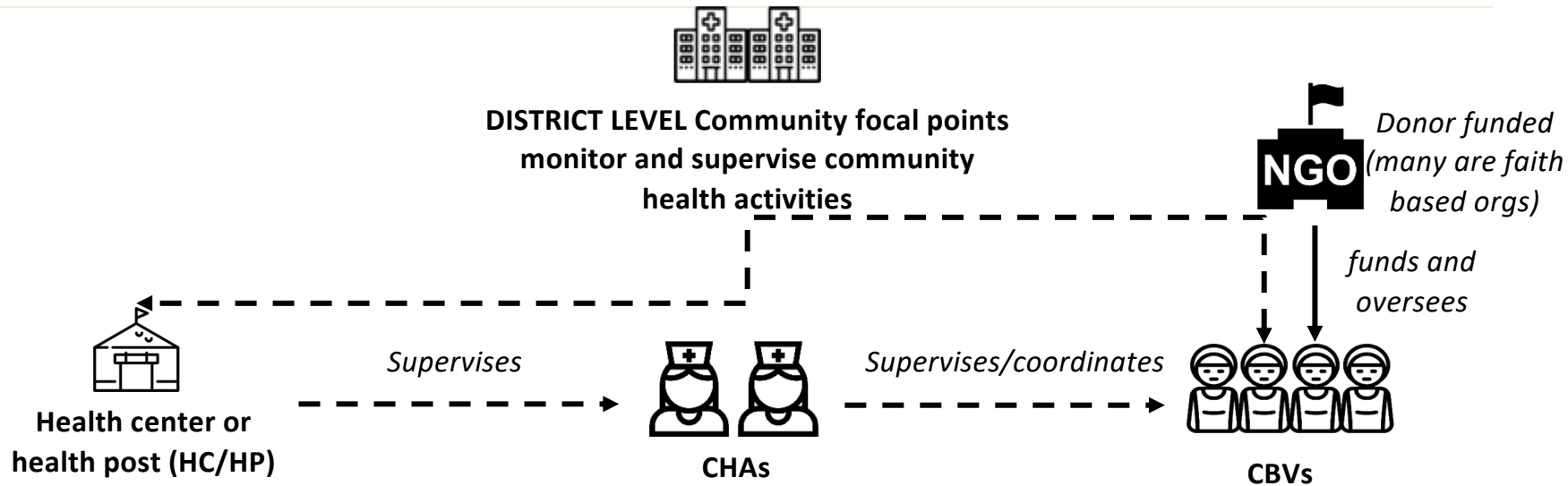
Financing Alliance for Health

Country Case Study: Zambia

Community health policies in Zambia began in 2007 and have advanced to a fully fledged program



Zambia has CHAs and CBVs; coordination among them varies widely



Community Health Assistants

- **# in workforce:** In 2018, 2502 trained and 2140 paid; target 5,000 by 2020
- **Time spent:** Full time, 20% at HC/P, 80% in the community (often more at facility given HRH shortage)
- **Interventions:** Promotive, preventive, and basic curative services; commodity distribution; community mobilization and needs identification
- **Selection:** 2 O-levels (12th grade), from the community, local leader endorsement; DMO and NHC interviews
- **Training:** 1 year theoretical + practical training
- **Health system linkage:** Refer clients to HC or HP
- **Incentives:** ~\$285/month salary, on govt payroll

Community Based Volunteers

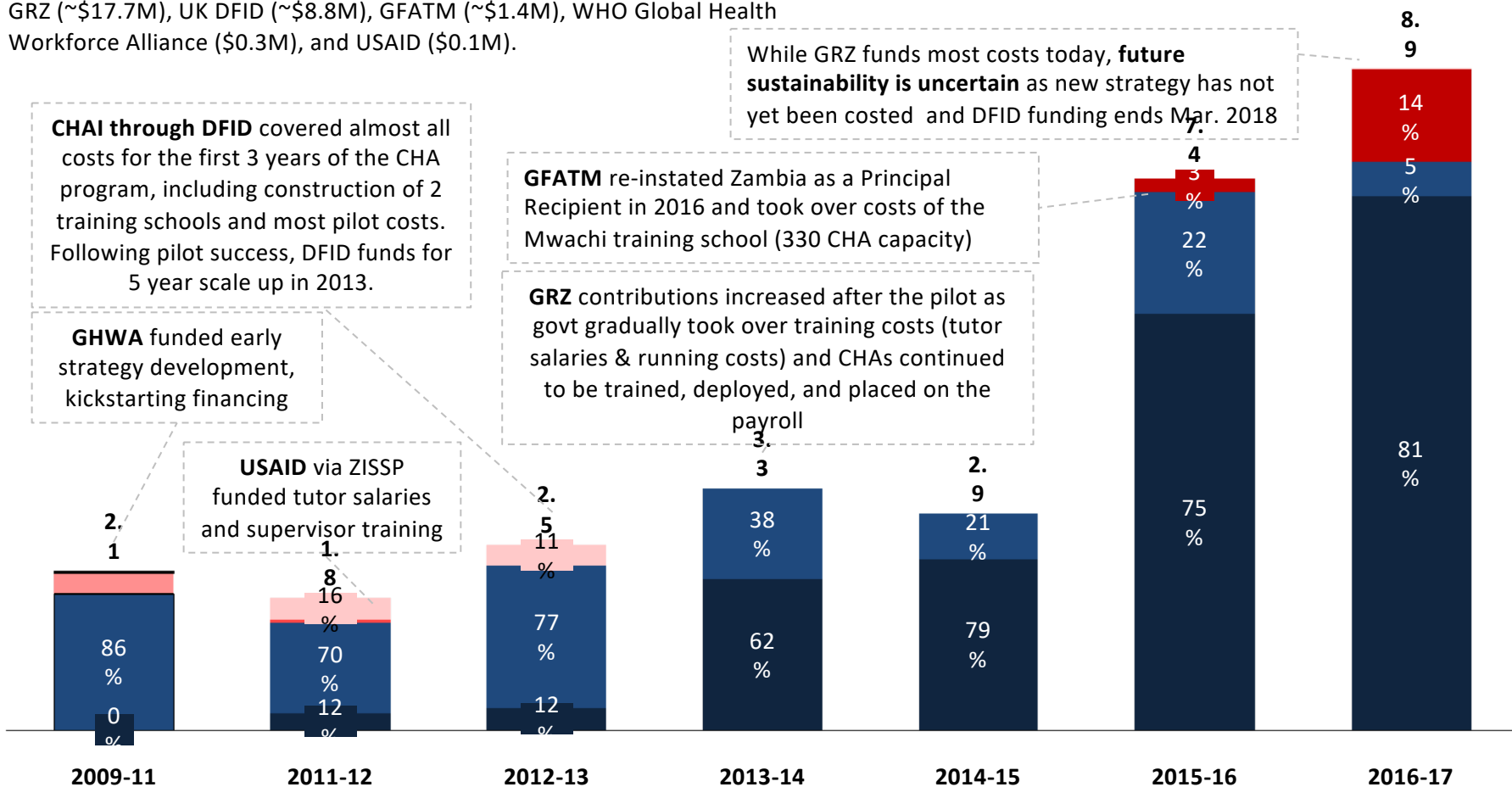
- **# in workforce:** 40,000 (estimates vary)
- **Time spent:** Varies by cadre and NGO; part time
- **Interventions:** Education, mobilization, commodity distribution. Varies based on disease priority area; plurality (~1/3) focused on HIV.
- **Selection:** No standardized process
- **Training:** 2-11 weeks; limited refresher training. Some duplication as CBVs are trained by multiple NGOs.
- **Health system linkage:** Theoretically connect clients to CHAs and health facility, but varies in practice
- **Incentives:** Vary by NGO and program; include stipends and non-monetary incentives (e.g., bicycle)

DFID funded almost all start-up & pilot costs; MoH and other donors have contributed more over time

Funding to CHA program over time, by source (\$ millions)



5 major funders contributed to the CHA program to-date: GRZ (~\$17.7M), UK DFID (~\$8.8M), GFATM (~\$1.4M), WHO Global Health Workforce Alliance (\$0.3M), and USAID (\$0.1M).



CHAI through DFID covered almost all costs for the first 3 years of the CHA program, including construction of 2 training schools and most pilot costs. Following pilot success, DFID funds for 5 year scale up in 2013.

GHWA funded early strategy development, kickstarting financing

USAID via ZISSP funded tutor salaries and supervisor training

GFATM re-instated Zambia as a Principal Recipient in 2016 and took over costs of the Mwachi training school (330 CHA capacity)

GRZ contributions increased after the pilot as govt gradually took over training costs (tutor salaries & running costs) and CHAs continued to be trained, deployed, and placed on the payroll

While GRZ funds most costs today, **future sustainability is uncertain** as new strategy has not yet been costed and DFID funding ends Mar. 2018

Excludes commodities. Sources: DFID Human Resources for Health Phase II Annual Reviews 2014 through 2017, DFID Business Case for Human Resources for Health in Zambia Programme 2013, CHAI Zambia data, National Community Health Worker Strategy 2010. These are the largest donors to the program, other smaller contributions were made from NGOs, partners, and community in-kind

Lessons emerge from Zambia's strong initial process, implementation challenges, and proposed path forward

Development &
momentum building

1 An **inclusive, iterative process**, led by the MoH, can help to secure buy-in and build momentum among stakeholders

2 **Evidence** on the health and human resource challenges (including re: CH volunteers) in-country, as well as **research** on the power of community health in international contexts, can help to build the business case to funders

Implementation &
scale up

3 **Flexible donors, committed partners, and diverse champions (especially locally)**, both at the outset and during scale up, can help to ensure resilience in the face **unforeseen exogenous factors** (e.g., change in MoH structure, increase in civil servant salaries, hiring freeze)

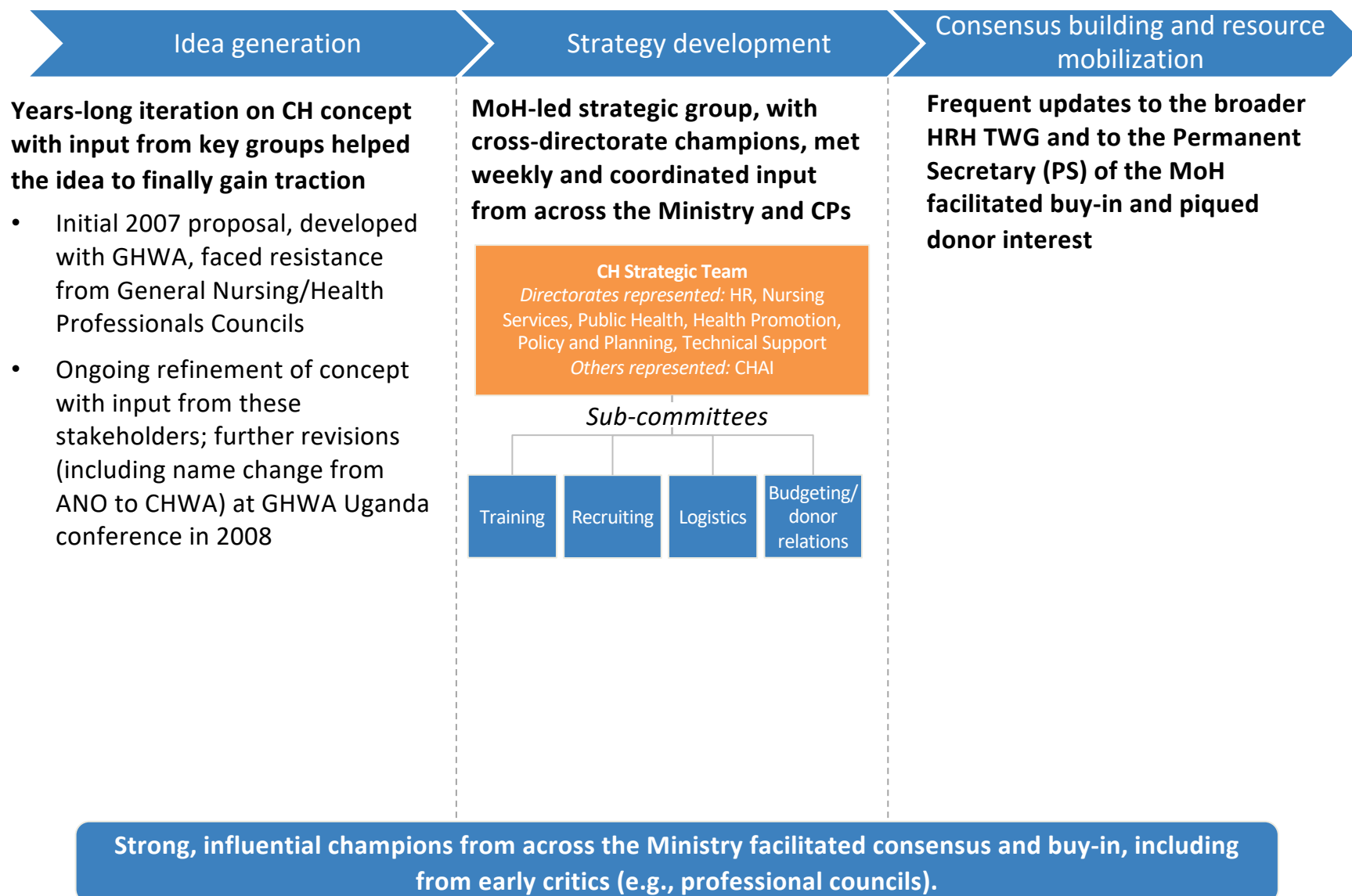
4 **Integration with existing community volunteer workforces** is critical to provide CHAs leverage and to improve resource efficiency, but requires strong coordination at both the central and local levels

Path forward

5 A **dedicated focal person or body** within the MoH is needed to **champion** community health, advocate for resource mobilization, coordinate among various stakeholders, and sustain momentum and political commitment over time

6 **Dedicated strategies to improve resource efficiency** in the near term (via harmonization and improved allocation), and to **mobilize new resources** in the longer term (e.g., via sin taxes, PPPs) can help to increase financial sustainability, though the success in Zambia remains to be seen

The MoH-led strategic team spearheaded an inclusive strategy and financing mobilization process



Data on the HRH crisis in Zambia and evidence from other countries convinced early champions of CH value

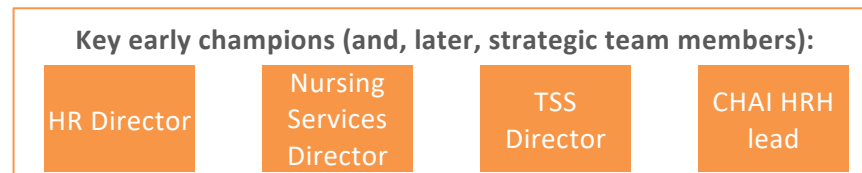
Data on Zambia's challenges

- MoH codified **broader HRH crisis** in Zambia, with health workforce at <40% of recommended target and shortages at all levels, particularly in rural areas
- 2009 MoH/CHAI situational analysis, undertaken with implementing partners, hospitals, District Medical Officers, and CHWs laid out the **challenges with existing community volunteers**
 - 20k+ CBVs (many HIV-focused), with variable recruitment, incentives, training, responsibilities, and supervision
 - Disseminated broadly to build consensus that new CH strategy was needed

International evidence on the impact of CH

- Key MoH representatives **travelled to Ethiopia** and Malawi see the impact of CH programs
- Some **initial critics** (e.g., from professional associations) **were brought along** on these trips to change their minds
- During strategy development process, CHAI helped conduct **thorough literature review** of successes and best practices in other contexts
- **Importance of official, govt-led cadres of CHWs** emerged from this research

Those early champions strategically tailored messages to mobilize buy-in and financing from key actors



Key influence pathways

	Permanent Secretary and Minister of Health	Ministry of Finance	Donors	Province, district, and local health leaders
Role	<ul style="list-style-type: none"> Approve strategic decisions PS liaises with MoF on budgeting Coordinates donor engagement 	<ul style="list-style-type: none"> Iterates with PS on health budget and allocates resources to MoH 	<ul style="list-style-type: none"> Fund various program costs over time 	<ul style="list-style-type: none"> Support implementation and resource allocation at local level
Engagement strategy	<ul style="list-style-type: none"> CHAI and HR Director advocated to PS to put CHAs on govt payroll pending pilot evidence, highlighting case for econ. growth HR Director briefed PS on strategy weekly to get continued buy-in 	<ul style="list-style-type: none"> MoH HR director liaised directly with MoF HR director to advocate for CHAs to be budgeted for as new positions in payroll. Strategic advocacy at key points in fiscal years during pilot phase PS also advocated to MoF for CHA budgeting 	<ul style="list-style-type: none"> Donors were engaged via HRH TWG, CP meetings, bilateral emails, and formal MoH requests, and were invited to strategic team budget meetings MoH, with support from CHAI, approached donors to fill gaps in funding, showing how CH related to their interests PS coordinated donor requests 	<ul style="list-style-type: none"> Champions presented early ideas, and, later, strategy to local govt health leads to get feedback and secure buy-in Advocated for districts to support supervision (e.g., fuel and staff time for facility staff to go to health posts)

While CH had been talked about for years, the combination of a strong group of champions and a unique window of opportunity (elections created political pressure from the top) accelerated progress.

Exogenous political decisions created roadblocks in coordination and financing for the CHA program...

Challenge

Description

Minimum wage hike for
all civil servants
August 2012

- To fulfill an 2011 election pledge, President Sata increased min. wage for all gov workers, increasing CHA monthly wage by 73% (1500 to 2600 Kwacha)
- Reduced GRZ's future capacity to put graduating CHAs on payroll and increased program cost overall

Shift of PHC from MoH
to MCDMCH
Dec. 2012-Sep. 2015

- Presidential directive to shift PHC services from MOH to MCDMCH, effectively splitting the ministry of health into two. Shifted CHA deployment and program management to MCDMCH, while training remained in MOH
- Weakened coordination and political support for CHA program as previous champions in MOH were no longer in charge and MCDMCH had own priorities

Govt-wide hiring freeze
2014-15

- 2-year GRZ hiring freeze due to financial pressures increased cost from min. wage hike meant that 3 graduating classes of 775 CHAs could not be placed on gov payroll

In 2018 The MoH instituted a new CH governance structure and established the community health unit to oversee the implementation of CH services

Challenge

No single directorate or individual was responsible for community health, hindering programmatic and resource mobilization strategies

- Initial strategic team dissolved after pilot
- Piecemeal involvement from HR, Policy/Planning, Public Health and Research, Health Promotion/Environment/Social Determinants, and other directorates

Solution

The MoH set up the community health unit to strengthen governance. In addition to this guidelines were developed to guide the appoint of focal persons that would sit at the central and at province/district level. As of 2019, official appointments remain to be made.

Potential impact

Strengthened resource mobilization

- Focal person could lead advocacy and engagement with donors and govt leadership
- Dedicated person/people also signals MoH commitment to sustaining and institutionalizing the program, which is key to securing sustainable funding

Strengthened resource coordination

- Stronger governance could enhance donor/NGO/govt coordination mechanisms for community health funding at the central and local levels
- Focal points at all levels could help to ensure district-level funding is being allocated to CH in line with national strategy

GRZ has plans to increase resources for CH guided by a recently developed investment strategy and health overall, though execution remains to be seen

Improving efficiency of resource use and increasing allocation of govt resources to CH (near term)

Financing channel

Channel resources and programming efforts from donors and govt in a harmonized and coordinated way so that allocations complement each other in area of work, geography of work, and utilization of CH workforce

Strengthen accountability at district level so that districts follow established protocols and dedicate at least 10% of their budgets to CH programming

Mobilization strategy

“Coordination needs to be strengthened to avoid partners duplicating efforts, and the government is the only stakeholder capable of bringing everyone to the table. They need to take leadership.” --HSS Team Lead, USAID Zambia Mission

“Govt will train District Directors of Health on the issue of min. allocations to CH, and district budgets will not be approved without such a CH component.” --Deputy Director, Directorate of Health Promotion, Environmental, and Social Determinants, MOH

Mobilizing new resources from donors, government, and communities (longer term)

Financing channel

Strengthen inter-sectoral collaboration within GRZ and establish non-MOH financial flows to CH as CHAs and CHVs can potentially deliver interventions of interest to other ministries (education, agriculture, housing, etc)

Revitalize GtG funding for CH (progress has been made: GFATM re-entered Zambia + SIDA, DFID & USAID working on GtG to MOH for maternal & child health)

Introduce sin taxes (alcohol, tobacco, sugary drinks)

Mobilization strategy

“The cabinet has adopted a Health in All Policies framework that sets out the nature of inter-sectoral collaboration among ministries. All of us must contribute because community, community, and community is our approach to health.” --Honorable Minister of Health, GRZ

“Purely relying on current treasury allocations is not sustainable to achieve UHC, and that is why we have established a new healthcare financing directorate in charge of developing innovative financing mechanisms.” --Honorable Minister of Health, GRZ

Other countries can apply these lessons in their own contexts

