



# National Community Health Strategy

2019-2021

*Community Health Driving Primary Health  
Care for Universal Health Coverage*

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## Foreword

The Government of the Republic of Zambia's goal in the health sector is to ensure that our people are healthy and productive to effectively contribute to making Zambia a prosperous middle income country by 2030. This aspiration is articulated in the Vision 2030, the 7<sup>th</sup> national development and the national health strategic plan 2017-2021.



The Government of the Republic of Zambia through the Ministry of Health aims at attaining universal health coverage in which all Zambians have access to essential health services without suffering financial hardship. Government places premium on attaining Universal Health Coverage through health systems strengthening using an integrated community and primary health care approach. This conviction is in line with the Alma Ata declaration of 1978, the World Health Assembly resolution on Universal health coverage and the United Nations General Assembly High level political declaration on Universal Health coverage in which Primary Health care has been prioritised as a vehicle to deliver health for all.

To further improve the health and wellbeing of our people, Government through the Ministry of Health embarked on a transformation agenda with its core focus being universal health coverage using an integrated community and primary health care approach, leaving nobody behind.

Government has demonstrated its commitment to community health by establishing a dedicated Community Health Unit within the department of Public Health mandated to coordinate and provide oversight on community health services in the country.

The development of the National Community Health Strategy 2019-2021 therefore, marks the beginning of a new era in transforming our health service delivery system in the country. The strategy is designed to strengthen community mechanisms to enhance access to services across the continuum of care spanning promotive, preventive, curative, rehabilitative and palliative health services.

It is clear that major challenges must be overcome if we are to achieve our goals in community health. We must scale up the community health workforce across the country, and address the fragmentation that has characterised the volunteering sector; we must strengthen community structures and ownership of health activities; provide infrastructure and address barriers to access; mobilise resources; and improve the use of data in decision making for community health.

It is therefore key that we embrace innovations that will allow us to reach all our people, improve quality of our services, and work more efficiently. The National community health strategy clearly sets out the approach that will enable us address the challenges affecting

community health in our country and significantly improve the health and wellbeing of our people.

I therefore urge all stakeholders to fully utilise this document and support my Ministry in the implementation of this Strategy as a core reference tool for planning, implementing, monitoring and evaluating of community health services as well as for mobilizing resources.

A handwritten signature in black ink, appearing to be 'y' followed by a stylized 'C' and 'F'.

**DR CHITALU CHILUFYA, MP**  
**MINISTER OF HEALTH**

## Acknowledgements

I would like to appreciate the contributions of all stakeholders who were involved at various stages of developing this strategy.

Thanks go to officers at the Ministry of Health for their immense contribution in moving this process to conclusion amidst various experiences. I am particularly grateful for the participation of our staff working at health facility and community levels, who were able to share valuable insights and perspectives on community health service delivery at the front line.



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- PATH
- UNDP
- USAID
- University of Maryland
- World Bank
- World Vision Zambia

To all of you, we remain grateful for your unwavering support.

A handwritten signature in black ink, appearing to be 'DK Malama', written in a cursive style.

**DR KENNEDY MALAMA**  
**PERMANENT SECRETARY – TECHNICAL SERVICES**

## Acronyms

CBDs	Community-Based Distributors
CBO	Community-Based Organization
CBVs	Community Based Volunteers
CH	Community Health
CHAs	Community Health Assistants
CHAI	Clinton Health Access Initiative
CHAZ	Church Heath Association of Zambia
CHC	Community Health Care
CHIs	Church Health Institutions
CHU	Community Health Unit
CHS	Community Health Strategy
CHW	Community Health Worker
CHWS	Community Health Worker Strategy
DHMT	District Health Management Team
DHIS	District Health Information System
DHO	District Health Office
EHT	Environmental Health Technologists
eLMIS	electronic Logistics and Management System
FBO	Faith Based Organization
GBV	Gender Based Violence
GDP	Gross Domestic Product
GRZ	Government of the Republic of Zambia
HC	Health Centre
HCC	Health Centre Committee
HMIS	Health Management Information System
HP	Health posts
HSDP	Health Sector Devolution Plan
ICCM	Integrated Community Case Management
MDGs	Millennium Development Goals
MoH	Ministry of Health
M&E	Monitoring and Evaluation
MSL	Medical Stores Limited
NCHWS	National Community Health Workers Strategy
NCHS	National Community Health Strategy
NDP	National Development plan
NGO	Non-governmental Organization
NHP	National Health Policy
NHSA	National Health Services Act
NHSP	National Health Strategic Plan
NHC	Neighbourhood Health Committee
PHC	Primary Health Care
PPP	Private-Public Partnerships
RBF	Results-based finance

RHCs .....	Rural Health Centres
RMNCH+N.....	Reproductive Maternal Newborn Child Health and Nutrition
SMAGs.....	Safe Motherhood Action Groups
SDG .....	Sector Devolution Guidelines
SOPs.....	Standard Operating Procedures
TA .....	Technical Assistance
TBA .....	Traditional Birth Attendants
THPAZ.....	Traditional Healers Practitioners' Association of Zambia
UHC.....	Universal Health Coverage
WHO.....	World Health Organization

## Executive Summary

The overarching goal of the NCHS 2019 - 2021 is to contribute to the achievement of the MoH legacy goals outlined in the NHSP 2017 – 2021. This will be done by improving access to health services at the community level.

The Government remains committed to providing universal, quality and equitable health care services to the people of Zambia. While Zambia has made significant strides in improving key health outcomes, significant challenges remain. The GRZ has made community health a key part of its strategy to continue to improve health outcomes for all Zambians.

The NCHS (2019-2021) aims to reposition and expand the current cadre of frontline workers in the formal sector, and strengthen the link to the informal sector. It is designed to guide in the strengthening of community mechanisms to improve the provision of preventive, promotive and minor curative health services. The NCHS Operational Plan (2019 – 2021) is the health sector's medium term costed strategic operational plan outlining objectives, strategies, interventions and activities supporting the successful implementation of the NCHS (2019 -2021).

This NCHS identifies six objectives that contribute to the achievement of the legacy goals that seek to improve access to health services at the community level. The first objective focuses on building a motivated, skilled, equitably distributed community health workforce. The key strategies to support this objective includes; (i) addressing the fragmentation of community-based volunteers (CBVs), (ii) strengthening and scaling up the CHA program, and (iii) strengthening management and coordination of community health at provincial and district level.

The second objective speaks to the roll out of formal community health structures to at least 110 districts by; (i) providing regulatory frameworks for the community health structures, (ii) rolling out integrated, functional community health structure and (iii) promoting ownership of community health initiatives at community level.

The third objective focuses on all Zambians having increased access to quality basic health services. This will be achieved by creating demand for health services, revitalizing community health service packages, enhancing community referral systems, strengthening supply chain management and provision of infrastructure.

Mobilising sufficient resources to implement the NCHS the fourth objective of the strategy. The Ministry will ensure adequate mobilization of resources to increase funding for community health programs. This will be achieved through fundraising activities with funding agencies as well as promotion of local community resource mobilization while ensuring efficient distribution of current resources.

The fifth objective of the strategy ensures timely availability of community health data for decision making. It is vital that the community health unit has access to accurate and timely information if it is to make informed, evidence-based decisions. The collection of community-level programme data will also assist other units in the MoH in their decision-making. Improved data reporting systems and improving the use for data in decision making are the key strategies under this objective.

The sixth and last objective aims at establishing a community friendly platform for appropriate and acceptable innovations. The community health unit is committed to going the extra mile to find new


and better ways of providing equitable access to quality health services at community level. The Ministry will therefore pilot high potential innovations for community health in partnership with local, regional and international partners, and scale up successful innovations nationally.

The implementation of these six objectives and their strategies will be fulfilled through the various interventions and activities outlined in this document. A two-page graphic, which summarises the goals, strategies, interventions and activities contained in this strategy can be found on pages 9 and 10 of this document.

This document should be read together with the Community Health Operational Plan, which outlines the specific activities and sub-activities that will be implemented between 2019 and 2021, and includes a timeline for implementation.

The NCHS will be implemented by the Community Health Unit under the Directorate of Public Health and its provincial and district structures in collaboration with Non-Governmental Organizations and other relevant stakeholders. It will be monitored and evaluated using the accompanying M&E framework/plan.

## ZAMBIA COMMUNITY HEALTH STRATEGY 2-PAGE SUMMARY

VISION: A nation of healthy and productive people				Zambia Community Health Strategy 2019-2021		MISSION: To provide equitable access to integrated, cost-effective and quality community health services as close to the family as possible.	
Context	<b>strengths</b> <ul style="list-style-type: none"><li>Dedicated CH unit est. 2018</li><li>Political will</li><li>Existing community structures</li><li>Salaried CHAs</li><li>CH prioritised in NHSP</li></ul>	<b>weaknesses</b> <ul style="list-style-type: none"><li>Weak coordination</li><li>Weak supervision and mentorship</li><li>Inadequate information systems</li></ul>	<b>opportunities</b> <ul style="list-style-type: none"><li>Growing partner interest in CH and PHC</li><li>Use of technology and innovation</li><li>Collaboration with other MoH units</li></ul>	<b>threats</b> <ul style="list-style-type: none"><li>Funding environment</li><li>Hard to reach populations</li><li>Lack of legal frameworks</li><li>Non-acceptability of CBVs by community</li></ul>			
Values	<b>Inclusiveness:</b> We serve all communities. <b>Ubuntu:</b> We see the value in all people and endeavor to meet every client’s need with compassion, respect and kindness <b>Team-work:</b> We work together and support each other to achieve our common goals <b>Innovation:</b> We walk the extra mile to find new and better ways to provide excellent community health services <b>Integrity:</b> We strive to do what is right and do what we say we will do <b>Commitment:</b> We are dedicated to delivering on our mission <b>Excellence:</b> We always strive to do better <b>Integration:</b> We break down siloes within and across programs and sectors to offer holistic services						
Overall Goal	To contribute to the achievement of the legacy goals by improving access to health services at community level						
Objectives	<b>1</b> Build a motivated, skilled, equitably distributed community health workforce	<b>2</b> Roll out formal community health structures to at least 80 districts	<b>3</b> Increase points of access so that all Zambians have access to quality basic health services	<b>4</b> Mobilise sufficient resources to implement the National Community Health Strategy	<b>5</b> Ensure timely community health data is available and used for decision-making	<b>6</b> Establish a community-friendly platform for appropriate and acceptable innovations	
Strategies	<ul style="list-style-type: none"><li>Address the fragmentation of community-based volunteers in Zambia</li><li>Strengthen and scale up the CHA programme</li><li>Strengthen management and coordination of community health at provincial and district level</li></ul>	<ul style="list-style-type: none"><li>Provision of regulatory frameworks for community health structures</li><li>Increase coverage of Community health structures</li><li>Promote ownership of community health initiatives at the community level</li></ul>	<ul style="list-style-type: none"><li>Demand creation</li><li>Develop community health service package</li><li>Enhanced community referral system</li><li>Supply chain management</li><li>Provision of infrastructure</li></ul>	<ul style="list-style-type: none"><li>Develop mechanisms for resource mobilisation at national and community level</li><li>Engage stakeholders for efficient resource distribution</li><li>Promote Results-based financing</li><li>Diversify sources of finances</li></ul>	<ul style="list-style-type: none"><li>Improved data reporting systems</li><li>Improve the use of data in decision-making</li><li>Evidence generation</li></ul>	<ul style="list-style-type: none"><li>Pilot high-potential innovations for community health</li></ul>	
Enabling partnerships	<ul style="list-style-type: none"><li>Funding partners</li><li>Implementing partners</li><li>Traditional leaders</li><li>Political leaders</li><li>Neighbourhood Health Committees</li><li>MoH units</li><li>Statutory boards</li><li>Community health workers</li><li>Religious leaders</li><li>Other line ministries</li></ul>						

## Zambia Community Health Strategy 2019-2021

Objectives	Strategies	Interventions
<b>1</b> Build a motivated, skilled, equitably distributed community health workforce	<ul style="list-style-type: none"> <li>Address the fragmentation of community-based volunteers in Zambia</li> <li>Strengthen and scale up the CHA programme</li> <li>Strengthen management and coordination of community health at provincial and district level</li> </ul>	<ul style="list-style-type: none"> <li>Develop national CBV database</li> <li>Equitable distribution of CBVs in all districts</li> <li>Standardise CBV incentive package</li> <li>Build capacity of community health workers to respond to health needs</li> <li>Improve coordination of CBVs</li> <li>Scale up the CHA programme</li> <li>Provide an enabling environment for CHAs</li> <li>Improve HR management and coordination</li> <li>Develop national-level guidelines for coordination of CH activities</li> <li>Develop guidelines for CH Nurses</li> </ul>
<b>2</b> Roll out formal community health structures to at least 110 districts	<ul style="list-style-type: none"> <li>Provision of regulatory frameworks for community health structures</li> <li>Increase coverage of Community health structures</li> <li>Promote ownership of community health initiatives at the community level</li> </ul>	<ul style="list-style-type: none"> <li>Legal framework for NHCs</li> <li>Regulatory framework for CBVs</li> <li>Strengthen the use of NHC/HCC guidelines</li> <li>Operationalise the CH Strategy</li> <li>Establish a functional community health structure</li> <li>Strengthen multi-sectoral collaboration, community linkages, and coordination</li> <li>Introduce social accountability mechanisms</li> <li>Introduce a system of recognition and rewards for NHCs and CBVs</li> </ul>
<b>3</b> Increase points of access so that all Zambians have access to quality basic health services	<ul style="list-style-type: none"> <li>Demand creation</li> <li>Develop community health service package</li> <li>Enhanced community referral system</li> <li>Supply chain management</li> <li>Provision of infrastructure</li> </ul>	<ul style="list-style-type: none"> <li>Address barriers to access</li> <li>Promote health education</li> <li>Roll out integrated community health package that incorporates preventative, curative, rehabilitative and palliative services</li> <li>Revitalize the referral and feedback systems</li> <li>Supply chain management</li> <li>Establish new health access points</li> <li>Rehabilitate existing infrastructure</li> </ul>
<b>4</b> Mobilise sufficient resources to implement the National Community Health Strategy	<ul style="list-style-type: none"> <li>Develop mechanisms for resource mobilisation at national and community level</li> <li>Engage stakeholders for efficient resource distribution</li> <li>Promote Results-based financing</li> <li>Diversify sources of finances</li> </ul>	<ul style="list-style-type: none"> <li>Document funding gap and identify priority funding partners</li> <li>Plan for mobilising resources</li> <li>Develop targeted proposals</li> <li>Improve partner coordination</li> <li>Reinforce DHO budget allocation to districts</li> <li>Promote community-level resource mobilisation</li> <li>Scale up results-based finance</li> <li>Explore private sector/hybrid models to supplement income for CH workers</li> <li>Fundraising activities</li> </ul>
<b>5</b> Ensure timely community health data is available and used for decision-making	<ul style="list-style-type: none"> <li>Improved data reporting systems</li> <li>Improve the use of data in decision-making</li> <li>Evidence generation</li> </ul>	<ul style="list-style-type: none"> <li>Standardise community health indicators</li> <li>Provision of reporting tools</li> <li>Mobile/electronic data capturing systems</li> <li>Incorporate community-level data into decision-making processes</li> <li>Undertake rigorous M&amp;E of community health activities</li> <li>Promote evidence-based policy making in community health</li> <li>Promote research in community health</li> </ul>
<b>6</b> Establish a community-friendly platform for appropriate and acceptable innovations	<ul style="list-style-type: none"> <li>Pilot high-potential innovations for community health</li> </ul>	<ul style="list-style-type: none"> <li>Develop framework for identifying and scaling CH innovations</li> <li>Collaborate with regional and international partners to identify CH innovations</li> <li>Roll out effective CH innovations</li> <li>Document and broadcast successful innovations</li> <li>Establish a model village to pilot innovations and document learnings</li> </ul>

# 1. INTRODUCTION

## 1.1. COUNTRY BACKGROUND

### 1.1.1. POLITICAL AND ADMINISTRATIVE STRUCTURES AND ECONOMY

The Republic of Zambia is located in the southern part of the African Continent. It covers approximately 752,612 km<sup>2</sup> and is surrounded by eight countries, namely: Tanzania and the Democratic Republic of Congo (DRC) in the North; Malawi and Mozambique in the East; Zimbabwe, Botswana and Namibia in the South; and Angola in the West. Administratively, the country is divided into 10 provinces and 110 districts. Out of the ten provinces, Lusaka and Copperbelt provinces are predominantly urban, while the rest are predominantly rural provinces.



Zambia has a population of 16.89 million people, growing at a rate of about 2.9% per annum<sup>1</sup>. The population is one of the youngest in the world (2/3 of the population are between 15 and 35 years).<sup>2</sup>

Zambia is a lower-middle-income country, with a per capita Gross Domestic Product (GDP) of around USD 1,315.8 in 2016<sup>3</sup>. In 2018, GDP growth was estimated at 3.7%<sup>4</sup>. Zambia has a mixed economy consisting of mining, agriculture and construction as major economic sectors.

<sup>1</sup> Central Statistics Office 2010a

<sup>2</sup> Zambia National Youth Policy

<sup>3</sup> CSO, "Zambia in Figures 2018"

<sup>4</sup> Central Statistics Office Monthly Bulletin, March 2019

There are high levels of inequality; in 2010, Zambia's Gini coefficient stood at 0.65 indicating a huge differential in wealth distribution accounted for mainly by variances between the rural and urban areas. Poverty levels in the rural areas are four times that in the urban areas. While only 20% of Zambians share more than half of the total national income, there is extreme poverty of around 60% in rural areas.

The unemployment rate (on the narrow definition) was 12.5% in the fourth quarter of 2018<sup>5</sup>; however, using an expanded definition of unemployment to include those not actively looking for work, the rate is 35.8%<sup>6</sup>.

### **1.1.2. HEALTH CARE SYSTEM IN ZAMBIA**

Health services are provided by the following main players: the public health sector with government owned and run facilities; faith-based not-for-profit providers; mine-owned health facilities; private-for-profit providers; Community-Based Organisations and traditional practitioners.

#### **1.1.2.1. PUBLIC HEALTH SECTOR**

The public health sector provides promotive, preventive, curative, rehabilitative and palliative health services to the population. Health service delivery is structured in a three-tier pyramidal referral system with primary health care (health posts, health centres and district hospitals); secondary health care (provincial referral hospitals); and tertiary health care (teaching hospitals). There are currently approximately 2000 health facilities in the country.

#### **1.1.2.2. HEALTH POSTS**

Health posts are at the lowest level of the Zambian health care system. Each health post caters for a catchment population of approximately 3,500 persons in rural areas and 1,000 to 7,000 people in an urban setting. All health posts are either positioned or earmarked to be set up within five km radius for sparsely populated areas. The types of health services offered at this level are promotive, preventive, curative, and rehabilitative care. As highlighted above, they refer patients and clients to health centres.

#### **1.1.2.3. HEALTH CENTRES**

There are two types of health centres in the national health care delivery system. These are Urban Health Centres which serve a catchment population of between 30,000 to 50,000 people and rural health centres, which serve a population of approximately 10,000 people. By the end of 2010, there were 436 UHCs Urban Health Centres and 1,060 Rural Health Centres throughout the country. These Health Centres offer promotive, preventive, curative and rehabilitative care services.

#### **1.1.2.4. FIRST LEVEL REFERRAL HOSPITALS**

First level hospitals are also referred to as district hospitals and are found at district level. They are the third largest levels of care after the second and third level referral hospitals. These first level referral hospitals serve a population of 80,000 to 200,000 people and provide services such as medical, surgical, obstetric, diagnostic, preventive and all clinical services in support of health centre referrals. Currently, there are 84 first level referral hospitals in the country.

#### **1.1.2.5. SECOND LEVEL REFERRAL HOSPITALS**

Second level hospitals, also referred to as provincial or general hospitals are found at provincial level. These hospitals are intended to cater for a catchment population of 200,000 to 800,000 people, with services in internal medicine, general surgery, paediatrics, obstetrics and gynaecology, dental care,

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<sup>5</sup> Central Statistics Office Monthly Bulletin, March 2019

<sup>6</sup> Central Statistics Office Quarterly Labour Survey Q1 2017

psychiatry and intensive care. These hospitals also serve as referral hospitals for first level institutions, including the provisions of technical back up and training functions. Currently, there are 21 second level hospitals in the country.

#### 1.1.2.6. THIRD LEVEL HOSPITALS

Third level hospitals are also known as specialist or tertiary hospitals and are the highest referral level of healthcare in Zambia. These have sub-specializations in internal medicine, surgery, paediatric, obstetrics, gynaecology, intensive care, psychiatry, training, and research. All complicated cases not attended to at second level hospitals are referred to third level hospitals. Currently, there are six third level hospitals in the country.

In addition to the health facilities under the MoH, the Ministry of Home Affairs, Ministry of Mines and Ministry of Defence have health institutions that provide health services primarily for their own staff, but which can also be accessed by non-staff members at a minimal fee. According to recent surveys<sup>7,8</sup> about 90 percent of patients seek care in facilities owned and run by the government.

#### 1.1.2.7. FAITH-BASED NOT-FOR-PROFIT

Catholic and Protestant Christian Missionary health workers from Church Health Institutions (CHIs) formed the Churches Health Association of Zambia (CHAZ) in 1970. The main purpose of establishing CHAZ was to improve the overall organizational effectiveness of the CHIs and Church Based Community Organizations involved in health service delivery in Zambia. CHAZ has 152 institutions - 36 Hospitals, (11 of which have training schools), 84 RHCs and 32 CBOs. All of these faith-based health institutions account for 30 percent of the total national health care and more than 50 percent of rural health care services (based on the population served and not on the number of health facilities and bed count). The majority of these health institutions are located in rural and hard to reach areas and in all the ten administrative provinces of Zambia serving the poor and the underserved. Faith-based health facilities also attend to patients from outside of their own catchment areas, districts and provinces.

CHAZ and its member units work closely with the Government of the Republic of Zambia (GRZ) through the Ministry of Health and within the National Health Framework.

#### 1.1.2.8. PRIVATE-FOR-PROFIT FACILITIES

The private health sector in Zambia consists of both private hospitals and private clinics. Private-for-profit facilities are estimated to provide care to approximately 3 percent of the population.

#### 1.1.2.9. TRADITIONAL HEALTH CARE PROVIDERS

The Government recognises traditional and alternative medicine as part of the health sector in Zambia and thus instituted various national policies governing this sector. The Traditional Healers Practitioners' Association of Zambia (THPAZ), established in 1978, serves as the national body for traditional healers and reviews and registers these practitioners for licensing. The organisation has about 40,000 members nationwide. There are still people who seek medical advice from traditional/alternative medicine prior to seeking care in orthodox health facilities.<sup>9</sup> TPHAZ has

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<sup>7</sup>Central Statistics Office. Living Conditions Monitoring Survey Report 2010. Lusaka: Central Statistics Office, Zambia; 2012

<sup>8</sup>Central Statistics Office. Zambia Household expenditure and utilisation Survey 2014 Lusaka: Central Statistics Office, Zambia; 2014

<sup>20</sup>PLoS ONE; Does User Fee Removal Policy Provide Financial Protection from Catastrophic Health Care Payments? Evidence from Zambia

[Felix Masiye](#), [Oliver Kaonga](#), and [Josés M Kirigia](#)

<sup>9</sup> WHO (2001) Legal Status of Traditional Medicine and Complementary/Alternative Medicine: A Worldwide

collaborated with the Ministry of Health in various areas, most notably in HIV and its members have received training in areas such as referral practices and health promotion.

#### 1.1.2.10. PRIVATE PHARMACIES AND DISPENSARIES

Although the data shows clearly that the public sector is the largest health care provider, many people choose self-medication and buy over-the-counter drugs from drugs stores or pharmacies.

## 1.2. POLICY AND REGULATORY FRAMEWORK

Starting in 2006, the GRZ embarked on a devolution policy, which includes decentralized public sector management across all sectors of government. According to the Sector Devolution Guidelines for Ministries, the vision of the Government is:

*"[To] achieve a fully decentralized and democratically elected system of governance characterized by open, predictable and transparent policy-making and implementation processes, effective community participation in decision-making, development, and administration of their local affairs while maintaining sufficient linkages between the centre and the periphery."*<sup>10</sup>

The devolution policy outlines a vision of "bottom-up" decision-making and planning, with districts given the responsibility to develop and implement plans according to their own needs. The key goals of the devolution policy are to improve accountability and transparency in the management of resources and to provide a legal and institutional framework that promotes autonomy in decision-making at the local level.

The Health Sector Devolution Plan (HSDP) (2015) supports the formulation of the organizational structures that accompany the transfer of functions and staff from the national to the district level. Structures and processes must be developed for the improved coordination of community health service delivery as these functions become decentralised. As a result, there is a clear need for management support for community health systems from the community to the national level. This can be addressed by appointing suitably qualified community health focal points at each level of the health system.

Prior to 2006, the legal framework for NHCs was provided by the National Health Services Act. In 2006 this Act was repealed but has not yet been replaced and as a result there currently is no legal framework for these structures.

Within the community health sector, there are several areas where regulatory frameworks must be improved to formalise community health structures in line with the decentralisation policy. These include i) developing a clear legal framework for NHCs and HCCs, and ii) formalising the role of CBVs, including standardised training, accreditation, reporting lines and incentives. This provides an opportunity to improve the regulatory framework for community health service delivery and adopt best practice procedures.

To strengthen the oversight role of the NHCs and HCCs, national NHC guidelines have been developed. This aims to improve the involvement of community representatives in all aspects of planning, implementation, and monitoring and evaluation, and to hold health workers and facilities accountable for service delivery.

A draft social accountability training manual has also been developed. The main goal of social accountability is to strengthen capacities of citizen groups and government to work together in order

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<sup>10</sup> Sector Devolution Guidelines for Ministries, 2006, p. 2

to enhance quality of public services delivered to citizens. It seeks to give voice to the needs and concerns of all citizens on the delivery and quality of public services.

### **1.2.1. POLICIES SUPPORTING THE DEVELOPMENT OF COMMUNITY HEALTH**

This strategy has been informed by the following key policy documents:

- The National Health Policy (NHP) 2012
- The Seventh National Development Plan (7NDP)
- The National Health Strategic Plan (NHSP) (2017-2021)
- The Community Health Worker Strategy (CHWS) (2010)

The NHP is built up on the 7 basic principles of the Zambia Vision 2030. This policy outlines a statement by the Zambian Government to set clear directions for the development of the health sector in Zambia over the long term. The policy is anchored in the Vision 2030. The implementation of this policy is guided by a series of successive National Development Plans and National Health Strategic Plans.

7NDP is the country's blue-print for development up to 2021. It contains ambitious plans to make Zambia a prosperous middle-income economy that offers decent employment opportunities for all Zambians. The plan emphasizes the importance of improved health and health related services as one of its key development outcomes.

The NHSP 2017-2021 spells out the Ministry of Health's transformation agenda, which focuses on building robust and resilient health systems. The plan focuses on delivering quality health services across the continuum of care which includes promotive, preventive, curative, rehabilitative and palliative care. The attainment of the universal health coverage will be made possible through primary health care with a focus on community health.

The Community Health Worker Strategy (2010) was developed to formalize and standardize the role of CHWs in the health sector in order to enable equity of access to high-impact primary health services.

At community and district level regarding community health delivery, several regulations and handbooks exist, the most important of which are: a community health planning guide, Action Planning for Health Centers, Health Posts and Communities, Action Planning Handbook for District Health Teams, Guidelines for the Roles and Functions of the Neighbourhood Committees the National Community Health Assistant Program Implementation Guidelines and Standard Operating Procedures for the Community Health Assistants.

Focal Point Persons oversee the coordination of community health activities and strengthen the community health system at their respective levels.

### **1.2.2. GOVERNANCE FOR COMMUNITY HEALTH SERVICES**

Health systems leadership and governance deals with the interrelationships, roles, and activities of the various agencies in the production, distribution, and consumption of health services. The policy directions under NHP 2012 and the Zambia Vision 2030 pose new requirements in the governance of the health sector. The National Health Policy sets out the guidelines for directing the implementation of national health strategies. The Health Policy is anchored in the devolution of functions to the lower, District level. The overall National Decentralization Policy provides the framework with which

the sector policy operates; it specifies devolution of functions and authorities with matching resources to local authority levels. Under the devolved governance system, the central level is expected to provide policy, strategic guidelines, overall coordination, and M&E. The local devolved units are in turn expected to concentrate on programme implementation.

The NHP also recognises the importance of multi-stakeholder collaboration across a range of sectors such as education, agriculture, and water and sanitation. In order to adequately address the demand for health services it is also necessary to include stakeholders from the private sector, non-profits and faith-based organizations.

At the same time, the NHP acknowledges that transparency and accountability between health facilities and communities are weak and most patients do not understand their rights when accessing services. The NHP seeks to improve accountability and transparency by introducing structures that promote social accountability at community level.

### **1.2.3. HUMAN RESOURCES**

The National Community Health Workers Strategy (NCHWS) 2010 was developed to strengthen community health service delivery. Its rationale is to bring basic health services closer to the family, in line with Ministry of Health's mission statement. This document first outlined the concept of the CHA programme.

Community Health Assistants (CHA) constitute the formal link between the communities and the health system. The training of the CHA is standardised and developed with inputs by professional bodies such as the General Nursing Council, MOH, HPCZ and various Medical Schools, conducted in two specialized training institutions namely; Ndola Teaching Hospital and Mwachisompola. The training encompasses 11 modules cutting across health sector issues including health promotion, disease prevention, clinical tasks and secondary duties like coordination, Technical Assistance (TA) to Community Based Volunteers (CBVs), mobilization and monitoring. Following training, the CHA are registered with the Health Professionals Council of Zambia before being deployed to health posts, where they will be stationed.

Community Health Assistants are meant to spend 80% of their time with the communities and 20% of their time side-by-side with skilled health workers in the health facilities, though studies have shown that many CHAs spend significantly less time in the community due mainly to staff shortages at health facilities. They have a variety of professional relationships in order to carry out their duties. These include health professionals, church leaders, NGO/CBO/FBO and other community groups, CBV, traditional leaders, church leaders, senior headmen/indunas and council members (chief's cabinet).

The WHO recently published new guidelines on community health workers. There is therefore a need to revise Zambia's National Community Health Worker Strategy (2010) to bring it in line with current global best practices.

## **1.3. COMMUNITY HEALTH SERVICE DELIVERY AS LAST MILE OF PRIMARY HEALTH CARE**

Community health care is essentially an integral part of Primary Health Care (PHC) as defined in the Alma Ata Declaration (1978)<sup>9</sup>: "Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to

individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.” Zambia reaffirmed its commitment to PHC under the Astana declaration in 2018.

Community health systems extend the four principles of Primary Health Care<sup>11</sup> to the last steps of PHC delivery - the households in the communities, to ensure better health outcomes through proactive health promotion, disease prevention and control, curative services, rehabilitation and palliative services. It facilitates care that is based in household and social institution (orphanages, homes for psychiatric care, etc.) where service delivery is limited.

Community health care supports the four PHC principles of equitable distribution of health services to achieve improved health outcomes by creating demand based on the PHC principle of participation of the community in health care delivery. A continuing effort is required to secure meaningful community participation in the planning, design, implementation, as well as monitoring and evaluation of health service delivery, beside reliance on local resources such as manpower, money and materials. Community health systems also support the PHC principle of inter-sectoral coordination through facilitating the interest of communities, all related sectors and factors that impact on health as health determinants. The fourth PHC principle, the use of appropriate technology is supported by community health in its aspect of adapting health care services to local needs through technology acceptable to those who apply and maintain it with the resources the community and country can afford. In the context of CHC the reference is mainly to technical know-how for strengthening community systems, but can also encompass technologies pertaining to telemedicine.

Community health is also a field in public health which concerns itself with the health of specific groups. “Community health refers to the health status of a defined group of people and the actions and conditions to promote, protect, and preserve their health.”<sup>12</sup> Thus community health is focusing on the predominant health care situation of social target groups or whole communities to take responsibilities to maintain and further improve their health status. It draws from other disciplines as required which deal with the health determinants. Community organizations and networks can help through their unique ability to identify the health determinants that affect their well-being through the physical environment, social status, cultural practices, income, education and working conditions, social support networks and welfare services, genetics, personal behaviour, coping skills and gender to target specific health problems.<sup>13</sup>

Within this scope community health increases the utilization and coverage of health services provided at community level through expanding access to basic health services and thus efficiently extends its support to the **eight essential components of primary health care** which are:

1. Education concerning prevailing health problems and the methods of preventing and controlling them.
2. Promotion of food supply and proper nutrition.
3. An adequate supply of safe water and basic sanitation.
4. Maternal and child health care, including family planning.
5. Immunization against major infectious diseases.
6. Prevention and control of locally endemic diseases.
7. Appropriate treatment of common diseases and injuries.

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11 WHO 2003, Chapter 7: Principled integrated care, pp. 105 – 131.

12 Mc Kenzie et al 2011, p. 7.

13 see WHO Regional Office for Africa, 2009, p 8.

## 8. Provision of essential medicines.

To this list of PHC components the scope of community health adds the:

## 9. Strengthening of referrals between the community health services and the health facilities

The Community Health Strategy 2017-2021 operationalizes the NHSP chapter through these components and guides communities in taking responsibility for their health, participating in the management of their local health services and strengthening the interface between service providers and community members in defined service delivery areas. This is in line with the National Community Health Worker Strategy (NCHWS) of 2010<sup>14</sup> which guides the development of Community Health Assistants (CHA).

Today health systems encompass communities as systems which pro-actively contribute to improved health outcomes of their members. The Government of the Republic of Zambia is determined to make better use of the option of engaging communities to contribute to key national goals. It recognizes them as resourceful part of a network of relationships for reliable support to the people when seeking health. Thus the health system can provide more space to innovative approaches based on synergies between health and community systems, resources and improved referral that foster complementary partnerships guaranteeing access to quality services.

Community systems are structures and mechanisms through which community members, its organizations and groups interact, coordinate, network and deliver their responses to the challenges and needs. A broad range of community actors provide communities with health and non-health services delivery like comprehensive home-based care, counselling, advocacy, legal support, referrals and transport for access to follow-up services.<sup>15</sup>

Such community-led systems enable inclusion of relevant non-health activities in funding mechanisms and allocations for health through cooperation with other sectors, private service providers and cross-sectoral actors such as from education, nutrition, agriculture, housing, water supply, sanitation, environmental and social protection.

## 1.4. PRIMARY AND COMMUNITY HEALTH SERVICE DELIVERY

Health services delivery in Zambia through community health services addresses the access problem to primary health facilities such as Health Posts, Health Centers and 1st Level Hospital in the districts. In 2014, 46% of rural households in Zambia still lived outside a radius of 5km from a health facility, compared to only 1% for the urban households.<sup>16</sup>

Both documents call for equitable access to quality health care and the inclusion of the disabled in society. Health services are complemented by community based rehabilitation services offered at rehabilitation centres at community level. The main challenges in rehabilitation are: inadequate human resources for outreach programs, skilled community health workers, resources for post illness care, and lack of partnerships for home based care.

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<sup>14</sup> MOH 2010

<sup>15</sup> This definition leans on the concepts of McKenzie et al. 2011, the GFTAM 2011 and Futures Group Europe 2009.

<sup>16</sup> Buleti Nsemukula 2014

The NHP 2013 advocates for public policies that support and promote health education and disease prevention (p. 27) to empower individuals, families and communities with appropriate knowledge to develop and practice healthy lifestyles in the priority areas (cf. pp. 29-36).<sup>17</sup>

Concerning Reproductive Maternal Newborn Child and Adolescent Health and Nutrition (RMNCAH+N), Government aims at ensuring equity of access to provide quality, cost effective and affordable RMNCAH+N services to reduce maternal, newborn and child morbidity and mortality and address male participation. Access to essential vaccines is key to preventing infections. Community involvement in maternal and child health can be strengthened through Safe Motherhood Action Groups (SMAGs) and Traditional Birth Attendants.

The Zambia Vision 2030, (p. 33) is explicit about the community health strategy to improve nutrition through

- Promoting the prevention and control of specific macro- and micronutrient deficiencies and appropriate diets and lifestyles throughout all stages of human life;
- Strengthening nutrition care practices for vulnerable groups: young children, adolescents, women in the reproductive age, and HIV/AIDS infected, and those affected by non-communicable diseases like diabetes, hypertension, coronary heart diseases and cancer.

More efforts shall be directed towards oral and eye health primarily in school and community health programs (p. 35), and typically so exposure to pesticides in agricultural work, from industrial waste and occupational injuries.

## 2. Chapter 2: Situation Analysis

### 2.1. OBJECTIVES AND METHODOLOGY

The objective of the situational analysis is to provide an understanding of the current state of implementation of community health services and the associated constraints that hinder effective service delivery. It informs the community health strategy.

The situational analysis is based on a review of national policies, regulations and guidelines and the literature on international best practices in community health. It has also taken account of assessments and evaluations of local and international community health programmes.

Consultations, workshops, and interviews were conducted with MOH managers at all levels and with stakeholders in the different service sectors (public, private, non-profit). In addition, field visits were undertaken to interview staff of DOH and the District Health Management Team. Interviews were also conducted at health facilities with clinical staff, EHT, CHAs and CBVs, as well as at the CHA training institution at Mwachisompola.

The section immediately below provides a snapshot of relevant health outcomes in Zambia, highlighting priority intervention areas for community health. The remaining sections of the situation analysis consider the current situation in community health according the WHO's six building blocks for health systems, namely (i) service delivery, (ii) health workforce, (iii) health information systems, (iv) access to essential medicines, (v) financing, and (vi) leadership/governance.

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<sup>17</sup> cf. GRZ 2006, p. 25ff

## 2.2. HEALTH OUTCOMES

The GRZ remains committed to providing universal, quality and equitable health care services to the people of Zambia. While Zambia has made significant strides in improving key health outcomes, significant challenges remain. The burden of disease matches well with that of other lower middle-income countries: a high, but falling, level of communicable diseases and injuries; and a relatively low, but increasing level of non-communicable diseases.

The government has made community health a key part of its strategy to continue to improve health outcomes for all Zambians.

Noted gains in key health indicators in recent years include:

- Under 5 mortality declined from 75 deaths per 1000 births in 2014 to 61 deaths per 1000 births in 2018<sup>18</sup>
- The infant mortality rate is 42 deaths per 1000 births, down from 70 per 1,000 births in 2007<sup>19</sup>
- Access to antiretroviral therapy (ART) has steadily increased: in 2018 78% of all adults, and 79% of all children, living with HIV were on treatment<sup>20</sup>
- Malaria incidence decreased from 382 cases per 1,000 population in 2016 to 312 cases per 1,000 population in 2018<sup>21</sup>

Despite these achievements, there is still a significant gap between current health outcomes and the targets set under the MoH's legacy goals.

Poverty is inextricably linked to health outcomes. In Zambia, 59% of the population lives below the poverty line and face high inequities. Nutrition indicators suggest that the poorest are 1.5 times more likely to be malnourished than the better-off. Malnutrition is consistently higher in rural than in urban areas; and also among boys than girls. It is a major public health problem in Zambia and contributes up to 42% of all under five deaths. Protein Energy Malnutrition figures indicate that 45% of Zambian children are stunted, 15% are underweight while 5% are wasted. These rates are among the highest in the sub-region.

In Zambia adult literacy was estimated at 72% in 2007. It is also estimated that fewer women (64%) than men (82%) are literate. Urban areas have higher literacy levels than rural areas. Gender bias, low education and low literacy levels are linked with poor health, poverty and higher birth rates.

The lowest economic quintile of women is giving birth to more than twice the children than women in the highest quintile (8.4 versus 3.4), and rural women give more births than urban women (7.5 versus 4.3).

Given these challenges, it is not surprising that it is these rural areas where the burden of disease and mortality ratios are highest. For example, one in five children under the age of five in rural areas contract malaria, while the immunization rates have remained at 65% for the last 10 years.

If Zambia is to overcome these challenges and achieve its goal of providing universal health care, community health has a vital role to play. Community health approaches can contribute to bringing health services to the doorstep of households that would otherwise not have access to these services including vulnerable groups and those in hard to reach areas.

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<sup>18</sup> Zambia Demographic Health Survey (2018)

<sup>19</sup> *ibid*

<sup>20</sup> [timeline.Avert.org](https://www.avert.org/timeline) (2018)

<sup>21</sup> Health Management Information System cited in National Health Strategic Plan 2017-2021

### 2.3. SERVICE DELIVERY

Community health services focus on providing promotive, preventive, curative and rehabilitative health services to the general public, in line with the packages of health services defined for these levels.<sup>22</sup> The national health policy<sup>23</sup> has adopted a human rights approach in the provision of PHC/CHC services which aims at ensuring availability, accessibility, acceptability and affordability of envisaged services.

In Zambia, Community Health Care is anchored in the PHC services at community and district levels through the care, management and coordination structures of outreach posts, Health Posts (HPs), Health Centres (HCs), district hospitals and Health Centre Committees (HCC) and Health Post Committees (HPC) that link PHC with the communities through Neighbourhood Committees (NHC). However, community health interventions in Zambia are currently highly fragmented.

The physical geography of Zambia presents a challenging environment for delivering health services. Over 60% of the Zambian population lives in sparsely populated rural communities. These regions often lack basic health and transport infrastructure. In 2014, 46% of rural households in Zambia still lived outside a radius of 5km from a health facility, compared to only 1% for the urban households. However, even within urban areas, health facilities are often congested, which is also a barrier to access.

The bulk of health services are provided at primary health facilities, which are the entry point to the public health care system. Since the 1990s the government has made significant investments to improve equitable access to health by increasing the number of Health Posts across the country. However, standard operating procedures (SOPs) are outdated and human resource constraints continue to be a challenge.

The referral system at community level must be revitalised. Currently inadequate health infrastructure and human resources shortages are compounded by a lack of transport and weak governance structures. Though some community referral guidelines exist, these tend to be for specific conditions and there is a need for integration and standardization.

Access to PHC services is inhibited by a lack of nurses, doctors, limited operating hours of local facilities and stock-outs of commodities. As a result, people directly access the higher level health facilities, leading to the congestion of these facilities.

### 2.4. HEALTH WORKFORCE

Zambia has 12.4 clinicians per 10,000 persons,<sup>24</sup> which is significantly below the World Health Organization's recommended threshold of 22.8 clinicians per 10,000 persons. While each of the country's health posts should be overseen by a nurse, currently 34% of nurse posts at health posts are vacant. Where a nurse is not available to serve as a facility in-charge, Environmental Health Technologists (EHT) are meant to substitute, however, 24% of EHT posts are also vacant. As a result, 23% of all CHA are acting as facility in-charges, which has a negative impact on their ability to work in the community<sup>25</sup>.

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<sup>22</sup> MOH, 2012a

<sup>23</sup> Ministry of Health, 2012a

<sup>24</sup> Ministry of Health and MoCDMCH, 2014

<sup>25</sup> cf. Secor, A., 2017

The WHO recommends a ratio of 2 medical doctors and 14.3 nurses per 1,000 population as a minimum to achieve the health related MDGs. The Zambian ratios of 0.07 medical doctors and 0.6 nurses per 1,000 population, is of extreme concern.<sup>26</sup>

After nurses, midwives, and clinical officers, EHT represent the category of skilled health worker with the largest distribution across Zambia.<sup>27</sup> EHT perform a number of services in their catchment areas including: conducting inspections; routine water and food field tests; investigating and controlling disease outbreaks; and protecting and improving environmental quality.

There is currently no formally appointed community health focal point person at provincial, district or health centre level. Guidelines for the appointment of these focal points will be developed as one of the activities outlined in this document. Currently, EHT often act as informal community health focal point persons, since they have the mandate to serve the community as well as the facility, and have been an integral part of the system for many years. Once the cadre of public health nurses (community health nurses) currently being trained have graduated and begin their service, they are likely to take over the functions of community health focal point person.

#### **2.4.1. COMMUNITY BASED VOLUNTEERS (CBV) AND COMMUNITY HEALTH ASSISTANTS (CHA)**

Community health workers are quick to train and are embedded within the communities that they serve, providing a cost-effective way to provide services at the community level. In Zambia community health workers include two main groups: CBV and CHA.

The NHSP 2017-21, which emphasises the role of community health, recognises the contribution being made by CBV in the provision of health service delivery. There is currently no national database of CBV, and estimates of the number of CBV in the country vary, with some estimates as low as 10,000 and others as high as 100,000.

CBVs work directly with implementing partners on a range of health projects across the country. This is currently a deeply fragmented space, with several types of volunteers all working in different vertical programmes. These include Safe Motherhood Action Groups (SMAGs), Community-Based Distributors (CDBs), TB Treatment supporters, HIV Adherence Supporters, Growth Monitoring Supporters, Community Health Workers, Youth Peer Educators, Infant and Young Child Feeding Promoters, ICCM Providers, and others. The training for each of these groups of CBVs differs in content, length and intensity. Selection criteria are not always clearly stipulated, and there are no standard guidelines for incentives or working hours for volunteers, which differ depending on depending on the funder, implementing partner and districts in which the work is implemented. This presents a number of challenges including high turnover rates of volunteers.

CHAs are employed by the ministry of health to act as the "eyes and ears" of the health system at the community level. They are nominated by the communities in which they will work and are trained for 12 months in basic healthcare including the treatment and prevention of common illnesses.

CHAs are meant to spend only 20% of their time in the health facility and the remaining 80% of their time in the community conducting home visits and community mobilisation activities. Again, due to resource constraints, this is rarely the case and CHAs often spend far more of their time at the health facility.

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<sup>26</sup> cf. Buleti Nsemukila, 2014

<sup>27</sup> Ferrinho, P. et al., 2011

According to the NCHWS, there should be two CHAs allocated to each health post, in addition to a nurse, a midwife and an EHT. According to a recent study<sup>28</sup>, however, 23% of the first cohort of CHA are working alone in facilities without the supervision of a skilled health worker. In addition many CHA - who hail from the communities where they serve, have too many villages to serve<sup>29</sup>.

The MOH set a target of training and deploying 5,000 CHAs by the end of 2020. To date, 2,502 CHA have been trained. Of these 1,669 are currently receiving a salary: 1,337 are on the GRZ payroll while another 332 are being supported by cooperating partners. In February 2019 a new USAID project was announced that will support an additional 600 CHA. A key reason that CHAs have not been deployed is a lack of funding to pay their salaries. To meet this target, the Ministry of Health will have to make greater provision for CHAs on its human resources establishment and mobilise resources to pay for their salaries.

Recent process evaluations of the CHA programme outlined the need to overcome their currently weak supervision and lack of a clear understanding by health facility staff of how community activities are to be coordinated and organized.<sup>30</sup>

## 2.5. HEALTH INFORMATION SYSTEMS

Community-level information relies on the collection of data by CHAs and CBVs. In 2012, the HIA4a form was developed to aggregate data collected by the CHAs, while in 2016 the HIA4b form was developed to aggregate CBV data collection. The roll-out of the integrated community HMIS system has been delayed and, as a result, there is a lack of reliable, timely community health data for decision making.

At community and health centre level, the HMIS system is still paper-based. Printed community data collection tools are filled out by CHAs and facility in-charges in order to collect community-level information. At district level, this information is aggregated and captured electronically before being sent to the provincial, and ultimately the national level.

A further difficulty with the community-level data collection is that these forms require CBVs and CHAs to capture clinical information that they may not have the appropriate equipment or training to capture. This information would be best captured through the clinical system. Community health indicators need to be streamlined with a focus on promotive and preventative services to simplify data collection at community level.

There is a customised community dataset within the national Health Management Information System online platform, DHIS2. This data is collected by CHAs, who submit completed data collection forms to the facility in-charge, who then submit this data to the district health office.

CHA programme data reported to HMIS via the DHIS2 system should be accessible to all relevant persons at the Ministry of Health. Partners outside of the MoH and the GRZ will receive access upon approval by the MoH.

The key reporting and recording tools used by CHAs and CBVs are:

- Household Activity Register (Part I and II)
- Community Mobilization and Surveillance Register:
- Patient Care Register

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<sup>28</sup> cf. Secor, A., 2017

<sup>29</sup> These data are sourced during field work in Chibombo District, the CHA implementation guideline states 5-10 households per day, reflecting incorrect orientation of the CHA

<sup>30</sup> CHAI and MOH 2015

- Tally sheets (of activities carried out/organized/coordinated by the CHA)
- HIA4a and b aggregation forms
- CHA Self-Assessment Form

The National Guidelines for Neighbourhood Health Committees provides tools for NHCs and communities to participate in monitoring and evaluation of community health activities. These tools have not yet been widely disseminated due to lack of funds. The dissemination of these guidelines and training in the tools provided is one of the interventions described in this strategy.

## 2.6. ACCESS TO ESSENTIAL MEDICINES

Effective distribution mechanisms to ensure the availability of essential medicines at community level improve health outcomes and reduce out of pocket spending. There is currently a weak system of quantifying, forecasting stocks and distributing essential medicines and commodities at facility and community level.

To address these challenges, an electronic Logistics and Management System (eLMIS) has been developed to improve control of stocks and reduce stock outs and expired stocks. eLMIS helps place orders in time to reduce unavailability of medicines in the district. eLMIS has been introduced in all provinces with distribution hubs in each of them that draw from Medical Stores Limited (MSL). Medicines and commodities are distributed to the last mile from these distribution hubs to health facilities.

Previously, pre-packaged medicine kits were carried by CBVs. These are no longer available through MSL because the selection of the compiled drugs did not match the needs of the people. This resulted in high expiry rates of medicines, with much stock being wasted and was hence not cost-effective, being waste of resources. Since the withdrawal of the pre-packaged medicine kits, CBVs have relied on health centre kits for medical supplies. There are plans to develop a community logistics management system that will enable CBVs and other community health workers to order medicines directly from MSL.

## 2.7. HEALTH FINANCING

Health financing is an important component of the health system as it impacts the production, delivery, and consumption of health services. The Government allocation to the health sector in nominal terms has been increasing even though the share of the health sector budget to national budget has been decreasing. The proportion of the MOH budget to the national budget was 9.9% in 2014, 9.6% in 2015 and 8.3% in 2016. It has consistently been below the Abuja Declaration target of 15%.

A stable number of CPs are committing funds and technical assistance to the health sector. However most of the assistance is still used for vertical programmes (i.e., disease-specific programmes such as malaria and HIV/AIDS) instead of targeting the entire health system, which would in the long run produce a greater impact on mortality and morbidity reduction. While donor support (estimated at 56% of total health expenditure in 2012) augments domestic resources, lower than expected nominal public expenditure levels create sustainability issues.

Under government policy, districts are expected to make budgetary provision of at least 10 percent of the total district grant for community health interventions. However, this policy is not always

adhered to for a number of reasons. These include the lack of capacity of the NHCs to manage funding for community-based interventions; the lack of guidelines for how these funds may be used; and a lack of transparency concerning allocations and expenditures, which may lead to funds being used at the facility level itself rather than trickling down to community-level interventions.

In its current form, the SHI bill addresses mostly reimbursements for major medical care, but does not take into account PHC services, nor is it looking at Community Health Financing.

The 2016 Household Health Expenditure and Utilization Survey (HHEUS) and further studies can be used as a tool for identifying health seeking behaviour and demand for health services in relation to income as a social determinant of health to inform the allocation of funding for PHC and Community Health Care.

The Health Financing Strategy and the Community Health Strategy documents can together set the guidelines to strengthen the capacity of Primary Health Care (PHC) for managing the different funding sources, such as those of the Government of the Republic of Zambia (GRZ), district and donors. The current fragmentation of the management of funds is a barrier for the implementation of community based interventions. There is a need to strengthen districts' financial management skills and tools, in particularly in tracking expenditures and reporting.

## **2.8. LEADERSHIP AND GOVERNANCE**

Leadership and governance involves ensuring that strategic policy frameworks exist and are combined with effective oversight, coalition-building, regulation, attention to system design, and accountability.

At the national level, the Ministry of Health established a community health unit in 2018 to provide strategic direction and oversee the implementation of community health activities in Zambia. The capacity at District level to provide appropriate support to community level structures and management are still weak. There are currently no formally appointed community health focal point persons at provincial, district or health centre level. Guidelines for the appointment of these focal points will be developed as one of the activities outlined in this document.

Community health systems in Zambia are highly fragmented, and the coordination mechanisms for community health organizational structures at all levels need to be reviewed and updated.

CBV lack an acknowledged regulatory framework and binding operational guidelines though they are coordinated and guided by NHCs and HCCs. Supportive mechanisms, planning, community score cards, and coordination mandates at district level are inadequate. While 84% of health zones report having an NHC, the functionality of these committees varies and depends largely on the guidance of District Health Office staff and the managerial skills of health facility staff. The National Guidelines for NHCs, which spell out the roles and responsibilities of NHCs, were developed and launched in 2018 and are awaiting dissemination.

The chairperson of an NHC automatically becomes a member of the HCC. Additional HCC members may be elected from the group of NHC executive members from all NHCs in a facility catchment area.

A critical structure for the NHCs to interface with is the Ward Development Committee (WDC). WDCs are established by a Town Clerk or Council Secretary and are responsible for working with councillors in the wards to implement development projects at the local level, including in the health sector. The

primary function of the WDC is to coordinate all developmental processes in their ward and provide a link between community members and the council and development agencies operating in the ward. The WDC holds quarterly meetings and reports to the Council, and is expected to give feedback on all developmental issues to the community. The HCC is expected to report to the WDC on health issues relevant to the ward and to represent the health interests of the community at ward level.

A draft social accountability training manual has been developed, which aims to improve the involvement of community representatives in all aspects of planning, implementation, and monitoring and evaluation, and to hold health workers and facilities accountable for service delivery.

Concerning the coordination of volunteers through NHCs, it is recognized that the mechanisms of coordination need to be strengthened and those of CP harmonized with the community systems.

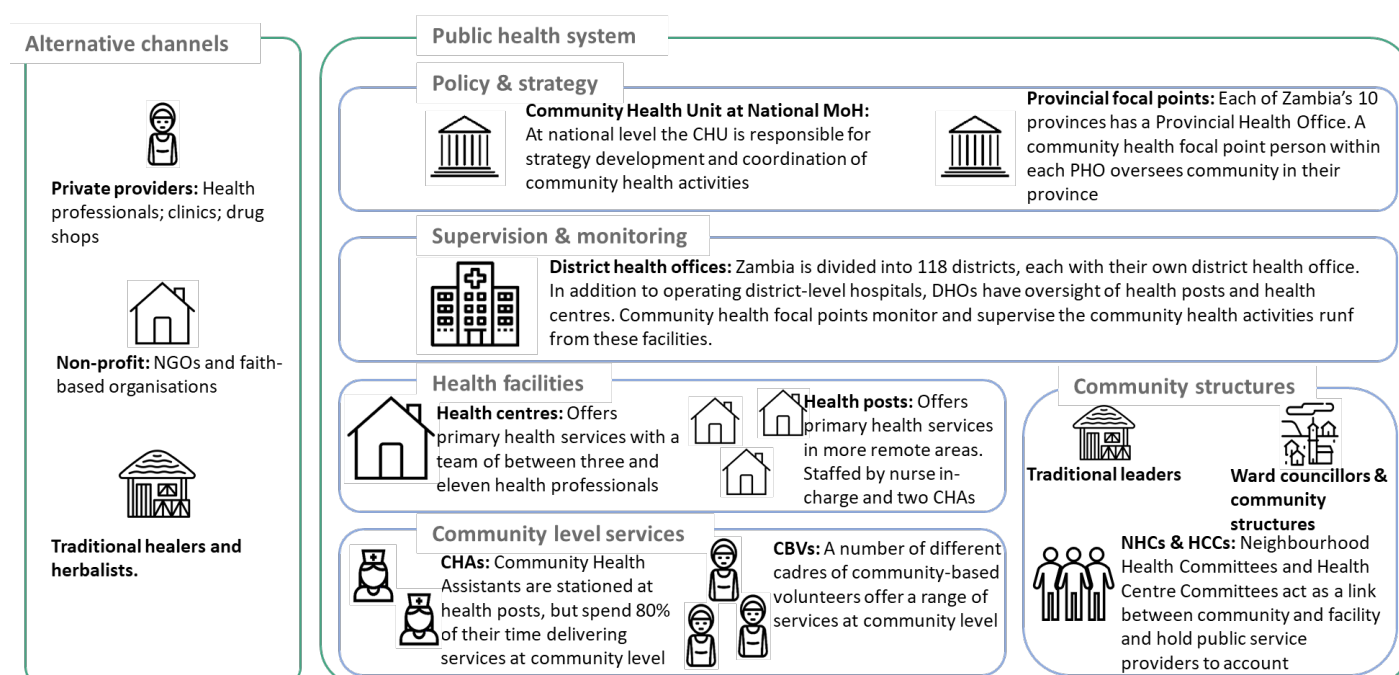
Though the CBVs operate in all zones of a health facility's catchment area, the coordination between the zonal activities is weak. The Health Post In-charges co-ordinate the CHA, who are tasked to coordinate the implementation of health interventions and the CBV during the interventions.<sup>31</sup> The ways in which the CHA should coordinate these interventions are not clearly outlined nor are standardized operational guidelines or strategies available at any level. This contributes to the current fragmentation of community health service delivery.

The coordination of implementing partner activities at all levels is challenging, particularly at provincial and district levels. Most of the activities that are implemented by partners are driven by the priorities of external funders, which may not always be aligned with the national development process. Weak harmonization of approaches and packages of support to CBV by different partners, leads to a lack of standardized training, inconsistent deployment, poor motivation, a lack of standardised incentives, as well as inconsistent reporting, monitoring, evaluation and tracking of the CBV.

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<sup>31</sup> cf. Ministry of Health, 2017d

The diagram below illustrates the structure of community health in Zambia



## 2.9. PURPOSE OF THE NATIONAL COMMUNITY HEALTH STRATEGY

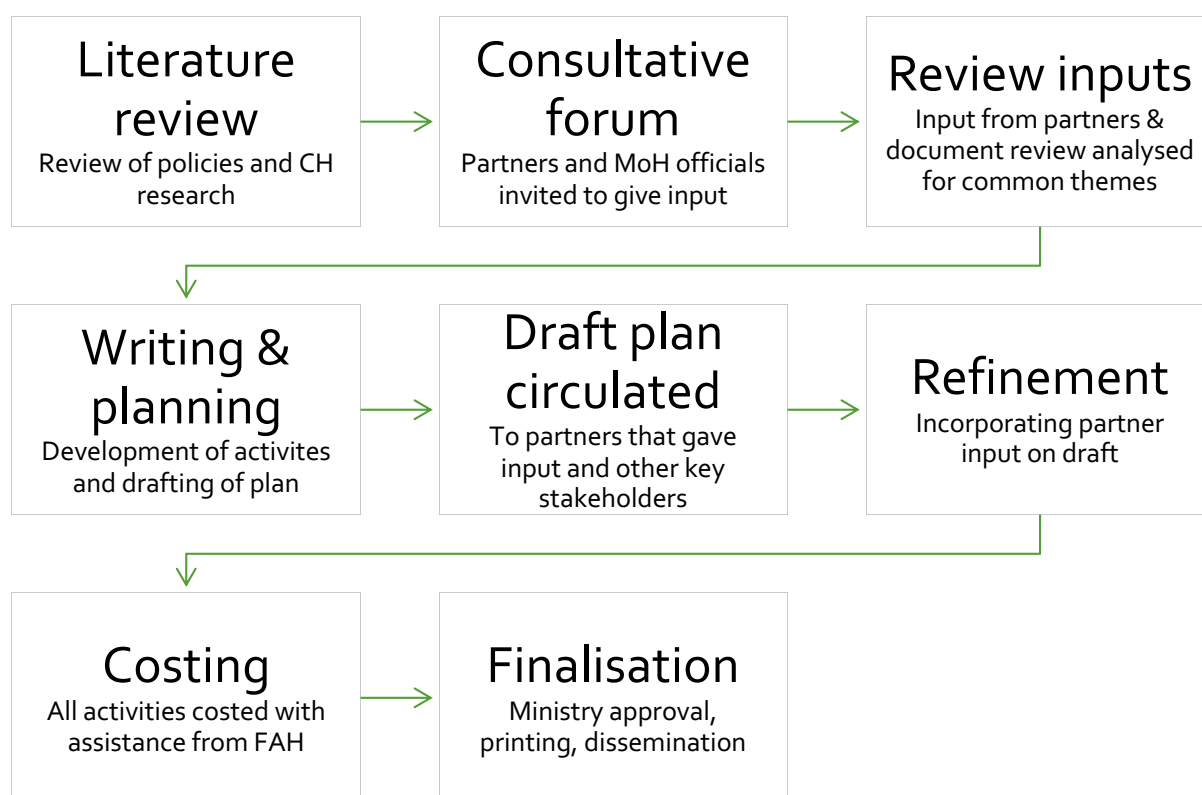
The National Community Health Strategy aims to contribute to the achievement of Zambia's health and development goals by setting the agenda for community health for the period 2019-2021. This includes laying out key actions necessary to create a more scientifically and culturally acceptable, sustainable, integrated, and efficient community health system.

Specifically, the strategy seeks to:

- **Build consensus** on integrated community health to unite stakeholders from multiple sectors around a unified plan. This consensus includes the vision and mission of community health, the priority issues, the strategies to address these issues and the specific community health activities to be implemented.
- **Identify gaps in support** for community health so that the MoH and partners can target where further resources and support are needed. This includes examining existing guidelines and policies, knowledge and skills in the community health system, and other resources.
- **Develop an integrated implementation plan** in order to translate consensus, resources, and ideas into action that will lead to improved community health outcomes. The integrated implementation plan, covers the period 2019 – 2021 and is aligned with the NHSP. It outlines key activities according to a timeline to ensure ease of use for stakeholders at all levels of the health system.
- **Build partnerships for effective implementation** in order to foster high-quality services and performance improvements; continuous leveraging of resources; and minimal duplication

### 3. Process for developing this strategy

The process followed for developing this plan is illustrated in the graphic below:



The literature reviewed included policy documents such as the National Health Strategic Plan (2017-2021); the Community Health Strategy (2017-2021); the National Community Health Worker Strategy (2010), the National Guidelines for Neighbourhood Health Committees (2018) and the Seventh National Development Plan. It also included a review of research carried out on a number of areas of community and primary health care including Community Health Assistants, community-based volunteers and other community-level health workers in Zambia.

#### 3.1. CONSULTATIVE FORUM

During the consultative forum, key issues facing community health were identified during a situational analysis. Implementing partners, NHC representatives, Ministry of Health staff, and health workers from all levels of the health system were given the opportunity to identify areas of concern and explain some of the difficulties that they experienced in implementing community health activities.

The input from this consultative forum was analysed and compared with the findings of the situational analyses in the Community Health Strategy, the National Health Strategic Plan, and partner research. This analysis informed the objectives and activities outlined in this plan.

## 4. Vision, Mission, Goal, Values & Guiding Principles

### 4.1. VISION

A nation of healthy and productive people.

### 4.2. MISSION

To provide equitable access to integrated, cost-effective and quality community health services as close to the family as possible.

### 4.3. OVERALL GOAL

To contribute to the achievement of the legacy goals by improving access to health services at community level

### 4.4. VALUES

The Community Health Unit is committed to the following values:

**Inclusiveness:** We serve all communities and are committed to delivering services to vulnerable and hard to reach people.

**Ubuntu:** We see the value in all people and endeavour to meet every client's need with compassion, respect and kindness

**Team-work:** We work together and support each other to achieve our common goals

**Innovation:** We walk the extra mile to find new and better ways to provide excellent community health services

**Integrity:** We strive to do what is right and do what we say we will do

**Commitment:** We are dedicated to delivering on our mission

**Excellence:** We always strive to do better

**Integrative:** We break down siloes within and across programs and sectors to offer holistic services

### 4.5. GUIDING PRINCIPLES

The implementation of this strategy is guided by the following guiding principles.

- We recognise that access to health care is a basic human right, and endeavour to leave no one behind
- We will give due consideration to gender, age, disability, and culture so as to minimise the barriers to accessing health services
- We will take a participatory and people-centred approach to our interventions, understanding that communities and individuals know their health needs best
- We will work with existing structures and service providers at community level, including traditional healers and private practitioners
- Where possible we will take an integrative approach, knowing that collaboration across sectors, disciplines and institutions is necessary to realise the vision of a healthy and prosperous nation
- We will make use of innovation and appropriate technology, and endeavour to look for new and better ways to deliver health services at community level
- We will take an evidence-based approach to developing appropriate community health interventions

## 5. THE NATIONAL COMMUNITY HEALTH STRATEGY

The strategy is organised into six broad objectives that, taken together, will lead to the realisation of the overarching goal for community health in Zambia, which is ***to contribute to the achievement of the legacy goals by improving access to health services at community level.***

These six objectives are:

1. **Build a motivated, skilled, equitably distributed community health workforce by 2021**
2. **Roll out formal community health structures to 90% of districts by 2021 in line with the decentralisation policy**
3. **Increase points of access so that all Zambians have access to quality basic health services within five kilometres or one hour's travel of their home by 2021**
4. **Mobilise sufficient resources to implement the National Community Health Strategy**
5. **Have timely community health data available and used for decision-making by 2021**
6. **Establish a community-friendly platform for appropriate and acceptable innovations by 2021**

In the sections that follow, the rationale for each of these six objectives is outlined in detail. The strategies and interventions that will contribute to the achievement of these goals are explained.

A detailed list of the activities and sub-activities, including an annual action plan can be found in the Community Health Operational Plan.

### 5.1. OBJECTIVE 1: BUILD A MOTIVATED, SKILLED, EQUITABLY DISTRIBUTED COMMUNITY HEALTH WORKFORCE BY 2021

#### 5.1.1. RATIONALE

As of December 2016, the Ministry of Health had an approved establishment of 63,057 positions, but only 42,515 had been filled. In rural Zambia, where over 60% of the population lives, this shortage is particularly acute: there are only 12.4 clinicians per 10,000 persons (significantly below the World Health Organization's recommended threshold of 22.8 clinicians per 10,000).

At the community level the Zambian health system relies on two main cadres of health workers. The first cadre are the Community Health Assistants (CHAs), who receive 12 months of comprehensive training in primary health care and are formally employed as civil servants by the Ministry of Health. The second cadre are community-based volunteers, who tend to work directly with implementing partners and are trained over shorter periods, usually with a focus on specific disease verticals.

In addition to these two cadres, there is a need to improve the coordination and leadership of community health activities at the national, provincial, district and facility level by employing staff and assigning responsibility for community health activities to appropriate personnel. This includes management staff as well as community health and public health nurses, who have a role to play in community outreach and supervising other community health workers.

CHAs are stationed at health posts across the country but are expected to spend 80% of their time in the community and only 20% of their time in the health facility. They are overseen either by the facility in-charge or the environmental health technician.

In 2010, a target was set to train and deploy 5000 Community Health Assistants (CHA) by 2021. To date, 2,502 CHA have been trained. Of these 1,669 are currently receiving a salary: 1,337 are on the GRZ payroll while another 332 are being supported by cooperating partners. In February 2019 a new USAID project was announced that will support an additional 600 CHA. A key reason that CHAs have not been deployed is a lack of funding to pay their salaries. To meet this target, the Ministry of Health will have to make greater provision for CHAs on its human resources establishment and mobilise resources to pay for their salaries.

An evaluation of the CHA programme by the Clinton Health Access Initiative (CHAI) found that there is a need to strengthen mentorship and supervision of the CHAs and to better orient other facility staff on the role that CHAs play. Formalising the support and supervision structures for CHAs is critical to the success of the programme.

Community-based volunteers (CBVs) are mainly supported by donors or NGO partners and are trained to implement selected health programs at the community level. CBV are not full-time employees, and the time spent volunteering is meant to be capped at a maximum of three days per week. This time should be spent in the community conducting health promotion, disease prevention and rehabilitative work. However, CBV often spend a significant portion of their time at health facilities assisting with curative services.

Estimates of the current number of CBVs vary, but the most often quoted number is 40,000. This is currently a deeply fragmented space; volunteers tend to work in programmes according to disease vertical, which results in different CBVs for TB, malaria, HIV, family planning, adolescent health and so on. Therefore this strategy aims to address the fragmentation of community-based volunteers in Zambia (**see strategy 1.1 below**).

This is inefficient and results in poor patient experiences; it is not uncommon, for example, to hear of community members who are visited by multiple volunteers within a matter of days. Patient fatigue could result in these volunteers being turned away. In addition, CBVs that are only trained to work with specific diseases may overlook other health problems when conducting home visits. There is therefore a need to develop a more comprehensive basic training package for CBVs.

The distribution of CBVs across the country is uneven and has little relation to the burden of disease, geography and catchment population. Some districts have many CBVs, while others have none. Others still have many CBVs a high concentration of CBVs focussing on some diseases, and very few focussing on others.

### **5.1.2. STRATEGIES, INTERVENTIONS AND ACTIVITIES**

To address the situation outlined above and to build a motivated, skilled and equitably distributed community health workforce, the community health unit will focus on the following strategies, interventions and activities:

#### **5.1.2.1. STRATEGY 1.1.: ADDRESS THE FRAGMENTATION OF COMMUNITY-BASED VOLUNTEERS IN ZAMBIA**

Currently there is no accurate and comprehensive database of CBVs in Zambia. Such a database is necessary to improve the coordination of CBV work, minimise duplication of training and work, and contribute to a more efficient allocation of resources. In addition, while some CBV training for specific disease verticals has been standardised, in other areas, training varies from partner to partner and

project to project. Having a standard basic training package for all CBVs will enable them to manage multiple activities and work more efficiently within their communities. Another result of the fragmentation of CBVs is that they are unevenly distributed across the country. Measures will therefore be taken to ensure that they are more equitably distributed. The desired ratio is 1 CBV to 250 households in rural and 1 CBV to 500 households in urban setups.

- **Intervention 1.1.1.: Development of national data base of community based volunteers.** Through the HRIS a data base of all CBVs attached to all health facility zones across the country will be developed with input from the community focal point person based at the health facility. Provision of user rights to the system at facility level will be key to achieving this. This will be achieved by Mapping of all CBVs; CHAs; and other community health human resource. The second activity will be to develop a database of current community health workforce.
  - Activity 1.1.1.1.: Mapping of all CBVs; CHAs; and other community health human resources
  - Activity 1.1.1.2.: Develop a database of current community health workforce
- **Intervention 1.1.2: Ensuring equitable distribution of CBVs.** Currently, donor support has determined the presence or absence of CBVs in provinces and districts. To date, the partners have not been provided with guidelines for selecting areas where they will work, and this has caused an inequitable distribution of CBVs especially in areas that have no presence of donor supported programs. The Community Health Unit will ensure the appropriate ratio of CBV to Household in both rural and urban areas is achieved. This will be achieved by developing CBV selection and training guidelines for CBVs in identified priority districts with a current shortage of CBVs as identified in the CBV database.
  - Activity 1.1.2.1: Develop selection and training guidelines for CBVs in identified priority districts with a current shortage of CBVs as identified in the CBV mapping
  - Activity 1.1.2.2.: Review 2010 guidelines for CHWs to include criteria for distribution and training of CBVs.
- **Intervention 1.1.3.: Providing a standardised cost effective incentive package for CBVs.** A lack of standard guidelines for incentives for CBVs has led to drastic variations in the payments made to CBVs. The Department of Public Health through the Community Health Unit will provide guidelines agreed with stakeholders outlining standard incentives for all accredited CBVs. Ministry of Health will continue engaging stakeholders and provide appropriate guidelines on cash and non-cash incentives.
  - Activity 1.1.3.1.: Table new incentive guidelines for all accredited CBVs at a consultative meeting with relevant partners
  - Activity 1.1.3.2: Provide job enablers for CBV
- **Intervention 1.1.4.: Building the capacity of Community Health Workers.** While CBV training has been standardised for some cadres, there are still significant variations in training depending on the implementing partner and the project. The MoH will develop standardised basic training materials for community health workers in line with the basic package of care. This will also include training, certification, mentorship and supervision and provision of enablers to community health workers in the various health related programs.
  - Activity 1.1.4.1.: Develop standardised basic training materials in line with the national health priorities

- Activity 1.1.4.2.: Training of Community Based Volunteers (CBVs)
- Activity 1.1.4.3.: Introduce a certification Process for qualified CBVs
- Activity 1.1.4.4.: Conduct support supervision to CBVs
- **Intervention 1.1.5.: Improving community level coordination of CBVs.** To address the fragmentation in the CBV landscape, the MoH will introduce tools to improve reporting and coordination. Structured supervision for CHAs and CBVs will also be implemented.
  - Activity 1.1.5.1.: Introduce CBV registers for NHC's
  - Activity 1.1.5.2.: Development of CBV supervision manual
  - Activity 1.1.5.3.: Training of CHA's and NHC's in coordination and supervision of CBV's.

#### 5.1.2.2. STRATEGY 1.2: STRENGTHEN AND SCALE UP THE CHA PROGRAMME

CHAs are trained in two schools the output did not meet the target. The decentralization policy will entail that CHAs are trained at provincial centres. The target will be reached in be assured. In order to meet the demand for CHA program, there is need to mobilize to resources in a coordinated way by Ministry of Health. In addition, there is need to ensure that resources are available to employ the CHAs after they are trained given that decentralised CHA training will result in increased numbers of CHAs trained annually.

- **Intervention 1.2.1: Scale up the CHA programme in line with the Community Health Worker Strategy.** The MOH set a target of training and deploying 5,000 CHAs by the end of 2020. To date, 2,502 CHA have been trained. This implies that a minimum of 2,498 additional CHAs must be trained if the MOH is to meet its target. The current capacity of the training schools is only 500 per year, so this target cannot be reached without changing the training approach. The Community Health Unit will therefore work closely with the HR Department to explore alternative training approaches. In addition, only 1,669 CHAs are currently receiving a salary: 1,337 are on the GRZ payroll while another 332 are being supported by cooperating partners. A key reason that CHAs have not been deployed is a lack of funding to pay their salaries. To meet this target, the Ministry of Health will have to make greater provision for CHAs on its human resources establishment and mobilise resources to pay for their salaries.
  - Activity 1.2.1.1.: Training of additional CHA's to reach the target of 5000 by 2021
  - Activity 1.2.1.2.: Mobilization of resources for CHA salaries
- **Intervention 1.2.2.: Provide an enabling environment for CHAs to be efficient.** CHAs are meant to spend only 20% of their time in the health facility and the remaining 80% of their time in the community conducting home visits and community mobilisation activities. Due to resource constraints, this is rarely the case and CHAs often spend far more of their time at the health facility. While there should be two CHAs allocated to each health post, in addition to a nurse, a midwife and an EHT, 23% of the first cohort of CHA have been found to be working alone in facilities without the supervision of a skilled health worker. In order to provide a more enabling work environment for the CHAs, the following activities will be undertaken.
  - Activity 1.2.2.1.: Recruit a CHA coordinator within the Community Health Unit
  - Activity 1.2.2.2.: Develop community health Standard Operating Procedures in line with the basic health package

- Activity 1.2.2.3.: Develop an integrated screening tool to guide CHAs and CBVs in screening patients and making referrals in line with the package of care
- Activity 1.2.2.4.: Provide job enablers (e.g. bicycles; bags)
- Activity 1.2.2.5.: Strengthen supervision and mentorship for CHAs
- Activity 1.2.2.6.: Develop in-service refresher courses for CHAs

#### 5.1.2.3. STRATEGY 1.3.: STRENGTHEN MANAGEMENT AND COORDINATION OF COMMUNITY HEALTH AT NATIONAL, PROVINCIAL AND DISTRICT LEVEL.

At the national level, the Ministry of Health established a community health unit in 2018 to provide strategic direction and oversee the implementation of community health activities in Zambia. The capacity at District level to provide appropriate support to community level structures and management are still weak. There are currently no formally appointed community health focal point persons at provincial, district or health centre level. There is therefore a clear need to strengthen community health structures at all levels of the health system.

- **Intervention 1.3.1.: Improve management and coordination of human resources for community health activities.** Key to ensuring that properly functioning structures are in place is the appointment of appropriately qualified personnel who will be responsible for coordinating and managing community health activities. An integrated database of all community health human resources should also be developed to enable management structures to make decisions.
  - Activity 1.3.1.1.: Employ community health officers at provincial and district level
  - Activity 1.3.1.2.: Create an integrated database of all community-level health workers (including CHAs, CBVs, community health nurses, etc).
- **Intervention 1.3.2.: Ensure that appropriate national-level guidelines are in place for the coordination of community health activities.** The Community Health Unit will review strategic documents to align them to current situations and trends. Documents to be reviewed will include: Community Health Workers Guidelines 2010; Community Health Planning guide; Action planning hand book for health centres, health posts and communities; Action planning hand book for district health teams; National Community Health Assistant programme implementation guidelines
  - Activity 1.3.2.1.: Review and finalisation of strategic documents.
- **Intervention 1.3.3.: Develop guidelines for Community and Public Health Nurses.** Community Health Nurses and Public Health nurses have an important function to play at community level, both through their outreach activities and home visits and in their supervision of community health workers (including CHAs and CBV). The MoH will therefore develop guidelines to guide the work of Community Health Nurses.
  - Activity 1.3.3.1.: Develop standardised basic guidelines for Community Health Nurses and Public Health Nurses in line with the national health priorities.

## 5.2. OBJECTIVE 2: ROLL OUT FORMAL COMMUNITY HEALTH STRUCTURES TO 90% OF DISTRICTS BY 2021 IN LINE WITH THE DECENTRALISATION POLICY

### 5.2.1. RATIONALE

Starting in 2006, the Government of the Republic of Zambia embarked on a decentralisation policy, which includes decentralized public sector management across all sectors of government. According to the Sector Devolution Guidelines for Ministries, the vision of the Government is:

*"[To] achieve a fully decentralized and democratically elected system of governance characterized by open, predictable and transparent policy-making and implementation processes, effective community participation in decision-making, development, and administration of their local affairs while maintaining sufficient linkages between the centre and the periphery."*<sup>32</sup>

The devolution policy outlines a vision of "bottom-up" decision-making and planning, with districts given the responsibility to develop and implement plans according to their own needs. The key goals of the devolution policy are to improve accountability and transparency in the management of resources and to provide a legal and institutional framework that promotes autonomy in decision-making at the local level.

The Health Sector Devolution Plan (HSDP) (2015) supports the formulation of the organizational structures that accompany the transfer of functions and staff from the national to the district level. Structures and processes must be developed for the improved coordination of community health service delivery as these functions become decentralised. As a result, there is a clear need for management support for community health systems from the community to the national level. This can be addressed by appointing suitably qualified community health focal points at each level of the health system.

Prior to 2006, the legal framework for NHCs was provided by the National Health Services Act. In 2006 this Act was repealed but has not yet been replaced and as a result there currently is no legal framework for these structures.

Within the community health sector, there are several areas where regulatory frameworks must be improved to formalise community health structures in line with the decentralisation policy. These include i) developing a clear legal framework for NHCs and HCCs, and ii) formalising the role of CBVs, including standardised training, accreditation, reporting lines and incentives. This provides an opportunity to improve the regulatory framework for community health service delivery and adopt best practice procedures.

To strengthen the oversight role of the NHCs and HCCs, national NHC guidelines have been developed. This aims to improve the involvement of community representatives in all aspects of planning, implementation, and monitoring and evaluation, and to hold health workers and facilities accountable for service delivery.

A draft social accountability training manual has also been developed. The main goal of social accountability is to strengthen capacities of citizen groups and government to work together in order to enhance quality of public services delivered to citizens. It seeks to give voice to the needs and concerns of all citizens on the delivery and quality of public services.

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<sup>32</sup> Sector Devolution Guidelines for Ministries, 2006, p. 2

### 5.2.2. STRATEGIES, INTERVENTIONS AND ACTIVITIES

To address the situation outlined above and to rollout formal community health structures in Zambia, the community health unit will focus on the strategies, interventions and activities below.

#### 5.2.2.1. STRATEGY 2.1.: PROVISIONAL OF LEGAL AND REGULATORY FRAMEWORK COMMUNITY HEALTH STRUCTURES

Following the repeal of the National Health Services Act in 2006, community health structures (particularly NHCs and HCCs) do not have a recognised legal structure. In addition, CBVs do not have a direct contractual relationship with the ministry. This exposes the MOH to risks and makes it difficult to enforce accountability mechanisms. This strategy will include the following interventions and activities:

- **Intervention 2.1.1: Ensure the Legal Framework for Neighbourhood Health Committees is in place**

This intervention will provide the legal framework for NHCs in line with the new National Health Services Act and other relevant legislation.

- Activity 2.1.1.1: Develop the statutory instrument to provide the legal framework for NHCs

- **Intervention 2.1.2.: Ensure regulatory framework for CBVs is in place**

This intervention will enable the provision of contracts and guidelines for community based volunteers. The guidelines will include the selection criteria, minimum training standards and content, certification processes and incentives for community based volunteer engagement.

- Activity 2.1.2.1: Provide contracts for CBVs
- Activity 2.1.2.2.: Provide guidelines for CBVs

- **Intervention 2.1.3.: Strengthen the use of NHCs/HCC guidelines in community health**

This intervention will aim at improving the capacities of NHCs/HCCs through the provision of national guidelines and training of NHCs/HCCs in their roles and responsibilities.

- Activity 2.1.3.1: Dissemination of national NHC/HCCs guidelines
- Activity 2.1.3.2: Train NHCs/HCCs in their roles and responsibilities

#### 5.2.2.2. STRATEGY 2.2: INCREASE COVERAGE OF INTEGRATED FUNCTIONAL COMMUNITY HEALTH STRUCTURES

Following the introduction of the Community Health Unit at National level, there is a need to roll out functional community health structures at all levels of the health system. This strategy will comprise of the following interventions and activities:

- **Intervention 2.2.1.: Operationalise the Community Health strategy.** This intervention will facilitate for the implementation of the strategy through its dissemination and inclusion of community activities into the annual plans and budgets at district level
  - Activity 2.2.1.1.: Launch and disseminate the CH strategy
  - Activity 2.2.1.2: Ensure that community activities are planned for at district level
- **Intervention 2.2.2.: Establish a functional community health structure.** The intervention will involve engaging a consultant to aid the process of developing a framework for the delineation of the roles and responsibilities of the community health structure. Further, it will

also ensure the recruitment of staff at various levels to support the implementation of CH activities. Standard operating procedures and community health guidelines will also be developed for all community health cadres.

- Activity 2.2.2.1.: Develop a framework for the delineation of the roles and functions throughout the community health system
  - Activity 2.2.2.2.: Recruit staff at national level to support implementation of NHC activities
  - Activity 2.2.2.3.: Develop standard operating Procedures for all community health cadres
  - Activity 2.2.2.3.: Develop CH guidelines
  - Activity 2.2.2.4.: Engage a consultant to strengthen community structures
- **Intervention 2.2.3.: Strengthen multisectoral collaboration community linkages and coordination.** The intervention is aimed at strengthening linkages and coordination of community health volunteers. This will be done through mapping of all projects/ programmes that play a role in community health; holding community health meetings with stakeholders at various levels.
    - Activity 2.2.3.1.: Conduct mapping of all projects that include community health component
    - Activity 2.2.3.2.: Hold regular meetings with community health stakeholders (TWG)
    - Activity 2.2.3.3.: Hold multi sectoral stakeholder meetings to discuss health issues at the community level

#### 5.2.2.3. STRATEGY 2.3.: PROMOTE OWNERSHIP OF COMMUNITY HEALTH INITIATIVES AT THE COMMUNITY LEVEL

In line with the GRZ's policy of "bottom-up" planning approach requires the participation of structures at the community level. It is therefore essential for effective health planning to promote participation in planning processes at a grass-roots level. This requires communities to take greater ownership of community health initiatives. This strategy will include the following interventions and activities:

- **Intervention 2.3.1.: Introduce social accountability mechanisms.** Social accountability mechanisms allow community structures to hold health facilities and health workers to account for the services that they are meant to provide. This contributes to better buy-in and community ownership, as well as improved service delivery. This intervention will consist of the following key activities:
  - Activity 2.3.1.1.: Develop social accountability manual
  - Activity 2.3.1.2.: Adapt WHO patient service charters
  - Activity 2.3.1.3.: Sensitise the community on their role in social accountability
  - Activity 2.3.1.4.: Hold Annual NHCs performance review meetings at district level
- **Intervention 2.3.2.: Introduce a system of recognition and rewards for NHCs and CBVs.** Performance will be rewarded through establishing a system of recognition which will be graded through performance reviews on an annual basis.
  - Activity 2.3.1.1.: Introduce a floating trophy to recognise NHC and CBV performance

### 5.3. OBJECTIVE 3: INCREASE POINTS OF ACCESS SO THAT ALL ZAMBIANS HAVE ACCESS TO QUALITY BASIC HEALTH SERVICES WITHIN FIVE KILOMETRES OR ONE HOUR'S TRAVEL OF THEIR HOME BY 2021

#### 5.3.1. RATIONALE

Upgrading health infrastructure is a major priority for the Ministry of Health. According to the National Health Strategic Plan 2017-2021, health infrastructure will account for over 17% of all health spending – the second highest allocation after human resources. A key component of this is to build and upgrade infrastructure at the community level. The government has adopted a policy that every Zambian household should be within a five-kilometre radius of a health centre or health post.

The location of health facilities is heavily skewed towards more urban areas: 99% of the population in urban areas live within 5km of a health facility compared with 46% in rural areas. Despite a large number of facilities in urban areas, however, access to care is restricted by long waiting times.<sup>33</sup>

While a 5km radius is a useful guideline, in some circumstances distance from a health centre may not be the best measure of access to health services. In some remote areas, impassable roads, wetlands or mountains may make it very difficult to access health facilities that are only a few kilometres away, while in urban areas congestion may mean that although health facilities are close by, high levels of demand mean that patients have long waiting times. We are therefore setting a goal of making basic health services available to all Zambians within one hour's travel from their home.

The Zambian health service suffers from a critical shortage of equipment and, owing to budget constraints and lack of experienced maintenance staff, much of the equipment currently in use is poorly maintained. The MOH has taken some steps to address the staff shortage by adding medical equipment maintenance officers to the approved establishment list for the health service, though at present this is only at the provincial level.<sup>34</sup>

In Zambia the social, economic, demographic and cultural situation has affected the health seeking behaviours of many within the communities. The cultural and social norms adversely affect demand for health services which ultimately promotes unhealthy lifestyles.

Health promotion is one of the major components of primary health care and community health. Health promotion enables individuals, families, households, and communities to realize the highest level of health and development irrespective of age, race, income, geographical location, or education level. The National Health Strategic Plan 2017-2021 advocates for public policies that support and promote health education and disease prevention to empower individuals, families, and communities with appropriate knowledge to develop and practice healthy lifestyles.

Health promotion also calls for the integration of activities across sectors and encourages multi-sectoral collaboration.

In the community, there is a fragmentation in the community health services being provided by the Community Based Volunteers (CBVs) thus affecting the quality of basic health services. A lack of a standardized health package results in inefficient provision of health services to the community

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<sup>33</sup> ACCA, 2013 "Key health challenges for Zambia"

<sup>34</sup> *ibid*

To address the situation outlined above and increase points of access so that all Zambians have access to quality basic health services, the community health unit will focus on the strategies, interventions and activities to be implemented in the table below.

### 5.3.2. STRATEGIES, INTERVENTIONS AND ACTIVITIES

To address the situation outlined above and increase points of access so that all Zambians have access to quality basic health services, the community health unit will focus on the strategies and interventions described below. A full list of activities, including a proposed timeline for implementation, can be found in the Community Health Operational Plan.

#### 5.3.2.1. STRATEGY 3.1.: DEMAND CREATION

The Zambian population is characterized by various cultural backgrounds which create varying health seeking behaviours shaped by education, gender, geographic location, income, age status and social norms. Focused efforts are therefore required to ensure that strategies which help to increase access to health are implemented that transcends barriers to access to health and provide information packaged in a systematic yet simplified manner to meet different individual needs .

The following key interventions have been identified to address demand creation as a strategy to enhance access to basic health services:

- **Intervention 3.1.1.: Address barriers preventing people from accessing health services.**  
People in Zambia face a range of barriers to accessing health services. A range of factors may contribute to these barriers including financial circumstances, culture, age, gender and geography. This intervention will consist of the following activities:
  - Activity 3.1.1.1.: Conduct research to understand cultural, ethnic, gender and geographic barriers to accessing community health services
  - Activity 3.1.1.2.:Engagement of traditional leaders
  - Activity 3.1.1.3.: Engagement of custodians of culture
  - Activity 3.1.1.4: Conduct a community awareness campaign
  - Activity 3.1.1.5: Strengthen Community Engagement
  - Activity 3.1.1.6: Implement “Holiday Health” using school facilities to offer health services at community level during school holidays when these facilities are vacant
  - Activity 3.1.1.7: Implement home visiting by nurses and community-based volunteers
- **Intervention 3.1.2.: Promote health education in a systematic and simplified manner.** An important component of demand creation is to provide health education. The purpose of this health education should be to empower communities with information to make informed, healthy lifestyle choices. This will contribute to the prevention of common health issues as well as improved knowledge of when it is appropriate to seek care and where such care can be found. This intervention will consist of the following key activities:
  - Activity 3.1.2.1.: Conduct health literacy training
  - Activity 3.1.2.2.: Develop a national health calendar
  - Activity 3.1.2.3.: Implement National Health Calendar

#### 5.3.2.2. STRATEGY 3.2.: DEVELOP COMMUNITY HEALTH SERVICE PACKAGE

In order to efficiently provide health care services that meet the basic health needs of the community, a comprehensive health package that integrates preventive, curative, rehabilitative and palliative services will be merged in one. It is envisaged that the provision of a well prioritized and integrated

community health package will maximize benefits to the community in ways that will capacity build and create demand for quality health services. The key intervention listed below addresses this strategy:

- **Intervention 3.2.1.: Roll out integrated community health service package that incorporates preventative, curative, rehabilitative and palliative services.** An integrated community health service package will allow for more effective budgeting of health activities at the community level. It will also serve as a guide both health workers and ordinary community members in where to access appropriate health services. This intervention will include the following key activities:
  - Activity 3.2.1.1.: Develop an integrated community primary health care package
  - Activity 3.2.1.2.: Review guidelines for palliative care at community level
  - Activity 3.2.1.3.: Orientation for community health teams on service package

#### 5.3.2.3. STRATEGY 3.3.: ENHANCED COMMUNITY REFERRAL SYSTEM

A weak referral system adversely affects the service delivery at all levels including community. An enhanced community referral system between community and facility that has a well-coordinated transport and feedback mechanism with appropriate screening and referral tools is essential to facilitate access to health services. The intervention and activities listed below are key in achieving this strategy and lead to access of basic quality health services as linkages are created between community and facility

- **Intervention 3.3.1: Revitalise the referral and feedback systems between health facilities and communities.** An effective referral system ensures a close relationship between all levels of the health system and helps to ensure people receive the best possible care closest to home. It also assists in making cost-effective use of hospitals and primary health care services. At community level it is necessary to revitalise the referral system by introducing more effective tools to ensure appropriate referrals are being made as well as to ensure that transport options are available for patients who require it to access appropriate care.
  - Activity 3.3.1.1.: Develop screening and referral tools for use at community level
  - Activity 3.3.1.2.: Ensure that appropriate transport options are available to facilitate referrals from community level

#### 5.3.2.4. STRATEGY 3.4.: IMPROVE SUPPLY CHAIN MANAGEMENT

To ensure provision of quality basic health services, an efficient and sustainable supply chain management mechanism which is well managed by trained personnel should be in place. The following intervention and key activities have been identified to ensure that supply chain management is improved at community level:

- **Intervention 3.4.1.: Ensure effective, efficient and sustainable supply chain management is in place.** Community-level structures have an important role to play in managing medical supplies over the last mile. It is therefore important to have appropriate training and systems in place for community structures.
  - Activity 3.4.1.1.: Provision of basic health supplies to all CBVs
  - Activity 3.4.1.2.: Employ community health supply chain management officer
  - Activity 3.4.1.3.: Train CHA peer supervisors in supply chain management
  - Activity 3.4.1.4.: CHAs to supervise CBVs in managing supplies

#### 5.3.2.5. STRATEGY 3.5.: PROVISION OF INFRASTRUCTURE

With only 46% of the rural population having access to health services within a 5 km radius, there is need to establish new health access points to meet the needs of all. Existing infrastructure also needs to be rehabilitated to be in a position to serve the needs of the community efficiently. As infrastructure is built and rehabilitated, adequate equipment should be installed to provide basic health services in a cost effective manner. The two interventions and the associated activities listed below address this matter and contribute to the identified strategy which supports the main objective of increasing health access points for all Zambians within a 5 km radius.

- **Intervention 3.5.1.: Establish new health access points in the community.** The main objective of the community clinics and health booths is to provide convenient access to basic health services for population groups that usually have difficulty accessing these services. The community clinics and health booths will create an opportunity for the community to have a spontaneous interaction with the health system, and a convenient opportunity to have their health checked. These health booths will offer basic health services and screenings, and will be staffed by different cadres of staff such as nurses (Public health nurses, community health nurses) clinical officers, community-based volunteers etc.
  - Activity 3.5.1.1.: Establish community market/bus station clinics and health booths
- **Intervention 3.5.2.: Rehabilitate existing infrastructure.** For a long time in Zambia, health centres have depended on outreach activities in order to reach people in hard to reach areas. There are a number of places with outreach posts. Some outreach posts are spaces at schools, churches, etc. Some places have infrastructures which are debilitated. Other are areas with no physical infrastructure at all and people assemble under a tree. This makes it very difficult to for operations to go on especially during the rainy season. Social welfare centres provide an environment for inter-sectoral collaboration. Health education will be given including skill transfers.
  - Activity 3.5.2.1.: Rehabilitate health outreach posts
  - Activity 3.5.2.2.:Revamp Recreation / welfare centres
  - Activity 3.5.2.3.: Provide guidelines and standard operating procedures for mothers' shelters.

## 5.4. OBJECTIVE 4: MOBILISE SUFFICIENT RESOURCES TO IMPLEMENT THE NATIONAL COMMUNITY HEALTH STRATEGY

### 5.4.1. RATIONALE

The Zambia Health Financing Strategy 2017-2027 highlights the low and erratic funding to the health sector, particularly for primary health care, as a major challenge to implementing effective health care strategies and realising the goal of universal health coverage.

The bulk of the financial support to the health sector is through vertical programs and earmarked financing which cannot be used to finance other national priorities. 97% of the resources from the cooperating partners were earmarked to HIV, RMNCH+N, Malaria, TB, and Health Systems Strengthening during the period 2011-2013. Vertical programs and earmarked financing have a potential risk of diverting attention and critical resources away from joint planning, implementation, and mutual accountability.

The Health Financing Strategy highlights the need for greater domestic resource mobilisation, the promotion of public-private partnerships, and the introduction of mechanisms to pool revenue from multiple sources to share risk and cross-subsidise health programmes.

### 5.4.2. STRATEGIES, INTERVENTIONS AND ACTIVITIES

To address the situation outlined above and increase the resources allocated to community health, the community health unit will focus on the strategies and interventions described below. A full list of activities, including a proposed timeline for implementation, can be found in the Community Health Operational Plan.

#### 5.4.2.1. STRATEGY 4.1.: DEVELOP MECHANISMS FOR RESOURCE MOBILISATION AT NATIONAL LEVEL.

The Community Health Unit was only established in 2018. In the absence of a central unit to coordinate the planning of community health activities, community health activities have generally been funded through vertical programmes. The creation of the unit presents an opportunity to mobilise resources for community health activities at a health systems level. This strategy will include the following activities:

- **Intervention 4.1.1.: Document funding gaps and identify priority funding partners.** In order to fund the community health activities planned in this strategy, it is necessary to first understand the existing funding gaps and to map the current donor landscape in Zambia. This will allow the community health team to develop targeted proposals for appropriate donors in order to ensure that the strategy can be implemented.
  - Activity 4.1.1.1: Review the cost framework of the Community health strategy and identify funding gaps
  - Activity 4.1.1.2.: Conduct donor mapping exercise for community health services
  - Activity 4.1.1.3.: Develop a donor prioritization matrix to identify the funding partners to engage.

- **Intervention 4.1.2.: Plan for mobilizing resources to address funding gaps.** Under this intervention will develop an investment case and plan for community health illustrating the return on investment case for supporting community health. The plan will detail the targeted service of financing community health activities.
  - Activity 4.1.2.1: Develop an investment case for community health illustrating the return on investment case.
  - Activity 4.1.2.2: Develop an investment plan for community health that details the targeted sources of funding for community health activities.
- **Intervention 4.1.3.: Develop targeted proposals for key potential funders.** This intervention will focus on building the capacity of the community health staff at various levels and selected NHCs in proposal writing.
  - Activity 4.1.3.1: Training for community health unit team in proposal writing
  - Activity 4.1.3.2: Develop proposals

#### 5.4.2.2. STRATEGY 4.2.: ENGAGEMENT OF STAKEHOLDERS FOR EFFICIENT RESOURCE DISTRIBUTION

Most of the assistance provided by cooperating partners at the community level is still used for vertical programmes (i.e., disease-specific programmes such as malaria and HIV/AIDS) instead of targeting the entire health system, which would in the long run produce a greater impact on mortality and morbidity reduction. By engaging with cooperating partners as well as other units within the MOH more regularly, the community health unit aims to contribute to the more effective allocation of community health resources.

- **Intervention 4.2.1.: Improve partner coordination.** The Community Health Unit will prioritise developing relationships with key partners in order to improve coordination and promote more efficient allocation of resources to community health across the country. In order to achieve this, the following activities will be implemented:
  - Activity 4.2.1.1: Develop guidelines to ensure a more equitable distribution of partners across the country
  - Activity 4.2.1.2: Develop a data base of MoUs with community level partners
  - Activity 4.2.1.3: Lobby to revert to “basket funding” approach

#### 5.4.2.3. STRATEGY 4.3.: DEVELOP MECHANISMS FOR RESOURCE MOBILIZATION AT COMMUNITY LEVEL

It is government policy that 10% of government district health budgets are allocated for community health activities. In practice, this spending has not been tracked sufficiently, and mechanisms must be introduced to ensure that this funding is being used as intended. In addition, there are opportunities to promote resource mobilisation at the community level through income-generating projects and by applying to programmes that are being implemented locally.

- **Intervention 4.3.1.: Reinforce DHO budget allocation to district level.** While government policy currently ringfences 10% of district health budgets for community-level activities, mechanisms for monitoring this spending are currently lacking.
  - Activity 4.3.1.1: Develop mechanisms for ensuring that 10% of DHO budget is reserved for community health activities.

- **Intervention 4.3.2.: Promote community level resource mobilization.** Under this intervention we will introduce income generating activities and train the NHC members and community focal persons in identifying funding opportunities and writing funding proposals.
  - Activity 4.3.2.1.: Introduce income generating activities
  - Activity 4.3.2.2.: Train NHC members and community focal point persons in identifying opportunities and writing funding proposals

#### 5.4.2.4. STRATEGY 4.4.: PROMOTE RESULTS-BASED FINANCING TO ENHANCE PERFORMANCE AND IMPROVE HEALTH OUTCOMES

Results-based finance (RBF) aims to increase autonomy, strengthen accountability, and empower frontline providers and health facility managers to make health service delivery decisions that best meet the needs of the communities they serve. It does this by linking financial incentives with specific health outcomes. Money earned from the RBF can be used to pay staff motivation incentives, for investments at the health facilities, and for monetary and non-monetary incentives to the communities who are the consumers of health services.

- **Intervention 4.4.1.: Scale up result based finance to incentivize performance at community level.** Under this intervention, we shall undertake RBF visits, adapt ABF guidelines and training package for community health services and build capacity in RBF for community focal persons. Additionally, we shall conduct a baseline survey for RBF and an evaluation research on the effectiveness of RBF.
  - Activity 4.4.1.1.: Undertake RBF learning visits
  - Activity 4.4.1.2.: Adapt RBF guidelines and training package for community health services
  - Activity 4.4.1.3.: Train community focal persons in RBF
  - Activity 4.4.1.4.: Conduct baseline survey on RBF
  - Activity 4.4.1.5.: Research on effectiveness of RBF.

#### 5.4.2.5. STRATEGY 4.5.: DIVERSIFY SOURCES OF FINANCES

In a funding environment where the government has limited fiscal space to support additional health activities, and where donor commitments to health are unlikely to increase in coming years, it is necessary to look beyond the traditional funding channels in order to finance community health activities.

- **Intervention 4.5.1.: Explore private sector/ hybrid models to support income for community health workers.** While there have been some partnerships with the private sector at community level in Zambia, these have generally been small-scale projects, and the potential to mobilise resources from the private sector remain largely untapped.
  - Activity 4.5.1.1.: Identify potential partners to implement hybrid models to supplement community health workers income
- **Intervention 4.5.2.: Mobilise resources through fundraising activities.** Fundraising activities can serve the dual function of mobilising resources and of raising the profile of community health in Zambia.
  - Activity 4.5.2.1.: Host one fundraising event per year.

## 5.5. OBJECTIVE 5: HAVE TIMELY COMMUNITY HEALTH DATA AVAILABLE AND USED FOR DECISION-MAKING BY 2021

### 5.5.1. RATIONALE

To make evidence-based decisions that will improve the delivery of health services at community level in Zambia, it is vital that the community health unit has access to accurate and timely information.

While there have been investments in improving the quality of community-level monitoring and reporting, significant gaps remain. New reporting guidelines have not been rolled out to all districts, and much of the information that is collected at the community level is not aggregated and passed on to decision makers in the health system.

Health information systems are still overly reliant on paper-based systems for reporting. Implementing digital reporting systems have the potential to improve data quality since information can be aggregated and analysed far more quickly and automated alerts can be set up to notify supervisors when reports are overdue or when irregularities are detected in the information submitted.

### 5.5.2. STRATEGIES, INTERVENTIONS AND ACTIVITIES

To address the situation outlined above and improve the use of data in decision making, the community health unit will focus on the strategies and interventions described below. A full list of activities, including a proposed timeline for implementation, can be found in the Community Health Operational Plan.

#### 5.5.2.1. STRATEGY 5.1.: IMPROVED DATA REPORTING SYSTEMS

Effective community health systems are best coordinated when reporting systems have standardized indicators, reporting tools and efficient data capturing systems. The reporting system must be able to capture relevant data from approved indicators at community level utilizing the appropriate reporting tools. The use of technology in the form of mobile/electronic capturing system improves efficiency and minimizes error in data capturing which is essential for quality data management. The listed interventions resonate with the identified strategy

- **Intervention 5.1.1.: Standardise community health indicators** Communities operating in different health set ups with varying expertise can capture various aspects of data that may not be relevant yet time consuming in its collection and interpretation. The need to have standardized indicators allows for a more coordinated M&E system which has approved program indicators for better performance evaluation.
  - Activity 5.1.1.1.: Develop a community health indicators handbook
  - Activity 5.1.1.2.: Train CH frontline workers in collecting data in line with HMIS
  - Activity 5.1.1.3.: Develop a community health module for DHIS2
- **Intervention 5.1.2.: Provision of reporting tools at community level.** While there have been investments in improving the quality of community – level reporting tools, significant gaps still remain. It is therefore imperative that the reporting tools at community level are

reviewed and made readily available so that there is timely community health information. The provision of data capturing tools and giving feedback on performance based on the data reviewed will enhance timely reporting and use of the provided tools.

- Activity 5.1.2.1.: Review community reporting tools to ensure key indicators will be captured
  - Activity 5.1.2.2.: Develop community reporting tools for maternal mortality
- **Intervention 5.1.3.: Mobile/electronic data capturing systems.** Technology is at the heart of efficiency and optimal program management that results in minimal error in collection of relevant data. Utilization of mobile/electronic data capturing systems enhances the timely collection and reporting of data collected within the program in community health hence the appropriateness of the intervention identified
  - Activity 5.1.3.1.: Pilot digital/mobile reporting mechanisms for community health

#### 5.5.2.2. STRATEGY 5.2.: IMPROVE THE USE OF DATA IN DECISION-MAKING

In the country context, there is need to have quality and timely data from health information systems which are the foundation of efficient and informed decision making processes. Program planning requires quality data from health information systems to plan at national, provincial, district, health centre and community levels. In order to improve the use of data in decision making, there is need for community health to systematically move away from over reliance on the use of paper based systems for reporting to embrace and systematically implement digital systems which has the potential to improve data quality as the information can easily be aggregated and analysed for quick decision making.

- **Intervention 5.2.1: Incorporate community-level data into decision-making processes.** Reporting tools at community level are largely partner driven. There is no common set of indicators and much of the information that is collected is not aggregated and passed on to decision makers in the health system. Regular profiling and assessment of key indicators will help maximize the impact in the use of data from community health activities in decision making
  - Activity 5.2.1.1.: Data review for decision-making
  - Activity 5.2.1.2.: Conduct data audit twice per year
  - Activity 5.2.1.3.: Conduct quarterly support supervision
  - Activity 5.2.1.4.: Launch two-way feedback and data review systems
- **Intervention 5.2.2.: Undertake rigorous M&E of community health activities.** In order to undertake rigorous monitoring and evaluation of community health activities, there is need to develop a systematic M&E framework through engaging of technical assistance. To have an effective community health system program, there should be an evaluation strategy which ensures that national program objectives under community health are described and measured. Assessment activities will address process outcomes and impact measures and results will be used to measure program implementation processes and effectiveness.
  - Activity 5.2.2.1.: Develop M&E framework
  - Activity 5.2.2.2.: Conduct mid-term and end-term reviews

#### 5.5.2.3. STRATEGY 5.3.: EVIDENCE GENERATION

Program interventions that are built around evidence create an impact of significant value as they form the basis for sound policy formulation. Research creates opportunity to gather such evidence which shape interventions that bring about real change in community program management. The

identified key interventions creates a wealth of information which builds a reservoir of evidence on which decisions can be formulated

- **Intervention 5.3.1.: Promote evidence-based policy making in community health.** In order to effect meaningful change in community health, policy formulation must be derived and generated from evidence. Interventions that promote evidence based policy formulation encourage development and progress in community health programs.
  - Activity 5.3.1.1.: Host an evidence day for best practices in community health
- **Intervention 5.3.2.: Promote research in community health.** Understanding the context and constraints in community health is key in developing strategies and interventions that effect change. Research is a channel that contributes to generation of evidence that helps to inform policy making relevant to specific community health needs. The identified intervention that promotes research builds on the identified strategy
  - Activity 5.3.2.1.: Identify priority research topics and questions
  - Activity 5.3.2.2.: Conduct interactive research and share research findings

## 5. OBJECTIVE 6: ESTABLISH A COMMUNITY-FRIENDLY PLATFORM FOR APPROPRIATE AND ACCEPTABLE INNOVATIONS BY 2021

### 5.5.3. RATIONALE

Zambia's ability to achieve the ambitious health legacy goals will be determined by the health sector's ability to harness appropriate technology and innovation.

Applying innovation to community health in Zambia will include looking to solutions that have been successfully applied in other contexts, emerging technology that has been shown to be effective in improving health outcomes, and unearthing some of the home-grown innovations being applied at a grass-root level by communities in Zambia.

To establish a community-friendly platform for appropriate and acceptable innovations, the community health unit will pilot high-potential innovations and scale-up the innovations that show the most promising results.

### 5.5.4. STRATEGIES, INTERVENTIONS AND ACTIVITIES

To address the situation outlined above and to establish a community-friendly platform for innovation, the community health unit will focus on the strategies and interventions described below. A full list of activities, including a proposed timeline for implementation, can be found in the Community Health Operational Plan.

#### 5.5.4.1. STRATEGY 6.1.: PILOT HIGH-POTENTIAL INNOVATIONS FOR COMMUNITY HEALTH

Zambia's ambitious agenda of achieving the established legacy goals creates opportune platform to embrace innovation and technology which can help transform community health service provision which would translate in improved health outcomes. Embracing new innovation and technology drawn from different forums both regional and international experiences with local specific application while encouraging home grown innovation for the purpose of scale-up is key to building on a community-friendly platform for appropriate innovations by 2021. The following listed key interventions are central in contributing to this strategy:

- **Intervention 6.1.1.: Develop a framework for identifying and scaling innovations that enhance community health systems and service delivery models.** A systematic approach to identify key innovations is anchored on a consolidated framework that is designed to effectively assess the available innovative approaches which will result into enhanced health systems and service delivery. Developing a framework is vital in contributing to a sound strategy that encourages innovation.
  - Activity 6.1.1.1.: Establish an annual event to showcase and reward innovations that have the potential to improve community health services in Zambia
  - Activity 6.1.1.2.: Identify opportunities for collaboration with partners to test innovations that have worked in other contexts (including Ministries of Health from other countries, NGOs, private sector companies, and development organisations).
- **Intervention 6.1.2.: Collaborate with regional and international partners to identify community health innovations that have the potential to be applied in Zambia.** Community health systems that meet the dynamic needs of various individuals must be innovative and evolving to adapt to the ever changing economic and social environments.

The vital need to draw lessons from innovations implemented internationally and within the region which have practical relevance of replication within the local community becomes paramount. The identified intervention which focuses on collaboration with various regional and international partners is of essential value

- Activity 6.1.2.1.: Participate in knowledge exchanges with partners focussed on innovations for community health
- **Intervention 6.1.3: Roll out effective community health system innovations throughout the country.** Community health innovation is focused on advancing reliable and evidence based healthcare delivery within the designated place of implementation. The evidence drawn from piloting innovations, forms basis for scale-up and thus inform decision makers to replicate the innovations by rolling out those proved effective to enhance community health at a larger scale.
  - Activity 6.1.3.1.: Identify key local and international innovations to be piloted in selected Zambian districts
  - Activity 6.1.3.2.: Implement high-potential innovative community health projects
- **Intervention 6.1.4.: Document and broadcast successful innovations.** Zambia operates in an integral health system which is sustained by the core values based on the ideology of sharing best practices for the purpose of creating a learning environment from various partners. The intervention is thus formulated to build on the strategy which is evidence based in advocating for innovation in community health
  - Activity 6.1.4.1.: Conduct case studies to demonstrate the effect of new innovations in community health in Zambia
- **Intervention 6.1.5.: Pilot innovations in a controlled setting and document lessons.** Innovation can be influenced by various social, economic, political and cultural factors, thus building an ideal model within a controlled setting and documenting lessons. This can help build relevant evidence on which effective implementation can ride with all potential constraints being factored in, while designing scale up programs for innovation in community health.
  - Activity 6.1.5.1.: Establish a community health model village to pilot innovations and demonstrate best practice

## 6. COSTING OF THE NCHS

### 6.1. OBJECTIVES OF COSTING

The Financing Alliance for Health supported the Community Health Unit to conduct a cost analysis of the Community Health Strategy and the Operational Plan. The aim of the cost analysis was to: inform review of the strategy; estimate total resource needs and; support investment planning and subsequent resource mobilization efforts.

### 6.2. METHODOLOGY

The UNICEF/MSH Community Health Planning and Costing Tool was used to model scale-up, coverage and cost of providing community health services over the strategy period from 2019–2021, starting at the baseline year of 2018. The Community Health Planning and Costing Tool is a spreadsheet-based tool that helps planners and managers to determine the costs and finances of community health services packages. It allows users to calculate the costs and financing elements linked to all aspects of the CHS packages, including service delivery, training, supervision, and management from community to central levels. While costs for supplies and commodities were calculated to arrive at system costs, they were excluded from community health strategy costs as they are incurred within the main government supply chain.

FIGURE 1: COMPONENTS INCLUDED IN THE COSTING

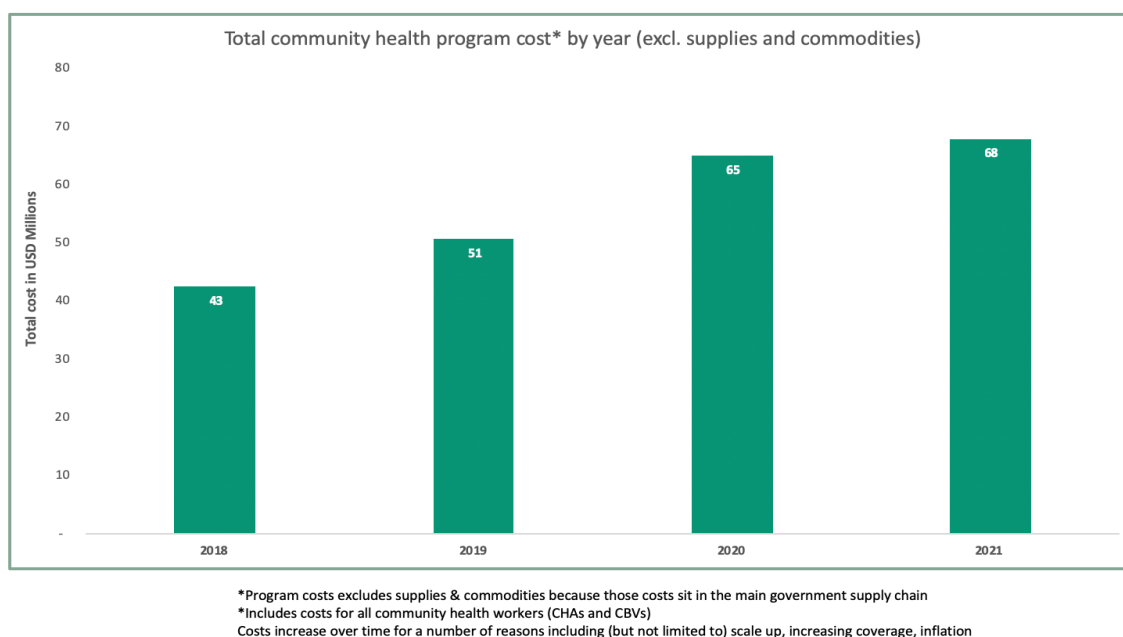
- **CHWs:** CHAs (scaling up from 1,669 in 2018 to 5,000 in 2021) and CBVs (estimated 40,000)
- **Supervisors:** Community focal point (each supervising about 16 CHWs)
- **Management Staff:**
  - Director of Public Health (1)
  - Assistant Director (1)
  - Chief Community Health Officer (2)
  - Community Health Coordinator (1)
  - Monitoring, Evaluation, Learning and Research Officer (1)
  - Supply Chain Officer (1)
  - Community Health Officer (2)
  - Provincial Community Health Officer (10)
  - District Community Health Officer (103)
- **Major trainings: (one-time trainings in the strategy – costed separately under start-up costs):**
  - **CHW Trainings:** CHA baseline training , In-service refresher, HMIS, CH guidelines etc.
  - **Supervisor Trainings:** Use of supervision tools, HMIS etc.
  - **Management Trainings:** Capacity building of CHU and focal points
- **Equipment:**
  - CHW Equipment, CHW supervisor equipment, Management equipment
- **Capital costs:**
  - Costs for meetings/consultations to realize objects under operational plan
  - Cost to procure capital goods
- **Supplies and commodities** are excluded because the costs sit in the main government supply chain

Data for the analysis was obtained from various primary sources including review of relevant documents of the Ministry of Health, Central Statistics Office of Zambia and partners. Secondary literature was also reviewed in journals, reports and through other literature search. In addition, discussions were held with various Ministry of Health officials at central level, district level, direct

community health worker (CHW) supervisors at health centres/health posts, CHWs (both CHAs and CBVs), and with partners. Inflation rate and exchange rate data were obtained from the Bank of Zambia website.

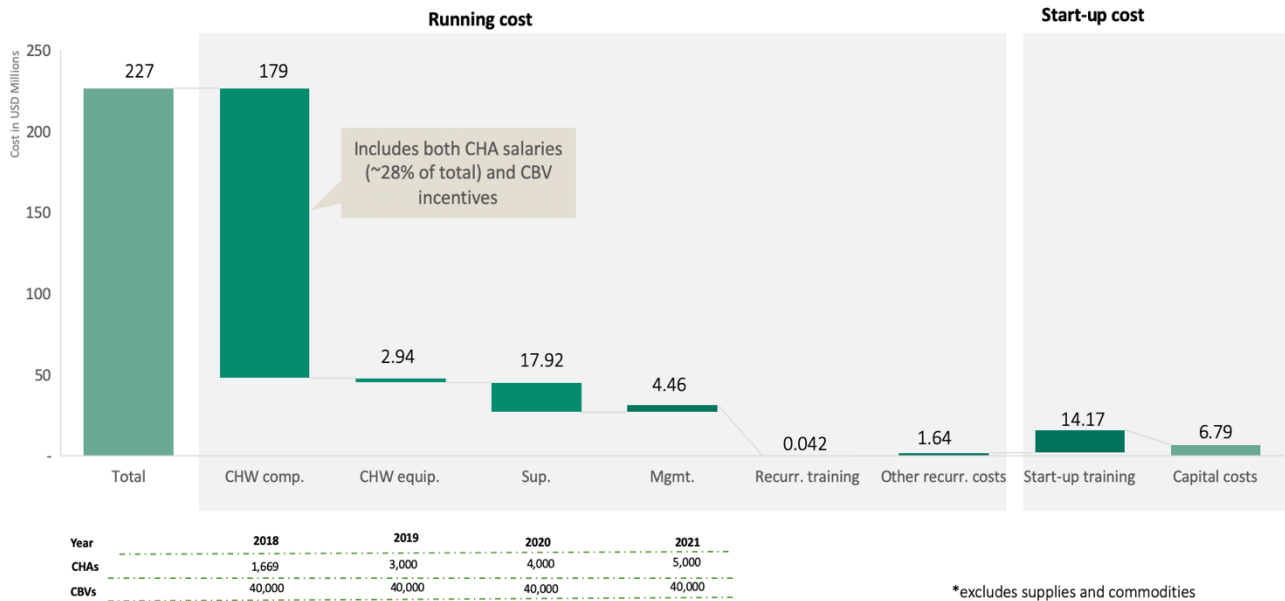
### 6.3. FINDINGS

Program cost to implement the objectives under the Community Health strategy from 2018 – 2021 is USD\$227 million, with USD\$184, million required between 2019 and 2021.

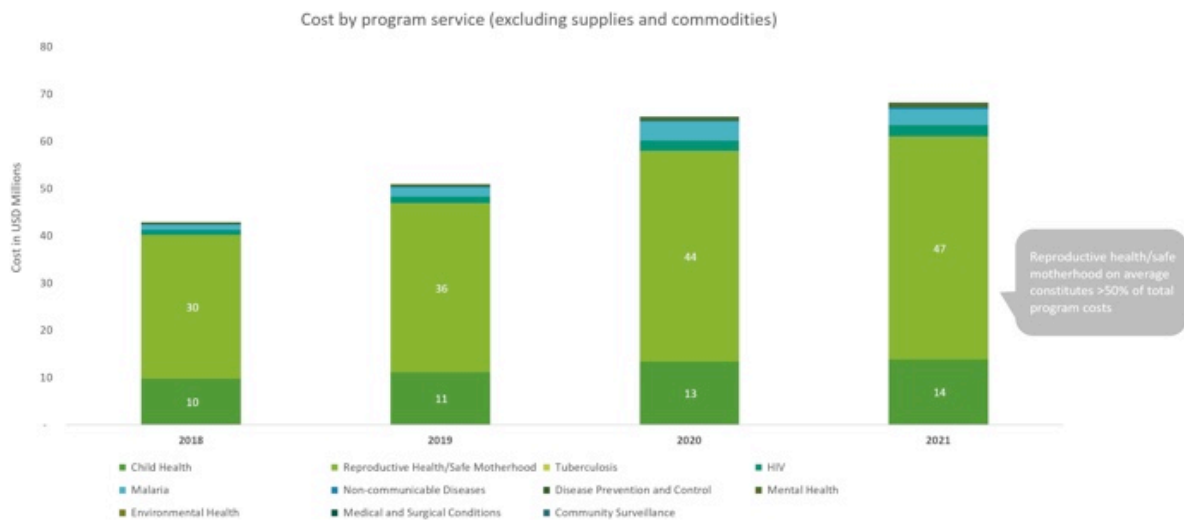


Since the community health program in Zambia is not new, start-up costs were relatively low at US\$21 million (9.25% of total program costs) compared to recurrent costs at US\$205 million for the period 2018 – 2021. Running costs ranged between US\$52 million – US\$58 million per year for the next three years. Of the running costs, CHW compensation including CHA salaries and proposed CBV incentives is the largest cost drivers at US\$178 million, followed by supervision at US\$17.92 million. Full running costs are shown in the graph below. Start-up costs comprised start-up training costing US\$14.17 million, primarily to support initial CHA training and capital costs at US\$6.79 million mainly to support development of frameworks and guidelines for community health, and to cascade these down to the community level.

Of the \$227 million in total program costs, \$205 million are running costs and \$21 million are start-up costs over 4 years (2018 until 2021)\*



The most resource intensive programs are Reproductive Health/Safe Motherhood and child health, together accounting for more than 50% of the total program costs, primarily on high frequency of service provision and size of population covered by these services.



## 6.4. LIMITATIONS

The main limitation of this analysis is that it assumes there are no bottlenecks in execution of the strategy and service delivery including any potential bottlenecks. It assumes bottlenecks have been solved, and only includes the costs of implementing the package of services. Also, the number of districts sampled were few (<5) relative to the number of districts in the country (103), therefore the data collected might not be sufficiently representative of the country as a whole.

## 6.5. CONCLUSION

The objective of this analysis was to project the costs to aid in decision making and finalization of the Community Health Strategy. The results will also form the basis for a return on investment analysis linking costs to potential returns from implementing the community health strategy. Finally, the analysis will support advocacy efforts needed to secure funding to ensure sufficient level of resources for community health services.