ZAMBIA

Summary of national priorities

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OVERVIEW OF COMMUNITY HEALTH SYSTEM AND SCALE UP PLAN

Community Health System: Zambia has 2 main cadres of community health workers; Community Health Assistants (CHAs) and Community-Based Volunteers (CBVs). CHAs receive 12 months training and are formally employed by the MoH, while CBVs work directly with implementing partners and are trained over shorter periods. CBVs usually focus on a specific programme area or disease resulting in high levels of fragmentation. CHAs are based at health posts, the lowest level health facility in Zambia, and are meant to spend 80% of their time in the community, however, this is rarely the case due to understaffing at health posts. Neighbourhood Health Committees (NHCs) are community-based groups that have historically acted as a link between health facilities and communities. These structures are currently weak and revitalizing them will be crucial for CH initiatives to succeed.

Scale-up plan and vision: The National Community Health Strategy sets out the key actions necessary to create a scientifically and culturally acceptable, sustainable, integrated, and efficient community health system. This includes building leadership and management capabilities at all levels of the system; increasing points of access; scaling up the CHA programme; addressing the fragmentation of CBVs; and improving the use of data in decision-making.

Linkages with broader PHC system: Community health services include promotive, preventive, curative, rehabilitative and palliative health services to the general public, in line with the packages of health services defined for these levels. The national health policy has adopted a human rights approach in the provision of CH services as a vehicle for delivering primary health services at community level, and ultimately contributing to the attainment of universal health coverage.

NATIONAL PRIORITIES

1. **Community Health Workforce**: Build a motivated, skilled, equitably distributed community health workforce including through scaling up the CHA programme and addressing the fragmentation of community-based volunteers
2. **Health systems strengthening:** Strengthen NHCs and promote sustainability, accountability and the ownership of health activities at community level
3. **Access to health services:** Promote demand for health services, increase points of access, and improve supply chain efficiencies so that all Zambians have access to quality basic health services within five kilometers of their home
4. **Health Information System:** Improve community-based health data reporting systems and use of data in decision making at all levels
5. **Innovation:** Support and identify innovations in implementing high-impact community health interventions

MAIN DEVELOPMENT PARTNERS

Funders

Implementing partners / NGOs

UN Agencies

Community Health System Structure and Delivery Channels

Public health system

Policy & strategy

Community Health Unit at National MoH: At national level the CHU is responsible for strategy development and coordination of community health activities

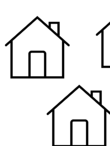
Provincial focal points: Each of Zambia's 10 provinces has a Provincial Health Office. A community health focal point person within each PHO oversees community in their province

Supervision & monitoring

District health offices: Zambia is divided into 118 districts, each with their own district health office. In addition to operating district-level hospitals, DHOs have oversight of health posts and health centres. Community health focal points monitor and supervise the community health activities runf from these facilities.

Health facilities

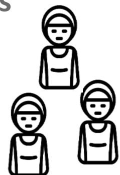
Health centres: Offers primary health services with a team of between three and eleven health professionals



Health posts: Offers primary health services in more remote areas. Staffed by nurse in-charge and two CHAs

Community level services

CHAs: Community Health Assistants are stationed at health posts, but spend 80% of their time delivering services at community level



CBVs: A number of different cadres of community-based volunteers offer a range of services at community level

Community structures

Traditional leaders

Ward councillors & community structures

NHCs & HCCs: Neighbourhood Health Committees and Health Centre Committees act as a link between community and facility and hold public service providers to account

Alternative channels

Private providers: Health professionals; clinics; drug shops

Non-profit: NGOs and faith-based organisations

Traditional healers and herbalists.

Scale-up plans

Scale-up Plans	From (2018)	To (by 2021)
Number of CHAs	2,502 (trained) 2,140 (paid)	5,000
Number of CBVs (est)	40,000	40,000
Maternal mortality /100k	252/100k	100/100k
U5 mortality / 1k	61/1k	35/1k
TB incidence rate	361/100k	313/100k
Malaria incidence rate	312/1k	5 per 100,000
HIV+ women receiving ARVs for PMTCT	92%	100%
Children below 5 years who are stunted	35 %	14%

Financing the Community Health Strategy

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An investment of US$227 million is needed to meet the program costs of the 2018-2021 strategy, with US$184 million required from 2019 - 2021

Total community health program cost* by year (excl. supplies and commodities)

Total cost in USD Millions

Year	2018	2019	2020	2021
Total cost (USD Millions)	43	51	65	68

*Program costs excludes supplies & commodities as these costs sit in the main government supply chain
*Includes costs for all community health workers (CHAs and CBVs)
Costs increase over time for a number of reasons including (but not limited to) scale up, increasing coverage, inflation

Financing the Community Health Strategy…cont'd

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9.2% of the costs are start up costs with running costs averaging US$52 million – US$58million per year for the next 3 years

- $205 million in total running costs and $21million in start-up costs over 4 years (2018 until 2021)*

Year	2018	2019	2020	2021
CHAs	1,669	3,000	4,000	5,000
CBVs	40,000	40,000	40,000	40,000

*excludes supplies and commodities

Overview of community health system

COUNTRY INFO

Population: 17.8m

Region: ESARO

U/5 Mortality: 61/1000 live births

Maternal Mortality: 252/100,000 live births

KEYS FACTS

Cadres and #/cadre: CHA (2502), 2,000 after scale-up; estimated 40,000 CBVss
Satus of national plan: National Community Health Strategy 2019-2021
Ministry department responsible for community health: Ministry of Health

DESCRIPTION OF COMMUNITY HEALTH SYSTEM BY MAIN CADRES

Element	CHA	CBV
Services offered:	Communicating and promoting health, disease prevention and control, primary health care, environmental health, basic diagnostic procedures, basic healthcare procedures, reproductive and maternal health, child health, health commodities management	CBVs include community-based distributors (CBDs) of FP services, HIV counselors, caregivers, and malaria control agents, among others.
User fees:	None	None
Supervision:	CHAs are supervised by professional staff at health centers and representatives from district-level offices.	CBVs are supervised by CHAs and health facility staff
Training:	12 month training program includes information on the health care system; health behavior change communication and promotion; environmental health; the human body; diagnostic procedures; basic first aid; reproductive health including FP; child health; communicable and non-communicable diseases; medicines and commodities management.	Curriculum and duration varies depending on programme. Ranges from 3 days - 1 month.
Compensation:	Monthly salary according to the MoH salary scale. They do not receive non-financial incentives. The Ministry of Health is working towards greater provision for CHAs on its human resources establishment and mobilise resources to pay for their salaries.	CBVs are volunteers and thus generally unpaid. Where incentives do exist, they are largely dependent on the particular program, e.g. per diems, cash or in-kind payments; membership in community-level cooperatives and/or income generating activities; t-shirts; or formal social recognition
Data collection:	CHAs and various CBVs are responsible for submitting community-level data. Data flows upward from the community level, starting with CBVs, who report to CHAs. CHAs report to supervisors at health facility who collate data and submit to district level, where it is captured into the HMIS. Zambia aims to have timely community health data available and used for decision-making by 2021.	
Health system linkages:	CHAs are a link between the community and the health facility.	
Community engagement:	Required to spend 80% of their time in the community and 20% at health facility and must report on community engagement activities.	Provide services at household level

Priority Needs (page 1 of 2)

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		Needs
National levers	Finance	• Mobilize **sustainable financing** to scale up to 5,000 CHAs • Mobilize resources to support the broader CH program (including staff, commodities) and also provide support for CBVs to receive a standardized incentive package
	System design and policies	• Establishing guidelines to coordinate CHA and CBV health service provision • Support the development of an **enterprise architecture to integrate health information systems** • Conduct **catchment mapping** to improve planning for the CH workforce • Improve CH integration with **multisectoral issues** (e.g., housing, social support, school health) and strengthen implementation of health promotive policies • Develop consolidated guidelines/policy document for both **urban and rural** community health.
	System management and leadership	• Develop and implement an **integrated performance management system** for CHWs (across cadres) and their supervisors, harmonizing across data systems and building on best practices from partners • Build **capacity for leadership and governance** for the entire CH system, from the national to the community level
	Health products	• Simplify, integrate, and **promote interoperability among different digital tools** and innovations to make CHA and CBV jobs easier
	Political prioritization	• Strengthen **collaboration across government agencies**, civil society, religious leaders, community leaders, and other partners towards a One Health approach

Priority Needs (page 2 of 2)

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		Needs
Program Delivery	Community engagement	• Strengthen **supervision** of CBVs, and develop effective models for **social accountability** for the CH system • Leverage IT tools to **strengthen communications and information dissemination**, promote service utilization, and empower communities as agents of their health • Empower communities to improve **rapid health response** for management of outbreaks and resilience to outbreaks • Implement strategies to ensure that CHAs spend 20% of their time at the facility and **80% in the community**
	Recruitment & accreditation	• Develop **certifications and standards of care** for the different cadres of CBVs
	Training	• Develop a **standardised basic package of training** for CBVs • Develop **in-service training** for CHAs
	Supervision	• Develop the **supervisory structures** for CH programs by leveraging new technology, scaling best practices, and harmonizing supervision systems across partners
	Remuneration/Reward & Advancement	• Improve and standardize the provision of **financial or non-financial incentives to CBVs**. • Establish a form to **recognise and reward innovation** in community health
	Supply chain management (incl. commodities)	• Strengthen **supply chain transparency, oversight, and management** for community health cadres and improve last-mile delivery • Increase the availability of **critical supplies and commodities** at community level, and develop a unified list of standard supplies for CBV
	Data & information systems	• Support **improved data-driven decision-making and data collection** • Promote documentation and **knowledge management** for CHW implementation efforts

Landscape of main development partners

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		Funders	Implementing partners/NGOs	UN Agencies
National levers	Finance	The Global Fund, UKaid, Global Financing Facility, Clinton Health Access Initiative, The World Bank	Financing Alliance for Health	unicef, UNFPA
	System design and policies	USAID, Clinton Health Access Initiative, UKaid		unicef, UNFPA
	System management and leadership	USAID, Clinton Health Access Initiative, UKaid	One Million Community Health Workers Campaign, jhpiego	unicef, UNFPA
	Health products	USAID, Clinton Health Access Initiative, UKaid	World Vision	UNFPA
	Political prioritization			unicef, UNFPA
Program Delivery		The Global Fund, Gavi, Bill & Melinda Gates foundation, Johnson & Johnson, Pfizer	jhpiego, Oxfam, World Vision, care, Clinton Health Access Initiative	unicef, unicef, World Health Organization

The government of Zambia engages across all of these levers and program delivery; this mapping portrays support provided by partners

Integration Opportunities

Existing coordination mechanisms

Type of integration	Ongoing efforts	Opportunities going forward
Integration of community health with the broader health system	• Support work of CHAs and CBVs in **integrating data systems** to feed information from the community level into the national online management system	• Support the **implementation of the community health strategy 2010 - 2020** • **Integrate community health supply chains** into the national health system's forecasting procurement and distribution platform • Improve data collection and reporting mechanisms
Integration across programs, partners, and disease areas in community health systems	• Engage in stakeholder dialogues around **CH implementation guidelines** to consolidate processes and programs in community health	**Conduct a mapping** of the different cadres/partners in the CH system, leveraging existing CHW registries, as a first step towards harmonizing training, performance management, incentives, etc. across actors, and resource mapping to **increase transparency** of donor funding to CH
Integration across sectors and agencies	• **Continue conversations with other government agencies** to help rationalize and unify the health service	• **Engage with the private sector** (e.g., drug shops, clinics) to better integrate them into the CH system and improve regulatory oversight