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Country Case Study: Zambia

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

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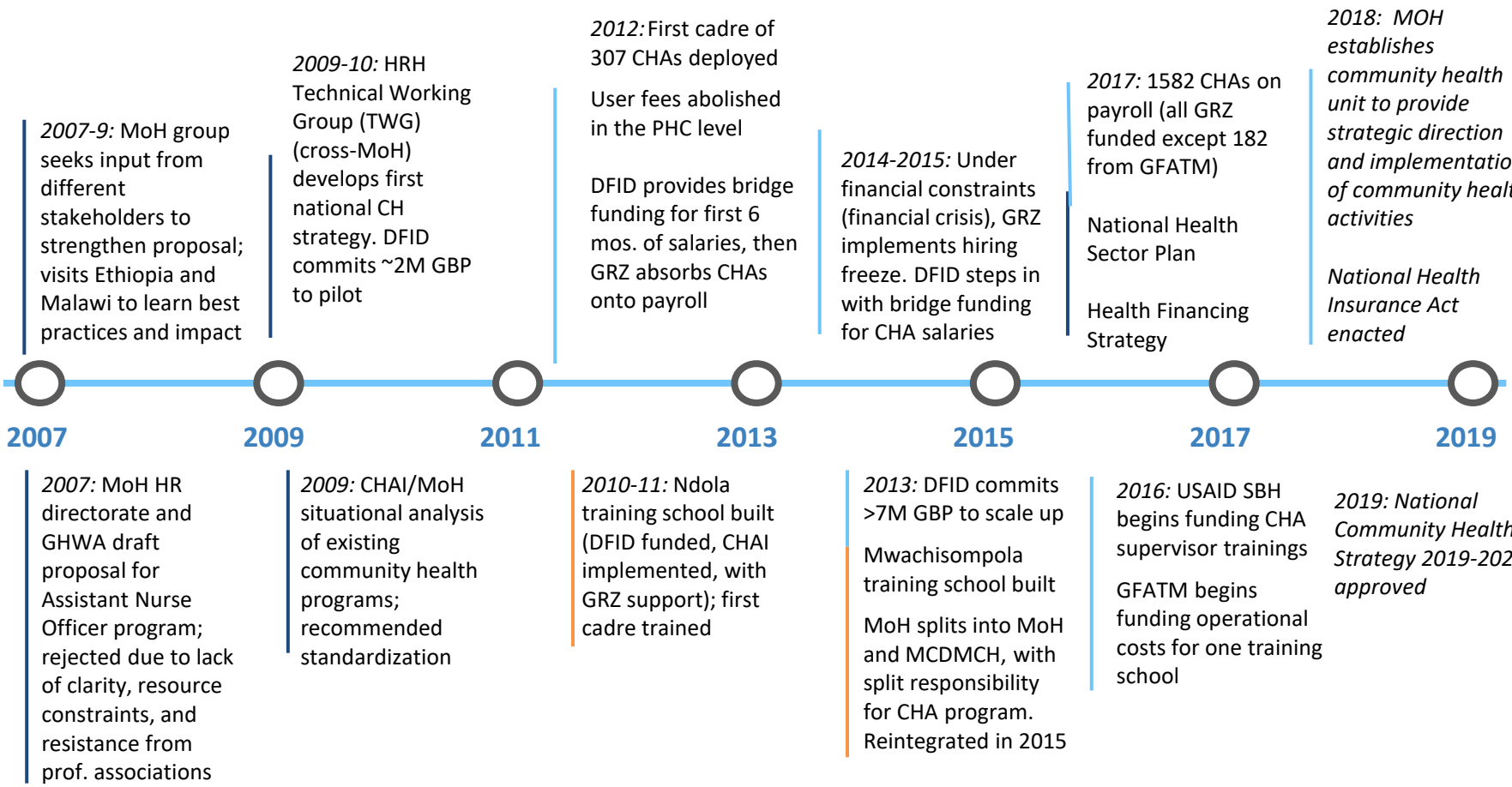

MCDMCH = Ministry of Community Development, Maternal and Child Health. Source: DFID HRH Programme Phase I and II, Business Case and Annual Reviews (2012-17); Zulu et al., Developing the National CHA Strategy in Zambia: A Policy Analysis (2013); expert interviews.

Zambia has CHAs and CBVs; coordination among them varies widely

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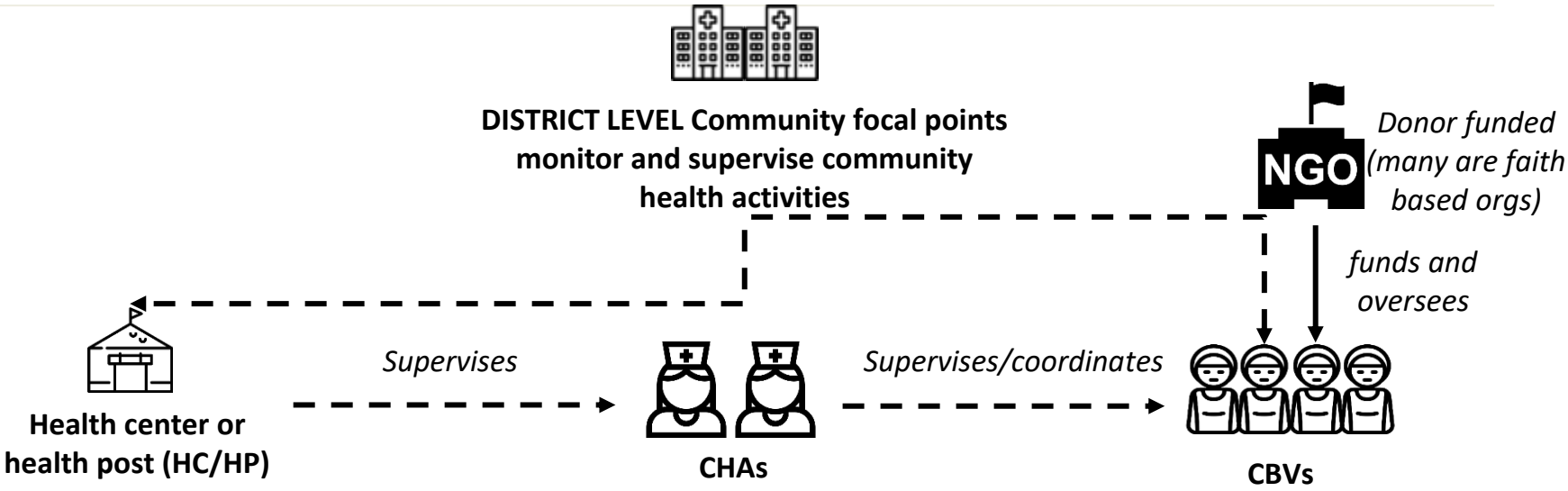

Community Health Assistants

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

Community Based Volunteers

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

Source: CHAI Community Health Assistant Brief (2016); Zambia National CHW Strategy (2010); Zambia National Community Health Strategy (2017); expert interviews. DMO= District Medical Officer. National Community Health Strategy, 2019-2021

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

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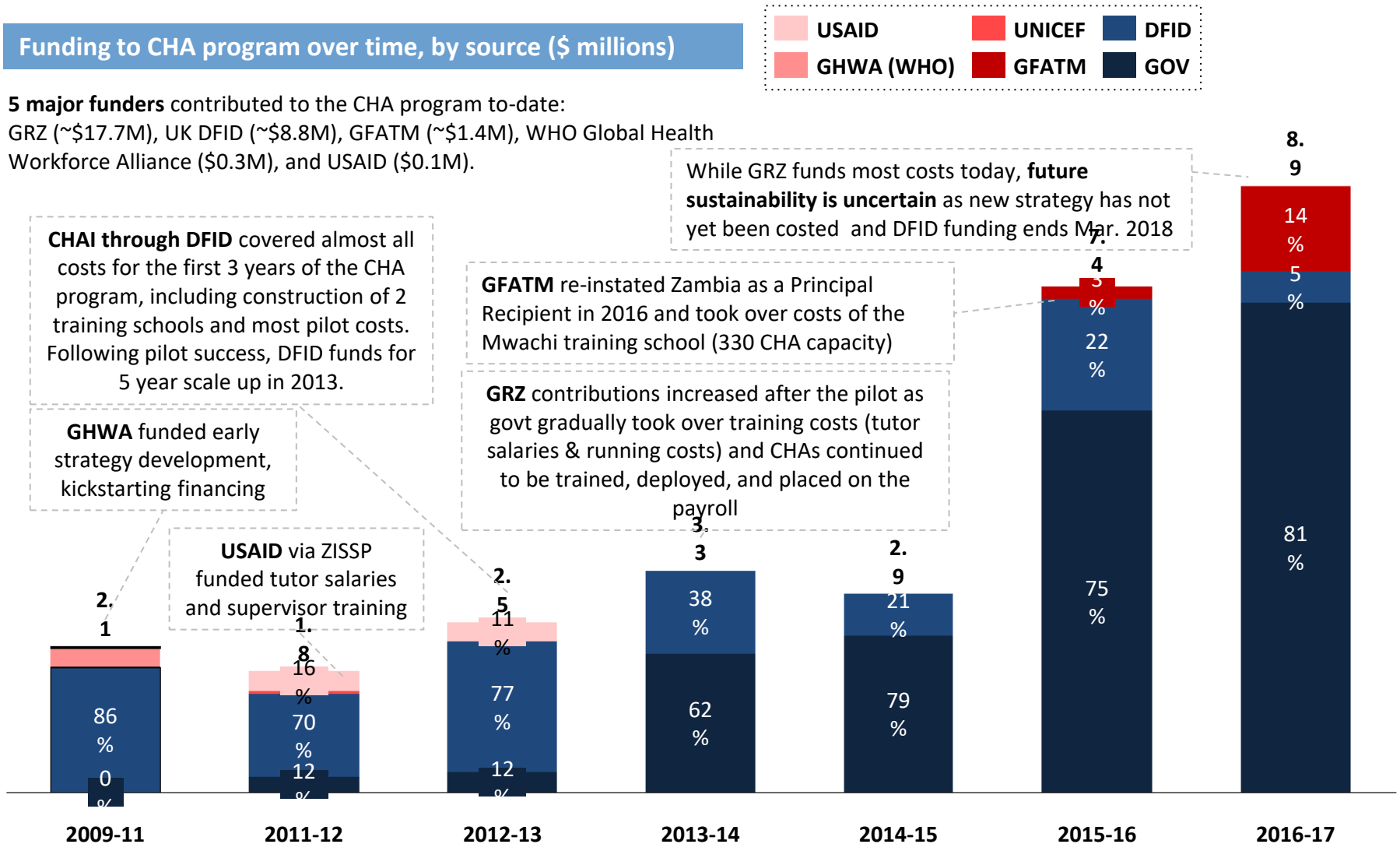
Funding to CHA program over time, by source ($ millions)

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



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

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

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Development & momentum building

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

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

Implementation & scale up

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

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

Path forward

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

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

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

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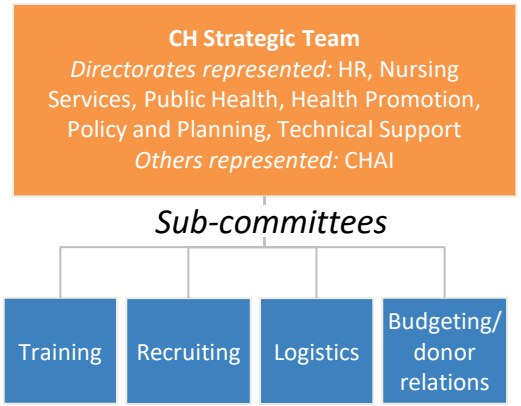
Idea generation

Years-long iteration on CH concept with input from key groups helped the idea to finally gain traction

- Initial 2007 proposal, developed with GHWA, faced resistance from General Nursing/Health Professionals Councils
- Ongoing refinement of concept with input from these stakeholders; further revisions (including name change from ANO to CHWA) at GHWA Uganda conference in 2008

Strategy development

MoH-led strategic group, with cross-directorate champions, met weekly and coordinated input from across the Ministry and CPs



Consensus building and resource mobilization

Frequent updates to the broader HRH TWG and to the Permanent Secretary (PS) of the MoH facilitated buy-in and piqued donor interest

Strong, influential champions from across the Ministry facilitated consensus and buy-in, including from early critics (e.g., professional councils).

Source: Zulu et al (2013); CHAI internal documents; expert interviews.

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

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Data on Zambia's challenges

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

International evidence on the impact of CH

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

Source: Zulu et al. (2013); National Community Health Worker Strategy (2010); expert interviews.

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

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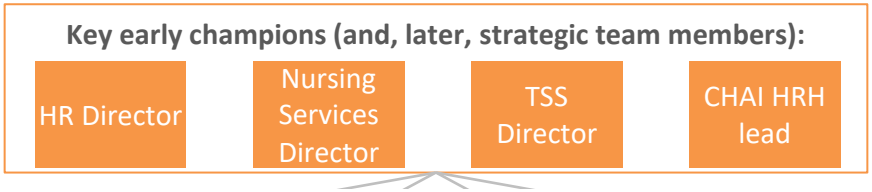

Key influence pathways

	Permanent Secretary and Minister of Health	Ministry of Finance	Donors	Province, district, and local health leaders
Role	• Approve strategic decisions • PS liaises with MoF on budgeting • Coordinates donor engagement	• Iterates with PS on health budget and allocates resources to MoH	• Fund various program costs over time	• Support implementation and resource allocation at local level
Engagement strategy	• CHAI and HR Director advocated to PS to put CHAs on govt payroll pending pilot evidence, highlighting case for econ. growth • HR Director briefed PS on strategy weekly to get continued buy-in	• MoH HR director liaised directly with MoF HR director to advocate for CHAs to be budgeted for as new positions in payroll. Strategic advocacy at key points in fiscal years during pilot phase • PS also advocated to MoF for CHA budgeting	• Donors were engaged via HRH TWG, CP meetings, bilateral emails, and formal MoH requests, and were invited to strategic team budget meetings • MoH, with support from CHAI, approached donors to fill gaps in funding, showing how CH related to their interests • PS coordinated donor requests	• Champions presented early ideas, and, later, strategy to local govt health leads to get feedback and secure buy-in • Advocated for districts to support supervision (e.g., fuel and staff time for facility staff to go to health posts)

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

Source: Expert interviews.

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

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Challenge	*Description*
Minimum wage hike for all civil servants *August 2012*	• To fulfill an 2011 election pledge, President Sata increased min. wage for all gov workers, increasing CHA monthly wage by 73% (1500 to 2600 Kwacha) • Reduced GRZ's future capacity to put graduating CHAs on payroll and increased program cost overall
Shift of PHC from MoH to MCDMCH *Dec. 2012-Sep. 2015*	• Presidential directive to shift PHC services from MOH to MCDMCH, effectively splitting the ministry of health into two. Shifted CHA deployment and program management to MCDMCH, while training remained in MOH • Weakened coordination and political support for CHA program as previous champions in MOH were no longer in charge and MCDMCH had own priorities
Govt-wide hiring freeze *2014-15*	• 2-year GRZ hiring freeze due to financial pressures increased cost from min. wage hike meant that 3 graduating classes of 775 CHAs could not be placed on govt payroll

Sources: DFID Human Resources for Health Phase II Annual Review 2014, DFID Human Resources for Health Phase II Annual Review 2015, DFID Human Resources for Health Phase II Annual Review 2016, National Community Health Worker Strategy in Zambia (2010), Expert interviews

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

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Challenge

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

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

Solution

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

Potential impact

Strengthened resource mobilization

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

Strengthened resource coordination

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

Source: Expert interviews.

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

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

Financing channel	Mobilization strategy
Channel resources and programming efforts from donors and govt in a harmonized and coordinated way so that allocations complement each other in area of work, geography of work, and utilization of CH workforce	*"Coordination needs to be strengthened to avoid partners duplicating efforts, and the government is the only stakeholder capable of bringing everyone to the table. They need to take leadership." --HSS Team Lead, USAID Zambia Mission*
Strengthen accountability at district level so that districts follow established protocols and dedicate at least 10% of their budgets to CH programming	*"Govt will train District Directors of Health on the issue of min. allocations to CH, and district budgets will not be approved without such a CH component." --Deputy Director, Directorate of Health Promotion, Environmental, and Social Determinants, MOH*

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

Financing channel	Mobilization strategy
Strengthen inter-sectoral collaboration within GRZ and establish non-MOH financial flows to CH as CHAs and CHVs can potentially deliver interventions of interest to other ministries (education, agriculture, housing, etc)	*"The cabinet has adopted a Health in All Policies framework that sets out the nature of inter-sectoral collaboration among ministries. All of us must contribute because community, community, and community is our approach to health." --Honorable Minister of Health, GRZ*
Revitalize GtG funding for CH (progress has been made: GFATM re-enterd Zambia + SIDA, DFID & USAID working on GtG to MOH for maternal & child health)	*"Purely relying on current treasury allocations is not sustainable to achieve UHC, and that is why we have established a new healthcare financing directorate in charge of developing innovative financing mechanisms." --Honorable Minister of Health, GRZ*
Introduce sin taxes (alcohol, tobacco, sugary drinks)	

Source: Healthcare Financing Strategy Draft (2017); expert interviews

Other countries can apply these lessons in their own contexts

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	Lessons from Zambia	Implications for other countries
Development & momentum	1 **Inclusive, iterative process** 2 **Research and evidence**	• **Identify influential champions** (e.g., MoH directors) who can engage with all levels of govt and with donors • **Take advantage of opportune moments** politically (e.g., elections) to accelerate ongoing efforts • **Tailor advocacy to different actors** based on their interests, using data to make the case (e.g., economic growth to MoF, impact on MCH for certain donors)
Implementation & scale up	3 **Resilience in the face of unforeseen exogenous factors**	• **Create risk mitigation plans** for various scenarios, including negotiating flexible financing arrangements with key donors and identifying diverse champions at all levels (especially local) who can sustain momentum despite political shifts • **Work with committed implementing partners** with strong govt relationships who can play a facilitative role, supporting the Ministry to ensure continuity in times of change • **Put CHWs on govt payroll** ASAP to institutionalize them throughout political shifts
	4 **Integration with existing community volunteer workforces**	• **Govt must drive donor/partner coordination at the central level**, clearly mapping resources, gaps, and plans • **Establish clear local supervisory structures** to ensure synergies among different cadres at community level
Path forward	5 **Dedicated focal person or body**	• **Identify the right place for CH leads to sit**, where they can facilitate intra-governmental and external coordination and resource mobilization
	6 **Dedicated strategies to improve resource efficiency and mobilize new resources**	• **Focus on resource efficiency in the near term, while proactively identifying new sources in longer term** • **Ensure CH stays high on the agenda** (via champions, advocacy) at central and local levels to ensure proper allocation of existing and new resources