Community Health Strategy
2017-2021

ACRONYMS and ABBREVIATIONS

APDHT	Action Planning for District Health Team(s)
ARI	Acute Respiratory Infection
BBC	British Broadcasting Corporation
CBD	Community Based Distributors
CBO	Community Based Organization(s)
CBV	Community Based Volunteer(s)
CBHI	Community Based Health Insurance
CH	Community Health
CHA	Community Health Assistant(s)
CHAI	Clinton Health Access Initiative
CHC	Community Health Care
CHE	Community Health Entrepreneur
CHS	Community Health Strategy
CMIS	Community Management Information System
CSO	Civil Society Organization(s)
CP	Cooperating Partner(s)
DDCC	District Development Council Committee(s)
DFID	Department for International Development
DHMT	District Health Management Team(s)
DHO	District Health Office
DHIO	District Health Information Office
DHIS2	District Health Information System 2
DHTM	District Health Management Team(s)
DIM	District Integrated Meeting(s)
DRC	District Resource Center(s)
DFP	District Focal Point(s)
EHT	Environmental Health Technologist(s)
EU	European Union
FBO	Faith Based Organization(s)
GBV	Gender Based Violence
GDP	Gross Domestic Product
GRZ	Government of the Republic of Zambia
HIA	Health Information Aggregation
HC	Health Center(s)
HCC	Health Center Committee(s)
HCCE	Health Center Committee Executive(s)
HCFP	Health Center Focal Point(s)
HEP	Health Extension Program
HP	Health Post(s)
HPC	Health Post Committee(s)
HPFP	Health Post Focal Point(s)
HPP	Health Policy and Planning
HR	Human Resources
HRH	Human Resources for Health

HSDP	Health Sector Devolution Plan
HSSP	Health Systems Strengthening Programme
HW	Health Worker(s)
iCCM	Integrated Community Case Management
INGO	International NGO(s)
IPA	Innovations for Poverty Action
IYCF	Infant and Young and Child Feeding volunteers(s)
JICA	Japan International Cooperation Agency
NGO	Non-Government Organization
Mamaz	More Mamaz Zambia (NGO)
MDAR	Monthly Data Aggregation Review meeting(s)
MDG	Millenium Development Goal(s)
M&E	Monitoring and Evaluation
MoCDMCH	Ministry of Community Development, Mother and Child Health
MOF	Ministry of Finance
MoGE	Ministry of General Education
MOH	Ministry of Health
MoHA	Ministry of Home Affairs
MNCHN	Maternal, Newborn, Child and Nutrition
MSL	Medical Stores Limited
MSH	Management Sciences for Health
MTEF	Medium Term Expenditure Framework
MTR	Mid-Term Review
NCHAP	National Community Health Assistant Program
NCHWS	National Community Health Worker Strategy
NCD	Non-Communicable Disease(s)
NDP	National Development Plan
NHC	Neighborhood Committee(s)
NHSA	National Health Services Act
NGO	Non-Government Organization(s)
NFP	National Focal Point
NHC	Neighborhood Committee(s)
NHP	National Health Policy
NHSP	National Health Strategic Plan(s)
NRC	National Resource Center
OPT	Out-Patient Therapeutic Feeding
PFP	Provincial Focal Point(s)
PHO	Provincial Health Office(s)
PHC	Primary Health Care
PPP	Public Private Partnership(s)
QA	Quality Assurance
QC	Quality Control
RMNCH	Reproductive, Maternal, Newborn and Child Health
SBA	Skilled Birth Attendance
SDG	Sustainable Development Goals
SHI	Social Health Insurance

SHN	School Health and Nutrition
SIDA	Swedish International Development Agency
SMAG	Safe Motherhood Action Group(s)
SOP	Standard Operating Procedures
SUN	Scaling-Up Nutrition
SWAp	Sector Wide Approach
TA	Technical Assistance
TICO	Tokushima International Cooperation
TWG	Technical Working Group
U5	Under-Five(s) (years of age)
UHC	Universal Health Care
UNICEF	United Nations International Child Fund
USAID	United States Agency for International Development
WASH	Water, Sanitation and Hygiene
WHO	World Health Organisation
ZAMRA	Zambia Agency for Medicine Regulation and Administration
ZCCP	Zambia Centre for Communication Programmes
ZDHS	Zambia Demographic and Health Survey

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FOREWORD

The health sector in Zambia is facing scarcity in human resources and financial support. Shortages of health workers are experienced at every service delivery level, including the primary level which also serves with outreach interventions to the communities. The Government of the Republic of Zambia (GRZ) recognizes that such scarcities are critical to the provision of quality health care and that it is essential that the Ministry of Health (MOH) and DHO in the decentralized health sector context ensure effective and efficient community health service delivery through frontline health workers in the formal setting as well as the informal setting of voluntary support. This Community Health Strategy (CHS) is laid out to strengthen the operationality and functionality of their relationships and facilitate quality and sufficient community health care (CHC).

Already in 2010, a National Community Health Worker Strategy has been developed by the Ministry of Health with the aim of repositioning and expanding the currently available cadre of frontline workers in the formal health sector and as a link to the informal sector. This cadre of Community Health Assistants (CHA) has brought about changes and improvements with regards to community interventions, but as the HRH scarcity cannot be amended quickly, it has become essential to enable community health institutions to have a sufficient number of Community Based Volunteers (CBV) who are needed to support the Community Health Assistant and the Environmental Health Technologist. The informal, voluntary system has to be strengthened in its organizational structures and coordination of the relationships and interventions. The CBV existing groups have fragmented over the last decade in terms of quality and training levels. A supportive mechanism has been very weak due to the clinical demands on the formal health sector staff. The potential of community participation and multisectoral collaboration have been neglected.

The new Community Health Strategy is designed to guide in the strengthening of these mechanisms and potentials to improve the provision of preventive, promotive and minor curative services at the community level. The goal of the community health strategy is to have a standardized trained and well-motivated community-based voluntary workgroup that will contribute towards improved health service delivery and the attainment of National Health priorities and goals. Ultimately, the harmonized and stabilized CBV cadre will contribute towards alleviating the human suffering where there is difficult access to health care, contribute to enhanced health knowledge levels and healthy environments to reduce morbidity and mortality, particularly amongst pregnant women and infants. It will be strengthened in its contribution to improved health status and productivity of the people.

The launch of the community health strategy marks the beginning of change and transformation in the health service delivery at primary and community care level. The new approach is based on recent years' of program experience and pilots in CHC and integrates international best practice that shall now be rolled out throughout Zambia. The Ministry of Health is proud to initiate this ambitious program, which we hope will produce sustained and expanded improvements for the health and well-being of community members country-wide.

Minister of Health

ACKNOWLEDGEMENTS

This Community Health Strategy was made possible through dynamic cooperation by Ministry of Health staff, representatives of cooperating partners, national and International NGO who actively and consistently participated in the development of this document. I am grateful to all of them individually and collectively for their time and commitment in contributing their experiences in community health care and support systems and making the collation of information for this community health strategy possible.

Special thanks go to the Directorate of Health Policy and Planning for initiating this strategic document and coordinating the respective health system players, the draft reviews and validation meetings. Mr Amadeus Mukobe, Mr Terence Siansalama and Mrs Maudy Kuoma inspired with their steady support and initiative to coordinate and facilitate the process of information collation and compilation. The Director of HPP, Mr Maximillian Bweupe communicated policy lines and ideally supported the strategy development. Field visits allowed colleagues from the provinces and districts to provide up-date information on community health care. The DHMT of DHO Mazabuka, DHO Kafue, DHO Chibombo and DHO Lusaka and the CHA and NHC of Chambuka Health Post and other Health Centers explained their roles, responsibilities and options to implement CHC.

On an ongoing basis the Directorates of Health Promotion, Environment and Health Determinants, of Public Health, of Human Resources and the Department of Monitoring and Evaluation painstakingly revised the various stages of the strategy development. Dr. Kennedy Malama, Mr Kaunga, Dr Bwalya, Mr Mate and their core teams contributed to this strategy with information, discussions and revisions. Mr Elias Siamatanga of HR persistently clarified the mandate and supervision of the work of CHA and CBV. Mr Kaliki and Mr Trust Mufune of M&E progressively communicated the up-date developments for the Community Management Information System. Many more colleagues from the national and district levels have inspired the writing of this strategy who are not mentioned but gratefully remembered for communicating local best practices.

Special thanks also go to the CP and international NGO who were highly committed to bring in their experience from programmes, projects and pilots. They persistently contributed to making this CHS a rich resource for interventions and guidance for implementation. Information contribution and efforts to revise the draft stages of this strategy have relentlessly come from EU, who funded the writing of this document by their HSSP advisor Dr Ute Schumann, and from USAID, UNICEF, JICA, SIDA, WHO, CHAI, Akros and TICO. All these have been outstanding in their support to clarifying the facts and mandates in the existing system and piloted amendments and improvements in CHC organization and coordination. In addition DFID and UNFPA ensured that community participation and accountability of the health system to the community are clearly entailed in this strategy. Valuable contributions on community based distribution of medicines and commodities were received from ZAMRA and MSL, the NGO Care International, Live Well and MSH, on organizational aspects from WB, Marie Stopes, Mamaz, World Vision and on community mobilization and communication from BBC Media Action and ZCCP. All supportive organizations not mentioned here are remembered with high appreciation for their valuable contributions.

Directorate of Health Policy and Planning

1. INTRODUCTION
1.1 Country Background

Zambia is a middle-income country and was until 2015 among the 10 fastest growing economies in the world. By 2015 annual growth fell from the decade average of 7.4 % to 3.2 %[1], due to decrease in the price of copper[2], depreciation of the Kwacha (62% against the USD dollar), lack of power, and decline in agricultural output by of 7.7% compared to 2014.

Zambia is also among the countries with the highest income inequalities and 60% of the 14.6 million people lived under the poverty line in 2010[3]. The population is one of the fastest growing (around 3% per year[4]) and youngest in the world (2/3 of the population are between 15 and 35 years).[5]

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 of the Republic of Zambia (GRZ) remains committed to providing universal, quality and equitable health care services to the people of Zambia. The Government's spending on health increased by 135% between 2011 and 2015 and amounted to EURO 65 per capita in 2012 or 6.4% of GDP. Health services are provided by about 2500 health facilities[6] (81% government, 13% private and 6% Churches Health Association of Zambia), organised with Third Level Hospitals, Provincial General Hospitals, District Hospitals, Urban Health Centres, Rural Health Centres and Health Posts.

Zambia embarked on accelerated health sector reforms in 1991 with the vision to ensure equity in access to cost effective quality health care for all Zambians and the National Health Policies and Strategies of 1992 intend to bring the "… *as close to the family as possible"*. One of the principles of the reforms was decentralisation of health services management to the district level and adoption of community involvement in health as a key strategy under the principle of partnership and empowerment of communities in management and delivery of health services through the primary health care approach, based on the Alma-Alta Conference declaration of 1978. Through the National Services Act of 1996, the government established community representative structures at all levels of health care and delegated significant decision-making powers to the district health management teams (DHMT), including the responsibility of overseeing community health initiatives. This decentralized governance has watered down following the repeal of the NHSA in 2006, but GRZ is determined to re-shape and strengthen the community health services with this Community Health Strategy. It is intended to further improve health gains that were made through the earlier reforms in health systems strengthening and increase access to health care for better progress in nutrition, maternal, new-born and child health outcomes under the Sustainable Development Goals (SDG), and build up on major achievements in the diagnosis and treatment of HIV/AIDS, malaria and tuberculosis.

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[1] World Bank 2016
[2] In the first half of 2016, average copper prices fell from US$5,934,41 per Mt to US$4,699.34 (see MOF 2016).
[3] Central Statistics Office 2010a
[4] According to own calculations, 13,092,666 and an average annual net grow rate of 2.8% would give a population of 14,621,790 at the end of 2014. (see Central Statistics Office 2010b)
[5] Zambia National Youth Policy
[6] MoH 2013a

The main strategic driver for guiding the implementation of the reform and allocation of resources to sector priorities is the National Health Strategic Plans (NHSP) for 2017-2021. The NHSP provides a strategic framework for ensuring efficient and effective organization, coordination and management of the health sector in Zambia. NHSP are developed based on the strategic objectives and focus of the National Development Plan. The current National Health Strategic Plan for the period 2011 – 2016, was developed within the context of long-term health development goals but also to implement Zambia's commitments to regional and international initiatives, focused on achieving sustainable social-economic development, including the MDGs, the Abuja, Maputo and the Paris Declarations.

While the new NHSP 2017-2021 is expected to provide an optimal national framework for further improving and developing the health sector in Zambia, the transformation of a better and more cost effective health system into improved health outcome will require full participation of individuals, communities and districts. For the first time, the NHSP 2017-21 promotes community health work explicitly and frames the new **community health strategy** which stands on its own. It complements the **separate strategy for Primary Health Care** (forthcoming). Together they build up the foundation for Universal Health Care (UHC).

The Community Health Strategy is seen as a tool for the districts to engage communities, families and individuals to take responsibility for improving their own health status. It will stimulate health care seeking behaviour and knowledge, innovative models of care, network as well as optimal referral. The Community Health Strategy will also address coverage, access and utilization of preventive, promotive and curative services and engaging individuals, organizations and community leaders to improve the outcome of treatment of priority diseases.

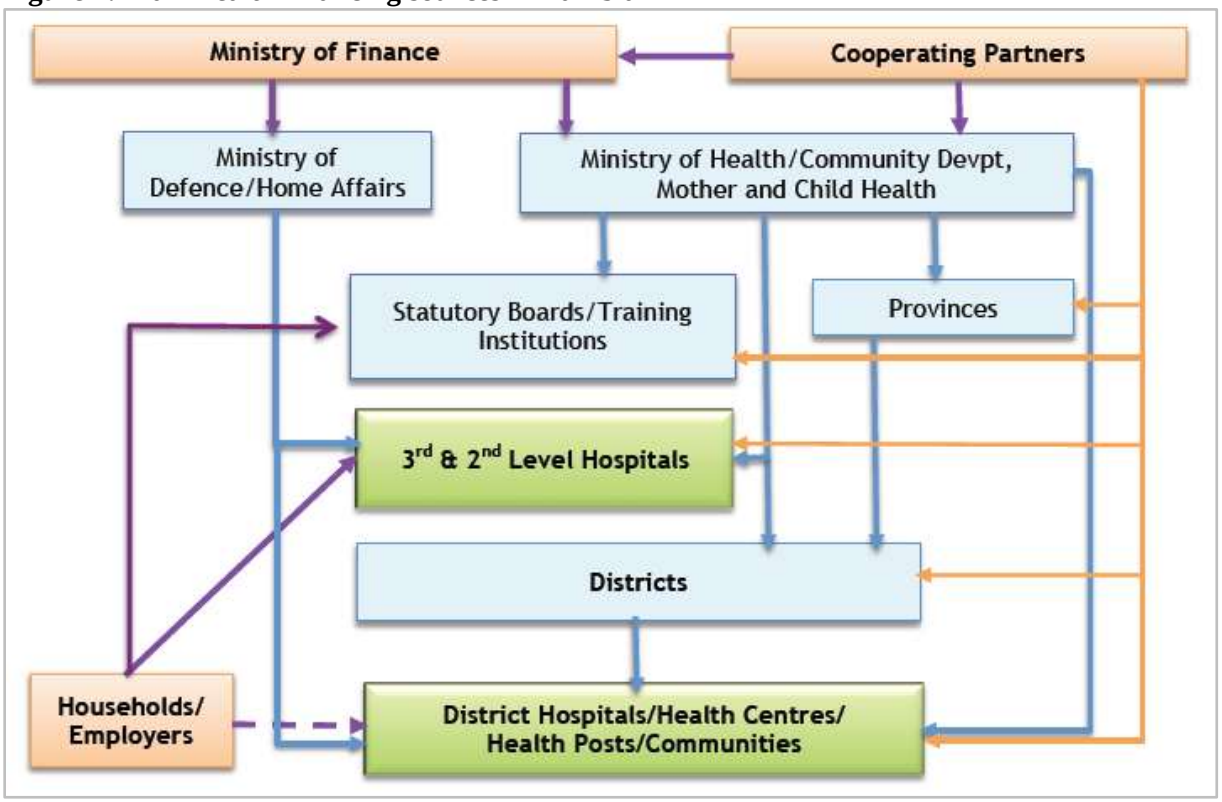
It is expected that the Community Health Strategy will be implemented with the support of the Cooperating Partners (CP) under the Health Sector Wide Approach (SWAp). A number of CP is already providing support for strengthening community health.

1.2 National and International Funding and Cooperation in Health Care in Zambia

The main financing sources in Zambia are the Ministry of Finance (MoF) with about 40% and Cooperating Partners (CP) and Households/Employers with about 60% of the overall health budget. The health budget has always been below the Abuja target of 15%.[7] The MoF is the fund holder for government generated funds and receives grants and loans from CPs. Part of the money from the MoF is disbursed directly to government line ministries such as the Ministry of Health (MoH), Ministry of Community Development, Mother and Child Health (MoCDMCH), Ministry of Defense (MoD), and the Ministry of Home Affairs (MoHA). The MoF disburses salaries and wages directly into individual bank accounts for all health workers on the Payroll Management and Establishment Control system. The MoF also is responsible for disbursing operational grants directly to provinces, statutory boards, training institutions, third and second level hospitals, and districts as shown in figure 1 below.

[7] Buleti Nsemukila, 2014

Figure 1: Main health financing sources in Zambia



Source: MTR 2015, p. 265ff

In addition to the funds managed by the MoF, CPs also disburse funds directly to different institutions at all levels of the Zambian health system through vertical projects and disease-specific programs. Households and Employers finance the Zambian health system through direct and indirect payments in form of payments to hospital-managed medical schemes, laboratory and other diagnostic tests, bypass fees, patient books, purchase of drugs that are unavailable in public facilities, and student fees, among other payments.

However, executed expenditures only account for MOH financed expenditures, not those from external funds. Most of the donors are funding provinces, hospitals, districts, and health centers directly but these expenditures are not recorded at the execution points. The field visits of the MTR 2015 revealed that not all donor funding to the districts is reported. For example, some health centers and mission hospitals which are supported by donors do not receive GRZ funds even if the MOH disburses the funds. As compensatory mechanism financial management at District Health Office withholds these funds for use in other underfunded areas handled by the district headquarters. Thus affected service delivery areas are prevented to have additional resources.

Apart from overall lower than needed funding levels, slow budget execution leads to underfunding. By the end of 2013, for example, less than one-third of the budget was eventually released to the districts with the highest release being for Northern Province at 35%. This shows that despite districts being the core of health care delivery services, they are not receiving sufficient funds even

for the minimum of operations, especially when over 80% of the allocations to districts also go for payment of personal emoluments.[8]

To address the situation, it will be important to improve recording and reporting of donor funds at all levels so that the Zambian Governments can have an idea of the full resource envelope and plan better. One way to resolve this would require the GRZ to demonstrate the adequate funding of district headquarters expenses, with the question remaining of who should fund for the monitoring and supervision? The allocation of resources can only be done better if the donor funds that are provided directly to the districts are factored in. Otherwise systematic planning and allocative efficiency is undermined.

1.3. Community Health Service Delivery as Last Mile of PHC

Community health care is essentially an integral part of Primary Health Care (PHC) as defined in the Alma Ata Declaration (1978)[9]: "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." Community health systems extend the four principles of Primary Health Care[10] to the last steps of PHC delivery - the households in the communities, to ensure better health outcomes through pro-active 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 i**nter-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."[11] Thus community health is

[8] cf. footnote 7, Assessement of the regulatory framework
[9] WHO 1978
[10] WHO 2003, Chapter 7: Principled integrated care, pp. 105 – 131.
[11] Mc Kenzie et al 2011, p. 7.

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 behavior, coping skills and gender to target specific health problems.[12]

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.
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[13] 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, counseling, advocacy, legal support, referrals and transport for access to follow-up services.[14]

[12] see WHO Regional Office for Africa, 2009, p 8.
[13] MOH 2010
[14] This definition leans on the concepts of McKenzie et al. 2011, the GFTAM 2011 and Futures Group Europe 2009.

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.

2. POLICY AND REGULATORY FRAMEWORK

2.1 Policies supporting the strategic development of community health

The National Health Policy (NHP) 2013 is built up on the 7 basic principles of the Zambia Vision 2030. Among these several principles are particularly relevant as basis for the community health strategy: *gender responsive sustainable development; democracy; respect for human rights; good traditional and family values; private-public partnerships*.

These principles are supportive to the objectives of the community health strategy for bringing health care delivery close to the households within a decentralized governance system that involves communities, including volunteers and traditional leaders and aims at facilitating the right choice of care for each individual and family. This approach includes the visions to reduce and ultimately eliminate gender imbalances and inadequate education, training and development. It also includes the prevention and reduction of Gender Based Violence against women and girls.

Further building up on the Zambia Vision 2030, the NHP of 2013 is strongly taking into consideration the influence of health determinants on the status of people's health, such as: environmental conditions, housing, employment, work environment, education, agriculture, food production, age, sex, and individual constitution. The existence of social and community networks, lifestyle factors as formed by cultural and socio-economic conditions as well as available health care services, determine the social determinants of health, i.e. they impact on the health status of individuals and communities.

The Zambia Vision 2030 and the NHP relate bad impact of health determinants to poverty levels and recognizes the necessity to reduce the national poverty level beneath 20 percent of the population, to attain education for all, reduce income inequalities, provide 100 percent access to safe drinking water and improved sanitation facilities to the people in urban and rural areas to exclude the major source of public health problems and epidemics in Zambia. Limited water supply coverage is a cause of over 80% of the health conditions presented at health institutions in Zambia, with significant adverse impact on the poor and children. The Zambia Vision 2030 envisages the attainment of 90 % access to sanitation for all by 2030.

The 7th NDP and NHSP 2017-2021 lay out 5 year planning cycles, enabling all to contribute to growth and ensuring corporate social responsibility by the private sector. This approach also includes improved family planning to better control the high population growth rate. However, current levels of poverty are exacerbated by HIV/AIDS, the infection undermines the prospects for economic growth (Zambia Vision 2030, pp. 25). It reduces health achievements: life expectancy at birth stood 57 years in 1990 but has progressively fallen since then due to 37% incidence in 2001. The estimated adult HIV prevalence rate currently stood at 16 % among the 15-49 year age group in 2006, the prevalence in urban areas (23 %) and among women (18 %) has been consistently higher than in the rural areas (11 %) and amongst men at (about 13 %).

Primary Health 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.[15]

Both documents call for equitable access to quality health care and include the disabled in society. Health services are complemented by community based rehabilitation services offered at rehabilitation centers 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.

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).[16]

Concerning RMNCH, Government aims at ensuring equity of access to provide quality, cost-effective and affordable RMNCH services to reduce maternal, newborn and child morbidity and mortality and address male participation. Access to essential vaccines is key to preventing infections. The strengthening of community involvement in maternal and child health through Safe Motherhood Action Groups and Traditional Birth Attendants is wanted.

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.

Poverty, Malnutrition and Sanitation

The NHP recognizes that 59% of the people live below the poverty line and face high inequities. Nutrition indicators suggest that the poorest are 1.5 times hit harder 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. Latest figures on Protein Energy Malnutrition 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. Further, only 40% of infants less than six months were exclusively breast fed and the median duration of exclusive breast feeding was found to be two months.

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.

In Zambia adult literacy was estimated at 72% in 2007. It is also estimated that less 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.

[15] Buleti Nsemukula 2014
[16] cf. GRZ 2006, p. 25ff

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). By improving health care delivery and health knowledge, Vision 2030 envisages to:

- Reduce the under-five mortality rate from the current 168 to 50 per 1000 live births by 2030;
- Reduce the maternal mortality ratio from the current 729 to 180 per 100,000 live births by 2030;
- Increase the proportion of rural households living within 5km of the nearest health facility from the current 50 to 80 percent by 2030;

Governance for Community Health Services

The policy directions under NHP 2013 and the Zambia Vision 2030 pose new requirements in the governance of the health sector. Hence the NHP 2013 refers in a couple of health areas to supportive measures for CH which promote partnerships for intervention implementation within the decentralized health care system. The NHP 2013 calls for "promoting awareness among Government employees and the community at large that health problems can only be adequately solved through multi-sectoral collaboration involving such sectors as Education, Agriculture, Water, Private Sector, including not for profit and faith-based organizations" (NHP 213, p. 27). It is further proposed to strengthen partnerships with other government ministries, communities, NGOs, civil society and international community within the framework of a sector wide approach. This shall facilitate public private partnerships in health and strengthen their coordination and harmonization (p. 43).

At the same time, the NHP acknowledges that transparency and accountability between the health facilities and communities are weak and most patients do not understand their rights when accessing services, indicating a lack of client friendly health facilities and services that require improvement. The NHP "ensure[s] the highest standards of transparency in the management of the health services, and accountability for the actions taken, resources utilized and to the communities served at all levels of health service delivery".

In view of community health the NHP (p. 43) seeks to improve the accountability of health facilities at community level and the understanding of patients' rights when accessing services. It aims at developing efficient and transparent management, representation and accountability systems and structures at all levels of the health sector to meet the expectations of all stakeholders. This shall be achieved with increasing professionalization of QA and QC where patient and community involvement can be facilitated. This development would include adoption of the patients' charter and the domestication of the patients' rights (cf. p. 44).

Private sector participation shall make CH services affordable. Also, the formation of community funds as part of the SHI shall be encouraged, along with funding from tax revenue and partially from community contributions (cf. NHP, p. 46). Other potentials shall be used through inter-sectoral cooperation to strengthen the structures for community participation, and transparency and accountability in the management of health services at community level (p. 48).

2.1.1 Sector Devolution Guidelines and Health Sector Devolution Plan

Starting in 2006 GRZ worked out the perspectives for decentralized public sector management, including of the health sector. According to the Sector Devolution Guidelines for Ministries, (SDG, 2006, p. 2) 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 center and the periphery."

The SDG 2006 envisage the center devolves decision-making authority, functions and resources to the district with matching financial resources for PHC which includes CHC. The District shall use mechanisms that ensure a "bottom-up" flow of integrated development planning and budgeting to the Central Government. The Councils and communities develop their capacity in planning, financing, coordinating and managing the delivery of services in their areas.

Devolution shall bring about enhanced political and administrative authority, consolidated by accountability and transparency in the management and utilization of resources and delivered in a legal and institutional framework which promotes autonomy in decision-making at local level.

The guidelines point out that the legal bases of Government functions require some amendments to current legislation (cf. p. 5f). This provides an opportunity to improve the regulatory framework for community health service delivery and adopt best practice procedures, most importantly that:

1. MOH ensures that community planning is incorporated into district action planning regulation
2. planners get oriented towards considering community plans in their budgeting exercise (cf. Action Planning for District Health Teams (APDHT) 2009, where this requirement is not emphasized)

In support of this there are several areas to which the regulatory framework needs to respond to:

1. incorporate compliance by DHO and all district and community level stakeholders with the social accountability framework
2. legitimate the coordination and monitoring procedures for CBV by NHC, HCC and HC
3. integrate the role and functions for support mechanisms, including TA, mentoring, supervision and research
4. Register and accredit CBV: in view of the current draft of the SHI, these prerequisites would allow for reimbursement of their services from insurance funds (see also p. 20f), if the SHI formulates respective packages and budget lines for PHC and CHC services.
5. Facilitate inter-sectoral cooperation and promote public private partnerships

The Health Sector Devolution Plan (HSDP) 2015 supports the formulation of the organizational structures that accompany the transfer of functions and staff from Ministries to Councils who both are bound to require changes in the delivery of the transferred functions. During the transformation period this need must be absorbed to support the CHS through respective structures and procedures for the improved coordination of community health service delivery. This affects particularly

additional management support for community health systems from the community to the national level, by means of establishing focal points at each level:

1. HC Focal Point (HCFP), District Focal Point (DFP), Provincial Focal Point (PFP) by strengthening the Senior Health Education Officer at provincial level, National Focal Point (NFP) at MOH. The District Focal Point oversees, catalyzes and ensures involvement of the communities into planning, monitoring and evaluating community health service delivery.
2. The Focal Points relate to resource centers at national and district level to mobilize TA inputs, mentoring support and research where necessary (cf. chapter 6).
3. Community monitoring by CBV gets coordinate and aggregated by the EHT and the responsibility increasingly rests with the EHT to free clinical time of the Nurse In-Charge. The EHT maintains a reporting link to the HF In- Charge who keeps up
    a. supervision of the monitoring requirements
    b. reporting to the HCC/HPC

The province will provide integrated support to Districts on primary health care (HSDP, p.38). This support will be channeled through four units which fall under the provinces; namely Public Health, Clinical Care, Human Resource and Administration, and Planning & Health System Support Units. The Provincial Health Director reports to the Director Health Promotion, Environment and Social Determinants who is answerable to the Permanent Secretary at the national level.

With reference to the community level and community participation, the Social Accountability Framework (see p. 64) promotes the strengthening of governance in community health in view of transparency based on improved health data communication and intervention planning. If headmen participate and communicate community health needs to their respective Chiefs who are selected into the Councils. With the enhanced responsibilities endowed on Local Government Councils, the participation of Headmen in NHC meetings should be encouraged to enable community health planning early to lobby in headmen offices and the councils in support of identified local priorities, needed interventions and required funding. The district level and DHO remain the major reference point for community health services and are strengthened by this CHS.

Filling the Human Resource Gap

The National Community Health Workers Strategy NCHWS 2010 has been developed to strengthen community health services delivery in a large-scale and qualitative framework through strengthening the human resources situation in Zambia. Its rationale is to bring basic health services closer to the family, in line with Ministry of Health's mission statement. It guides the NCHAP which repositions and expands the already existing CBV and builds up their capacity to the grade of Community Health Assistants (CHA) based on a 12 months education in required skills in health care delivery, community mobilization and coordination of interventions for the volunteers from communities and from outside of the community. The NCHWS integrates this cadre into the health system where they are attached to the HC and supervised by trained In-Charges of the health facilities as well as indirectly by the DHO.

The CHA constitute the formal link between the communities and the health system. The formal lines commence during recruitment of the CHA who is recommended through the NHC, and

processed under the participation and review of the DHO (p. 25), the Health Center and the traditional leaders for meeting the selection criteria (cf. p. 23f) in order to be considered for recruitment. This distinguishes those who become a CHA, from the common CBV, who can informally join the NHC to contribute to health services in their communities. According to the NCHWS (p. 19) the CBV do not need to meet any selection criteria, however, latest assessments of the CBV cadre point at higher sustainability if the CBV is a community nominee and recruited by the NHC rather than the health facility as this enhances the social accountability.

The training of the CHA is standardized and developed with inputs by professional bodies such as the General Nursing Council, MOH, HPCZ and various Medical Schools and conducted in two specialized training institutions. It encompasses 11 modules cutting across health sector issues to do with health promotion, disease prevention, clinical tasks and secondary duties like coordination, TA to CBV, mobilization, monitoring, etc. (see p. 25). Following training, the CHA get registered with the General Nursing Council and work under a Statutory Instrument.

CHA take on roles in the broader health system structure, namely the Health Center or Health Post Committees, where they and the In-Charges meet with NHC to review the community health service interventions. Thus they strengthen the linkage between the communities and the formal health system. CHA also take a function in the NHC, where they regularly discuss with the CBV and Traditional Leaders, community health interventions for planning and receiving feedback from the NHC members on issues concerning processes and results. Within this system of formal linkages with community and the health system, CHA ideally share 80% of their time with the communities and 20% of their time side-by-side with skilled HW in the health facilities. They have a variety of professional relationships in order to carry out their duties, i.e. with: health professionals, church leaders, NGO/CBO/FBO and other community groups, with CBV, traditional leaders, church leaders, senior headmen/induas and council members (chief's cabinet).

The scope of work encompasses the basic areas of: health promotion, disease prevention, and basic curative and rehabilitation activities ranging from common ailments, first aid to treatment of the major communicable diseases (HIV, TB, Malaria, ARI and Diarrhea) to providing support to care in the health facilities.

The formal environment of this regularized and salaried cadre further distinguishes them from the CBV. In cases where an optimal environment is established and 2 CHA serve under a skilled HW, they are fairly able to carry out their duties as envisaged. Since the healthcare workforce gap is huge, vacancies for health professionals are high (cf. p. 6); there are frequent situations in health facilities where task shifting draws the CHA into the role of the skilled HW. About 20% of the CHA[17] therefore expect to be promoted into a permanent position in the long term. This is in line with the NCHWS, which aims at up-grading those CHA who worked diligently for at least 3 years into nursing, environmental health and clinical officer programs (p. 24). The IPA[18] observed that as expected from CHA job description, new services are expanding the external services of HPs:

- Community mobilization: 57%
- Health inspections 43%
- School outreach 38%

[17] cf. Secor, Andrew, 2017
[18] ditto

- Disease prevention 24%
- Under-5 clinics 14%
- Family planning 14%

Looking at **health outcomes**, certain priority areas are not achieved, such as the expected number of ante-natal visits (cf. annex 16) and referral. Other weak areas remained supplies and available medicines, social accountability, community monitoring, reporting and aggregation of data for inclusion into DHIS2 and action planning.

2.2 Regulations and Guidelines for Community Health Care in Zambia

Several regulatory frameworks have been drafted to legitimize roles and functions of health workers. A draft bill on service level mandates (NHSA) is pending with the Parliament that introduces a renewed National Health Services Act which empowers and improves the organization and coordination structures and legitimizes the community health interactions through a new legal framework. It builds up a strong basis for community health institutions, particularly concerning the role and functions of DHO, HC/HP, HCC/HPC, NHC and community participation.

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 Neighborhood Committees the National Community Health Assistant Program Implementation Guidelines and Standard Operating Procedures for the Community Health Assistants.

The utmost pre-requisite to prevent future fragmentation of community health services anchors the approach for community interventions in the mandates of the above framework of public sector delineation of roles and functions by which all stakeholders, including CP, are bound. Therefore, all implementing partners follow the MOH defined structure for implementation and coordination at district and community level.

Role of Health Centers (HC)/Health Posts (HP)

Health Centers form Health Centre Committees (HCC), drawing members from all NHC, NGO/CBO/FBO (ex-official) within the catchment area, from the HC the In-charge (Secretary) and other staff involved in to community or public health work, e.g. the EHT and from the Health Post the CHA (ex-official). With the support of the Health Center Focal Point (HCFP), the health center ensures all HCCs are functional in the following areas:

- The Health Center or Health Post shall be the secretariat to HCC/HPC meetings responsible for scheduling quarterly HCC/HPC meetings, taking minutes
- The HC/HP In-charge holds the HCC/HPC secretariat and calls for meetings
- The HC/HP In-charge is supervising the CHA and EHT, all are trained in defined monitoring functions and the In-Charge is responsible for the aggregation of the data in the HIA4 forms. The in-charge may delegate the data entry into the HIA4b form, which aggregates the data of all CBVs to the EHT. The in-charge or EHT aggregates the data during Monthly Data Aggregation and Review (MDAR) meetings with the CBV and CHA.

- The EHT coordinates the data aggregation of the CBV, the CHA the interventions (see annex 1-4 for all coordination roles).
- The CHA mobilizes the community and coordinates the interventions or regular annual health events, and orients the CBV by providing TA where necessary and within their competency.
- HC/HP ensure that HCC/HPC receive capacity building in areas that need strengthening such as leadership and governance, coordination and supervision skills, quality improvement, resource mobilization, communication and reporting, monitoring and evaluation, genders and health
- The data that is aggregated through the HIA4b form at the MDAR is discussed in the HCC meeting.
- the HCFP identifies gaps in capacity building resources and reports actual requirements to the DHMT for implementation where HC/HP TA is insufficient

Role of Health Centre Committees (HCC) and Health Posts Committees HPC

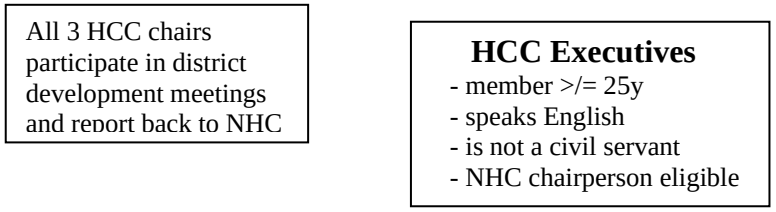
HCC/HPC shall ensure that NHC in their catchment areas are formed as prescribed in the NHC guidelines. The HCC/HPC shall provide support to NHCs in the following areas

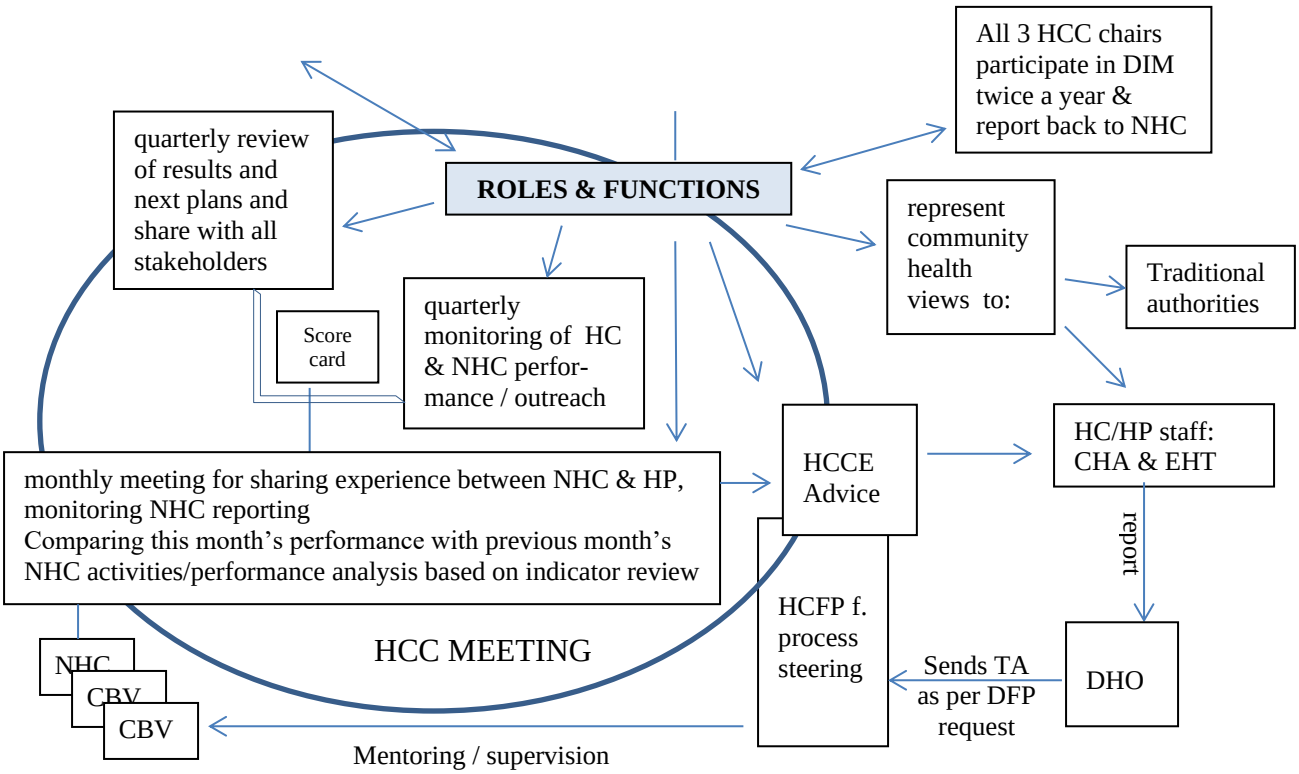
- HCC/HPC receive monthly reports on community health interventions
- HCC/HPC quarterly performance review meetings are held. These meetings shall require:
    - health centers to present the quarterly performance and review of monthly reports, as a platform to invite community participation on how service utilization can be improved
    - In-charges or EHT to give an update on the results of community data that has been collected through the MDAR, so that it can be used for decision making.
    - NHC members/NHC chairs to bring in their experience based on the monthly and quarterly reporting,

  HCC/HPC members review any other supporting document on community health intervention, including narratives, minutes, and memos of NHC meetings.
- Capacity building where they are trained as trainers or facilitators, supported by HCFP and DRC
- Monthly supervision to NHCs to ensure planned activities are implemented
- Develop plans to mobilize resources required for NHCs to implement planned activities, where possible based on data collected through the MDARs
- Collect vital information from NHCs such as population data, CBVs trained in various service areas, NHC membership details, number of NHC members receiving training, mentorship in various areas

Figure 2

Roles and Functions of HCC Executives (HCCE)





Adapted from: Neighborhood Guidelines 2017 and CHS 2017, pp. 22, 77 - 79

Role of Neighborhood Health Committees (NHC)

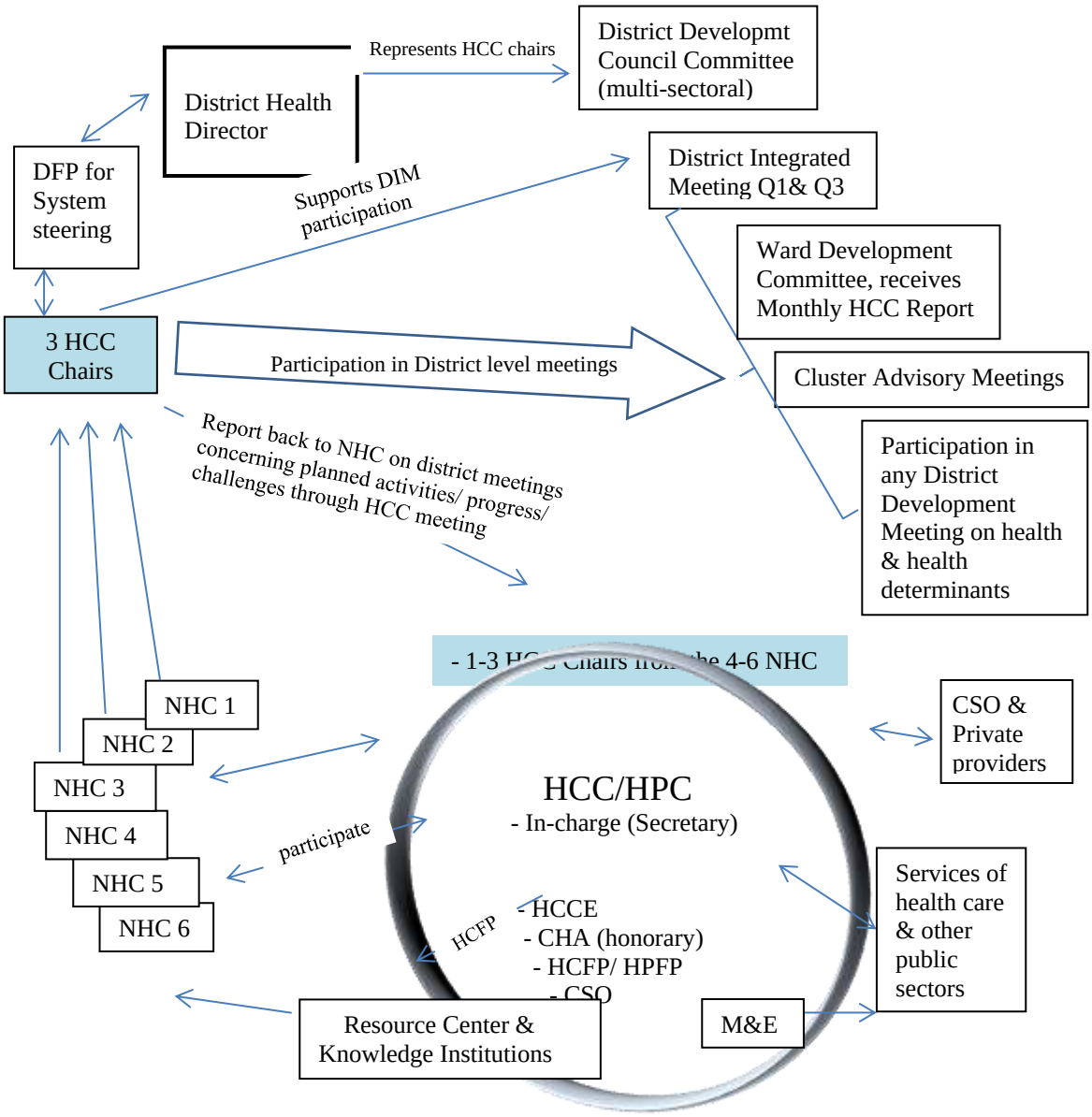
The NHC shall be the link between the community and the health care system through the HCC. These are community-based groups that help their communities meet health needs more effectively. Members shall be selected as stipulated in the NHC guidelines. NHC shall perform the following functions.

- NHC select leaders to attend all HCC/HPC quarterly review meetings, they are eligible to becoming elected as HCC/HPC chairman
- Coordination of CBVs in its catchment area
- Coordination of the community health action planning process
- Monitoring of action plan implementation
- Engaging stakeholders in its catchment area to mobilize resources and support in care and transportation
- NHC members note down findings from the aggregated community data and discuss these findings and possible implications at their respective NHC meeting.

Recent programs like the MGDi or the Chipimo District pilot have shown the required linking of NHC to the HCC and the district level to be an effective community health institution, as shown in the figure 3 below.

Figure 3

NHC Connecting to District Level and Reporting Back to Community



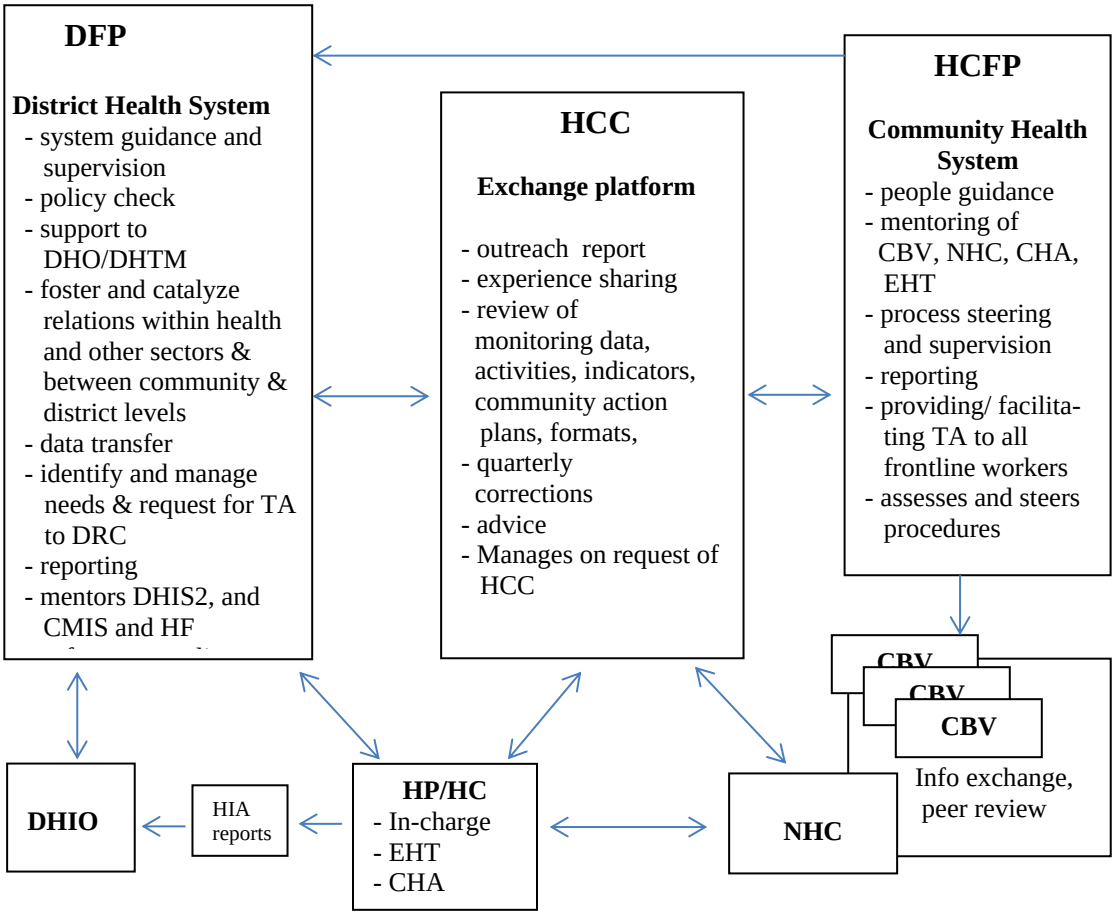
For detailed information see CHS 2017, pp. 71 - 79 and NHC Guidelines 2017

Focal Points at Health Posts (HPFP), Health Center (HCFP), District Health Office (DFP) and MOH (NFP)

The Focal Points oversee the operationality of the system (DFP) and functioning of procedures (HCFP) and strengthen the community health system at their respective levels. They are pre-occupied with systems maintenance, liaison between the levels, ensuring meeting cycles are observed, policy followed, defining and communicating TA for the community level with support of the NFP and the resource centers at national and district level. Adopted from international best practice, the interaction can be depicted as follows in the figure 4 below for the CH system.

Figure 4

Role of Focal Points at District and Community Level in Parenting Strategy



(cf. MOH 2017b, NHC Guidelines, p. 39 and CHS, p. 72 - 76)

2.2.1 Action Planning for CHC Service Delivery

The HSDP (2015) states that Zambia will change the MTEF approach which is currently used in the health sector, following the Action Planning for District Health Teams (APDHT) 2009, as the PHC/CHC budget will be part of the council allocation: some MOH funds will be channeled to the

devolved functions. The allocation that the MoH is providing the functions to be devolved to the councils comprises both personnel emoluments and the programs budget but does not comprise the capital development expenditures' budget, pre-service training and the drug budget (p. 65).

Until date, there is a wide range of responsiveness of District Health Management Teams to community health issues across the districts up to the extent that guidelines seem to be short-tracked. Stronger accountability towards the communities will motivate future district level planners to better consider local needs and follow transparency and accountability regulations.

The community participatory level is not well detailed in the APDHT 2009, so that current health planning at the community and district level is biased towards a top down approach. The handbook does not connect to community level institutions for community participation, but makes reference to communities abstractly and/or assessed through health workers. In conclusion it currently seems that the guidelines are insufficiently applied to planning.

At the threshold to implementing devolved functions in the health sector during this transformative phase, health services planning, including those at community level, is envisaged to be taken over by a more participatory and bottom up approach that co-ordinates and implements mechanisms to ensure bottom–up flow of integrated development planning and budgeting from the district to the central government; promotes accountability and transparency in the management and utilization of resources; and envisages to develop the capacity of Local Authorities and Communities in development planning, financing, coordinating and managing the delivery of services in their area. Among other elements these will guide community based action planning in the decentralized system for PHC (Health Sector Devolution Plan (HSDP) 2015, p. 18).

Within the transformative approach health sector authorities from the National to the Community levels have put much work into developing frameworks that support the bottom-up planning and financing, such as in adding community planning guidelines, guidelines on leadership development, guidelines on NHC which include guidance on HCC/HPC roles and functions, as well as the new NHSA. These documents are still in draft version but far advanced for soon use in the sector (cf. chapter 6, Implementation Framework).

In the decentralized health sector, the province will provide integrated support to Districts on primary health care through four units: Public Health, Clinical Care, Human Resource and administration and Planning & Health System Support Units. The District Health Officers remain answerable to the Provincial Health Officers concerning the four units, for 1stLevel Hospitals, Health Centers and Health Posts and integrated service delivery on PHC/CHC.

While only few or no structural implications are envisaged for the Provincial Health Office Headquarters, there will be many structural implications at this level as all the PHC/CHC functions being performed by the District Director of Health, Health Centers and Health Posts will be devolved to the local government councils. There is need to accommodate the new statutory functions for the remaining ministerial responsibilities at district level. The system of local government in Zambia encompasses three categories of single tier structures of local self-government: city, municipal and district councils.[19]

[19] Local Government Act, Cap. 281

The councils, as established under the Local Government Act, are corporate bodies that can enter into contracts, sue and be sued, empowered to exercise planning, legislative and executive powers. Each council has a governing or political structure and a management team or administrative structure for its operations. This facilitates the exploitation of close partnerships at the community level, which is all around intended in the strengthening of community health systems.

Devolution of PHC functions from MOH to Councils results in organizational structure changes in councils because there are no full time structures that deal specifically with neither PHC nor CHC yet. These changes require the development of appropriate organizational structures in councils for them to effectively implement and deliver the devolved health services. The Health Sector Devolution Plan envisages functions to be devolved related to prevention of diseases, promotion of health and basic curative services, their administration, monitoring, planning, technical support and referral under council health departments. This situation is conducive for the integration of the revised community system functions described in this community health strategy, particularly to be matched with the revised guidelines for constitution, functions and roles of the community based health organization of the NHC (May 2017) which links the community and health facility, ensures participatory community health activity implementation and monitoring, as well as effective coordination of community health activities.

2.2.1.1 Health Centre and Community Joint Action Planning of CHC Service Delivery

The Health Centre/Health Post ensures that HCC/HPC and NHC participate in the planning process. Since Community planning takes longer across all levels, the community starts the process even before the national launch of planning. Commencement may be as early as in February of each year. The communities engage into planning of their action plans during February through April. Following planning, which should be ready by May, budgeting is due from May through July. Thereafter, the budgeted plans should be handed over to the PHO and MOH. Chapter 6, Implementation Framework, describes the detailed procedures, cf. also chapter 2.2 and figure 8.

HCFP/HPFP support HC/HP and NHC in enabling communities to do the planning and call for TA in form of lectures, short seminars or the like to catalyze the process of informed development, beginning with the outlining of the process as per the community planning guidelines, the conditionalities for planning as per the Guidelines for Health Action Planning at District level.

The HCFP/HPFP act as catalyzer and facilitator, e.g. by identifying knowledge and skills gaps and drawing in TA from the District Resource Center, bringing the right actors and information together at the right point of time of the planning process, etc. The HC FP oversees the process and involvement of either NHC, HCC, or health workers (CHA, EHT, etc.), and the CBV.

2.2.2 Financing of CHC in the Decentralized Context

The HSDP 2015 (p. 65) aims at changes to processing the current Medium Term Expenditure Framework (MTEF), the three year top-bottom, bottom-up approach rolling plan which is used for budgeting at the District level and then taken to the Province for consolidation and later to MOH Headquarters, before it is submitted to the Ministry of Finance (MOF). This will change as the PHC/CHC budget will be part of the council allocation and decisions can be taken at district level.

The administration of the payroll has been decentralized. Most of the budget of functions providing primary health care is already decentralized and districts receive direct funding from Ministry of Finance. The revenue from the councils' own sources are used mainly to cover council administrative functions rather than service delivery for pro-poor development.

The regulations of the devolution plan may cause conflict of pieces of legislation regarding financial management and audit in councils. This requires revision of the legislations and adjustments once the devolution plan is worked out.

The Health Sector Devolution Plan (2015, p. 77) encourages CP to support the districts by pooling funds in a common basket to be based at the Ministry of Health. The Ministry of Health will directly disburse funds from the basket to the district health offices under the councils upon the latter meeting set targets.

3. SITUATION ANALYSIS

3.1 Objectives and Methodology

The objective of the situation 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 shall inform of options for the improvement of community health service organization and coordination to guide on improving coverage and quality of the services.

The community health strategy is based on review of the existing national policies, regulations and guidelines for community health service delivery and the literature on international best practices in community health programs. Review has also taken account of assessments and evaluations of local and national developments, achievements and gaps in community health work including analyses of the social determinants of health in the communities that impact on needs and demands for health care services and interventions and the conditions for referrals.

Consultations, workshops, and interviews have been conducted with MOH managers at all levels and with stakeholders in the different service sectors (public, private, non-profit) to seek information about national best practice and intervention conditions. 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, CHA and CBV, as well as at the CHA training institution in Central Province with teaching staff.

The analysis identifies the constraints and conditions for health outcome improvements in the context of previous achievements of Community Health within the four principles of PHC. The methodology also takes into consideration the analysis of international state of the art conceptual developments of community health, its financing and low cost interventions for the realization of the implementation of community health in Zambia.

3.2 Community Health Systems

In the last decade the delivery of health services through community participation has increasingly fragmented in terms of contents and quality of services, coordination mechanisms and

organizational structures. CBV lack an acknowledged regulatory framework and binding operational guidelines though they are coordinated and guided by NHCs and HCCs.[20] Supportive mechanisms, proper planning, community score cards, and proper coordination mandates at district level are inadequate. While the NHCs still exist in 84% of health zones,[21] their functionality varies and depends largely on the guidance of District Health Office staff and managerial skills of HP and HC staff. NHC expected performance at HC is not guided. Meetings to determine community priorities are rarely held. Accountability mechanisms and tools for health facility staff to be accountable to the community are lacking. Weaknesses in the organization, coordination and general management of NHCs seem to have been addressed in some areas supported by development partners by at times using standardized training based on the existing National Training Operational Plan, developing standardized reporting structures, supportive structures for the CBV, continuously improving reporting tools and monitoring structures of NHCs, including community registers,[22] and using own training schemes at other times.

The capacity at District level to provide appropriate support to community level structures and management are still weak. The reiteration of the National Decentralization Policy in December 2016 is now an opportunity to develop the capacities for sustainable community health systems. A simplified guide to community action planning[23] and a hand book[24] are supposed to be available at the Health centers and health posts. Achievements are based on communities participating in planning, budgeting, implementation, monitoring and evaluating the interventions in some districts yet reviewing community action plans is generally weak; community capacity assessment tools are not available nor are health facilities monitoring community performance explicitly. Best practice now shows that doing so strongly motivates volunteers to sustain their inputs, so are supportive supervision, mentorship and CBV efficacy self-assessments.[25]

A draft Framework has been developed for the involvement of community representatives in all aspects of planning, implementation, monitoring and evaluation to strengthen social accountability; it would be even stronger if communities are getting involved into budgeting their strategies.

3.2.1 Community Health Performance and PHC

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

[20] cf. Masange, John C., 1997: The "Integrated Guidelines for Frontline Health Care Workers, On The Road to Deliver Promotive Preventive Curative Cost-effective Interventions" were published by the Central Board of Health, Lusaka. These guidelines are not used any more on a binding level since 2005. New guidelines are drafted by May 2017 by MOH and partners (EU, Jica, UN Zambia), called the: Neighborhood Health Committee Guidelines. These and the "Neighborhood Health Committee Constitution" (MOH, EU, UN Zambia, Dec 2016) were validated by the Millenium Development Goal Initiative (MDGi) and are likely to be finalized in mid 2017. They constitute the basis of the implementation framework in this CHS document.

[21] MOH, MoCDMCH, June 2015

[22] GRZ/Unicef, November 2016: A feasible coordination structure is mapped on slide18, with HCC relating to TA, DHIS2, Ward/District Development Coordination Committees.

[23] Ministry of Community Development Mother and Child Health, 2013

[24] Ministry of Health, 2011b

[25] See JICA (TICO) experience of community empowerment in Chisamba District (2014-17), cf. MDGi experience, footnote 22

(HPs), Health Centres (HCs), district hospitals and Health Center Committees (HCC) and Health Post Committees (HPC) that link PHC with the communities through Neighborhood Committees (NHC). CHC 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.[26] The national health policy[27] 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.

3.2.1.1 Distribution of Health Services and Referral

The bulk of health services are provided at PHC level in available health facilities which act as entry point to the public health care system and have been the major investment since the 1990s to improve the equitable distribution of primary health care by increasing Health Posts infrastructure across the country. However, SOPs remained outdated, the HRH deployed in PHC facilities are of inadequate numbers and constrained in the effective management of Community Based Volunteers (CBV), hence the distribution of services closer to the families remains constrained.

The referral to PHC services is negatively impacted by inadequate health infrastructure, HRH, transport and weak governance structures. Though community referral guidelines exist, the support to community referral systems is limited and shows high dropout rates among CBV, communities and local councilors involve little into it as funds for developing community referral systems lack. Access to PHC services is inhibited by a lack of nurses, doctors, limited hours of local facilities and stock outs of commodities. People directly access the higher level health facilities, where congestion is observed. There are 12.4 clinicians per 10,000 persons,[28] which is significantly below the World Health Organization's recommended threshold of 22.8 clinicians per 10,000 persons. In the current situation of PHC at community level -where the disease burden is highest, HR have a gap of 30% midwifes and 34% nurses. Where a nurse as In-charge in the health post is not available, Environmental Health Technicians (EHT) substitute, yet they also lack 24% of placements, and 23% of all CHA are acting as facility in-charge[29]. In terms of ratios, the WHO recommended proxy ratio of 2 medical doctors and 14.3 nurses per 1,000 population to achieve the health related MDGs, the Zambian ratios of 0.07 and 0.6 per 1,000 population for medical doctors and nurses, respectively, is of extreme concern.[30]

After nurses, midwives, and clinical officers, Environmental Health Technologists (EHT) represent the category of skilled health worker with the largest distribution across Zambia.[31] EHT perform a number of services in the Zambian health facilities including: conducting inspections and routine water and food field tests in their catchment area, investigation and control of disease outbreaks and protecting and improving environmental quality around the facility.

[26] MOH, 2012a
[27] Ministry of Health, 2012a
[28] Ministry of Health and MoCDMCH, 2014
[29] cf. Secor, A., 2017
[30] cf. Buleti Nsemukila, 2014
[31] Ferrinho, P. et al., 2011

In addition, though not formally, they are typically the community focal point person and in many cases also call the Neighborhood Health Committee meetings, e.g. when there is no CHA. Since EHT are widely spread in Zambia, are already on GRZ payroll, have the mandate to serve the community as well as the facility, and have been an integral part of the system for many years, these health care workers are instrumental in providing and improving primary health care. EHT are ideal candidates to monitor services and data provided at the community level.

3.2.2 Community Based Volunteers (CBV) and Community Health Assistants (CHA) as Agents of Health Promotion and Disease Prevention

The recognition of the community component in the NHSP 2017-21 in planning for Primary Health Care and implementation is alive to the fact that government appreciates the contribution being made by CBV in the provision of health service delivery. In 2017, Zambia has about 23000 CBV. Another pillar of community health services was consolidated already in 2010 with the implementation of the National Community Health Workers Strategy, NCHWS. This was developed to support the scarce HRH at the primary facilities and led to the establishment of two Community Health Assistants Training Schools (Copperbelt and Central Provinces). By 2016 they had trained 1577 Community Health Assistants[32] out of the envisaged 5000. The annual output is 500 CHA. Ideally two CHA support the Health Post In-charges and cooperate with the CBV in community health work. The CBV also spend time in a health post and in the communities supported by Government or Cooperating Partners' (CP) projects in various categories: Safe Motherhood Action Groups (SMAG), Infant and Young and Child Feeding (IYCF) volunteers, Out-patient Therapeutic Feeding (OPT), Integrated Community Case Management (iCCM), Community Based Distributors (CBD), Peer Educators, WASH champions, ART, TB and Malaria Agents (see figure 8). This group is fragmented through different recruitment and training of volunteers by the community systems and the CP.

The CHA should spend 80% time in the communities and 20% time in the facilities, yet the reality is inverse depending on whether there is other qualified healthcare staff at the health post and the supervision they receive. Many CHA report that they are not able to meet the expectations set into them since workload in the facilities is too high. A recent study[33] outlines that 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 (20) to serve[34]. They consider attendance to about 7 villages in their catchment areas as feasible. In addition to this discrepancy, the previous NHSP outlined that only 19% of CBV were active to support them.[35] A process evaluation observed that adequate staffing through a nurse or a midwife at the health post does allow realizing the envisaged ratio.

The implementation guide for the National Community Health Assistant Program (NCHAP, MOH 2012, pp. 18-20) clearly lays out the various coordination and management layers of the CHA

[32] cf. Clinton Health Access Initiative, August 2016b.
[33] cf. Secor, A., 2017
[34] 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
[35] NHSP 2011-2016

programme. Given, however, that the CHA is not able to meet the envisaged community to facility ratio their management mandate appears overambitious as constraints emerged:

- Not all HP or HC are having any CHA, many have only one CHA instead of two.
- CHA are expected to stand in for unavailable HW in HP/HC, taking on their roles. In their job description there is no clear or comprehensive description of the CHA role and functions in such cases.
- Given the HW scarcity, CHA in near future will not be able to fulfil their managerial *and* coordination roles.
- The community participation concept poses a high challenge to the CHA by putting her into the lead rather than the community representatives at the NHC.

The NCHWS implementation, though constrained, nevertheless does show evidence of the impact of the CHA cadre on health outcomes at the community level but there is much potential to improve on this.[36] Recent process evaluations of the cadre 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.[37]

There are currently three levels of coordination of CBV interventions[38]

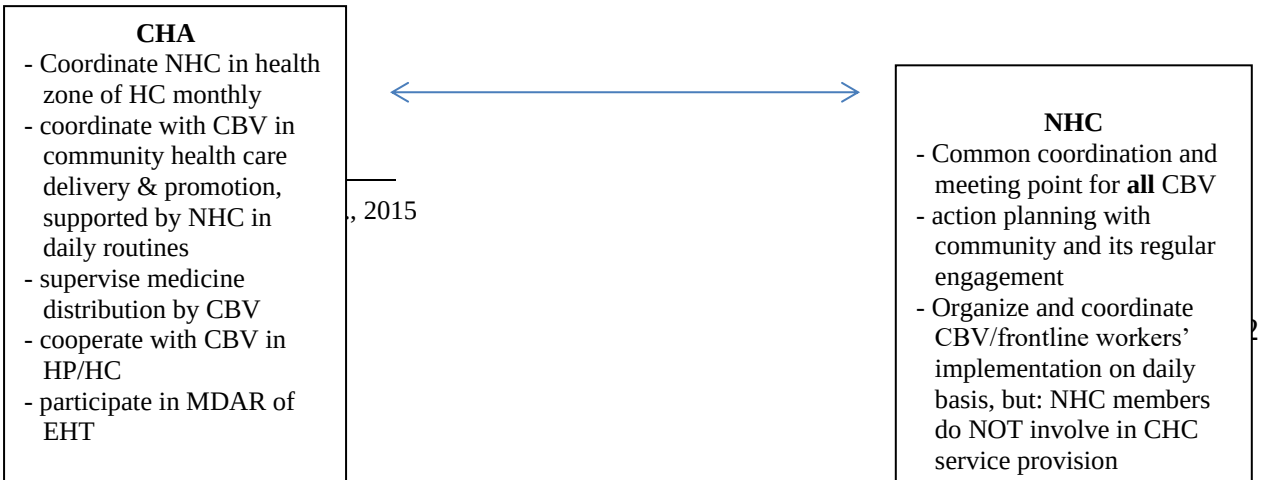
1. Directly at community level through NHC or implementing partners
2. Coordination of CBV through the Health Center In-charge (Nurse or EHT) or CHA
3. Coordination of CBV and CHA collected community monitoring data through the health facility In-charge or delegated to the EHT for aggregation and up-loading into the DHIS2 during Monthly Data Aggregation Review meetings (MDAR)

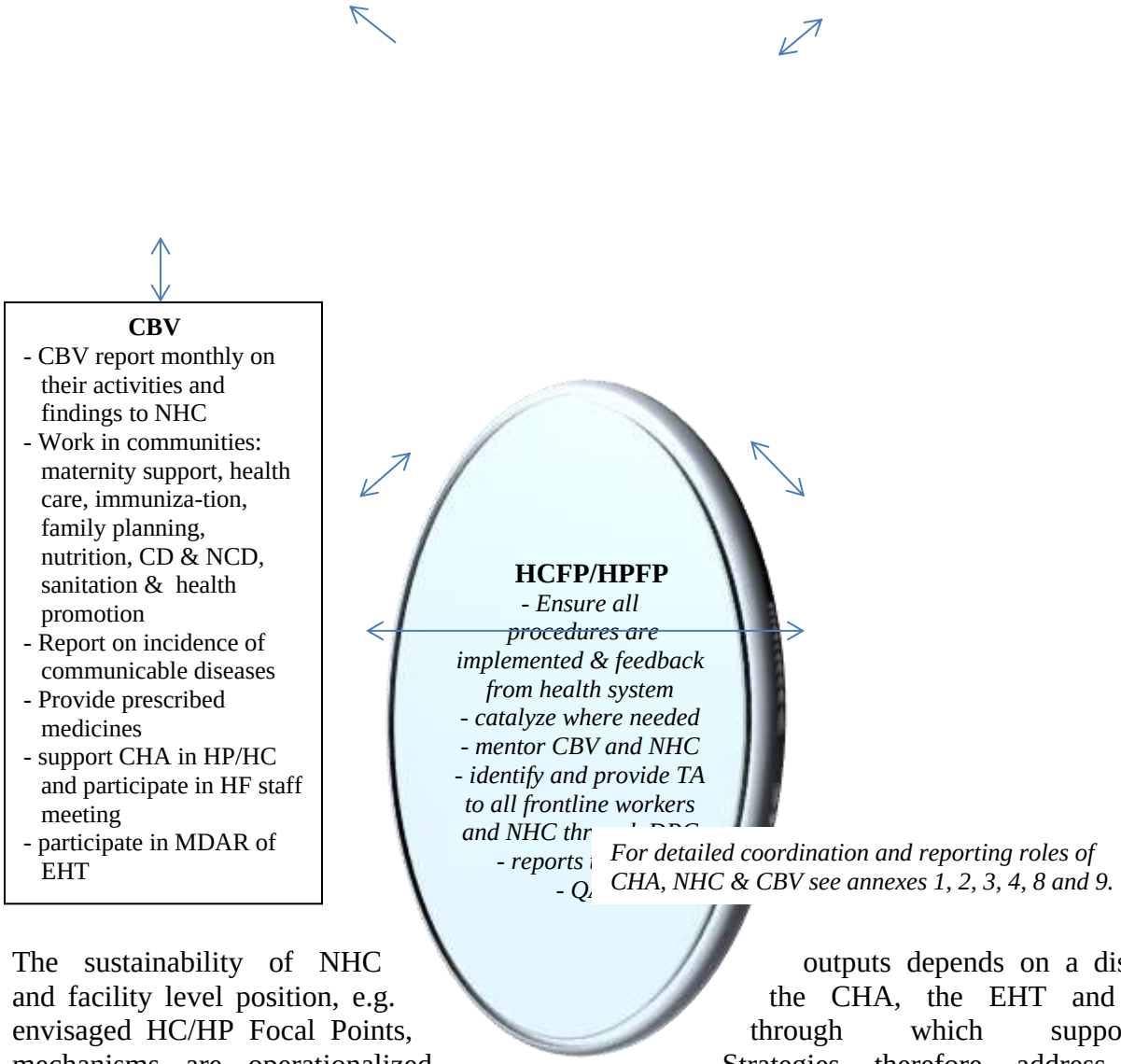
Concerning the coordination of volunteers through NHC, it is recognized that the mechanisms of coordination need to be strengthened and those of CP harmonized with the community systems, i.e. the NHC. Pilots on NHC related mechanisms have been conducted in a representative number of districts and yielded results in terms of operational approaches, structures and impact of the interventions. (See annexes 1, 2 and 4 on coordination tasks, esp. of CHA and NHC).

While the coordination task of the Nurse in-charge/EHT is straightforward, there are overlaps in the coordination mandates of the NHC and the CHA (see annex 1). Given, however, that the CHA at the most are able to visit a community 6 times a year, it becomes clear that the NHC practically carry out any overlapping coordination mandate throughout the rest of the year, besides their specific coordination tasks (see annexes 1, 2, and 4).

Figure 5

Major Roles and Functions of NHC, CHA and CBV, with Support Mechanism





The sustainability of NHC outputs depends on a district and facility level position, e.g. the CHA, the EHT and the envisaged HC/HP Focal Points, through which supportive mechanisms are operationalized. Strategies therefore address the coordination issues by means of adjusting their routines to the existing guidelines for the implementation of community health interventions through CHA and NHC, which is by adopting and duly carrying out their prescribed roles as per those documents.

3.2.2.1 Success Factors for Strengthening and Maintaining CBV

Efforts to develop common denominators for the contributions of volunteers in community health service delivery in Zambia need to yield sufficient results in bridging the human resource gap and maintain a steady volume of CBV. The proposed harmonization of CBA is built on international practice and aims at retaining CBV in the long term, cf. Box 1.

Eight success factors **Box 1.**

Five success factors serve to harmonize the fragmented groups of volunteers and tie them into the Primary Health Care System: Selection and Recruitment, Initial Training depending on the health priorities, Simple Guidelines and Standardized Protocols, Regulatory Framework and Political Support, Alignment with Broader Health Systems Strengthening.

In the Zambian context, independent projects have identified culture sensitive success factors that contribute to higher volunteer retention rates, such as:

- a team approach applied by the NHC and HCC/HPC for strengthening CBV,
- involving informal monitoring methods like storytelling, participatory monitoring and peer review as a management tool of the NHC that informs on immediate work results,
- the volunteers build a one-cadre identity and experience of mutual support that follows the same mission of improving the health status of the community members,
- Volunteer activities that could be scheduled around other work and activities

The CBV as the operational component of NHC need to mend the split into various groups of: SMAGS, IYCF, OPT, ICCM , CBD, Peer educators with different own committees, different training levels (up to 20 days in the public sector, several weeks to months in CP services). They require one set of standards for promotive, preventative, curative service delivery and referral.

Based on Zambian experience,[39] training a large group of CBVs in each community (10-16) helps reach the entire community, including those who are difficult to reach, usually least receptive and who are most in need. Zambian and international experience (Rwanda) look at a minimum of at least 6-7 CBV per village required to have functional community health services. A cascade training approach can help to keep the cost of training multiple CBVs at low cost.

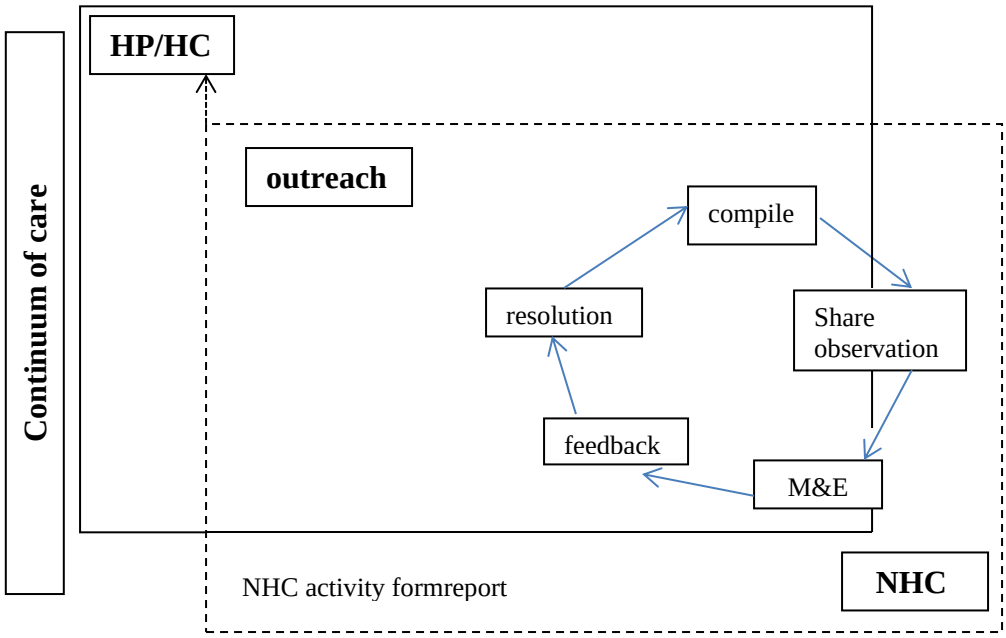
Looking at good practice in India training gradually built up the CBV through a range of modules, as in the SMAGS development in Zambia. Training begins with core modules in basic health care, health promotion, disease prevention and monitoring. It then advances through refresher trainings to more detailed knowledge and health management tasks required in NHC. CBV have options to choose appropriate timings and modules to build their capacity.

Furthermore, the Chipimo Process program has shown that self-assessment of CBV efficacy with respect to the continuum of care provided through HP/HC and NHC is a useful tool to improve their skills and enhance their motivation to continue their contributions to CHC, as shown in figure 6:

[39] cf. More Mamaz Zambia (NGO)

Figure 6

Self-Efficacy Assessment to Enhance Continuum of Care



Adapted from: TICO/JICA presentation on Chipimo Process in Chisamba District, February 2017, ppt slide no. 21

3.2.3 Leadership and Governance: Roles and Functions of HC, HP, HCC and NHC

3.2.3.1 Coordination of Community Interventions

Though the CBVs operate in all zones of an HC's/HP's catchment area, the coordination between the zonal activities is weak. The lack of funding at the District level means that the 10% of allocated funds for community outreach is rarely actualized. When it is districts and CP who work at the community level they often plan their activities separately. The activities of the two funding sources (MOH and external) are not always coordinated at district level, leaving the DHO and HC/HP with a lack of overview and coordination constraints. The strengthening of coordination mechanisms by HCC/HPC, EHT, CHA and NHC requires some revision of organizational structures at community level and re-designing of the interface with the HC Focal Point (cf. chapter 6).

Role of HC and HP

The HC, manned with a team of three to seven staff: clinical officer, registered nurse/In-Charge, registered midwife, EHT, dentist, laboratory, CHA provide the service delivery of the health system at the community level. Ideally, more remote communities also have Health Posts, which are manned by at least one Enrolled Nurse and two CHA, both categories are delegated from the HC within which catchment area they are situated, and ideally a Health Post In-Charge, a midwife,

an EHT and up to four support workers. Both levels have been mostly adjusted recently except for the registered staff at HC and the enrolled staff level at HP.

The major roles of the Health Center and Health Post include:

- Provision of promotive, preventive, curative, rehabilitative and palliative services;
- Provision of technical backup services to the health posts;
- Provision of first contact treatment in the catchment area where there are no health posts.

In relation to Planning, the Health Centre's roles include the following:

- The Health Centre/ Health Post will work with the DHMT and the Health Advisory Committees to select appropriate interventions to include in the action plan.

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.[40] 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.

However, newly piloted community Monthly Data Aggregation and Review (MDAR) meetings called by EHT are a basis not only for consolidating data of all community workers to be used to strategically drive further programming and CBV distribution. The MDAR meetings potentially also form "corporate" identity of the CBV and enhance their team experience.

Roles of HCC/HPC and NHC

The roles of HCC and NHC are outlined in the new NHC guidelines (MOH, NHC Guidelines, May 2017 (draft)). Key features are also indicated above in chapter 2.2 and 2.2.1, and - in more detail, in chapter 6 which outlines the implementation framework. Until mid-2017, community health service delivery varies highly due to the missing legal framework of the NHSA.

Incentives for the CBV

The new NHC guidelines (MOH, NHC Guidelines, May 2017 (draft), p. 25) finally describe incentive schemes for the volunteers which so far were not harmonized. The differences in incentives draw the volunteers to the more attractive package causing imbalanced distribution of CBV and considerable challenges to the District Health Offices to implement effective community health interventions. According to the forthcoming NHC guidelines, the new incentive scheme will be coordinated through the DHO and ranges from refreshments, lunch, transport refund; training and orientation; providing IDs; providing protective clothing; encouraging exchange visits; involving NHCs in national health events; great attention from the DHO and HCs; free health consultation at HC and involving NHCs members in ToT and training of other CBV in health promotion and community health.

[40] cf. Ministry of Health, 2017d

3.2.3.2 Community Monitoring and Data Reporting Structures

National level guidance is being provided to M&E in line with the NHSP 2017-2021, and the national M&E Plan and its framework. This framework builds on a bottom up approach to health planning and is a great opportunity to strengthen community planning and integrate several different players (line Ministries and government departments; Churches Health Association of Zambia; Private Sector; Traditional and alternative medicines sector; civil society/Communities into the existing health sector institutional and coordinating framework. If utilized fully, the improved community based HMIS strengthens planning, management and resource allocation of community interventions to the district & facility level. The Community HMIS was introduced in 2016 and is being scaled up in 2017 with the prerequisite of printed community registers before national reporting rates can be improved, training has commenced in May 2017.

At present there exists a bespoke Community Dataset within the national Health Management Information System online platform, DHIS2. In some areas the dataset is populated with data from the Community Health Assistants and is present in all rural districts where CHAs operate. The role of the CHA is to collect data on their own performance of interventions and treatments at the community level on the HIA4a form and ensure its quality remains high in terms of consistency, timeliness, accuracy, completeness. CHA will subsequently hand over their data to the EHT for aggregation.

The HIA4b form aggregates the community data from all CBV and CHA in order to provide a complete picture of what is happening in the community via community level interventions (including those of the CHA) for the catchment area, similar to the HIA1, 2 and 3 forms. Having aggregated both, HIA4 a and b, the EHT sends the forms for review to the In-Charge who will send the aggregated HIA4 forms along with facility forms (HIA1 & HIA2), hence all HIA4 reports, to the District Health Information Officer for entering into the DHIS2 system. This is providing a means for the CHA and CBV community data to feed the National HMIS system.

CHA program data reported to HMIS via the DHIS2 system can be accessed by all relevant persons at the Ministry of Health at all levels of its structure (headquarters, provinces, districts and facilities). Cooperating Partners are also able to access DHIS2 after being provided with individual access credentials (user name and pass words).

There are three key data collection tools/registers that are specific to the CHAs:

1. Household Activity Register (Part I and II)
2. Community Mobilization and Surveillance Register:
3. Patient Care Register

The formats used for data compiling, summarizing and analyzing the data are:

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

The data aggregated by the in-charge or EHT (HIA4b) form on all community members can be accessed by relevant officers at MoH, but specifically the facilities, the corresponding districts and

provinces and the national level. Partners outside of the MoH and the GRZ will receive access upon approval by the MoH.

While the HIA4a is the assessment tool for the CHA's performance, the HIA4b is the form for the complete community data aggregate dataset and is a platform to build upon. To date, it has not thoroughly been tested. In order to close this gap, the Ministry of Health M&E team is currently piloting HIA4b which attempts to provide a more comprehensive data reporting system that is disaggregated into zonal or HC catchment areas and incorporates the work of various CBV and the CHA. These monitoring data are being collated by the EHT in coordination with the Facility In-Charge during monthly meetings with the CBV and CHA when they are getting aggregated. During the same meeting, previous data of the previous month(s) are reviewed; hence the meetings are called Monthly Data Aggregation and Review (MDAR). The MDAR meeting helps to clarify on differences in needs and approaches of interventions and to harmonize understanding of the diversity and common bases of the CBV health service delivery. In addition, the MDAR provides the basis for the data review that is done at the HCC by the in-charge or EHT. NHC members who attend the HCC will then bring the data review to their NHC meetings. This will allow data driven decision support at the community level.

CHMIS for Community Based Distributors of Family Planning commodities have also been trialed in 4 districts.[41] They need to be assessed within the overall efforts of MOH/M&E and considered for scale up if feasible.

Recent Experience of Involving Communities into M&E

12 districts experienced improvements in outreach by better involving the communities into planning, monitoring and evaluating the interventions.[42] A simplified guide to community planning (2013) is available, a community planning hand book available at the Health centers and health posts and a community monitoring format is developed for the CHA and introduced (HIA4). Community involvement in planning and community action plan implementation is being strengthened with the introduction of HIA4b which is used by the CBV and reflect their inputs.

However, reviews of community action plans are seldom undertaken, community capacity assessment tools are not available nor are health facilities monitoring community performance explicitly. The 12 districts experience shows that doing so does constitute a strong motivational factor for the volunteers to sustain their inputs. It is further strengthened through establishing supportive supervision and mentorship as well as self-assessment. The introduction of a strengthened role of EHT into zonal community data aggregation in coordination with the Facility In-Charge constitutes a first step towards scaling up the pilot experience on monitoring and using the information from monitoring for improvements in planning.

A social accountability framework has been developed under the MDGi Program of MOH and other partners in at least 11 districts (see figure 8; it requires to be scaled up for the countrywide strengthening of community planning and reviewing.

[41] Luangwa, Nyimba, Shibuyunji and Mumba district

[42] In 11 Districts, MOH, EU and Unicef implemented the MDGi program, in the 1 District of Chisamba, TICO implemented a JICA funded project. Both interventions were comprehensive and led to simiilar results.

3.2.3.3 Inter-sectoral Collaboration

Non-health sector inputs from agriculture, education, housing and infrastructure, etc. are rare in community health activities though community structures and volunteers for other line ministries exist. The NHSP aims at promoting and ensuring harmonized and strengthened intersectoral Action on Health using a Whole Government and Whole Society approach within the Health in All Policies framework. This shall be achieved through organizational structures and coordination mechanisms that support regular interaction for comprehensive community health which are needed to allow interactions between the sectors and for financial support to community structures, participation in other sector meetings and outreach activities.

The enforcement of the public health legislation is weak. Measures are needed to: improve the safe water and hygiene in congregate settings particularly learning institutions, prisons, markets, health facilities in particular and communities in general, to enhance knowledge levels for improving food preparation and feeding practices for Under-5s. Several initiatives are aiming at encouraging cross-sectoral work on nutrition and developed coordinating committees; such as the Scaling-up-Nutrition program (SUN) which developed ward level committees. Similarly, in other districts, District Nutrition Coordinating Committees are coming up, including with SOP for these committees.

Inter-sectoral collaboration between Health and Education is a preferred option for the MOH to widely improve the knowledge of nutrition and hygiene. Hence the Ministry adopts the comprehensive School Health and Nutrition (SHN) program. The implementation needs planning, monitoring and evaluation between MOH and the Ministry of General Education (MoGE) with dedicated staff to coordinate SHN and develop the available school infrastructure, participation of learners and teachers in planning and decision making. Cooperating communities already signed Letters of Understanding with MoGE.

3.2.3.4 Coordinating NGO Activities

The coordination of NGOs activities at all levels is challenging, particularly at provincial and district levels. We observed that most of the activities that are implemented by NGOs are driven by the priorities of external funders, which may not always be aligned with the national development process. The 2009 NGO Act provides a basic legal and institutional framework to coordinate the NGO; however, the MOCDMCH is amending this legislation which should provide MOH/MOCDMCH with an adequate leadership mandate to address the delays in operationalizing the NGO Act of 2009.

Some NGOs have different financial years and planning cycles as compared to the Government, thereby making it difficult to accommodate their activities at planning and implementation stages. The other challenge is that the majority of the agreements between the NGOs and Government are signed at national level without the knowledge of provincial and district level staff. As a result, management at provincial and district levels only get to know about the programs being implemented by NGOs when they are on the ground.

3.2.4 Financing and Supplies

Under government policy, districts are expected to make budgetary provision of at least 10 percent of the total district grant for community health interventions. The underutilization of community health systems resulted in maintaining low public funding and mobilization levels for community services and health related activities. While public funds flow through budgetary provisions for community health interventions and through partner projects, the capacity of NHCs and HCCs for the management of the different funding sources for community based interventions is insufficient.

A major symptom is lack of transparency concerning allocations, disbursements and expenditures. Thus provided funds may reach to the HC, but their poor funding situation causes absorption of funds at the HC level itself rather than trickling down of the funds into community level interventions.

The lack of a funding mechanism for inter-sectoral cooperation impacts on the financing of the cooperation between activities for the improvement of health outcomes through community health and the health system. Some initiatives are funding nutrition coordination across 6 different ministries. Key here is that one fund is made available for all. GRZ is working towards common initiative by integration of inter-sectoral provisions into the NHSP throughout all departments und MOH and relating ministries.

Advances in availability of essential medicines and effective distribution mechanisms are achievements to build upon and reduce out of pocket spending. 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 have advanced into the provinces with distribution hubs in each of them that draw from Medical Stores Limited (MSL). Medicines and commodities are distributed on the last-mile from the hubs to the HC.

However, the last-*meter* distribution mechanism in communities is still reduced since pre-packaged medicine kits carried by CBVs 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, much stock being wasted and was hence not cost-effective, being waste of resources. The termination of the CBV medicine kits also came in the context of general funding gaps for essential medicines which altogether summed up to 8,336,222 $ as per the MTR 2015, cf. p195. Feasible mechanisms substituting the earlier distribution mechanisms are in the planning to close the gap.

Some INGO implement micro-enterprise schemes with CBV to bring basic drugs and commodities to the communities and households against minimal fees for the subsidized drugs and commodities that the CBV can retain as incentive for sales. Others developed social funds or income generating activities (see annexes 10/1.5, 10//1.6, 10/1.7, 11 and 14).

An example for public-private cooperation concerning medicine supply is undertaken by the Zambia Medicines Regulatory Authority, ZAMRA. This government agency joined forces with donors, NGO and CSO and is funded externally. ZAMRA regulates products for facilitation of Over-The-Counter sales. The scheme facilitates private drug shops, also called Health Shops. It involves setting of standards for the type of drugs that can be sold and the facility that sells, training

of dispensers, accrediting the shops and branding them for easy identification and safe access to drugs. ZAMRA also widely informs people about the meaning of the brand to educate on safe medicines. The scheme is currently piloted in two provinces[43] and likely to be scaled up nationally with the help of private franchises to NGO, CSO. A roll out will align with national priorities such as RDT testing and ACT for malaria treatment, and can also involve CBV as happening in Tanzania to strengthen referrals, information dissemination and/or organize these through the Health Shop.

The soon to be ratified SHI bill addresses mostly reimbursements for major medical care, not PHC, nor is it looking at Community Health Financing. The financing of non-personal services has also not been addressed; only medicalized personal services are envisaged for reimbursement. The number and type of package(s) of care is not clear.

Given the current wording of the SHI bill, Community Health services could only be reimbursed if volunteers are getting included in the Health Professions Act (Act No. 24 of 2009) and become accredited to receive payments from the social insurance, especially when these are interchanged with facilities. As long as the CBV are not considered health providers nor formally attached to a health facility their services could not be compensated. This also applies for non-personal health services (residual indoor spraying, community health promotion activities like safe water, sewage) which would need to have explicit funding. A possibility of insurance coverage of services is indicated for vaccination and family planning methods depending on whether they get included in the package of care.

3.3 Determinants of Health

Social and environmental health determinants are conditions that impact on the well-being of people. They arise respectively from the ways in which people are born, live, learn, work, play, worship, and age in the geographic and climatic conditions that form their environment. These determinants of health affect a wide range of health, functioning, and quality-of-life outcomes and risks. Several areas of health care have evolved to specifically address the dominant health determinants, such as maternal and child health, environmental health, school health and nutrition. The communication model for health promotion as in below figure 7, captures best the multi-layered societal and environmental effects on health and is used in the MOH approach to Health Environments, Cities and Institutions:[44]

Figure 7

[43] Muchinga Province and Western Province
[44] European Union, United Nations, Government of Zambia, 2016

A Social-Ecological Model for Physical Activity - Adapted from Heise, L., Ellsberg, M., & Gottemoeller, M. (1999)

In an effort to establish entry points for community health engagement, the MOH with its partners uses this Social Ecological Model as an overarching structure to facilitate the segmentation of community profiles for matching messages. This model has been adopted to reflect the influence of different structures on different decision makers that need to partner in mobilizing communities for health and social change to reduce poverty caused by illness.

Poverty is a major determinant that impacts on health outcomes, causing low educational levels, weak immune system and malnutrition. The 2015 living conditions monitoring survey has revealed that 40.8% of the country's population is living in extreme poverty. The demographic survey has also revealed that 54.4% of the country's population is poor, while 13.6 percent of the population is moderately poor. The survey indicates that 76.6 percent of the population in rural areas is poor, compared to 23.4% of poor urban population. Western province has the highest population of the poor at 82.2% with Lusaka province having the lowest 20.2%.[45] The population below poverty line as per a 2010 estimate was at 60.5%,[46] indicating that the volume of job opportunities is limited since the unemployment rate averages at about 14.4%.

The unemployment rate in Zambia increased to 13.30 percent in 2014 from 13.10 percent in 2013. Unemployment Rate in Zambia averaged 14.44 percent from 1986 until 2014, reaching an all-time high of 19.70 percent in 1993 and a record low of 12.00 percent in 1998. As per a press release of the African News of January 2017, Zambia's youth unemployment stands at 10.5 percent, which is still high and a source of concern. The general unemployment rate is forecasted as being on an

[45] https://www.lusakatimes.com
[46] http://www.theodora.com

upward trend, leading to a rate of 14.1 % by the end of the 2017, and rises probably to 15.4% by 2020.[47]

Any community health scheme needs to consider the poverty and income diversity in the various regions of the country and the consequences of poverty on health and on the people's health services purchasing power. In addition, the ethnic diversity of the people of Zambia is reflected in the presence of 4 major language groups and an even higher number of dialects (12) within the number of 72 tribal groups and a vast cultural diversity that requires sensitivity to cognition and practices with regards to health issues and the underlying social orders.

Decisive for media based health promotion and prevention of disease is the coverage of radio and TV. Among the availability of assets in 2014, only 37% households had TV, but slightly more than half (57%) had radio while two third of the people own mobile phones. This pattern would determine the approach to prioritizing the use of mass media or local, traditional media for disseminating health messages which are directly delivered in the communities.

3.3.1 Maternal and Child Health

The focus of community health promotion, disease prevention and control and basic health care services needs to address maternal and childhood problems, as well as reproductive health (e.g. to prevent HIV infection and AIDS) and nutrition. The maternal morbidity is still high (398/100000) in Zambia, while more than the average one ANC visit are too few to ensure safe birth, particularly when rural facility based deliveries are not even sought by half of the women, least in Northern Province, where GBV is also highest in the country. Almost 30% of women do not seek PNC even after 3 days. Newborns and U5 would benefit from increased utilization rates, since U5 mortality is at 75/1000 and IMR is still at 45/1000. The rates are much higher in rural areas (U5: 85/1000) and occur highest, i.e. at more than a doubled rate, among uneducated mothers' children (109/1000) and in poor households. On a similar pattern, the total fertility rate is reflected, where the poorest two quintiles bears the majority of children (7.1 – 7).

Community health service delivery through CBV has shown good results in providing a safer environment for delivery. CSO and DHMT partners achieved a 25% increase in institutional deliveries (from 64% to 89%) and a 32% increase in skilled birth attendance rates (from 46% to 78%) over a two year period,[48] and CBV can play a role in timely referral to a health facility.

3.3.2 Gender based Violence

Gender is yet another major determinant of health since it influences access to health care and vulnerability. Just a quarter of households are led by women rather than men, while almost half of the houses are owned by women. The role of women is also diverse in terms of decision making; a good quarter of women cannot participate in own health care decision making. Own decisions cannot be made by many women with regards to departure from house, sexual intercourse or own opinion. Gender Based Violence, also as a consequence of own decision making, is accepted by almost half of the women. The ways of decision making differs from province to province and

[47] http://www.tradingeconomics.com, also see annex 16
[48] cf. More Mamaz Zambia

between ethnic groups. Community health intervention will carefully have to consider local patterns.

3.3.3 School Health and Nutrition

The enforcement of the Public Health Act and Food and Drug Act is weak. In the intersectoral context, measures are still required to address the inadequate Water, Sanitation and Hygiene (WASH) situation in Health Facilities, Schools and Communities. A Ministry for Water has been established, otherwise, sufficient initiatives are lacking to enhance knowledge levels for improving the poor food preparation and feeding practices for Under 5s. In a system perspective, starting from the absence of a comprehensive School Health and Nutrition policy**,** there is low involvement of and linkage with other sectors to improve the low coordination, planning monitoring and evaluation between MOH and MoGE. Yet MoGE still lacks dedicated staff to coordinate SHN which does not fall under anyone's core responsibility. Overall, data to inform programming and decisions are inadequate and out dated.

Though school health and nutrition is recognized as relevant strategic intervention in NHSP is has not yet been developed within the available school infrastructure, nor found meaningful participation of learners and teachers in planning and decision making in SHN. On the horizon, communities show willingness to cooperation and Letters of Understanding exist as the perspective to mold young people's healthy practices is rich with 25% of the population passing through educational institutions annually.

The MOGE recognizes school health as a primary health care complement to the school health services provided by the Ministry of Health (MOH) and vehicle for equity messages (cf. policy document "Educating our Future"). Since education indices generally tend to show a bias against the rural poor, orphans and vulnerable children and girls, SHN programs are intended to address the health and nutrition challenges that impede learners' participation in the education sector. They reduce the frequency when ill or malnourished children cannot attend school on a regular basis by enhancing the education about health that leads to healthier lifestyles and in the case of girls the benefit can extend to the next generation.[49]

Multiple conditions that are detrimental to the health of children are often present in disadvantaged and underprivileged societies due to inadequate food, poor diet or parasitic infections, leading to protein energy malnutrition and micronutrient malnutrition. Safe drinking water and sanitation remained problematic according to ZDHS (2014): Households that do not treat drinking water account for 66 percent. Rural households are more likely not to treat water before drinking (78 percent) compared with urban areas (50 percent). Furthermore (ditto) one in four (25 percent) has access to an improved (not shared) facility; one in five (20 percent) has access to a shared toilet facility; while 55 percent have access to a non-improved facility. Sixteen percent of households still use a bush or open field for defecation, but this is an improvement since 2007, when one in four households had no toilet facility. Rural households are more likely than urban households not to have a toilet facility (27 percent versus 2 percent). This situation is still creating a suitable environment for the transmission of water related diseases, weakened immune systems of the

people, particularly children, and thus increased susceptibility to other infections and cognitive development of learners. In children this leads to increased school absenteeism due to frequent episodes of illness, in adults, this is resulting in reduced capacity to perform, thereby compromising economic growth and household wealth. Accordingly, there is a Letter of Understanding between MOH and MOGE that guides implementation of SHN interventions to address these ills. However the appropriate technologies to improve hygiene, sanitation, or water safety are yet to reach out.

Some of the programs that have been implemented under SHN are;

- Mass drug administration (MDA) in all primary schools by MOH and MoGE
- Human Papilloma Virus vaccination
- ITN distribution in schools
- School WASH
- HIV and AIDS
- Home Grown School Meals (HGSM)

Most of these interventions are implemented in selected districts across the country but resource constraints and poor coordination capacity hinder the national coverage. A comprehensive school health program is seen capable to close this gap by addressing hygiene and nutrition in schools by 2020 when 2 million primary school pupils shall be reached.[50]

3.3.4 Environmental Health

Health determinants cause infectious diseases like diarrheal diseases such as cholera and typhoid which continue to be a public health problem due to poor sanitation and cost Zambia close to 946 billion Kwacha ($194 Million).

- Environmental (Water and sanitation) related diseases remain a public health problem associated with over 80% of morbidity in Africa and south-west Asia
- 4.8 million Zambians live without access to clean water and 6.6 million lack access to sanitation (UNICEF, 2010)
- water supply coverage - 78%
- sanitation coverage - 54% (urban) and 43% (rural)

Diarrhea prevalence in Zambia 2014 varies between age groups, with half to 3 year olds suffering the highest prevalence of about 27% and adult males suffering slightly higher prevalence (16.6%) than females (15.6%).[51]

Besides engagement into health related activities, the comprehensive consideration of health determinants through involvement of other sector inputs by means of **inter-sectoral cooperation**, as indicated, from agriculture, education, housing, water and sanitation and infrastructure, etc. Yet it is hardly seen in community health activities though community structures and volunteers for other line ministries exist. There are no harmonized organizational structures, nor coordination mechanisms that support regular interaction for comprehensive health promotion, disease prevention and advocacy. Linkages with other sectors are weak.

[50] http://www.wfp.org/operations
[51] Central Statistical Office et al., 2015

3.4 Challenges for Community Health

Despite these efforts, primary health care still faces a number of challenges which include:

- Facilitation of community health guidelines for use across the communities and a legal framework to support community health governance and leadership structures. Moreover, the enforcement of existing Public Health Legislation like the Public Health Act and Food and Drug Act as well as community health prioritization are weak:
    a. Environmental Health Technicians (EHT), and Community Health Assistants, (CHA) are responsible to coordinate and implement Community Health programs and services at district and community level, both cadres often lack support of fully skilled clinical health workers. There is no staff identified yet at provincial and district level. Most of the CHA are drawn away into health facility tasks rather than attending to the issues of coordinating interventions at community level.
    b. Weak harmonization of approaches and packages of support to CBV by different partners, leading to a lack of standardized training, deployment, motivation, incentives, reporting, monitoring, evaluation and tracking of the CBV
    c. Lack of official standardized donor coordination platform at district level and beyond at community and facility level.
    d. No SOPs for Health Facilities and Districts on how to support operationalization of community health by different CBV in the respective catchment population.
    e. Demotivation of CBV which result in high turnover and inconsistent implementation performance due to a lack of standardized mechanisms of motivation, supervision and other supports from GRZ and CP. For instance, a show case for non-standardized motivation scheme for CBV is provision of incentives like bicycles, materials and monthly stipend of K250 to some CBV, while others were not provided anything.
    f. Low prioritization, weak guidelines and tools on health promotion and prevention and control within primary health care as evidenced by paucity of dedicated resources until now when community health becomes a thematic area for the first time in the NHSP. Inadequate community involvement and skills in community health planning.
    g. Lack of implementation mechanisms (standardized reporting mechanisms and reporting structures on community health data) of the introduced Community HMIS (2016) which feeds in to the health facility, district and ultimately the national HMIS and lack of comprehensive Community HMIS for all community agents.
    h. Poor implementation and enforcement of existing planning and budgeting guidelines at the district level.

- Inadequate Resources at PHC/CHC
    a. Insufficient core health workers at PHC level, including volunteers resulted in reduction in effectiveness of community level interventions, as health workers including CHAs and volunteers tend to spend more time at HP rather than in the community.
    b. Lack of the allocation of the dedicated minimum of 10% of district budgets to Community Health programming due to budget constraints and lack of advocacy to demand and to supervise the planning to ensure a fair distribution of resources among activities.

c. Insufficient funding and delays in disbursement of overall operational funds to districts, HCs and HPs to effectively execute PHC services at community level such as community outreach health services.
d. Inadequate funds allocated to the preventive health services
e. Insufficient and inequitable distribution of equipment and infrastructure at PHC level.
f. Insufficient transport and communication in health facilities to conduct routine community health interventions such as outreaches, campaigns and household follow ups.
i. Unclear how many of the PHC/CHC services will be compensated given the current version of the National Social Health Insurance Bill. In particular, how indoor residual spraying, counselling and testing for HIV and other non-personal health services will be considered in the Package of Care, or otherwise be funded through a separate fund.

- Supply chain and logistics
  a. Weak system of quantifying, forecasting stocks and distribution of essential medicines and commodities at facility and community level

- Primary Health Care service quality at community level
  a. Apart from among the cadre of CHA there is inadequate capacity and skills to promote health, prevent and manage diseases at community level especially NCDs. The number of CHA is still insufficient and task shifting in health facilities draws them away from promotion and prevention activities in the communities.
  b. Inadequate continuous skills development for community cadre (CBV) through mentorship and support supervision, including CHAs.

- Weak client/patient referral system:
  a. Lack of dedicated and trained teams and resources to operationalize the established community level standardised emergency and programmed referral system along with lack of feedback from HC to CBV and CBD
  b. Critical shortage of logistics needed for referral which include transportation and communication materials
  c. Weak feedback system from facilities to CBV on the referred clients/patients
  d. Insufficient funding for referral mechanisms at PHC

6. Inadequate platform for community engagement for innovations in community health
   a. Inadequate innovative income generating mechanisms for community level services
   b. lack of locally relevant community service delivery models
   c. Inadequate innovative incentives for community level cadre

Given the importance of the weak financial management at the district level, addressing these challenges is key to improved community health services. A presentation of these challenges follows, highlighting the additional complications for the fiduciary control and accountability of donor and partner support, and the coordination of NGOs supporting the national primary health care development efforts.

3.4.1 Challenges and Opportunities for the Financial Management of Primary and Community Health Care

The implementation of the 2016 Health Sector Devolution Plan is an opportunity to develop a sustainable community health system in support of districts and communities to manage their primary health care and referral services to district hospitals, general hospitals and third level and specialist hospitals. The Health Sector Devolution Plan concerns the provision of PHC only and envisages this to become the responsibility of the District Councils and equivalents in municipalities and cities. MOH is tasked to send funds from the common basket directly to the DHO under the councils upon the latter meeting set targets (Health Sector Devolution Plan, p. 77).

Under the NHSP 2011-16 the development and implementation of a health financing policy/strategy began by collating sufficient evidence to inform the development of the health financing strategy. The 2016 Household Health Expenditure and Utilization Survey (HHEUS) and further studies can be used as a tool for identifying health seeking behavior 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 an urgent need to strengthen districts' financial management skills and tools, in particularly in tracking expenditures and reporting of the expenditures by vertical funds. The supervision and support from the higher levels MOF and MOH can provide support with financial management skills specifically for the allocation of funds, for planning and budgeting, and for the timely and full budget execution and report of expenditures. Furthermore, external funding should become better integrated into the general fund flow and expenditures recorded at the district level to allow improvements in allocative efficiency of resources and district level coordination for community health services

Under GRZ policy, districts are expected to make budgetary provision of at least 10 percent of the total district grants for community health interventions. Close monitoring is needed to ensure the provision and recording of the expenditure of these funds to improve public sector allocations and mobilization levels for community services and health related activities. Furthermore, additional community funds are needed to develop community referral and transportation systems for emergency and scheduled care. Inadequate advocacy for the assignment of at least 10% of district budgets to Community Health and lack of resource allocation and planning within the district to facilities and communities contribute to a trickle of funds for community health programs, aggravated by untimely disbursement of funds and execution and the lack of an annual or more frequent reporting mechanism for the use of funds.

The main reason for erratic funding is the untimely disbursement by MOF, funds arrive in lesser quantities and later than expected to districts and health facilities. While the health budget has been growing for the districts, low budget execution raises questions on governance and financial accountability at MOF and MOH, and the spending areas (districts, hospitals, health centers, etc.).

Budget execution has improved at the MoH since 2011, but additional improvements are necessary.

3.4.2 General Patterns in Health Financing from Donors and other Partners: Need for Harmonization and Alignment of External Funding

The main sources of external funding for the health sector during the period under review were the Cooperating Partners (CP) and INGO, financial and technical support was being provided to the health sector through various mechanisms and funding modalities. The main funding modalities are: direct project funding at various levels of the public health system and/or through NGOs; disease-specific funding through the public health system or NGOs; basket funding where finances are disbursed directly to the public health sector; and General Budget support through the Ministry of Finance.

During the review period (2011-13), the GRZ continued to implement tighter fiduciary controls and accountability measures. These actions contributed to restoring donor confidence, which had deteriorated due to allegations of financial irregularities in 2009. This is evidenced by the implementation of over 80% of the action points outlined in the Governance and Management Capacity Strengthening Plan (GMCSP) as well as the reinstatement of the MOH as one of the Principal Recipient for the Global Fund in 2015. However, 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 CPs were earmarked to HIV, RMNCH & Nutrition, 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 combination of delayed disbursements and the prevalence of vertical funding are distorting districts' ability to effectively plan and implement programs, and account for resources. If not properly managed, funding through earmarked programs will continue creating inefficiency among the implementers by diverting their time and resources away from mainstream sector priorities. It is important that CP are accountable to the health sector by adhering to existing leadership and coordination mechanisms, guaranteeing efficiency in resource allocation and utilization, and committing to the principle of health systems strengthening. The Health Financing Strategy should include directives on to determine how CP are accountable to the health sector, determining specific coordination mechanisms, and the reporting of support to vertical programs by district and participation in the tracking of resources.

3.5 STRATEGIC DIRECTIONS OF COMMUNITY HEALTH WORK

The Ministry of Health has adopted the PHC approach to attain Universal Health Coverage. This is in line with the Ouagadougou Declaration whose core values are equity, solidarity, social justice, principles of multi-sectoral action, community participation and healthier lifestyles.

The National Health Strategic Plan emphasizes facilitation of an environment that enables people to maintain and improve their own health. It aims at developing Community Health Systems with supportive mechanisms for community participation in organization, coordination and financing. The strategic interventions for community health support the promotion of healthy lifestyles, advocacy, home care, disease prevention and control to reduce the risk of disease and complications, thus also reducing the case load at health facilities. Community health seeks to incorporate disability and gender mainstreaming and GBV prevention into all relevant programs. There is focus on improving the implementation of the CHA Program supported by CBV interventions by increasing the number of Environmental Health Technologists who supports the In-Charge in monitoring the frontline workers (CBV and CHA) for effective and efficient interventions. Key is the deployment of multidisciplinary cohorts of dedicated trained health workers including community Nurses, Nutritionists, Health Promotion and Surveillance Officers at community level delivering high impact interventions to the households. The community based health services are linked to strengthened services at primary health facilities.

Supported by CBV, health facilities cooperate in their outreach to the communities to take promotion and prevention close to the family and provide professional support. They are supported by legally and organisationally strengthened Neighbourhood Health Committees and their participation in decision making on the use of public funds. NHC and HCC members coordinate their efforts to ensure delivery of quality health services. Community health incorporates established support mechanisms at community *and* district level to facilitate the process of community mobilization for health action, quality procedures and functional systems.

The health services delivery approach for reaching the communities and households is to establish clear guidelines for the coordination of strengthened community health volunteers and NHCs through the community and district level support mechanism, in coordination with the primary health care frontline worker in the facilities and in the communities.

Some directions for the development of community volunteers were outlined in the draft National Integrated Strategy for Community Based Services and Volunteers in Zambia from 2014,[52] which is still a model for a community health concept that also seeks support from other sectors through inter-sectoral cooperation. The NHSP hence attempts to tie other Ministries into cooperation by building commitments to health into their sector strategies. Interventions for a more inclusive approach to community health shall thus also work through support of CBV from other sectors and extension workers from the departments to broaden the scope of support and enable the health sector to meet the need of about 100.000 voluntary supporters in primary health care delivery at the community level.[53]

4. VISION, MISSION, OVERALL GOAL AND PRIORITIES

4.1 Vision, Mission, Overall Goal

Vision

[52] MOH and Ministry of Community Development, Mother and Child Health, 2014
[53] Ditto, p. 8.

A Nation of healthy and productive people.

Mission

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

Community structures facilitate health service delivery close to the households through improved organization, coordination of frontline workers and referral for improving infant, child and maternal health and nutrition, reducing incidence of diseases caused by the environment and lack of health knowledge.

Overall Goal

To improve the health status of people in Zambia in order to contribute to increased productivity and socio-economic development by providing guidance to the provision of comprehensive and sustainable quality and cost-effective community health services that allow access for all, encompass a gender sensitive community health care implemented with the participation of the communities for improving the health outcomes of the people.

4.2 Objectives of the CHS

General Objective

To empower communities taking responsibility for improving their own health status through community health interventions in line with the principles of PHC by providing synergy to the community and health systems and leveraging resources.

Specific Community Health Objectives

The Community Health Strategy outlines the steps and priorities that will ensure the timely operationality of the national community health objectives under the NHSP. The strategy will contribute to revitalizing the community health structures, define the mandates that shape the relationships within and between the community systems and the health sector system. The three specific objectives absorb the objectives as formulated in the NHSP and relate all of its strategic intervention under these.

1. To strengthen community health systems by improving organizational structures and coordination mechanisms at the national, district and community levels for effective community health service delivery, monitoring and allocation of resources to legitimize the mandate and accountability of community systems in line with the decentralization policy.

2. To build capacity of community frontline workers through improved training, support mechanisms and recognition to ensure continuity and quality service and health promotion delivery, and support through timely financing, materials and medical supplies.

3. To strengthen the participation of communities in health engagements, planning, budgeting, financing and monitoring for social accountability and quality of community health services.

5. RESULTS FRAMEWORK TO ACHIEVE THE OBJECTIVES

The Strategic Interventions towards achieving the objectives is supportive to the health policy objective: "***To provide guidance to the provision of comprehensive and sustainable quality community health services that allow access for all, encompass a gender sensitive primary health care implemented with participation of the communities***."

The interventions are aligned with the NHSP 2017 to 2021 whose overall goal is "***To improve the health status of people in Zambia in order to contribute to increased productivity and socio-economic development***" (NHSP 2017-2021).

This Community Health Strategy addresses the gaps and challenges that have been identified in the situation analysis and the NHSP chapters on community health and focuses the national health priorities on maternal and child health, environmental health, communicable and non-communicable diseases.

National Health Priorities

The national health priorities as listed in the NHSP 2017 to 2021 and the NHP 20013 encompass PHC, MNCHN with ante/post-natal care and nutrition, Youth and Adolescent Health, Communicable Diseases (malaria, HIV/AIDS, STIs, TB, Pneumonia, Diarrhea and Neglected Tropical Diseases,) Non-Communicable Diseases, Disease Outbreaks, Epidemics Control and public health surveillance, environmental health and food safety, health services referral systems, health promotion and education, trauma, including from gender based violence.

The NHSP further prioritizes support systems through HRH, essential pharmaceuticals and medical supplies, infrastructure and equipment and health information. Furthermore, the NHSP identifies the development of service quality, health systems governance and health care financing as health systems priorities. The CHS is settled within this framework and outlines needs in each of the areas that require strategic development.

In order to achieve the objectives, major outcomes and outputs have been identified during extensive consultative processes with a variety of stakeholders at national, provincial and district levels. Outputs are formulated that will contribute to the outcomes by means of implementing key strategies

The strategic plan comprehensively envisages interventions for strengthening Community Based Volunteers[54], qualified health workers and health managers by improving the clarity for their

[54] Community Based Volunteers (CBVs) targeted under the VSO survey (2014) were defined as: Active Zambian citizens from the communities who are delivering services under programs in the field of community development, mother and child health, and/or social welfare to their community on a voluntary (unpaid) basis. (cf. MOH 2010, NCHWS)

functions, coaching and supervisory powers within the context of social accountability and a revised concept of coordination, management and fund flows.

The strategy addresses system issues and empowerments or mandates in line with the national strategy for community health workers. The CHS incorporates the roles and profiles of the CBVs, qualified health workers in facilities, particularly the EHT and where available, the Community Health Assistants both who deal with the CBVs on a regular basis. It also envisages roles for Health Center Focal Points for maintaining systems' oversight and functioning with managerial competence and coordination responsibilities but not necessarily clinical or environmental responsibilities that could draw them away from the managerial tasks.

These get linked with the coordinating committees in the neighborhoods (NHCs), HCC at the health facilities and local government with regards to coordination, management, WDC, DDCC, supervision and empowerments that enhance the efficiency and effectiveness of community and primary health care and the link with CBOs. The following section outlines how community health work shall strengthen health promotion and also catalyse pro-active health prevention communication and social accountability.

5.1 The Community Health Strategy Logical Framework on Objectives, Outcomes and Outputs

Community Health Strategy Objective: To empower communities taking responsibility for improving their own health status through community health interventions in line with the principles of PHC by providing synergy to the community and health systems and leveraging resources.

Specific Objective 1	Specific Objective 2	Specific Objective 3
To strengthen community health systems by improving organizational structures and coordination mechanisms at the national, district and community levels for effective community health service delivery, monitoring and allocation of resources to legitimize the mandate and accountability of community systems in line with the decentralization policy.	To build capacity of frontline workers through improved training, support mechanisms and recog-nition to ensure continuity, quality in service and health promotion delivery and support through timely financing, materials and medical supplies.	To strengthen the participation of communities in health engagement, planning, budgeting, financing and monitoring for social accountability and quality of community health services.
Outcome 1	**Outcome 2**	**Outcome 3**
Improved organization and coordination of the community systems HC, HCC, NHC, CMIS, funding and financial management.	Improved resilience and quality of service delivery among Community Based Volunteers and improved coordination of CBV.	A Social Accountability Framework guides the involvement of communities, CBV, NHC, HCC and ward and district level committees.
Output 1.1: A framework for compatible and effective structures and coordination through clear mandates for roles and steering of interventions and monitoring.	Output 2.1: Training includes integrated health and development curricula, business and community health service management training. The quality of the training is measurable and assessable, and can be certified.	Output 3.1: The strategic plans of communities in Zambia vary from community to community to capture the social and environmental health determinants.
Output 1.2: DHMT Officers, Focal Points and District Resource Centre, NHC, and HCC/HPC got adjusted with the community health processes. The CHA, EHT/HC/HP and NHC representatives optimized their routines and functions to improve their community outreach, planning of services, monitoring functions and supervisory activities with CBVs in the context of defined empowerments.	Output 2.2: The CBV skills became a protected package. Its implementation is measurable and the CBV performance can be evaluated. The CBV can be accredited on the basis of good implementation of standardized packages of community health services.	Output 3.2: Outlined procedures clarify how the NHC will be admitted and allowed to contribute at different levels of the health system: HCC, DHO, and the local government: DDCC and ward development committees. Action Planning is done with participation of community representatives. It is based on information from monitoring data of previous interventions and communicated to the DHO
Output 1.3: The roles and responsibilities of health workers (EHT, CHA), NHC and the management of primary health care and community health work are revised and clarified in the overall	Output 2.3: On the community level, the effectiveness of health service delivery is improved. The tool of team formation helps to level differences and "grades" among the volunteers through mutual learning	Output 3.3: Integration of community representatives and traditional leaders into the meetings of the NHCs contributes to formulation of community needs. Perception of ongoing implementation are

perspective of implementers, coordinators and supervisors of the implementation and their interfaces.	particularly during the transition time of harmonization of CBV.	considered during NHC meetings and shared in HCC meetings and if significant, communicated to Local Government Councils for further action, e.g. fund raising.
Output 1.4: Improved response and efficiencies in community health interventions enhance quality of service delivery. The health interventions are based on locally relevant strategies tailored around community needs and CBV know-ledge of the respective environmental and social determinants of health.	Output 2.4: Competitive selection through NHC is based on standard eligibility profiles for CBV to optimize the right choice of CBV for the envisaged tasks. This has proven to enhance the sustainability of recruited CBV. NHC recruitment of CBV enhances acceptability of CBV by the community as well as reduction of attrition. The resilience of CBV is stronger and they continue working over a sustained period of time.	Output 3.4: Depending on the pattern of needs born out of local social determinants, communities match these with their existing networks of support and service providers, apart from utilizing improved support of community health services by the public system of PHC services.
Output 1.5: Patient friendly health services which are accessible and cost-effective	Output 2.5: NHC recognized and operating within the Social Accountability Framework (see chapter 5.3) contribute to higher continuation of CBV. In addition, motivation of CBV is strengthened when they receive official recognition by the health system and thus stay on longer or get their sought after social recognition in support of planning their future.	Output 3.5: Strong social accountability keeps up the demand for good governance of health services and availability of medicines, supervision of health standards and referral mechanisms.
Output 1.6: Guideline with assessment criteria for efficient and cost-effective community health services	Output 2.6: The aspirations of CBV are technically and socially recognized and given the perspective of being involved in a rewarding and ongoing learning process. There are various modules defining levels of training and refinement of skills. The CBV gradually acquire an educational basis up to job entry maturity	Output 3.6: Traditional governance structures are integrated and headmen involved into decision making processes. The consideration of social determinants of health thus gains more attention for enhancing community dialogue, capturing local cultural practices and shaping relevant health messages.
Output 1.7: Developed cost-effective health service models which can be rolled out in other districts and provinces	Output 2.7: The streamlined processes work cohesively between the actors: CBV, NHC and HC are drawn into a team approach with informed decision making for health interventions and referral, based on monitoring, review and mentoring.	Output 3.7: Assessment of local health conditions and disease incidence

Output 1.8: The excessive task-shifting from nurses to CHAs at the facility level is reduced and limits CHA time in the HC/HP to 20% as envisaged in NCHAP.	Output 2.8: Supportive mechanisms and integrated supervision tied into community health service delivery ensure that the success factors of voluntary community health work are monitored, communicated and/ or supported. They are integrated into the strategic approach to community health systems strengthening for support to interventions and CBV/CHA by: - Administrators - Health workers with TA roles for - community health experts of resource units and of CP	Output 3.8: Community level management guidelines for disaster events and their implementation improve the preparedness, expertise for emergencies and public health effects and enable timely and effective responses.
Output 1.9: Management guidelines for HC/HP In-charges, EHT, CHA, a strengthened and stabilized CBV cadre are based on known skills and job descriptions for CBV and NHC, with clear lines of interactions and of the coordination of community health interventions.	Output 2.9: Research & evidence gathering contribute technically to strong support by formally documenting and publishing information on interventions	
Output 1.10: Community based health services, health promotion and prevention have reduced the burden on primary health facilities and increased the number of facility based deliveries.	Output 2.10: Support provides clarity and guidance on the next steps during interventions, coupled with follow up and feedback on performance. It develops an enabling environment for community, NHC and HP through meetings.	
Output 1.11: Analyses of community level primary facilities inform on management practice, clinical governance, type of health care or intervention and referral gate keeping to improve access to diagnosis and quality care at primary level.	Output 2.11: The National Resource Center provides TA for prevention, promotion and public health expertise inputs.	
Output 1.12: Ministries are committed to health promoting and disease preventing activities. Community health service delivery integrates health interventions in all community development programs, particularly school education on hygiene and sanitation and nutrition.	Output 2.12: The District Focal Point supports with institutionalized quarterly/biannual input on review analysis and feedback and also organizes for TA from DRC for community level. DRC guides HCFP/HPFP in mentoring and supervising CBV, CHA/EHT, In-Charge and NHC representatives	

Output 1.13: Improved training of CBV follows an integrated approach for community development and health service delivery. Communities are informed about the benefits of community health services and demand for their delivery.	Output 2.13: Guideline for recognition and rewarding of voluntary work.	
Output 1.14: Packages of hygiene and sanitation interventions, nutrition information and reduction of GBV developed.	Output 2.14: Guideline for harmonizing material and financial incentives for all implementing agencies.	
Output 1.15: Community health budgets are at least at a level of 10% of district budgets and allocated in view of most needy communities with high disease burden. Budgets include also funding for multi-sectoral activities.	Output 2.15: The roles and responsibilities of CHA are delineated in case they represent an In-Charge in an understaffed HC.	
Output 1.16: The poor performance of waiver schemes and the very high administrative costs due to lax beneficiary identification is prevented and costs saved for investments, e.g. the payment of CBV incentives.	2.16: The community health system has a steady and sustainable supply of essential commodities and equipment stock.	
Output 1.17: In the context of scarce resources for health in Zambia, CBV are provided with the opportunity of generating an income from the sale of supplies and health related goods like in Uganda or some districts even in Zambia or from funds saved from other schemes.		
Output 1.18: Community health service delivery got integrated into financial planning for community health. Capacity developed to advocate for investments in community health. Identification of eligible groups for community based health insurance starts in small steps.	Output 1.19: Reports of health expenditures from external sources by district.	Output 1.20 External funds are included into the financial planning for community health service delivery. Capacity develops to reduce gaps in funding and to advocate for adequate investments for community health
Output 1.21: CBVs are interchangeable from NGOs and other providers creating a larger support for Community Health services.	Output 1.22: The districts are regularly provided with a fresh baseline of information to guide the decision making process for the planning of new activities at district level. The data became accessible to the Ministry to provide a holistic view of the number of CBVs in the country and identify possible gaps.	Output 1.23: Community data is used for decision making and operational planning by the facility and the community.

5.2 STRENGTHENING OUTREACH OF COMMUNITY HEALTH CARE DELIVERY

OBJECTIVE 1
To strengthen community health systems by improving organizational structures and coordination mechanisms at the national, district and community levels for effective community health service delivery, monitoring and allocation of resources to legitimize the mandate and accountability of community systems in line with the decentralization policy.

OUTCOME 1
Improved organization and coordination of community the systems HC, HCC, HPC, NHC and CMIS, connected to a supportive mechanism and resource center at district level increase efficiency and effectiveness of community health services. Timely and improved funding and financial management led to effective services resulting in higher service utilization and knowledge levels about health.

Improved management of all CBV by the community health institutions and supervision by support mechanisms for community health interventions. Clear understanding of health facility staff of how community service delivery are to be coordinated and organized[55]. The strengthened role of the EHT in coordinating volunteers for reporting of community data (from CBV and CHA) and their aggregation reduced the work load of In-Charges at the facility level and increased their clinical availability. The CHA became available in the communities as envisaged. HCC/HPC and NHC oversee efficiency and effectiveness of frontline workers.

The PHC Package and Referral to health services at community level with reference to the NPHC got adjusted to the strengthened capacity of CBV.[56] Accessible and cost effective innovative health services models at community level get developed.

District health funds are sufficiently distributed to communities to enable provision of required services at health facility and community system level, particularly the implementation of community health interventions through CBV. GRZ improves compensation schemes for CBV, allowing for monetary and non-monetary incentives for the provision of services, and facilitate them to carry-out micro-entrepreneurial activities to generate additional income.

Districts manage external health funds (from donors and partners) aligned with other sources of funding, help cover gaps and improve the distribution of resources to communities to enable them to provide the required services at health facility and community system level.

Community data systems are developed and aligned with district indicators and enable improvements and relevant changes to action plans for improved health interventions and strengthening the CBV. Improved community health services require community based monitoring of indicators. The community data HIA4a, the performance assessment tool for the CHA, and HIA4b are merged with the DHIS2. The communities use the data which their CBV

[55] Clinton Health Access Initiative & Ministry of Health, 2015
[56] cf. MOH 2012b. (NHCP) p. 25-62: Detailed descriptions of Disease Condition Interventions by Level of Health Care, Table, NHCP

collected in order to make decisions for their community plans. Funding for community level interventions is backed up by data.

5.2.1 Improving Organisation and Coordination of CBV, NHC and the Health System

Output 1.1: A framework for compatible and effective structures through clear mandates for roles and steering of interventions and monitoring.

Key strategies:

1. facilitate inclusion of community health structures at all levels into the existing and emerging regulatory frameworks such as the Public Health Act or the reinstated National Health Services Act
2. establish national, district and community support structure to ensure functionality of the district and community structures with appropriate technical skills and stakeholder coordination to enhance effective execution of community health strategy at all levels
    a. Establish focal points at each level in support of system and frontline workers
3. enable compliance with the links between community service deliverers: CHA/EHT/HC/ HP and CBV/NHC and CBO, FBO etc. in relation to defined standards of operation in primary and community health services following Guidelines of NHC, NCHAP and CHS
4. enhance capacity of EHT and CHA to maintain and coordinate the links by regular monitoring reports (CHA, CBV) in monthly data aggregation meetings (EHT), the regular reporting and participation of CHA and EHT in review meetings of HCC/HPC, organized and supported by HCFP/HPFP
5. strengthen organisational structures for the provision of community health services for health promotion, disease prevention and control in line with the health priorities
6. strengthen support mechanism for volunteers to reduce attrition rates and improve quality of community health service delivery through mentoring and better supervision
7. Strengthen multi-sectoral collaboration, community linkages and coordination within the Health in All Policies framework

Output 1.2: Within the devolved framework strengthened by Focal Points and District Resource Center, NHC, HCC/HPC and the DHMT Officers responsible for community health work got adjusted with the processes.[57] The CHA, EHT/HP, EHT/HC and NHC representatives optimized their routines to improve their community outreach, planning of services, monitoring functions and supervisory activities with CBVs in the context of defined empowerments.[58]

Key strategies:

1. Revive the use of NHC, HCC guidelines, the implementation guide for the NCHAP in community health through advocacy during their respective meetings with the help of the

[57] The circular has been issued in December 2016 directing government officials to establish structures and functions for the decentralization of health services.

[58] Similarly, such interventions should be required for the CBV of other sectors' government community cadres that are on government payroll, like Agricultural Extension Workers, Social Welfare Officers and Community Development Assistants to facilitate future multisectoral collaborations.

HC/HP Focal Point and strengthen the role of the IN-Charge and EHT in coordinating community data collation and aggregation in MDAR.

2. Across the districts streamline the contents and role of the NHC as bureaus representing the community at district level through the HCC/HPC and thus enlarge number of optimized community service delivery.
3. Empower the HCC/HPC to enhance efficiency by following up on reporting and reviewing to give account to community members and ensure supervision and mentoring of the CBV through the HC Focal Point.
4. CHA and EHT intensify community/ household service delivery and monitoring as per their mandates
5. reduce the number of the CBV group and introduce the NHC as common point of contact for all CBVs to facilitate better coordination of the volunteers
6. Design and implement standardized management including incentive schemes for the CBVs.

Output 1.3: The roles and responsibilities of health workers (EHT, CHA), NHC and the management of primary health care and community health work are revised in the overall perspective of implementers, coordinators and supervisors of the implementation and their interfaces.

Key strategies:

1. Clarify the mandates of coordinating and supervising primary health care functions from district, HC/HP to community level, i.e. DHO, HC, Enrolled Nurse, EHT, and CHA as per the respective guidelines (see also annexes).
2. Refine the profile of EHT, CHA, and NHC in the context of coordinative mechanisms and the enlarged qualified health workforce and clarify on the extent of the coordination throughout the year.
3. Develop locally relevant task descriptions and code of conduct for volunteers.
4. Ensure familiarity of roles and responsibilities of every level in the community institutions and committees
5. Ensure regular coordination and interaction with Area Development Committees and Ward Development Committees, DDCC, DIM as mandate that enables participation of committees beyond the health structures in coordination with the HCC/HPC and NHC.

Output 1.4: Improved response to and efficiencies in community health interventions enhance the quality of service delivery. The health interventions are based on locally relevant strategies tailored around community needs and CBV knowledge of the respective health determinants.

Key Strategies:

1. Use color coded score cards to monitor and adapt community action plans with Community members and structures like NHC, HCC and facility staff jointly track and improve interventions
2. Hold milestone meetings to monitor and follow up on tasks of the action plans

3. Open up options for stabilizing the CBV volume[59] by developing locally relevant strategies within the context of environmental and social health determinants, non-personal health services, and a multi sectoral character of community health work.

5.2.2 Establishing a Community Friendly Platform for Innovations in CHC Delivery

Output 1.5: Patient friendly health services which are accessible, gender sensitive and cost-effective

Key strategy:

1. Explore options to identify
    a. health service delivery methods that are acceptable to peoples' living conditions in rural and urban communities
    b. cost-effective options for community health services
    c. effective service mixes including referral and transportation to health facilities
    d. health services that enhance access
    e. gender sensitive interventions
2. provide support to developing a variety of service delivery models: as single interventions, in a mix of health services (technically or sectoral), as innovative group care models or by established networks of health and non-health providers, including the media
3. assess digital diagnosis options as alternatives for transportation to health facilities from the community and identify the sources of financing
4. aim at strengthening and/or complementing Primary Health Care facilities through alternative provider models to reach at an appropriate mix of HR, equipment and supplies, distribution of essential medicines and commodities to enable a more complex case-mix management at the household, community and/or primary health care level
5. Establishing national, district and community support structure to ensure functionality and technical skills of the district and community structures and stakeholder coordination to enhance effective execution of community health strategy at all levels
6. establishing district and national level resource centres to connect NHC with the community systems and the health system through focal points
7. engage district focal points and HC/HP Focal Points into oversight and catalysing of development of appropriate service models, CBV cadre, functional relationships with committees
8. encourage cross-sectoral synergies that would enhance access to (priority health and non-health) services (e.g. schools as hubs for a range of child-focused services, birth registration as link to immunization and vice versa, school enrolment as link to growth monitoring & immunization)

[59] Clinton Health Access Initiative & MOH 2015

Output 1.6: Guideline with assessment criteria for efficient and cost-effective community health services

Key strategy:

1. develop a framework of equity oriented innovations for enhancing gender sensitive community health systems and service delivery models

Output 1.7: Developed cost-effective health service models which can be rolled out in other districts and provinces

Key strategy:

1. conduct cost assessment of proposed health service model, award cost effective ones and MOH/DOH provide support and subsidy for roll out
2. roll out community health system innovations throughout the country

5.2.3 Revising PHC Package and Referral to Improve Capacity of Districts, Hospitals and Health Centres and Health Posts to Cater to Community Health Needs

Output 1.8: The excessive task-shifting from nurses to CHAs at the facility level is reduced and limits CHA time in the HC/HP to 20% as envisaged in NCHAP.

Key Strategies:

1. overcome the lack of understanding by DHO and facility staff of the role of CHAs in reducing the case load through preventative and promotive health and nutrition at the community level,[60]
2. Strengthen the role of the EHT to aggregate community level data through monthly data aggregation and review meetings and free In-Charge time for clinical duty.
3. Strengthen structures that promote data use in decision- make processes by: HCC, NHC and HC (EHT and CHA), supported by Focal Points at facility and district levels
4. use data to guide decision making in the NHC, HCC/HPC and DHO and specify the role of CHA in the coordination of community health activities, e.g. for handholding or mentoring and TA to CBV as per requirements of interventions, and of EHT for community data aggregation

Output 1.9: Management guidelines for HC/HP In-charges, EHT and CHA for a strengthened and stabilized CBV cadre are based on known skills and job descriptions for CBV and the NHC. They delineate clear lines of interactions and of the coordination of community health interventions.

Key Strategies:

[60] This is commonly referred to as 'turning off the tap at the community level'. It is especially important for coordination of non-personal community health services such as identifying mosquito breeding sites, residual indoor spraying with insecticides to reduce mosquitos, counseling and testing for HIV, Tb screening and case identification, health promotion and activities to improve water and sanitation.

1. implement a standardized management for the CBVs, which is applied by all: HC, DHMT, donors and other stakeholders and supported by the HP/HCFP
2. clarify on roles and functions and clearly spell out responsibilities and feasible mechanisms to manage and coordinate the CBV basic health services to the community:
    a. based on qualifications of CHA and CBV and
    b. the plans for a community health nurse (CHN)
3. provide skills and job descriptions of CBVs and approval of those for the CHA[61]
4. Provide user friendly Information Education and Communication (IEC) materials about range of services at the health facilities and in the communities and households, how to access the services and seek support

Output 1.10: Community based health services, health promotion and prevention have reduced the burden on primary health facilities and increased the number of facility based deliveries.

Key strategies:

1. train health workers on the effects of health promotion, disease prevention and nutrition at community level;
    - on reduction of case numbers of preventable illness, and
    - provision of basic curative services

    in order to free clinician-time and allow health facilities to focus on cases that require skilled medical expertise.[62]
2. CBVs mobilize and empower communities in SBA, efficient referral network (household to health facility), in a sustainable context through performance based incentives, e.g. for delivery referrals)

Output 1.11: Analyses of community level primary facilities inform on management practice, clinical governance, type of health care, intervention and referral gate keeping to improve diagnosis and referral for treatment at right level of care.

Key strategies:

1. assess clinical governance and the availability of equipment and medicines,
2. Develop a framework for the delineation of the roles, functions and SOPs to support community health and technical skills at each level of health care relating to community health services
    a. assess the governance of interlinking the health service level with the management capacities to supervise standard operating procedures
    b. Increase coverage of household visits to ensure identification and referral of cases in need
    c. Counselling on chronic disease management (HIV/AIDS, cancer, diabetes, blood pressure, eye care…)

[61] These have already been developed for CHA by MoH and have been submitted to Cabinet office for formal approval, cf. MOH 2017d

[62] The CHAI and MOH 2013 "Task Shifting Analysis" came to this conclusion.

   d. Home based rehabilitation and care options
   e. medicine kits and distribution at community level
3. assess access to primary care and upwards through mapping patient pathways at primary level and the current referral mechanisms in order to revitalize the referral and feedback systems between health facilities and communities and improving the functionality of the referral system
   a. Aggregate the number of referrals using the HIA4 forms.
   b. Use monitoring and assessment data to demand for sufficient financing at Council/DHO
4. Develop an operational ambulance system which reacts to emergency calls managed by CBVs and CHA's in consultation with HP staff and/or coordination with the receiving health facility and accompany clients if advised by health facility staff.
   a. train CBV and CHA on danger signs and conditions that require immediate hospitalization and on escorting patients when necessary und given geographic conditions
   b. scale up good practice ambulance models, including PPP options
   c. be innovative in modelling also for alternative means of transport

5.2.4 Strengthening Health Promotion, Education and Disease Prevention at Community Level

Output 1.12: Ministries are committed to health promoting and disease preventing activities and agreed on a framework for the involvement of different sectors and the management of their inputs. Community health service delivery integrates health care interventions in all community development programs, particularly school education on hygiene, sanitation and nutrition. A multi sectoral accountability structure is established at national level and managed by the NFP.

Key Strategies:

1. Scale up standardized capacity building for health promotion and education at facility and community level
2. Strengthen integration of health promotion, disease prevention and control, nutrition in all community level programmes, diagnosis and treatment of childhood illness, healthy pregnancy, newborn care and nutrition, sanitation and communicable diseases (ARI, Diarrhea, HIV, Malaria, TB), as well as leading lifestyle diseases (diabetes and high blood pressure), and recognition of danger signs for referral.
3. Develop and distribute print information
4. Develop mass education interventions for modern and traditional media
5. Scale up existing programmes like WASH, etc.
6. Strengthen multi-sectoral collaboration, community linkages and coordination in line with decentralization policy to address Social Determinants of Health (SDH) and within the Health in All Policies framework
7. Develop/strengthen multi-sectoral coordination mechanisms at national, provincial and district levels that function to support the rest of the listed strategies
8. Engage a high level champion to bring together relevant stakeholders, mobilize resources and sustain national momentum

9. Define roles and responsibilities of the various line ministries through the national multi-sectoral accountability structure (NFP) and those of key stakeholder
10. Link the national level multi-sectoral structures with equivalent structures at sub-national level (led by the focal points)

Output 1.13: Improved training of CBV follows an integrated approach for community development and health service delivery in communities/households. Communities are informed about the benefits of community health services and demand for their delivery.

Key Strategies:

1. Develop integrated training modules for CBV which address health, gender, environment, housing and other non-health topics
2. Train CBV on advisory role how to place requests through NHC and/or directly to the DHO and local government to effectively improve health determinants

Output 1.14: Packages of hygiene interventions, nutrition information and reduction of GBV are developed.

Key Strategies:

1. Strengthen comprehensive learning in institutions on nutrition, sexual health education, safe drinking water and sanitation
2. Develop programmes to enhance demand creation for gender sensitive community health services that advise on prevention of GBV
3. Implement health promotion and disease prevention activities

5.2.5 Community Health Financing, Resources and Supplies to Strengthen Community Health Service Delivery Supported by Harmonized Incentive Schemes for CBV

Output 1.15: Community health budgets are at least at a level of 10% of district budgets and allocated in view of most needy communities with high disease burden. Budgets include also funding for multi-sectoral activities.

Key strategies:

1. Develop a binding framework for investment and impact measurement of a minimum of 10% grant allocated to DHOs for community health activities, including a sound monitoring of allocation and expenditure
2. Revising financial flows to reflect the changes in functions within the health system and MoH, considering the services included in the package of care included in the National Social Health Insurance.
3. Identifying the sources for financing multi-sectoral activities
4. Involve communities into budgeting of action plans.

Output 1.16: The poor performance of waiver schemes (see annex 12) and the very high administrative costs due to lax beneficiary identification is prevented and costs saved for investments elsewhere, e.g. the payment of CBV incentives.

Key strategies:

1. Prioritize equitable resource allocation considering demographic/geographic and disease burden as well as gender.
2. Eliminate waiver schemes

Output 1.17: In the context of scarce resources for health in Zambia, CBV are provided with the opportunity of generating an income from the sale of supplies and health related goods like in Uganda or some districts even in Zambia[63] or from funds saved from other schemes.

Key strategies:

1. improve community services through paid CBV, well trained and with supervision, a good information system, and permission to distribute supplies through drug kits, as well as eventually supplementing the income of the CBV[64], starting with small numbers and types of interventions included in community health care programs with an option to expand the package of care when more resources are available.
2. Develop guidelines regarding the goods that could be sold, and ensure that preventive care and enlisting of members are services provided free of charge.
3. substitute waiver schemes with free services in which CBV with a set stipend, distribute "free" supplies along with discounted price supplies for other services and/or invest fund saved from repealed waivers are invested into income generating schemes (cf. the Rwanda example, annexes 11, 12, 14, 15,).

Output 1.18: Community health service delivery got integrated into financial planning for community health. Capacity develops to advocate for investments in community health. Identification of eligible groups for community based health insurance starts in small steps.

Key strategies:

1. Strengthening the capacity of District Health Offices to carry-out financial planning and management responsibilities, involve community members into budgeting and support the full implementation of the 2009 Action Planning Handbook for Districts
2. Increase investments into health service delivery and integrate performance into financing mechanisms, linked with monitoring of CBV performance
3. Use the community level data coming in the HIA4 and 4b forms to strategically plan community funding
4. Reintroducing drug kits for distribution of common medicines and commodities at household level
5. If set for social health insurance: starting with the identification of the groups for risk-pooling as the first step to develop any social health insurance systems

[63] by the NGO Live Well
[64] as in Uganda and Zambia in the Living Goods Projects, see details in Annex 11

6. MOF to provide fund for reimbursements for community health services as long as these are not covered by SHI

5.2.6 Strengthening Community Health Systems at the District Level by Aligning External Funds and Other Resources

Output 1.19: Reports of health expenditures from external sources by district.

Key Strategy:

1. Develop and introduce guidelines to report budgets and expenditures from external funds at the district level.

Output 1.20: External funds are included into the financial planning for community health service delivery. Capacity develops to reduce gaps in funding and to advocate for adequate investments for community health.

Key Strategy:

1. Track and report external funds at the district level and reduce duplication of activities with different funding sources. Identify the interchangeability of funds by source and improve allocation efficiency by reducing duplication and covering gaps in funding.

Output 1.21: CBVs are interchangeable from NGOs and other providers creating a larger support for Community Health services.

Key Strategies:

1. Increase coordination of activities from vertical programs and NGOs at the community level.
2. CVB engaged by NGOs participate in activities to strengthen their motivation, they have equivalent remuneration schemes and are integrated into the established coordination, supervision and monitoring structures

5.2.7 Improving the Community Health Information System to Effectively and Reliably Plan and Support the Implementation of Community Health Interventions

Output 1.22: The districts are regularly provided with a fresh baseline of information to guide the decision making process for the planning of new activities at district level. The data also become accessible to the Ministry to provide a holistic view of the number of CBVs in the country and identify possible gaps. Finally the data are available to other partners, in order to facilitate the planning of activities by these partners.

Key Strategies:

1. Harmonize community level indicators

2. Ensure monthly data aggregation and review meetings take place and the HIA4b data is integrated into the HMIS and presented at the HCCs and NHCs
3. Streamline data reporting in CP interventions with public sector reporting district requirements
4. harmonize procedures:
    a. for CBV from all groups and
    b. of CBV from all health zones
5. train on analysis and use of information from monitoring data for adjustments to prioritization and of action plans, promote use of community health self-assessment
6. support the development of the community based monitoring system for the health zones and compliance with the reporting lines to the EHT, CHA or In-charges of facilities
7. promote use of data from community based monitoring for analysis and improvements in health zones by communities, CBO and CSO

Output 1.23:
Community data is used for decision making and operational planning by the facility and the community.

Key Strategies:
1. Improve skills and capacity of facility staff, HCC and NHC members to make decisions based on data.
2. Use data to inform the decisions to be made by the HCCs and NHCs, e.g. for improved operational and action planning.
3. Make use of the community data to request funding from Council.

5.3 BUILDING CAPACITY OF FRONTLINE HEALTH WORKERS

OBJECTIVE 2
To build capacity of frontline workers through improved training, support and recognition to ensure continuity and quality service and health promotion delivery, supported by timely financing, materials and medical supplies.

OUTCOME 2
Improved resilience and quality of service delivery among Community Based Volunteers and improved coordination of CBV by the NHC and HC/HP sustain the community health system by providing support, enhancing motivation and skills of the CBV and reducing attrition amongst the CBV. The CBV and their NHC got well connected to the health system and imbalances are reduced to allow CBV and CHA to primarily work in the communities through household visits, health promotion and disease prevention. Community health services focus on the health priorities, expanded dissemination reach and less case load in understaffed facilities.

5.3.1 Harmonizing CBV Groups by Selection, Training, Tasking, Review and Support

For improvements in the quality of community health work through harmonization of the CBV there is need for assessing and streamlining of differences between the groups and tasks of CBV.

Output 2.1: Training includes integrated health and development curricula, business and community health service management training. Acquired knowledge and skills are evaluated to determine successful CBV trainees to become active CBV who are entitled to monthly one day refresher trainings on key health and management/business topics and for knowledge assessment. The quality of the training is measurable and assessable, thus it can be certified.

Key Strategies:

1. define standardized training packages for CBV that include prevention, health and nutrition promotion and disaster management, identification of local health priorities and service delivery management elements, maternal and child care, management of chronic and leading lifestyle illness, and integrated services for a healthy community development
2. develop refresher training modules and CBV knowledge assessment formats
3. group the overall skill mix by training modules that define gradual CBV competence
4. optimize integrated packages with multi-facetted training curriculums
5. regularly assess the performance of CBV in refresher trainings and through the MDAR and HCC meetings
6. issue certificates per module of training successfully passed
7. conduct refresher trainings combined with knowledge assessments
8. reward good performance based on training achievements as per training modules completed and refresher trainings taken

Output 2.2: The CBV skills became a protected package. Its implementation is measurable and the service deliverers' (CBV) performance can be evaluated. The CBV can be accredited on the basis of good implementation of the certified training and standardized package of community health and nutrition services.

Key Strategies:

1. develop/adopt the QA criteria for certification of CBV performance
2. empower NHC on the same to enable them better support and supervise CBVs
3. formally certify and register the eligible CBV

Output 2.3: On the community level, the effectiveness of health and nutrition service delivery is improved. The tool of team formation helps to level differences and "grades" among the volunteers through mutual learning particularly during the transition time of harmonization of CBV.

Key Strategies:

1. regularly organize NHC meetings for peer reviews and storytelling for the CBV
2. regularly provide feedback to CBV also from the HCC
3. during the transition time, strengthen mentoring and supervision through HCFP/HPFP and DRC efforts
4. train CBV on team work, effectiveness and efficiency

5.3.2 Improving Continuity, Acceptability and Gender Balance of CBV

Output 2.4: Competitive selection of CBV through NHC is based on sstandard eligibility profiles for CBV to optimize the right choice of CBV for the envisaged tasks. This has proven to enhance the sustainability of recruited CBV. NHC recruitment of CBV enhances acceptability of CBV by the community as well as reduction of attrition. The resilience of CBV is stronger and they continue working over a sustained period of time.

Key Strategies:

1. Use of standard eligibility profiles for application in the selection of CBV as per new NHC guidelines
2. Scale up of standardized recruitment and retention of community based volunteers
    a. Determine the NHC for identification and selection of all CBV through a competitive procedure with a consideration of the gender, culture and required tasks.
    b. Provide for female quota to balance gender participation in cadre as per new NHC guidelines, particularly in villages where scale-up is planned.
    c. Ensure a minimum number of seven operational CBV per NHC

Output 2.5: NHC recognized and operating within the Social Accountability Framework (see chapter 5.3) contribute to higher continuation of CBV. In addition, motivation of CBV is strengthened when they receive official recognition by the health system and thus stay on longer or get social recognition in support of planning their future.

Key Strategies:

1. Defining the work area: technically (cf. annex 8) and assign 200 to maximum 400 households
2. Maintain CBV reporting systems at community level
3. Outline the mechanism for measuring the performance of the CBV in cooperation with NHC and HCC
4. Monitor, audit and publish assessed performance of CBVs by the HCC and the DHO
5. NHC develop and maintain tracking data base for CBV on entry, frequently review number of CBV and train more CBV, permanently assess retention levels and report regularly to HCC and DHO
6. NHC strengthen contact with EHT during the monthly data aggregation and review meetings for all CBV (public and NGO) to improve corporate identity of CBV
7. Equip CBV with job Aids, add mobile technology to promote coverage and health services, re-introduce medicine distribution by CBV and carry out community level monitoring
8. Develop equipment protection and branding

Output 2.6: The aspirations of CBV are technically and socially recognized and given the perspective of being involved in a rewarding and ongoing learning process. There are various modules defining levels of training and refinement of skills. The CBV gradually acquire an educational basis up to job entry maturity that helps them take a step into health related employment or a formal education with a life supporting perspective.

Key Strategy:

1. determine supervision mechanisms and mentorship arrangements

5.3.3 Support Mechanism for CBV Development and Retention to Enhance Quality and Continuity of Service Delivery

A supportive mechanism serves to enhance motivation and retention of CBV. The District Resource Center can provide the required technical, and complementary mentoring and supervisory support to the CBV and the community health programs and developments. Such resource center needs to streamline processes to uphold the CBV cadre. It is supported by a District Focal Point and a HC/HP Focal Point.

Output 2.7: The streamlined processes work cohesively between the actors: CBV, NHC and HC/HP who are drawn into a team approach with informed decision making for health interventions and referral, based on monitoring and review.

Key Strategies:

1. Train CBV on monitoring responsibilities of community health and referral activities
2. make monitoring the basis for coordination in which relationships are defined
3. establish performance based incentives for referral and community health service delivery

5.3.4 Interfacing Routines and Support for CBV and Primary Health Care Workers

Output 2.8: Supportive mechanisms and integrated supervision tied into community health service delivery ensure that the success factors of voluntary community health work are monitored, communicated and/ or supported. They are integrated into the strategic approach to community health systems strengthening for support to interventions and CBV/CHA by:

- Administrators
- Health workers with adjusted PHC roles for TA to community health
- experts of resource units and of CP

Key Strategies:

1. establish focal points for community health work at national, district and community level
2. Delineate their roles and functions as per implementation framework (output 1.1)
3. Define communication lines
4. Include linkage to resource center at district level
5. Plan the training of focal points and district resource center
6. Roll-out training of focal points and district resource center

Output 2.9: Research & evidence gathering contribute technically to strong support by official documentation and publication of interventions at HC/HP by HCFP/HPFP.

Key Strategies:

1. Based on monitoring and review results, HCFP and DRC-TA at community and district levels identify gaps and weaknesses in performance and intervention when addressing health priorities and social determinants and support outputs 1.2, 1.7. 1.10, 1.11 and 1.18.
2. task district resource center to
    a. develop research and assessments
    b. support evaluation and analysis of monitoring data

Output 2.10: Support provides clarity and guidance on the next steps during interventions, coupled with quarterly review by the HCC, follow up, feedback on performance and self-assessments concerning structure and organization of community health work to NHC. It develops an enabling environment for community, NHC and HP through meetings. The documentation and results are shared with the HCFP/HPFP for requesting TA from the DRC for coaching, mentoring and if necessary assessments or research.

Key Strategies:

1. Provide and ensure through HCFP/DRC the implementation of:
    a. Storytelling and peer review in NHC meetings
    b. Data aggregation and review meetings with EHT
    c. hold regular HCC meetings and provide HCC feedback
    d. ensure participation of HC staff and DHO through the HC focal point
    e. develop supervision schedules in supportive activities and complementary to regular schedules with HC, HP, NHC, HCC/HPC res a) – d)
    f. Coordination and monitoring through HCC/HPC/District Health Manager
    g. provide supervision through DRC on regular basis
    h. ensure NHC feedback of results to CBV and to DRC through HCFP/HPFP
2. Develop supervision schedules in supportive activities and complementary to regular schedules with HC, HP, NHC, HCC/HPC
3. Provide supervision through DRC on regular basis

5.3.5 Mentoring, Supervision and Incentives

Following models of various pilots and best practice, the strategies below have proven to produce successful outputs towards developing mentoring, supervision and an incentive scheme to increase the resilience of the CBV and keep them committed in the longer term.

Output 2.11: The National Resource Center provides TA for prevention, promotion and public health expertise inputs to the District level.

Key Strategies:

1. expand the mandate for currently provided technical guidance from HC/HP to the District Resource Center, the DFP and HCFP to cooperate with NHC and CHA through a supportive mechanism
2. design the wider reach of the District Resource Center, spanning from the national level to the community level with coordination and impact at district and community level

Output 2.12: The District Focal Point supports with institutionalized quarterly/biannual input on review analysis and feedback and also organizes for TA from DRC for community level. DRC guides HCFP/HPFP in mentoring and supervising CBV, NHC, CHA/EHT, and In-Charges.

Key Strategies:

1. Provide coaching/TOT to CHA/EHT and HC/HPFP to selectively provide CBV and NHC with sound technical guidance on common ailment diagnosis, patient pathways and referral to the health post/health center and mentor on these issues.
2. Provide and ensure review and feedback (cf. output 2.12) through HCFP/HPFP and:
    a. Through DRC technical and organizational support to interventions as appropriate
    b. Mentoring and Supervision through HCFP/HPFP
    c. Institutional development through: orientation, rotation, familiarity between CBV
    d. Redressal mechanism to HCCE or the Focal Person at the Resource Unit
    e. task and responsibility assignments to achieve shared goal, mutual support

Output 2.13: Guideline for recognition and rewarding of voluntary work.

Key Strategies:

1. Develop document with eligibility criteria.
2. Consider various levels of rewarding as per achievements by number and level of modules.

Output 2.14: Guideline for harmonizing material and financial incentives for all implementing agencies. Guideline is based on measurable activities of CBV, like: home visits to educate households on essential health behaviors, provision basic medical care, referral of severe cases to the closest health center, to incentivize by performance. It also considers distribution or sales of preventive and curative health products.

Key Strategies:

1. develop policy and guideline documents to support harmonization of material and financial incentives
2. Provide an educational perspective[65] as incentive defined in a guideline by number of training modules, recognition by levels, awarding by levels and excellence assessed in performance reviews. The strategy is based on the observation of VSO (2014) that 41% of CBV consider skills development as incentive, another 20% do voluntary work to get into education.
3. Introduce Guidelines to harmonize the material and financial incentive levels based on measurable activities and clearly set out to all, CSO, CP and Government how to fairly and equally reward CBVs for their work; and therefore help to prevent competition between programs.

[65] UNZA refers to job entry maturity or qualification

Output 2.15: The roles and responsibilities of CHA are delineated in case they represent an In-Charge in an understaffed HC/HP

Key Strategy:

1. Regulate the roles and the extent of responsibilities for a CHA when closing the HRH gap where there is no In-Charge in the HC.

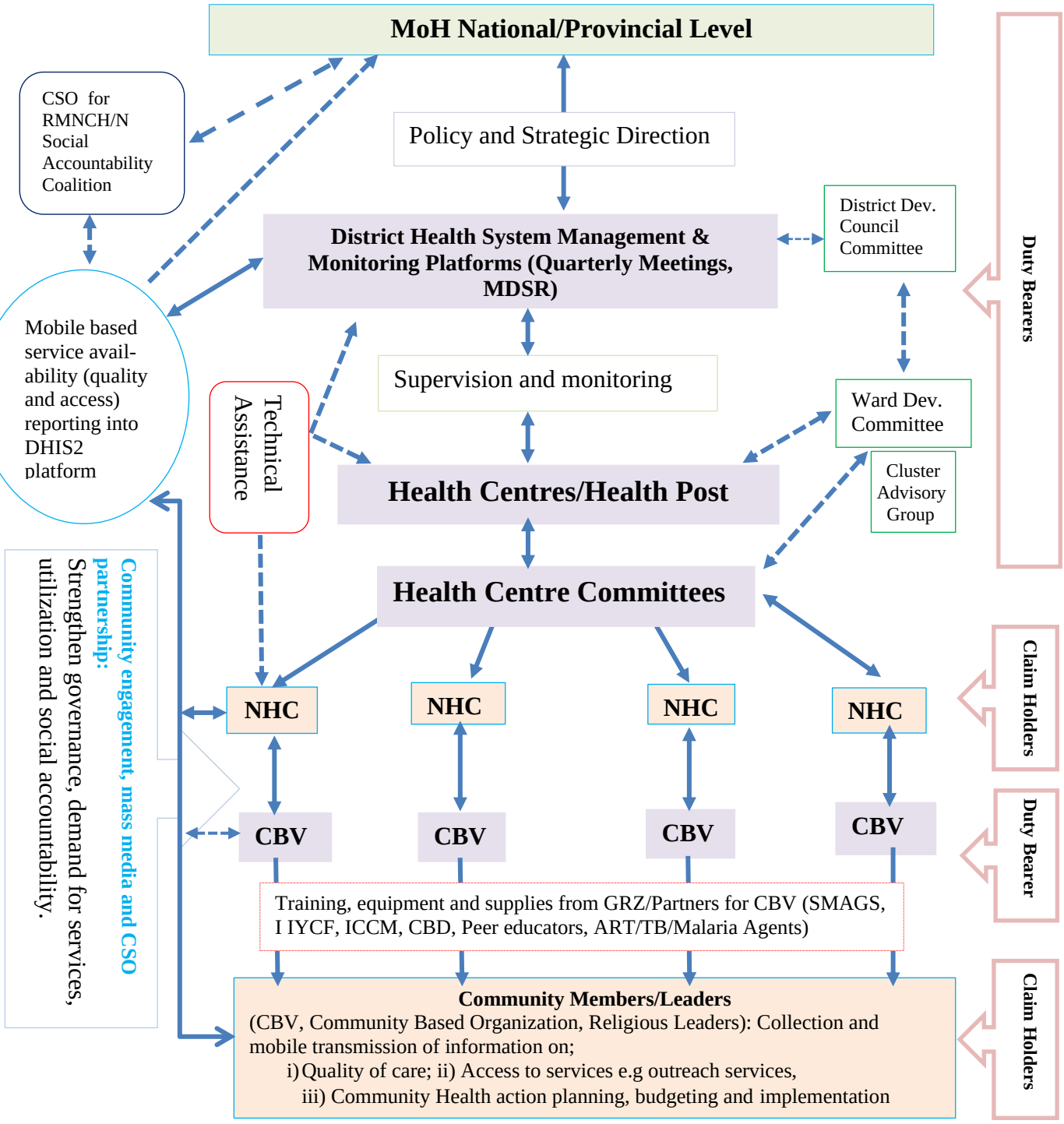
Output 2.16: The community health system has a steady and sustainable supply of essential commodities and equipment.

Key strategies:

1. Develop guidelines for supply chain management for community health systems
2. Build capacity of the various community structures on supply chain management;
3. Develop a framework for social accountability for supply chain
4. Allow for innovative models of supplying medicines and commodities to households, e.g. by means of income generation schemes through CBD and others
5. Revive medicine kit for supervised medicine distribution –prescribed and non-prescribed essential medicines, by CBV

5.4 Community Participation in a Social Accountability Framework: the NHC as Platform

Figure 8



Source: Adapted from: MOH, April 2017b. Schematic Representation of the interactions of the Community Health: System Players for Social Accountability in Central and Western Provinces in the NHC Guidelines.

The social accountability framework aligns with the guideline for Community Health Planning and for Neighborhood Committees (both MOH 2017) allowing for the planning of locally relevant strategies, consideration of cultural practices, transparent processes and accountability of the actors. The following strategic objectives for community participation, outcomes and outputs are set in this context.

OBJECTIVE 3
To strengthen the participation of communities in health engagements, planning, budgeting, financing and monitoring for social accountability and quality of community health services.

OUTCOME 3
A Social Accountability Framework guides the involvement of communities, CBV, NHC, HPC, HCC and ward and district level committees. It enhances communities' influence on health services planning and development, increased access to improved services, resources are spent on locally relevant interventions. Enhanced dynamics with community partners and networks, knowledge institutions and private service providers contribute to increased relevance and effectiveness of services for the people at lower cost. The facilitation of health care service planning allows for availability and access to specific services for the improvement of people's health related social, cultural and environmental living conditions. Responses to emergencies and disasters got improved through a comprehensive community health approach, including multi-sectoral collaboration and locally available expertise.

5.4.1 Health Service Planning and Delivery

Output 3.1: The strategic plans of communities in Zambia vary from community to community to capture the social and environmental health determinants.

Key Strategies:

- Ensure community participation in health needs assessments for planning and implementing health action plans.
- Involve CBVs and civil society in health promotion and disease prevention in community health.
- Involve communities and CBV into policy oriented advocacy to ensure inclusion of priorities.
- Strengthen learning experience in social accountability between service providers and users

Output 3.2: Outlined procedures clarify how the NHC will be admitted and allowed to contribute at different levels of the health system: HPC/HCC, DHO, and the local government: DDCC and ward development committees. Action Planning is done with participation of community representatives. It is based on information from monitoring data of previous interventions and communicated to the DHO (see organigram, pp. 24 and 76).

Key strategies:

1. HCFP/HPFP ensures provision of NHC guidelines to each NHC/HC for reference by stakeholders
2. NHC representatives and HCC/HPC members clarify in HCC/HPC meetings on the lines of communication, responsibilities, roles and function
3. HCC chairmen seek support from HCFP/HPFP for timely information about
    a. district level meetings for development
    b. DIM
    c. DDCC
    d. Ward development committee meetings
4. NHC representatives regularly attend the scheduled HCC/HPC and district level meetings and during NHC meeting communicate the issues to the CBV and community representatives for further action planning and fine-tuning of ongoing intervention
5. CHA and NHC to mobilize the community members for action planning timely and organize meeting and planning utensils, supported by HCFP/HPFP.

Output 3.3: Integration of community representatives and traditional leaders into the meetings of the NHC contributes to formulation of community needs. Perception of ongoing implementation are considered during NHC meetings and shared in HCC/HPC meetings and if significant, communicated to Local Government Councils for further action, e.g. fund raising.

Key strategies:

1. NHC ensure that community planning of health action has taken place to inform NHC of necessary support for any particular intervention or action.
2. Invite community representatives and traditional leaders into NHC meetings for the identification and prioritization of environmental, social, health care and access needs.
3. Encourage comments on received community health interventions.
4. Jointly agree on community interventions/solutions to address the priority needs and basic indicators to track progress.
5. Jointly develop a work plan and budget for the community interventions, including assigning roles and responsibilities, monitoring and reporting timelines.
6. Ensure notes are taken during meetings to document discussion in minutes.
7. Announce follow up meeting or date for next NHC meeting.

Output 3.4: Depending on the pattern of needs born out of local health determinants, communities match these with their existing networks of support and service providers, apart from utilizing improved support of community health services by the public system of PHC services.

Key strategies:

1. Engage communities in resource mapping for surely meeting community voiced needs for health care delivery concerning available community based support and type of needs.

2. Factor available resources into planning of health action or intervention required ad hoc, e.g. in case of emergency (emergency fund, unforeseen expenditure)
3. HC, CHA and EHT to identify gaps and problem areas and advise on problem solving approaches, HCFP to follow up and support/finalize their effort, particularly over a period of time and when other than the health sector inputs are required
4. facilitate community participation through regular NHC meetings for reporting back from district level integration and development meetings and gathering opinion for improvements

Output 3.5: Strong social accountability keeps up the demand for good governance of health services and availability of medicines, supervision of health standards and referral mechanisms.

Key *strategies*:

1. Establish the legitimation of community responsibilities (bottom-up governance) and obligations within the formalized (top-down) approach by following the available regulations guidelines on community planning, NHC and HCC/HPC roles and functions and contribute to district plans.
2. Create an enabling environment for participation of traditional, CSO, FBO, media, academia in executing an all-inclusive gender sensitive community health system

Output 3.6: Traditional governance structures are integrated and headmen involved into decision making processes. The consideration of health determinants thus gains more attention for enhancing community dialogue, capturing local cultural practices and shaping relevant health messages.

Key Strategies:

- Enable transparent decision making and spaces where normal citizens are able to engage in processes concerning their communities
- Incorporate other sector representatives and extension officers to participate in NHC meetings, including hospital committees, legitimately by means of membership and regulated interactions.
- Encourage participation of headmen into community planning and feedback meetings of NHC

5.4.2 Community Planning by Health Determinants

Output 3.7: Assessment of local health and nutrition conditions and disease incidence[66]

Key strategies:

1. During development of action plans for community health interventions, social and environmental health determinants are considered by degree of prevalence:

[66] Central Statistical Office et al., 2015, see also overview in annex 16

    a. Ideally, monitoring data of previous community health interventions are considered, if not available, relevant DHIS2 data or
    b. regular self-assessment meetings using community HIA4, identification of health problems and agreed action plans as basis for planning and monitoring implementation
    c. any other health documentation that can serve as evidence basis for planning
2. Develop disease prevention, control and health promotion packages that are based on local conditions
3. Develop approaches to reduce gender based violence and gender discrimination that limits access to health services
4. Modification of media messages to the local circumstances, culture and language

Output 3.8: Community level management guidelines for disaster events and their implementation improve the preparedness, expertise for emergencies and public health effects, and enable timely and effective responses.

Key Strategies:

1. Strengthen the partnership with the Disaster Management and Mitigation Unit (DMMU) under the Office of the Vice President and develop strategies together with them
2. If relevant in the region/province, develop guidelines for community systems adaptation in public health emergency situation through devastation of infrastructure and sanitation, drought, water logging, far spread loss of shading/sun protection, food, housing
3. Implement the digital Disease surveillance and Response System of Zambia (IDSR) with its household coordinates.
4. Commit communities to feed required information on notifiable diseases to IDSR for follow up.
5. Develop training inputs and schedules for community members, NHC and CBV to acquire the required skills
6. Develop the necessary infrastructure in the communities to be able to respond to disaster episodes quickly, e.g. storage facilities and necessary materials, identify gathering points, etc.

6. IMPLEMENTATION FRAMEWORK

6.1 Institutional and Coordination Framework at National, District and Community Level

Coordination and Support Mechanisms for CBV

Within the context of Zambia, the strengthening of CBV through revitalization and support mechanisms has not yet been entirely conclusive. There is urgent need to overcome the currently inappropriate and insufficient supervision of CBV in view of the observation that supervisors as health staff are already overloaded.[67] Best practices in this regard point at an additional level of managing community health service delivery by non-health personal, e.g. from the management or social work field like in India, the help desk in Rwanda, or by direct inclusion of health extension workers into the health work force, i.e. maintaining a paid cadre which appears to be the trend in several countries' approaches to community health, like in Uganda or Ethiopia.

The following directions for strengthening the implementation framework for community health work are developed on this background and on the basis of the pilots and local community driven initiatives in some districts of Zambia.

For further improvement of governance there is need to develop an operational guide for the CHS that encompasses:

- job descriptions for national and local coordinators of community health work
- Operational guide for Neighbourhood Health Committees terms of office (ongoing and under revision), determining: rotation, frequency of meetings, composition, gender representation and financial support for NHCs and relations to other committees.
- Standard methods of administering supervision and mentoring CBV across all types of CBV
- Linking the mandates of CHAs for coordination, TA and supervision of the volunteers' interventions with those of NHC, HCC, DHO and additional management layers (FP)
- regulatory arrangements to maintain the smooth operation of the system at community level through well-defined empowerment of FP and CHAs to supervise and coordinate the CBV interventions. This shall be developed in relation to the supervisory and coordinating structures in the public sector and as linked up with CBO.
- Operational guide for the Monthly Data Aggregation and Review meetings

There is need to overcome the current situation of little staff availability that does not yet allow the full implementation of the CHA responsibilities with a high volume of tasks in clinical and outreach responsibility as well as management, coordination and community mobilization.

Hence, in order to strengthen the management and coordination of volunteers, managerial tasks are better assigned to an additional layer. It takes on management, coordination of system processes between the committees and frontline workers, TA, supervision and mentoring of the CBV and in some areas of the CHA in support of the In-Charges. Thus the now foreseen layers for these functions link up with existing structures, clarify their roles and provide complementary guidance for a strong leadership and management in community health (see figure 9 below on support mechanism). This proposal is in line with the recognition of the fact that "lack of

[67] Care Zambia, 2017

management skills appear to be the single most important barrier to improving health throughout the world".[68]

6.1.1 National and Provincial Level

Restructuring at MoH and PHO

The Directorate of Public Health establishes a National Focal Point (NFP) at the national level for overseeing the policy directions, management and facilitation of all relationships involved in the implementation of the community health strategy. The NFP is envisaged as function under both, the Directorate for Health Promotion, Environment and Social Determinants as well as Directorate of Public Health within which it shall be hosted to oversee and facilitate the joint implementation of the CHS at the community level by the two Directorates. The NFP also regularly reviews the CHS to identify deviation and systemic bottlenecks at a national level, use these to revise the country-specific role of CBV, the interventions and national level indicators.

This will also involve inter-sectoral collaboration and thus inclusion and networking with non-health ministries of GRZ, like the Ministry of Housing and Infrastructure, Ministry of Water Sanitation and Environmental Protection, Ministry of Fisheries and Livestock, MOCDMCH and other relevant Ministries. The NFP scope of work also includes the networking with these ministries and management of an inter-sectoral budget and resource mobilization for strengthening community interventions which require inputs from any one or more of these Ministries or their Departments at District level.

The NFP also networks and coordinates with the Cooperating Partners, INGO, local NGO and TWG for Community Health Care/Primary Health Care and with national and international academia in respective fields, mainly public health and related health and HR disciplines.

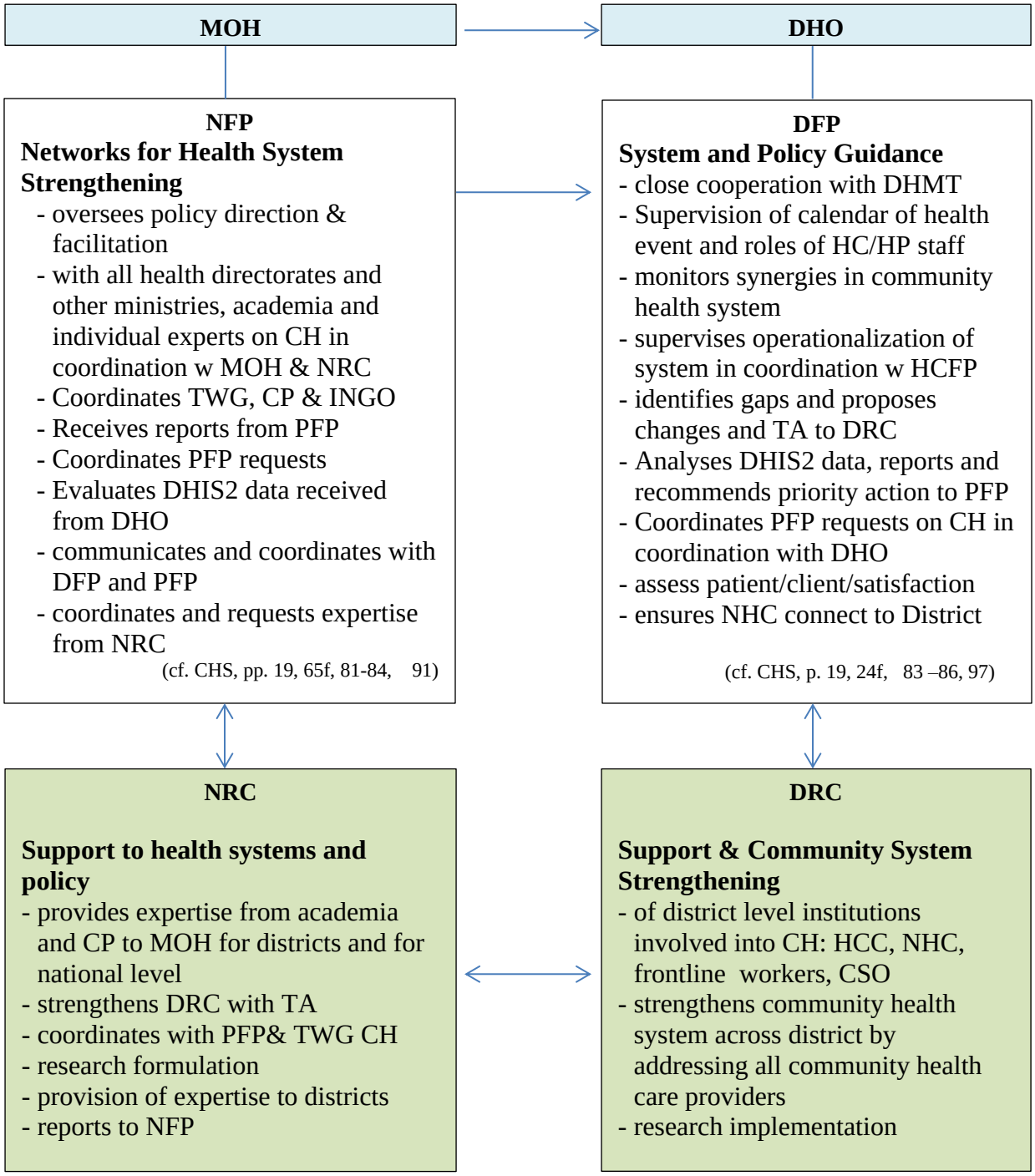
The NFP initiates an agreement with a Resource Centre that seeks inputs from academic public health and non-health institutions based on the reporting from the provinces on identified technical and operational problems to provide solutions for the districts and communities and for strengthening the community health systems and HRH, networks, managers and executives of CH, the CHA, CBV, community members and public opinion. The inputs at the various levels shall be defined, taught and delegated to relevant disseminators, mainly to the District Resource Center, the PHO and their PFP.

Following best practices, there is further need for the MOH NFP to coordinate with the Provincial Health Offices through a Provincial Focal Point (PFP) responsible to collate all community health related requests from provincial level and district level for technical and operational support for health promotion, disease prevention and control, basic care inputs as well as management of the community and primary health care system.

[68] See The Aspen Institute 2017: This Management Partnership for Health overview is based on support and analysis of community health work in a variety of African countries: Rwanda, Ethiopia, Malawi, Sierra Leone, Kenya.

Figure 9

Roles of NFP, DFP, NRC and DRC at National and District Level



Provincial Focal Point

The role of the Provincial Focal Point can be carried out by the Senior Health Education Officer at the provincial level and has a minor role in the decentralized set up: The PFP receives all reports

from the District Focal Point (DFP) and summarizes them and the requests for capacity building in monitoring and evaluation, training and support tools for CBV (diaries, refresher training, planning and budgeting). The PFP reports on gaps in the functioning of the community health system. A collated report with district requests for support, mentoring, coaching and research is communicated regularly to the National Resource Center that designs the requested support for the District and community health volunteers.

The PFP coordinates all District communication in both directions to and from the national level to the District, and compiles reports on district and community needs and communicates these to the National Focal Point, who assesses the reports against the policy and regulatory background as well as expected community health results through the HMIS. The NFP mobilizes the National Resource Centre for required inputs and coordinates their dissemination to the districts through the PFP.

6.1.1.1 Role of Resource Centre at National and District level

The ongoing support of mainly public health technical expertise is required to establish, consolidate and successfully implement the CHS for the expected improvements in health outcomes. The National Resource Centre coordinates closely with the NFP at MOH, the TWG for Community Health, public health academia and respective health institutions, non-health related ministries and CP to formulate and compile the respective inputs for:

- providing regular analysis of the performance and inputs for achieving the required improvements to the District Resource Centres (DRC) and
- Strengthening of the DFP, HCFP/HPFP and the PFP on district and community health planning and implementation. The inputs are coordinated by the NFP at national level for the PFP and the DFP for generic inputs into District level.
- providing continued inputs to the DHO and DFP through the DRC for
    - management training to resource persons at district and community health facilities
    - training on CH for improving CBV skills, e.g. in refresher trainings and mentoring
    - strengthening supervision
    - carrying out reviews and assessments of interventions and district health data with the District and Community Focal Persons
- Coordinating with TWG Community Health and CP
- Supervising district and community level focal points with regards to:
    - management of the
        - community health coordination
        - supervision and assessment of technical and operational monitoring
    - community mobilization
    - Community action planning and budgeting
    - Tracking CP funding in terms of allocations, disbursements for CH work and CH expenditures

- Aligning the NHC revitalization in the broader community revitalization of the Ministry of Health as integrated into the NHSP 2017-2021, with involvement of inter-sectoral and private sector cooperation.

6.1.2 District and Community Levels

The various levels of coordination and monitoring of CBV and the interactions with the health system require management to ensure regular processing of activities and procedures for maintaining an enabling environment for CBV and the quality and functioning of interventions. Best practices in Ethiopia and India show establishment of a management mechanism that supports the actual service providers and administrative set-up in an own space for management support to review performance, mentor, supervise and enhance skills of CBV, CHA and HW for improving relationships and the effectiveness to implement community health interventions (e.g. the Program Manager in India, or the Health Officer in Ethiopia).

The improved structures at district level support the system through a District Focal Point, (DFP), based in the DHO and lead on activities that help to strengthen the community health system as integrated into the district health system and related to the DRC. The DFP coordinates all district level activities concerning community health and community representation. This function relates partly to supporting the DHD to ensuring the regular participation of the three HCC chairs in two of the District Integrated Meetings, their frequent participation in the meetings of the District Development Coordination Committee meeting and district development meetings when health determinants play a role. The DFP also ensures organization of and participation in the biannual meetings of all HCC/HPC chairs in the district and their participation regularly in the district level meetings: District Planning Meeting, District Planning Review Meetings, District Integrated Management Meetings, Maternal Death Review Meetings, District Health Promotion Team, District Data Review meetings. In addition, the DFP is supported by a Focal Point at Health Centers (HCFP) and Health Post (HPFP) who supports the functioning of the community health systems across the communities relating to the HC/HP.

The DFP ensures in cooperation with the HCFP that the information from DIM and DDCC meetings on planned activities, progress and challenges are communicated to the HCC/HPC in the monthly meetings and from there through NHC chairs to the CBV and communities during NHC meetings. There must be a time for the presentation of the aggregated community data in order to help the NHC make data driven decisions.

The DFP receives reports from the HC Focal Point (HCFP)/HP Focal Point (HPFP) and maintains the oversight of the functioning of the community health system by reviewing performance and monitoring reports of the CHA/EHT and the In-charges, and by providing analysis of intervention data in comparison with the official reporting from the HC on community health data, and from monthly reports from the CSO, networks for care and advocacy, inter-sectoral and PPP activities. The DFP consults with the NHC/HCC/HPC on needs and demands, communicates them to the Ward and District Development Coordination Committees to trigger interest in inter-sectoral collaboration or involvement of the private sector. The DFP compiles monthly reports for the PFP and DHO.

In collaboration with the District Resource Centre, the DFP rapidly assesses community health service user satisfaction such as from households, mothers, chronically ill people and target achievements in view of DHIS2 data by attending NHC and HCC meetings and engaging with community members likely addressed by priority programs, such as environmental health, maternal and child health intervention, school health or health promotion activities. The DFP, unless otherwise agreed with the DRC, send collated reports to the PFP and DHO. These also include overview over support to interventions through capacity building for administrators, health workers with adjusted PHC roles through the DRC experts and CP experts.

The District Focal Point strengthens the interfaces between the community systems and the health system based on feedback about the community structures and the community health related functions of outreach at the HC and Health Post, and about the activities of representatives at the HCC (HCCE, NHC representative, In-Charge, CHA) provided by the HCFP. The DFP seeks information from the HCFP on provided support to community systems. The DFP also interacts with the District Development Council Committee and the Ward Development Committee to enhance political will and seek support from other sectors when needed (see figures 3, 5 and 9).

The HCFP/HPFP, based at the health facility and participants of HCC meetings, strengthen the community systems by ensuring timely reporting and monitoring inputs about cadres, networks of care and support, interventions and organizational activities like planning, coordination, reviews and peer exchange at NHC meetings. They support the HCCE to carry out their duties and support NHC members in their roles and functions. They request for TA to CBV, CHA and NHC from the HC/DHO or Resource Center.

The HCFP/HPFP support the frontline health workers by offering supervision, coaching and mentoring to the EHT, CHA and CBV, track attrition of CBV, mediate redressal bottom up and top down[69] with them and the HW, ensure involvement into facility staff meetings, feedback from the health system (HCC/HC) and recognition of their efforts through publication and rewarding, involving community into budgeting health plans and ensuring advocacy on the benefits of community health services and community participation. The HCFP also ensures that the operational and technical health monitoring cycles take place timely to feed the system and to ensure feedback, further developments and improvements of the community systems, including from other technical and the private sectors, NGO and care giver networks. HCFP/ HPFP quarterly ensure quality control of CBV performance by review of results and next plans, practical/technical advice, including peer based feedback and participatory monitoring during HCC and NHC meetings.

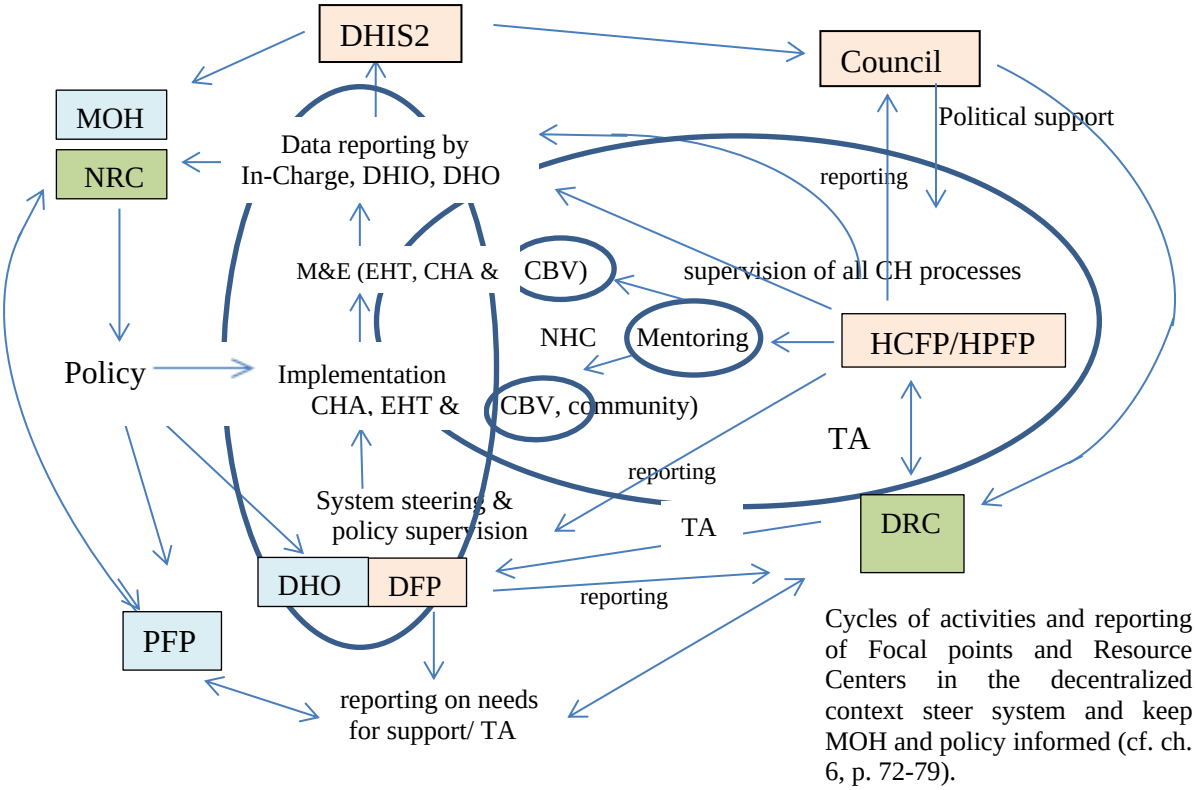
The HCFP/HPFP thus complements the roles and functions of the CHA; while the CHA and EHT cooperate with the CBV, the HCFP/HPFP maintains the cadres' motivation and strength to operationalize the community system. While the CHA interacts with CBV in terms of care and participation in interventions and offering care from within the health system, the HCFP/ HPFP encourages these activities to take place timely, in good quality and as per planning and supports the strengthening of the community systems from the external community perspective. The HCFP/HPFP may have a background in management or social work. The HCFP/HPFP will also supervise the roles and functions of the NHC, particularly those in support of the CBV and CHA.

[69] cf. MOH, 2012c, p. 18 to 20.

The roles and functions of the CHA are documented in detail in the National Community Health Assistant Program document (NCHAP, p. 18-21). Generally, the CHA mobilize, coordinate and guide CBV on specific tasks for interventions – and coordinate the latter in cooperation with the DHO, provide and track training of CBV and their entry into the cadre, addresses issues of priority in the community. The CHA mobilizes community participation in developing plans and implementing interventions, takes stock of medicines at month end and, has a role in health promotion, prevention, basic health care and referral. These activities are done during the household visits, community meetings, school health visits and services at the health facility. The CHA monitors by means of filling registers and reporting on CHA/EHT activities, uses such data in NHC meetings and monthly compiles reports for the HC/HP In-charge to whom the CHA report. The monthly reporting becomes critical if the CHA stands in for an in-charge position[70] as it causes conflict of interest regarding her core functions and skills development.

Figure 10

Support Mechanism



6.1.3 Revitalized and Streamlined NHC

[70] This happens with more than 20% of the CHA, cf. Secor, A. 2017

The relationship of NHC and CHA is envisaged mutually beneficiary (see NCHAP, p. 20f). While the CHA coordinate the NHC in their catchment area, the NHC sensitize, organize and mobilize CBV to support CHA interventions, needs assessments, follow ups. They participate in meetings called by CHA concerning program performance in community and at health post level, recruit and participate in CHA selection for training. NHC participate in Community Health self-assessment, to come up with agreed action points with deadlines for action by either, CBV or community members or any other member as appropriate.

Since 2006 NHC, the community-based health organizations formed by the HC/HP to which they are affiliated, have much diversified their operations, composition and various levels of functioning. Different experience of recent years in the revitalization of NHC independently show common features required for successful routine practice of its role and functions, its monitoring and community involvement which are documented in newly established NHC guidelines[71]. The features became the recommended profile for NHC composition and routines (see box 2, p. 92, cf. also figures 3, 5 and 6).

The revitalized NHC encompass strengthened management skills and ongoing supportive mechanisms based on monitoring. This implies the need for offers to up-grade the CBV through TA inputs and the institutionalization of support for system strengthening and maintenance through management training and the cooperation with the HCFP/HPFP for advice on performance level stability through timely planning, coaching for implementation and monitoring documentation, evaluating impact through analysis and providing feedback for future improvements of implementation.

Strengthened NHC include availability of a sufficient number of a minimum of 7 CBV per NHC identified to ensure the functioning of an NHC. The development of a community owned database for CBV shall allow communities to keep update records on the availability of CBV working with their NHC and facilities. Such a system allows the NHC to observe entry and attrition of CBV, their training level, modify the details of change of their existing CBVs, and undertake timely advocacy measures when attrition of CBV are announced or observed.

Furthermore, engaged community gatekeepers and members as part of the NHC membership composition enhance the acceptability of the community health efforts as implemented by CBV, CHA, CSO and enhanced utilization of networks of caregivers.

The four functions which the NHC are expected to work on:

1. advocating for appropriate PHC,
2. mobilizing community participation,
3. managing the community health system through NHC and HCC/HPC,
4. M&E of service delivery performance

6.1.3.1. NHC Profile

[71] MOH, May 2017b

Box 2

The NHC Profile for Success

Encompasses:

- a core group of community members coordinating community health interventions among upto 200 households in rural and upto 1000 households in urban settings each
- encompass community representatives (equal gate keepers) engaged in:
    - addressing social norms
    - building capacity of caregivers and families to demand and access health services
    - networking with relevant institutions

with:

- Trust of community in capacity to support DHO in production of action plans
- a mechanism to advocate among community members to take charge, use networks and communicate priorities/create demand
- mechanism to share experience among peers
- capacity for planning, analyzing health problems, identifying and prioritizing health interventions
- co-operations with mass media
- linkage to a health facility and a minimum number of 7 CBV
- responsive relationships with Ward and District Development Council Committees for multi-sectoral cooperation
- relations to civil society based District Health Promotion Teams and public sector DHO-DHMT

and routines:

- in record keeping at community level through reporting tools
- in use of community registers to track home visits and defaulters
- as platform for participation of community from action planning to outreach in collaboration with the HC of affiliation
- in maintaining a tracking database for entry and attrition of CBV linked to advocacy measures for up-holding numerical strength of CBV group
- joint NHC meetings

6.1.3.2 NHC linkages to the health system

The strengthening of community health management skills of the CBV of the NHC identified key elements for successfully contributing to community health service delivery. A complexity of relationships determines the success of community health systems. This challenge for the NHC model can be ensured jointly by the NFP/DFP at district level and the HCFP/ HPFP at facility level.

Currently, revitalization of the organization of community health services through CBV depends on community management and health systems development that is well linked and monitored. The NHC is responsible for basic structures are shown in box 3:

Box 3

Essential NHC linkages with Health System

1. with Health Center/Health Post
   - Formed by HC/HP and affiliated to it
   - participation of CBV under affiliated NHC in staff meetings of HC/HP
   - monthly reporting to In-charge, EHT, (and CHA) of health data
2. with HCC/HPC for:
   - participation of NHC chairmen in catchment area
   - representation as HCC chair (three)
   - Monthly reporting to HCC meeting on interventions
   - Quarterly results review by HCC of NHC and CBV
   - M&E of HC by HCCE, quarterly of performance of outreach of HC
   - Coordination by HCC of HC community outreach program with NHC, including inter-sectoral activities through HCC and Ward Development Committee
   - guidance for community participation/action plan format, quarterly
3. with the HCFP/HPFP to be assured of effective delivery of above functions
   - Monthly outreach plan of HC
   - Monthly monitoring in HCC meet
   - Quarterly community action plan
   - Redressal
   - CBV Tracking Databank up-date and review
   - Facilitation of TA, Mentoring and supervision
4. with DHO through technical functions
   - monitoring of HC participation in HCC and
   - through TA from HC
   - DHD facilitates biannual meetings of all HCC chairs to disseminate planned activities, progress and challenges, and report back to NHC
   - DHD represents HCC chairs in DDCC Meeting
5. with District Local Government
   - various district management meetings (see NHC guidelines)
   - biannually District Integrated Meeting
6. with District Resource Center
   - support and development
   - mentoring and supervision

6.2 COMMUNITY AND DISTRICT MONITORING AND EVALUATION

Any monitoring originates in action plans which are ideally developed by community members and community representatives. An action plan format has been tested for a quarterly cycle of planning in a number of districts leading to improvements in community health services through volunteers. Implementation follows the action plans and is accompanied by documentation for monitoring and evaluation of the activities.

For the HIA4b data collection system from the community health zones, the facility In-charge is responsible to aggregate community level health data about the community level interventions, including those of the CHA for the catchment area, coming in from the various groups of CBV and the CHA. Both groups, CHA and CBV are all expected to come to the Health Center for a monthly data aggregation meeting. The In-charge may delegate this function to the EHT as the dedicated officer who calls the community health workers together and then enters the data into the system if the facility has a laptop, or passes it to the District if the facility does not have a laptop. Where the facilities have laptops, the EHT receive training in DHIS2. Where there is no facility laptop HIA4b is aggregated by the EHT on paper and this data will be reviewed by the in-charge who passes it on to the district for entry into DHIS2. At present HIA4b is being piloted which is intended to provide a comprehensive platform to monitor CBV community interventions.

This new strategy includes the review of previous data during the monthly aggregation meeting. The HIA4b form, aggregated by the In-Charge or EHTs is a first step to achieving a more comprehensive community data collection system that aggregates data from all CBV and inputs it into the existing HMIS.

The monthly aggregation meeting format allows identity formation and team building amongst the CBV because the performance from the previous month will also be discussed so that the CBV receive feedback about the performance of the various thematic sectors (such as HIV, Malaria etc.). In addition, CBV focal point people, coming from the various catchment zones may be required to present the data at their NHC meeting so that it can be used for decision making. Where there is a CHA the CHA should be the preferred zonal representative. However, the In-charge or EHT will also present the data and that of the last quarter at the HCC meeting. These findings can then be used by the NHC members of the HCC, in their respective NHC meetings.

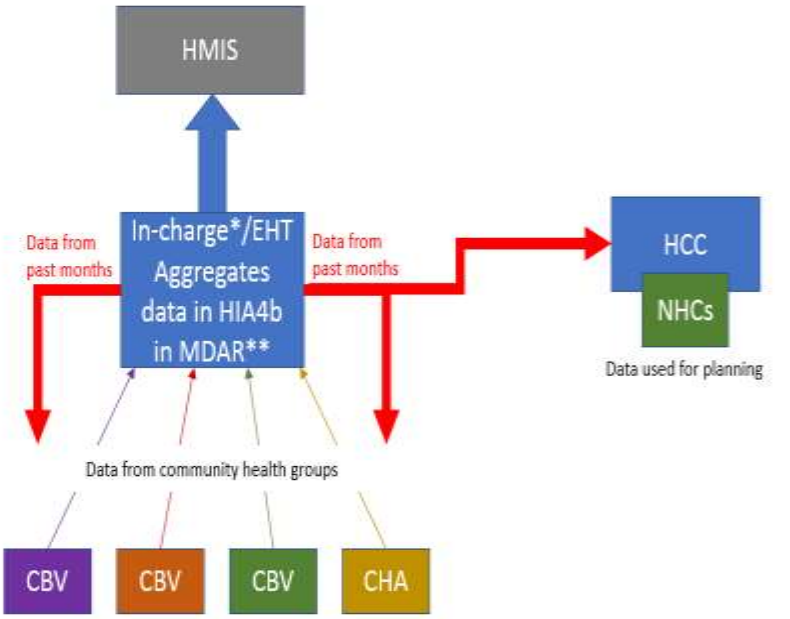
The Monthly Data Aggregation and Review Meetings (MDAR) are currently being piloted through the MoH. Under the lead of the EHTs - and the final responsibility lying with the in-charges, the MDAR seek to consolidate the data that is reported through the various community health volunteers. The data aggregated into the HIA4b form also list the different types of community groups, whose data is entered, including the CHAs. At these meetings the EHTs will also discuss the data from previous months to show where there is need for improvement in total and/or by the respective implementing CBV group or CHA.

Figure 11

HIA4b Community Level Data Aggregation and Integration into the HMIS and the NHCs

Monthly Data Aggregation and Review Meeting

1. The In-charge or EHT calls for the monthly data aggregation and review meeting
2. All CBVs and the CHAs are required to come
3. All data is aggregated into the HIA4b form
4. If the In-charge or EHT has been trained and there is a laptop at the facility then he/she will type this data into the HMIS
5. Where there is no laptop the In-charge or EHT shall give the HIA4b form to the district to enter the data into the HMIS
6. The In-charge or EHT will also review the data from the previous months during the meeting, highlighting trends and needs
7. The In-charge or EHT will present the data in the HCC meetings so that the NHC participants are updated
8. The NHC members that attended the HCC will then be able to discuss the data in their respective NHC meeting and make operational decisions based on the data.



* The In-charge is responsible for the community data but may delegate the aggregation and review to the EHT
**Monthly Data Aggregation and Review meeting (MDAR)

Source: MOH/M&E Department, May 2017

The HCC/HPC receives the monitoring information from the EHT or Facility In-Charge through the Monthly Data Aggregation and Review meetings where data from all CBVs is aggregated into the HIA4b form, which is also integrated into the online HMIS. Two monitoring cycles have proven to enhance the efficiency and quality of community health service delivery by CBV:

- monthly monitoring of activities or interventions
- quarterly monitoring of performance and results and
    - review of results and next plans
    - with practical, respectively technical advice

The documentation of the volunteers' activities and interventions is complemented by peer feedback and/or storytelling, also called participatory monitoring, during NHC meetings. The HIA4b aggregate forms will provide the NHC with the necessary "hard" data to help drive strategic and informed decision making. It considers all levels of the CBV activities and assigns scores to the performance per facility, hence called facility score. This is displayed in charts during the NHC meetings and serves for learning purpose and improvements during interventions. In facilities where no printers are available, NHC members should take notes of the data review so they are able to discuss the findings at their respective NHC meetings.

In addition, the quarterly evaluation by HCCE is based on minutes, reports on action plans and the charts which provide ffeedback on performance to the NHC by the HCCE. The additional

instrument of Joint NHC meetings (incl. community members) of DHO and the resource unit at facility and district level has proven in various NHC revitalization approaches as success factor of CBV interventions and maintenance of the cadre.

Given the evaluation of performance against the action plan, the next planning cycle can be initiated. Hence, quarterly work plan development is recommended based on the CBV participation in monitoring and the evaluation of their performance by the NHC and HCC/HPC as shown in the facility score. The work plan then takes orientation according to the facility score.

Current M&E activities shall be streamlined in view of the type of data collection and information flows that serve the public and the community systems. At district level intervention results shall feed into the DHIS2 for further aggregation and transmission to the national level.

The ongoing work on linking HMIS & Community HMIS through key indicators to DHIS2 platform needs to be continued. The community monitoring format to be used and further consolidated after the current pilot phase (HIA4 and HIA4B) shall be rolled out to all communities and districts.

In order to doing so, adjustments are needed:

- to close gaps in community monitoring and the existing community health information management system concerning government indicators, by strengthening the EHTs so they can hold monthly data aggregation and review meetings
- to develop a monitoring and evaluation framework that includes routine community indicators and ensure this is in line with the HIA4b form.
- for CBV to mandatorily follow compatible methodologies (HIA4 and 4B) and information flows and require cooperating partners to provide data to government how and when relevant to the government system,
- to agree the range of data collection and in particular the indicators they shall feed. Data that are not required to feed into the community and government HMIS, shall not burden the CBV at times when their input is required for addressing pressing public health measures and planned activities. Indicators must relate to the decisions that should be made based on the data.
- to further outline how community data collected by various community agents (CBVs, NHCs, etc.) can feed into the HIA4 to enable comprehensive community data to be collected through monthly data aggregation and review meetings led by the EHT.
- to have also CPs using the HIA4 community data that entails all government requirements, and accepting that it is of public interest to streamline their data requirements with government
- Have HCC work with NHCs to fill out self-assessment forms to empower the NHC to understand, analyze and use their own data for planning
- to introduce digital technology (tablets, internet) for data transmission and real time management and reporting, particularly necessary for outbreaks
- Data must be relevant to the community level and enable them to make informed decisions.
- Selected facility (In-charge/EHT) and community members such as the NHC chair person, must be able to interpret and utilize the data to make decisions

- For monitoring and evaluation clear indicators must be set, along with a timeframe of when these indicators should be met. Data from the HIA4b form will then be used to monitor and evaluate the progress.

As a tool for quality improvement and/or control there is consensus that:

- the interventions shall be documented on a monthly basis and monitored by the HCC
- the results of documented interventions shall be quarterly communicated back to the NHC to feed into a quarterly planning cycle for community action planning.

6.3 COOPERATING PARTNERS AND ROLE OF THE NON-HEALTH AND PRIVATE SECTORS

Cooperating partners is the term subsuming mostly funding agencies, bilateral or multilateral donors. Practically they are complemented by INGO, CSO, other sector operational and knowledge institutions and non-health public and private sector initiatives and organizations contributing to improving health outcomes.

All CP and other stakehlders supported interventions in the community should be in line with orientations of the CHS and operational guide for iplementation of communtiy health activities and monitoring of results. CP and external health agencies will more closely coordinate their community health interventions with the DHO and surrender to process monitoring cycles. Their entry point for implementation should be through the DHO in any respect; for projects, recruiting CBV and enter into a contract with the DHMT for using CBV. TA, capacity building or training of CBV is channeled through the DFP to allow harmonized cadre and incentives.

The CP also need to adopt the same indicators for reporting and use compatible monitoring formats that can be streamlined with government system: all CBV report mandatorily to and through government system. Therefore CBV shall be assigned through the DFP and HCFP/ HPFP.

CP role has always been to take initiatives, such as:

- capacity assessment among the partners,
- looking at gaps to carry out functions and terms of roles
- taking into account the current limitations of having a dedicated staff and plans of addressing human resources gaps by the government

CP now fully adjust with the requirements of the DHIS2 and need to:

- use data from the HIA4 forms to strategically provide funding based on these data
- allow for harmonized district and community intervention planning
- strengthen strategic planning by contributing to the given data collection formats
- follow the given data collection, collation and aggregation channels

They now shall renew their own inputs planning based on gap analysis, in transition phase, providing for expertise resource unit, integrating activities into district wide approach/social accountability framework.

6.4 LIST OF MAJOR ACTIVITIES FOR COSTING OF THE CHS

Outputs to Outcome 1	**Who**	**What**	**Where**	**Additional resources**
Output 1.1: A framework for compatible and effective structures and coordination through clear mandates for roles and steering of inter-ventions and monitoring	MoH/NRC MoH and District focal points/DRC District resource center and focal points	Prepare document with framework establishing district and community structures, focal points, reporting and supervision Carry out meetings with districts to validate the framework Meetings where Districts present framework to communities Include community health structures in regulatory frameworks	Office Meetings with Districts Meetings with communities During re-view of new regulation	Consultant Facilitators and venue for meetings Travel expenses for meetings with districts and for travel to communities Printing and distribution of documents.
Output 1.2: DHMT, focal points and District Resource center NHC, and HCC/HPC got adjusted with the community health processes. The CHA, EHT/HC and NHC representatives optimized their routines and functions to improve their community out-reach, planning of services, monitoring functions and supervi-sory activities with CBVs in the context of defined empowerments.	District resource center and HC/HP focal points working with CHA, EHT/HC and NHC representatives District resource center and focal points MoH	Facilitated working groups develop new processes for 10 key activities including at least one each for community outreach, planning, monitoring and supervision of CBVs, and creating incentives for CBVs. Develop a homogeneous beneficiary identification for community health programs Pilot testing of beneficiary identification and the new processes including incentives for CHVs Meeting to sharing results of pilot testing (best practices and failures) Redesign of processes according to best practices, streamline incentives and processes within districts and adopt in other districts. Continuous improvement of processes to increase the number of optimized community service delivery, and standardized management and monitoring	Meetings within Districts National meeting on monitoring instruments and data collection, analysis Meetings within districts	Consultant Facilitators and venue for meetings Data collection expenses Travel expenses for meetings Resources to incentivize CHVs, for management and monitoring community health services. Printing and distribution of documents.
Output 1.3: The roles and responsibilities of health workers, volunteers, and	MoH with District resource	Prepare a document that contains job descriptions and the standardized roles and	Office Meetings	Consultant Facilitators and venue for meetings

Outputs to Outcome 1	Who	What	Where	Additional resources
the management of primary health care and community health work are revised in the overall perspective of implementers, coordinators and supervisors of the implementation and their interfaces.	centers and HC/HP focal points working with CHA, EHT/HC and NHC representatives District resource center and focal points	responsibilities of health workers, volunteers, managers and focal points. Develop locally relevant task descriptions for CBVs Meetings where Districts present the roles and responsibilities at the district and community staff	Meetings within districts	Travel expenses to attend meetings and meetings with districts. Printing and distribution of documents.
Output 1.4: Improved response and efficiencies in community health interventions enhance the quality of service delivery. The health interventions are based on locally relevant strategies tailored around community needs and CBV knowledge of the respective social determinants of health.	MoH with District resource centers and HC/ HP focal points working with CHA, EHT/HC and NHC representatives District resource center and focal points	Develop scorecards to track and monitor community action plans. Prepare and carry-out quarterly monitoring and follow-up meetings Develop parameters to optimize the number of CBV,	Office tracking and monitoring meetings	Consultant Travel to meetings meetings
Output 1.5: Patient friendly health services which are accessible and cost-effective	MoH/NRC with CHA, EHT/HC and NHC representatives	Prepare document with options including enhancing availability of supplies and reducing transportation barriers Prepare document with service delivery interventions that are gender sensitive	Office and meetings	Consultant Travel to meetings meetings
Output 1.6: Guideline with assessment criteria for efficient and cost-effective community health services	MoH/NRC and DRC with CHA, EHT/HC and NHC representatives	Prepare document with guidelines and criteria to evaluate cost efficient services	Office	Consultant Travel to meetings meetings
Output 1.7: Developed cost-effective health service models which can be rolled out in other districts and provinces	MoH/NRC/ DRC with evaluators	Evaluate on-going community health interventions that are innovative in task-shifting according to cost-effectiveness guidelines Prepare documents with plans to roll-out cost-effective interventions adjusted to task-shifting & approved roles/	Facilities	Consultants and Evaluators Resources for data collection and analysis Travel for data collection

Outputs to Outcome 1	Who	What	Where	Additional resources
		responsibilities Outputs 1.2, 1.3, 1.8, 1.9 Roll-out cost effective interventions and evaluate roll-out		Resources for training, meetings and travel for roll-out
Output 1.8: The excessive task-shifting from nurses to CHAs at the facility level is reduced and limits CHA time in the HC/HP to 20% as envisaged in NCHAP.	MOH/District resource center and focal points Focal points and staff (HCC, NHC, EHT and CHA)	Meetings where Districts present the roles and responsibilities of CHAs to district and community staff Monthly aggregation of data and facilitate quarterly review meetings at the facility and district level.	Meetings within Districts Meetings at facilities and at district.	Consultant to finalize community data aggregation and review model. Venue for meetings. Travel expenses for meetings
Output 1.9: Management guidelines for HC/HP In-charges, EHT and CHA, a strengthened and stabilized CBV cadre are based on known skills and job descriptions for CBV and the NHC. They delineate clear lines of interactions and of the coordination of interventions to improve management of community health interventions	MoH MoH and District focal points District focal points	Prepare management guidelines for HC/HP. Training of district focal points to train HC, DHMT, donors and other stakeholders and supported by the HP/HCFP on the management guidelines for HC/HP Preparation of IEC material for communities on how to access care at facility and community level	Office Trainings at district level Distribute to community leaders and key people (teachers, priests, local government officials)	Consultant and facilitators Venues for trainings Travel expenses for trainings Printing and distribution of IEC documents and training materials.
Output 1.10: Community based health services, health promotion and prevention have reduced the burden on primary health facilities and increased the number of facility based deliveries.	MOH, NRC/DRC evaluators CHA, EHT, CBV, focal points	Prepare a before and after study to evaluate the roll-out of community health interventions. Carry-out the before-after study Community intervention	Office Facilities and communities	Consultants and Evaluators Resources for data collection and analysis Travel for data collection Interventions Media
Output 1.11: Analyses of community level primary facilities inform on management practice, clinical governance, type of health care or intervention and referral gate keeping to improve	MOH, NRC/DRC, evaluators	Prepare the study the supply and management of primary care facilities to inform community health roll-out plans. Identify gaps in financing, governance, skills, and supplies, and map referral patterns.	Office Facilities	Consultants and Evaluators Resources for data collection and analysis Travel for data collection

Outputs to Outcome 1	Who	What	Where	Additional resources
access to diagnosis and care.		Carry-out the study and inform groups preparing innovations for roll-out		
Output 1.12: Ministries are committed to health promoting and disease preventing activities. Community health service delivery integrates health interventions in all community development programs, particularly school education on hygiene and sanitation and nutrition.	MOH/NRC, focal points and representatives of other ministries and sectors, and community health focal points	Prepare document with framework establishing multi-sector collaboration at the national, district and community levels, identify focal points, reporting and supervision activities in line with decentralization policy to address Social Determinants of Health (SDH) and within the Health in All Policies framework Carry out meetings with other ministries and sectors to validate the framework Capacity building and coordination at the district level. Develop and distribute printed information at the community level	Office Meetings District	Consultant venue for meetings Travel expenses for meetings Trainings at the district level Printing and distribution of materials media
Output 1.13: Improved training of CBV follows an integrated approach for community development and health service delivery. Communities are informed about the benefits of community health services and demand for their delivery.	MOH District resource center and focal points	Develop training courses for CHV Cascade training of CHV	Office Training courses	Consultant Trainers Training and travel expenses Printing of training materials
Output 1.14: Packages of hygiene interventions, nutrition information and reduction of GBV are developed.	MOH/NRC District resource center and focal points Frontline workers and CBV	Develop guidelines for hygiene, nutrition and GBV reduction. Develop training courses for CHV Cascade training of CHV	Office Training courses development & imple-mentation	Consultant Trainers Training and travel expenses Printing of training materials Media dissemina-tion
Output 1.15: Community health budgets are at least at a level of 10% of district budgets and allocated in view of most needy communities with	MOH, focal points and representatives of MOF, other ministries and sectors, and	Develop a framework for financing community health, include the monitoring of at least 10% fund to DHOs for community health activities	Office	Consultant

Outputs to Outcome 1	Who	What	Where	Additional resources
high disease burden. Budgets include also funding for multi-sectoral activities.	health focal points	Revise financial flows to community health activities. Identify additional sources of funds for multi-sector activities involve communities into budgeting for community action plans.		
Output 1.16: The poor performance of waiver schemes and the very high administrative costs due to lax beneficiary identification is prevented and costs saved for investments elsewhere, eg. the payment of CBV incentives developed as part of output 1.2	MOH District resource center and focal points	Prepare a document that identifies and has a plan to phase-out poor performance community health schemes Eliminate waiver schemes to provide free care for those in the greatest need. Monitor the phase-out of poor performing schemes	Office and districts Districts	Consultant Expenses for data collection Travel for data collection Expenses to supervise the phase-out of poor performance schemes
Output 1.17: In the context of scarce resources for health in Zambia, CBV are provided with the opportunity of generating an income from the sale of supplies and health related goods like in Uganda or some districts even in Zambia or from funds saved from other schemes.	MOH District resource center and focal points and CBV representatives	Prepare a document that identifies the goods that could be sold, and has guidelines to ensure preventive care and enlisting of members are services provided free of charge. Validate the guidelines. Prepare a plan for introducing income generating activities and incentives for CBVs and to substitute waiver schemes Monitor the introduction of CBV income generating activities	Office and districts Meeting with stakeholders and districts Office Districts	Consultant Expenses for validation meeting. Expenses to supervise the introduction of income generating activities
Output 1.18: Community health service delivery got integrated into financial planning for community health. Capacity developed to advocate for investments in community health. Identification of eligible groups for community based health insurance starts in small steps	MOH, MOF District resource center and focal points	Prepare a training for District Medical Offices to carry-out financial planning and management responsibilities, and for the implementation of the 2009 Action Planning Handbook for Districts Prepare a document for the integration of incentives for performance linked with monitoring of CBV performance. Use community level data from HIA4 and 4b forms to plan and monitor community funding	Office and districts Meetings with stakeholders and districts	Consultant Expenses for meetings with stakeholders Expenses for training District Medical Officers and travel expenses. Expenses to supervise District planning activities

Outputs to Outcome 1	Who	What	Where	Additional resources
		Prepare a document to propose the introduction of SHI.		
Output 1.19: Reports of health expenditures from external sources by district.	MOH, partners District resource center	Prepare a document with guidelines to report budgets and expenditures from external funds at the district level and training for those collecting the data	Office Districts	Consultant Expenses for training
Output 1.20: External funds are included into the financial planning for community health service delivery. Capacity develops to reduce gaps in funding and to advocate for adequate investments for community health.	MOH, partners District resource center	Track and report external funds at the district level and reduce duplication of activities with different funding sources Review the amount and source of funds and identify the fungibility. Propose an improvement in allocation reducing duplication and covering gaps in funding	Districts	Consultant Expenses for data collection
Output 1.21: CBVs are interchangeable from NGO, other providers & NHC creating a larger support for Community Health services	MOH, partners District resource center and focal points	Prepare a document with guidelines to coordinate CBV activities in a geographical region, especially those working with NGOs Monitor the coordination of CBV activities	Office District	Consultant Expenses for meetings and travel. Expenses for monitoring coordination of activities by districts
Output 1.22: The districts are regularly provided with a fresh baseline of information to guide the decision making process for the planning of new activities at district level. The data also become accessible to the Ministry to provide a holistic view of the number of CBVs in the country and identify possible gaps.	MOH District resource center DHO HCC/HPC NHC	Prepare guidelines and district reports to help monitor community health activities progress and planning. Include information on CBV available and gaps in deployment of CBV and HW	Office District	Consultant
Output 1.23: Community data is used for decision making and operational planning by the facility and the community.	District resource center/DHO Focal points, HCC, HPC NHC/CBV	Prepare training for facility staff, HCC and NHC members to make decisions based on data Train staff	Office District	Expenses for training and travel.

Outputs to Outcome 2	**Who**	**What**	**Where**	**Additional resources**
Output 2.1: Training includes integrated health and development curricula, business and community health service management training. The quality of the training is measurable and assessable, thus it can be certified.	MoH/NRC DRC MoH and District focal points District focal points	Develop modules for cascade training of CBV according to role and responsibilities defined in outputs 1.2, 1.3, 1.8. Include prevention, health promotion and disaster management, identification of local health priorities and service delivery management elements, maternal and child care, management of chronic and leading lifestyle illness, and integrated services for a healthy community development Develop knowledge assessment and refresher modules for CBV developing standards for minimum and optimal knowledge and skills Prepare a plan for rewarding good performance based on training achievements as per training modules completed and refresher trainings taken. Roll-out of Training of trainers for CBV Issue certificates of achievement per module of training successfully passed at minimum and optimal level and reward program Periodic assessment of CBV in refresher trainings and through the MDAR and HCC meetings	Office Trainings at district level	Consultant and facilitators for TOT Venues for trainings TOT for districts and for CBV within the districts. Travel expenses for trainings, TOT and for CBV Rewards for CBV achievements in training Printing documents and certificates for competing training modules.

Outputs to Outcome 2	Who	What	Where	Additional resources
Output 2.2: The CBV skills became a protected package. Its implementation is measurable and the service deliverers' (CBV) performance can be evaluated. The CBV can be accredited on the basis of good implementation of the certified training and standardized package of community health services.		Develop certification of CBV including standardized methods for verification of compliance with minimum standards and an additional recognitions for excellence Training of evaluators to certify CBV Certification and registry of eligible CBV	Office Training of evaluators and go Certification at district level	Consultant Venues for trainings of evaluators for evaluation of CBV within the districts. Travel expenses for trainings and for CBV certification and registry.
Output 2.3: On the community level, the effectiveness of health service delivery is improved. The tool of team formation helps to level differences and "grades" among the volunteers through mutual learning particularly during the transition time of harmonization of CBV.	MOH District Focal Points, HCC, HCFP and DRC	Develop materials to train on teamwork, effectiveness and efficiency through mutual learning for CBVs. Train district focal points and HCC to support the development of CBVs during the transition and motivate for certification process. Organize periodic NHC meetings for CBV peer reviews and story telling Monitoring and supervision of CVBs through HCFP and DRC HCC/HPC FP provides periodic feedback to C CBV	Office Districts and communities	Consultant Travel expenses for training
Output 2.4: Competitive selection through NHC is based on standard eligibility profiles for CBV to optimize the right choice of CBV for the envisaged tasks. This has proven to enhance the sustainability of recruited CBV. NHC recruitment of CBV enhances acceptability of CBV by the community as well as reduction of attrition. The resilience of CBV is stronger and they continue working over a sustained period of time.	MOH District resource center, focal points and DHOs	Develop standards for the competitive selection of CBVs, share with team working in achieving Outputs 1.2 and 1.3. Develop a plan for the scale up the recruitment and retention of community based volunteers After approval of standards and incentives Training of DHO on recruitment and Scale up recruitment of CVBs	Office District	Consultant Travel expenses for consultations with districts and training of recruiters
Outputs to Outcome 2	**Who**	**What**	**Where**	**Additional resources**

Output 2.5: NHC recognized and operating within the Social Accountability Framework contribute to higher continuation of CBV. In addition, motivation of CBV is strengthened when they receive official recognition by the health system and thus stay on longer or get their sought after social recognition in support of planning their future.	MOH, District resource center, NHC and HCC DHO	Develop for NHC a tracking database for CBV to produce periodic reports to HCC and DHO. NHC develop a CBV reporting system at community level to send to DHO Develop the mechanisms to standardize the measurement of CBV performance by DHO Develop the system to monitor, audit and publish assessed performance of CBV Train on the use of the tracking, the reporting and performance evaluation systems.	Office District	Consultant Travel expenses for consultations and training Publishing expenses
Output 2.6: The aspirations of CBV are technically and socially recognized and given the perspective of being involved in a rewarding and ongoing learning process. There are various modules defining levels of training and refinement of skills. The CBV gradually acquire an educational basis up to health employment or formal education	MOH District resource center DHO DRC Focal points	Develop a mentorship program for CBVs, identifying the characteristics of mentors for a pilot program to support the development & resilience of CBV, graduate to health employment, continue their formal education. Prepare a plan for the pilot testing of a mentorship program. Pilot test and evaluate the mentorship program Roll-out an enhanced mentorship program.	Office District	Consultant Expenses for the pilot testing of mentors from the selected District resource centers Expenses for the rollout of the enhanced mentorship program
Output 2.7: The streamlined processes work cohesively between the actors: CBV, NHC and HC/HP are drawn into a team approach with informed decision making for health interventions and referral, based on monitoring and review.	MOH District resource center DHO HCFP/HPFP	Develop a training program for CBV on monitoring responsibilities of community health and referral activities Develop a plan to make monitoring the basis for coordination with defined relationships according to Output Prepare a plan to establish performance based incentives for referral and community health service delivery that can be part of output 1.17	Office	Consultant Trainers Training venues and per diems

Outputs to Outcome 2	Who	What	Where	Additional resources
Output 2.8: Supportive mechanisms and integrated supervision tied into community health service delivery ensure that the success factors of voluntary community health work are monitored, communicated and/ or supported. They are integrated into the strategic approach to community health systems strengthening for support to interventions and CBV/CHA by: - Administrators - Health workers with TA roles for community health experts of resource units and of CP	MOH/NRC District resource centers and focal points	Establish focal points for community health work at national, district and community level Delineate the roles and functions of focal points as per framework developed for Output 1.1 Define communication lines and linkages to district resource center and DHO and ensure coincidence with Outputs 1.1- 1.3 Prepare a plan for communicating and training focal points. Roll-out training of focal points and district resource center staff	Office	Consultant Travel expenses for consultations with districts and training of focal points and district resource center staff Printing of material for trainings
Output 2.9: Research & evidence gathering contribute technically to strong support by formally documenting and publishing information on interventions.	MOH District Resource centers	Based on monitoring and specific data collection efforts review results, identify gaps and weaknesses in performance and interventions to address health priorities and social determinants in support of Outputs 1.2, 1.7. 1.10, 1.11 and 1.16 District resource centers are prepared to develop research and assessment and support evaluation and analysis of monitoring data	Office Districts	Consultant Expenses for training district resource center staff Expenses for travel to support district resource centers

Outputs to Outcome 2	**Who**	**What**	**Where**	**Additional resources**
Output 2.10: Support provides clarity and guidance on the next steps during interventions, coupled with follow up and feedback on performance. It develops an enabling environment for community, NHC and HP through meetings.	MOH/NRC DRC HCC/HPC Focal points DHO	Prepare a plan to provide guidance and support for the implementation of: a. Peer review b. Data aggregation and review meetings c. Storytelling, peer review and feedback for monitoring d. HCCE feedback e. coordinate supervision schedules with HC, HP, NHC, HCC/HPC/District Health Manager Provide guidance and support in quarterly meetings facilitating outputs 1.2, 1.6, 1.8, 1.9, 1.11, 1.15, 1.16, 1.18, 1.21, 1.22 and 1.23 Facilitate quarterly HCC meetings a. ensure participation of HC staff and DHO through the HC focal point b. ensure feedback of results to CBV and to DRC through HCFP/HPFP	Office and periodic meetings	Consultant Travel expenses
Output 2.11: The National Resource Center provides TA for prevention, promotion and public health expertise inputs.	MOH National resource center District resource centers, focal points and DHO	Design and develop a plan to expand the national resource center. The national center should provide guidance from HC/HP to district resource/focal point center to cooperate with NHC through a supportive mechanism Design and develop a plan for the expansion of the District Resource Centers to coordinate with the national level	Office	Consultants

Outputs to Outcome 2	Who	What	Where	Additional resources
Output 2.12: The District Focal Point supports with institutionalized quarterly/biannual input on review analysis and feedback and also organizes for TA from DRC for community level. DRC guides HCFP/HPFP in mentoring and supervising CBV, CHA/EHT, In-Charge and NHC representatives	MOH/ NRC DRC HCFP/HPFP	Design and prepare a plan to develop the District Focal points. Provide training to Focal Points so that they can a) coach and train CHA to provide CBV with sound technical guidance as per strategy 1. and b) are functioning as redressal, mentoring and supervisors for CBV as per strategy 2 Plan for biannual review meetings through HCFP/HPFP/DRC	Office Training Bi-annual meetings Community/ HC/HP	Consultant Resources for training District Focal Points and for bi-annual meetings Resources for monthly meeting with CBV during NHC meeting
Output 2.13: Guideline for recognition and rewarding of voluntary work.	MOH HCFP/HPFP/ DRC	Design and develop a document with eligibility criteria and rewards for voluntary work to be considered for Outputs 1.2 and 1.16.	Office	Consultant
Output 2.14: Guideline for harmonizing material and financial incentives for all implementing agencies.	MOH/NRC HCFP/HPFP/ DRC	Design and develop a document with incentive defined in a guideline by number of training modules, recognition by levels, awarding by levels and excellence assessed in performance reviews to be considered for Outputs 1.2 and 1.16.	Office	Consultant
Output 2.15: The roles and responsibilities of CHA are delineated in case they represent an In-Charge in an understaffed HC.	MOH/ NRC	Regulate the roles and the extent of responsibilities for a CHA when closing the HRH gap where there is no IN-Charge in the HC.	Office	Consultant
Output 2.16: The community health system has a steady and sustainable supply of essential commodities and equipment.	MOH/NRC/DRC	Develop guidelines for supply chain management for community health systems build capacity of the various community structures on supply chain management; develop a framework for social accountability for supply chain	Office HC	Consultants

Outputs to Outcome 3	Who	What	Where	Additional resources
Output 3.1: The strategic plans of communities in Zambia vary from community to community to capture the social and environmental health determinants.	MOH HCFP/HPFP/ DRC National and District Resource Centers and district focal points, DHO Representative CVBs, partners and civil society from communities	Design and develop the guidelines and tools for a two-day participatory community action-planning meeting. The activities at the meeting should promote local policy oriented advocacy to ensure inclusion of priorities. Prepare a training course for DHO and district focal points to lead the development of community action plans. Plan for at least 40 participatory action-planning meetings for selected communities in each district. Facilitate the development of at least 40 community action plans with the participation of the community in health needs assessments for planning and implementing health action plans, the involvement of CBVs and civil society to carrying out health promotion and disease prevention activities Review the experience of community action planning and revise guidelines to strengthen participation and social accountability between service providers and users. Roll-out the guidelines for community action planning According to products of Output 1.4 develop and implement the monitoring of community action plans through trimester meetings.	Office Training meetings Community planning meetings	Consultant Resources for training and 40 community action planning meetings. Resources to evaluate results of community action plans Resources to reproduce community action planning guidelines and training for DHO and district focal points

Outputs to Outcome 3	Who	What	Where	Additional resources
Output 3.2: Outlined procedures clarify how the NHC will be admitted and allowed to contribute at different levels of the health system: HCC, DHO, and the local government: DDCC and ward development committees. Action Planning is done with participation of community representatives. It is based on information from monitoring data of previous interventions and communicated to the DHO	MOH HCFP/HPFP/ National and District Resource Centers and district focal points, DHO, HCC, local governments, DDCC and ward development committees CBV, partners and civil society	Develop procedures for NHC and expected contributions from HCC, DHO, local government, DDCC and ward development committees. Plan and conduct dissemination meetings for the roles and responsibilities at different levels for community action planning and evaluation.	Office District disseminatio n meetings	Consultant Resources for travel to dissemination meetings and for venues
Output 3.3: Integration of community representatives and traditional leaders into the meetings of the NHCs contributes to formulation of community needs. Perception of ongoing implementation are considered during NHC meetings and shared in HCC meetings and if significant, communicated to Local Government Councils for further action, e.g. fund raising.	District Resource Centers and district focal points, DHO HCC, local governments, and NHC	Design and develop guidelines to promote NHC participation in community health action planning and monitoring for pilot testing concurrent with Output 3.2. Define how to communicate to NHC the initiation of a community action plan, and send periodic updates to request participation and additional funding following the experience of the initial 40 community action plans. Facilitate community participation through regular NHC meetings for reporting back from district level integration and development meetings and gathering opinion for improvements. Disseminate guidelines to all district resource ccnters, focal points and DHO	Office Districts and communities Disseminatio n meetings	Consultant Resources for Travel to districts and communities for data collection Resources for printing guidelines and for dissemination meetings

Outputs to Outcome 3	Who	What	Where	Additional resources
Output 3.4: Depending on the pattern of needs born out of local social determinants, communities match these with their existing networks of support and service providers, apart from utilizing improved support of community health services by the public system of PHC services.	District resource centers and focal points, DHO HC, CHA EHT, and HCFP	Prepare guidelines for community level resource mapping of CVBs and community based support using the material developed for Output 1.11 and aligned with gaps identified in the activities to achieve Output 1.22, and measuring gaps for meeting community needs for health care. Define the time and place to add the needs for additional needs for CVBs and community support in the community action plans. Train HC, CHA and EHT to identify gaps and problem areas and to propose solutions. Prepare HCFP to follow up and finalize the planning effort, especially when inputs beyond the health sector are required	Office Districts Communities	Consultant Resources for printing guidelines and for dissemination meetings Resources for travel to facilitate gap analysis using the guidelines
Output 3.5: Strong social accountability keeps up the demand for good governance of health services and availability of medicines, supervision of health standards and referral mechanisms.	MOH HCFP/HPFP National and District Resource Centers and district focal points, DHO NHC and HCC/HPC traditional, CSO, FBO, media, academia	In coordination with activities for Output 3.2 prepare guidelines that establish the community responsibilities, roles, functions and obligations within the formal community action planning, district planning, and their monitoring and evaluation. Share the guidelines to be included in the regulations for community and district plans. Enable the participation of traditional, CSO, FBO, media, academia in preparing and executing an all-inclusive gender sensitive community health system	Office Communities	Consultants

Outputs to Outcome 3	**Who**	**What**	**Where**	**Additional resources**
Output 3.6: Traditional governance structures are integrated and headmen involved into decision-making processes. The consideration of social determinants of health thus gains more attention for enhancing community dialogue, capturing local cultural practices and shaping relevant health messages.	MOH HCFP/HPFP National and District Resource Centers Councils	Revise NCH meeting regulations to enable transparent decision-making and spaces for the participation of citizens representing their communities. In the revisions of guidelines for NHC meetings incorporate membership for representatives of other sectors, extension officers, and hospital committees so that they can legitimately participate. Encourage the participation of headmen in community action plans ant their monitoring and evaluation within NHC	Office	Consultant
Output 3.7: Assessment of local health conditions and disease incidence	District focal point, DHO, Frontline health workers DHIO	Design of a training course to prepare local health assessments as inputs for community action planning activities Training of DHO/DHIO staff for the preparation and support of local health assessments Implementation of assessments prior to planning annual action	Office Training meetings	Consultant Train DHO/DHIO, CHA, NHC representative, selected CBV, NGO and community leaders Travel expenses Assessment material/equipment
Output 3.8: Community level management guidelines for disaster events and their implementation improve the preparedness, expertise for emergencies and public health effects and enable timely and effective responses.	District focal point, DHO	Design of a training course to prepare local disaster management plans to complement community action plans Training of DHO for the preparation of local disaster management plans	Office Training meetings	Consultant Training venue and materials Travel expenses

ANNEXES

ANNEX 1: The Three Coordination Levels in Community Health

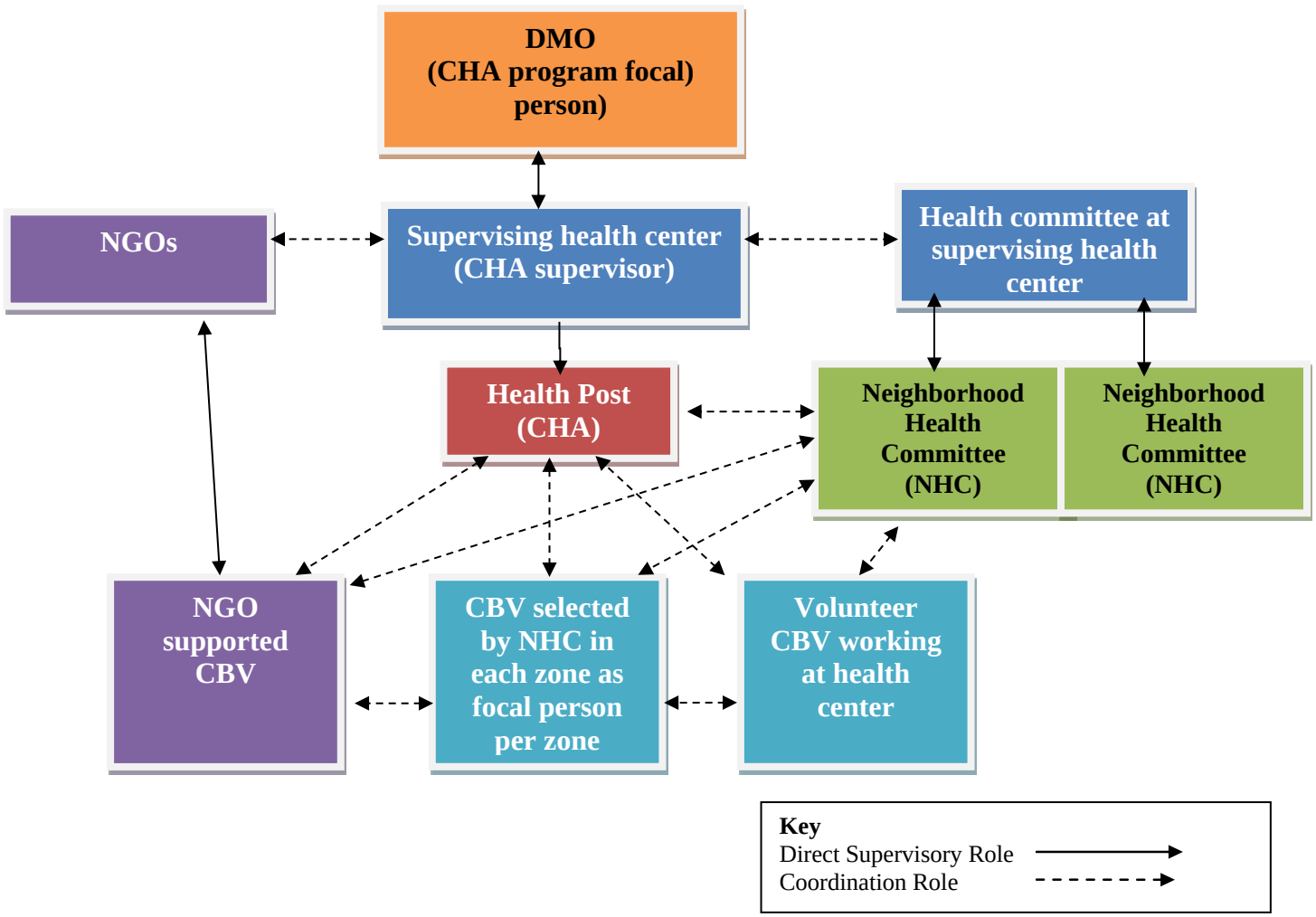
I. Coordination of Activities		
Neighborhood Committee	**frequency**	**Source: NHC guidelines**
- Coordinating mobilization of volunteers to Assist CHA in following up on patients and household visits	Throughout calendar and year	p. 18-20, p. 30
- Coordinating volunteers to support in planning, profiling, health promotion and prevention	Throughout calendar and year	p. 18-20
- Coordinating volunteers for effective community implementation and monitoring	Throughout calendar and year	p. 10
- Coordinate CBV and CBO in the community	Throughout calendar and year	p. 19,
- Ensure coordination of the community health activities -	Throughout calendar and year	p. 10, p. 19
- coordinate resource mobilization and accountability	Throughout calendar and year	p. 19,
- Coordinating and supervising community-based activities identified to address health problems	Throughout calendar and year	p. 19
- coordinate monthly to discuss community health problems and peer review on-going activities and performance with CBV	Monthly	pp. 18-20
NHC chairperson - coordinates health related programs/activities between the HC and the community -	Throughout calendar and year	pp. 18-20
- Coordinates and participates in HCC and other organized meetings to ensure views from the community on quality and availability of care is heard	Monthly and quarterly	pp. 18-20, p. 30,

II. Coordination of Activities		
Community Health Assistant	**frequency**	**Source: NCHAP**
Meetings and activities of the NHC	Monthly and as per need	
Resource mapping	Annually, on request	pp. 18-23 (for details see excerpts below)
Community action plans	Annually, regular reviews and adjustments	
Community level activities	6 times a year, 80% of CHA time in HP/HC catchment area	
Community level meetings	Monthly once	
Health promotion and prevention	During 6 household visits 80% of CHA time in HP/HC catchment area	
Participatory Community level intervention	As per calendar	

III. Coordination of Activities		
Environmental Health Technician	**frequency**	**sources**
Environmental activities: sanitation, spraying, prevention of infection, …	Throughout calendar year	NHSA
Monthly data aggregation and review meetings with data verification and team building discussions	monthly	CHS p. 81

ANNEX 2: CHA Coordination with other Community Stakeholders

Source: adopted from: MOH 2012c, The National CHA Programme: Implementation guide, p. 31



This adopted Figure illustrates that:

- CHA will be supervised directly by the supervising health centre in-charge and receive monthly supportive supervision.
- CHA will coordinate with the local NHC to plan and implement CHA program activities and share monthly activity reports with the NHC before submitting the report to the CHA supervisor.
- CHA will be playing a primary coordinating role for any type of community health work within the catchment population of the HPs by other community health workers (such as NGO supported CBV and NHC supported CBV) in such a way that common program implementations can be planned and accomplished in partnership. This partnership will help to maximize resources and avoid duplication within the same community, along with reporting duties (see annex 9).

- NHC should identify existing community volunteers in each zone that are willing to work with them. CHA will use these volunteers to circulate information to each household within a short time period, and ensure that household level health interventions continue to be implemented by household members after the CHA's visit (as a CHA will only be able to visit a household approximately 6 times a year).
- Supervising health centers in collaboration with NHC ensure that such coordination exists and maintains its functionality.
- CHA will organize monthly meetings with other community based health volunteers and NHC to discuss activities accomplished within the given time period and review their plans for the next month to avoid duplication of efforts and best use of resources.
- CHA Coordination and collaboration activities include**:**
    - Organizing a community level needs assessment for the preparation of community and household health profiles
    - Conducting household visits and providing health education on specific topics
    - Organizing community meetings and campaigns including school health activities
    - Following up of clients on care and treatment programs either at hospital, health center or health post level
    - Monitoring and evaluation of community work within their community

ANNEX 3: The Role and Functions of the Community Health Assistants (CHA) and their Relations to the Other Players: NHC, CBV, Community Members, Traditional and Local Leaders, Schools and Other Governmental Sector Offices and NGO

Source: MOH 2012c: The National CHA Programme: Implementation Guide, p. 18-23

Coordination role

- ***Resource mapping***: Document all trained human resources within their own community by type of their training and specialization, during the needs assessment/ community diagnosis period, to maximize intervention capacity and minimize duplication of interventions.

- ***Community action plans:*** Lead and coordinate community action plans in collaboration with key community stakeholders quarterly and annually

- ***Community level activities:*** Coordinate all community level activities, including services provided, trainings and data reporting, of other CBV and NHC and compile a report to the CHA supervisor on monthly basis

- ***Community level meetings:*** Organize and facilitate community level meetings to discuss specific health issues depending on priority problems at community level

- ***Organize***, ***coordinate, train and provide guidance*** to community health volunteers and families in community on how to promote health behaviors and prevent common diseases

- ***Participatory Community level intervention*****:** In collaboration with DHO and health facilities, organize and coordinate all community cadres to focused community based interventions such as child health week, health campaigns and submit summary report of collective performance report on those occasions to supervising health center in-charge.

Management /Administrative role

- ***Data collection and documentation***: Use demographic and health related information on the community, found during the needs assessment, report on progress made against the community health targets and interventions, and report all client and patient data using standard registers namely 'Patient Care Register', 'Household Activity Register' and 'Community Mobilization Register'.

- ***Monthly Reporting:*** Send monthly summary reports to the CHA supervisor

- ***Collaboration:*** Collaborate with local government or non-governmental organizations to plan and conduct activities at community level
- ***Equipment and supplies:*** Manage equipment and supplies at Health posts and conduct an inventory of the stock, at least once a month

- ***Patient follow-ups:*** Participate in the active follow up of the patients/clients referred to the health facility, to strengthen the referral system and minimize the loss of to follow up cases

- ***Health behavior:*** Monitor performance of every household on specific favorable health behavior at every visit, identify challenges with households to adopting the behavior change, and partner with the household to problem solve and improve health seeking behavior

Health Promotion and Disease Prevention role

- ***Conduct*** regular house to house visits, using ETL principles (active listening which includes the communication methods of open ended questions, affirmations, reflective listening) coaching patients to overcome the barriers to adopting positive behavior change

- ***Provide health education*** and disease prevention services at household level on all CHA primary health care packages

- ***Sensitize*** and organize community members for group health interventions such as "Child Health Week" and other types of campaigns, environmental sanitation improvements on a community level, awareness creation of health challenges and active problem solving with community members

- ***Promote*** healthy behaviors and disease prevention methods at household level, one on one, and to the whole community using available communication media, such as traditional ceremonies, meetings, special occasions, before/after church services, etc.

- ***Provide*** school health services to prevent common diseases and promote health behaviors among students and their families

Basic Health Care and the Referral System

- ***Provide*** basic health care services such as diagnosis of malaria, pneumonia and diarrheal diseases at health post and household level as per the standard care and treatment

- ***Encourage*** health seeking behavior among community members by providing education and CHA primary health care packages (cf. Figure 5)

- ***Provide*** immediate referrals to next level of care for conditions which need advanced medical care

Community Mobilization

- ***Communicate*** health messages using all mechanisms and venues available. For example, integrate health issues with political events, schools, etc., to mobilize the community and target all audiences (children, adults, adolescents, religious groups) in a way that mobilizes and provides a suitable setting to tailor specific messages

- ***Strategize*** about how to educate a specific population group in the community and tailor the messages delivered

- ***Create mobilization techniques using ETL principles***- dramas, story-telling, special events and campaigns etc. to make health promotion activities get more participation

- ***Use all existing resources in community*** which include trained volunteer community health workers, religious leaders, traditional leaders to spread health message

- ***Identify priority gaps in community health*** in a participatory approach with the community and design discussion topics based on needs of community

Neighborhood Health Committees and other volunteer CBV
Focal person: NHC chairperson

- ***Be models in the community:*** Be a change agent in community health by accepting and advocating CHA program interventions in collaboration with CHA

- ***Assist CHA*** in collecting community and household health profiles through needs assessment survey

- ***Support CHAs*** in planning, implementing, monitoring and evaluating CHA programs at health post and community level

- ***Organize*** the community for effective implementation of CHA programs and facilitate activities for CHA to work on

- ***Play an active role in mobilizing the community*** for health education sessions

- ***Inform CHA during epidemical conditions*** immediately and assist in interventions to address major public health issues/problems

- ***Assist CHA in following up on patients*** or clients defaulting routine preventive services as well as care and treatment for chronic illness

- ***Ensure implementation of preventive activities*** by CHA at household level in routine check-ups of action points recommended by CHA at household level

- ***Report all activities at community level to CHAs***, as and when needed and participate in meetings organized by CHA to monitor CHA program performance at community and health post level

- ***Recruit and participate*** in the selection of new CHA for training

Community members
Focal Person(s): Village headmen

- ***Participate in planning, implementation, and monitoring and evaluation*** of CHAs and CHA program activities in their community

- ***Encourage adoption of positive health behaviors*** and preventive mechanisms initiated by the CHA and other CBV as per the standard

- ***Participate in giving quick information to CHA*** and other CBV on epidemics or other urgent issues (i.e., emergencies) at household or community level

- ***Mobilize resources*** to assist effective CHA program implementation in the community

- ***Participate in different community mobilization and sensitization activities*** organized by CHA and other CBV and implement recommendations of those events

Traditional and Local Leaders
Focal person: Village headmen

- ***CHA program Planning:*** Participate in advocacy, planning, coordination, and monitoring and evaluation activities of the CHA program

- ***Community Sensitization:*** Support CHA program in sensitization and coordination of all stakeholders at community level (local community associations, faith based organizations, government and non-government organizations, community members) for effective implementation

- ***CHA Motivation***: Encourage community members and stakeholders to motivate CHA in their work at health post and community level by providing feedback and to be an active part of solutions for challenges in program implementation

- ***New CHA candidate selection:*** Participate in the recruitment of CHA to support CHA program implementation at health post and community level

- ***Facilitation:*** Invite CHA to discuss health related matters at community forums such as during community ceremonies, meetings and special occasions

- ***Resource mobilization:*** Support the CHA program in mobilizing local resources (including health post construction and completion of buildings) for effective program implementation

Schools and other Governmental Sector Offices

Focal Person(s): Heads of respective sectors (school headmaster, heads of other government sectors)

- ***Participate*** in CHA school health program implementation (both teachers and students)
- ***Motivate and organize*** interested students in 'health clubs' to take important health behavior recommendations from CHA to implement it in their household/family and monitor the progress of implementation.
- ***Demonstrate*** health program packages at schools (such as clean and safe water use, dry waste disposal facility, latrine construction and utilization, HIV testing campaigns)
- ***Encourage*** female and male adolescent students to provide peer health education, encourage family planning and HIV prevention interventions at school and community level
- ***Ensure*** personal hygiene of students (lice, scabies, etc.) regularly and provide advice to implementation of healthy behaviors

- ***Dedicate time during the regular school curriculum each month to talk about health*** with their students integrated with specific subjects (E.g. providing time to talk about malaria, ARI, maternal health, HIV/AIDS, etc. once in a month, and create assignments to reinforce messages, per each classroom)

Non-governmental organizations (NGOs), Community Based Organizations (CBOs) and Faith based organizations (FBO)

Focal Person(s): NGO/CBO/FBO focal person

- ***Partner with CHAs*** to align specific programs with CHA program implementation to avoid duplication and parallel systems at community level
- ***Support the CHA program implementation*** in all health-related programmatic work in the community.
- ***Assist with resource support*** when appropriate
- ***Utilize CHA*** and CBV to mobilize community towards favorable health behavior
- ***Encourage CHA*** through inclusion of in-service trainings and other motivational mechanisms with direct coordination with the District
- ***Participate in CHA health programming plans***, implementation and program M&E at community level
- ***Exchange best practices*** from other communities, community members and Volunteer CHWs within country or abroad.
- ***Participate*** in all NHC meetings for CBV
- ***Recognize NHC as common platform*** for all CBV and follow their advice and cooperate as per their requests

ANNEX 4: Coordination Roles of NHC

Source: MOH 2017b, NHC Guidelines (draft)

Objective of the NHC

- To act as the link between the Health Facility and the Community on all health related issues in the community
- To ensure participatory community health activity implementation and monitoring.
- To ensure effective coordination of community health activities

ditto, (p. 10)

NHCs takes Leadership to ensure Coordination of Community Health Activities

- To represent the community at Health Centre Committee meetings (HCC).
- Identify training needs for the community
- Facilitate select community members to be trained as Community Based Volunteers and to monitor their activities.
- Every month discuss community health problems and review on-going activities with Community Based Volunteers (CBVs).
- Coordinating and supervising community-based activities identified to address health problems
- Advocate for the community health issues including gender, youth and the physically challenged to participate in community health related activities
- Support/coordinate the CBVs/CBO in the community.
- NHCs take leadership and ensure coordination of the community health activities, including resource mobilization and accountability.
- Writing project proposals, especially for Income Generating Ventures (IGVs) to Support the CBGs / NHCs programs and other community based activities

Roles and Responsibilities of NHC Office Bearers
Chairperson:

The responsibilities of the Chairperson are:

- To convene and chair the NHC meetings and CBG joint meetings
- To propose the monthly meeting agenda items in collaboration with the NHC secretary and other members
- To coordinate and oversee the smooth running of the NHC
- To mediate between NHC members if disputes arise
- To maintain NHC members' attendance records at meetings
- To have a deciding vote if the meeting is evenly divided on a decision
- To be a signatory to the NHC account if one exists
- To act as the first contact point in the catchment area for the HC
- To attend the health center committee (HCC) meetings as NHC representative
- To coordinate health related programs/activities between the HC and the community
- To mitigated on any differences that may occur between HC staff and the community
- To monitor the usage of community/ NHC funds
- Consolidate and prioritize community/NHC health needs

- Initiate and participate actively in health related activities at household and community levels
- Support CBV in the catchment area
- Mobilize and account for resources
- Consolidate , analyze, use and disseminate data as part of monitoring progress
- Contribute to preventive maintenance and security of the health center
- Provide guidance on community involvement/participation in the implementation of community programs and projects
- Interpret government health policy to the community through the NHCs at that level
- Coordinate and participate in HCC and other organized meetings to ensure views from the community on quality and availability of care is heard.

Secretary:

- To mobilize the community for health-related activities
- To take the lead on data collection whenever possible
- To provide feedback from the community regarding planned activities
- To updated Community Information Board regularly

Committee members:

The responsibilities of all the NHC Members (Executive and ordinary members) are:

- To carry out community health programs.
- To carry out activities in accordance with the NHC aims (education, mobilization, etc.).
- To attend the NHC meetings and CBG joint meetings regularly.
- To take on tasks as heads of sub-committees, like fund-raising or project management.
- Coordinate and participate in HCC and other organized meetings to ensure views from the community on quality and availability of care is heard.

(ditto, p. 18-20)

NHCs are expected to:

- Advocate with the Government and other partners for appropriate health services for their communities i.e. effect social accountability at primary healthcare level
- Mobilize communities to participate in health service delivery as providers of services (through supporting CBVs), demand and utilize health services and foster personal responsibility for healthy living.
- Manage the community level health system through the NHCs and the HCCs
- Monitor and evaluate the progress of service delivery in their particular catchment areas.

(ditto, p. 30)

ANNEX 5: Roles and responsibilities of supervising Parent Health facility (health center or health post with trained health worker)

Source: MOH 2016a, The National CHA Programme: Implementation guide, p. 17f

Focal person: Health facility In-charge (in-charge of health center or health post-when staffed by trained health center worker)

- ***CHA program planning:*** Participate in CHA community planning and provide technical guidance on activities, prioritization of interventions, setting targets and implementation of tasks. Approve the final annual action plan by CHA and community health stakeholders

- ***Training:*** Provide on-site trainings for CHAs to develop their practical skills through coaching and mentoring at the health post and during community level activities

- ***Supervision:*** After being trained for 5 days on supervision of CHA using standard supervisors manual and check lists for this purpose**,** health center/health post in charges should conduct regular/monthly supportive supervision to CHA and provide technical guidance and feedback accordingly.

- ***Referral system:*** Support enhancement of functional referral system through feedback loop from health center or health post trained staff to CHAs on referred cases, to promote on-site learning and enhance continuum of care. Ensure that referred patients are followed up by the CHA, if necessary, in the community.

- ***Supplies at HP:*** In cases where CHA are the only trained staff at the health post, ensure health posts have adequate stock of drugs and commodities and if not, report to the DMO for possible action.

- ***Supply chain management at HP:*** Provide supportive supervision to CHA on the supply chain management system (stock checking, stock-out management, handling expired drugs, etc.)

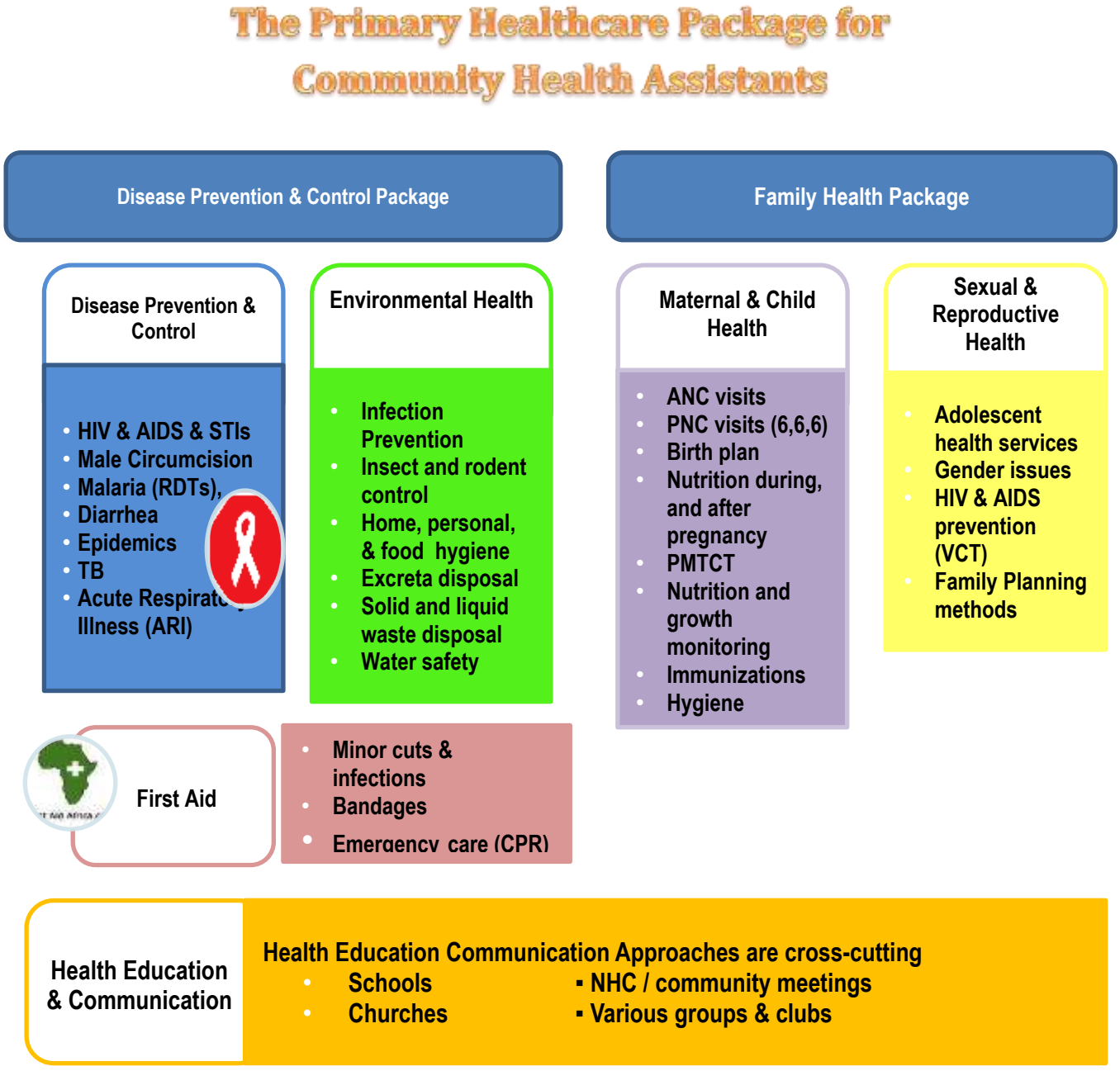
- ***Coordination with CHA:*** Coordinate with CHA for additional adherence counseling and advice at community and household level for clients with chronic illness, before clients are lost from follow up. In addition, in coordination, the health center and the CHAs together can conduct focused community health promotion and disease prevention activities such as HIV testing campaigns, Child Health week, hand washing day, etc.

- ***Information exchange:*** Conduct regular information exchange on important health information with Health posts, such as lost to follow-up tracing, epidemic diseases, health campaigns, outreach activities, common health behavior gaps, etc., during monthly supportive supervision meetings and all other means of communication with CHAs

- ***Performance assessment:*** Conduct performance assessments of CHAs and the CHA program in collaboration with the DMO team.

ANNEX 6: The Primary Healthcare Package of Community Health Assistants

Source: MOH 2016a, The National CHA Programme: Implementation guide, p. 6



ANNEX 7: Recommended Health Care Core Tasks of CHA

in Basic Facility Health Care

1. as service in health facilities to assist health professionals:
    - Taking temperature, blood pressure, pulse,
    - Weighing patients, primarily children,
    - Bed-making,
    - Dressing uncomplicated wounds,
    - Rapid diagnostic testing,
    - Registering patients.

in Basic Community Health Care

2. as service in communities and households, as above plus:
    - Reproductive, maternal and child care, nutrition,
    - Providing basic essential (non-prescription) medicines and supplies,
    - Preventing and managing diseases, particularly NCD,
    - Addressing environmental health and sanitation.

Curative activities of CHA

- History taking, recognition of vital signs, managing fevers, general pain relief, administration of specified drugs to patients, wound care
- First aid and common surgical conditions
- Treatment of common medical problems such as Malaria, Diarrhea, Respiratory Infections
- Simple diagnostic procedures: collection of tissue for laboratory: sputum for TB test, staining of slides for Malaria
- Facilitate referrals to the health center or health facility

ANNEX 8: Roles and Responsibilities of CBV

Source: MOH 2017b, NHC Guidelines (draft), pp. 27f

Roles & responsibilities of CBVs in the community

- Promotive activities
- Preventive activities
- Curative services
- Community empowerment
- Distribution of supplies e.g. condoms and contraceptives
- Provision of lay counselling services
- Maintenance of basic records/registers for clients and activities
- Recording and collation of data

Technical skills

- encourage pregnant women to deliver in health care facility with professional assistance.
- visit newborns within the first 48 hours of life.
- Correctly identify children suffering from severe acute malnutrition (using MUAC) and refer them for treatment.
- Promote knowledge of healthy lifestyles
- Distribute and/or sell products at a discount, according to program goals. A list of possible products to consider including for sale by CBV are: prevention goods (insecticide treated bed nets, water purification tablets and vitamins); curative treatments (oral rehydration salts, zinc, ACTs, anti-malarial drugs, DOTs, single dose antibiotics); other health related commodities (diapers, detergent and hand soap); durable goods with health benefits (improved cook stoves, solar lights and water filters)
- Follow up under five children for access to core interventions (including EPI, vet A, bed net use, growth monitoring etc.)
- Promote key family practices at household level (e.g. timely care seeking, water safety, hand washing with soap, infant and young child feeding practices)
- Identify danger signs and refer, whilst also triggering multi-sectoral services

Roles & Responsibilities of CBVs in relation to NHCs

- Support community based health initiatives planned by the NHCs
- The CBVs will provide activity plans requiring support or facilitation of the NHCs,
- Provide to the NHCs monthly activities findings
- Report emergencies or unforeseen circumstances/crises to the NHCs.

Responsibilities of CBV under NGO:

- Utilize NHC as common platform of all CBV
- Participate in all NHC meetings with CBV

ANNEX 9: Reporting Responsibilities of the Frontline Workers

Source: adapted from the NHC Guidelines (draft), MOH May 2017, pp. 28f and the M&E section of MOH, May 2017

a) Reporting of CBVs

CBVs shall be part of the community based health workforce and report within the Primary Health Care system structures, mostly the CHA (on interventions) and the EHT (performance data).

The CHA will need to request that all volunteers (of NHC and NGO) share their activity reports so that the CHA (and EHT) can consolidate the report and submit one report per Health Post, which will then be fed into the district and national HMIS system at Health center level, as well as for CHA supervisors to review.

They also report monthly to the NHC to up-date the committee on their activities, issues and problems.

b) Reporting of NHCs

The NHCs shall report to the Health Center Committee monthly giving feedback on their planned activities, observations on the agreed indicators on the health catchment area community score card and inputs from the community on perception of quality of health care services.

C) Reporting of CHAs

The CHAs are part of the salaried Health Care workforces. They shall hence report to appropriate leadership within the system and shall play an important role of supporting and coordinating the roles of CBVs as outlined in annex 1 above.

They shall submit summary report of collective performance reports of CBV on focused interventions, their three registers (for patients, clients and community mobilization), and their performance to the supervising health center in-charge.

d) Reporting of CBOs & FBOs

All the CBOs working in health shall report to the health facility on a regular interval. The information shall be given to the HCC by the HCC Secretariat.

e) Reporting of the EHT

The EHT shall report monthly to the HF In-Charge on the collated and aggregated community health data from the health zones of the HC/HP catchment areas as collected by the CBV and the CHA and reported to the EHT during the MDAR meetings.

ANNEX 10: Notes for the Strengthening of Financing of Community Health Work

1.1 Harmonization of Community Health Procedures through Re-defined Fund Flows

Since separate fund flows for same purposes cause duplication, divert from public sector plans, compete for same volunteers, undermine public sector planning structures, cause inequity in the incentive system to compensate CBVs for their efforts at community level, pooling of funds at district levels can strengthen organizational procedures for community health and shall be designed on the background of decentralization.

The CHS requires the revision of the financial flows to reflect:

- new outlining after the recent changes of functions within the health system and MoH
- sources for financing multi-sectoral inputs and
- new financing responsibilities at district level, particularly the financial management capacity at District Health Office requires strengthening

The challenge to re-define financial flows is both, an opportunity to empower the district level with financial responsibilities for the implementation of their plans and to streamline the fund flows by:

- Improving on timeliness of financial flows and equitable distribution of funds, taking into account different economic strengths of regions, districts and communities impacting on the development of community health facilities and staffing
- improving on accountability in accounting and auditing of community health funds at all levels
- making CP coordinate closely with the National, Provincial and District levels along set rules and abandon direct funding particularly of facilities, but also districts and provinces and switch to budget support/SWAP or basket funding with attached TA components for knowledge transfer where needed
- re-visiting the fund-flows for supervising and monitoring community health work as well as for mobilizing volunteers and carrying out activities
- elaborating options for reimbursement and financing of incentives for volunteers and community groups to support monitoring
- improving utilization of CBVs by developing a perspective of common incentives' and by social accountability. Such incentive perspective may also include facilitation of access to income generation and strategies that allow to deriving benefit from volunteer work
- developing concepts for sustainability through providing incentives (financial, in-kind and by means of career perspectives) to CBVs that enhance their motivation to stick with DHO implementation or be ambitious about government programs.
- outlining financing of community level activities including resource mobilization, pooling of resources from government and donors, developing allocation principles and responsibilities in financing interventions and activities through the district and health facilities, disbursement mechanisms, reporting and accountability at all district and sub-district levels and upwards where needed to allow a smooth fund flow.

A further challenge is funding of inter-sectoral cooperation. This may draw attention to:

- pooling of resources from various ministries of GRZ for the development of inter-sectoral plans and activities, or
- opt for negotiation of earmarked funds for inter-sectoral activities by the various ministries.

It needs to be decided which district level entity shall receive and manage such pooled or earmarked funds.

1.2 Financing of Community Networks, Intersectoral Collaboration and PPP

The lack of a framework for intersectoral cooperation impacts on the financing of the cooperation between activities for the improvement of health outcomes through community health. Resources are needed to mobilize communities, subsidize transport and ambulances, costly medications, nutritional support, psychiatric conditions and NCD.

Besides engagement into health related activities, the comprehensive consideration of health determinants through involvement of other sector inputs by means of intersectoral cooperation, as indicated, from agriculture, education, housing and infrastructure, etc. is still weak. Community health activities through community structures and volunteers for other line ministries hardly exist. This is not only attributable to lack of efficient coordination between the sectors but also to a lack of financial support to community level structures to tackle intersectoral challenges, resulting in low community participation in meetings, outreach activities and hardly and intersectoral cooperation except for emergencies caused by natural disaster through the District Development Committees.

Since no framework for regular multi- or intersectoral cooperation, nor a platform for intersectoral coordination are available, this also impacts on the financing of the cooperation between health and non-health activities and the engagement of stakeholders in financing community programs. Further to the lack of resources to mobilize community participation and intersectoral cooperation, resources are lacking to support out-of-pocket expenses incurred to access services through transport and ambulances, accompany sick people to the next health facility, providing nutritional support for malnourished mothers and children, for people taking strong medication, and for people with a burden of psychological disturbances and psychiatric conditions.

On 23rd January 2013, 23 external partners, NGOs and civil society organizations signed the revised Sector Wide Approach (SWAp) MOU/MAF and in the process made a commitment to provide financial and technical support to the NHSP 2011-16. Much of this support is off-budget and provided outside the SWAp framework, with minimal coordination and prioritization. The Ministry of Health' determination to address the donor/aid coordination challenges in the health sector requires strengthening of the efforts to better align partnerships to enhance prioritization, coordination, harmonization and funding.

Further, partnerships with the private sector need more strengthening. Currently, public-private partnerships (PPPs) are minimal and mainly coordinated at local level focusing on provincial, district, and community priorities. The MTR (2015) found no effective existing policies and institutional frameworks for strengthening health services contracting, performance-based financing, and expanding coverage of health services through the private sector. The MOU/MAF is not legally binding and focuses more on the method of working with external partners, NGOs,

and civil societies but is silent on the role of the private sector which can develop and provide an abundance of technical and managerial support to the delivery of community health care, as described exemplary in section 3.2.3.

1.3 Costing of the Strategy and Allocation of Funds

It has been perceived as almost impossible to develop a realistic budget along criteria of equity and need. An additional difficulty is the non-costed National Health Care Package (NHCP) which was finalized in 2012. It was meant to serve with a rationalization of resource allocation by providing cost estimates and guidelines on the interventions and services to be provided at the various levels of the Zambia health care system and referral pathways to prevent, control, and treat the most common diseases. However the NHCP is not costed, making it impossible to ascertain the costs of providing health services at the various levels of the Zambia public health system and allocate sufficient funds. The NHCP in its current form is not robust enough to be adjusted in the advent of changes in the disease burden and overall costs in the advent of medical inflation (cf. MTR 2015, p 274f). As a result, changes in the disease burden, such as currently taking place in the case of growing Obesity, Diabetes and High Blood Pressure are not adequately compensated for in resource allocation and purchasing. Careful prioritization of public services and assessment of equitable PHC service is therefore of great importance.

Inadequate funding and erratic disbursements to districts and facilities, HC and HP and inconsistencies in budget execution have been weakening health service delivery. This situation was further weakened by a lack of coordination of funding sources, particularly for the vertical programs into which huge numbers of Community Based Volunteers (CBV) are involved. At the same time, there is inadequate funding to PHC community outreach and rehabilitative programmes, and transportation for emergency care lead to reduced supply and demand for health care services, and unmet need for the Zambian people.

According to the Mid-Term Review of the NHSP in 2015, the revision of the resource allocation formula for districts (RAF) was expected to be completed in 2014 and is delayed. The intra-district RAF is yet to be developed. The MTR reports low funding in relation to budget allocation and financial needs, and delayed budget execution and low disbursement and execution at the district level. Even when there has been an increase in the share of the GRZ budget going towards district health services there is a concurrent decline in the share going to Tertiary Hospitals and Central/Provincial levels. The health budgets are skewed towards the financing of human resources. At the district level the wage budgets are 85 percent of total GRZ budget, which is very high, compared to the average 50 percent in sub-Saharan Africa, and limit the ability to finance drugs and supplies, maintenance, other operation expenses and investment in new infrastructure.

The implementation of the Integrated Financial Management Information System (IFIMIS) for resource tracking is functional at MoH and some Provincial Health Offices. Additional efforts for full implementation in provinces and roll-out to districts and facilities are still required. The strengthening of human resource capacity for finance functions at the district and facility level will improve data collection, the information of all available resources and use for evidence-based policy making.

All factors discussed above do not allow reaching at an understanding of the cost to be paid for PHC and CHC, hence relevant measures are required to mend the situation.

1.4 Allocation of GRZ Operational Grant by Level of Health Care

The GRZ budget allocation for health increased significantly, per-capita expenditure from $20 USD in 2009 to $46 USD 2013-2015. Given the incipient system for reporting other sources of funds there is a lack of comparable information regarding total health expenditures. Health financing is linked to the macro-fiscal context and the national development process and is competitive with the funding of other sectors like education and social protection. Although the health budget increased in nominal terms between 2015 and 2017 the fiscal space for health is limited, with limited prospects for additional contributions from the GRZ to the health budget. It is unlikely that the GRZ health funds will provide the necessary level of funds to meet planned health targets. Insufficient harmonization of support from various partners and unpredictable donor funding compound the gaps in funding. It is necessary to consider the mobilization of other sources of funds. For example, there could be an expansion of the scope of social responsibility initiatives with the private sector programs for malaria control.

Comparing the last 3 years preceding the NHSP 2011-16 and the period 2011-15 shows that on average, the percentage allocation to districts increased by 2%, General Hospitals remained static at 9%, Tertiary Hospitals reduced by 2%, and Central/Provincial levels reduced by 4%. This suggests that there has been an increase in the share of the health budget going towards district health services with a concurrent decline in the share going to Tertiary Hospitals and Central/Provincial levels (p275). For the districts, though, only 67% of the budgeted amount was disbursed in 2013, funding to the districts has been erratic since the split of the MOH (particularly in 2013), and indications are that the situation worsened for all the districts, Tertiary and General Hospitals in 2014.

1.5 Allocation to Supplies in Community Outreach Services

Comparing the trends on expenditure on drugs as a percentage of total government health spending with other countries in the region, which is estimated at 33% (Bennett et al. 1997), the performance in Zambia is below par (i.e. less than half the expected norm). This is identified in the MTR review as affecting the availability of drugs given the high disease burden and high demand for drugs. This is seen in the context of Zambia, like other developing countries, which is dependent on drug therapies rather than on technologies (cf. MTR, p275). If community health work is supported by medicine kits along with educational and basic clinical intervention this dependency can be slightly mitigated.

1.6 Need for Allocations and Incentive Schemes

The MTR of the NHSP 2011-2016 observed (p 170) that PHC services suffer from staff shortages. These are partly explained by the lack of attraction to work in rural sites. Though the MOH intends to enhance attraction through incentives/allowances, the MTR identified “high staff debts” in form of unpaid allowances, including outstanding arrears on rural retention allowances and across the board for both rural and urban sites. However, the rural retention scheme was recently discontinued by the GRZ. MoH is currently considering providing non-financial incentives to increase retention of staff in rural sites.

As CBV are also used as substitute for insufficient staff numbers, the demand for some recognition of their efforts CBVs. In an overall context of a general lack a mechanisms of motivation, they ask for incentives or other options and supervision. Those who do not serve CP programmes are often demotivated because they do not even receive any incentives or reimbursements for their mobility and other occasional payments in support of community level service delivery, such as having to buy food from outside caterers or else.

It is necessary to include a scheme of incentives for the CBV. This is justified by the fact that they to a great extent compensate for non-existent staff in PHC facilities and outreach service delivery and thus constitute an important, though voluntary, work force. The time spent by volunteers was estimated by CARE for their ZPCT 1,100 volunteers and translated into 630 person years per year. The work of volunteers is considerable and has an impact on service delivery. Small incentives are possible and cost-effective. The lack of incentives has so far contributed to a high attrition of CBV, which in turn challenged the organization of NHCs and doubled their effort for recruitment. The voluntary support thus constantly suffers set-backs and losses of (trained) volunteers while it struggles to provide necessary outreach services.

1.7 Alternative Financing Tools of Voluntary Health Work

The current financing situation results in little enabling facilitation of community participation and demand creation for health service delivery and financing by the communities, even though this is aimed at in the health policy through various policy measures. Nevertheless, a few initiatives for establishing sustainable community health care financing mechanism are implemented. Some developments are observed and should be considered for emulation:

- in Chazanga Compound (Lusaka District) a cooperative was formed to generate income for the support of CBV. The CBV of Chazanga also organized themselves into daily shifts to delivery community health services reliably and also support the health post. Such stringency can only be maintained if their general needs are supported. People in Chazanga succeeded in doing so through the generated income and good organization of their availability for meeting the community health needs.

- In other models, Health related income generation through micro-social entrepreneurship in the combined area of voluntary participation in medicine distribution are implemented, though on a small scale in two districts. This initiative of an INGO in Zambia reports that more than half of the voluntary participants generate monthly incomes of US$20,- which allows them to sufficiently sustain their needs and continue with their voluntary community activities.[72]

- Of similar supportive volume of financial support is a local income generating model of Zambia through the establishment of a social fund managed by the DHMT. This cooperation of a CSO with the public sector gives groups of CBV working in teams a financial incentive of between GBP 100-150. It enables CBV to establish a variety of income-generating schemes that enabled them to sustain the community systems (e.g. food

[72] cf. Live Well under Care Zambia

banks, community emergency savings schemes, emergency transport schemes) that they had established to support women's access to maternal health services. The Social Fund helped to motivate the CBV and sustain their work. The particular value of this scheme lies in providing group rather than individual incentives.[73]

- Options like community performance based financing are not mentioned as projects in the relevant literature on Zambia, but for other countries.

  The table 1 provides an overview with short descriptions of examples of different community health financing approaches and recommendations to facilitate decision making or consideration of a particular model, respectively a mix of models for the financing of CBV.

At this stage it is important that discussions take place between MOH, MOF and Ministry of Internal Affairs that coordinates with provinces/ and districts thus supporting decentralized levels of government) to determine (a) feasible option(s), given that incentive schemes constitute a success factor in community health programs supported by voluntary cadres.

[73] cf. activities of NGO MAMaZ

Annex 11: Best Practice and Recommendations for the Financing of Community Based Volunteers

Community Income Generating Schemes as Financial Support of CHC services

Project Name, Country	Brief description	Dates	Characteristics	Source of finance	Documented benefits
National community health worker (CBV) program, **Rwanda** (Condo Mugeni et al. 2014)	National CBV program. Every village (100–250 households) has four CBVs. Multidisciplinary CBV, focus on case identification and referral for a variety of diseases, treat childhood diseases like pneumonia, diarrhea, and malaria, and provide community support for malnutrition. The maternal health worker identifies pregnant women, provides antenatal care visits, and refers for delivery at health facilities. The cell coordinator is in charge of social affairs in the community and is responsible for the compilation of performance-based financing reports. In communities with chronic care CBV they support patients with advanced conditions or who require daily visits (DOTs).	Since 2007	CBVs are trained and supervised. Integrated to the health system. A team of 4-5 people: maternal health CBV, multidisciplinary CBV, binômes, chronic care CBV, and cell coordinators. CBVs receive performance-based financing through cooperatives. Works in parallel with Community Based Health Insurance (CBHI) The salaries paid to CBV provide income to their families and support community development. CBV strategy funded by government and partners.	Government and development partners	CBVs have contributed to: Reduction in infant mortality and under five mortality ratio. Decline in malaria prevalence and acute respiratory infections Decline in the prevalence of HIV/AIDS Increase in contraceptive prevalence rate

Project Name, Country	Brief description	Dates	Characteristics	Source of finance	Documented benefits
Community Based Health Insurance (CBHI), **Rwanda** (Kalisa Musange et al. 2015)	CBHI covers primary health care services that are mainly delivered at the health center level. Patients with CBHI can be referred to secondary care delivered at the district hospitals by qualified medical doctors. if patients cannot be managed at the district level, they are referred to national referral hospitals with specialized doctors. Performance-based financing is an important complement providing incentives to improve service provision/ supply.	Pilot prepayment schemes 1999-2003 Expansion phase 2004-2010 Consolidation phase 2011-2014	*S*trong and consistent governmental political and operational leadership and support from the highest levels down to the local levels. Strong demand and support from communities and related organizations. Financial and technical support from development partners Governments developed clear policies, regulations, and guidelines (risk management, financial management, financial solvency and sustainability) that provide standard instructions and guidance for all those involved in the CBHI schemes.	Households pay premiums[74] and copayments Government and development partners subsidize the poor.	74% coverage of targeted population. CBHI has improved access to health services at all levels. More health services are utilized and medicines are available. The higher use of health services has resulted in healthier and better-off families. CBHI has improved financial protection lowering members' health care costs and reduced catastrophic patient costs.

[74] In some districts the banks provide soft loans to households to help pay premiums

Micro Entrepreneur-Based Community Health Delivery Program, **Uganda** (Bjorkman Nyqvist, and Guariso et al. 2016)	Scale-up of a Community Health Worker (CBV) program as a strategy to improve child survival. A cooperative was formed to franchise direct selling (business in a bag) to CBV to increase access to low-cost high-impact health products and free basic newborn care. The selling of health related products generate income for the support of CBV. The main challenge of this CBV program was the insufficient incentives to deliver timely and appropriate services.	Pilot started in 2007, scale-up 2011-2013. Evaluated three years after program started	Training of outreach volunteers to earn income by selling preventive and curative products, this keeps them motivated and active in the community. Defined financial incentives for the CBV to register pregnant women and visit newborns within the first 48 hours of birth allowing for the integrated community case management of maternal, newborns and child health services. Assessment of the market for health commodities and drugs to set target keeping prices at least 20% lower than prevailing local market prices. Setting up sites that can sell the goods at wholesale prices 30%-50% below market price allowing for earned income from the sale of products.	Government	Evaluated through a Cluster-Randomized Controlled Trial embedded within the scale-up of a CBV program Found a significant improvement in child survival (27% reduction in the under five mortality, infant mortality 33% lower and neonatal mortality 27% lower). Program coverage 24% households visited in previous month, follow-up visits 50% and up to 2 times more than controls, health knowledge at least 11% higher, prevention at least 5% higher, and treatment for malaria, diarrhea 16& higher, antenatal, delivery and

Project Name, Country	Brief description	Dates	Characteristics	Source of finance	Documented benefits
					postnatal care.
Live Well Social Enterprise, Zambia (CARE)	Live Well recruits, trains and supports a network of Community Health Entrepreneurs (CHE) to promote healthcare and to sell health-impact products into underserved communities. Live Well addresses a real need at household level, by: 1. raising awareness of health issues 2. increasing access to health impact products 3. providing CHE with a livelihood opportunity	Feasibility study conducted in 2015 and pilot started April 2016 to date	Recruit and train high quality CHEs in health and business skills, providing livelihood opportunities Build a supply chain which reliably increases access to affordable, quality health products at a household level, saving consumers time and money from visiting clinics. Provide income-generating opportunities to attract, retain and incentivise CHE, many of whom are front line health workers. Be sustainable and scalable to reduce dependence on donor funding. Align to government priorities, and seek to reduce the burden on government clinics, through healthcare awareness and minor ailments being treated at household level	Live Well Social Business Ltd is a new Zambian-led enterprise, affiliated with CARE and currently funded by GSK and Barclays, and with technical support from Living Goods. An innovative partnership, bringing together skills from the private and not-for-profit sectors.	Live Well has over 400 CHEs trained in health and business skills, and has sold over 75,000 health impact products. These products meet local health needs such as high prevalence of diarrhoea, malnutrition and oral health. Without Live Well, affordable products such as painkillers, anti-diarrhoea medicine, fortified porridge, toothpaste and solar lighting are not easily accessible in the communities we serve.

ANNEX 12: Best Practice of Community Financing Schemes

Financing mechanism	Name of project, Country	Dates	Brief Description	Key constraints	Success factors	Impact on health outcomes and others
Government supported	Bwafwano includes Chazanga District, **Zambia** (Mwewa, Saili et al. 2013)		Community caregivers who are a key part of the delivery of health services Linked to the public health facilities through the NHCs Does not include premium payment/ exemption mechanism?	Strong supervisory and financial involvement of government representatives Extent of cost recovery varies, usually not self-sufficient. Without exemption mechanism it is not pro-poor Lack of proper funding for waivers/ exemptions that covers all costs (consultations, drugs and supplies) Administrative costs of waivers Leakage due to waiver or exemption problems and under coverage of the most needy	Community acts as agent to reach rural and excluded populations. Community participation in the management of the scheme (control moral hazard and costs). Definition of an affordable package of care. Effective exemption mechanisms or sliding scales with objective criteria. Flexibility in revenue collection. Control on moral hazards (referrals, treatment guide-lines, utilization review). Reduction of adverse selection. Mechanism to manage covariant risk (disaster, epidemic).	

Financing mechanism	Name of project, Country	Dates	Brief Description	Key constraints	Success factors	Impact on health outcomes and others
Government supported	**Ethiopia** (WHO GHWA 2008)		Training of a new cadre of health workers for community health	Without exemption mechanism it is not pro-poor Lack of proper funding for waivers/ exemptions that covers all costs (consultations, drugs and supplies) Administrative costs of waivers Leakage due to waiver or exemption problems and under coverage of the most needy	Strong supervisory and financial involvement of government representatives Extent of cost recovery varies, usually not self-sufficient.	Reduced neonatal mortality
Community cost sharing (Prepaid Discount)	Kitwe pre-purchase discount card, Livingston pre-paid card scheme District Model, **Zambia** (WorldBank 2004)	Started 2002 and 2003	Out-of pocket at point of service Pre-purchase discount cards	Purchase ties available household cash, thus better-off more likely to buy pre-paid High costs for social mobilization, training and administration. Require strong government commitment or donor funding to be sustainable Require institutional frameworks No risk sharing Exemption mechanisms should reduce the barriers of the extremely poor to access health care	Strong leadership from the Minister of Health and the active support of the Prime Minister Motivation Supervision Monetary incentives Reimbursement for travel costs/ mobility Food?	Not mentioned

Financing mechanism	Name of project, Country	Dates	Brief Description	Key constraints	Success factors	Impact on health outcomes and others
Community cost sharing	Drug revolving funds and Bamako initiatives in **Nigeria** and West Africa (WorldBank 2004)	1986 evaluated in 1991	Drug revolving funds that generate funds for toping up financing for PHC at the local government level coordinated at district level. The objective is to recover the cost of drugs and to generate surplus funds for other development projects. Developed and supported by DFID	exemption mechanisms proved to be extremely limited in scope, covering only the physically and mentally disabled	District development committee Realistic national drug policy Provision of basic essential drugs	improved utilization of maternal and child health care drug availability and relative affordability of PHC
Community cost sharing	Drug franchising schemes **Kenya**		Community based pharmacy distribution programs, income generating activities supported by NGOs and donors			
Community cost sharing	Social marketing clinics ZamHealth **Zambia** (WorldBank 2004)	1996	Social franchising primary health clinics pattered after Prosalud model in Bolivia. In Bolivia Prosalud expanded the access, quality and coverage of health services to low income communities by mobilizing community resources through user fees. Cross-subsidization among services (paid curative care and unpaid preventive care), units and persons was essential to provide under-served, low-income communities.	Not sure feasibility study was followed with implementation in Zambia.	Donor financial support covered the funding gap	In Bolivia high quality preventive and curable care are provided by decentralized, multipurpose and permanent clinics to previously underserved low income communities.

Financing mechanism	Name of project, Country	Dates	Brief Description	Key constraints	Success factors	Impact on health outcomes and others
Community prepayment schemes	Village Health insurance (Lundazi, Mambwe) **Zambia** (WorldBank 2004)	Described in 2003	Restitution payment for villagers living in game-parks. Zambia Wildlife authority pays for foregoing game meat. Resources are used for pre-payment of health care. risk-sharing	Limited to people living in game-parks	Not mentioned	Not mentioned
Voucher/Waiver financing scheme under user fee programs	PWAS and Health care cost scheme **Zambia** (World Bank 2004)	1950s-1990s new program 2004	Mandated under Zambia's Public Welfare Assistance (PWAS) paid by GZR, and the other financed by UNICEF Restitution of waived and exempted services	Coordination challenges with executing ministries, weak management and information system Lack of community participation Low and erratic funding Targeting, Adequate promotion /awareness, Degree of redemption Administrative costs Due to incomplete cost-recovery requires government or donor support to keep the schemes afloat Lack of exemption mechanisms or social protection excludes the participation of the extremely poor	Not mentioned	Not mentioned

Financing mechanism	Name of project, Country	Dates	Brief Description	Key constraints	Success factors	Impact on health outcomes and others
Voucher/Waiver financing scheme under user fee programs	Youth Health Care Cost Scheme (YHCCS), MCDSS, Lusaka and Siavonga District, **Zambia** (WorldBank 2004)	2002	Waivers for care of poor orphans and vulnerable children (OVC) 5 years and under. 6-16 not covered. Pilot financed by UNICEF	Feasibility due to the number of OVCs and the need for care for those 6-16 due to HIV-AIDs Costs of identifying target population high in relation to the value of the transfer		increased their demand for services by 43 to 45 percent
Government supported?	St. Paul's **Zambia** from (Mwewa, Saili et al. 2013)		Community caregivers who are a key part of the delivery of health services linked to the public health facilities through the NHCs			
Government supported	Chikankata **Zambia** from (Mwewa, Saili et al. 2013)		Community caregivers who are a key part of the delivery of health services linked to the mission hospital, which provides trainings and supervision			
Government supported	**Uganda** (Bjorkman Nyqvist, and Guariso et al. 2016)		A cooperative was formed to generate income for the support of community-based volunteers (CBV). Health related income generation through micro entrepreneurship of voluntary workers who participate in medicine distribution			

Financing mechanism	Name of project, Country	Dates	Brief Description	Key constraints	Success factors	Impact on health outcomes and others
Community resource mobilization	Atusole Women's Club-**Zambia**, Kapyanga Village, Mumbwa District, Central Province, (WorldBank 2003)	Started 1988/89 Evaluation data 1995	Originated as a literacy intervention organized with assistance from WHO by illiterate adult women. Provided health, education, and income-generating services to the village. The income-generating activities supported livelihood and nutrition. Growing crops in 4.5 hectares: 1.8 devoted to maize, 0.5 groundnuts, 0.5 soybeans, and guavas. They also own mills for grinding maize, a piggery, a grocery store, and sewing machines for dressmaking and tailoring. Its loan program distributes fertilizers and feed maize. They sponsor financial management training, and small business enterprise management training.	Donor dependent. Institutional weaknesses of CBOs and NGOs Limits to revenue generation Lack of resources for social mobilization Bias for capital assets vs recurrent cost support for example the pending requests from Atusole to donors in 1995 were: (a) 10 more bicycles; (b) radio communication device; (c) training of two peer educators; and (d) 3 more boreholes Poor access to grant information and barriers for preparing proposals.	Community ownership and self-selected	Health indicators have shown an upward trend since the early 1990s when the project started. Immunization coverage has increased to 65 percent in 1995. During the same period, family planning acceptance increased to 13 percent, while families with pit latrines increased to 55 percent. In 1995 250 adult women and 27 adult men have passed through literacy classes, many of whom now are involved in income generating projects.

ANNEX 13: Lessons and Challenges for CBV Strengthening in Uganda, Ministry of Health Community Health Extension Workers Strategy (2015/16- 2019/20)

Lessons	Challenges and/or difficulties
Human resources drive health system performance. The periods of acceleration in health achievements have been sparked by mobilization of workers in the societies	Commitment from Government to allocate adequate resources for: training, procurement of supplies and equipment, salaries and regular supportive supervision.
Improvement of population based health and survival indicators are associated with higher health worker density and quality.	Human resources for health crisis is one of the factors underlying the poor performance of health systems to deliver effective and efficient health care, critical in developing countries.
Participation of CBVs has been promoted for decades, and there is evidence that they can significantly improve health indicators, particularly in settings with shortage of skilled, motivated and capable health professionals.	
For the enhanced functionality of CBV programs: • CBV candidate should be selected from their own community, preferably by community members • The selection of CBV candidates should comply with age and education[75] limits, and their sex, marital status and occupational should correspond to their communities culture and social values. • Training is a crucial element in the implementation of the CBVs program, it should be extensive, thorough and complete and always be appraised by the exam or practical evaluation that ensures competency in working with the communities. • Supervision has proven to be effective in improving the impact of CBVs driven interventions • Creation of effective linkages between communities and the health care system, where they can refer cases • Monetary and non-monetary rewards (career advancement, and recognition and rewards for their services) increase CBV retention, and reduce the costs of selecting and training new CBV	In countries where CBV programs have achieved significant social and health gains. Following is a list of the most significant: • The role of CBVs in the community is incomplete if they work in isolation, without formal links with health care system. Weak referral systems and linkage with the formal health system, limited capacity of health systems to effectively provide support from the higher levels to the CBV program creates a big challenge. • The lack of opportunities for upgrading, training and refresher courses on relevant areas for active CBV • The lack of promotion, and professional advancement tracks for CBV. • The lack of revision and adjustment of the curriculum and the modules for CBVs training to match country specific goals and targets. Also the curriculum may have more theory than hands-on practice. • Deficiencies in the practical training of CBVs particularly on skilled delivery and key clinical skills due to limited training facilities for trainees • Lack of guidelines regarding the deployment, transfers, leave of absence, and career structure for CBVs • Some CBVs programs do not have clearly instituted documentation and reporting system. • Lack of adequate working and living conditions for CBVs compounded by poor communication and transportation system and long distances from health centers.

[75] The educated person gives responsible direction to the community and at the same time has their own social standing and respect in community, and helps their role to impart knowledge and bring about modifications in attitudes and practices about health.

Lessons	Challenges and/or difficulties
Investment in provision of proper supervision, equipment and supplies, and linkages with health system is required	Most of the programs can have shortages of medical equipment for patient examination, and essential supplies useful for promotive, preventive and curative health services.

Annex 14: Best Practices in CBV remuneration schemes: challenges/difficulties.

Country	Dates	Description	Challenges and difficulties	Health outcomes
Ethiopia	Up to mid 1990	Health care system skewed toward urban centers, following the distribution of health facilities. Voluntary community health workers of different types were introduced to deliver health promotion and prevention services and commodities.	Due to the voluntary nature of CBV and the poor ownership of the lower levels of the government structures the functionality and sustainability of these arrangements proved to be unsatisfactory.	Poor results and outcomes
Ethiopia (Nejmudin Bilal et al. 2011) (WHO GHWA 2008)	1997 Scaled 2005	Health Extension Program (HEP), for institutionalized primary health care. Included a package of health care interventions, delivery mechanisms, and human resource development. HEP was premised on the belief that access and quality of primary health care for rural communities could be improved through the transfer of health knowledge and skills to households. HEP improved PHC in rural areas through a community based approach focusing on prevention, healthy living, and basic curative care. Health extension workers. The program is owned and led by local governments. A new cadre of CBV were recruited based on nationally agreed-upon criteria including residence in the village, knowledge of the local language, graduation from 10th grade, and willingness to serve their community. The CBVs were trained and are have supportive accountability, adequate supplies and an effective information system. The local government pays CBV salaries and builds or	Housing needs were not covered it is proposed that housing is to be provided on or near the health post compound for all CBVs. The CBV could benefit from a small credit for acquiring essential commodities such as safe water and a toilet. Poor transport and communication are also problems. A lack of guidelines for structuring time use, transfers, annual leave and career progression were also identified as problem areas.	Reduced under five and neonatal mortality Improved Immunization, contraceptive use, personal and environmental hygiene.

Country	Dates	Description	Challenges and difficulties	Health outcomes
		rehabilitates the infrastructure. Partners have paid for medical equipment, drugs, supplies, pre- and in-service training and teaching materials, and contributed technically and financially to the distribution of commodities		
Zambia, (Mwewa, Saili et al. 2013)	2013	Zambia has a long history of involving community caregivers in the provision of health care at facility and community levels. The community caregivers are linked to the health system primarily through the organizations they work for, namely government facilities, mission hospitals and NGOs.	Poor coordination of CBV programs, gaps in information from public health services with local and partner supported stand-alone initiatives Reduced and delayed funding for community health from government and partners specially for stipends and logistical support (bicycles, boots and umbrellas) that has a negative effect on motivation and retention of CBV. Absent regulatory framework for payment and incentives for community care givers result in varied remuneration both in types and their values. Among those that receive money the amounts vary significantly. The non-monetary incentives could be: training and training degrees (by modules), bicycles, t-shirts, boots, or meals when training. This leads to tension within communities and gravitation of caregivers to those with better remunerations.	?

Annex 15: Small Steps towards Pooled Resources for Health Financing and Community Based Health Insurance: The Rwanda Example

Experience in Rwanda suggests that community based health insurance, CBHI, is a possible path to achieve universal coverage in a developing country. Four major phases marked its development: (1) political commitment and piloting; (2) expansion of independent, district-level schemes across the country; (3) consolidation into a national scheme and standardization; and (4) ensuring the scheme sustainability.

The development of CBHI in Rwanda has benefited from the strong and high level political commitment towards the well-being of the population. Also well-coordinated development and implementation of Government-led policies were required, regulations and guidelines in collaboration with development partners, strong administrative support, high involvement of local authorities, religious leaders, and beneficiaries in the design and management of the scheme, furthermore continuous education and sensitization efforts on the role and importance of health insurance, adequate financial management systems, and financial assistance to subsidize the poor. All these factors can be introduced in community health work over a medium term period.

Financial solvency and sustainability of a social insurance scheme in a developing country is not likely to be self-financing, given that the informal sector and the poor cannot afford premiums and copayments. These populations require subsidies from the government and support from donors. Rwanda has shown that a carefully planned insurance can be solvent although the government has to ensure not to create too much dependency. In Rwanda even though there are limitations on how much members can pay, it is important to eventually have one pool for all citizens so that the better-off can subsidize the less well-off. It is also essential that principles of cost-effectiveness and efficiency are getting applied, both for the operations of the scheme and for the health services that the scheme is helping to fund.

Finally it is important to note that the goals of maximizing health revenue and maximizing participation in community-based health insurance in a developing country are generally mutually exclusive. Ensuring access to all citizens hence is the recommendable option as the currently only remaining priority.

ANNEX 16: Data on Health Determinants

Source: Central Statistical Office et al., 2015: ZDHS 2013-14, except for internet quotation of "tradingeconomics"

household size on average:
5 members (5.1)
27% led by women

Safe drinking water available to:
Total: 65%
Rural: 47%
Urban: 90%

Sanitation
Toilet, household owned, non-shared:
Urban: 25%
Rural 75%

Assets
Population owns:
TV : 37%
Radio: 57%
Mobile phones: 66%

Houses owned by:
46% women
42% men
33% men and/or women

Insurance coverage
2% employer based
97% do not have any

Employment
60% women 15-49 years
97% men
Level of income: 66% women earn less than their husbands
Decision making on spending: 35% women decide independently

Unemployment rate

source: www. tradingeconomics.com/Zambia/

2014

Zambia Labour	Last	Previous	Highest	Lowest	Unit	
Unemployment Rate	13.30	13.10	19.70	12.00	percent	[+]
Population	15.47	15.02	15.47	3.08	million	[+]
Living Wage Family	4445.50	4443.50	4864.60	4443.50	ZMK/ Month	[+]
Living Wage Individual	2423.60	2511.70	2511.70	2413.20	ZMK/ Month	[+]
Wages High Skilled	6060.00	6000.00	6060.00	5500.00	ZMK /Month	[+]

FORECAST **source:** ditto

Zambia Labour	Last	Q1/17	Q2/17	Q3/17	Q4/17	2020
Unemployment Rate	13.3	13.93	13.98	14.02	14.07	15.34
Population	15.47	62.09	62.2	62.31	62.42	267
Living Wage Family	4446	4533	4549	4551	4552	4552
Living Wage Individual	2424	2481	2447	2467	2456	2460
Wages High Skilled	6060	6113	6115	6116	6116	6117

Zambia Unemployment Rate Forecasts are projected using an autoregressive integrated moving average (ARIMA) model calibrated using the analysts expectations. Modelled is the past behaviour of Zambia Unemployment Rate using vast amounts of historical data, adjusted by coefficients of the econometric model, taking into account analysts assessments and future expectations. The forecast for - Zambia Unemployment Rate - was last predicted on Monday, March 27, 2017.

Gender Based Violence
43% experienced, 52% when divorced/widowed
Yes to GBV: 47% women agree, 33% men agree

GBV for following reasons:

- burning food, unannounced departure from house, neglecting children, refusing sex, arguing with husband

Regional patterns:
Physical Violence: 34% in Easten Province, 53% in Northern Province
Sexual violence: 12% in Lusaka, 23% in Southern Province
Spousal abuse: 35% in Eastern Province, 51% in Luapula and Northern Province

Help seeking patterns:
40% women do seek help, of this

- 70% through own family,
- 43% through husband or his family

42% never express it or seek help

Health Lifestyle

Tobacco:
Women: 2% consume
Men: 20% consume, most of them between age 45-49 years of these:

- 38% smoke 3-5 cigarettes,
- 12% >10
- With secondary education: 8%
- without education: 31%

Nutrition Patterns
Feeding
Breast feeding
98% do, 66% within 4 hrs,

75% exclusively breast fed for about 5 months,
83% age 6-9 months breastfed and complimentary foods

Iodized salt
96% of households use

Vitamin A
77% children received supplement between 6-59 months
60% mothers postpartum dosage

Iron
50% general iron rich
7% supplementary
60% pregnant women supplementary

Stunting
U5: 40%, mostly Northern Prov (50%). Less in Lusaka, Copperbelt, Western province (36%)
Less educated parents' children: 45%
From poorest householdes: 47%
Wasting (acute malnutrition): 6%
Underweight: 15% children

Obesity
Average: 23%
rural: 15%,
urban 32%,
Lusaka >33%

Decrease of thinness by 5% in last decade, increase in obesity by 11%

HIV+
Prevalence between 6.4% (Muchinga Prov), 7.2% (North Western) and 18.2% (Copperbelt Prov), average 13.3% in age 15-49 yrs
Urban:18.2%
Rural: 9.1%

Vaccination
Average: 68%, urban: 76% and rural: 65%,
Regional variation: Luapula: 60%, Copperbelt: 81%

Access to health care
26% women cannot participate in won health care decision
66% have at least one problem in accessing health care
40% perceive drugs assume non-availability of drugs
37% worry about distance to facility

Childhood Mortality
Infant: 45/1000
U5: 75/1000
Declining (1992: 107/1000, infants 191/1000 U5)
Rural: 85/1000
Urban: 72/1000

Children of:
uneducated mothers: 109/1000
educated mothers: 43/1000
poor households: 100/1000
wealthy households 58/1000

Maternal health
Ante Natal Care:
1 time: 96% at skilled provider
<4 times: 56%
With: 94% blood test
89% blood pressure
41% urine sample
88% IEC on complications

Facility Based Delivery (FBD)
Delivery at facilities: 66%
Urban: 89%
Rural: 56%
Increase FBD last decade: 21%-23% (skilled – FBD)

Regional
Lusaka: 89%
Northern Province: least

Post Natal Care
60% within 2d
28% nil in 41d

MMR
398/100000 (323-474), decline since last decade: from 792/HT

Total Fertility Rate
5.3 children,
declining by each quintile:
poorest: 7.1,
2^{nd} : 7.0,
3^{rd} : 6,
4^{th} : 4.2,
5^{th} : 3

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