Country Case Study: Zambia
Community health policies in Zambia began in 2007 and have advanced to a fully fledged program.

- **2007**: MoH HR directorate and GHWA draft proposal for Assistant Nurse Officer program; rejected due to lack of clarity, resource constraints, and resistance from prof. associations.
- **2007-9**: MoH group seeks input from different stakeholders to strengthen proposal; visits Ethiopia and Malawi to learn best practices and impact.
- **2009-10**: HRH Technical Working Group (TWG) (cross-MoH) develops first national CH strategy. DFID commits ~2M GBP to pilot.
- **2009**: CHAI/MoH situational analysis of existing community health programs; recommended standardization.
- **2010-11**: Ndola training school built (DFID funded, CHAI implemented, with GRZ support); first cadre trained.
- **2012**: First cadre of 307 CHAs deployed. User fees abolished in the PHC level.
- **2013**: DFID commits >7M GBP to scale up. Mwachisompola training school built. MoH splits into MoH and MCDMCH, with split responsibility for CHA program. Reintegrated in 2015.
- **2014-2015**: Under financial constraints (financial crisis), GRZ implements hiring freeze. DFID steps in with bridge funding for CHA salaries.
- **2017**: 1582 CHAs on payroll (all GRZ funded except 182 from GFATM). National Health Sector Plan. Health Financing Strategy.
- **2018**: MoH establishes community health unit to provide strategic direction and implementation of community health activities. National Health Insurance Act enacted.
- **2019**: National Community Health Strategy 2019-2021 approved.
- **2020**: USAID SBH begins funding CHA supervisor trainings.
- **2021**: GFATM begins funding operational costs for one training school.

Zambia has CHAs and CBVs; coordination among them varies widely

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

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

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

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

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

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

GHWA funded early strategy development, kickstarting financing

USAID via ZISSP funded tutor salaries and supervisor training

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

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

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

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

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

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

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

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

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

6. **Dedicated strategies to improve resource efficiency** in the near term (via harmonization and improved allocation), and to **mobilize new resources** in the longer term (e.g., via sin taxes, PPPs) can help to increase financial sustainability, though the success in Zambia remains to be seen.
The MoH-led strategic team spearheaded an inclusive strategy and financing mobilization process

- **Idea generation**
  - Years-long iteration on CH concept with input from key groups helped the idea to finally gain traction
    - Initial 2007 proposal, developed with GHWA, faced resistance from General Nursing/Health Professionals Councils
    - Ongoing refinement of concept with input from these stakeholders; further revisions (including name change from ANO to CHWA) at GHWA Uganda conference in 2008

- **Strategy development**
  - MoH-led strategic group, with cross-directorate champions, met weekly and coordinated input from across the Ministry and CPs
    - CH Strategic Team
      - **Directors represented:** HR, Nursing Services, Public Health, Health Promotion, Policy and Planning, Technical Support
      - **Others represented:** CHAI
    - **Sub-committees**
      - Training
      - Recruiting
      - Logistics
      - Budgeting/donor relations

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

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

Source: Zulu et al (2013); CHAI internal documents; expert interviews.
Data on the HRH crisis in Zambia and evidence from other countries convinced early champions of CH value

**Data on Zambia’s challenges**

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

**International evidence on the impact of CH**

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

Source: Zulu et al. (2013); National Community Health Worker Strategy (2010); expert interviews.
Those early champions strategically tailored messages to mobilize buy-in and financing from key actors.

Key early champions (and, later, strategic team members):
- HR Director
- Nursing Services Director
- TSS Director
- CHAI HRH lead

Key influence pathways
- Permanent Secretary and Minister of Health
  - Approve strategic decisions
  - PS liaises with MoF on budgeting
  - Coordinates donor engagement

- Ministry of Finance
  - Iterates with PS on health budget and allocates resources to MoH

- Donors
  - Fund various program costs over time

- Province, district, and local health leaders
  - Support implementation and resource allocation at local level

Role
- CHAI and HR Director advocated to PS to put CHAs on govt payroll pending pilot evidence, highlighting case for econ. growth
- HR Director briefed PS on strategy weekly to get continued buy-in

Engagement strategy
- MoH HR director liaised directly with MoF HR director to advocate for CHAs to be budgeted for as new positions in payroll. Strategic advocacy at key points in fiscal years during pilot phase
- PS also advocated to MoF for CHA budgeting
- Donors were engaged via HRH TWG, CP meetings, bilateral emails, and formal MoH requests, and were invited to strategic team budget meetings
- MoH, with support from CHAI, approached donors to fill gaps in funding, showing how CH related to their interests
- CHAI and HR Director advocated to PS to put CHAs on govt payroll pending pilot evidence, highlighting case for econ. growth
- CHAI and HR Director advocated to PS to put CHAs on govt payroll pending pilot evidence, highlighting case for econ. growth

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

Source: Expert interviews.
Exogenous political decisions created roadblocks in coordination and financing for the CHA program...

<table>
<thead>
<tr>
<th>Challenge</th>
<th>Description</th>
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<tbody>
<tr>
<td>Minimum wage hike for all civil servants</td>
<td>• To fulfill an 2011 election pledge, President Sata increased min. wage for all gov workers, increasing CHA monthly wage by 73% (1500 to 2600 Kwacha)</td>
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<td>August 2012</td>
<td>• Reduced GRZ’s future capacity to put graduating CHAs on payroll and increased program cost overall</td>
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<td>Shift of PHC from MoH to MCDMCH</td>
<td>• Presidential directive to shift PHC services from MOH to MCDMCH, effectively splitting the ministry of health into two. Shifted CHA deployment and program management to MCDMCH, while training remained in MOH</td>
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<td>Dec. 2012-Sep. 2015</td>
<td>• Weakened coordination and political support for CHA program as previous champions in MOH were no longer in charge and MCDMCH had own priorities</td>
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<tr>
<td>Govt-wide hiring freeze</td>
<td>• 2-year GRZ hiring freeze due to financial pressures increased cost from min. wage hike meant that 3 graduating classes of 775 CHAs could not be placed on govt payroll</td>
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In 2018, the MoH instituted a new CH governance structure and established the community health unit to oversee the implementation of CH services.

**Challenge**

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

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

**Solution**

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

**Potential impact**

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

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

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

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

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

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<td><strong>Strengthen inter-sectoral collaboration within GRZ</strong> and establish non-MOH financial flows to CH as CHAs and CHVs can potentially deliver interventions of interest to other ministries (education, agriculture, housing, etc)</td>
<td>“The cabinet has adopted a Health in All Policies framework that sets out the nature of inter-sectoral collaboration among ministries. All of us must contribute because community, community, and community is our approach to health.” --Honorable Minister of Health, GRZ</td>
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<td><strong>Revitalize GtG funding for CH</strong> (progress has been made: GFATM re-entered Zambia + SIDA, DFID &amp; USAID working on GtG to MOH for maternal &amp; child health)</td>
<td>“Purely relying on current treasury allocations is not sustainable to achieve UHC, and that is why we have established a new healthcare financing directorate in charge of developing innovative financing mechanisms.” --Honorable Minister of Health, GRZ</td>
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<td><strong>Introduce sin taxes</strong> (alcohol, tobacco, sugary drinks)</td>
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Source: Healthcare Financing Strategy Draft (2017); expert interviews.
### Lessons from Zambia

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

- Identify influential champions (e.g., MoH directors) who can engage with all levels of govt and with donors
- Take advantage of opportune moments politically (e.g., elections) to accelerate ongoing efforts
- Tailor advocacy to different actors based on their interests, using data to make the case (e.g., economic growth to MoF, impact on MCH for certain donors)
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- Work with committed implementing partners with strong govt relationships who can play a facilitative role, supporting the Ministry to ensure continuity in times of change
- Put CHWs on govt payroll ASAP to institutionalize them throughout political shifts
- Govt must drive donor/partner coordination at the central level, clearly mapping resources, gaps, and plans
- Establish clear local supervisory structures to ensure synergies among different cadres at community level
- Identify the right place for CH leads to sit, where they can facilitate intra-governmental and external coordination and resource mobilization
- Focus on resource efficiency in the near term, while proactively identifying new sources in longer term
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