ADVANCING PARTNERS & COMMUNITIES

COMMUNITY HEALTH SYSTEMS CATALOG COUNTRY PROFILE: ZAMBIA

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Advancing Partners & Communities
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ACRONYMS

APC	Advancing Partners & Communities
CBD	community-based distributor
CBV	community-based volunteer
CBW	community-based worker
CDA	community development assistant
CHA	community health assistant
CHS	community health system
CHW	community health worker
DMO	district medical office
FP	family planning
IUD	intrauterine device
MCDMCH	Ministry of Community Development, Mother and Child Health
NGO	nongovernmental organization
NHC	neighborhood health committee
PHC	primary health care
PMO	provincial medical office
TB	tuberculosis
USAID	United States Agency for International Development
WASH	water, sanitation, and hygiene

INTRODUCTION

This Community Health Systems (CHS) Catalog country profile is the 2016 update of a landscape assessment that was originally conducted by the Advancing Partners & Communities (APC) project in 2014. The CHS Catalog focuses on 25 countries deemed priority by the United States Agency for International Development's (USAID) Office of Population and Reproductive Health, and includes specific attention to family planning (FP), a core focus of the APC project.

The update comes as many countries are investing in efforts to support the Sustainable Development Goals and to achieve universal health coverage while modifying policies and strategies to better align and scale up their community health systems.

The purpose of the CHS Catalog is to provide the most up-to-date information available on community health systems based on existing policies and related documentation in the 25 countries. Hence, it does not necessarily capture the realities of policy implementation or service delivery on the ground. APC has made efforts to standardize the information across country profiles, however, content between countries may vary due to the availability and quality of the data obtained from policy documents.

Countries use a wide variety of terminology to describe health workers at the community level. The CHS Catalog uses the general term "community health provider" and refers to specific titles adopted by each respective country as deemed appropriate.

The CHS Catalog provides information on 136 interventions delivered at the community level for reproductive, maternal, newborn, and child health; nutrition; selected infectious diseases; and water, sanitation, and hygiene (WASH). This country profile presents a sample of priority interventions (see Table 6 in the Service Delivery section) delivered by community health providers and for which information is available.

APC regularly updates these profiles and welcomes input from colleagues. If you have comments or additional information, please send them to info@advancingpartners.org.

ZAMBIA COMMUNITY HEALTH OVERVIEW

Policies governing community health in Zambia are in a period of transition. In 2011, sub-departments of the Ministry of Health joined the Ministry of Community Development and Social Services to form the Ministry of Community Development, Mother and Child Health (MCDMCH), which aims to holistically reduce poverty and improve primary health care (PHC) at the community level.

In 2014, the MCDMCH developed a draft policy called the *National Integrated Strategy for Community Based Health & Social Development Workers and Volunteers in Zambia* to define and align efforts of: 1) community-based workers (CBWs), including community health assistants (CHAs) and community development agents (CDAs);[1] and 2) community- based volunteers (CBVs), of which there are many uncoordinated cadres in the country. The community health strategy is supplemented by other national vertical and comprehensive health strategies, such as the *National AIDS Strategic Framework* and *Human Resources for Health Strategic Plan*, which include community health components.

Community health policy guidance exists for specific health areas, such as malaria and FP, and includes basic information about community health provider selection criteria, scope of service, training, supervision, and incentives. The community plays a role in managing its health priorities through neighborhood health committees (NHCs), which serve as a link between the community and the national health system. However, the absence of a process to register and track the many volunteer community health provider cadres remains a challenge for understanding the community health realities on the ground.

CHAs, Zambia's primary community health cadre, are formally trained and incorporated into the national health system. The CHA cadre evolved from a community health worker cadre that the Ministry of Health formalized in 2010 under the *National Community Health Worker Strategy*, which aims to improve service delivery through more equitable access and cost-effective health care to families.

Table 1. Community Health Quick Stats

Main community health policy/strategy	*National Integrated Strategy for Community Based Health & Social Development Workers and Volunteers in Zambia* (Draft)
Last updated	2014
Number of community health provider cadres	1 main cadre[1]: community health assistants (CHAs)
Recommended number of community health providers	5,214 CHAs
Estimated number of community health providers	307 CHAs[2]
Recommended ratio of community health providers to beneficiaries	1 CHA: 3,500 people (rural) 1 CHA: 7,000 people (urban)
Community-level data collection	Yes
Levels of management of community-level service delivery	National, provincial, district, community
Key community health program(s)	CHA Program

[1] There are other uncoordinated cadres of community-based volunteers (CBVs), including community-based distributors (CBDs) of family planning.
[2] There are an estimated 100,000 CBVs.

1 CDAs are not health-focused and are therefore not discussed in-depth in this profile.

The CHA program is funded by the government and international donors and implemented at the district level. At times, international and local non-governmental organizations (NGOs) support training and provide financial incentives and supplies. The program operates in rural and peri-urban areas and is currently scaling up to the national level. The first cohort of 307 CHAs was trained under a new curriculum in 2012 and deployed to health posts in 47 of 105 districts as part of a pilot phase. Over the next four phases, the program aims to scale to 5,214 CHAs nationwide. CHAs are supported by other CDAs and CBVs. Further details about CHAs and these other cadres are provided in the Human Resources section and throughout the country profile.

Table 2. Key Health Indicators, Zambia

Total population[1]	15.9 m
Rural population[1]	60%
Total expenditure on health per capita (current US$)[2]	$86
Total fertility rate[3]	5.3
Unmet need for contraception[3]	21.1%
Contraceptive prevalence rate (modern methods for married women 15-49 years)[3]	44.8%
Maternal mortality ratio[4]	224
Neonatal, infant, and under 5 mortality rates[3]	24 / 45 / 75
Percentage of births delivered by a skilled provider[3]	64.2%
Percentage of children under 5 years stunted[3]	40.1%
HIV prevalence rate[5]	12.9%

[1] PRB 2016; [2] World Bank DataBank 2014; [3] CSO, MOH, and ICF International 2014; [4] WHO 2015; [5] UNAIDS 2015.

LEADERSHIP AND GOVERNANCE

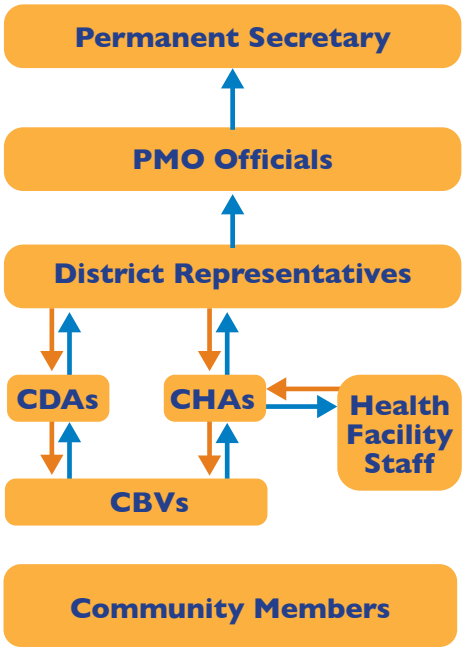
Community-level service delivery in Zambia is managed and coordinated across the national, provincial, district, and community levels. Each level has a distinct role in supporting policy and program efforts.

Zambia's 2014 draft community health policy serves as a basis for understanding how the national, formalized cadres of community health providers and other volunteer cadres should align efforts at the operational level to better reach families with critical health and social welfare services.

- The **national-level** governing body, the MCDMCH, is led by the Permanent Secretary and oversees operations of each of its constituent departments: community development, social work, and mother and child health. The MCDMCH develops policies and strategies, coordinates programs and projects, and supports provincial and district implementation of PHC programs.
- The provincial medical office (PMO) coordinates the MCDMCH medical offices at the **provincial level** and is responsible for planning, monitoring and evaluating district-level program implementation.
- The district medical office (DMO) manages health service delivery at the **district level** and collects and synthesizes monitoring and evaluation data from health centers.
- At the **community level**, NHCs determine health priorities and coordinate health programs and activities, often in collaboration with CBWs and CBVs who work through health centers and health posts.

Figure1 summarizes Zambia's health structure, including managing administrative bodies, service delivery points, and key actors.

Figure 1. Health System Structure

Level	Managing Administrative Body	Service Delivery Point	Key Actors and Their Relationships
National	MCDMCH	Level 3 Hospital	
Provincial	PMO	Level 2 Hospital	
District	DMO	Level 1 District Hospital	
Community	NHC*	Health Center Health Post	

* Includes representatives from community development, social welfare, and medical offices.

Supervision
Flow of community-level data

HUMAN RESOURCES FOR HEALTH

The 2014 draft policy defines two main categories of community providers working in Zambia: CBWs and CBVs. CBWs include CHAs, Zambia's main cadre of community health provider, and CDAs, who provide social services (other than health) in their communities. CBWs are formally trained and paid monthly according to the MCDMCH salary scale.

CBVs, on the other hand, are supported by other, often smaller public and private programs and initiatives operating at the community level in the domains of health, social welfare, and community development. CBV work is intended to complement and support CBW activities. Health-related CBVs include community-based distributors (CBDs) of FP services, HIV counselors, caregivers, and malaria control agents, among others. The MCDMCH has had difficulty counting and defining CBVs because of their different roles and lack of coordination between the programs that support them. Recent country estimates show that there are at least 100,000 CBVs operating in Zambia, including both those who are health-focused and those who are not.

Table 3. Community Health Provider Overview

	CHAs	CBDs	Other CBV cadres
Number in country	307 trained and deployed as of 2012	*Information not available in policy*	Estimated 100,000[1]
Target number	5,214 after scale-up	*Information not available in policy*	*Information not available in policy*
Coverage ratios and areas	1 CHA: 3,500 people (rural) 1 CHA: 7,000 people (urban) Operate in rural and peri-urban areas	*Information not available in policy*	No ratio specified Usually operate in a subsection of a health post or health center catchment area
Health system linkage	Employed by the government	Supervised by CHAs and health facility staff	Supervised by health and social welfare professionals (e.g., CHAs, CDAs)
Supervision	Supervised by professional staff at health centers and representatives from district-level offices for community development, social welfare, and health	Supervised by CHAs and health facility staff	Supervised by CHAs, CDAs, health facility staff, and/or sponsoring NGOs
Accessing clients	On foot Bicycle Public transport Provide services from their homes, health posts and health centers	Door-to-door services	On foot Bicycle Public transport Provide services from their homes
Selection criteria	Chosen by community Grade 12 education Two O-levels; one O-level in English[2] 18-38 years old Women preferred over men Previous CBW/CBV experience	Endorsed by community Permanent resident of community Male or female 24-45 years old or as approved by community Volunteer Able to read and write English Completion of grade 9 Committed and trustworthy Good communication skills Role model	Endorsed by community Permanent resident of community Able to read, write, keep records and teach Other criteria may vary by program
Selection process	Identified and selected by community structures	*Information not available in policy*	Identified and selected by community structures

Table 3. Community Health Provider Overview

	CHAs	CBDs	Other CBV cadres
Training	12 months' training, including classroom and practicum sessions	Pre- and in-service	Duration of training varies by NGO and type of health program, ranging from 3 days to 1 month. Some programs include follow-up training.
Curriculum	*National Community Health Assistant Curriculum* (2012). Includes information on the health care system; health behavior change communication and promotion; environmental health; the human body; diagnostic procedures; basic first aid; reproductive health including FP; child health; communicable and non-communicable diseases; medicines and commodities management.	*Community Based Distribution of Family Planning Participants' Manual* (2014 draft). Includes client rights; reproductive anatomy; FP concepts, benefits, methods, misconceptions, counseling, and communication; commodity management; sexually transmitted infection/HIV prevention, treatment, and management; prevention of mother-to-child transmission of HIV; youth-friendly services; reporting; referrals; follow-up; community assessment, and social mapping.	Varies by program, but policy recommends 2 major training packages (one on health, one on social development) and a standardized curriculum.
Incentives and remuneration	Salaried; no non-financial incentives Financed by the government	Information not available in policy	Generally unpaid, though incentives are largely dependent on the program and may include per diems, cash or in-kind payments; membership in community-level cooperatives; t-shirts; or formal social recognition. Supported by NGOs. 2014 draft policy recommends CHVs receive a standardized incentive package.

[1] Estimate includes both health-focused CBVs and non-health-focused CBVs.
[2] O-level, or "Ordinary Level" refers to a secondary school subject-based qualification within the British education system.

HEALTH INFORMATION SYSTEMS

CHAs and various CBVs in Zambia are responsible for submitting community-level data including activity reports, stock sheets, and registers of the number of clients they serve to their supervisors at health posts and health centers. Health data collection is integrated with data collected by CDAs supporting community development programs.

Data flows upward from the community level, starting with CBVs, who report to CBWs (CHAs and CDAs). CHAs report to supervisors from both the district level and health facility. DMOs compile data from health facilities into reports, which are then passed on to PMOs and then to the MCDMCH. The data is then entered in the national health management information system. The blue arrows in Figure 1 show how the data moves through the health system.

While this data informs some future actions, like when to replenish stock, it is unclear if there is a formal mechanism for feeding data back from higher levels to inform community-level decision making.

HEALTH SUPPLY MANAGEMENT

Supervisors at health posts and health centers provide CHAs and CBVs with the materials, products, and supplies they need to complete their work. Implementing NGOs may also provide this support to CBVs working on their programs. Community health providers are given a start-up package according to their estimated number of clients, and they replenish stocks according to the stock sheet balances. They bring medical waste to the health facility for disposal. Although the full list of commodities that CHAs and CBVs provide is not available, information about selected medicines and products included in the *Zambia Essential Medicine List* (2013) is presented in Table 4.

Table 4. Selected Medicines and Products Included in the *Zambia Essential Medicine List* (2013)

Category		Medicine / Product
FP	☐	CycleBeads®
	☑	Condoms
	☑	Emergency contraceptive pills
	☑	Implants
	☑	Injectable contraceptives
	☑	IUDs
	☑	Oral contraceptive pills
Maternal health	☑	Calcium supplements
	☑	Iron/folate
	☑	Misoprostol
	☑	Oxytocin
	☑	Tetanus toxoid
Newborn and child health	☑	Chlorhexidine
	☑	Cotrimoxazole
	☑	Injectable gentamicin
	☑	Injectable penicillin
	☑	Oral amoxicillin
	☐	Tetanus immunoglobulin
	☑	Vitamin K
HIV and TB	☑	Antiretrovirals
	☑	Isoniazid (for preventive therapy)
Diarrhea	☑	Oral rehydration salts
	☐	Zinc
Malaria	☑	Artemisinin combination therapy
	☐	Insecticide-treated nets
	☑	Paracetamol
	☐	Rapid diagnostic tests
Nutrition	☑	Albendazole
	☑	Mebendazole
	☐	Ready-to-use supplementary food
	☐	Ready-to-use therapeutic food
	☑	Vitamin A

SERVICE DELIVERY

CHAs and CBVs provide health education, mobilize communities, and deliver select preventive and treatment services. Table 5 highlights the modes by which they conduct these activities.

CHAs provide condoms, oral contraceptive pills, and injectable contraceptives in communities. Discussions of piloting the provision of implants by CHAs are also underway at the national level.

Community health providers refer clients to the next tiers of service—health posts, health centers, and district hospitals. Often, CBVs may refer clients to CHAs. Counter-referrals are rarely mentioned in policy, though referral forms for CBDs, who deliver FP services, include a box to indicate counter-referrals.

Using FP as an example, CHAs and CBDs may refer clients to:

- **Health posts** for injectable contraceptives and emergency contraceptive pills.
- **Health centers** for methods available at health posts, implants, and intrauterine devices (IUDs).
- **District hospitals** for methods available at health posts and health centers and permanent methods.

Table 5. Modes of Service Delivery

Service	Mode
Clinical services	Door-to-door
	Periodic outreach at fixed points
	Provider's home
	Health posts or other facilities
	Special campaigns
Health education	Door-to-door
	Health posts or other facilities
	In conjunction with other periodic outreach services
	Community meetings
	Mothers' or other ongoing groups
Community mobilization	Door-to-door
	Health posts or other facilities
	In conjunction with other periodic outreach services
	Community meetings
	Mothers' or other ongoing groups

Table 6 provides details about selected interventions delivered by CHAs and CBDs, according to policy, in the following health areas: FP, maternal health, newborn care, child health and nutrition, tuberculosis (TB), HIV, malaria, and WASH.

Table 6. Selected Interventions, Products, and Services

Subtopic	Interventions, products, and services	Information, education, and/or counseling	Administration and/or provision	Referral	Follow-up
FP	Condoms	CBD, CHA	CBD, CHA	Unspecified	CBD
	CycleBeads®	Unspecified	Unspecified	Unspecified	Unspecified
	Emergency contraceptive pills	Unspecified	Unspecified	Unspecified	Unspecified
	Implants	CBD, CHA[1]	CHA[2]	CBD, CHA	CBD, CHA[3]
	Injectable contraceptives	CBD, CHA	CBD[4], CHA	CBD, CHA	CBD, CHA[3]
	IUDs	CBD, CHA[1]	No	CBD, CHA	CBD, CHA[3]
	Lactational amenorrhea method	CBD, CHA[1]		Unspecified	CBD
	Oral contraceptive pills	CBD, CHA	CBD, CHA	CBD, CHA	CBD, CHA[3]
	Other fertility awareness methods	CBD, CHA[1]		Unspecified	CBD
	Permanent methods	CBD, CHA[1]	No	CBD, CHA	CBD, CHA[3]
	Standard Days Method	CBD, CHA[1]		Unspecified	CBD
Maternal health	Birth preparedness plan	CHA	CHA	Unspecified	Unspecified
	Iron/folate for pregnant women	Unspecified	Unspecified	Unspecified	Unspecified
	Nutrition/dietary practices during pregnancy	CHA		Unspecified	Unspecified
	Oxytocin or misoprostol for postpartum hemorrhage	Unspecified	Unspecified	Unspecified	Unspecified
	Recognition of danger signs during pregnancy	CHA	CHA	CHA	CHA
	Recognition of danger signs in mothers during postnatal period	CHA	CHA	CHA	CHA
Newborn care	Care seeking based on signs of illness	CHA			Unspecified
	Chlorhexidine use	Unspecified	Unspecified	Unspecified	Unspecified
	Managing breastfeeding problems (breast health, perceptions of insufficient breast milk, etc.)	CBD		Unspecified	Unspecified
	Nutrition/dietary practices during lactation	CBD, CHA		Unspecified	Unspecified
	Postnatal care	CHA	Unspecified	CHA	CHA
	Recognition of danger signs in newborns	CHA	CHA	CHA	CHA

Subtopic	Interventions, products, and services	Information, education, and/or counseling	Administration and/or provision	Referral	Follow-up
Child health and nutrition	Community integrated management of childhood illness	CHA	CHA	CHA	CHA
	De-worming medication (albendazole, mebendazole, etc.) for children 1–5 years[5]	Unspecified	CHA	Unspecified	Unspecified
	Exclusive breastfeeding for first 6 months	CBD		Unspecified	Unspecified
	Immunization of children[6,7]	CHA	No	CHA	CHA
	Vitamin A supplementation for children 6–59 months	Unspecified	CHA	Unspecified	Unspecified
HIV and TB	Community treatment adherence support, including directly observed therapy	Unspecified	Unspecified	Unspecified	Unspecified
	Contact tracing of people suspected of being exposed to TB	Unspecified	Unspecified	Unspecified	Unspecified
	HIV testing	CBD[8]	CHA	Unspecified	Unspecified
	HIV treatment support	Unspecified	CHA	Unspecified	Unspecified
Malaria	Artemisinin combination therapy[9]	Unspecified	Unspecified	Unspecified	Unspecified
	Long-lasting insecticide-treated nets	Unspecified	Unspecified	Unspecified	Unspecified
	Rapid diagnostic testing for malaria	Unspecified	CHA	Unspecified	Unspecified
WASH	Community-led total sanitation	CHA	CHA		
	Hand washing with soap	Unspecified			
	Household point-of-use water treatment	CHA			
	Oral rehydration salts[10]	Unspecified	CHA	Unspecified	Unspecified

[1] Not explicitly stated in CHA training curriculum; only states information for FP methods generally.
[2] Plans for CHAs to pilot administration of implants.
[3] Follow-up is only mentioned as it applies to all clients referred to health facilities; follow-up is not mentioned for each specific FP method.
[4] Plans for CBDs to pilot administration of injectable contraceptives.
[5] Also applies to people other than children under 5 years.
[6] Immunizations include measles, DPT3, BCG, TT2, TT2+, and poliomyelitis.
[7] Includes newborns and children under 5.
[8] CHAs may provide information / education about HIV testing during pregnancy. Information / education about HIV testing is not otherwise specified in available policies.
[9] CHA scope of work indicates CHAs can treat malaria, but does not specify whether or not this includes children under 5 years or use of ACT.
[10] Includes children under 5 years and general population.

KEY POLICIES AND STRATEGIES

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