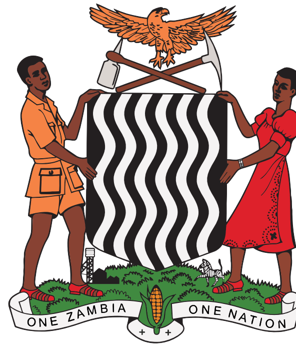
National Community Health Strategy

Community Health Driving Primary Health Care for Universal Health Coverage



Republic of Zambia

Ministry of Health

National Community Health Strategy

Community Health Driving Primary Health Care for Universal Health Coverage

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FOREWORD

Human development entails having a well-educated, highly skilled and healthy labour force to propel Zambia to a thriving and industrialised economy as espoused in the Vision 2030. Thus, in the 8NDP, interventions will focus on increasing access to and improving the quality of education, health and water and sanitation as well as enhancing social protection. This will contribute to the reduction in poverty and inequality. This aspiration is also articulated in the National Health Strategic Plan 2022-2026.

The Government of the Republic of Zambia through the Ministry of Health aims at attaining universal health coverage in which all Zambians have access to essential health services without suffering financial hardship. Government places premium on attaining Universal Health Coverage through health systems strengthening using an integrated community and primary health care approach. This conviction is in line with the Alma Ata declaration of 1978, the World Health Assembly resolution on Universal health coverage and the United Nations General Assembly High level political declaration on Universal Health coverage in which Primary Health care has been prioritised as a vehicle to deliver health for all.

Government has demonstrated its commitment to community health by establishing a dedicated Community Health Unit within the department of Public Health mandated to coordinate and provide oversight on community health services in the country.

It is clear that major challenges must be overcome if we are to achieve our goals in community health. We must scale up the community health workforce across the country, and address the fragmentation that has characterised the volunteering sector; we must strengthen community structures and ownership of health activities; provide infrastructure and address barriers to access; mobilise resources; and improve the use of data in decision making for community health.

It therefore key that we embrace innovations that will allow us to reach all our people, improve quality of our services, and work more efficiently. The National Community Health Strategy 2022-2026 clearly sets out the approach that will enable us address the challenges affecting community health in our country and significantly improve the health and wellbeing of our people.

I therefore urge all stakeholders to fully utilise this document and support my Ministry in the implementation of this Strategy as a core reference tool for planning, implementing, monitoring and evaluating of community health services as well as for mobilizing resources.

Hon. Sylvia T. Masebo,

MP **MINISTER OF**

HEALTH

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I would like to appreciate the contributions of all stakeholders who were involved at various stages of developing this strategy. Thanks go to officers at the Ministry of Health for their immense contribution in moving this process to conclusion amidst various experiences.

I am particularly grateful for the participation of our staff working at health facility and community levels, who were able to share valuable insights and perspectives on community health service delivery at the front line.

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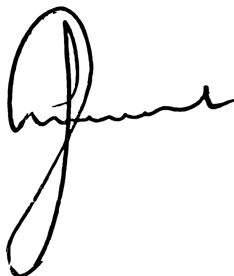
- Aspen Management Partnership for Health (AMP Health)
- Clinton Health Access Initiative (CHAI)
- Maternal and Child Health Survival Program (MCSP)
- PATH
- USAID
- University of Maryland
- World Vision Zambia

To all of you, we remain grateful for your unwavering support.



Prof. Lackson Kasonka

PERMANENT SECRETARY – TECHNICAL SERVICES

EXECUTIVE SUMMARY

The Government remains committed to providing universal, quality and equitable health care services to the people of Zambia. While Zambia has made significant strides in improving key health outcomes, significant challenges remain. The Government has made community health a key part of its strategy to continue to improve health outcomes for all Zambians.

The NCHS (2022-2026) aims to reposition and expand the current cadre of frontline workers in the formal sector, and strengthen the link to the informal sector. It is designed to guide in the strengthening of community mechanisms to improve the provision of preventive, promotive and

minor curative health services. The annexed NCHS Operational Plan (2022 – 2026) is the medium term costed strategic operational plan outlining objectives, strategies, interventions and activities supporting the successful implementation of the NCHS. The Operational Plan also includes the indicators that will measure the progress against the Objectives and Strategies.

This NCHS identifies six objectives that together will achieve the overall vision to contribute to universal health coverage by providing holistic community health services to the doorstep of all Zambians close to the family as possible.

The first objective focuses on building a motivated, responsive, skilled community health workforce, being equitably distributed across the country. The key strategies to support this objective includes; 1.1: Strengthen coordination of community health at all levels; 1.2: Address the fragmentation of community-based volunteer; 1.3: Strengthen and scale up the CHA programme.

The second objective speaks to ensure relevant infrastructure, equipment, medicines and supplies are available for Community Health by 2.1 Guarantee adequate supply of medicines, supplies and basic equipment are available for Community Health; 2.2 Strengthen linkages between the community and the health facilities.

A fully funded National Community Health Strategy 2022- 2026 is the third objective of the strategy. This will be achieved through 3.1 Expand the resource envelop for community health services; 3.2 Increase and optimise partner contributions; 3.3 Strengthening local community-based income generating initiatives.

The fourth objective of the strategy is to strengthen access, accuracy and utilization of the Community Health Information Management System that informs decision-making and policy development. The key strategies under this objective are 4.1 Strengthen Community Health Information Systems; 4.2 Enhance the use of information for decision making and policy development for Community Health.

The fifth objective focuses on providing high-quality health services at the household and community level. This will be achieved by 5.1 Strengthen Demand Generation and Health Promotion; 5.2 Develop, Disseminate and Institutionalize Community Health Service Package; 5.3 Strengthen quality community health services to all, with a specific focus on special populations; 5.4: Enhance supervision of the provision of health services at community level; 5.5: Pilot high-potential innovations for community health; 5.6 Strengthen Community Health in Urban Areas.

The sixth and final objective aims to provide effective leadership and governance in the formation, maintenance and management of community health structures. This will be achieved through 6.1 Strengthen governance of community health structures at all levels; 6.2 Enhance leadership and coordination of community health structures; 6.3 Empower decentralized community health structure to take up oversight role.

The Objective and Strategies are summarised in below diagram. The implementation of these six objectives and their strategies will be fulfilled through the various interventions and activities outlined in the NCHS Operational Plan, that is annexed.

Vision 2030	A PROSPEROUS MIDDLE-INCOME NATION BY 2030					
8TH NDP	DEVELOPMENT OUTCOME 2: IMPROVED HEALTH, FOOD AND NUTRITION					
NCHSP 2022-26	TO CONTRIBUTE TO UNIVERSAL HEALTH COVERAGE BY PROVIDING HOLISTIC COMMUNITY HEALTH SERVICES TO THE DOORSTEP OF ALL ZAMBIANS CLOSE TO THE FAMILY AS POSSIBLE					
STRATEGIC PRIORITY AREAS (OUTCOMES) FROM NCHS 2022-2026	WORKFORCE	MEDICINES, EQUIPMENT, INFRASTRUCTURE	FINANCING	MONITORING AND EVALUATION	SERVICE DELIVERY	LEADERSHIP, GOVERNANCE
	Build a motivated, responsive, skilled community health workforce, being equitably distributed across the country	Ensure relevant infrastructure, equipment, medicines and supplies are available for Community Health	Fully funded National Community Health Strategy 2022-2026	Strengthen access, accuracy and utilization of the Community Health Information Management System that informs decision-making and policy development	Provide high-quality health services at the household and community level	Provide effective leadership and governance in the formation, management and maintenance of community health structures
STRATEGI|ES (OUPUTS) NCHS 2022-2026	1.1: Strengthen coordination of community health at all levels 1.2: Address the fragmentation of community-based volunteers 1.3; Strengthen and scale up the CHA programme	2.1 Guarantee adequate supply of medicines, supplies and basic equipment are available for Community Health 2.2 Strengthen linkages between the community and the health facilities	3.1 Expand the resource envelop for community health services 3.2 Increase and optimise partner contributions generating initiatives 3.3 Strengthen local community-based income generating initiatives	4.1 Strengthen Community Health Information Systems 4.2 Enhance the use of information for decision making and policy development for Community Health	5.1 Strengthen Demand Generation and Health Promotion 5.2Develop, Disseminate and Institutionalize Community Health Service Package 5.3 Strengthen quality community health services to all, with a specific focus on special populations 5.4 Enhance supervision of the provision of health services at community level 5.5 Pilot high-potential innovations for community health 5.6 Strengthen Community Health in Urban Areas	6.1 Strengthen governance of community health structures at all levels 6.2 Enhance leadership and coordination of community health structures 6.3 Empower decentralized community health structure to take up oversight role

ACRONYMS

ACT	Artemisinin-based Combination Therapy
ANC	Antenatal Visit
ARV	Antiretrovirals
CBV	Community Based Volunteer
CDC	Centers for Disease Control
CHA	Community Health Assistant
CHAI	Clinton Health Access Initiative
CHCC	Community Health Coordinating Committee
CHE	Current Health Expenditure
CHU	Community Health Unit
CHW	Community Health Worker
CMMB	Catholic Medical Mission Board
CITAM+	Christ is the Answer Ministries
DFID	Department for International Development
G2G	Government to Government
GDP	Gross Domestic Product
GF	Global Fund
GFF	Global Financing Facility
GHE	Government Health Expenditure
GRZ	Government of the Republic of Zambia
HC	Health Center
HCC	Health Center Committee
HCFS	Health Care Financing Strategy
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HP	Health Post
HSDP	Health Sector Development Plan
iCCM	Integrated Community Case Management
ITN	Insecticide Treated Nets
JATA	Japanese Anti-Tuberculosis Association
JHU	Johns Hopkins University

LiST	Lives Saved Tool
MDG	Millennium Development Goal
MNCH	Maternal New-born and Child Health
MOF	Ministry of Finance
MOH	Ministry of Health
NACC	National Aids Control Council
NCHS	National Community Health Strategy
NGO	Non-Governmental Organization
NHC	Neighborhood Health Committee
NHSP	National Health Sector Plan
OOP	Out of Pocket
PEPFAR	Presidents Emergency Plan for Aids Relief
PHC	Primary Health Care
PMI	Presidents Malaria Initiative
PMTCT	Prevention of Mother to Child Transmission
PNC	Postnatal Visit
RBF	Results Based Financing
RDT	Rapid Diagnostic Testing
RMNCAH-N	Reproductive, Maternal, New-born, Child and Adolescent health and Nutrition
ROI	Return on Investment
SDG	Sustainable Development Goal
SIDA	Swedish International Development Cooperation Agency
SMAG	Safe Motherhood Action Group
TB	Tuberculosis
TGE	Total Government Expenditure
UHC	Universal Health Coverage
UNICEF	United Nations Children Fund
USAID	United States Agency for International Development
USG	US Government
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization
ZACHI	Zambia Ambassadors for Community Health Initiative
ZAMSA	Zambia Medical Supplies Agency

1. COUNTRY BACKGROUND

1.1 Political, Administrative Structures and Economy

The Republic of Zambia is located in the southern part of the African Continent. It covers approximately 752,612 km and is surrounded by eight countries, namely: Tanzania and the Democratic Republic of Congo (DRC) in the North; Malawi and Mozambique in the East; Zimbabwe, Botswana and Namibia in the South; and Angola in the West. Administratively, the country is divided into 10 provinces and 116 districts. Out of the 10 provinces, Lusaka and Copperbelt provinces are predominantly urban, while the rest are predominantly rural provinces.

Zambia has a population of 18 million[1], growing at a rate of about 2.9% per annum[2]. The population is one of the youngest in the world (2/3 of the population are below 35 years)[3]. Gross Domestic Product (GDP) of USD$26.7 billion[4]. Zambia is reclassified as a lower income country with a gross national income of less than US1,005 per person annually for the fiscal year 2023[5]. 59% of the population lives below the national poverty line, and poverty levels in rural areas are four times that in urban areas.

1.2 The Health Care System in Zambia

Health services are provided by the following main players: the public health sector with government owned and run facilities; faith-based not-for-profit providers; mine-owned health facilities; private for-profit providers; Traditional health care providers, private pharmacies and dispensaries.

1 ZAMSTAT, 2022
2 Central Statistics Office 2010a
3 Zambia National Youth Policy
4 World Bank Data. https://data.worldbank.org/indicator/NY.GDP.PCAP.CD?locations=ZM
5 World Bank Data. https://data.worldbank.org/indicator/NY.GDP.PCAP.CD?locations=ZM

Public Health Sector

The public health sector provides promotive, preventive, curative, rehabilitative and palliative health services to the population. Health service delivery is structured in a three-tier pyramidal referral system with primary health care (health posts, health centres and district hospitals); secondary health care (provincial referral hospitals); and tertiary health care (teaching hospitals). There are currently approximately 2,304 government health facilities in the country[6].

Health Posts

Health posts are at the lowest level of the Zambian health care system. At the end of 2019 there were 998 Health Posts in Zambia6. Each health post caters for a catchment population of approximately 3,500 persons in rural areas and 1,000 to 7,000 people in an urban setting. All health posts are either positioned or earmarked to be set up within five km radius for sparsely populated areas. The types of health services offered at this level are promotive, preventive, curative, and rehabilitative care. As highlighted above, they refer patients and clients to health centres.

Health Centres

There are two types of health centres in the national health care delivery system. These are Urban

Health Centres which serve a catchment population of between 30,000 to 50,000 people and rural health centres, which serve a population of approximately 10,000 people. By the end of 2019, there were 258 UHCs Urban Health Centres and 1,080 Rural Health Centres throughout the country6. These Health Centres offer promotive, preventive, curative and rehabilitative care services.

First level referral hospitals

First level hospitals are also referred to as district hospitals and are found at district level. They are the third largest levels of care after the second and third level referral hospitals. These first level referral hospitals serve a population of 80,000 to 200,000 people and provide services such as medical, surgical, obstetric, diagnostic, preventive and all clinical services in support of health centre referrals. Currently, there are 84 first level referral hospitals in the country.

Second level referral hospitals

Second level hospitals, also referred to as provincial or general hospitals are found at provincial level. These hospitals are intended to cater for a catchment population of 200,000 to 800,000 people, with services in internal medicine, general surgery, paediatrics, obstetrics and gynaecology, dental care, psychiatry and intensive care. These hospitals also serve as referral hospitals for first level institutions, including the provisions of technical back up and training functions. Currently, there are 21 second level hospitals in the country.

Third level hospitals

Third level hospitals are also known as specialist or tertiary hospitals and are the highest referral level of healthcare in Zambia. These have sub-specializations in internal medicine, surgery, paediatric, obstetrics, gynaecology, intensive care, psychiatry, training, and research. All complicated cases not attended to at second level hospitals are referred to third level hospitals. Currently, there are 6 third level hospitals in the country.

6 National Health Facility Census Analytical Report 2019

In addition to the health facilities under the MoH, the Ministry of Home Affairs, Ministry of Mines and Ministry of Defence have health institutions that provide health services primarily for their own staff, but which can also be accessed by non-staff members at a minimal fee. According to surveys[7] about 90 percent of patients seek care in facilities owned and run by the government.

Faith-based not-for-profit

Catholic and Protestant Christian Missionary health workers from Church Health Institutions (CHIs) formed the Churches Health Association of Zambia (CHAZ) in 1970. The main purpose of establishing CHAZ was to improve the overall organizational effectiveness of the CHIs and Church Based Community Organizations involved in health service delivery in Zambia.

CHAZ has 152 institutions - 36 Hospitals (11 of which have training schools), 84 RHCs and 32 CBOs. All of these faith-based health institutions account for 30 percent of the total national health care and more than 50 percent of rural health care services (based on the population served and not on the number of health facilities and bed count). The majority of these health institutions are located in rural and hard to reach areas and in all the 10 administrative provinces of Zambia serving the poor and the underserved. Faith-based health facilities also attend to patients from outside of their own catchment areas, districts and provinces. CHAZ and its member units work closely with the Government of the Republic of Zambia (GRZ) through the Ministry of Health and within the National Health Framework.

Private-for-profit facilities

The private health sector in Zambia consists of both private hospitals and private clinics. Private-for-profit facilities are estimated to provide care to approximately 3 percent of the population.

Traditional health care providers

The Government recognises traditional and alternative medicine as part of the health sector in Zambia and thus instituted various national policies governing this sector. The Traditional HealersPractitioners' Association of Zambia (THPAZ), established in 1978, serves as the national body for traditional healers and reviews and register these practitioners for licensing. The organisation has about 40,000 members nationwide. There are still people who seek medical advice from traditional/alternative medicine prior to seeking care in orthodox health facilities[8]. TPHAZ has collaborated with the Ministry of Health in various areas, most notably in HIV and its members have received training in areas such as referral practices and health promotion.

Private pharmacies and dispensaries

Although the data shows clearly that the public sector is the largest health care provider, many people choose self-medication and buy over-the-counter drugs from private drugs stores or pharmacies.

1.3 Relevant Policies and Goals

Vision 2030

Zambia aspires to become "A Prosperous Middle-Income Nation by 2030". By 2030, Zambians want to live in a strong, dynamic, competitive and self-sustaining middle-income industrial nation resilient to external shocks while providing opportunities for improving the well-being of all.

7 Central Statistics Office. Zambia Household expenditure and utilisation Survey 2014 Lusaka: Central Statistics Office, Zambia; 2014

8 WHO (2001) Legal Status of Traditional Medicine and Complementary/Alternative Medicine: A Worldwide

The Vision coincides with the 2030 Agenda for sustainable development, which aims to end poverty, fight inequality and injustice and tackle climate change through the pursuance of the Sustainable Development Goals (SDGs). By this time the country should have made substantial progress towards the attainment of the global goals.

Global goals - SDGs

The SDGs are a collection of 17 goals created by the United Nations to build a more equitable and sustainable future. Community health can help make advances in many of the thirteen targets for this SDG, including SDG 3 focuses on good health and wellbeing, contributing to decreasing the maternal mortality ratio (SDG3.1); increasing family planning coverage (SDG3.7) and ensuring health emergency response preparedness (SDG3.d); SDG 2: Zero Hunger, SDG 5: Gender Equality, SDG 6: Clean Water and Sanitation, SDG 10: Reduced Inequality, among many others.

Global goals - UHC

UHC is the ability for all people to access quality healthcare when they need it, at a cost that does not cause financial hardship. Primary healthcare and community health have been identified by the WHO as a key focus area for achieving UHC[9]. Community health extends health services to the last mile, providing access to care for those who have previously been left out. Additionally, community referrals to health facilities can ensure curative care for those in hard-to-reach areas. This is line with the country's National Health Strategic Plan 2022-2026 which states the mission of the Ministry of Health as that of "to provide equitable access to cost effective, quality health services as close to the family as possible".

Eight National Development Plan

Human development entails having a well-educated, highly skilled and healthy labour force to propel Zambia to a thriving and industrialised economy as espoused in the Vision 2030. Thus, in the 8NDP, interventions will focus on increasing access to and improving the quality of education, health and water and sanitation as well as enhancing social protection. This will contribute to the reduction in poverty and inequality.

During the Plan period, intervention will be aimed at increasing access to quality healthcare by scaling up; recruitment of health personnel to reduce the health personnel ratio, ensure availability of medicines and medical supplies. In addition, infrastructure development as well as the equipping of health facilities will be prioritised. Further, the national health insurance will be rolled-out to include informal sector. The Government will leverage on the national health insurance scheme to facilitate wider healthcare delivery by onboarding more private sector providers. Further, Government will partner with the private sector to create centres of specialisation in the provision of health services.

Devolution Policy

According to the Sector Devolution Guidelines for Ministries, the vision of the Government is: "Achieve a fully decentralised 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 centre and the periphery."

9 https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc)https://www.who.int/news-room/fact-sheets/deetail/universal-health-coverage-(uhc)

The devolution policy outlines measures that are aimed at ensuring that districts and local communities are given power in planning and implementation of projects in their respective communities. It is hoped that the devolution process will enhance accountability and transparency in the management of resources and to provide a legal and institutional framework that promotes autonomy in decision-making at the local level.

The Ministry of Health operationalised the National Devolution plan through the creation of the sector specific Health Sector Devolution Plan (HSDP) of 2015. The HSDP supports the formulation of the organisational structures that accompany the transfer of functions and staff from the national to the district level.

National Health Strategic Plan 2022 – 2026

Zambia's National Health Strategic Plan (NHSP) 2022-2026 outlines the health sector plan through 2026, including the overall goal "to improve the health status of people in Zambia in order to contribute to increased productivity and socio-economic development."[10]

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 recognises them as a 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 for better access to quality services. Through strengthening the tenets of Primary Health Care as a vehicle to advance Universal Health Coverage, the Ministry shall make a move towards improvement of health outcomes for all Zambians without leaving anyone behind.

1.4 Health Status of the Population

Zambia has made important improvements in the health status of its population in recent years, but more work is merited to continue to improve health outcomes. The impacts of the coronavirus (COVID-19) pandemic, recurrent climate-related shocks like droughts and floods, public health emergencies including outbreaks of cholera and polio, and an already strained economy have compounded existing challenges and increased deprivations, particularly among the most vulnerable.

The epidemiological profile of Zambia is similar to that of other lower middle-income countries marked by a high but falling level of communicable diseases and injuries and a relatively low but increasing level of non-communicable diseases – estimated at 29% in 2016[11].

10 NHSP 2022-2026 (draft)
11 WHO https://www.who.int/nmh/countries/zmb_en.pdf?ua=1

Table 1: Health indicators in Zambia

Indicator	Value (2013/14)	Value (2018)	Source
Life expectancy at birth (years)	60.8	63 2017)	World Bank
Pregnancy-related mortality (PRMR) (pregnancy related deaths/100,000 live births)	398	278	2018 DHS survey
Infant mortality rate (deaths/1,000 live births)	45	42	2018 DHS survey
Births attended by a skilled provider	64%	80%	2018 DHS survey
Under 5 mortality (deaths/1,000 live births)	75	61	2018 DHS survey
Children below 5 who are stunted (%)	40%	35%	2018 DHS survey
Acute malnutrition or wasting (% children <5)	6%	4%	2018 DHS survey
Infants exclusively breastfed ((% of infants <6 months)	73%	70%	2018 DHS survey
Contraceptive prevalence rate, married women aged 15-49 (%)	49%	50%	2018 DHS survey
Total fertility rate (children/women)	5.3	4.7	2018 DHS survey
TB prevalence rate (per 100,000 population)	455	346	PLOS ONE[12]; WHO[13]
Malaria incidence rate (per 1,000 population)	409	382 (2016)	ZNPHI[14]; PMI[15]
HIV prevalence (% adults aged 15-49)	12.6%	11.3%	Zambia National AIDS Council[16]; UNAIDS[17]
HIV+ women receiving ARVs for PMTCT	97%	92%	Zambia National AIDS Council; Avert[18]
Individuals with access to insecticide treated nets (ITNS)	47%	55%	2018 DHS survey
Children (12-23 months) all Basic vaccinations received	68%	75%	2018 DHS survey

12 Kapata N, Chanda-Kapata P, Ngosa W, Metitiri M, Klinkenberg E, Kalisvaart N, et al. (2016) The Prevalence of Tuberculosis in Zambia: Results from the First National TB Prevalence Survey, 2013–2014. PLOS ONE 11(1): e0146392. https://doi.org/10.1371/journal.pone.0146392

13 WHO Tuberculosis Profile Zambia 2018.
https://extranet.who.int/sree/Reports?op=Replet&name=/WHO_HQ_Reports/G2/PROD/EXT/TBCountryProfile&ISO2=Z-M&outtype=pdf

14 Inambao AB, Kumar R, Hamainza B, Makasa M, Nielsen CF. Malaria incidence in Zambia, 2013 to 2015: Observations from the health management information system – the health press – Zambia. http://znphi.co.zm/thehealthpress/malaria-incidence-in-zambia-2013-to-2015-observations-from-the-health-management-information-system/.

15 Presidents Malaria Initiative Zambia. Malaria Operational Plan FY 2018. https://www.pmi.gov/docs/default-source/default-document-library/malaria-operational-plans/fy-2018/fy-2018-zambia-malaria-operational-plan.pdf?sfvrsn=7

16 Zambia Country Report, Monitoring the Declaration of Commitment on HIV and AIDS and the Universal Access. National AIDS Council, Republic of Zambia. March 2014. https://www.unaids.org/sites/default/files/country/documents/ZMB_narrative_report_2014.pdf

17 UNAIDS Zambia. https://www.unaids.org/en/regionscountries/countries/zambia

18 https://www.avert.org/professionals/hiv-around-world/sub-saharan-africa/zambia

2. COMMUNITY HEALTH CARE, LAST MILE OF PRIMARY HEALTH CARE

Community health care is essentially an integral part of Primary Health Care (PHC) as defined in the Alma Ata Declaration (1978) "*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." Zambia reaffirmed its commitment to PHC under the Astana declaration in 2018.

Community health systems extend the four principles of Primary Health Care[19] to the last steps of Primary Health Care (PHC) delivery - the households in the communities, to ensure better health outcomes through proactive 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 inter-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."[20] Thus community health is 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 behaviour, coping skills and gender to target specific health problems.[21]

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 National Community Health Strategy 2022-2026 operationalizes the PHC 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 [22]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, counselling, advocacy, legal support, referrals and transport for access to follow-up services[23].

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.

22 National Community Health Worker Strategy (NCHWS), Ministry of Health, 2010

23 This definition leans on the concepts of McKenzie et al. 2011, the GFTAM 2011 and Futures Group Europe, 2009.

3. DEVELOPMENT PROCESS OF THE STRATEGY

The process followed for developing the NCHS 2022-2026 is illustrated in the graphic below:

End Term Review NCHS 2019-21

To assess and understand the level of progress that has been made against planned interventions, expected outputs, outcomes, and impact pathways, the Ministry of Health and its partners implemented an End Term Review (ETR) exercise of the NCHS 2019-21. The ETR included a literature and desk review, primary data collection from MoH National, Provincial and District Partners, Neighbourhood Health Committees (NHCs), Community Based Volunteers, Community Health Assistants, community members and people living with disabilities, data analysis and review meeting.

Literature Review

The literature reviewed included policy documents such as the National Health Strategic Plan (2022-2026); the End Term Review of the Community Health Strategy (2017-2021); the National Community Health Worker Strategy (2010), the National Guidelines for Neighbourhood Health Committees (2018), Health Sector Devolution Plan (2015), Local Government Act No. 2 of 2019, Constituency Development Fund Act No. 11 of 2018, Zambia National Health Care Financing Strategy (2017 – 2027), and the Eight National Development Plan. It also included a review of research carried out on a number of areas of community and primary health care including Community Health Assistants, Community Based Volunteers and other community-level health workers in Zambia.

Consultations and Interviews

During the consultations and individual interviews, key issues facing community health were identified. Implementing partners, NHC representatives, Ministry of Health staff, and health workers from all levels of the health system were given the opportunity to identify areas of concern and explain some of the difficulties that they experienced in implementing community health activities. This informed the Situational Analysis in this strategy, in addition to the findings of the End Term Review of the National Community Health Strategy (2019-2021), the National Health Strategic Plan and other evaluations done.

Writing Workshop

During the writing workshop, the key issues facing community health were reviewed and representatives from implementing partners, Ministry of Health staff and health workers from all levels of the health system designed the objectives, interventions and activities for the National Community Healthcare Strategy 2022-2026 to address these issues.

Consultative and Validation Meeting

After the first draft of the National Community Healthcare Strategy 2022-2026 was completed with the inputs from the Writing Workshop, a Consultative and Validation meeting was organised with representatives from implementing partners, Ministry of Health staff, and health workers from all levels of the health system. During this meeting alle the Objectives, Strategies, Interventions, Activities, the Operational Plan and its Indicators were reviewed.

Draft shared for comments

With the inputs from the consultative meeting a new draft of the National Community Healthcare Strategy 2022-2026 was prepared. This draft was shared with all stakeholders for review and comments. A new final draft of the Strategy was prepared based on the comments received.

Operational Plan Workshop

A workshop was held with the members of the Community Health Unit and Finance to further detail and cost the Operational Plan.

Launch and Dissemination

The National Community Healthcare Strategy 2022-2026 will be launched nationally. After the launch, the Ministry of Health will facilitate for the implementation of the strategy through dissemination of this document and other essential community health policy documents and guidelines to all levels of the health care system, including to Districts, health facilities and communities.

4. VISION, MISSION, GOAL, VALUES & GUIDING PRINCIPLES

4.1 Vision

A nation of healthy and productive people

4.2 Goal of NCHS 2022-2026

To contribute to universal health coverage by providing holistic community health services to the doorstep of all Zambians close to the family as possible.

4.3 Values

We are committed to the following values:

- Inclusiveness: We serve all communities and are committed to delivering services to vulnerable and hard to reach people.
- Ubuntu: We see the value in all people and endeavour to meet every client's need with compassion, respect and kindness
- Team-work: We work together and support each other to achieve our common goals
- Innovation: We walk the extra mile to find new and better ways to provide excellent community health services
- Integrity: We strive to do what is right and do what we say we will do
- Commitment: We are dedicated to delivering on our mission
- Excellence: We always strive to do better
- Integrative: We break down siloes within and across programs and sectors to offer holistic services

4.4 Guiding Principles

The implementation of this strategy is guided by the following guiding principles.

- We recognise that access to health care is a basic human right, and endeavour to leave no one behind

- We will give due consideration to gender, age, disability, and culture so as to minimise the barriers to accessing health services

- We will take a participatory and people-centred approach to our interventions, understanding that communities and individuals know their health needs best

- We will work with existing structures and service providers at community level, including traditional healers and private practitioners

- Where possible we will take an integrative approach, knowing that collaboration across sectors, disciplines and institutions is necessary to realise the vision of a healthy and prosperous nation

- We will make use of innovation and appropriate technology, and endeavour to look for new and better ways to deliver health services at community level

- We will take an evidence-based approach to developing appropriate community health interventions

5. SITUATIONAL ANALYSIS OF COMMUNITY HEALTH IN ZAMBIA

The objective of the situational analysis is to provide an understanding of the current state of of community health in Zambia, according to the six building blocks of WHO (Workforce, Service Delivery, Governance, Medicines Equipment and Infrastructure, Monitoring & Evaluation, Financing. It informs the community health strategy.

The situational analysis is based on a review of national policies, regulations and guidelines, studies and the literature on international best practices in community health. It has also taken account of assessments and evaluations of local and international community health programmes, including the End of Term Review of the NCHS 2019-21.

5.1 Workforce

Community health in Zambia is currently mainly composed of two cadres: Community Health Assistants (CHAs), who undergo a one-year training and are formally employed by the government of Zambia; and Community-Based Volunteers (CBVs), an informal cadre of volunteers often managed by NGOs, who commonly receive incentives for specific job functions. In the recent past the government has also embarked on training, recruitment and appointment of human resources for health in Public Health such as Public Health Specialists (PHS) and Officers, Community Health Focal Point Persons (CHFPP) and Public Health Nurses.

Community Health Assistants

Community Health Assistants (CHA) constitute the formal link between the communities and the health system. The training of the CHA is standardised and developed with inputs by professional bodies such as the General Nursing Council, MOH, HPCZ and various Medical Schools, conducted in private and public training institutions. The training encompasses 11 modules cutting across health sector issues including health promotion, disease prevention, clinical tasks and secondary duties like coordination, Technical Assistance (TA) to Community Based Volunteers (CBVs), mobilization and monitoring. Following training, the CHA are registered with the Health Professionals Council of Zambia before being deployed to health posts, where they will be stationed.

Community Health Assistants are meant to spend 80% of their time with the communities and 20% of their time side-by-side with skilled health workers in the health facilities, though studies have shown that many CHAs spend significantly less time in the community due mainly to staff shortages at health facilities. They have a variety of professional relationships in order to carry out their duties. These include health professionals, church leaders, NGO/CBO/FBO and other community groups, CBV, traditional leaders, church leaders, senior headmen/indunas and council members (chief's cabinet).

By July 2022, about 3,400 Community Health Assistants (CHAs) have been trained of which 1,354 (40%) have been put on payroll by the Government of Zambia. Another 300 are supported by cooperating partners.

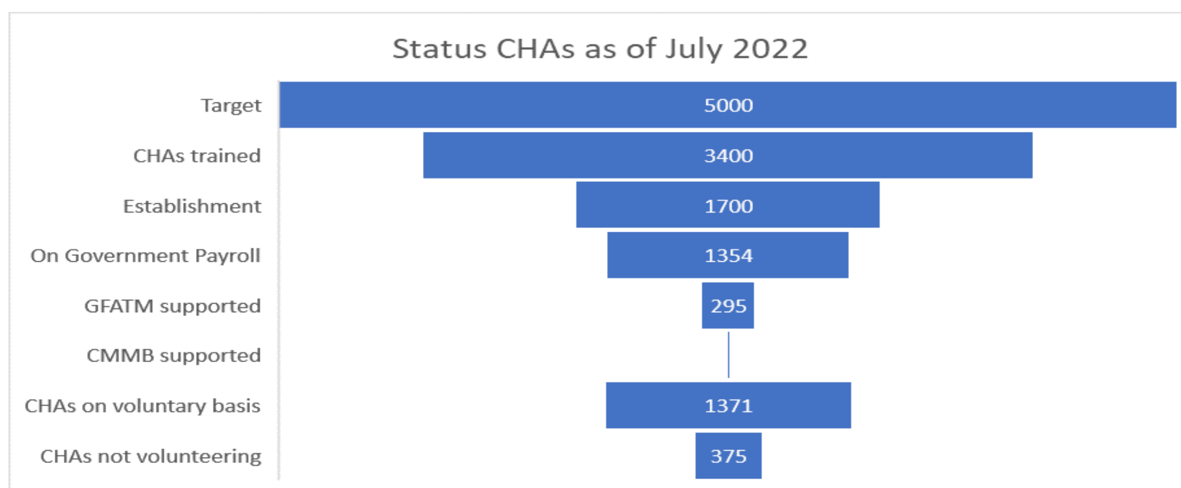


Figure 1: Shows the number of Community Health Assistants in Zambia who are trained against the target, employed by Government and partner support as well as those volunteering as of July 2022.

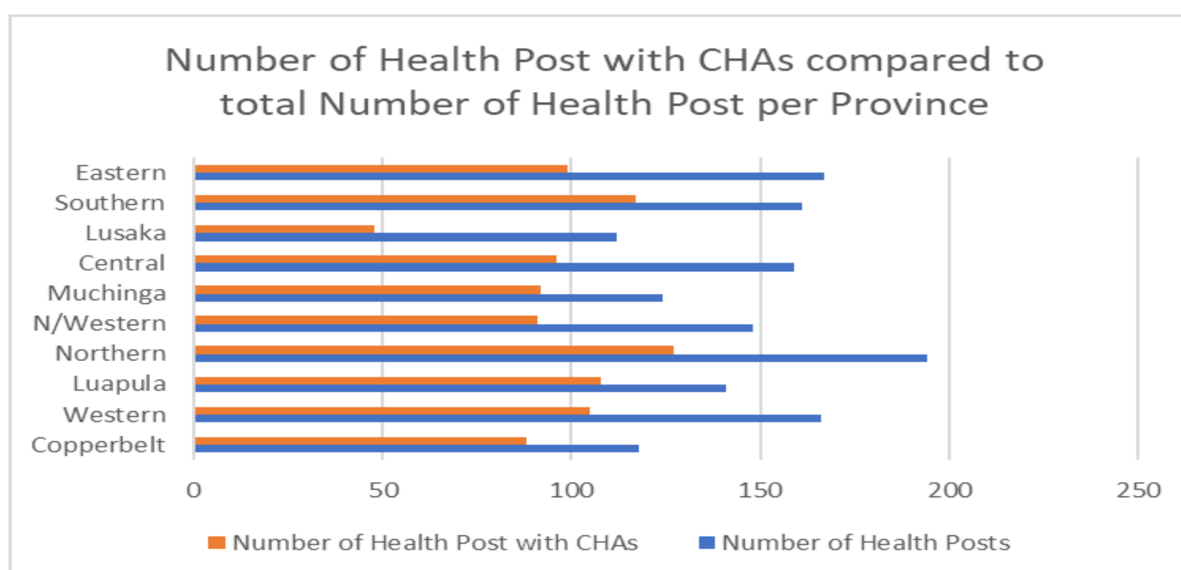


Figure 2: Shows the distribution of Community Health Assistances in Zambia in comparison to a number of Health Post per Province.

Above figure shows that the distribution of CHAs per Province is not equally distributed. Lusaka is mostly an urban setting but still has a substantial number of Health Posts, but only 43% of them have one or more CHAs, while in Luapula Province 77% of the Health Posts have one or more CHAs deployed.

According to a recent study[24] the longer a CHA had been working in a given community, the more aware their communities were of their services, as well as the more the communities accessed CHA services. Review of data from the Health Management Information System (HMIS) from 2019 (when the CHAs were deployed) and 2020 showed that the health facilities that had CHAs performed better than those health facilities that had no CHAs in postnatal care (PNC), antenatal care (ANC), institutional delivery, children fully immunised as well as deliveries by skilled birth attendants.

24 Effectiveness of the Community Health Assistants Program in the Zambian Health System, An Evaluation Report, Clinton Health Access Initiative (CHAI) and Ministry of Health (MoH), 16th August 2021

Community Based Volunteers

According to 2020 Community Health mapping report for Community Based Volunteers (CBVs), there are a total number of 90,016 CBVs against the country population of over 18 million[25]. There are however significant differences in the selection criteria, training and enablers received, tasks being done and the qualifications of the different types of CBVs.

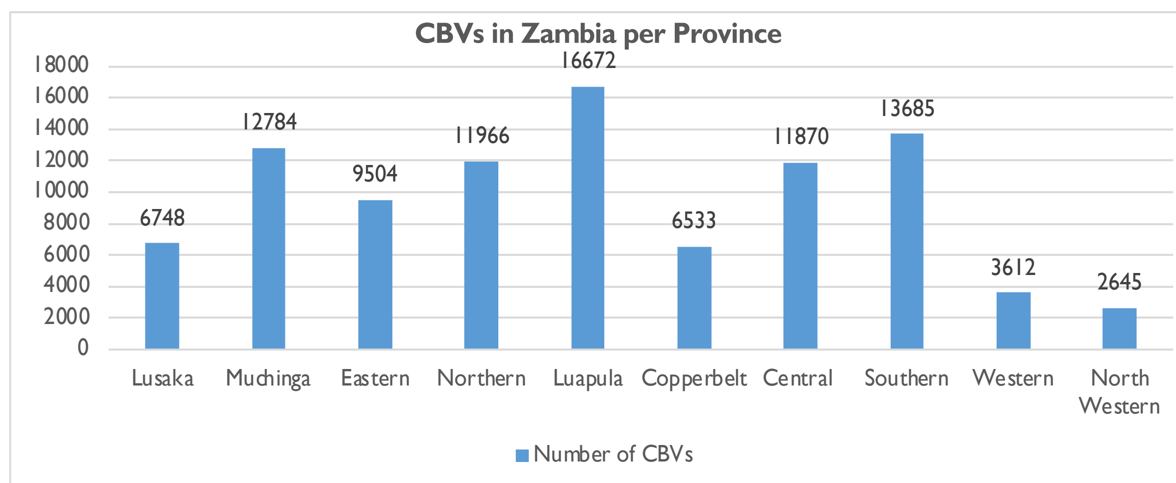


Figure 3: Shows the Distribution of Community Based Volunteers in Zambia for respective Provinces.

CBVs are the most bulk and complementary resource in implementation of Primary and Community Health Care related approaches, but they are unevenly distributed across the country. From the above figure it is clear that Luapula holds the most Community Based Volunteers with 16,672 registered, while Lusaka (being the province with the most inhabitants) holds only 6,748 volunteers.

According to a survey recently done[26] approximately 80.4% of the CBVs are the primary individuals responsible for earning income for their household. 72.9% of CBVs are simultaneously serving in multiple volunteer health worker roles.

Satisfaction with incentives vary by province, duration of service, and gender and may be closely tied to challenges faced by CBVs throughout the region. When asked about preferred incentives, CBVs often expressed the need for additional resources to support their role, such as replacement rain gear, soap, bike parts, more mobile airtime, etc. CBVs also frequently mentioned some form of financial incentive, some noting that these would help offset costs of supplies, travel, or other expenses incurred while carrying out their duties.

Approximately 93.1% of the CBVs communicate with a supervisor at least once a month, a frequency preferred by 96.2% overall. CBVs also indicated that important supportive tasks were regularly conducted by supervisors.

Public Health Specialists (PHS) and Officers, Community Health Focal Point Persons (CHFPP), Public Health Nurses (PHN)

Community Health Nurses and Public Health nurses have an important function to play at community level, both through their outreach activities and home visits and in their supervision of community health workers (including CHAs and CBVs). Zambia government commenced training of Public Health Specialists (PHS) and Officers, Community Health Focal Point Persons (CHFPP), Public Health Nurses (PHN) in 2019. Some of these have completed their training and are awaiting deployment.

Challenges and Opportunities related to Workforce

The following Challenges and Opportunities were noted in the end term review of the Community Health Strategy 2019 – 2021 and in the partner consultations that took place to prepare this new strategy.

Challenges

Inadequate health workforce at facilities

Zambia's 12.4 clinicians per 10,000 population is well below the WHO recommendation of 22.8 clinicians. At the health facility level, 34% of nursing positions and 24% of Environmental Health Technologist positions at health posts are unfilled, leaving CHAs to fill the gap at the facility. This prevents CHAs from providing their services inside the communities as envisaged.

Motivation Challenges

There have been delays with deployments and inclusion onto the official government payroll system for personnel for a significant number of CHAs that have completed their respective trainings. This is resulting in low motivation for the affected cadres.

CBV fragmentation

While CBVs provide critical contributions to many health programmes, there is a high degree of fragmentation among CBVs, leading to programmatic duplications and inefficiencies. Many CBVs are employed under multiple programs and, as a result, training differs in content, length and intensity depending on the programme and the implementing organisation. Sometimes CBVs are trained multiple times for the same service; selection criteria are not always clear; and there are no guidelines for incentives and working hours. There is limited knowledge at a high level of the number of CBVs currently working, the degree of their involvement with community health activities, and their quality of work. All of these factors contribute to high attrition rates among CBVs.

Limited options for advanced learning and certification

The training that Community Based Volunteers receive is often not certified, making it difficult to be recognised by official learning institutions for credits. This limits the advanced learning options for many Community Based Volunteers to progress to formal healthcare cadres.

Confidentiality of information

Through their work CBVs often access sensitive information about the communities they serve. It is important that this information is being kept confidential to ensure that people feel confident to access their services. There is currently no legal framework in which this confidentiality is being ensured and measures defined when this confidentiality is breached.

Long distances

As populations are dispersed across the rural areas in Zambia, CBVs have to cover far distances to reach all households. CBVs therefor need transport options, like (motor)bikes, to perform their work adequately. Unfortunately, these are not available for most CBVs. Furthermore, maintenance of the transport that was provided, is difficult due to lack of spare parts and funding.

Opportunities

National Volunteer Policy

Government with the lead of the Ministry of Community Development and Social Services is close in finagling a National Volunteer Policy. The implementation of the policy will include registration requirement, formal contract, harmonization of trainings and incentives for volunteers.

System of recognition and rewards for NHCs and CBVs

The review recommended the introduction of a floating trophy to recognize NHC and CBV performance at national, provincial, district and community level. This could be an important means of incentivizing the lower structures. Celebration could be done annually at International Volunteer Day on 5 December.

5.2 Service Delivery

Community health 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[27]. The national health policy[28] 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.

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 (HPs), Health Centres (HCs), district hospitals and Health Centre Committees (HCC) and Health Post Committees (HPC) that link PHC with the communities through Neighbourhood Committees (NHC).

However, community health interventions in Zambia are currently highly fragmented. The physical geography of Zambia presents a challenging environment for delivering health services.

Over 60% of the Zambian population lives in sparsely populated rural communities. These regions often lack basic health and transport infrastructure.

The bulk of health services are provided at primary health facilities, which are the entry point to the public health care system. Since the 1990s the government has made significant investments to improve equitable access to health by increasing the number of Health Posts across the country.

However, standard operating procedures (SOPs) are outdated and human resource constraints continue to be a challenge. The referral system at community level must be revitalised. Currently inadequate health infrastructure and human resources shortages are compounded by a lack of transport and weak governance structures. Though some community referral guidelines exist, these tend to be for specific conditions and there is a need for integration and standardization.

Access to PHC services is inhibited by a lack of nurses, doctors, limited operating hours of local facilities and stock-outs of commodities. As a result, people directly access the higher-level healthfacilities, leading to the congestion of these facilities.

27 MOH, 2012a
28 Ministry of Health and MoCDMCH, 2014

Challenges and Opportunities related to Service Delivery

The following Challenges and Opportunities were noted in the end term review of the Community Health Strategy 2019 – 2021 and in the partner consultations that took place to prepare this new strategy.

Challenges

Special Groups

During the review process, it was established that no deliberate focus was given by most Community Health Programmes to special groups such as people with disabilities, adolescents and Paid Sex Workers. Given the uniqueness and special needs of these LNOB groups, special consideration should be given to them.

Weak referral systems to health facilities

Referral of patients from the community level to a health facility is often uncoordinated and poorly standardized. The referral system is affected by significant distances to nearest health facility, poor transportation in rural areas and limited availability of support systems at community level.

COVID19

In the review, it was established that the COVID-19 pandemic had a great negative impact on the implementation of the NCHS interventions. The main impacts emanated from resource reallocation, both human and financial from community health initiatives to those aimed at fighting the COVID-19 pandemic. Additionally, at the peak of the pandemic, it became difficult to implement community health initiatives due to restrictions on movement and physical meetings. Even when meetings were allowed, structures were still affected by infections which resulted into isolations by members of the various structures. The risk of new COVID-19 variants should be considered in the implementation of the new strategy and mitigation mechanism designed. Some of the mitigation mechanisms include ring facing funds for community health, as well as leveraging on digital platforms.

Opportunities

Cooperating Partners are scaling up Community based interventions in Zambia

Some of the well-funded programmes (like HIV-AIDS, Malaria and Vaccines) intend to make a substantial investment to scale up community cadres in Zambia in the next couple of years to reach full national coverage.

5.2 Governance

Leadership and governance involve provision of policy frameworks besides ensuring effective oversight, regulations, making sure designed structures in the system are functional, and accountability. Figure 4 below provides a detailed overview of the community health governance structure and delivery channels in Zambia[29].

29 National Community Health Strategy 2019 – 2021

Community Health System Structure and Delivery Channels

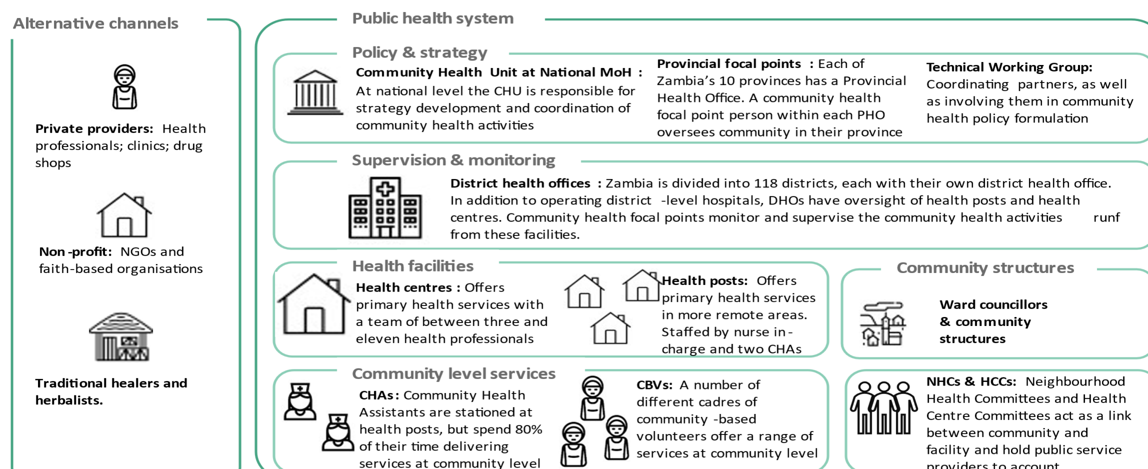


Figure 4: Community health system structure and delivery

National Community Health Technical Working Group

The community Health unit has formed a National Technical Working Group (TWG) as a way of coordinating partners as well as involving them in community health policy formulation. So far, the TWG is however not performing as it first started. Meeting attendance has gone down. Plans are underway to revamp the National TWG as well as escalate the TWGs to the provinces, as well as districts.

Community Health Focal Points

Despite having strong leadership at central level, the capacity has not yet trickled down to provincial, district and community level, this is because there are no formerly appointed community health officers at all levels and those who were appointed administratively are overdue and others have moved. Officers working as community focal point persons both at provincial and district levels have other commitments from there substantive positions making it even difficult for central level to hold them accountable.

Neighbourhood Health Committees (NHCs) and Health Centre Committees (HCCs)

Community Health cadres operate under the supervision and coordination of Health Posts (HPs) and Health Centres (HCs), which are local posts providing primary health services. Additionally, Neighbourhood Health Committees (NHCs) and Health Centre Committees (HCCs) are local committees that act as a link between the community and the health facility. The chairperson of an NHC automatically becomes a member of the HCC. Additionally, HCC members may be elected from the group of NHC executive and ex-officio members from all NHCs in that particular facility catchment area. The NHC/HCC provide a platform for the citizenly to participate in the health care system of the country, however these structures need to be strengthened for effective functionality.

The Neighbourhood Health Committees (NHCs) are unfortunately functioning suboptimum and, in some areas, do not even exist. A number of reasons can be attributed to weak functionality of NHCs, such as inadequacies in both knowledge and resources to foster the work of the NHCs, the absence of legal framework to back the existence and operations of the NHCs, Lack of recognition and motivation by both the community as well as the health care staff and lack of interest from

the members of the public to join NHCs. The Knowledge gap in both NHCs and Health care staff is one biggest contributing factor to the failure of the NHCs to perform according to the expected standard.

Despite the development of the NHC guidelines with a very big launch, most NHC members and Health care staff are not oriented to the roles and responsibilities of the NHCs and as such, it has been difficult for the health facility staff to support and mentor NHCs and also the NHCs to perform their roles adequately. Lack of legal framework to support both existence and operations of NHC has contributed to week functionality.

Lack of public interest to join NHC due partly to lack of publicity, and as such, there has been prolonged occupancy of NHC offices even over the expected tenure of office i.e. three (3) years.

The unit has made head ways to provide a platform for NHC to perform their social accountability role by developing a community scorecard, however, this may also not be utilised if NHCs are going to remain inactive. So far eight (8) out of Ten (10) provinces are trained in community scorecard, efforts to roll out to all provinces down to the NHCs are underway.

Ward Development Committee (WDC)

A critical structure for the NHCs to interface with is the Ward Development Committee (WDC). WDCs are established by a Town Clerk or Council Secretary and are responsible for working with councillors in the wards to implement development projects at the local level, including in the health sector. The primary function of the WDC is to coordinate all developmental processes in their ward and provide a link between community members and the council and development agencies operating in the ward. The WDC holds quarterly meetings and reports to the Council and is expected to give feedback on all developmental issues to the community. The HCC is expected to report to the WDC on health issues relevant to the ward and to represent the health interests of the community at ward level.

Challenges and Opportunities related to Governance

The following challenges were noted in the end term review of the Community Health Strategy 2019 – 2021 and in the partner consultations that took place to prepare for this new strategy.

Challenges

Dissemination of strategy documents and tools

The National Community Health Strategy, National Community Health Investment Case, and the Neighbourhood Health Committee (NHC) Guidelines are key in the realisation of a timely and inclusive community health delivery system. During the review exercise, it was unfortunately established that although there has been a national launch and roll-out, there was low distribution of strategic documents at District, Health Facility and Community level.

Legal and supportive mechanisms for CBVs are lacking

CBV currently lack an acknowledged regulatory framework and binding operational guidelines though they are coordinated and guided by NHCs and HCCs. Supportive mechanisms, planning, community score cards, and coordination mandates at district level are inadequate.

Neighborhood Health Committees need strengthening

While 84% of health zones report having an NHC, the functionality of these committees varies and depends largely on the guidance of District Health Office staff and the managerial skills of health facility staff. A survey found these were functioning well in only 50% of the facilities. The National Guidelines for NHCs, which spell out the roles and responsibilities of NHCs, were developed and launched in 2018, but the review found that they are not disseminated all the way down to the health facilities, NHCs and their communities. Generally, there is need to consider reorientation and training of community structures for enhanced capacity in the discharge of their duties.

Coordination between the different levels needs strengthening

It is recognized that the mechanisms of coordination of volunteers through NHCs need to be strengthened and those of CP harmonized with the community systems. Though the CBVs operate in all zones of a health facility's catchment area, the coordination between the zonal activities is weak. 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.[30] 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.

Coordination of partner activities

The coordination of implementing partner activities at all levels is challenging, particularly at provincial and district levels. Most of the activities that are implemented by partners are driven by the priorities of external funders, which may not always be aligned with the national development process. Weak harmonization of approaches and packages of support to CBV by different partners, leads to a lack of standardized training, inconsistent deployment, poor motivation, a lack of standardised incentives, as well as inconsistent reporting, monitoring, evaluation and tracking of the CBV.

Opportunities

Mapping and coordination with other community health partners

Given the need for further strengthening of community health partner coordination, the review noted that Ministry of Health should consider the mapping of all relevant partners at National, Provincial and District level that have an interest in Community Health. The Ministry could use the mapping data that is generated by the Health Cooperating Partners and other groups. The mapping could assist the Ministry of Health to allocate partners in thematic areas and highlight their main area of focus/strength and facilitate partner alignment to the interventions and activities in the strategy.

Joint Learning and Coordination Platforms

There is an opportunity for cross learning initiatives for partners working in the community health stakeholders. These online or offline platforms can have partner presentations on workable solutions, challenges being faced and emerging opportunities. Further, the Ministry of Health can use this platform to present any relevant data and findings from the field. This can help in facilitating/ catalysing continuous use of M&E data in informed decision making for improved programming.

30 cf. Ministry of Health, 2017d

Formal appointment of Community Health Focal Persons at Provincial and District level

During the review, it was established that community health focal point persons are key in the successful implementation of the NCHS at different levels. However, these officers very often do not have formal appointments offered to them. Therefore, the review recommended that the Ministry of Health should make an effort to formally appoint Community Health Focal Persons at Provincial and District level as are key in the success of the implementation of the strategy, supporting service delivery, monitoring and overall coordination.

5.3 Medicines, Equipment and Infrastructure

The physical geography of Zambia presents a challenging environment for delivering health services. Over 60% of the Zambian population lives in sparsely populated rural communities. These regions often have inadequate basic health infrastructure and transport. Currently there are 998 Health Posts, 258 UHCs Urban Health Centres and 1,080 Rural Health Centres[31]. 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. However, even within urban areas, health facilities are often congested, which is also a barrier to access. While a 5km radius is a useful guideline, in some circumstances distance from a health facility may not be the best measure of access to health services. Therefore, the Ministry of Health revised the goal of making basic health services available to all Zambians within one hour's travel from their home.

The Zambian health service suffers from a critical shortage of equipment and, owing to budget constraints and lack of experienced maintenance staff, much of the equipment currently in use by Community Based Volunteers and Community Health Assistants is poorly maintained. This limits their effectiveness in the field.

Effective distribution mechanisms to ensure the availability of essential medicines at community level improve health outcomes and reduce out of pocket spending. An electronic Logistics and Management System (eLMIS) has been developed in Zambia 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 has been introduce in all provinces with distribution hubs in each of them that draw from Zambia Medical Supplies Agency (ZAMSA).

Medicines and commodities are distributed to the last mile from these distribution hubs to health facilities. CHAs and CBVs in Zambia operate under a health facility that supplies them with diagnostics and treatment, for instance with rapid diagnostic tests (RDTs).

Previously, pre-packaged medicine kits were carried by CBVs. These 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, with much stock being leading to waste of resources. Since the withdrawal of the pre-packaged medicine kits, CBVs have relied on health centre kits for medical supplies. Unfortunately, there are overall challenges with availability of drugs at this level, leading to shortages of drugs for CHAs and CBVs. There are plans to develop a community logistics management system that will enable CBVs and other community health workers to order medicines directly from Zambia Medical Supplies Agency.

31 National Health Facility Census Analytical Report 2019

With the expansion of the HIV-AIDS and other programmes, people are getting more medicines to take home. The issue of safe storage and disposal at community level has therefor increased in importance.

In a recent survey[32], CBVs indicated that prevention of stock-outs is important for both directly addressing infections and ensuring CHW services are valued and sought in communities. Access to other medical commodities, such as medication for fever and pain management, may be less reliable but still important for maintaining high community service utilization.

Challenges related to Medicines, Equipment and Infrastructure

The following challenges were noted in the end term review of the Community Health Strategy 2019 – 2021 and in the partner consultations that took place to prepare for this new strategy.

Challenges

Weak supply chain

The supply chain for medicines and commodities at the community level is ineffective in its ability to forecast need and resupply on time. Unfortunately, stock outs at health posts and health centres are common, resulting in CBVs/CHAs not being provided with the drugs, commodities and tests they need to do their work effectively. This is causing patients to seek out higher levels of care where medicine stock is more reliable.

Lack of support services at health facilities

At facility level, one of the major challenges that was observed in the ETR process was lack of funding and inadequate key support services to facilitate for smooth running of community health activities, including lack of clean water and transport.

Opportunities

Outreach Posts and Community Health Boots

In the recent years Ministry of Health has piloted some new (temporarily) structures like outreach posts and community health boots, to provide community health services to the public in remote areas and urban settings. These could provide interesting models to bring down the distance of the community to the nearest health care providers and a base for Community Based Volunteers to work from.

Reintroduction of the Health Facility Medicine Kits

To overcome the current shortages, Government and its partners are planning investments in procuring Health Facility Kits, that include commodities for community healthcare.

New technology for supply chains

Emerging technology in supply chains has been shown to be effective in improving health outcomes, both in Zambia and abroad. The Ministry of Health could apply and scale up some of the solutions that have been successfully applied in other contexts, emerging technology that has been shown to be effective in improving health outcomes, and unearthing some of the home-grown innovations being applied at a grass-root level by communities in Zambia.

32 Zambia National Malaria Elimination Programme Community Health Worker Survey Report, PATH, 2019

5.4 Monitoring & Evaluation

Zambia has an established data management system. The Ministry of Health uses the improved District Health Information System (DHIS2), an electronic web-based system for data handling and analysis. While the Ministry has its own data collection tools, some partner supported programs have different tools. There are observed inconsistencies in the primary data tools and what is found in the secondary tools (electronic systems).

Community-level information is still paper-based and relies on the collection of data by CHAs and CBVs and. In 2012, the HIA4a form was developed to aggregate data collected by the CHAs, while in 2016 the HIA4b form was developed to aggregate CBV data collection. Printed community data collection tools are filled out by CHAs and facility in-charges in order to collect community-level information. At district level, this information is aggregated and captured electronically before being sent to the provincial, and ultimately the national level.

CHA programme data reported to HMIS via the DHIS2 system are accessible to all relevant persons at the Ministry of Health. Partners outside of the MoH and the GRZ receive access upon approval by the MoH.

The key reporting and recording tools used by CHAs and CBVs are:

- Household Activity Register (Part I and II)
- Community Mobilization and Surveillance Register:
- Patient Care Register
- Tally sheets (of activities carried out/organized/coordinated by the CHA)
- HIA4a and b aggregation forms
- CHA Self-Assessment Form

The Ministry of Health recently completed the Community Health Strategy Monitoring and Evaluation Framework. This supported and operationalized the National Community Health Strategy by facilitating linkage between indicators collected by the c-HMIS and other mechanisms to the overall health goals.

Challenges and Opportunities related to Monitoring & Evaluation

The following challenges and Opportunities were noted in the end term review of the Community Health Strategy 2019 – 2021 and in the partner consultations that took place to prepare for this new strategy.

Challenges

Lack of reliable community health data

Community information system data remains difficult to capture in one place and aggregate. Community HMIS was introduced, but the review noted challenges with the capture of the data at community level and the entry into DHIS II at District level. The review noted that in most districts, it was observed that the community health data was not prioritised and there was no organised verification and reporting of data into the DHIS2.

Community Health Data is not being used for decision making

Most provinces and districts reported the lack of awareness of the community health reporting tools due to turnover and lack of training for those that needed training. The End Term Review of the NCHS 2019-21 found that at NHC level, the communities are often not aware of the data being collected. With this status, it meant the generated data was not being utilised in an informed and timely manner for decision making aimed at improving the implementation process of the community health initiatives.

Duplication of registers and community information gathering

Multiple partners and different health programmes maintain separate registers, preventing a more holistic integrated approach to record keeping / data collecting at community level. This results in a heavy burden on data collection and data entry for health care workers, including CHAs and CBVs.

Opportunities

Leverage on the data collected by cooperating partners

The review noted that the Ministry of Health could leverage on the data collected by its cooperating partners, who have programmes at the community level. This could be done for high level indicators, that are common for both the partners and Ministry of Health. A first inventory of these indicators was done during the Community Health Strategy Monitoring and Evaluation Framework development. To operationalise this, there should be further harmonization in the definition of indicators across stakeholders.

Digitisation of Community Health Information Systems

There is need to explore the opportunities that might come with digitalisation of community health in Zambia. Given the findings of adverse effect of lack of sufficient funds and the COVID-19 pandemic on the implementation of the NCHS initiatives, digitisation might offer a solution. Further, digitalisation of the process might also address the high-cost of data generation that was observed in the NCHS review exercise.

Mid- and end-term review of the National Community Health Strategy 2022-2026

Alongside the routine monitoring activities, the review noted that the Ministry of Health should ensure a mid- and end-term review of the National Community Health Strategy 2022-2026 is conducted. This is important in ensuring continuous learning and refinement of strategy interventions. Funds should be put aside for this important task.

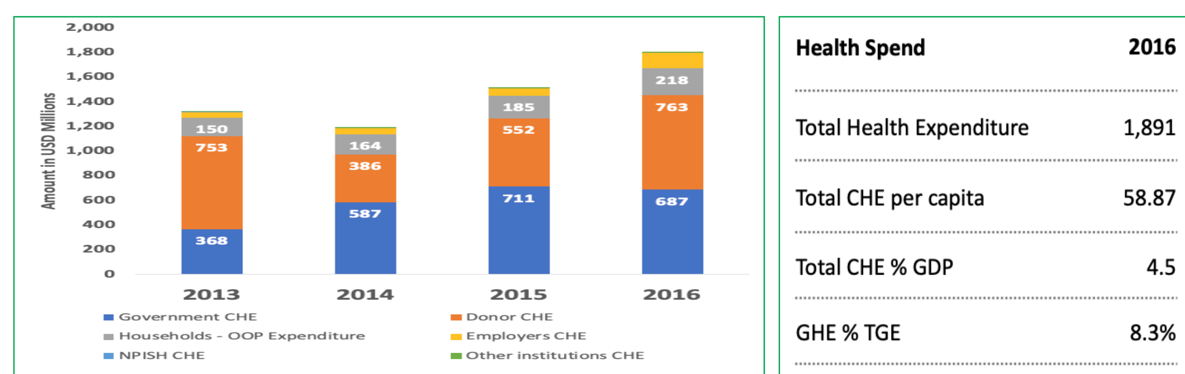
5.5 Financing

Zambia's fiscal space for health is constrained by many competing Government priorities. Over the past few years, the level of government budgetary allocation to the health sector has consistently fallen short of the Abuja Declaration target of 15%.

Table 3: Share of health budget to the total government budget[33]

2011	2012	2013	2014	2015	2016	2017
8.0%	7.7%	12.6%	9.9%	9.6%	8.3%	9.3%

External resources continue to make a significant contribution to total health spending, accounting for 42.5% of the current health expenditure (CHE) in 2016. Most of these resourced are channelled to disease-specific vertical programs. Other key non-government contributors to Zambia's current health expenditure as of 2016 were: out-of-pocket payments (12.2%), the majority of which is spent on secondary and tertiary levels of care and employers (7%)[34].



Health Spend	2016
Total Health Expenditure	1,891
Total CHE per capita	58.87
Total CHE % GDP	4.5
GHE % TGE	8.3%

Figure 5: Current Health Expenditure (CHE) by source

The abolition of user fees for all users at the primary care level throughout Zambia in 2011 led to a decline in the share of out-of-pocket (OOP) expenses with the majority of Zambians (80%) seeking care at the primary care level not paying user OOP[35]. While most Zambians do not have to pay for primary health services at the point of care, inadequate funding constrains the ability of the government to provide equitable access to high quality care at the community level. In 2018, the government enacted the National Health Insurance Act, which is anticipated to accelerate progress towards UHC[36].

Challenges and Opportunities related to Financing

The following challenges and Opportunities were noted in the end term review of the Community Health Strategy 2019 – 2021 and in the partner consultations that took place to prepare for this new strategy.

Challenges

Limited funding for Community Health

Districts are expected to provide at least 10% of health funding they receive from Government budget toward community health, but this funding does not always get to the community level. Party this is due to the limited funding currently available at District and Health Facility level, but also due to issues with knowledge about the guidelines, limited capacity at NHCs to prepare proposals, transparency, and accountability for how the funding was used.

Fractured financing

Financing for community health is often fractured among vertical programs, rather than general health system funding.

Opportunities

Public Private Partnerships

Many companies in Zambia, particularly those with large workforces, are already investing in the health of their employees and surrounding communities. These investments are currently primarily in the form of workplace and community programmes organized around prevention and behavior change communication. In some cases, companies also arrange for the provision of treatment support for a range of primary health services and drugs, provided through company clinics or hospitals. There are opportunities for Government for increasing the engagement with the private sector when it comes to community health, focusing on areas which offer a win-win situation for both businesses and the Government.

Investment Case for Community Health and Community Health Roadmap Countries

Zambia has developed a Community Health Investment Case. These can be used for further advocacy within Government and with Cooperating Partners for resource mobilization. Zambia is also one of the original Community Health Roadmap Countries. This can provide a platform to make investment gaps known outside the country and attract additional resources.

Constitutional Development Funds

With the increase of the budget for Constitutional Development Funds from ZWK1.6 million to ZWK25.7 million per constituency[37], local structures such as the District Development Committees have been given considerably more responsibilities and resources in the planning and implementing of community projects. Given this change, the District Health Offices, Facilities and NHCs should advocate and apply for resources towards improving the delivery of community health services. This can help in addressing some of the funding limitations that the Ministry of Health faced in the implementation of the previous strategy.

Revenue generating activities supported by cooperating partners

Partners are putting in solar panels, water chlorine production and other revenue generating activities at health facility level, that could provide for additional resources for community

37 National address to Parliament by President Hakainde Hichilema, 22 March 2022

healthcare.

National Health Insurance Scheme is expanding

The National Health Insurance Scheme was written into law in Zambia in 2018. The scheme provides coverage for an estimated seven (7) million eligible beneficiaries, representing about 35% of the Zambian population. The aspirations of Government through the scheme is to gradually impact quality of healthcare delivery through increased financial investments into health facilities through claims[38].

5.6 Summary of Strengths, Weaknesses, Opportunities and Threats

38 NHIMA, Update on the Performance & Status of the National Health Insurance Scheme, 24th February, 2022.

7. COMMUNITY HEALTH STRATEGY 2022-2026

STRENGTHS

SERVICE DELIVERY

- Development of the draft Community Health Service Package underway.
- Training of Community Health Nurses has been established
- Sign language training for CHAs Tutors
- Covid19 online training developed for CHAs and CBVs
- Covid19 Safety Officers training in selected markets and schools
- Covid19 compliant markets established in Lusaka
- Opening of market and bus station clinics

WORKFORCE

- 3,400 Community Health Assistants (CHAs) have been trained of which 1,354 (40%) have been put on payroll
- Zambia has over 96,000 CBVs
- Two more CHA provincial training schools have been established in Muchinga and North-Western, in addition to Copperbelt and Central
- Government developed draft National Volunteer Policy, including registration, formal contract
- Development of community health service package, integrated training manual and incentive guidelines for volunteers.
- Development of (web based) CBV Information Management System
- Training of Community/Public Health Nurses

MONITORING AND EVALUATION

- Community HMIS developed and deployed (Form A+B)

WEAKNESSES

SERVICE DELIVERY

- CHAs/CBVs are not equally distributed across the country
- Strategy didn't have specific interventions that cater for needs of PWD.
- Service delivery is fragmented between programmes, no definition of community health service package
- Home visits by medical staff is not happening
- Weak referral systems to health facilities, affected by significant distances to nearest health facility, poor transportation in rural areas and limited availability of support systems at community level.
- Inadequate access points for service delivery for communities

WORKFORCE

- Inadequate health workforce at facilities
- Community Health positions not filled at various levels
- Motivation challenges
- CBV fragmentation, leading to programmatic duplications and inefficiencies. CBVs are trained multiple times for the same service; selection criteria are not always clear; and there are no guidelines for incentives and working hours, leading to high attrition rates among CBVs.
- There is limited knowledge at a high level of the number of CBVs currently working, the degree of their involvement with community health activities, and their quality of work.
- Confidentiality of information is not enforced

MONITORING AND EVALUATION

- Only 16% of Districts trained on CHMIS
- Reporting rates are at 26%, as it is not being prioritized

- End Term Review done for NCHS 2019-21	- Community HMIS Recording and Reporting tools are not available everywhere - Community Health Data is not being used in an informed and timely manner for decision making - No dedicated M&E Position for Community Health - Registers Form A+B are too bulky - Lack of harmonisation and duplication of registers/community information gathering at community level - Community Health M&E Strategy developed only towards end of Strategy 2019-21
MEDICINES, EQUIPMENT AND INFRASTRUCTURE - eLMIS rolled out to facility level for drugs	***MEDICINES, EQUIPMENT AND INFRASTRUCTURE*** - Shortages of enablers for CHAs/CBVs (thermometers, backpacks, bicycles, etc.) - Weak supply chain from national down to community level, stock outs are common, resulting in CBVs/CHAs not being provided with the drugs, commodities and tests. - Inadequate transport at community level to facilitate for referrals.
FINANCING - Community Health Investment case developed by Ministry of Health	***FINANCING*** - Limited funding for Community Health at all levels - Districts are not adhering to allocating 10% of grant to community health - Issues with knowledge about the guidelines - Limited capacity at NHCs to prepare proposals, - Transparency, and accountability for how the community funding (10%) is being used. - Financing through vertical programs, rather than general health system funding

LEADERSHIP AND GOVERNANCE

- Political will and support for Community Health from Government and traditional leadership
- Community Health Unit established
- TWG established for partners and Government to strengthen collaboration
- Community Health Strategy
- Mapping of community health partners could inform improved coordination structures
- NHC guidelines and Incentive guidelines developed
- Score cards developed to get feedback from communities on quality of care

LEADERSHIP AND GOVERNANCE

- Inadequate dissemination of strategy documents and frameworks to lower levels
- Legal and supportive mechanisms for CBVs are lacking. Supportive mechanisms, planning, community score cards, and coordination mandates at district level are inadequate.
- No formal appointment of Community Health Focal Persons at Provincial and District level
- Neighbourhood Health Committees are weak.
- Coordination between the different levels is weak. This contributes to the current fragmentation of community health service delivery.
- Coordination of partner activities at all levels is challenging, particularly at provincial and district levels.

OPPORTUNITIES

SERVICE DELIVERY

- Partners making substantial investment to scale up community cadres in Zambia

WORKFORCE

- A system of recognition and awards for NHCs and CBVs could improve motivation.

THREATS

SERVICE DELIVERY

- COVID19 pandemic had a great negative impact on the implementation of the NCHS interventions.
- Some sectors of society have become suspicious of certain community health interventions
- Social and cultural believes influence health seeking behaviour

WORKFORCE

- Delays in the deployment of Community/Public Health Nurses and CHAs
- CBVs prefer to work for partner supported programmes

MONITORING AND EVALUATION

- Availability of partner funds for Digitization of Community Health Information Systems. Study will be done shortly to identify options and costs
- New Digital Health Strategic Plan 2022-2026 could enable leveraging on the data collected by cooperating partners at community level
- Revision of registers Form A and B could lower costs of printing and distribution.

MEDICINES, EQUIPMENT AND INFRASTRUCTURE

- Government and its partners are committed to make investments in procuring Health Facility Kits, that include commodities for Community Health
- Emerging technologies have been shown to be effective in improving health outcomes

FINANCING

- Partners are putting in solar panels, water chlorine production at health facility level, that could provide for additional resources for community healthcare
- Partner support for Community Health
- A number of global coalitions are advocating for investments in Community Healthcare
- Government has increased allocations to Constituency Development Funds
- Collaboration with other line Ministries through Health for All
- Public Private Partnerships

LEADERSHIP AND GOVERNANCE

- Renewed interest from partners in Community Health
- Renewed efforts to implement Decentralization Policy

MONITORING AND EVALUATION

- Limited funding for CHMIS
- Parallel reporting structures being set up and supported by Partners

MEDICINES, EQUIPMENT AND INFRASTRUCTURE

- Pilferage of drugs
- Poor storage conditions for drugs in community
- Disposal of medical waste

FINANCING

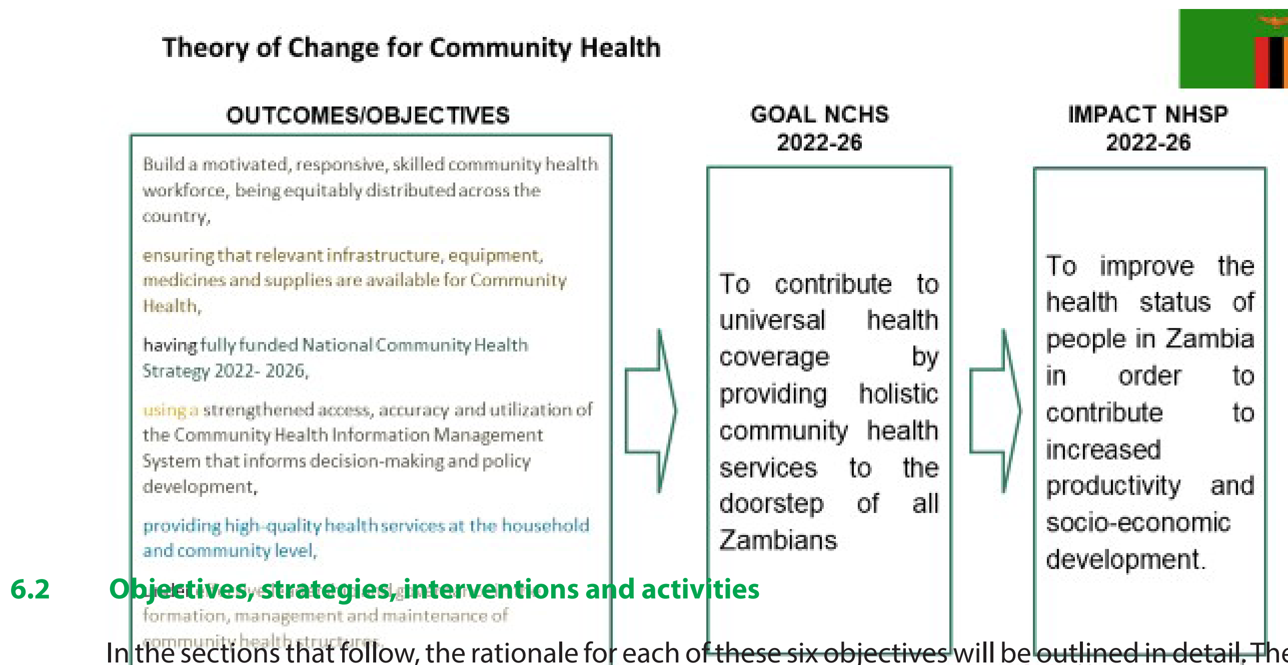
- Inflation
- Prioritization towards other interventions
- Pre-packaged interventions by partners
- Lack of sustainability plans

LEADERSHIP AND GOVERNANCE

- Lack of incentives for CBVs/NHCs
- Coordination of partner activities at all levels is challenging, particularly at provincial and district levels.

6.1 Theory of Change

The strategy is organised into six broad objectives that, taken together, will lead to the realisation of the overarching Objective for the Community Health Strategy 2022-2026, which is to "***Contribute to universal health coverage by providing holistic community health services to the doorstep of all Zambians"***.



6.2 Objectives, strategies, interventions and activities

In the sections that follow, the rationale for each of these six objectives will be outlined in detail. The strategies and interventions that will contribute to the achievement of these goals are explained. A detailed list of the activities and sub-activities, including an action plan can be found in the Community Health Operational Plan that is Annexed.

OBJECTIVE 1: Build a motivated, responsive, skilled community health workforce, being equitably distributed across the country by 2026

RATIONALE

As of December 2016, the Ministry of Health had an approved establishment of 63,057 positions, but only 42,515 had been filled. In rural Zambia, where over 60% of the population lives, this shortage is particularly acute: there are only 12.4 clinicians per 10,000 persons (significantly below the World Health Organization's recommended threshold of 22.8 clinicians per 10,000).

At the community level the Zambian health system relies on two main cadres of health workers. The first cadre are the Community Health Assistants (CHAs), who receive 12 months of comprehensive training in primary health care and are formally employed as civil servants by the Ministry of Health. The second cadre are community-based volunteers, who tend to work directly with implementing partners and are trained over shorter periods, usually with a focus on specific disease verticals.

In 2010, a target was set to train and deploy 5000 Community Health Assistants (CHA) by 2021. To date, 3,400 CHA have been trained. Of these 1,654 are currently receiving a salary: 1,354 are on the

GRZ payroll while another 300 are being supported by cooperating partners. A key reason that CHAs have not been deployed is a lack of funding to pay their salaries. To meet this target, the Ministry of Health will have to make greater provision for CHAs on its human resources establishment and mobilise resources to pay for their salaries.

An evaluation of the CHA programme found that there is a need to strengthen mentorship and supervision of the CHAs and to better orient other facility staff on the role that CHAs play. Formalising the support and supervision structures for CHAs is critical to the success of the programme.

Community-based volunteers (CBVs) are mainly trained to implement selected health programs at the community level, with support from donors or NGO partners. CBV are not full-time employees, and the time spent volunteering is meant to be capped at a maximum of three days per week. This time should be spent in the community conducting health promotion, disease prevention and rehabilitative work. However, in reality CBV often spend a significant portion of their time at health facilities assisting with curative services.

Estimates of the current number of CBVs vary, but according to 2020 Community Health mapping report for Community Based Volunteers (CBVs), there are a total number of 90,016 CBVs. This is currently a deeply fragmented space; volunteers tend to work in programmes according to disease vertical, which results in different CBVs for TB, malaria, HIV, family planning, adolescent health and so on. This strategy aims to address the fragmentation of community-based volunteers in Zambia.

This is inefficient and results in poor patient experiences; it is not uncommon, for example, to hear of community members who are visited by multiple volunteers within a matter of days. Patient fatigue could result in these volunteers being turned away. In addition, CBVs that are only trained to work with specific diseases may overlook other health problems when conducting home visits. There is therefore a need to develop a more comprehensive basic training package for CBVs.

The distribution of CBVs across the country is uneven and has little relation to the burden of disease, geography and catchment population. Some districts have many CBVs, while others have none. Others still have many CBVs a high concentration of CBVs focussing on some diseases, and very few focussing on others.

There is also need to improve the coordination and leadership of community health activities at the national, provincial, district and facility level by employing staff and assigning responsibility for community health activities to appropriate personnel. This includes management staff as well as community health and public health nurses, who have a role to play in community outreach and supervising other community health workers.

STRATEGY 1.1: Strengthen coordination of community health at all levels

At the national level, the Ministry of Health established a community health unit in 2018 to provide strategic direction and oversee the implementation of community health activities in Zambia. This unit is currently however limited in size to perform all its duties. The capacity at Provincial and District level to provide appropriate support to community level structures and management remain weak. There are currently no formally appointed community health focal point persons at provincial, district or health centre level. There is therefore a clear need to strengthen community health structures at all levels of the health system.

Intervention 1.1.1 Improve management and coordination

Key to ensuring that properly functioning oversight structures are in place is the appointment of appropriately qualified focal point personnel from Government who will be responsible for coordinating and managing community health activities at national, provincial and district level. An integrated database of all community health human resources should also be maintained to enable management structures to coordinate, communicate and make decisions.

Intervention 1.1.2 Ensure that appropriate national-level guidelines are aligned

The Ministry of Health will review relevant strategic documents and guidelines to align them to new Strategic Plan, current situations and trends. Documents to be reviewed will include: Community Health Workers Guidelines 2010; Action planning hand book for district health teams; National Community Health Assistant programme implementation guidelines

STRATEGY 1.2: Address the fragmentation of Community Based Volunteers

While CBVs provide critical contributions to many health programmes, there is a high degree of fragmentation among CBVs, leading to programmatic duplications and inefficiencies. Many CBVs are engaged under multiple programs and, as a result, training differs in content, length and intensity depending on the programme and the implementing organisation. Sometimes CBVs are trained multiple times for the same service; selection criteria are not always clear; and there are no guidelines for incentives and working hours. There is limited knowledge at a high level of the number of CBVs currently working, the degree of their involvement with community health activities, and their quality of work. All of these factors contribute to high attrition rates among CBVs.

Intervention 1.2.1 Development of web-based Community Health master list

The Ministry of Health has started to put together an accurate and comprehensive database of CBVs attached to all health facility zones across the country with input from the community focal point person based at the health facility. CHAs and Community Health Focal Points are captured in HRIS of the Ministry. The Ministry of Health will develop a comprehensive master list with all the Community Health and their contact details during the new Strategy. Such a master list will support the tracking of equitable coverage and supply/equipment provision to CBVs/CHAs. It will also help to improve the coordination of Community Health work, minimise duplication of training and contribute to a more efficient allocation of resources.

Intervention 1.2.2 Ensuring equitable distribution of CBVs

Currently, donor support has mostly determined the presence or absence of CBVs in provinces and districts. To date, the partners have not been provided with guidelines for selecting areas where they will work, and this has caused an inequitable distribution of CBVs especially in areas that have no presence of donor supported programs. The Ministry will develop CBV selection and training guidelines for CBVs in identified priority districts with a current shortage of CBVs as identified in the CBV database. This will also take into account the enablers for CBVs in areas difficult to cover, as for example bicycles. The desired ratio is 1 CBV to 250 households in rural and 1 CBV to 500 households in urban setups.

Intervention 1.2.3 Definition of Standard Community Health Services Package

In order to efficiently provide health services that are responsive and meet the basic needs of the community, the Ministry of Health is in the process of developing a comprehensive yet contextualized Community Health Services Package (CHSP). This will improve the responsiveness

of the CBVs and contribute to increasing access to quality basic health services. The package will also promote linkages to services outside the health sector that are also delivered at community level, for example birth registration and child protection. This will also allow for more effective budgeting and planning of health activities at the community level.

Intervention 1.2.4 Promotion of integrated training for CBVs to deliver quality services

While some CBV training for specific disease verticals has been standardised, in other areas, training varies from partner to partner and project to project. The MoH will develop standardised basic training materials for CBVs in line with the basic package of care. This will also include training, certification, mentorship and supervision, requirement of enablers to CBVs in the various health related programs. This will enable CBVs to manage multiple activities and work more efficiently within their communities.

Intervention 1.2.5 Operationalize the CBV incentive guidelines

A lack of standard guidelines for incentives for CBVs has led to drastic variations in the payments and other incentives provided to CBVs. The Ministry of Health has developed guidelines for standard incentives for all accredited CBVs. The Ministry of Health will continue engaging stakeholders to implement these guidelines on cash and non-cash incentives.

Intervention 1.2.6 Provision of adequate and appropriate enablers for CBVs

The Basic Service Package for CBVs will determine which enablers (equipment, drugs, tests) the CBVs need to effectively provide their services to the community. The Ministry of Health will quantify these needs and work with partners to ensure the adequate and appropriate supply of enablers to all registered CBVs. Information about enablers will be included in the CBV master list to track distribution, maintenance and replacement needs.

Intervention 1.2.7: Improve community level coordination of CBVs.

To address the fragmentation in the CBV landscape, the MoH will introduce tools to improve reporting, coordination and structured supervision of CBVs. These will take into account opportunities for integration with other supervision platforms and Primary Healthcare services being provided (outreach, etc). The Ministry of Health intends to introduce CBV registers for NHC's, develop a CBV supervision manual and training of CHA's and NHC's in coordination and supervision of CBV's.

Intervention 1.2.8: Recognise and celebrate the work of CBVs

Ministry of Health will explore opportunities for recognition and appreciation of CBVs for their contribution towards improvement of indicators and general health outcomes at community level.

STRATEGY 1.3 Strengthen and scale up the CHA programme

The Ministry of Health set a target of training and deploying 5,000 CHAs. The decentralised CHA training has resulted in increased numbers of CHAs trained annually to meet this target. In order

to meet the overall targets for CHA program, there is however need to ensure that resources are available to employ the CHAs after they are trained.

Intervention 1.3.1 Develop long-term Roadmap for CHAs

The Community Health Assistants were introduced in Zambia through the National Community Health Worker Strategy in 2010. The Ministry of Health wants to review the strategy and look at the long-term goals, sustainability and role of the Community Health Assistants in Zambia.

Intervention 1.3.2 Lobby for additional training of CHAs

To date, more than 3,400 CHAs have been trained. This implies that another 1,600 additional CHAs must be trained if the MOH is to meet its target. The current capacity of the current public and private training schools is only 500 per year, so this target can be reached within four years without changing the training approach. The Ministry of Health will map the current deployments of CHAs against the recommendation to have 2 CHAs attached to each Health Post. Based on this mapping, the Ministry will lobby for training of CHAs where the target deployment has not yet been achieved.

Intervention 1.3.3 Lobby for additional placements of CHAs

Currently only 1,354 CHAs are on government payroll. An additional 300 are being supported by cooperating partners. A key reason that CHAs have not been deployed is a lack of funding to pay their salaries. To meet its targets, the Ministry of Health will have to make greater provision for CHAs on its human resources establishment and mobilise additional resources to pay for their salaries. The Investment Case can be used for this purpose.

Intervention 1.3.4 Improve supervision and mentorship for CHAs

CHAs are meant to spend only 20% of their time in the health facility and the remaining 80% of their time in the community conducting home visits and community mobilisation activities. Due

to resource constraints, this is rarely the case and CHAs often spend far more of their time at the health facility. Due to limited workforce at the facilities, CHAs also often lack the supervision of a skilled health worker. In order to provide a more enabling work environment for the CHAs, the Ministry of Health will recruit more qualified staff at health facilities, a CHA coordinator at Ministry level and develop community health Standard Operating Procedures, including mentorship guidelines for CHAs.

Intervention 1.3.5 Provide for continuous learning and career planning for CHAs

There is no clear and specific training or career path for CHAs, which will lead to lower performance and higher attrition over time. The Ministry of Health will define the continuous training package that will increase their skills and knowledge to improve their performance and a career path that will retain CHAs in community.

OBJECTIVE 2: Ensure relevant infrastructure, equipment, medicines and supplies are available for Community Health by 2026

RATIONALE

The government has adopted a policy that every Zambian household should be within a five-kilometre radius of a health centre or health post. The location of health facilities is heavily skewed towards more urban areas: 99% of the population in urban areas live within 5km of a health facility compared with 46% in rural areas. Despite a large number of facilities in urban areas, however, access to care is restricted by long waiting times.

While a 5km radius is a useful guideline, in some circumstances distance from a health centre may not be the best measure of access to health services. In some remote areas, impassable roads, wetlands or mountains may make it very difficult to access health facilities that are only a few kilometres away, while in urban areas congestion may mean that although health facilities are close by, high levels of demand mean that patients have long waiting times. The Ministry therefor set a goal of making basic health services available to all Zambians within one hour's travel from their home.

The Zambian health services suffers from a critical shortage of equipment and, owing to budget constraints and lack of experienced maintenance staff, much of the equipment currently in use is poorly maintained.

Since the withdrawal of the pre-packaged medicine kits, CHAs/CBVs have relied on health centre kits for medical supplies. Unfortunately, there are overall challenges with availability of drugs at this level, leading to shortages of drugs for Community Health.

STRATEGY 2.1 Guarantee adequate supply of medicines, supplies and basic equipment are available for Community Health

Intervention 2.1.1 Provision of medicines/medical supplies to improve effectiveness of CBVs/ CHAs

Based on the defined Basic Service Package for Community Health Workers, the Ministry of Health will define the necessary equipment, drugs and other medical supplies that need to be provided to CHAs/CBVs to do their work effectively. The Ministry of Health will ensure these are included in the quantification exercises and procurement of drugs and other medical supplies. The Ministry will also invest in medicine cabinets for CBVs to store their stocks responsibly.

Intervention 2.1.2 Train CHAs/CBVs in quantification and Drug Management

To ensure they are accountable and responsible for the drugs and supplies provided to them, the Ministry of Health and its partners will train CBVs/CHAs in quantification, requesting and reporting for drugs and supplies.

Intervention 2.1.3 Strengthen drug and therapeutic committees at facility level

To improve the accountability towards the community, the Ministry of Health will arrange for quarterly review meetings at facility level that include CHAs, CBVs and members of the NHCs.

Intervention 2.1.4 Improve the knowledge of community members on drug security and safety

To improve the knowledge of the community members on how to store, use and dispose of drugs responsibly, the Ministry of Health will develop materials to sensitize people about drug

security and safety. These materials will be disseminated through media platforms and community meetings.

STRATEGY 2.2 Strengthen linkages between the community and the health facilities

Intervention 2.2.1 Expand existing and establish new health posts, booths and outreach posts

With only 46% of the rural population having access to health services within a 5 km radius, there is need to establish new health access points to meet the needs of all. These can be permanent (Health Posts) or temporary through outreach points, like health boots or using other existing infrastructure like schools. Existing infrastructure also needs to be rehabilitated to be in a position to serve the needs of the community efficiently. As infrastructure is built and rehabilitated, adequate equipment should be installed and maintained to provide basic health services in a cost-effective manner.

Intervention 2.2.2 Strengthen integrated transport system at community level

The Ministry of Health will ensure that there are appropriate transport options available at community level for outreach activities, community programmes and for transporting patients who require it to access appropriate care.

Intervention 2.2.3 Improve bi-direction referral between the Community and Health Facilities

The Ministry of Health will be printing and distribute referral forms to communities to improve bi-directional referral between communities and health facilities. In addition, trainings will be provided to CHAs/CBVs to strengthen timely referral and follow ups.

OBJECTIVE 3: Fully funded National Community Health Strategy 2022- 2026

RATIONALE

The Zambia Health Financing Strategy 2017-2027 highlights the low and erratic funding to the health sector, particularly for primary health care, as a major challenge to implementing effective health care strategies and realising the goal of universal health coverage.

Government guidelines provides for ringfences 10% of district health budgets for community-level activities. These funds however are often not accessible and mechanisms for monitoring this spending are currently lacking. Government recently has started to send funding directly to certain health facilities in the country, this might be an opportunity for better enforcement of allocations to Community Health.

Most of the assistance provided by cooperating partners at the community level is still used for vertical programmes (i.e., disease-specific programmes such as malaria and HIV/AIDS) instead of targeting the entire health system, which would in the long run produce a greater impact on mortality and morbidity reduction. Vertical programs and earmarked financing have a potential risk of diverting attention and critical resources away from joint planning, implementation and mutual accountability.

For improving sustainability, Ministry is also looking at local revenue generation for Community Health, either through successful application to Constitutional Development Funds, CSR budgets of major construction works or engaging in local economic activities by NHCs.

STRATEGY 3.1 Expand the resource envelop for community health services

Intervention 3.1.1 Ringfence DHO budget allocation to community level.

By adding the adherence to the prescribed 10% allocation of district health budgets for community-level activities to the community score card, the Ministry of Health will be able to better track the adherence to the current policy and provide focussed interventions (providing guidance to Districts etc) where necessary.

Intervention 3.1.2 Develop Community Business Plans to engage with the Private Sector

The Ministry of Health will develop Community Business Plan to engage with the private sector. This will include a feasibility analysis for public-private partnerships, identification of potential business projects across the country and other opportunities to develop specific business cases for companies to engage in community health activities.

STRATEGY 3.2 Increase and optimise partner contributions

Intervention 3.2.1 Update the Investment Case for Community Health

The Ministry of Health will update the existing Investment Case for Community Health to account for the recent global and local changes and lessons learned. This will illustrate the return-on-investment case for supporting community health. The plan will detail the targeted service of financing community health.

Intervention 3.2.2 Develop a resource mobilization and optimization plan

By engaging with cooperating partners, the National Health Insurance Scheme as well as other units within the MOH more regularly, the community health unit aims to contribute to the more effective allocation of resources to community health. The Ministry of Health will develop a Resource Mobilization and Optimalization Plan based on the updated Investment Case. This plan will identify and link partner projects to the costed Strategy for Community Health 2022-2026 and provide guidelines on partner engagement.

STRATEGY 3.3 Strengthen local community-based income generating initiatives

Intervention 3.3.1 Expand on local revenue generating activities by Communities

The Ministry of Health will promote revenue generating activities by Communities, for instance growing and selling chlorine, vegetables or providing laundry services. The Ministry will work to support NHCs to establish community cooperatives, for accessing local resources available and to contribute to the sustainability of the Community Health work.

Intervention 3.3.2 Build capacity of NHCs to engage with local stakeholders, including Ward Development Committees

The Ministry of Health, other Government organisations and line Ministries will extend the capacity of the NHC to further engage local stakeholders e.g. Chiefs, Ward Development Committees and others in all the districts to prepare proposals and apply for local resources for community health, including from CDF and major (road) construction projects in the area.

OBJECTIVE 4: Strengthen access, accuracy and utilization of the Community Health

Information Management System that informs decision-making and policy development by 2026

RATIONALE

To make evidence-based decisions that will improve the delivery of health services at community level in Zambia, it is vital that the community health unit has access to accurate and timely information.

While there have been investments in improving the quality of community-level monitoring and reporting, significant gaps remain. New reporting guidelines have not been rolled out to all districts, and much of the information that is collected at the community level is not aggregated and passed on to decision makers in the health system.

Health information systems are still overly reliant on paper-based systems for reporting. Implementing digital reporting systems have the potential to improve data quality since information can be aggregated and analysed far more quickly and automated alerts can be set up to notify supervisors when reports are overdue or when irregularities are detected in the information submitted.

STRATEGY 4.1 Strengthen Community Health Information Systems

Intervention 4.1.1 Harmonize data collection and reporting with partners

The Ministry of Health will work with its programmes, other Ministries and its partners to further standardize and streamline indicators, recording and reporting tools and procedures to improve Government CHMIS, building on the work already done with the development of the M&E Framework.

Intervention 4.1.2 Roll out CHMIS to remaining Districts

Currently only 16% of the districts have been fully trained on the use and tools of Community Health Information Systems (CHMIS), from District Health Office all the way down to community level. The Ministry of Health will make an effort to ensure the remaining districts will be trained in the period of the new Strategy.

Intervention 4.1.3 Equip facilities and communities with digital tools for data entry, reporting and decision making

The use of technology in the form of mobile/electronic capturing systems has the potential to improve efficiency and minimize error in data capturing, which are essential for quality data management. The Ministry of Health will pilot digital tools that can facilitate data entry, reporting and decision making at facility and community level to assess their potential for scale up.

Intervention 4.1.4 Improve the routine data management and quality

The Ministry of Health and its partners will strive to work to standardize and streamline indicators, recording and reporting tools and procedures across different platforms. The Ministry will further ensure data quality by focusing on assuring standardization and continuous and/or periodical data quality audits and reviews at Provincial, District, Health Facility and Community level.

STRATEGY 4.2 Enhance the use of information for decision making and policy development for Community Health

Intervention 4.2.1 Formulate community and facility activity scorecards

Under this intervention the Ministry of Health will build the capacity of the NHCs/CBVs to use the data collected by the Community for decision making. This process will be facilitated by formulating community and facility activity scorecards.

Intervention 4.2.2 Incorporate community-level data of partners into decision-making processes.

Reporting tools at community level are often partner driven. Much of the information that is collected is not aggregated and made available to all relevant decision makers in the health system. The Ministry of Health will have regular coordination meetings to enable profiling and assessment of key indicators being collected by partners. This will help maximize the impact in the use of data from community health activities in decision making by all partners.

Intervention 4.2.3.: Promote research in community health.

Understanding the context and constraints in community health is key in developing strategies and interventions that effect change. Research contributes to the generation of evidence that helps to inform policy making relevant to specific community health needs. The Ministry of Health will continue to work with partners to identify research questions, conduct research and implement the lessons learned and recommendations to improve the quality of community health services being provided.

Intervention 4.2.4.: Mid and End Term Evaluations of the NCHS 2022-2026

To assess and understand the level of progress that has been made against planned objectives, strategies and interventions, the Ministry of Health and its partners will commission a Mid Term Evaluation (MTE) in 2024 and an End Term Review (ETR) exercise of the NCHS in 2026. It is anticipated that the findings of this exercise will help in proving and improving strategies, and in the identification of new approaches for potential strategy refinement and roll-out.

OBJECTIVE 5: Provide high-quality health services at the household and community level by 2026

RATIONALE

Health promotion is one of the important components in the continuum of care in service delivery at community level. Health promotion enables individuals, families, households, and communities to realize the highest level of health and development irrespective of age, race, income, geographical location, or education level. The National Health Strategic Plan 2022-2026 advocates for public policies that support and promote health education and disease prevention to empower individuals, families, and communities with appropriate knowledge to develop and practice healthy lifestyles.

There is a fragmentation in the community health preventive, curative ad support services being provided by the Community Based Volunteers (CBVs) across departments, Ministries and parastatals, affecting the quality of basic health services. Furthermore, a lack of a standardized basic health

package results in inefficient provision of health services to the community.

STRATEGY 5.1 Strengthen Demand generation and Health Promotion

Intervention 5.1.1 Address barriers preventing people from accessing health services

The Zambian population is characterized by various cultural backgrounds which create varying health seeking behaviours shaped by education, gender, geographic location, income, age status and social norms. To overcome cultural and disability barriers the Ministry of Health will continue holding stakeholder advocacy and community dialogues (INSAKA) meetings to promote traditional, religious and other community leaders' participation in community health services. The Ministry of Health will also raise awareness on community health services using multimedia platforms (meetings, electronic, social and print media including IEC materials among others).

Intervention 5.1.2 Promote health education

An important component of demand creation is to provide health education. The purpose of this health education should be to empower communities with information to make informed, healthy lifestyle choices. This will contribute to the prevention of common health issues as well as improved knowledge of when it is appropriate to seek care and where such care can be found. Focused efforts are required that transcends barriers to access to health and provide information packaged in a systematic yet simplified manner to meet different individual needs. This will include developing evidence informed SBC interventions that will respond to the needs of the communities, building capacity of community-based service providers in SBCC, timely referral and follow ups and conducting door to door sensitization of communities.

STRATEGY 5.2 Develop, Disseminate and Institutionalize Community Health Service Package

Intervention 5.2.1 Develop a comprehensive Community Health Service Package

In order to efficiently provide health care services that meet the basic health needs of the community, a comprehensive health package that integrates preventive, curative, rehabilitative and palliative services will be merged in one. It is envisaged that the provision of a well prioritized and integrated Community Health Service Package will allow for more effective budgeting and planning of health activities at the community level and contributes to increasing access to quality basic health services. It will also serve as a guide both health workers and ordinary community members in where to access appropriate health services and how to follow up on referrals.

Intervention 5.2.2 Disseminate and orient Community Based Service Providers on the Community Health Service Package

Once the package is concluded the Ministry of Health will launch it nationally with other relevant Ministries and partners, in view of the inter-departmental coordination required. The Ministry will also hold provincial and district dissemination meetings to orient district and communities.

Intervention 5.2.3 Institutionalise the Community Health Service Package

After the Community Health Service Package is disseminated, the Ministry will conduct technical service support to community-based service providers to ascertain adherence to Community Health Service Package.

STRATEGY 5.3 Strengthen quality community health services to all, with a specific focus on special populations

Intervention 5.3.1 Identify and map different special populations and address their needs

During the end term review process for the NCHS 2019-21, it was established that no deliberate focus was given to special groups, such as people with disabilities. Given the uniqueness of this group and many others, special consideration should be given to them. The Ministry of Health will therefor identify special populations, clarify their specific needs, map their presence and develop specific community interventions to reach them. These could be for instance specific health days for hard-to-reach populations, establishing special community outreach posts or training in sign language for community healthcare providers.

STRATEGY 5.4: Enhance supervision of the provision of health services at community level

Intervention 5.4.1: Scale up peer-to peer supervision and mentorship

At community level supportive supervision and mentorship is often lacking due to limited availability of healthcare staff. The Ministry of Health will put together a training package and orient CBVs in Peer-to-Peer Supportive Supervision and Mentorship. The Ministry will develop the training package and roll this approach out to the communities.

STRATEGY 5.5: Pilot high-potential innovations for community health

Intervention 5.5.1.: Develop a framework for identifying promising innovations

Community health systems must be innovative and evolving to adapt to the ever changing economic and social environments. The Ministry will develop a systematic approach to identify key innovations and assess their potential for enhancing community health systems and service delivery to encourage innovations in Community Health. In addition, the Ministry will establish an annual event to showcase and recognise innovations and operational research.

Intervention 5.5.2 Pilot innovations in a controlled setting and document lessons

Innovation can be influenced by various social, economic, political and cultural factors, thus the Ministry of Health and Cooperating Partners will pilot innovations within a controlled setting and document lessons. This can help build relevant evidence on which effective implementation can ride with all potential constraints being factored in, while designing scale up programs for innovation in community health.

STRATEGY 5.6 Strengthen Community Health in Urban Areas

Intervention 5.6.1 Scale up and develop new models for delivery of Community Health interventions in Urban Areas

Most of the CBVs/CHAs are currently deployed in rural areas, while the populations in urban areas in Zambia are growing fast. Zambia is one of the countries with the highest urbanisation rates in Africa. The Ministry of Health has piloted some new community health models, like market and bus station clinics, that it intends to scale up, but it also wants to explore other innovative models to reach urban populations with community health services.

OBJECTIVE 6: Provide effective leadership and governance in the formation, management and maintenance of community health structures by 2026

RATIONALE

Structures and processes must be developed for the improved coordination of community health

service delivery as these functions become decentralised. As a result, there is a need for

management support for community health systems from the community to the national level. The Ministry wants to address this by creating establishment and appointing suitably qualified community health focal points at each level of the health system.

Prior to 2006, the legal framework for NHCs was provided by the National Health Services Act. In

2006 this Act was repealed but has not yet been replaced and as a result there currently is no legal framework for these structures.

Within the community health sector, there are several areas where regulatory frameworks must be improved to formalise community health structures in line with the decentralisation policy. This provides an opportunity to improve the regulatory framework for community health service delivery and adopt best practice procedures.

To strengthen the oversight role of the NHCs and HCCs, national NHC guidelines have been developed. This aims to improve the involvement of community representatives in all aspects of

planning, implementation, and monitoring and evaluation, and to hold health workers and facilities accountable for service delivery. These have been launched, but not rolled out to community level in many Districts.

A draft social accountability training manual has also been developed and it is ready to be rolled out. The main goal of social accountability is to strengthen capacities of citizen groups and government to work together in order to enhance quality of public services delivered to citizens. It seeks to give voice to the needs and concerns of all citizens on the delivery and quality of public services.

STRATEGY 6.1 Strengthen governance of community health structures at all levels

Intervention 6.1.1 Disseminate essential policy documents and guidelines

Following the introduction of the Community Health Unit at National level, there is a need to roll out functional community health structures at all levels of the health system. The Ministry of Health will facilitate for the implementation of the strategy through dissemination of essential community health policy documents and guidelines (including this Strategy) to all levels (including Districts, health facilities and communities) and inclusion of community activities into the annual plans and budgets at district level.

Intervention 6.1.2 Provide the legal framework to formalise NHCs/HCCs and CBVs

Following the repeal of the National Health Services Act in 2006, community health structures (particularly NHCs and HCCs) do not have a recognised legal structure. The Ministry will therefor develop new statutory instruments to provide the legal framework for NHCs/HCCs. CBVs do not have a direct contractual relationship with the ministry. This exposes the Ministry of Health to risks and makes it difficult to enforce accountability mechanisms. The Ministry therefor is in the process of developing and adopting a formal contract between CBVs and the Ministry of Health.

STRATEGY 6.2 Enhance leadership and coordination of community health structures

Intervention 6.2.1 Strengthen community health structures

The Ministry of Health will develop a framework for the delineation of the roles and responsibilities of the community health structure, including for resource mobilisation. The Ministry of Health will ensure the establishments and recruitment of staff at various levels to support the implementation of Community Health activities. Standard operating procedures and community health guidelines will also be developed for all community health cadres.

Intervention 6.2.2 Strengthen multisectoral collaboration linkages and coordination

The Ministry will strengthen linkages and coordination of community health interventions at National, Provincial, District and Community level. This will be done through mapping of all projects/ programmes that play a role in community health and holding community health meetings with other line Ministries, Government Agencies, partners and other stakeholders at various levels.

Intervention 6.2.3 Improve partner coordination, mobilization and monitoring

After the Resource Mobilization and Optimalization Plan is launched, the Ministry of Health will convene round table meetings with its Cooperating Partners to negotiate and improve alignment. The Ministry will convene round table meeting annually with senior representatives and at the working level convene monthly implementation monitoring meetings by the subcommittee for Finances of the Community Health Technical Working Group for the partners. The Ministry will also implement an online implementation monitoring system to inform the monthly meetings.

STRATEGY 6.3 Empower decentralized community health structure to take up oversight role

Intervention 6.3.1 Roll out of the new NHC Guidelines

The Ministry of Health will disseminate and train health facility staff and NHCs in the NHC guidelines it developed and provide onsite mentorship in the management of Community Health Services.

Intervention 6.3.2 Strengthen social accountability mechanisms.

Social accountability mechanisms allow community structures to hold health facilities and health workers to account for the services that they are meant to provide. This contributes to better buy-in and community ownership, as well as improved service delivery. This intervention will consist of development of a social accountability manual, a community score card, sensitise the community on their role in social accountability and holding annual NHCs performance review meetings at district level.

9. MONITORING AND EVALUATION

This section outlines what will be monitored and how by describing the monitoring methodologies at the various levels, expected outputs and data quality control mechanisms during the implementation of the National Community Health Strategy 2022-26. The timing and frequency of conducting monitoring activities and monitoring responsibilities from national level flowing to provinces, districts, sub-districts, Health posts and communities is outlined.

9.1 Monitoring processes

- Monitoring will be done for routine key indicators, process and output indicators
- Once data is collected, analysed, and summarized, it will be critical to review and use the information for decision making
- Reviews will be done by holding regular data review meetings at National, Provincial, District, Health Facility, NHC levels to understand what is going well and apply action steps to build on those successes and address weaknesses
- The process will facilitate identification of challenges so that the Ministry can make changes and improvements as needed
- The timing of reviews will be structured to match needs. In most areas, reviews will be done monthly, quarterly and annually
- With technology, it will become more common to review data even more frequently

Table Monitoring at various levels

Level	Activity	Process	Output	Timeline/ Frequency	Responsible
Community level	Reporting on Community Indicators	Complete and submit returns on the community health indicators using a CHA form (HIA 4b)	Completed summary Reports (HIA 4b)	Monthly	CHAs
		Complete and submit returns on the community health indicators using a CBV form (HIA 4a)	Completed summary Report (HIA 4a)	Monthly	CBVs/NHCs
	Community Open days	Review community indicators performance and health concerns, community scorecards	Community open Day Report	Monthly, Bi-annually	CHAs
	Community Monthly Chalkboard	Monthly meetings with opinion leaders to communicate key public health events arising from the community health teams' interactions or service provision during the reporting period	Community Monthly Chalkboard report	Monthly/ Quarterly	HCC Chair
	NHC meetings	CBVs share progress reports	NHC Report; Community action plans	Monthly/ Quarterly	NHC Chair
	Health centre committee (HCC)	NHCs present their progress reports Health Centre/Health post present the facility score card or progress report	HCC report	Quarterly	HCC Chair
	Validation of submitted Community data	Review forms submitted by CHWs and note any concerns that needs addressing	Validated reports forwarded to the district level	Monthly	Facility I/C
	Data Quality Audit	Conduct Routine Data Quality Audit	Data Quality Audit reports	Quarterly	CHA
	Regular Joint/Integrated Supportive Supervision	Conduct supportive supervision/mentorship visits	Supervision Checklist and Report	Quarterly Monthly/ Quarterly	CHA Facility I/C
	Manage the CBV Master Community Health Units List	Update the CBV Community Health Units List	Updated Community Health Units List	Quarterly	Health Centre Community Focal Point Person (HCCFPP)

District level	Capture Community reports into the DHIS	Capture and upload community reports into the DHIS	Community reports uploaded into the DHIS	Monthly	DHO/DHIO/SHIO
	Data review meetings	Conduct Routine data review meetings	Reports; Cleaned community data	Quarterly	DHO/DHIO/SHIO
	Data Quality Audit	Conduct Routine Data Quality Audit	RDQA Report	Quarterly	DHIO/SHIO
	Community scorecards	Generate community score cards from the DHIS data	Community score cards	Quarterly	DHIO
	District integrated meetings (DIMs)	Review of HCC progress reports Feedback to HCCs	Reports	Quarterly	DHIO, HCC chairperson
	Regular Joint/Integrated Supportive Supervision	Conduct multi-disciplinary supportive supervision	Supervision Checklist and Report	Quarterly	District Community Focal Point Person
	CHW records	Maintain and report on CBVs and CHAs currently deployed within the District	CHW reports	Quarterly	District Community Focal Point Person
	Manage the CBV Master Community Health Units List	Update community Health Units List	Updated Community Health Units List	Quarterly	District Community Focal Point Person (DCFPP)
Provincial level	Community Health reports	Produce Provincial community health reports	Provincial community health progress reports	Monthly	PHO/PHCC
	Conduct Routine Data Quality Audit	Conduct Routine Data Quality Audit	RDQA Report	Quarterly Bi-annually	CHMT/SCHMT
National level	Community health Performance Review Meetings	Progress review against the Community health targets	National CH Performance Progress Report	Bi-annual	CHU-M&E
	Conduct Routine Data Quality Audit	Conduct Routine Data Quality Audit	RDQA Report	Bi-annual	CHU /M&E
	Integrated Supportive Supervision	Conduct CH supportive supervision	Supervision Checklist and Report	Quarterly	CHU, provincial & District teams
	Community health assessments	Carry out community health assessments to monitor program performance	Assessment reports	Bi-Annually	CHU, provincial & District teams
	Manage the CB Master Community Health Units List	Update	Updated Community Health Units List		CHU/ M&E FPP

10. COSTING OF THE NCHS

Objectives of Costing

The Ministry of Health has conducted a high-level cost analysis of the Community Health Strategy and the Operational Plan. The aim of the cost analysis was to inform review of the strategy; estimate total resource needs and support investment planning and subsequent resource mobilization efforts.

Methodology

Data for the analysis was obtained from various primary sources including review of relevant documents of the Ministry of Health, Central Statistics Office of Zambia and partners. Secondary literature was also reviewed in journals, reports and other publications.

Findings

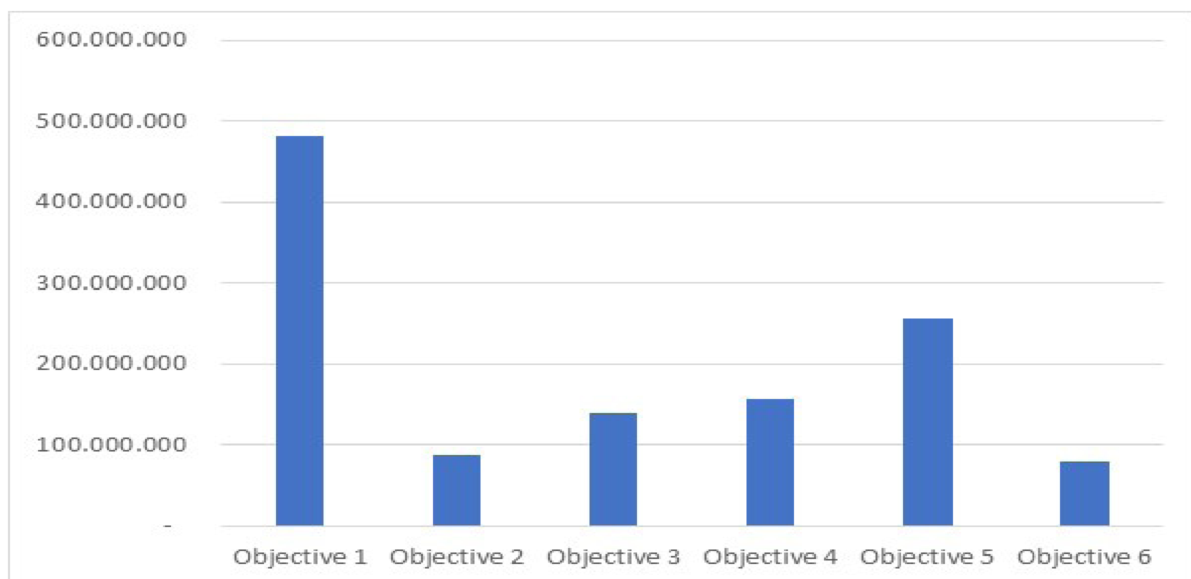


Figure 7: Budget NCHS per Objective (ZMW)

Program cost to implement the objectives, strategies and interventions under the National Community Health Strategy 2022 – 2026 is close to ZMW 1,200 million.

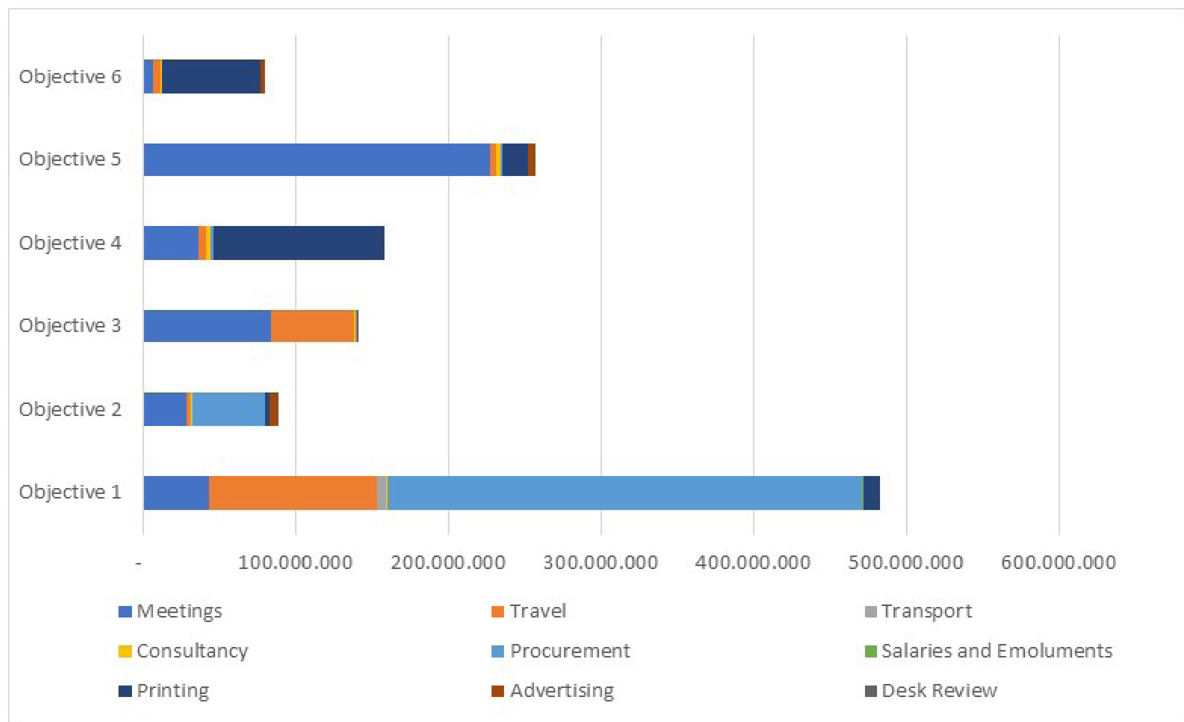


Figure 8: Costs NCHS per year, broken down per category (ZMW)

Costs are broken down in the graph above. Of the proposed budget, Meetings at ZMW423 million and procurement of transport, health boots, medicines and other equipment at ZMW 363 million, Printing at ZMW 207 million and Travel at ZMW 179 million are the largest cost drivers. These are followed by Advertising at ZMW 16 million, Consultancies at ZMW 10 million, Transport at ZMW 7 million, Salaries and Emoluments at ZMW 1 million.

Limitations

The main limitation of this analysis is that it assumes there are no bottlenecks in execution of the strategy and service delivery. It assumes bottlenecks have been solved, and only includes the costs of implementing the planned interventions.

Conclusion

The objective of this analysis was to project the costs to aid in decision making and finalization of the Community Health Strategy. The results will also form the basis updating the Investment Case for Community Health, linking costs to potential returns from implementing the community health strategy. Finally, the analysis aims to support the Resource Mobilization and Optimalization Plan and other advocacy efforts needed to secure funding to ensure sufficient level of resources for community health services.

11. THE CASE FOR INVESTMENT IN COMMUNITY HEALTH

Community health has proven critical to improving health outcomes, especially in low- and middle-income countries. While community health is not new for Zambia and already has proven its impact in the country, the creation of the Community Health Unit within the Ministry of Health in 2018 bring a renewed push to optimize Zambia's community health system.

Implementing the ambitious strategy however requires additional investment in community health to realise the important health, economic, and societal benefits, as well as cost savings to the broader health system. There are three main reasons to do so, which will be further deliberated in this chapter.

9.1 Reaching Global and National goals

The global health community has committed to two global goals by the year 2030: the sustainable development goals (SDGs), which apply to health along with other development areas, and universal health coverage (UHC). Alongside global goals, Zambia has its own national goals for the health system, as articulated in the National Health Strategic Plan 2022-2026. For these and other priorities such as reducing child and maternal mortality, preparing for future crises and eliminating diseases, a strong and well-resourced community health program is a critical ingredient in Zambia's ability to realistically achieve these goals.

A key aspect of achieving UHC is having enough health workers to serve the population. Zambia's 12.4 clinicians per 10,000 is well below the WHO recommended 22.8. Community health workers contribute in addressing the human resources for health shortage to build toward UHC goal.[39]

Finally, financing is an important component of UHC as Zambians should not only have access to care, but additionally shouldn't need to pay a financially prohibitive cost. Zambia's policy of providing care at the primary level and below free to the patient at the point of service ensures that community health care is both accessible and affordable to the patient, both of which are critical for the expansion of UHC.

Community health is a critical investment area for Zambia as Zambia works to achieve the SDGs by 2030. Community health can also help Zambia make progress toward achieving SDG 3 (good health and wellbeing), but also other SDGs. For example, community health brings meaningful, high-quality employment to women employed as CHAs, contributing to SDG 5 (gender equality). Community health also makes healthcare more equitable by centering care on those who previously did not have reliable and/or affordable access, which contributes to SDG 10 (reducing inequalities). Each of the broader societal benefits of community health, to be explored later in this section, contribute to a development priority outlined within the SDG framework.

9.2 Community Health impact within various disease areas

While community health has already made a significant impact, a well-resourced community health system can deliver impact beyond what has already been achieved. The current and potential impact in various disease areas are highlighted below.

Malaria

Zambia remains a high burden malaria country. In 2021 there were 7,050,968 malaria cases; malaria case incidence was estimated to be 340/1,000 population/year; prevalence in children under 5 was found to be 29% (RDT-based); and the incidence of inpatient malaria deaths was 8/100,000 population per year[40].

In the last decade the Malaria Programme has trained around 16,000 Community Based Volunteers in every district in Zambia to test for and treat uncomplicated malaria cases, catching many more cases and greatly reducing the burden on health facilities.[41] To diagnose and treat, volunteers are supplied with rapid diagnostic test kits, anti-malaria medicine, lancets for finger pricks, and educational materials. In addition, these volunteers receive bicycles and mobile phones, allowing them to reach communities and regularly report cases and share malaria data within the national health system.

Making sure local and national information is integrated and providing ongoing support for the community health volunteer network are essential to the program's goal of strengthening provincial health services for long-term success fighting malaria. Data from the Ministry of Health's malaria unit state that from 2015 to 2019, 34% of the 816,634 total passive confirmed malaria cases were confirmed by community health workers.[42]

Child health

Infant mortality in Zambia marginally declined from 45 deaths per 1,000 livebirths in 2013/2014 to 42 deaths per 1,000 live births in 2018. Infant mortality is slightly higher in urban areas (44 deaths per 1,000 live births) than in rural areas (41 deaths per 1,000 live births)[43].

Community health has proven essential for prevention and treatment of child diseases, including malaria, malnutrition, pneumonia, and diarrhoea, which are all leading causes of child mortality in Zambia[44]. A 2013 paper evaluating integrated community case management of childhood malaria and pneumonia by community health workers in Southern province found that 94 – 100% of children were diagnosed and treated correctly by the community health workers, demonstrating that CHWs are capable of providing high-quality treatment of child illnesses.

Community Health is also playing an important role in supporting children with Non-Communicable Deceases, Mental Health and Disabilities. A 2015-2016 study done in Southern Province used an intervention where community health workers were trained to perform bi-weekly home visits to screen children for malnutrition and refer them to the health facility if necessary, and to run bi-weekly parenting meetings on topics including mental health and child nutrition.

40 HMIS 2021; MIS 2021

41 Davidson H Hamer, Erin Twohig Brooks, Katherine Semrau, Portipher Pilingana, William B MacLeod, Kazungu Siazeele, Lora L Sabin, Donald M Thea & Kojo Yeboah-Antwi (2012) Quality and safety of integrated community case management of malaria using rapid diagnostic tests and pneumonia by community health workers, Pathogens and Global Health, 106:1, 32-39, DOI: 10.1179/1364859411Y.0000000042

42 MOH malaria unit

43 Zambia Demographic and Health Survey 2018

44 Mulenga, Peter & Daka, Lincoln & Mulenga, Edith & Kapita, Peter. (2017). Determinants of Under-Five Mortality: Evidence from Zambia. Journal of Economics and Sustainable Development. 8. 2222-2855.

Communities receiving this intervention had 45% reduced odds of stunting compared to control groups, showing the significant impact of this community-based intervention[45]. Other studies confirm that community stakeholders attribute higher demand for and utilization of health services, especially for children, to the presence and work of community health workers[46].

Tuberculosis (TB)

An important aspect to TB control is identifying all TB cases and getting treatment to those with TB to control the spread of TB. Community health workers have been pivotal thus far in detecting TB cases. In Kanyama, a recent intensified case finding intervention found 203 active TB cases, of which 25% were detected at the community level. In 2018, three districts (Kitwe, Kalumbila and Sinazongwe) piloted a results-based financing scheme where CBVs were trained to detect and report suspected TB cases, receiving an incentive for every suspected case reported. In Q4 2018, this results-based financing mechanism with CBVs caught 67% of the new TB cases in the participating districts[47] [48]. The high percentage of TB cases identified at the by community health workers demonstrates the criticality of community-level TB detection programs.

Sexual, Reproductive Maternal, Adolescent and Newborn health

Pregnancy related mortality in Zambia declined from 398 deaths per 100,000 live births in 2013/2014 to 278 deaths per 100,000 live births in 2018[49]. Pregnancy related mortality is caused by both direct and indirect factors. The percentage of women who had ANC in the first trimester increased from 10% in 1992 to 37% in 2018. There has been an appreciable increase in the proportion of deliveries from health facilities and attendance by skilled providers to 80% in 2018. Women in urban areas are more likely to be assisted by a skilled provider (93%) than women in rural areas (73%).

Total Fertility Rate (TFR) in Zambia was 4.7 births per woman in 2018. It is higher (5.8 children per woman) in rural than urban areas (3.4 children per woman). Zambia has seen a slight reduction total fertility rate among adolescents aged 15 to 19 years from 146/1000 adolescents in 2007 to 135 in 2018. Teenage pregnancy rate has not significantly changed since 2007 when it was 27.9% compared to 29.2% in 2018.

CBVs/CHAs promote family planning and improve maternal health through the promotion of ante-natal and post-natal care, and encouraging mothers to deliver at a health facility. Community-based messaging urging women to deliver in a facility rapidly increased the percentage of women giving birth at a health facility from 63% to 84% from the baseline in 2012 to the end of the study period in 2013[50]. Community-based interventions, alongside facility and primary care improvements, have contributed to reductions in maternal mortality in Zambia. In addition, self-care interventions for Sexual and Reproductive and Health Rights are being promoted and CBVs play an educative and advisory role.

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45 Rockers PC, Zanolini A, Banda B, et al. Two-year impact of community-based health screening and parenting groups on child development in zambia: Follow-up to a cluster-randomized controlled trial. *PLOS Medicine*. 2018;15(4):e1002555.

46 Aaron M Kipp, Margaret Maimbolwa, Marie A Brault, Penelope Kalesha-Masumbu, Mary Katepa-Bwalya, Phanuel Habimana, Sten H Vermund, Kasonde Mwinga, Connie A Haley, Improving access to child health services at the community level in Zambia: a country case study on progress in child survival, 2000–2013, *Health Policy and Planning*, Volume 32, Issue 5, June 2017, Pages 603–612, https://doi.org/10.1093/heapol/czw141

47 National Tuberculosis and Leprosy Programme

48 Southern Africa TB and Health Systems Support (SATBHSS) Project

49 Zambia Demographic and Health Survey 2018

50 https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-017-1222-y

Safe Motherhood Action Groups (SMAGs) have been important community-based structures that improve reproductive and maternal and new born health. A 2014 intervention study done in six districts trained SMAGs to hold sessions on safe practices in pregnancy and delivery and organized increased emergency transport for mothers in labor. Compared to a control group, this community intervention increased the uptake of appropriate ANC and PNC visits for mothers and their new borns, increased the percentage of deliveries accompanied by a skilled-birth by over 25%, and increased the use of contraception immediately after giving birth by about 10%[51].

HIV-AIDS

Significant progress in HIV epidemic control has been noted in Zambia in the last couple of years. The mother-to-child transmission rate however remains high at 11 per cent. Only 58 per cent of children (0-14 years) and 53 per cent of adolescents (10-19 years) living with HIV are receiving anti-retroviral treatment.[52]

CBVs/CHAs in Zambia are at the front lines of HIV testing and treatment and community-based interventions have thus far been successful in bringing Zambia closer to the UNAIDS 95-95-95 goal. Home-based HIV counselling and testing (HCT) by community health workers has been shown to increase the population aware of their HIV status. Peer educators have been deployed to increase knowledge of adolescents. In one study in Zambia, community health interventions were found to improve adolescent knowledge of one's own HIV status from 27.6% to 88.5%[53]. A separate study found that home-based HCT was the most effective method in reducing one's own stigma of having HIV[54].

The voluntary medical male circumcision (VMMC) program has been used in Zambia as one of the key pillars of HIV prevention since 2009. According to the WHO, there is compelling evidence that male circumcision reduces the risk of heterosexually acquired HIV infection by approximately 60%[55]. To achieve the ambitious target of circumcising about 400,000 males in Zambia in 2018, one of the strategies implemented was having community health promoters (mobilizers) use interpersonal communication to generate demand for the program. According to data from the HIV unit within the MOH, this strategy, in addition to alleviating client concerns about circumcision, encouraged them to get circumcised, significantly contributing to the program surpassing the target - 121% against target, and averting over 26,000 new HIV infections compared to 2017[56].

WASH

Poor access to water, sanitation and hygiene (WASH) can cause diarrhoea, a leading cause of death among children (0-5 years). In Zambia, 36 per cent of the population lacks access to basic drinking water services. Only 28 per cent of the rural population have access to basic sanitation services and 15 per cent to basic hygiene services, compared to 41 and 24 per cent respectively in urban areas[57].

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51 Ensor T, Green C, Quigley P, Badru AR, Kaluba D, Kureya T. Mobilizing communities to improve maternal health: Results of an intervention in rural zambia. Bulletin of the World Health Organization. 2014;92(1):51. doi: 10.2471/BLT.13.122721.

52 2021 UNAIDS Estimates

53 Shanaube K, Schaap A, Chaila MJ, et al. Community intervention improves knowledge of HIV status of adolescents in Zambia: findings from HPTN 071-PopART for youth study. AIDS. 2017;31 Suppl 3(Suppl 3):S221–S232. doi:10.1097/QAD.0000000000001530

54 Jurgensen M, Fossgard Sandoy I, Michelo C, Fylkesnesa K. Effects of home-based voluntary counselling and testing on HIV-related stigma: Findings from a cluster-randomized trial in zambia. Social Science & Medicine. 2013;81:18-25. doi: 10.1016/j.socscimed.2013.01.011.

55 https://www.who.int/hiv/topics/malecircumcision/en/

56 MOH data

57 Zambia Demographic and Health Survey 2018

Peri-urban areas face some of the worst water supply and sanitation services. Girls and women, who often carry the burden of seeking water from remote sources, are particularly affected by poor access to WASH and this also impacts their menstrual hygiene management.

In the last decade, the Ministry of Water Development and Sanitation in cooperation with its partners have trained Sanitation Action Groups (SAGs) and Community-Led Total Sanitation Champions in over 10,000 villages in Zambia. Sanitation Action Groups are composed of five men and five women and are trained to support households, monitor progress in each village and to claim Open Defecation Free (ODF) status once achieved[58]. Verification of ODF status is then carried out by the District Water, Sanitation and Hygiene Education (DWASHE) unit and EHTs at ward level, and includes the chiefs at chiefdom level. Mass verifications and ODF certification also includes the Provincial Water, Sanitation and Hygiene Education (PWASHE) teams and the National CLTS Coaches.

During the implementation of this WASH programme there was a significant decrease in the overall prevalence of stunting, severe stunting and the prevalence of wasting. The beneficial effect on stunting was associated with households that had improved, not shared facilities and handwashing station with water and soap, thus suggesting that the changes in sanitation and hygiene that resulted from the programme may have contributed to a reduction in stunting.

Nutrition

The role of Community Healthcare is important to reduce stunting and micronutrient deficiencies by implementing programmes that facilitate dietary diversity, provide integrated nutrition-sensitive interventions and promote gender and social norms that encourage optimal care behaviour and practices. This includes promoting breastfeeding, diversified complementary food and feeding practices and nurturing care, supporting maternal nutrition and providing child nutrition services as part of the Integrated Management of Neonatal and Childhood Illness package.

To ensure the early detection and treatment of wasting, including in humanitarian settings, community-based approaches for the integrated management of acute malnutrition are important. This includes active case finding, referral, follow up and counselling, and linking children to outpatient and in-patient therapeutic treatment programmes.

Routine Immunization with a focus on Zero dose children, under-immunised children and missed communities

The CBVs/CHAs are important to identify and mobilize Zero Dose Children. Zero dose children are defined as any eligible child who hasn't received a single dose of DPT while under immunised children are those that have not received DPT 3. In 2021, there were 79,4918 (10%) zero dose children, a -14% reduction from 2020 but on par from 2019 figures. In Zambia, fifteen districts accounted for half the zero dose children. There were 36 districts with negative figures, where the number vaccinated was higher than the projected surviving infants indicating data quality issues. For missed children, outreach is needed by reliable, well trained and trusted community health workers who are in the communities building trust about the vaccines.

58 Impact evaluation of the sanitation and hygiene program in Zambia, Zambian Centre for Applied Health Research and Development Limited, 2017

Another focus area with the primary health care strengthening approach is the shift from childhood to life course immunisations. The number of adolescent and adult immunisations has increased from the routine Tetanus Toxoid (TT) to include Human Papilloma Virus (HPV) for adolescents and COVID 19 give from 12 years of age. CBVs/CHAs are utilised to bridge the gap in between communities and health facilities and facilitate community mobilization and address any kind of vaccine hesitancy.

Non-Communicable Deceases

Non-Communicable Diseases (NCDs) refer to a group conditions of long duration and generally slow in progression, which include cardiovascular diseases (CVDs), cancers; chronic respiratory diseases and diabetes. Others include mental disorders, epilepsy, trauma (mostly due to road traffic accidents and burns), haemoglobinopathies (sickle cell anaemia), including some oral diseases, eye and ear disorders.

Lately, Zambia has recorded increased morbidity and mortality due to NCDs[59]. Mortality attributable to NCDs in Zambia increased from 23% in 2014 to 29% in 2016 with 18 percent increased risk of dying prematurely (between the ages of 30 and 70)[60].

Cervical cancer contributes the highest to Zambia's cancer burden. The country had the third highest incidence rate of cervical cancer in the world with 66.4 new cases per 100,000 women (age-standardised to the world population). Zambia introduced the HPV vaccine on a pilot basis in 2013 and it became part of the national EPI in 2019. Current programme performance however has been declining and lagging behind the given targets.

Contributing factors include programme challenges: lack of standardised data collection tools and inclusion in the national HMIS system, vaccine hesitancy due to myths and misconceptions in some communities, high populations in urban areas making it a challenge for the number of out of school girls to be known. CBVs/CHAs can help to overcome these challenges, identify girls that not yet been vaccinated and facilitate transportation to the facilities where the vaccines are available.

Public Health Security

Zambia's national health security constantly faces both external and in-country threats arising from emerging and re-emerging infections and other public health threats, including the current COVID-19 pandemic and recent outbreaks of Ebola virus disease, measles, cholera, vaccine-derived polio, Listeriosis, yellow fever, influenza, typhoid, Rift Valley fever, dengue, plague, anthrax, Marburg and Foot and Mouth Disease among others.

CBVs/CHAs can simultaneously prevent, detect and respond to pandemics and maintain delivery of essential health services. Community resilience is critical to minimize the effect of the ongoing emergencies and be better prepared for future crises and public health emergencies. Therefore, investing in Community Health is important as the foundation of resilient health systems and our first line of defence.

In 2020 for instance the Government of Zambia with support from its partners, recruited and deployed community youth volunteers across the country for door-to-door sensitization, to

59 MOH 2020 Annual Progress Report
60 Non-communicable diseases country profiles 2018: Zambia. Geneva: World Health Organization [Online] 2018 (http://www.who.int/nmh/countries/en, accessed 5 July 2019)

strengthen community preparedness and response to the COVID-19 pandemic. By August 2020 the door-to-door initiative reached an estimated 700,000 households with more than 833 community youth volunteers on the frontline debunking myths and spreading life-saving messages in Lusaka and surrounding communities as well as Chirundu in Southern Zambia and Chipata in the Eastern Province. The volunteers shared life-saving prevention measures, including up-to-date messaging on COVID-19, ranging from educating on precautionary steps to keep families safe from infection, providing information on medical assistance and managing stigma associated with the virus. [61].

9.3 Broader societal benefits

The community health program includes other potential benefits. This section highlights a few of them.

Making healthcare more affordable for patients

Out-of-pocket expenses account for 12% of health spending in Zambia.[62] This is relatively low compared to similar countries, likely related to the abolition of user fees at the primary care level and below. However, there is room to make healthcare more affordable to patients, and providing free care to patients at the community level can prevent future high treatment and transportation costs at higher levels of care.

Providing employment

Zambia's unemployment rate is high for both youth and adults. Formal unemployment and underemployment rates are as high as 7.9% and 10.2% respectively. From 2017 to 2018 formal sector employment decreased from 45.7% to 31.1%, while in the same period, informal sector employment increased from 31.0 % to 45.4%[63]. Implying that more than one in every three people in the labour force did not have a formal job in 2018. Community health provides meaningful livelihoods for CHAs, training and incentives for many CBVs, and jobs at the supervision and management level, locally and nationally. Employment under the community health system can be stable, well-paid, and meaningful work for many underemployed Zambians.

Empowerment of women and marginalized groups

Community health workers represent the communities they serve, which includes women, youth, and members of marginalized groups. Women, youth in Zambia often participate in unpaid, low quality, or low-income jobs, often due to their being female, youth or part of a marginalized group. Employment under the community health system provides economic empowerment for these individuals. About half CHAs and the majority of CBVs are women, providing the stated employment and empowerment benefits.

Community empowerment

Community health empowers communities to take control of their own health and builds capacity at the community level. Employment of community health workers allows community members to be part of the solution, and enables communities to tailor solutions to their needs.

APPENDIX 1 - OPERATIONAL PLAN AND RESULTS FRAMEWORK

EXPECTED OUTPUTS	PLANNED ACTIVITIES	SUB ACTIVITIES	RESPONSIBLE PARTNER	PLANNED BUDGET (ZMW) Budget ZMW	0,0625 USD	Source Funding	Budget Description	TIMING 2022	2023	2024	2025	2026
OBJECTIVE 1: Build a motivated, responsive, skilled community health workforce, being equitably distributed across the country by 2026												
Indicator: CHWs per 10,000 population - Baseline: 1:XXX Rural 1:XXX Urban by District Target 2026: 1:200 Rural 1:500 Urban by District												
STRATEGY 1.1: STRENGTHEN COORDINATION OF COMMUNITY HEALTH AT ALL LEVELS	**Intervention 1.1.1.: Improve management and coordination**											
Indicator: % of Districts with formally appointed Community Health Focal Points	Lobby inclusion of the positions of Community Health Offciers to be included at National, Provincial and District levels to be included in the establishment	Write a concept note including the scope of work	MoH	-	-		Letter					
Baseline: 0		Write to Permanent Secretary	MoH	-	-		Letter					
Target 2026: 100 %		Arrange for a meeting with Human Resource	MoH	-	-		Meetings					
	Mobilise resources to employ officers in community health	Call for a one day partner meeting in Lusaka, for 45 people (1 from each Province, 5 from MoH HQ and 20 from Cooperating Partners) to mobilize resources	MoH	120.450	7.528		Meetings					
		Employ, National level: M&E officer, Community Health Specialists (1 at National Level and 10 at Provicial level), Community health officers (3), one Community Health Technical Advisor, one CHA coordinator Provincial level: community health officer (10) Community Health Specialist(10) District level: Community health officers (10)	MoH	1.080.000	67.500		Salaries and Emoluments					
	Finalisation of establishment	Finalisation of establishment	Public Service Commission	-	-		Salaries and Emoluments					
	Recruitment and Appointment	Finalisation of recruitment and appointment	MoH	-	-		Salaries and Emoluments					
	Intervention 1.1.2.: Ensure that appropriate national-level guidelines are aligned											
	Review relevant strategic documents and guidelines to align them to new Strategic Plan, current situations and trends	Hold 10 day meeting for 30 people in Lusaka (2 from each Province, 10 from MoH HQ) to review the documents	MoH	147.245	9.203		Meetings					
		Hold a 4 day consultatative meeting with 20 cooperating partners and 4 people from MoH HQ in Lusaka	MoH	5.355	335		Meetings					
		Hold 6 day meeting for 35 people (2 from each Province, 10 from MoH HQ and 5 Cooperating Partners to refine the documents	MoH	390.245	24.390		Meetings					
		Hold a 1 day meeting in Lusaka for 200 participants to launch the package		120.250	7.516		Meetings					
		Hold a day dissemination meeting of the documents to 20 partners and 2 people from each Province	MoH	142.625	8.914		Meetings					
			Total Strategy 1.1	**2.006.171**	**125.386**							

STRATEGY 1.2: ADDRESS THE FRAGMENTATION OF COMMUNITY-BASED VOLUNTEERS	Intervention 1.2.1 Maintain an Intergrated CBV Data Base						
Indicator: % of CHWs with updated data captured in the integrated database	Training subnational level staff in the utilization of integrated community based Volunteere mgt tool	**National ToT-** Hold training (2), one in the Northern and Southern regions for 5 participants from each province in Ndola and Kafue	MoH	461.946	28.872		Meetings
		Provincial ToTs- Hold 10 trainings drawing 3 participants from each district for 5 day	MoH	1.207.994	75.500		Meetings
Baseline: 0		**District Trainings-** Hold 1 trainings for 20 Facilities drawing for 3 participants from each Facility and 3 NHCs from each zone for 3 day	MoH	1.739.567	108.723		Meetings
		Formating of the documents		5.000	313		Printing
Target 2026: 100%		Print and distribute 16,000 NHC registers and 16,000 integrated CBV database guidelines	MoH	3.200.000	200.000		Printing
		Distribution of guidelines and registers	MoH	101.094	6.318		Transport
	Mapping of CBVs working with partners and CSOs	Hold two 1 day meeting for 40 delegates at national level to orient the cooperating partners and CSO to the CBV database	MoH	31.375	1.961		Meetings
		Hold a 5 days provincial training to train 20 people from CSO and 30 people from cooperarting partners in CBV mapping and utilisation of the Integrated CBV database.	MoH	11.070	692		Meetings
	Monitor utilization of the integrated CBV database	National level: 10 quartely visits*3people per province*5 days.	MoH	959.641	59.978		Travel
		Provincial level level: 5 quartely visits*2people per district*5 days	MoH	911.760	56.985		Travel
		District level : Montly visits* 2 people per facility *2 day	MoH	105.001.000	6.562.563		Travel
	Intervention 1.2.2 Ensure Equitable Distribution of CBVs						
	Conduct CBV distribution gap analyisis	Engage technical assistance to conduct gap analysis	MoH	160.000	10.000		Consultancy
		Hold 2 day meeting to disseminate the findings to 40 delegates (2 people from each Province, 5 people from MoH HQ and 15 partners and stakeholders) in Lusaka.	MoH	185.205	11.575		Meetings
		Meet with partners in Lusaka to train more CBVs	MoH	1.834	115		Meetings
	Intervention 1.2.3 Definition of Standard Community Health Services Package						
	Finalization of the service package	Engage tecnhical assistant to develop CHSP	MoH	160.000	10.000		Consultancy
		Hold 5 day meeting in Chilanga for 20 paricipants (1 from each Provinc, 10 from MoH HQ) to review available documents	MoH	52.120	3.258		Meetings
		Conduct a data collection field trip for 4 officers* 5 days in 2 provinces Copperbelt and Western Province.	MoH	118.194	7.387		Travel
		Hold 3 day consultative meeting for 40 paricipants (2 from each Province, 10 from MoH HQ and 10 Cooperating Partners) in Lusaka	MoH	235.975	14.748		Meetings
		Hold 4 day validation meeting for 40 participants (2 from each Province, 10 from MoH HQ and 10 Cooperating Partners) in Chongwe	MoH	303.471	18.967		Meetings
	Printing of the Service package	Print 5,000 copies of the CHSP	MoH	502.500	31.406		Printing
	Launch and disseminate the Service Package	Hold a 1 day meeting in Lusaka for 200 participants to launch the package	MoH	120.250	7.516		Meetings
		Conduct a TOT meeting in Kabwe for 5 days * 3 people per province to disseminate the CHSP to 10 provinces	MoH	373.446	23.340		Meetings

	Activity	Sub-activity	Responsible	Cost	Cost 2	Partner	Category
	Intervention 1.2.4 Promotion of integrated training for CBVs to deliver quality services						
	Development of the training manual	Engage technical assistance to develop training manual	MoH	160.000	10.000	UNICEF	Consultancy
		Hold a two day consultative meeting for 35 participants with partners and stakeholders	MoH	53.525	3.345		Meetings
		Conduct a 5 day field visit by 3 officers to 2 provinces to collect data on the harmonisation of the training manual	MoH	113.134	7.071		Meetings
		Conduct a 5 day meeting for 30 people (2 from each Province and 10 from MoH HQ) in Chongwe to develop the training manual	MoH	310.316	19.395		Meetings
		Conduct a 3 day validation workshop in Kabwe for 45 participants (2 from each Province, 10 from MoH HQ and 10 Cooperating Partners)	MoH	261.542	16.346		Meetings
	Printing of the training manual	Print 5,000 copies of the trainig manuals	MoH	502.500	31.406		Printing
	Dissemination of the training manuals	Conduct a TOT meeting for 5 days * 3 people per province to disseminate the training manual to 10 provinces	MoH	383.010	23.938		Meetings
		Conduct a training 5days*2 people per district to disseminate the training manual to the districts	MoH	1.382.567	86.410		Meetings
		Conduct 6 trainings of 30 people each for 7 days per district to train CBV in community health service package	MoH	1.739.567	108.723		Meetings
	Intervention 1.2.5 Operationalize the CBV incentive guidelines						
	Printing, Dissemination & Distribution of the CBV incentive guidelines and printing	Printing of 10,000 copies of the incentive guidelines	MoH	1.002.500	62.656		Printing
		Hold a day dissemination meeting for incentive guidelines to 30 cooperating partners and 20 from PHO (provinces) in Lusaka	MoH	141.410	8.838		Meetings
		Hold a 1day*10 provincial dissemination meeting for 50 people	MoH	1.382.567	86.410		Meetings
		Distribute the incentive guideline to the 10 provincess	MoH	101.094	6.318		Transport
	Intervention 1.2.6 Provision of adequate and appropriate enablers for CBVs						
	Conduct needs assessment of the requirements	Develop a concept note and the data collection tools	MoH	-	-		Consultancy
		Hold a 1 day consultative meeting with 20 TWG members in Lusaka (5 from MoH HQ, 1 from each Province, 5 Cooperating Partners)	MoH	104.420	6.526		Meetings
		Conduct 5 field visits to the 5 provinces (3 people per team for 10 days).	MoH	307.167	19.198		Travel
		Hold a 5 days meeting of 20 people (1 from each Province, 5 from MoH HQ and 5 Cooperating Partners) to analyse data and do a report in Chilanga.	MoH	52.120	3.258		Meeting
		Hold a 2 day validation meeting for 50 people (20 Cooperating Partners, 2 from each Province and 10 people from MoH HQ) in Lusaka	MoH	151.095	9.443		Meeting
		Hold 1 day dissemination meeting for 130 people (1 from each Province and District) in Lusaka.	MoH	378.555	23.660		Meeting
		Hold a 5 day meeting for 30 people to quantify and budget for the CBV requirements in Chongwe	MoH	174.795	10.925		Meeting
	Provision of enablers	Procure enablers according to identified needs	MoH	311.800.000	19.487.500		Procurement of equipment
		Distribution of enablers to 10 provinces	MoH	101.094	6.318		Transport

Intervention 1.2.7: Improve community level coordination of CBVs.					
Develop peer to peer supervision training package	Engage Technical Assistance to develop of peer supervision training package	MoH	160.000	10.000	Consultancy
	Hold 1 day consultative meeting in Lusaka for 35 people (2 from each Province, 10 from MoH HQ and 5 Cooperating Partners) to consult	MoH	130.025	8.127	Meeting
	Conduct a 5 day field visit by 3 officers to 2 provinces to collect data on the harmonisation of the training package	MoH	194.473	12.155	Meeting
	Conduct a 5 day meeting for 30 people in Chongwe to develop the training package	MoH	176.010	11.001	Meeting
	Conduct a 4 day validation workshop in Kabwe for 45 participants (2 from each Province, 10 from MoH HQ and 15 from CSB/NGOs)	MoH	395.987	24.749	Meeting
Train Peer Supervisors	Conduct a TOT meeting for 5days * 3 people per province to disseminate the training package to 10 provinces	MoH	262.185	16.387	Meeting
	Conduct a training 5 days*2 people per district to disseminate the training package	MoH	1.382.567	86.410	Meeting
	Conduct 6 trainings of 30 people each for 7 days per district to train peer supervirors (NHCs and CHAs) in the package	MoH	1.739.567	108.723	Meeting
Develop CBV supervision Manual and tool	Develop concept note	MoH	-	-	Desk Review
	Hold 5 day meeting *25 people to develop CBV supervision in Chongwe	MoH	196.430	12.277	Meetings
	Conduct a 5 day field visit by 3 officers to 2 provinces to pre-test CBV supervision manual and tool	MoH	134.983	8.436	Meetings
	Hold a 5 days meeting of 40 people (2 from each Province, 10 from MoH HQ and 10 Cooperating Partners) to validate supervision tool in Kafue.	MoH	50.369	3.148	Meetings
	Print 10,000 CBV supervision manual and 20,000 tools	MoH	3.001.250	187.578	Print
	Distribution of CBV supervision manuals and the tools to the 10 provinces	MoH	101.094	6.318	Transport
	Conduct Service Quality Audit to all the 10 provinces to identify gaps (5*10*7*4)	MoH	959.641	59.978	Travel
Conduct technical support supervision	Conduct quarterly Technical Supportive Conduct quarterly Supervision to 10 provinces *3 people per province*5days	MoH	959.641	59.978	Travel
Intervention 1.2.8: Recognise and celebrate the work of Community Based Volunteers					
Development of awarding guidelines	Develop a concept note	MoH	-	-	Deskwork
	Develop a zero draft	MoH	-	-	Deskwork
	Hold a 5 day consultative meeting for 30 people in Kabwe. (10 MoH central level,10 people from the Province, 10 from the Districts)	MoH	346.366	21.648	Meetings
	Hold a 2 day validation meeting for 40 people with partners provinces in Lusaka (15 people from central level,10 from the Provinces, 15 partners).	MoH	158.475	9.905	Meetings
	Hold a 1 day meeting for 100 people (20 provinces, 20 central level, 30 partners, 20 districts, 10 NHCs) to disseminate the awarding guidelines	MoH	165.915	10.370	Meetings
	Distribute the guidelines to the 10 provinces	MoH	101.094	6.318	Transport
Commemorate the world volunteer day/event	Hold a 5 day preparetory meeting with stakeholders and partners to mobilise resources (1*40) and identify CHWs to be awarded	MoH	29.350	1.834	Meetings
	Procure 50 trophies and gifts	MoH	100.000	6.250	Procurement of equipment
	Hold a 1-day meeting fro 50 people (5 from MOH HQ,1 from each Province, 5 from other Ministries, 30 Cooperating Partners) to commerate world volunteer day and present awards.	MoH	146.655	9.166	Meetings
		Total Strategy 1.2	**447.338.497**	**27.958.656**	

Intervention 1.3.1 Develop long-term Roadmap for CHAs						
Revision of National Community Health Worker Strategy 2010 & Development of CHA Roadmap	Develop concept note	MoH	-	-		Desk Review
	Hold 5 day meeting *25 people. 10 MOH programme officers, 5 SHRMOs, 2 HPCZ, 2 UNZA, 2 Levy University, 4 training schools & Partners.	MoH	52.120	3.258		Meeting
	Conduct a 5 day field visit by 3 officers to 3 provinces to data from the CHAs	MoH	132.750	8.297		Travel
	Hold a 5 days meeting of 40 people to validate in Kafue.(10 province, 15 Moh programme officers,5 HR, 2HPCZ,2 UNZA, 2 LEVY UNIVERSITY, 6 per Training schools, partners	MoH	405.898	25.369		Meeting
	Hold a 1 day meeting dissemination for 80 people in Chibombo(20 people central level, 20 Province, 20 CHA schools, 10 stakeholders, 10 TWG members	MoH	199.758	12.485		Meetings
	Print 10,000 revised Community Health Assistants Guidelines and Road Map	MoH	1.002.500	62.656		Print
	Distribute 10,000 revised Community Health Assistants Guidelines and Road Map to 10 provinces	MoH	107.305	6.707		Transport
	Distribute 10,000 revised Community Health Assistants Guidelines and Road Map to 116 district	MoH	5.309.754	331.860		Transport
Intervention 1.3.2 Lobby for additional training of CHAs						
CHA Distribution Gap Analysis	Develop concept note and assessment tools	MoH	-	-		Desk Review
	Conduct desk review	MoH	-	-		Desk Review
	Conduct verification visits in 5 provinces* 4 people per province for 2 weeks	MoH	404.903	25.306		Travel
	Hold a 3 day meeting in Chilanga for 40 people to aggregate the findings and write report.(20 Central level,10 province,10 TWG,5 Training schools,5 partners)	MoH	279.258	17.454		Meeting
	Hold a 1 day Virtual meeting with TWG members and parnersto disseminate report/findings and recommendations	MoH	-	-		Desk Review
Conduct CHA training needs assessment	Collect data from all 10 provinces for health posts with no CHAs through the province-Desk review	MoH	-	-		Desk Review
	Create a data base for Health Posts with no CHAs/ 1 Cha	MoH	-	-		Desk Review
	Hold a 1 day virtual meeting for all training schools, provinces to disseminate the needs assessment report	MoH	-	-		Meetings
Development of CHA trainning target and plan	Hold a 5 days meeting with 5 people per training school, 2 people per province and 6 people from central level	MoH	393.534	24.596		Meetings
CHA recruitment verification exercise	Receive and verify the recruited CHAs per province-Desk review	MoH	-	-		Desk Review
Performance Assessment to the training schools	Conduct 5 day bi annual visits to the 3 tarining schools . 3 people per team.	MoH	71.268	4.454		Travel

Intervention 1.3.3 Lobby for Increased positions/establishment of CHAs					
Placement of CHAs on payroll	Hold meeting to engage HR to Lobby Govrnment for positions	MoH	-	-	Desk Review
Mobilise donors to support CHA Salaries	Hold a 1 day high level meeting for 30 people in Lusaka (1 from each Province, 10 from MoH HQ and 10 Cooperating Partners0	MoH	113.807	7.113	Meetings
Intervention 1.3.4 Improve supervision and mentorship for CHAs					
Needs assessment for CHA supervisor Training	Conduct mapping of health facilities without trained CHA superviors-Desk review	MoH	-	-	Desk Review
Review of the CHA supervision training package & Mentorship tools	Develop concept note	MoH	-	-	Desk Review
	Hold 5 day meeting * 30people (6 MOH programme officers, 5 SHRMOs, 2 HPCZ, 2 per training schools & Partners) in Kabwe	MoH	242.126	15.133	Meetings
	Conduct a 5 day field visit by 3 officers from MoH HQ to 3 training schools to data from the CHAs	MoH	51.528	3.221	Meetings
	Hold a 5 days meeting of 40 people to validate in Kafue.(10 from Province, 15 MoH HQ programme officers,5 HR, 2HPCZ, 6 per Training schools, partners)	MoH	407.634	25.477	Meetings
Training of CHA supervisors	Conduct 5 days TOT training for 3 people per provinces in Ndola.10 people from central level	MoH	488.362	30.523	Meetings
	Conduct 5 day district CHA supervisor training in the 10 provinces for 3 people per district. 3 people from MOH per team.	MoH	1.382.567	86.410	Meetings
	Conduct 5 day facilite CHA supervisor training in the 116 districts for 1 person per facility. 1 people from MOH and 1 person from the province per team.	MoH	13.585.920	849.120	Meetings
Mentorship and Techincal Support Supervision	Conduct quartely visits to all 10 provinces for 4 people per team from the MOH and province	MoH	1.139.069	71.192	Meetings
Intervention 1.3.5 Provide for continuous learning and career planning for CHAs					
Develop continuous learning and career planning for CHAs	Hold 5 day meeting *25 people. 10 MOH programme officers, 5 SHRMOs, 2 HPCZ, 2 UNZA, 2 Levy University, 4 training schools & Partners in Kabwe	MoH	399.344	24.959	Consultancy
	Hold a 5 days meeting of 40 people to validate in Kafue.(10 province, 15 Moh programme officers,5 HR, 2HPCZ,2 UNZA, 2 LEVY UNIVERSITY, 6 per Training schools, partners	MoH	405.898	25.369	Meetings
	Hold a 1 day meeting dissemination for 80 people in Lusaka(20 people central level, 20 Province, 20 CHA schools, 10 stakeholders, 10 TWG members	MoH	192.667	12.042	Meetings
	Print 10,000 Community Refresh course package	MoH	1.002.500	62.656	Print
	Distribute 10,000 Refreashal course package to 10 provinces	MoH	107.305	6.707	Meeting
	Distribute 10,000 Refreashal course package to 116 district	MoH	5.309.754	331.860	Meetings
		Total Strategy 1.3	**33.187.530**	**2.074.221**	
	TOTAL OBJECTIVE 1		**482.532.198**	**30.158.262**	

EXPECTED OUTPUTS	PLANNED ACTIVITIES	SUB ACTIVITIES	RESPONSIBLE PARTNER	PLANNED BUDGET (ZMW)			
				Budget ZMW	0,0625 USD	Source Funding	Budget Descriptio
OBJECTIVE 2: Ensure relevant infrastructure, equipment, medicines and supplies are available for Community Health by 2026							
Indicator: % of CHWs with all the key tracer commodities in the last reporting period Baseline 2022: XX% Target 2026: 100%							
STRATEGY 2.1 Guarantee adequate supply of medicines, supplies and basic equipment are available for Community Health	**Intervention 2.1.1 Provision of medicines/medical supplies to improve effectiveness of CBVs/CHAs**						
Indicator: % CBVs/CHAs trained on supply chain management	Quantify the drugs and other medical supplies for CBVS/CHAs	Meeting in Lusaka with 10 people from HQ to develop ToR and RFP	MoH	81.700,00	5.106		Meetings
Baseline 2022: 0 %		Publish ToR and RFP	MoH	20.000,00	1.250		Advertisement
Target 2024: 50 %		Meeting in Lusaka with 10 people from MoH HQ to select and contract Consultant	MoH	81.700,00	5.106		Meetings
Target 2026: 100 %		Stakeholder meeting in Lusaka for two day with 2 people from all 10 provinces (20), cooperating partners (20) and people from MoH HQ (10)	MoH	169.020	10.564		Meetings
		Local Consultant to work for 20 days to perform analysis and write a report	MoH	400.000	25.000		Consultancy
		Validation meeting for one day with 2 people from all 10 provinces (20), cooperating partners (20) and people from MoH HQ (10) in Lusaka	MoH	112.695	7.043		Meetings
	Procurement drugs and other medical supplies for CBVs/CHAs	5 day Meeting in Lusaka with 10 people from HQ to develop ToR and RFP	MoH	38.200	2.388		Meetings
		Publish ToR and RFP	MoH	20.000	1.250		Advertisement
		Meeting in Lusaka with 10 people from ZAMSA to select and contract Supplier	MoH	81.700	5.106		Meetings
		Purchase and Delivery of drugs and other medical supplies	MoH	400.000	25.000		Procurement of Drugs and Medical Supplies
	Intervention 2.1.2 Train CHAs/CBVs in quantification and Drug Management/phamcovigilance						
	Development of training package for CHAs/CBVs	Hold fiv days Meeting in Lusaka with 10 people from HQ to develop ToR and RFP	MoH	79.167	4.948		Meetings
		Publish ToR and RFP	MoH	20.000	1.250		Meetings
		Meeting in Lusaka with 10 people from MoH HQ to select and contract Consultant	MoH	79.167	4.948		Meetings
		Stakeholder meeting in Lusaka for one day with 2 people from all 10 provinces (20), cooperating partners and people from MoH HQ (10)	MoH	112.695	7.043		Meetings
		Local Consultant to work for 20 days to perform analysis	MoH	400.000	25.000		Consultancy
		Validation meeting for one day with 2 people from all 10 provinces (20), cooperating partners and people from MoH HQ (10) in Lusaka	MoH	112.695	7.043		Printing
	Train CBVs/CHAs in quantification and reporting for drugs and supplies	Hold a 2-day orientation meeting for partners and provincial focal points (total 60 delegates) on training package for CHAs/CBVs in Lusaka	MoH	219.770	13.736		Meetings
		Hold 10 x 2-day provincial orientation meetings (one per province)		1.588.400	99.275		Meetings
		Hold 2-day district training meetings with 30 people (one per district)		5.440.400	340.025		Meetings
	Conduct technical support supervision	Travel to all 10 provinces with team of 3 people from MoH HQ Lusaka	MoH	269.996	16.875		Travel
		Travel to all Districts by team of 3 from Provincial Office in each of 10 Provinces	MoH	911.760	56.985		Travel

	Intervention 2.1.3 Strengthen drug and therapeutic committees at facility level					
Indicator: % Health Facility that have and held at least one drug and therapeutic committee meeting/year at facility level including NHCs	Hold quarterly review meetings at Facility level, including NHCs	Support quarterly one day review meetings at 3,500 facilities for 10 people	MoH	10.500.000	656.250	Meetings
Baseline 2022: 0 %	Quantification meetings at National, Provincial and District level for Community Health	Hold a two day Quantification meeting at National level for 30 people in Lusaka annually	MoH	267.711	16.732	Meetings
Target 2024: 50 %	**Intervention 2.1.4 Improve the knowledge of community members on drug security and safety**					
Target 2026: 100 %	Develop materials to sensitize community about drug safety	Hold a five day meeting for 25 people (2 per Provinces and 5 from HQ) in Kabwe to develop materials	MoH/ZAMSA	326.500	20.406	Meetings
		Hold a Validation meeting for 3 days with 2 people per provinces (20), cooperating partners and 10 people from MoH HQ in Lusaka	MoH/ZAMSA	109.219	6.826	Meetings
	Dissemination through media platforms and community meetings	Printing of 100,000 1 pager with information about drug safety	MoH/ZAMSA	2.502.500	156.406	Printing
		Distribution of one pagers to all 116 Districts	MoH/ZAMSA	101.094	6.318	Transport
		Provincial (10) Media Breakfast Lusaka	MoH/ZAMSA	53.700	3.356	Advertisement
		District (116) Media Breakfast Lusaka	MoH/ZAMSA	407.000	25.438	Advertisement
		Public & Private Television Stations Talks (Community health and neighbourhood health committee)	MoH/ZAMSA	2.813.000	175.813	Advertisement
		Public & Private Television documentary/series on good practices on community health	MoH/ZAMSA	1.552.000	97.000	Advertisement
	Public & Private Radio Stations Talks (Community health and neighbourhood health committee) in the 5 provinces	Radio Maria Catholic 10 provinces	MoH/ZAMSA	640.000	40.000	Advertisement
		10 other Community Radios in provinces	MoH/ZAMSA	80.000	5.000	Advertisement
	Trophy for best perfoming radio /TV presenters.	Local Languages	MoH/ZAMSA	80.000	5.000	Advertisement
	Trophy for best perfoming Radio /TV stations.	trophy	MoH/ZAMSA	500.000	31.250	Advertisement
	School Debates	trophy	MoH/ZAMSA	20.000	1.250	Advertisement
		airing	MoH/ZAMSA	20.000	1.250	Advertisement
		trophy and prizes	MoH/ZAMSA	3.000.000	187.500	Proccurement
		Conduct community sensitization in all the 116 districts, once a year	MoH/ZAMSA	25.000	1.563	Meetings
			Total Strategy 2.1	**33.636.789**	**2.102.299**	

STRATEGY 2.2 Strengthen linkages between the community and the health facilities	**Intervention 2.2.1 Expand existing and establish new health posts, booths and outreach posts**					
Indicator: % of Districts with integrated transport system that includes facility/community level	Design the model for the community health booths	Develop a concept note	MoH	0	-	Deskwork
Baseline: 0		Meeting with DMOs; PMOs; public health specialists	MoH	51.700	3.231	Meetings
Target 2026: 100%		Validation meeting for one day with 2 people from all 10 provinces (20), cooperating partners and people from MoH HQ (10) in Lusaka	MoH	109.219	6.826	Meetings
	Mapping and assessment for placement	Identify gaps in healthcare delivery	MoH	480.000	30.000	Consultancy
	Procurement/construction of the booths	Meeting in Lusaka with 10 people from HQ to develop ToR and RFP	MoH	81.700	5.106	Meetings
		Publish ToR and RFP	MoH	20.000	1.250	Advertising
		Meeting in Lusaka with 10 people from MoH HQ to select and contract Supplier		81.700	5.106	Meetings
		Delivery and placement of furniture and equipment including BP machines, scales)		623.000	38.938	Transport
	Intervention 2.2.2 Strengthen integrated transport system at community level					
	Conduct a rapid assesment of transport status in the country at community level	Develop a data caputuring tool	MoH	0	-	Deskwork
		Collect data from the 116 districts country wide.	MoH	0	-	Deskwork
		Hold a two day meeting of 10 people from Lusaka at MoH to write a report and analyse the data findings from the data collected	MoH	257.769	16.111	Meetings
		Meeting in Lusaka with 10 people from HQ to develop ToR and RFP	MoH	81.700	5.106	Meetings
		Publish ToR and RFP	MoH	20.000	1.250	Advertisement
		Meeting in Lusaka with 10 people from MoH HQ to select and contract Consultant	MoH	81.700	5.106	Meetings
	Develop an integrated transport policy (including maintenance)	Stakeholder meeting in Lusaka for three days with 2 per provinces (20), cooperating partners and people from MoH HQ (10)	MoH	109.219	6.826	Meetings
		Local Consultant to work for 20 days to develop draft policy	MoH	480.000	30.000	Consultancy
		Validation meeting for one day with 2 people per provinces (20), cooperating partners and people from MoH HQ (10) in Lusaka	MoH	109.219	6.826	Meetings
		Finalization of the transport policy	MoH	0	-	Deskword
	Procurement of motor vehicles and bikes	Procurement 126 Toyota Land Cruisers (1 for each of 116 Districts and 1 for each of 10 Provinces)	MoH	44.100.000	2.756.250	Procurement of Vehicles/Bikes
	Intervention 2.2.3 Improve bi-direction referral between the Community and Health Facilities					
	Develop tools for CBVs/CHAs to strengthen timely referral and follow ups	Hold a 3-day meeting for 20 delegates in Kafue to develop a screening tool and referral form	MoH	130.503	8.156	Travel/Trainings
		Pre-test the tool for 2 days in Kafue with 10 people	MoH	12.020	751	Meetings
		Hold a 1-day meeting for 20 delegates from the Provinces in Lusaka to finalise the screening tool and referral form	MoH	178.259	11.141	Meetings
	Printing and distribution of booklets	Printing and distribution of 50,000 referral form booklets (100 pages A5)	MoH	175.000	10.938	Printing
		Hold 10 x 2-day orientation meetings for 30 people (one per province)	MoH	193.038	12.065	Meetings
	Orientation and Training	Hold 2-day orientation of health centre focal points on NHC content (one delegate per health centre)	MoH	665.000	41.563	Meetings
		Hold 1-day dissemination meeting for 40 people at each of the 3500 health facilities	MoH	7.000.000	437.500	Meetings
		Total Strategy 2.2		**55.040.747**	**3.440.047**	
		TOTAL OBJECTIVE 2		**88.677.537**	**5.542.346**	

EXPECTED OUTPUTS	PLANNED ACTIVITIES	SUB ACTIVITIES	RESPONSIBLE PARTNER	PLANNED BUDGET (ZMW) Budget ZMW	0,0625 USD	Source Funding	Budget Descriptio	TIMING 2022	2023	2024	2025	2026
OBJECTIVE 3: Fully funded National Community Health Strategy 2022- 2026												
Indicator: % of the Community Health Strategic Plan 2022-2026 Operational Plan Annual Budget funded Baseline: 0 % Target 2026: 100 %												
STRATEGY 3.1 Expand the resource envelop for community health services	**Intervention 3.1.1.: Ringfence DHO budget allocation to community level.**											
Indicator: Number of successful Community Business Plans funded	Incoperate allocation 10% to Community Health on the the Community scorecard	Add to the Community Score Card if the DHO has allocated 10% of its budget to Community Health	MoH	-	-		Desk Review		Jun			
		Write memo to districts providing guidelines on the application of 10% of funding to community level	MoH	-	-		Desk Review		Jul			
Baseline: 0		Hold a 10 provincial meeting with all 116 district CFPs i with 2 facilitators per team from Lusaka and 1 person from the province to orient them on importance of community health and the scorecard	MoH	1.207.994	75.500		Meetings		Aug–Sep			
Target 2024: 2	**Intervention 3.1.2 Develop Community Business Plan to engage with the Private Sector**											
Target 2026: 6	Feasibility analysis for public-private partnerships	Meeting in Lusaka with 10 people from HQ to develop ToR and Request for Proposal for Consultant	MoH	81.700	5.106		Meeting		Jan			
		Publish ToR and Request for Proposals for Consultant	MoH	10.000	625		Advertisement		Feb–Mar			
		Meeting in Lusaka with 10 people from MoH HQ to select and contract Consultant	MoH	81.700	5.106		Meeting		Apr			
		Local Consultant to work for 20 days to perform analysis and write report	MoH	128.000	8.000		Consultancy		May–Jun			
	Identification of potential business projects across the country	Hold a two day Stakeholders meeting in Lusaka for 50 people (one particpant per province, one particpant per provicial town, 20 stakeholders and 10 staff from HQ)	MoH	171.705	10.732		Meetings		Jul			
		Hold a Validation meeting for one day with 2 participants per province, 20 cooperating partners and participants from MoH HQ (10) in Lusaka	MoH	121.161	7.573		Meetings		Aug			
	Printing and dissemination of business plan	Print 140 copies of the business plan	MoH	16.500	1.031		Printing		Sep–Oct			
		Hold a one day meeting in Lusaka for 100 delegates from the Private Sector to disseminate the plan and lobby for funds	MoH	72.735	4.546		Meetings		Nov			
			Total Strategy 3.1	**1.891.495**	**118.218**							

STRATEGY 3.2 Increase and optimise partner contributions	Intervention 3.2.1 Update the Investment Case for Community Health					
Indicator: % of existing partner projects aligned to the NCHS2022-26 by Q2 2023	Update of the Investment Case	Hold a Five day meeting in Kabwe to update the community health investment case with 1 participant per Province (10), Cooperating Partners (10) and 5 people from MOH HQ.	MoH	249.921	15.620	Meeting
Baseline 2022: 0		Hold a two day validation meeting in Lusaka with 2 participant per province (20), cooperating partners (10) and 10 from MoH HQ (10)	MoH	190.607	11.913	Meetings
Target 2023: 50 %	Printing of the revised Investment Case	Design and Printing 500 copies of the revised Investment Case	MoH	52.500	3.281	Printing
Target 2026: 100%	Dissemination of the Investment Case	Hold a 2-day orientation meetingin Lusaka for Cooperating Partners(10),MoH HQ (20) and all provincial focal points	MoH	160.307	10.019	Meetings
	Intervention 3.2.2 Develop a resource mobilization and optimization plan					
	Donor/Project Mapping	Local Consultant to work for 20 days to do donor /project mapping	MoH	200.000	8.000	Consultancy
	Identify potential partner and funding opportunities	Meetings with 30 Partners in Lusaka virtual meeting for partners outside Lusaka	MoH	23.500	1.469	Travel/Meetings
	Development of resource mobilization and optimization plan	Engage consultatnt for 20 days to Develop first draft of resource mobilization and optimization plan	MoH	200.000	12.500	Consultancy
	Presentation and dissemination of plan	Hold a 2-day orientation meetingin Lusaka for Cooperating Partners(20),MoH HQ (10) and provincial focal points (2 per Province)	MoH	199.607	12.475	Meeting
		Hold 2-day district training meetings with 30 people (one foreach of 116 districts)	MoH	4.963.640	310.228	Meetings
	Follow up with Partners	Hold a 2 day annual Meetings for 60 with Partners in Lusaka and two participant per province	MoH	208.607	13.038	Meetings
			Total Strategy 3.2	**6.448.689**	**398.543**	
STRATEGY 3.3 Strengthen local community-based income generating initiatives	**Intervention 3.3.1 Expand on local revenue generating activities by Communities**					
Indicator: % of Districts with Community Health Cooperatives established	Promote the establishment of Community Health cooperatives	Hold a 5-day meeting for 20 delegates in Kafue (one from each Province, 10 from Lusaka) to develop materials for establishment of Community Health Cooperatives	MoH	240.025	15.002	Meetings
Baseline: 0	Local stakeholder meetings	Stakeholder meeting in Lusaka for one day with 2 people from all 10 provinces (20), cooperating partners and people from MoH HQ (10)	MoH	140.967	8.810	Meetings
Target 2024: 40%		Hold a 5 day consultantive meeting with 5 people from Ministry of Small medium Enterprises, 5 people from PACRA 10 people form MOH to formation of cooperatives in Chongwe	MoH	93.484	5.843	Meetings
Target 2026: 100%		Hold trainings for 10 HCC in 20 towns in each Province(3 facilitators from central level, 2 from/ province, 1 person per district	MoH	3.439.467	214.967	Meetings
		Register 20 cooperatives at PACRA	MoH		-	
	Capacity building of NHC in local revenue generating activities	Hold 10 x 2-day training meetings for TOT 30 people (two per Province and 10 from MoH HQ) in Kabwe	MoH	301.691	18.856	Meetings
		conduct 2 day study tours for provincial focal points and 10 NHC members in each Provinces to experience and learn from successful income-generating activities	MoH	266.967	16.685	Meetings
		Concurrently Hold 1-day dissemination meeting for 40 people at each of the 3,500 health facilities	MoH	71.400.000	4.462.500	Meetings
		Produce content for TV, radio and print media showcasing best practices in income generating activities for community health	MoH	110.000	6.875	Advertisement
		Provide SEED funding to one NHC per year to initiate an innovative income-generating project	MoH	1.000.000	62.500	Procurement
	Follow up and mentorship	Teams of 3 people from 116 Districts to travel to all 3,500 health facilities to follow up and provide mentorship for 1 day in each facility	MoH	53.900.000	3.368.750	Travel
	Intervention 3.3.2 Build capacity of NHCs to engage with local stakeholders, including Ward Development Committees					
	Sensetize the NHC on stakeholders engagement and WDCs	Health facility staff to oreint all the NHCs on Stakeholder engagement and accessing CDF funds	MoH	-	-	Meetings
	Follow up and mentorship	Travel to all Districts by team of 3 from Provincial Office in each of 10 Provinces	MoH	334.000	20.875	Travel
			Total Strategy 3.3	**131.226.601**	**8.201.663**	
		TOTAL OBJECTIVE 3		**139.566.786**	**8.718.424**	

EXPECTED OUTPUTS	PLANNED ACTIVITIES	SUB ACTIVITIES	RESPONSIBLE PARTNER	PLANNED BUDGET (ZMW) Budget ZMW	0,0625 USD	Budget Description
OBJECTIVE 4: Strengthen access, accuracy and utilization of the Community Health Information Management System that informs decision-making and policy development by 2026						
Indicators: 1) Reporting rates for form HIA 4a, 2) Reporting rates for form HIA 4b Baseline 2019: 1) 6 % 2) 5% Target 2024: 1) 40 % 2) 40% Target 2026: 1) 80 % 2) 80%						
STRATEGY 4.1 Strengthen Community Health Information Systems	**Intervention 4.1.1 Harmonize data collection and reporting with partners**					
Indicator: % Proportion of Districts with operational cHMIS	Mapping of community data being collected by partners	Write to the partners to avail data elements they are collecting and analyse submissions	MoH/Partners	33.100	2.069	Meeting
Baseline 2021: 16%		Hold a 5 day meeting with 25 participants. 15 from Central level and 1 from each Province (10 participants) to analyse the data being collected by partners in Chongwe	MoH/Partners	256.450	16.028	Meetings
Target 2023: 50 %		Hold a 2 days stakeholder meeting to share the findings with 35 participants. 10 are partners, 15 from Central level and 1 from each Province (10 participants) in Chongwe	MoH/Partners	117.100	7.319	Meetings
Target 2026: 100%	Standardize and streamline indicators, recording; reporting tools and procedures	Hold a 14 days meeting with 45 participants, 2 from each province (20), 25 from MOH HQ to review and update existing guidelines on community health data management in Kabwe	MoH/Partners	1.109.716	69.357	Meeting
Indicator: % of timely reports		Hold a 6 day meeting with 50 participants. 2 from each province (20 participants), 20 from MOH HQ and 10 Partners to develop a zero draft of the standardised recording and reporting tool for community health data in Kabwe	MoH/Partners	491.231	30.702	Meetings
Baseline 2021: 26%		Hold a 6 day finalisation meeting for 25 participants. 1 from each province, 10 from MOH and 5 partners to finalise the standardised R@R tools for community health	MoH/Partners	296.210	18.513	Meetings
Target 2023: 50 %		Hold a 3 day validation meeting with 40 people inclusive of 10 participants from the provinces to validate the standardised R@R tools for community health in Lusaka	MoH/Partners	204.590	12.787	Meetings
Target 2026: 100%		Launch the developed standardized tool and update in DHIS2	MoH/Partners	62.850	3.928	Meetings
		Disseminate the tool to all the provinces with 20 participants from MOH HQ for 4 days	MoH/Partners	339.430	21.214	Meetings
		Hold a 5 days ToT training workshop on the developed standardized tool for 60 participants. 5 from each province, 10 from MOH HQ	MoH/Partners	475.821	29.739	Meetings
		Conduct a 4 by 5 days training workshops on the developed standardized tool for all Districts with 47 participants per meeting. 5 from MOH HQ, 13 from PHO, 29 from DHOs	MoH/Partners	1.223.233	76.452	Meetings
	Development of roadmap to include partner community health data in Government systems	Hold a 5 days consultative meeting in Kabwe for 50 participants. 10 partners, 20 from PHOs and 20 from MOH HQ	MoH/Partners	416.929	26.058	Meetings
		Hold a 5 day finalisation meeting with 40 people in Kabwe. 10 from PHOs, 10 partners and 20 from MOH HQ	MoH/Partners	362.329	22.646	Meetings
	Roll-out roadmap	Hold a 3 day validation meeting with 25 people to validate the standardised R@R tools for community health in Lusaka. 5 from PHOs, 5 from partners, 15 from MOH HQ	MoH/Partners	179.765	11.235	Meetings

	Activity	Task	Responsible	Cost	Cost	Category
	Intervention 4.1.2 Implement CHMIS					
	Assess the effectiveness of cHMIS in 6 selected provinces	Develop TORs	MoH	0	0	Desk Review
		Conduct a 5 days Meeting with 20 Partners and Stakeholders to Mobilize resources, 15 from MOH HQs	MoH	67.575	4.223	Meeting
		Procure local consultancy services for 3 Months	MoH	576.000	36.000	Consultancy
		Hold a 3 day validation meeting with 25 people to validate the protocols in cHMIS in Kabwe. 5 from PHOs, 5 from partners, 15 from MOH HQ	MoH	123.117	7.695	Meetings
		Conduct field visits for data collection in 6 provinces for 14 days with 30 participants. 1 from PHO, 1 from DHO and 3 MOH HQ per team	MoH	544.891	34.056	Travel
		Hold a 5 days meeting to Analyse data collected and report writing with 20 particpants in Chongwe	MoH	136.248	8.515	Meetings
		Hold a 3 days meeting to validate the report on the findings with 20 participnats in Lusaka. 20 from MOH HQ	MoH	65.220	4.076	Meetings
		Pretest the cHMIS tool. 2 from MOH HQ per province	MoH	206.203	12.888	Travel
		Hold a 3 days meeting with 30 participants in Lusaka to finalize the tool. 10 from PHOs and 20 from MOH HQ	MoH	204.590	12.787	Meetings
		Print 4,000 copies of the tool	MoH	1.000.000	62.500	Printing
		Hold a 1 day meeting to disseminate the report to all stakeholders	MoH	39.700	2.481	Meetings
	Reviewing of the Tools	Hold a 4 days meeting in Lusaka with 30 participants to review the tools and update DHIS2. 20 from MOH HQ, 10 Partners	MoH	104.800	6.550	Meetings
		Printing and distribution of 32000 copies	MoH	8.068.803	504.300	Printing
	Roll out cHMIS to all the provinces	Hold a 5 days ToT training workshop on cHMIS in all the 10 provinces for 70 participants. 5 from each province, 20 from MOH HQ	MoH	683.439	42.715	Meetings
		Conduct a 5 days training workshop on cHMIS in 10 provincial towns for all the districts	MoH	1.481.311	92.582	Meetings
		Conduct a 5 days training workshop on cHMIS for 4000 facilities and Zones. 5 facilitators from each province, 5 from MOH HQ per province	MoH	18.439.932	1.152.496	Meetings
	Intervention 4.1.3 Equip facilities and communities with digital tools for data entry, reporting and decision making					
	Procure tools for data entry and reporting	Procure 140 laptops for the Provinces and Districts	MoH	1.680.000	105.000	Procurement of Equipment
		Procurement of 15,000 HIA 4A and 500,000 HIA 4B registers for the health centres	MoH	103.000.000	6.437.500	Printing
	Intervention 4.1.4 Improve routine data management and quality					
	Implementation of data quality audits of Provincial, District, Health Facility and Community level	Conduct Bi Annual Data Quality Audits. 5 per team from MOH HQ	MoH	407.840	25.490	Meetings
		Conduct Quaterly data review meetings in Lusaka for 20 participants from MOH HQ.	MoH	20.250	1.266	Meetings
		Total Strategy 1		**142.418.674**	**8.901.167**	

STRATEGY 4.2 Enhance the use of information for decision making and policy development for Community Health	**Intervention 4.2.1 Implement Community Health scorecards**						
Indicator: % of NHCs using community score cards	Technical Support Supervison in the implementation of Community Health Score Card	Conduct Technical Support Supervision in all the 10 provinces for 30 participants. 2 per team from MOH HQ	MoH	3.154.340	197.146		Travel
Baseline: 0	Peer to Peer Supervison	Hold a 5 days meeting in Chilanga to develop standards for Peer to Peer supervision with 30 participants. 10 from PHOs and 20 from MOH HQ	MoH	297.884	18.618		Meetings
Target 2025: 40%		Hold a 3 days meeting with 40 participants in Lusaka to validate the standards. 10 from PHOs and 20 from MOH HQ and 10 partners		195.390	12.212		Meetings
Target 2026: 100%							
	Intervention 4.2.3.: Promote research in community health						
	Work with partners to identify research questions	Constitute a Community Health Research Technical Working Group (TWG)	MoH/Partners	0	0		Meetings
		Hold a 7 days retreat for reasearch proposal writing with 20 participants from MOH HQ	MoH/Partners	151.998	9.500		Meetings
		Conduct 28 days field data collection exercise on a particular research topic in all the provinces with 30 participants from MOH HQ	MoH/Partners	206.203	12.888		Travel
		Hold a 14 days meeting for data analysis in Livingstone with 20 participants from MOH HQ	MoH/Partners	3.257.822	203.614		Meetings
		Hold 5 days meeting in Ndola for report writing with 20 participants from MOH HQ	MoH/Partners	212.899	13.306		Meetings
		Hold a 3 days meeting in Kafue to validate the report with 20 participants from MOH HQ	MoH/Partners	158.198	9.887		Meetings
		Publish the report	MoH/Partners	27.550	1.722		Travel
	Intervention 4.2.4.: Mid and End Term Evaluations of the NCHS 2022-2026						
	Mid Term Evaluation	Develop a concept note for possible buy in from partners	MoH	0	0		Desk Review
		Procure International consultancy services for 40 days	MoH	512.000	32.000		Consultancy
		Procure local consultancy services for 3 Months	MoH	576.000	36.000		Consultancy
		Hold a 3 days meeting in Chilanga to Develop data collection tools for Mid Term Evaluation of the NCHS 2022-2026 for 20 participants from MOH HQ	MoH/Partners	112.343	7.021		Meetings
		Hold a 3 days meeting in Chongwe to finalize the data collection tools for Mid Term Evaluation of the NCHS 2022-2026. 20 participants from MOH HQ	MoH/Partners	113.766	7.110		Meetings
		Hold a 3 days meeting in Kafue to validate the data collection tools for Mid Term Evaluation of the NCHS 2022-2026. 20 participants from MOH HQ	MoH/Partners	114.884	7.180		Meetings
		Conduct 28 days field data collection exercise on a particular research topic in all the provinces with 30 participants from MOH HQ	MoH/Partners	1.197.540	74.846		Travel
		Hold a 14 days meeting in Chilanga to analyse data collected for Mid Term Evaluation of the NCHS 2022-2026 for 20 participants from MOH HQ	MoH/Partners	513.043	32.065		Meetings
		Hold 5 days meeting in Ndola for report writing with 20 participants from MOH HQ	MoH/Partners	225.299	14.081		Meetings
		Hold a 3 days meeting in Chongwe to validate the report on findings for the Mid Term Evaluation of the NCHS 2022-2026 for 40 participants. 10 from PHOs, 10 from partners, 20 from MOH HQ	MoH/Partners	213.687	13.355		Meetings
		Hold 5 days meeting in Ndola to finalize the findings with 20 participants from MOH HQ	MoH/Partners	225.299	14.081		Meetings
		Printing and dissemination of 100 copies the Mid Term report	MoH/Partners	10.000	625		Printing

End Term Evaluation	Develop a concept note for possible buy in from partners	MoH	0	0	Desk Review
	Procure International consultancy services for 40 days	MoH	512.000	32.000	Consultancy
	Procure local consultancy services for 3months	MoH	576.000	36.000	Consultancy
	Hold a 3 days meeting in Chilanga to Develop data collection tools for Mid Term Evaluation of the NCHS 2022-2026 for 20 participants from MOH HQ	MoH/Partners	112.343	7.021	Meetings
	Hold a 3 days meeting in Chongwe to finalize the data collection tools for End Term Evaluation of the NCHS 2022-2026. 20 participants from MOH HQ	MoH/Partners	113.766	7.110	Meetings
	Hold a 3 days meeting in Kafue to validate the data collection tools for End Term Evaluation of the NCHS 2022-2026. 20 participants from MOH HQ	MoH/Partners	114.884	7.180	Meetings
	Conduct 28 days field data collection exercise on a particular research topic in all the provinces with 30 participants from MOH HQ	MoH/Partners	1.197.540	74.846	Meetings
	Hold a 14 days meeting in Chilanga to analyse data collected for End Term Evaluation of the NCHS 2022-2026 for 20 participants from MOH HQ	MoH/Partners	480.843	30.053	Meetings
	Hold 5 days meeting in Ndola for report writing with 20 participants from MOH HQ	MoH/Partners	225.299	14.081	Meetings
	Hold a 3 days meeting in Chongwe to validate the report on findings for the End Term Evaluation of the NCHS 2022-2026 for 40 participants. 10 from PHOs, 10 from partners, 20 from MOH HQ	MoH/Partners	240.834	15.052	Meetings
	Hold 5 days meeting in Ndola to finalize the findings with 20 participants from MOH HQ	MoH/Partners	225.299	14.081	Meetings
Dissemination of the report and review of lessons learned for new Strategy	Printing and dissemination of 100 copies the Mid Term report	MoH/Partners	10.000	625	Printing
Develop NCHS 2027-2032	Develop Concept Note	MoH/Partners	0	0	Desk Review
		Total Strategy 4.2	**15.284.949**	**955.309**	
		TOTAL OBJECTIVE 4	**157.703.623**	**9.856.476**	

EXPECTED OUTPUTS	PLANNED ACTIVITIES	SUB ACTIVITIES	RESPONSIBLE PARTNER	PLANNED BUDGET (ZMW) Budget ZMW	0,0625 USD	Source Funding	Budget Descriptio	TIMING 2022 2023 2024 2025 2026
OBJECTIVE 5: Provide high-quality health services at the household and community level by 2026								
Indicator: % of CBVs/% of CHAs receiving refresher effective supervision visit in the last one year Baseline 2021: CBV:TBC CHA:TBC Target 2026: CBV:80% CHA:100%								
STRATEGY 5.1 Strengthen Demand Creation and Health Promotion	**Intervention 5.1.1 Address barriers preventing people from accessing health services**							
Indicator: % of Planned community awareness activities conducted	Engage traditional leaders to participate in promotion of community health services	1. Hold a 3 day high level meeting of 40 per province (20 chiefs* 5 provincial* 16 district*5) per province	MoH	10.745.200	671.575		Meetings	
Baseline 2022: 0 %		Hold a 2 days meeting with 15 people in Lusaka to consolidate the action points from the chiefs' engagement and mobilisation road map	MoH	22.150	1.384		Meetings	
Target 2024: 40%		Print 5,000 copies of the community mobilisation road	MoH	10.767.350	31.406		Printing	
Target 2026: 80 %		Disseminate community mobilisation road map to 116 districts through the province	MoH	192.798	12.050		Transport	
		Distribute community mobilisation road map to 116 districts through provincial health office.	MoH	98.186	6.137		Transport	
	Awareness raising on community health services using multimedia platforms (meetings, electronic (TV, Radio), social and print media including IEC materials)	1. Develop jingles and scripts	MoH	22.150	1.384		Advertising	
		Hold a 5 day meeting in Kabwe for 30 people to develop IEC materials	MoH	212.615	13.288		Meetings	
		Conduct a (5 day* 2 people per team*2teams) Field visit to pre- test the IEC materials	MoH	30.402	1.900		Meetings	
		Hold a 3 day meeting to validate the IEC materials in Kabwe	MoH	131.200	8.200		Meetings	
		Print 10000 copies IEC materials	MoH	702.500	43.906		Printing	
		Distribute IEC materials to all the 116 districts through the PHO	MoH	96.899	6.056		Transport	
		Content and script writing for TV/Radio talk shows and adverts.	MoH	-	-		Deskwork	
		Book 20 TV/Radio appearance to promote community health services	MoH	700.000	43.750		Advertisement	
		Arrange for 20 TV/Radio spots to raise public awareness on community health services	MoH	2.100.000	131.250		Advertisement	
	Intervention 5.1.2.: Promote health education together with other programmes							
	Conduct Household visits.	Hold a 5 DAY meeting in Kabwe for 30 people to develop Key household health messages	MoH	212.615	13.288		Meeting	
		Pre-test the key messages in both rural and Urban households, for 2 days *2 teams of 3 people each	MoH	21.642	1.353		Travel	
		Hold a 3day meeting in Kabwe to validate Household key message for 30 people	MoH	131.200	8.200		Meetings	
		Print 10000 copies of IEC material (Household key messages)	MoH	702.500	43.906		Printing	
		Hold 3 day meeting in provincial centres to Orient Districts in the use of household key messages and distribute the material	MoH	254.584	15.911		Meetings	
		Hold 2 day orientation meeting 40000 CBVs to Household key message	MoH	9.720.000	607.500		Meetings	
			Total Strategy 5.1	36.863.990	1.662.446			

Intervention 5.2.1 Develop a comprehensive Community Health Service Package						
Finalisation of Community Health Service Package	Engage tecnhical assistant to develop CHSP	MoH	477.000	29.813	UNICEF	Consultancy
	Hold 5day meeting for 20 paricipants to review available documents in Chilanga	MoH	107.500	8.086		Meeting
	Conduct a data collection field trip for 4 officers* 5 days in 2 provinces copperbelt and western.	MoH	33.190	2.074		Travel
	Hold 3 day consultative meeting for 40 paricipants in Lusaka	MoH	151.290	9.456		Meeting
	Hold 4 day validation meeting for 40 6.6. participants in Chongwe	MoH	208.960	13.060		Meeting
Printing of Service Package	6. Print 5000 copies of the CHSP	MoH	3.502.500	218.906		Printing
Intervention 5.2.2 Disseminate and orient Community Based Service Providers on the Community Health Service Package						
Launch and Disseminate the Community Health Service Package	Hold a 1 day meeting for 100 participants to launch the package(20 people from Province, 20 people central level,20 from the districts, 30 partenrs & stakeholders, 10 CBVs and NHCs	MoH	192.773	12.048		Meetings
Moblise Funds	Hold a 1 day high level meeting with 30 funding partners to mobilise in Lusaka	MoH	209.343	13.084		Meeting
Training of Staff and CBVs	Conduct a TOT meeting for 5days * 3 people per province to disseminate the CHSP to 10 provinces	MoH	209.343	13.084		Meetings
	Conduct provincial trainings for 5 days for 4 people per district.	MoH	242.794	15.175		Meetings
	Conduct monthly district trainings for 5 days for 2 people per facility and 10 people per zone	MoH	8.534.010	533.376		Meetings
Develop community self assessment tool	Develop concept note	MoH				**Deskwork**
	Hold 3 day meeting *20 people to develop the tool in Kabwe	MoH	174.696	10.918		Meetings
	Conduct a 2day field visit by 3 officers to 3 provinces to pre-test the tool	MoH	47.368	1.845		Meetings
	Hold a 2days meeting of 20 people to validate supervision tool in Kafue.	MoH	178.263	11.141		Meetings
	Print 10000 self assessment tools	MoH	702.500	43.906		**Printing**
	Distribute self assessment tools to the 10 provinces	MoH	148.513	2.988		**Printing**
Capacity building in performance improvement approach	Hold a 3 day meeting *20 people to develop training package in Mazabuku	MoH	198.317	12.395		Meetings
	Conduct a 2 day onsite trainings to 40,000 CHWs in all the 10 provinces	MoH	189.669.200	11.854.325		Meetings
	Conduct TSS and mentorship to community-based service providers to ascertain adherence	MoH	769.865	48.117		Travel
		Total Strategy 5.2	**205.757.424**	**12.853.797**		

Intervention 5.3.1 Identification and mapping of different special populations and address their needs						
Mapping special populations, clarify their specific needs	Engage tecnhical assistant for 30 days to map special population and clarify their specify needs.	MoH	192.000	12.000		Consultancy
	Hold a day high level advocacy meeting for 60 people in Lusaka to advocate for health services teilored to meet health needs for special populations	MoH	233.120	14.570		Meetings
Develop specific community interventions to reach them	Engage tecnhical assistant to develop intervention package for specific special population.	MoH	233.120	14.570		Consultancy
	Hold 3 day consultative meeting in Lusaka with 45 people to design intervention package for specific special populations	MoH	192.000	12.000		Meetings
	Hold a 5 day orientation meeting for 50 people in Kabwe and Mansa	MoH	34.370	2.148		Meetings
	Pilot Health intervention package for special population in 2 provinces (Central and Luapula) for 12 months	MoH	945.498	59.094		Travel
	Conduct Quarterly TSS for 2 teams , 5 people per team for 5 days.	MoH	10.378	649		Travel
	Conduct a 5 day meeting in chilanga with 20 people to compile the report and plan for scale up	MoH	1.540.815	96.301		Meetings
Hold specific health days and establish special outreach posts to service different special populations	Hold 5 day outreach services sessions in provicial capitals for special populations prior to the comemoration of World health day.	MoH	219.865	13.742		Meetings
		Total Strategy 5.3	**3.601.165**	**225.073**		
Intervention 5.4.1: Scale up peer-to peer supervision and mentorship						
Put together Peer to Peer Supportive Supervision Guidelines and Training materials		MoH	0	0		Deskwork
Orient Community Based Health Service Providers (CBHSP) in Peer-to-Peer Supportive Supervision	Hold a 5 day orientation meeting for 50 people in Kabwe and Mansa	MoH	34.370	2.148		Travel
Hold quarterly performance review meetings	MoH	MoH	769.865	48.117	Travel	Meetings
		Total Strategy 5.4	**804235**	**50265**		

Intervention 5.5.1.: Develop a framework for identifying promising innovations					
Develop a framework to identify and assess innovations	Write concept note	MoH	-	-	Deskwork
	Hold 5day consultative meeting with 30 people in Chongwe to develop the inovation framework and assessment tool	MoH	231.900	14.494	Meetings
	Field visit for 1 team of 4 people inLuapula and Copperbelt for 5days to assess existing innovations	MoH	70.529	4.408	Travel
	Hold a 3 day meeting in Lusaka to compile the findings and rate the best innovations	MoH	22.150	1.384	Meetings
Annual event to showcase and recognise innovations and operational research.	Hold 5 preparatory meetings for a day each, of 20 people in Lusaka.	MoH	53.650	3.353	Meetings
	Procure the Trophies and mobilise funds for gifts(Award 10 innovations per year in 4 years)	MoH	422.000	26.375	Procurement of materials
	Hold a 1 day community innovations day every year for 4 years to showcase and award best practices	MoH	1.430.744	89.422	Meetings
Publication and dissemination of innovations and research	Engage an international consultant to develop community health hub that will have a section for innovations and implementation publications	MoH	256.000	16.000	Consultancy
	Produce a bi-annual innovation magazine	MoH	2.200.000	137.500	Advertisement
	Produce bi-annual TV/Radio documentaries to show case community health best practices	MoH	844.680	52.793	Advertisement
Intervention 5.5.2: Pilot innovations in a controlled setting and document lessons.					
Work with partners to pilot high potential innovations	Conduct 2 research studies on best practices and innovations in community health	MoH	2.000.000	125.000	Consultancy
	Support atleast 8 people to attend 4 interntional conferences	MoH	1.832.960	114.560	Travel
	Organise and host 1 regional or international conference for 60 people in Livingstone for 3 days.	MoH	234.800	14.675	Meetings
Estabbilsg community health model in a Family, village, district or province	Write a concept note and identify implementing partners and write to PS	MoH	-	-	Deskwork
	Hold a 3 day consultative meeting with 30 people in Lusaka	MoH	48.910	3.057	Meetings
	Invite partners to implement over a period of 1 year	MoH	-	-	Consultancy
	Conduct bi-annual evaluation to identify best practices and gaps, 4 people in province for 7 days	MoH	42.694	2.668	Meetings
	Hold a 3 day meeting for 20 people to write and analyse the findings and reccomendation for roll out as well as draw a roll out plan = Chilanga	MoH	64.769	4.048	Meetings
	Implement the lessons learned and recommendations* (TBD)	MoH	-	-	Deskwork
	Total Strategy 5.5		**9.755.786**	**609.737**	
Intervention 5.6.1: Scale up and develop new models for delivery of Community Health interventions in Urban Areas					
Work with partners to pilot Community Health Interventions in Urban settings	Write a concept note and identify implementing partners and write to PS	MoH	-	-	Deskwork
	Hold a 3 day consultative and resource mobilisation meeting for 30 people (15 MoH program officers and 15 partners) in Lusaka	MoH	51.175	200	Meetings
	Invite partners to implement over a period of 1 year in controlled setting.	MoH	-	-	Deskwork
	Conduct bi-annual evaluation to identify best practices and gaps 5 people to 1 province for 7 days	MoH	49.814	3.113	Meetings
	Hold a 3 day meeting for 20 people to analyse the findings and make recommendations in Chongwe	MoH	123.169	7.698	Meetings
	Document and implement the lessons learnt* (TBD)	MoH	224.159	14.010	Consultancy
	Total Strategy 5.6		**448.318**	**25.021**	
	TOTAL OBJECTIVE 5		**257.230.918**	**15.426.338**	

EXPECTED OUTPUTS	PLANNED ACTIVITIES	SUB ACTIVITIES	RESPONSIBLE PARTNER	PLANNED BUDGET (ZMW) Budget ZMW	0,0625 USD	Source Funding	Budget Descriptio	TIMING 2022	2023	2024	2025	2026
OBJECTIVE 6: Provide effective leadership and governance in the formation, maintenance and management of community health structures by 2026												
Indicator: % of NHCs that have been trained and are aware of the NHC Guidelines Baseline 2022: TBC Target 2026: 100%												
STRATEGY 6.1 Strengthen governance of community health structures at all levels	**Intervention 6.1.1 Disseminate essential policy documents and guidelines**											
Indicator: % of Districts that have included Community Activities in their annual budget	Printing of strategic documents	Print 4000 copies of the 2022-2026 NCHS	MoH	402.500	25.156		Printing	Dec	Dec			
		Print 500 copies of the NCHS 2022-2026 Operational Plan	MoH	52.500	3.281		Printing	Dec	Dec			
Baseline 2022: TBC		Print 4000 copies of the NCHS M&E framework 2022-2026	MoH	402.500	1.406		Printing	Dec	Dec			
Target 2024: 40%		Print 200 copies of the NCHS-IC 2022-2026	MoH	22.500	1.406		Printing	Dec	Dec			
Target 2026: 80 %		Print 200 copies of the NCHS-BP 2022-2026	MoH	22.500	1.406		Printing		Dec			
		Print 100,000 copies of the Community Health service package	MoH	10.002.500	625.156		Printing		Dec			
		Print 100,000 copies of the Community health guidelines	MoH	10.002.500	625.156		Printing		Dec			
		Print 100,000 copies of the Community Health workers' guidelines	MoH	10.002.500	625.156		Printing		Dec			
		Print 100,000 copies of CBVs incentives package	MoH	10.002.500	625.156		Printing		Dec			
		Print 100,000 copies of CBVs incentives guidelines	MoH	10.002.500	625.156		Printing		Dec			
		Print 16000 copies of the NHC guidelines	MoH	1.602.500	100.156		Printing		Dec			
		Print 100,000 copies of the CBVs legal framework guidelines	MoH	10.002.500	625.156		Printing		Dec			
	Launch and Disseminate Key Strategic documents	Hold a 1 day National Launch meeting in Lusaka to launch and disseminate key strategic documents. Participation TBA	MoH	204.465	12.779		Meetings	Dec				
		Hold a 1 day Provincial Launch meeting in all 10 provinces to launch and disseminate key strategic documents to the Districts. Participation TBA	MoH	162.305	13.959		Meetings	Dec				
	Monitor implementation of planned community health activities at Provincial & district level	Conduct a 21 days Bi-annual Monitoring of Annual Plans and Budgets at Provincial and District levels for 30 participants. 20 from MOH HQ, 10 from PHOs	MoH	833.965	52.123		Travel		Jan, Jul	Jan, Jul	Jan, Jul	Jan, Jul

Intervention 6.1.2 Develop the legal framework to formalise NHCs/HCCs and CBVs					
Develop new statutory instruments to provide the legal framework NHCs	Develop TORs for the Consultancy services for the Development of NHC legal framework guidelines	MoH	-	-	Deskwork
	Procure local consultancy services for development of NHC Legal framework guidelines	MoH	128.000	8.000	Consultancy
	Hold a 7 days meeting in Chilanga to conduct an internal validation of the first draft of the NHC legal framework guidelines with 20 participants from MOH HQ	MoH	290.658	10.715	Meetings
Stakeholder meetings	Hold a 7 days meeting in Chilanga to conduct an external validation of the first draft of the NHC legal framework guidelines with 40 participants. 20 from MOH HQ, 10 from PHOs and 10 from partners	MoH	406.086	25.380	Meetings
	Present the NHC legal framework guidelines to Senior Management for validation. Desk work	MoH	-	-	Deskwork
	Hold a 5 days meeting in Chilanga for 20 participants from MOH HQ to finalize the NHCs legal framework guidelines	MoH	209.657	13.104	Meetings
Lobbying for adoption	Hold a 1 day Meeting with Cooperating Partners in Lusaka by MoH HQ for adoption of the legal framework for NHC	MoH	27.621	1.726	Travel
Total Strategy 6.1			**64.782.758**	**4.021.533**	
Intervention 6.2.1 Strengthen community health structures at all levels					
Staff Establishment at various levels to support the implementation of Community Health activities.	Write a concept note including the scope of work	MoH	-	-	Deskwork
	Hold a 7 days lobbying meeting in Siavonga with 15 participants from Lusaka	MoH	123.344	7.709	Meetings
Mobilize resources to employ community health officers	Conduct a 1 day partner meeting in Lusaka to lobby for resources	MoH	20.871	1.304	Meetings
Recruit and Appoint CH Officers at all levels	National level: M&E officer, Community Health Specialists, Community health officers, Community Health Technical Advisor, CHA coordinator (SEE OBJECTIVE 1.1)	MoH	-	-	Staff Salaries and Emolments
	Provincial level: 10 community health officers & 10 Community Health Specialist (SEE OBJECTIVE 1.1)	MoH	-	-	Staff Salaries and Emolments
	District level: 116 Community health officers (SEE OBJECTIVE 1.1)	MoH			Staff Salaries and Emolments
Intervention 6.2.2 Strengthen multisectoral collaboration linkages and coordination					
Hold community health meetings with stakeholders at various levels	Hold quaterly TWG meetings at National level in Lusaka for 50 participants	MoH	589.120	36.820	Meetings
	Hold quaterly TWG meetings at Provincial level in all provincial centres (NCA)	MoH	833.965	52.123	Meetings
	Hold quaterly TWG meetings at District level in all districts (NCA)	MoH			Meetings
Total Strategy 6.2			**1.567.300**	**97.956**	

Intervention 6.3.1 Roll out of the new NHC Guidelines						
Orient health facility staff, NHCs in new NHC guidelines	Hold a 3 days meeting in Livingstone for 25 participants (2 from each Province, 5 from MoH HQ) to orient all provinces	MoH	163.981	9.499		Meetings
Provide onsite mentorship in the management of CH Services	Conduct 20 mentorship visits to all provinces with team of 3 participants from MOH HQ for 7 days each	MoH	3.914.123	244.633		Travel
Intervention 6.3.2 Strengthen social accountability mechanisms.						
Develop social accountability manual	Develop TORs for the Consultancy services for the Development of Social Accountability Manual	MoH	-	-		Deskwork
	Procure local consultancy services for development of Social Accountabilty Manual	MoH	192.000	12.000		Consultancy
	Hold a 7 days meeting in Chilanga to conduct an internal validation of the first draft of the Social Accountability Manual with 20 participants from MOH HQ	MoH	253.557	15.847		Meetings
	Hold a 7 days meeting in Chilanga to conduct an external validation of the first draft of the Social Acountability Manual with 40 participants. 20 from MOH HQ, 10 from PHOs and 10 from partners	MoH	521.919	32.620		Meetings
	Present the Social Accountabilty Manual to Senior Management for internal validation. Desk work	MoH	-	-		Deskwork
	Hold a 5 days meeting in Chilanga for 20 participants from MOH HQ to finalize the Social Accountabilty Manual	MoH	253.557	15.847		Meetings
Develop community score card	Develop TORs for the Consultancy services for the Development of Community Score Card	MoH	-	-		Deskwork
	Procure local consultancy services for development of Community Score Card	MoH	192.000	12.000		Consultancy
	Hold a 7 days meeting in Chilanga to conduct an internal validation of the first draft of the Community Score Card with 20 participants from MOH HQ	MoH	260.157	16.260		Meetings
	Hold a 7 days meeting in Chilanga to conduct an external validation of the first draft of the Community Score Card with 40 participants. 20 from MOH HQ, 10 from PHOs and 10 from partners	MoH	465.219	29.076		Meetings
	Present the Community Score Card to Senior Management for internal validation. Desk work	MoH	-	-		Deskwork
	Hold a 5 days meeting in Chilanga for 20 participants from MOH HQ to finalize the Community Score Card	MoH	290.657	18.166		Meetings
Develop Service Delivery Charter	Develop TORs for the Consultancy services for the Development of the Service Delivery Charter	MoH	-	-		Deskwork
	Procure local consultancy services for development of the Service Delivery Charter	MoH	192.000	12.000		Consultancy
	Hold a 7 days meeting in Chilanga to conduct an internal validation of the first draft of the Service Delivery Charter with 20 participants from MOH HQ	MoH	290.657	18.166		Meetings
	Hold a 7 days meeting in Chilanga to conduct an external validation of the first draft of the Service Delivery Charter with 40 participants. 20 from MOH HQ, 10 from PHOs and 10 from partners	MoH	409.919	25.620		Meetings
	Present the Service Delivery Charter to Senior Management for internal validation. Desk work	MoH	-	-		Deskwork
	Hold a 5 days meeting in Chilanga for 20 participants from MOH HQ to finalize the Service Delivery Charter	MoH	290.657	18.166		Meetings
Printing of strategic documents	Print 20,000 copies of the Social Accountability Manual	MoH	2.002.500	125.156		Printing
	Print 3,500 copies of the Service Delivery Charter	MoH	352.500	22.031		Printing
Disseminate strategic documents to all Provinces	Conduct a 3 days exercise per Province to disseminate the Service Delivery Charter and Social Accountability Manual. 2 people per team from MOH HQ	MoH	104.843	6.553		Meetings
Sensitise the community on their role in social accountability	Procure media airtime for TV and radio	MoH	3.290.400	205.650		Advertising
		Total Strategy 6.3	13.440.646	839.290		
		TOTAL OBJECTIVES 6	**79.790.704**	**4.958.780**		
	TOTAL BUDGET FOR THE NCHS 2022-2026		**1.205.501.766**	**74.660.628**		

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