Case Study Brief

March 2015

Produced by Lusaka District Health Management Team with Training and Research Support Centre In the Regional Network for Equity in Health in East and Southern Africa

Health centre committee involvement in local government planning for health in Zambia

Zambia's health profile

Indicator	Value
Population	14 539 000
Percent population urban	40
Gross national income/capita PPP US$	3 070
Percent population living on <US$1/day 2010	74
Adult literacy rate 2010	71
Life expectancy at birth 2012	57
Under 5 year mortality rate 2012	89
Maternal mortality /100 000 live births	280
Adult HIV prevalence	12.5
Unmet need for family planning 2007	27
Antenatal care coverage, one visit + 2007	94
Antenatal care coverage, four visits 2007	60
Measles immunisation in 1 yr olds 2012	83
Nurses and midwives / 10 000 people 2012	7.8
Per capita expenditure on health PPP$ 2008	80

2013 data unless otherwise specified.
Source: WHO Global Health Observatory 2015

Source: CSO,MoH TD RC, Unz Marco International Inc, 2009 Map of Zambia showing provinces

Zambia is a lower middle income country, with economic growth but also with persistently high levels of poverty and socio-economic inequality. Malaria was the leading cause of death in both children and adults in 2010 according to the Ministry of Health. The country's profile of both communicable and non- communicable diseases calls for prevention, early detection and care. Zambia thus gives priority to improved environments and food safety, control of epidemic outbreaks, health promotion and primary health care services for family health, communicable and chronic conditions. Most of the population use public sector and faith-based services, although there are also private services such as those provided by mining companies, private practices and traditional healers. The Ministry of Health is responsible for health care, with the Ministry of Community Development and Child Health and the Ministry of Local Government and Housing. Health services are provided at health posts (HPs) and health centres (HCs) at community level, who refer to district hospitals, then provincial hospitals and then national tertiary hospitals. The priority areas raised above mean that primary care services need to be available, accessible and to have good outreach to local communities, to improve health.

Neighbourhood health and health centre committees in Zambia

Zambia's health reform in the 1990s was precipitated by a rapid deterioration in health care services and infrastructure and a demoralization of health staff during the 1980s structural adjustment led reforms. In 1991, government committed to building a health care system that provided "equity of access to cost effective quality health care as close to the family as possible," and made a commitment to participation of stakeholders, including local communities, in health service planning and delivery. Neighbourhood health committees (NHCs) were set up in 1994 to support this. The strategy in the 1990s recognized that most diseases can be dealt with when the community collaborates with the health centre, so that NHCs were set up across the country. NHCs were seen as the vital link between the community and the health system. While the current 1996 Zambian

HCC chairpersons planning at district level, Lusaka
© M Daka 2013

Constitution provides for the right to life but not explicitly the right to health or health care, the National Health Services Act 1995 provided for NHCs and the principle of participation in law. The introduction of pooled 'basket-funding' of external funds and the collection of fees at services called for bottom up planning and budgeting.

Guidelines set out the role of NHCs to:

- identify health needs in the community, collect community evidence and plan and work with the health center staff on shared concerns, together with community based organisations;
- Support information exchange between health services and communities, and with community health volunteer groups.

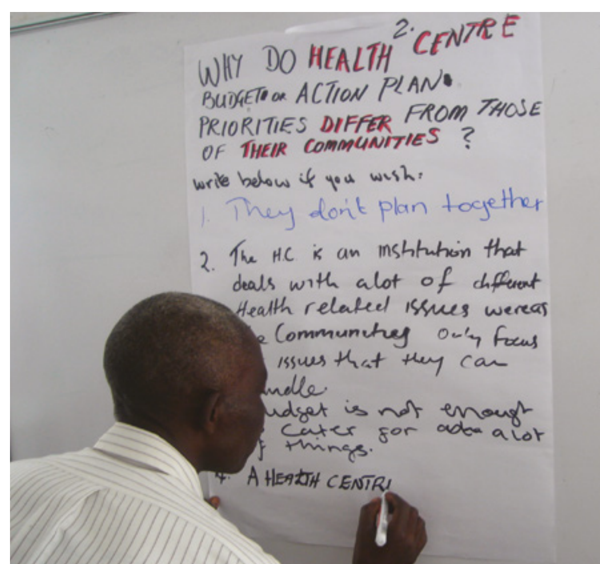
NHCs have been set up in all ten provinces in Zambia and district community health offices. In the ideal situation the community picks people from zones of a HC to create a NHC and a chairperson is elected to become leader for the zone. Each NHC chairperson becomes a member of a health centre committee (HCC) at the health facility. The HCC also involves health staff. The nurse in charge at the health centre is the secretary to the HCC and a chairperson is selected from amongst the NHC chairpersons.

In 2006, as part of wider reforms, the 1995 National Health Services Act was repealed, removing the legal mandate of NHCs. The NHCs continue to function drawing their mandate from respective national health strategic plans and from guidance in the annual planning and budgeting handbooks. However LDHMT facilitated training in 2014 found that while NHCs and HCCs were functioning in all provinces, their representation of communities may need to be strengthened, as many members were not included on HCCs after nomination or electoral process, many did not have constitutions or operational guides to ensure accountability to their communities. The Ministry of Health is now drafting a new National Health Services Act and, acknowledging the important role communities play in health, is committed to strengthening community structures and their role and participation in the planning, management, implementation, monitoring and evaluation of health services. NHCs and HCCs play a key role in this.

HCC roles in local government health planning and budgeting

While the role of NHCs and HCCs is being strengthened across the country, there are many examples of efforts that have been made to promote HCC participation in planning, budgeting and health actions.

Lusaka DHMT has, for example, prepared a constitution for its HCCs, and with partner support has trained HCCs in planning and budgeting and held nine Annual General Meetings for NHCs. Participatory reflection and action methods were used to support participation. Communities identify their health problem or issue to be addressed, reflect on their causes and dialogue with health workers on priorities and actions.



NHC member contribution to plans, Matero Lusaka
© C Mbwili 2006

Cleanup campaign in Chipata Lusaka
© I Zulu 2013

Communities are the change agents themselves. They are trained in health literacy, act with the local health workers on identified priorities, and use participatory monitoring tools to measure and review progress. For example in Ngombe, the NHC, HCC, and local government have addressed water and sanitation, garbage and housing in the area.

HCCs in a number of areas of Lusaka have identified environmental health as a priority, and carried out clean up campaigns with local government support with chlorine, garbage trucks and other inputs. HCCs have managed public toilets, hammer mills for maize grinding (in Ngombe), and concrete block making.

In Chaisa HCC, an international partner has provided the HCC with bicycles and entrepreneurship skills, while in George HC, a farm was donated to the HCC for income generating from food production.

In Kafue district HCCs support mobile phone appointments and follow up of HIV positive mothers, while NHCs in other areas have distributed and monitored use of mosquito nets.

While the HCCs mobilise resources locally for these actions, including from their own income generating activities, the district health offices also allocate funds for these activities from government grants.

Lessons to share

These approaches have increased informed, self-determined participation in planning and budgeting by NHCs, community members and local health workers. They have increased mutual respect between community members and health workers, and increased awareness on the constraints health services face in the resources health centres are allocated from district and central level.
In communities where health literacy facilitators have been trained, the communities were able to make plans and budget because they were able to identify problems and also lobby for funds both from the health system and from stakeholders.

The HCCs have contributed significantly to ownership of plans and budgets generated at community level. In 2005 most presentations on plans and budgets at the NHC annual general meeting were done by health workers and non-state actors. Since 2012 in areas where HCCs have been trained and supported, the HCC members themselves have presented the plans and budgets of the HC, and have prepared displays and reports on what they are doing in the health centres.

HCCs and NHCs have lobbied for resources for community activities on health and for improvement of the health centre, including for events to report back to communities and other stakeholders. The HCCs in Zambia show that it is possible to increase the skills and participation of community members on planning and budgeting for health at primary care level, including to mobilise other sectors to support actions on the social determinants of health. Cholera was endemic in Lusaka, but in 2010 there was no cholera outbreak. Waste sites that used to be a site of disease and abuse have been removed.

NHC annual general meeting display of activities, GoCentre, Lusaka © I Zulu 2013

Advocacy march of health workers and community members, Matero Lusaka © I Zulu 2011

However we also recognise that we need a more united voice to influence the public budgets allocated to primary care level and to community health. The stated policy support from government needs to be reinforced by continuing to raise our voice on the positive impact in practice of working with HCCs and communities, to improve governance and accountability in planning and budgeting for primary health care, and to improve health outcomes.

The role of HCCs in planning and budgeting is increasing in practice, and now needs to be backed by law again. The new Health Services Act in Zambia should enshrine the HCC and NHC to bring back their legal mandates, with clear guidelines for HCC functionality. The experience in Zambia indicates that all HCCs should have a local constitution, training materials and processes that are specific for their function, using participatory reflection and action approaches, with health literacy training for the wider community.

Acknowledgements

We acknowledge the ongoing participation and invaluable contribution of the NHCs and community health volunteers working with Lusaka District Community Health Office and across the country. The brief was written by Clara Mbwili, Adah Zulu, Moses Lungu, Rene Loewenson and Barbara Kaim. We recognise the tireless efforts and commitment of the late Moses Lungu who passed on in December 2014, and who dedicated much of his working life to promoting equity and uplifting health and health care. He was a lead in this work, a life member of the NHCs and a trainer and mentor to many NHCs countrywide.

References

1. Lungu M (2014) 'The changing legal status of Zambia's neighbourhood health committees, in TARSC, CWGH, Medico Int (2014) 'Strengthening health centre committees as a vehicle for social participation in health in east and southern Africa: Regional meeting report, Harare, Zimbabwe 30 January - 1 February 2014, EQUINET: Harare.
2. Lusaka District Health Management Board (LDHMB) (2012) 'Revised NHC constitution', LDHMB: Lusaka.
3. Mbwili-Muleya C, Lungu M, Kabuba I, Zulu Lishandu I, Loewenson R (2008) Consolidating processes for community – health centre partnership and accountability in Zambia, Lusaka District Health Team and Equity Gauge Zambia, EQUINET Participatory Research Report An EQUINET PRA project report. EQUINET: Harare
4. Ministry of Health Zambia (2011) National Health Strategic Plan 2011-2015 accessed at http://www.moh.gov.zm/docs/nhs.pdf. December 2014.
5. TARSC, LDHMT (2011), Strengthening Health Worker-Community Interactions through Health Literacy and Participatory approaches, Zambia Training workshop report, TARSC, Harare.
6. World Health Organisation (2015) Global Health Observatory Country Profiles: Zambia accessed at http://www.who.int/gho/countries/zmb/country_profiles/en/ February 2015

Produced March 2015 with support from OSISA

Cite as: LDHMT, TARSC in EQUINET (2015) Health centre committee involvement in local government planning for health in Zambia , EQUINET Case study brief, EQUINET Harare

Contact Lusaka DCHO, Ministry of CDMCH Zambia at ldcmo@quickedge.com
Contact EQUINET at email: admin@equinetafrica.org, www.equinetafrica.org

Produced by Lusaka District Health Management Team with Training and Research Support Centre In the Regional Network for Equity in Health in East and Southern Africa