Health Partnerships in Zambia

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1 Background

Although Zambia was one of the most prosperous countries in sub-Saharan Africa for the decade after independence in 1964, thanks to its copper mining industry, dramatic declines in people's welfare have been experienced over the past two decades due to a combination of factors. The copper industry is no longer as lucrative as it was because of the big declines both in copper prices and the mineral reserves, which are beginning to be exhausted. The farming industry has suffered major droughts, which have persisted since the early 1980s. The economic Structural Adjustment Programme (SAP) with its insistence on market liberalisation has led to the withdrawal or collapse of government companies so that agricultural inputs are difficult to purchase. There are difficulties in obtaining farm credit and fewer markets for small farmers to sell their produce. Company closures and privatisation, together with the rationalisation of the public sector demanded by SAP, has meant cutting down on employment and hence massive job losses. Finally, the fishing industry is no longer lucrative because of the depletion of the fish stocks.

This period of rising poverty levels has also seen the rise of morbidity and mortality rates for infants, children and adults (Simms 1998, Milimo 1997). Life expectancy has reduced while HIV infections have greatly increased. It has also created new categories of vulnerable people: increasing numbers of orphans and child-headed households, female-headed households, and unemployed, commonly referred to as retrenchées. These three categories together with the old poor and indigents (disabled, old, sickly, etc.) are most vulnerable to health problems.

Health problems have been ranked among the top four or five major concerns experienced by communities in their daily lives since 1994. Rarely have they been ranked first or second; these positions have almost invariably been taken by hunger/food and water. However health issues should not discussed in isolation from the other problems that are of concern to communities. Food/hunger, water, shelter, health and education are seen as very closely interlinked issues, and problems in one are invariably reflected in the others. Therefore community involvement in the delivery of quality health services requires that health issues must be

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viewed in the broader context of the other problems communities experience.

2 Partnership and Accountability: Key Concepts in Zambia's Health Reforms

In order to improve the deteriorating health status of the Zambian population and the health service delivery system, Zambia embarked upon a health reform programme whose primary aim is to provide quality health services as near to households as possible. The reforms are centred around three key themes, namely: leadership, accountability and partnership.

Leadership is to be provided by a reduced team at the government ministerial headquarters, which comprises the minister and a small team of technocrats. These are expected to devolve power downwards, in particular to the district, the province and hospital levels where the key elements in the reform programme are to take place.

Accountability is envisaged as a key element in the reform programme in respect of the way health providers are to relate both to the users of services and to the providers of resources. This relationship is to lead to the final theme, namely partnership.

Partnership is perceived in terms of bringing about a positive relationship between all elements who interface in health services, and of stimulating improvements in the provision and sustainability of the reformed health services. In terms of users this would entail contributing to the cost of health care. With regard to government and donor agencies, this implies working more closely and in partnership in the implementation of the Health Reform Programme (Sumaili 1996, p.1).

The devolution of power referred to in the first cornerstone of the reforms has necessitated the establishment of new structures, which, although autonomous, would be accountable to the government, the donor agencies and the community for the use of the various resources at their disposal. The structures which have been created include:

- The Central Board of Health (CBoH), which has in practice taken over most of the functions that the ministerial headquarters used to perform.
- District Health Management Teams (DHMTs). These have been set up in all the districts and are responsible for all health issues in their respective district.
- Hospital Boards, which are responsible for each hospital.
- Health Centre Committees, the majority of which are still struggling to exist and to function. These are responsible for health matters at the various health centres, and are formed of members of the neighbourhood committees, community health workers and traditional birth attendants (see below).
- The (Health) Neighbourhood Committees (NCs). The word 'health' is put in brackets because, although started by health care providers, it was envisaged that these community-based organisations (CBOs) would be responsible for other community work, like agriculture, water and sanitation, thus doing away with the need to establish a number of committees, which usually have the same members.

The (Health) Neighbourhood Committee (NC) has been identified as the CBO through which partnerships will be made with the community on the one hand, and with health and social service providers on the other. These committees began to be formed in 1995.

3 Existing Health Providers with Whom the NC Form Partnerships

Although the government is the primary provider of health services in Zambia, other health providers do exist, some supported by government, and others operating independently. Government health providers are structured as follows:

- Staff at modern health facilities, including fully trained medical doctors, nurses and support staff (cleaners, security guards, etc.), some of whom often carry out the functions of trained staff because of shortage of the latter.
- Community Health Workers (CHWs) run remote health posts. They have some basic training and administer some essential drugs. Being predominantly male, they are often unable/disqualified from attending to specifically women's needs.

- Traditional Birth Attendants (TBAs) are an important component of health service delivery systems, given the long distances expecting mothers have to travel to health centres, especially in rural areas. Many have received some training from the formal health service delivery system.
- Community Based Distributors (CBDs) distribute family planning products (FPPs). They are either private entrepreneurs, mainly grocery owners, who sell FPPs in their shops, or have been especially hired by donor and non-governmental organisations (NGOs) to distribute these products. Both groups of CBDs receive some training.

Besides government facilities there are a variety of other health providers, such as church-run health institutions, some of which reach the remotest parts of the country. These facilities receive a government subsidy and are perceived to provide better quality services. Mine hospitals are predominantly found in the Copperbelt and are also perceived to provide good quality services. However, the economic crisis of the mining industry has meant that health services are no longer provided free to mine employees. Private health practitioners run health clinics, mainly in urban areas. Traditional healers use remedies consisting mainly of herbs; although they are often more expensive than modern health facilities, many people go to them because they accept payments in instalments. Relatives and friends of sick patients are also health workers, though not officially recognised as such. They are usually totally untrained, but increasingly they are taking over the roles of the trained nursing staff in feeding and cleaning and sometimes administering medications.

4 The Neighbourhood Committee and its Functions

The following are the functions of NCs as defined by the Ministry of Health: identify community needs and integrate these into Health Centre Action Plans; form the link between communities, health centre staff and the other providers described above; initiate and participate actively in health-related activities at household and community levels; develop mechanisms for sustainability for community-based health workers; initiate and strengthen local development initiatives with other sectors, such as education, agriculture, housing, social welfare, etc.; identify training needs for community-based health care volunteers, and support them; collect relevant community-based data; and mobilisation and accountability of local resources (Source: 'District Guidelines', 1995, p.18).

While the above are the official functions of NCs, some have taken on other functions, many of which relate to their function of building partnerships for social and health service delivery. Some of these are: relay community complaints to health authorities; assist in the identification of the poor for exemption from health user fees; generation of income to assist those who cannot afford to pay health fees; promotion of hygienic conditions in the area, i.e. promoting the digging of pit latrines, rubbish pits, racks for drying dishes, etc.; constructing roads and paths; and reporting outbreaks of epidemics.

5 Zambia's Experience with Community-Based Organisations

In order to ascertain whether or not CBOs, and in particular NCs, can fulfil the functions described above, and so that those concerned with the delivery of health services can learn from related experiences, there is great value in looking at other sectors to see what has been achieved.

Zambia abounds with success stories of CBOs, including: Seed Distribution CBOs, which are being supported by CARE International; Outgrower Schemes promoting cash and food crops; World Bank and European Union sponsored Microprojects Unit (MPU), operated through CBOs for social infrastructure rehabilitation, extension and construction; and microcredit CBOs. Boxes 1 and 2 give further details of experiences.

The following factors have contributed to the success of such CBOs:

- Training, e.g. in business management
- Common felt needs, i.e. people coming together and achieving desired goals
- Acceptability of CBOs to the community and other stakeholders, i.e. elected committees
- Representation of all interest groups in CBO committees, e.g. in terms of gender and age
- Transparency, accountability and information flows.

Box 1

Outgrower Schemes (supported by the Cooperative League of the United States (CLUSA)) are operating in districts which were relatively better off agriculturally until the droughts intensified. They promote the growing of high value cash crops as well as food crops, and are having a very positive impact on people's livelihoods, ensuring them both food security and cash incomes. Through these CBOs, the often voiceless and powerless population is now able to access previously inaccessible markets for both their farm requirements and produce.

Box 2

Microcredit CBOs are usually small organisations, consisting of only ten people. Working together they are able to access credit, utilise it for productive purposes and, above all, repay it. The latter is a very big achievement in Zambia where a culture of loan non-repayment often prevails. Not only are they succeeding in repaying their loans, the CBOs have enabled their members to move out of severe poverty, i.e. to have three meals a day instead of one, to send children to school, to access health services and so on.

Some less successful CBOs exhibited poor performance for the following reasons:

- Excessive dependency on the donor or government
- The CBO development activities not identified by the community
- Inadequate preparation and training
- Lack of transparency and accountability, particularly in terms of money

These are valuable lessons that the NCs should take into account in their activities in order to ensure higher likelihood of success.

6 The NC as the Health/Social Service Partnership CBO

In order to perform the partnership role required, the NC needs to be streamlined. Some of its current functions could be revised, and a few additional ones made. These additional functions could relate to the following areas.

- Through their apex organisations, i.e. the Health Centre Committee, the NCs could be responsible for the purchase of drugs, cleaning materials and so on, which are presently administered by central government or donors. This would make purchasing more relevant and accountable.
- Allow NCs to manage funds for the employment of the health centre staff. Currently staff are paid by central government which is too far away to monitor them. If the NCs manage the fees and salaries of the extension staff, they would then be accountable to the community members and not to some distant bureaucrat. The community and the NC is in the field and thus better able to fulfil supervisory and monitoring functions.
- Assist Health Centre staff in providing more relevant health education, for example, incorporating traditional values and tackling cultural barriers that currently cause conflicts in service access and types of provision.

In order to ensure that NCs are an effective mechanism across the country, a number of things still need to be done. NCs should be established in any communities where they currently do not exist. They should cultivate a sense of independence from their founder and promoter from the start. The guideline that at least half of the committee members be women should be followed. In addition, it is important to ensure that the concerns of all interest groups (farmers, fishermen, youth, etc.) are represented on the committee. Intensive training should be provided to both the NC members and to the communities at large on 'the new thinking', i.e. on the central role of the NCs. All categories of service providers (government, church, private, traditional, the most trained medical doctors as well as the less well trained) should be sensitised to the key role of the NCs as the contact point in the partnership of health and other services. If the NCs are to handle funds they will also need thorough training in business management skills.

7 Conclusions: The NC as the Partner in Health Service Delivery

Experiences with CBOs in other sectors have shown that these organisations are capable of such important undertakings as initiating and managing relatively big development activities. They are able to handle relatively large amounts of money, to link effectively communities that are usually voiceless and powerless to those with power, to hire and fire workers and so on. These lessons learnt from previous experience with CBOs in other sectors should be taken into account when adopting NCs as the link between users/consumers and providers of health, and indeed other social services.

Finally, it is worth mentioning that a survey was carried out a year after the establishment of the NCs in 1995, and it revealed they already ranked third among the most widely spread institutions that assist the poor (after churches and the government department of social welfare) and second in terms of the trust people have in them. Three years later (1999) the World Bank 'Consultations With the Poor' study confirmed these findings, and the NC is now better known than it was in 1995. Although they are relatively young, NCs are beginning to be effective, though the scope for further improvement exists.