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**THE LIVINGSTONE WORKSHOP
ON PARTNERSHIPS IN COMMUNITY-BASED
HEALTH CARE REFORM IN ZAMBIA**

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ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
HIV	Human Immunodeficiency Virus
NGO	Non-governmental Organization
SCALE One	Successful Communities as Learning Examples
SCALE Squared	Self-help Center for Action Learning and Experimentation
UNICEF	United Nations Children's Fund
WHO	World Health Organization

EXECUTIVE SUMMARY

In the past five years, Zambia has become one of the most innovative examples in Africa of Community Based Health Care Reform. National leaders are pioneering a courageous new conceptualization of how Zambians can themselves solve priority health problems with self reliance and sustainability. In local projects they are making good progress in evolving and adapting new community based models in partnership with the best international expertise. Conceptualization and documentation of progress is outstanding. The partnerships must now be redefined for the next and most challenging stage, which is how to “scale up” or extend these new models in a national program that equitably improves health for all Zambians. This Livingstone workshop made great progress in mobilizing a framework and enthusiasm for new ways to restructure services systematically and in reviewing new guidelines for changes down to district level. This workshop focused primarily, however, on the next challenge which is the bottom-up components of community capacity building and how they can be activated in dynamic new partnerships. Some recommendations are outlined for priority action.

ZAMBIAN PROGRESS AND POTENTIAL

As the WHO–UNICEF–World Bank Commission chaired by Dr. Halfdan Mahler, Emeritus Director General of the World Health Organization, said in their 1997 report “the health reform in Zambia is something remarkable in Africa—a movement based on the principles of equity, accountability and partnership. What is happening here is an example and challenge to many countries in Africa. By your success, you will supply what has so far been lacking in Africa—a demonstration that a reform of the health system is possible.”

The most pioneering aspect of present planning is the focus on a new paradigm of community based capacity building in a health system where communities are empowered to take responsibility for their own care. A new framework of internal and external partnerships will support community potential. The Central Board of Health, with Dr. J. J. Banda as Director of Health Commissioning, has made great progress in thinking through lessons learned and changes needed in past efforts to develop health services and they have mapped imaginative but realistic options for the future. Their economic analyses show that projected total expenditures on health services in Zambia will be about \$14 per capita per year. Of that about \$4 will reach district level and of that about \$1.6 per capita per year may be available for community activities. They say these are optimistic projections. Committees will have to take responsibility not only for their own health care but also for related social development.

COMMUNITY BASED DEMONSTRATION PROJECTS

Fifteen community based projects in Zambia have undertaken detailed self-study in the past six months. During an intensive two days of pre-conference analysis, the responsible persons

summarized the lessons learned. These demonstration projects had varied sources of support and focus of action, they have been active from 1.5 to 15 years. NGOs started several projects and government agencies others, mostly with support from international donors. Most were started to address particular problems such as nutrition, family planning, behavior change to limit HIV/AIDS transmission or women's income generation. Two are particularly interesting because community action took off after outside agencies terminated their direct input.

Excellent presentations covered the walls of the conference hall with flip charts full of background information, objectives, data on performance, pictures and "defining moments." Considerable sophistication was evident in using modern qualitative and quantitative research and teaching methods. The evident achievements produced profound awareness among participants that major transformations were occurring in the potential for health care reform. Realization grew into enthusiasm about examples that reversed old stereotypes of health personnel sitting in clinics giving only episodic care to an unending stream of sick and malnourished children and adults. A new vision emerged that people were ready to act with appropriate support and that self-financing was an immediate reality, not a distant dream. Even though there were only a few true community representatives present at the conference, it was health professionals and officials who shared surprise as they became aware of what communities were doing and that they could do much more.

My role was to applaud their demonstrations of success, and my reactions were genuine because the community based projects have done extremely well. To show them that they are not alone, I presented worldwide experience, with almost 10 hours of lecture-discussion and three extended evening slide shows of success stories demonstrating that community based social development can "go to scale" with case studies from Tibet to the Peruvian Andes and including African examples. It seemed important that they realize they are part of a worldwide grassroots movement. The first modern community based primary health care project was in Ding Xian, China, in the early 1930s, so the concept is still relatively new. In 1978, the watershed Alma Ata World Conference on Primary Health Care (where I was one of two outside consultants who prepared the background document) defined the basic concepts. However, the movement was diverted in the 1980s as international donors poured millions of dollars into top-down "selective primary health care." Although progress was made in implementing some specific interventions, realization has grown that eventually these much publicized campaigns will be sustainable only if there is infrastructure for an integrated health system. Much talk about community participation has evolved into sophisticated community manipulation to get people to do what they are told. Old arguments between proponents of top-down and bottom-up approaches have proved to be false confrontation since both are needed although for different functions.

In the workshop a palatable surge of optimism grew in spite of a sobering opening speech by the new Minister of Health who had been appointed just a week before the conference. She bluntly expressed the challenge that the national cabinet thought the health services had taken enough time to conceptualize community based reforms and that it was now time for urgent action. She announced a ban on any more workshops for the next months.

SPECIFIC SUGGESTIONS FOR FUTURE ACTION

- 1 The Minister is right in that the time for more direct action has come. She said she is going to spend the next three months traveling the country and expects to see health personnel in the field. Together they will then decide on next directions. The immediate challenge is to sort out what is doable. One suggestion is that, since the appearance of change may encourage more substantive change, communities might start the process by painting and refurbishing health facilities.
- 2 The great enthusiasm generated in the workshop by the 15 demonstration projects showed that groups of villages can take responsibility and implement change. A scaling-up process for such change is described in a UNICEF monograph on sustainable community based development. The first stage of scaling-up is that successful projects be designated as SCALE One with the acronym "Successful Communities As Learning Examples." An immediate option in Zambia now is to select one project in each of the four regions to be upgraded into a SCALE Squared Center with the acronym "Self-help Center for Action Learning and Experimentation." It is extremely important to pay attention to the concern that has been expressed in the Central Board of Health that the term "center" not be interpreted as building an institution. The concept is that all the communities in a defined area themselves are the demonstration center. The population may be from 15,000 to over 100,000 and the present demonstration projects have this coverage. Eventually, most districts may want to have such a center. However, to become an upgraded center of learning they should sign a contract that they will expand in two ways: first, to cover their whole district with self-reliant development in cooperation with other projects, and second, to extend their range of activities to include a wide ranging, community-determined, set of priorities to meet basic needs.
- 3 There seems to be some confusion about who is supposed to do what. This is natural in a reform process, but now is the time to start work on role reallocation needed for community based care. The Minister said that after the present period of intensive field visits there will be open dialogue to make judgements about what to do next. Part of that process might be for each region to do a careful functional analysis for role reallocation using a joint planning methodology that was described in the workshop. Great differences in socioeconomic and cultural conditions will require regional models adapted to the local availability of personnel and resources. Communities will presumably provide most of their own care, but services will need to help with capacity building in the use of simple and cost-effective interventions. Health centers and the health hierarchy would assume new supportive roles as communities and families take responsibility. This will require significant changes in attitudes and values as health providers learn to cooperate with people, showing less arrogance and perhaps genuine humility. Just as they will be training communities, an important function of the SCALE Squared Centers will be to train officials and experts for their new roles in capacity building. Donors should also be

part of the functional analysis because they will also be expected to assume new roles as they balance global priorities with local priorities

- 4 A major concern in making the transition from prior declarations of community by the government to “free care” is that even more attention must be given to equity. Earlier claims were based on the pretense that everyone had access to limited health facilities, but this access was always hopelessly distorted by the funding going into elite care in teaching and other hospitals as compared with remote rural areas. Financing is always only one of many barriers to access and the stark geographical, economic and social realities in Zambia probably make all claims of “free care” irrelevant. Rather than continuing past patterns of dependency, social justice requires that people be helped as they take responsibility using whatever resources they can mobilize. Political reality probably means that urban residents will continue to receive the care they received in the past. To provide some service for those in greatest need, dogma and rhetoric need to be adjusted to evolving a new balance of mixed funding with more self financing from everyone. Insurance mechanisms can be expanded so that people who have jobs or money pay for their own care, which they will eventually prefer because providers tend to be more accountable. People in poor and remote areas should be permitted to pay for what they prefer to pay for. The irony is that these are often the items that politicians and donors have in the past insisted on paying for because they know that they will get most credit for responding to existing demand for items such as free medicines, highly publicized campaigns, and putting up buildings even though they quickly become dilapidated. Since the facilities were paid for by the government, the communities assume that they will also be responsible for maintenance. However, it seems clearly better for donor and public money to pay for deferred benefits for which there is little existing demand or possibility of sustainable self financing. A realistic principle is that such funds pay for general support, such as preventive services, training, quality control, logistics of essential drugs and other material supplies, and to implement a policy framework for ensuring equity and a safety net of care for the poorest people.
- 5 The Central Board of Health has shown dynamism and courage in pioneering innovative approaches and consideration should be given to strengthening their leadership role. A major change might be to broaden their membership to include two important groups: first, more representation for the private agencies which have provided more than 60 percent of health care in Zambia, e.g. the Christian Medical Association of Zambia, and second, to validate the rhetoric about community based decision making by having more bottom up representation, with a third to half of the members coming from the communities in greatest need, e.g. the poor, women and youth. Great care should ensure that these positions not be taken over by local elites or be manipulated for political purposes. Balanced representation will bring the greatest political credibility and make certain that the stated goals of equity, accountability, and partnership become reality.