



Original Research Article

Lessons learned from short-lived transfer of maternal and child health services from Ministry of Health to Ministry of Community Development in Zambia provides guidance for deepening of decentralization

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Government of Zambia restructured the health sector in order to strengthen linkages between Primary Health Care (PHC) and community development health systems in 2012. PHC and local disease response were transferred from Ministry of Health (MoH) to Ministry of Community Development. MoH retained health sector coordination policy/strategy and central level disease surveillance. To conduct a rapid assessment of the realigned health sector and inform policy review. A desk review and focus group discussions and key health sector stakeholders were interviewed. Although realignment aimed at demand creation, inadequate preparation was confounding. Continuum of services from central to community levels was constrained. Functionality of the community health strategy was suboptimal. Preventive outreach maternal and child health and community based care services declined. Capacity in detecting and responding to disease outbreaks underperformed. The noble idea was to strengthen disease prevention and control. Instead the process yielded the opposite; weakening of PHC, due to disjoint between community and health facility. The imminent deepening of decentralization of health services need to be informed by lessons learnt from the foregoing. The community health strategy needs to be revitalised and change management introduced to beneficiary institutions prior to devolution.

Key words: Decentralization of health services, creating demand for quality health services, functionality of community health strategy, continuum of services.

INTRODUCTION

Alma Ata declaration of 1978 on Primary Health Care (PHC) strengthened the ambitions of countries to deliver quality health care for their populations especially the perennially disadvantaged rural areas (Bryant et al., 1991). There has been a disparity between the scope and quality between rural and urban services with the latter getting better services (Hjortsberg et al., 2002). The PHC approach has remarkably improved health services in some areas but not

to level of attaining universal health coverage (UHC) (Yach, 1997).

The WHO target and guiding mantra in the 1990s and before was "Health for all by 2000" (Bossert et al., 2002). While this ambitious target was derailed by inter-alia emergence of diseases such as HIV/AIDS and weak health systems, that WHO pronouncement inspired countries to continue to be innovative and adapt approaches to continue

improving quality of services to the remotest of the remote hard to reach areas (Bossert et al., 2003). The 2008 Ouagadougou declaration on revitalization of primary health care and the universal health coverage are similar subventions in support of equity; an expression of vote of confidence in the long potential of PHC (Dussault et al., 2003).

Health system strengthening and pronouncement of policy strategic blueprints such as decentralization have been formulated and implemented with varying degrees of success in several countries with mixed results (Tang et al., 2000). Decentralization of the health sector was introduced in Zambia in the 1990s culminating in a sector wide approach which was a marvel for many countries to study and emulate this improvisation. However some findings from analysis of the performance of the sector during decentralization did not show the expected significant differences between 1995-8. (Campos-Outcalt et al., 1995).

Decentralization has been subdivided into three types; deconcentration, delegation and devolution respectively in order of increasing extent of transfer from central to the community. Each type can be classified based on the extent to which the functions are decentralized also referred to as "decision space" (Saide et al., 2001). A recent critical analysis of effectiveness of different types of decentralization; deconcentration, delegation and devolution was conducted in Ghana, Uganda, Philippines and Zambia (Stringer et al., 2013). In spite of the various degrees of implementation, this analysis did not find adequate evidence for decentralization improving health outcomes. Some of the observed and reported critical challenges have been inequitable allocation distribution of resources human and financial to the targeted communities (Makasa, 2008).

Countries have been therefore at pains to adapt, adjust and emulate best practices elsewhere to make meaningful strides to realization of universal health coverage the golden target standard (Campos-Outcalt et al., 1995). One of the latest developments in the Zambia health sector is the restructuring of the health sector which was conducted within the ongoing framework of decentralization which is in various advanced stages of implementation. Zambia is currently implementing the revised National Health Strategic Plan (NHSP) 2011-2016. In 2012, the Government carried out a major policy directive restructuring the health sector with the objective of strengthening linkages between PHC and the community health systems and community development structures. Through this restructuring, health sector functions and responsibilities were realigned. PHC systems and services under the jurisdiction of district and community levels were transferred from the Ministry of Health (MOH) to the Ministry of Community Development and Social Welfare and renamed, Ministry of Community Development, Mother and Child Health (MCDMCH). The MOH remained responsible for secondary and tertiary health care services, health statutory boards, national

coordination of health sector policy and regulation, strategic planning, resource mobilization and capacity building.

The 2013/14 Zambia Demographic Health Survey showed significant improvements in some areas but not enough to attain the health related Millennium Development Goals (WHO; 2012). Anecdotally, the situation prevailing in the communities did not match the promising results from the DHS. In addition the frequent reports of outbreaks in more than 6 of the 10 provinces in the first half of 2015 clearly showed a disconnect prompting the Government to request the WHO for a rapid assessment of the health sector.

METHODS

This two week assessment conducted between 20 September and 7 October 2015 was a culmination of many inclusive consultations with health sector stakeholders. The assignment was undertaken through desk review of key documents using the Midterm reviews of the health sector strategic plan periods from 2006 to 2010 and from 2010 to 2014. Key informant interviews and focus group discussions with senior officials of the MOH senior management and technical staff, MCDMCH senior management and technical staff, Decentralisation Secretariat executive team, Medical Stores Limited management, key cooperating partners' representatives. Field visits to 2 provinces and 2 districts were conducted. Provincial and district health management teams and health facility teams were interviewed on policies, reports and perceptions.

Additional emphasis was laid on documentation of lessons learnt during the realignment period; the necessary adjustments for reintegration of the MCH into MOH; the current on-going devolution process and make recommendation for the way forward in line with the developments.

RESULTS

Benefits to the health systems that can be attributable to the realignment

With respect to leadership and governance, the 2012 realignment was an innovative Government policy aimed at demand creation through strengthening community development linkages that was meant to improve successful primary health care implementation. The objective of the realignment was to improve maternal and child health outcomes. The health sector plan was extended in line with the National Development plan and a Midterm review concluded to guide the new plan 2017-21.

The pillar of human resources benefited through the continued expansion of production of all cadres including

nurses, doctors and expansion of the community health assistant. The MCH unit expanded from 9 staff members to more than 20 including a standalone directorate during the realignment period. Curative services at the district level also had increased deployment of some categories of staff. The existence of the National Human Resources for Health Strategic Plan 2011-2016, HRH information system and Training Plan 2013-16 provides an opportunity for future HRH developments. Service provision expanded significantly through the strengthening of tertiary hospitals and increased number of health facilities. In line with establishment of new districts and the attendant facilities, continuation of the extensive road infrastructure was developed to increase access.

The WHO estimates for 2011 shows that 16.4% of general government expenditure was spent on health, up from 12.2% in 2000. This is higher than average in the African region of 9.7% in 2011, which demonstrated strong Government commitment compared to the 15% Abuja target. Total health expenditure per capita is US \$ 99 higher than most countries in the region which averages US \$45 per capita¹³. The financing of the health increased by 28% and the utilization of funds remained at around 92% during the period of restructuring.

The PHC indicators of achievement of the 2008 and 2014 MTR and the 2007 and 2013 ZDHS show some improvement in the areas of maternal health services.

Some of the shortcomings of the restructuring of the health sector

In spite of some benefits from the short term realignment of the health in 2012, when the decision to reverse the process in 2015 was done anecdotally there were already some shortcomings in the health system.

Within the stewardship and governance pillar of health system, the political decision was not accompanied by strategic guideline and orientation such as change management and defining of a clear continuum of services from the central level to the community. The division of labour between the 2 ministries was not clear with need for stronger planning, coordination and monitoring of the process requiring stronger communication and tracking. Resource allocation still tilted in favour of curative services offsetting the overall intention of strengthening community based promotive and preventive services. The glaring absence of a robust community health strategy to guide the operationalization continuum from district health service to the community was conspicuous and prescriptive for mediocrity. Despite the existence of long standing coordination structures there remained a problem harmonization of efforts and resources around the national health sector plan due to 2009 accountability issues and subsequent struggle to understand and manage the 2012 Governments MOH realignment. Whilst all support was aligned to the health plan however, it was reported that most of it was provided off-budget and outside the sector

coordination mechanism.

The component of health care financing posed some challenge. Districts and MCDMCH reported on average receipt of 6-8 months disbursement of allocated funds annually from 2012 which was considerably less than in previous years. PHC did not benefit due to inconsistent and incomplete funds disbursement. Curative services continued to receive priority disbursements resulting in diminished promotive and preventive health care services such as outreach for maternal and child health, community based care and routine immunization.

The performance of the disease surveillance, outbreak detection and response is one symptomatology of the system that raised a flag. There were disease outbreaks such as bubonic plague, mumps, typhoid, anthrax, meningitis, bloody diarrhoea during the second quarter of 2015. The system was slow to detect and respond. The overall health system surveillance and response existing mechanism was not cohesive and robust enough to ensure resilience. Disease surveillance was a MOH responsibility but the local level response was handled by District Health Management Teams under MCDMCH. However, MCDMCH had inadequate structural and systems capacity in place. The necessary tools such as motorcycles and laboratories and microscopies and microscopes were limited if available. Integrated Disease Surveillance and Response roll out stopped at the district level and not extended to facility and community levels and it was noted that there are no substantive posts for district surveillance officers with that role assigned to officers doing other chores.

The public health laboratory capacity was inadequate although health facility diagnostic laboratory infrastructure was developed. Thus, the health sector resorted to Veterinary and University of Zambia Teaching hospital laboratory facilities this for example, caused the delay of the bubonic plague diagnosis and confirmation.

The National Health Policy and Mid-term Review Reports did not make reference to disaster risk management even though The National Policy on Disaster Risk Management (2005) and The Disaster Management Act (2010) tasks MOH to lead the health sector response during disasters including disease outbreaks. It is critical to note that Disaster and Risk Reduction Management under the Office of the Vice President is one of seven functions targeted for devolution to Councils by end of 2015 necessitating health sector overall framework and early implementation.

Although the country was able to produce adequate numbers of health workers medical doctors, nurses, and community health assistants the capacity to recruit new workers was currently limited with new graduates unable to get employment in the public sector to meet the minimum 23 health per 10,000 people as benchmarked by WHO. According to the WHO Global Atlas of the Health Workforce, August 2010, Zambia had 8/10,000. Despite increased recruitment in the health sector since 2011 about 40% of the established posts remain vacant. The reasons attributed to this situation are; limited funded posts,

insufficient qualified specialists in the market to fill the posts, challenges in attracting skilled staff to work in underserved/remote areas and attrition from the sector. All these are compounded by unequal distribution of staff.

DISCUSSION

Zambia conducted realignment or restructuring of the health within the decentralization framework, a form of refinement of decentralization. Decentralization being a process of transfer of responsibility to provincial, district and community health facilities is largely considered to be a valuable intervention designed to improve UHC in both developed and developing countries. Decentralization of health services has been adapted and implemented by many countries in order to bring services closer to the people by empowering the community to create demand for quality services (Bossert et al., 2002).

Decentralization is being practiced in many developing countries with different geopolitical dispensations and with a myriad of outcomes both positive and negative because of inequities in resource allocation and inadequate preparation and lack of continuum of supportive supervision to the community levels (Saide et al., 2001). Some of the challenges facing decentralization in Papua New Guinea were limited capacity of supervisors, misappropriation of resources financial and human, lack of professional support and oversight of health professionals and lack of continuity link between districts and community (Campos-Outcalt et al., 1995).

The current study illustrates the same challenges as experienced in Mozambique especially inadequate preparation and inequitable resource allocation and poor supportive supervision. Decentralization is not new to the Zambian setting. In the 1990s Zambia embarked on a determined decentralization exercise where the managers had some flexibility over expenditures, contracting, and governance and user fees. An assessment conducted for the period 1995-98 examined the decision space referring to the degree of decentralization by looking at the functions that were transferred to the recipient institutions. That study found minimal evidence of the impact of decentralization on set health indicators⁵. The level and scope of decentralization varied depending on setups and capacity of the recipient institutions with mixed results and outcomes. A further assessment done in an across country study comparing Uganda, Zambia, Ghana and Philippines showed little evidence for the impact of decentralization after 3 years of implementation (Bossert et al., 2002).

According to Zambia Vision 2030, "the nation should have an economy which is competitive, self-sustaining, dynamic and resilient to any external shocks, supports stability and protection of biological and physical systems and is free from donor dependence to provide equitable access to quality health care to all by 2030" (Vision 2030 Zambia; 2006). One of the reasons which catapulted the

rapid assessment was the frequent disease outbreaks experienced in the country and the delay in detection and response. Although some of the health indicators according to the DHS 2014 were improving from DHS 2007, the prevailing situation on the ground was painting a different picture instead pointing to a weakening health system and further away from UHC (Ferrinho et al., 2011).

The focus of decentralization has been on the hardware issues such as structures and processes of the intervention with minimal attention on the software issues such as the human resources. The production, recruitment and retention of human resources play a critical role in the success of the decentralization. In the current study in Zambia, staff was not well oriented and change management was not actively pursued prior to realignment especially pertaining to role allocation, responsibilities and management as has been recommended (Central Statistical Office Zambia; 2014). Unfortunately these country experiences have not been widely shared (Bossert et al., 2003).

With respect to UHC in Zambia, the major obstacle reported were long distances to health facilities especially during the rain farming seasons (Hjortsberg et al., 2002). In public health facilities it was reported that the rich had better access to the hospitals and the poor used primary health care facilities. The issue of long distances to health facilities is being aggressively addressed by government through the construction of clinics throughout the country all at an advanced stage plus the extensive road networks. Little has been done to systematically address the human resource conundrums where the staff are available and unemployed but cannot be recruited or incentivised for deployment in hard to reach areas where dire shortages exist because of fiscal budgetary issues (Ferrinho et al., 2011; Phiri et al., 2014).

One of the shortcomings in decentralization processes has been the absence of a linkage that operationalizes the continuum of service and supportive supervision between the community and the centre. An ongoing intervention in Lusaka Zambia has initiated this approach with results anticipated (Makasa, 2008).

Conclusion

The lessons learnt from this rapid assessment are not new. UHC is still a pipeline dream. As the health sector in Zambia thrives to deepen decentralization including transfer of responsibility of service provision to the Ministry of Local Government, there is need for adequate preparation focusing on systems and structures as well as the human resource factor including change management approach. This human resource software requires a paradigm shift with need to target the WHO benchmarks on the basic minimum 23/10000 health workers per population (right now we have less than 8) to attain UHC (Central Statistical Office Zambia; 2014) to enable the requisite continuum of

interventions across the district community divide to ensure the community is fully engaged and empowered. The dysfunctional status of the community health strategy in the Zambia setting is a major cause of disjointedness of the continuum of care between community and health facility. There is clearly an urgent need to strengthen the community systems and revitalize the community health strategy within the context of primary health care.

Conflict of interest: The authors declare that there is no conflict of interest

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