Effectiveness of District Health Boards in interceding for the community

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Summary.

In 1992 the government of Zambia introduced major health reforms (HRs) in the public health sector. The vision the HRs is to "provide Zambians with equity of access to cost effective and quality health care as close to the family as possible". Within the HRs context. The community is viewed as an important stakeholder and available resource. To facilitate community involvement in health care delivery and to ensure equity in health the government through the act of parliament established health governance structures. However there has been no systematic studies, which show whether these structures are effective in interceding for the community.

Therefore the overall objective of the study was to assess the effectiveness of health governance structures in enhancing equity of access and community participation in the delivery of health care services in Zambia. The specific objectives were to: (i) describe the status of health governance structures in Zambia; (ii) examine the linkages between the health governance structures and community; (iii) asses how the health governance structures represent and respond to community inters and needs; (iv) determine the extent to which the community is involved in the planning of health care services and resource allocation and (v) propose option for enhancing equity of access and community participation in the delivery of health care services.
A cross-sectional study design was used. Both qualitative and quantitative data were collected using various techniques; interviews, focus group discussion and review of records. Four districts (two rural and two urban) were covered in two provinces.

The major findings are: (i) health governance structures were established but the community is not aware of their existence and roles (ii) there is willingness by the community to participate in health issues but lack of knowledge limits there participation (iii) these structures are not effective in carrying there functions mainly due to a weak link between the community and the governance structures and (iv) gender issues are not adequately addressed in terms of composition membership to the structures and participation. The study concludes by making recommendations to make the structures more responsive to community needs and interest as well as revitalise community participation.

Abbreviations

AHBs	Area Health Boards
CBDs	Community Based Distributors
CHWs	Community Health Workers
DHBs	District Health Boards
DHMTs	District Health Management Teams
EQUINET	Equity in Health Network
FGDs	Focus Group Discussions
HBs	Health Boards
HCCs	Health Centre Committees
HMBs	Health Management Boards
HRs	Health Reforms
HWs	Health Workers
NHCs	National Health Committees
TBAs	Traditional Birth Attendants

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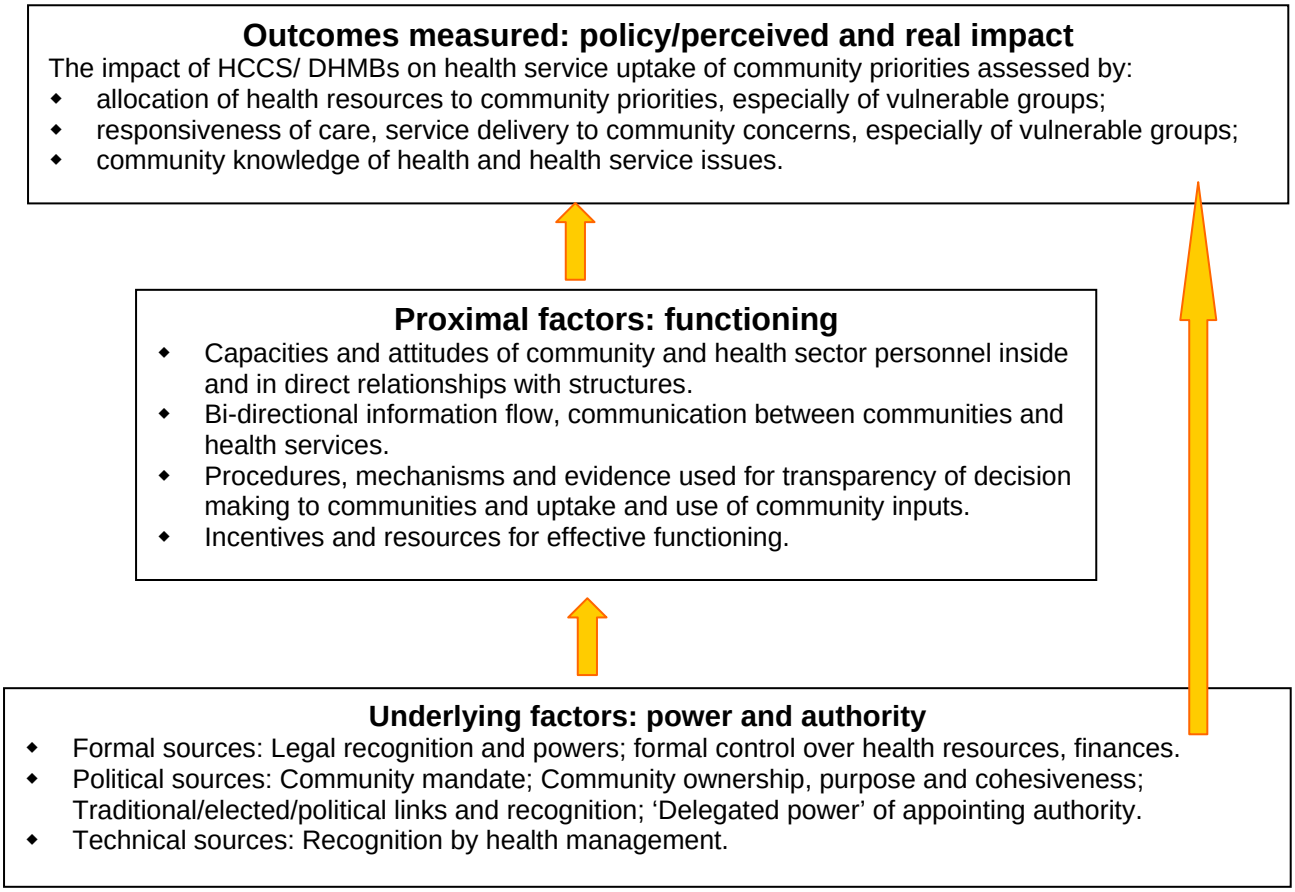
1. Introduction

The Regional Network on Equity and Health in Southern Africa (EQUINET) (www.equinetafrica.org) has noted that equity related work needs to define and build a more active role for important stakeholders in health, and to incorporate the power and ability people (and social groups) have to make choices over health inputs and their capacity to use these choices towards health. To do this requires a clearer analysis of the social dimensions of health and their roles in health equity, i.e. the role of social networking and exclusion, of the forms and levels of participation and of how governance systems distribute power and authority over the resources needed for health. To understand these factors, EQUINET has been carrying out research work to evaluate the current and desired forms of participation within health systems in Zambia, Zimbabwe and Tanzania amongst other Southern African countries. The Training and Research Support Centre (TARSC) and Community Working Group on Health (CWGH) in Zimbabwe, CHESSORE (Centre for Health and Social Science Research) and Institute of Economic and Social Research (NESOR) in Zambia embarked on a multicountry research programme in 2002/3 to assess the impact of Health Centre Committees (HCCs) on the health system. This work was carried out under the EQUINET Governance and Equity Research Network. This work is based on a conceptual model for assessing governance as a contributor to health equity underlying the multicountry programme.

The conceptual framework highlights three factors: outcome measures; proximal factors; and underlying factors (*Figure 1*).

Figure 1: *Framework for assessing governance structures as contributor to health equity.*



1.1 Background

At the time of independence (1964), the Zambian government inherited a health care system that was inequitable. The medical care system was designed to serve the interests of the minority white settlers, consequently the majority, indigenous population had limited access to medical care; they relied on traditional medicine (Macwan'gi, Sakala and Kamwanga, 1999). To reverse this situation the goal of the nationalist government that assumed power in 1964 was to provide free health services to all Zambians in both rural and urban areas (MoH, The Planning Unit, 1990). During the first decade post-independence the government extended coverage of social services including health to all Zambian people. Massive investments into the health sector were made resulting in drastic growth of the health facilities. The number of government hospitals increased by 121% from 19 in 1964 to 42 by 1990 (CSO, 1992: 42) while the number of government rural health centres increased by 253% from 187 in 1964 to 661 by 1990 (CSO, 1992: 42).

Despite the government efforts to expand health facilities and to provide free health services, by the end of the first post-independence decade (1974), inequities in health were still evident with the urban population being more advantaged than the rural population in terms of access. Disparities in the allocation of government health funds between urban and rural areas, which are both cause and effect of the imbalances in the availability of health facilities, were also evident. In 1980, for example, the three major hospitals (Kitwe, Lusaka and Ndola) along the line of rail serving only a third of the total Zambian population consumed 60% of the national health budget (GRZ/MoH, 1991). Barriers to access health care included long distances to health facilities, perceived poor quality of care and high indirect costs of health care (GRZ, 1995). In urban areas 99% of households were within 5km radius of health facilities. The corresponding figure for rural areas was 50% (CSO, 1998). In some remote areas of the country, people cover up to 30km or walk the whole day to the nearest health facility.

To improve on this aspect, in 1980, the government adopted a primary health approach following the Alma Ata World Conference on Health For All in 1978 (Limbambala and Choongo, 1994). While the government aimed at increasing access to health service by provision of free health care, a fiscal crisis reduced government spending in real terms. Consequently health services deteriorated in both quality and quantity that made a mockery of free services.

In 1991, the government introduced major health reforms to revitalise the health care system. The **vision** of the current health reforms (HRs) is "to provide Zambians with equity of access to cost effective, quality health care as close to the family as possible" (MOH, 2004). HRs are designed to emphasise and accelerate the implementation of the primary health care (PHC) approach officially adopted by the Zambian government in 1980.

Under the highly centralised health care system, the community, the principal stakeholder was merely a passive recipient with no meaningful input in the health care system designed to serve them. Consequently, the health care system was not responsive to the needs and interests of the people. Hence, one of the main focuses of the health reforms is decentralisation of responsibilities for service provision with the district as the focal point (JIM Vol. II, April 2000). Accountability and effective community participation are two underlying principles of the current health reforms (National Health Strategic Plan, 2001–2005). It is hoped that the decentralisation process will contribute to greater involvement of the community in health matters affecting them and that health providers will be more responsible and accountable for the quality of the services they provide in terms of responsiveness to the communities they serve. Decentralisation is not only intended to encourage the involvement of the people in the planning and implementation of developmental projects but is also viewed as a tool for reducing inequalities in the distribution of national resources among different population groups by ensuring that resources are channelled to the delivery levels in line with PHC concept (Alma Ata).

Within the PHC context, community is viewed as one of the key stakeholders and a major resource available to implement the reformed health care system in order to produce better health for the Zambian people. The Ministry of Health (MoH) Policy and Strategic Document (1994) categorically states that the implementation process of the health reforms cannot succeed without community involvement. Therefore, one of the prerequisites to effective implementation of PHC is that the community must be actively involved in all stages of PHC. Community involvement is viewed as fundamental to the PHC approach in ensuring that quality health services are equitable, accessible and acceptable to all including the vulnerable groups in both urban and rural areas.

PHC begins at the community level through the interface between community representatives and the local health centre (HC) staff and permeates all levels of health care. Through this interface and dialogue, the community is expected to participate in the identification of their health needs, priority setting, planning and formulation of local plans as well as implementation of identified programmes.

To facilitate effective partnership between stakeholders and to foster community involvement in the planning, decision-making and delivery of health care, health boards – popularly known as popular structures – are created at various levels (see *Figure1*). The need to decentralise the health sector is reflected in the Medical Services Act of 1985, which provided for formation of semi-autonomous hospital management boards (HMBs) for all big hospitals in the country with more than 200 inpatient beds. In 1992, HMBs were created and in the same year, legislation was passed to establish District Health Boards (DHBs) to oversee the delivery of health services in the districts. The following year (1993), district health management teams (DHMTs) were established as health technical bodies in each district throughout the country and in 1994 DHBs were created parallel to the HMBs as supervisors and employers of DHMTs. In 1995, a National Health Service Act was passed which introduced major changes in the role and structure of the Ministry of Health (MoH) and for the establishment of an autonomous Central Board of Health (CBoH). The CBoH then became an implementation body responsible for monitoring, integrating and coordination of the programmes of the HMBs, while the MoH is responsible for formulation of policy and guidelines and for regulatory functions.

Thus the current organisation of the health service delivery system is based on four distinct levels as presented in *Figure 2*:

- the CBoH, functioning as the national coordinator of health service delivery, with the CBoH management team as the technical body;
- the provincial health office which is a link between the CBoH management team and DHMTs;
- DHMTs and hospital managements governed by DHBs and HMBs respectively; and
- health centres (HCs), which provide health services at the community level under the supervision of DHMTs and DHBs.

Figure 2. Existing community based structures and their linkages to technical teams.

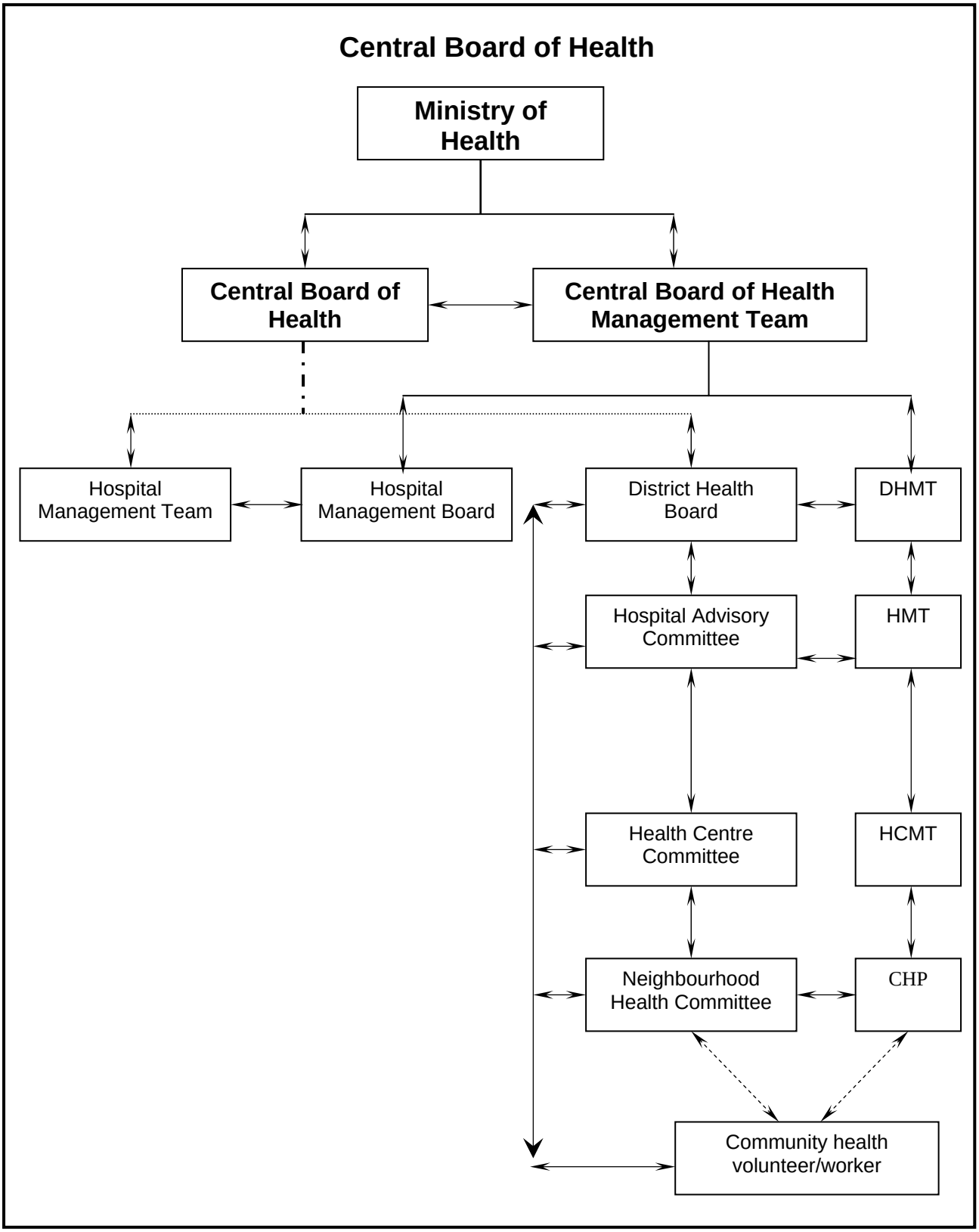
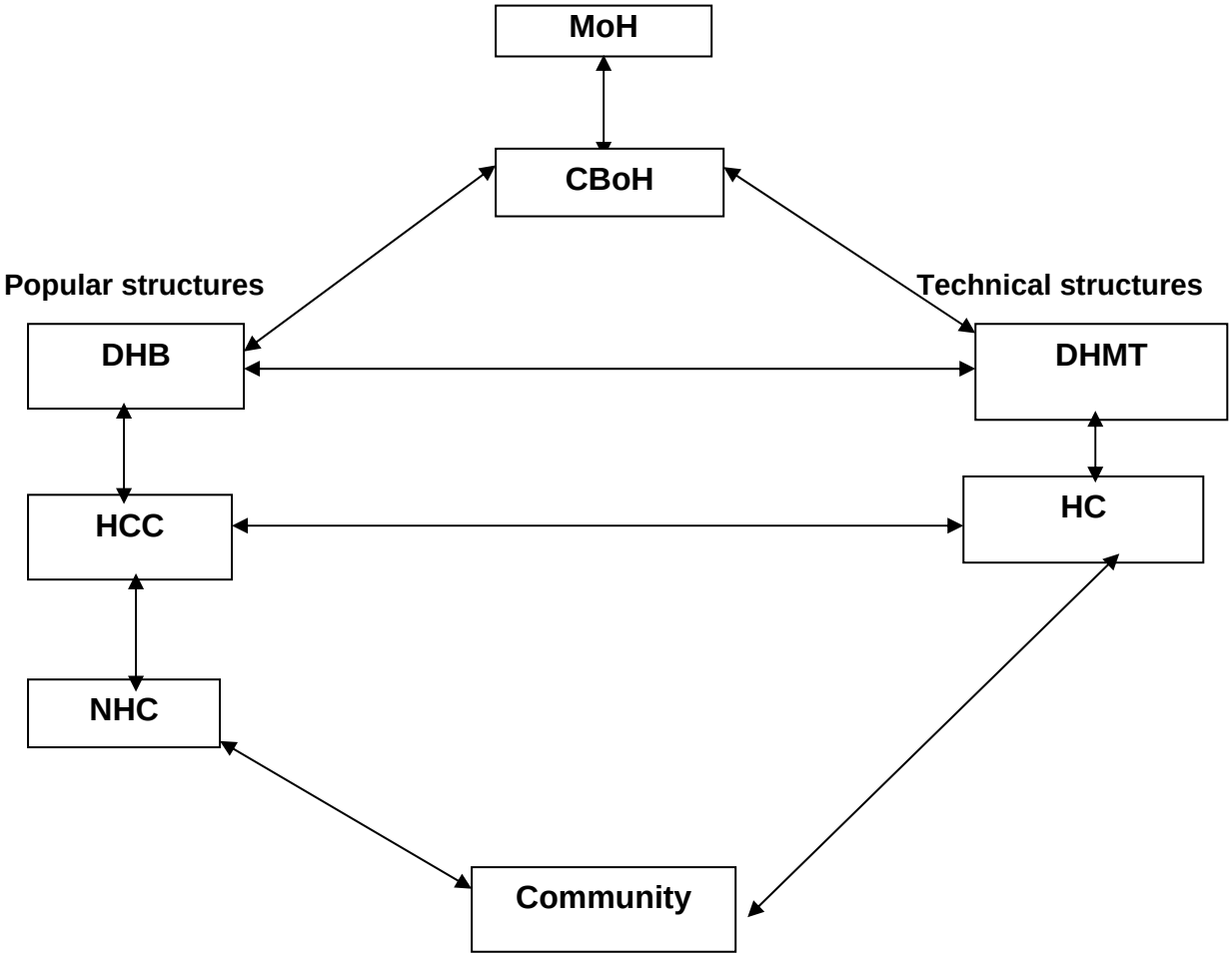


Figure 3. Existing community based structures and their linkages to technical teams.



The establishment procedures, responsibilities and functions as well as the composition and selection of DHB members are outlined by the Central Board of Health (CBoH, 2000). The main responsibilities of DHBs include ensuring that the District Health Management team provides quality based cost-effective district health services. These should take into account equity of access to health care, with services provided as close to the family as possible, without discriminating any individual and/or groups of people and ensuring that the health care system is responsive to community priority needs.

The specific functions of the DHB include**:**

- approving all health development plans/budgets in the district, including those of non-governmental and private health providers and all initiatives for the local mobilisation of financial and other resources including user fees;
- monitoring and evaluation of the progress of all health related activities and reporting to the CBoH;
- attending to appeals, petitions, complaints and suggestions from staff members and from community members. The DHB, however should refer all complaints of a professional nature to relevant bodies normally dealing with this kind of complaints such as the General Nursing Council, Medical Association of Zambia, etc; and
- initiating mechanisms for sustainability of community based volunteer health workers such as TBAs, CHWs, and CBDs as well as facilitating the process of establishing AHBs and NHCs.

Based on these functions, DHBs are cardinal to the success of HRs. The DHMTs are considered to be the engine for the delivery of health services in the districts while DHBs are

envisioned as a force that drives the engine. Therefore, the successful implementation of the HRs depends on how effectively DHBs carry out their functions. However, to understand how DHBs intercede for the community one needs to put DHBs in context of the lower popular structures, HCCs and NHCs.

Functions of the DHBs stipulated in the CBoH guidelines

The specific functions of DHB through the DHMT shall be as follows:

- approve all health development plans in the district, including those of non-governmental and private health providers;
- approval of all annual plans and budgets;
- approval of all quarterly reports and revisions of the district health plans and budgets;
- approval of all initiatives for the local mobilisation of financial and other resources including user fees;
- monitoring and evaluation of the progress of all health related activities and reporting to the CBoH;
- ensure quarterly internal and external audit of all assets, equipment, financial and human resources within the district;
- attend to appeals, petitions, and complaints from staff members and from community members. The DHB however should refer all complaints of a professional nature to relevant bodies normally dealing with this kind of complaints i.e. General Nursing Council, Medical Association of Zambia;
- provide mechanisms to create conducive working environments, which motivate and retain qualified and well-performing staff;
- ensure inter-sectoral cooperation in the district with relevant government departments and private organisations;
- initiate mechanisms for sustainability of community based volunteer health workers such as, TBAs, CHWs, CBDs, etc;
- facilitate the process of establishing AHBs and NHCs**.**

2. Objectives and methodology

2.1 Objectives of the study

The overall objective of this proposed study is to assess the effectiveness of District Health Boards (DHBs) in enhancing equity of access and community participation in the delivery of health care services in Zambia.

Specific objectives of the study are to:

- describe the composition and functions of DHBs;
- examine the form and relative strengths of information exchange mechanisms between DHBs and different key stakeholders (CBoH, DHMTs, NHCs, community development committees (CDCs) and the community) in relation to the delivery of health care services;
- assess how the DHBs represent and respond to community interests;
- assess the mechanisms and the extent of inclusion of community evidence in health service planning and resource allocation; and
- use results of the study to propose options for enhancing community representation in key areas of health service planning.

2.2 Methodology

The study was a cross-sectional survey which combined qualitative and quantitative methods. These complementary methods required three techniques: interviewing, reviewing and focus group discussions (FGDs). Triangulation of research methods was required for eliciting the necessary data. Data was gathered from both secondary and primary sources through record review at the provincial health office and interviews with members of DHMTs, DHBs, HCCs and the community as a whole. Focus group discussions were also held. Data sources included the key actors in the units of analysis: the community, health centre advisory committees, district health management teams, district health boards and provincial health management teams (Table 3.1.2). Seven tools were employed in this study: three structured questionnaires, two checklists and two focus group guidelines.

Two provinces (Lusaka and Southern) were selected and two districts per province randomly selected. The districts are Lusaka and Luangwa for Lusaka province while Livingstone and Monze where for Southern province. At the district level, three health centres (HCs) were selected, giving a total of 12 HCs. The sample sizes consist of three provincial health officers; eight DHMT members; 11 current or former DHB members or former members; 21 health centre staff; 19 HCC community members; 20 NHC members and 280 community members for the survey in eight health centre catchments. There were at least six FGDs per district with about 10–12 people in each group (two for women, two for men, and two for youths), giving at least 24 FGDs.

3. Findings

Findings of this study are presented in five sections: (1) Study sites and description of the population; (2) Social services profile of the study sites; (3) Knowledge about popular structures; (4) Information exchange mechanisms between DHBs and the community; and (5) Performance of DHBs.

3.1 Study sites and population

This study was conducted in two provinces, Lusaka and Southern. In each province, two districts were selected, Livingstone and Monze districts in Southern province, and Luangwa

and Lusaka districts in Lusaka province. Table 3.1.1 shows the distribution of the population by study site. In each district, two health centres and their catchment areas were selected, representing both urban and rural communities. A total of 280 respondents evenly distributed over all the study sites participated in the community survey.

Table 3.1.1 Distribution of respondents who participated in the community survey by site

Study site	**No.**	**%**
Province		
Lusaka	140	50
Southern	140	50
Total	**280**	**100**
District		
Lusaka	70	25
Luangwa	70	25
Livingstone	70	25
Monze	70	25
Total	**280**	**100**
Health centre catchment		
Bauleni	35	12.5
Kamwala	35	12.5
Chindende	35	12.5
Boma	35	12.5
Linda	35	12.5
VIC Falls	35	12.5
Chisekesi	35	12.5
Nchete	35	12.5
Total	**280**	**100**

In addition, to the community survey, this study collected data using in-depth interviews with key informants at all levels and FGDs with community members. Table 3.1.2, shows that a total of 80 in-depth interviews were conducted. Of these 80, 13 were with DHB members.

Table 3.1.2 Distribution of key informants who participated in the in-depth interviews by study site and level

Province/district	**Key informants by level**					
	CBoH staff	DHMT staff	DHB member	HCC member	NHC member	**Total**
Lusaka:						
Lusaka	1	1	4	11	3	**20**
Luangwa	-	2	3	9	4	**18**
Southern:						
L/Stone	3	1	3	8	4	**19**
Monze	-	2	3	12	6	**23**
Total	**4**	**6**	**13**	**40**	**17**	**80**

Table 3.1.3 shows that 23 focus groups were conducted. A total of 259 community members participated in FGDs: of these, 63 were men, 99 were women and 97 were youths. For each FGD that involved youths, there was equal representation of females and males.

Table 3.1.3 Distribution of FGD participants by study site

Province/district Type of group	No. of FGDs	Total no. of participants
Lusaka province		
Lusaka:		
Men	2	16
Women	2	25
Youth	2	29
Luangwa		
Men	2	23
Women	2	25
Youth	2	23
Southern province		
Livingstone		
Men	2	15
Women	2	20
Youth	2	21
Monze		
Men	1	9
Women	2	29
Youth	2	24
Total	**23**	**259**

3.1.1 Social demographic characteristics of the community survey respondents

Table 3.1.4 shows that the community survey respondents were aged between 15 years and 75 years and that there were more respondents in the age groups 20–24 years (16%), 25–29 years (20%) and 30–34 years (14%). In addition, there were more females (64%) than males (36%). Table 3.1.4 also shows that majority of the respondents (38% and 44%) had completed primary education (Grade1–7) and secondary school (Form 1–6) respectively.

Table 3.1.4. Social demographic characteristics of the community survey respondents

Characteristic	No.	Percent
Sex		
Females	179	64
Males	101	36
Total	**280**	**100**
Age group (years)		
15–19	25	9
20–24	44	16
25–29	57	20
30–34	39	14
35–39	31	11
40–44	30	11
45–54	35	12
55 and above	18	7
Total	**280**	**100**
Educational level		
Didn't complete Grade	22	8

1		
Grade 1–7	107	38
Form 1–6	122	44
Diploma/certificate	26	9
University degree	3	1
Total	**280**	**100**

Further, Table 3.1.5 shows that there were more females (10%) in the category that did not go to school and/or did not complete Grade 1 compared to males (5%) and that more males (50%) had received secondary education (Form 1–6) compared to females (40%).

Table 3.1.5 Educational status of community survey respondents by sex

Education level	**Females no. (%)**	**Males no. (%)**	**Total no. (%)**
Less than Grade 1	17 (10)	5 (5)	**22 (8)**
Grade 1–7	77 (43)	30 (30)	**107 (38)**
Form 1–6	71 (40)	51 (50)	**122 (44)**
Diploma/certificate	12 (7)	14 (14)	**26 (9)**
University graduate	2 (1)	1 (1)	**3 (1)**
Total	**179 (64)**	**101 (36)**	**280 (100)**

3.2 Social services profile of the study sites

The distribution of social services such as source of water, sanitary facilities and accessibility of health facility is an equity issue. The distribution of social services favours the urban population more than the rural population. Therefore this study accessed the availability of these social services. The most common source of drinking water was piped water (225; 80%). The source of drinking water for all (100%) urban households surveyed (Livingstone and Lusaka) was piped water, while in Luangwa, the most rural district, only 50% had access to piped water.

Table 3.2.1. Source of drinking water by district

	District				
Source of water	**L./Stone no. (%)**	**Luangwa no. (%)**	**Lusaka no. (%)**	**Monze no. (%)**	**Total no. (%)**
Borehole and river	0	30 (43)	0	16 (23)	**46 (17)**
Piped water	70 (100)	35 (50)	70 (100)	50 (71)	**225 (80)**
Others	0	5 (7)	0	4 (6)	**9 (3)**
Total	**70**	**70**	**70**	**70**	**280 (100)**

Table 3.2.2 shows the type of toilet by district with the most common being flush toilet (133; 48%) followed by pit latrines (151; 43%). Note that about half (49%) of the households in Luangwa district, the most rural district, use pit latrines. On the other hand, Lusaka district, the most urban district, also has a large proportion (50%) of its households using pit latrines. This is due to the high-density areas (squatter settlement) not being serviced by the local authority. A third, 30%, of the households have no toilet facilities and depend on the bush.

Table 3.2.2 Type of toilet by district

Type of toilet	L/Stone no. (%)	Luangwa no. (%)	Lusaka no. (%)	Monze no. (%)	Total no. (%)
Bush/field	21 (30)	0	0	5 (7)	**26(9)**
Pit latrine	7 (10)	49 (70)	35 (50)	30 (43)	**151 (43)**
Flush toilet	42 (60)	21 (30)	35 (50)	35 (50)	**133 (48)**
Total	**70**	**70**	**70**	**70**	**280 (100)**

Access to health facility, which was measured by the time it takes to walk to the health facility, shows that the urban population was advantaged. More than two-thirds (70%) of the urban population (Lusaka and Livingstone) were within ten minutes' walk of the nearest health facility, compared to half (50%) from the two rural districts (Luangwa and Monze).

Table 3.2.3 Time it takes to walk to the nearest health centre by district

Time	Livingstone no. (%)	Luangwa no. (%)	Lusaka no. (%)	Monze no. (%)	Total no. (%)
Less than 10 minutes	49 (70)	38 (55)	50 (75)	34 (48)	**171 (62)**
10–30 minutes	19 (27)	30 (43)	14 (21)	31 (45)	**94 (34)**
More than 30 minutes	2 (3)	2 (2)	3 (4)	5 (7)	**12 (4)**
Total	**70**	**70**	**67**	**70**	**277**

Table 3.2.4 gives the perceptions of the survey respondents in terms of waiting times and of how they were treated by the health personnel at the health centre the last time they were sick. The study results show that slightly above half (152; 55%) of the respondents were satisfied (happy) with the waiting time while about two-thirds (179; 65%) were also happy with the way they were treated by health personnel. 45% of the respondents were not satisfied (unhappy) with the waiting time, while about a third of the respondents were not happy with the care they received.

Table 3.2.4 Community perceptions of waiting time and care received at the HF

Perception	Waiting time no. (%)	Care received at HF no. (%)
Happy	152 (55)	179 (65)
Unhappy	125 (45)	98 (35)
Total	**277 (100)**	**277 (100)**

When the respondents were asked to compare their health status to what it was a year ago, 82 (31%) said it was better, while half (135; 50%) said it was the same. The remaining 51 (19%) said their health situation had worsened (Table 3.2.5).

Table 3.2.5 Perception of health status compared to a year ago by district

Health status	Livingstone no. (%)	Luangwa no. (%)	Lusaka no. (%)	Monze no. (%)	Total no. (%)
Better	14 (22)	31 (47)	20 (30)	17 (24)	**82 (31)**
The same	34 (54)	27 (47)	39 (57)	35 (50)	**135 (50)**
Worse	15 (24)	8 (12)	10 (16)	8 (26)	**51 (19)**
Total	**63 (100)**	**66 (100)**	**69 (100)**	**70 (100)**	**268 (100)**

Note: Information for twelve (12) respondents was missing.

Respondents were asked about care seeking behaviour, specifically, “what would you do if someone in your household had TB?” Almost all (256; 92%) said they would take or refer the person to a health facility (health centre, clinic and hospital) for treatment. A few (6; 2%) of community survey respondents said they would take care and encourage the person to be taking the TB drugs. Only 6 (2%) said they didn’t know what to do. Very few respondents said they would isolate the person (e.g. give them their own kitchen utensils). Others said things such as: “I will pray for the person,” “I will treat the person since I am a traditional healer,” “I will just live with the person.”

3.3 Knowledge about popular structures (PSs)

Knowledge is instrumental in facilitating community participation. For members of the community to be involved in issues and/or activities related to their own health and the health care system, they require knowledge and/or understanding of the roles and functions of PSs. Therefore, this study assessed knowledge about DHBs among the community and ‘health providers’ by asking study respondents questions related to: existence of popular structures (NHCs, HCCs and DHBs); composition and appointment procedures of District Health Board members; and functions of the DHBs.

3.3.1 Community knowledge about existence of popular structures

To assess knowledge about PSs, the study asked whether respondents who participated in the community survey and FGDs were aware of the existence of the PSs in their communities. In addition, perceptions about the Health Centre Committee (HCC), Neighborhood health committee (NHC) and District Health Board (DHB) were assessed. The study found that almost all survey and FGD participants were aware of the existence of NHCs but very few or almost none were aware of the existence of DHBs.

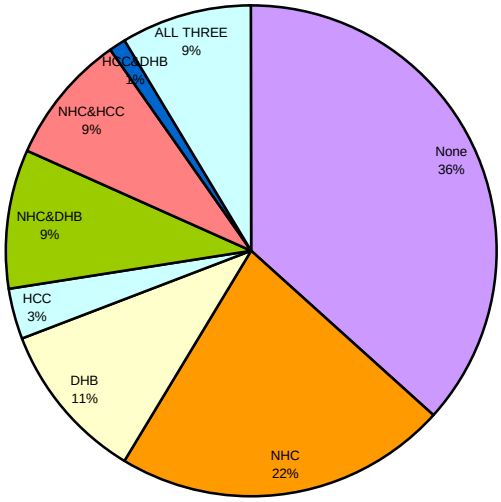
Table 3.3.1 gives awareness levels of the three popular structures (NHC, HCC and DHB) by the community who participated in the survey. About half (48%) of the 280 respondents were aware of the existence of NHCs, while less than a third (29%) and less than a quarter (22%) were aware of the HCCs and DHBs in their communities respectively.

Table 3.3.1 Awareness of existence of popular structures by the community

Awareness	**NHC no. (%)**	**HCC no. (%)**	**DHB no. (%)**	**None no. (%)**
No	145 (52)	218 (78)	199 (71)	**179 (64%)**
Yes	135 (48)	62 (22)	81 (29)	**101 (36%)**
Total	**280**	**280**	**280**	**280**

Figure 3.3.1 further illustrates the knowledge level about existence of PSs in the community, and shows that more than a third (103; 36%) of the respondents were not aware of the existence of any PS in their communities while only (24; 9%) were aware of all PSs. Eleven percent knew only the DHBs, 3%, knew only the HCCs, while 22% knew only the NHCs. Those who only knew the NHC&DHB, NHC&HCC and HCC&DHB were 9%, 9% and 1% respectively.

Figure 3.3.1 *Awareness of popular structures: NHCs, HCCs and DHBs.*



Qualitative data from FGDs also show that knowledge about existence of DHBs is low. In general, very few participants in FGDs said that they were aware of DHBs. Even then, despite having heard of the existence of these structures, community members reported that they did not know how DHBs were formed and what their specific functions were. In most cases, the existence of DHBs was only reported in FGDs with youths. A number of youths reported that they saw the inscriptions of DHBs or DHMTs written on vehicles. In Luangwa, which are the most rural districts, none of the participants in all the FGDs was aware of the existence of DHBs, as highlighted below:

"*We know about the NHCs because we are the ones who put them in the office…. But we do not know about the DHBs."*
Male participant from Mpuka community, Luangwa

"We do not know about the DHBs, the VHCs have not started doing anything in our community because they have not been trained yet. Once they are trained we will be able to know the functions of DHBs."
Male participant from Monze

Limited knowledge about the existence of the DHB among the community was attributed to lack of community education. Improved interaction between community representatives and the community in terms of meetings and visitations to communities by DHB members was suggested as the most reliable means of publicising the existence of PSs and their functions. It was however acknowledged that in some communities, NHCs needed to be seriously reactivated as most were essentially non-functional and this was reported to be one of the factors why the general community did not know about the existence of DHBs.

Consistent with the survey data, results from FGDs show that although NHCs were reported to be the most known popular structure created to facilitate community participation in health planning and delivery, there were a lot (52%) of people who still do not know about NHCs. This was, however, not the case in Monze and Luangwa. Most of the community members interviewed in Monze urban clinic catchment area reported that they were not aware of the existence of the NHCs. A few that knew about NHCs pointed out that these committees were not active and hence not known by most residents. It was reported that these structures, if

anything, only existed on paper. In Luangwa Boma township most community members reported that they were not aware of the existence of NHCs. Others indicated that NHCs were just being formed; this is despite the fact that NHCs have been in place for over a decade.

3.3.2 Appointment and composition of District Health Board members

The Central Board of Health (CBoH) gives guidelines on how members of PSs should be selected and appointed. These guidelines indicate that using a democratic process, the DHMT shall, through the Office of the District Council Secretary, nominate and submit the names of the board members to the minister of health for appointment as provided for under the National Health Services Act, No. 22 of 1995. Members shall include a representative from the Ministry of Community Development and Social Services (MCDSS) and a representative from the area health boards (AHBs) which are commonly known as NHCs and that there should be equal representation of men and women on the boards. Therefore, the study assessed whether participants both at district and community level were aware of who is eligible to be a DHB member and how board members were selected and appointed as well as the composition.

Results of this study show that ordinary community members who participated in the study were generally not aware of the procedures used to select and/or appoint the DHB. As a result, they were not able to discuss this topic adequately as statements below highlight. However, in Monze, one female FGD participant reported that residents submitted applications to CBoH for consideration. And in Livingstone and Lusaka, community members reported that DHB members are selected through the institutions they work for and from NHC members.

> *"I do not know how DHB members are chosen, but I know that there is a balanced number of people from all the three zones."*
> Female participant from Linda township, Livingstone
>
> *"I have no idea about how DHB members are appointed… women are supposed to know, because it is mostly women who attend antenatal care and NHC meetings … because most of them are ordinary housewives, they have time to spend on these issues.*"
> Male participant from Bauleni township in Lusaka

Even more surprising was that DHB members and DHMT staff, interviewed like community members, were also not clear of the actual process used to identify and select community members for recommendation as DHB members. But in general the selection process for DHBs was not well articulated by either DHB members or DHMT staff. The DHB members just said they are asked for the curriculum vitae and names are submitted to the MoH through CBoH and the minister of health chooses among the list the required member. It was mentioned that the minister is uncomfortable with those who are not members of the ruling party to be on the boards. When DHB members were asked about the communities they represent most were not sure. However, those who were on the boards by virtue of their office, i.e. council secretary and district welfare officer, reported that they were representing their offices.

In Lusaka, there was a general view that appointment of DHBs was a prerogative of the DHMT and that the positions were a preserve of prominent people in society (Table 3.3.2). This was mostly common among recently appointed members, who had just received their letters of appointment, especially in Monze and Luangwa. In Livingstone, it was also reported that once curriculum vitae of identified persons are submitted to the DHMT,

appointment was not automatic – candidates were also screened or interviewed by the office of the president.

Table 3.3.2. Reported eligibility criteria for being a DHB member by district

District	Criteria
Livingstone	Any prominent resident of the district. Anybody capable of understanding the nature of DHBs, in terms of functions, roles and responsibilities. A community leader. Someone who can dedicate part of his/her own time to the work of the Board. Someone who is not in formal employment.
Monze	Any prominent member of the society. Ex-civil servants. Individuals who are recommended by chiefs or headmen. Businessmen. Political leader, e.g. an area member of parliament.
Luangwa	A resident who has contributed to the community on health matters.
Lusaka	Ability to speak English. Interest in community work. Ability to read and write in English. One with no criminal record.

Despite inadequate knowledge about the procedures used to select and appoint DHB members, a number of participants at the district level raised some concerns. The major concern was that the procedures used were not democratic and that the people selected are only those known to the appointing authorities and may not represent the community. For example, in Livingstone and Monze participants indicated that the CBoH guidelines for identifying/selecting DHB members were not followed properly. Instead, the DHMT and the district council use unconstitutional means to handpick prominent people in society and recommend them to the minister for appointment.

Consistent with respondents' knowledge about the procedures for selecting and appointing DHB members, the respondents at district level indicated various characteristics of people in the community who are eligible to be DHB members. People with high socio- economic standard representatives, former civil servants and those who are able to read and write were identified. And this is consistent with what is obtained on the ground. Box 1 illustrates that current and past DHB members were drawn from people of high standing in the society.

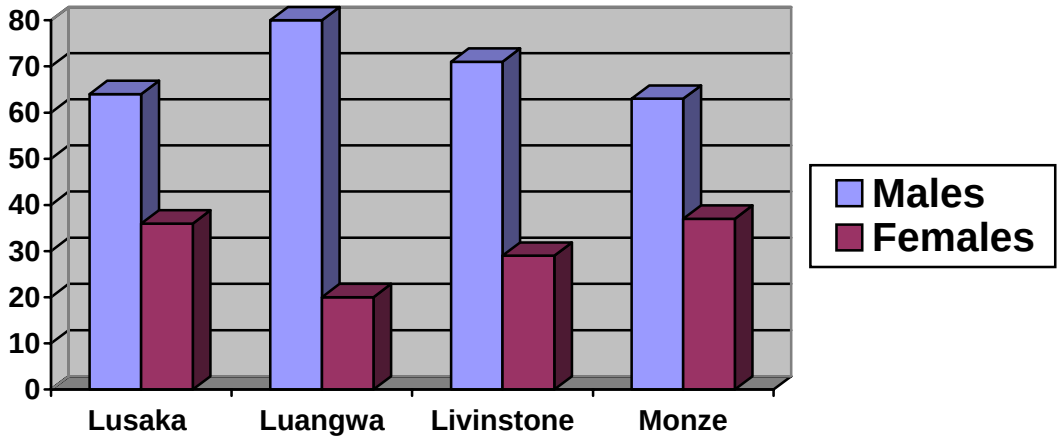
Box 1. Profile of current and past DHB members who were interviewed

- Retired nurse
- Principal of a training college
- Retired teacher
- Former councillor
- Managing director from private company
- Religious minister
- Council secretary
- District social welfare
- Director of city council
- Principal lands officer
- Police officer
- Environmental health committee member

To assess gender balancing, the study examined the composition of members of PSs by sex. The study found that despite the government guidelines that representation of men and women on PSs' committees/boards be equal, gender considerations are not the primary concern of the community. For example, few of the key informants in the study mentioned gender balancing as an important criterion for selecting board members. This is consistent with what is obtained on the ground in general at district and community levels. At the DHB level, all the boards had more males than females as shown in Fig 3.3.2. The worst situation

was observed in Luangwa district where 80% of DHB members were males compared to only 20% females. A similar pattern biased towards men was also observed at community level PSs, i.e. at NHCs and HCCs.

Figure 3.3.2 Reported composition of DHB members by district and sex.



The representation of women on the DHB was low. On average, only 32% of the DHB members were women. When asked if the representation of women on the DHBs was adequate, most DHB members said it was not and attributed this to a number of factors such as “lack of suitable candidates” and that “not enough women come forward”. In addition, it was reported that gender balancing is unattainable as representation on the boards is drawn from already existing institutions such as government ministries and other public recognised community organisations which favour men.

The respondents made a number of suggestions on improving women’s representation on the DHBs. Since the DHBs are appointed by the minister, there is need to sensitise the appointing authority to have 50% women. Make specific instructions on women’s representation especially on members drawn from the community. There is need to sensitise the women to participate in lower popular structures so that they can be recognised. There is need to have a deliberate policy to have 50% female representation. One DHB member said “unless women are deliberately involved as in Zambia Social Investment Fund ….women’s participation in health issues will be difficult to realize.” Those who knew about the CBoH guidelines said the guidelines must be strictly followed when appointments are made otherwise, the views and concerns of women will remain unheard.

3.3.3 Knowledge about roles/functions of District Health Boards

Decentralisation of essential health functions to the district and community levels is one of the major elements of the current Zambian health reforms. Through the decentralisation process, PSs are formed to facilitate effective partnerships between stakeholders and to foster community involvement in the planning, decision-making and delivery of health care at community level. The study therefore assessed whether PSs were established and functioning as envisioned by the current health reforms and whether DHB members understood their roles and functions, as well as whether the community was aware of the roles and functions of DHBs.

At the time of the study, DHBs had been established in all the study districts but most of them had not started functioning effectively, as they were dissolved in the past two years or more. In one of the districts (Monze) new DHB members were just being oriented at the time of data collection while in Livingstone and Luangwa they were yet to go for orientation.

Knowledge about the roles and functions of DHBs is high among the DHB members and DHMT staff but very low among the ordinary community members who participated in the study, as illustrated in the statement below. Table 3.3.3 shows functions of DHBs as reported by DHMT staff/DHB members and generally these are similar to DHB functions as per CBoH guides.

"Some members of the NHC don't believe in leaving the office when their term of office expires. They feel these are personal to holder positions. They do not know their roles, they do not report to the community, they feel they are the community themselves that is why we do not know what the DHMT or the DHB is doing in our community."
Male youth, Kamwala, Lusaka

"*I have just been hearing that we have a DHB, but I do not know what they do, I do not even know where they meet."*
Male participant from Kamwala catchment clinic, Lusaka

Table 3.3.3 Reported roles, responsibilities and functions of DHBs by DHB members

District	Reported role, responsibility and function
Livingstone	Provision of policy guidelines to DHMT. Liaison officers between DHMT and community. Supervision of health centres in the district. Spearheading of sensitisation on health issues in the district. Assisting DHMT in putting up new clinics. Mobilisation of financial resources on behalf of MoH. Determination of district health budgets in collaboration with the DHMT. Lobbying for health facilities and services i.e. new health centres
Monze	Overseeing the activities of the DHMT. Mobilisation of financial resource for health activities in the district. Ensuring participation of the community in health delivery. Supervision of health personnel in order to effect discipline. Community representation. Ensuring availability and proper distribution of drugs. Carrying out physical inspection of health facilities.
Luangwa	Formulation of health related policies in the district. Approval/disapproval of plans and expenditure of DHMT. Mediating between the council and operations of DHMT. Ensuring that decisions, resolutions and programmes of HCCs are incorporated in the district plans of action. Monitoring implementation of planned health activities in the district. Scrutiny of health plans during quarterly meetings. Ensuring that the link between DHMT and community is maintained through establishment of intermediary structures like HCCs and NHCs.
Lusaka	Mobilisation of financial resources for the DHMT. Ensuring quality provision of health services to residents. Providing a link between health providers and community. Consolidation of district health action plan. Monthly approval of DHMT expenditure and plans.

Other concerns expressed were that while NHCs were ideally appropriate structures, some members of these structures did not know or understand their roles in the community. In some cases, it was argued that even when these members knew their roles and functions, they would conveniently ignore the guidelines, as adhering to them would mean they would not benefit much as individuals. It was reported that this was exacerbated by the fact that some people who were active in these structures were either unemployed or had no reliable source of income. It was reported that some NHC members solicited for favours from ordinary community members with promises of giving them (community) drugs or choosing them to attend workshops. In Lusaka, it was reported that some NHC members even prescribed drugs in the communities. Others were reported to be interfering with the operations of health facilities; they tended to act as supervisors of HC staff. In some cases, it was also reported that other NHC members tended to shun advice from ordinary community members, often arguing that they were more knowledgeable about health matters and that they were recognised in health care delivery systems by the government.

Although DHB members had high knowledge about their roles and functions, the reported functions are mainly limited to resolving conflicts between stakeholders (i.e. the community and HC staff). Other reported functions include dissemination and coordination of information exchange between stakeholders and fundraising activities. Key functions related to planning and decision-making, such as approval of annual plans and budgets as well as

health development plans in the district, and monitoring and evaluation of the progress of all health activities in the district were less frequently reported.

3.4 Information exchange mechanisms between community and DHBs

Information flow between the community and PSs was assessed to determine whether DHBs are accountable for the quality of services being provided by DHMTs and responsive to the communities they represent. In addition, channels of communication between the community and PSs and the type of information exchanged between these parties were assessed.

Health reforms laid a foundation for communication among PSs and the community through the establishment of PS at the community. However the results of the study show that in general the linkages between the community and PS were not functioning properly. The interaction between the community and PS was largely informal. Most respondents at district level reported that the DHBs dealt more with DHMTs and not with other PSs and/or the community. Some respondents also reported that the chairperson communicated his/her views directly with the CBoH mainly through letters and written reports and with individuals known to him/her as there is no formal system to engage the wider community.

The interaction between DHB and DHMTs was reportedly mainly through meetings. Full board meetings were reportedly to be held quarterly. Meetings of sub-committees were reported to take place more often than full board meetings. It was also reported that in all the districts, the offices of the DHMT were open to DHB members and in most cases, the interaction was more frequent. Communication between HCCs and NHCs was reported to be through their NHC representatives who sit on these committees. Additionally, it was reported that board members often officiated at community health functions such as immunisation campaigns, when funds and logistics, like transport, were available. It was further observed that such functions also provided for some feedback from the community.

Common reported communication channels between community and PSs that are being used in the study sites are:

- public meetings;
- under-five/ antenatal clinics;
- visiting the health centres by community based providers/ members of PSs;
- informal interaction (personal contacts) between members of the community and PSs i.e. NHC & DHBs;
- observation of community participation in planned activities by the elected members of PSs;
- verbal reports by NHCs to village headman;
- use of posters ;
- public address systems;
- use of public media i.e. Radio Chikuni; and
- door-to-door community education campaigns.

Reported content of information communicated include:

- illnesses in the community;
- community projects and expected community input, mostly labour;
- introduction of new staff;
- utilisation of user fees;
- planned/ongoing activities;
- complaints about health services; and
- planned visits by important persons (i.e. government/political party officials, donors and researchers).

In communities where NHCs were functional they were reported to be a direct link between communities and health care providers at health centre level. In general, participants reported that NHCs were an appropriate linkage between communities and health providers. However, while acknowledging this, it was generally reported that the linkage was not effective, as its coverage was limited to the few who are influential in the community.

Major factors that limit the interface between the PSs and the community were identified**.** Firstly, it was argued that in most cases, communication between NHCs and their communities was poor, as meetings between the two parties were not regularly held. Secondly, in terms of representation, some participants felt that individual members of NHCs felt very strongly that they (committee members) were 'communities' themselves and as such, they regarded their views as community views even without engaging in a consultative process with ordinary community members. Thirdly, it was reported that NHCs often were selective in terms of community members they dealt with. The door-to-door education approach that the PSs use further complicates the situation because it does not bring community members together.

3.5 Performance of District Health Boards (DHBs)

This section presents the performance of DHBs in interceding for the community. In addition, the performance of lower structures (i.e. NHCs and HCCs) is also presented because it is through these structures that the community is linked to DHBs. It is difficult to understand how the DHB intercedes for the community if it is discussed in isolation of these lower structures. According to the CBoH guidelines, the core functions of DHBs are identification of community problems and development, approval and monitoring and evaluation of appropriate plans to address identified community problems. To determine whether DHBs are functioning as intended or not, the study examined: the quality of health services provided by the DHB; community representation and participation; and planning and implementation of district health activities.

3.5.1 Quality of services provided by District Health Boards

Results of this study show that in general DHBs are perceived not to be performing well compared to the NHCs and HCCs (Table 3.5.1 Most (61%) of the respondents were not happy with the performance of DHBs compared to less than a quarter of the respondents who reported that they were not happy with NHCs or HCCs.

Further, it can be observed from Table 3.5.1 that there were very few respondents who had taken or reported complaints or issues about health services in their area to the popular structures. Only 30 (22%) for NHCs, 17 (27%) for HCCs and 14 (17%) for DHBs reported issues to their PSs. The ability of these popular structures to deal with the complaints or issues about the health services was also assessed. Respondents' perceptions differed among the three structures. Of the 30 who took complaints/issues to NHCs, only 12 (40%) said the NHC was able to resolve the issue, while out of the 17 who took complaints or issues to the HCCs, 11 (65%) said the HCC was able to resolve the issue. Among the 14 who took complaints/issues to the DHBs, 7 (57%) said the DHB was able to deal with the matter.

Table 3.5.1 Quality of services provided by popular structure

Performance	NHC no. (%)	HCC no. (%)	DHB no. (%)
Level of satisfaction			
Happy	81 (60%)	39 (63%)	32 (39%)
Unhappy	54 (40%)	23 (37%)	49 (61%)
Total	**135 (100)**	**62 (100)**	**81 (100)**
Taken complaint or issues to PS			
Yes	30 (22)	17 (27)	14 (17)
No	105 (78)	45 (73)	67 (83)
Total	**135 (100)**	**62 (100)**	**81 (100)**
Ability of PS to deal with complaints			
Yes	12 (40)	11 (65)	8 (57)
Partially	2 (7)	1 (6)	0 (0)
No	16 (53)	5 (29)	6 (43)
Total	**30 (100)**	**17 (100)**	**14 (100)**

The type of complaints taken to the popular structures are given in Table 3.5.2. The main complaints/issues taken to the HCCs were the lack of toilets and negative attitudes and behaviour of health centre staff towards patients. On the other hand, the complaints reported to the DHBs included the problem of paying registration and user fees when there are no drugs at health facilities. In the community's view, the registration and user fees were meant for drugs not consultations. As a result the community members were unhappy when they were given prescriptions. Other complaints are lack of transport for emergencies, lack of mothers' waiting shelter, lack of pit latrine and lack of water at health facilities.

Table 3.5.2 Community complaints reported to the PSs

Complaint s reported	Popular structure		
Community related	**NHC**	**HCC**	**DHB**
Lack of safe drinking water in the community	X		
Water points too far	X		
No pit latrines in the community	X		
Mosquitoes in homes	X		
Lack of information on health matters	X		
Health facility related			
Hospital too far for delivery	X		
Lack of delivery services	X		
Lack of mothers' waiting shelter	X		
Lack of water at health facilities	X		
Lack of toilet/sanitation facility at health facilities		X	X
Lack of transport for emergencies		X	
Making us pay user fees when there are no drugs at health facilities			X
Health Centre Committee not effective	X		
Negative health staff attitude and behaviour	X	X	

DHBs were reported to be responsive to complaints/issues reported to them by the community. For example, in one community the DHB sunk boreholes after community demonstrations over water problems and in another case a pit latrine at a health facility was built after complaints from the public. Another case was when the community was promised a mothers' shelter by the DHB following their complaint. The general response given for the DHB not being able to address the complaints/issues raised by the community is that "the DHBs have no powers to do anything".

The respondents were also asked whether the HCCs and DHBs were capable of disciplining health workers. Table 3.5.3 shows that only about a quarter of respondents (27% and 21%) reported that HCCs and DHBs respectively were capable of disciplining health workers. The rest said none of the PSs were capable of disciplining health workers and/or that they did not know. Factors that limit PSs from disciplining health workers were discussed. At the HCC level, main constraints were related to the socioeconomic differences between health workers and the community they represent. Health workers were reported to be more educated on health matters than the HCC members and ordinary people were perceived not to be knowledgeable and competent on health issues. The other factor was that, the health workers have supervisors, and reported that it was more appropriate for these supervisors and/or DHBs to discipline their staff than HCC members. At the DHB level, one of the main reported factors as to why DHBs fail to discipline workers was that DHBs have no power to discipline health workers (Box 3.5.1).

Box 3.5.1 Why DHBs cannot discipline health workers

" The DHB has failed to act, as you can see, there is no improvement in terms of medication and the quality of care patients receive. A patient died due to negligence of the nurse and nothing was done."

"I do not think the DHB has powers to discipline because I have never seen them disciplining a HW, this has never occurred here."

"They choose members to be on the board who are "toothless", who cannot act, easily get intimidated, do not understand their role and their powers are minimum."

"Too much corruption so they cannot discipline a worker".

Some of the measures taken by DHBs to discipline health workers include transfer of a nurse who used to insult TB patients and another worker who consistently did not take advise of supervisors and DHB members. The other aspect of assessing the performance of the popular structures was to find out whether the respondents thought that the HCCs or DHBs were capable of determining user fees in their areas. Very few, only 11% and 12% of respondents, reported that HCCs and DHBs respectively were capable of determining user fees (Table 3.5.3). The majority (61% for HCC and 72% for DHBs) of the respondents didn't know if HCCs or DHBs are capable of increasing user fees.

Table 3.5.3 Community perceptions on popular structures to discipline staff and determine user fees

Capability	HCC no (%)	DHB no. (%)
Discipline staff		
Yes	17 (27)	17 (21)
No	9 (15)	13(16)
Don't know	36 (58)	51 (63)
Total	**62 (100)**	**81 (100)**
Increase user fees		
Yes	7 (11)	10 (12)
No	17 (28)	13 (16)
Don't know	38 (61)	58 (72)
Total	**62 (100)**	**81 (100)**

3.5.2 Community participation

The MoH Policy and Strategic Document (1994) categorically states that implementation process of health reforms cannot succeed without community involvement. The community is supposed to be an active participant or partner at all levels of health care. The community should have a meaningful input into problem identification programme planning/design and implementation.

Community participation in the planning and delivery of health care was assessed considering four aspects: selection of NHC members of planning of community based activities; decision making in health related matters; implementation of planned activities; and monitoring and evaluation of health activities. The section on community participation refers to NHCs only, since these are the only PSs known to most members of the community. Therefore, this section gives the findings on whether and how DHBs represent the community. Results of the study revealed that membership to DHBs is mainly drawn from recognised institutions and community members of high socioeconomic standing. Ordinary community members, especially those who are influential in the community, also participate on these boards. Although attempts are being made to sensitise the community on their role in health planning and delivery, the majority of the ordinary community members (those not influential) do not participate in health decisions and planning. Participants observed that limited involvement of ordinary community members meant that those who developed action plans incorporated only elements that suited their own agenda and this results in the exclusion of community interests.

Levels of involvement cited in all the districts in the study were: participation in elections of office bearers; planning; and implementation of activities. In areas, where communities were aware of NHCs, they reported that even though not all community members attended meetings called by NHCs, those who usually attend participated in deliberations for these committees. It was recommended that more sensitisation on the role of the community and functions and existence of popular structures would ensure that all the stakeholders shared the same vision – which, it was argued in Luangwa and Monze, was not the case at the time of the study.

Decision-making was closely linked to the planning process. Planned activities were, in most cases, presented by HC staff to the HCC and decisions were made at that level. The NHC/VHC, reports that community consensus was generated prior to undertaking some activities but to a very limited extent. In contrast, ordinary community members were not aware of the decisions made on most of the activities being undertaken in their communities

and at the HC, such as how money raised from user fees is used or how it should be utilised by the HC.

3.5.3 Planning and implementation of district health plans

This section looks at four aspects related to the implementation process of health planned activities at district level and these are: health planning and decision making; recruitment and supervision of DHMT staff; resource allocation; and implementation of planned district health activities.

3.5.3.1 Health planning and decision making

Results of this study show that community involvement in health planning and the decision-making process was limited. However, Table 3.5.3.1 shows that, community members who participated in the FGDs acknowledged that they were sometimes consulted on their health concerns or problems. The approaches used to consult the community included meetings and door-to-door visits by NHC members. In some cases, concerns were raised during health education talks given by NHC members. Personal contacts also played a role, individual community members also directly reported their concerns to individual members of NHCs, who in turn presented the concerns and suggestions raised by ordinary members to HC staff for possible inclusion in health centre plans.

At the same time, the study observed some constraints that limits the community from participating in planning and decision making . These include that consultations between PS members and the community did not effectively engage all the relevant stakeholders: they were restricted to a few, those who live near members of the NHCs. Further, these consultations were reported to be irregular. For example, sometimes meetings were cancelled at short notice and without adequate explanations. Further, NHCs were reported to be predominantly associated with community health education, the content of which was rarely determined by the community.

In Lusaka and Livingstone, it was reported that it was not uncommon to find situations where NHCs simply informed community members on what the committees intended or planned to do. This was common in such activities as planned extensions of facilities, which would involve among others, contribution from the community. In Luangwa, it was explicitly stated that communities were only called to meetings after the NHCs have already come up with plans of action. These meetings were called for the purpose of informing ordinary community members.

To improve community participation in health planning and decision-making, the community suggested that among other things, the concept of bottom-up planning and/or decision making should be operationalised.

Table 3.5.3.1 Involvement of the community in health planning and decision making

Strengths	Constraints	Recommendations
◆ Community consulted on their health concerns/ problems. This is done through meetings, door-to-door visitations by NHC members and during community health education sessions. ◆ Some community members have personal links with NHC members and report their concerns/suggestions directly for possible inclusion in the HC plans. ◆ NHC members as part of the community, are aware of problems in the community they live in and 'make' reports to HCs.	◆ Community role in planning and decision making is limited because the activities undertaken by NHCs and HCs are too technical. ◆ The major activity of NHC is community health education, but the community has no input into the content of the health education designed for them. ◆ Consultations with the community are limited in coverage. Often the community is just informed about NHC planned activities.	◆ -There is a need to operationalise the concept of bottom-up planning and/or the decision-making process. ◆ The community should 'truly' be involved in the planning and decision making of health issues or programmes in their area. ◆ The community felt needs should be reflected in health action plans at all levels.

3.5.3.2 Recruitment and supervision of DHMT staff

According to CBoH guidelines, DHBs have powers and authority to recruit senior management level staff (director of district health management team, and the managers for administration and planning and development). However, divergent views were revealed. Some respondents reported that the extent to which this was so, was limited. It was argued that it was not clear whether hiring and firing of management DHMT staff was the prerogative of the DHBs or not. Other respondents reported that this was yet to be realised because currently, DHBs are only involved in mere ratification of these candidates.

Further, Table 3.5.3.2 highlights the major factor that limits DHBs from effectively carrying out functions related to staff recruitment and supervision is lack of adequate funding. This is because most, if not all, senior management health staff at the district level were in the civil service and were only seconded to DHMTs, with little or no allegiance to DHBs. And that recruitment of staff is depended on availability of funds. No DHB was reported to be financially self-sustaining to have the power or authority to hire and/or fire any erring DHMT management staff.

The supervisory role of DHBs over DHMT health staff was not clear among the members. Different responses emerged within and between the same districts. Some respondents reported that they did not know who their supervisor was, others identified a range of supervisors. These were: the minister of health, chairperson of CBoH, director-general of CBoH, and provincial CBoH offices.

Table 3.5.3.2 Recruitment and supervision of DHMT staff by the DHBs

Strengths	Constraints	Recommendations
◆ National guidelines indicate that DHBs have the power to hire and fire senior management staff.	◆ DHBs not able to hire and/or fire civil servants paid by government. ◆ DHBs have no funds or budget to make substantial decisions related to human resources.	◆ -DHBs should have an operational budget.
◆ One of the DHB functions is to supervise DHMTs and make them more accountable.	◆ DHB members do not know their role; they interfere with the routine operations of the clinic. ◆ DHB members cannot supervise technical staff, because they have no knowledge and skill to do so.	◆ DHB members should be adequately inducted, so that they understand their roles. ◆ Appointment criteria should be stringent to allow only capable men and women to represent the community.

3.5.3.3 Resource allocation

Almost all the key informants in the study, acknowledged that DHBs play a role in resource allocation. Table 3.5.3.3 shows that the strengths that DHBs have were seen in: the powers that DHBs have in approving and/or disapproving the district health plans and budgets; potential multiple sources of funding; and that there is high community willingness to support the resource allocation process. However, it was also reported that the limited understanding of budgetary processes and technical (medical) aspects made it difficult for some DHB members to have meaningful input into resource allocation. Generally it was difficult for DHB members to disagree with what is presented by DHMT staff who are medical experts. In most cases, it was reported that the DHMTs not DHBs were instrumental in determination of resources. Another major limitation was that did not have much input in the resource allocation process.

Table 3.5.3.3 Allocation of resources to health activities by the DHBs

Strengths	Constraints	Recommendations
◆ Approves/disapproves district health plans. ◆ Multiple sources of funding – government grants, user fees, fundraising, donors, and community contribution i.e. labour, time and funds. ◆ Community willing to take part in resource, mobilisation, allocation and monitoring. ◆ Mechanisms to monitor use of resources in place.	◆ Input of DHBs minimal because DHB members have limited understanding of budgetary processes and related technical aspects. ◆ Community has no input on finances for at least two reasons (i) community does not know how much money is available and (ii) no forum to discuss financial issues between technical staff and the community.	◆ Community should be informed about available resources and planned use.

3.5.3.4 Implementation of planned district health activities

District health action plans incorporate NHC and HCC plans. As in allocation of resources, it was commonly reported that the DHBs were responsible for approval or disapproval of the district health plans but that their influence was limited due to lack of capacity, mainly inadequate funding and lack of expertise. (Table 3.5.3.4), gives details of strengths and constraints DHBs have and recommendations to facilitate effective implementation of their activites.

On the other hand, the community's role in implementing planned health activities was limited to mainly contributing their labour and other resources (i.e. building materials and cash contributions) for construction works of health facilities and involvement in garbage collection. In Livingstone, Luangwa and Monze, it was reported that community labour was mobilised during health facility expansion works. The specific facilities mentioned were Linda and Victoria Falls clinics in Livingstone and Chisekesi health centre in Monze. Both finances and labour contributions formed part of the 15% community contributions as recommended by the Zambia Social Investment Fund for community projects. In Luangwa, labour was mobilised by NHCs for construction of primary health care (PHC) units in the communities with the support of the Christian Children's Fund (CCF). In Lusaka, community involvement was by way of participating in garbage removal in compounds. It was also reported that, in some instances, ordinary community members shunned this activity and NHC members themselves carried out this task alone.

The community reported being involved in health issues through the translation of knowledge acquired from community health education into practice such as pit latrine construction, putting up of racks for dishes, taking children to under-five clinics and taking suspected tuberculosis patients to health facilities.

Table 3.5.3.4 Strengths, Constraints and Recommendations to improve the performance of DHB

Strengths	Constraints	Recommendations
◆ DHB responsible for approval of DH plans. ◆ High political will. ◆ Has power and authority because it is enacted by parliament (legal entities). ◆ DHB members are appointed by high office (minister of health). ◆ DHBs receive support from DHMTs: transport (mobility); organisation of meetings; secretarial services; and technical advice from experts (DHMT staff).	◆ Community involvement limited to contributing mainly time their labour and materials and money towards constructing health projects. ◆ DHB influence on development and implementation limited. ◆ Roles by various stakeholders not clear. ◆ Lack of resources (inadequate funding) to implement planned activities. ◆ Lack of office space makes it difficult for contact and/or follow-up on issues. ◆ Dependency of DHBs on government funds undermines their semi-autonomous status. ◆ Most DHB members are not competent for their jobs (this is despite the orientation and guidelines they receive). ◆ Demands on DHBs are complex to understand and deal with. They require people with technical expertise and relevant experience. ◆ Poor motivation among DHB members. ◆ Poor participation of DHB members in planned activities. ◆ In reality DHBs have limited power and authority.	◆ Develop/strengthen the capacity of DHBs to carry out their functions. ◆ Train DHBs so that they understand their roles. ◆ Government should make resources available to match the needs and priorities of the community. ◆ Increase presence of DHBs in the community. ◆ Although DHB members are volunteers, they need incentives, i.e. training and allowances, to motivate them. ◆ Appointment of DHB members should be based on transparency and democratic principles and their term of office should be observed. ◆ DHBs should assume high power and authority because they are created by law and DHB members are appointed by a high office (minister of health).

3.5.4 Capacity of DHBs in performing their functions

The main objective of this study was 'to assess the effectives of DHBs in interceding for the community'. Therefore, the study explored whether DHBs had the capacity to carry out their functions. Table 3.5.4 shows the strengths, constraints and recommendations made by participants to increase capacities of DHBs. In general, DHBs were said not to be functioning effectively for various reasons. Two factors emerged as main constraints: inadequate resources; and inadequate competencies among DHB members.

Lack of resources was reported to be a critical element limiting DHBs from carrying out their functions. In all the districts, respondents observed that DHBs had inadequate funding to implement planned activities. Inadequate funding was further exacerbated by lack of capacity by the individual boards to mobilise resources (i.e. fundraising), resulting in failure to meet community expectations. In Lusaka, this was reported to be a major challenge. As a result of limited financial resources, DHBs are, in most cases, unable to undertake such responsibilities as improving staffing levels in health facilities. The boards were also said to be unable to adequately remunerate staff, raising the problem of poor motivation among staff. In all cases it was mentioned that DHBs solely depended on government – thus ultimately undermining the boards' perceived semi-autonomous status.

The competence of DHB members emerged in a number of interviews. Notwithstanding the point that appointed members undergo an orientation course and are given CBoH guidelines, a number of shortcomings were pointed out. In Monze and Livingstone, for example, some respondents reported that the mandatory requirements to appoint members of NHCs did at times pose difficulties. It was argued that while in some cases the appointees may be competent and conversant with issues at NHC/HCC level, the demands at DHB level were different and relatively complex for them to comprehend. As a result, it was further argued that a number of board members did not participate fully in DHB matters and delivered little if anything of what is expected of them.

Some suggestions to improve capacity and functioning of DHBs were made by participants. It was suggested that while recognising the fact that the work of board members was voluntary, they needed incentives such as exposure to training. It was also reported that board members would also be motivated if funding levels were increased to ensure that resources matched community needs and priorities as well as facilitating board members to plan and carry out activities so that they are more present in the community through visits.

Finally, it was echoed in nearly all interviews that appointments of DHB members should be done democratically and that the term of office should be observed to ensure smooth transition and avoid gaps in service provision and that there should be plans to involve the poor people who need services on the DHBs.

3.5.5 Relevance of District Health Boards

Since DHBs were dissolved, participants at the district level were asked why the DHBs were dissolved and whether DHBs are necessary. A number of respondents reported that they did not know why the DHBs were dissolved in the first place. Some respondents however indicated that the DHBs were dissolved because they had outlived their terms of office and as such were operating illegitimately, without any mandate whatsoever. Some argued that DHBs were dissolved by the minister who had the right to do so at any time. However, in all the interviews respondents indicated that DHBs, if operating effectively, were a necessary entity in both planning and delivery of health services. DHBs were reported to have a pivotal role in policy guidance and advisory services to the DHMT. It was also observed that their revival and continued existence is also justified by the fact that DHBs are legal entities created by an Act of Parliament.

However, respondents had different views regarding to DHB operations in the past. In Lusaka, respondents reported that a number of successes were recorded. These included: the purchase of ambulances for health centres; facilitation of training for health personnel; and building of five new health centres in addition to upgrading four others. In Monze, respondents also reported about upgrading of a number of health facilities. On the other hand, some respondents in Luangwa reported that not much was achieved. They said that generally the performance of the DHB was poor, as nothing much was done to ensure that the community became aware of the role of DHBs as well as understand their roles in planning and delivery of health services. In Livingstone, respondents pointed out that in their case the DHB was not officially dissolved and hence they continued operating. Among the successes highlighted was a greater involvement of communities in health issues.

As indicated in the section on knowledge of the structures, ordinary community members were less conversant with PSs created to represent them at district level such as DHB and DHMT. As a result it was difficult for the ordinary community members who participated in the study to define the nature of the linkages and assess their effectiveness. In most cases, communities simply referred to the district health offices as being responsible for the running and/or supervision of health centres/staff. In only a few cases, the DHBs were perceived as the overall entity that was charged with the responsibility of all health related matters at district level and that this structure also supervised the district health office. This only emerged in one FGD in Monze and two FGDs in Lusaka. Generally, the community reported that linkages were more visible between HCCs and NHCs and between NHCs and the community. But even then coverage of these linkages to ordinary community members was limited. It is on the basis of who is easily accessible to committee members. The DHB members interviewed said they inform the community through the NHC and other community based structures such as the village health committee and nutrition groups. In addition, the DHBs make sure that members officiate at functions in the community. They also mentioned visiting health centres and talking to individuals.

A big communication gap is also observed between the community and PSs, as no systematic way exists between these partners. The channels used are limited in coverage and are usually initiated by members of PSs and/or health providers. The general meetings, where most community members participate, are often held annually and their main purpose is to: elect new committee members; announce activities or procedures for implementation that require community involvement; and solicit support and agree on course of action. Unlike among PSs, where the flow of information is from lower to higher structures, in this situation the communication flow is top-down from PSs/health providers to the community. At this level, it is important to note that while NHCs represent the community, there is a lack of mechanisms for reaching out to the wider community.

4. Discussion

There is low knowledge about DHBs among the community

Generally, the community is not aware of the existence and functions of the DHBs. 36% of respondents in the community survey did not know any, while 48%, 22% and 29% know about NHCs, HCCs and DHBs respectively. To underscore the point, DHB members who participated in the study also admitted that they have limited interactions with lower level PSs (HCCs and NHCs) and the community and that such interactions are mainly limited to officiating at special functions such as annual events and visits of high government officials at HCs or in the community. Low knowledge about DHBs among the community was mainly attributed to lack of resources. However, other explanations could be advanced:

- lack of a plan and implementation for community education to publicise existence and functions of DHBs by the government and/or the DHBs themselves;
- weak linkages between DHBs and other lower level PSs such as HCCs and NHCs; and
- maybe it is unrealistic to expect the community to know about DHBs, as they may be removed from district health governance structures compared to lower level structures.

Indeed the later argument is supported by one of the findings of this study, that the community was more knowledgeable about community based PSs, more so the NHCs. However, the finding that the community is not aware of the high level health governance structures that are supposed to represent them in health matters may mean that the community cannot make effective use of DHBs.

DHBs are not effective in carrying out their functions

According to reports from DHB members and DHMT staff who participated in the study, DHBs are not effective in carrying out their functions mainly due to:

- reported lack of resources to support DHB activities; and
- limited competencies among DHBs in technical areas that limit meaningful input into different processes such as review of plans and budget.

Further, DHB members did not adequately understand their roles and functions, perhaps because some of the DHB members were new and were just being oriented to their new work at the time of the data collection

Lack of community evidence in health service planning and resource allocation

Current national procedures for developing district health plans allows for community input/evidence in health care planning and resource allocation. District health plans are supposed to begin from NHC level, which is the lowest functional unit. From NHC level, draft plans are submitted to the HC level, where they are aggregated and forwarded to the district level for consolidation.

However, there are some gaps in the process of developing district plans:

- at NHC level, full participation of ordinary community members is not assured due to lack of effective mechanisms to engage the wider community;
- once the plans are submitted to the district level through the HCC, either the HCC or the DHMT is at liberty to make changes and decisions (i.e. exclude some of the activities identified at NHC level or include some activities which are not identified by the community) without giving adequate feedback to the community;
- board members, especially those drawn from NHCs with limited technical capacity and social standing in the community, are not empowered to challenge the decisions/actions of the DHMT who are considered to be experts and an authority in health matters; and
- although the district health budget includes a 5% for community projects, this is rarely used because the community/NHCs do not have adequate capacity to develop fundable projects and others do not know about this provision.

The link between DHBs and community is weak
The necessary linkage, in terms of structure, has been put in place. However, there is a major breakdown between the DHBs and the community and between PSs (i.e. DHBs and HCCs). There is no formal system of communication between DHBs and the communities they represent. In addition, the NHC members who are in the HCCs do not effectively report back to the NHCs they represent. This communication breakdown means that views of the community are not effectively channelled into the health care system.

There is limited community involvement in health planning and delivery
The current health reforms have placed emphasis on building institutions. This is demonstrated by the results of this study, which show that PSs have been created to facilitate community participation into their health matters in all the study districts. However, the selection of board/committee members to represent the community on these structures does not effectively involve all segments of the population. The general community was not aware of the criteria or procedures for selecting DHB members. Even some senior DHMT staff expressed ignorance about how DHB members were identified and appointed in their own districts. The study also found that vulnerable groups, the poor and other people of low standing in the community are not actively participating in leadership roles. This means that their views and needs are not represented and/or are not adequately factored into the planning and design of health programmes. In addition, gender issues are not considered, as a result this study found that women are not adequately represented on these committees. This is a serious gap: it means that a large segment of the population is excluded from decision-making roles and hence has no influence on health matters that affect it.

Results of this study show that the process of community participation is beginning to take ground. In general, the community participates in selecting their NHC representatives. In addition, the community participates towards implementation of community project activities by providing labour and making contributions in the form of materials, and this the major form in which the community participates. However, the study observed that in general, the community is not effectively involved in the planning and decision making of PSs (i.e., NHCs and DHBs) and the 'wider' community as there are no effective mechanisms for sharing NHC plans with the community. This results in limiting participation to people who live near health facilities and/or are personally known to the appointing authorities.

The weak link between the community and NHCs is critical because it affects information flow between stakeholders.

The distribution of social services favours the urban population more than the rural population
Results of this study show that water and sanitation services and the quality of health care, as measured by waiting time, was better in urban than rural areas. This means that the government vision of reaching all Zambian families with equity of access to cost-effective, quality health care as close to the family as possible, is far from being realised. What is needed is to define the way forward, and answer the question: Can the community be effectively involved in health planning and decision making?

Conclusion
The findings of this study are that:
- the community is not aware of the existence of DHBs, governance structures that are supposed to intercede for them;
- DHBs are not functioning effectively as outlined in the CBoH guidelines;
- the community is not fully engaged and participating in the health planning and decision making practice; and

- there are weak linkages (communication channels) between PSs and the community.

These all raise questions about the effectiveness of DHBs in interceding for the community and leaves one to conclude that DHBs in their current form are not effectively interceding for the community. Based on these results, several questions emerge:

- Can the community represent themselves and demand for services and do they have the capacity to absorb resources?
- Communication is so important, but there are no formal channels of communication – how then do the community and their representatives on the boards share vital information?
- Participation and representation of women on PSs is limited, what can be done to increase women's participation and representation in leadership roles in health and governance? What policy or mechanisms are needed to facilitate equitable representation of men and women in health governance?

These questions need answers that will help us to identify inequities and make them visible, identify ways of addressing observed inequities and to promote the involvement of all key actors, including women and the poor, in governing their own health.

5. Recommendations

Composition and selection
Although there are elaborate criteria and procedures for selecting and appointing DHB members, in practice, those selected and recommended for appointment are influential people and those known by the DHMTs and/or those who are mandated by virtue of their office. Therefore, it was difficult to realise gender representation.

Therefore, the selection and appointment procedures need to be reviewed in favour of general community members and women.

In general, DHB members and DHMT staff are aware of their expected roles but not functioning effectively.

DHBs need more leadership training and exposure beyond the initial course.

The framework for linkages between different structures exists. But there is no defined mechanism for how the information (as in reports and feedback) should flow between the community and the various PSs created to represent them.

There is, therefore, a need to review current communication systems between and within structures and between structures and community in view of developing a more responsive system of communication. In addition, there should be an implementation plan to effect information exchange mechanisms among PSs and between PSs and the community.

In general, the community is not well informed about its role and place in health planning and delivery, and the linkages between various structures makes its participation difficult.

There is a need to develop well-tailored community sensitisation and education about community structures and roles to facilitate more interaction between the community and DHBs and other structures.

Currently, the achievements and constraints of DHBs are not well understood or documented.

There is therefore a need to do an impact study, which will provide baseline data for monitoring and evaluation.

The capacity of DHBs to perform their roles and functions is very low, for example, they have no resources of their own.

Strengthen the capacity of DHBs, i.e have operational budgets and skills.

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