Governance, participatory mechanisms and structures in Zambia's health system:
An assessment of the impact of Health Centre Committees (HCCs) on equity in health and health care

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Terms and abbreviations used

Terms used

Autonomy That in a partnership arrangement the relationships developed should not undermine each partner's autonomy.

Chingola: A copper-mining town in Zambia

Clinician: A health worker trained to diagnose and manage disease conditions

Dresser: An untrained health worker authorised to provide clinical care to patients

Due process: This notion refers to the arrangements through which partnerships (stakeholder groups) are governed. It incorporates the notion that transparency of decision-making to the public is essential, as well as measures to remove conflicts of interest such that information is not controlled or censored.

Equity: The notion that benefits should be distributed to those most in need (especially the poor and vulnerable).

High performing: An assessment of the performance of the HCC based on capacity for financial management or capacity to positively influence access to health services by the poor and vulnerable in communities.

Low performing: An assessment of the performance of the HCC based on the perceptions of health managers, and/or in relation to the performance of others in a sampled district.

Lusaka: The capital city of Zambia

Ndola: A copper-mining town (the third biggest town in Zambia)

Quintile: Asset scores for 20% of households grouped in ascending order, where quintile 1 represents the lowest 20% of asset scores (the **poorest** households), quintile 2 the next 20% (the **very poor**), quintile 3 the next 20% (the **middle poor**), quintile 4 the next 20% (the **less poor**) and quintile 5 represents the asset scores for the top 20% of households (the **least poor**) – this being socially correct terminology for a poor country like Zambia.

Abbreviations used

CBC	Community Based Care
CBO	Community Based Organisations
CBoH	Central Board of Health

CDE	Classified Daily Employee
CHESSORE	Centre for Health, Science & Social Research
CHW	Community Health Worker
CO	Clinical Officer
DFID	Department For International Development (British)
DHMBs	District Health Management Boards
DHMT	District Health Management Team
DHO	District Health Office
EHT	Environmental Health Technician
EQUINET	an NGO set up to Promote Equity in Health in Southern Africa
GRZ	Government of the Republic of Zambia
HBC	Home Based Care
HC	Health Centre
HCC	Health Centre Committee
IMF	International Monetary Fund
MCH	Maternal and Child Health
MoH	Ministry of Health
NGO	Non-Governmental Organisation
NHC	Neighbourhood Health Committee
OPD	Outpatients' Department
PA system	Public Address system
PRA	Participatory Research Appraisal
RHC	Rural Health Centre (the first point of contact with the health system)
STDs	Sexually Transmitted Diseases
STIs	Sexually Transmitted Infections
TARSC	Teaching and Research Support Centre
TBA	Traditional Birth Attendant
USD	United States Dollar
UTH	University Teaching Hospital
WB	the World Bank
Zonal RHC	a Rural Health Centre with laboratory facilities, an inpatient facility and usually a referral centre for health centres in a designated health zone

Summary

Background: In 1992, the Zambian government had introduced country-wide health reforms in the public sector. Between 1994 and 1998, CHESSORE undertook a 2-phased study to monitor and evaluate the implementation of the Zambian health reforms, with a view to identify good practices, bottle necks and feed information into the implementation process for better outcomes. The key features of the reforms were centred on the core principles of leadership, accountability and partnerships at all levels in the health system. Around these core principles, implementation strategies were developed with the objective to attain the reform vision "to provide equity of access to cost-effective quality health care as close to the family as possible for all Zambians". At the lower level of the system, the implementation of the core reform principles were to be attained through the creation and activities of health centre committees (HCCs) at health centres; supported by activities of community based health volunteers [the neighbourhood health committees (NHCs), community health workers (CHWs) and traditional birth attendants (TBAs)].

Introduction: The policy to attain equity in health through greater community participation in health had not yielded the intended results by the time we concluded our monitoring work in 1998. The attempt to introduce HCCs as an interface between the health system and the community was faced with many challenges before any meaningful outcomes could be realised from its activities. The studies undertaken by CHESSORE and other research groups identified several problems in the implementation of community participation for leadership, accountability and partnership in the Zambian health system. While many HCCs had failed to assume their rightful roles, there were few that, despite problems encountered, managed to innovatively find their way to exert perceptible positive impact both at the health centre and in their communities. This study undertaken by CHESSORE, as part of a collaborative multi-country study through EQUINET was designed to assess whether these perceptible positive gains were sustained; and if so, what factors contributed to this outcome. In addition, the study compared the performance of these four 'successful' HCCs with four poorly performing HCCs in districts with matching socioeconomic characteristics. The study also sought to identify the ideal desired features to successful community participation in the Zambian health system.

Methods: Using a semi-structured questionnaire, along with key in-depth interviews, PRA tools, stakeholder workshops, outcome mapping techniques and the collection of available data at health facilities. A sample of 574 community interviews were undertaken, with 47 in-depth interviews, 35 key informant interviews, a stakeholder workshop, and 10 PRA sessions. To assess the impact of HCCs on the poor and vulnerable groups in the community four special group discussion sessions were held with representatives from marginalised groups (widows, orphans, the disabled and the elderly). The data was captured and entered into the SPSS computer statistical software package for storage and analysis. This data was analysed by frequencies and cross tabulation of variables. The EPIInfo statistical software package was used to assess for

significance in outcomes between variables. Group discussion sessions were tape recorded, transcribed, typed and stored in Microsoft word software package. The group discussion data was later analysed grouped into key theme areas of concern to equity and by the vulnerable groups.

Findings: The HCCs were still in existence at all sampled health facilities. Those that performed well during the earlier survey had continued to perform well, despite facing challenges such as hostility from the health system. The innovations introduced were still in place and functioning. However, on average HCCs were known to no more than 20% of community residents. HCCs were better known among the less poor socioeconomic groups than among the poorest groups in society. The better performing HCCs were also performed well with respect to participation in decision making, priority setting, monitoring expenditure and quality of services. Some HCCs had acquired authority to make own decisions on certain things. The better performing HCCs kept their user fees lower and provided for other alternatives to cash payments than the poor performing HCCs. All key stakeholders at district level, whether from HCCs, frontline health workers and from the DHMT were unanimous to say that HCCs have made an impact and their value to the health system was acknowledged. However, this impact was limited in terms of the desired equity goals and coverage. There was consensus too that HCCs had little or no impact among vulnerable groups and in important decision making roles at the health centre, especially in relation to clinical care services. Channels of communication have been developed between the health system and HCC in health promotion and provision of preventive services. Even then, there were still problems in the flow of information, which was usually one way from the health system to communities, with feedback being rare infrequent and ineffective.

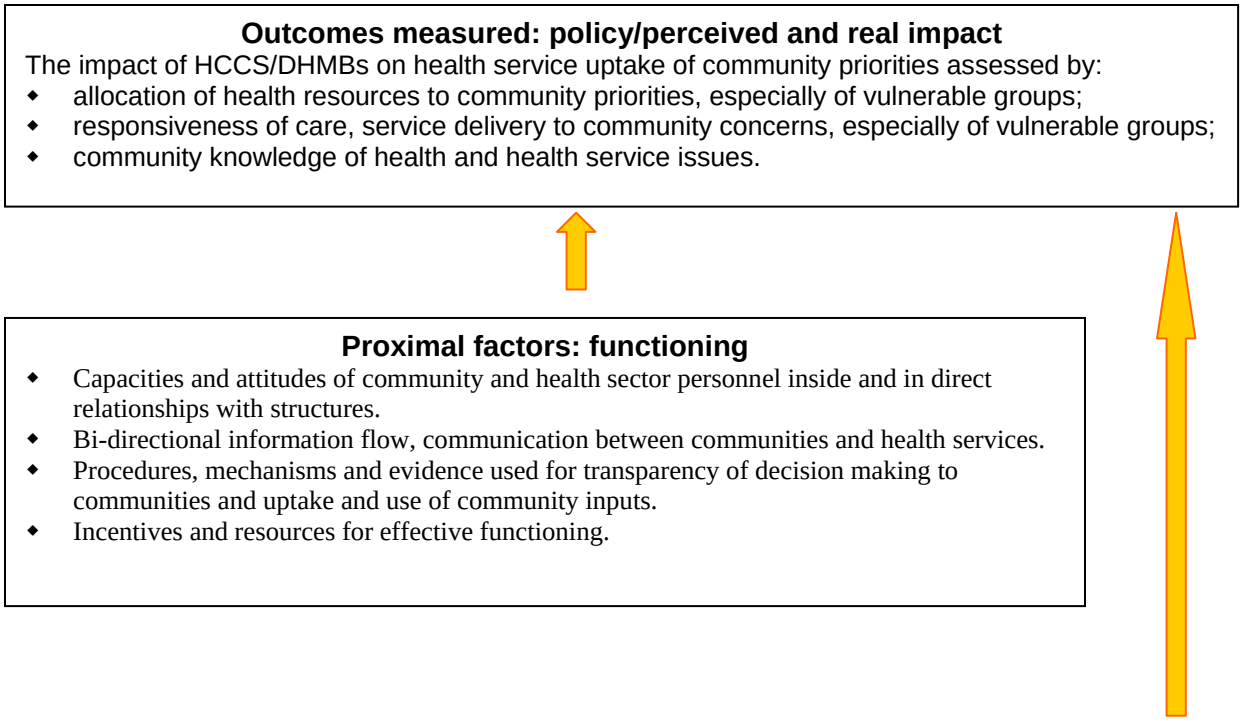
Conclusion: Key stakeholder groups discussed and agreed on what features should constitute ideal features to look for, for effective community participation in the Zambian health services. The challenge now is to find approaches that translate these ideals into practice in order to attain the desired equity goals.

1. Introduction

The work reported here was undertaken as part of an effort to try and feed into the implementation process of the Zambian health reforms, with a view to enhancing positive outcomes from the policy of community participation in the Zambian health services. This work was done as a collaborative study with the Regional Network on Equity and Health in Southern Africa (EQUINET) (www.equinetafrica.org).

EQUINET 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 that 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 and INESOR in Zambia embarked on a multi-country 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 (GovERN). The conceptual model for assessing governance as a contributor to health equity underlying the multi-country programme was defined as below.

Figure 1:



Underlying factors: power and authority

- Formal sources: Legal recognition and powers; formal control over health resources, finances.
- Political sources: Community mandate; Community ownership, purpose and cohesiveness; Traditional/elected/political links and recognition; 'Delegated power' of appointing authority.
- Technical sources: Recognition by health management.

It was agreed that as part of the research process all studies should enhance local understanding of the issues and local problem solving and action on consolidating benefits or dealing with problems in governance mechanisms.

This paper presents a study of the performance of HCCs as governance structures for bringing about equity in health in the Zambian health system. The HCCs were established through an Act of Parliament following the passing of the Health Services Act of 1995 bill by the Zambian parliament. With this bill passed, a ministerial instrument was passed, detailing the roles and responsibilities of different actors and stakeholders in the new governance mechanisms at public health facilities in Zambia [1]. From 1995, HCCs were progressively established at public health facilities in Zambia, till about 1998 by which time the HCCs were established at all public health centres in Zambia [2].

1.1 Background

Since 1980, the Zambian government has undertaken a series of reform measures to try reviving its health services as well as provide equity in health service provision through greater involvement of its people. In 1992 this effort culminated in a vigorous health reform programme that created legal structures, functions and roles of governance structures in health (using a decentralised approach) while at the same time undertaking financing reforms [1,2]. The core objective of this reform programme has been to try mobilising extra revenues while at the same time striving to bring about equity in health service delivery [2]. Prior to the Zambian health reforms, expenditure on health largely favoured urban settings with rural areas being grossly disadvantaged. More money and other resources were spent to maintain tertiary health facilities at the expense of primary health care services. Planning in the health system followed top-down implementation while priority setting was either unheard of or managed centrally for centrally designed priorities. This scenario resulted in a situation where nearly 70% of the country's health budget was spent on the few secondary and tertiary hospitals, with the balance being for the many firstly referral hospitals and thousands of public health centres. The distribution of drugs, supplies, and equipment as well as health personnel also mirrored this urban bias. The worsening economic fortunes of the country added to make the situation worse, leading to rundown infrastructures, poor working conditions, shortages of drugs and other supplies, staff shortages and failure to provide necessary services, especially in rural areas [3]. The current phase of the health reforms in Zambia is committed to reverse the trends by ensuring that 70% of public resources to health was devoted to primary health care services and the balance of 30% used for secondary and tertiary services.

1.2 Literature review

Like most other developing countries, Zambia has embarked on various reforms to its socio-economic development programmes, embracing the increasing role of the private sector in the economy (structural adjustment programmes) as well as reforms in the provision of social services (such as the ongoing health sector reforms). The health reforms programme is rooted in improving efficiency, equity and resource mobilisation, through leadership, accountability and partnerships at all levels in the health system. A bottom-up policy implementation approach has been advocated as a way to ensure efficiency, equity and resource mobilisation in addressing locally relevant priority health problems. At the central level, partnerships have been created between bilateral and multi-lateral development partners for leadership, accountability and partnerships at central level. At the grassroots level, this arrangement is represented by links between the governance structures in health (the HCCs and the District Health Boards [DHBs]) and the health system, at the health centre and district health service levels, respectively. Priority setting to address local health issues is planned to take place with and through these governance structures, Annex 1 and [14].

1.3 Previous work done

Between 1995 and 1998, CHESSORE undertook monitoring and evaluation work of the Zambian health reforms implementation to review structures, processes and outcomes from the programme [5,6,8,]. Two phases of the study were undertaken, a baseline study (1995/1996) and a follow up study (1997/1998). There was a two-year period between the phases to allow for detection of possible changes in outcomes from the reform programme. The key feature of this applied research project was to get verifiable outcomes and to use the findings to feed into the implementation process as a way of trying to ensure more positive outcomes from the health reforms. It was through this work that the research team came into contact with some of the difficulties encountered by both health workers and communities at the grassroots level in implementing the policy of community participation in health [5,6,8,15]. The problems faced in the implementation of policy of community participation were also confirmed by other studies done in Zambia [2,9]. Problems were encountered due to the differences in level of knowledge, skills, information, level of education, technical knowledge of health systems, and resistance from health workers as well as the lack of resources for more meaningful community participation in health. At this point in time, the key form of involvement was where health workers and/or the community identified a health problem at the community level and the members of the governance structures were given the task to mobilise community resources and labour to undertake the agreed tasks. The continual reliance on community labour and inputs without reciprocal gains generated resistance to the extent that people were asking: ‘What do we get in return for giving our labour and resources?’ At the time of the baseline study, more and more community representatives in health, at the level of the HCCs, reported that they found it difficult to mobilise people and resources, as people resisted and argued that they cannot continue providing their labour for free [6,15]. These problems were not unique to Zambia as such, but were part of a general phenomenon that has been observed in other countries as well [1618].

Despite the problems encountered, there were some signs here and there of successes in the process of implementing community participation in health. These examples provided a welcome change to the difficulties that most of the governance structures reported in trying to engage the health system. Depending on how the structures dealt with their health workers, some HCCs became effective arbitration bodies and were used as structures for appeals by users of health facilities – if unable to pay user fees or if they encountered bad reception/service from health workers. Some HCCs went as far as assuming disciplinary powers when health workers erred or disputes arose between the health centres and their communities [6,15]. Even where HCCs members were not sure of what their prescribed roles were, some HCCs used the opportunity to introduce socially desired features for health service provision at their health centres. Some of these innovations were taken up into the health system to become accepted features in service delivery [6]. Two innovative approaches to effective community participation were striking for their outcomes and impact. In one set of health facilities, the HCCs had successfully interceded to bring about greater and more equitable access to health services in the face of difficulties experienced by residents in paying cash at the time of presentation when sick. This kind of innovation was seen at Sinjembela and Mulanga rural health centres (RHCs) in Shangombo and Chinsali districts of Zambia, respectively [5,6]. Another innovation involved mobilising and managing community resources for health promotion in the community. This kind of positive innovation was seen at the Chivuna and Kanyanga RHCs in Choma and Lundazi districts, respectively [2].

The difficulties faced by the HCCs in implementing effective community participation, coupled with the realisation that the health system was able to bend backwards to allow for innovation and infusion of new ideas gave the idea of undertaking more applied research in this area of health policy. The Zambian government has not been prescriptive in setting up the various governance structures in the health system. Rather it has taken the attitude of learning by doing, in the hope that positive experiences can be taken on board and be incorporated in the 'routines' of service provision. Thus on one hand, our research centre developed a project to establish an equity gauge in Zambia as a route through which to undertake applied research on community participation in the Zambian health system. The proposal was discussed with senior officials in the Ministry of Health (MoH) and the Central Board of Health (CBoH) for their comment and input. With their consent, equity gauge chapters were set up in four districts to work very closely with the respective district health services. On the other hand, following participation at a regional meeting of EQUINET in 1999 [17], CHESSORE had linked up with EQUINET to undertake research to better understand issues and problems with effective community participation in the Zambian health system, as part of a sub-regional collaborative effort.

1.4 Research questions

The work presented in this report was undertaken as part of a multi-country study to try and answer the following research questions regarding community participation in the Zambian health system.

- To what extent are the problems faced on community participation in health a common feature found in other countries in the sub-region?
- What progress has been made in terms of community participation in the Zambian health services?
- To what extent were the innovations reported in the previous studies sustained and/or improved on by the year 2002/2003?
- What are the desirable features of community participation in the Zambian health services that can help to bring about and sustain effective community participation?

2. Statement of the problem and objectives

Despite the often-stated policy desire to bring about equity in health service provision through community participation and the measures that have been taken to try bringing this about, in Zambia, this has largely not happened. Similarly, the strategy introduced in the form of 'bottom-up' implementation of the decentralised planning and budgeting as one way to identify local priorities and thereby ensure equity in health service delivery, has not happened to any significant degree. Many research studies have been done, and many factors that affect this have been identified [613,16,17]. So, there are still questions to be answered, if meaningful community participation in the Zambian health system is to be achieved. More specifically, this work had focused on coming up with answers to a number of questions, such as: What are the common problems that block meaningful community participation in the Zambian health system? Where does the balance of power lie between health workers and the communities they serve? What can we learn from the few 'successful' HCCs that have managed to bring about meaningful and sustained participation in the governance systems at their health centres? And on a practical level, there is the question, 'How can an understanding of the successful few HCCs guide us in coming up with solutions to the problem of poor performance[1] of the community governance structures in the Zambian health system?'

2.1 The major objective

This study re-examined these issues by following up and comparing the performance of the four 'high performing' HCCs identified in earlier studies with four 'low' performing HCCs.

2.2 Specific objectives

In studying this major objective, the researched focused on the following **specific objectives** of the study:

[1] The poor performance of the community governance structures in the Zambian health system is gained from their lack of positive influence to bring about equitable, more accessible, more cost-effective, better quality services that are as close to the family as possible; in line with the mission statement of the Zambian health reform programme.

- to review and evaluate the issues that affect the performance of HCCs in Zambia's health system and to what extent these are shared with those in other countries of the Southern African sub-region;
- to evaluate the performance of HCCs in relation to promoting the goal "to provide equity of access to affordable quality care for all Zambians", since inception;
- to determine the extent to which the innovations reported in the previous studies have been sustained and/or improved on by the year 2002/2003;
- to identify desired and socially acceptable features of governance structures in the Zambian health services for effective community participation; and
- to use the results of the study to build and enhance stakeholder understanding and action of their roles/functions.

In order to try and answer these specific objectives, the study used the research methodology, tools and techniques as outlined below.

3. Methodology

In order to undertake this work with objectives as outlined, the CHESSORE research team linked up with other researchers in the sub-region as earlier explained. So, the initial steps involved developing some common focus with common tools on certain issues and objectives in order to make them comparable across country health systems. Through email correspondence and later, sub-regional meetings, a consensus on these was reached and each research team incorporated these common issues into their research instruments; in addition to the issues pertinent to their area of focus for the level in the system focused on.

3.1 Tools and techniques

The following research tools and techniques were developed and used to get the desired information relevant for this study.

Semi-structured questionnaires were developed to collect information from respondents at the district health offices, health centres, representatives of community governance structures in health, key informants in the community and randomly selected community residents. For most health system respondents, the questionnaires were administered as self-filled, and only in a few cases was it necessary for our research assistants to administer these tools to respondents. For community level respondents, our research assistants administered the questionnaires, and more often required translating issues for discussion into local languages. A total of 574 questionnaires were successfully administered.
Discussion guides were also developed for use by individuals (as key informants) as well as with groups of stakeholders. Discussion guides with issues relevant for each level were developed and suggested probes included for guiding the discussion where this was needed. The discussions were either tape-recorded or noted down. **Individual discussion interviews** were undertaken with key district health managers (usually following the titles held or roles and responsibilities exercised), key members of HCCs, as well as

community leaders and identified opinion makers. **Group discussions** were held with community residents as well as focus group discussions with special groups comprising the poor and/or vulnerable members in the community, who very often tended to be excluded from actively participating in health.

Other **participatory research appraisal (PRA) tools** were also developed and used with community residents in areas served by sampled HCCs and their health centres. These tools were also administered to groups of community representatives in health to help them identify issues relating to services provided, distribution of benefits from services provided, priority health problems in the community and which social groups are most affected by these problems. The PRA tools and the key informant interview guide were administered to purposely-selected stakeholders, based on their social status or the specific roles they played in their communities. The respondents in this category were drawn from the HCCs and the Neighbourhood Health Committees (NHCs), health personnel, as well as community and traditional leaders. The tools and approaches were pre-tested before use in the field. The PRA tools comprised drawing maps, diagrams and models by selected participants and social mapping exercises. Through these exercises, participants identified and ranked health problems and actions implemented in their areas.

In addition, an adaptation of the **outcome mapping approach** was used to come up with behaviour change related outcomes from community participation from the point of view of health workers and HCC representatives; with the HCC as the boundary partner assessed for outcomes in this regard. This outcome mapping approach was also used to identify what the stakeholders considered as key attributes for effective community participation in health.

Checklists: A health facility checklist was also administered to the health centre in charge to obtain available data on relevant records and activities at the health centre.

Informal Interviews: These were undertaken as and when opportunities arose with a view to validate and/or follow up on issues coming through from the study. The issues raised in this way were captured in the fieldwork diaries of assistants (being captured in writing well after the interviewee had left). These interviews were conducted with respondents drawn from such groups as health administrators, health workers, traditional leaders, local non-governmental organisations (NGOs) and other social groups.

A **review of existing literature** was also undertaken in order to identify other issues already covered in other studies. Some of these have been referenced at the end of this report.

3.2 Sampling/sample sizes

The sampling procedures used were a combination of purposive and random sampling approaches. **The study sites** were purposively selected from available data on HCCs that had performed well in terms of financial management of locally generated funds or where the HCCs had enhanced equity of access to health care services by minimising or

overcoming the barrier created by mechanisms of cash payment at presentation. This approach guided the selection of health facilities to sample. HCCs around four of these facilities were thus purposively sampled. The corresponding control sites were taken from the four equity gauge districts in which the Zambian equity gauge is currently undertaking project works. District health managers were asked to list the better and poorer performing HCCs in their districts. By random sampling, one of the poor performing HCCs was sampled to serve as a control group. Thus four such health facilities were identified. Overall, eight HCCs around the eight health centres were purposively selected.

Sampling units: Around each health centre, two communities were sampled, one near (within 5km distance) and one far (over 5km distance from the health centre). Community respondents in the near and far communities were randomly selected. Key informant interviewees were identified from community leaders, HCC members, NHC members, local business leaders, community health workers (CHWs) and traditional leaders. At health centres, the health centre in-charges were purposively selected as well as one or two other health workers, depending on staffing levels and availability at the time of the visit. At the district level, the district director of health and/or the manager – planning and development were purposively targeted to be interviewed. In default, a senior member of the DHMT was to be interviewed.

Sampling: The research team had identified four HCCs that had been cited as relatively successful in the implementation of some key aspects of Zambia's health reforms programme, based on two previous research works [2,6,8]. The successes were judged by how they contributed to generation and accounting of resources for health (Chivuna and Kanyanga RHCs) and also on how they tacked the barriers brought about by user fees as a way to enhance equity of access to health and health care (Sinjembela and Mulanga RHCs).

The other four RHC committees (HCCs) were selected from the four equity gauge districts by random sampling from a list provided to the research team by the district health management. The research team specifically requested from management a list of top performing, middle performing and low performing HCCs in their districts. From the list given, the research team randomly sampled one of the low performing HCCs as observed by district officials. The choice of the four equity gauge districts was done because the research team intends to undertake governance work programmes in these districts with a view to enhancing community participation and governance in health. Hence the selection of these HCCs served two purposes. In the first place they served as control in terms of assessing HCC performance in a comparative way, in order to help determine whether or not the said contributing factors had really been responsible for the documented successes at the said successful HCCs[2]. Secondly, they served to provide the research team with baseline data before intervening with capacity-building activities in these equity gauge districts.

[2] The four successful HCCs were Mulanga zonal RHC in Chinsali District (Northern Province), Chivuna RHC in Mazabuka District (Southern Province), Kanyanga zonal RHC in Lundazi District (Eastern province) and the Sinjembela RHC in Shang'ombo District of Western Province.

3.3 Data entry and analysis

Data from all the tools applied was entered into an SPSS statistical computer software programme for both storage and analysis. The data was cleaned and checked for logical correlations after completing the data capture. Competent and experienced data entry clerks were used to enter the data, following a double blind approach. Thereafter the data was analysed through cross-tabulation of various variables and also all variables were assessed for frequency tabulation.

3.4 Quality control

Quality control was ongoing throughout the project period. Before commencing work, the three teams communicated and met to harmonise their objectives and research approaches to ensure that similar and comparable information was collected to certain variables. This was done to allow for cross-country comparisons. Before commencing fieldwork, a pre-fieldwork workshop was undertaken to orient the researchers and research assistants to the tools and techniques they would be using in the field. This pre-fieldwork training also ensured that the fieldworkers had a similar level of understanding of the various research tools and techniques to enable them collect same information to questions asked. Fieldwork supervisors were assigned to each team of 2–3 assistants to ensure smooth administration of questionnaires as well as to check for completeness and logical correlations to linked questionnaires.

In addition, the research was implemented in a phased manner to allow the three groups to meet and share notes on progress, problems, data interpretation and identification of core issues to focus on in the next phase. Following the meeting of the research teams, the start of the next phase commenced with a stakeholder data interpretation workshop, in order to ensure greater understanding of issues as well as confirming the key issues that affect the implementation of governance activities in health and how these impact on hequity concerns. The stakeholder workshops also served as ‘consensus’ workshops.

3.5 Biases and limitations

There were some biases and limitations associated with this research. The criteria used to select the control ‘poor performing’ districts were not as objective as one would have liked. The selection was based more on perceptions by district health managers, rather than on objective criteria. This limitation manifested itself during the stakeholder workshop when the so-called poor performing HCCs appeared to have made better progress than some of the ‘well performing’ HCCs when assessed using the outcome mapping approach.

4.0 Findings

Six of the eight districts and nine HCCs were studied in this phase one part of our project work. The nine HCCs comprised four high performing HCCs and five low performing

HCCs (Table 10). In all, a total of 574 respondents were interviewed in this part of the study, Table 1.

4a Socio-demographic characteristics

The following results were obtained in the study, starting with socio-demographic profiles on health worker respondents and the health systems.

Table 1 Districts sampled and sample size of key informant respondents

Name of RHC	District where located	Frequency	Percent
Chawama	Lusaka	3	6.4
Chivuna	Mazabuka	6	12.8
Kanyanga	Lundazi	5	10.6
Kanyelele	Chama	6	12.8
Kaunda square	Lusaka	4	8.5
Mbabala	Choma	6	12.8
Muchinshi	Chingola	5	10.6
Mulanga mission	Chinsali	6	12.8
Sinjembela	Shangombo	6	12.8
Total (no.)		**47**	**100.0**

4a.1 Socio-economic characteristics of the areas studied and respondents

4a.1.1 Community

These research findings, at this stage of the report, are derived from the eight targeted districts (Table 1a). A total of 574 community respondents were interviewed on a range of issues concerning the health system and community participation in governance and equity in health. In addition a total of 14 PRA discussion sessions and 47 key informant interviews were undertaken. Between five and seven key informants were interviewed in each of the eight districts sampled and included up to this phase of the study (Table 1a). The majority of the key informants interviewed came from the HCCs or NHCs, with some belonging to both (Table 1b). In terms of ranks or titles of these key informant respondents, most occupied key positions in the HCCs, being chairperson or vice, secretary or vice and in some cases, treasurer (Table 1b). Health workers, who were the in-charges and by default were secretaries to the HCCs, were also interviewed as key informants (Table 1b).

4a.1.2 The age and gender distribution and distances to health facilities of respondents

The majority of respondents were aged between 21 years and 45 years (67.80%), with nearly 8% aged 15 to 20 years and nearly 23% were over 45 years old (Table 2a).

A large proportion of respondents (42.0%) lived far from their nearest health facilities and had to cover a distance of between 10 and 16km to reach their health facility when

sick. Another 36.6% of respondents lived within 5 to 8km of their nearest health facility. No more than 18% of sampled respondents lived with 5km distance of their nearest health facility (Table 2b).

In terms of gender, more females (53.9%) were interviewed than males (45.3%) in this study up to this point (Table 3). The majority of respondents interviewed (74.6%) were within the age range 21-45 years irrespective of the socio-economic category of the respondent (Table 4). Fewer teenage adults and younger people were interviewed, while three times as many people aged over 45 years were interviewed compared to the younger ones (Table 4).

Table 1a Districts sampled and sample size of community respondents and key informants

Name of district	Community		Key informants	
	Sample sizes (no.)	Proportion of respondents (%)	Frequency	Percent
Chama	75	13.1	6	12.8
Chingola	71	12.4	5	10.6
Chinsali	70	12.2	6	12.8
Shangombo	71	12.4	6	12.8
Choma	69	12.0	6	12.8
Lundazi	74	12.9	5	10.6
Lusaka	71	12.4	7	14.9
Mazabuka	73	12.7	6	12.8
Total	**574**	**100.0**	**47**	**100.0**

Table 1b Type of respondent and type of institution represented by HCC members

Title of key informant respondent	Type of institution representing (HCC or NHC)			Sub-total (%)	
	HCC	NHC	HCC & NHC		
Chairperson	4	5	3	12	34.3%
Committee member	2	2	1	5	14.3%
Health centre in-charge	5	0	0	5	14.3%
Secretary-NHC	0	1	2	3	8.6%
Committee member-EHT	2	0	0	2	5.7%
NHC secretary & HCC member	0	0	2	2	5.7%
Secretary	0	2	0	2	5.7%
Treasurer	0	1	0	1	2.9%
Treasurer-NHC	0	0	1	1	2.9%
Vice Chairperson	0	0	1	1	2.9%
Vice Secretary	0	1	0	1	2.9%
Total	13	12	10	35	
	37.1%	34.3%	28.6%	100%	

Table 2 Age range (A) of interviewees and distances to nearest health facility (B)

(A) [Age of respondents]		
Age Range	**(no.)**	**(%)**
Below 20	50	8.7
21–45	389	67.8
46 and above	132	23.0
Blank	3	0.5
Total	**574**	**100.0**

(B) Distance from health facility		
Range	**(no.)**	**(%)**
Within 5km	101	17.6
5–8km	211	36.6
Over 8km	241	42.0
Blank	21	3.8
Total	**574**	**100.0**

Table 3 Gender distribution of respondents in the study

Sex of respondent	No.	Percent (%)
Male	260	45.3
Female	309	53.9
Blank	5	0.8
Total	**574**	**100.0**

Table 4 Age range of respondents grouped by socio-economic quintiles

Age of respondents	Quintile classification by pooled district samples					Row totals (no.)
	Poorest	Second	Middle	Fourth	Least poor	
Below 20	12.2%	7.8%	10.4%	7.8%	5.3%	50
21–45	65.2%	65.2%	73.0%	60.9%	74.6%	389
46 and above	22.6%	27.0%	15.6%	30.4%	19.3%	132
Blank	0.0%	0.0%	1.0%	1.0%	0.9%	3
Totals	**115 (100%)**	**115 (100%)**	**115 (100%)**	**115 (100%)**	**114 (100%)**	**574**

4a.1.3 Educational status of respondents

Almost two-thirds of respondents had an educational attainment of Grade 7 or below. Some 16% had not gone beyond Grade 1, while 52.8% had not completed Grade 7 (Table 5).

Table 5: Educational levels of respondents

Highest education completed	Performance rating of HCC		Sample size (no.)	Percent (%)
	High	Low		
Not completed grade 1	23%	10%	95	16.6
Grade 17	51%	55%	303	52.8
Grade 8-12	25%	31%	160	27.9
Certificate/diploma	0.4%	2.8%	9	1.6
Graduate/post graduate	0.4%	0.7%	3	0.5
Blank	1%	0.3%	4	0.7
Total	**288**	**286**	**574**	**100**

Up to 28% of respondents had a secondary school level of education (Grades 8–12), while 1.6% were of diploma or certificate level and less than 1% had a university level of education (Table 5).

4a.1.4 Socio-economic status ranking of respondents

The majority of sampled households (and respondents) were of low socio-economic standing. Generally, the lower the educational attainment of the respondent, the lower was the socio-economic standing in society (Table 6). The majority of respondents (59.1–62.6%) in the poorest four quintiles went no further than Grade 7 in school. Among the least poor, many (48.2%) attained an educational level of between Grade 8 and Grade 12 (Table 6).

Table 6 Correlation between educational attainment and socio-economic status of respondents

Highest education completed	Socio-economic status by sample quintiles					Total
	Poorest	Second	Middle	Fourth	Least poor	
Not completed grade 1	15.6%	14.8%	18.3%	22.6%	11.4%	**95**
Grade 1–7	62.6%	59.1%	59.1%	47.8%	35.1%	**303**
Grade 8–12	20.0%	26.1%	22.6%	22.6%	48.2%	**160**
Certificate/diploma	0.0%	0.0%	0.0%	5.2%	2.6%	**9**
Graduate/postgraduate	0.9%	0.0%	0.0%	0.0%	1.7%	**3**
Blank	0.9%	0.0%	0.0%	1.7%	0.9%	**4**
Total	**115**	**115**	**115**	**115**	**114**	**574**

When the respondents were assessed for their wealth using asset scores based on nationally determined cut-off points into quintiles, a wealth classification of districts was obtained, representing wealth distribution within these six districts. The proportions mirror a normal distribution curve, with fewer households at either extreme (*Figure 2*).

The study included fewer people from the most vulnerable groups (the poorest of the poor), with most respondents being derived from the second poorest and middle-income group households. When analysed by districts, using the nationally derived cut-off points, the data give us a picture of the wealth ranking of districts. This mirrors wealth distribution and resource allocation patterns between the six districts.

Most of the non-poor (and the more advantaged) household respondents were from Lusaka district, followed by Chinsali, Shangombo, Mazabuka, Chingola, Lundazi, Choma and Chama districts (Table 7).

This finding further reaffirms that wealth distribution in Zambia still closely mirrors the rural-urban divide, despite all past efforts to diversify the economy and favour wealth distribution to rural areas. There is still inequity in terms of wealth distribution along this criterion. Lusaka is still the most advantaged district, even though the sample of respondents used in the study was derived from among the poor of Lusaka who lived in

the peri-urban settlements[3]. Over 75% of respondents emanated from among the poorest up to those of the middle socio-economic groups of the sample, with the majority coming from the second and middle-income groups.

4a.1.5 Social groups in the community

Apart from Lusaka and one health centre in Chingola, all the community respondents were from rural settings away from the district townships. The communities sampled in Lusaka were all urban residents, while for Chingola and the rest of the other districts studied the respondents were all rural residents. The profiles of socio-economic status need to take this factor into account when considering some of the finds and how they may relate to or contrast with other sources of data and information.

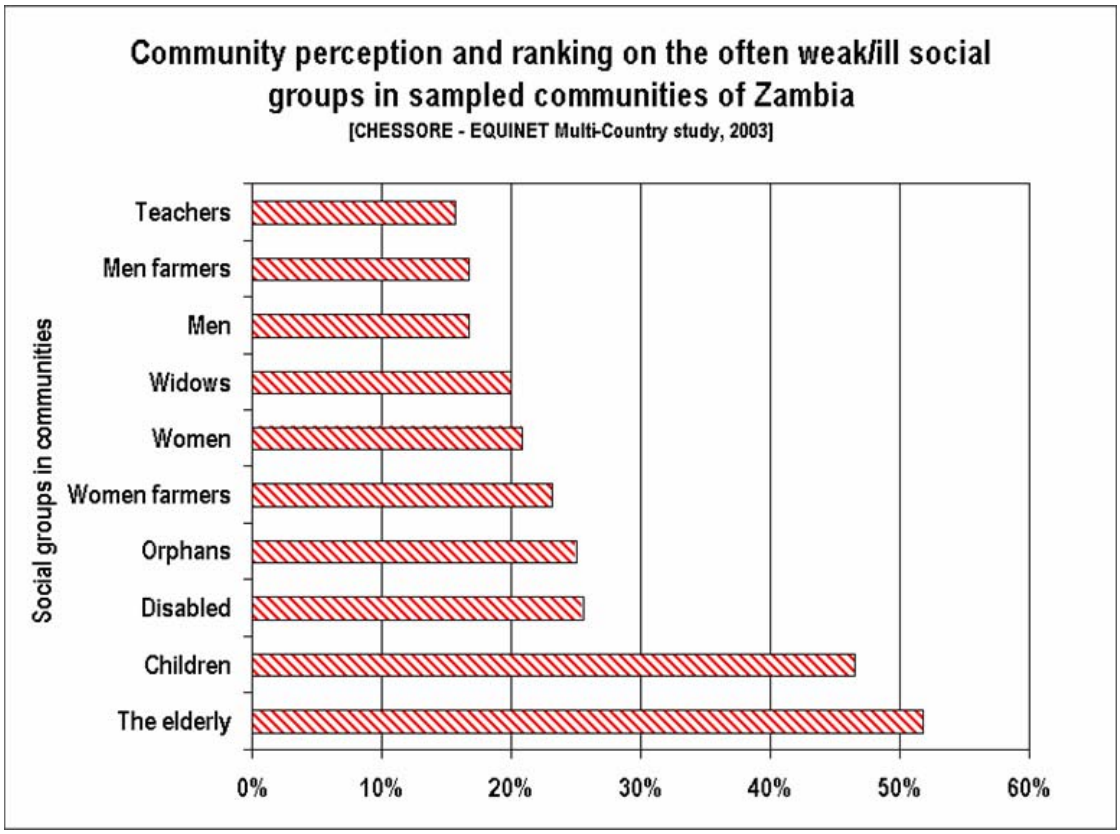
Social groups and social status in the community: At community level, a total of 10 social groups were recognised and different attributes attached to each (*Figure 2*). The communities recognise social groups such as: elderly people (the aged); children; orphans; widows; men; women; farmers (men and women categories); teachers (professional civil servants); and disabled people. Patterns in terms of health status, access to public services, social status and influence in the community are broadly viewed and explained along these categorisations.

Community perceptions of influence and use of public services indicated that it follows one's social status. The elderly, the disabled, children, orphans, women and widows were cited as being often weak or ill in the community (*Figure 2*). These were also the same social groups that were considered less powerful and not that respected in society (*Figure -5*).

Socio-economic standing of districts: In terms of national wealth profiles, the sampled population used represents a normally distributed population (*Figure 4*). By adding the proportions of individuals in quintiles 3 to 5, a fair assessment of socio-economic ranking of districts was gained. The wealth rankings derived according to this technique shows Lusaka as 1st, followed by Mazabuka (2nd), Shangombo (3rd), Choma (4th), Chinsali (5th), Lundazi (6th), Chama (7th) and Chingola (8th). This ranking was not correlated with the burden of disease (morbidity patterns) as presented in *Figure 3*.

[3] Both the Chawama and Kaunda square townships [compounds] were started off as informal peri-urban settlements, which were later upgraded by the Lusaka City Council.

Figure 2: *Community identification of social groups and perception on the health status ranking of the groups.*



National socio-economic rankings of respondents: The asset ranking scores accumulated for each household sampled were fitted into the national quintile cut-off points for Zambia[4], (*Figure 4*). When disaggregated by the eight districts studied, the wealth ranking puts Lusaka as first, followed by Chinsali (2nd), Shangombo (3rd), Mazabuka (4th), Choma (5th), Lundazi (6th), Chingola (7th) and Chama (8th)[5] (Table 9).

4a.2 Health, health-seeking behaviour and health status in the study areas

Ill health was a predominant feature among respondents in this study, with up to 23.2% not falling sick over a six-month period prior to the day of the study. The frequency of ill health was highest in Choma, Chama, Mazabuka and Lundazi districts, respectively and in that of decreasing morbidity (*Figure 3*). Lusaka, Shangombo, Chingola and Chinsali were the districts with lower morbidity rates, in that increasing order, respectively.

[4] Socioeconomic Differences in Health, Nutrition, and Population in Zambia; By David R. Gwatkin, Shea Rutstein, Kiersten Johnson, Rohini P. Pande and Adam Wagstaff. Health, Nutrition and Population (HNP) Programme. The World Bank (May 2000).

[5] This ranking order was derived by step-wise comparison of the proportion of respondent socio-economic categories using national quintile cut-off points. First the proportions of respondents in the 5th quintile were used to rank districts; thereafter quintiles 3 to 5 (and later quintiles 1 and 2) were summed up to derive district rankings for 3rd to 8th positions.

Even with this **burden of disease**, an average of 35.4% of respondents reported that they felt better at the time of the visit than over the past 12-month period. This outcome did not relate to the performance rating of HCCs: in that 38.1% of respondents from the low performing HCCs reported better health status outcomes compared with 32.6% of respondents from the high performing HCCs. Similarly, 28.7% of respondents from low performing HCCs reported experiencing worse health outcomes compared with 38.5% of respondents from the high performing HCCs. Overall, 33.6% of respondents reported experiencing worse health outcomes over the one-year period before the study.

Health seeking behaviour: On average, 18.5% of respondents that were sick did not seek health care for their illness. A further 35.1% attended health care for some of the sickness episodes they experienced over a six-month period. No more than 22% of respondents were able to attend health care whenever they fell sick. This situation does not show a clear relation to the distance of respondents from health facilities (Table 7).

Top health problems in the community: At the PRA sessions held, participants were asked to list the top health problems in their communities and identify which social groups were most affected by the identified problem. Malaria came out as the top health problem in the community, affecting all age groups and all social categories. There was a near unanimous consensus among all the different groups on this (Table 8). Diarrhoea, HIV/AIDS, eye infection, coughing (chest problems), malnutrition, TB, anaemia, measles and pneumonia followed in 2nd to 10th positions respectively.

4b Structure and position of HCCs for good governance in health

The term governance as used in this report denotes “a process whereby an organisation or society steers itself”; It comprises the systems of rules, norms, processes and institutions through which power and decision-making are exercised [11–13]. The associated term of good governance will be used to denote the assessment of the performance of governance structures (the HCCs) in terms of (1) representative legitimacy; (2) accountability; (3) competency and appropriateness; and (4) respect for due process [11]. Thus the HCCs in the Zambian health services have been assessed along these criteria with a view to examining and understanding their performance impact on equity in the Zambian health services. This assessment is presented below in the same order as listed above from responses given during questionnaires, key informant interviews, stakeholder consultation, PRA sessions held, and other available sources of information as cited.

Table 7: Health status and health-seeking behaviour among community respondents

Performance ranking of the HCCs	Frequency of access to health care when sick		Health facility distance (categories)			Total
			Very near [0–5km]	Medium [6–10km]	Far/very far [Over 10km]	
High	Did not attend health care		25.0%	26.9%	48.1%	18.1%
	Attended some episodes		30.0%	30.0%	40.0%	34.7%
	Attended each episode		19.0%	39.7%	41.3%	21.9%
	Was not sick		14.7%	33.8%	51.5%	23.6%
	Blank		20.0%	60.0%	20.0%	1.7%
	Sub-sample average	Sampled (no.)	66	95	127	288
		%	22.9%	33.0%	44.1%	
Low	Did not attend health care		24.1%	53.7%	22.2%	18.9%
	Attended some episodes		35.0%	36.9%	28.2%	36.0%
	Attended each episode		42.6%	39.3%	18.0%	21.3%
	Was not sick		46.9%	37.5%	15.7%	22.4%
	Blank		25.0%	25.0%	50.0%	1.4%
	Sub-sample average	Sampled (no.)	106	116	64	286
		%	37.1%	40.6%	21.7%	

Table 8: Top health conditions as discussed and identified at PRA sessions held

Health problem in community	Groups that mentioned problem as first on list	Total group sessions that identified this as problem	Rank order scored
Malaria	11	14	1st
Diarrhoea	2	13	2nd
HIV & AIDS	1	11	3rd
Eye infection	0	11	4th
Coughing	0	9	5th
Malnutrition	0	8	6th
TB	0	5	7th
Anaemia	0	5	8th
Measles	0	4	9th
Pneumonia	0	4	10th
Total (no.) group sessions	**14**		

Figure 3: *The burden of illness in the sampled districts – frequency of illness over a six-month period among respondents.*

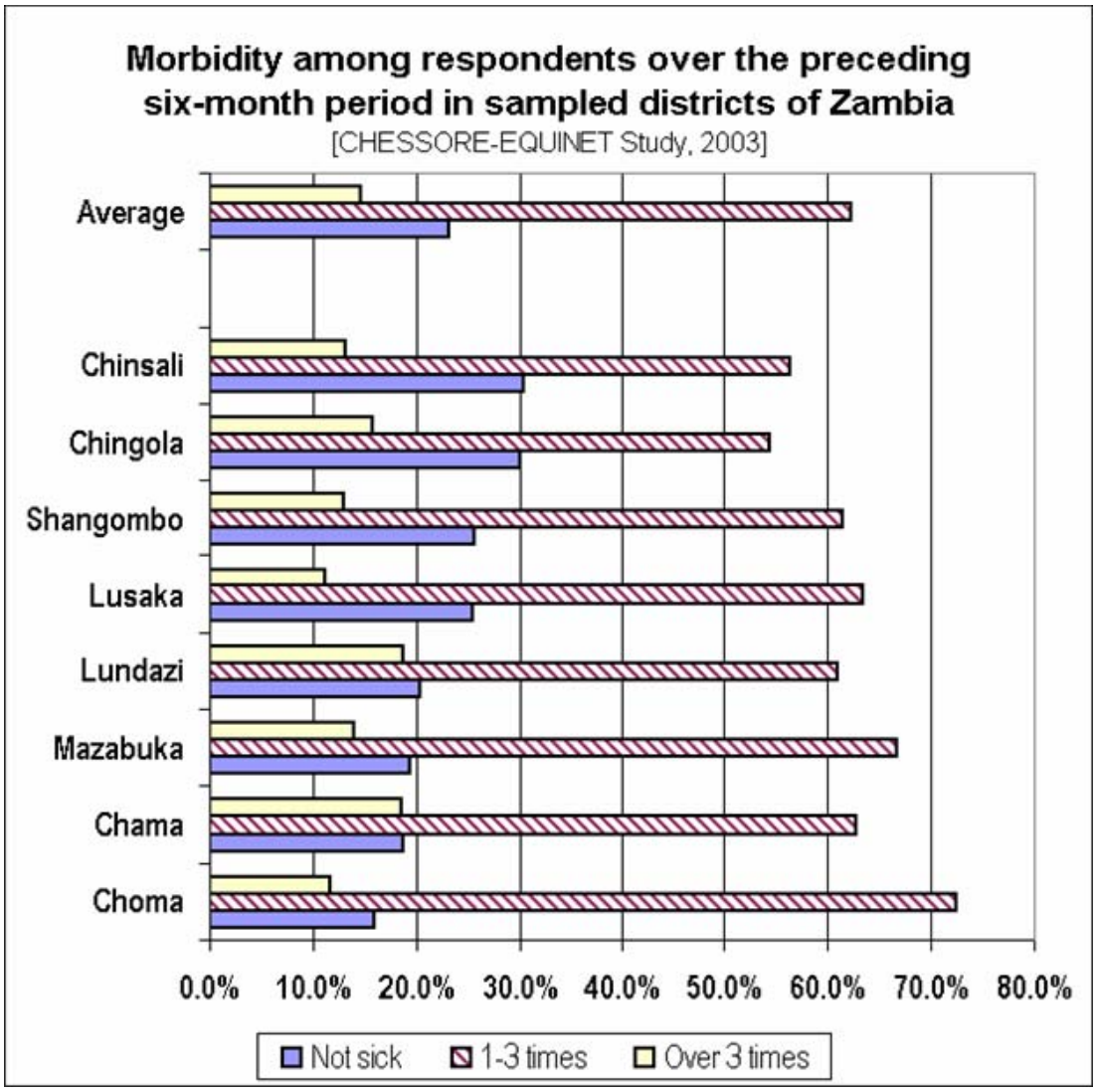
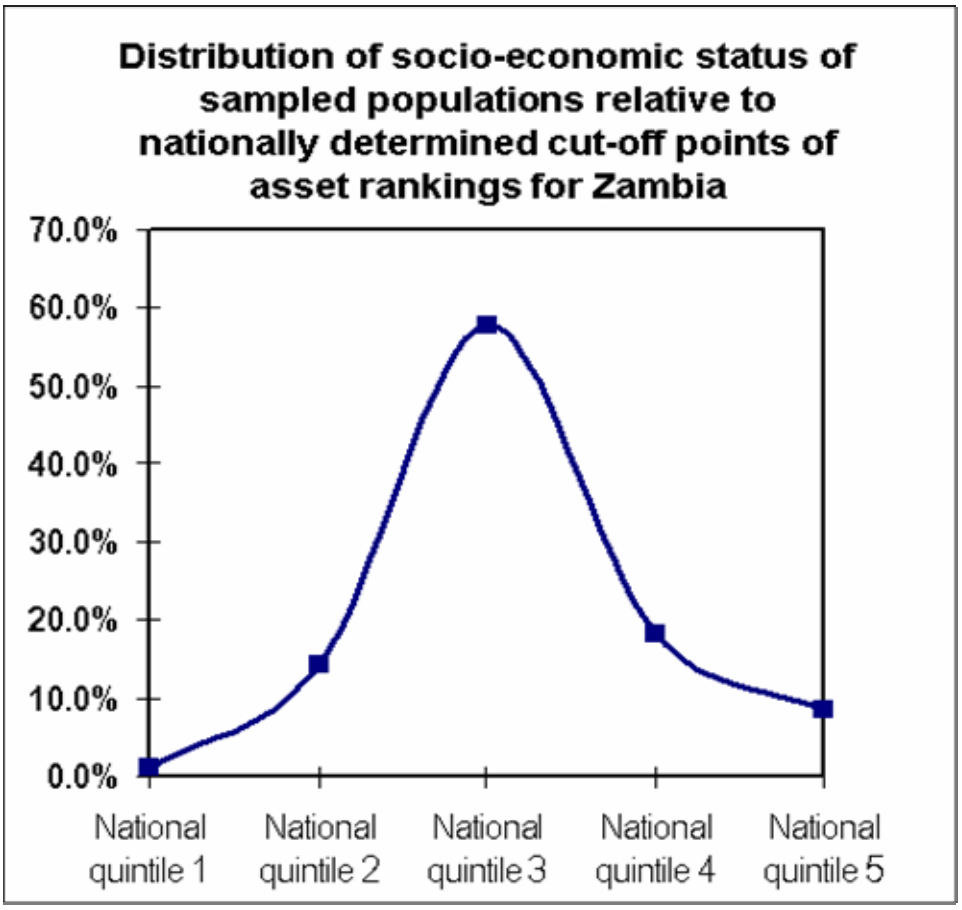


Figure 4: *The proportions (%) and socio-economic status of sampled households in relation to nationally determined wealth ranking cut-off points.*



Source: CHESSORE-EQUINET Study 2003, Zambia

Table 9 Socio-economic standing of respondents in the districts using nationally determined asset ranking cut-off points

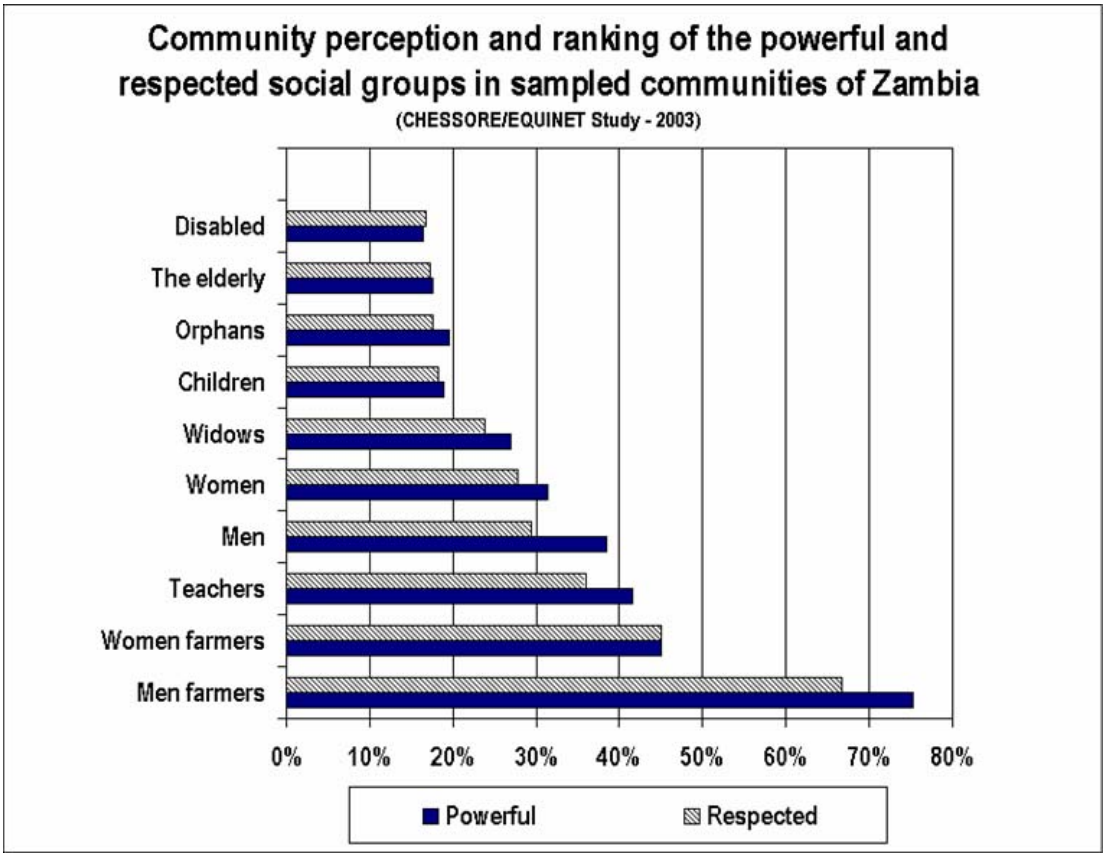
Name of district	Use of national quintile cut-off points for socio-economic classification of respondents in the eight studied districts					Total
	Poorest quintile 1	Very poor quintile 2	Poor quintile 3	Less poor quintile 4	Least poor quintile 5	
Chama	2.7%	24.0%	73.3%	0.0%	0.0%	**75 (100%)**
Chinsali	0.0%	15.7%	41.4%	31.4%	11.4%	**70 (100%)**
Shangombo	0.0%	8.5%	67.6%	23.9%	0.0%	**71 (100%)**
Lundazi	1.4%	18.9%	70.3%	9.5%	0.0%	**74 (100%)**
Mazabuka	1.4%	5.5%	74.0%	19.2%	0.0%	**73 (100%)**
Choma	0.0%	11.6%	79.7%	8.7%	0.0%	**69 (100%)**
Chingola	2.8%	29.6%	52.1%	15.5%	0.0%	**71 (100%)**
Lusaka	0.0%	0.0%	2.8%	39.4%	57.7%	**71 (100%)**
Totals	**6**	**82**	**332**	**105**	**49**	**574**

Table 10: The names and performance classification of HCCs studied

District	Name and type of facility	Sample (no.)	(%)	HCC rating
Lusaka	Chawama UHC	35	6.1	Low
	KAUNDA Square UHC	36	6.3	
Mazabuka	**Chivuna RHC**	**73**	**12.7**	**High**
Lundazi	**Kanyanga zonal RHC**	**74**	**12.9**	**High**
Shangombo	**Sinjembela RHC**	**71**	**12.4**	**High**
Chinsali	**Mulanga zonal RHC**	**70**	**12.2**	**High**
Chama	Kanyelele RHC	75	13.1	Low
Choma	Mbabala RHC	69	12.0	Low
Chingola	Muchinshi RHC	71	12.4	Low
Total		**574**	**100.0**	

Note: Zonal health centres have an inpatient facility and laboratory services.
Kanyanga and Mulanga RHCs are owned and managed by faith-based organisations.

Figure 5: *Social groups, social status, power and influence in a Zambian community.*



4b.1 Representative legitimacy of the HCCs

The HCCs in Zambia were created from a government policy directive as part of the health reform process. Their legitimacy is rooted in an Act of Parliament, and their roles and responsibilities were later outlined in the policy instruments issued by the minister of health. The findings in this and other research done [5,6,8,9] shows that HCC formation was largely through a popular mandate at the grassroots level. Health workers supervised the process. The catchment area of a health centre was demarcated into 8 to 12 zones, and representatives elected for each zone comprised the NHC. Office bearers were elected from among the group, and the chairperson from each NHC automatically represented the zone on the HCC. The chairpersons from each zone and the health centre in-charge made up an HCC of the particular health centre. This sort of arrangement looks ideal for equitable representation in decision-making at the health centre. In practice, this was not so, and various scenarios were given.

4b. The performance of the HCCs as governance structures in the Zambian health services since their inception

This will be assessed by comparing the views expressed by the different stakeholders interviewed along the four attributes of good governance of:

- representative legitimacy;
- accountability;
- competence and appropriateness; and
- respect for due process.

The findings have been grouped in this way in order to reflect on the current attributes that HCCs have for performing their prescribed roles in the governance of the health system in Zambia.

Representative legitimacy: In this section the representative nature of HCCs was assessed (Table 11). There is widespread feeling that representation on the HCC largely favoured certain social groups in the community. This perception was especially strong from PRA sessions held in the catchment areas of the high performing HCCs. A total of 10 social groups were identified in the communities surveyed. As to which of the identified social groups were involved on the HCCs, the responses revealed that 3 of 10 (30%) social groups were included in both the low and high performing HCC catchment areas (Table 11). Respondents from the high performing HCC areas included some HCC representatives from the poor and vulnerable groups. More women participated on the HCCs from the high performing areas of health centres examined.

Table 11 The representative nature of HCCs for legitimating their roles on governance in the Zambian health services

Attribute of governance	Attribute/factor of governance assessed	Response/ perception	
		High HCCs	**Low HCCs**
Representative legitimacy	◆ Representation mentioned to be from selected sections of community [PRA sessions].	87.5%	33.3%
	◆ Proportion of identified social groups involved in HCCs.	30%	30%
	◆ Representation includes those from the poor and vulnerable groups in the community [PRA sessions].	12.5%	0%
	◆ Women participate as HCC members [key informants].	87.0%	73.9%
	Is the independence of the representative group compromised in any way by some partner(s)? [KIs]	Yes	Yes
	Do representative groups have circumscribed powers and limited choice? [KI interviews]	**Yes**	**Yes**
	◆ HCCs decide which projects to embark on.	43.5%	17.4%
	◆ HCCs decide budget from own funds.	17.4%	4.3%
	◆ HCCs decide problems to prioritise.	0%	8.7%
	◆ HCCs do not have any authority.	13.0%	21.7%
	◆ HCCs can change user fees.	4.3%	4.3%
	◆ HCCs hire & fire casual workers.	4.3%	4.3%
	What is the extent to which agenda setting and policy formulation is controlled by the dominant partner(s)?	39.1%	43.5%
	• HCC members cannot influence health workers [KI].	4.3%	8.7%
	• Health workers make all decisions + have final say [KI].	36%	19%
	• HCCs have capacity to control staff [community].	28%	19%
	• HCCs were capable of disciplining staff [community].		

Although the HCCs are reputed to be autonomous bodies, in reality the autonomy is compromised by competing interests in the partnership. The result is a perception that HCCs merely had circumscribed powers with limited choices. They have some powers to decide on which (community) projects to embark on, especially in the high performing HCCs (43.5%). The HCCs from high performing areas have the capacity to generate their own funds and therefore are able to decide on how and where to spend these funds. Otherwise there was a perception among key informants interviewed that HCCs did not have any authority in the partnership (13% in high performing areas and 21.7% in low

performing areas). HCCs had limited influence on user fees, with some powers (8.7%) to decide on and prioritise health problems in their areas and limited powers to hire and fire casual workers employed to undertake work at health facilities.

The result was that agenda setting and policy formulation were heavily controlled by the dominant partners (the health workers) in the partnership at this lower level of interface between the health system and their communities. There were strong feelings among both community respondents and key informants interviewed that HCCs were in no position to exert control and influence on health workers. This made it difficult for them to acquire the necessary legitimacy they needed from the communities they served.

4b.3 Accountability

This aspect of partnership arrangements is broadly concerned with being held responsible for one's actions. In this regard, the HCCs will be assessed by examining how well they have incorporated the need to have well-established mechanisms of accountability, (reporting to shareholders – community, district health boards and health personnel), and (in the public sector) for these administrative structures to earn their mandate to represent their people through the contestability of those social responsibilities.

To start with, HCCs were known by 20% of respondents interviewed. This in itself is not healthy for democratic accountability. From this proportion of respondents, nearly half of them were not convinced that their HCCs had the necessary capacity to perform assigned roles and responsibilities (Table 12). The tenure of office bearers in the HCCs was known to between 5% and 7% of these respondents, whether in high performing or low performing HCCs. Between 6% and 8% of respondents replied to say that they knew of procedures to remove HCC members from office. These community representatives did not know the specific roles and responsibilities of the HCCs were. The one thing most of them knew was that they were appointed to work very closely with the health centre in-charges and thereby served as a bridge between the health workers and the community.

Ideally, the role of link between communities and their health centres would have meant bringing together the interests of both parties for joint and/or mutually desired action during planning and budgeting at the health centres. However, over 80% of respondents were not aware of channels to link them up with their HCCs when need arose. Although over 50% of community respondents credited HCCs with the capacity to solve problems at health centres following people's complaints, and a similar proportion were satisfied with the work of HCCs, the majority of respondents were not able to mention specific benefits from the work of their HCCs (Table 12). In terms of other aspects of work that communities could expect from the HCC, a view from key informants interviewed was that they did know that they had powers to monitor the performance of their health centres. Others stated that the HCC did not consult with their residents on issues of budgets and planning. Thus, even when things went wrong, the overwhelming view from the community was that the HCC had no powers to discipline staff on mistakes they had made in the course of their work. In this regard, the notion of accountability that talks of the development and deployment of systems of sanctions that should apply to negligent

partners was essentially non-existent. Between 3% and 8% of community respondents replied that HCCs had powers to discipline staff that made mistakes in the course of their work (Table 12).

Table 12 The capacity of HCCs for accountability through governance functions in the Zambian health system

Attribute of governance	Factor of governance to assess	Response/ perception	
		High HCCs	Low HCCs
Accountability	[Being responsible for one's actions]		
	◆ HCC capacity to perform assigned roles/ functions.	56.5%	52.2%
	◆ HCC tenure of office (was reported) known.	5.7%	7.1%
	◆ Community procedures to remove HCC members exist.	8.7%	6.3%
	[Distance between partners and beneficiaries]		
	◆ HCCs known by communities served [community].	23.3%	17.0%
	◆ Channels for linking with HCCs not available [community].	83.6%	90.6%
	[Duration for benefits to accrue]		
	◆ HCCs solve problems identified in the community.	70.0%	52.0%
	◆ Community respondents satisfied with HCC work.	70.0%	48.0%
	◆ HCCs are good at intervening for people on problems complained of at health facilities.	60.0%	40.0%
	◆ Benefits from HCC work not known to community.	80.7%	87.7%
	[On objectives, activities, roles, & responsibilities] [KI views]		
	◆ The HCCs don't know that they have powers to monitor activities.	9.5%	0.0%
	◆ The HCCs do not consult the community on budgets.	21.7%	17.4%
	HCC Partnerships goals and responsibilities [FGDs]	Not clear	Not clear
	[Enforcement & sanctions applied to negligent partner] HCCs had powers to discipline staff on mistakes they had made in the course of their work [comm.]	8.5%	3.5%

4b. Competence and appropriateness

The work performance of the HCCs will be examined for competence and appropriateness in undertaking assigned roles. In this regard, the functional arrangements between members in the HCC partnership will be assessed for the existence of and adherence to established norms and standards that govern partnerships and relations between actors (Table 13).

The process of creating the HCCs through administrative mechanisms has brought a degree of uncertainity in terms of whose interests were more at stake. The HCCs in Zambia were created through an Act of Parliament and the policy instruments resulting from this. In practice this meant that guidelines were developed and handed down to district health managers. They in turn gave directives or went to communities in their own capacity to catalyse the formation of HCCs. Community meetings were held to elect representatives on the NHCs and, from among these, representatives on the HCCs. While people participated in choosing their representatives for many HCCs, this was a one-time event. Thereafter health centre in-charges usurped the responsibility of hiring and firing members of the HCCs. At the time of forming the first NHCs/HCCs, the district health managers emphasised that the key role of these committees was to work with their health centre in-charges in order to solve local problems. The fact that the health centre in-charges were designated to serve as secretaries to the HCCs, was also understood to mean that all communication from the HCCs to the district health office should come via the HCC secretary.

Table 13 Competence and appropriateness in the performance of HCCs to bring about equity in health and health care of the Zambian health system

Attribute of governance	Factor of governance to assess	Response/perception	
		High HCCs	Low HCCs
Competence and appropriateness	Do standards and norms of operation equitably reflect the interests of all partners?	To some extent	No
	• The in-charges decided on expenses, HCCs merely endorsed.	13.0%	21.7%
	• HCCs do not monitor service quality, staff do this.	8.7%	34.7%
	• HCCs never define health services & priorities, health workers do.	4.3%	8.7%
	• Budgets are imposed by health centre staff.	4.3%	17.4%
	HCC mode of operation and bias [for dominant partner]		
	• Are the standard-setting bodies appropriately placed to serve the interests of all in the partnership?	No	No
	• DHMT supervision/involvement in HCCs work [FGDs].	No	No

Respect for due process	Do partnerships resort to short-cuts in order to side-step the interests of the weaker partners; rather than exhaust all channels to suit the due process to enable all to present their interests? [From FGDs and KI interviews]	Yes	Yes

The result from these work arrangements has been that no clear operating guidelines were available. The HCCs have functioned with supervision and involvement of the DHMTs. Any efforts to contact and consult the DHMT without express authorisation by the secretary (the health centre in-charge) were disapproved of by DHMT officials because no channels existed and the right channels were not followed. Key informants interviewed expressed frustration for the lack of arbitration when problems arose in which the in-charge was an interested party. The outcome from this was that the standards and norms of operation did not equitably reflect the interests of all stakeholders in the HCC partnership (Table 13). The practices were such that in-charges made decisions and merely requested HCC officials for endorsements. HCCs did not monitor service quality, as it was thought a preserve of the health workers. When health centre budgets were prepared (usually by health workers) these were merely imposed on the HCC for acceptance ad compliance, rather than for discussions and consensus. The notion of due process in decisionmaking does not appear to have been incorporated in the HCCs' work (Table 13). The notion of due process in good governance incorporates the notion of transparency of decision-making to the public, as well as measures to remove conflicts of interest so that information is not controlled or censored.

4c Performance rating of HCCs in bringing about equity in health

The outcomes from the work of the HCCs in Zambia will be examined by looking at some key expected outcomes in terms of (a) the possible equity gains achieved so far, and (b) the performance levels in terms of effectiveness, acceptability, accessibility and responsiveness rating of the health system to the work activities of the HCC partnership. The views of all stakeholders – community respondents, key informants, health workers and from the PRA group sessions held will be examined and compared wherever possible.

4c.1 Some equity gains from the current performance of governance structures in health

The capacity and potential of the HCCs to attain the desired equity gains for the Zambian health services will be gauged from an assessment of how well the partnership has been able to co-opt the interests of all parties in the partnership (Table 14).

Table 14 The capacity and potential for attaining realistic equity gains through the performance of governance structures in health

Attribute of capacity and potential for attaining equity in the Zambian health system through HCC partnerships	Performance/ response	
	High HCCs	Low HCCs
Are there clearly specified, realistic and shared goals?	No	No
Are there clearly delineated and agreed roles and responsibilities?	No	No
Are there distinct benefits for all parties involved in the partnerships?	No	No
Is there a perception of transparency?	No	No
Are there any measures to ensure the active maintenance of the partnership?	No	No
Is there equality of participation in terms of priority setting for health?	No	No
Does the collaboration succeed in meeting agreed obligations, inter alia?	No	No
Have the values of the HCCs (or other weaker partner) been co-opted by the stronger partner (RHC staff, DHMT staff, etc)?	No	No
Note: There is always a potential clash between partners over principles and values. Partnerships need to overcome and sort out these clashes.		

The poor channels of communication between stakeholders and the reliance on principles of bureaucracy in running the partnership have made the possibility of attaining the desired equity goals remote. The principles described for the bottom-up approaches that should have accompanied the smooth operation of the bottom-up planning and budgeting for primary health care have not been adhered to. The performance rating [11] as outlined in Table 13 points to the fact that action will be required along these lines in order to ensure the attainment of satisfactory equity gains through the work of the current governance framework.

4c.2 Performance rating of HCCs in Zambia

As outlined above, examining the effectiveness, acceptability, accessibility and responsiveness in the HCC partnership so far established will assess this. The findings are presented below in this order.

4c.2.1 Effectiveness (key outcome factors)

The key outcomes expected will be looked at through changes in health status, morbidity and mortality patterns, and governance arrangements with respect to decision-making, information flow and other stakeholder perception. Whenever possible, these variables will compare high performing and low performing HCCs.

Health status outcomes were gauged from self-perception of health by comparing the current perception with perception of health status 12 months ago. Respondents had the option to rate their health status as being worse, the same or better than in the past 12 months. The changes in health status outcomes were later correlated with sickness in a previous six-month period as well as with socio-economic status ranked using the asset index as developed for Zambia by the World Bank. Among those that were never sick in the six-month period prior to the survey, 56.82% reported better health outcomes, 51.5%

from the high performing HCCs and 62.5% from the low performing HCCs. Among those that were sick one or two times, 34.8% reported better outcomes, 31% from high performing HCCs and 38% from low performing HCCs (Table 15). For those respondents that were sick three or more times over this six-month period there was an even lower proportion (18.8%) that reported better outcomes, with 18% in the high performing HCCs and 19% from the low performing HCCs (Table 15). In all these cases, the data consistently show that overall health status outcomes are not influenced by the performance rating of the HCCs. Rather the frequency of illness among respondents negatively affected health outcomes (*Figure 6*). Thus if HCCs are to have an impact on health status outcomes, then they need to do more to promote hygiene and disease prevention efforts at individual, household and community level.

Table 15: Health status outcomes and the performance of HCCs in Zambia

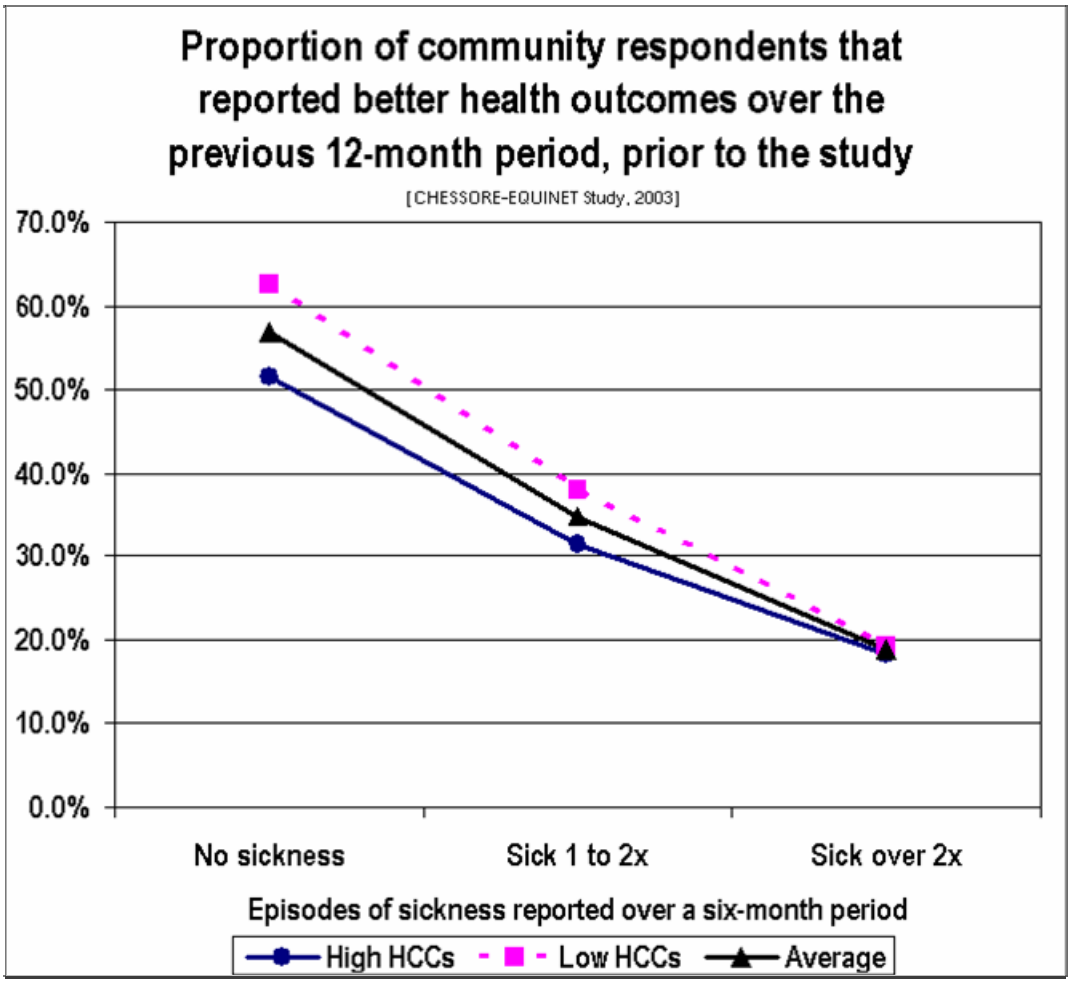
Compared to last year (12 months ago) and today, how would you say your health has changed on the whole?				
Sickness in last six months	**Health status outcome**	**Performance ranking of the HCCs**		**Total**
		High	**Low**	
None	Better	51.47%	62.50%	56.82%
	The same	36.76%	31.25%	34.09%
	Worse (bad)	11.76%	6.25%	9.09%
	Total	**68**	**64**	**132**
1–2 times	Better	31.47%	38.13%	34.75%
	The same	27.27%	31.65%	29.43%
	Worse (bad)	41.26%	30.22%	35.82%
	Total	**143**	**139**	**282**
Over 2 times	Better	18.18%	19.28%	18.75%
	The same	24.68%	37.35%	31.25%
	Worse (bad)	57.14%	43.37%	50%
	Total	**77**	**83**	**160**

There was no clear trend in relationship between health status outcomes and the socio-economic classification of households interviewed (Table 16 and *Figure 7*). Similarly, there was no clear-cut relationship between the performance rating of the HCCs and health status outcomes for the sampled population in the study (Table 16). Even among respondents that were aware of the existence of an HCC at their health centre and reported better outcomes, 11% were in quintile 1 (the poorest), 27% in quintile 2, 18% in quintile 3, 24% in quintile 4 and 20% in quintile 5 (the least poor category). These unclear trends serve to reinforce the impression that the work activities of HCCs have no direct influence on the health status of the communities they serve at this point in time.

On the other hand, key informant interviews and community respondents have stressed the role the HCCs play in health promotion and providing health education to people in their catchment area. If this were so, then the proportion of people getting sick should be coming down. It transpires from an assessment of HCC performance and distance of respondents that high performing HCCs reached more communities including those far

from health centres. Though some people were unable to go for health care at all or for some of the illness episodes, the proportion of respondents that were not sick was highest among respondents that lived far and were served by high performing HCCs. In contrast, the reverse was noted for low performing HCCs. The proportion of people that were either not sick, or that accessed health services each time they fell sick, was highest among those living within 5km distance compared to those that lived far (*Figure 8*). These effects may be attributed more to impact on behaviour change from the health education activities of HCCs rather than from other possible explanations.

Figure 6: *Morbidity rates among respondents in relation to changes in health status.*



Rated performance in governance in health: At the stakeholder feedback consultation, the proportion of groups that reported effective participation of HCCs in decision-making, presence of incentives, information flow and programme implementation, ranged from 27% to 35% of the groups into which stakeholders were divided. Participation in decision-making was the aspect of governance in which HCCs were least involved. The HCCs were most involved in information flow, usually from the health centre to the community; and not vice-versa (*Figure 9*). Similarly, as earlier noted, feedback on issues was rarely given by HCCs

Several studies undertaken previously by different research groups on the performance of HCCs have shown that health workers used information as a tool to control the communities they served [6,8,9,15]. The various aspects relating to information flow between partners were assessed to see where the strengths and weaknesses were (*Figure 10*). Information flow was generally one-way, feedback being rare. This was the case whether concerning clinical care issues, malaria prevention activities, provision of under-five services or other services provided to the community by the health system (*Figure 10*). Channels for flow of information were available to pass information through the HCCs for malaria prevention activities, provision of under-five services and much more so for other forms of services provided to the community by the health system. Nearly all stakeholders consulted reported that there was free flow on malaria prevention activities through the work activities of HCCs and the case was similar for the under-five and other services provided to the community. Free flow of information was weakest on malaria treatment services (*Figure 10*).

Table 16 Relationship between socio-economic classification and health status outcomes

District quintile	Health status outcome	Performance ranking of the HCCs		Total
		High	Low	
Quintile 1 (poorest)	Better	33%	39%	36%
	The same	29%	27%	28%
	Worse (bad)	38%	34%	36%
	Sub-sample (no.)	**58**	**59**	**117**
Quintile 2 (second)	Better	35%	40%	38%
	The same	32%	39%	35%
	Worse (bad)	33%	21%	27%
	Sub-sample (no.)	**60**	**57**	**117**
Quintile 3 (middle)	Better	29%	33%	31%
	The same	29%	39%	34%
	Worse (bad)	41%	28%	35%
	Sub-sample (no.)	**58**	**57**	**115**
Quintile 4 (fourth)	Better	26%	37%	32%
	The same	32%	25%	28%
	Worse (bad)	42%	39%	40%
	Sub-sample (no.)	**57**	**57**	**114**
Quintile 5 (non-poor, rich)	Better	40%	41%	41%
	The same	22%	38%	30%
	Worse (bad)	38%	21%	30%
	Sub-sample (no.)	**55**	**56**	**111**

4c.2.2 Accessibility (structural and functional access)

The performance of the HCCs will now be examined for coverage as well as for impact on access to health and other related services.

Physical access to HCCs: The work activities of HCCs were known to within 15km of health centres surveyed (*Figure 11*). Awareness of HCC activities was highest among those that lived with 5km of a health centre. However, whether living near or far, no more than 22% of residents in each of these areas were aware of the existence of an HCC at their health centres. By inference, this situation means that nearly 80% of residents in each of these areas were not able to access and benefit from the activities of their HCCs.

Physical access to health services was weakened the further away a patient was from the health centre by factors of user fees, transport costs, the cost of feeding and tending to the patient, in addition to the actual lack of transport. Previous studies undertaken in 1997/1998 had shown that some HCCs, notably at the Sinjembela RHC (in Shangombo district) and the Mulanga RHC (in Chinsali district), had devised interventions that somewhat eased the cost of accessing health care even for those that lived far. Payment-in-kind mechanisms or credit facilities or other alternative mechanisms to cash payments at presentation were devised to ease access to health care after consultations with health workers. These efforts had resulted in significantly increased access to health care for nearly all, whether living near or far. This time around, this specific initiative to improve access to health care was reassessed to see whether it was a sustainable one. Payment-in-kind mechanisms were still in use at the Sinjembela RHC, while alternative approaches to payment at presentation with some payment-in-kind approaches were still working at the Mulanga RHC. Till this time around, the close collaboration on this issue between the HCCs and health workers has managed to sustain the initiatives, which still bring about significantly better access to health care for one sick person [Yates Corrected $\chi^2 = 59.6$, p-value 0.0000000] and a corresponding significant difference in access to health care for two or more sick persons seeking care at the same time from the same household [Yates Corrected $\chi^2 = 14.4$, p-value 0.0001488]. The prevalence of hunger in Shangombo district and the generally difficult agricultural marketing arrangements tended to make it difficult for families to part with more food if two or more people were sick at the same time. This resulted in lowering of families (though significant) that were able to pay for more than two patients sick at the same time. Incomes realised from agricultural produce/business was the major source of financing access to care for 85% of individual respondents around the Mulanga RHC and for 37% around the Sinjembela RHC. User fees charges were reported to be affordable for 31% of respondents around the Sinjembela RHC to pay one sick person; with the corresponding figure of 0% among the Mulanga RHC respondents. About 20% of respondents around the Mulanga and Sinjembela RHCs complained of inability to pay from use of agricultural produce when more than one person fell sick because produce available was not enough to meet the cost. For this, some respondents (15% around the Sinjembela RHC) tried to find additional resources from relatives.

Functional access to HCCs: Formed as an interface between the health system and the communities served, it was expected that the performance of the HCCs would have a positive influence on access to health and health care. The most pronounced barrier to accessing the reformed Zambian health services was the introduction of user fees for health care. As such it was expected that the performance of the HCCs would somehow relate to this aspect of access to health care. On average, the user fees charged at the OPD

of health facilities with high performing HCCs were lower than those prevailing at low performing HCCs. Previous work done had also showed this trend (Table 17 and [5,6]).

Figure 7: *The relationship between health status outcomes and socio-economic quintiles.*

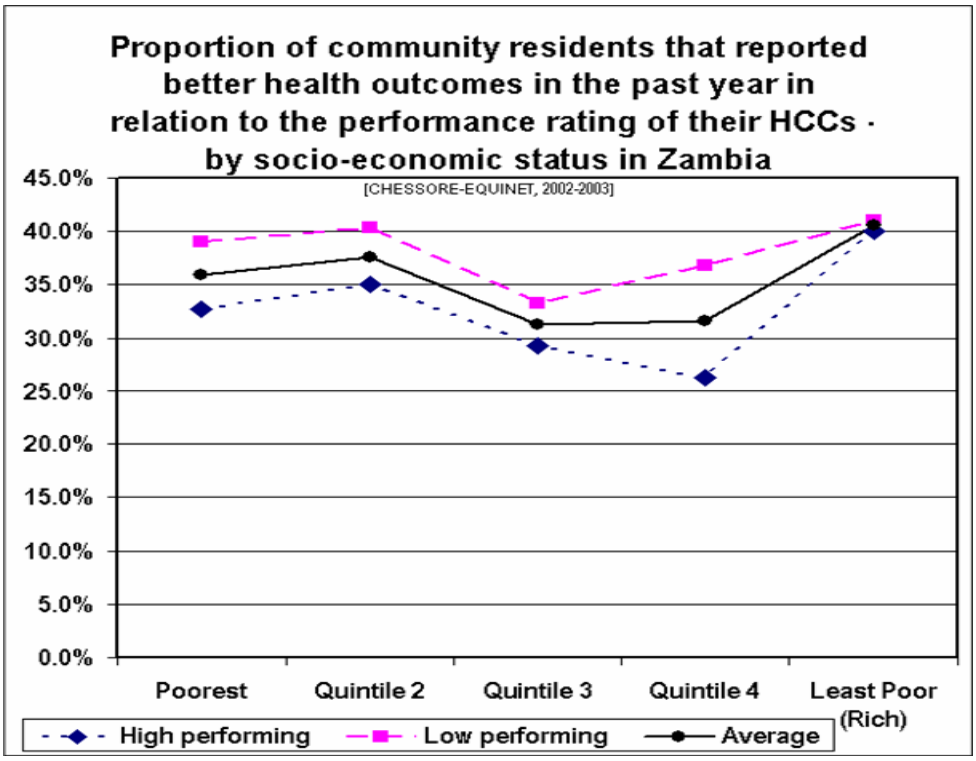


Figure 8: *Morbidity prevalence and access to health in areas served by high and low performing HCCs in Zambia.*

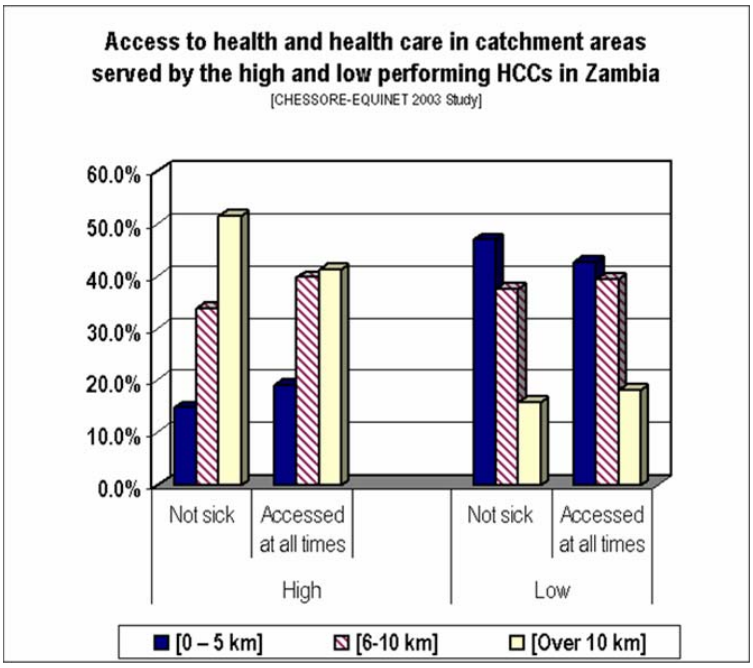


Figure 9: Performance effectiveness rating of HCCs by stakeholders in the health system – a view from the stakeholder consultation sessions.

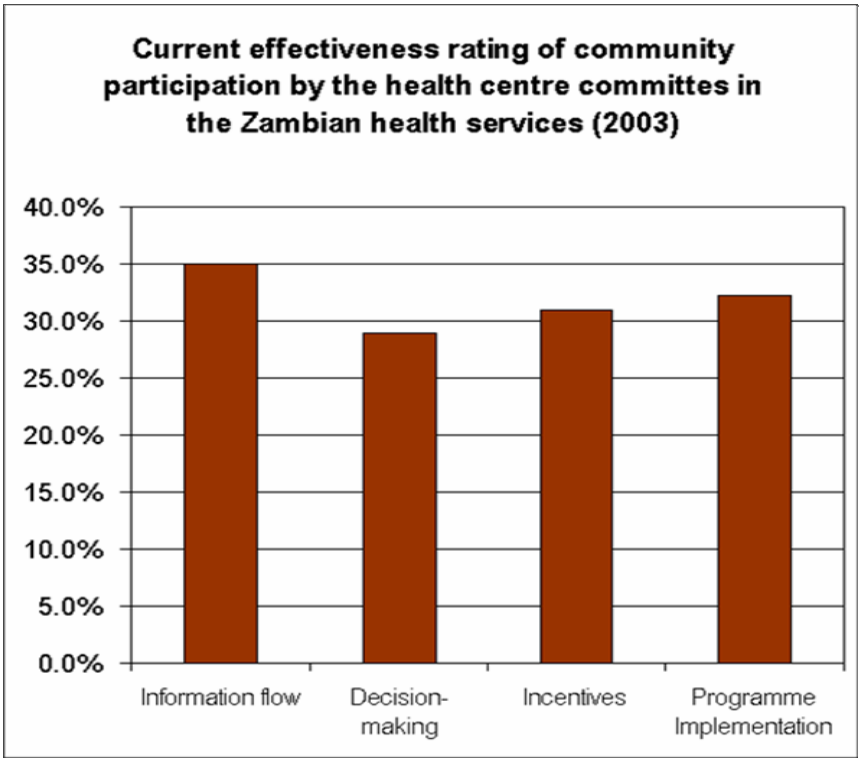
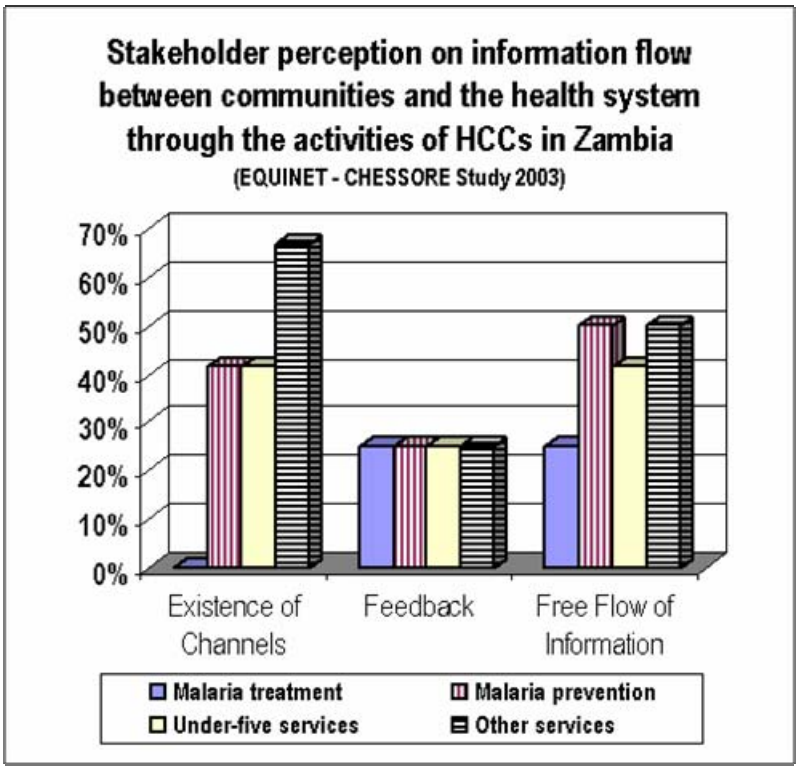


Figure 10: *Stakeholder perception on strengths and weaknesses in information flow between partners in governance in health.*



Health seeking behaviour and access to health services

Up to 75% of respondents were sick at least once in the preceding six-month period. Nearly 19% of sick respondents did not bother to seek health care (*Figure 12*). Of those that did not seek health care, 77% of them were sick one or two times and 23% were sick more than twice over the same period. Of those that did not seek care in areas served by high performing HCCs, 87% reported being sick one or two times while 13% reported being sick more than twice. Among those that knew of the existence of HCCs at their health centres, significant differences in prevailing morbidity rates were noticeable. In the areas served by low performing HCCs 69% were sick one or two times while 31% were sick more than twice. This difference in morbidity rates between the two areas served by two categories of HCCs was significant [MH 4.86, p-value 0.027].

Figure 11: *Awareness of HCCs in relation to distance from their health centres.*

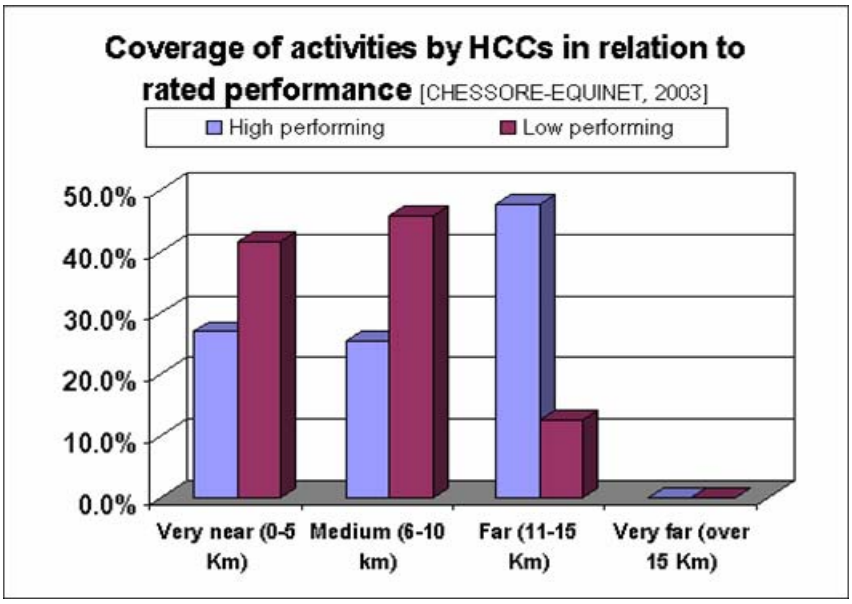


Figure 12: *Prevailing morbidity rates and access to health care services.*

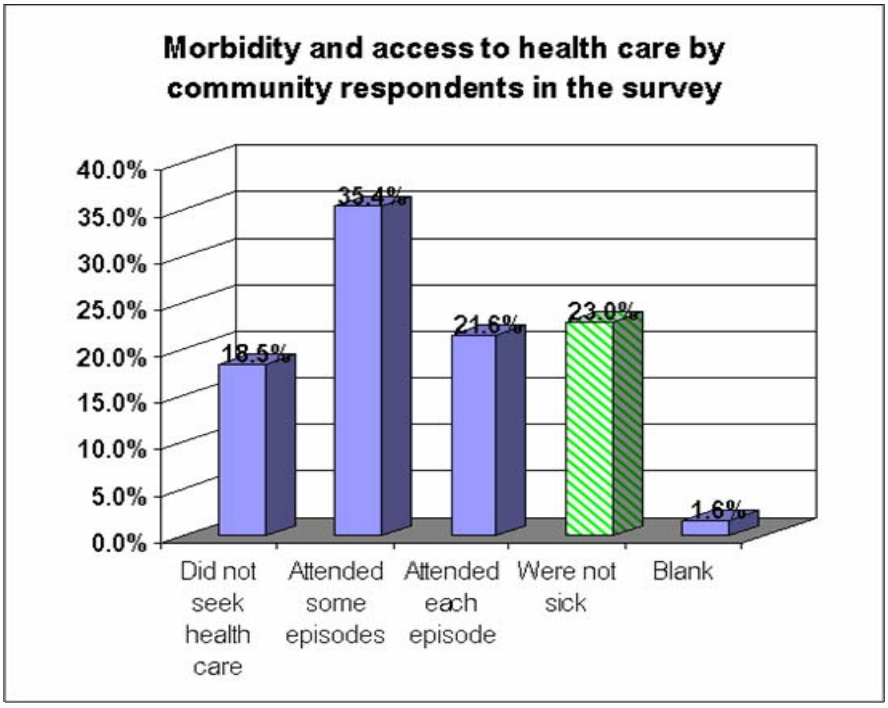


Table 17 User fees charged and the performance rating of HCCs

Quintile category	Performance rank of the HCCs	How much (mean) people paid when attending OPD	How much (mean) people paid at when admitted into care
Poorest (quintile 1)	High	ZMK 2,250.03	ZMK 3,595.00
	Low	ZMK 2,759.04	ZMK 2,954.93
	Quintile mean	ZMK **2,500.07**	ZMK **3,283.46**
Very poor (quintile 2)	High	ZMK 2,291.68	ZMK 2,908.53
	Low	ZMK 2,574.20	ZMK 2,700.55
	Quintile mean	ZMK **2,425.51**	ZMK **2,809.06**
Poor (quintile 3)	High	ZMK 1,896.66	ZMK 3,198.41
	Low	ZMK 2,660.47	ZMK 2,340.06
	Quintile mean	ZMK **2,261.36**	ZMK **2,788.57**
Less poor (quintile 4)	High	ZMK 2,213.04	ZMK 2,990.79
	Low	ZMK 2,913.06	ZMK 2,500.43
	Quintile mean	ZMK **2,563.05**	ZMK **2,745.61**
Least poor (well off) [quintile 5]	High	ZMK 2,103.87	ZMK 2,198.55
	Low	ZMK 2,718.27	ZMK 2,068.79
	Quintile mean	ZMK **2,416.76**	ZMK **2,134.29**
Overall average	High	ZMK 2,152.01	ZMK 2,991.37

costs	Low	ZMK 2,725.47	ZMK 2,519.31
	Sample mean	ZMK **2,433.06**	ZMK **2,761.34**
	Sample Size (no.)	555	550
	Exchange rate 1US$ = approx 4,750 Zambian Kwacha		

Some 35% of sick respondents were unable to attend health care for some sickness episodes experienced with nearly 25% being able to attend each time they fell sick. Up to 77% of those that attended some of the time reported being sick one or two times over the preceding six-month period; while among those that attended each time 65% reported being sick more than twice. This was also the same group that reported worse health outcomes in the past 12-month period. Thus most of the chronically (frequently) sick were able to access health care each time they were unwell, but did not experience improved health outcomes from the kind of services they received.

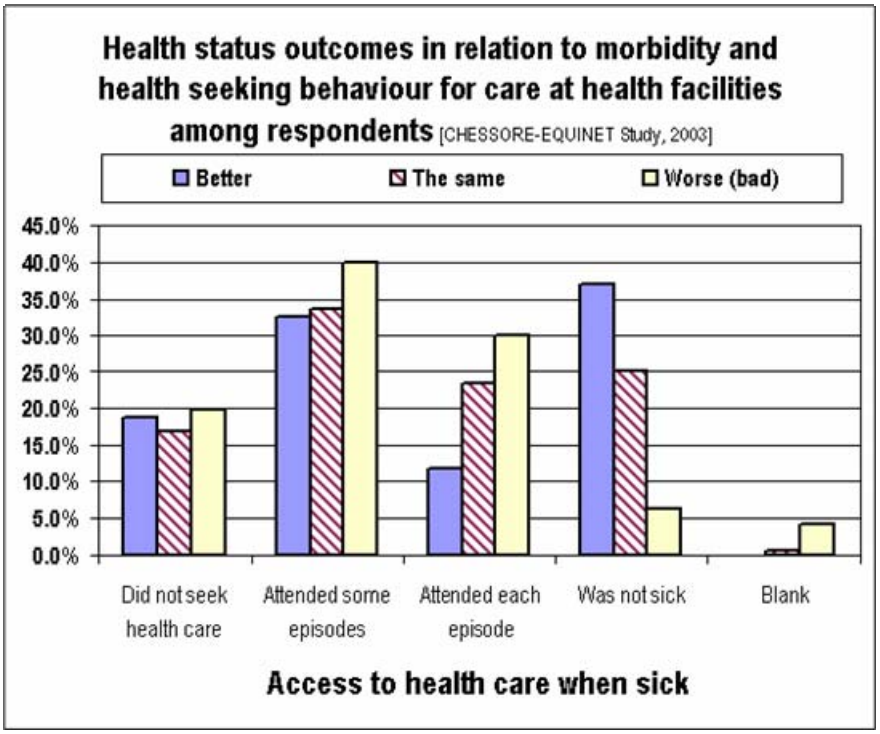
This rather paradoxical effect was probably due to the policy of exemptions for the chronically ill, when receiving health care at OPD of the Zambian health services. This possible effect from exemptions was not different between the high and the low performing HCCs (*Figure 13*).

If health and equity outcomes were to be dependent on knowledge and activities of HCCs, then at the present level of activities, HCCs (especially the low performing ones) would be unable to bring about equity and/or better serve the interests of the poor and vulnerable in their areas (Table 13). The HCCs were more inclined to be better known among the less and the least poor members of society. While on average the proportion of respondents that were aware of their HCCs was 20%, the proportion among the poorest quintile was approximately 10% *(Figure 14).*

4c.2.3 Acceptability (structural and proximal)

HCCs in the Zambian health services are well established at health centres, though not well known in the communities surveyed. From key informant interviews, which included HCC members, the view was that the HCCs were now an accepted part of the health system – at least in theory. There was still some information that this was not so in practice, since many health workers tended to dislike ‘meddling’ from HCC members. Some in the community appeared resigned to the idea of HCCs being an effective instrument for community participation. There were many in the community that disregarded the role and place of HCCs in that it meant very little to their lives. Yes, shortcomings were identified in the performance of their HCCs (Table 18).

Figure 13: *Health seeking behaviour, frequency of illness and health status outcomes.*



The major weaknesses in the performance of HCCs were identified as that:

- they didn't care (about their responsibilities);
- there was poor communication;
- they lacked resources to do work;
- they had an inherent fear of talking to educated people;
- they didn't know their roles;
- they lacked transport;
- they had no constitution to guide committee members in their work;
- they worked with stakeholders other than the HCCs to which they belonged;
- they didn't work together as a team; and
- many were usually new to their jobs at any one time.

High performing HCCs were weakened by lack of resources and poor communication channels (Table 18). Low performing HCCs were constrained by ‘don’t care’ attitude and by the fact that they did not know their roles and responsibilities.

The perception of a ‘don’t care’ attitude was strongest among the poorest quintile (33%), while issues of poor resource base and poor communication were identified by respondents in the 2nd to 4th quintiles 12%, 26%, 4% and 12% 15% 11%, respectively. The least poor (quintile 5) observed that HCC members did not know their roles and had inherent fears of talking to educated people like health workers. Up to 8% of respondents in the poorest quintile had observed that HCCs had no powers over health workers and were therefore ineffective in dealing with issues for equity at the health centre.

Figure 14: *Knowledge of HCCs by socio-economic category of respondents.*

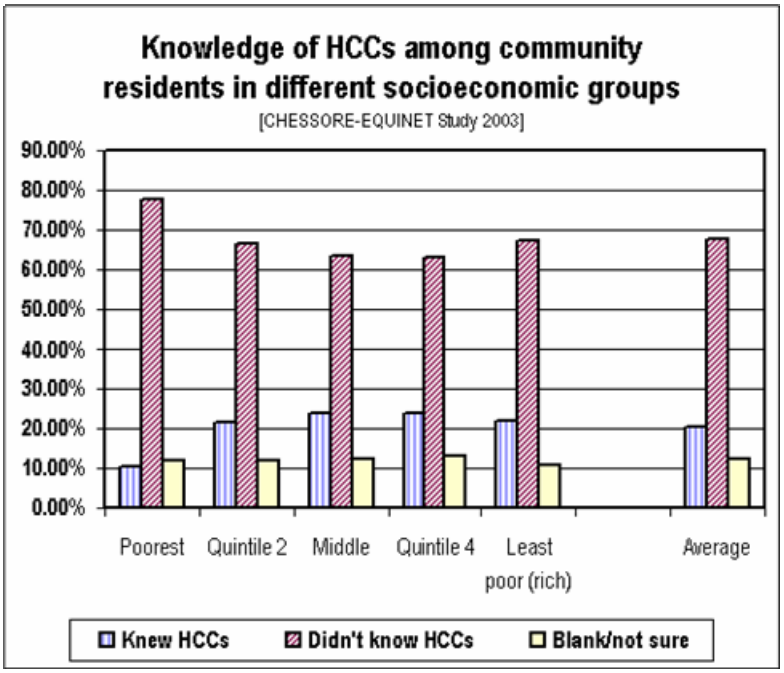


Figure 14a: *Perception of HCC members on the performance and acceptability of the work of the HCCs.*

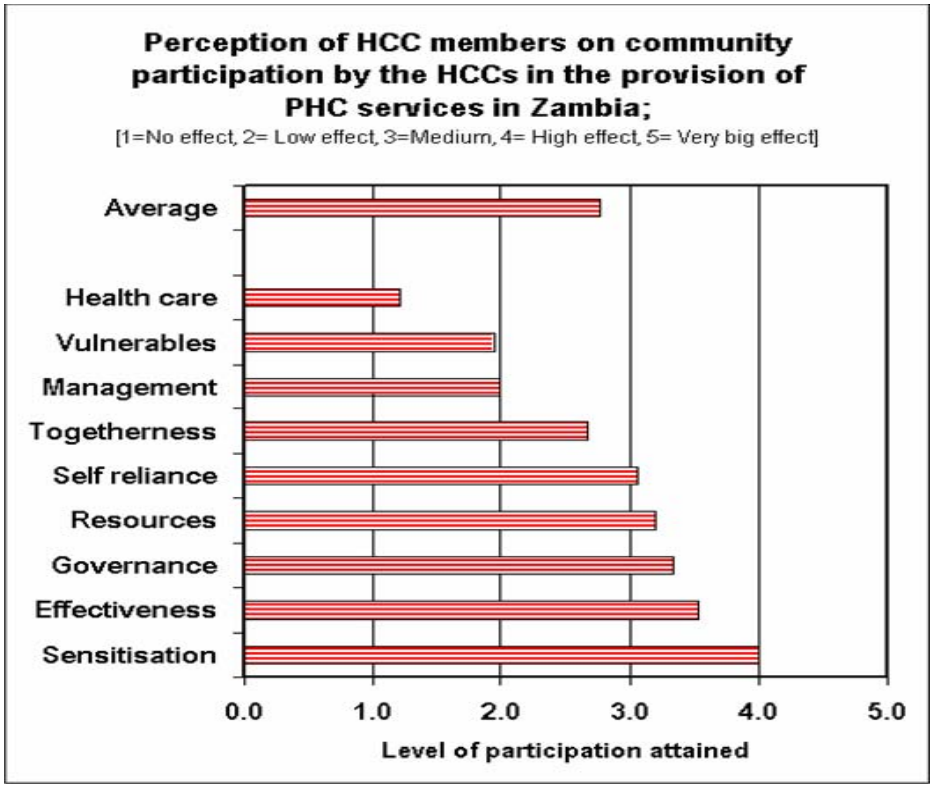
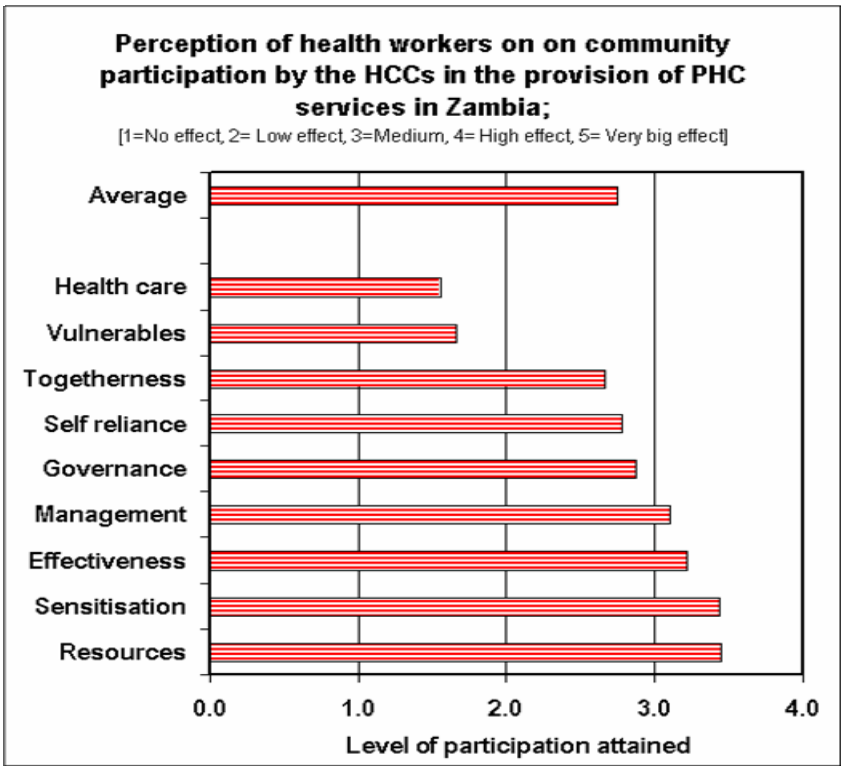


Figure 14b: *Perception of health workers on the performance and acceptability of the work of the HCCs.*



PRA assessments: At the PRA sessions, all stakeholders (HCC members, health centre in-charges and DHMT staff) were unanimous on the vital role that HCC members played in health promotion through health sensitisation, resource mobilisation (human, material and other) for the health centres, contribution to broader governance at health centres and general improvement in the effectiveness of health centre management. In the process, the work of the committees was credited with improving the spirit of self-reliance among community residents, which was also helpful for other development initiatives (*Figures 14a and 14b*).

Key informant perceptions on acceptability of HCCs: Key informants reported that HCCs worked very hard for their communities and this has registered its impact through health education as well as in the various community health-related activities now underway (Table 19). Key informants pointed out that their communities appreciated that HCCs made home visits to the sick (39%), undertook health education activities in the community (28%), helped out at outpost centres for under-five services (13%), used effective drama groups to spread health messages at their clinics (8%), and provided information on HIV/AIDS in their communities (5%).

Table 18 Identified weaknesses in the capacity and performance of HCCs from a community perspective

Weaknesses identified by community respondents on the capacity and performance of their HCCs (among those that **knew** HCCs)	**HCC performance rating**		**Average**
	High	**Low**	
They don't care (about their responsibilities)	16%	**23%**	19%
Poor communication	15%	4%	10%
Lack of resources	15%	6%	11%
Fear of talking to educated people	6%	8%	7%
They don't know their roles	4%	**10%**	7%
Lack of transport	6%	0%	3%
Lack of constitution to guide committee members	3%	2%	3%
Should work solely through NHC	3%	2%	3%
They don't work together	1%	4%	3%
They do not research their problems/roles	1%	2%	2%
Negligence and ignorance, new to job	7%	0%	5%
They think they know everything	3%	0%	2%
Lack supervisory skills	3%	0%	2%
Too many leadership wrangles	0%	2%	1%
The HCC has no power over the clinic workers	0%	2%	1%
HCC only interested in their own views	0%	2%	1%
Did **not** know	22%	30%	26%
(no.)	**67**	**48**	**115**

Acceptability of HCCs' work by community

Despite having a number of observations of the HCCs' weaknesses, those that knew of their existence expressed some satisfaction with the roles they have played so far (*Figure 15*). The community served rated the high performing HCCs better than low performing HCCs. In either case, no more than 24% of respondents aware of HCCs had expressed unhappiness with their performance.

Table 19 Acceptability and impact of HCCs in the community (health outreach, health education, and community health activities)

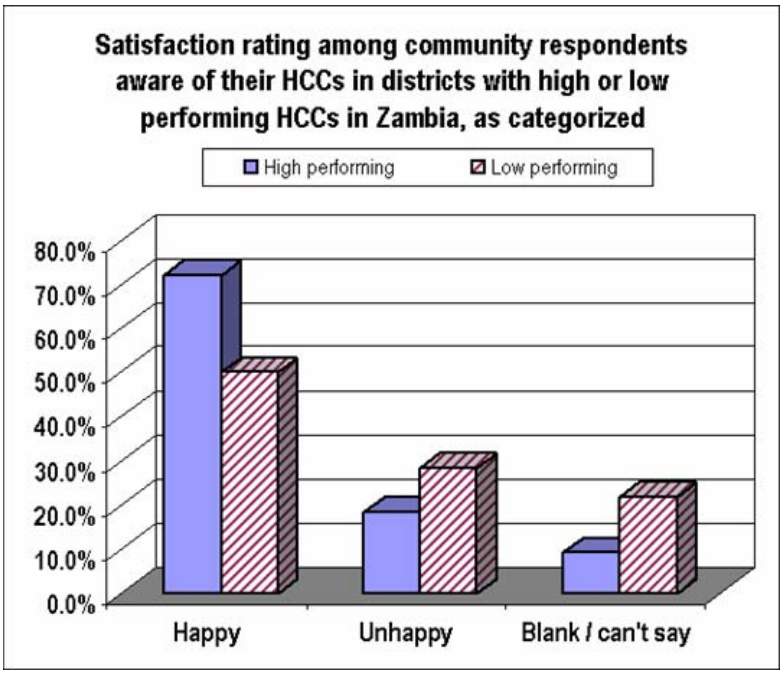
HCC impact on health outreach (health education, community health activities)	**Performance ranking of HCCs**		**Total**
	High	**Low**	
Regular outreach activities home based care	42.1%	35.0%	38.5%
Conducted health education	26.3%	30.0%	28.2%
Conducted under-five outposts	5.3%	20.0%	12.8%
Had health centre educational drama group	10.5%	5.0%	7.7%
People knew the impact of HIV/AIDS	5.3%	5.0%	5.1%
There had been positive response from breastfeeding mothers	10.5%	0%	5.1%
Though facilities are far, we reached them	0%	5.0%	2.6%
Sub-total (no.)	**23**	**24**	**47**

4c.2.4 Responsiveness (structural and proximal)

Although HCCs were initially formed through a public mandate at a public meeting (about eight years ago), the difficulties faced through the sometimes-hostile work environment made them lose touch with their electorate (the community). With time, most HCC members have steadily lost their electoral mandate and replacements and/or hiring were taken over by health centre staff. In a few cases, and among the high performing HCCs; traditional rulers had filled the vacuum and intervened to make HCC members accountable to the communities they served rather than only to the satisfaction of health workers. The lack of guidance in this respect is manifested by little knowledge among community respondents on things such as tenure of office for HCC members, procedures for removal from office and other democratic values necessary for greater transparency, accountability and responsiveness (Table 20a).

Though the major mode of payment for health was cash at presentation, some HCCs had managed to introduce options through payment-in-kind, pre-payment schemes and introduction of credit facilities. Some of these measures were helpful to residents in the lower quintile groups. Problems were experienced in the use of user fees money, with many in the lower quintile groups unaware of how such monies were spent (Table 20a). HCCs were credited with solving health problems in the community (63%) and intervening for people on problems complained of at the health facilities (46%). Thus 61% of respondents were satisfied with the current performance of HCCs (Table 20a).

Figure 15: *Community rating and satisfaction with the services of their HCCs.*



In terms of resource management, HCCs were weak and had very little capacity to generate resources to enable them to respond to health needs in their communities (12%). They had little capacity to discipline health workers (24%). In terms of representative legitimacy, nearly half the respondents (45%) knew how HCCs were elected, but 48%

did not know the tenure of office of HCCs. Some 36% of respondents replied that they knew procedures for removal of HCCs members from office, with another 50% saying they did not know of any such procedures. An average of 65% reported knowing channels for passing ideas to and linking up with their HCCs. Up to 31% of the respondents confirmed that they were able to reach and pass on their ideas to their HCCs (Table 20a). Some 11% of those who took issues to their HCCs also confirmed that action had been taken on the issues raised.

In terms of performance rating, the high performing HCCs were rated better on the essentially positive impacts of HCCs (Table 20b).

Responsiveness to needs of the poor, orphans and vulnerable children
The HCCs were known to have neglected the interests of the poor and vulnerable groups, despite their claims to the contrary (*Figures 14–16* and Table 21a). Work in the HCC appears to be predominantly for men, with the elderly and the disabled virtually excluded (Table 21a). The reason for the exclusion of the disabled was largely because of being disabled and incapable of undertaking the heavy manual work required of HCC members (Table 21b).

4d Findings from outcome mapping and stakeholder consultation session

An outcome mapping assessment of the performance of HCCs was undertaken with a view to identify attributes that need to change for effective performance of the committees as well as to learn what has changed so far from this policy implementation. The first thing was to find out what stakeholders saw as the ideal set of features for effective HCC performance on governance in the Zambian health system.

4d.1 Desired features in the performance of governance structures in the Zambian health system

A modified version of the outcome mapping technique was used to try and find out possible outcomes from the current efforts at community participation in the running of health services in Zambia. In this effort, stakeholder sessions were held with DHMT groups, health workers and HCC members from target districts. The boundary partner discussed was the HCCs. As a group, a general discussion was undertaken to define the ideal actions and activities that would pass as representing true community participation within the Zambian context. This was defined and desired activities and outcomes identified (Annex 1).

Following the joint session to define the desired attributes for effective community participation, the stakeholders were divided into three groups consisting of HCC members only, health workers only and health managers (at DHMT level) only. Each group was then requested to identify which of the ideal listed activities were taking place in their localities. The activities mentioned by 50% or more of the groups were considered common and therefore constituted the category of activities that one can more

likely expect to see at health centres in Zambia. The other activities are uncommon but one would like to see more of those also taking place. Then there were activities done by HCCs on their own initiatives, in the sense that these were not covered by the official guidelines. This group formed the kinds of activities that one would love to see more of at health facilities.

Table 20a: Democratic accountability and responsiveness for equity in the work of HCCs rated by socio-economic category of respondents

Variables on democratic accountability for equity (among those that knew of HCCs)		Socio-economic status of respondents					Overall average
		Poorest	Very poor	Poor	Less poor	Least poor	
		Q1	Q2	Q3	Q4	Q5	
HCCs and user fees money							
Mechanisms existed to allow access for the very poor without user fee money		50%	44%	63%	70%	71%	61%
Mode of payment	Cash at presentation	100%	96%	100%	93%	92%	96%
	Prepayment schemes	25%	20%	7%	37%	33%	24%
	In-kind payments	42%	32%	48%	11%	33%	32%
	Credit facility	0%	0%	0%	4%	0%	1%
Use of FEES money	Did not know	50%	28%	41%	33%	21%	33%
User fee expenditure	Did not know	58%	52%	59%	44%	58%	54%
Satisfaction with HCC performance							
Good for work at health facility for health workers		50%	28%	41%	33%	21%	33%
Good as messengers for health workers		42%	68%	52%	48%	42%	51%
HCCs are good at solving problems identified in the community		67%	76%	63%	56%	54%	63%
HCCs are good at intervening for people on problems complained of at facilities		58%	76%	56%	30%	42%	46%
Proportion of respondents happy with current performance of HCCs		67%	68%	67%	52%	54%	61%
Resource management for health							
HCC has capacity to control staff		50%	28%	41%	33%	21%	33%
HCCs are capable of disciplining staff		25%	28%	30%	15%	25%	24%
HCCs do generate extra funds for health centres		8%	12%	19%	11%	8%	12%
Representative legitimacy							
Knew how HCCs were elected		42%	44%	44%	56%	38%	45%
Did not know how HCCs were elected		8%	8%	22%	7%	29%	16%
Did not know the tenure of office of HCCs		50%	52%	44%	52%	42%	48%
Knew of procedures for removal from HCCs		25%	44%	41%	33%	29%	36%
Did not know procedures for removal of		67%	40%	52%	52%	50%	50%

HCC members						
Channels known/exist for passing ideas/suggestions to HCCs	67%	84%	59%	59%	58%	65%
There are **no** channels for passing suggestions to HCCs	0%	12%	22%	33%	25%	24%
Did not know of channels for linking up with HCCs	33%	4%	19%	7%	17%	10%
Respondents that had accessed the HCC for an issue/problem	17%	28%	37%	30%	38%	31%
Knew of the action taken for problems complained of	8%	4%	7%	19%	17%	11%
Total (no.)	**12**	**25**	**27**	**27**	**24**	**115**

Table 20b Democratic accountability and responsiveness for equity in the work of HCCs rated by performance rating of HCCs

Among community respondents that knew of the existence of HCCs at their health centres		**Performance ranking of the HCCs**		**Total**
		High	**Low**	
Mechanisms existed to allow the very poor access to health		61%	60%	61%
Mode of payment	Cash at presentation	97%	94%	96%
	Pre-payment schemes	16%	35%	24%
	In-kind payments	37%	25%	32%
	Credit facility	0%	2%	1%
Amount from fees [did not know]		31%	35%	33%
User fee expenditure [did not know]		54%	54%	54%
Satisfaction with HCC performance				
Good for work at health facility for health workers		58%	38%	50%
Good as messengers for health workers		61%	38%	51%
HCCs good at solving problems identified in the community		70%	52%	63%
HCCs are good at intervening for people on problems complained of at facilities		60%	40%	51%
Happy with current performance of their HCCs		70%	48%	61%
Management of resources for health				
HCC has capacity to control staff		36%	19%	29%
HCCs are capable of disciplining staff		28%	19%	24%
HCCs do generate extra funds for health centres		15%	8%	12%
Representative legitimacy				
Knew how HCCs were elected		46%	44%	45%
Did not know how HCCs were elected		16%	15%	16%
Did not know the tenure of office of HCCs		54%	40%	48%
Knew of procedures for removal from HCCs		37%	33%	36%
Did not know procedures for removal of HCC members		52%	48%	50%
Channels exist for passing ideas/suggestions to HCCs		72%	56%	65%
There are **no** channels for passing suggestions to HCCs		21%	29%	24%

Did not know of channels for linking up with HCCs		7%	15%	10%
Respondents that had accessed HCC for an issue/problem		36%	25%	31%
Knew of the action taken for problems complained of		13%	8%	11%
Totals	**(no.)**	**67**	**48**	**115**
	Proportion of sample total	12%	8%	20%

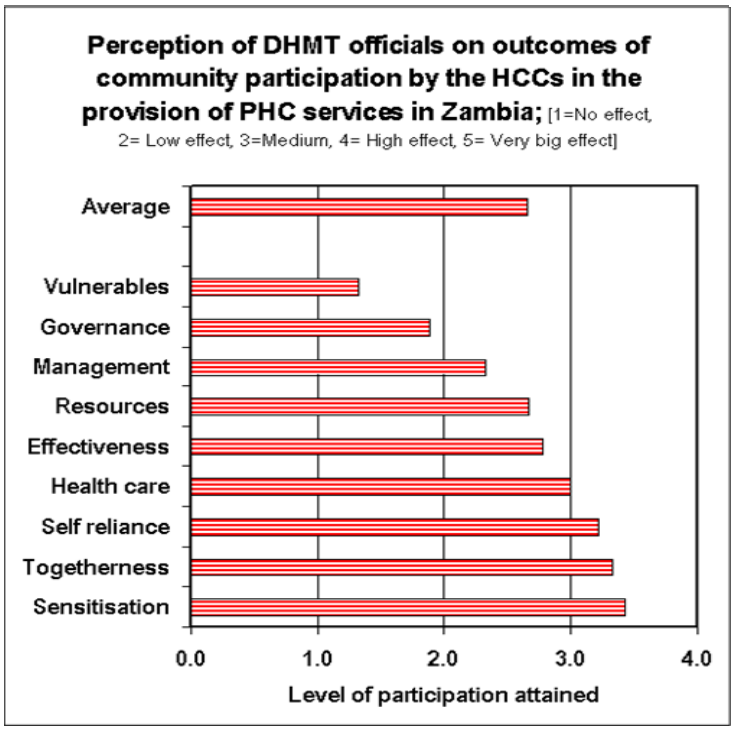
Table 21a PRA session assessment of involvement of social groups in the work activities of the HCCs

Social groups involved in the HCCs: an assessment from key informants			
	Performance rating of HCC		
HCC involvement/representation	**High**	**Low**	**Average**
Social groups represented on the HCC			
Everyone	13%	67%	36%
Widows	50%	0%	29%
Men	50%	0%	29%
Men and women	25%	33%	29%
Women	38%	0%	21%
The elderly	13%	0%	7%
Social groups not represented on the HCCs			
The elderly	75%	17%	50%
Disabled	63%	33%	50%
Orphans	25%	0%	14%
Children	13%	17%	14%
Widows	13%	17%	14%
Teachers	0%	33%	14%
None	0%	50%	21%
Knew procedure for becoming an HCC member	25%	17%	21%
(no.)	**8**	**6**	**14**

Table 21b PRA session assessment of reasons for lack of involvement of the poor and vulnerable social groups in the work activities of the HCCs

Reason given for not being involved	**Performance ranking of HCCs**		
	High	**Low**	**Average**
Because of their disability	50%	0%	4
Not applicable (had said all were involved)	0%	50%	3
Don't know	0%	17%	1
Do not have capacity to perform well	50%	17%	5
Teachers don't attend meetings called by the community	0%	17%	1
Total (no.)	**8**	**6**	**14**

Figure 16: *DHMT assessment of the effectiveness of HCCs from outcome mapping stakeholder sessions.*



The following then stand out as key outcomes from community participation in the delivery of PHC activities in Zambia.

4d.2 HCC activities that one can expect to see in Zambia

The following are some of the activities that were commonly undertaken by HCCs as part of their community participation responsibilities. As such, these are the kinds of activities that one expects to see when reviewing the performance of the HCCs in Zambia today.

- Free flow of information on activities for malaria prevention in the community, between HCCs and the health system (50%). This has resulted from the fact that there was now an atmosphere of free flow of information between community representatives and health centre staff (50% of stakeholder groups). Through participation in the PHC services, HCCs have now established channels of communication with the health system (33%) and actively give ideas to public health programmes.
- The prestige community representatives enjoyed from their participation as individuals. They are motivated by the new knowledge gained (67%), by the training they receive (67%) and from the material gains received in the form of refreshments, T-shirts, caps, etc (58%). HCC participation was also motivated by the knowledge gained in the process of participation (50%). These incentives propel them along to do even more.
- Health promotion work (58%) and health education work (67%) on malaria.

- With respect to activities for, HCCs were reported to be actively involved in the planning stages (50%) under-five services, thereby exerting some influence in decision-making at health facilities. HCCs have also influenced decisions on how much should be paid as user fees (58%) as well as on the modalities to be used for user fee payments (67%); whether as in-kind or cash payments.
- HCCs in Zambia are now said to be influencing decisions at their health facilities.
- HCCS are actively involved in giving ideas and half the groups (50%) reported that formal channels have been created through which to channel their ideas for the attention of health centre staff.
- HCCs were actively participating in events such as planning (58%) and during health promotion events for diseases such as HIV, TB, and in tobacco-free days, etc (75% of groups).
- HCCs have acquired new knowledge from their participation in public health activities and health care (50%),
- HCCs were now being involved in planning and budgeting for their health centres (58%).
- Health workers reported that HCCs were most certainly being over-used by health centre personnel. To this extent they now understood why these volunteers demanded compensation from opportunity costs incurred.

The HCCs were reported to be working hard in their assigned tasks and this resulted in some volunteers demanding that they be paid for the opportunity costs incurred in the form of money. Others argued that although money was important, they were committed to their work because they derived some satisfaction in the performance of their assigned roles. Their perceptions of self-esteem and social status are also raised by the training they receive when participating in health centre and health related activities (50% of groups). A further 42% noted that they were motivated by the appreciation shown to them by the community as they performed their work activities. Some of this knowledge gained had helped them to provide home-based care for their families (42%). HCC members have been motivated by an increased sense of ownership, which they derive from being consulted about malaria prevention programmes by their health centres (33%).

The HCCs were also involved in the implementation work of some health programmes that were of greater complexity and/or that had greater impact on service provision and outcomes. A start has been made, and one would like to see more of these in promoting the role of community participation and governance in health.

4d.3 Activities one would like to see more often

The HCCs took part in a number of other activities as part of promoting community participation at the health centre level, with varying degrees of involvement, but not as common as to the extent of involvement for the ones listed above. Take-up on these has been slow. Such activities include:

- involvement in the planning stages of the annual action plans (25%);

- the obligation to give feedback to community on assigned tasks or ideas (25%);
- active surveillance of diseases in their communities (42%);
- providing some information on malaria to communities (25%). With respect to incentives for community participation, their involvement in malaria control issues has motivated them more as it provided them with knowledge to protect even their own families. HCC members were similarly motivated by the training courses they had undergone to assist with health promotion in the community (42%);
- formal channels for exchanging ideas with the health system (25%) and for feedback on their ideas (25%). It was also stated that HCCs actively participated in certain events such as planning (42%), health promotion during malaria commemorative days (42%);
- close collaboration between HCCs and health workers on malaria prevention work, which has had the effect of making health workers feel they were part of the communities they served (33%);
- supportive work to monitor disease outbreaks in their communities as part of the health centre surveillance system (33%);
- community-based data for the attention of health workers (25%);
- an influence on decision-making on malaria prevention by defining local priorities for action (33%);
- ideas are considered and feedback received (25%), and active participation in budgeting and planning (33%) for community level activities (location, logistics, food for health workers, and assignment of tasks to HCC members) as well as undertaking health promotion work (in disseminating information and urging mothers to attend) to increase coverage (25%); and
- the implementation of some health programmes such as health education in the community (42%); taking part in planning and prioritising expenditure of funds on health programmes (33%); explaining policies to communities on things such as user fees (25%), making decisions on which groups should be exempt from paying user fees (25%).

There were a number of activities that HCCs undertook but are preceding even more slowly, and the stakeholders would like to see more effective involvement in these areas by HCCs. In terms of active involvement there is need:

1. to improve on how budgeting and allocating of money to health activities and programmes is done (42%);
2. for more formal channels of communication needed to be created between HCCs and the health system (25%);
3. for effective feedback on how the ideas submitted by the HCC were considered and taken into account (25%); and
4. for some kind of capacity building programmes as a way out to bring about effective participation in these areas. Stakeholders expressed the need for the capacity of HCCs to influence more decisions in health and health care, in areas such as:
    a. prioritisation of health problems to tackle (42%);

b. supplying community based data on issues such as social groups and their needs (42%);
c. the need to learn how to develop consensus other than having ideas and decisions imposed on HCCs (25%); and
d. that effort should be made to have the HCCs prepare adequately before important meetings and decision-making sessions (25%).

The stakeholder group discussion participants would have liked to see more effective and wider involvement by HCCs in the implementation of public health programmes.

4d.4 Activities that stakeholders would love to see more often

Since the inception of the health reforms agenda in Zambia, community representatives have undertaken a number of initiatives for community participation in health. These initiatives have been above and over what was contained or implied in the guidelines put forward to effect community participation in health. These are the kinds of activities that one would love to see more of in this partnership with the health system. Initiative for community participation included actively giving ideas, influencing decisions, taking measures to increase motivation of community volunteers and actually taking part in the implementation of health programmes. The following were some examples of the major initiatives commonly undertaken by HCCs in promoting community participation in health and health care:

- promoting healthy living in their communities (75%);
- organising community groups to undertake work activities at their health centres (75%);
- actively giving ideas on community mobilisation strategies for malaria prevention activities (67%);
- influencing decisions in health service provision such as embarking on sensitisation to help stakeholders accept the concept of participation in malaria prevention activities (58%);
- communities were now coming forward to provide help (58%);
- teamwork approaches and skills have been developed to tackle identified health prevention problems in the community (50%). These activities by the HCCs were said to have increased solidarity and teamwork approaches in the community, especially on health matters (50%);
- health workers and HCCs now work and are seen to be working together on health issues (50%) during PHC services such as the under-five health services;
- HCCs have influenced communities to be coming forward to help out on health interventions (50%) aimed at improving under-five services; and
- participation in health promotion activities in things such as promoting community hygiene, refuse disposal, and advising children born outside the clinic to go for BCG vaccination at the health centres (67%).

Generally, stakeholder workshop participants were of the view that communities were now coming out more often to offer help to the health services (50%); and that health

workers were getting more interested in development initiatives taking place in their communities (50%).

4e Desired help to overcome the above barriers (stakeholder views and current performance ratings)

An examination of the general activities undertaken by HCCs, as well as the more specific activities recently performed in the course of their work, gives hope that the concept of governance in the Zambian health system has taken root and novel approaches are increasingly being resorted to make HCCs relevant to all stakeholders. New ground is being broken and there is need for positive lessons to be amplified and scaled up, without letting each HCC 'reinvent the wheel', as a way to accelerate the process.

4e.1 Potential for sustaining positive initiatives undertaken by governance structures in Zambia's health system

As previously stated, the HCCs can be said to operate in a rather hostile environment, with resistance from the health workers in close partnerships and frustration and lack of perceptible encouragement from the communities they represent. However, the fact that HCCs were able to manoeuvre and achieve some success is a sign of potential for sustaining these initiatives already started. The clear differences between high performing and low performing HCCs are yet another sign of the potential to do even more should circumstances permit.

Table 22 Key informant self-assessment of HCC impact on PHC services

Defined areas of impact from the work activities of HCCs in Zambia	Performance rating of HCCs		Total
	High	Low	
Health knowledge through health education	22.7%	42.9%	32.6%
The community now has health posts	27.3%	9.5%	18.6%
The community has become sensitive to disease outbreaks	22.7%	14.3%	18.6%
Malaria and STIs have reduced due to HCC	13.6%	4.8%	9.3%
Conduct under-five growth monitoring programmes	4.5%	4.8%	4.7%
Have conducted immunisations	0%	9.5%	4.7%
Don't have the capacity to perform	0%	4.8%	2.3%
The HCC is only active at the health centre level	0%	4.8%	2.3%
No impact	9.1%	4.8%	7.0%
Blank	4.5%	14.3	9.2%
Total (no.)	**23**	**24**	**47**

4e.2 Comparison on outcomes from governance variables between high performing and low performing HCCs

When asked what could have been their more noticeable achievements from their work activities, key informant interviewees cited a number of things such as knowledge imparted through health education activities (32%), creation of new health posts through

their influence on construction and decisions on where to site them for the sake of greater equity (19%), that the communities are more sensitive to disease outbreaks and epidemic preparedness responses (19%) and with perceptible reduction in prevalence rates for malaria and STIs (Table 22).

Table 23 Effectiveness rating of HCCs at PRA group sessions held, and reasons given for those ratings

Performance ranking of HCCs compared with community rating of effectiveness				
Community HCC rating	**Reason associated with rating given**	**Pre-survey performance rating of HCCs**		**Total**
		High performing	**Low performing**	
Quite effective	Blank	1	1	2
	Make monthly visits [for meetings]	1	1	2
	Undertake sensitisation on health matters	3	1	4
	There is good distribution of drugs	1	0	1
	Sub-total [no.]	75% [6]	50% [3]	64% [9]
Average	People can't afford [user charges]	1	0	1
	Sub-total [no.]	13% [1]	0% [0]	7% [1]
Ineffective	Blank	1	0	1
	Don’t hold [sensitisation] meetings	0	1	1
	They can't control people letting pigs on the loose [that bring diseases]	0	1	1
	[Don’t take action on the] presence of water ponds [that] breed mosquitoes	0	1	1
	Sub-total [no.]	13% [1]	50% [3]	29% [4]
Total PRA sessions held [no.]		**8**	**6**	**14**

While key stakeholders had defined desired attributes for effective community participation, community PRA group sessions had rated their HCCs for effectiveness from the achievements so far recorded and noted by people in the community (Table 23). The PRA group sessions were asked to rate their communities on a scale of three, whether (a) quite effective, (b) average, or (c) ineffective, and give reasons for the rating given. Some 75% of the PRA sessions from the high performing HCCs were rated as effective because of their work activities in sensitising communities on health issues. The other attributes noted were the undertaking of regular community visits and ensuring a fair distribution of drug supplies. Measures to try improving the affordability of user fees were another sensitive indicator for effective rating of HCCs. From the low performing HCCs, it transpired that lack of community sensitisation on health issues, inability to control factors that could lead to disease outbreaks from the very factors that they try to discourage people from were additional factors for ineffective ratings given (Table 23).

4e.3 Comparison between current performance rating between the high and low performing HCCs

As earlier stated, attributes for high and low performance ratings of HCCs will also be assessed by looking at the general things they were involved in and the specific things they had recently undertaken in different areas.

Table 24a Participation of HCCs in making budgets for health

Making budgets for health ...general action	Performance ranking of HCC		Total
	High HCCs	Low HCCs	
Prepare budgets for the clinic	65.2%	56.5%	60.9%
We hold meetings	17.3%	8.7%	13.0%
Problems were identified in communities	13.0%	4.3%	8.7%
Prepare action plans for the year	0.0%	17.4%	8.7%
Don't know	0.0%	4.3%	2.2%
Not applicable	4.3%	8.7%	6.5%
Total	**23**	**24**	**47**
Making budgets for health ...last specific action	**Performance ranking of HCC**		**Total**
	High HCCs	**Low HCCs**	
Bought cleaning materials, bicycles or drugs	17.3%	27.2%	22.2%
Budgeted for fuel, boreholes, other supplies	17.4%	13.6%	15.5%
Allocated some percentage of money to immunization	13.0%	9.1%	11.1%
Budgeted for the clinic	13.0%	4.5%	8.9%
Money was allocated to purchase fertilizer for fundraising	17.4%	0.0%	8.9%
We bought sprayers	4.3%	9.1%	6.7%
Garbage collection	0.0%	13.6%	6.7%
Treatment of water in the community	8.7%	0.0%	4.4%
Construction of an maternal & child health (MCH) office	4.3%	4.5%	4.4%
Control of epidemics	0.0%	4.5%	2.2%
Building large health centre	0.0%	4.5%	2.2%
Organised workshops	0.0%	4.5%	2.2%
Not applicable	4.3%	9.1%	6.7%
Total	**23**	**24**	**47**

In terms of making budgets for health, the general activities in which the HCCs were involved included preparing budgets for their clinics (61%), holding meetings for the same (13%), identifying problems in the community (9%) and preparing annual action plans (9%). In this regard, the last specific actions undertaken to fulfil this role were mentioned as buying cleaning materials (13%), allocating money for immunisations campaigns (11%), budgeting for the clinic (9%), buying fertilizer for a fundraising project (9%), buying sprayers (7%), buying drugs (7%), buying farm implements (4%),

buying fuel (4%) and construction of an MCH office (4%). Others mentioned the buying of bicycles, budgeting for boreholes and organising workshops (2% for each one) (Table 24a).

Table 24b Participation of HCCs in making decisions on how money should be spent

Deciding how money should be spent ...general action	Performance ranking of HCC		Total
	High HCCs	Low HCCs	
HCC meeting was called to discuss expenditure	56.5%	47.8%	52.2%
In the meeting, health problems were identified	13.0%	8.7%	10.9%
The in-charges decide, HCCs only endorse	13.0%	21.7%	17.3%
Went through the accounts of the clinic	13.0%	4.3%	8.7%
Don't know	0.0%	8.7%	4.3%
Blank	4.3%	8.7%	6.5%
Total	**23**	**24**	**47**
Deciding how money should be spent ...last specific action	**Performance ranking of HCC**		**Total**
	High HCCs	**Low HCCs**	
Allocate money to malaria control	21.7%	8.3%	14.9%
Allocated money for fridge	8.7%	12.5%	10.6%
Allocated money for NHC farms	17.4%	0.0%	8.5%
Allocated money for repairs	13.0%	4.2%	8.5%
Allocated K 300,000 to NHCs	13.0%	0.0%	6.4%
Garbage collection	0.0%	8.3%	4.3%
Allocated money for materials shovels, picks & slashers	8.7%	0.0%	4.3%
Allocated money for refreshments	0.0%	8.3%	4.3%
Allocated money for floor mats	0.0%	8.3%	4.3%
HCCs don't know they have powers to decide how money is spent	8.7%	0.0%	4.3%
Fixed the sanitation problem	0.0%	4.2%	2.1%
Erection of mothers' shelter	0.0%	4.2%	2.1%
Allocated money for drugs	0.0%	4.2%	2.1%
Expansion of the clinic	0.0%	4.2%	2.1%
5% of user fees allocated to NHCs	0.0%	4.2%	2.1%
Don't know	0.0%	8.3%	4.3%
Nothing	0.0%	8.3%	4.3%
Not applicable	4.3%	8.3%	6.4%
Total	**23**	**24**	**47**

In terms of making decisions on how money should be spent, the general actions undertaken were calling HCC meetings to discuss expenditure (52%), calling meetings to identify health problems (11%) and going through the accounts of the clinic first (9%).

Otherwise the in-charges made such decisions (13%) with the HCCs merely endorsing such decisions (4.3%). In terms of the most recent decisions made, respondents mentioned allocating funds for malaria control (15%), buying a fridge (11%), allocating funds to buy farm implements and inputs (9%) and allocating money to buy spares, work tools or refreshments during meetings. An extreme view was that HCCs did not know that they had such decision-making powers (8.7%) (Table 24b).

Table 24c Participation of HCCs in monitoring how money was spent for health

Monitoring how money is spent ...general action	Performance ranking of HCC		Total
	High HCCs	Low HCCs	
Monitoring and supervising expenditure of resources	43.5%	43.5%	43.5%
Monitoring the activities of NHC	30.4%	4.3%	17.4%
Plan for monitoring visits to community	13.0%	4.3%	8.7%
Done by health personnel/staff	4.3%	4.3%	4.3%
Done by the DHMB	4.3%	4.3%	4.3%
Nothing	0.0%	4.3%	2.2%
Responsibility of health centre staff	0.0%	4.3%	2.2%
Don't know	0.0%	13.0%	6.5%
Blank	0.0%	8.7%	4.3%
Not applicable	4.3%	8.7%	6.5%
Total	**23**	**24**	**47**
Monitoring how money is spent ...last specific action	**Performance ranking of HCC**		**Total**
	High HCCs	**Low HCCs**	
Conducted budget reviews	33.3%	15.0%	24.4%
A person was sent to check the activities of NHC	14.3%	5.0%	9.8%
Allocated more on purchase of sprayers and drugs	4.8%	15.0%	9.8%
Bought solar batteries/panels/bulbs	4.8%	10.0%	7.3%
HCC members monitored accounts of the secretary	9.5%	5.0%	7.3%
We verified the costs of these inputs in our town	9.5%	0.0%	4.9%
HCC don't know that they have powers to monitor activities	9.5%	0.0%	4.9%
Renovated clinic	0.0%	5.0%	2.4%
Bought slashers, hoes, picks, shovels	4.8%	0.0%	2.4%
Nothing was done	4.8%	0.0%	2.4%
Blank	0.0%	10.0%	4.9%
Don't know	0.0%	10.0%	4.9%
Nothing	0.0%	15.0%	7.3%
Not applicable	4.8%	10.0%	7.3%
Total	**23**	**24**	**47**

In terms of action to monitor how money was spent, the general activity undertaken was monitoring and supervising expenditure of resources (44%). The next common activities were monitoring the activities of NHCs (17%) and HCCs monitoring visits into the community (9%). Otherwise this was something left to be done by health personnel at health centres and at the DHMTs. In terms of the most recent specific actions, respondents mentioned conduction of budget reviews (24%), sending people to check activities of NHCs (10%), making allocations to purchase sprayers and drugs at health centres, buying of solar power items (7%) and the high performing HCCs respondents mentioned scrutinising the accounts of the secretary (10%) and going all the way to shops in town to verify the cost of inputs bought (10%) (Table 24c).

Table 24d Participation of HCCs in defining services and health priorities

Defining services and health priorities ...general action	**Performance ranking of HCC**		**Total**
	High HCCs	**Low HCCs**	
We meet to prioritise health problems	56.5%	56.5%	56.5%
Went through the action plans of the clinic	17.4%	4.3%	10.9%
Poverty eradication and looking at critically ill people	13.0%	0.0%	6.5%
Meet to hear peoples problems	0.0%	8.7%	4.3%
Malaria	4.3%	4.3%	4.3%
HCCs never define health services & priorities, health workers do	4.3%	8.7%	6.5%
Look into the problem of garbage in catchment area	0.0%	4.3%	2.2%
Don't know	0.0%	4.3%	2.2%
Not applicable	4.3%	8.7%	6.5%
Total	**23**	**24**	**47**
Defining services and health priorities ...last specific action	**Performance ranking of HCC**		**Total**
	High HCCs	**Low HCCs**	
Gave first priority to malaria problem	22.7%	28.6%	25.6%
Conducted community education on malaria prevention	27.3%	9.5%	18.6%
Erected a mothers' shelter	9.1%	14.3%	11.6%
The HCC decided to give donated items to the community	18.2%	0.0%	9.3%
Made boxes for garbage collection	0.0%	14.3%	7.0%
Sensitisation on HIV/AIDS	9.1%	0.0%	4.7%
TB follow-up was first priority	9.1%	0.0%	4.7%
Make sure there are enough drugs available	0.0%	9.5%	4.7%
Correlate household numbers to garbage throwing	0.0%	4.8%	2.3%
No specific action taken for a long time now	0.0%	4.8%	2.3%
Budget for the underweight babies (food)	0.0%	9.5%	4.7%
Don't know	0.0%	4.8%	2.3%
Blank	4.5%	9.5%	7.0%

Total	**23**	**24**	**47**

In terms of action to define services and health priorities, over 50% of respondents from both low and high performing HCCs mentioned that they met to undertake these activities. They met to go through health centre action plans (11%) and also met the people to hear their problems (4.3%). A few (4.3%) felt that this was something done by health workers and that it had never happened during their time at the HCCs. In terms of specific actions that they last undertook, many mentioned prioritising specific diseases such as malaria (25%), health education on malaria (19%), sensitisation on HIV/AIDS (4.7%), and undertaking follow-up actions on TB patients (4.7%). Some said that they had prioritised the erection of a mothers' shelter (12%) (Table 24d).

In general terms of monitoring service quality, nearly a third of respondents said they monitored the performance of outreach services in the community. Another 17% of respondents said that they undertook visits to observe and monitor the quality of service being delivered at health centres. Other activities undertaken included disease surveillance to monitor the very sick in the community through NHCs. Other than this, this was said to be the domain of health workers and that nothing of the sort took place (Table 24e).

Table 24e Participation of HCCs in monitoring the quality of services for health

Monitoring service quality ...general action	**Performance ranking of HCC**		**Total**
	High HCCs	**Low HCCs**	
Outreach activities to asses quality of services delivered	34.8%	30.4%	32.6%
Observe the health delivery activities at the centre	26.1%	8.7%	17.4%
The NHC were told to identify those with serious problems	21.7%	4.3%	13.0%
HCCs do not monitor service quality, staff do this	8.7%	34.7%	21.7%
Garbage collection	0.0%	4.3%	2.2%
Monitor budget implementation	4.3%	0.0%	2.2%
Don't know	0.0%	8.7%	4.3%
Not applicable	4.3%	8.7%	6.5%
Total	**23**	**24**	**47**
Monitoring service quality ...last specific action	**Performance ranking of HCC**		**Total**
	High HCCs	**Low HCCs**	
Monitored the building of pit latrines	28.6%	25.0%	26.8%
Visited community to ensure implementation was in order	14.3%	10.0%	12.2%
We went with the NHC to give donated items to the people	19.0%	0.0%	9.8%
Ensued that all waste was collected in breeding areas	0.0%	20.0%	9.8%
Ensued the right dosage for malaria drug for prevention	9.5%	5.0%	7.3%
Had meeting with management to point out areas of weakness	9.5%	0.0%	4.9%
Nothing	0.0%	10.0%	4.9%

Visited CHWs to deliver clean delivery kits	4.8%	0.0%	2.4%
Monitor suspected whooping cough	4.8%	0.0%	2.4%
Provided slashers for clearing environment	4.8%	0.0%	2.4%
Don't know	0.0%	15.0%	7.3%
N/A (blank)	4.8%	15.0%	9.7%
Total	**23**	**24**	**47**

When asked to give specific details on the most recent action undertaken to monitor service quality, 27% mentioned monitoring the building of pit latrines, 12% mentioned community visits to monitor implementation and progress made, 10% went out to donate on behalf of a charity while a further 10% took action to ensure that hygiene was maintained and breeding sites for disease eliminated. Some 4.8% of respondents from high performing HCCs mentioned taking clean delivery kits to community health workers and TBAs (Table 24e).

In general terms, an average of 40% of key informant respondents claimed that they informed their communities on health issues; an activity that was undertaken through calling community meetings. A further 25% said that they drew up plans of how to inform their communities on health issues. Some door-to-door approaches were undertaken as a way to disseminate health information (13%); Awareness campaigns on specific disease epidemics were another channel used for informing communities on health issues (12%). When pressed to name the last such specific kinds of actions undertaken, nearly 28% mentioned cholera and malaria awareness campaigns, 14% mentioned calling specific community meetings on HIV/AIDS (especially so among respondents from high performing HCCs). A further 14% of respondents reported an example of calling for a meeting during specific disease outbreaks. In a few cases (4.7%), the HCCs met to explain the shortages experienced at their health centres (Table 24f).

Table 24f Participation of HCCs in informing the community on health

Informing the community on health ...general action	**Performance ranking of HCC**		**Total**
	High HCCs	**Low HCCs**	
Calling a community meeting	54.5%	23.8%	39.5%
Make plans on how to disseminate information	27.3%	23.8%	25.6%
Going door-to-door	21.7%	4.8%	12.8%
Awareness on various epidemics	0.0%	23.8%	11.6%
Had training with HCC	9.1%	0.0%	4.7%
Going round using PA systems to disseminate information	0.0%	4.8%	2.3%
Inform NHCs in village on new information	0.0%	4.8%	2.3%
Nothing (of that sort)	0.0%	4.8%	2.3%
Don't know	0.0%	4.8%	2.3%
Not applicable	4.5%	4.8%	4.7%

Total	23	24	47
Informing the community on health ...last specific action	**Performance ranking of HCC**		**Total**
	High HCCs	**Low HCCs**	
Cholera and malaria awareness	19.0%	36.4%	27.9%
We had a community meeting on HIV/AIDS	23.8%	4.5%	14.0%
Conducted meeting to inform community on disease outbreak	14.3%	13.6%	14.0%
Encourage good hygiene in communities	14.3%	4.5%	9.3%
Had meeting on how to deliver information to the community	4.8%	4.5%	4.7%
Met the NHCs and community to explain shortfalls of clinic	9.5%	0.0%	4.7%
Encourage people to use mosquito nets	0.0%	4.5%	2.3%
Teaching family planning	4.8%	4.5%	4.7%
Nothing (of that sort)	0.0%	4.5%	2.3%
Review of medical fees	4.8%	0.0%	2.3%
Meeting on measles, diarrhoea, syphilis & malaria	0.0%	4.5%	2.3%
Don't know	0.0%	4.5%	2.3%
Blank	0.0%	9.1%	4.7%
Not applicable	4.8%	4.5%	4.7%
Total	**21**	**22**	**43**

In response to the question, 'What authority do HCCs have to make their own decisions?', nearly 30% said that they had authority to decide which projects the HCCs should embark on to promote health. Up to 11% of respondents said that they had authority to decide their own budgets for the money in their control, especially so among respondents from high performing HCCs (26%). Otherwise the HCCs felt that they had authority to decide on which disease prevention activities to embark on and/or include in their work activities. HCCs also had authority decide which community problems were to be prioritised (4.3%), which people were to be trained from the community (4.3%), and that they had the power to hire and fire (casual workers for specific tasks at their health centres). But for an average of 17%, the view was that HCCs did not have decision-making powers, especially so from respondents of low performing HCCs (21%). Otherwise the practice was that health workers (at the DHMT or health facilities) actually made all the decisions at their health facilities (Table 24g).

Table 24g Issues in which HCCs have authority to make decisions for health

What issues does the HCC have its own authority to make decisions in?	**Performance ranking of HCC**		**Total**
	High HCCs	**Low HCCs**	
We decide which projects to embark on	43.5%	17.4%	30.4%
HCCs don't have any authority	13.0%	21.7%	17.4%

We decide our own budgets	26.1%	4.3%	10.9%
Educate people on health hazards and prevention	4.3%	17.4%	10.9%
Malaria prevention by spraying	4.3%	8.7%	6.6%
Decide what health problems should be prioritised	0.0%	8.7%	4.3%
Decide who to train	0.0%	8.7%	4.3%
Power to employ and fire	4.3%	4.3%	4.3%
Health centre staff make all decisions	0.0%	8.7%	4.3%
HCC have not been well informed on their roles	8.7%	0.0%	4.3%
Change the user fees for the health centre	4.3%	4.3%	4.3%
DHMT has final say in all decisions	4.3%	0.0%	2.2%
Call meetings with the NHC/community	0.0%	4.3%	2.2%
We decide when to meet	0.0%	4.3%	2.2%
Decide who to excommunicate	0.0%	4.3%	2.2%
Establish growth monitoring points (GMPs) in all zones to avoid congestion (for health centre outreach activities of under-fives)	0.0%	4.3%	2.2%
Total	**23**	**24**	**47**

With respect to planning for their health centres, nearly 85% of key informant respondents said that community interests were taken into account and incorporated in planning for primary health care activities. But when pressed to come up with specific examples, nearly 22% of respondents were of the view that this did not happen as community views were largely sidelined, especially so among respondents from low performing HCCs. Another 11% said that though present, these mechanisms did not work. Otherwise, meetings were called in some cases (4.3%), or that the community was free to call on any HCC members (4.3%) or that people in the community can request the HCCs for a meeting as need arose (6.5%). In some cases, the HCCs consulted individuals such as village headmen (4.3%) or individual HCC members made decisions, which they felt represented the interests of their communities. The general perception was that NHCs were already in place to represent community interests (Table 24h).

About half the respondents acknowledged that mechanisms existed for including community evidence and/or interest in budgeting for primary health care at their health facilities. This situation was especially true among high performing HCCs. When asked to specify what actually takes place, no specific examples were forthcoming. Nearly 20% of key informant respondents were of the view that no mechanisms existed and their HCCs never consulted their communities in this regard. To the contrary, some respondents said that health centre staff, regardless of whether or not there was community evidence, imposed budgets on them. This was especially the case among respondents from low performing HCCs. Otherwise the only evidence that community views were incorporated into budgets came from the fact that village headmen generally backed the issues they took to their health centres, more particularly among the high performing HCCs. Discussion sessions with respondents revealed that high performing HCCs used the influence of their traditional rulers much more than low performing HCCs (Table 24i).

Table 24h Awareness of HCC mechanisms for including community views/interests in planning for health

Are you aware of mechanisms for including community views/interests in health planning? …(yes or no)	Performance ranking of HCC		Total
	High HCCs	Low HCCs	
Yes	87.0%	82.6%	84.8%
No	13.0%	17.4%	15.2%
Total (no.)	**23**	**24**	**47**
Perceptions on mechanisms for including community views/interests in health planning	**Performance ranking of HCC**		**Total**
	High HCCs	**Low HCCs**	
Community views are sidelined as secondary to those at health centre	17.4%	26.1%	21.7%
NHCs meet to list problems of the community	13.0%	17.4%	15.2%
Represent the community through NHCs	13.0%	13.0%	13.0%
Inform people about disease prevention through NHCs	4.3%	17.4%	10.9%
Though present, they don't work	17.4%	4.3%	10.9%
At the request of the people, we donated food to the needy	13.0%	0.0%	6.5%
HCC gave loans to community to help HCC generate money	8.7%	0.0%	4.3%
The community is free to meet us as the doors are open	0.0%	8.7%	4.3%
Call the headman to discuss plans for the health centre	4.3%	4.3%	4.3%
Hear peoples problems during meetings with them	4.3%	4.3%	4.3%
I decided on the programme of building toilets at RHC	4.3%	0.0%	2.2%
Not applicable	0.0%	4.3%	2.2%
Total	**23**	**24**	**47**

Just over half of the key informants agreed that follow-up on issues was undertaken by HCC members. On balance, the data still show that high performing HCCs undertook more follow-up and provided more feedback to community on issues of interest, compared with the low performing HCCs. However, lack of knowledge by HCC members was singled out as a major contributor to lack of follow-up on issues. In some cases, the community was known to press for feedback on issues from their HCC representatives. Follow-up on issues, especially with health centre staff, was sometimes misunderstood to imply that the HCC members are indirectly soliciting for jobs (Table24j).

4f Community participation and access to health services by the poor/vulnerable in communities

The poor and the vulnerable were identified as being isolated from services (*Figure 17*). Thus special sessions were undertaken to get the views and perceptions of the poor and vulnerable in terms of equity in health service provision. A narrative approach has been

used to enable these sentiments get to the attention of health managers and policy makers in the Zambian health services after data dissemination sessions, following this report.

In the last part of the study, special sessions were held with the social groups earlier identified as the poor and socio-economically vulnerable groups. These social groups comprised widows, orphans, the elderly and the disabled. This section presents a picture on their representation in terms of improved access to decision-making within the context of the HCC partnership arrangement in health.

Table 24i Awareness of HCC mechanisms for including community evidence/interests in budgeting for health

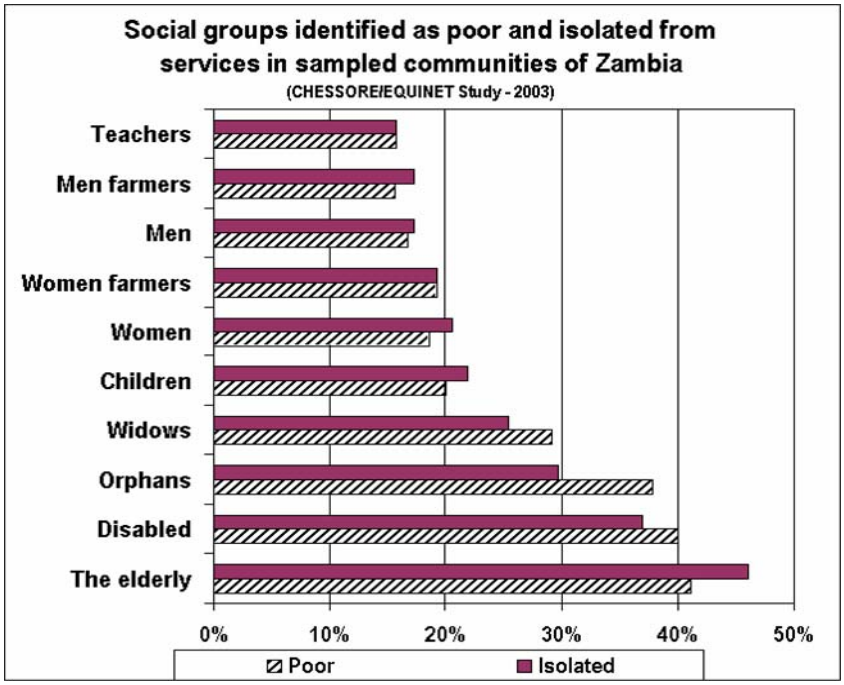
Are you aware of mechanisms for including community evidence/interests in budgeting? ...(yes or no)	Performance ranking of HCC		Total
	High HCCs	Low HCCs	
Yes	56.5%	43.5%	50.0%
No	43.5%	56.5%	50.0%
Total	**23**	**24**	**47**
Perceptions on mechanisms for including community evidence/interests in budgeting? ...if yes, specify	**Performance ranking of HCC**		**Total**
	High HCCs	**Low HCCs**	
NHC represent community on problems and budgets	34.8%	21.7%	28.3%
The HCC does not consult the community on budgets	21.7%	17.4%	19.6%
Budget imposed by health centre staff	4.3%	17.4%	10.9%
We asked money to buy cement for the toilets	13.0%	0.0%	6.5%
Community identifies health problems	4.3%	8.7%	6.5%
Headmen have backed issues we brought to the health centre by HCC	8.7%	0.0%	4.3%
80% of money obtained should remain at clinics	0.0%	8.7%	4.3%
N/A	13.0%	26.1%	19.6%
Total	**23**	**24**	**47**

Table 24j Awareness of HCC mechanisms for the community to followup or get feedback from the HCC

Are you aware of mechanisms for the community to follow up or get feedback for the HCC? ... (yes or no)	Performance ranking of HCC		Total
	High HCCs	Low HCCs	
Yes	57.1%	47.8%	52.3%
No	42.9%	47.8%	45.5%
Don't know	0.0%	4.3%	2.3%
Total	**23**	**24**	**47**
Perception on mechanisms for the community to follow up or get feedback for the HCC? ...if yes, specify	**Performance ranking of HCC**		**Total**
	High HCCs	**Low HCCs**	
NHC makes follow ups on suggestions made to health centre	34.8%	9.1%	22.2%
We were asked at one time to update the people on	21.7%	13.6%	17.8%

projects			
Lack of knowledge hinders follow-ups	17.4%	13.6%	15.6%
Community requests for feedbacks on problems in meetings	4.3%	13.6%	8.9%
Followed up dysentery outbreak and stressed chlorination	0.0%	9.1%	4.4%
The community does not know the role and existence of HCC	0.0%	9.1%	4.4%
NHCs not firm on follow-ups	0.0%	9.1%	4.4%
Misunderstood as looking for jobs when make follow-ups	4.3%	4.5%	4.4%
Its just hard to make/get feedbacks	4.3%	0.0%	2.2%
Community does not use existing structures	4.3%	0.0%	2.2%
Blank	8.7%	18.2%	13.3%
Total	**23**	**24**	**47**

Figure 17: *PRA rankings of social groups in the community in terms of the level of poverty and isolation from publicly provided social services.*



4f.1 Poverty, disability, vulnerability and health problems experienced

These were identified as (i) malaria (ii) diarrhea (iii) pneumonia, (iv) body pains, and (v) coughs; in that order of prioritisation for attention. Malaria was a top priority condition because (a) “It is always with us,” and (b) “We always suffer from it [Malaria].” As such it contributes to the hardships experienced by the vulnerable in society on a day-to-day basis in the following specific ways.

> "As a disabled person, I find it difficult to walk long distance to the clinic. Not only that, but sometimes our colleagues, the able-bodied, easily finish the drugs because they have easy (and faster) access to them."
>
> "We don't have the strength to immediately respond to the arrival of drugs at the clinic by making a visit to the clinic. As we wait to gain strength or to feel better, our friends are busy collecting the drugs without our consideration [or considering the needs of others who have not yet presented at the clinic]."
>
> Another participant added: "Equally, we fall out of the health worker's focus – they don't mind [consider] our situation [being disabled and vulnerable]."

"Also as vulnerable people, we hardly find money with which to pay for user fees at the clinic; our physical disabilities seriously incapacitate us."

General impacts from illness when sick

The need for special attention arises because, when sick, the vulnerable groups become helpless even to perform ordinarily simpler tasks such as walking about to move from one place to another. They may fail even to lift a cup of drinking water for themselves. They thus spend most of the time immobilised and helpless, even with mild illnesses. They also reported that they usually lacked concentration to do anything in times of illnesses as their sleep patterns become distorted due to insomnia.

Problems faced on user charges

Respondents were unanimous to state that they encountered no social discrimination because of their status. But of the above problems faced, the major one was identified as being the lack to pay for user charges, whether set to be cash or through payment-in-kind. Either way, the vulnerable people faced a predicament that proved difficult to overcome. With respect to paying user charges through in-kind payments the lack of a capacity to produce crops and other agricultural produce was a hindrance: "Where are we going to find the maize with which to pay at the clinic as user fees?" they asked. They explained as follows: "As vulnerable people, it was very difficult to access farm inputs. Not even on loan, because everyone doubts our abilities to pay back due to what they consider us to be 'the weak members of their community'."

After malaria, diarrhoea was the next major health problem faced. As one respondent put it, "It is always malaria on top and if you are not suffering from it, then you have diarrhoea."As a common disease experienced, a sickness episode necessitates them going to seek health care at RHCs, which are located far from where they lived (being either 16km or 8 km away. "We have a problem of long walking distances from the clinic. We have difficulties to cover such walking distances." They added: "Do not forget that we have nothing to take to the clinic in exchange for their drugs." And they suggested that, "To solve this problem, tell them that we need to be provided with medicines to cleanse our dirty drinking water [chlorine] free of charge as a vulnerable group; otherwise, we will just perish since no one seems to be concerned about our health plight as a vulnerable people."

The third problem they faced was pneumonia, variously referred to as *'Tutapwi'* (in Lozi) and *'Kalaso'* (Senga, Tumbuka, Bemba, Nyanja). The perception in this regard was that pneumonia was a common disease and also it often resulted in severe attacks requiring urgent attention with powerful drugs. As such the disease was a health problem of concern because (a) "We need strong drugs to combat this since we are already a weak group" (b) "We are in dire poverty and lack warm clothing or beddings and this makes the cold to easily penetrate our chests." They suggested that in this regard, "The pneumonia drugs should be free of charge at least for us as a disadvantaged group."

The fourth health problem faced was that of body pains. This was explained as follows: (a) "Although, it may seem not to be severe, most of us even as we are here are experiencing body pains. It is another common health problem affecting us." (b) In old age body pains is a common manifestation, with many senior citizens in need of body-pains-drugs on a regular basis, "because their bodies were is generally weak due to their advanced age". In addition they pointed out that: (c) "Since we all experience malaria, it goes, therefore, without say that body pains are as a result of our malaria frequent concurrencies."

The problem of coughs and coughing was a fifth major problem faced by the vulnerable groups in society, for which they felt some special attention was needed. Coughs were a frequent occurrence among the vulnerable because "we don't have warm clothes to protect us from the cold weather which causes coughs." They suggested that: "As a special group, we need to have special drugs which should be packed separately and free of charge to help us recover quickly."

Participation in HCC work programmes

All participants in these special group discussion sessions were unanimous in saying that their health problems were never considered either by the HCCs or the work programmes undertaken by the HCCs. A key explanation that the 'authorities' and HCC representatives gave to justify their exclusion from the committees was that they were incapable of undertaking the heavy physical work that was associated with current work activities of HCCs. Much of the time the HCC members were reported to be walking long distances on an empty stomach to undertake health education talks in the community. For those that were widows, the common explanation was that they should concentrate on looking after their children since they did not have a spouse to help them. For the aged (senior citizens), the justifications given were centred on being physically weak and not able to relate to the modern social environment in a meaningful way. The view from these group discussion participants was that this was unfair because these 'physically fit' and somewhat 'suitable' community representatives never had a clue as to what the special needs of the poor and disabled could be.

The feeling of their exclusion from the work activities of the HCC was also somewhat confirmed in the individual discussion sessions held with key informants in the community. Although some respondents claimed that all social groups were involved,

four respondents cited widows as being involved and only one respondent specifically stated that old people were involved.

4f.2 Actions taken by HCCs and others to redress their plight

When pressed further for possible actions taken by the local HCCs to reduce their plight, the firm and overwhelming response was “NO!”, adding, “Those [committee members] do not help us in any way.” The general feeling was that they were not represented in any way through the activities and work plans developed by their HCCs (see below for details).

The NGOs were praised for the positive discrimination they exercised in ensuring that vulnerable groups were given priority allocation during the distribution of food relief supplies in times of famine (which was generally endemic these days).

In terms of help (or actions) received from other government departments, the unanimous answer was that they received “nothing” from government. The same response was given with respect to possible actions from traditional rulers. When referring to traditional leaders, an accompanying explanation given was that “they [the traditional leaders] were also helpless” (in that they had no independent financial source of funds, and that their salaries were always paid in arrears and they were wholly dependent on government and goodwill from government). The best that traditional leaders could do was “just to sympathise with us – by words without any support in form of resources needed”.

4f.3 Action taken to try solving the health problems of the poor and vulnerable

The discussants considered this in terms of the various health problems complained of. On malaria, the general and overwhelming response was that “nothing” in terms of corrective actions had been done either by themselves or others within their communities. The key reason for this was that they lacked capacity (physical, social or financial) to overcome their problems, stating that: (a) “We don’t have any capacity, physically or financially to confront the malaria problem,” (b) “We cannot buy bed nets … to prevent malaria,” and generally, (c) “No one has ever bothered himself to try and assist us solve them.” The latter factor emanated from the fact that the communities considered them to be ‘weak citizens’ who “cannot contribute anything to any development activity in our community”. Thus health services are considered to be part of a developmental agenda where the contribution of the community is measured and valued in terms of the physical effort they (can) put in. Taken to be ’worthless’ members of a community, the perception by discussants was that they were being treated as “second-class people in their communities”.

Table 25: Action in the community to address the plight of the poor and vulnerable

Organisations working with the poor & vulnerable	Citation, comment for being ranked and recognised
"The Church"	Church organisations were credited with providing the most relief as well as being the most concerned and committed to addressing problems bought about by their socio-economic vulnerability
PAM (Programme Against Malnutrition)	Came in as a distant second in that it offers food relief in the form of maize, preferentially to the vulnerable groups as well
The CHW and the NHC	The help given was only limited to giving panadols (painkillers) and chloroquine (anti-malarial); which are done sometimes, but not always. Some members of the local NHC also called on the vulnerable to pay simple visits to keep them company
The HCC	The answer was an overwhelming "Nothing! No help at all." At another discussion session, the HCC members helped by collecting firewood for some categories of the vulnerable groups, especially the elderly
Traditional leaders (chiefs, headmen)	Were credited with providing (psychological) comfort and cushioned the vulnerable from unfriendly remarks (ridicule) by members of society
Government public health care providers	"Those! … nothing," explaining that, (a) "They have no mercy on us," and (b) "They insist on us paying something for our medication knowing fully well the predicament brought about by our social status."
The poor and vulnerable persons themselves	The common answer to this question was "Nothing", pointing out that they felt helpless because of their socio-economic vulnerability and the negative societal attitudes towards them these days. The prevailing attitude was that "no one ever thought of them to be of any use in one form or another. Any suggestion that they may be of use was treated with scorn and laughter."

4f.4 Health outcomes in the last 12 months

When asked for their self-assessed perceptions of their health over the last 12 months, the overall response was their health status had faired "very badly". To explain this perception they cited the following as having contributed to their poor health status outcomes: (a) That they were in a poverty trap, being "economically tied up" and thus were unable "to raise funds nor access health services" when sick, and (b) that due to lack of cash incomes at their households, "we are unable even to by drugs from the retail outlets in our communities." The fact that the local retail outlets did not accept in-kind payments made their situation "really bad".

5 Discussion

This study has demonstrated that the concept of community participation is still alive and being variously pursued by the health system in Zambia. The government had gone a step further by raising the proportion of budget to be allocated for community based health activities from 5% to 10%. This clearly demonstrates a stronger government commitment to increased community participation in health issues at local levels.

HCCs were still functional, in one form or another, at all public health centres and clinics. These health centres were active to differing extents. However, one thing appears clear at this stage of the study. Those HCCs that were active and performed better in 1997/1998 still performed better up to the time of this study, while those that were low performing seemed to remain low performing. On the other hand, there were scattered reports that some NHCs were non-functional or defunct at community level due to a number of reasons, including lack of funding and lack of support from health authorities.

The HCCs had taken on an increasing number of roles, especially so with respect to participation in the planning and budgeting at the health centres and clinics. In this regard, both the health workers and the community have recognised this important role for HCCs. Perceptions as to how effective these committees were differed among key stakeholders. Up to 29.8% of key informants were of the view that the HCCs had the capacity to increase health expenditure on communities. But the majority opinion was that the committees did not have the capacity to increase spending on health problems in the community.

In terms of expenditure for health concerns in the community many respondents felt that this did not happen or that money was not enough to get an increase in spending. In some cases, despite money being allocated, nothing was done to spend on health problems in the community. Otherwise the main positive development was that there was an acknowledgement from the key informants that some money was allocated and transferred to the HCCs for improving health in the community.

Even fewer key informants (23.4%) could say that the HCCs had taken some form of action to try to increase health spending by communities. The majority view was that this was not the case (72.3%).

Nearly a quarter of key informants had not noticed any such changes to allocation of funds for improving health in communities, with another 40.4% reporting that the money allocated belonged to their health centres and that communities did not have the function and authority of spending money for the health centres. If more money was needed for undertaking health activities in the community, the correct procedure to be followed by the HCCs was to try embarking on fundraising projects. In this regard, some HCCs had embarked on gardening projects to try raising more money to support their community health programmes.

However, the view from key informants was that, by their actions, the HCCs had acquired a capacity to influence the health services in one way or another. Up to 74.5% of the key informant respondents thought this.

This influence was brought about by the active involvement of the HCCs in health-related activities. The HCCs provided health education to communities (34.0%) and influenced the location and construction of health posts (12.8%). In addition, the HCCs had the channels to reach their communities with health-related information, through the network of NHCs.

The HCCs were known to help in prioritisation of health problems for action and 'checked' the attitude of health workers at health centres. The HCCs had access to both the health system and the communities, and thereby wielded more power to help influence the provision of local health services. In a similar way, the majority view from key informants was that the HCCs had also acquired a capacity to influence health personnel in their areas (57.4%).

The capacity to influence health personnel arose from the fact they had the privilege of discussion with health workers on complaints received from the communities they served (14.9%), as they served the role of being a link between the health centre and the community. Where problems arose, HCC members were in a position to offer advice to health workers on how to change and thereby improve on cooperation with community residents. The HCCs were also said to take on the role of motivating those health workers that performed better by offering presents, such that in one case, an HCC managed to dissuade a clinical officer from taking part in an ongoing general strike action.

It was not all plain sailing trying to influence health workers. The task was particularly difficult with respect to issues of staff discipline. Health workers with professional formal training were more difficult to deal with than the untrained health care providers (the CDEs). Up to 29.8% of key informant categorically stated that HCCs did not have the capacity to influence health personnel.

Despite many in the community (80.1%) not being aware of the existence of an HCC at their local health centre, the majority of key informants (80.9%) were of the view that the HCCs were relevant to the task of prioritising health problems in the community.

The HCCs were deemed relevant because they served to link the health centre to communities (31.9%) and also provided health education to communities (8.5%). In addition, the HCCs supplement the efforts of health workers by making it possible to increase coverage and thereby bringing community health problems to the attention of the understaffed and under-funded health services. The work of the HCCs in sensitising their communities on health problems faced was credited with having saved some lives in the community where health education sessions were being undertaken.

Despite being accepted for some roles on issues of health at health centres and in the community, HCC members were still handicapped in effectively playing their roles, in

part due to the asymmetry in information between them and health workers. This asymmetry in information advantaged health workers during meetings as health workers influenced the committee in deciding what plans to make and how resources should be allocated. It has been observed that health workers (and also the members of an HCC) lacked the necessary capacity to appreciate and undertake some of the roles and responsibilities brought to them by the decentralised structures of governance in health [10].

Health workers were part of the HCCs, which met to plan and budget for the inclusion of community health priorities into health centre action plans. In coming up with a health centre plan, the procedure followed was that first members of staff and the HCC meet together at a planning meeting. At this meeting, the HCC members also brought their community plans at the health centre for inclusion. The health needs from the committee were to be incorporated into health centre action plans in this way. However, before discussions could commence, the observed tendency was that the health centre personnel '***first acquaint the Health Centre Committee members with the operations of the health facility'***. Thereafter the committee proceeded to discuss the plans and priorities in order to draw up a health centre action plan. After this each health centre submitted its plan, for onward submission to the DHMT. The District Health Board later scrutinises the district budget for adherence to guidelines and possible approval. "At the end of it all," said a district health office (DHO) official, "I would say we receive some funding, but not very much." This perhaps provided some motive for staff to try using all possible funds to purchase items for the health centres rather than spend some for community health activities.

6 Conclusions

In conclusion, the HCCs have assumed an increasing role and with increasing importance to all stakeholders for their roles and function in highlighting health problems in the communities in Zambia. This is recognised as such by all stakeholders at district level health services. It is also recognised that these structures of community participation are having an effect on the delivery of primary health care services, at least at the local level.

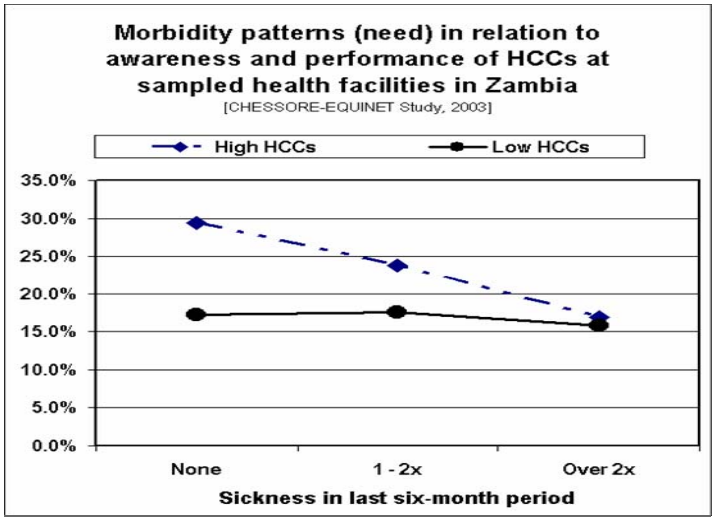
6.1 Comparison of sustaining gains in previous study as reflected by findings in this study

HCCs have been credited with undertaking a number of outreach activities with and/or on behalf of health workers. In this task, HCCs have undertaken health education campaigns to provide knowledge and sensitise communities on how to prevent illness as well as how to fight epidemics, should these happen. This attribute to the functioning of HCCs attracts and strikes a positive note with the community. This study followed up the performance of two categories of HCCs, one group from the high performing and another from the low performing HCCs. Though not statistically significant, the trend shows that where there are high performing HCCs the morbidity rates were lower than where there were low performing HCCs (*Figure 18*). This factor could be an important value added element to

health system performance. This is more so when one takes into account the fact that the HCCs operated in an under-resourced, hostile environment.

The high performing HCCs exhibited a greater capacity to identify opportunities that existed before them to obtain as much advantage as the opportunity allowed for their communities. This can be gauged from the general functions they performed and the last specific actions they undertook under a particular subject variable assessed (Tables 24a-24f). High performing HCCs were more involved in issues of budgeting and allocating resources to projects with direct benefits to their communities. High performing HCCs were more involved in discussion expenditure issues at health centres while at the same time they managed to 'audit' health centre accounts. Health workers at clinics served by high performing HCCs were less likely to impose decision for mere endorsement by their HCC (Table 24b). High performing HCCs took more seriously their prescribed role of monitoring the performance of the NHCs under their control (30% versus 4% for low performing HCCs). In addition, high performing HCCs were active in drawing up work plans for monitoring health issues in the communities they served (Table 24c). High performing HCCs took their responsibilities seriously and took initiatives to widen the scope to include poverty eradication and examining their potential role in looking after the more critically ill within their communities. High performing HCCs were more active in undertaking health education and sensitisation activities in their communities such as sensitisation on HIV/AIDS, TB and malaria (Table 24d). Key informant respondents from low performing HCCs felt that their HCCs had no role in monitoring quality of service at their health centres, while the high performing HCCs made efforts to observe how care was being delivered at their health centres and worked more closely with their NHCs to identify people with serious health problems for the attention of the health centres (disease surveillance) (Table 24e). High performing HCCs took the initiative to undertake door-to-door meetings at household level as a way of ensuring more effective communication with the people they served while also holding frequent meetings with community stakeholders on health issues (Table 24f).

Figure 18: *A comparison of morbidity rates with the performance rating of HCCs.*



The role and value of HCCs in the Zambian health services was evaluated at an outcome mapping session held with the boundary partners of HCCs as stakeholders. All stakeholders were essentially agreed that the HCCs had a somewhat high effect in helping to sensitise communities on public health problems and possible solutions to take. This had helped to make it possible for many in the community to participate in health programmes, thereby making the take-up of public health interventions more effective. There was also consensus among stakeholders that HCCs had a low effect in terms of directing resources towards the poor and vulnerable groups in society. Overall, the consensus by all stakeholders (the HCCs, health workers and DHMT staff) was that these governance structures had a low to medium effect on the performance of PHC activities. In some areas the HCCs were reported to be more effective than in others. DHMT respondents, for example, felt that the HCCs had a low effect in trying to improve governance roles at health facilities. They have not been able to improve the responsiveness of health services to the needs of local populations (such as transforming health workers to become more polite and willing to help, or in improving efficiency in the delivery of services by making it possible for health workers to work harder than before) (Table 26). It is interesting to note, though, that health manages desired that the HCCs could play a more active part in transforming the social attributes of health workers. This view was previously expressed by HCCs, who noted that current health managers had failed to control staff and merely used transfer to remote areas as a solution. They had then argued that if they can admit failure then they would be prepared to take on that role "since these health workers possessed the same socio-cultural background as us" [5,6].

However, a number of obstacles and challenges still stood in the way of increased effectiveness of HCCs in this noble task of community participation in governance in health. For a start, both the community and health system stakeholders tended to look down on the activities of the HCCs in view of their low level of professional knowledge on health issues. This perception hindered the effectiveness of HCCs, who in turn were at a loss as to how to overcome this. In addition, many from the community held the view that HCC members did not know or understand their roles and functions correctly enough to benefit their communities. There was a common perception that some HCC members lacked the necessary capacity (knowledge and tact) to engage the health system in meaningful dialogue to order to effectively prioritise health problems and stimulate the necessary action in the community for positive health outcomes. To this end, our earlier report from the pilot work done prior to this study had noted:

> The worrying observation was that NHCs and HCCs seem to play a very little role as a governance structure in the community, vis-à-vis health and health provision. The NHC/HCC role seem to be relegated to provision of health education and not to the formulation of health policy and holding the health centre (HC) accountable to the community in the provision of health services.
> (CHESSORE-EQUINET, stakeholder consultation, March-April 2002)

The lack of motivation and appropriate incentives further reduced the effectiveness of HCCs in carrying out their tasks. Incentives were not factored in to the work activities of

HCCs. In addition, the generally negative attitudes of health workers to these organs for community participation also hindered effective actions and impact from HCCs. It was clear that both stakeholders (health workers and community representatives) needed to be reoriented to their tasks and appropriate social skills imparted to them through appropriate training and workshops.

The way the committees were formed, though largely democratic, made it difficult for them to feel accountable to their communities in their work activities. As these meetings to elect representatives were called by health workers, there appeared to be a feeling that the committees were formed to serve the interests of health workers, being the initiators of the process. A good example in this regard was at one of the high performing HCCs where the local chief took over the role of the place where HCCs should account for their work activities. The local chief was able to sermon the committee to account for why things happened the way they did at their health facility. Where possible the chief sanctioned the removal of ineffective members from the committee to replace them with ones who would be accountable to the people and their chief. As such, health workers could not needlessly remove the HCC members at that health facility from their posts, unless health workers won the consent of the chief. This kind of action had the effect of making stakeholders from the community and the health system accountable to a neutral person who represented the wider interests of the community.

Table 26 Assessment of the current impact of community participation of the HCCs in primary health care delivery in Zambia

Area of assessment of outcomes from work programmes of governance structures in health	HCCs	Health workers	DHMT staff
Have helped to increase the resources available for health (by getting more resources from the DHMT, the local community and from other sources)	Medium effect	Medium to high effect	Low to medium effect
Have helped increase the uptake and effectiveness of interventions (have made it possible for many in the community to participate in health programmes, making many to benefit)	Medium to high effect	Medium effect	Medium to high effect
Have helped improve the quality of health care (e.g. HCC helps to make drugs available)	No effect	Nil to low effect	Medium effect
Have helped increased the quality of management, (e.g. health workers now give information to community, have solved some problems at the health centre)	Low effect	Medium effect	Low effect
Have helped sensitise communities to health problems and possible solutions (thereby preventing diseases from breaking out)	High effect	Medium to high effect	Medium to high effect
Have increased the feeling of solidarity (togetherness) in a community	Low to medium	Low to medium	Medium effect
Have helped to direct resources towards needs of vulnerable groups (e.g. the elderly, widows, orphans,	Low effect	Nil to low effect	Nil to low effect

and the disabled)			
Have helped to improve governance, and the responsiveness of health services to the needs of local populations (e.g. health workers now polite and willing to help, health workers now work harder than before)	Medium effect	Medium effect	Low effect
Have increased self-reliance and local skills base (e.g. most decisions and actions are taken at the health centre without need to take to the district)	Medium effect	Low to medium	Medium effect
Overall assessment of performance	**Low to medium**	**Low to medium**	**Low to medium**

The activities of HCCs are now largely concentrated on gaining access to key operations at the health centre with a view to bring in community interests in health and health care. This has not happened to any meaningful way, with both communities and their representatives feeling frustrated by the slow pace of influence gained so far. In the meantime there are more community level activities being done by the HCCs of a health-related nature. They took health messages to the community, packaging them in way communities can more easily relate to.

Significant correlations have emerged in this study to show that the greater the community perception of the degree of HCC control on health centre staff, the more pleased people became (MH 10.52, p-value 0.00118). Significant correlation emerged between community perception on the capacity of their HCCs to discipline staff and satisfaction with performance (MH 6.93, p-value 0.0084). Satisfaction with HCC rating was even greater where communities had rated the capacity of their HCCs to solve problems complained of as average to very good (MH 16.29, p-value 0.000054).

There were no statistically significant differences in the self-perception of health status outcomes between the higher (quintiles 4 and 5) and lower (quintiles 1 to 3) socio-economic groups whether or not they knew of the presence of HCCs and/or NHCs at their health facilities. This finding supports the view expressed by HCC and NHC representatives that they worked to serve the health interests of both the poor and the rich in their communities.

Overall, there was a significant correlation between the performances of HCCs as gained from the two previous assessments and the satisfaction rating by community respondents who knew of the existence of their HCCs (MH 6.91, p-value 0.0085). This might indicate that, due to restrictions on the roles played by HCCs, their (potential) capacity to make a difference could be gauged from any one of the activities where their performance was greatest. This would perhaps be the best position from which to exert capacity building and spreading to increase the impact of this capacity to other areas of health and health care.

7. Recommendations

The following recommendations are being made as a result of findings from this research work.

- In the first place, more research work is needed to try and understand the dynamics of interaction between health workers and members of the community, with a view to determining an equilibrium for optimal performance by either stakeholder.
- There is need to equip members of the HCCs with an appropriate set of tools, techniques and knowledge as a way to empower them to bargain with the health system for effective inclusion of community health priorities in the local health centre budget.
- It will be necessary to review current guidelines on community participation with a view to strengthen and ensure the participation of the community when the plans and budget go to the ministry HQ as well as when the funds reach health centres.
- The selection/election procedures of HCCs need to be revised so as to clearly and explicitly indicate to whom the committees would be accountable from then on. Available evidence indicates that a neutral body or persons with interest in the well-being of communities (such as traditional rulers) could fill this void.
- Better supervision and interest in the work of the HCCs by district health officials could provide the committees with the necessary support and additional incentives to do better. In particular, there is need to set up grievance procedures in order to avoid HCC members from being needlessly victimised if they raised certain question in the performance of their work.
- There is also a need to educate and equip health workers with the necessary social skills to engage the various communities they serve, within their socio-cultural contexts and perceptions on health issues, as a way to accommodate desired health priorities. These stakeholders need to accept and value each other’s contribution to health.

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Annexes

Annex 1: Prescribed functions and roles of health centre committees (HCCs) in the Zambian public health services

To consolidate\prioritise community needs.
To initiate and participate actively in health-related activities at household and community level.
To support community-based health care volunteers.
To support all local development.
To mobilise and account for resources.
To consolidate, analyse, use and disseminate data.
To contribute to preventive maintenance and security of the health centre.
To monitor and evaluate progress.

Responsible to:	The District Health Board through the Area Health Board, where applicable.
Proceedings:	To meet monthly.
Reference:	*District Guidelines on Roles, Functions and Responsibilities of Boards and Committees and Job Descriptions for Directors and Advisors*, Health Reforms Implementation Team Secretariat (HRIT), Ministry of Health, Lusaka, Zambia (November 1995).

Annex 2: Desired 'ideal' definitions of community participation and actions for community participation in Zambia

The term 'participation' means

1) Actively giving ideas
    a. Create formal channels for getting ideas
    b. All ideas should be taken and considered on merit
    c. Feedback on how ideas were considered
    d. Active participation in certain events
        i. planning stages
        ii. budgeting and allocating money to activities
        iii. community mobilisation strategies
        iv. health promotion events (TB days, AIDS days, etc)

2) Influencing decisions
    a. There must be free flow of information
    b. Ensure adequate preparation before meetings/workshops
    c. Sensitisation to help accept and adopt the concept of participation (at health centre and in the community)
    d. Should be aiming to develop consensus with stakeholders, and not to impose ideas/suggestions.
    e. Define some areas where there can be influence, e.g. prioritisation on health problems
    f. Knowledge and use of proper channels for communicating ideas and information
    g. Supportive (advocacy) approaches
        i. Communities coming forward to help out
        ii. Active surveillance on health problems in the community with early reporting to health centres
        iii. Supplying community based data on social groups and their health needs for the attention of staff
        iv. Health workers should show interest in community activities and demonstrate they are part of the community, e.g. taking part in brick-making during community development projects.
        v. Develop skills in the community, such as teamwork approaches, how to tackle certain health hazards/problems, etc
        vi. Health workers and HCCs should be seen to be one, and work in a united way; This will help to give HCCs the much needed support and recognition for the roles they play
        vii. The DHMT should include consultations with the HCCs during their supervisory visits to health centres and work to promote dialogue with health workers.

3) Incentives for community participation
    a. From the health system

i. Knowledge gained
ii. Training given
iii. Sense of ownership responsibility in being consulted
iv. Psychological – in being involved in planning, budgeting, etc (social prestige)
v. Material gains in form of refreshments, T-shirts, etc
vi. Friendship with health workers and the health system (hence exemptions from certain payments and easier access to certain services)

b. From the community
   i. Community appreciation
   ii. Community labour to help TBAs, CHWs, and possibly HCC members
   iii. Top-up incentives for health workers (such as with cash)
   iv. Undertake income-generating activities to be used as a source of incentives

4) Sometimes playing a role in implementation of health programmes or policies

a. Health promotion (community hygiene, refuse disposal, advising children born in villages to go for BCG, etc)
b. Health education in the community
c. Community groups can help to carry out some work activities at the health centre
d. Influencing decisions on **cost sharing**
   i. Explaining the policy of fees to community
   ii. Decide on amount of user fee charges
   iii. All should pay user fees (including HCC members, who should lead by example)
   iv. Modalities of payment (cash or in-kind payments)
   v. Exemptions (deciding who should not pay)
   vi. How user fees money should be spent; and also
   vii. On which priority programmes money should be spent

e. Influencing the allocation of resources to health priority problems in community
f. Influencing the allocation of resources to different (especially the vulnerable) groups in the community
g. Community to generate resources or income to solve health problems in the areas
   i. Operating local ambulance services (buy bicycles to transport patients from community to health centre)
   ii. Raising money to support certain programmes at the health centre (e.g. buying ambulances to be used at the health centre)