Assessing the impact of Health Centre Committees on health system performance and health resource allocation

Training and Research Support Centre (TARSC) Zimbabwe
Community Working Group on Health

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Executive summary

This study sought to analyse and better understand the relationship between Health Centre Committees (HCCs) in Zimbabwe as a mechanism of participation and specific health system outcomes, including:
- improved representation of community interests in health planning and management at health centre level;
- improved allocation of resources to health centre level, to community health activities and to preventive health services;
- improved community access to and coverage by selected priority promotive and preventive health interventions;
- enhanced community capabilities for health (through improved health knowledge and health seeking behaviour, appropriate early use of services); and
- improved quality of health care as perceived both by providers and users of services.

Methods

The study was carried out in three districts: Goromonzi, Makoni and Gweru District. These areas had well-established HCCs set up by the CWGH and were chosen for logistic access. The study was implemented to compare four wards with and four wards without HCCs in these districts.

In the first phase, in February to June 2003, information was gathered on health outcomes, on HCCs' roles and functions, attitudes towards HCCs, inclusion of community priorities, impacts on resource allocation, impacts on health care utilisation and perceived quality and responsiveness of health care at the selected health centres. This was done through:
- cross-sectional community surveys, done in the wards sampled in February 2003, covering HCC and non-HCC wards with 30 people per community fraction (women, youth, the elderly, men) in each ward, and a total of 1006 people interviewed, or 0.2% of people in the three areas;
- key informant interviews in February/March 2003 of nurse, EHT, community health workers, district nursing officers, district medical officers and local government CEOs and elected, traditional and civic leaders;
- focus group discussions using a participatory assessment tool in four community meetings in each area; and
- analysis in March/April 2003 of health information system and health expenditure records from district and health centre level using 2001/2002 data.

The second phase of the study included:
- preparing and translating a simple summary of the findings with a balance sheet of positive, negative and non impacts of participatory mechanisms based on findings;
- reporting back to the community and other stakeholders to discuss the findings and the follow-up recommendations;
- development of case studies on key issues, arising from the findings to better understand the findings;
- key informant interviews with the district and central MoHCW; and
- gathering of statistical information from the health services on primary health care indicators and health services resources.

Findings

The study findings are summarised below.

Communities depend largely on public sector primary care health services

The communities in all areas are primarily poor. There are wealthier and more powerful groups (business people, those with political influence, the large-scale farmers and mine employers). There are also extremely vulnerable groups (orphans, the elderly, disabled people). Groups at either end of the extreme of the spectrum of wealth and poverty do not participate in the HCC, which is otherwise judged to be relatively representative of community groups.

The communities in the survey, like many in Zimbabwe, are generally relatively well educated (to secondary school level) but have high levels of unemployment and unskilled labour, meaning that the economic and professional resources available for health work is low.

People generally use public sector clinics as the primary source of health care, making it important to them that these function well. There is however variation around this that potentially undermines the focus of communities on their clinics and on the HCC that works with them: highly vulnerable groups use traditional medicine; those living close to public hospitals use these for primary care instead of clinics; and some in urban and farm areas use private services instead of public clinics. The groups that fall out of public clinic use have less interest in making their clinics work and thus have less interest in supporting the work of the HCC.

Public clinics are generally but not always accessible, and shortage of fuel for outreach and shortage of transport to clinics breaks links between communities and their health services. There seems to be a vicious (or virtuous) circle, where distant clinics do not have strong outreach and thus have significantly reduced interaction with their communities, while closer clinics also have more outreach contact.

Resources to clinic level are not easy to determine, as clinic spending is not clearly defined in district budgets and allocations not managed at clinic level. The bulk of the district expenditures in the study districts in 2001 was on medical supplies (59–89%) with 2.6% or less allocated to disease control, the vote which includes community health promotion activities.

Health Centre Committees are associated with improved health outcomes

In the study, clinics with HCCs had on average more staff, (nursing, EHT and general) and there was some evidence of higher budget allocations from MoHCW than clinics without HCCs. They also had more EPI campaigns than those without HCCs. Drug availability at the clinics with HCCs was better than those without HCCs, although drug availability was generally poor. It could be argued that improved health performance and staffing in these areas is associated with an improved capacity to draw and use health resources. If this is the case then there is a virtuous cycle for those clinics with HCCs and a vicious cycle for those without.

The study indicated also that areas with HCCs performed better on Primary Health Care (PHC) statistics (EHT visits, ORS use) than those without, and that there is improved contact with the community in areas with HCCs. Community health indicators (health knowledge, health practices, knowledge and use of health services) were higher in areas with HCCs than in those without. Communities in areas with HCCs had a better knowledge of the organisation of their health services from the indicators assessed, making services more transparent to them. There was also evidence of improved links between communities and health workers in these areas.

The evidence indicates that areas with HCCs thus perform better on a range of health indicators compared to those without: in the level of resources within the clinics; in PHC coverage; and in community health indicators. Many of the areas of improved performance relate to the primary

health care system, where communities can exert impact, rather than to the medical care services.

The study suggests an association between HCCs and improved health outcomes, even in the highly under-resourced situation of poor communities and poorly resourced clinics.

HCCs have acted on and improved primary health care services
Community, HCC and health authority sources all reported that HCCs have taken up environmental health and service quality issues. Their primary mode of action seems to be more of an additional service outreach and link. They find out community needs and organise service inputs such as drug purchases, building waiting mothers' shelters, water tanks and toilets. They also provide health information. These roles appear to enhance their credibility with the community and the health staff. In two cases they have also been able to mobilise additional resources for health from community and other sources.

HCCs and their communities concur strongly on the priority health issues affecting communities, particularly in the areas where the HCC is reported to have stronger communication links with communities (Goromonzi and Gweru). These priorities relate to health service issues at the primary care level (drugs, emergency transport, staffing) and environmental health issues (water and sanitation).

HCCs share community priorities, but have variable levels of communication and representation of communities
While the HCCs have been successful – at least in two areas – in enhancing primary health care 'deliverables' and in health promotion, many in the community are not aware of the HCCs or their work. HCCs appear to relate well to particular subsections of the community, but have not been able to widely mobilise the whole community around issues or assume visibility for this role.

Communities and HCCs agree that communication is the biggest limiting factor in improved HCC performance. HCCs themselves get no resource support for this role and are poorly equipped with information.

HCC members and health authorities observe that the poorest groups in communities do not participate in the HCCs and that specific additional efforts are needed to ensure that the interests of the poorest groups are represented.

HCCs have not been able to influence health budgets directly but have improved primary care resources from their own resource mobilisation
HCCs have not had direct influence over core health budgets and have little influence in how their clinics are managed and run. The improved resources to clinics in areas with HCCs indicate some indirect association between HCCs and primary care resources. This may be exerted through support for clinic security, for staff needs, for clinic facilities and outreach and other services.

Communities judge the HCC's effectiveness from its impact on health services. The HCCs have worked hard to deliver PHC gains but have not been able to significantly change the quality of care as they have little or no authority over the budgets, staffing and drugs that influence this. Recognising this, two HCCs used community funds to buy drugs for the clinic to secure such impact. Notably, evidence indicates improved drug supplies in areas with HCCs.

HCCs have played little or no role in monitoring budgets or making services accountable on their 'policies and promises'. They have visited services and in one area informed health staff of complaints over services. This is a somewhat tentative step towards public accountability. Efforts

to take up financing issues (such as around the AIDS Levy fund) appear to work better when backed by strong community links and reasonable relationships with health authorities.

The study thus indicates that HCC effectiveness centres on community linkages and communication. HCCs have been given little or no budgetary resources or authority, and have in some cases mobilised their own resources to deal with perceived health needs.

HCCs have weak formal recognition, are poorly resourced and are poorly trained or informed for their role
HCCs seem to be vulnerable to a number of factors limiting their effectiveness, including weak formal recognition by health authorities, lack of own area of authority and unclear reporting structures and role definition. Given this, their performance is influenced by the attitude and responsiveness of the health authorities and the participation of strong community leaders, both highly variable across districts. The HCCs note their lack of knowledge or training on the health system and lack of resource investment in their functioning. Health authorities show some ambivalence and lack of consensus on HCC roles.

Strong PHC systems with community outreach support the efforts of HCCs
There is a virtuous cycle between the strength of the PHC system and that of the HCC, with each positively reinforcing the other. Health worker outreach and reasonable investments in PHC were noted to be important to trigger this virtuous cycle.

On their part HCCs are better able to translate these health system resources into improved health outcomes when they understand the health system, communicate well with communities, have links across all community groups and with political and community leaders.

Hence, despite the association with improved health outcomes, there appears to be inadequate formal recognition, role definition or resourcing of HCCs to draw or sustain positive impacts. In part this is due to ambivalence on HCCs in health authorities, including on their roles and formal status.

Conclusions

Recommendations for improved functioning of HCCs call for formalisation of their roles and authorities (rationalising their roles and those of ward health teams), strengthened communication with district health personnel, training in key areas of their functioning and in health systems generally, and resources to support their work, particularly for communication and outreach. There was concurrence between health authorities and HCC members on these necessary inputs to improved performance.

Better representation of vulnerable groups was identified as a necessity, through direct representation, outreach and through community health workers such as the village health workers.

This study sought to examine the role of HCCs at three levels:
- in terms of perceived and real health outcomes associated with their work;
- in terms of their functioning; and
- in terms of the underlying factors influencing their performance.

There is strong evidence of positive health outcomes associated with HCCs in this study. The evidence, supported by the mechanisms of community resource mobilisation, information outreach and social actions around health, indicate that HCCs play a positive role within health systems. They provide evidence of roles for community participation beyond dialogue and consultation.

They are however constrained by weaknesses in their own capacity and functioning, particularly in terms of knowledge of the health system, capacities for communication and information links with communities, and the basic resources for their functioning.

More deeply they are constrained by the resource limitations within their communities and in the primary care level of the health system they operate in, particularly where there are falling resources allocated to district outreach, to primary health care and to quality of care at clinic level. The ambivalence around their recognition and functioning and the lack of resources directed at their activities appear to be part of the general under-resourcing of the primary care level of the system. Effective demand or organised voice at community level is not easily sustained, and may be defensively responded to in such a situation.

It may thus be argued that the strengthening of HCCs as a vehicle of community participation is thus deeply bound with the strengthening of the PHC and primary care level of the health system. There are clear signals in this study of the virtuous cycles of positive health outcomes between HCCs and performing clinics. What is needed perhaps is to translate this into wider national policy and practice.

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1. Background

1.1 Participation and health

Participation of communities is widely argued to be an important factor in improving health outcomes and the performance of health systems. Despite this, and the common inclusion of 'participation' as both means or ends in health policy, participation is poorly conceptualised and operationalised, both in governance in health and in technical health interventions, undermining systematic analysis of its specific contribution to health and health systems outcomes.

Following positive gains in social mobilisation and health service delivery in Zimbabwe there has in the 1990s been mounting public and professional concern over declining quality, access and equity in health services and increasing demand on people to finance and contribute to health services. Local government mechanisms for participation developed post-independence were weakened by centralised decision making and authority, the dominant input of administrative officials, the exclusion of civil society groups, and by limited capacity and authority. In health, participation was focused on social mobilisation and compliance with centrally defined programmes, leaving social groups and health officials dissatisfied with the level and forms of community participation. Surveys have indicated that communities and public health personnel are dissatisfied with both the level and distribution of health resources, particularly in the shortfall to primary care level and to preventive health and with the declining quality of care at primary care level. Hence while equity has continued to remain a core policy of the Ministry of Health in Zimbabwe, there is evidence that old inequities have not been fully addressed, and indeed that some reversals in health equity gains made post-1980 had taken place (CWGH, 1998; MoHCW, 1997; Loewenson, 2000; Ropi, Loewenson, Sikosana and Zigora, 2001; Ropi, 2000).

There is evidence of a relationship between social participation and health outcomes. These indicate that enhanced prevention, compliance with treatment and rehabilitation demand dialogue between health services and communities on their mutual roles and the technical, resource and social inputs needed to fulfil those roles (Gilson, Kilima and Tanner, 1994; Loewenson, 2000).
While participation in governance and increased public accountability is increasingly claimed as a goal of health systems, such as in decentralisation policies, it is poorly achieved in practice.

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[1] **TRAINING AND RESEARCH SUPPORT CENTRE** (TARSC) is a non profit organisation based in Zimbabwe that provides training, research, information and other support services on economic and social policy to civil society organisations. Contact TARSC at Box CY2720, Causeway, Harare, Zimbabwe, Tel +263-4-708835, Fax +263-4-737220 email: admin@tarsc.org

Ambiguous or vague roles, limited authority, weak information access, weak impact on budget allocation, weak representativeness and upward rather than downward accountability have, amongst other factors, undermined the practical implementation of meaningful forms of participation. Participation is often directed at management and implementation of systems, when the major claim being made by many social groups is for policy making and its execution to be accountable to the public.

If participation and accountability are to be strengthened in Zimbabwe's health sector, there is need for a review, involving interest groups, of current practice at district, referral hospital and national level, to recommend changes that would enhance public accountability in governance at each of these levels. Recommendations for future practice should be supported by information on how different social groups have in the past raised and pursued health issues, how these issues and public concerns on quality, access and equity have been addressed within existing structures and the impact that participatory processes and structures have had on health systems.

1.2 Mechanisms for participation and health in Zimbabwe

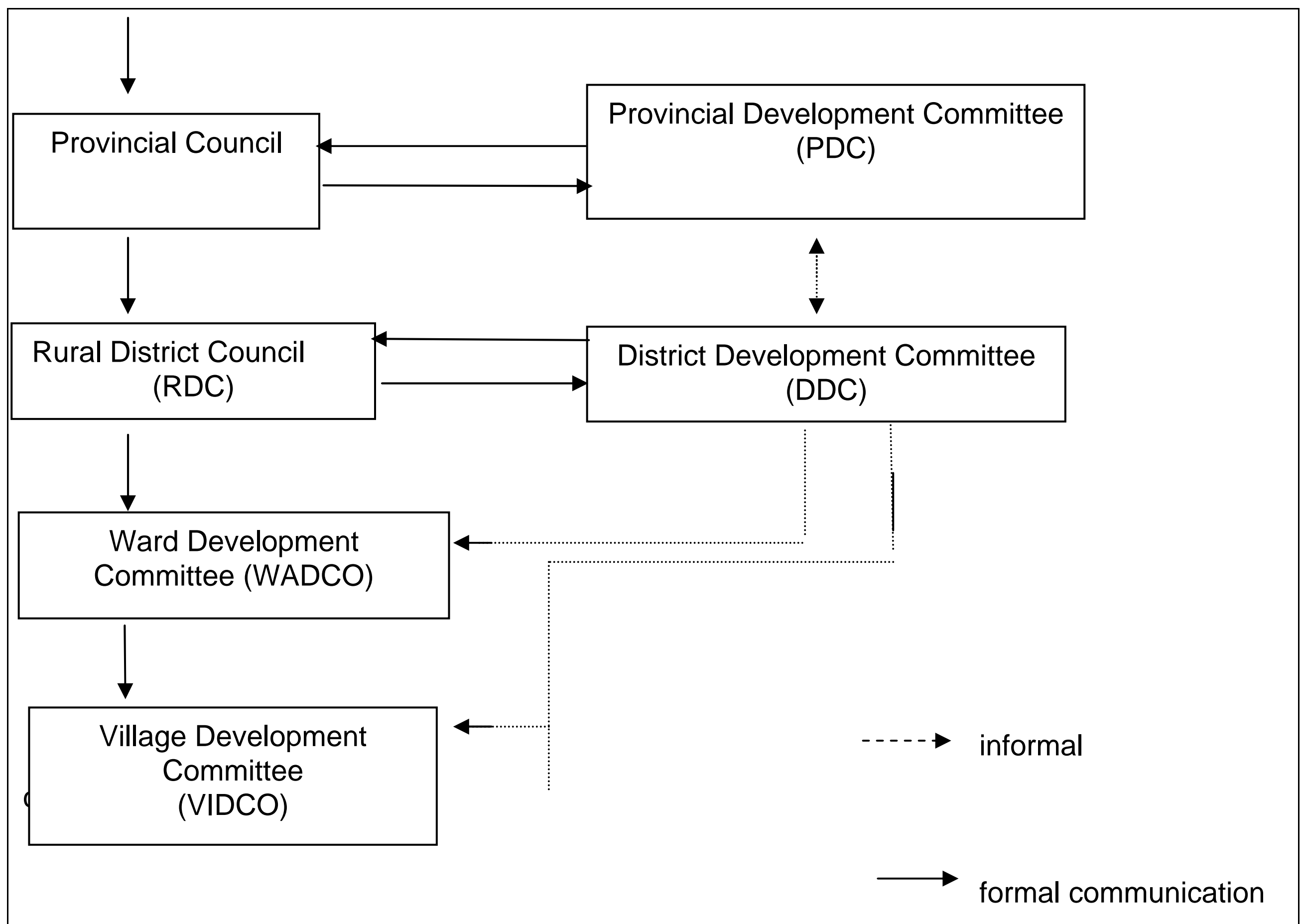
Loewenson (1999) provides an account of mechanisms for participation in Zimbabwe. While pre-1980 structures provided sometimes powerful instruments for making the state accountable to white minority interests, independence in Zimbabwe offered an opportunity for both widening and deepening participation in the governance of many spheres of public activity, including health. A series of institutional reforms were effected in local government to facilitate wider participation. Racial segregation in law was abolished and universal franchise introduced in all areas of local government. There was deconcentration of central government activities through ministry representation at local level and through outreach or extension workers. Organisational structures for participation in development planning were established in the Prime Minister's Directive on Decentralisation (1984 and 1985), which provided the basis for a hierarchy of representative bodies at village, ward, district and provincial levels (Stewart et al, 1994), shown in *Figure 1*.

In the 1980s, there was evidence that village and ward development committees enhanced coordination between ministries at local level, generated capacity in local development planning and provided information for public investment programmes. They created channels for participation by political interest groups in self-help projects, such as in rural water supply and sanitation, village grazing and land reorganisation schemes and appear to have facilitated some diversification of sources of local revenue (Mutizwa-Mangiza, 1990).

The health sector had at each local government level (village/ward, district and province) health executives and participated in the local government development committees. Specific health committees were also set up in some districts, linked with health centres or hospitals. These structures played a positive role in more 'self-reliant' health interventions, but did not make services planned and financed at central level more responsive to user demands or inputs, particularly given weak district discretion on areas of spending or retention of revenue and lack of meaningful authority in planning. In addition to the existing Public Health Act that provides for a national Public Health Board, since 2000 legislation has been passed to provide for community health councils at district level and hospital advisory boards at hospital level that include community representatives in advising on client care and health management issues, but that have weak or no policy or resource allocation authority. There is no law that provides for similar structures at health centre level, also reflecting that the health centre/clinic is itself not a cost centre and thus has no control over its own budgets.

Figure 1: *Local authority representative bodies.*

Central Government



Source: Loewenson (1998: 4)

While these structures facilitated enhanced community roles in health they also had weaknesses undermining effective participation (Stewart et al, 1994; Loewenson, 1999):

1. While the law provided for special representation of women and youth on these structures, this was through nomination of elected structures, while local constituent groups representing women, residents, workers, etc had no rights of participation. In the scenario of a single dominant party, and the absence of a secret ballot system for voting, the election of members to structures has been criticised for more closely reflecting nominees from higher levels of the party hierarchy than direct community interests. Villages identified on administrative grounds also did not always relate to traditional community boundaries, and traditional leaders who remained outside these structures remained influential. At higher levels, such as ward and district levels, there was weak consultation with communities on decisions made, with many members of communities not aware of the structures or their powers and duties.

2. The allocation of functions between different levels of government has neither been well defined nor agreed between central and local government. This has led to swings in authority, such as in the takeover of district council powers to recruit and pay teachers by central government. Local decision-making was also dominated by central government employees, both in their larger numbers on local planning structures and in their technical approach to issues.

3. Local authorities, particularly district councils, were strongly dependent on central grants tied to specific purposes, with the proportion of revenue raised locally up to 1991 only about 15% in district councils, although higher in urban councils. DCs have had limited powers to raise local revenue, while UCs and RCs have in the past raised local revenue through rates on property and

beer levies. As beer sales have been commercialised and housing sold to tenants, there has been a decline in local authority revenue from these sources without substantive new sources to replace them. Local authority financial figures also do not reflect the large extent of self-help contributions that have gone into health, education and other facilities.

4. Provincial governers and administrators are nominated by the executive and central government, and thus have stronger accountability upwards, and councils have no directly elected members. While central control may have been motivated by the desire to neutralise the threat of provincial ethnic and political power blocks, it has weakened the transfer of decision making to locally elected structures.

5. District and provincial plans have in some areas been poorly conceived, formulated, prioritised or costed and poorly linked to any knowledge of prospective budget allocations. The planning process itself has been poorly supported with financial and technical resources.

6. Plans produced at district or provincial level had little or no influence in national planning, particularly in budget allocations which are generally carried out through budget requests made from sectoral ministries. District and provincial plans were not by 1990 handled in any systematic way at central government level (Mutizwa-Mangiza, 1990). Unpredictable timing of central fund disbursements weakened planning and implementation at local level, while foreign donors bypassing district councils through direct relationships with sectoral ministries or village level have weakened the capacity of the DCs to organise, manage and sustain the projects funded.

Though district councils come up with a district plan, the council does not have the resources to implement the plan. The District Health Management Board, which receives and disburses funds based on central government guidelines, does not report to the Rural District Council but to central government.

Loewenson (1999) points out that except in larger urban areas, these weaknesses have reportedly led to elected local government officials largely rubber stamping plans emanating from central government and produced by administrators, with low levels of beneficiary participation (Makumbe, 1996). In a review of decentralisation of local government in Zimbabwe, Stewart et al (1994) note three major factors to have weakened effective local government participation in Zimbabwe – “the dominance of decision making structures by central officials, the tendency of a small elite to represent local interests, with limited popular participation, and the strong role of the Party".

Hence a health policy that from 1980 strongly endorsed community participation was implemented within a system where decision making was generally centralised and dominated by administrative inputs. The health sector expressed its policy through mobilisation of communities for primary health care programmes, community contributions to health infrastructures through support of clinic building, establishment and community support of village health workers and community organising towards child supplementary feeding and drought relief, amongst other initiatives. These programmes were primarily directed by strong state intervention, with community participation expressed as mobilisation for or compliance with state defined programmes, complementing strong technical and financial support from the state.

In the absence of wider, more coherent powers and responsibilities given to local structures, some of the somewhat ad hoc roles given them became a source of tension. User fees were, for example, imposed and defined at central government level, and until 1998, were not retained locally. Elected councillors were given the authority to provide exemption letters to citizens earning less then Z$400 a month, who were entitled to free health care in the public services. Complaints were made however that councillors misused this authority, refusing to issue letters

on grounds that "there were too many unemployed people", or that "people had not voted in the last election" (Mutizwa-Mangisa, 1997; CWGH, 1998a; Loewenson, 1999; Loewenson and Chikumbirike, 2000). Hospital exemption certificates had to be obtained from the department of social welfare, while councillors provided certificates for clinics, adding to the burden poor people faced in accessing health care. When user fees were scrapped in rural health facilities in 1995, it was evident that the system had been poorly conceived with inadequate consultation with and input from local communities (Zigora, Chihanga, Makahamadze, Hongoro and Ropi, 1996).

1.3 The Community Working Group on Health

In early 1998, a network of membership based civic organisations was formed in Zimbabwe that focused advocacy, action and networking around health issues, called the Community Working Group on Health (CWGH). The civic groups identified public discontent with the manner in which community participation is being expressed in Zimbabwe and the need to strengthen the mechanisms for participation, transparency, consultation and accountability within the health sector from local to national level. A survey of membership views and constituent organisation discussion in the CWGH consistently noted the dissatisfaction of communities with what was being termed 'participation' in the health sector. To a large extent, this was perceived to mean compliance with state defined programmes. It also appeared to exclude many civil society actors. None of the civic organisations in CWGH were represented on existing 'community' health structures, nor did they know what took place in them. This confirmed a view expressed during meetings by civic representatives and health officials that there is a persistent gap in structured communication with communities that acts as an impediment for health promotion (CWGH, 1998d; MoHCW, 1997).

The CWGH initiated a programme of work that enhanced information and networking on health issues at local level. They initiated district level meetings between health care providers and civic/constituent organisations in the area to promote and exchange dialogue at local level on promotion, prevention and management of health problems, and to strengthen informed participation in local health planning, set up local CWGH forums, carried out health education and advocated for primary health care policies. Backed by research carried out by TARSC, the CWGH observed that government was allocating inadequate human, financial, drug and other resources to health centre and preventive levels of the health system. This was evidenced from the poor allocation of nursing staff relative to workloads (3% of nurses for about 40–70% of outpatients at health centre level), the declining budget allocation to preventive and outreach services (from 15% in 1985 to less than 10% by 2001), the significant shortfall in drug availability at clinic relative to district hospital level (65% vital drug availability at clinics relative to 83% at district hospitals in a 2001 survey). This starved the health system at the very point of interface with the community, undermining policy commitments to equity in health and towards meaningful participation in health systems.

The negative impact of this was evident in fallout from and increased delays in using services: For example, long delays in seeking sexually transmitted infection (STI) treatments are an important factor in poor control of STIs in Zimbabwe. Longer in women than in men, these delays relate less to service availability than to social factors influencing health seeking behaviour and quality of care (Communication from NACP Zimbabwe, 1998). Delay in seeking care was found to be the most common avoidable factor in maternal death in Zimbabwe (Fawcus, 1996), due to poor knowledge in communities of signs of puerperal sepsis and other risk factors in pregnancy and delivery, and poor transport to services. User fees and doubling of medical costs with poorly functioning public exemption systems and negative attitudes in providers further undermined contact with health services (CWGH 1997). This also undermined the complementarity of health sector/community roles in disease management, shown in Table 1, and weakened disease control efforts.

Table 1: Selected health problems, strategies and community roles

Health problem	Management strategy	Community role (examples)
Malaria	Residual spraying; Larviciding, use of bed nets and personal protection; Rapid notification; Early reporting and clinical management; Control of localised outbreaks	Larviciding, use of bed nets and personal protection; Early reporting of illness
Tuberculosis	In patient TB treatment (2mths); New approach: DOTS; Case tracing	Building improved housing and ventilation; Early reporting; Case tracing; Supervision of DOTS
STIs	Safe sexual patterns; Condom use; Early reporting of infection; Partner tracing and reporting; Syndromic management; Prevention of reinfection	Safe sexual patterns; Condom use; Early reporting; Partner notification; Prevention of reinfection
HIV	Safe sexual patterns; Condom use; Early reporting and syndromic management of STIs; Early reporting and treatment of infections; Promote improved diets; Prevention of infection in newborns; Discharge to home care	Safe sexual patterns; Condom use; Prevention, early reporting and treatment of STIs & infections; Improved diets, hygiene and health promotion; Care and support of people with HIV/AIDS; Fostering orphans

Source: MoHCW (1997)

1.4 Health Centre Committees

In 2001, the CWGH initiated a process of setting up or revitalising Health Centre Committees (HCCs) to strengthen the capacities to demand resources for these levels of the health system (CWGH, 1998d).

A TARSC survey in October 2000 of HCC members in Bindura showed that the HCCs in that area:

- had a strong perception of their roles in relation to making improvements at the clinic, less so in relation to their role in primary health care and community health. They saw their role primarily as a communication vehicle between health services and communities, less so in terms of organising community health actions;
- saw the local council, community and MoHCW as their main source of inputs, particularly the council, and noted the need for resources to reimburse their transport, materials for projects and training on health and financial management to support their work;
- were more confident of their chances of succeeding in areas relating to communication and information than in accessing or mobilising resources or making a real difference to health services; and
- needed education on key areas of health systems, on their role and on issues such as budgets.

(Loewenson and Chikumbirike, 2000).

By 2001 the CWGH covered 21 districts, and in about half of these set up HCCs, and supported these with training and capacity inputs. The roles of the HCCs were set out as in Box 1 below. The committees were trained to identify priority community needs and actions, plan the resource inputs to meet these needs and make organised demands on district health budget and on the

Health Services Fund. The latter is a sector-wide fund comprising retained fees and donor funds, allocated to the district and to be spent on a 60:40 ratio at district hospital level and below.

Box 1: Functions of Health Centre Committees

Health Centre Committees:
- facilitate people in the area to identify their priority health problems, identify what they think can be done about them, using participatory approaches and information from technical personnel;
- plan how to raise their own resources, organise and manage community contributions, and tap available resources for community health activities;
- use information from the health information system and from communities in planning and evaluating their work and should be trained to do this;
- assess whether the health interventions in the area are making a difference to people's health using health information system and community information;
- are a channel for information flow from the community to the RDC/DHT and back to the community;
- are informed about the activities of different health providers in the area (RDC, MoHCW, Zinatha, private);
- raise and discuss aspects of patient care and represent communities on issues they raise on services offered, to see how these can be addressed;
- obtain information from the RDC and DHT on budget allocations for health, on ward level allocations, on the HSF, give input and feedback to the RDC and DHT on budget planning and keep communities informed on health budget issues, particularly where this relates to local resource mobilisation; and
- work with the RDC to motivate and implement public health standards, such as for water supply and sanitation.

TARSC research showed that in fact less than 10% of the Health Services Fund was in 2000 being spent at clinic or community level. The CWGH activities aimed to shift participation in health from mobilisation for and compliance with centrally defined programmes to mechanisms through which communities can shape their health systems and make services more responsive to their interests. This is in harmony with the policy in Zimbabwe of decentralisation, proposed to 'strengthen democracy and civic responsibility' and transfer authority and functions from central and local level (MoHCW/SDU, 1997). This has been implemented through setting up hospital boards and community health councils at district level, but with little attention given to the health centre level.

Does setting up such structures enhance public participation in governance in health?

Evidence from experience indicates that in the absence of specific measures to enhance accountability, and there is weak evidence of promised benefits in equity, access, quality, accountability or in increased public participation (Gilson et al, 1994; Gaventa and Robinson, 1998). Building stronger participation is not simply a matter of legal definition or policy directives on structures and roles. The literature documents many problems with such structures, including inadequate structural and systemic support, weak information access, limited authority and vague roles. This renders participation face value and weakens the sustainability and responsiveness of such structures (Kahassy and Baum, 1996; Bennett, Russell and Mills, 1995; Gilson et al, 1994).

It was thus felt to be useful to analyse the relationship between these mechanisms of participation and specific health system outcomes, including:
- equity, access and quality of health services, including resource allocations for health;
- improved allocation of resources for and access to promotive and preventive health interventions;
- enhanced community capabilities for health (through improved health knowledge and health

seeking behaviour, appropriate early use of services, enhanced mobilisation of resources for health and health services);
- enhanced access, utilisation of health services and capabilities for health in specific marginal groups (women, the unemployed, migrants, youth, the very poor) and thus improved equity in health; and
- improved quality of health care as perceived both by providers and users of services.

2. Objectives and methods for the study

The Regional Network on Equity and Health in Southern Africa (EQUINET) (www.equinetafrica.org) has noted that equity related work needs to define and build a more active role for important stakeholders in health, and to incorporate the power and ability people (and social groups) have to make choices over health inputs and their capacity to use these choices towards health. To do this requires a clearer analysis of the social dimensions of health and their role 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 multicountry research programme in 2002/3 to assess the impact of HCCs on the health system. This work was carried out under the EQUINET Governance and Equity Research Network (GovERN). It was implemented through national health and community mechanisms with agreement from and support of the health and civil society structures in each of the study areas secured through the CWGH. As part of the ethical requirement, report on the findings was made during the study process to the communities and authorities and their feedback on the findings sought and included into the study report. The full report will also be made available to the communities and authorities for follow-up of the findings and will be used by the CWGH to enhance work at community level.

2.1 The pilot

In the first phase of work on this research a pilot study was carried out to:

- hold a stakeholder meeting to discuss the proposed research (this is separately reported); and
- develop and test the research tools and two areas (this is separately reported).

In two districts (Arcturus and Ckikwaka) an initial feasibility and stakeholder assessment was done in July to:

- plot the catchments and obtain relevant demographic and institutional data for the study areas;
- verify data quality for health information collected at district and health centre level to identify indicators that can be used in the study;
- identify the extent of spillover of effects across wards and districts to design comparative assessments across districts/wards without HCCs;
- carry out community and provider assessment to identify selected indicators of perceived quality and responsiveness of health care; and
- verify the feasibility of selected indicators for secondary data and survey assessment of other parameters of health impact.

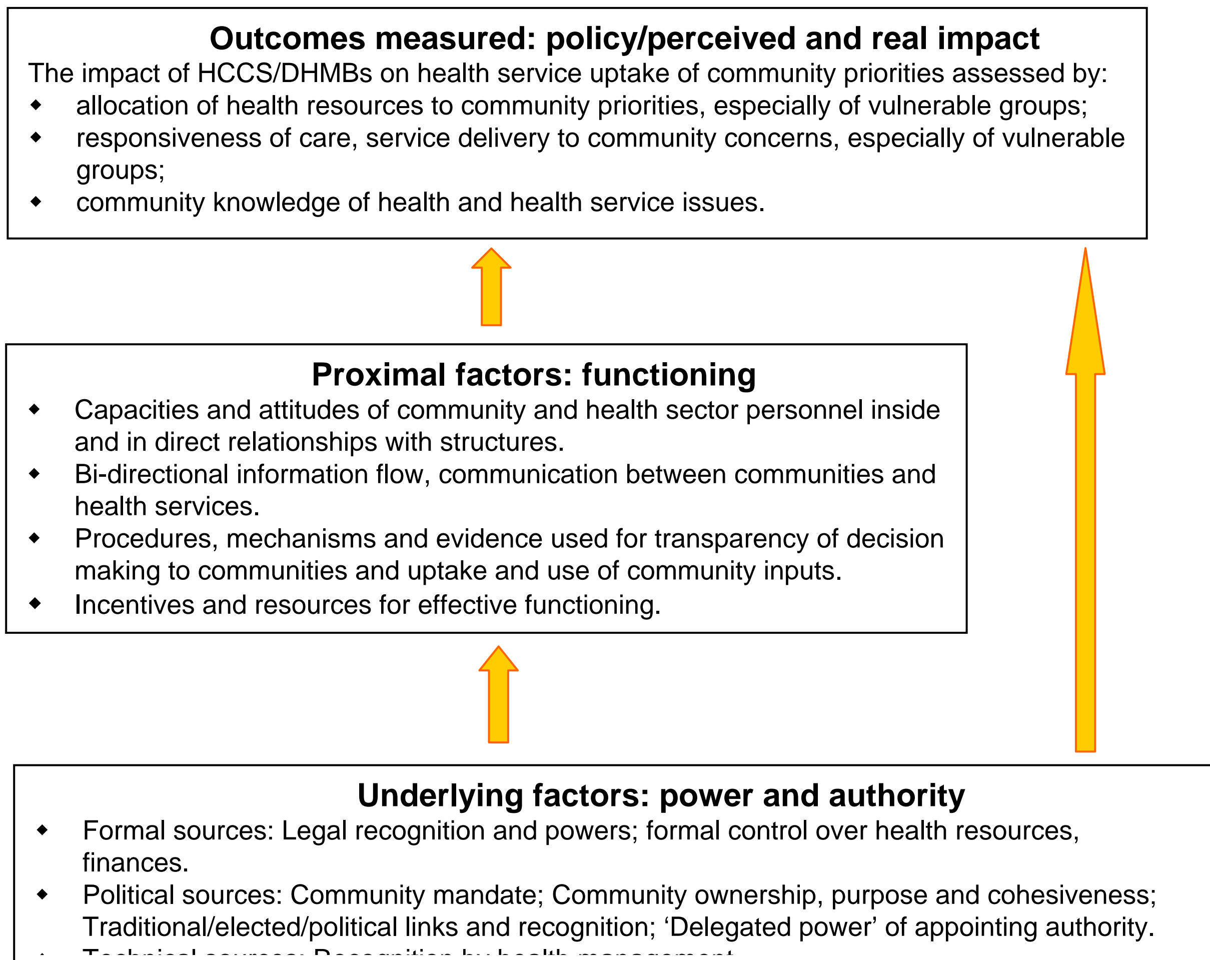
The tools were developed through review of the Zimbabwe data to be collected, the household surveys and health information system indicators collected and the indicators identified as relevant in the EQUNIET regional workshop in January 2002. The pilot was used to revise the protocol and tools and the stakeholder meeting to build commitment in and obtain feedback from key stakeholders in the study areas on the work.

The pilot indicated that at present the HCCs do not know about budgetary resources and how surpluses can be used. The HCCs involvement in health annual plans was not clear. The HCC is worried about the HCC structure set out by the government. The pilot also showed that the HCC expected some incentives for the work they are doing. Stakeholders noted that community control over health services means community diagnosis, community identification of solutions, community monitoring and community protection of their services and rights. It was proposed that the research look at the impact of HCCs on quality of care – staffing, essential drugs, accessible services, trained personnel, referral system and waiting time and on whether communities are more actively participating in their health care, especially budgeting and evaluation.

2.2 Conceptual framework for the study

The pilot was also discussed with the research teams from Zambia in a planning workshop on 28 September 2002 (TARSC et al, 2002). At this meeting a conceptual model was developed for assessing governance as a contributor to health equity. This is summarised below. 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.

Figure 2.1:



2.3 Objectives for the study

The study sought to analyse and better understand the relationship between HCCs as a mechanism of participation and specific health system outcomes, including:

- improved representation of community interests in health planning and management at health centre level;
- improved allocation of resources to health centre level, to community health activities and to preventive health services;
- improved community access to and coverage by selected priority promotive and preventive health interventions;
- enhanced community capabilities for health (through improved health knowledge and health seeking behaviour, appropriate early use of services); and
- improved quality of health care as perceived both by providers and users of services.

Specifically the study sought to assess the following parameters in wards where HCCs exist and in areas where they do not (and compare across these different types of areas).

- **Describe** the composition of the communities served by the health centres, the different social groups, and their relationship to health service planning mechanisms at health centre and district level.
- **Describe** the presence of ward, local government or health centre planning mechanisms, their composition, authorities and performance over a health planning cycle and their roles in

relation to health planning, quality of care and resource allocation and the attitude of community members and health service decision makers towards them.

- **Analyse** the extent to which different sections of the community are aware of the role and functions of the HCC, perceive their health priorities to be taken up by the HCCs and perceive the HCCs to be improving the responsiveness of the health system to their health needs. The specific community fractions that will be differentiated based in prior community assessments of vulnerability include adult men; adult women; youth and the elderly[2].
- **Analyse** the form of and extent to which community priorities are organised, presented and incorporated into health planning at health centre and district level.
- **Analyse** the distribution of district, HSF and AIDS Levy budget allocations between levels of care and types of care within the district in 2001 and during the study period.
- **Analyse** the patterns of health knowledge, health seeking behaviour, utilisation and coverage in the wards covered by the health centres, across the different community groups in 2.3 above.
- **Analyse** the perceptions of health service quality and responsiveness in the different community groups and the extent to which gains or losses are linked to the HCCs.

2.4 Methods

Control sites were selected in the same districts where there are no Health Centre Committees with sufficient distance between catchment areas to avoid spillover of results. In the first phase of the study the personnel for field work were recruited, trained and the tools finalised and printed, taking account of the common areas across the three studies in the multicountry programme. Communities were informed about the work. Field personnel were trained in several rounds of training. Community surveys were carried out in three districts:

- Goromonzi;
- Makoni; and
- Gweru District.

These areas were chosen because they had well-established HCCs set up by the CWGH, and for logistic access.

A total of eight wards were selected:

- four serviced by clinics with an HCC; and
- four with clinics NOT serviced by an HCC.

Wards with clinics with HCCs were purposively sampled from the group where CWGH training had been done. District maps from the Surveyor General's Office showing social infrastructure were used to randomly sample the control wards (with no HCCs). The study sites selected are shown in Tables 2.1a and b below.

[2] Note this does not specifically identify orphans and those facing stress due to HIV/AIDS although these have in the pilot been identified as a vulnerable group. If the community groups agree that this is culturally appropriate this group will be included. The implications of separating out these fractions are that they will be able to be differentiated in any tools used for community inputs.

Community survey

In February 2003 cross-sectional community surveys were done in the three districts sampled, covering HCC and non-HCC wards with 30 people per community fraction (women, youth, the elderly, men) in each ward. Within these wards the study population was cluster sampled using the maps. A sample of 960 was aimed at and a total of **1006 interviewees** finally interviewed, or 0.2% of people in the three areas (1992 census population of 474,586). The survey covered 120 households per ward. Table 2.2 and *Figure 2.2* below show the distribution of the respondents.

Table 2.1: Information on districts and study sites

a.

Province	District	Ward	Ward has HCC?	Clinic	Type of area and estimated population
A. Mashonaland East	Goromonzi	Ward 14	Has HCC	Arcturus mine Clinic	Peri-urban
		Ward 9	No HCC	John Reimer	Large-scale
		Ward 7	Has HCC	Mwanza clinic	Communal
		Ward 18	No HCC	Rusike clinic	Communal
B. Manicaland	Makoni	Ward 4	Has HCC	Vengere	Urban 26,000
		Ward 25	No HCC	Tsanzaguru	Communal 26,905
C. Midlands	Gweru	Ward 12	Has HCC	Gunde	Communal 4,586
		Ward 15	No HCC	Somabhula	Large-scale 6,749

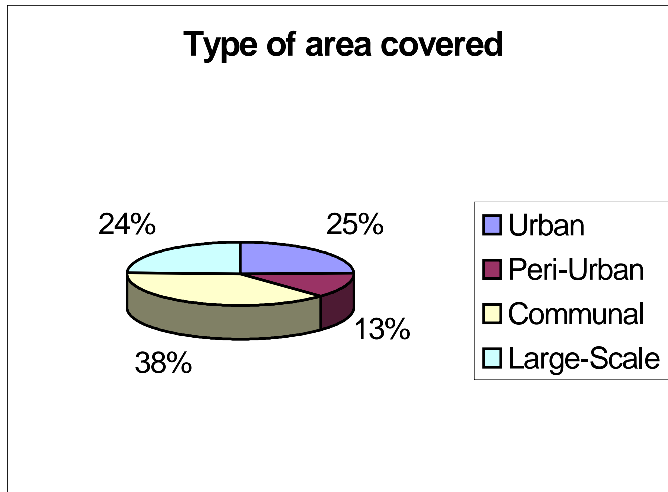
b.

	Goromonzi	Makoni	Gweru
Health centres in district	23	49	18
Nurses at health centres	18	n.a	27
Nurses at hospital	68	114	197
EHTs in district	10	17	12

Table 2.2: Distribution of respondents in the community survey

Type of area	Frequency	Percentage %
Communal	383	38.1
Urban	249	24.8
Peri-urban	128	12.7
Large-scale farm	246	24.4
Total	1006	100.0

Figure 2.2: *Areas in the community survey.*



The survey provided baseline indicators of knowledge of HCCs, community access to and coverage by health interventions, health knowledge, health seeking behaviour, and perceived quality and responsiveness of health care. The data from the survey was analysed and initial assessment of the data done to check the focus of the interviews and participatory tools.

The population ratios in the survey represent the ratios in the study areas. In relation to national proportions communal area and peri-urban populations constitute about 53% of the total population (51% in the survey), urban populations 32% of the total population (25% in the survey), while large-scale commercial farming areas constitute 9.4% of the total population (24% in the survey). There is thus a stronger representation of large-scale farm areas in the survey compared to national levels. However as the survey is aimed at assessing the relative difference between areas with HCCs and those without this is less problematic than if it were aiming to provide national population estimates.

The distribution of the study population by area is shown in Table 2.3 below, showing the gender breakdown. The Goromonzi district sample numbers are double those of other areas as they cover two separate case-control areas (Arcturus and Mwanza). In total there were 511 respondents from areas with HCCs and 494 from wards without HCCs. The male:female ratio in the same was relatively even (54:45). The sample was deliberately chosen to ensure adequate female representation.

The age distribution across the study areas and across areas with and without HCCs varies somewhat, with a statistically significantly older population in the areas with HCCs (Chi squared $p<0.05$). The male:female ratio is relatively constant across all age groups, although with a lower male proportion in the 21-45 year age group (Chi square $p<0.05$) viz:

Below 20 years: Male:female = 51:49
21-45 years: Male:female = 48:52
46-60 years Male:female = 55:45
+60 years: Male:female = 53:47

Table 2.3: Study population distribution

	Goromonzi				Makoni (Rusape)				Gweru			
Sex	**With HCC**		**Without HCC**		**With HCC**		**Without HCC**		**With HCC**		**Without HCC**	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Male	135	*53.1*	122	*49.0*	54	*43.5*	63	*50.8*	67	*50.4*	66	*54.5*
Female	119	*46.9*	127	*51.0*	70	*56.5*	61	*49.2*	66	*49.6*	55	*45.5*
Total	254	*100*	249	*100*	124	*100*	124	*100*	133	*100*	121	*100*

Table 2.4: Age group distribution between districts

Age group	Goromonzi		Makoni		Gweru	
	Number	**%**	**Number**	**%**	**Number**	**%**
Below 20	97	*18.5*	40	*16.1*	40	*15.7*
21-45	256	*46.5*	136	*54.8*	139	*54.7*
46-60	95	*22.0*	40	*16.1*	37	*14.6*
60+	55	*13.0*	32	*12.9*	38	*15.0*
Total	503	*100*	248	*100*	254	*100*

Table 2.5: Age distribution between areas with and without HCCs

Age	**With HCC**		**Without HCC**	
	Number	**%**	**Number**	**%**
Below 20	83	*16.2*	94	*19.0*
21-45	259	*50.7*	272	*55.1*
46-60	90	*17.6*	82	*16.6*
60+	79	*15.5*	46	*9.3*
Total	511	*100*	494	*100*

Participatory assessment and key informant interviews

In February/March 2003 key informant interviews were conducted of nurse, EHT, community health workers, district nursing officers, district medical officers and local government CEOs (six interviews) on the HCC's role and functions, attitudes towards HCCs, inclusion of community priorities, impacts on resource allocation, impacts on health care utlisation and perceived quality and responsiveness of health care at the selected health centres. Key informant interviews were also be conducted of elected, traditional and civic leaders on HCC's role and functions, attitudes towards health planning and HCCs, inclusion of community priorities, impacts on resource allocation, and impacts on health care utilisation and perceived quality and responsiveness of health care at the selected health centres. Finally a participatory assessment tool was used to guide discussion in four community meetings in each area to describe the community, and assess community awareness of the HCC's role and effectiveness, inclusion of community priorities in health

planning and perceptions of health service quality.

Key health informants in the study areas included the district nursing and medical officer, local government chief executive officer, two elected leaders, two civic leaders, two traditional leaders, nurse, community health worker, environmental health technician (EHT) and lastly representatives from community groupings such as women's clubs amongst others.

The Participatory Rural Appraisal (PRA) technique was used in groups. Selected focal area persons were asked to identify 25 participants and gender balance was a prerequisite. The composition of the participants also incorporated the aspect of age so as to get varied responses and so the youth, the elderly and those in the economically active age groups were selected in all areas.

Health information system and resource analysis

In March/April 2003 information was gathered using health information system and health expenditure records from district and health centre level to assess resource allocation and health service performance using data for 2001 and 2002.

Participatory reflection on findings

Midway during the study an EQUINET GoVERN review meeting held in May 2003 reviewed interim findings from the three studies from Zambia and Zimbabwe and identified key areas for follow-up research in phase 2. These included:

- understanding the underlying links between the participatory mechanisms (HCC/DHB) and positive or negative health differences found;
- understanding the attitudes and perceptions of different parts of the system – the community, community representatives, health workers, managers, political leaders, higher levels of government – and how they influence the functioning of the HCCs and DHBs; and
- assessing the representativeness of the structures and how the gap in representation of vulnerable groups is affecting their work and outcomes.

It was also agreed that the next phase of work should further explore the underlying power and authority factors influencing the performance of these mechanisms for participation. It was noted that the research findings needed to be widely disseminated and feedback obtained to test the validity of findings. The first phase results should thus be discussed with communities and HCCs in the study sites, health workers and authorities, parliamentarians and health authorities at central and district level.

The phase 2 Zimbabwe study protocol thus included:

- preparing and translating a simple summary of the findings with a balance sheet of positive, negative and non impacts of participatory mechanisms based on findings;
- reporting back to the community and other stakeholders to discuss the findings and the follow-up recommendations;
- development of case studies on key issues arising from the findings to better understand the findings;
- key informant interviews with the district and central MoHCW; and
- gathering of statistical information from the health services on primary health care indicators and health services resources.

Community feedback meetings

Community feedback meetings were held in Goromonzi (covering four wards) , Makoni and Gweru district with HCC and non-HCC (covering two wards each). The feedback meetings were conducted in the three districts in August and early September 2003 and were held at Mwanza clinic, Arcturus mine clinic, Crocodile motel in Rusape and Ndhlela centre in Gweru. Participants gathered from the various wards in the study clinic catchment areas to discuss the findings. Participants included health personnel, farmworkers, school representatives, councillors, local traditional leaders and village health workers (see Table 2.6).

Table 2.6: Feedback meetings held on the findings

Areas	Dates (2003)	Groups	Participant number
Mwanza clinic	16 August	HCC members Mwanza; Non-HCC Rusike (traditional leaders, health staff, youth, school representatives)	25
Arcturus mine	15 August	HCC members Arcturus; Non-HCC John Reimer (traditional leaders, health staff, farm representatives, village health workers)	17
Gweru	28 August	HCC from Gunde; Non-HCC from Somabhula (traditional leaders, councillors, health staff, farm representatives, village health workers)	23
Rusape	5 September	HCC from Vengere; Non-HCCs Tsanzaguru (councillor, health staff, farm representatives, school and civic representatives, village health workers)	26

No major constraints were experienced during the feedback meetings. The meetings were well attended by the participants from the various areas.

Case studies

Eight case studies were compiled from the study areas on issues that were identified as important by the communities and from the evidence gathered. They obtained information from key informant interviews and covered the following issues:

- information flow from health authorities to HCCs and from HCCs to the communities;
- mechanisms for inclusion of community priorities in health plans and their strengths and weaknesses;
- the extent to which people with power are willing to use this for enhanced community role in health;
- resource mobilisation by HCCs and impact of this on district budgets;
- community awareness of and organisation around their legal rights ;
- community perceptions of public budgets; and
- representation of needs of vulnerable groups by the HCC.

Interviews

District and central interviews were conducted to gather information from key health informants on their views on the functioning and roles of HCC members. Interviews were designed using the findings of the phase one study and to explore the immediate and underlying factors affecting HCC performance. Key health informants interviewed shown in Table 2.7 included district health personnel and ministry health personnel at central level. A total of nine interviews were

conducted in September 2003.

Table 2.7: Key informants interviewed

Place	Position of person interviewed
Gweru district	DNO Principal Environmental Health Officer
Goromonzi district	DMO DEHO Hospital Administrator
Makoni district	DNO
Head office	Deputy Director of Policy and Planning Director of Environmental Health Environmental Health Officer

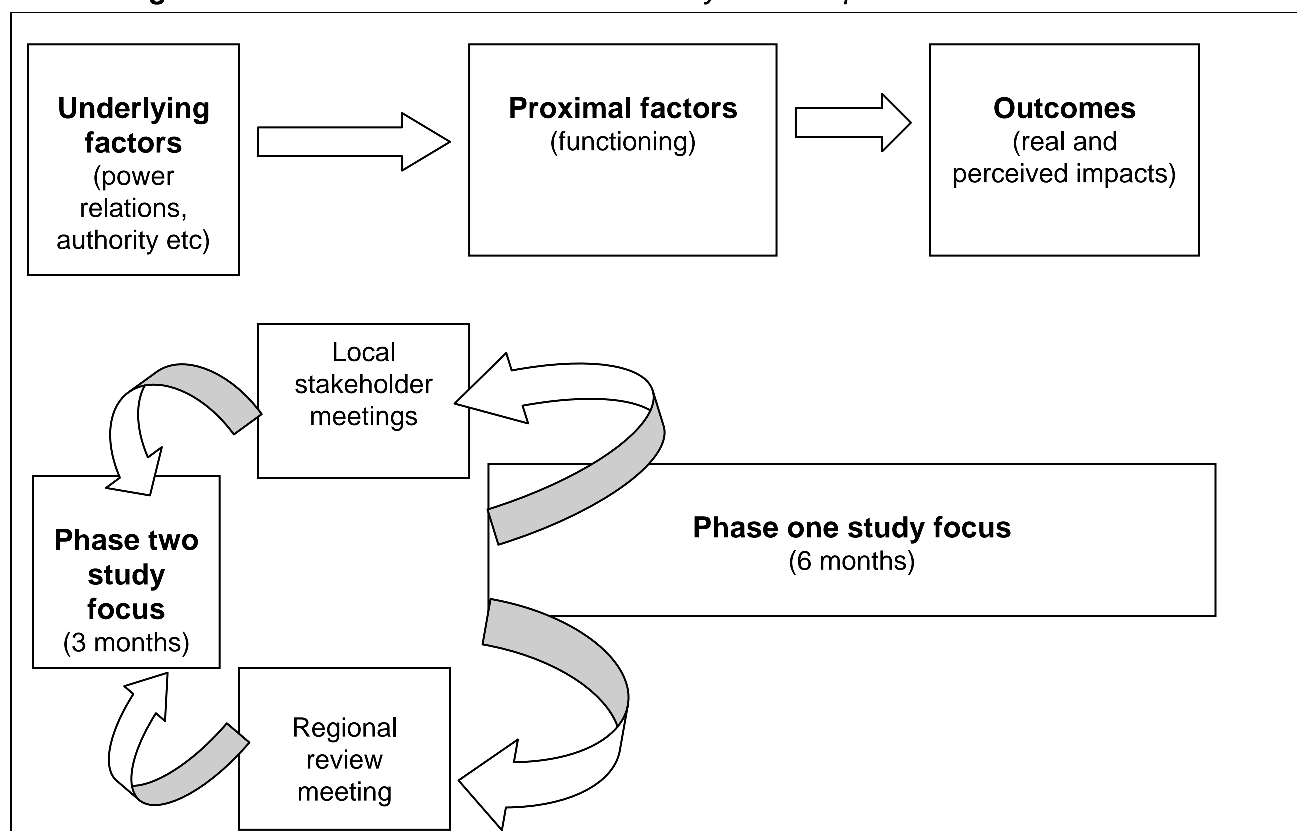
Statistical data and health information

Statistical data was collected from health centre and district records on health service performance and health financing information. The fact that the clinics are not cost centres of the health system in Zimbabwe meant that it was not possible to collect some of the information required. Where information could be collected at health centre level, the information was disaggregated between centres with and without HCCs.

This report outlines the full findings of the study.

The case studies are shown as boxes in the report. The method outlined in *Figure 2.3* below has been completed. The regional review meeting on the findings under the EQUINET GovERN Theme is still to be held in 2004.

Figure 2.3: *Schematic overview of multicountry research protocol.*



3. Characteristics of the communities

The participatory assessments carried out with community groups led to an identification of the following key groups in the community (see Table 3.1 below).

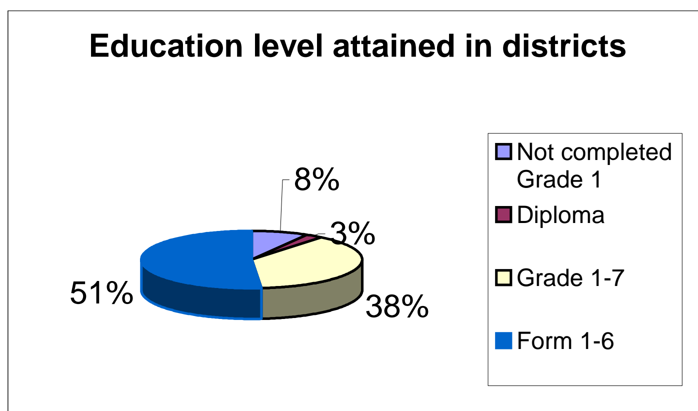
Table 3.1: Participatory assessment of community characteristics

Key features of groups	Goromonzi	Gweru	Makoni
Poor	Unemployed, orphans, farmworkers, widows, youth, elderly, business people	Orphans, children, disabled, widows	Children, orphans, unemployed, elderly
Weak/ill	Employed (miners), orphans, elderly	Elderly, few disabled	Disabled, employed
Far from clinic	Orphans, elderly	Disabled, resettled farmers	Few, elderly unemployed
Powerful	Gold panners, business people	Few resettled farmers	Employed
Respected	Employed	Few farmers, commercial farmers	Few employed, few resettled farmers
Seasonal poverty	Gold panners, few farmers	Disabled, widowed, elderly	Majority resettled farmers

Across the three areas, 8% of respondents have not completed grade 1, 38% have primary

education, 51% secondary education and 3% diploma level and higher. This indicates a relatively educated population.

Figure 3.1: *Education level attained by respondents.*



As education is an important factor in participation in social institutions, in using health services and in community health action, this finding of a relatively high educational level is important. Of the 8% who have not completed Grade 1, 57% were aged 60+ years.

Table 3.2: Highest level of education

Level	Goromonzi		Makoni		Gweru		With HCC		Without HCC	
	No.	%	No.	%	No.	%	No.	%	No.	%
Not completed grade 1	39	7.7	14	5.7	30	11.8	40	7.8	43	8.7
Grade 1-7	212	42.2	74	30.0	90	35.4	176	34.5	200	40.6
Form 1-6	241	48.0	144	58.3	130	51.2	282	55.3	233	47.3
Diploma after primary or secondary	8	1.6	15	6.1	7	2.8	10	2.0	16	3.2
Graduate/ postgraduate	2	0.3	0	0	1	0.3	2	0.4	1	0.2
Total	502	100	247	100	254	100	510	100	493	100

Table 3.2 indicates that education levels are higher in Makoni than Gweru and Goromonzi. This relates to the significant presence of large-scale farm communities in Goromonzi and Gweru where education facilities are lower (see Table 3.2b). The distribution of educational levels between areas with and without HCCs is however not significantly different.

Table 3.2b: Highest level of education by area

Area Level of education	Large-scale farm % N=246	Communal area % N=508	Peri-urban area % N=128	Urban area % N=124
Not completed grade 1	10.2	8.3	7.8	4.8
Grade 1-7	48.0	30.1	21.1	33.1
Form 1-6	39.8	58.1	66.4	58.9
Diploma/certificate	1.6	3.3	3.9	3.2
Graduate/postgraduate	0.4	0.2	0.8	0.0

Despite reasonably high levels of education the majority of people in the study population are unemployed, or 68% overall.

Figure 3.2: *Employment status.*

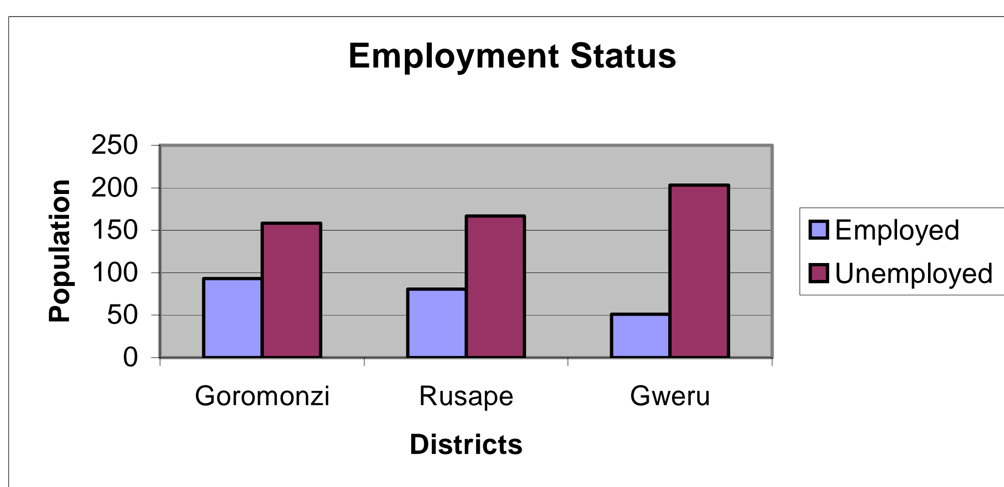
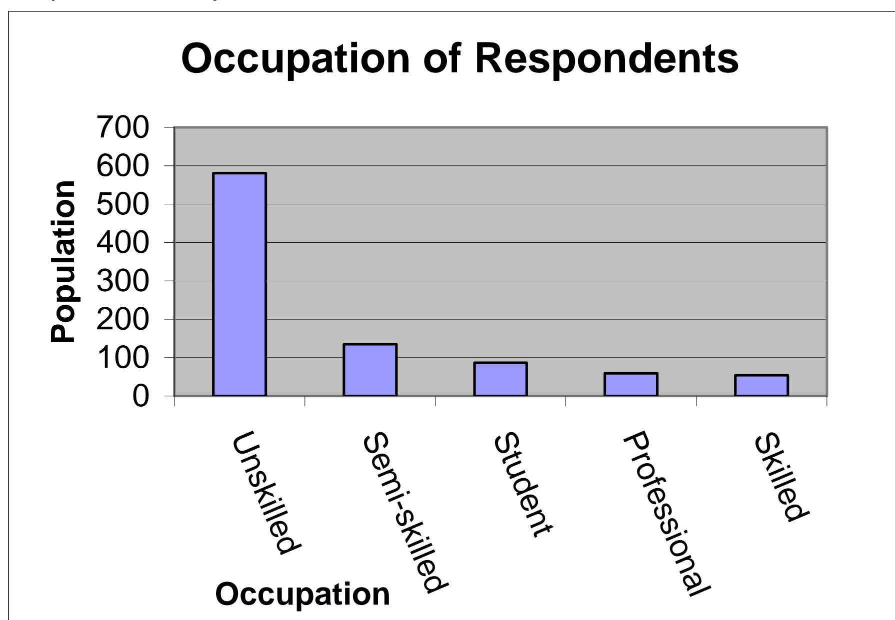


Figure 3.3: *Occupation of respondents, all districts.*



The majority of the sample is unskilled, although 11.2% of the total are skilled or professional. This means that there are reasonably high levels of skills and professional training to call on for health activities, including for community health governance.

Unemployment levels are higher in Gweru and Makoni (Rusape) than in Goromonzi, despite lower education levels in the latter. Makoni also has higher levels of skilled professionals (23%) than the average although they have amongst the highest unemployment levels. It has been found in other surveys that skills levels are not associated with employment status and indicate the level of unemployed highly skilled people in Zimbabwe.

There is a significant difference in employment levels between areas with and without HCCs, with significantly higher levels of unemployment in areas with HCCs than in those without. No difference was found however in skills levels between areas with HCCs (10.7% skilled/professional) and those without (11.8% skilled/professional).

Table 3.3: Employment status

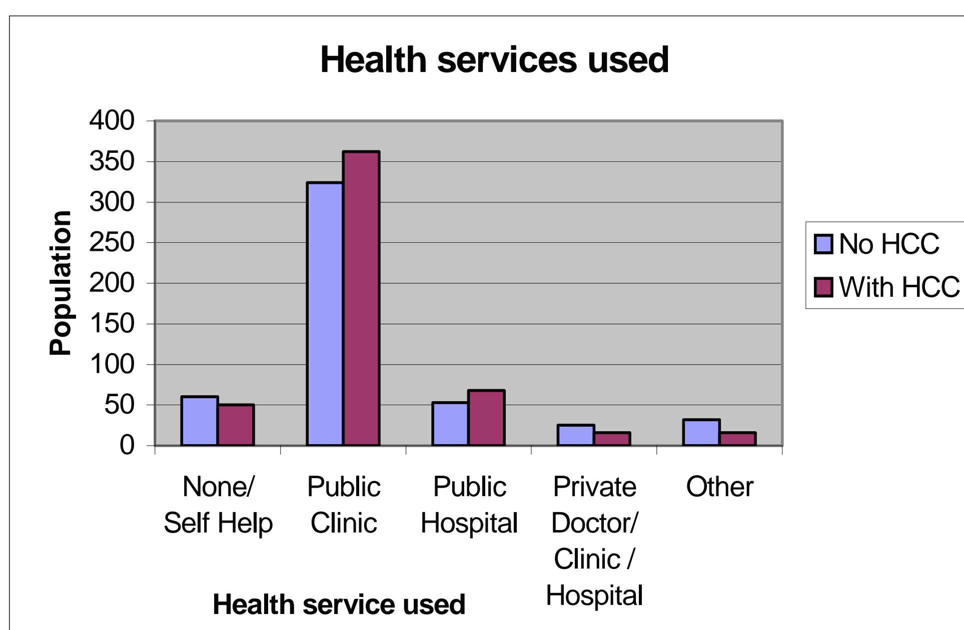
Level	**Goromonzi**		**Makoni**		**Gweru**		**With HCC**		**Without HCC**	
	No	**%**	**No**	**%**	**No**	**%**	**No**	**%**	**No**	**%**
Employed	186	37.0	81	22.7	51	21.1	118	23.1	200	40.6
Unemployed	317	63.0	167	67.3	203	79.9	393	76.9	293	59.4
Total	503	100	248	100	254	100	511	100	493	100

4. Characteristics of the health system

4.1 Access to and use of health services

The majority of the people in all areas use the public clinics (68.2%). The distribution between areas and between wards with and without HCCs is shown in Table 4.1. The table indicates that wards without HCCs have a statistically significantly higher likelihood of not using health services (12.1%) for last illnesses compared to those with HCCs (9.8%) (Chi squared, $p<0.05$). In areas without HCCs there is a greater share of users of traditional and private medicine. The field research suggests that these utilisation patterns relate in part to issues of access and quality of care.

Figure 4.1: *Health services used for last illness.*



Across the three districts, Makoni has lower levels of non-use of services, and greater use of private services, reflecting its urban nature. Gweru has the lowest use of public clinics. In Gweru 21.7% of people reported using the public hospital, indicating higher use of what is actually a tertiary care institution as the primary care facility. This problem in the referral system has been noted in previous studies in Zimbabwe. In Goromonzi, private facility use is low and there is higher use of traditional healers, reflecting to some extent the poorer provision of Western health services in the large-scale farm areas.

Table 4.1: Health service used

Level	Goromonzi		Makoni		Gweru		With HCC		Without HCC	
	No	%	No	%	No	%	No	%	No	%
None	70	13.9	13	5.5	27	10.6	50	9.8	60	12.1
Public clinic	358	71.2	172	72.9	156	61.4	362	70.7	324	65.6
Public hospital	36	7.2	30	12.7	55	21.7	68	13.3	53	10.7
Private doctor/ clinic or hospital	8	1.6	23	9.7	10	3.9	16	3.1	25	5.1
Traditional med/ pharmacy	31	6.1	11	4.7	6	2.3	16	3.1	32	6.5
Total	503	100	236	100	254	100	512	100	494	100

Use of services also relates to access. As shown in Table 4.2 below, clinics with HCCs are within 5km in 81–100% of cases, while clinics without HCCs are within 5km in only 31–98% of cases, and generally access is worse in these areas. In two districts, Goromonzi and Gweru, clinics without HCCs were more than 8km from where people lived in 12% and 57% of cases respectively. This level of access falls below nationally prescribed standards. Hence while having an HCC appears to be associated with use of the clinic, this is strongly mediated by the distance travelled.

Table 4.2: Distance to nearest clinic

	Goromonzi				Makoni (Rusape)				Gweru			
	With HCC		Without HCC		With HCC		Without HCC		With HCC		Without HCC	
Distance	No	%	No	%	No	%	No	%	No	%	No	**%**
< 5 Km	254	100	143	57.7	121	96.8	122	98.4	107	80.5	38	31.4
5-8 Km	-	-	76	30.6	3	2.4	-	-	16	12.0	14	11.6
> 8 Km	-	-	29	11.7	1	0.8	2	1.6	10	7.5	69	57.0
Total	254	100	248	100	125	100	124	100	133	100	121	100

This survey assessed primary health care use through two indicators, diarrhoeal disease treatment and use of antenatal care. In 15% of households it was reported that there had been a pregnant woman in the past year, while in 13% it was reported that a child under 5 years of age had had diarrhoea. The pattern of antenatal care attendance and use of oral rehydration solution for diarrhoeal disease is shown in Table 4.3 below.

Table 4.3: Primary health care indicators

	With HCC		Without HCC		Total	
	No.	% total	No.	% total	No.	% total
Children <5 yrs with diarrhoea in the past 2 weeks	57	11.2%	68	13.8%	125	12.5%
Diarrhoea treated with ORS	47	82.5%	51	75.0%	98	78.4%
Total pregnant women in past year	84		194		278	
% pregnancies attended ANC	69	82,1%	72	37,1%	141	50,1%
Environmental health technician visited in the past month	190	37,1%	95	19,2%	285	28,3%
Total	512		494		1006	

The table indicates that wards with HCCs experienced less diarrhoea and used ORS more than those without, signalling both improved disease statistics and higher levels of primary health care implementation. As noted earlier, education levels, often associated with ORS use, did not differ significantly between wards with and without HCCs, and clinic distance should be less critical in this instance as ORS can be given at home. In fact there was no statistical association between ORS use and educational status in the survey result. This difference in use may relate to health knowledge, outreach and perceptions, discussed further in the next section. Pregnant women in areas with HCCs were more than twice as likely to attend antenatal care than those in areas without HCCs, a significant difference (Chi square $p<0.05$).

Visits by environmental health technicians (EHTs) signal the extent to which communities are supported in primary health care outreach. EHTs support monitoring of TB and communicable disease case tracing and treatment, health promotion and environmental health interventions. They are an active link between the community and the health services. Generally EHT outreach was low, with only a quarter of households visited in the past month, more so in Gweru and least in Makoni. As shown in Table 4.4, distance of households from clinics was inversely associated with frequency of visits from EHTs, indicating that EHT visits seem to be more frequent in areas where clinics are already closer to people. EHT visits were significantly more frequent in areas where there was an HCC than in areas without.

Table 4.4: Visits made by EHT vs distance to the nearest clinic

Number of times EHT visited in past month	Distance					
	<5km		**5-8km**		**>8km**	
	No	%	No	%	No	%
Never	547	70%	82	75%	87	78%
Once	168	22%	23	21%	18	16%
+2	66	9%	4	4%	6	5%
Total	781		109		111	

4.2 Health Service provision

Statistical data collected from the clinics and district records indicate selected health service indicators collected for areas with and without HCCs. Table 4.5 indicates the variability between districts in budget resources available to the districts and reported expenditures by the health centres. The bulk of the district expenditures is on medical supplies (59–89%) with 2.6% or less allocated to disease control, which includes community health promotion activities.

Table 4.5: Health indicators for the study districts

	Goromonzi	**Makoni**	**Gweru**
District health budget 2001	$11,576,000	$60,788,398	$97,820,965
Expenditure reported at health centres With HCCs Without HCCs	Not available	Vengere $212,380	Gunde $3,600,000 Somabhula $1,700,000
District expenditure: (Z$) Medical supplies Disease control	6,846,200 306,800	28,918,900	86,709,679 344,813
Total HSF funds (Z$) HSF share to clinics	1,896,903 n.a.	4,792,365 1,916,946	11,633,397 n.a.
Direct funding to HCC	None	None	n.a.
% < 1s immunised	81	54	75
% pregnant women going to ANC	***42***	***51***	***n.a.***
TB Default rate (%) in 2001	***16***	***n.a.***	***1***
Toilets built in 2001	***1***	***653***	***12***

Source: GOZ Expenditure Reports, Districts Annual Reports, Rusape Revenue Estimate Reports (2001)

As shown in Table 4.6, generally the clinics with HCCs had on average more staff, (nursing, EHT and general) and higher budget allocations from MoHCW than those without HCCs. They also had more EPI campaigns than those without HCCs. The improved health performance in these areas and improved staffing in these areas appears to be associated with an improved capacity to draw and use health resources, creating a virtuous cycle for those clinics with HCCs and a vicious cycle for those without.

Clinics without HCCs appear to perform better in toilet and well construction. In part this is due to the HCC clinics being in peri-urban area and urban areas (Arcturus and Vengere) where infrastructures are already established. Constraints to environmental health and health outreach campaigns were noted in newly resettled areas due to the lack of transport, distance and lack of interest in the new settlers. Some improvement was beginning to be noted however as some farmers were bringing their children for immunisation. Health staff noted the need for intense outreach campaigns in these areas made difficult by lack of transport.

Table 4.6: Health indicators for areas with and without HCCs

	Average for wards/clinics with HCCs	Average for wards/clinics without HCCs
Number of health staff Grade	6 nurses/nurse aids	4 nurses/nurse aids
Number of EHTs	0.75	0.5
Other clinic/ward level staff (ambulance driver, clerk and general hand)	2	1.5
Annual budget allocation to health centre from MoHCW Z$ 2002 January-June 2003	 212,674.13 131,989.84	 74,736.80 70,129.65
Number of EPI outreach campaigns in ward 2001 2002 Jan-June 2003	 8.3 11.3 7.5	 1.0 0.5 1.5
Number of wells dug in ward 2002 Jan-June 2003	 1.8 0.8	 2.5 1.0
Number of toilets built in ward 2002 Jan-June 2003	 4.5 1.5	 13.8 21.0

Fundraising by Mwanza HCC
In Goromonzi district the HCC of Mwanza clinic in 2001 engaged in fundraising with the community to improve health services. The HCC members initiated the idea of a security fee at a meeting three years ago when they realised that thefts at the clinic were increasing. The HCC had gone to the police to request for a police officer to guard their clinic and were told to pay a fee that they could not afford. They decided then to fundraise for their own guard. They discussed the idea in the HCC and then with the community and agreed on a maximum fee that would be paid by all members of the community and all users of the clinic. In 2001 this fee was $5 and it was increased to $100 in 2003. For transparency, the community elected a treasurer from the HCC. The HCC opened a bank account at Metropolitan Bank, Murehwa in 2001 to place their funds. Currently the fund has a balance of about $90,000.

The fund has been used for various health activities including paying the security guards, building toilets and pits for clinic waste, to purchase benches and make a signpost for the clinic. It has also paid for transport costs for health staff and HCC members when they visit Makumbe District Hospital to request for drugs or when banking. The HCC and the community decide on its use and all have benefited from the improvements made on the clinic. The understanding of the community and the visible gains the fund brings were viewed as important for sustaining the fund.

There are some issues to be addressed. The fund cannot meet all the costs required to be made at the clinic because of the low fee. Reaching an agreement on an affordable amount is difficult at the community meetings. This fund has indirectly reduced the health budget for the area as the community has now taken over costs of security guards and construction material, which was supposed to have come from the health budget. There has not been an improvement in the budget to match the community contribution, which would have encouraged the community further.

As shown in Table 4.7 below, the drug availability at the clinics with HCCs was also better than those without HCCs, although drug availability was generally poor. The vital and essential drugs surveyed were not available at many clinics, with only aspirin and chloroquine widely available. Antiobiotics were not widely available and stock levels were low where they were. Hence while the clinics with HCCs were in a better position, generally there is room for significant improvement in drug availability at clinic level.

Table 4.7: Drugs available at clinics

Drugs available	% clinics with drugs available and average months of drug stock remaining	
	With HCC	Without HCC
Asprin/paracetamol	100 2 months	75 1.5 months
Chloroquine tablets	100 1.5 months	100 2.5 months
Chloroquine syrup	75 3.5 months	0
Amoxycillin 250mg	25 0.25 months	25 0.25 months
Amoxycillin suspension	25 0.25 months	0
Cloxacillin caps 250mg	25 0.25 months	0
Cloxacillin suspension	0	0
Metformin tablets	25 0.25 months	0
Frusemide tablets	50 1.5 months	0
Salbutamol syrup	25 0.25 months	0

Drug availability was highest at mine clinic in Arcturus. Supplies there were consistent and supplied on a monthly basis. At clinics with low or no supplies poor drug availability was attributed to lack of deliveries, (some not having received since December 2002), and to errors made in the ordering of the drugs at the health centre, such as not clearly specifying the drugs needed and illegible handwriting leading to requests for orders to be resubmitted to the district. Generally, clinics (except for the mine clinic) did not know when their next supplies would come and could not predict a consistent supply of drugs.

4.3 Health knowledge

Knowledge of appropriate management of TB, malaria and diarrhoea were used as one set of indicators of health knowledge. These are common diseases in the areas surveyed and treatment approaches have been part of primary health care management for some time. Table 4.8 summarises the findings. Generally Makoni was least aware of treatment methods for TB (77% correct) and Gweru most (94.5%).This pattern of knowledge across districts held for other areas of health knowledge. People were generally more knowledgeable about malaria treatment, then TB treatment, with least knowledge about correct treatment of diarrhoeal disease. Nevertheless levels of knowledge of 80% of respondents and higher indicates that health knowledge is not the most significant constraint to health practice.

Table 4.8: Health knowledge indicators

	With HCC		Without HCC		Total	
	No.	% total	No.	% total	No.	% total
Correct knowledge of TB treatment	451	88.1%	422	85.4%	873	86.8%
Correct knowledge of malaria treatment	480	93.8%	447	90.4%	927	92.1%
Correct knowledge of diarrhea treatment	416	81.3%	393	79.6%	809	80.4%
Know what the district nursing officer does	54	10.5%	23	4.6%	77	7.7%
Total	512		494		1,006	

Wards with HCCs generally had higher levels of knowledge than those without across all areas of health knowledge. In relation to knowledge of who manages health in the district this improved knowledge was statistically significant (Chi squared $p<0.05$). As education levels do not differ between areas with and without HCCs this cannot be attributed to education status and needs to be related back to other inputs.

HCCs could be argued to improve knowledge not simply of primary health care interventions, but also of the organisation of health services in an area, how they run and who manages them., They are intended to bring communities closer to their health services. Knowledge of services was tested by asking whether people knew the role of the district nursing officer. As shown in Table 3.8 above, while this knowledge is generally lower than that relating to management of common diseases, it is higher in wards with HCCs than in those without.

4.4 Perceptions of health priorities

Communities were asked what they perceived to be their most common health problems. Environmental health problems ranked highest, followed by food shortages (the survey was done during a period of severe food shortages) and then problems with clinic quality.

Table 4.9: Most common health problems being faced in all the districts

Problem	Frequency	%	Rank
Contaminated or inadequate water	194	21.7	1
Non-functional toilets and sewer system	157	17.6	2
Food shortages/food expensive	153	17.2	3
Poor sanitation/dirty environment	136	15.3	4
Poor service at clinic (rude staff, drug shortages)	126	14.1	5
Clinic far/transport problems/no maternity facility	52	5.8	6
AIDS/STD/TB related problems	23	2.6	7
Diarrhoea	22	2.5	8
Other problems	16	1.8	9
Other diseases	13	1.4	10
Total	892	100	-

As shown in Table 4.10, wards with HCCs rate water and environmental problems as a higher priority than quality of and access to care issues, while those without HCCs rate access and quality concerns higher. It would appear that the HCC presence is associated with an improvement in these issues, or at least less perceived problems with clinic services within communities.

Table 4.10: Priority health problems for wards with and without HCCs

Problem	Rank for wards with HCC	Rank for wards without HCC	Rank Total
Contaminated or inadequate water	1	6	1
Non-functional toilets and sewer system	2	4	2
Food shortages/food expensive	3	4	3
Poor sanitation/dirty environment	6	4	4
Poor service at clinic	5	1	5
Transport and access problems	4	1	6
AIDS/STD/TB related problems	7	7	7

In the participatory assessment communities raised the priorities shown in Table 4.11 below. Community concerns were similar to those raised in the survey, to be expected, relating primarily to clinic costs and quality of care, transport to clinics and environmental health issues.

Table 4.11: Priority health problems from participatory assessment

Problem	Goromonzi	Makoni	Gweru
High clinic fees and costs	5	2	
Drug shortages at the clinic	3	1	4
No waiting mothers' shelter at clinic			2
Diarrhoea	5		
Transport and clinic access problems	1		1
Contaminated or inadequate water	2		3
Non-functional toilets and sewer system	6	3	
Food shortages/food expensive	6		
Poor sanitation/dirty environment		2	
AIDS/STD/TB related problems	4		
Other diseases	4	3	

Not surprisingly given their priority problems, in the survey communities prioritised in terms of actions to be taken.

1: Provide clean water 22% respondents
2: Provide food relief 21% respondents
3: Improve sewerage/sanitation 14% respondents

Improving the clinic in Vengere

The HCC in Vengere in Makoni District faced various problems in its operations in 2002 after its formation in 2001 by the Rusape CWGH members who facilitated the exercise. The CWGH district members called for a meeting of civic organisations in their area and also invited the MoHCW representatives and the local councillor. Various people were nominated at this meeting and these included the councillor, nurse, members from ZINATHA, headmaster from a local school, member of the residents association.

The community in Rusape informed the HCC of their views that their clinic was too small and needed to be expanded, as it had a wide catchment area with many people coming to the clinic to receive treatment. People also complained that they were being served late due to the high workload of the health staff at the clinic. The HCC took the issue to the health staff at the clinic, but had not had regular communications with the health staff prior to this. The HCC had not been meeting regularly. The health staff received the complaints and were aware of what was happening but felt this was a matter for the local authority. To date the issue has not been taken up with the local authority.

5. Characteristics of the Health Centre Committees

Communities were asked whether the HCC had helped to deal with these priorities. This was only asked in the survey of communities in areas where there was an HCC.

A third of respondents (33.2%) felt that the HCC had dealt with their priority problems. A quarter (26.2%) of respondents were not sure, indicating that they do not know what the HCC is doing. A further third (37.1%) said the HCC had not dealt with priority issues. The distribution of those saying the HCC had helped with priority issues by areas was 26% in Goromonzi, 59% in Gweru and 5% in Makoni. The next section explores more closely the community knowledge of the HCC and its work.

The participatory assessments gave more information on what the HCCs have done in the different areas around these priorities.

In Goromonzi: In wards with HCCs, community members reported that the HCC was dealing with the water issue and reported improvements after the problem was reported to the HCC. The HCC, in a bid to improve sanitation and hygiene, has ensured that the toilets are cleaned twice a day. Health services in the area were reported to be working together with the HCC in both Goromonzi wards with HCCs and had provided health information to the community. The issue which was not being adequately addressed was reported to be that of drug shortages. In a second clinic the HCC had purchased drugs using the ‘security fund’. Communities reported paying $50 per month per household to this fund, organised by the HCC, and it was used to pay for the security guard, to purchase drugs and purchase benches at the clinic. Security organised by the HCC had cut down on theft of drugs and supplies from the clinic. The HCC had paid transport costs incurred when one was sent to purchase drugs, as the clinic did not have the funds. The HCC was also educating the community on TB case tracing and treatment and had built toilets for the health staff, although cement shortages were hampering this.
In wards without HCCs: communities reported that problems were not being dealt with as nothing had changed at the Rural Health Centre.

In Gweru: In the ward with an HCC, community members reported that the HCC was dealing with the water issue, had dug a borehole and installed a water tank. The HCC had made a request to the district for an ambulance but was still waiting for a response. The HCC had also procured bricks for a waiting mothers’ shelter but needed more resources to complete. Health services in the area were reported to be working together with the HCC.
In the ward without an HCC: communities reported that problems were not being dealt with as nothing had changed at the Rural Health Centre.

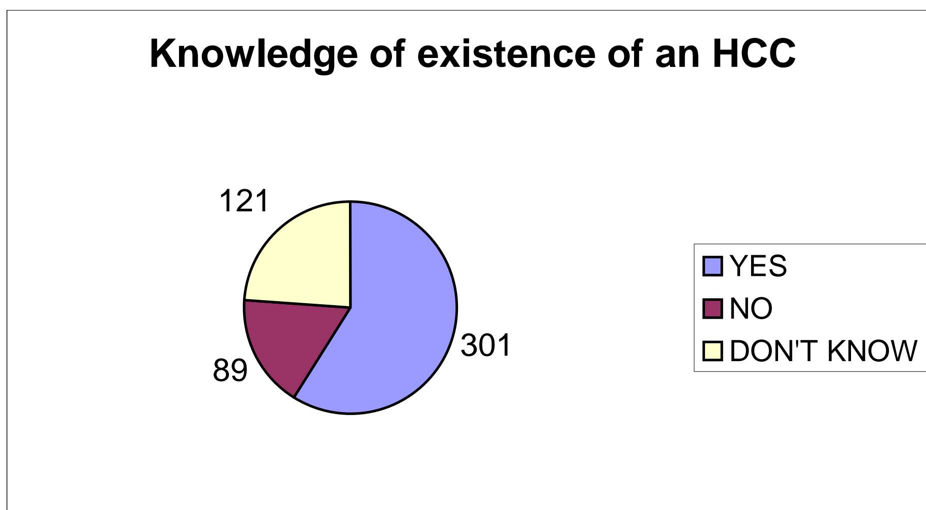
In Makoni: In the ward with an HCC, community members reported that the HCC had taken their concerns on the sewerage issue to the local authority but that the local authority had not responded. Health services in the area were reported to be working together with the HCC and had also taken up the community issues with the local authority but they had also not received a response.
In the ward without an HCC: communities reported that the issue of AIDS had been dealt with.

In general it seems from the reports that the HCCs have been able to take up community issues. They have been more successful at resolving these when they have mobilised local resources than when they have relied on resources from the ministry of health or the councils. It would appear that their efforts are not being met by resource transfers from higher levels.

5.1 Knowledge of the HCC and its work

Respondents in areas where HCCs existed were asked what they knew about their HCCs. While 17% of respondents said they did not know about an HCC in their area, 59% said that they did. A further 24% were not sure about the HCC (see *Figure 5.1*). Knowledge varied significantly across districts with 24% of people in Makoni knowing their HCC, 64% of respondents in Goromonzi and 81% in Gweru.

Figure 5.1: *Knowledge of the existence of the HCC.*



In the participatory assessments community members noted that HCCs did reflect a range of social groups in the community: unemployed and employed, men and women (Arcturus); farmers, youth, unemployed, employed and widowed (Mwanza); widowed and elderly (Gweru) and employed unemployed and widowed (Makoni).

They also noted that orphans, disabled people, the elderly and youth were not found on the HCC. The reasons given were that vulnerable groups have difficulty in attending such meetings and are often overlooked in local structures.

To test their familiarity with the HCC, interviewees were also asked whether they knew the names of the people on the HCC. Nearly half of the respondents (48.3%) were able to do so, indicating that generally those who knew about the HCC, knew who was on it This also varied by district, with 11% knowing the names in Makoni, 52% in Goromonzi and 77% in Gweru. This indicates

that not all HCCs are fully in contact with their communities, particularly in Makoni.

In the participatory assessment, communities reported that HCC members were chosen by nomination and voting at community meetings. through a voting system were members were nominated and voted into by the community. In Makoni and Gweru District members were stated to have been selected from the different groups they were representing and the community voted them into positions. Key informants in all areas stated that some members were chosen because of their status and role in health services, such as councillors, traditional leaders and health personnel.

Communities in the survey felt the primary role of the HCC was to address community health problems, and give advice to communities on health issues. They thus see the HCC as health promoters and advisors, and as bridges to ensuring that health interventions address community health problems (see Table 5.1).

Table 5.1: Community perceptions of the role of the HCC

Responses	Frequency	% of respondents	Rank
Address health problems/visit community	147	17.1	1
Advice on cleanliness	81	9.4	2
Advise on looking after orphans/needy	76	8.8	3
Help run clinic	21	2.4	4
AIDS/TB awareness	20	2.3	5
Advise on where to build toilets	15	1.7	6
Advice on family planning	6	0.7	7
Nothing/don't know/not applicable	496	57.5	8
Total	862	100	

Table 5.2 shows the compiled analysis of the responses in the participatory assessments to the role and work of the HCCs in the three districts. The composition of the HCCs are similar across all the districts. The HCCs are reported to report to the health services,. Their reporting to the community is to the CWGH. It is interesting that communities do not see that the HCCs report directly to them and signals that in areas where the CWGH may not exist there may be lack of communication to the community from HCCs.

The HCCs were noted in the participatory assessment to be meeting their primary roles raised in the survey, viz addressing community health problems, giving advice to communities on health issues, providing health information and taking up issues with health services. In some areas they are clearly going further to make direct improvements to services. Further as reported from their report of issues discussed at the last HCC meeting in Makoni they are also playing a role in making public funds accountable, such as in finding out how the AIDS Levy fund was used.

While communities see the HCC as a 'bridge' and advisor on health issues, only 38.9% of

respondents in the survey said that people took their complaints and issues to the HCC (15.3% in Makoni, 39.8% in Goromonzi and 59.4% in Gweru). A relatively similar share (32%) indicated that the HCC had helped to deal with the problems, with a similar distribution across districts (see *Figure 5.2* below).

Table 5.2: Summary table showing roles and functioning of HCCs reported in participatory assessments

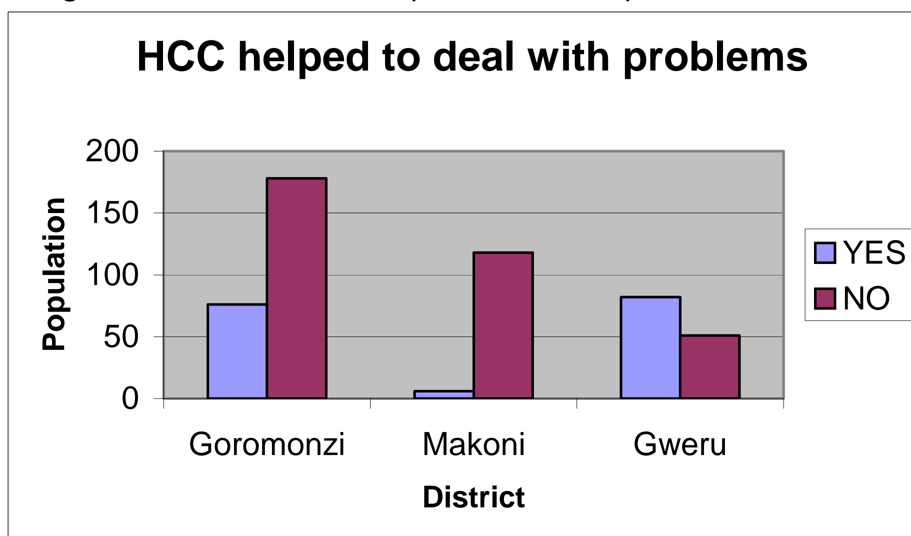
Topic	Goromonzi	Gweru	Makoni
Composition of HCC	EHT, nurse, headman, councillor, village health worker, traditional healers, teachers, business people	EHT, nurse, headman, councillor, village health worker, traditional healers, teachers, school heads, chiefs, church representatives	EHT, nurse, headman, councillor, village health worker, traditional healers, teachers/school head, youth, NGO representatives
Who does HCC report to	CWGH Clinic District health team	CWGH & clinic DHT Social Services Committee	CWGH & clinic Council
What does HCC do	Arranges meetings with community to identify and discuss health issues; Organises awareness campaigns on HIV/AIDS; Sanitation; Visits the sick in the community; Works and helps with clinic in articulating community problems; Collects money for security fund	Encourages community to maintain and improve health standards; Is on the outlook in community and schools to identify and receive complaints encountered; Checks that toilets present tally with population at schools; Educates community on health issues	Observes what is occurring in the community in terms of health; Identifies health problems and comes up with solutions
Issues discussed at last HCC meeting	Health issues: HIV/AIDS, how to look after the sick & orphans; Development of Rural Health Centres; Security issues; Construction of toilets; Sanitation; Accommodation & Welfare of workers; Food aid; Health Brigades	Take up need for Blair toilet at clinic; Water and sanitation issues; Have taken up need for stand for the water tank; Staff shortages at clinic; Annual plans; Construction of maternity room	On need of additional health staff at clinic; On how $5 million for AIDS orphans was distributed; Preparation for World Aids Day; Health budgets

5.2 Satisfaction with the HCC

It would appear that some of the study population (over a third) are actively interacting with the HCCs, while others are not. For those interacting there is some indication that the HCCs are assisting, while those who do not interact or take issues to the HCC do not obtain responses or results from the HCC. This does seem to indicate that there is a ‘two-way street’ between HCCs and communities: Those who know, interact with, take issues to and get feedback from the HCC are reinforced and see the value of the HCC. This is reflected in the levels of satisfaction with the

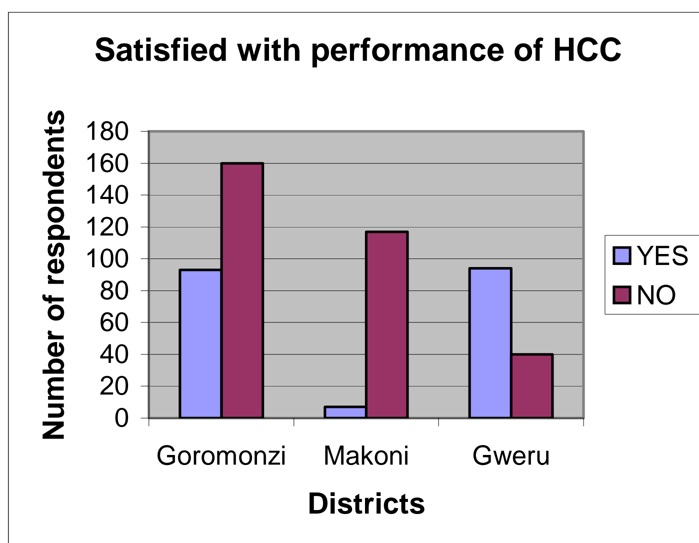
HCC, higher in Gweru and lowest in Makoni (Chi Square $p<0.05$).

Figure 5.2: *Has the HCC helped to deal with problems?*



Overall, 38% of respondents indicated that they were satisfied with the performance of the HCC (see *Figure 5.3*). Those who do not make contact with the HCC get more isolated and do not see the value of the HCC. There is a risk in this that the HCC narrows its links with a smaller and more active share of the community, who may not be the most vulnerable.

Figure 5.3: *Reported satisfaction with the HCC.*



The reasons given for not being satisfied with the HCC are not all within the control of the HCC. The most common reason – poor communication – raised by 46% of respondents is certainly within their control and indicates a need to pay more attention to HCC–community interactions. The others (see Table 5.3) relate to health service factors and indicate frustration at the HCC related to lack of improvement within the health services.

Table 5.3: Reasons for being dissatisfied with the HCC

Responses	Frequency	% of respondents	Rank
Poor communication by HCC	211	45.6	1
No drugs and drugs not affordable	67	14.5	2
Clinics small and rude staff	47	10.2	3
Poor medical services throughout	39	8.4	4
Poor sanitation and unhygienic conditions	29	6.3	5
No food or financial assistance	27	5.8	6
No toilets and sewage problems	19	4.1	7
Water problems	9	1.9	8
Total	**463**	**100**	

The Gunde Health Centre water tank

Gunde HCC in Gweru District in 2000 and 2001 was involved in the procurement of a water tank for the health centre. The problem with the water tank began in 2001 when the community realised that the water tank at the clinic was leaking. It needed to be replaced to have adequate water stored for the activities of the clinic. The HCC held a meeting. The nurse, who had just come from another area, told them that the health authorities were giving clinics tanks after the destruction caused by Cyclone Eline. She suggested that they apply for one.

The HCC members asked the nurse to write the proposal to the health authorities to request for the water tank. They sent the request to the hospital administrator through the DNO. The nurse also raised the issue in the District Health Executive meeting. Because the water shortages were affecting operations at the clinic, the nurse reported the issue verbally and on paper through the minutes. The councillor of the area also visited district health authorities to inform them of the issue. Within a month, the district hospital administrator phoned the HCC and advised them that their request had been successful. He asked them to come to collect their tank! The HCC have collected the tank and are organising to purchase cement to put up the stand and get the diesel for the pump. The community has been mobilised by the HCC and has committed itself to provide labour once the cement is found.

5.3 HCC member and health worker views on HCCs

The views of HCCs and health services on the roles of HCCs are summarised in Table 5.4. There does however seem to be some variation in who the HCCs report to at the level of the authorities, to some extent tracing back to a lack of certainty on who initiated the HCCs and their formal legal status. This lack of formal clarity must hamper the work of the HCC.

The HCCs and officials both concur that HCC authorities relate to issues of clinic security and dealing with sanitation. The HCCs also see thay they have authority in mobilising resources for health, in wider environmental health action and in health promotion and follow-up care in the community. Neither indicates authority in raising community priorities for budgets, improving clinic quality or in any respect of resource allocation. These areas of authority are viewed to lie at other levels. Hence while the HCCs and health authorities note that they have good communication between them, there is frustration reported by the HCC over the time taken to take decisions over issues that they deal with, which is an issue that frustrates them. From earlier participatory assessments communities at present understand that bottlenecks on delivery in these areas relate back to the authorities but also note that it negatively impacts on the work of the HCC.

Table 5.4: Roles of HCCs as perceived by HCCs and health workers

Activities	HCC views	Health worker and local authority views
Roles	Key informants in all districts highlighted the main roles of the HCCs as identifying health needs of the community and finding ways of dealing with them, educating on community health issues; encouraging people to treatment and notifying the communities on health activities.	Similar views to HCC. Role in the community appreciated but some officials stated that they did not fully accept the work of the HCC as it had not formally introduced itself into the area. One health official stated that they did not attend HCC meetings because the HCC was failing to organise itself.
Reporting of issues by the HCC agenda	Decisions reported in all areas to be taken to either the clinic, local authority, district health team or to the CWGH. Key informants in Arcturus also stated that issues were conveyed to company managers. Farmworkers were also approached when issues of health in the farming areas were to be decided upon.	Views varied: Some said the CWGH, others the clinic while others the District Health Team. HCC seen as a source of information for health services on community issues and events.
Issues that HCCs have decision making authority in	Goromonzi district: ◆ number of times toilets should be cleaned – hygiene issues; ◆ disposal of litter, grasscutting; ◆ visiting the sick and orphans in the community; ◆ fundraising. Gweru district: ◆ construction of toilets. Makoni district:	Issues on security and sanitation.

	◆ sanitation; ◆ fundraising.	
Communication and time taken for response to decisions on issue to be made	Varied depending on the issues being discussed. In Goromonzi district decisions on the farm areas reported to be slow but those made by mine authorities made quickly. Following the required channels has brought delay. Protocol viewed as a hindrance but all issues always dealt with.	Generally report good communication, and that when called for meetings health staff always attend. One key informant felt that the HCC had not always been forthcoming on its issues.

Given that the communities perceive that the HCC plays a role in communicating health priorities to the health services and that the HCC is not perceived to have direct authority in allocation of health resources to priorities, how are priorities set in communities? The key informant interviews provided the feedback shown in Table 5.5.

Table 5.5: Priority setting for health budgets

Views of	Goromonzi	Gweru	Makoni
HCC	From visits to the community; From complaints made by the community to their elected leaders at meetings	Visits and observations of what is occurring in the community; Discussions at community meetings	Observations of what is occurring in the community; From meetings with the community
Health and local authorities	**From evidence in clinical records; From participatory health and hygiene education exercise; From surveys;** From the Rural District Service Social Committee	From clinic records or statistics; From National Health Priorities; From Rural District Council Plans	From health statistics from the clinics; Guidelines from National Health Priorities; From Civil Protection Committee

According to the HCCs priority setting for budgets is done through visiting the community, meetings and specific complaints raised by the community. This is primarily thus qualitative information. The Health and local authorities report using more quantitative evidence – clinic records, surveys and plans. Notably none mention using the community evidence gathered by the HCC, despite the consultation and community interaction carried out by the HCC.

The role of the HCCs in quality of care is thus given a lower profile than in community health activities, even through quality of care issues rate equally or higher in community views and communities raise complaints on quality of care and access issues to the HCC. As shown in Table 5.6, HCCs have monitored service quality at the clinic and have informed health staff of problems, but this is not being applied across all areas. HCCs have played a role in communication to communities and in social mobilisation around health campaigns, but again this is not uniform across areas. The possible role of HCCs is thus relatively under-recognised and under-utilised across areas both by the community and the health system.

Construction of a waiting mothers' shelter in Gweru

Communities raised the need for a waiting mothers' shelter in Gweru district in 1999 during ward meetings they held with their councillor and traditional leaders. Communities told their

local traditional leaders that pregnant women and ill people found the long distances to travel to and from the clinic a problem. The traditional leaders and village health workers informed the health staff that they felt that the communities were reporting more home deliveries as there were no facilities for staying at the clinic. The HCC at their meeting agreed that the solution was to construct a waiting mothers' shelter for expectant mothers and ill people. The former councillor for Gunde was tasked to obtain permission from the rural district council to build the shelter. The rural district council agreed to the proposal and said it would draw the plan.

The HCC informed the DNO of their proposal. She was aware of a donor willing to fund the project. The HCC bought building material, window frames and doorframes and the community provided labour for the bricks. However the project then stalled. The RDC did not draw the plans, and the donor pulled out, reportedly due to delays in completion of the project documents. A new HCC was voted in and the members were not well informed on the project. They now had to find a new source of funds, and that struggle is continuing. Currently they are still trying to identify possible donors and make proposals in future. The district health authorities are also trying to assist them in identifying donors who could assist through raising their needs when they sit with various stakeholders in different forums.

In relation to health budgets, Table 5.6 indicates that the role of the HCC has been minimal. Areas where the HCCs have reported some action, such as in relation to orphan care and sanitation do not seem to be recognised by authorities and all concur that the HCCs have not played any role in monitoring how health budgets are spent. HCCs do give information to authorities on community health needs for inclusion in the budgets, however except for one isolated case and in relation to budgets in the area of orphan care and sanitation, have not been part of the budget setting process.

Table 5.6: Role of the HCC in service quality and resource allocation issues

Activities	HCC report	Health and local authority report
Making budgets for health	Views varied. Community and some informants stated that they made inputs health needs to the CWGH. Most HCC members and the community stated that they did not have such power.	Generally no action except in one area where health budget done once with HCC.
Deciding how money should be spent	Have decided on how much was to be spent on meeting orphan needs and on sanitation issues and made input on how funds should be spent.	No action.
Monitoring how money is spent	Currently do not do anything in this area.	Currently do not do anything in this area.
Defining service and health priorities	Currently do this through meetings with the community and HCC members to discuss main health issues affecting the area.	Have meetings with the community and pass suggestions to the health services at local and district level.
Monitoring service quality	HCCs visit the clinic to observe how health staff treat patients, meet the community to discuss views on services provided in the area.	Response varied. HCC noted to have observed treatment of patients and to inform health staff when things were not right.
Informing the community on health	Call meetings or do household visits.	HCCs have held meetings with community, eg on TB, malaria, immunisation.
Coordinating health services	Varied views. Have organised and coordinated activities such as TB awareness campaign. Others state that the HCC does not did not have much power in this area but assists or participates in activities.	Generally no action. In one area HCC noted to have coordinated the national immunisation day as it played a role in social mobilisation.

5.4 Impact of HCCs on health

Table 5.7 shows the areas where key informants report the HCC has had an impact. The table indicates significant achievements in Goromonzi and Gweru, and very little in Makoni. In the former two areas these impacts relate to social mobilisation for health promotion, environmental health and some quality of care issues (all priorities for communities). However in relation to transport and access, another set of community priorities, the HCC has not had an impact. The HCC has had less reported impact on bringing resources into communities than on quality of care issues. Given that resource constraints are recognised to be fundamental in addressing quality of care, not being able to substantially influence resource flows does pose a constraint to dealing with quality of care, recognised by the community.

Table 5.7: Summary of areas of impact of the HCC Role of HCC

Area	Goromonzi	Gweru	Makoni
Areas of impact of the HCC	Water quality improved; Blair toilets constructed in farm areas; Litter collection and general cleanliness improved; Health information to communities; Contributed to drug purchases for clinic; Employed a security guard at clinic; Constructed staff toilets; Bought benches for patients; Fenced clinic; Bought drugs for clinic; Mobilised community	HCC acted on concerns of the need for the water at the clinic, mothers' shelter and boreholes; Fenced the clinic; Moulded bricks for toilets; Promoted health awareness in the community; Improved water supply to clinic through the water tank; Negotiated for additional nursing staff; Involved in feeding children; Dug wells in the community Informed authorities on health needs of the community; Helped purchase drugs at the clinic	Taken up sanitation issues with local authority
The HCC has brought more money into the community	Yes: Food aid to orphans; Security fund for benches, security guard and drugs	Through the food aid	No
The HCC has improved the quality of clinic health services	Yes: Reduced health staff workload through visiting the sick and home based care; Renovated clinics, improved security; Improved health staff living conditions through construction of staff toilets	Yes: Through the renovations it has made the two toilets dug at the clinic; On the issue of the nursing staff as the district will be giving the clinic extra staff; Water tank now present on site	Varied views: Helped improve drug supply; Some said it had done nothing
The HCC has brought community priorities into the health budget	Variable: not sure; Improvements in the water purification	No impact	No impact

In areas where the HCCs have had more impact (Gweru and Goromonzi) they have mobilised additional resources from communities or other sources outside the health budget.

At district level, key informants constantly referred to Mwanza HCC as an ideal example of an HCC which had been able to become independent in finding ways of addressing problems, mainly with the introduction of its security fund. The informants also stated that the major achievement of the HCCs in Arcturus and Mwanza (both in Goromonzi) were that they had helped to instill a sense of ownership in the communities of their health centres and that communities with HCCs had a higher level of awareness in terms of health issues and their rights than those without.

6. Participatory reflection on the findings

6.1 Community views

Participants were given the results in both English and Shona at community meetings and the results were discussed. In all areas participants felt the results and the graphical representations were a true reflection of the situation. They did however raise a number of issues to explain or comment further on the findings.

HCCs have improved health knowledge
In all areas except Vengere the HCCs felt that higher health knowledge in areas with HCCs than in those without resulted from HCC involvement in health education campaigns together with health staff. HCCs had been active in mobilising the community and encouraging them to visit the clinic. In Gunde HCC members stated that they had worked with village health workers and used the ward meetings to address such issues. Where areas without HCCs were also achieving high health education outcomes this was due to the fact that communities in those areas were also spreading information of health through educational programmes and through the village health workers.

HCCs have weak knowledge of the health system
Participants acknowledged in many areas that they did not know the district nursing officer (DNO) and where they had heard of her they had no knowledge of her role, and so they could not inform the community of this.

Use of the health services fund in Arcturus
People in Arcturus, Goromonzi District, are not aware of the health services fund (HSF), which is only known to health staff. The HSF is a collection of user fees and donor funds set up to fund health projects. Hospitals are entitled to 60% and health centres 40%. The CWGH informed people about the HSF but the HCC has since then had difficulties with organising how to access and use it. The HCC has been able to access funds for health from the employers in the farm and mine areas. The HCC convinced the employers to purchase more chemicals for the improvement of their water supplies, which the community felt was contaminated. The HCC approached the water engineer and the mine management with samples of the dirty water to demonstrate the need to purify the water. After this action was taken, the water was purified. The HCCs learnt that collective effort is more effective than individual effort. The HCCs feel that communities have a right to access health resources, but are not informed or confident about how to do this. They called for more training and information to empower them to access the health resources available at the district. The district health staff agree that the HCCs should know about the HSF. Training

was carried out on the HSF when it was introduced but has not been done since. Although the HSF is used for clinic improvements like electrification and water tanks, the community is not aware of these actions. They feel that the HCC should know the operations of the HSF to use it effectively.

Some community groups are not well represented by the HCC
Participants in all areas except Gunde agreed that HCCs represented certain social groups and not all. Groups like farmworkers, gold panners, those living some distance from the clinic, disabled people and orphans were noted to be excluded. They felt this could be one reason for some people not being satisfied with their performance. They noted that they had been effective in representing people on particular issues, such as dealing with contaminated water at the mine in Arcturus.

Communities may not be informed of the work of the HCCs
Participants verified the information on performance of HCCs, including from Makoni District, where performance was judged to be poorer. In Gweru HCC members from Gunde clinic did not however feel that the community perception was a true reflection of their HCC as they had been working hard in improving the health services in their area. They had been able to deal with the problems of the water tank, hence helping to solve some of the problems that had been identified in the survey. The HCC in Mwanza suggested that although they were active and making several improvements, those who were not aware of their existence may be those who lived further from the clinic. The HCC feedback does verify that HCC commitment is one aspect but so too is effective promotion of what they do in communities for their role to be appreciated.

Communication is a major factor in community satisfaction with the HCC
The survey results revealed that communication was the main reason for respondents being dissatisfied with the HCC. All meetings agreed that communication was essential for effective HCC performance, both within the HCC and between the HCC and the community. Participants in Goromonzi noted that Arcturus mine HCC were not well known by all in their ward as they had mainly focused on the farms. In Vengere the HCC noted that poor communication to communities and within the HCC was an impediment to effective impact. They observed a problem of lack of commitment and attendance of meetings by key people including the councillor. Others saw communication as less of a barrier. In Gunde the HCC stated that communication was not a problem in their area because they were well known, held meetings often with the community and made input to the ward meetings called for by the local leadership. The councillor from Somabhula, Gweru (area without HCC) stated that even if an HCC were to be set up, communication would still be a problem, especially in the newly resettled areas. Access to the clinic was difficult, challenging the work of the HCC. Similar views were expressed by staff from John Reimer clinic who stated that access and lack of transport made it difficult to communicate on health issues.

HCCs have little impact on health budgets and resources
The HCCs generally agreed in all areas that they had little or no impact in monitoring health budgets and services. They said this was due to their having poor knowledge of health resources such as the health services fund, of required staffing levels or budget processes. They noted that the CWGH had promised to train them on their roles in budgeting and in the HSF but had yet to do so. The health staff from one clinic noted that while HCC members made input of the things needed to improve their health centre, the health centre itself was not involved in coming up with a budget as this was done only by the health authorities at the district, who sometimes did not take account of the priorities set at clinic level.

They noted that few HCCs had played as strong a role in resource mobilisation as in Mwanza clinic, which had raised resources through their security fee. They noted how the HCC in Mwanza had complemented the health budget through its activities, including paying $15,000 per month to the security guards, purchasing benches and paying for transport to HCC members who travelled to other areas on HCC business.

HCCs have contributed to health service improvements
The delegates agreed with and took note of the findings that HCCs had taken up community concerns around health services. This included water and sanitation improvements in Gweru and Arcturus, implementing the security fee in Mwanza used to pay security guards, purchase benches, build toilets for health staff and provide money for transport when the health staff travelled to the district hospital to request for drugs. In this area the HCC had not only improved health resources but also created employment for their youth who were the security guards. They noted however that they had not paid as much attention to the quality of care at the clinic (services, staff attitudes) as they had focused primarily on social mobilisation.

The attitudes of health authorities towards HCCs vary
Views varied amongst the delegates. The Gweru HCC highlighted that they worked well with District authorities as they visited their health centres and appreciated the work they did, while in Goromonzi the HCCs highlighted that they did not know who the District Nursing officer (DNO) was and her role in affecting any of their activities. In Vengere there were complaints that the local leaders and health authorities were not committed to the HCC leading them to be less effective.

The Sewer problem in Vengere
In Makoni District, the HCC assisted in identifying the burst sewer pipes in Vengere high-density suburb in 2002. The sewer problem in Vengere began in 2002 when old sewer pipes were bursting, posing a health hazard for the children who were now playing with the unclean water. Some HCC members reported the issue to the housing department of the council. The HCC did not take the issue to the health authorities, as they believed it was the local authority that was responsible for fixing the pipes. The council did attend to the sewer pipes but gave no feedback to the HCC members who had reported the issue. It is not known why the council did not give any feedback to the members who reported the issue. They knew that their report had been noted when they saw that the pipes were being fixed.

Support from health authorities and community leaders is central
The HCCs identified a number of factors influencing the health outcomes found. Positively they observed that HCCs were able to educate communities on importance of health services, identify cases of those requiring home based care and give advice, identify health issues and problems, take these issues to health service personnel and pass information to communities on health issues through local structures. Where local and traditional leaders were actively involved, the HCC was able to accomplish more than where they were not. Equally where health staff were responsive and cooperative, where the DNO makes outreach visits and particularly where the EHT was effective and linked to the HCC, the HCCs were able to have a more positive role.

The major comments made in each area around the results are summarised in Table 6.1 below.

Table 6.1: Summary of discussions on the findings

Issues	Gweru	Makoni	Mwanza	Arcturus
Community representation	Successfully represented the various social groups in their area including the vulnerable groups.	Had failed to fully represent the community which it operated in.	Represented the community living around the clinic but not those living furthest from the clinic in areas such as Juru. Represented community in dealing with their needs in addressing security issue at clinic after thefts. The elderly were being represented as HCC agreed that all those over 60 were not to pay the security fee.	HCC had addressed the water issue, which affected majority of the social groups indicated in the survey. Confessed to have failed to fully represent the needs of farmworkers and settlers in other farms as they had had bias on mine compound only. Had not fully represented the needs of orphans and disabled in the area.
HCC impact on improving health services	HCC helped to acquire a water tank to help solve the water problem at the clinic. Assisted health services to mobilise community for outreach programmes.	Identified that the sewer pipes in the area were bursting and reported to responsible authorities.	Purchased benches. Constructed toilets, sharp pits. Made signpost for the clinic. Involved in outreach programmes to promote health awareness eg: HIV/AIDS awareness campaigns.	Assisted in improving health in the community by approaching mine authorities to purify contaminated water. Involved in outreach programmes to educate community on health.
HCC impact on improving health resources for community priorities	Indirectly the HCC together with health services drew up annual plan which included health needs but no positive feedback came from health	No main role was played but at one time tried to get information on the AIDS Levy but failed. Nothing was done on the	Contributed indirectly through the security fees which was used to improve the clinic. Cut grass at the clinic and indirectly cut costs of health	Indirectly through encouraging the mine authorities to purchase chemicals to purify water. Tried to access AIDS Levy but failed. Has little knowledge

	authorities. Not much was done because of lack of knowledge on HSF. HCC did not do much to access the AIDS Levy.	HSF.	authorities in paying for labour. Has little knowledge on HSF.	on public funds such as the HSF.

Village leaders in Mwanza
Headman Chiuri of Mwanza in Goromonzi District got involved with health issues after attending a meeting at the clinic. The meeting made him realise that health was important in his area. He became involved with the HCC, encouraging members of his community to join health activities, assisting the health staff to campaign for HIV/AIDS testing and counselling, and educating the community on the importance of HIV/AIDS testing. He also played a role in improving security at the clinic after various thefts had occurred in his area. When the chairman of the HCC reported the issue to the police he was not taken seriously and no response was given. The police respected the respected, so when he went to report they listened and took action. People in the community were more receptive to health issues when these came from someone of his status. He encouraged other HCCs to involve local leaders when they wanted to reach out effectively to health authorities and to the community if they wanted to have an impact.

Lack of information, communication and resources weaken HCC roles
On the negative side, the HCCs were rendered less effective by a number of factors:
- lack of information on their roles, including from CWGH;
- transport problems preventing outreach to more distant communities from the clinic;
- difficulty with accessing certain communities (e.g. gold panners, disabled people);
- assumptions that health outreach staff were reaching vulnerable groups that were no longer valid e.g. MoHCW rehabilitation technicians who used to visit disabled people no longer visiting often;
- in some cases, poor communication between HCCs, communities and health authorities;
- weak commitment from some HCC members;
- lack of HCC knowledge of activities that occurred at the clinic and of health budgets and resources and how they could be accessed;
- difficulty with meeting bureaucratic requirements to access resources; and
- non-responsiveness of authorities to HCC queries.

The HCCs noted that they had little or no knowledge of their roles and hence cannot have any meaningful impact in accessing resources from the health budget, AIDS Levy or HSF. They looked forward to the promised training from the CWGH.

Non-responsiveness from authorities
HCCs have made several efforts to access the AIDS Levy fund for their communities. In Arcturus some HCC members stated that at one point in 2002 they had tried to be involved in accessing the AIDS Levy for 45 orphans in their area but had not been given feedback. They had gone to the RDC on the issue and were told to bring the birth certificates of the children and death certificates of the parents so that their applications could be processed. They experienced a

major challenge in accessing these documents as some of the children did not even have birth certificates. The headmaster of one of the primary schools, a member of the HCC then probed the matter but had not been given a response. In some areas the HCC members stated that they had approached representatives from DAAC to enquire on the AIDS Levy but no feedback was ever given to them on how to access these funds.

The AIDS Levy fund in Vengere
Very few people in Vengere clinic catchments in Rusape are aware of the existence of the AIDS Levy fund or its uses. The AIDS Levy is the fund set aside by the government to assist those infected and affected by HIV/AIDS, and is administered by the National AIDS Council. The HCC members followed up to get information on the fund from the District AIDS Action Committee (DAAC) which is a committee of ward representatives, mainly councillors involved in the disbursement of funds and took names of community members they knew to be infected and affected by HIV/AIDS so that they could be supported by the fund. Mr Nyamukunda and Mr Hucker, the two HCC members, held a meeting with DAAC representatives on the issue but did not get any feedback. The HCC heard that their district had received $5 million Zimbabwe dollars from the AIDS Levy fund but were unable to get information from the DAAC on how it was being used. At the meeting the DAAC representative refused to disclose information on how the fund is being used and so they failed to acquire information. The HCC felt that they were not taken seriously by the DAAC as their delegation did not include local leaders like the councillor and have decided in future to make approaches through these leaders. They also feel that collective effort is better than individual effort and will strengthen their links with the community.

Communities thus identified their major gaps as resources, communications and skills, and called for training and improved communication. In general they noted that there were gaps in their representation of extremely vulnerable groups, those more distant from the health centre and also in accessing the more influential business people. Most of the HCCs identified that improved interaction with these groups was necessary and resolved to carry out actions to support this. They also noted the importance of regular communication with communities if they were to understand the work of the HCC. HCCs generally felt they were held back by lack of knowledge of their roles, of key health personnel like the DNO and lack of direct contact with health authorities. They identified a need for direct meeting with the district health authorities.

The HCCs reported a number of areas of success in health improvement and noted that these were mainly in the communities and less so in the health services or in influencing health resource allocation which they did not understand as well. Where health staff and the HCC have worked closely together this has improved the HCC effectiveness and their role in the community.

6.2 Views of health workers and community leaders

The interviews with community leaders and health authorities highlighted a number of determinants of the functioning of the HCCs. The individual informants are not identified, but where their district or central status is relevant (e.g. where there are conflicting views) this is noted.

Lack of formal recognition of the HCC
Health authorities generally recognised the existence of HCCs within their areas, but noted that not all were functioning effectively. De facto recognition of HCCs is thus not an issue within the

health services. What appears to be more of a problem is clarity on their roles and the authority, support and resources they should get to implement them.

All district level key health informants highlighted that HCCs were set up in the 1980s after the Ministry of Health and Child Welfare at central level passed a directive for their formation in all health centres. They could not remember the name of this directive. They understood their formation to be in line with promoting equity in health. Central level officials understood them to be a means towards promoting community participation in the health system.

Central MoHCW reported that HCCs were set up in line with an operational framework stipulated in a document by the MoHCW on MoHCW Structures, Roles and Relationships and in line with the Public Health Act. These instruments set up the HCC in principle as the MoHCW document referred to provides for village health committees while the Public Health Act does not specifically refer to HCCs. One central MoHCW informant felt that there was no need for a law to define their functioning as they were empowered through the Public Health Act and operational guidelines. Another felt that if there was no legal provision that set out and governed HCC operations this should be put in place as this was the means by which they would be empowered to operate and through which they could receive an allocation from the national budget for their activities.

Lack of consensus on HCC roles
At central MoHCW the roles of the HCC are perceived to be:
- identifying community needs and reporting them to the ward;
- coming up with health related activities and plans;
- monitoring health centres and disease outbreaks;
- creating awareness of health problems; and
- giving advice on health matters to communities.

Central level informants recognised that HCCs strengthened the health system, promoting environmental health through construction of toilets and assisted health staff in promoting health awareness in communities. The major roles identified in the central interviews related to health planning and awareness. The HCC is not seen to have a role in improving the performance of health services or in allocating health resources, except indirectly through their plans and proposals. The central level officials noted, however, that they were not aware of the specific activities of HCCs as this information did not reach them.

In contrast the district informants identified a number of areas of implementing services and improving infrastructures where HCCs are playing a role, shown in Table 3, and noted the need for them to have more direct access to budget resources to play these roles. Some specific examples of HCC work included:
- Mangwande Clinic HCC which purchased benches and parts to fix their sink;
- St Patrick’s clinic HCC which worked with traditional midwives to refer people to the clinic;
- Gunde HCC which organised for a water tank for the clinic;
- Gunde HCC which assisted abused children with funds to seek treatment from the hospital;
- Goromonzi District HCCs which purchased equipment, built toilets and hired security guards with their own resources;
- Mwanza and Chikwaka HCCs which were involved in grass cutting and general maintenance activities;
- Gosha HCC which tried to purchase drugs for the clinic;
- Makoni district HCCs which were hiring security guards; and
- Dewedzu HCC which had constructed houses for clinic staff.

District health authorities saw their role as to share guidelines on functioning with HCCs and help them to become established. They also saw their role as to train and supervise the HCCs through

workshops that they conducted with community members and the RDCs.

Table 6.2 shows that informants report HCCs playing a role in improving health centres through purchasing equipment and general maintenance, without having real impact in budget, monitoring and planning processes.

Table 6.2: Areas of current and proposed impact of HCCs

Areas	Gweru	Makoni	Goromonzi
HCCs *have* had impact	Purchased equipment for clinic; Maintenance of clinic; Improved security at clinics by hiring guards; Educating community on the need to use the public clinic; Promoting health awareness and home based care	Purchasing equipment and improvement of clinic through construction of structures such as toilets; Improved security by putting up burglar bars at clinics; Promoting health awareness and home based care	Purchasing equipment for clinics such as benches and drugs; Maintenance of clinics through grass cutting; Construction of clinic facilities such as toilets; Digging boreholes; Upgrading health facilities; Promoting health awareness
HCCs *should* have had impact	Getting resources from the health budget; Assisting AIDS orphans	Planning health programmes; Promoting health prevention programmes	Monitoring health activities; Infrastructure development; Making input to the planning process

Importance of a strong primary health care system
It appears that the past vision of HCCs assisting well-funded primary care services with awareness and bringing community needs to health planners has been taken over by the reality of financial and more direct contributions from HCCs to under-resourced primary care services. This may signal a need to review their formal roles and authority. They are already in practice performing a wider range of roles, but without getting direct budget resources or strengthened roles in planning. Their lack of visibility at central level means that these changes may not be perceived and thus acted on at that level.

HCCs are a voice of the community
HCCs were stated by all key informants at both central and district level as being a voice of the community. They are regarded as a link between health services and the community. They are perceived to have political backing because of the presence of key political leaders such as the councillors and the traditional leaders. Some health informants identified councillors as key figures in influencing the performance of the HCCs as they had the authority and links to impact on issues. Where councillors were not involved in health issues the HCCs were often non-functional. At the same time some informants noted that in some areas some councillors were using health issues for political mileage rather than for community gain.

The weakest community groups are not well represented
In general health informants felt that groups such as the poor, the elderly and orphans were not fully represented, although some HCCs had made specific efforts to take up their concerns, such as the efforts of Gunde HCC to assist abused children. They felt that while HCCs had tried to represent all groups, most vulnerable groups did not fully participate in health activities, including HCC activities. They usually did not attend meetings and so did not have a sense of ownership of

activities occurring in their areas.

Representation of vulnerable groups in Arcturus
Twenty-two-year-old Luke lives in Arcturus, a farming and mining area in Goromonzi district in Mashonaland Province. He is a disabled person with injury to his leg, and has problems with and gets headaches from walking. He remembers getting support from a government initiative programme, Basic Education Assistance Programme (BEAM). BEAM is a government initiative programme under the Ministry of Education and Culture which assists disadvantaged children. He was assisted along with other disabled children who also needed school uniforms. He has also been to the clinic and his headaches were treated, but has not raised his mobility problems as he was not aware they could be dealt with. Luke had not heard of the HCC and said that they had not done anything for him or any of the disabled persons he knew in his area. He felt that the authorities did not pay attention to any of his needs, like for special shoes. He appreciated the role of the HCC but said that if they were to help him then it was important for them to communicate to all members of the community, including the disabled members. Other disadvantaged groups were also not aware of the HCC. An orphan interviewed in the area said that she did not know of the HCC. She had little support over her difficulties at home, except when she went to the clinic for treatment. She did not get counselling or social support. The HCC members agreed that they have not been assisting vulnerable people and stated that they need training and counselling.

7. Recommendations made by communities and health workers

How then could HCCs improve their performance? The community and health worker groups interviewed made proposals for improved functioning from their own assessments.

7.1 Community views

The Mwanza case study provided inspiration to many about what an HCC can do to mobilise and organise resources for the health system and gave many ideas about how to improve its own work.

The **HCC members** raised a number of options for improving the performance of HCCs:
- hold training sessions on how to identify and assess priority health needs in their area and on making environmental health improvements;
- provide bicycles and funds to permit them to travel to areas which were out of reach, especially the farming areas;
- ensure more involvement of the district nursing officer in their activities and supervision to help them function effectively;
- provide uniforms so that community easily identifies them and remuneration to motivate them;
- make the roles clear, have more frequent meetings and ensure that health staff attend these meetings;
- avoid being over-reliant on the CWGH to initiate activity from within communities; and
- avoid overfocus on collecting money and ensure that community health priorities are taken up with health management and are funded.

The HCCs called for information, training on their roles, regular meetings and improved record of meetings through minutes. They requested training on health budgets, health structures, public relations skills as well as counselling to help them to be relevant to vulnerable groups in their

areas.

The different areas came up with a number of recommendations on how they could improve the functioning of the HCCs.

In Gweru District
- Training on health budgets and HSF and refresher courses on the health system.
- Involve influential leaders from the business community in the HCC.
- Hold more regular minuted meetings of the HCC.
- Have meetings with vulnerable groups to improve their representation of HCCs.
- Meet the DHT to acquaint them with the HCC and discuss how they can work together.

In Makoni District
- Promote volunteers to work with the HCC on health education to increase the impact of the HCC.
- Improve communication within the HCC and hold meetings.
- Hold training on health financing resources such as the HSF, on how it can be accessed, and on standards for health services and staffing.
- Work together with community representatives, councillors, local leaders and health staff.
- Carry out fundraising activities as done in Mwanza.
- Hold training on problem and disease identification so that they notify authorities of problems.
- Training on how to lobby health authorities on issues such as drug shortages.

In Arcturus
- Carry out work on health budgets, human resources and on the AIDS Levy and HSF.
- Train the HCC on MoHCW organogram so that they have understanding on how the health centre works and on staff requirements.
- Train the HCC on health budgets and the HCC role and on how the HSF can be accessed.
- Hold regular minuted meetings with all HCC members and also with mine authorities, farm managers and members of parliament so as to promote communication.
- Carry out active outreach to promote the HCC and its work.
- Carry out more outreach programmes to vulnerable groups such as the disabled and orphans to understand their health needs.
- Train the HCC on counselling skills to reach out to vulnerable groups.
- Train the HCC on health issues and health promotion (e.g. on TB, family planning and so on).
- Educate the HCC on its roles.

In Mwanza

- Incorporate representatives from areas further from the clinic in the HCC.
- Work more with influential members of the community, such as the business people, to gain their support.
- Take advantage of the ward meetings to expose HCC activities to the communities.
- Give feedback to the community on how issues have been resolved or on what the HCC plans to do.
- Provide the HCC with identification such as T-Shirts, caps so that they can easily be recognised in their communities.
- Provide the HCC with a transport allowance to travel to any part of the community.
- Carry out fundraising activities and source funds from business people.
- Educate the HCCs on advocacy skills so that they are able to reach out effectively in their communities.

These specific proposals indicate that generally HCCs need:

- greater clarity on and common understanding of their roles and functions from government, civil society and health personnel;
- training on areas necessary for their functioning, including health budget processes, accessing the AIDS Levy and the HSF, the functioning of the health system and disease prevention; and
- support to reach communities, particularly to expand their outreach to vulnerable groups and to improve communication through feedback meetings with communities.

7.2 Views of health authorities

Key informants for **health and local authorities** stated that to improve performance the HCCs needed to:

- build their capacity on how to manage the health problems at their Rural Health Centres, on financial management and organisational skills;
- coordinate better with and send their action plans to the district health team;
- make themselves known within the community; and
- avoid duplicating activities of other structures (i.e. rationalise HCCs with ward health teams where these exist).

One central MoHCW informant felt that there was no need for a law to define their functioning as they were empowered through the Public Health Act and operational guidelines. Another felt that if there was no legal provision that set out and governed HCC operations this should be put in place as this was the means by which they would be empowered to operate and through which they could receive an allocation from the national budget for their activities.

Authorities also proposed actions to ensure better representation of vulnerable groups.

- Vulnerable groups should be identified and asked to elect their own representatives to be part of the HCC.
- HCC members should reach out more to vulnerable groups in ward meetings and household visits.
- Village health workers (VHWs) should bring up issues of vulnerable groups as they penetrated their communities. If VHWs these were strengthened issues of vulnerable groups could be also brought out.

8. Conclusions

Communities primarily depend on public sector primary care health services
The communities in all areas are primarily poor. There are wealthier and more powerful groups (business people, those with political influence, large-scale farmers and mine employers). There are also extremely vulnerable groups (orphans, the elderly, disabled people). Groups at either end of the spectrum of wealth and poverty do not participate in the Health Centre Committee (HCC), which is otherwise judged to be relatively representative of community groups.

The communities in the survey, like many in Zimbabwe, are generally relatively well educated (to secondary school level) but have high levels of unemployment and unskilled labour, meaning that the economic and professional resources available for health work is low.

People generally use public sector clinics as the primary source of health care, making it important to them that these function well. There is however variation around this that potentially undermines the focus of communities on their clinics and on the HCC that works with them: highly vulnerable groups use traditional medicine; those living close to public hospitals use these for primary care instead of clinics and some in urban and farm areas use private services instead of public clinics. The groups that fall out of public clinic use have less interest in making their clinics work and thus have less interest in supporting the work of the HCC.

Public clinics are generally but not always accessible, and shortage of fuel for outreach and of transport to clinics breaks links between communities and their health services. There seems to be a vicious (or virtuous) circle where distant clinics do not have strong outreach and thus have significantly reduced interaction with their communities, while closer clinics also have more outreach contact.

Resources to clinic level are not easy to determine, as clinic spending is not clearly defined in district budgets and allocations not managed at clinic level. The bulk of the district expenditures in the study districts in 2001 was on medical supplies (59–89%) with 2.6% or less allocated to disease control, the vote which includes community health promotion activities.

Health Centre Committees are associated with improved health outcomes
In the study clinics with HCCs had on average more staff, (nurse, EHT and general) and there was some evidence of higher budget allocations from MoHCW than those without HCCs. They also had more EPI campaigns than those without HCCs. Drug availability at the clinics with HCCs was better than those without HCCs, although drug availability was generally poor. It could be argued that improved health performance and staffing in these areas is associated with an improved capacity to draw and use health resources. If this is the case then there is a virtuous cycle for those clinics with HCCs and a vicious cycle for those without.

The study indicated also that areas with HCCs performed better on primary health care (PHC) statistics (EHT visits, ORS use) than those without, and that there is improved contact with the community in areas with HCCs. Community health indicators (health knowledge, health practices, knowledge and use of health services) were higher in areas with HCCs than in those without. Communities in areas with HCCs had a better knowledge of the organisation of their health services from the indicators assessed, making services more transparent to them. There was also evidence of improved links between communities and health workers in these areas.

The evidence indicates that areas with HCCs thus perform better on a range of health indicators compared to those without, both in the level of resources within the clinics, in PHC coverage and in community health indicators.

The study suggests an association between HCCs and improved health outcomes, even in the highly under-resourced situation of poor communities and poorly resourced clinics.

HCCs have acted on and improved primary health care services
Community, HCC and health authority sources all reported that HCCs have taken up environmental health and service quality issues. Their primary mode of action seems to be more of an additional service outreach and link. They find out communitiy needs and organise service inputs such as drug purchases, building waiting mothers' shelters, water tanks and toilets. They also provide health information. These roles appear to enhance their credibility with the community and the health staff. In two cases they have also been able to mobilise additional resources for health from community and other sources.

HCCs and their communities concur strongly on the priority health issues affecting communities, particularly in the areas where the HCC is reported to have stronger communication links with communities (Goromonzi and Gweru). These priorities relate to health service issues at the primary care level (drugs, emergency transport, staffing) and environmental health issues (water and sanitation). Many of the areas of improved performance relate to the primary health care system, where communities can exert impact, rather than to the medical care services.

HCCs share community priorities, but have variable levels of communication and representation of communities
While the HCCs have been successful – at least in two areas – in enhancing primary health care 'deliverables' and in health promotion, many in the community are not aware of the HCCs or their work. HCCs appear to relate well to particular subsections of the community, but have not been able to widely mobilise the whole community around issues or assume visibility for this role.

Communities and HCCs agree that communication is the biggest limiting factor in improved HCC performance. HCCs themselves get no resource support for this role and are poorly equipped with information.

HCC members and health authorities observe that the poorest groups in communities do not participate in the HCCs and that specific additional efforts are needed to ensure that their interests are represented.

HCCs have not been able to directly influence health budgets but have improved primary care resources from their own resource mobilisation
HCCs have not had direct influence over core health budgets and have little influence in how their clinics are managed and run. The improved resources to clinics in areas with HCCs indicates some indirect association between HCCs and primary care resources. This may be exerted through support for clinic security, for staff needs, for clinic facilities and outreach and other services.

Communities judge the HCC's effectiveness from its impact on health services. The HCCs have worked hard to deliver PHC gains but have not been able to significantly change the quality of care as they have little or no authority over the budgets, staffing and drugs that influence this. Recognising this, two HCCs used community funds to buy drugs for the clinic to secure such impact. Notably evidence indicates improved drug supplies in areas with HCCs.

HCCs have played little or no role in monitoring budgets or making services accountable on their 'policies and promises'. They have visited services and in one area informed health staff of complaints over services. This is a somewhat tentative step towards public accountability. Efforts to take up financing issues (such as around the AIDS Levy fund) appear to work better backed by strong community links and reasonable relationships with health authorities.

The study thus indicates that HCC effectiveness centres on community linkages and communication. HCCs have been given little or no budgetary resources or authority, and have in some cases mobilised their own resources to deal with perceived health needs.

HCCs have weak formal recognition, are poorly resourced and poorly trained or informed for their role
HCCs seem to be vulnerable to a number of factors limiting their effectiveness, including weak formal recognition by health authorities, lack of own area of authority, unclear reporting structures and role definition. Given this, their performance is influenced by the attitude and responsiveness of the health authorities and the participation of strong community leaders, both highly variable across districts. The HCCs note their lack of knowledge or training on the health system and lack of resource investment in their functioning. Health authorities show some ambivalence and lack of consensus on HCC roles.

Strong PHC systems with community outreach support the efforts of HCCs
There is a virtuous cycle between the strength of the PHC system and that of the HCC, with each positively reinforcing the other. Health worker outreach and reasonable investments in PHC were noted to be important to trigger this virtuous cycle.

On their part, HCCs are better able to translate these health system resources into improved health outcomes when they understand the health system, communicate well with communities, have links across all community groups and with political and community leaders.

While the majority of HCCs studied demonstrated these positive outcomes, there was one where the results were more disappointing. This example of weaker performance highlighted the contribution of the wider environment of support from community and technical leadership in the area, the relationship of trust between communities and health workers in building successful interactions, the role of communication and the role of capacities and skills within the community mechanisms.

Overall, despite the association with improved health outcomes, there appears to be inadequate formal recognition, role definition or resourcing of HCCs to draw or sustain positive impacts. In part this is due to ambivalence on HCCs in health authorities, including on their roles and formal status.

Recommendations for improved functioning of HCCs call for formalisation of their roles and authorities (rationalising their roles and those of ward health teams), strengthened communication with district health personnel, training in key areas of their functioning and in health systems generally, and resources to support their work, particularly for communication and outreach. There was concurrence between health authorities and HCC members on these necessary inputs to improved performance.

Better representation of vulnerable groups was identified as a necessity, through direct representation, outreach and through community health workers such as the village health workers.

Obtaining an agreed understanding of the status, role and functions of the HCC and communicating this within health, local government and communities would appear to be an important basis for training and other inputs. In follow-up meetings with officials of the Ministry of Health and Child Welfare (MoHCW), it was observed that the study confirmed the MoHCW understanding that community participation mechanisms worked better where the PHC system was stronger, with an important role for community health personnel in this.

Section 4 of the Public Health Act provides the current legal basis for HCCs, and any further steps towards formalisation need to be aligned with the decentralisation policies under local government and with community roles linked to the roles of village councils, chiefs and headmen in local government, and aligned with health service roles at the primary care level. The decentralisation policies are being spearheaded by the Ministry of Local Government who have a central role in this respect.

In line with the 13 principles defining the division of functions between central government and local authorities adopted by cabinet in 1996, and the Presidential Review Commission on Health recommendations adopted by Government in 1999, the functions of the HCC would follow closely that of the Ward Health Committees (WHCs), which are noted to provide leadership and support to communities to ensure that their needs are reflected in the overall district health plan. The WHCs comprise the headman, councillor, village health worker, headmaster/school health teacher, church leader, non-governmental organisation representative, nurse at local clinic, EHT, community nurse, youth representative and women's representative. The committee:

- identifies health problems in the area and suggests possible solutions;
- uses information from communities to plan, monitor and evaluate programmes;
- coordinates any health programmes in the area serviced by the health centre;
- solves complaints from communities with relevant authorities;
- supports local health centre planning activities, including resources mobilisation;
- formulates and documents the local health centre and programme budget;
- encourages the community to participate in ward health programmes;
- acts as a channel of information flow from the community to the RDC/DHE and back to the community;
- raises and sources community funds for agreed health programmes including funding for drugs;
- ensures the security of health resources;
- supports local community based workers i.e. village health worker and community based distributors;
- supports home based care activities; and
- supports HIV/AIDS awareness activities

Some comparison of the HCCs and WHCs is shown in the table below indicating the scope for harmonisation and some of the areas where functions may be reviewed.

Table: Comparison of WHCs and HCCs

Issue/function	WHC	HCC
Level of health system	Ward, clinic	Clinic, ward (although clinic catchment area may be wider than a single ward)
Composition	Headman, councillor, village health worker, school head/ school health teacher, church leader, non-governmental organisation representative, nurse at local clinic, EHT, community nurse, youth and women's representative	Councillor, clinic nurse, EHT and local health workers, organisations representing civil society groups in the area including women and youth, school head/school teacher, church leader, traditional leaders, traditional healers, other health providers
Elected how	Not specified	Communities elect the committee and health workers sent representatives

Relates to local government how	Subcommittee of local government at ward level	Not clear – links through the councillor
Relates to health system how	Through the health staff to the District Health Executive	Through the health staff to the District Health Executive
Functions	**WHC**	**HCC**
Identifying health needs and mobilising community participation	Identifies health problems in the area and suggests possible solutions. Encourages the community to participate in ward health programmes.	Facilitates people in the area to identify their priority health problems, identifies what it thinks can be done about them, using participatory approaches and information from technical personnel.
Local resource mobilisation	Supports local health centre planning activities, including resource mobilisation. Raises and sources community funds for agreed health programmes including funding for drugs.	Plans how to raise its own resources, organises and manages community contributions, and taps available resources for community health activities.
Using community and health system information for planning	Uses information from communities to plan, monitor and evaluate programmes.	Uses information from the health information system and from communities in planning and evaluating its work.
Evaluate health programmes	Uses information from communities to plan, monitor and evaluate programmes.	Assesses whether the health interventions in the area are making a difference to people's health using health information system and community information.
Information channel between communities and health services	Acts as a channel of information flow from the community to the RDC/DHE and back to the community.	Acts as a channel for information flow from the community to the RDC/DHT and back to the community.
Information channel on other health providers		Is informed about the activities of different health providers in the area (RDC, MoHCW, Zinatha, private).
Represents communities in health service issues	Solves complaints from communities with relevant authorities.	Raises and discusses aspects of patient care and represent communities on issues they raise on services offered, to see how these can be addressed.
Health centre budget planning	Supports local health centre planning activities, including resources mobilisation. Formulates and documents the local health centre and programme budget.	Obtains information from the RDC and DHT on budget allocations for health, on ward level allocations, on the HSF, gives input and feedback to the RDC and DHT on budget planning and keeps

	Ensures the security of health resources.	communities informed on health budget issues, particularly where this relates to local resource mobilisation.
Coordinate health progs and local government promotion of public health	Coordinates any health programmes in the area serviced by the health centre.	Works with the RDC to motivate and implement public health standards, such as for water supply and sanitation.
Support community based health workers and HIV/AIDS activities	Supports local community based workers i.e. village health worker and community based distributors. Supports home based care activities. Supports HIV/AIDS awareness activities.	

The comparison indicates that harmonising the HCC and the WHC is not likely to be a difficult exercise given the overlap on role, composition and functions. Rationalising the functions would imply strengthening in a few areas the proposed WHC functions. Formalising this could be done through an agreed guideline between Ministry of Local Government and Ministry of Health under the Public Health Act and the decentralisation policy.

Finally…

This study sought to examine the role of HCCs at three levels:
- in terms of perceived and real health outcomes associated with their work;
- in terms of their functioning; and
- in terms of the underlying factors influencing their performance.

There is strong evidence of positive health outcomes associated with HCCs in this study. The evidence, supported by the mechanisms of community resource mobilisation, information outreach and social actions around health, indicate that HCCs play a positive role within health systems. They provide evidence of roles for community participation beyond dialogue and consultation.

They are however constrained by weaknesses in their own capacity and functioning, particularly in terms of knowledge of the health system, capacities for communication and information links with communities, and the basic resources for their functioning.

More deeply they are constrained by the resource limitations within their communities and in the primary care level of the health system they operate in, particularly where there are falling resources allocated to district outreach, to primary health care and to quality of care at clinic level. The ambivalence around their recognition and functioning and the lack of resources directed at their activities appear to be part of the general under-resourcing of the primary care level of the system. Effective demand or organised voice at community level is not easily sustained, and may be defensively responded to in such a situation.

It may thus be argued that the strengthening of HCCs as a vehicle of community participation is thus deeply bound with the strengthening of the PHC and primary care level of the health system.

There are clear signals in this study of the virtuous cycles of positive health outcome between HCCs and performing clinics. What is missing perhaps is to translate this into wider national policy and practice.

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