Consolidating processes for Community – Health Centre Partnership and Accountability in Zambia

A Participatory Research Report

Ministry of Health
Lusaka DHMT

Lusaka District Health Team:
Equity Gauge Zambia
with the
Regional Network for Equity in Health in East and Southern Africa (EQUINET)

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Cover photo: Community members participating in Child Health growth monitoring (GMP) activities; © Roydah Zulu, 2008, Chipata health centre

Through institutions in the region, EQUINET has been involved since 2000 in a range of capacity building activities, from formal modular training in Masters courses, specific skills courses, student grants and mentoring. This report has been produced within the capacity building programme on participatory research and action (PRA) for people centred health systems following training by TARSC and IHRDC in EQUINET. It is part of a growing mentored network of PRA work and experience in east and southern Africa, aimed at strengthening people centred health systems and people's empowerment in health.

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Executive Summary

In 2006 a team representing Zambia Equity Gauge and Lusaka District Health Board carried out a pilot project using a participatory reflection and action (PRA) approach in two districts of Zambia namely Lusaka city and rural Chama district. The work was done within the Regional Network for Equity in Health in Southern Africa (EQUINET) theme work on participation and health, co-ordinated by Training and Research Support Centre and Ifakara Health Institute. The pilot was targeted at health providers and community health volunteers from two health centres from each district, and aimed to strengthen community-health centre partnership and accountability.

The action research in 2006 showed that the PRA methods can be used in rural or urban settings, with positive impact on the attitude of health workers (HWs) towards community members (CMs) as partners in health planning and on information sharing between health workers and community members. This led the team to explore whether such an intensive process could be sustained and extended to other health centres, as a basis for institutionalizing the programme. The 2007/8 action research thus sought to move from the more intensive and isolated pilots towards wider application of the approach, to learn how to institutionalise the approaches used. The work

- consolidated the participatory approaches initiated in 2006 to further enhance the community voice in planning, budgeting and implementation activities at HC and community level
- extended the process to two new health centres in Lusaka, and
- built the capacity of the 2006 group to facilitate scale up of the work to other centres

An intervention study was designed using a spiral model of iterations of participation, reflection and action by the targeted groups. Experiences, issues and areas for change were elicited through focus group discussions (FGDs) and participatory tools in workshops of health workers and communities, followed by an implementation phase of the activities planned during the workshop. Regular review meetings were held to reflect on the activities and outputs achieved, followed by the further action identified to be necessary. A pre and post intervention questionnaire was administered to assess change in the new HCs involved.

For the original project group (termed the '2006 group') the review discussion gave evidence of improved interaction between health workers and community members, increased confidence in community members to input to planning processes, and a positive spillover effect on improved interaction between health workers and clients. Community plans were now included in overall plans. Most activities proposed were incorporated into the ongoing HC programme activities, PRA tools were used to resolve emerging issues, and there was interest in the process from other centres. Sustainability of these gains was seen to call for formalization of the process in mechanisms and meetings, involvement of local leaders, orientation of new health workers at the health centres, efficient disbursement of funds for planned HC activities, guidelines to support the process and briefs to disseminate information on outcomes more widely in the system. The 2006 group had reached most of the progress markers they had set in 2006 by the end of the 2007 exercise, two years after they had begun their exercise. At one of the 2006 HCs the Neighbourhood Health Committee (NHC) chairperson who had been in office for many years was able *to hand over the baton* and attributed the smooth hand over to the HC's participation in the PRA process. The electorate went on to appoint him an honorary member. Involving district health

office managers and health centre in-charges from the start of the project also enhanced the chances of the project succeeding.

In the two new health centres (called 'the 2007 group') the PRA process exposed the same problems in communication and information flow between health workers and community members in planning processes as had been found in 2006. The process uncovered simmering tensions between communities and health workers that were addressed as the process progressed and both groups began to articulate a mutual appreciation of each others' roles in shared goals, the importance of communication, and the need for involvement of affected communities in the planning stages of activities. A series of information sharing activities were planned, to integrate community inputs into the 2008 planning cycle, and to discuss jointly the use of the 25% share from the monthly user fees collections allocated to HCs.

The progress in these activities was variable across the two clinics. While they had made some progress, the 2007 group had not achieved all of their progress markers. Triangulation of the three different tools used to assess change showed that health worker and community expectations of participation in planning and budgeting changed, with greater convergence between the community and health worker views and a greater perceived assessment of participation levels in planning and information exchange. While perceptions of HC roles in resource allocation had risen in both areas, they remained relatively low in practice. The difference in the changes between the 2006 and 2007 groups signal the time needed for these type of interventions to have impact, and the importance both of sustaining the processes across longer term (two year) time frames, without jumping too early to assessments of impact.

The project demonstrated that the PRA process could de-mystify and remove suspicions surrounding the district and health centre planning process, strengthen dialogue between communities and health workers, increase community involvement in planning and budget processes and resolve issues in the interface between health workers and communities. The changes take time, need continuous mentoring and resource support in the early stages, need to be integrated within routine work and supported by authorities, with orientation of new health workers.

Not investing in scale up of the process leads to persistence of disharmony between health workers and communities caused by lack of communication and information flow, undermining the functioning of health systems as envisaged in policy. In contrast HCs such as Matero Ref. where implementation of the PRA process was exemplary and sustained could become centres of excellence to support scale up, with a horizontal spread of skills to build a pool of HWs and community members as PRA facilitators through mentored learning by doing. This calls for responsibilities for the process to be assigned, skills building and mentoring, guidelines on tools and processes, and integration of the process into routine activities. The major cost in holding the workshops and follow up meetings could be managed by using existing forums and meetings to share and apply the PRA methods. To formalize the process we suggest that the DHMT appoint a focal person, probably the Community Coordination Officer to be responsible for it and for facilitating research initiatives relating to community involvement or partnerships in the district, and that the DHMT plan for the scale up of the PRA approach to four more HCs during the next year.

In conclusion, although positive results may not be achieved at all the new sites within the project period, the 2007/8 project did show that the PRA interventions continue to have sustained positive impact and can be scaled up and sustained through a process of mentorship at HCs under Lusaka DHMT.

1 Introduction

The Regional Network for Equity in Health in East and Southern Africa (EQUINET) through Training and Research Support Centre (TARSC) and Ifakara Health Institute IHI) has implemented since 2006 a programme of training on methods for participatory reflection and action (PRA) to strengthen community voice in planning and implementing primary health care and health services at primary care level. Research, implemented in a participatory manner, can itself raise community voice and strengthen more collective forms of community analysis and organization to take up their interests in health. Evidence from research suggests gains in primary health care uptake and in the community knowledge and use of health systems when such methods are used (EQUINET SC 2007). In 2006, the Zambia Equity Gauge implemented and reported on PRA work that this proposal builds on. That study revealed positive change in the attitude of health workers towards Community members as they now viewed them as necessary & valuable partners, and increased health worker to health worker information sharing, as health workers were just as likely to be misinformed as Community members (Equity Gauge Zambia and Lusaka District Health Board, 2006).

During the most recent health reform in Zambia, many policies have been developed to guide the attainment of the health vision of "…*providing equity of access to cost-effective quality health care as close to the family as possible*". The underlying principles were centred on *leadership, accountability, partnerships and sustainability (affordability)* at all levels of the health system and included the development of community governance structures such as the Neighbourhood Health Committees (NHCs) to specifically enhance accountability and community participation in the implementation of health activities (Ministry of Health, 1992).

In spite of these efforts however implementation at the health centre and community level has not been as smooth as expected. Misunderstandings between health workers and the local communities they serve have been commonplace. As a result these mechanisms have not always contributed effectively to the attainment of expected outcomes towards satisfactory health services.

It was in light of these barriers between the health workers and community members that the pilot project was carried out with two district health management teams (DHMTs) in Chama & Lusaka districts in 2006, using the participatory, reflection and action approach (PRA) as an intervention strategy. The pilot study was aimed at:

- Reducing existing misunderstandings between health workers and Community members;
- Enhancing the community voice; and
- Contributing to promoting a people-centred health service in the 2 districts.

Some of the major findings from that small intervention study revealed that:

- There was positive change in the attitude of health workers towards Community members as they now viewed them as necessary & valuable partners.
- There was increased health worker-to-health worker information sharing, as health workers were just as likely to be misinformed as community members.
- The PRA approach can be used to strengthen interactions between health workers & community members in health planning in rural and urban DHMT settings in Zambia (Equity Gauge Zambia, LDHB 2006).

The challenge in this next phase was to move from the more intensive and isolated pilots towards wider application of the approach, to learn how to institutionalise the approaches used. The first aspect was thus to widen the practice. In the second round of this work, we aimed to scale up the empowerment process by mentoring the teams that were trained in the 2006 pilot project to have the capacity and initiative to train and mentor another group using the PRA methodology to tackle issues and problems relating to their work as either

health workers or community health volunteers. The 2006 teams worked with two new teams from two new health centres (HC) using the PRA approach, with a view to achieving the changes in behaviours and practices that obtained during the 2006 Zambia PRA pilot project. The change aimed at was in the attitudes of both health workers and community volunteers in terms of their working rapport, communication and information sharing as well as their appreciation of each other's roles in carrying out health activities particularly in planning, budgeting and activity implementation. The research team maintained the issues from the 2006 pilot of health worker and community volunteer participation in planning, budgeting and activity implementation, as the stepping stones for the proposed scale up.

The second aspect was to sustain and consolidate the initial processes in the pilot areas. The mentors thus continued to work with the 2006 pilot group to strengthen and consolidate the relationships and partnerships that were achieved in the first round. Through this mentoring process it was hoped that the 2006 group would shift from the *point of reflection* to the *point of actions* that are sustainable and are driven by the community members and/or health workers themselves. For example it had been observed that the community volunteers who participated in the 2006 pilot initiated their planning process by mobilizing the zonal units for their health centre catchment areas to incorporate their views of the activities they wanted included in the 2008 health plans. Previously only the Neighbourhood Health Committee (NHC) executive, with little input from the zonal leaders, made this type of input.

The health workers who participated in the two pilot areas had gained recognition by their colleagues as liaison persons in community related activities and some had been invited to share their PRA experience in other health centre forums. It had also been observed that health staff from the departmental level were pushing for their needs and not leaving it to a small core management team to decide for them.

Finally, we sought to explore further whether this health worker and community participation is moving from 'rubber stamping' decisions made elsewhere to more meaningful involvement in decision making (Macwan'gi and Ngwengwe, 2004).

Objectives

The round two programme of work thus worked to:

- Consolidate the participatory approaches initiated in 2006 to further enhance the community voice in planning, budgeting and implementation (PIB) of activities at HC and community level. This implies consolidating the 2006 work and building capacity of the 2006 group to facilitate scale up of the work to other centres.
- Extend the process to two new health centres for deeper understanding of 'what works' in strengthening the confidence of communities to speak out on health issues that affect them.
- Build skills for participatory communication in the participating health providers and community members at HC level, increasing capacities for reflection and action for the 2006 teams.

As a result of the process the planned **outcomes** were

- A more effective participation by community members in the PIB process.
- Strengthened communication and information exchange between and amongst community members and health workers on action in health, and on the availability and utilization of the health resources at the HCs.
- Greater capability on the 2006 PRA group to use and facilitate the PRA approach.
- Increased understanding of the methods and issues in scaling up and institutionalising participatory approaches in PIB at health centre level.

2 Methods

The research team included four mentors from the 2006 pilot project including those participating in the 2006 TARSC-Ifakara PRA training in Bagamoyo (Mr Leigh Chilala, Mr Moses Lungu, Mrs Irene Kabuba & Dr Clara Mbwili-Muleya - although the former had to leave just as the project started to pursue further studies abroad). One member trained in PRA methodology in Bagamoyo in 2007 (Mrs Adah Lishandu); and a sixth member was incorporated from the district health office (Mr Maxwell Kasonde). Four of the 2006 pilot participants were selected as lead facilitators to steer the process for the two new health centres. These were Mrs Adah Lishandu (HW) Mr Davison Chibilika (CM), Mrs Roydah Zulu (HW) and Mr Oswell Mbuza (CM). R Loewenson (TARSC) gave input to the design, analysis and documentation of the work and mentored the programme. Peer review inputs are acknowledged at the end of the report.

The design was an intervention study using the spiral model concept of participating, reflecting and acting by the targeted groups in an iterative manner (Loewenson et al, 2006). Identification of issues and areas targeted for change and baseline data on these change areas was collected through qualitative techniques - focus group discussions (FGDs) and participatory tools - during an orientation workshop. This was followed by an implementation phase of the activities that were planned during the workshop on planning and budgeting at the participating health centres. Regular review meetings were held to reflect on the activities and outputs achieved, followed by the further action identified to be necessary. A pre and post intervention questionnaire was administered to assess change in the new HCs involved.

The target groups were community members and health workers participating in planning, budgeting and implementation of activities in the selected health centres of Mandevu HC (facilitated by Chipata HC) and George HC (facilitated by Matero Ref. HC). The community members included NHCs, community health volunteers and Equity Gauge members. The latter are community members who participated in orientation trainings as part of the Zambia Equity Gauge Pilot project initiated in 2001 and facilitated through Centre for Health, Science and Social Research (CHESSORE). Health workers involved included the HC in-charges or their deputies, community health coordinators, departmental in-charges, environmental officers, MCH nurses and nutritionists. Health centres were encouraged to try to balance the participants by gender.

As in 2006, the entry point for the work was the process of participation in planning and the levels of information exchange and communication between health workers and Community members at the different levels (HC, community and district level). The 2006 research had identified concern in relation to the availability of resources, dissemination of the planning updates and guidelines and their timely communication and dissemination from the district level.

The methods used for data collection and assessing progress and changes during the project were both quantitative and qualitative. The quantitative methods included a **pre and post-test intervention questionnaire** for participants from the two new health centres. The questionnaire was administered on the same individuals for the pre and post-test and obtained data on the (changes in) perceived levels of information sharing and communication on planning, implementation, budgeting and resource allocation between community members and health workers from the new scale up HCs,

The participants from the two new HCs were invited to an introductory meeting where the pre-test baseline questionnaire was administered followed by a short discussion to introduce the PRA approach as well as to agree on the date for the orientation workshop. Unlike in the prior study, the questionnaire was done outside of the workshop as a way of reducing bias through participants responding to the questionnaire according to what they

think the researchers want. The health workers (HWs) and community members (CMs) were separated while completing the questionnaire individually, supported by facilitators who clarified questions where needed.

The pre-test was completed by seventeen people (11 females and 6 males). A repeat of the questionnaire after the intervention was done with the same respondents at their respective HCs a few days before the final evaluation meeting. Fourteen (14) participants (8 females & 6 males) responded to the post test questionnaire. The three non-respondents were all health workers. Two health workers from Mandevu were away on leave (maternity and vacation), whilst the health worker from George withdrew from the project soon after the pre test due to other commitments. The baseline survey findings were then analysed using SPSS and compared with the final survey findings.

A wheel chart, a qualitative tool, was also used to provide an assessment of perceived change on levels of participation in PIB process. Four outcome areas were assessed using the wheel Chart tool, with a segment for each area:

i. participation in planning
ii. being given information for planning
iii. involvement in implementation of planned activities
iv. participation in resource allocation

The participants were divided into groups of health workers and community members for the two different HCs to allow for comparison between the HCs.
The participants were asked to colour the portion in each segment that represented their current level of participation in that area, and a line to show their desired level of participation for that area. The groups quantified the coloured areas using percentages to grade the areas shaded. Participants also completed individual wheel charts. Both charts would be further used for review during the project period.

Progress Markers (PMs) adapted from the Outcome Mapping approach for achieving an Outcome Challenge (Earl et al., 2001) were developed as a further qualitative monitoring tool. The Outcome Mapping concept focuses on behaviour change, so the PMs selected were used to assess change in the attitude of health providers towards community members as mutual partners; and in the confidence of community member and health worker participation and response to the partnership. Specific PMs were identified by participants from the prioritised problems and actions identified in terms of what participants would

- *'Expect to see'* (usual situation)
- '*Like to see*' (higher level or improved situation)
- *'Love to see'* (more ideal situation) progress markers.

PMs were used to monitor progress towards the desired outcomes on these actions, as well as the overall change in the action research. It was acknowledged that *love to see* PMs could probably not be achieved but would be included and monitored beyond the project period.

A 2 days orientation workshop on the participatory, reflection and action methodology was held with the new 2007 group, facilitated by the mentors and four of the 2006 trainee facilitators, using tools from the 2006 pilot and adapted from the Training Tool Kit: Participatory Methods for a People Centred Health System (Loewenson et al, 2006) and from other facilitators and work in the EQUINET regional PRA Network. The report of the Round one work was presented and reflected on by the mentors and the 2006 group, to identify areas of concern and issues to address in the 2007 work.

The PRA workshop, hosted by Chipata HC, was aimed at identifying areas of concern in PIB, identified areas of change and actions for this, and indicators & progress markers to monitor progress towards these changes (See Table 1 below). Activity plans were set for the project period of six months.

Table 1: Summary of Workshop Methodology

Steps	PRA tools Tools/Method	Expected output
• Hold an orientation workshop with new 2007 group. 2006 PRA group will facilitate supported by mentors and aimed at equipping the 2007 group with skills in PRA approach & methods. • Team use findings from baseline information to identify the PRA tools to be used during the workshop. • Participants develop activity plans and identify indicators & progress markers to monitor their progress towards behaviour change.	• **brain storming** to list perceived problems; • **ranking & scoring** to prioritise problems; • **but why tree** to find root causes; • **Johari window & spider web** to determine how communication is happening; • **Incomplete stories** to establish how communities are involved in health services; • **spider diagram** to identify roles in health planning & service delivery; • **stepping stones** to engage communities & stakeholders; • **wheel chart** to establish & monitor levels of participation; • **market place** to empower individuals & groups to participate; • **plenary discussions** to get consensus on issues; • **progress markers** to monitor progress towards change. • **ballot in the box** to evaluate workshop and allow freedom of particpation;	Activity plan and monitoring tools developed for 2007 participants.

Qualitative methods were used to assess the learning on PRA methods and ability to use these in other health activities.

The proceedings were recorded on tape, in writing and verbatim on computer by a specifically assigned facilitator. Further, a one day review meeting was held with facilitators and mentors from the 2006 group to deepen the understanding on the process and methods and chart the way forward on the scaling up process.

Health workers and community members were involved in separate focus group discussions on progress in involvement in planning and implementation, budgeting and resource allocation (PIB) since the pilot project ended, to encourage participation. In other parts of the process, where appropriate, participants worked as HCs rather than by social group, as this was the group responsible for action and review of progress. The changes from the 2006 PRA process in relation to PIB were identified, as were the gaps, and common action points were identified.

The mentors held two technical support meetings with the 2006 team during the project period to review progress on their activity plans, monitor the progress markers and reflect on the PRA approaches used. Periodic review meetings were held with both the 2006 HC and the 2007 HC participants to review project activities and progress of behaviour change using FGDs, and reviewing progress markers and wheel charts. A final evaluation meeting was held at the end of the project period for both groups.

3 Findings of the PRA interventions

3.1 Consolidating Participatory Approaches to Strengthen Community Voice

The review meeting of the 2006 work was held in August 2007 for the 2006 PRA trained group. Two of the initial 16 participants (a health worker from Matero Reference HC and a community member from Chipata HC) did not attend due to personal commitments. The Chipata HC opened the review meeting noting that it was one of the rare meetings where health workers and community members worked together on shared plans. In comment on the 2006 process, health workers and community members both noted the improved interaction between health workers and community members and the increased confidence community members had to input to planning processes.

"We have seen better interaction between Community members and Health workers [since the PRA intervention]. They are able to express themselves even in areas we think they can't comment. Health Workers are seen participating in planning. This time they don't need guidance but they were even guiding. We have appreciated their inputs."
Sister In Charge, Chipata HC

There seemed to be a spillover effect on communication, as health workers observed improved interaction with clients, although the change process was acknowledged to be variable in pace and timing.
"We are able to interact with mothers and they are able to say what they want to be done."
Nurse Chipata Health Centre

"Sometimes it takes too long to notice change, while at times change is seen immediately. So you can build on even little change."
Health worker at Chipata HC

The 2006 PRA group assessed their progress in participating, reflecting and acting on the process of planning, implementation, budgeting and resource allocation (PIB) since the pilot project ended, and the gaps that still existed. Their reflections are summarized below, separately for the two groups.

Box 1: Community Member perceptions of change since the 2006 PRA

Change in participation in PIB at the HC: In Matero a change was noted, in the shift from participation in action only to participation in resource allocation and decisions on use of funds allocated. In Chipata HC, members were still not aware that 25% of user fees go back to the Community.

Change in communication with health centre staff and community members: In both settings was noted to have improved through combined meetings and working with staff involved. However it was noted that this had not spread to other departments or staff not directly involved.

Change in the performance of activities since the PRA pilot: Groups of volunteers are called and meet to share in the decisions on activities with HWs. For example the Measles campaign was cited where every community member participates in both HCs, compared to prior practice where only NHC members participated.

Involvement in PIB in the last 3 months: Community members were involved. Meetings are first held in the units then the top 10 NHC chairpersons sit. Matero was given a task to plan and prioritize then community members sat together with health workers to finalize the planning. The sister in charge and the MCH and OPD departments took the lead. In Chipata, the community did the plan then gave it to the Sister In charge.

Remaining areas of concern in PIB:

- In the planning process turnover of community members mean that new members then have to be updated on what is going on through quarterly meeting as CBOs.
- Communication with new staff who come from HCs where there has not been PRA work. This needs to be done by sister in charges to educate them on the relationship with the community and for health workers to meet and share information. It also needs higher levels to support the process and a grievance handling mechanism with the sister in charge.
- Documentation – the previous work needs to be reported through summary brochures circulated to all the departments. Feedback from the top is slow and documentation is necessary for people to know what was happening.
- These issues also need to be tackled at higher levels.

Rating of the change in behaviour or attitude between health workers & community members:
Very big (5) Big (4) Medium (3) Little (2) Very Little (1)

The highest rating positive change was in Matero HC while in Chipata, the change was rated as medium. HWs are now going to NHCs for consultation and having the sister in charge as PRA member has really helped. When the two HCs meet in different forums they discuss but do not meet formally.

Box 2: Health Workers perception of change since the 2006 PRA

Change in participation in PIB at the HC: Increase in staff participation in planning for all staff in both HCs, not just the sister in charge. Staff also attending district planning workshops.

Change in communication with health centre staff and community members: In both settings this was noted to have improved with community members more freely approaching health workers and having a better understanding of community needs. Health workers also appreciate community knowledge and inputs to a greater degree in planning.

Change in the performance of activities since the PRA pilot: Communication of activities is not left to the in charge, but departments are also communicating on the activities. Increase in the participation in the activities between workers and the community and the relationship has improved.

Involvement in PIB in the last 3 months: Every department was give an opportunity to plan the budget in both HCs, and staff now plan together, including issues such as staff leave.

Remaining areas of concern in PIB:

- Need to have guidelines to guide the activities, and have someone responsible to follow up on activities. Putting a time-frame & monitoring to be done to achieve the objectives.
- There is need to work more on information sharing at the two centres
- Information flow within the HCs has some gaps. For example the community may be available but the health workers may be busy.

Rating of the change in behaviour or attitude between health workers & community members:
In both Chipata and Matero HC the rating was positive with reduced complaints through using peer and support groups to educate the community; a shift in community attitudes and appreciation from the health workers. However there had been little interaction between health workers from the two HCs after the 2006 work.

A summary reflection on the outcomes, gaps and next steps provides in the PRA process is presented in Table 1.

Table 1: Reflections on the 2006 Pilot

ACHIEVEMENTS & POSITIVES	GAPS	WAY FORWARD
Health Workers Community and health workers involvement in planning increased with most planned activities done jointly. More decentralized planning at HC departmental level. Open communication and reduced conflict between HWs and CMs. Enhanced transparency and accountability on funds Community have a better understanding of how funds are spent eg 25% user fees and grant allocation	**Planning** Time frame not well followed Tasks not well assigned to members **Implementation** Shortage of staff Funds not available Plan for review of activities not available **Budget Allocation** Not all activities are funded	• Follow plan and clearly assign members for monitoring of activities • More commitment needed by HWs. • Continue sharing information with other HWs and CMs • Promote ownership of activities • Refresher courses in planning & budgeting

Community members Timely information on planning and planning process Increased community involvement in planning Most of the planned activities were done jointly by community and health workers Good communication between community and health workers and openness on resource allocation Improved community knowledge and capacities in planning and budgeting	**Planning** Communication between community and health coordinators still not very effective Some planned activities not done **Implementation** Lack of funds for some planned activities **Budget Allocation** Erratic funding and actual funding figures from DHMT not well known	• Orient new staff and volunteers in planning • Continue giving timely information on planning • Continue conducting joint meetings for HWs, CMs and CBO partners • DHMT/HC to disclose actual amounts received • Increase funding for all activities to be done • Community to hold meetings at all levels • Orientation on budgeting for all levels

In the discussion on the 2006 work there was general agreement that there had been positive change in participation in PIB since the PRA pilot. Both Matero and Chipata HCs had gone through one planning cycle (ie 2007 for 2008) since the pilot and both HCs reported the increased participation of community members, moreso in Matero than Chipata given the joint decision making in the former, while in the latter the community plan was merely submitted for inclusion. Community input and partnership was recognized by health workers and this seems to have ensured that community plans were included in the overall plan. Another influencing factor was probably the knowledge that district managers were involved in the PRA project would monitor the plans, since they were pilot HCs. Communication levels were identified as still needing improvement, in relation to information sharing particularly amongst health workers. This shortfall was detrimental to gains made in HW-CM relations, particularly when new health workers were not sensitized to the PRA process.

Many of the gaps identified in Table 1 were ones that were seen to be within the scope of the the group to tackle itself, except for the inadequacy of funding and shortage of staff. One area that groups could work on was to know the funds allocated to their HCs and how it was disbursed. Matero members were more involved and knowledgeable on the funds and resource allocation as they were benefiting from the recently introduced Lusaka district guide (in 1st quarter 2007). This allowed 25% of user fees collected at the HC to be directly ploughed back as long as the requested activities had been identified and agreed upon by both HC and community members and as much as possible were part of planned activities. Minutes signed by both parties agreeing to the submitted budget were submitted with the requests.

Both health workers and community members from both HCs positively rated the change in attitude between themselves (ie 3 or 4 on a scale of 1-5), but sustainability of these gains were seen to be threatened if continuity was not assured, given the absence of formal mechanisms and meetings, and a lack of local leaders in the process. In response to this a steering team of six members comprising health workers and community members was selected representing both HCs and recognized as lead facilitators. As noted in Boxes 1 and 2, groups also called for guidelines to support the process and briefs to disseminate information on outcomes more widely in the system.

Follow-Up Activities

After the meeting, the 2006 PRA group from Matero Ref. and Chipata HCs continued to monitoring and review their activity plans against the progress markers and wheel charts set up in the pilot. Most activities proposed were incorporated into the ongoing HC programme activities in HIV and AIDS, maternal and child health (MCH); in departmental

and general staff meetings, community based group meetings and stakeholder meetings with wider community. They used the opportunities to share the PRA process as well as use some of the PRA tools to resolve emerging issues. Minutes (and photos when a camera was available) were kept as documentation for these activities.

Each team reported on several activities they had done as part of their PRA mentoring process and in this report we highlight some of the notable ones.

- In Matero the team successfully used PRA to resolve a conflict situation between the health staff and the community. The HCs in Lusaka had recorded several incidents of staff being threatened and even being assaulted by clients bringing patients to the facilities who were dissatisfied with the service they received, including at Matero HC. PRA tools such as brainstorming and the problem tree were used to find out the underlying causes for the attacks on staff, and solutions identified together using brainstorming and stepping stones. The NHC Chairpersons and the community-based groups (CBGs) working within the catchment area of Matero HC sensitized the community members in churches, markets and schools on the roles of both health workers and community in health service delivery and encouraged communities to dialogue with the health workers in order to appreciate their constraints and share their ideas. The community members and health workers from Matero HC facilitated the process and to date the HC has not recorded any such incidents; the HC has in fact been praised through letters written by clients in the national print media (THE POST Newspaper, 12/02/08).

- Matero HC held an inaugural stakeholders meeting to share information on HC activities and obtain feedback on community perceptions on existing health services. The stakeholders present included representatives of business houses such as banks, shops, schools, churches and ordinary members of the community. During the brainstorming it emerged that stakeholders were ignorant on many of the services offered and PRA tools were used to identify information barriers on NHCs and lack of opportunities for community and health workers to share information. As a result of this meeting the stakeholders funded and supported the World TB Day at Matero HC allowing the HC to use minimal funds from their own budget for the event. This highlighted the resources within local communities to be tapped to supplement HC resources, if stakeholders are engaged effectively.

- Chipata used PRA tools such as Problem Tree and Stepping Stones to map out a strategy for tackling the impending perennial cholera outbreak with the community volunteers in their catchment area. The result was a well planned preventive strategy that despite the heavy rains experienced they recorded fewer numbers of cholera cases and deaths.

- Chipata HC further reported using the PRA tools during planning and budgeting meetings with their CBGs and requested them to bring back the required inputs from their zones including items for spending from the 25% user fees collection. The HC involved the community through the NHC, in carrying out the HC self-assessment, which is a part of a mandatory district quarterly assessment using a prescribed tool to gauge the HC performance and progress against targets. In an effort to improve knowledge on resource allocation Chipata HC invited the accounts staff to explain to community members and staff on the other funds received by the HC as well as the cash flow. This accorded those present a chance to clarify funding issues.

This feedback from Chipata and Matero Ref. was encouraging as it appeared that the HC management was opening up a little more on the issue of transparency on all resources available and not only the 25% user fees allocations. Community members at Matero Ref. made an interesting comment saying *'…we as CBOs are now able to attend meetings with the NHC Chair…'* suggesting that there was more inclusiveness in the operations of the

NHC. Other stakeholders including business houses, schools etc. had been brought on board by initiating stakeholder meetings and forming a Stakeholders Committee used to create awareness on health services and obtain input for the action plans. The groups also spoke about improved HW-to-HW communication through more *open door* approach by departmental heads and the HC in-charge. In the words of a HW:

'*I used to fear being called to the in-charges office; but after PRA I know every problem has a cause and therefore can be resolved.*'

HCs reported that there were more people inquiring on how to join the PRA activities due to the positive changes they had observed. Although this was a welcome output, the mentors also saw it as a challenge. Some people viewed the PRA activities as some sort of *club,* but the PRA is only sustained when understood as an *integrated process* to enhance health services at different levels. It was positive that most of the 2006 group understood this.

Generally, the discussions with the 2006 PRA group were encouraging. The inadequacy of human and financial resources was a health system bottleneck and the district level, although much improved, was expected to be more efficient in disbursement of funds for planned HC activities.

3.2 Building PRA capacities in Health Centre personnel to sustain the process

One of the key aspects of sustaining and spreading the PRA process was widening the capacities in PRA. The PRA Orientation workshop for the new 2007 teams was held at George HC (one of the new HCs) and fifteen participants attended the workshop- seven health workers and eight community members. Gender balance was not achieved amongst the health workers with only one male participant, reflecting the low number of male professional staff at urban health centres, particularly at smaller HCs like Mandevu and George HCs chosen for round two.

The mentors and four of six lead facilitators from the 2006 PRA team members made up the Steering team for this work. Two health workers involved in 2006 opted out of this capacity building due to pressure of work on other programmes during this period. Each facilitator was paired with a mentor during the workshop with the new HCs as a capacity building tool, although the duplication of facilitators was found to be distracting for participants in the sessions.

Discussion was held after the workshop with the 2007 HCs on how to manage capacity building for PRA. At a post workshop debrief the team agreed that if more time was spent on preparations and a dummy run done before the workshop, especially for PRA tools that were more difficult for them, the new facilitators would have been more confident and would have needed less input from mentors during the workshop. For example frustration in the session around the lack of remuneration to volunteers and with leaders and managers seen as major stumbling blocks in the responsiveness of health systems generated issues and conflict that facilitators found difficult to handle. At this point the mentors had to reassure the facilitators that as a team they could use another tool at some point to redirect the proceedings back to the issue at hand, the planning, budgeting and implementation process. Some processes, like the development of progress markers (PMs), were not contentious but were difficult to manage.

After the workshop the facilitators took up their task of mentoring their respective HC teams.

An interesting milestone occurred in October 2007 just after the 2007 project began. This was the appointment of two of the lead facilitators as HC in charges that is for Matero and Chipata HCs respectively. Although this development was an advantage in terms of decision-making, it posed challenges for the two health workers in terms of availability and capacity to lead the PRA activities. It was more evident at Chipata HC where the team's capacity to mentor their scale-up health centre Mandevu seemed to have been adversely affected. The issue was discussed at a monitoring meeting to find out from the facilitators themselves the underlying reasons for the greater progress in causes the Matero team's work with George HC compared to the Chipata team's work with Mandevu HC.

The difficulties the Chipata team were experiencing were attributed to problems of personnel shortfalls (a health worker had resigned to join another organization and three others (1 HW & 2 community members) were nominated to participate in the district malaria indoor spraying programme. This was in contrast to the Matero team who had the full complement of people, and whose team leader had participated in the 2007 PRA training in Bagamoyo and was thus more confident to take the process forward and *to hand over the baton* when necessary.

It was observed in this discussion that the PRA process works better when team members are available, committed and convinced about the process, able to see positive results or change and having resources and time and making inputs to sustain follow-up. This was felt to demand the integration of the approaches used into existing projects and programmes. On contrast, ineffective, absent or poorly delegated leadership; with insufficient time and people allocated, high levels of competing demands and poor two way feed back between leaders and participants were felt to undermine the processes. The shortfalls were also seen to be strategic: in not taking advantage of opportunities; or having a poor understanding of or commitment to the process.

A number of "remedies" were proposed to strengthen practice

- Assign specific tasks and targets and give up some power through delegation;
- Encourage, have an open door policy with and joint planning with key players from the start;
- Broaden involvement beyond the team, encourage accountability and feedback through meetings, newsletters, flyers, posters etc.

It was agreed that the facilitators from the two HCs would work as one team in order to assist the Chipata team. This worked well and gave both teams more confidence as their combined skills and experiences were being shared as they mentored the scale up HCs together.

Most of the mentors' activities were centred on strategizing and planning for the project activities as well as mentoring and supporting the old and new teams. The mentors shared their knowledge and skills with the whole 2006 group through follow up meetings, where they provided technical support on various topics such as facilitating and basic writing skills that were identified as gaps in other processes (Monticelli 2004). The mentors also held several meetings with the lead facilitators to provide support either in preparation and/or analysis of their planned activities with the 2007 teams.

3.3 Scaling up the PRA process to strengthen community voice in planning

The PRA orientation workshop for the 2007 group provided the forum for identifying issues affecting the community voice at George and Mandevu HCs. A Spider Web tool was introduced by one of the facilitators from a previous experience. The participants could *visualise* the ideal and real flow of information as they threw the ball of string amongst themselves, as shown in the diagram below. The tool was able to stimulate a candid discussion after the activity on the flow of information.

Chipata Health Centre Team leaders (HC in-charge with NHC vice chair) holding a PRA meeting with Mandevu Team, Source Roydah Zulu, 2008, Chipata health centre

The notice is short and the health centre staff start informing other people verbally. The NHC chairperson calls people nearby and not everyone is involved!' *Community member*

'Should communication always start from the In-charge, and why not from the NHC chairperson?' *Community member*

The in-charge should be aware of what is happening because you can't work in isolation. It depends on the information. Community members may have information they need to work together. The In-charge is the entry point for things to move smoothly.'" *Health worker*

The activity raised problems in the communication and information flow between health workers and community members in planning processes at the new HCs. Participants agreed that communication channels needed to be clear, appropriate and with adequate time for information sharing.

Discussion on the *perceived underlying causes of the communication problems* raised issues of corruption, jealousy and selfishness undermining health worker advocacy of community roles or remuneration to communities. [This expectation was despite health volunteers being aware that there is no policy in Zambia currently to offer them monetary remuneration]. On the other hand health workers felt community members were too rigid in their ways and were 'unwilling to give and take'. The *But Why* technique used did help both groups 'let out steam' by bringing out some of these deep seated concerns which would otherwise have remained brewing. By the end of the discussion the Community members were able to appreciate its value saying '…*The exercise made us think over issues.*'

The Market Place tool equally allowed participants freedom of expression within a structured affirmative process. Discussion was active on ideas for improvements, if not always recorded. It was seen as an approach where some difficult messages could be conveyed *"The Market was busy; people were saying the community is not important; community should have funds given separately; communities should be called when funding is ready; community should contact the funders directly; they [HWs] should buy things together with the community."*

As the process progressed, both groups began to articulate to a greater extent the importance of involving local and affected communities from planning stages of activities. In the process using *incomplete Stories* health workers acknowledged that they too were part of the 'same community' and therefore needed to work with others to achieve their health goals. The *Stepping Stones* exercise helped to cement the concept of working together -'…It was better to work together at all times to make things easier.'
'…*There was need for partnerships. It is not only health workers that CMs can work with, but also with other stakeholders.'*
Health worker

By the end of the workshop one of the key messages the participants took home was the importance of mutual trust and respect between the health workers and community members;
'It has been an eye opener to the health worker and the community. It has helped not to look down on the health worker or the community.'
Workshop participant

The group proposed that various forums be used to share the issues raised, including through community meetings and departmental meetings for health workers. The sessions with community members and community-based groups should explain planning formats and finance issues. The participants themselves planned to use the PRA tools in these processes.

The 2006 facilitators (separately by HC and then jointly as one team) visited the sites to monitor these activities and support the facilitators and the mentors held two joint follow up meetings with facilitators and the new HC teams.

The first set of actions related to **information sharing** within and between HWs and community members. For example, Community members from Mandevu HC reported having used the *Market Place and Johari window* as a way of improving information sharing with the NHC members and CBOs; however the team also observed that there was apathy in information sharing amongst the health workers. This is the same HC where health workers were reported as *'taking too many short leaves'.* [The feedback was also providing information for management at higher levels such as the District Health Officer to act given the possible weakness in the HC leadership.] The health workers at George HC said they had used the *Problem Tree* to explain to other health staff the cause for delays regarding their housing allowances that was actually a provincial health office problem.

Both HCs reported having acquired more knowledge on the planning process through orientation meetings and most had been able to see a copy of the HC Action Plan for 2008. They were geared to have better input into the 2008 planning cycle activities that were due to begin in the same quarter.

On the allocation of resource allocation, both HCs now had knowledge on how to request for the 25% from the monthly user fees collections and said the decision on how to spend the funds was being done jointly. It was interesting to note that the Community members at George HC who during the PRA workshop had said *'…we don't know what our friends [HWs] use their half on but they know what we use ours on!'* They reported that they sat with the HC in-charge to decide how much and on which activities the funds would be spent on. At Mandevu HC the information had even been disseminated at neighbourhood zonal levels and *'the CBOs decided to buy weighing scales for the GMP activities'.*

Community members assisting HW as she receives HC supplies
Source Roydah Zulu, 2008, Chipata health centre

By the end of the project period the Community members seemed to have gained greatest in terms of growing in confidence and enthusiasm to see the process push forward. However for the HWs one sensed a fear of being 'exposed or losing power.' Particularly in Mandevu the HWs were still quite defensive during discussions and appeared not to have been able to share what they were learning effectively with their colleagues as was reported in a follow up meeting:
'…We are still stuck as there is need to sit down with management as PRA team so that we can iron out a few things, such as removing the few gaps that are existing.'

Mandevu HC was unable to send a health worker to the final evaluation meeting (two were said to be on maternity and vacation leave; one was attached to another project; and one was on duty). Absenteeism of health staff at Mandevu HC was raised as an issue by community members for follow up by the Medical Superintendent of the area.

In contrast, the George health workers appeared to have made real efforts to bridge their gaps with community members although they did not go as far as holding a *reconciliation party* as proposed during the PRA workshop! They noted that their relationship with the community had improved, and that this had had an impact on the use of HC resources
'The relationship has strengthened especially that health workers now attend community meetings. Nurses used to think that only health workers should participate in planning.'
Health worker, George HC

George HC shared the information on PRA with their Community based groups (CBOs) and used some of the tools especially *Stepping stones* in developing their cholera prevention preparedness plan. Through this interaction a window of communication between the CBOs and the health workers had been created. The CBOs said they were now freer to approach the health workers. A community member expressed the extent of their earlier fear saying *'…ala twalebatina icine cine…'* which literally means *'we were really terrified of them'!*

3.4 Assessment and monitoring of changes in the planning process

As indicated in the methods section, the project used both qualitative and quantitative tools to assess progress of planned activities and monitor change in the planning, budgeting and implementation (PIB) process in the project sites, that is the pre and post test questionnaire survey, the progress markers (PM) and the wheel chart.

Mentors meetings with facilitators and participants were used to monitor changes in both processes, the consolidation and capacity building in the 2006 group and expansion of the process to the 2007 HCs.

The mentors also held their own ongoing meetings to review the progress of the project and to document the experiences from the team reports and activities and report writing.

Monitoring change against identified actions using progress markers

Based on the re-prioritised problems that had been identified, 2007 participants developed progress markers (PMs) to monitor progress towards solving their problems; and despite the limited project period, the group also identified some *Love to see* PMs. The 2006 group also continued to monitor the PMs they had developed during the pilot phase.

This tool was a little challenging for all participants and was part of a learning process even for the mentors. Monitoring was done at 2 monthly intervals and both new HCs George and Mandevu managed to complete their *Expect to see* PMs and a few *Like to see* on tackling communication and information flow.

Table 2: Progress Markers 2007 group

Problem: Inadequate Information And Communication On Planning Process							
EXPECT To See Progress Markers		***Progress Monitoring**					
		GEORGE			MANDEVU		
		1	**2**	**3**	**1**	**2**	**3**
1	HC staff meetings with CMs having schedules, agendas & minutes.		■	■	■	■	■
2	HC staff & CMs disseminating or sharing information on planning and any other current issues		■	■	□	□	■
3	HC giving CMs feedback on planning activities and any other current issues as soon as it is received		■	■	■	■	■
4	HWs & CMs respecting each others views during meetings & discussions		■	■	■	■	■
5	Participants who attended the 2007 PRA orientation workshop sensitizing or sharing the information with their immediate workmates and colleagues.		■	■	■	■	■
LIKE To See Progress Markers							
1	HC providing necessary materials & simplified guidelines to CMs on planning process		□	■			
2	HCs & CMs beginning the planning cycle activities without being prompted by higher level						
3	HC providing & sharing information to CMs on budget allocation & expenditure for HC			■	■	■	■
LOVE To See Progress Markers							
1	75% of HWs conversant with planning process						

Key: **Done** ■ **Started/Ongoing** □ **Not Started/not done** □

Most of the “expect to see” progress markers on information sharing were achieved by both HCs. George HC had better outcomes in the “like to see” outcomes, while not surprisingly neither HC had achieved the “love to see” outcomes (Table 2).

Table 3: Progress Markers 2007 group

Problem: Too few people involved in annual planning process activities							
EXPECT To See Progress Markers		***Progress Monitoring**					
		GEORGE			MANDEVU		
		1	**2**	**3**	**1**	**2**	**3**
1	HWs and CMs sitting together to review & monitor their planned activities & HMIS data quarterly		■	■	■	■	■
2	CMs forming Core Planning Teams at NHC unit level						
3	2007 PRA participants orienting others on planning process through ongoing informal methods e.g. 'one-to-one' technique		■	■	■	■	■
LIKE To See Progress Markers							
1	HC holding briefing & orientation meetings on planning process for staff & CMs needing the knowledge.		□	■			
2	New people joining the Core Planning Team at HC & NHC level						
3	More departmental staff & CMs at NHC unit level having their ideas or input into the HC & Community Action plan.						
LOVE To See Progress Markers							
1	More HWs and CMs oriented in PRA methods	□		■	□	□	□
2	More stakeholders beyond HC boundaries having input in the HC plans						

Key: **Done** ■ **Started/Ongoing** □ **Not Started/not done** □

Again, most of the "expect to see" progress markers on involvement in planning were achieved by both HCs. George HC had better outcomes in the "like to see" outcomes and "love to see" outcomes, but both HCs had begin to achieve some of these in the period (Table 3). The HCs achieved fewer PMs on direct planning process activities perhaps because by the end of the project period the planning cycle for the district had not officially commenced.

Table 4: 2006 PRA Group Progress Markers

Expect To See Progress Markers		**Lusaka**	**Chipata**	**Matero Ref.**
		2007	**2008**	**2008**
1	HC receive formats and guidelines on next year's plan	■	■	■
2	HC Management Committees give HCCs and departments feedback on planning guidelines	■	■	■
3	HC & community hold planning meetings together for next year's plan	■	■	■
4	Participants present able to explain planning format to others	□	■	■
Like To See Progress Markers				
1	Agree on priority activities for next year's plan	■	■	■
2	Draft Action Plan done together with community	□	■	■
3	Feedback on planning activities through regular meetings between HWs and CMs	■	■	■
4	HCC & departments receive a quarterly financial report		■	□
5	Participants present able to write a plan as per format	□	■	□

Key: **Done** ■ **Started/Ongoing** □ **Not Started/not done** □

The “expect to see” progress markers had been achieved by the 2006 group by the end of the 2007 exercise, about 18 months – 2 years after they had begun the exercise. Equally a lot of their “like to see” outcomes had been achieved or were ongoing (Table 4). This signals the time needed for these type of interventions to have impact, and the importance both of sustaining the processes across these time frames and not jumping too early to assessments of impact. The 2006 group had achieved their PMs from the previous year and were in the process of setting new targets as part of the ongoing activities.

Pre and post test questionnaire findings

This section reports findings from the pre and post-test questionnaires with the 2007 group on planning, information sharing resource allocation, and activity implementation.

Tables 5-8 present the responses in the pre test on the perceptions by health workers and community members on their involvement in decision making in different areas of HC functioning.

Table 5: Community members say in health activities at their HC.

Community members have a say on which health activities their HC should carry out from the Action Plan				
	Health Workers		**Community Members**	
	Pre-test N=9	**Post-test N=6**	**Pre-test N=8**	**Post-test N=8**
Agree	89%	83%	75%	75%
Disagree	11%	17%	25%	25%

Table 6: Areas where community input is seen to be most useful

In which of the following do you think the *community's input* is most useful?				
	Health Workers		**Community Members**	
	Pre-test N=9	**Post-test N=6**	**Pre-test N=8**	**Post-test N=8**
Doing action plans	11%	33%	13%	38%
Deciding on use of funds	11%	0%	13%	0%
Doing health activities	78%	67%	75%	63%

Table 7: Areas health workers are perceived to see community input as most useful

In your view, in which of the following do *health workers* think the *community's input* is most useful?				
	Health Workers		**Community Members**	
	Pre-test N=9	**Post-test N=6**	**Pre-test N=8**	**Post-test N=8**
Doing action plans	0%	33%	0%	13%
Deciding on use of funds	11%	0%	0%	0%
Doing health activities	89%	68%	100%	88%

Table 8: Areas where health worker input is seen to be most useful

In which one of the following do you think *health workers' input* is most useful?				
	Health Workers		**Community Members**	
	Pre-test N=9	**Post-test N=6**	**Pre-test N=8**	**Post-test N=8**
Doing action plans	44%	50%	38%	50%
Deciding on use of funds	22%	17%	0%	25%
Doing health activities	33%	33%	63%	25%

Both health workers and community groups perceived that community members have some say in the health activities carried out in the action plan, less so for community members. This did not change over the period (See Table 5). Community input was however generally rated by both groups as most useful in the implementation of health activities and not in areas such as planning and decisions on resources. The perception of the usefulness of community inputs on use of funds fell in the post test. From comments made in the meetings it appears that the limited extent of this involvement became clearer in the exercise. It also appeared that the intervention had not yet shifted perceptions on community roles in decision making on use of funds (See Table 6). There was general consensus that health workers perceive communities to have little role in planning or budget setting. Over the intervention, there was an increased perception of health workers valuing community inputs to planning by health workers themselves (Table 7). Health worker roles were seen to be wider, making inputs in planning and activities, but still not strongly rated in decisions on resources. This was sustained in the post test, although with some increase in the perceived role in planning (Table 8). The numbers in both the pre and post test were small, so these figures on their own do not provide robust evidence, but are useful when triangulated with the other assessments of change.

For example, it was interesting to find that health workers were more confident at the pre test that community members knew the role of the HC (none said no) but were less convinced that they themselves knew the functions of the health centre committees (HCCs). This finding was verified during the workshop discussions, where some health workers admitted to not even knowing the HCC membership. By the post test there was greater shared knowledge of the HCCs.

The extremely limited perceived role of community members – “carrying out health activities”- shows how far attitudes needed to shift for the types of changes aimed at in the PRA process. Indeed, during the PRA workshop some community members pointed out that they feel their role in health activities is too high, expecting more of a role for health workers in health actions as this is their employment. This view highlights both the shortage of health workers to carry out activities and the heavy reliance on community health volunteers.

How far had these perceptions shifted in the intervention?

Generally, community members had significantly lower ratings than health workers of the extent of their participation in planning from the start. This was not dissimilar to findings from the 2006 round. For both groups their rating of participation fell, but particularly amongst the health workers (Table 9). While this appears to be paradoxical for a process that strengthens participation, the PRA activity appeared to have raised the understanding of what could be considered as *community input in planning,* particularly amongst health workers. They realised that even at the community level involvement in planning was inadequate. There was a renewed understanding of what sitting together meant after the invention, meaning more than a simple presence but active participation.

The greatest shift was in the appreciation of how low the participation level is amongst ordinary community members, and how top-down or top heavy HV planning is, including for health personnel.

Table 9: Participation in the planning process

Questions	Health workers		Community Members	
	Pre-test N=9	Post test N=6	Pre-test N=8	Post-test N=8
Does the community have input in the development of HC Annual Action Plan	100%	50%	63%	25%
Do CM and HW sit together in developing the health Action plan	100%	83%	50%	38%
Do community leaders sit together with other community members in developing HC Action Plan	67%	33%	13%	13%
Does ordinary staff actively participate in action planning at your HC	56%	17%	13%	13%

Prior to the intervention health workers had a more favourable rating of information sharing than community members. In particular community members felt starved of information by the district office (Table 10). This area noticeably improved after the intervention. There was a major improvement in both groups in the assessment of information sharing and community and health worker views converged to a greater degree. Both groups felt there was still need to improve on the timeliness of information. The improvement in the rating of district office performance was greatest in the community groups and suggests that HCs were not communicating district information effectively with community members.

Table 10: Information sharing for health planning

Questions	Health workers		Community Members	
	Pre-test N=9	Post test N=6	Pre-test N=8	Post-test N=8
Do the HC staff give Communities required information to help them participate in action planning	78%	100%	63%	75%
Does the district office give HC required information for HC and Community level action planning	78%	83%	25%	88%

Both groups in the pre-test had low ratings of community knowledge on the resources available for health or how they were allocated, with poorer ratings in community members. This area improved after the intervention, with greater convergence between health worker and community views (Table 11). It appeared that neither health workers nor community members felt that they could decide on the use of funds for their HCs. The FGDs raised the perception that resource allocation was a district level activity. However it was encouraging to see some shift towards the perception of the knowledge on resources, as an entry point to shifting perceptions on the roles of health workers and communities at HC level in decisions on resources.

Table 11: Roles in resource allocation

Questions	Health workers		Community Members	
	Pre-test N=9	Post test N=6	Pre-test N=8	Post-test N=8
Do Community members know how funds for health are allocated to the HC from the district	56%	67%	25%	63%
Do community members know the different types of resources or support available for there HC activites?	44%	67%	38%	50%

Although knowledge on resource allocation appears to have improved amongst the participants as seen from follow up meetings, it still remains a challenge. Knowledge on the types of resources available appears to be related to those resources channelled through the structured health system. It does not include resources beyond Ministry of Health allocations available within catchment areas, such as those from churches, businesses, transporters and non-government organisations.

Monitoring and assessment of participation using the Wheel Charts

The Wheel Chart tool was used to assess and monitor the following 4 selected areas of concern:

i. Participation in planning
ii. Access to information for planning
iii. Implementation of planned activities
iv. Participation in resource allocation

In the pre intervention Wheel charts, although the community members from Mandevu HC had reported working together and communicating very well with their health workers, they rated their levels of participation in planning process much lower than George HC who had openly declared that their relationship was poor. Mandevu HC appeared to be less ambitious about their expectations of participation compared to George HC. At Mandevu HC the health worker's assessments of their participation was also lower in three of the four areas. These collectively produced findings contrast with the pre-test questionnaire responses where health workers and community members reported high levels of participation in all areas except resource/budget allocation (Table 12).

During the discussion and reflection session at the orientation workshop, the participants declared that *'…change can only come by people participating actively and reducing the gaps'*.

On why resource allocation had been a problem, the participants declared:
'*It is the allocation, which is not enough'*.
HCs were seen to be excluded from discussions when funds are allocated, especially community members and few at the HC itself.

Table 12: Wheel Chart Levels for the 2007 PRA Group

Mandevu HC	**Pre intervention**		**Post intervention**	
	CM N=4	**HW N=4**	**CM N=4**	**HW N=2**
Participation in planning	10%	25%	65%	60%
Have Information in Planning	5%	25%	70%	75%
Implementation of activities	5%	25%	55%	70%
Resource Allocation	10%	25%	55%	50%

George HC	**Pre intervention**		**Post intervention**	
	CM N=4	**HW N=4**	**CM N=4**	**HW N=3**
Participation in planning	20%	70%	35%	75%
Have Information in Planning	40%	95%	45%	70%
Implementation of activities	85%	30%	55%	70%
Resource Allocation	10%	10%	35%	30%

CM= Community Members; HW= Health workers

After the intervention there was greater convergence between the wheel chart findings and the test questionnaires, and between the community and health worker views at Mandevu HC, less so at George HC. In both HCs there was an improvement in the assessment of participation levels in planning, in information exchange, and in activities, except for George

HC where the assessment of adequacy of information for planning had gone down. Assessment of participation in resource allocation had risen in both areas, but was still relatively low.

Triangulation of the three different tools allows for assessment with some confidence of change from the intervention. Initially health worker assessments of participation in PIB were significantly more favourable than those of communities, but both groups saw that participation in resource allocation and financing decisions was low for both health workers and communities at HCs. There were information blockages, such as in the flow of information from districts to community level through the HCs.

While the HCs were at variable levels in achievement of intended progress they had both achieved the more process oriented markers that they "expected to achieve". The greater achievement of progress markers by the 2006 groups signals that change processes need at least one or two years for changes to take place, especially in budget and planning processes.

After the intervention there was greater convergence between the community and health worker views. While the increased expectations of participation had led to a more critical assessment of practice, there was across both the wheel chart and questionnaires a perceived improvement in the assessment of participation levels in planning, in information exchange. While perceptions of HC roles in resource allocation had risen in both areas, they remained relatively low.

4 Lessons learned from intervention and study

Having recorded some positive outcomes from the pilot project of 2006, scaling up to other HCs under Lusaka District Health Management Team seemed the most logical next step. The team in Zambia, and more widely in the regional work in EQUINET, was interested to learn the lessons of how to institutionalise both the PRA processes for enhanced health worker- community interaction in health planning, and the health systems outcomes of the pilot. This meant exploring how to sustain and consolidate the PRA process in the first two HCs, building capabilities for horizontal roll out of the process to new areas, and expanding the HCs involved.

The 2007 project provided some valuable lessons on what may enhance or hinder this process.

On sustaining and deepening the activities in the first two HCs:

- The 2006 PRA group used the PRA methods for a wider range of (unplanned) issues such as planning with stakeholders; participation of communities and conflict resolution. This showed that the PRA approach and capacities can be applied to resolve many issues in the interface between health workers and communities) but the appropriate tools need to be identified depending on the situation/issue at hand and the capacities deepened in the team to "think on ones feet" and be responsive to local context and issues. This is further explored in the discussion on capacities.
- The changes take time: The group affirmed that continuous mentoring of the new HCs was necessary for a longer period beyond the project period to ensure sustainability of the PRA concept. The 2007 HCs were at variable levels in achievement of intended progress they had both achieved the more process oriented markers that they "expected to achieve". The greater achievement of PMs by the 2006 groups signals that change processes need at least one or two years for changes to take place, especially in budget and planning processes.
- A turnover of health workers can challenge the process, especially when this brings in those that have no experience of or orientation towards participation. The induction and

in-service training that health workers get need to include such issues, so they do not destabilise existing processes.

- Sustainability depends in part on having adequate health workers, with adequate time for these activities. This depends too on it being integrated into roles and functioning of health centres. During the final evaluation discussion the participants brought out the issue of too many activities taking place at HCs with too few personnel, creating competing demand and undermining sustained participation in the PRA work. While this means that as many people as possible need to be oriented, at all levels, for continuity of the activities, it also raises the importance of adequate health care workers for Primary health care oriented systems to succeed.
- Sustainability is however not always a matter of how adequately the health services resource this work. Sometimes throwing back the problem to the community to find the possible solution can result in more positive and long-term solutions and ownership of the outcomes.

'PRA has helped us explain difficulties HWs face; we became their voice to educate them [communities] on the shortage of staff.'

Community member

The scale up to new areas demonstrated common barriers to participation experienced in the 2006 round, and common progress in addressing these barriers.

- The experience from working and mentoring the new 2007 group confirmed the fact that the gaps on the interaction between community members and HWs existed in many other HCs. Much of the disharmony was seen to be caused by lack of information about each other's roles on both sides; and that higher levels [DHO] did not disseminate enough information on integration and partnership
- The roles of community members and health workers are not well understood, information sharing in inadequate and late, and both health workers and community members undermine and are unaware of their roles in resource allocation, and thus poorly participate in this. Participation is still seen to be implementing activities decided by others. But Zambia has a policy framework to do things differently, has an infrastructure of HCs in communities, has set up mechanisms like NHCs for community involvement, has resources that communities can access and should play a role in and has health workers able to support wider involvement in health. The PRA process was able to unblock suspicions, information blocks and negative attitudes in a way that acknowledged these, but that steered the process towards shared recognition of roles and partnership. As in 2006, the PRA process was successful in achieving change in perceived roles, in attitudes and in some level of practice around information exchange, communication, and involvement in planning.
- There were some necessary ingredients to this change- for HWs to have and to make time for community activities; timely information sharing; openness in communication; a change of attitudes towards clients and community volunteers in health workers; resources and time for PRA processes.
- It is important that the overall authority in the organization is informed and updated on the work being done as this ensures support to the process, and that the HC in-charges were also fully involved in HCC activities.
- To some extent the process depends on a willingness of health workers to give up a degree of control over the process to communities, so that both health workers at HCs and communities become a more effective force for directing resources towards their needs. This wasn't always perceived by health workers, and some found the shift in control difficult to accept. Equally however others in authority saw the process as reinforcing of the functioning and performance of the HC. The leadership signals are important for this, and the promotion of two trained PRA facilitators to be in charge at the HCs will be a useful test of this leadership.
- These processes demand initial funding- to build capacities and generate the initial processes and the exchanges that can deepen them and enable their spread to other HCs.

'There's a big change since we started and I am part of the change. I am a voice for the voiceless'.

Health worker

On the capacity building and mentorship needed to scale up PRA processes

- Many participants highlighted the need for more training in PRA activities and for orientation of other HCs in the district. Others suggested exchange visits and using the trained members to mentor other centres.
- It is not always the time spent but the content of what is shared with target audiences that counts. It was overwhelming and encouraging for mentors and facilitators to see how a two-days PRA workshop could provide such marked revelations for the participants.
- The new facilitators felt they needed more preparation time with the workshop sessions. A dummy run would have assisted to give them more confidence in facilitating. Mentors and facilitators acknowledged the need to be conversant with tools they use for participatory activities and that mentors should fully guide facilitators prior to activities There was need for more practice on the PRA tools for facilitators to enable them cope with unexpected reactions from participants.
- Facilitators themselves needed to be ready to learn from participants. This finding is similar to that described by Hofnie-//Hoebes K (2006) in the Namibian pilot.
- There was a lot of personal learning by facilitators and mentors through their interaction. Regular group reviewing of the steps helped to re-focus the activities to the change aimed at in the project. It was therefore important for the team leader to keep the team on course.
- Having a team member dedicated to documenting the process greatly reduced the loss of valuable information during the sessions and made post activity discussions easier.
- Although most of the activities were done as planned, reporting on the activities was the greatest challenge for the facilitators and the mentors alike. Time constraints due to other work commitments were a major contributor, as well as the limited interpretation and analytical skills within the teams.
- The mentors and research team were drawn from different organizations, therefore commitment and sacrifice, particularly of time, was important to the success of the project. At the same time the different backgrounds offered varied skills, experiences and perspectives to the project.

'PRA has helped us to consult amongst HWs and CMs on information. There was that fear but now we can discuss even at meetings- it needs to be introduced in churches, schools and wards [local council]'.
Community member

5 Recommendations and conclusions

If this process is to be expanded and institutionalised within the health system there needs to be greater investment in the processes and skills for it. Some of the issues for this are raised in the previous section.

For us, within the Lusaka Health team and the regional learning network on people centred health system in EQUINET, we have some more specific recommendations for our own follow up.

The process is robust and has positive impact on implementing the policy commitments to participation in PIB. It has also had wider, sometimes unanticipated positive impact on other areas of health system interface with communities.

Despite the challenges of time and competing activities, the project progressed well and received positive feedback from participants and non-participants especially from the community. This was a result of the trainees sharing their activities with others within the district even through informal discussions and encounters. This has resulted in the district facilitators getting requests for PRA orientation from NHC members from other unexposed HCs.

It can be scaled up to new health centres, if we are able to build the mentoring and capacities to support this.

We need to include some new areas of skills building within the PRA process as teams develop, including on mentoring, on the basic reports or documentation tools for all levels, and Outcome Mapping tools should be included and adapted to monitor behaviour change amongst boundary partners.

We suggest that the DHMT appoint a focal person, probably the Community Coordination Officer to be responsible for facilitating and coordinating the participatory approaches, and that this person also be responsible for facilitating research proposal initiatives from the different levels relating to community involvement or partnerships in the district. The DHMT would need to plan for the scale up of the PRA approach to four more HCs during the next planning year.

A comment made informally by the NHC Chairperson from George who participated in the PRA training, to the district Community Coordinator, highlighted the level of enlightenment he felt:
'As NHC chair I thought I knew a lot, but I found out that there was a lot that I still needed to learn.'

It was interesting to note that the achievements and challenges seen at the end of the project for the 2007 PRA group were very similar to those of the previous 2006 PRA group. However during this phase, the 2006 group demonstrated that their previous experience resulted in better involvement of the community members and health workers at their respective HCs in planning and resource allocation. It is hoped that the same *seed has been sown* in the 2007 teams and with the continued support by the facilitators and mentors the same outcomes can be achieved.

In conclusion, although positive results may not have been achieved at all the new sites within the project period, the 2007 PRA project did show the feasibility of both sustaining and scaling up a PRA intervention through a process of mentorship at HCs under Lusaka District Health Management Team.

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