Impacts of participation and governance on equity in health systems:

Report of a research review meeting of the GovERN network

EQUINET / TARSC / CHESSORE /CWGH / UNZA
In collaboration with IDRC (Canada)
Harare, May 29 2003
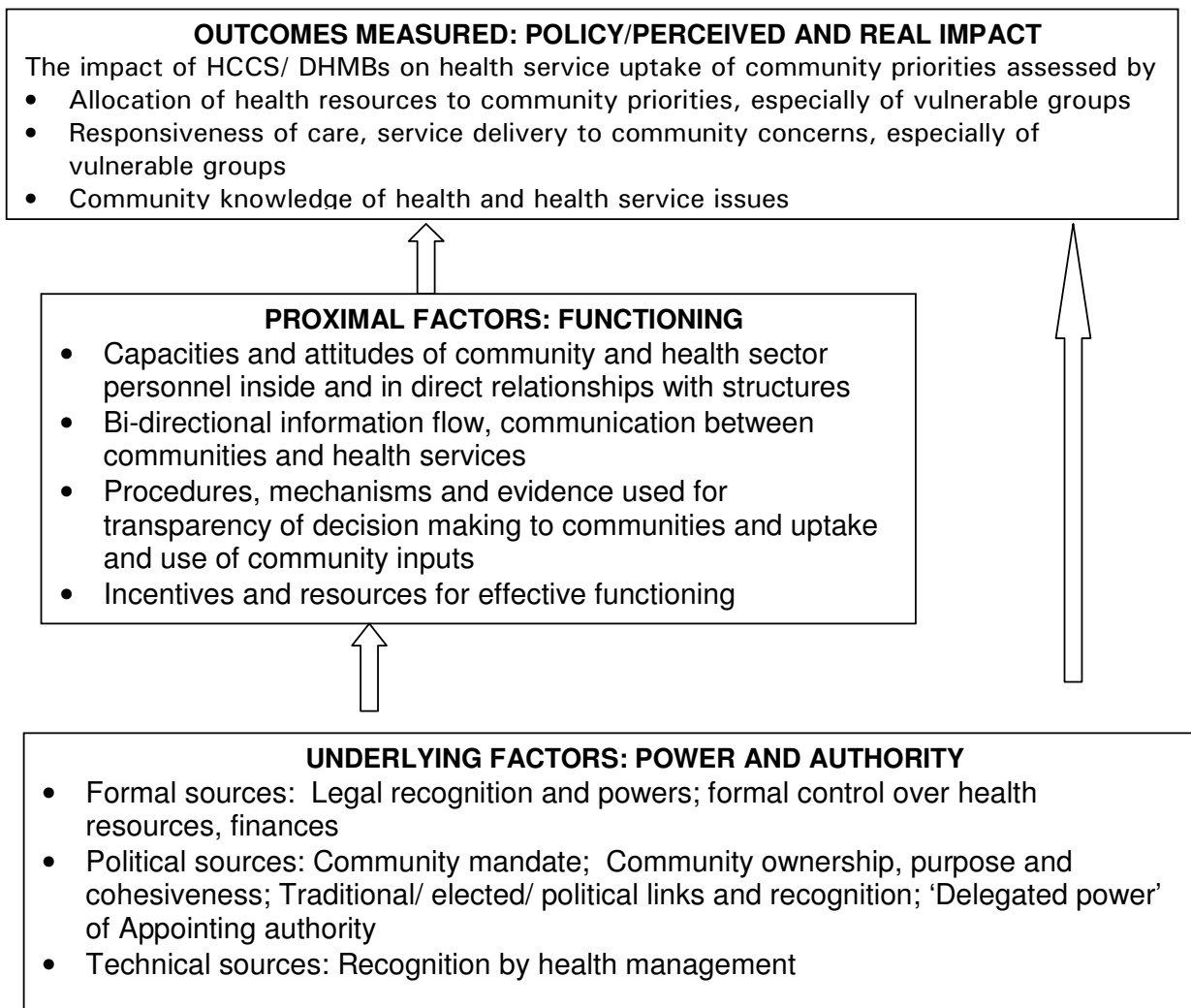
REPORT BY CHESSORE/TARSC
JUNE 2003

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1.0   INTRODUCTION

The Regional Network on Equity and Health in Southern Africa (EQUINET) has been carrying out research work to evaluate the current and desired forms of participation within health systems in Mozambique, Zambia and Zimbabwe amongst others. The Training and Research Support Centre (TARSC) in Zimbabwe, CHESSORE and INESOR in Zambia embarked on a research to assess the impact of Health Centre Committees on the health system.

At a meeting in September 2003 The conceptual model for assessing governance as a contributor to health equity underlying the multi-country programme was defined as below:

OUTCOMES MEASURED: POLICY/PERCEIVED AND REAL IMPACT

The impact of HCCS/ DHMBs on health service uptake of community priorities assessed by
- Allocation of health resources to community priorities, especially of vulnerable groups
- Responsiveness of care, service delivery to community concerns, especially of vulnerable groups
- Community knowledge of health and health service issues

PROXIMAL FACTORS: FUNCTIONING

- Capacities and attitudes of community and health sector personnel inside and in direct relationships with structures
- Bi-directional information flow, communication between communities and health services
- Procedures, mechanisms and evidence used for transparency of decision making to communities and uptake and use of community inputs
- Incentives and resources for effective functioning

UNDERLYING FACTORS: POWER AND AUTHORITY

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

Following the meeting in September 2002 the first phase of the research was carried out by the teams, following the framework and exploring the hypotheses shown in Appendix 1. Reports of the first phase of field work were circulated to the teams prior to the meeting.

A review meeting was held in Harare on the 29th of May with two representatives from each of the teams. The meeting aimed to
- Review work done to date, findings on outcomes and functioning and trends across the common data set
- Outline approaches for exploring the underlying political and authority determinants of the findings and any other follow up work to be done
- Discuss the 'next steps' on the work

At the meeting were the following team members:
Zimbabwe - Dr. Loewenson (TARSC), Mr. Itai Rusike (CWGH), Miss. Memory Zulu (TARSC/CWGH)
Zambia INESOR: Dr. Alasford Ngwengwe (INESOR)
Zambia CHESSORE: Dr. T. J. Ngulube (CHESSORE; Mr. Laxonie Mdhluli (CHESSORE)
Apologies were given by Dr Mubiana Macwang'i (INESOR)

1.1   OPENING AND DISCUSSION OF MEETING PLAN

Dr R Loewenson the EQUINET Programme manager opened the meeting by welcoming all participants and asked them to introduce themselves and to give background of their various disciplines. Mr. Ngwengwe gave an apology from Dr Mubiana Macwang'I, who could not make it to the meeting due to malaria. The meeting plan was reviewed and agreed to include
- presentations from each team on the outcomes of the three studies
- discussion on the outcomes in terms of the conceptual framework
- discussion on the synthesis of the studies
- discussion and consensus on the next phase of the research.

The key research questions were restated

i.   Do participatory structures represent the interests of communities (and of which sections)?
ii.   Do participatory structures have any role in health system performance and resource allocation?
iii. Do participatory structures include community preferences in health planning and resource allocation
iv.   Do participatory structures improve equity in resource allocation?
v.   Do participatory structures improve health system performance, especially   in relation to equity?

The governance agenda aimed not only to research but to support community understanding and use of structures for democracy within the health system, to enhance community control over their health.

2.0   PRESENTATIONS OF THE FINDINGS

2.1.0   The CHESSORE Study, Zambia

The study findings were presented by Dr. Ngulube. The CHESSORE study arose from previous work monitoring the implementation of health reforms in Zambia. It emerged from

that study that health centre committees could be categorized by their performance. Successful HCCs had managed to put in place workable programmes in terms of resource mobilization and management, improve access to health services and made an impact on governance roles at the health facilities generally. The CHESSORE study focused on comparing 4 'successful' HCCs with other 4 'control' HCCs. CHESSORE had to date completed field work in 6 districts (2 with well performing HCCs and 4 with the 'control' HCCs). Their findings indicated that

- ✓ HCCs performed better where traditional leaders and others of influence where involved, where communities played a strong role in HCC selection, where people with higher levels of education were involved in the HCC, where there were incentives for participation, where meetings were well organized, and supported by professional staff with more training.
- ✓ Low performing structures tended to have irregular meetings, usually only called at pleasure of health center in-charges.. Low Performing centers had low staffing and usually with lower professional attainment and less understanding of health reform issues. Communities tended to view such staff negatively. In low performing HCCs staff would persuade community representatives to forego their agenda and instead support Health service Priorities. Non performing structures were also stated to be full of complaints and took no initiatives to improve. They did not mobilize community and meeting attendance was poor and this had prevented them from improving.
- ✓ No HCCs, regardless of their level of performance, were told about money released and available to address identified health centre and/or community priorities contained in the annual action plans.

HCCs were set by law through the Health Services Act of 1995, which clearly stated their roles and responsibilities. However it was noted that health staff were not telling people of their health rights in full and so few people knew of their legal powers.

2.2.0   The INESOR Study, Zambia

The INESOR study was based on the health reforms in Zambia and the new roles given to District Health Boards (DHB), for policy and guidance at district local level. At the time of the study, most DHBs were being reconstituted after having been dissolved in the previous 2 years. The study found that

- o Most DHBs did not know their roles and responsibilities, had not been properly oriented, lacked control over their work and were expected to function through the District Health Management Teams who apparently did not have the capacity or resources for this. Powers that the DHBs had in theory, like hiring and firing staff, were not exercised in practice, and DHB appointments involved political screening from the state and political structures at higher levels.
- o DHBs had weak or absent links with neighbourhood health committees (NHCs) and were ineffective in dealing with issues brought to them.

It was noted that the issue of community representativeness of these structures needed to be more thoroughly explored.

2.3.0   The TARSC/CWGH Study, Zimbabwe

The TARSC/CWGH study was presented by the team. The work followed the CWGH efforts to revitalize Health Centre Committees (HCCs). The study was carried out comparing wards with HCCs and wards without in four districts. Some difficulties were experienced in getting information on finances at this level as the districts do not disaggregate budgets to clinic level. The study found that

- • Communities used the clinics as their primary source of health care, but clinics were under resourced and some distant from communities.
- • Health knowledge was higher in areas with HCCs, as were primary health care indicators, but it was not clear whether the HCCs had been the vehicle for this.
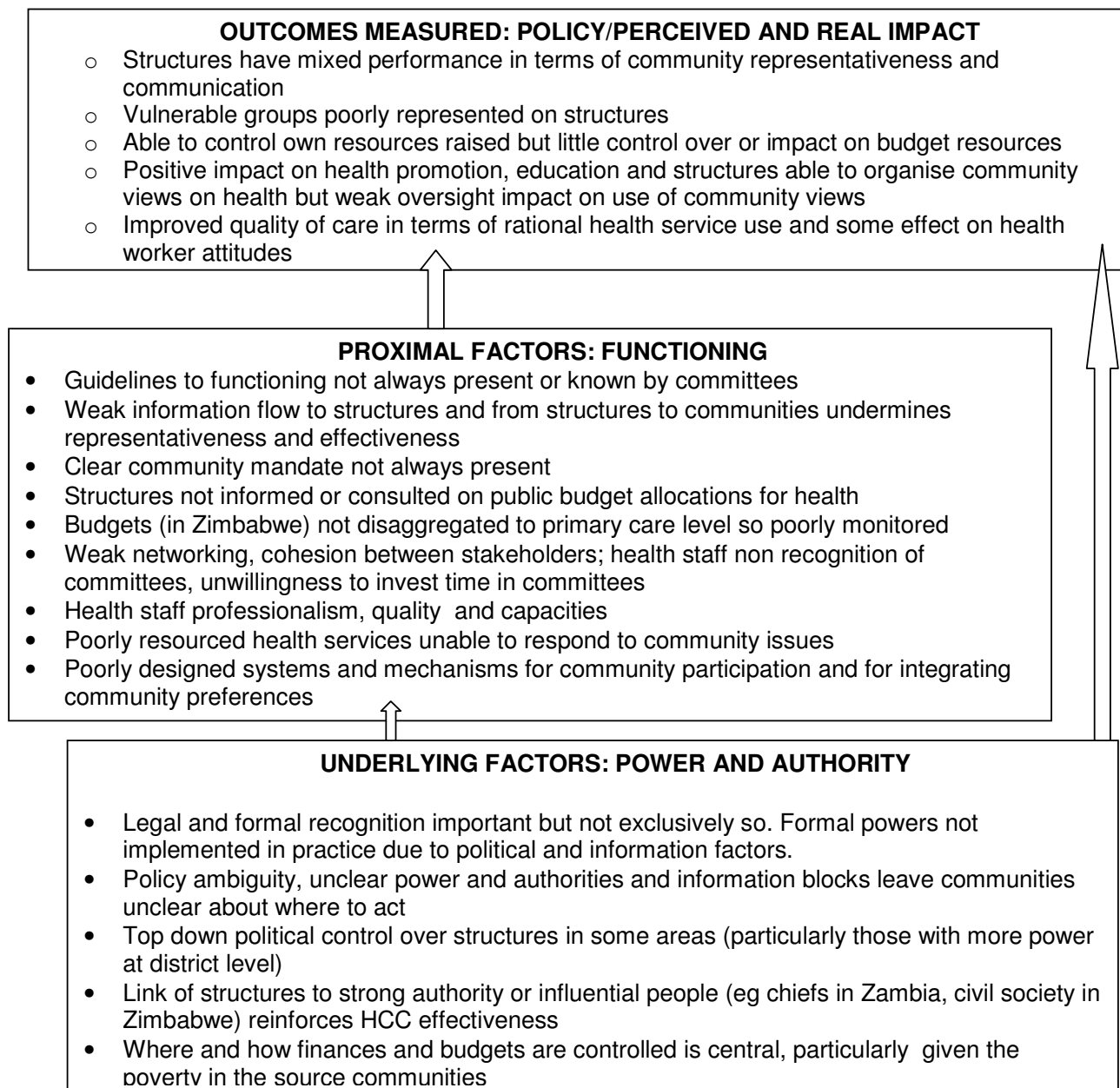
HCCs had played a role in social mobilization on health and in organizing community financing of health activities.

- HCCs were not yet playing a role in monitoring expenditure and were not given information on finances. HCCs were hampered by lack of guidelines, training and formal recognition. Health staff were keen to associate with HCCs performing well but reluctant to spend time on those not performing well. Where HCSS and health staff are not working well together communities do not find the system responsive to their issues.

It was noted that there is potential for exchange of information and comparison between HCCs in Zimbabwe and Zambia, given the difference in their formal status. It was noted that similar features of marginalization from resource allocation decisions occurred in both.

3.0   CROSS-CUTTING AND MULTICOUNTRY ISSUES

A number of issues emerge from the studies to date across the three studies in the two countries. These are summarized in the figure below.

OUTCOMES MEASURED: POLICY/PERCEIVED AND REAL IMPACT
- Structures have mixed performance in terms of community representativeness and communication
- Vulnerable groups poorly represented on structures
- Able to control own resources raised but little control over or impact on budget resources
- Positive impact on health promotion, education and structures able to organise community views on health but weak oversight impact on use of community views
- Improved quality of care in terms of rational health service use and some effect on health worker attitudes

PROXIMAL FACTORS: FUNCTIONING
- Guidelines to functioning not always present or known by committees
- Weak information flow to structures and from structures to communities undermines representativeness and effectiveness
- Clear community mandate not always present
- Structures not informed or consulted on public budget allocations for health
- Budgets (in Zimbabwe) not disaggregated to primary care level so poorly monitored
- Weak networking, cohesion between stakeholders; health staff non recognition of committees, unwillingness to invest time in committees
- Health staff professionalism, quality and capacities
- Poorly resourced health services unable to respond to community issues
- Poorly designed systems and mechanisms for community participation and for integrating community preferences

UNDERLYING FACTORS: POWER AND AUTHORITY

- Legal and formal recognition important but not exclusively so. Formal powers not implemented in practice due to political and information factors.
- Policy ambiguity, unclear power and authorities and information blocks leave communities unclear about where to act
- Top down political control over structures in some areas (particularly those with more power at district level)
- Link of structures to strong authority or influential people (eg chiefs in Zambia, civil society in Zimbabwe) reinforces HCC effectiveness
- Where and how finances and budgets are controlled is central, particularly given the poverty in the source communities

The HCCs had exerted some form of control on issues of health, in one form or another. Some had acquired some control over resources; they were invited to planning meetings; they were able to call and hold meetings over issues of health; and they were used as an important conduit of information to and from the community.

However the system appears to be poorly designed to accommodate or encourage this input. The resources provided were inadequate to support the work of the committees with question on where the resources for the committees would come from. This is important given the underlying poverty levels in the communities the committees are operating in.

Political factors also influenced the functioning of the committees. The strength of political commitment to issues of community participation in health governance is not clear, given the policy ambiguity in some cases around these mechanisms. It did appear that there were efforts to ensure that the committees were acceptable to the political establishment and were susceptible to political interference in their functioning. Health worker and technical inpu6ts were important in this, but health workers themselves were not clear about the committee roles, and were not convinced of the need for them.

4.0   ISSUES FOR THE PHASE 2 RESEARCH

The results as provided so far have raised a number of questions, to which answers are needed.

- o Where positive impacts have been found it is important to be clear whether the health centre committee or DHB is responsible for these changes and under what conditions. Beyond describing the key changes, the studies in the next phase need to identify the determinants of those changes.
- o Where there are strengths and weaknesses in functioning that are determinants of health impacts the studies need to explore further the underlying reasons for those conditions
- o The attitudes and perceptions of different parts of the system – the community, community representatives, health workers, managers, political leaders, higher levels of government – all influence the functioning of the HCCs and DHBs. What is shaping these attitudes? What is shaping the extent to which communities are willing to take up their claims to inclusion in decision making and the roles given to them, and the responses from other stakeholders.
- o The issue of representativeness of the structures was identified as critical. How is the gap in representation of vulnerable groups affecting their work and outcomes.

In the next phase as planned more work would also need to be done on the underlying power and authority factors influencing the performance of these mechanisms for participation. The key gaps identified in their functioning in the first phase of
- o Representativeness and mandate
- o Communication and information flow (to and from the committees)
- o Resources for committee functioning
- o Formal recognition and clear setting of roles, powers and duties
- o Health worker and political establishment responses
- o Primary care level capacities to interact with community mechanisms
- o Deficient mechanisms for inclusion of community priorities
- o Highly limited or absent devolution of budget authority
Would need to be traced back to the underlying factors influencing these outcomes.

This includes issues of
- The legal status and recognition of the committees (and their own awareness of this)
- The cohesion and relations between various stakeholders in the health system, political, technical and community
- The extent to which people with power are willing (and able) to use this for enhanced community role in health, including health staff and influential leaders
- The cohesion, mandate and organization within communities and their awareness of their rights and obligations in health
- The perception of public budgets, who controls them, whose funds they are perceived to be and what they are perceived to be for

It was noted that in all areas there appears to be some equilibrium reached between health services and community mechanisms over the participation of communities and the ways in which these health structures operate. However the question can be asked: is this equilibrium equitable? Who has borne the cost of the accommodations made to ensure harmony between health services and communities?

In follow up therefore some issues were noted for the next phase of work:

4.1   On impact:

- Are the poorest or vulnerable groups being reached, consulted and experiencing the noted impacts from HCCs / DHTs? (use focus group discussions with identified vulnerable groups such as orphans, the elderly, widows, women or those identified from the previous PRA findings as vulnerable. The guidelines should try to bring out their experiences with the committees and access to health. Key areas of interest would include how health staff treats them, on whether they know the HCC and if they felt represented on health issues under current arrangements. Also key informant interviews with health workers).
- Summarise a balance sheet of positive, negative and non impacts of participatory mechanisms based on findings.

4.2   Functioning

- More detailed assessment of forms and factors influencing information flow from health authorities to the structures and from structures to the communities.
- Further analysis of the factors influencing public budget allocations to primary care level.
- Quantitative and/or qualitative analysis of funds raised/allocated, perceptions of whose funds they are what they are for
    a) Money raised by the community
    b) Money paid by communities for services locally
    c) Money allocated to clinic from government budget
    d) Donor and NGO money
- Further analysis of health staffing at primary care level and the relationship between quality and level of staffing and attitudes towards participatory structures.
- Focus group and key informant interviews with health staff, managers, higher authorities, political authorities, local govt , HCCs, to explore perceived reasons for positive and negative impacts of the HCCs/ DHTs.
- Case studies on mechanisms used for inclusion of community priorities and their strengths and weaknesses

4.3   Underlying Factors

Analysis of
- The legal status and recognition of the committees (and their own awareness of this)

- o The cohesion and relations between various stakeholders in the health system, political, technical and community
- o The extent to which people with power are willing (and able) to use this for enhanced community role in health, including health staff and influential leaders
- o The cohesion, mandate and organization within communities and their awareness of their rights and obligations in health
- o The perception of public budgets, who controls them, whose funds they are perceived to be and what they are perceived to be for

This can be done through interviews and use of case studies.

It was noted that the steps need to be taken to consult widely and reach consensus, for validity of findings. The first phase results should thus be discussed with
- o Communities and HCCs in the study sites
- o Health workers and authorities
- o parliamentarians
- o Ministries of Health, Central Board of Health, Parliamentary committee on health, District health officials

The final phase of work will be disseminated through scientific publication.

The workplan is shown below: The Regional meeting is planned for sometime between January-June 2004. This will among other things discuss the next phase in the governance research agenda. A writers' workshop is also planned, to be held sometime between January and June 2004. The outcomes from these workshops will feed into the EQUINET workshop scheduled to coincide with the ISEqH[1] conference to be held in June 2004, in South Africa.

Month	Year	Deadline	Activity/ Actions
June	2003	Beginning	Next 45% Disbursement (based on satisfactory reports)
		End	Finalise phase one field work and analysis
July	2003	Beginning	Phase 2 research and Stakeholder meetings
July	2003	End	Multicountry analysis – TARSC/CHESSORE
June – August	2003	End	Fieldwork Submit draft reports on phase 2 work
September	2003	End	Feedback on drafts from reviewers Submit final financial reports
September	2003	End	Circulation and discussion of draft lit review from Godfrey Mubyazi
October	2003	End	Submit Final project reports
November	2003	Beginning	Final 10% disbursement on grant (on receipt of satisfactory reports)
Nov/December	2003		National dissemination meetings
Nov/December	2003		Multicountry analysis – TARSC/CHESSORE
Mar - May	2004		Write up for Publication of findings
Between Mar and May	2004		Regional dissemination meeting
June	2004		Writers workshop

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[1] The acronym ISEqH stands for the "International Society for Equity in Health".

Appendix 1: SUMMARY OF RESEARCH PROTOCOLS SUBMITTED FOR THE REVIEW

AREA	ZANBIA (INESOR)	ZAMBIA 2 CHESSORE	ZIMBABWE (TARSC/CWGH)
BROAD OBJECTIVE	To assess the effectiveness of District Health Boards (Dubs) in enhancing equity of access and community participation in the delivery of health care services in Zambia.	To assess the impact of the health system's governance mechanism on performance of the HCCs as well as how these mechanisms impact on the integration of community preferences in health planning, resource mobilisation and resource allocation.	To analyse and better understand the relationship between health centre committees as a mechanism of participation and specific health system outcomes, including Improved representation of community interests in health planning and management, improved allocation of resources to health centre level, to community health activities and to preventive health services and improved community access to and coverage by selected priority promotive and preventive health interventions
SPECIFIC OBJECTIVE	(i). Describe the status (responsibilities, functions and composition) of DHBs. (ii). Examine the form and relative strengths of information exchange mechanisms between DHBs and different key stakeholders (CBoH, DHMTs, NHCs, Community Development Committees (CDC) and the community) in relation to the delivery of health care services. (iii). Assess how the DHBs represent and respond to community interests. (iv). Assess the mechanisms and the extent of inclusion of community evidence in health service planning and resource allocation. v. Use results of the study to propose options for enhancing community representation in key areas of health service planning	1. To review and evaluate the role of HCCs in Zambia's health system in terms of their structure and relationships with other organs in the governance system. 2. To evaluate the performance of HCCs in relation to the promotion of equity of access to affordable quality care for all Zambians. 3. To identify the impact of socio-economic, political and cultural factors on the performance of HCCs 4. To identify and examine community perceptions on the role and benefits of community participation in the governance mechanisms of health system, and 5. To identify common positive features of governance systems that influence participation, priority setting and incorporation of community preferences into health planning, resource mobilization and	1. **Describe** the composition of the communities served by the health centres and their relationship to health service planning mechanisms at health centre and district level. 2. **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 3. **Analyse** the extent to which different sections of community members (men, women, youth, elderly) are aware of the role and functions of the NCC, perceive their health priorities to be taken up by the HCCs and perceive HCCs to be improving responsiveness of the health system 4. **Analyse** the form and extent to which community priorities are organised, presented and incorporated into health planning at health centre and district level. 5. **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. 6. **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 7. **Analyse** the perceptions of health service quality and

		resource allocation.	responsiveness in the different community groups and the extent to which gains or losses are linked to the HCCs.
DESIGN	Cross sectional descriptive survey	Case/control comparison through a single cross sectional survey. Comparison of 4 HCCs cited as successful with 4 'non successful' HCCs.	Case control comparison through repeated cross sectional survey to compare wards with and without HCCs; different types of community groups (between areas with and without HCCs) and time (before and after the HCCs were established / reactivated)
STUDY POPU-LATION	DHBs and HCCs and their catchment community in 20 districts urban and rural 4 districts per each of 5 provinces through stratified sampling and 1 DHB and 4 HCCs per district through statified sampling.	4 provinces with one HCC per province (successful case studies). 4 Equity Gauge districts for non successful case studies. Study will cover the HCC members, health personnel at HCC and DHT level, community members, traditional leaders, NGOs and data bases on HCCs.	4 districts with one case HCC and one control HC per district 8 HCCs and surrounding wards total Communities including subgroups of adult women, adult men, youth and elderly Nurse, EHT, community health workers, district nursing officers, district medical officers and local govt CEOs (6 interviews)
SAMPLE SIZES	20 DHBs and 80 HCCS No community survey	4 case HCCs, 4 control HCCs 70 households per HCC site – 560 in the 8 sites	4 case and 4 control HCCs 6 key informant interviews per district 960 people total, 480 each in HCc and non HCC wards, 120 each by group and by HCC presence disaggregated.
TOOLS	PRA focus group discussions with community and HCC members Structured questionniares – health staff district and province, DHMT members, DHB members Secinary data analysis through review of records – DHB records plans and minutes	PRA focus group guides for the community Checklists for Health Centre data Semi structured interviews for health personel, HCC personnel Informal interviews with health personnel, NGOs, traditional leaders	PRA community sessions Checklists for health centre and district data Key informant interviews Community questionnaire
OUTCOMES AND USES		Workshop with reps from all study sites Presentation of findings at national forums and university Book project	Workshop with reps from study sites Presentation of findings at national forums and university Publications
TIMING	3 months. Start date not specified	5 months. Start date not specified	I year, start date Oct 2002
BUDGET (Usd)	Above $20 000	$19 970	18 800

Appendix 2: AREAS FOR INCLUSION OIF COMMON INDICATORS IN ALL TOOLS

Areas were identified **prior to the meeting** from the tools submitted for possible inclusion into all country tools. These will be further developed by TARSC and separately reported on. The preliminary list of possible indicators and tool from which the indicator can be drawn is shown below (CH = Chessore; IN = Inesor; ZW = TARSC/CWGH):

⇒ **In the Community questionnaire**
- Changed perception of health (CH)
- Time to walk to clinic (CH)
- Use and coverage of services (ZW)
- Satisfaction with waiting time, staff access /treatment, drug access, referral (CH)
- Awareness of HCC (ZW) Representativeness of HCC/DHB (not well covered)
- Control of HCC/DHB of health staff (CH)
- Drinking water and toilet supply in household   (CH)
- Bed net supply and knowledge of bed nets (CH)

⇒ **In the PRA tool**
- Community mapping (Zw)
- Priority health issues (Zw)
- Satisfaction with waiting time, treatment by staff, drug access, staff access, referral (ZW but needs to be modified)
- Views on representativeness of HCC/DHB (ZW but needs to be modified)

⇒ **In the key informant interviews**
o HCC/DHB Relevance - Does it meet, impact on health expenditures, Perceived relevance by communities, clinic and district health staff (ZW)
o Relevance of HCC /DHB work to community priorities –impacts on quality of primary care services (adequacy of drugs and staffing, treatment by staff, service infrastructures, referral system); on water and sanitation; health outreach through health education and community health activities (None cover this well)
o Ability to influence health budgets – share of work impact/ inputs financed by mobilising community resources vs directing district resources, (noting poor communities do contribute but are resistant to increase contributions alone), changes made to resource allocations by HCCs, powers over hiring and firing of personnel (IN, ZW, needs to be discussed)
o Factors influencing impact
o Link between the community and the HCC/DHB – representativeness (esp of poorer groups), gender equity (IN, needs to be discussed),
o Information flow to and from communities and HCC/DHB (and role in accountability), (In) synergy in understanding of roles; (ZW, CH)
o Capacities of community, HCC members,   (IN)
o DHT support; attitudes of HCC members and DHT support; (None cover this well)
o Incentives for making HCCs effective (IN)

⇒ **In the checklist**
- Drug availability, Staff availability (None cover this well)
- Water and sanitation (ZW?)
- PHC coverage (ZW)
- Use and form of community evidence (None cover this well).
- Resource allocation (ZW)
- HCC/DHB functioning (IN)

Appendix 3: ACTIVITIES IN THE governance programme

In terms of common outputs of the GoVERN multicountry network (additional to the specific country outputs) the following were defined:

- A Position paper on governance, equity and health
- A toolkit on PRA methods for health
- A Regional dissemination workshop and report
- A Book project with an introductory chapter on the issues drawn from the background literature, chapters from each of the studies (including Tanzania) and a final summary chapter.
- Reports for the Equinet news letter, Governance e-mail
- Policy briefs for policy review
- Good practice briefs for training inputs
- Scientific papers in peer reviewed journals
- Training modules/materials for health workers.

To strengthen the national and regional work it was also discussed that the following skills and technical Inputs were needed:

- A literature Review on governance, equity and health (prepared through TARSC/CHESSORE)
- A PRA methods Training workshop open to other Equinet projects
- A Regional review meeting between phase one and two of the studies that brings in the study leader and one person from the programme / policy stakeholders
- A writers workshop, possibly with support from a journal like social science and medicine, to provide capacity support for production of papers for peer reviewed journals (using draft materials already produced by teams)

Appendix 4: INTERIM COUNTRY STUDY REPORTS

1. Title of Project
ASSESSING THE IMPACT OF HEALTH CENTRE COMMITTEES ON HEALTH SYSTEM PERFORMANCE AND HEALTH RESOURCE ALLOCATION

2. Project leader and email address.
   Dr Rene Loewenson (rene@tarsc.org), with I Rusike, Memory Zulu

3. Project objectives (one para)

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

4. Work done to date (half page max). This should indicate the methods used, the areas covered, the timing, the areas of the protocol completed and any problems / gaps / issues in the work done to date, strengths and weaknesses in the methods used.

   Community surveys were carried out in 3 Districts: Goromonzi, Makoni and Gweru District. as these areas had well established Health Centre Committees set up by the CWGH and were chosen for logistic access. In February 2003 cross sectional community surveys were done in the 4 districts sampled, covering HCC and non HCC wards with 30 people per community fraction (women, youth, 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. In February/March 2003 key informant interviews were conducted of nurse, EHT, community health workers, district nursing officers, district medical officers and local govt CEOs (6 interviews) on the HCCs role and functions, attitudes towards HCCs, inclusion of community priorities, impacts on resource allocation, and impacts on health care utlisation and perceived quality and responsiveness of health care at the selected health centers.   Key informant interviews were also be conducted of elected, traditional and and civic leaders on HCCs 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 centers. 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 HCc roles and effectiveness, inclusion of community priorities in health planning and perceptions of health service quality. 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.

All aspects of the work have progressed reasonably smoothly. The last stage on collection of health information and resource data is still in progress due to problems in accessing information in some areas (health personnel, fuel and other problems). The stakeholder meeting will be held AFTER the regional review meeting to take account of issues raised at that meeting.

5. Work outstanding on phase 1 work on outcomes and functioning, including national stakeholder discussion and proposed timing for completion. (half page max)

See above. This should be completed by June 2003.

6. Key findings from phase 1. This should list the major findings and conclusions drawn to date (one page max)

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

2. The communities in the survey are generally relatively well educate (secondary school) but have high levels of unemployment and unskilled labour meaning that the economic and professional resources available for health work is low.

3. People generally use their 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 work with them: highly vulnerable groups use traditional medicine; areas close to public hospitals may use these for primary care instead of clinics; urban and farm areas may 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 may not support the work of the HCC.

4. 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. Does this relate to resource levels or resource choices across different

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clinics and areas?

5. It does appear that areas with HCCs perform better on PHC statistics (EHT visits, ORS use) than those without, and that there is improved contact with the community in areas with HCCs. Which preceeds? Do good clinics with stronger PHC hace HCCs or do HCCs improve PHC? Need to do some historical analysis for this.

6. Communities in areas with HCCs have a better knowledge of the organization of their health services from the indicators assessed, making services more transparent to them. They also seem to improve the links with community for health workers, and make community issues more accessible to health workers.

7. Community health indicators (health knowledge, health practices, knowledge and use of health services) also seem to be higher in areas with HCCs than in those without Still need to do some of the stats significance testing on this. Again do HCCs improve awareness or do aware communities set up HCCS?.

8. These is some synergy between community, HCC and health service views of the priority issues facing communities, with stronger relationship between the HCC and community views, particularly in the two 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.. Need to relate these priorities DIRECTLY to budget allocations within districts – how much did they get relative to other areas?).

9. Within these areas there is evidence from community, HCC and health authority sources that the HCCs have taken up issues – on environmental health and service quality. Their primary mode of action seems to be more of an additional service outreach and link. They find out communitiy needs and organize service inputs such as drug purchases, building waiting mother 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 mobilize additional resources for health from community and other sources. Which roles have given the HCCs greater credibility with the different actors- their social mobilization role or their service delivery role?

10. However it does not appear that they have then been able to use this to leverage greater power over core health budgets, or to obtain greater authority in how their clinics are managed and run. In all areas these were aspects of health service functioning that both HCCs, communities and health authorities said that the HCCs had had little role in or impact on. This authority remains firmly within the health authorities, even in cases such as Mwanza where it is clear that there is significant initiative, capability and resources (possibly as much or more than what is in the health sector at the primary care level.   Why is this- is this a legal problem or a reluctance to share authority, or inconfidence in the community?

11. It would appear from the results that while the HCCs have been extremely successful –at least in two areas- in enhancing primary health care 'deliverables' and in health promotion It would   appear that there are some biases in the direction of how they are using their social mobilization roles. The community survey indicated that about 40% of community members knew about their HCC, which meant that 60% did not. At ward level this seems to signal that the HCCs relate well to particular subsections of the community, but have not been able to widely mobilize the whole community around issues or assume visibility for this role. This implies that their advocacy role is still weak. Why is this- is this a consequence of current political conditions? To what extent has views of the HCC - part of the health delivery system or part of the community – affected the strength of the HCc to act as vehicle of social pressure for community health priorities?

12. The HCCs have thus played little or no role in monitoring budgets or making services accountable on their 'policies and promises'. They have visited services and in one case are noted to have informed health staff when 'things were not right'. This is a somewhat tentative step towards public accountability. Ironically the one area that reported taking on accountability issues, Makoni around the AIDS Levy Fund, was the poorest performing HCC. IT seems the HCC took on this role with little or no communication to the community it came from and so was not able to build any social support for or force behind this role. Why do HCCs not play a stronger role in monitoring health providers?

13. The feedback from the field work indicates that communication is the area communities feel is the biggest limitation on HCC performance. HCCs themselves get no resource support for this role and note that they are poorly equipped with information for this role. Communities also judge the HCC effectiveness from 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.   It is not yet clear what impact this had on budget allocations from councils and health authorities to the clinics. Did it lever further funds or further weaken resource allocation to these levels. This needs to be explored

14. While the evidence indicates that they have proven effectiveness in terms of PHC indicators, they seem to be vulnerable to a number of issues: variable levels of communication and social mobilization, dependency on recognition by health authorities for their legitimacy, resource constraints in impacting on areas that are priorities for communities and lack of authority in areas that are important to direct resources towards community priorities. The health authorities clearly view the HCC as a source of community information and a resource for transmitting plans made within the health sector. This does not fundamentally transform the model of control and authority that in the literature review was noted to have led to the atrophy or collapse of the old ward health teams. Why do the old views continue to prevail – is this the case right to the top of the health system? Parliament?

7. **Key issues to be taken forward from phase 1 findings, proposed issues to explore in phase 2 and proposed workplan for phase 2 (noting the focus on power relations and challenges ahead)**

OUTCOMES MEASURED: POLICY/PERCEIVED AND REAL IMPACT

HCCS have probably enhanced community knowledge, PHC indicators, knowledge of health systems and use of health services. They have generally through their own resources improved quality of care and mobilised additional resources for this. The extent to which they have shifted the allocation of health resources to community priorities, and made services more responsive to community concerns is FAR less evident. *Have these gains been spread across all groups – women? Youth? Most vulnerable?*

PROXIMAL FACTORS: FUNCTIONING

HCCs have taken on their roles with little capacity support and weak formal recognition of or provision for their roles. Community support seems evident but in so far as the HCC delivers to the community, and less in terms of more direct community mobilization. Health service support is variable, and rooted in concepts of community- health service relations that have changed little since the 1980s. HCCs have enhaced bi-directional information flow and communication between communities and health services, but their communication links with communities are not inclusive or consistent, and the information they access from health services is limited mainly to health promotion roles. While HCCs provide information on community priorities to services, they are not given a role in decision making around those priorities and have to wait for feedback from health or local authorities. Neither are they monitoring health plans and spending. They receive minimal resources for their functioning, including training or operational resources.   They have however been able in some cases to mobilize their own resources from communities to implement community priorities. *These issues around functioning need to be further discussed with stakeholders together to see how they see them.*

UNDERLYING FACTORS: POWER AND AUTHORITY

The HCCs suffer from lack of clarity on their formal authority. While new laws have been brought in to govern the functioning of structures to district level, nothing stipulates functioning at clinic level. Also changes in local government law and political conditions have led to some confusion on old and new roles. *This needs to be explored. Why have clinic level mechanisms not been provided for in law as all other levels have? Why are clinics not cost centres for Ministry of Health? How have the legal and practical relations between elected local authority powers and health authority powers in law and in practice affected the difficulty in defining the role and powers of the HCC? . What does this imply?*

UNDERLYING FACTORS: POWER AND AUTHORITY, CONTINUED….

The real level of community mandate; ownership, purpose and cohesiveness in relation to HCCs needs to be further explored. *How do communities see the different roles of health service extension vs community advocate and mobiliser? How do communities perceive issues of public accountability, in what, and with what role for the HCC? Where do communities see the real resource constraints in meeting their priorities and what mechanisms do they have for addressing these that will work? What does this imply for the HCC?*

Health sector personnel appear to have a cautious positive response to the HCC. They have largely left the HCC out of decision making and used them as a conduit for PHC. *How does this relate to how the health sector makes clear and manages the technical vs political choices in resource allocation and health programmes? How far is the health sector able to accommodate more participatory forms of health planning and why? Is health likely to be a place where changes in the state take place that widen real participation and why? What implications does this have?*

2: INESOR ZAMBIA

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

Specific Objectives of the study are to:
- (i).   Describe the status (responsibilities, functions and composition) of DHBs.
- (ii).   Examine the form and relative strengths of information exchange mechanisms between DHBs and different key stakeholders (CBoH, DHMTs, NHCs, Community Development Committees (CDC) and the community) in relation to the delivery of health care services.
- (iii).   Assess how the DHBs represent and respond to community interests.
- (iv).   Assess the mechanisms and the extent of inclusion of community evidence in health service planning and resource allocation.
- (v).   Use results of the study to propose options for enhancing community representation in key areas of health service planning.

Work done to date.
The tasks completed and to be completed will be discussed in three parts, data collection, data entry and analysis in reference to each of the study tools. There were six tools used in this study, namely questionnaire for (i). NHC and HCC members, (ii). DHMT and DHB members, (iii).   Provincial health Officers, (iv). Community survey, (v). FGD Guide for community and (vi). Checklist for DHMTs and DHB records

(i).   Data collection.
 The Data collection has been completed in all the four districts namely; Livingstone, Monze, Luangwa and Lusaka for the NHC, HCC, DHMT/DHBs and community survey as well as FGDs.

(ii).   Data Entry.
The data entry has been completed for (i) Community survey (ii) NHC and HCC members. The data entry remaining is for the DHMT/DHB and the Provincial health officers.

(iii).   Data analysis
Preliminary analysis is done for the quantitative and qualitative data collected using (i) community survey, (ii) FGDs and in-depth interviews.

Work outstanding on phase 1
The remaining tasks are data entry for DHMT/DHB and the PHO as well as analysis for the remaining qualitative and quantitative data. The discussion with national and other stakeholders will take place towards the end of June 2003. These tasks will be completed by mid July 2003. Then the final report can be ready by 25th August 2003.

Key Findings and Conclusions from phase 1.
Major findings of this study include that:

High political will and government commitment
There is a political will towards the establishment of DHBs. The government of Zambia is committee. At the time of the study, a lot of resources and effort were going into establishing the DHBs, training manuals/guidelines are developed and provincial orientation courses are being conducted for new and re-appointed board members. In one of the study sites (Monze district) fieldwork had to be re-scheduled because all board members were out of the station attending the orientation course. Political will is also demonstrated by the involvement of the Office of the President in screening of candidates so that only men of integrity represent the community/sit on the boards.

Concept of partnership understood and welcome by the community.
The concept or sprit of partnership is well entranced in the community. Generally, the community feels that they need to participate in health care delivery but what is missing is the mechanism of translating this sprit into reality.

Low Knowledge about DHBs among the community.
Generally, the community is not aware of the existence, formation and or functions of the DHBs. To underscore the point, DHB members also admitted that have limited interactions with other community based structures and the community. They reported that their interactions are limited to officiating special functions at HCs. Lack recourses were reported as the main limitation. However, community members are aware of the other lower level structures namely HCCs and NHCs. The former were the most widely know structures. And more interactions were reported between the DHB and DHMT in Lusaka than in other districts. In general DHB members and DHMT staff are aware of the expected roles of DHBs.

There **is limited community involvement in health planning and delivery.**
The general community is not involved in the selection of DHB members; they did not even know the criteria or procedures for selecting DHB members. Even some senior DHMT staff expressed ignorance about how DHB members were identifies and appointed in their own districts At the provincial level in Livingstone, the absence of an electoral college to identify potential individuals to sit on the DHBs was seen as a gap that facilitates DHMTs to target influential people for recommendations and appointment as DHB members.

DHBs are not effective in carrying out their functions
According to reports from DHB members and DHMT staff who participated in the study, DHBs, are not effective in carrying out their functions mainly due to: (i). reported lack of resources, (ii). some of the DHBs in the study sites were dissolved in the past mainly because of political interference and (iii). were just being revived at the time of the data collection and limited technical capacity to have meaningful input into different processes such as review of plans and budget. However, in all the study sites, DHB members and DHMT staff interviewed, indicated that they participate in approving and or disapproving of district health plans and budget because this only involves. This is mostly because this involved inexpensive meetings, which also attracts sitting allowance. And the since the community are not aware of the existence of DHBs, they could not comment on their functions.

Inclusion of community evidence in health service planning and resource allocation
Current national procedures for developing district health plans allows for community input/ evidence in health care planning and resource allocation. District health plans

are supposed to begin from NHC level, which is the lowest functional unit. From NHC level, draft plans are submitted to the HC level, where they are aggregated and forwarded to the district level for consolidation.

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

(I)   At NHC level, full participation of ordinary community members is not assured,
(ii)   Once the plans are submitted to the district level, the district is at liberty to make changes and decisions (i.e. exclude or include some of the activities identified at NHC level) without giving adequate feed back and consultation,
(iii)   Board members especially those drawn from NHCs with limited technical capacity and social standing in the community feel not empowered to challenge the decisions/actions of the DHMT,
(iv)   Although the district health budget includes a 5% for community projects, this is rarely used, because the community/NHCs do not have adequate capacity to develop fundable projects and others do not know about this provision.

The link between DHBs and community is week.
The necessary linkage in terms of structure is assured. However, there is a major breakdown between the DHBs and the community and the HCCs and NHCs. There is no formal system of communication between DHBs and the communities they represent. In addition, the NHC members who are in the HCCs do not effectively report back to the NHCs they represent.

RECOMMENDATIONS:

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

Therefore, the selection and appointment procedures need to be reviewed in favour of general community members and women.
In general, DHB members and DHMT staff are aware of their expected roles but not functioning effectively.

  DHBs, need more leadership training and exposure beyond the initial course.
The framework for linkages between different structures exists. However there is no defined mechanism for how the information (as in reports and feedback) should flow between the community and various structures created to represent them.

There is therefore, need to review current communication system between and within structures and between structures and community in view of developing more responsive system of communication.
In general, the community is not well informed about their roles and their place in health planning and delivery, and the linkages between various structures making their participation difficult.

There is a need to develop well-tailored community sensitisation and education about

community structures and their roles to facilitate mere interaction between the community and DHBs and other structures.

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

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

5.   Key issues to be taken forward from phase 1 findings, proposed issues to explore in phase 2 and proposed work plan for phase 2 (noting the focus on power relations and challenges ahead). Issues for follow-up in phase II will be determined when the data analysis is completed.

CHESSORE ZAMBIA

**Project Title: Assessing the Impact of Health Centre Committees (HCCs) on
                       Equity in Health and Health Care**
Project Leader: Dr T. J. Ngulube and Mr Laxonie Mdhluli

 Key Area of Interest and Rationale:
 Any critical evaluation and assessment of Zambia's current health system should have some emphasis on understanding the role of HCCs and their impact on the various aspects of the health system reforms. There is need for a critical analysis of how the assigned and assumed roles of the HCCs relate to such aspects of the health system as equity and quality of care.

 Project Objectives
 This study will focus on assessing the performance and effectiveness of 8 HCCs (in 8 districts[1]), out of which there will be 4 case studies where some significant successes in various aspects of the health system had been noted[2]. There is also a corresponding number of HCCs that were not rated as 'successful' in the way they implemented their assigned roles. Hence the **major objective** of this study is to assess the impact of the health system's governance mechanism on performance of the HCCs as well as how these mechanisms impact on the integration of community preferences in health planning, resource mobilisation and resource allocation.

 The Specific objectives of the Study are to:
1. To review and evaluate the role of HCCs in Zambia's health system in terms of their structure and relationships other organs in the governance system.
2. To evaluate the performance of HCCs in relation to the promotion of equity of access to affordable quality care for all Zambians.
3. To identify the impact of socio-economic, political and cultural factors on the performance of HCCs
4. To identify and examine community perceptions on the role and benefits of community participation in the governance mechanisms of health system, and
5. To identify common positive features of governance systems that influence participation, priority setting and incorporation of community preferences into health planning, resource mobilization and resource allocation.
6. To use the results of the study to build and enhance stakeholder understanding and action of their roles/ functions.

The Conceptual Framework and Key Research Questions in the Study

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[2] Issues and areas to be included in the assessment include (a) The general governance and management of the health system; (b) The integration of community preferences in the health planning process; (c) The mobilisation of resources for the health sector; (d) Allocation of resources to identified priority preference areas including for primary care and public health; (e) Issues of accountability and transparency in the health care system; (f) The general promotion of equity in the health care system.

The following are the research questions that this project work seeks to answer.(a) How do the structures of the health centre committee relate to other organs of governance in the health services?; (b) How do socio-economic, political and cultural factors impact on the performance of the health centre committee in terms of effectiveness and potential for sustainability; (c) How has the existence and work of HCCs impacted in fulfilling the government desire to attain equity of access to cost effective quality care as close to the family as possible for all Zambians?; (d) How do communities perceive the role and impact of HCCs on governance in the health system?; and finally, (e) what are the common features that positively influence community participation, priority setting and incorporation of community preferences into health planning, resource mobilization and resource allocation?

Work done to date
The research team has managed to administer the research tools[3] at 6 of the 8 selected HCCs in the country. Of the 6 HCCs studied so far, 2 were from the well performing group and 4 from the poorly performing group.

Data Collection is thus incomplete and comparisons in performance will be made between these two categorizations of the health centre committees studied.

Data entry and Analysis
This has been done for the data collected and the first data cleaning phase completed while secondary cleaning in terms of actual logical correlations with other tools is in process and going along with report writing phases. Discussions sessions have been entered into a computer word processor programme for storage and analysis

Outstanding Work from Phase 1
Two main pieces of work remain to be done. We need to complete data collection in the remaining 2 districts. In addition to this, we shall call for a stakeholder meeting to discuss the findings as well as to get further input from stakeholders and thereby validate our findings, conclusions and recommendations. We anticipate that this will be complete around October. The stakeholder national sessions cannot take place now or in the next 2 months because rural stakeholders need to be given time to harvest and store their produce. However, the next 2 months will be used to complete data collection in the 2 districts.

Key Findings and Conclusions from Phase 1 Work

The following are the key findings from this work so far.

High Political (Government) commitment - The structure set up for community participation at health facilities in Zambia are still in place and functioning with varying degrees of performance. Government commitment to the committees has been sustained as evidenced by actual budgetary allocations from central levels.

Control of Resources for Health: Different committees have achieved different successes in accessing the above financial resources from government. In general, the

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[3] The research tools comprised of a Community Questionnaire, A key Informant Interview guide, A PRA tool, A FGD Guide and A Checklist.

high performing committees have secured access to these resources while the low performing ones have not.

Overall, there is still a division in areas of influence such that health centre based activities and management of resources is for and by health workers while community based activities and those resources generated by community representatives fall and the control and management of the health centre committees. The committees have still not succeeded to hold the health services accountable for resources at local health centres.

Participation in the Planning Process: As things stand now, the participation of community committees in the planning process is a one-way affair. Generally, the committees are called and involved to fulfil the planning guidelines through their participation. The input of communities into the plans is variously blocked by the health system, who preferred to put forward and stress the importance of making sure that health facility-based activities are funded preferentially, usually to the exclusion of community preferences as funding ceilings are exceeded. The fact that the health centre in-charges (alone) were the ones who went and were briefed on guidelines and expenditure ceilings for the forthcoming planning cycle ensured that the committees remained excluded from effective participation. In addition to these shortcomings on community participation and control of resources in health, the committees were not required for any amendments that arose if budget cuts were required of the budgets submitted. The revisions were made administratively without consulting the community representatives. And finally, when the budgets were approved and funds released, there was no requirement for community involvement, either when securing funds from the DHMTs or in spending. Hence many committees were unaware if funds for plans made had arrived and whether these funds were spent accordingly as per plans. In the well performing committees, the arrival of any funds from higher authorities was known by the regularity with which their government-mandated 10% community participation fund was disbursed to them by their local health centre in-charges. Other than for this, the committees were ignorant on how resources for health at their local centres were allocated and utilized.

Participation in Community Activities: Both the committees and health agree that they cooperated on some community health activities, such as health education and holding of outreach activities for health promotion and services. The community appreciated the role the committees were playing on health, but they needed to do more in order to satisfy the majority in the community in terms of their relevance to community health needs. Otherwise there were some in the community who regarded the role of the HCCs and NHCs as hopeless or ineffective.

Overall Performance rating and Impact of HCCs/NHCs: It is clear from this study that the HCCs/NHCs can have an impact and sustain this. In 1997/98 two studies undertaken gave the impression and basis for better performance of 4 of the HCCs selected in the study. We have evidence that for 2 of these where this study has been completed, these committees continue to do well and are generally appreciated in their communities for the services they do as well as by the health centre staff who spoke highly of them. This was despite the prevailing status quo of "none interference in each other's affairs". The two exist and are gently charting the common areas of cooperation to their mutual liking as opposed to what was contained in the national guidelines. Perhaps this stage forms a mutually acceptable starting point for sustainable.

An overall assessment of the performance of the HCCs/NHCs between the two categories identified in or study is given in a tabular form below.

A SUMMARY OF FACTORS UNDERLYING THE POTENTIAL FOR THE POOR (LOW) AND WELL (HIGH) PERFORMING HCCs / NHCs

<u>**HIGH PERFORMANCE HCC HCCS**</u> <u>**CHIVUNA AND KANYANGA**</u>	<u>**LOW PERFORMANCE**</u> <u>**MUCHINCHI, MBABALA, KAUNDA SQ, KANYELELE & CHAWAMA**</u>
<u>**SELECTION**</u> - Publicity voted by Community - Autonomous	<u>**SELECTION**</u> - Some voted, some appointed - Usually dictated to by higher authority
• <u>**EDUCATION**</u> - All educated, retired govt. workers - Able to understand issues issues	<u>**EDUCATION**</u> - Mixed, Low education, illiterate - Have difficulty to understand
• <u>**COMMUNITY RESPECT/REGARD**</u> - There's sense of HCC ownership by Community - Community is supportive of programmes	<u>**COMMUNITY RESPECT/REGARD**</u> - Little known – referred to as '**their HCC'.** Low co-operation - '**HCC** programmes'
• <u>**ATTITUDE TOWARDS COMMUNITY COMMUNITY**</u> - Positive, … 'HCCs are our good people' around'	<u>**ATTITUDE TOWARDS**</u> - Negative 'HCC are difficult people
• <u>**POLITICKING/TRADITIONAL/HEALTH STAFF INTERFERENCE INTERFERENCE**</u> - Low (Non-existent) interference interference	**POLITICKING/TRADITIONAL/HEALTH STAFF** - High politicking and other
• <u>**CONSTITUTIONAL/LEGAL BASIS**</u> - Not clearly explained - Don't know	<u>**CONSTITUTIONAL/LEGAL BASIS**</u> - Completely no idea - Don't know
• <u>**FREQUENCY OF MEETINGS**</u> - Consistently meet	<u>**FREQUENCY OF MEETINGS**</u> - Highly inconsistent (almost none)
• <u>**DRUG AVAILABILITY**</u> - Said to be often available - Drugs under strict monitoring and control days of arrival - Drugs Issuance only by chart	<u>**DRUG AVAILABILITY**</u> - Said to be often out of stock - Said to disappear within - No issuance procedures
• <u>**DRUG PILFERAGE**</u> - Low complaints generally - Difficult due to control mechanisms in place control mechanisms	<u>**DRUG PILFERAGE**</u> - High complaints in community - There are no

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- **<u>SPIRIT OF VOLUNTARISM</u>**
- High commitment

<u>SPIRIT OF VOLUNTARISM</u>
- Low commitment

HIGH PERFORMANCE HCC HCCS	LOW PERFORMANCE
CHIVUNA AND KANYANGA	**MUCHINCHI, MBABALA, KAUNDA SQ, KANYELELE & CHAWAMA**

• **BY-DIRECION INFORMATION FLOW FLOW**	**BY-DIRECION INFORMATION**
- From Top (HCC/DHB) to bottom and (HCC/DHB) to the top	- One-Way flow from top from bottom to bottom with no bottom up
• **HCC – INCENTIVES**	**HCC – INCENTIVES**
- Lead by example – they pay first existed	- User fee exemptions for members
• **INFRASTRUCTURE**	**INFRASTRUCTURE**
- Pleasant outlook	- Dirty building
- Well maintained	- Unattended to
- Repairs done	- No repairs to infrastructure
• **STAFFING LEVELS**	**STAFFING LEVELS**
- Low (staff shortages)	- Low (staff shortages)
• **STAFF QUALIFICATIONS**	**STAFF QUALIFICATIONS**
- Good academic)	- Poor (both professional &
- Low absenteeism of staff (shortages)	- High absenteeism levels
- Mostly trained staff	- Many Untrained Staff
• **COMMUNITY/OUTREACH**	**COMMUNITY/OUTREACH**
- High engagement with community engagement	- Very low (- non-existent)
• **HCC DESIRED INCENTIVES**	**HCC DESIRED INCENTIVES**
- Transport – bicycles	- Transport – bicycles
- allowances (monthly)	- allowances (monthly)
- Exchange visits HCCs	- Literature of roles and functions of
- User fee exemptions (where it is not effected) exemptions (if not done)	- HCC User Fee
- Support Literatature on roles and functions of HCCs	
• **RECOGNITION BY HEALTH MGT. MANAGEMENT**	**RECOGNITION BY HEALTH**
- Recognized by existence only	- Recognized by existence only
• **CONTROL OVER HEALTH RESOURCES HEALTH RESOURCES**	**CONTROL OVER**
- None	- None
• **HCC – FUNDRAISING ACTIVITIES GENERATION**	**HCC'S OWN INCOME**
- Farming – maize – beans	- None
• **COMMUNITY KNOWLEDGE ABOUT HCC ACTIVITIES**	
- High	- Low

HIGH PERFORMANCE HCC HCCS CHIVUNA AND KANYANGA	LOW PERFORMANCE HCCS MUCHINCHI, MBABALA, KAUNDA SQ, KANYELELE & CHAWAMA
• **DECISION MAKING PROCESS**	**DECISION MAKING PROCESS**
- Health staff lobby HCC views	- Health staff tend to impose own
- Consensus tolerated	- Divergent views generally not
- Democratic	- Authoritative tendencies
• **HCC – REPRESENTATIVENESS**	**HCC – REPRESENTATIVENESS**
- Excludes the youths	- Excludes the youths
- Excludes the disabled (especially the blind) disabled (esp. the blind)	- Excludes the
- Excludes some civil servants servants	- Excludes some serving civil
• **HCC – KNOWLEDGE ABOUT POSSIBLE KNOWLEDGE ABOUT POSSIBLE MONTHLY CASH ALLOCATION**	**HCC –** **MONTHLY CASH ALLOCATION**
- Know about funds that are allocated DHMT from DHMT (figures are mentioned)	Not told of any funds that come from
• **HCC – and Fees EXEMPTION POLICY EXEMPTION POLICY**	**HCC – and Fees**
- No exemptionsfor HCC members (lead by example) accorded to HCC members	- Exemptions
- All service user must pay community)	- 10% of user fee (not given to
- From User fees community gets K300,000 monthly available. (twice as much as stipulated by the 10% guidelines on fees in addition to the 10% of the monthly grant for community activities).	even if

Poverty, Equity and Governance in Health

The high poverty level situation experienced by both the health workers and the community have made the spirit of volunteerism that much difficult to bear for either party. The desire to overcome the poverty effect by taking advantage of any opportunities existing in the process of community participation mechanisms have led many stakeholders put their personal gains above any other. This has made it difficult for communities to see many of the desired benefits from the policy of community participations. None of the stakeholders entrusted with the task of safeguarding community interests and preferences felt duty bound to persevere and overcome any hurdles that came their way in order to do these. The lack of supportive supervision made this task that much more difficult to accomplish effectively.

Recommendations

The following are the recommendations from this study

1. Governance on issues of health at local health facilities is possible and some capacity exists to bring this about.
2. In order to improve on governance there will be need to undertake three kinds of capacity building programmes, one for the community and another for health workers. The third kind of capacity building approach needs to be joint health worker and community programmes. In both cases, there is need to impart both knowledge and understanding of roles and responsibilities to each party, separately as appropriate and jointly as appropriate. In particular, community leaders need some knowledge on how to engage the health system in a meaningful and sustained manner to bring about some desired changes.
3. The DHMT officials need to play a greater supervisory role on linkages between the community and their local health facilities. It does not help the policy of community participation if the DHMT limits their role to working with and meeting only the health workers. This kind of situation has left the community feeling helpless and hopeless when they faced difficulties with local health centre in-charges.
4. The findings from this study need to be fed to higher authorities at the level of the ministry headquarters and the central board of health with a view to highlighting strengths and weaknesses in the current approaches to community participation. There is need to revise current guidelines on community participation and make them more appropriate to meet the prescribed tasks.

The potential still exists in the current structures for enhancing community participation and governance in health.

Key Issues to be taken forward from the Phase 1 findings
The key issues to be taken forward from this study will become clear after the study is complete. But at this point, it is recommended that a community action and empowerment programme is necessary as a way to build and strengthen community capacity to participate in governance in health. An action needs to be worked out, based on the strengths and weaknesses highlighted. Similarly, a programme to systematically alter health worker attitudes and (mis)perceptions on community participations and governance in health needs to be considered and implemented. The specifics to these issues will become clear after validating the findings following the holding of the forthcoming stakeholder meeting in the next phase of this project work.

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[1] The 8 Districts and the target HCCs to be included in the study are: Lusaka (Chawama and Kaunda Square Clinic HCCs), Mazabuka (Chivuna RHC HCC), Choma (Mbabala RHC HCC), Chama (Kanyelele RHC HCC), Lundazi (Kanyanga RHC HCC), Chingola (Muchinshi RHC HCC), Shang'ombo (Sinjembela RHC HCC) and Chinsali (Mulanga RHC HCC).