

Impacts of participation and governance on equity in health systems: Report of a research review meeting

EQUINET / TARSC / CRESSORE /CWGH / INESOR
In collaboration with IDRC (Canada)
Harare, September 28 2002



*Produced by R Loewenson, T Chikumbirike TARSC as a report of the Governance Research meeting, Harare, Sep 28 2002. This document has **five** sections:*

1. **Background and framework:** *The background to the work that sets out the steps, identified institutions and links, agreed goals, research questions and methods that guide the governance work.*
2. **Feedback from the pilot:** *Information arising out of the pilot work carried out in Zambia and Zimbabwe is reported, with key areas of learning from the pilot. A broad framework finalised at the meeting for the multi-country work is reported.*
3. **Review of the proposals:** *The section outlines the submitted proposals and research tools and changes agreed at the meeting.*
4. **Follow up:** *Logistic, timeline and administrative information about the next stage of GovERN and cross cutting issues for strengthening the multi-country work*
5. **Links with Municipal Services Project.** *A summary of the key areas for potential co-operation between Equinet GovERN and MSP.*

1. BACKGROUND:

From work to date:

- Equity includes the extent to which communities have the power, capability and means to take **control** over the resources for health.
- The TARSC research in 2000 on governance and health using PRA approaches; TARSC/ WHO / CRESSORE regional meeting on participation in health and Jan 2001 EQUINET SC identified the need for work to
 - ✓ **Develop tools and materials**, including guidelines to PRA methods for obtaining and organising community inputs to health planning; for community monitoring of quality of care; guidelines, norms and standards relating to participatory structures and their functioning; and training materials for health workers and communities on participation and health.
 - ✓ **Develop skills / capacity** to support participatory mechanisms, particularly in district health teams and community members.

- ✓ **Research** the impact of mechanisms for community participation in the health system on effective integration of community preferences in health planning, and on mobilisation and allocation of health sector resources for the health priorities of low income communities
- The GovERN network was set up in Jan 2002 co-ordinated, by TARSC Zimbabwe (Dr R Loewenson) and CHESSORE Zambia (T J Ngulube). Teams were present from Zambia (2), Zimbabwe, Tanzania and Mozambique.
- The 2001 Zambia meeting defined priority issues for GovERN research as:
 - 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?
- It was agreed that ALL research should include a number of these research questions, while the research work jointly should aim to address ALL the questions. Important **context** issues to be included in the background to ALL the projects were agreed to be:
 - ✓ Policies on participation and policy debates.
 - ✓ The legal framework.
 - ✓ The identified key equity issues in health system and resource allocation that may be a focus of attention in participatory structures
 - ✓ The structures and key roles of the mechanisms for participation in health and government
- The first regional workshop observed the need for rigour and clarity in:
 - Definition of the 'community' (geographical, social, demographic, political and cultural profile).
 - Who participates
 - What information flows between committees and communities and how
 - What information and evidence is used by committees
 - Interactions between community personnel and health service personnel
 - Areas of authority of community structures
 - Indicators of 'success' in participation- process or outcome or 'process outcome'?
- Possible research methods were noted to include community profiles, stakeholder analysis, systematic client consultation, beneficiary assessment, participatory / rapid appraisals, process monitoring, sentinel Site Surveillance and questionnaire surveys
- Prior research has judged resource allocation in terms of equity, necessity, effectiveness, value for money efficiency, dignity, need and solidarity, fairness and consistency with community values and priorities. It is necessary to be clear what criteria are being used.
- Criteria used to assess financing outcomes or goals need to be made clear – whether in terms of total resources raised, equity in financing (payment based on ability to pay), equity in access (access to resources based on need), community influence on resource use and so on.
- Health system performance criteria also need to be clear, whether in terms of goal attainment (improving health, responding to peoples expectations and fair financing); assessing the responsiveness of health systems to communities; and assessing the utilisation of health services.

By September 2002 pilot research had been done by Zambia (2) and Zimbabwe (1) and research proposals for research submitted. A concept paper was submitted by NMRI in

Tanzania on possible linked work with the network and a broad proposal submitted by ACCORD. The meeting was thus held to review the learning from the pilot and the research proposals submitted and finalise the country and multi-country dimensions of the GovERN research programme. The meeting involved TARSC Zimbabwe / regional (R Loewenson, T Chikumbirike); CHESSORE Zambia (TJ Ngulube) CWGH Zimbabwe (I Rusike) INESOR Zambia (M Macwan'gi).

2. FEEDBACK FROM THE PILOT

The meeting reviewed the findings of the pilot work. The pilot proposals gathered evidence on field issues, stakeholder views and tested the tools.

2.1 INESOR Zambia

District health boards did not function for two years but business went on as usual – what does this imply? Why were they dissolved? The eligibility for membership of Boards is not clear to communities and the CBOH guidelines may not adequately represent communities. The powers and authorities of the boards over the DHMT and health programmes are not clear, nor is it clear how the Boards were appointed or who the Boards are answerable to or monitored by. Conflict existed between District Health Management Teams, the management teams thought that the Health Boards were not necessary. Women are not adequately represented on Boards and Board members do not have adequate incentives for their work. Information flow between Boards and community is vital, but weak mechanisms are provided for this and improvements could be made on information flow. The pilot found that these issues were uniform across districts..

Stakeholder views were that functioning of District health boards needs to be assessed in terms of whether they meet, what they achieve, what difference it makes whether they are there or not and how they can be secured. Are the CBOH guidelines representative of communities? Do the boards have the capacities for their roles and do the District health teams and communities have the knowledge and capacities to make the inputs required of them by the Boards? What are the boards powers, who are they accountable to and monitored by? How can information flow to and from Boards and communities be improved? How can gender equity on boards be improved, and how can incentives for participation in boards be strengthened?

2.2 CHESSORE Zambia

Health Centre committees (HCCs) were created by law 6 years ago. The background pilot survey found that clinics are accessible to most people (75%) but that a quarter rated services as bad or very bad. People are aware of their Neighbourhood health committees but are not entirely clear of how they are elected, their tenure, their roles, especially as initiators of health programmes or as representing community views. The Health management board had no idea how the HCC functions. Health Management were found to get issues to be addressed from Health staff not from the communities. HCCs are less well known, as are their roles. People felt HCCs were good at solving problems due to real activities implemented and for their health education work and supervision of community health workers but communities were resistant to HCCs collecting money from poor people and felt that HCCs should focus on making health services more efficient and effective in terms of drug supplies, confidentiality, staffing, fee barriers, and investment in health facilities. It was noted that HCC members are voluntary and that this also imposes a load

on them. Health centre committee members expected some form of remuneration for the work they do. It was also felt that they lack mechanisms for adequately getting information from communities and thus make individual decisions.

Stakeholders were concerned about reasons for weak community participation in budgeting process through HCCs/ NHCs, weak flow of information to and from communities and HCCs/NHCs and gaps between different fractions of the community (skilled and unskilled).; levels and roles of community participation in HCC activities including budgeting and planning and factors influencing this, including SE factors and rewards to HCC members. Concern was also expressed about rural/urban differences in HCC/NHC coverage.

2.3 TARSC/ CWGH Zimbabwe

Past evidence highlights that Health Centre committees and other structures have been ad hoc and sometimes inconsistent and without real impact in resource allocation, even while community participation is a central policy. HCCs have had a visible positive impact in some areas- eg mobilising additional resources, improving security of health institutions, referring deliveries to clinics and building waiting mother shelters. Organised mechanisms like the CWGH are needed to take this further. This enhances collective efforts, avoids unnecessary service duplication and produces tangible and relevant gains. Is the HCC understood at the district level however for supervision and support. At present the HCCs do not know about budgetary resources and how surpluses can be used. The HCCs involvement in health annual plans was not clear. The HCC is worried about the HCC structure set out by the government. The pilot that the HCC expected some incentives for the work they are doing.

Stakeholders noted that community control over health services means community diagnosis, community identification of solutions, community monitoring and community protection of their services and rights. What are the perceptions of district level personnel of the HCCs and their role and members? How effective is the district support and supervision of the HCCs? Need to look at the impact of HCCs on quality of care – staffing, essential drugs, accessible services, trained personnel, referral system and waiting time. Also need to assess their performance in whether water and sanitation is improving and whether communities are more actively participating in their health care, especially budgeting and evaluation. Do the HCCs keep records of their work and are their plans integrated into the DHT plan?

2.4 Common issues to carry forward:

The pilot was felt to be important for a number of reasons

- It enabled tool development and assessment of availability of survey information
- It clarified issues and questions and brought a clearer picture of the current situation
- It refocused the thinking and approach, although without making major changes to approach
- It opened stakeholder dialogue.
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The Issues raised were found to be similar across districts enhancing the representativeness of a sample survey.

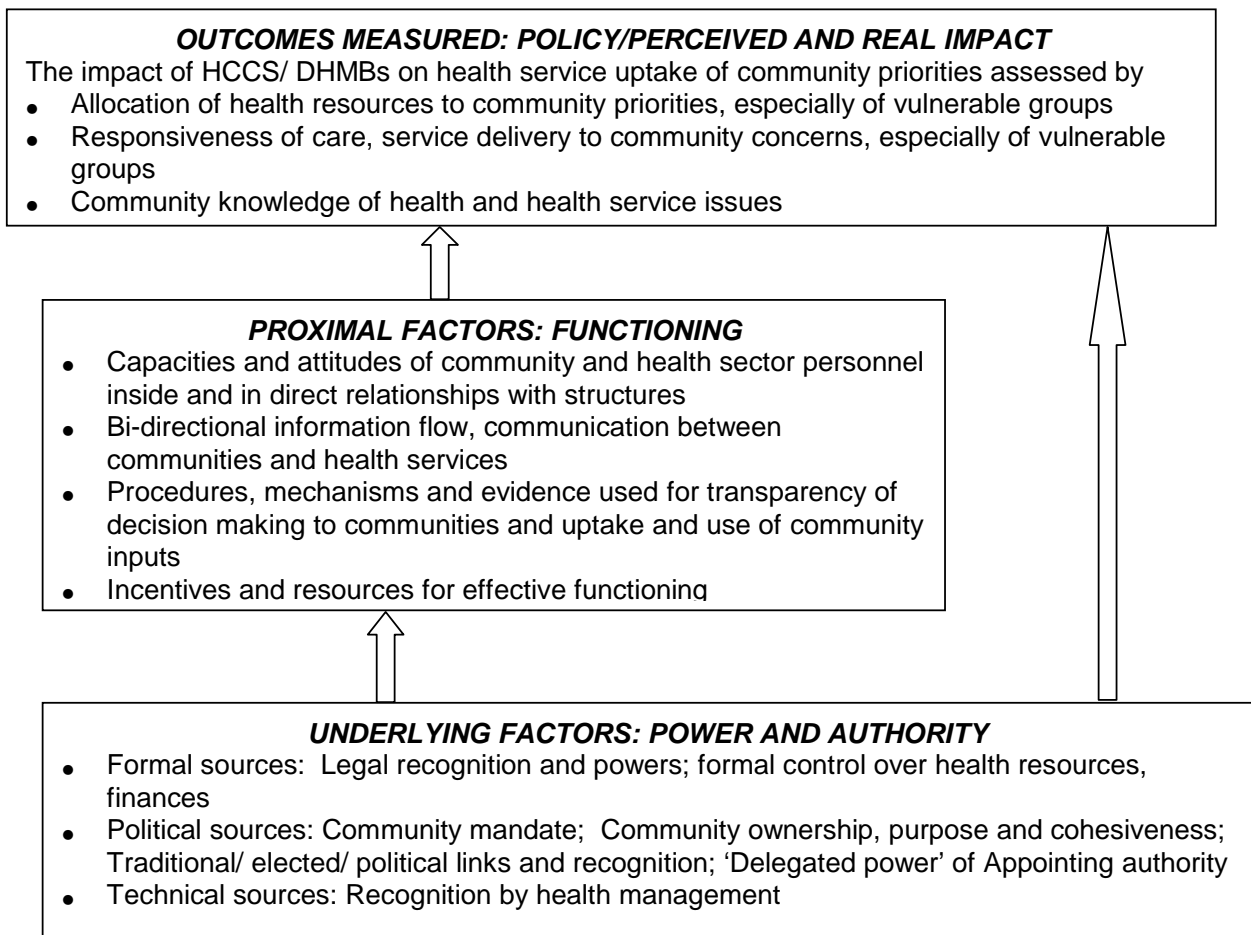
The pilots indicated that Boards and HCCs are not functioning or functioning in an ad hoc manner in both countries. Some of the factors found to be related to their poor functioning

were

- Weak or ad hoc information and communication channels to community and health staff and weak relations with health service management
- Unclear authority and powers, particularly in relation to annual plans and budgets for wards or districts
- Knowledge gaps in board members.
- Distorted gender representation with few women on boards.
- Inadequate formal recognition of structures
- Inadequate formal recognition leading to poor provision for HCC payment or incentives weakening community commitment.
- Variable performance of HCCs with some successes in terms of health service improvements

The meeting discussed the findings of the pilot in terms of the general implications for the research framework. It was noted that while the initial aspiration of the work was to assess the impact of functional HCCs on responsiveness of health resource allocation and health service performance to community priorities, the poor functioning of many HCCs/DHMBs meant that greater focus should be given to examining factors identified to be important for their functioning. Further the pilot indicated that while impact could be partially explained in terms of functional strengths and weaknesses, there were underlying factors relating to the distribution of formal and informal forms of power and authority that affected both functioning and impact of these structures.

The **conceptual model for assessing governance as a contributor to health equity** underlying the multi-country programme was thus summarised as below:



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

It was agreed that this model will guide the framing of proposals and analysis of the findings to understand both whether the HCCs/DHMBs are having an impact on health equity and to understand the impacts (or absence of impacts) found.

3. REVIEW OF THE PROPOSALS

The three proposals were submitted before the meeting. Table 1 highlights features of all the submitted study protocols.

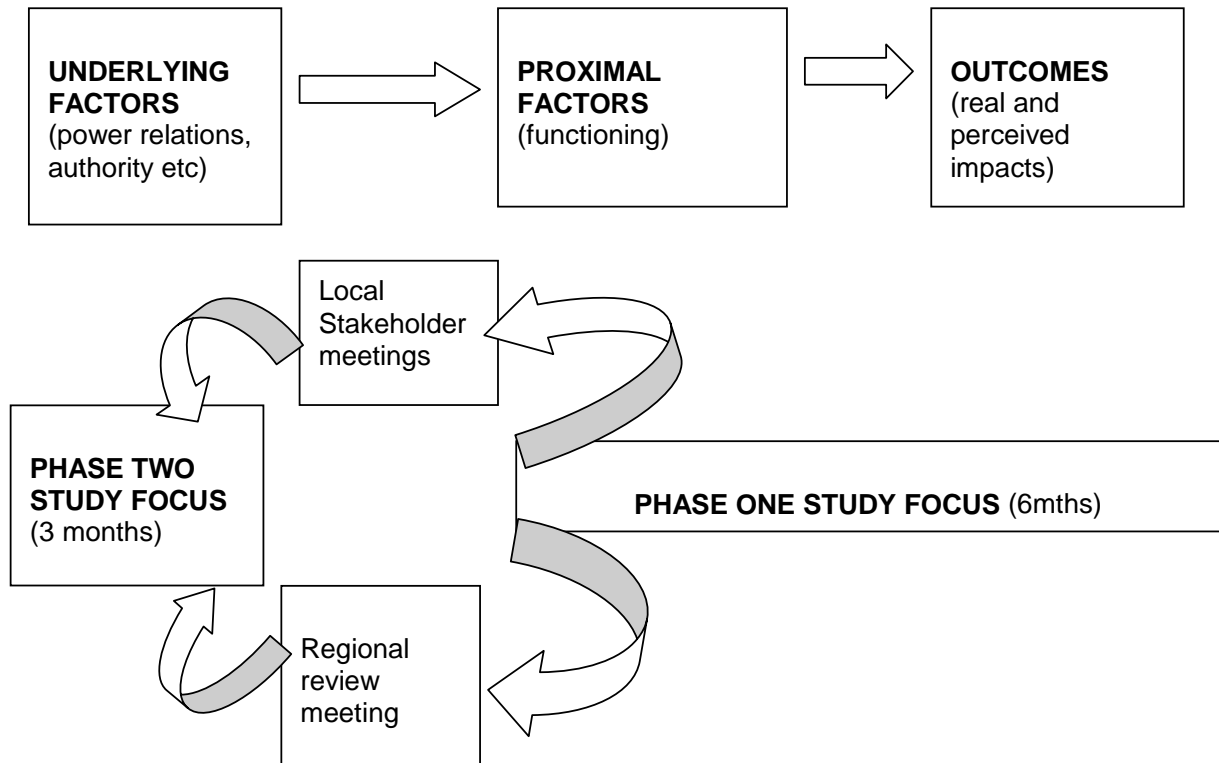
In the discussion on the three protocols at the review meeting the following inputs were made:

3.1 Generally For All Proposals

- i. All proposals should reflect and show their objectives in terms of the three levels of the conceptual model above and their 'causal' links, viz
 - Impacts of governance systems
 - Functioning of governance systems
 - Underlying power relations
- ii. The study design should allow for research team *and* stakeholder reflection on the findings as a part of the protocol. This means that a **first phase** can include assessment of impacts and factors reflecting functioning. The analysis of these relations and the questions around these should then be used to design a second phase of research to explore underlying power relations and to feed back the first round of findings to key stakeholders collectively from the study areas to obtain information on their explanations of the findings and their views on appropriate areas of action. This stakeholder input should be documented as part of the findings and also used to design the **second phase** of work aimed at exploring underlying power and authority issues to be addressed. Between the first and second phase and after the national stakeholder meetings a regional review meeting can be held to review the work to date, provide skills inputs (see later) and strengthen cross country outputs. This will also ensure that the research moves from problem identification towards solution identification *within* the research framework.

DESIGN STAGE	ACTIVITY
Phase one	Data collection and analysis on impact and proximal factors (functioning)
National level stakeholder meeting	Participatory reflection on research findings with key stakeholders to obtain their explanations for outcomes and consequences for intervention
Regional research meeting	Research team review of national findings, synthesis of cross cutting issues, inputs on follow up phase and skills training
Phase two	Data collection and analysis on underlying factors influencing impact - functioning outcomes and relations
Regional synthesis	Research team review of national findings, synthesis and reporting on multi-country analysis and issues

See diagram below for schematic overview of multicountry research protocol



- iii. It was agreed that all protocols should include community surveys to assess impact and should ensure that PRA tools include more structured approaches than focus group questions alone.
- iv. It was agreed that all protocols should include community surveys to assess impact and should ensure that PRA tools include more structured approaches than focus.
- v. Community analysis should provide for disaggregations, including by gender, rural/urban status, age (youth / elderly / adults) and socio- economic status.
- vi. All studies will include a selection of COMMON questions/ indicators of impact, functioning and underlying factors to enable a degree of more direct cross-country assessment. TARSC will review the tools submitted for the review meeting and provide proposed indicators / questions for teams to include. (An initial assessment of key areas was prepared for the meeting shown in Appendix 1 and the final work on this is separately reported).
- vii. The studies should be adjusted to fit a similar time frame for key points. It was agreed that the following common points be adopted and included for ALL studies:
 - o Start date: Beginning November 2002
 - o Completion of stakeholder and regional meetings to review phase one: End May 2003
 - o Completion of field studies: End August 2003

Table 1: SUMMARY OF RESEARCH PROTOCOLS SUBMITTED FOR THE REVIEW

AREA	ZAMBIA (INESOR)	ZAMBIA 2 CRESSORE	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	<ul style="list-style-type: none"> (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 	<ul style="list-style-type: none"> 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 resource allocation. 	<ul style="list-style-type: none"> 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 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 POPULATION	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 stratified 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 questionnaires – health staff district and province, DHMT members, DHB members Secondary 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	1 year, start date Oct 2002
BUDGET (Usd)	Above \$20 000	\$19 970	18 800

3.2 For Specific Proposals

INESOR (ZAMBIA)

- Needs to add an **impact** indicator. Agreed that this can be the impact of enhanced participation itself given the formal commitment to this outcome. Should therefore add to its broad objectives 'To examine the extent to which community participation (as an outcome) has been achieved and perceived to have been achieved in the District Health Management Boards'
- Should provide an operational definition of community participation that can be measured in the study.
- Should specify the indicators the study is looking at.
- Need to strengthen and diversify PRA tools

CHESSORE (ZAMBIA)

- Needs to strengthen the assessment of factors relating to **functioning** of HCCs. Objective 5 needs to be strengthened and 'unbundled' to make clear the factors to be investigated.
- Need to strengthen and diversify PRA tools

TARSC/ CWGH (ZIMBABWE)

- Need to put the term 'community' before participation in the broad objective
- Needs to include in the assessment of **power relations and authorities** the legal provisions for authorities of HCCs in Objective 1.
- Objective 3 mixes functioning and impact questions and this should be separated.
- In the design change the repeat cross sectional surveys after 6 months (as little change can be anticipated within 6 months) and include a follow-up phase to explore underlying factors.

4. FOLLOW UP ACTIONS

The meeting discussed and agreed on a schedule for implementation of follow up work for the network. This is shown in the Table below:

Month	Year	Deadline	Activity/ Actions
October	2002	Mid month	Revised Proposals submitted by research teams
		End	Cross cutting Tools proposed Tools reviewed by national teams
November	2002	Beginning	Contracts signed and 45% grant disbursement
		End	Feedback on tools and finalised
December-Feb	2002		Fieldwork
March	2003	End	Interim Financial and technical Report submitted by national teams
April	2003	Beginning	Next 45% Disbursement (based on satisfactory reports)
		End	Finalise phase one field work and analysis
May	2003	Beginning	National Stakeholder meetings
		End	Regional Review Meeting
June – August	2003		Fieldwork
		End	Submit final financial and technical reports
September	2003	Beginning	Final 10% disbursement on grant (on receipt of satisfactory reports)
Sep/Oct			Regional dissemination workshop

The common inputs and outputs of the multicountry programme were also discussed.

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)

The countries and research networks with whom links existed need now to be followed up:

- i. **Tanzania** The NIMRI concept paper was reviewed and agreed to be a good start and in the right area. It now needs to be strengthened in terms of the framework from the GovERN network. TJ Ngulube to meet with the NIMRI team, brief on the GovERN programme, follow up on their proposal, and request a full proposal structured with an initial pilot phase. The Tanzania team to be brought on in any capacity building workshops.
- ii. **Mozambique** The Mozambique team noted that they had difficulties on how they can link up with the network. There is an acute shortage of skilled human resources, especially at district level, affecting their linkage with other teams. It was agreed to follow up including with SDC in terms of what type of resource support they need and to bring them into the PRA training workshop when the GovERN team can review with them their protocols and desired work.
- iii. **TEHIP** TJ Ngulube will visit TEHIP whilst he is in Tanzania to find out what they are doing in this area and what links can be made.

5. LINKS WITH THE MUNICIPAL SERVICES PROJECT

The Municipal Services Project (MSP) is exploring relationships between Municipal services such as water, electricity / energy and sanitation with health outcomes, and has a link with EQUINET. One dimension of interest is the influence of governance mechanisms in policy choices on municipal services, particularly in relation to privatisation or pro-poor choices.

Patrick Bond (MSP) reported that the MSP is working with civil society groups such as the South African Municipal Workers Union. Fifteen researchers are working on this project and have recently added Maputo, Harare and Lusaka. They have already carried out a research on 200 households in Soweto on the impact of electricity disconnections, which was used to pressure government for free electricity up to a certain consumption. They are also campaigning for a certain level of free water as a public good.

In the discussion on linkages with GovERN it was agreed to

- Include questions on water and sanitation into the GovERN outcomes indicators in phase one but not on electricity as this fell outside the scope of the HCC-health service focus at this stage, even while an important issue.
- Obtain information from MSP on governance and health equity reviews that they have done, in particular on the framing of 'participation' and governance' by international agencies and what impact this has had on the policy agenda.
- Include the above issue which is of mutual concern into the GovERN literature review.
- Bring in MSP experience and perspectives when the GovERN team reach their next regional review meeting after phase one work is complete in order to discuss the power relations and authority issues now being addressed with MSP.

Appendix 1: AREAS FOR INCLUSION OF 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

- HCC/DHB Relevance - Does it meet, impact on health expenditures, Perceived relevance by communities, clinic and district health staff (ZW)
- 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)
- 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)

Factors influencing impact

- Link between the community and the HCC/DHB – representativeness (esp of poorer groups), gender equity (IN, needs to be discussed),
- Information flow to and from communities and HCC/DHB (and role in accountability), (In) synergy in understanding of roles; (ZW, CH)
- Capacities of community, HCC members, (IN)
- DHT support; attitudes of HCC members and DHT support; (None cover this well)
- 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)