



Local Perceptions, Participation and Accountability in Malawi's Health Sector

Report 2/2013





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Note on layout and language

The layout of the document has tried to conform to guidelines for accessibility and ease of reading, which require Arial font and left (not full) justification of the text.

The report has tried to avoid unnecessary use of acronyms and abbreviations.

Disclaimer:

The report is the product of its authors, and responsibility for the accuracy of data included in this report rests with the authors. The findings, interpretations and conclusions presented do not necessarily reflect the views of Norad Evaluation Department.

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List of abbreviations

ADP	Area Development Plan
ARV	Anti-Retroviral
BLM	Banja La Mtsogolo
CBO	Community-Based Organisation
CDF	Constituency Development Fund
CHAM	Christian Health Association of Malawi
DC	District Commissioner
DCC	District Consultative Committee
DDP	District Development Plan
DEC	District Executive Committee
DFID	Department for International Development
DHMT	District Health Management Team
DHO	District Health Officer
DHS	Demographic and Health Survey
DEHO	District Environmental Health Officer
EHP	Essential Health Package
FBO	Faith-Based Organisation
FGD	Focus Group Discussion
HCAC	Health Centre Advisory Committee
HMIS	Health Management Information System
HSAs	Health Surveillance Assistants
HSSP	Health Sector Strategic Plan
IKI	Invest in Knowledge in Malawi
KII	Key Informant Interview
LA	Artemether-Lumefantrine (Anti-Malarial Drug)
LDF	Local Development Fund
MoH	Ministry of Health
MoLGRD	Ministry of Local Government and Rural Development
MP	Member of Parliament
NGO	Non-Governmental Organisation
NORAD	Norwegian Agency for Development Cooperation
OPM	Oxford Policy Management
PoW	Programme of Work
STEPS	STEPwise Approach to Surveillance
STI	Sexually Transmitted Infection
SWAp	Sector-Wide Approach
TBA	Traditional Birth Attendant
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VAP	Village Action Plan
VDC	Village Development Committee
VHC	Village Health Committee

Executive Summary



Executive summary

Overview of the study

Seeking to achieve a participatory approach to development has been the focus of much donor attention, as well as an expressed objective for the governments of many developing countries.

This report has been prepared as part of a study commissioned by Norad's Evaluation Department, the overall objective of which is to develop and pilot test a methodological framework that can be used by international development agencies (and others) to improve understanding of the importance of local ownership and participation for aid effectiveness.

This pilot study report presents the findings from an application of this framework to the health sector in Malawi, and provides substantive findings on local ownership and participation in this sector. These are intended to be of value to the Malawian government, its development partners, and wider civil society, in terms of strengthening participation and improving service provision.

The pilot study examined community participation in the health sector in Malawi, to identify and characterise the forms that participation takes, the factors influencing this, the results of this participation in terms of its impact on service delivery and community ownership, and finally the implications of these findings for the design and implementation of government programmes and of donor support to these programmes.

The pilot study was based on qualitative community-level fieldwork across six districts, supplemented by a district-level study of the political economy context in two of the selected districts. The six selected districts for the study are Rumphi and Nkhata Bay in the North, Mchinji and Nkhotakota in the Centre, and Balaka and Neno in the South.

Local perceptions of the health system

Rural communities in Malawi are generally well informed about their rights, have expectations of good treatment and have improving access to health information. Communities regard the formal health system as their principal point of call for most common health problems.

The study was designed to identify any major differences in perceptions of care and accountability, access to information and across the three geographical

regions of Malawi, the six districts selected for the study, and the two catchment areas in each district. Of these latter two areas, one was the catchment of a government health centre and the other the catchment area of a private hospital run by the Christian Health Association of Malawi (CHAM), usually in a remote area. Although the team could not visit a large enough sample of facilities to provide conclusive evidence, it appears that neither differences across regions nor across districts were substantively significant.

The strongest apparent differences were between government facilities and CHAM facilities. Facilities run by the CHAM are regarded as generally providing a somewhat higher quality of care than government facilities but may be more expensive than government facilities and far from many catchments areas, so government facilities are preferred by the poor. Health Surveillance Assistants (HSAs) are the most immediate point of contact for communities. Private clinics were generally inaccessible either because of distance or cost for the rural communities interviewed. Traditional health providers are resorted to only for a subset of health problems which are not regarded as within the province of the formal health system, or if treatment through the formal health system does not yield results.

Much information is disseminated to communities through the media, health centres, volunteers for community outreach programmes, churches, schools and traditional authorities. It is also shared informally through people's social networks.

Radio stations appear to have played an important role in reaching communities and in providing health information and fostering discussion of rights and system performance. Women and women's social networks play a particularly important role in the dissemination and sharing of health information.

Local factors appeared more important in explaining any observed differences than any systematic differences based on regional, ethnic or cultural factors. The nature of social differentiation also appeared generally uniform, with the significant distinctions being those relating to gender, education, wealth, access to persons of influence, and local social standing and reputation. Other ethnic, social or religious factors did not appear to be of major significance in explaining access to services or perceived influence over service providers. Those at the favoured end of each spectrum (male, educated, relatively wealthy, politically connected and with a good local reputation) could generally expect better treatment and to exert more influence.

One motivation for this study was to assess how development aid was perceived at the local community level, and to what extent perceptions of aid and priorities expressed "from below" might differ from those expressed in dialogue between aid donors and national government. It appeared that development aid (and the donor community) is effectively invisible at community level. Resources are seen as coming from the government or from Non-Governmental Organisations (NGOs) who deliver in the field, not from the donors providing ultimate funding,

although there is awareness of the ultimate dependence of government spending on donor support. This is the result of the alignment of much aid on the use of government and other national systems.

Participation in planning, budgeting and programme design

Decentralisation has established an institutional framework for community participation in planning through Village Development Committees (VDC) and Area Development Committees (ADC). When functioning well, this set-up appears to have the potential to express community priorities, with the large exception being the under-representation of women. However, the lack of genuine decentralisation of authority – in terms of the level of resources that can be programmed, or significant decisions that can be made, either at district or sub-district level – rendered participation through these bodies of generally limited significance. While they also have a potential role in the monitoring of the use of resources and the performance of government service provision, they lacked either the access to information or the authority to perform this role. Community influence over NGO programmes was limited by the lack of flexibility in NGO funding to respond to community needs (rather than those determined by the funding source), as well as the status inequality between educated NGO staff (with access to funding sources) and community members.

Participation in service delivery

There is a significant level of community involvement in support to service provision, prevention activities, and community mobilisation for tasks such as building under-five clinics and other small works. There are many sustainable and well-established networks of voluntary action in the health sector, operating through faith-based and other community organisations, as well as through initiatives organised by HSAs and NGOs. Although NGOs can play an important role in developing local capacity (for instance in VDCs and ADCs), much NGO-induced participation is unsustainable and driven by donor and NGO objectives rather than those of communities.

The extent and effectiveness of community participation around government programmes depends in part on the motivation and capability of HSAs, who vary greatly in their presence and effectiveness in communities. As the first point of contact for communities, the HSA plays a significant role both in promoting local participation and in the provision of information and services.

The effectiveness of community mobilisation for collective action depends on chiefs, who generally hold their office on a hereditary basis, and who also vary greatly in their motivation and effectiveness.

Monitoring and accountability

Despite an awareness of their rights and expectations in regard to services and treatment, community members lack effective channels for communicating their priorities, exercising rights and ensuring accountability within the health system. Communities did not have access to information about the performance of the local health system, the resources available to it, and how these resources were used. The weakness of monitoring and supervision within the government health system and the lack of effective sanctions over poorly performing staff (in part reflecting the continuing shortage of qualified medical staff) limit the effectiveness and responsiveness of service provision. Management appears to be somewhat stronger within CHAM facilities, accounting for the general preference for the use of these facilities where they are available, and among those able to afford CHAM services where these are being charged for.

The absence of any elected officials below the level of Member of Parliament (MP) limits the prospects for one potential channel of accountability. Changes to the system of district assembly elections which have increased the size of electoral wards and introduced payment for assembly members were expected to undermine the community links and responsiveness of elected assembly members when district elections do occur, compared to the situation before 2005.

Constraints limiting participation and likely implications for service delivery

Constraints limiting participation varied across the programme and policy cycle and can be summarised as follows:

- Effective participation in the planning and budgeting of public services is constrained by the lack of genuine decentralisation of decision-making, or of local elected democratic institutions, as well as the very limited representation of women. This is likely to make service provision less well tailored, and responsive, to local needs than a more effectively participatory system.
- Effective participation in the design of NGO programmes is limited by the lack of flexibility in the donor programmes, which limits the extent to which programmes can respond to locally expressed needs, as well as an imbalance of power between educated, externally linked NGO staff and local communities.
- Constraints on more effective participation in service delivery and prevention activities generally relate to the varying levels of motivation and competence of local health staff (particularly HSAs) and traditional authorities who play a major role in community mobilisation, as well as the limited resources (financial and equipment) available to be used at this level.
- Effective participation in monitoring (including the ability to voice and hold health sector workers accountable in relation to grievances) is constrained by power imbalances at the local level (which may be offset by active and competent local traditional authorities), but most significantly by weaknesses

in regard to supervision and a lack of effective sanctions for poor performance within the public health system.

- Lack of the provision (for instance to ADCs) or publication of information on financial or other resources flows or service provision performance against targets is a further problem. Again, the absence of locally elected bodies is a limit on the capacity for effective monitoring and the ability to ensure accountability.

The areas where actions to overcome these constraints are likely to be most immediately effective in terms of the likely impact on the quality of service delivery relate to strengthening supervision and management within the public health system, and to the enhanced provision of information to local communities and community bodies.

Principles for enhancing participation in health

The study has found scope for increased participation from communities in health, particularly to strengthen accountability (both through providing more information about development programmes and the use of resources, and to ensure more effective responses to complaints and concerns about service delivery). Community and official structures exist that do play a role in fostering participation, and which could play a greater role. However, in practice many attempts to foster participation through NGO programmes create expectations that cannot be sustained and that risk undermining other forms of community participation. The study therefore presents challenges both for government, and for donors and NGOs.

The findings from this study, together with a broader perspective on lessons from experience for achieving aid effectiveness, suggest a set of principles to guide initiatives that are better aligned to the needs of the community and for strengthening community participation in the health system:

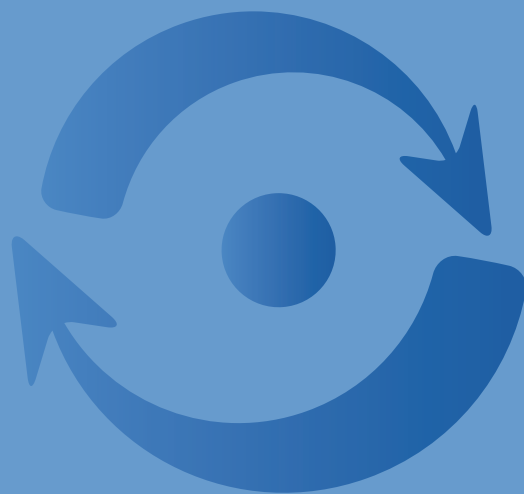
- I. Support provided through NGOs needs to be carefully designed to reinforce local participation and ownership and to build capacity, in order to avoid a situation where programmes that may not match a community's objectives are imposed on them.
- II. More interaction and engagement with communities requires a better understanding of the formal and informal structures through which communities engage and participate in programmes. The analysis of participation (for instance using the framework and tools that have been developed for this study) should be a standard part of the process of programme design and evaluation, since the strength and form of community participation is likely to have implications for the level of ownership and effectiveness of accountability. At the very least, questions about participation should be asked, and addressed using a more systematic and comprehensive approach than appears generally to have been the case in international experience.
- III. Sustainable participation is likely to be rooted in existing social organisations and networks, as well as in the formal structures of budgeting and

planning. Initiatives outside these will generally be unsustainable. Poorly designed support may risk undermining these organisations.

- IV. Strengthening participation in planning and budgetary processes requires the provision of additional discretionary financial resources at the district level and enhanced oversight of how these resources are used, including through existing structures such as VDCs and ADCs. There may be scope for donors to support pilot initiatives of this kind.
- V. Initiatives that provide more resources to be controlled at a decentralised level, while in principle having scope to improve ownership and effectiveness, need to be carefully designed so as to ensure that accountability is enhanced along with the resources provided.
- VI. Strengthening participation in service delivery should wherever possible build on existing community-led structures and initiatives (particularly through FBOs and community mobilisation through chiefs). Direct NGO involvement in the formation of new participation structures and the selection of volunteers are unsustainable and risk undermining the existing structures and should be avoided.
- VII. Improving the effectiveness and accountability of health service provision requires strengthened management (supervision, monitoring, and sanctions) within the public system (particularly for HSAs and health facility staff). Community led initiatives without any attention to this is unlikely to yield significant changes to the way in which services are delivered. The strengthening of line management arrangements and accountability should be a central objective of donor support.
- VIII. Improving the ability of communities to monitor the effective use of resources and to ensure accountability requires greatly increased transparency in access to information.

These principles could, if accepted in their current or an adapted form, provide a structure for the main elements of a policy or guidelines on participation in health.

Main Report



1. Introduction

1.1 Background to the study

Seeking to achieve an effective and participatory approach to development has been the focus of much donor attention, as well as an expressed objective for the governments of many developing countries. A review of a large number of projects that have sought to apply participatory approaches notes that:

Over the past decade, the World Bank has allocated almost \$85 billion to local participatory development. Driving this massive injection of funding has been the underlying belief that involving communities in at least some aspects of project design and implementation creates a closer connection between development aid and its intended beneficiaries. Indeed, local participation is proposed as a method to achieve a variety of goals, including sharpening poverty targeting, improving service delivery, expanding livelihood opportunities, and strengthening demand for good governance (Mansuri and Rao, 2013, p. 1).

Participation has therefore been seen as an instrument for building ownership and ensuring programme effectiveness. Community participation in the process of public service planning and delivery may also have the potential to improve service effectiveness and responsiveness, and hence the effectiveness of aid.

This report has been prepared as part of a study commissioned by NORAD's Evaluation Department, the overall objective of which is to develop and pilot test a methodological framework that can be used by international development agencies (and others) to improve understanding of the importance of local ownership and participation for aid effectiveness. The proposed methodological framework that has been developed is set out in a Framework Report, published in parallel with this pilot study.

This pilot study report presents the findings from an application of this framework to the health sector in Malawi. The pilot study had two objectives:

- First, to provide substantive findings on local ownership and participation in the health sector in Malawi, which are intended to be of value to the Malawian government, its development partners, and wider civil society in strengthening participation and improving service provision; and
- Second, to provide a test of the applicability and value of the framework proposed, and to inform the development and finalisation of this framework. This is the subject of a separate report.

1.2 Overview of the pilot study

Research hypotheses

This pilot study has examined community participation in the health sector in Malawi, to identify and characterise the forms that participation takes, the factors influencing this, the results of this participation in terms of its impact on service delivery and community ownership, and finally the implications of these findings for the design and implementation of government programmes and of donor support to these programmes. The study has focused on obtaining evidence in relation to the following three core hypotheses:

- I. Access to information improves the ability of communities and different social groups within communities to engage with and participate in the health sector.
- II. Community participation in health service planning, delivery and monitoring improves the type, acceptability and quality of services delivered.
- III. Community participation in health service planning, delivery and monitoring improves access to and uptake of health services by the local population.

During the Inception Phase, background reviews were undertaken covering literature and experience on the following issues:

- An overview of the structure of the health system in Malawi, including the role of donor support, progress with decentralisation, and formal governance and accountability structures.
- An overview of the main Norwegian-supported programmes in the health sector.
- A summary of lessons from experience with community participation in health service delivery in Africa.
- An analysis of findings from previous research on power, protest and participation in Malawi.

The background reviews were used to inform the design of the study and to identify specific issues for more detailed inquiry.

Approach and methodology

This pilot was based on qualitative community-level fieldwork across six districts in Malawi and supplemented with district-level studies of the institutional and political economy context. The core of the data collection process was a series of structured field investigations, aimed at developing an understanding of the main features of participation and accountability relations in the health sector in rural areas, comparing areas mainly served by government health facilities with those served by facilities managed by faith-based organisations (FBOs) (who are the other main providers of health services in Malawi). The full details of the methodology for the community-based field data collection are set out in a separate Research Guide, but also summarised in Annex C. The field data collection focused on the following issues: (a) health outcomes and service provision; (b) access to information and knowledge sharing; and (c) participation

and accountability. The study was designed to maximise the opportunities for observing heterogeneity. In brief:

- Six districts were selected; two in each of the three main geographical regions of the country, North, Centre and South. Each region has a different predominant language and religion, and each has several ethnic groups with different customs.
- Within each region, two districts were selected on the basis of the following three indicators:
 - a. Proportion of deliveries attended by skilled health personnel;
 - a. Children under five given full immunisation;
 - b. Under-five diarrhoea inpatient death rates / per 1,000 new cases;
- The study aimed to select a pair of districts with the best and relatively worse performance against the above indicators (at least best or worse in two out of the three indicators). This resulted in the selection of Rumphu and Nkhata Bay in the North, Mchinji and Nkhosakota in the Centre, and Balaka and Neno in the South.¹ Although we used three district-level indicators to select the districts for this study, it was not possible to conclude which district is the worst or best performing one across all three indicators within each region,² since the ranking of the districts varied across selected health indicators.
- Within each district, the field team selected two health facility catchment areas for the field data collection: one was the catchment area of a government facility and the other the catchment area of a CHAM facility, in order to permit comparing the perceptions of the services in each type.
- Within each catchment area the team selected two villages, one close to the catchment facility and another in a hard-to-reach area. Male and female community members were selected through 'snowball sampling' around these villages and around the health centres visited by the research team.

Field data collection took place over two weeks using three parallel field teams. Each team was headed by a member of the OPM team, and the data collection was headed by an experienced field supervisor from the region who spoke the local language and knew the area well. Each team also included a translator for the team leader and three experienced interviewers who conducted Focus Group Discussions (FGDs) and Key Informant Interviews (KIIs). In each district a total of 10 FGDs and a minimum of 15 KIIs were conducted, resulting in a total of 40 FGDs and over 60 KIIs.

Most of the participants in these exercises were community members. However, in each catchment area a FGD on social mapping was conducted with HSAs who provide basic care in the villages and with at least one member of the

1 The original sampling strategy was based on selection of districts with a wide range of health services to use as proxies for different aid modalities. This strategy was later changed to the sampling strategy described. The letter of authorisation from the MoH, however, included the original list that contained Balaka and Nkhosakota as field sites in the South and Centre respectively. In order to undertake the study as scheduled the team decided to replace Chiradzulu with Balaka and Ntcheu/Dedza/Salima with Nkhosakota.

2 It is important to note that there were three districts in the Centre region, each having the worst performance under one of the three selected indicators. Since Nkhosakota was named in the original letter of authorisation we decided to proceed with this district. Nkhosakota performed poorly in one of the three selected indicators: proportion of deliveries attended by skilled personnel percentage of women delivery with professional health personnel.

health facility staff. At the end of each day, the team members met to summarise the findings of the day.

The main outputs from the field data collection are a set of findings on the nature of community perceptions of health services and the health system, and on the main features of community participation, summarised in the Participation Matrix.

To complement this core of field data collection, a district-level study of the political economy context was undertaken by a three-person team: the Team Leader, a Malawian political scientist and a Malawian public health specialist. This took place over one week of the field data collection, and covered two of the six districts (Mchinji and Balaka). It was based on KIIs with district officials (e.g. the District Commissioner (DC), the District Minister of Health, the district hospital ombudsman, etc.) and group discussions with key informants, such as members of the VDCs and the ADCs. This aspect of data collection focused mainly on examining participation in the planning and budgeting process.

Preliminary findings from the study were discussed with staff of the Royal Norwegian Embassy in Lilongwe, and with other sector stakeholders in Malawi during a follow-up visit in February 2013.

1.3 Limitations of the study

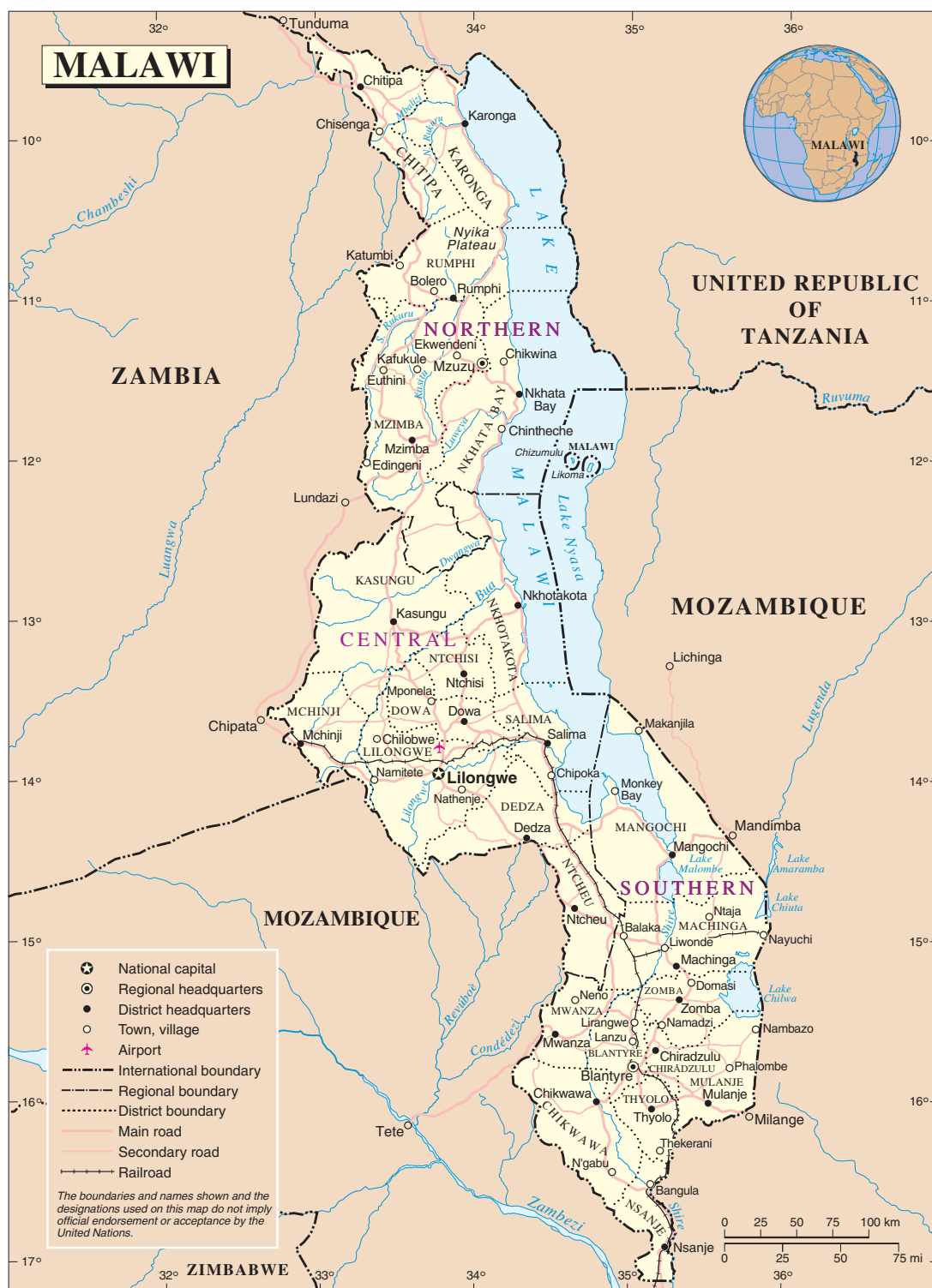
This pilot study is not an evaluation of any specific programme; instead, it is a testing of a conceptual and evaluation framework and the use of selected tools to apply it. The study is based on qualitative research that captures the views and perceptions of community members on health issues in twelve health catchment areas in six districts. While the information gained from the fieldwork has been triangulated, including through a review of wider literature and studies in the health sector in Malawi, it is not statistically representative of the entire country. These findings provide: (i) detailed and internally valid insights into how community members perceive and participate in the health sector in the sampled communities within the selected catchment areas; (ii) strong indications as to how health services are perceived and communities participate in the targeted catchment areas and to some extent the districts within which the sampled catchment areas are based; and (iii) indications as to the more general nature of community participation and accountability in the health sector in rural Malawi at a national level. While the study questions and data collection approaches used have been driven by the research hypotheses identified above, the study methodology was limited in the extent to which it has been possible to measure the effects of participation, although community perceptions of the effects of participation have been captured.

1.4 Report structure

The structure of the remainder of the report is as follows:

- Chapter 2 summarises the conceptual framework for the study;
- Chapter 3 provides an overview of the social and political context of Malawi, and the main features of the Malawian health sector;
- Chapter 4 examines the perceptions and expectations of the health system that community members have;
- The findings of the study in relation to community participation are presented in sections 5 to 7, based around evidence in relation to the main stages of the programme or policy cycle:
 - Section 5 examines evidence on participation in policy, planning, budgeting and design;
 - Section 6 presents evidence on participation in service delivery;
 - Section 7 addresses evidence on community participation in monitoring of programmes and service delivery, and the extent to which service providers are accountable to users.
 - Section 8 summarises the conclusions of the study and discusses their implications for government, donors, and NGOs.

Figure 1 – Map of Malawi and selected districts



Source: United Nations (2004), Department of Peacekeeping operations Cartographic Section.

2. Summary of the study framework

The core of the methodological framework proposed for analysing the role of participation in programme effectiveness is presented as the Participation Matrix in Table 1.³ This framework can in principle be applied for any type of aid programme or for any particular service delivery sector. The Participation Matrix provides a basis for classifying participation as follows:

- Categories of participation are distinguished in relation to the main phases of the programme (or policy implementation) cycle, which are associated with different forms of participation.
- Forms of participation are identified to map out who (among potential beneficiaries or other stakeholders) is participating, recognising that opportunities for participation may be structured by social and political conditions.
- Motives for participation (which again may vary between stakeholder groups) are likely to be significant for understanding ownership. For instance, voluntary participation may be a marker of stronger ownership (in the sense of commitment) compared to participation that is dependent on the provision of particular side-benefits such as payments.
- Preconditions for effective participation may relate to the availability of information as well as to the capacity of individuals or social groups, and the distribution of power between them.
- The results of participation can be assessed in relation to the degree to which citizens or service users can be judged as exercising effective control over decision-making, the extent to which accountability is achieved, or improvements in service delivery.

Understanding participation requires an understanding of the perceptions and expectations of potential participants. Relevant considerations will include the information to which community members have access, their understanding of their rights and ability to act to realise them, and local perceptions of service quality and concerns, which may differ from those reported through formal data systems. Effective participation can be seen as a prerequisite for “ownership” of specific programmes, although ownership is not an appropriate concept to apply to service delivery in general. The Participation Matrix may be used in analysis of the theory of change of a specific programme or project, through identifying how improvements in participation of various kinds are expected to improve

3 The rationale for the proposed framework and other conceptual and methodological issues are discussed in the Framework Report.

programme effectiveness. These issues are discussed further in a separate report, which sets out the framework and discusses its possible use in relation to the wider literature on participation.

Table 1 – Framework for analysing participation and programme effectiveness

Category of participation (across programme/ policy cycle)	Form of participation [Examples listed]	Who participates	Motives for participation	Conditions for effective participation	Results of participation
Policy, Budgeting, Planning, Design	Advising, advocacy, lobbying and activism, e.g. through political parties, professional organisations, other civil society organisations active on specific issues, media advisory committees, hearings processes to set priorities and plans or design programmes				
Service Delivery	Participation in campaigns, information sharing, awareness raising, volunteering				
Monitoring and Evaluation	Citizen charters, social monitoring, community monitoring (e.g. of expenditure, availability of physical resources, staff attendance), boards or oversight committees, making complaints				

Source: See Framework Report

The completion of the Participation Matrix needs also to be informed by an understanding of the wider network of power relationships. Stakeholder mapping and political economy analysis can be used to explore these issues, focusing on: the appropriate disaggregation of stakeholders to analyse a particular intervention or issue (such as a particular form of participation); identifying what are the most important power and resource flow relationships and how power is exercised in a particular institutional context; and examining how stable these power relationships are and the factors that might lead to changes in the distribution of power.

The Participation Matrix is related to the voice and accountability framework from which it is partly derived.⁴ Voice (defined as the “expression of preferences, opinions and views”) is one potential instrument for participation, to the extent that mechanisms exist for voice to be expressed and acted upon. These mechanisms can be both formal and informal and potentially include a variety of individual or collective (civil society) citizen actions such as public demonstrations, protests or advocacy campaigns. More formal mechanisms can include engagement with the media or organised processes of dialogue with public authorities. Voice is an important potential form of participation in policy and planning, as well as in processes of monitoring and holding service users to account.

Accountability relationships determine to whose interests a service provider needs to be responsive.⁵ In the context of service provision, it can be useful to distinguish short-route and long-route accountability mechanisms (World Bank, 2004). The short-route mechanism involves the direct relationship between the client (user of services) and the service provider, including through a market or quasi-market relationship where the returns to the service provider depend directly on the client’s action. Long-route accountability relies instead on service users lobbying policy makers or others with direct influence either over service providers or those with influence in the policy and budget formulation process.

In general, three main types⁶ of accountability relationship can be distinguished for service providers:

- Accountability through the formal line management or reporting relationship, which may be either to managers within the hierarchy or to an elected or other form of supervisory body (such as an auditor);
- Accountability to clients to whom services are provided; and
- Accountability to others, outside the formal management structure, to whose interests the service provider is answerable. This may include kin to whom obligations exist, community members who are able to exercise different forms of social pressure, or members of other social groups to which the service provider may belong or be answerable (e.g. religious, political, professional, etc.).

⁴ See the Framework Report for more details.

⁵ Accountability is defined as “the process of holding individual agencies and organisational actors to account for executing their power according to certain standards, involving a measure of answerability and enforceability”. Answerability requires the duty bearers to provide information and justify action and enforceability requires the possibility of penalties or consequences in the event of inability to answer accountability claims (Goetz and Jenkins 2005).

⁶ These three categories broadly correspond to what are sometimes termed horizontal, vertical, and social (or diagonal) accountability respectively.

3. Context for the pilot study: Power and health in Malawi

3.1 Power in Malawi

Understanding participation requires an understanding of the wider political and social context and the ways in which power is exercised in society. Power in Malawi flows down through several distinct hierarchies, and these hierarchies may either reinforce or be in tension with each other. The most important hierarchies are those of government (political and bureaucratic), traditional authorities, religious denominations, international governments and NGOs. There is also an informal status hierarchy based on education. Local politics in Malawi reflects the interplay of three main types of authority: traditional, bureaucratic and political. The state has a centralised structure but limited ability to exercise effective control over policy implementation throughout its territory.

The political imperative to maintain strong central authority to guarantee the survival of the regime militates against effective decentralisation of control over resources, with a pattern of reversal of decentralisation initiatives when the president has felt under political threat. District assemblies are in principle elected, but elections have been held only once (in 2000), and elected local councils have not been in place since 2005, as the president has discretion over the timing of local elections and presidents have been unwilling to hold these elections in circumstances where the opposition might build a political base through local elections. Since 2005 they have been replaced by unelected District Consultative Committees (DCCs). The actual composition of these committees varies greatly (depending on the DC and pressures from external actors). They have no legal basis so cannot enact by-laws or borrow money.

Intense competition (through political parties under the multi-party system) tends to politicise all decision-making processes that involve resource allocation. The need to maintain electoral support requires political leaders to maintain strong links to communities, but emphasises the directly personally attributable supply of favours and privileges rather than effective policy-making⁷ within a general culture of deference. While Malawi's recent political history has seen some increase in active dissent and protest this has tended to be restricted to the urban population, reflecting the uncertainty and insecurity facing the predominantly rural population. Women are the primary users of most health services provided at local level, but women have low social statuses, limited

⁷ For instance, a 2008 Afrobarometer survey found that 76% of Malawians expect MPs to deliver goods and services to their community. The role of politicians was understood as being principally to promote local development, while the legislative and accountability functions of MPs were not regarded as important.

voice and mobility, and low levels of literacy, which constrains their capability to engage with service providers (DFID, 2011).

Cammack (2011, p.2) has noted that there have been significant continuities across Malawi's post-independence political history (which has, however, varied in the extent of policy coherence under different regimes):

A strong tendency towards centralisation of power in the hands of the President (vis-à-vis parliament, the judiciary, and parastatals; local and district government; ruling party machinery; and chiefs) explains why democratic (political) decentralisation, pressed on government by donors in the mid-1990s, has stalled while administrative decentralisation moves forward. Patronage politics with ties ('dyads') reaching through party-political clients all the way into villages and urban areas sees the exchange of rents for votes. Clientelism and nepotism undermine civil service reforms, which affects policy making and public goods delivery. The details of how state resources have been used to create wealth for the elite and enable them to retain power are different for each of three post-colonial regimes [Banda, Muluzi, Mutharika]. However, they have followed a similarly non-developmental logic.

Cammack's study (2012) of governance and service delivery highlighted several ways in which the political context affected the effective provision of public goods in the peri-urban context of Malawi. These included: (i) incoherent policy-making, non-compliance with rules and regulations, and the creation of networks reaching from national to grassroots levels to control public resources; (ii) the role of chiefs in filling gaps left by the state in terms of providing a channel for voice in favour of strengthened service delivery (NB: although chiefs are relatively ineffective in fulfilling this role, there are nevertheless clear common expectations of how leaders should perform that influence behaviour); (iii) "The role of social divisions as well as lack of organisation skills and capacity in inhibiting people from forming self-help groups... Collective action in limited areas by small groups centred on chiefs or political party leaders is more common."⁸

These features have suggested several factors likely to constrain effective community participation and ownership of health programmes, and to limit the prospects for effective voice and accountability to service users in the Malawian health system:

- Health staff in rural facilities are likely to have little power in relation to the MoH hierarchy above them, but to have a great deal of power, both institutional and social, to affect the delivery of health services to villagers. They are the ones who interact directly with the villagers, and they have the power to give or to withhold services and resources. Health staff are civil servants and are protected from dismissal. Educational status is likely to reinforce this authority of service providers over service users.

⁸ Cammack (2012, p.2)

- NGOs working in local communities, while in principle requiring local consultation and engagement with their initiatives, can often in practice by-pass this through the access they have to donor resources, while also being able to by-pass local ownership to the extent that the funding agenda to which they have to respond focuses on issues that are not necessarily community priorities.
- Collective action organised independently of the main power hierarchies is unlikely to be pursued, but communities and individual community members are likely to have some avenues for influence since both politicians and traditional leaders are expected to show responsiveness to community concerns.
- International and Malawian evidence suggests that programme “ownership” is a characteristic of participation in organic (deeply socially rooted) groups, but not of mandated or induced groups.

3.2 The health system in Malawi: Trends, organisation and participation

Trends in diseases and health outcomes

Health facilities in rural areas primarily target women of child-bearing age and their children: there are special services for women (antenatal care, postnatal care, family planning and maternity) and for children under five (immunisation, growth monitoring). It is also the case that the facilities are perceived as women’s space. In our visits to the facilities, in the mornings the waiting room was crowded with women and children, whereas in the afternoons there were more men, usually attending for out-patient services.

The overall trends in national indicators^{9 10} of maternal and child health outcomes are positive. Although Malawi is unlikely to reach all its Millennium Development Goal targets in health, there is evidence of improvement in the health indicators shown below. These also suggest the degree to which community members value the health services, shown in their willingness to expend the time and effort to access them; correspondingly, the indicators suggest the success or failure of the health system to address effectively specific health issues. Below we rely on two sources of data, the Malawi Demographic and Health Survey (DHS) and the Health Management Information System (HMIS).

9 The analysis is based on data from 2008 to 2011 obtained from the HMIS as well as data from the DHS in 2004 and 2010.

10 The indicators we analyse are selected based on their importance in understanding health outcomes in Malawi, the availability of such indicators in the HMIS dataset and their ease of comparability with data in other countries and settings.

Table 2 – Trends in selected national health indicators

Indicator	2004	2010
Children under five		
Stunting	49	47
Acute malnutrition	5	4
Children under five underweight	22	13
Child mortality (per 1000 live births)	133	112
Full immunisation of children (12–23 months)	64	81
Malaria – child with fever treated with malaria drugs	15	44
Diarrhoea	22.3	17.5
Maternal health		
Deliveries attended by skilled personnel	56	71.4

Source: DHS 2004b and 2010b

We have less confidence in the precision of the district-level data: the DHS data only has district data for all districts for 2010, and the indicators collected through the HMIS are not the most appropriate for analysing trends. We can therefore not firmly conclude that there has been either improvement or deterioration in the population-level health situation at the six districts we visited during our field trip in November and December of 2013. The remainder of this section summarises the change in key national health indicators.

Children under five underweight

Children stunting, or children too short for their age, has changed only slightly, decreasing from 49% to 47% between 2004 and 2010. Wasting, or acute malnutrition, also remained largely unchanged, going down from 5% to 4% during the same period. This is despite the sustained provision of resources in the form of free nutritional supplements (“plumpy nut” and likuni phala) and sanitation campaigns to prevent debilitating diarrhoea in recent years. The national trend in the percentage of children underweight, or children too thin for their age, showed more improvement. It declined from 22% to 13% between 2004 and 2010 (DHS 2004a, 2010a).

Child mortality

Malawi has shown good improvement in under-five mortality rates. In 2004, one in eight children did not reach their fifth birthday, with an under-five mortality rate of 133 per 1,000 live births. Six years later, in 2010, it had fallen to one in 10 children (DHS 2004a, 2010a).

Immunisation of children

In 2004, only 64% of children between 12 and 23 months were fully¹¹ vaccinated against the six major childhood diseases. In 2010, the figure had increased to 81%. This suggests that the decentralisation of vaccination to village clinics has been effective in improving vaccination rates and/or community members have increasingly perceived the value of vaccination for their children's health and survival. Interestingly, the upward trend at national level has only brought Malawi back to its 1992 level (DHS 2004a, 2010a).

Deliveries attended by skilled personnel

More than two-thirds of women in Malawi delivered in the presence of skilled personnel (i.e. a doctor, a clinical officer, a nurse or a midwife) in 2010. The remainder of newborns were delivered with help from a traditional birth attendant (TBA) (14%) or presumably untrained friends and relatives (9%).¹² This is a significant improvement from 2004 figures where only 56% of deliveries were attended by skilled personnel (DHS 2004a, 2010a). However, almost half the women did still not attend a postnatal check-up in 2010, which helps prevent complications after childbirth (DHS 2010a).

Malaria

Malaria is one of the most commonly cited diseases in Malawi. The standard procedure is to treat a child with a fever with malaria drugs and only a small share actually get tested prior to treatment. DHS 2004 and 2010 recorded that 35–37% of children under five had a fever in the two-week period before the survey. Out of those, only 15% took anti-malarial drugs in 2004, rising to 44% in 2010 (DHS 2004a, 2010a).

Diarrhoea

Less than 20% of children under five suffered from diarrhoea within a two-week period of the DHS surveys (DHS 2004a, 2010a). This is only a small decrease from 2004 figures. If we exclude Nkhata Bay, DHS data for our six districts show only moderate variation around the national level.

11 A child is fully vaccinated if he or she has received a single dose of BCG vaccine given at birth, three doses each of DPT (diphtheria, pertussis and tetanus vaccines given at approximately six, 10 and 14 weeks of age) and polio vaccine (given at six, 10, and 14 weeks of age) and one dose of measles vaccine (at nine months of age).

12 Some TBAs, friends and relatives may have received training in midwifery. Some community members report delivery by a cleaner if a health worker is not available or unwilling to attend a patient at night.

Main features of the health system in Malawi

The main features of the primary health care system in Malawi may be characterised as follows:

- Government commitment to provide free access to essential health care has been hampered by lack of resources and management problems.
- Around 60% of primary health care is provided by government facilities and about 37% by CHAM facilities.¹³ CHAM facilities are owned by various denominations (around 60% by the Catholic Church) and employ their own staff. However, staff at CHAM facilities are employed on common terms with the public sector and government meets the cost of these staff, with service agreements between CHAM facilities and government defining the services that are provided and the financing arrangements. Generally, CHAM facilities have been regarded as better managed and the staff more responsive and better motivated than in the public sector. However, public facilities have tended to provide better access to free drugs (USAID 2012).
- There is a severe shortage of qualified medical personnel. Generally in the public health system there are medical doctors available only in district hospitals, and qualified nursing staff are also based at district hospitals. Health facilities are headed by medical assistants, or in some cases medical officers, with diploma-level medical training.¹⁴
- HSAs are the main connection point between the formal health system and communities. HSAs are used to relieve the burden of care at health facilities through task-shifting, and have been made responsible for activities including community-based integrated management of childhood illnesses, family planning, tuberculosis (TB) sputum collection, and community maternal and neonatal health. Through community-centred activities, HSAs increase the reach of Essential Health Package (EHP) services. They also provide vital health information at community level, including seeking to counteract harmful traditional practices in maternal and neonatal care.
- The health sector is heavily dependent on donor funding, particularly through a sector-wide approach (SWAp) supporting the Health Sector Strategic Plan (HSSP). Donor assistance in general has had a relatively strong emphasis on HIV/AIDS, leading to the creation of specific structures for HIV/AIDS, as well as other vertical programmes.
- While some moves have taken place towards the decentralisation of health service provision, most resourcing and staffing decisions remain centrally determined.

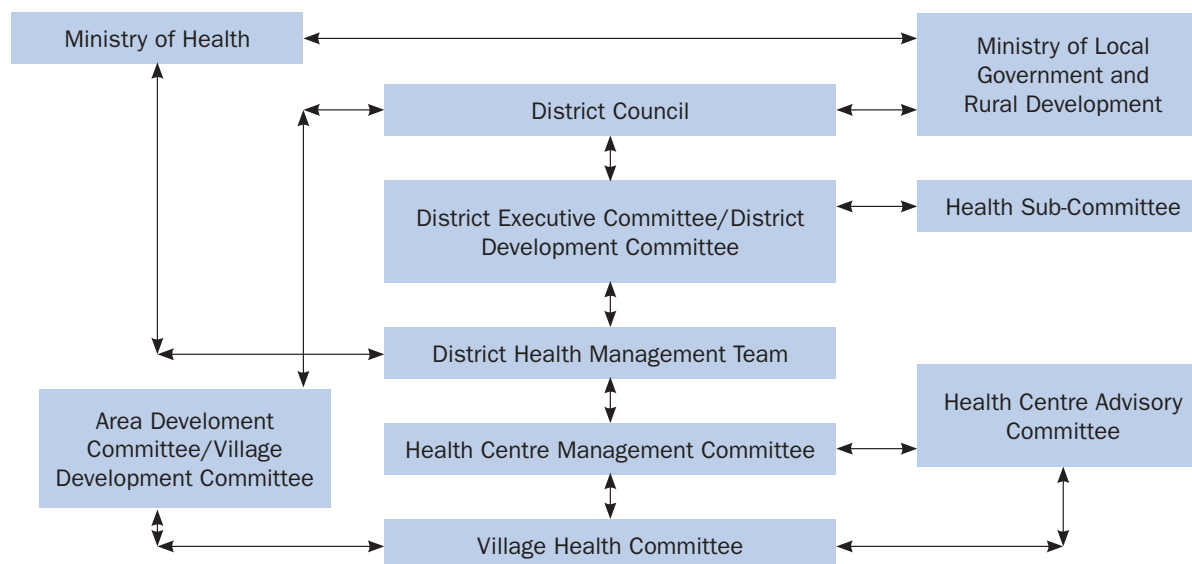
¹³ The remainder of services are provided by the Ministry of Local Government and Rural Development (MoLGRD), private practitioners, commercial companies, the army and police, and other NGOs. In the non-governmental subsector, Banja La Mtsogolo (BLM) runs 31 static clinics and 364 community outreach sites. USAID (2006) states that BLM runs 5% of Malawi's health facilities. (USAID 2006, 2012).

¹⁴ The term "doctor" was generally used by communities to refer to anyone with medical training, and this is reflected in the interview transcripts.

District-level management and governance structures for health

The management and governance structure for district health service delivery in Malawi is set out in Figure 2 –below.

Figure 2 – Management structure for the health sector: district level



Source: MoH (2011)

There have been significant moves towards the decentralisation of the management of health services as part of a wider process of decentralisation over the period since the ending of the one-party state in 1994. Health administration in Malawi is divided into three levels: national, zones, and districts (Rudner, 2011):

- At national level, the MoH is responsible for the development, review and enforcement of health and related policies for the health sector; spearheading sector reforms; regulating the health sector (including the private sector); developing and reviewing standards, norms and management protocols for service delivery and ensuring that these are communicated to lower-level institutions; planning and mobilising health resources for the health sector including allocation and management; advising other ministries, departments and agencies on health-related issues; providing technical support supervision; and coordinating research monitoring and evaluation.
- At zone level, Zonal Offices provide technical support to District Health Management Teams (DHMTs) in planning, delivery and monitoring of health service delivery at the district level and facilitation of central hospitals' supervision to districts.
- At district level, the District Health Officers (DHO) are responsible for managing primary and secondary health facilities and contracting CHAM facilities through service-level agreements. DHOs are frequently located within the district hospital. DHOs only partly answer to the MoH, as they are part of the district administration, headed by the DC. This is particularly

important in financial aspects, as the health budget for a long time has been the single most important budget allocation to districts (up to a half of total expenditure). Roles, mandates and priorities are not always entirely clear and there is some competition between the MoH and the district administration. For example, districts and line ministries use different types of budgeting and accounting systems, which are not well harmonised.

Reviews have concluded that this process of decentralisation has led to some improvements, such as greater financial autonomy and decision-making authority at the district level. Along with progress there are also continued challenges, however, such as limited local authority in human resource management (including hiring, firing and promoting), weak communication and relationships between MoH and MoLGRD. Responsibilities in regard to moving the decentralisation process forward are poorly defined, while planning at the decentralised level remains challenging for both DHOs and DCs. In addition, the planning processes for central hospitals are insufficiently linked to the planning processes of the districts they serve (Ergo et al, 2010).

Policies for participation in the health sector

The framework for health policy in Malawi has been provided by the 2004–2010 Programme of Work (PoW) for the Health SWAp, and subsequently the HSSP 2011–2016. The core of donor support to the sector has been aligned on these programmes, although there are many other donor programmes and projects in the sector, as well as a separate sector programme for support focused on HIV/AIDS.

Community participation was highlighted in both the PoW and the HSSP as a component of the strategy for improving services and health outcomes. For instance, one part of Programme Six of the PoW focused on strengthening VDCs and other local participation structures, and the PoW proposed that the Village Health Committee (VHC) should be the sole “health-related committee” at community level, replacing other committees with task teams to plan and implement specialised programmes. The PoW also included a commitment to enhance dialogue with NGOs operating at sub-district level to harmonise and reconcile approaches to community participation and empowerment in decision-making in health.

The HSSP “seeks to focus on community participation, in line with the Ouagadougou Declaration” and in particular the approach to improving quality assurance emphasises local participation (MoH 2011, p. 46). The guiding principles for the HSSP include accountability (to the people of Malawi) and that community participation should be encouraged in the planning, management and delivery of services). The strengthening of community participation is highlighted as one of the strategies to enhance access of health services. The MoH is currently (in March 2013) beginning a process of developing either a policy or guidelines on community participation in health.

This review suggests, however, that while there is a policy-level commitment to community participation and decentralisation in the health system in Malawi, and structures and processes have been established for this purpose, there are significant obstacles to the realisation of this commitment. These arise from a political imperative to maintain central control which has led successive regimes to retreat from the implementation of effective decentralisation, as well as from inequalities entrenched, in particular, in gender and education status.

4. Community perceptions of health services

4.1 Introduction

Understanding participation requires understanding of the perceptions and expectations of potential participants. Relevant factors include the information to which community members have access, their understanding of their rights and ability to act on them, and local perceptions of service quality and concerns, which may differ from those reported through formal data systems. This chapter examines these issues.

The terms of reference for this study included: (1) an emphasis on understanding community perceptions of aid and of aid donors; and (2) comparing community perceptions of health outcomes with evidence from other sources such as official statistics. However, many of the most significant aid programmes (those that are strongly aligned on the use of government systems) are not separately visible from the perspective of service users, and those programmes that are visible – primarily those implemented by NGOs – are potentially questionable in their modality from an aid effectiveness perspective. In the case where (as in the Malawi health sector) much aid is provided through government or non-government service providers that supplement government service provision, issues relating to participation will need to be assessed in relation to engagement with these service providers rather than to specifically identified aid activities.¹⁵

The remainder of the chapter is structured as follows. Sections 4.2 and 4.3 examine the preconditions for participation – namely community members' access to information and knowledge of health issues, their understanding of rights, and their willingness and ability to exercise them. Section 4.4 summarises the diseases and health problems that community members said they and the socioeconomic profile of the communities in this study. Section 4.5 captures community perceptions of access to services and quality of treatment. In section 4.6 we highlight the stated needs and priorities of community members. Section 4.7 describes community perceptions of donor agencies and NGOs, to the extent to which these were identified, and section 4.8 concludes.

¹⁵ These service providers are proximate representatives of the various aid modalities. Budget support and SWAps are channelled through state-delivered health care and other aid modalities through FBOs and NGO support.

4.2 Perceptions of rights and health services

Community members¹⁶ in rural Malawi have a good understanding of their rights and privileges as citizens in relation to the health sector. They knew they were entitled to certain services and materials such as mosquito nets, supplemental food for malnourished children, Lumefantrine-Artemether (LA) to treat malaria and appropriate treatment for their illnesses. Moreover, they understand that it is wrong for facility staff to disrespect them, to verbally and physically abuse them, and to provide poor treatment. We learned also that while they had many complaints about mistreatment and poor quality services, these complaints were mainly aired in local social networks and their rights were seldom claimed.

Yes we know them [rights as a client] but we don't exercise them fully. Let's say when the doctors have done something wrong to us and we tell the chief about it, sometimes the chiefs are afraid to take the matter to the DC.¹⁷

Most respondents stated that they heard about rights through the radio, while information provided from other channels was primarily focused on prevention. However, in their view, as health service users, this did not result in any improvement in the behaviour of health personnel:

We heard [about the rights of the clients] from the radio. [The message from the radio stated that] the patient has a right to tell medical personnel the type of medicine he or she does not want. You have the right to tell him that you do not take aspirin. And you will find out that the medical personnel dispense aspirin to you. They do not respect our rights. We just take the medication and find an alternative. [Do the health workers inform you about your rights?] They do not have time to inform us about this... They start working soon after arrival. You will never find a health worker disseminating information about the patient's rights but the radio does.¹⁸

As for the radio, we just know the most famous ones like ZodiacZ which has a programme that talks about the programme for the sick which broadcast on Saturday in the morning and took a bit of time to tell people who are sick about their rights. And those who were lucky, they were hearing about the rights of the sick even though the rights will not be respected because they are oppressed ...we consider health worker as those who always shout, even we ourselves it happens that our human rights are oppressed there.¹⁹

The respondents' perceptions were corroborated by the health workers, who said they seldom talked about rights and when this was done it was either very brief or actually done by some NGOs or civil society organisations. In Nkhata Bay during a FGD with HSAs, participants agreed that when providing Voluntary Testing and Counselling services they themselves do not 'really' talk about

¹⁶ The term "community" can refer to collectivities ranging from the entire population ("Our Malawian community"), a collection of villages under a Group Village Headman, a single small village, a religious organisation or a People Living With AIDS support group. A village is under a village headman (or headwoman), who is spoken of as the "owner" of the village. His or her power derives in part from tradition (the position is almost always inherited) and his control of the land, which in rural areas is effectively control of subsistence.

¹⁷ FGD, Male, Institutional Mapping, Nkhatakota.

¹⁸ FGD, Female, Wellbeing Analysis, Nkhata Bay.

¹⁹ FGD, HSAs, Nkhatakota.

patients' rights and only tell them 'you have a right to test or not' and noted 'but for us to go deep in details, we don't do that'.

Some people in the villages also noted that they seldom heard about their rights as patients from the health workers themselves. This was encapsulated by one community member who said of his recent visit to a health clinic:

I went there early in the morning but I never heard health workers explaining information about patients' rights.²⁰

Most health facilities have educational posters on their walls, in the waiting areas and the treatment rooms. There also exists a poster setting out the basic rights of a patient, which include the right of the patient to refuse treatment and seek alternative medication, but these were rarely observed during our visits to health facilities.

In summary, while community members knew their basic rights and complained when they perceived that these were violated, they complained to each other rather than to the staff or to the government-mandated accountability structures that were established to channel complaints (see section 6.4 for more detail).

4.3 Access to information

Health information through formal channels

Much health information is developed internationally and designed for dissemination by the MoH and by NGOs. It then cascades downwards through the districts to the communities. The information is disseminated through the media, health centres, volunteers for community outreach programmes, churches, schools and traditional authorities. It is also shared through informal social networks.

At the health facilities, information is provided through interactions between staff and clients, regular "Health Talks" targeting mothers of children under five given by health personnel, through posters in the health facilities, and, occasionally, a meeting at the chief's compound. This information, like the services provided, is disproportionately targeted at improving maternal and child health and improving sanitation and hygiene:

We receive information on sanitation; we also receive information on HIV/AIDS prevention and how to take medication for those people who have it. We also receive information from health personnel on how to prepare nutritious food for our children so that they should not be malnourished. For those of us with children that attend the under-five clinic, we receive information when we go to the under-five clinic.²¹

Community outreach programmes are primarily the responsibility of HSAs, the lowest rung of the professional health staff and often assisted by volunteers from the VHC and from NGO projects (see description of VHCs in Section 6.2). At

20 FGD, Male, Wellbeing analysis, Nkhotakota.

21 FGD, Female, Institutional Mapping, Nkhata Bay.

regular “Health Talks” and village under-five clinics for women, those who are pregnant are instructed to make antenatal and postnatal visits to the health facility, immunise their children, use family planning, and get tested for HIV along with their husband. The HSAs and volunteers also conduct campaigns to urge community members to build and use pit latrines, to construct a place to bathe and to make a drying rack for dishes. In addition, the HSAs alert communities to outbreaks of contagious diseases:

... if a new disease has come, we know fast through these people [HSAs]. Even this thadzi (Oral Rehydration Supplement) we receive, we know that even if we suffer from diarrhoea, we can go and get medication from them and we don't have to queue for it.²²

Sometimes we write letters to these churches to talk about health issues to their members too. So they help us in that way and they do it willingly (all agreeing). Churches help us a lot. Indeed they help.²³

Information also reaches communities through other formal channels, primarily the mass media (radio, TV and newspapers – see

Box 1), but also through volunteers trained by NGOs to deliver messages personally and through dramas.

Box 1 – Health messages from the radio

National radio programmes cover a broad range of health topics including the rights of patients and health information on maternal and child health, sanitation, HIV/AIDS and reproductive health. A group of female FGD participants from Nkhosakota said they heard about maternal and children health and hygiene issues and learned the following lessons from Radio Maria, Radio Alinafe and Nkhosakota:

- They say if a child comes from the toilet give it a bar of soap to wash its hands. If the child wants to eat, she/he should first wash her hands; the cloths and bedding should be clean. If you have a mosquito net, you should always make sure that the child is covered with it.
- Elders too, you should wash your hands after visiting the toilet. In the morning when you wake up, you should make sure that you have washed your face, to remove whatever you have produced in the night when you were sleeping; then you can start preparing food.
- Pregnant women should go to the hospital in time. When you go to the hospital you should not hide the disease from the doctor. It helps the doctor to give you a medicine that suits the disease you are suffering from. If you hide and say another disease which you are not suffering from, it will hurt you.
- If you are expecting do not go to the TBA.
- A group of women in Nkhata Bay also noted learning about ‘malaria prevention, cholera prevention, vaccinations and information about HIV/AIDS. They also noted hearing about cancer of the uterus.

²² FGD, Female, Neno.

²³ FGD, HSAs, Mchinji.

Understanding and use of information

As illustrated above, respondents in our FGDs and KIs were often able to narrate in detail the type of information they received and from what sources, suggesting that community members heard these messages and understood them. They also appreciated this information:

On mosquito nets distribution they [health facilities] are doing fine; they are distributing nets to every pregnant woman and every newborn child receives a net. This is what is happening. They also send information to the villages that the hospital will start distributing nets. Many people come to receive nets. We are mostly satisfied because they are for the betterment of the community. [Moderator: you are all mostly satisfied?] Yes, why not. They disseminate information in good time and we are not bitten by mosquitoes after receiving the nets.²⁴

We mean [when we say we are satisfied] that we are really informed and people come here [to the clinic], for example, when there is family planning meeting. Women really come in large numbers. When, for example, there are distributions of mosquito nets we are informed and we come to receive nets. That's what we mean when we say we are fully satisfied with the information from the health centre.²⁵

The community score card analysis conducted as part of this research also showed a high level of satisfaction, with over 81% of respondents being mostly or fully satisfied with the information provided to them by health workers (see Box 2).

Figure 3 – Health messages on a village house



This house depicts a health message translated as: 'Wash hands before you start preparing food'. In this rare community many of the houses had messages relating to hygiene and sanitation, HIV/AIDS and maternal and child health.

24 FGD, Male, Community Score Card, Rumphi.

25 FGD, Female, Community Score Card, Nkhata Bay.

The health workers themselves, not surprisingly, thought their information had led to change:

We also see a difference with how things are being done in some areas. Let's say the leaflet might be on the ITN (insecticide-treated nets), sanitation and other areas, and we have given it to the people. We know where these people stay and when we are doing some village registrations, we monitor whether that person has learned anything from what we gave her and in that way we know that the message we gave is really working.²⁶

Box 2 – Findings from the community score cards

The study conducted a community score card exercise in 11 FGDs with a total of 77 participants across the six districts of the study. Each participant first filled out a questionnaire (with the help of a team member for those who could not read); then they re-united and, after often lengthy discussion, agreed on a group score. Often, the group score differed from the average of the individual scores, suggesting peer influence. Below is a summary of the key findings of individual and group responses:

General treatment

Just over 50% of the respondents found the services they received satisfactory and the explanations given by the health personnel on illness and treatment clear. 58% of respondents were “mostly or fully satisfied” with the services provided by non-government health centres such as CHAM facilities. Given this, surprisingly close to 70% of respondents were “mostly or fully satisfied” with the behaviour of the health workers towards them during their last visit. This was lower when individuals voted as a group with just over half of the groups being “mostly or fully satisfied”. Nevertheless, over 40% of the respondents were “not fully or at all satisfied” with the honesty and transparency of health workers at the clinic. Over 50% of the group scores also stated this.

Physical access

Physical access to health centres was not a major constraint with 70% of respondents finding their health facilities to be “accessible or fully accessible”. However, only 35% of individual respondents were either “mostly or fully satisfied” with the health services near their communities; this was slightly higher when they voted as a group at 50%.

Cost

Individuals and groups had a less positive experience when it came to cost of health care and availability of medicine. Only 36% of individuals and 30% of groups were “mostly or fully satisfied” with the cost of medical treatment at the health centres. Moreover, over 50% of individual respondents were not fully or at all satisfied with the availability of medicines at their health facilities.

Health staff

Respondents had a more positive view of community health workers compared to health facility staff. 82% of respondents were “mostly or fully satisfied” with the HSAs in their community.

Information

81% of the respondents were satisfied with the information provided to them by health workers. 87% of individuals noted being satisfied with the work of VHCs, although close to 30% of the groups noted this response to be inapplicable since no VHCs existed in their communities.

Service providers and NGOs

65% of the respondents were mostly or fully satisfied with the response of health NGOs in their communities and 64% of individuals were either mostly or fully satisfied with the government's response to health problems.

²⁶ FGD, HSAs, Nkhata Bay.

Information through informal networks

Community members also receive health messages through their own informal social networks. For example, at the market or standing in a line at a borehole, women exchange experiences with family planning and advise each other what to do if their husband is unfaithful, thus exposing them to the risk of AIDS and other Sexually Transmitted Infections (STIs). Someone who has seen the notified vehicle bringing drugs to the facility tells others, who pass the information along.

Correspondingly, someone just returned from the clinic reports that the drugs are not available at the health clinic. During social gatherings such as funerals and church services, religious leaders and chiefs talked about health issues, especially related to the event they were participating in. The Traditional Authority for an area, for example, would talk about safe motherhood practices at a funeral for a mother who had died during childbirth.²⁷

We tell them [other people in the community] what we were told there [at the under-five clinic]. They [health workers] even tell us to tell our friends who did not attend. When we are chatting we tell our friends what we learnt at the h Or when we meet them on the road we tell them the information we got from the hospital. The friend that you shared the information with also tells her neighbour and other friends. ... During funerals the chief will share information because people gather during these events. During church gatherings information is also shared; for example, they tell us that tomorrow the people from the hospital are coming.²⁸

Gender and information dissemination

Women play a key role in disseminating information, since they are the majority of the clients of the health centres. It is women who come for antenatal care, postnatal care, and treatment for sick children (as well as for themselves):

Some of us who are married, when our wives have gone to the hospital they are the ones who bring us the information.²⁹

The HSAs perceived that information targeted at women was more likely to reach the communities and result in change than were men to be targeted:

So most people who receive messages are females, mothers. If you say to them that we should meet on such and such [a date] you find 10 females, two males. Or sometimes you will only find mothers only. [The men] think it will not help them. They do not take the things seriously. They say health issues are for the women or mothers. It is so because it is the mothers who take children to be weighed at under-five clinics. So if you [say] anything, they just think it is for the children. If we call the male they think maybe we just want to tell them something ordinary.³⁰

27 KII, Traditional Authority, Nkhata Bay.

28 FGD, Female, Institutional Mapping, Nkhata Bay.

29 FGD, Male, Institutional Mapping, Nkhotakota.

30 FGD HSA, Mchinji.

4.4 Disease and health problems

Communities were well aware of the common diseases, especially the infectious and chronic diseases and of reproductive health issues such as STIs.

While the rankings and order of importance differed slightly across research sites, the same diseases and ailments were mentioned. The most common sources of poor health were perceived to be malaria, diarrhoea, pneumonia/ respiratory tract infections and malnutrition. AIDS was mentioned, but often only after probing. There was far less mention of mental illness or eye and oral problems.

There was a widespread perception that although the communicable diseases affected the entire community, they tended to affect children under the age of five years old and the elderly more severely than the rest of the population. This was especially perceived to be the case with malaria and respiratory tract infections and, for children under five, malnutrition and diarrhoea. Some of the illnesses and diseases were seasonal, for example diarrhoea, cholera and malaria, which were perceived to increase during the rainy season. Outbreaks of cholera were linked to flooding of toilets and lack of adequate boreholes affecting the sources of clean water available to households. Community members were aware that a lack of proper hygienic practices in the community contributed to the incidence of diarrhoea and other gastro-intestinal tract infections and that this was the point from which diseases could spread to other families living in those localities.

Some individual respondents stated in KIIs that the communicable disease burden was equally distributed across different socioeconomic groups within the community. However, the findings from our wellbeing analysis, conducted in FGDs with a social mix of participants,³¹ showed that most perceived malaria, diarrhoea and cholera to affect the poorer members of their community disproportionately due to their living conditions and habits. Their houses were damp and dark, they did not use mosquito nets and they did not have enough money to buy chlorine for the borehole. The poorer households were also perceived to delay seeking treatment, thus increasing the severity of the illness.

Malaria, reported both by health care workers and community members as the most prevalent illness, was widely perceived as both avoidable and treatable. Rural Malawians are well aware that mosquitoes were the vectors for the malaria parasite and that preventing mosquito bites was an effective way of reducing malaria incidences. Many had received free mosquito nets from the government: to reduce barriers to possessing an insecticide-treated mosquito net, since 2007 insecticide-treated mosquito nets were given to pregnant women and children under five years old attending a public health facility (Skarbinski et al. 2011). However, in the FGDs, it became apparent that some community members did not have mosquito nets and that some who had nets did not use them. An FGD

31 The participants were randomly selected through snowball sampling and invariably included a socially mixed group of participants. While there was no way of ascertaining the social status of the respondent, the groups in many instances identified themselves as poor or very poor and some as better off.

participant reported that he sometimes felt that, when using his mosquito net, *'he should open here so that some air can pass and mosquitoes gain their entry through there'*. Others said that *'we will use the net when we hear the mosquitoes; we don't like the smell of the nets'*.³²

Outbreaks of cholera and measles appeared to be particularly alarming, perhaps because deaths are concentrated in a relatively short period of time. Speaking of the head of a health centre, who was said to be lazy and unwilling to see patients at night, a member of a FGD said:

*However, when there is a cholera outbreak he works hard, because cholera is a deadly disease. If people go to him at night he wakes up instantly. Because he knows that if people die because of his negligence, men in the community will violently attack him and beat him. So because of this he becomes a dedicated health worker during cholera times.*³³

AIDS was believed to particularly affect rich men and young women. During FGDs, participants suggested that the rich men were more sexually active because they had a higher income, and thus were fair game for mercenary young females who were *'after their wealth and resources'* and *'who seduce Roman (rich) men so that they are given cooking oil and money'*.³⁴ Additionally, the rich were seen to use their money to dominate the sexual relationship:

*[Rich men are more affected by] AIDS because they have more money and they chase women. [The poor woman is at risk] because she can meet a rich person and say "This is money, I want to do something with you [sex] and even if the woman says "I would like to protect myself with Nyuchi [meaning honey in Chichewa, this is a Malawian condom brand], the rich man can say "this is money! I am not going to accept putting on the condom because I have money and the poor woman can accept (because she wants) money and she will not have protection.*³⁵

The rich were also perceived to be more susceptible to lifestyle diseases. A STEPS survey conducted in Malawi in 2009 supports this perception and confirmed that a total of 32.9% of Malawians aged 25–64 years were hypertensive, while 8.9% suffered from cardiovascular diseases.³⁶ In our research, those in formal employment – and therefore with steady dependable incomes – were seen to be well-off and to be afflicted by non-communicable diseases like diabetes, hypertension and obesity much more than those who were seen as poor and who typically were either unemployed or engaged in small-scale retail. The FGD respondents remarked that *"sugar disease [diabetes] affects them [The better off]... because they have tea daily. Here we drink tea when we have done [been paid for] a piece of work."*³⁷ Other non-communicable diseases mentioned were cancers, including Kaposi's sarcoma in

32 FGD, Male, Social Mapping, Neno.

33 KII, Male, Balaka.

34 FGD, Female, Wellbeing analysis, Rumphi.

35 FGD, Female, Wellbeing analysis, Neno.

36 Malawi national STEPS survey for chronic non-communicable diseases and their risk factors. Final report. Lilongwe, Government of Malawi, MoH, and WHO, 2010.

37 FGD, Male, Rumphi.

HIV positive people, uterine cancer and breast cancer. Kaposi's sarcoma was mostly seen in HIV positive community members. Cancer of the uterus was believed to be caused by "early age of sexual initiation, numerous deliveries and using corrosive sex herbs like *munowa* and *sekeseke*".³⁸

Chronic illnesses, such as arthritis and rheumatism, were of much less interest than contagious diseases. The former were perceived to primarily affect the elderly, with no differences by sex or socioeconomic status.³⁹

The only mental diseases explicitly mentioned in the FGDs and KIIs were youth who "ran mad" because of smoking marijuana (dagga) and depression, sometimes attributed to marital problems or to "nerves" consequent on receiving an HIV positive diagnosis.

There was scant mention of oral or eye diseases. With no national oral health policy to guide development of dental services, dentists are concentrated in urban areas and there is a distinct lack of awareness amongst the rural community about oral health issues.⁴⁰ The only eye disease mentioned was conjunctivitis. With a population of 11.3 million people, and an estimated prevalence rate of blindness of 1.0%, Malawi has about 113,000 blind people in the country, of which up to 80% of all blindness is a result of five preventable or treatable conditions: cataracts, glaucoma, trachoma, childhood diseases that cause blindness and harmful traditional practices.⁴¹ There were no diseases that were seen to affect certain communities or tribes exclusively.

4.5 Access to services, quality and treatment

Sources of treatment

From the FGDs and KIIs, it appeared that all Malawians have access to formal health facilities, they use them and they value them highly. The only exceptions mentioned were small religious groups whose doctrines forbade it and the use of traditional healers for a small set of health problems that were perceived as more effectively treated by a traditional healer. Because of the costs of transportation by bus and the opportunity costs of time spent walking to a distant facility, most people attend the nearest health facility. The major differences in perceptions of treatment and services were between those who attended the government facilities, where services and drugs were free but users complained about service quality, and those who attended the private CHAM hospitals, where users complained about the fees for services and drugs but appreciated the respect they were shown by service providers.

The first port of call, when a community member fell sick, was usually the government medical facility with referrals to other hospitals, if need be. For very minor illnesses community members also consulted the HSAs:

38 FGD, Female, Institutional Mapping, Rumphi.

39 FGD, HSAs, Nkhata Bay.

40 WHO, African Health Observatory http://www.aho.afro.who.int/profiles_information/index.php/Malawi:Analytical_summary_-_Non-communicable_diseases_and_conditions

41 National Strategic Plan for Eye Care in Malawi, 2004–2008.

We started going to the government hospital and sometimes they tell us that [for] this type of disease you are suffering [from] we do not have the medicine for it so maybe you should try the private hospital, maybe they can help you very quickly there.⁴²

Private facilities were also sometimes used if they were nearer to the patient's home, such that relatives could more easily provide them with food and personal care.⁴³ Private medical facilities (mainly CHAM) were also believed to provide higher-quality health care and better customer service, as well as being more likely to have drugs available:

[Among the hospitals you have mentioned, which one gives you good services?] The Roman Catholic hospital. It is a paying hospital [You select this because they give you good services?] Yes, if you go they don't hesitate in helping you. It is because they know you will pay them. They know that it's money. If they see you they see money!⁴⁴

However, households' ability to access private facilities depended on their income levels and ability to meet costs. In a wellbeing analysis exercise, participants noted that the very poor rarely visited private clinics and that it was only the very rich or middle-income individuals who were able to go to private clinics. However, the poor within the catchment areas of CHAM facilities are exempt from the costs of certain services, especially related to maternal and child health.

People referred to HSAs, especially for their children under five. They were preferred because they were accessible and tended to the needs of the community. Most community members spoke of HSAs positively: *'when you are sick (with) cholera, they help you accordingly, and they give you medication for cholera, so they help you'*. They also said that *'the HSA also works more than a doctor⁴⁵ and more than a clinician because he knows that he chose to be an HSA working with people in the village.'*⁴⁶ In the community score cards, in the scoring as an FGD group and individuals, over 60% of respondents were mostly satisfied or fully satisfied with HSAs in their community.⁴⁷ The HSAs are also closer than the facility staff in terms of social status: the HSAs only have secondary education and a short period of training for the job whereas the staff have more education and more training. When there were complaints about the HSAs, it was because the HSA did not live in his/her assigned village but rather in a trading centre and thus was not accessible or because he was lazy. As one FGD participant put it: *'they just visit us'*, which was not enough – she wanted drugs or nutritional supplements, not just a visit.⁴⁸

Although the formal health facilities were considered more important than either traditional healers, TBAs or the few individually-owned private clinics (primarily in district capitals or large trading centres), rural Malawians are pragmatic: when

42 This refers to government clinics. Community members used hospitals interchangeably with government clinics, but when they actually meant hospitals they would refer to it as district hospital.

43 FGD, HSAs, Rumphi.

44 FGD, Female, Mchinji.

45 Community members often call the medical assistants and other health workers 'doctors'.

46 FGD, Female, Community Score Card, Balaka.

47 Refer to Community Score Card summary results.

48 FGD, Female, Community Score Card, Balaka.

treatment at a formal structure was not effective, they looked elsewhere, such as to a religious leader or a traditional healer. In addition, traditional healers were perceived to be more useful than clinic staff for a set of specific problems: snake bites, infertility, epilepsy, 'yachikondi' (love disease), 'kasipa' (being bewitched), 'kamatira' (urinary and faecal incontinence) and chronic unexplained illnesses. For these, even the health centre staff would sometimes advise patients to visit a traditional healer:

For something like epilepsy, the option of going to the hospital comes second [after going to a traditional healer]. [What have you said about sharpening (kusula)?] That's when you are not fertile enough in the house, you are not giving birth and you can't go to the hospital with such a problem but a traditional doctor... He is very important... people kill each other through magic but if we go to the Mfiti ndichiza [traditional healer] he removes the magic spells, whereas at hospitals it is impossible to remove [them]. At the hospital they say that you are not sick. They cannot scan them at the hospital while at Mfiti ndichiza people get healed; he removes the magic.⁴⁹

Community members usually heard about traditional healers through word of mouth and visited them at their homes, although this might be at a distance away. FGD participants explained that there were advantages to the traditional healer: there would usually be no queues, the service was personalised, and drugs were always provided – there was never a shortage, unlike the situation in the government facilities where there were stock-outs.

Community members also reported fewer deliveries through TBAs in recent years. In a number of institutional mapping experiences, for instance, TBAs were often ranked as the least important of all the service providers and were also perceived to be socially far from the community members. Participants explained that the government had banned the use of TBAs, with the local authorities fining those found to deliver through TBAs. Although the ban was lifted by President Mutharika in late 2010, during our fieldwork births with a TBA were still perceived to be illegal, so it may be that this led the FGD participants to say that the TBAs were not important. There were said to be advantages to the TBAs – delivery at home or at the home of the TBA and personalised care from a respected neighbourhood figure – and indications that some women continued to deliver with TBAs. To avoid a scolding when she went to the facility for postnatal care or immunisations or a fine from the chief, a woman who did not deliver in the facility explained that labour began so suddenly that she was unable to reach the facility.

The institutional mapping exercises asked participants to name the institutions that were relevant for health, and to categorise them according to the degree to which they were important⁵⁰ and the degree to which the participants felt socially

49 FGD, HSAs, Balaka.

50 Importance was explained as those:

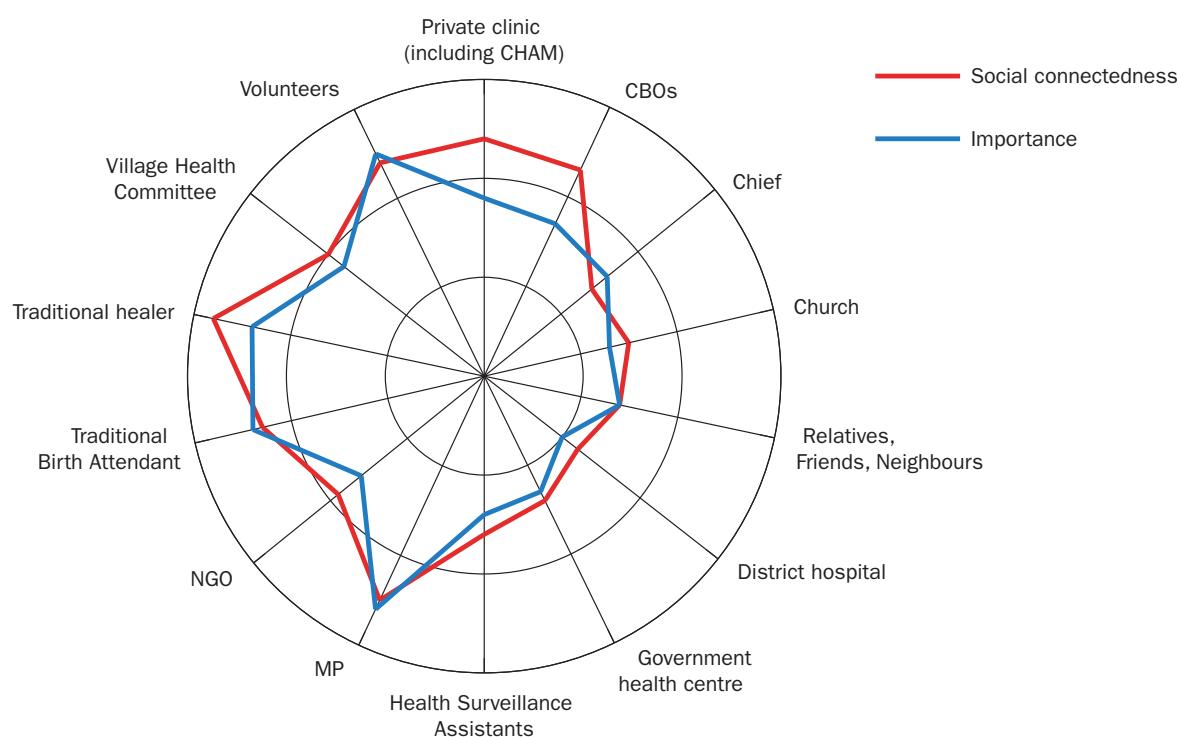
- a. That have **knowledge, experiences** and **resources** to **help and treat people** in the community when they are sick or to **keep the community healthy** (for example by immunising your children or teaching you about cleaning your latrines).
- b. Who are also involved in making decisions that affect health programmes, policies or types of resources distributed at the community

close⁵¹ to them. While the findings from this exercise varied from group to group, there were significant commonalities (See Figure 4):

- Government health facilities and district hospitals were ranked as very important and socially close in most FGDs;
- Church and other informal social networks (friends, relatives, and neighbours) were almost always very important and very close;
- HSAs were usually important and respondents felt socially connected to them;
- CHAM facilities and private clinics were important, but not socially close due to costs; and
- VHCs and individual volunteers were less important and not socially close to the respondents.

Traditional healers, TBAs and MPs were the least important and socially far from the respondents.

Figure 4 – Who matters: findings from the institutional mapping (Venn diagram) analysis



Note: 1) Importance and social connectedness are signified by proximity to the centre of the diagram. The closer the institutions are to the centre the more important they are to the respondents.
 2) These plots show the average score given for each institution when mentioned in the FGDs. Some institutions were only reported in some of the FGDs. Community-Based Organisations (CBOs) were only mentioned in three FGDs (out of 11). The remaining institutions contained scores from at least five FGDs.

51 Social connectedness was explained as respondents being able to reach them if they had a problem, rely and depend on them and know they would take care of them.

Quality of services

What was perceived to constitute good-quality health care differed, with the most important differences being between the perceptions of those who attended government facilities and those who attended CHAM facilities. For both types of users, the quality of care had two components: treatment and services. Treatment was the primary concern, whereas how it was delivered was less important.

Generally, community members felt that good-quality health care was something that allowed them to receive all the prescribed medicine required from one place and that the time from arrival at the health facility to receiving care was 'reasonable'. There was no consistency regarding what constituted 'reasonable' time but the consensus seemed to be that medical workers were expected to see patients on time, listen attentively to their concerns, carry out the requisite physical examinations and laboratory tests, and prescribe and dispense all the necessary medicine. It was highly desirable that this healthcare also be affordable to the local populace.

HIV positive community members were of the opinion that good-quality health care was one that allowed them to receive anti-retroviral (ARV) medication on time. They also wanted medical personnel to respect their confidentiality and privacy rights.⁵²

The HSAs felt that good-quality health care was about *'receiving treatment at the right time with the right medication and by the right person. This person has taken all the courses. And the patient has received quality treatment in which all the instructions have been followed'*.⁵³

Good-quality health care was also judged on the tangible outcomes of the healthcare-seeking process rather than the process itself. Respondents considered their interaction with health personnel to be highly successful if they received medication that they considered to be effective. It was important to be given *'strong medicines'*: there was some suggestion that injections were *'stronger'* than pills and were highly desirable as they were thought to work faster, be more potent and produce visible results like *'making people sweat and getting them healed'*.⁵⁴

Those who attended CHAM facilities said that drugs were readily available, albeit at a cost for many of the drugs. But those who attended government facilities, where all drugs were free but not always available, said that the strong medicines were withheld from the poor and given to the rich, or that the poor got half a pill rather than a whole pill, or that the drugs were sold to the CHAM hospitals, while those at the public facilities got Panado (paracetamol).

52 FGD, Female, Institutional Mapping, Nkhata Bay.

53 FGD, HSAs, Rumphu.

54 FGD, Female, Mchinji.

In one FGD with those in a government catchment area the view was that treatment was inadequate because *‘they mostly just prescribe Panado for every disease’*. They compared this with an example of a good doctor who was no longer there. He would send them to have an X-ray taken and then afterwards tell them what their problem was.⁵⁵

Perceptions of the quality of the services depended on the interactions with the staff, although to a much lesser extent than the effectiveness of the treatment. Particularly important was the respect, or disrespect, shown to the clients. The clients of the CHAM facilities praised the services, while those in the government catchment areas were more likely to speak of disrespect and abuse.

Disrespect was communicated by behaviour, such as keeping people waiting by opening the clinic late (See Box 3) or by chatting with co-workers rather than attending to clients, by verbal abuse and contempt, and sometimes by physical abuse (slapping, hitting and even beating):

*It happened one time that I was supposed to be operated on. I was lying down on the bed and they had to put a drip in my hand. The nurse told me that I should sign the paper. I told the nurse that how can I sign with all the things around my hands? The nurse slapped me on my cheek. When I see this nurse I feel bad about her for what she did.*⁵⁶

*When you enter the health facility they shout at you, and when you ask the measure of the drugs they shout at you as well. For example, we are told that when your child gets sick suddenly you have to go to the hospital. But there was a time when my child was sick during the afternoon, I went there, they said today we work a half day here, so go to Chiyendausiku.*⁵⁷

Examples of verbal abuse and shouting were widely reported in the catchment areas of government facilities in all study sites. In one FGD in Neno a patient's relative told a story of a nurse shouting at them and saying abusive things, like *‘I am educated, you can't tell me what to do’*. Another woman in the same FGD went to the hospital when she was critically ill and was not attended to, but when the guardians started complaining they said *‘no you go and buy fuel and take this person to Mwanza Hospital yourself’*. Another woman, however, disagreed: *‘No, I think it depends because I went there with my father who had an eye problem and he was treated well’*.⁵⁸

55 FGD, Male, Community Score Card, Neno.

56 FGD, Female, wellbeing analysis, Nkhata Bay.

57 FGD, Female, Balaka.

58 FGD, Female, Community Score Card, Neno.

Box 3 – A patient's experience of health care, Neno

In a FGD on the most significant change in health that participants had experienced, most chose to tell stories of their unsatisfactory interactions with a health provider. Daisy*, a young mother from a village in Neno who was a participant in a female FGD, told the others that one day she had gone home at noon to check on her child who had been unwell for several days. She found that the child was very weak due to diarrhoea and took the child to the local government health centre. When she arrived she found that the medical personnel had already gone for lunch yet it was only a little past noon. Daisy said that seeing how critical her child's situation was, she mustered enough courage to go to the medical personnel's houses to seek emergency care. When she found them, she was told "we should eat first because you have come at lunch time". Daisy said that she continued to desperately plead with them for assistance for her child but they were adamant that they would not help, adding "it's impossible unless we eat". Describing herself as calm and resolved, she reluctantly went back to the waiting area and gave the child frequent sips of water as she waited for the medical personnel to return from their lunch break. They resumed work at around 2 p.m. By then, the child's condition had deteriorated and she died a short while later. Daisy said that had she known that she would encounter such unhelpful medical personnel, she would have sought help elsewhere and her child would probably have still been alive. She says she 'lives with that regret'.

*Names changed

Correspondingly, respect and listening to patients was appreciated: one male FGD participant recounted how he went to the hospital suffering from a long-term illness. When the doctor started prescribing before he had heard his entire history, this man spoke up and corrected the impatient doctor:

When he went to the doctor the doctor started writing, the guy said ah no, look at the passport [health booklet] first. So he did, and the doctors said you are right, so I am changing the drug.⁵⁹

Although community members complained about the rude behaviour of the health workers, some were also sympathetic and understood that the doctors who shouted and turned them away at night were overworked and that more health personnel were needed in the system to reduce this load:

There is a need for either two or three doctors. That means one can work during the day and the other one during the night. That means everyone that comes like, for example in the middle of the night, his or her problem will be dealt with by the one on night duty. That means they won't be sending us back and they won't be shouting at us again. That means the shouting would have decreased because they will have shifts. But because there is only one, he sees that he has been working during the whole day up to the evening. So, for him he takes evening as time for resting, but illnesses do not see that this is the morning, this is the afternoon, this is the night. They just come any time.⁶⁰

59 FGD, Male, Social Mapping, Neno.

60 FGD, Female, Community Score Cards, Balaka.

The perceptions of those who used the CHAM facilities were much less critical. They said that drugs were available, the staff explained the diagnosis in a respectful and friendly manner, and the facilities were clean. Instead, their most frequent complaint was about the cost of treatment and services:

We can say that at the CHAM health centre we are helped very quickly, you don't have to wait for a long time to get help, even if you have a child who is weak they [see] him fast. Only the price is a problem... In terms of (quality of) care we are satisfied but in terms of charges we are complaining.⁶¹

Preferred choice of service providers

Although those respondents who attended the CHAM facilities had some of the same complaints as those attending government clinics, they felt that the quality of services provided at the CHAM facilities was much better than the services provided in government clinics and were satisfied with the care that they receive from CHAM institutions. Analysis of community score cards showed that close to 60% of the respondents were mostly or fully satisfied with the services provided by CHAM institutions. This contrasted with just 35% of respondents being either mostly or fully satisfied with the health services near their communities, which were in most cases government facilities (see Box 2). Most patients felt the waiting period at the CHAM facility was reasonable and they could understand what the health provider was telling them.⁶²

The analysis of the KIIs and the FGDs confirmed that people in the vicinity of catchment areas containing both CHAM and government facilities preferred the CHAM facilities because of the availability of drugs and their friendly and respectful staff who provide explanation of the diagnosis to the client. Some respondents felt the facilities were very clean and were perceived to provide good-quality services. Free provision of maternity services was also mentioned to have motivated women to use the CHAM facilities.

Barriers to access

Some of the observed barriers to community members accessing health services were costs, geographical distance, frequent drugs shortages and disrespectful behaviour at government facilities and, for a small number, religious convictions that prohibited secular healing.

Geographical distance

Close to 70% of the FGD participants found their health facilities to be accessible (see Box 2). When they were not, it was due to the costs associated with distance: the monetary cost of transport and/or the opportunity cost of time spent walking. When treatment at the health facilities was insufficient, clients were referred to the government district hospital that is geographically distant, posing a constraint for households unable to pay for transport costs. Government hospitals were meant to provide free ambulances to ferry patients to the hospitals, but these were rarely available and often arrived very late.

61 FGD, Women, Mchinji.

62 Refer to Community Score Card summary results.

Cost

The cost of health care was the most frequently mentioned barrier to access. Government treatment and services are free, but CHAM is not. In practice, however, both entail costs that may be a barrier to timely health care. Users of government facilities do pay a cost when drugs are not available and they are told to buy the drugs themselves. In this situation, they may delay purchasing the drugs in the hope that they will improve without treatment or that the drugs will soon be available. Users of the CHAM facilities may also delay timely health care because at the time they did not have the resources to pay for the services and drugs. According to the clinical officer in charge of the CHAM-run health centre in Rumphi, CHAM facilities mitigated this problem by offering credit, secured by something valuable such as a bicycle, a health passport or even a woman's *chitenje* (wrapper). Still, if the client defaulted, he/she could be turned away at the next visit. Access to ambulances in emergencies appeared to be particularly troubling. Often no ambulance was available and when it was there was often a fee for its use:

*... to call an ambulance you need to pay 8000 kwacha (US \$22). It is very expensive. With the poverty of Malawi it is very difficult (and) this is our biggest problem.*⁶³

Ambulance trips were free, but only for expectant mothers.⁶⁴

Access to drugs

Persistent stock-outs of drugs – especially of the anti-malarial LA, paracetamol (Panado) and antibiotics – were a barrier to users of the government health services. This discouraged community members from seeking services at government health centres and some would resort to travelling directly to other government or private facilities that were believed to have drugs available:

It takes time for the hospital to receive the drugs after the end of the previous drug stock. We experience a lot of problems. People go to private clinics because at times we do not have enough drugs here.

*...And the government should supply more drugs in these areas, enough for the population of that area. At times, the government sends medication which does not match with the equivalent population of the area.*⁶⁵

To overcome the drug shortages government facilities sometimes prioritised the young over the elderly or reduced the dosage given to patients.

Staff behaviour and discrimination

Staff behaviour was perceived as a barrier primarily for users of the government facilities. Users of CHAM, although they complained about the costs, were pleased with the way the services were delivered. Those in the government catchment areas, however, took their own previous experiences as well as the

⁶³ KII, HCAC, Rumphi.

⁶⁴ KII, HSA Supervisor, Rumphi.

⁶⁵ KII, member of HCAC, Rumphi.

stories told by neighbours into account when they decided whether to go to a health facility immediately, to delay, or to not go at all.

Community members were wary of seeking treatment out of hours or when a particular health team member was present based on past experiences of verbal abuse and mistreatment, as discussed above. Some would forgo treatment at government health clinics altogether:

Like for me if am pregnant, I cannot go to deliver at the hospital because I know I will be shouted at and [they will] say at your age are you still giving birth?⁶⁶

A common perception was that the health workers treated the rich and those of a higher status better than the poor. When the rich went to government facilities they were said to be attended to more quickly and ahead of the queue and were given sufficient and potent medications while the rest were given paracetamol:

[The rich] when they come to the hospital receive treatment quickly because they are known and some of them are businessmen.

The rich receive the real drugs, underhand rather than through the pharmacy. The poor don't get the real drugs – they get their drugs from the pharmacy. The rich get injections rather than Panado and the poor don't.⁶⁷

As a result the rich were not likely to complain but when they did complain about poor service, they were perceived by the non-rich to be more likely to have access to a staff member, a member of the Health Centre Advisory Committee (HCAC) or the DHO. For example, one district official in Balaka said he waited with his sick child for 20 minutes and then called his friend, the DHO.⁶⁸

Beyond social status and wealth, the research found no evidence of discrimination based on religion⁶⁹ or ethnicity. There was no mention in FGDs of discrimination in service provision across ethnic groups, and the health personnel insisted that there was none.

The study also found no clear evidence of discrimination by gender, although many of the complaints of bad behaviour related to experiences of women in the maternity wards, often as a result of bad treatment by a female nurse. As a result many female FGD participants had a preference for male over female nurses.

66 FGD, Female, Wellbeing analysis, Nkhata Bay.

67 FGD, Female, Wellbeing analysis, Neno.

68 KII, Male, Balaka.

69 There were a few cases of religious practices and beliefs impeding community members from accessing and utilising health care services. In Nkhata Bay district, the HSAs reported that the Jehovah and Michael cult barred its members from being immunised. In 2010, there was a measles-related fatality and had it not been for prompt quarantine measures against that community, there had been an imminent danger of a measles outbreak in the area.

4.6 Needs and priorities

Priorities varied across categories of respondents and geographical regions. HSAs and health personnel prioritised resources that would improve their working conditions, particularly better housing, more training, and more ambulances. In general, the needs and priorities of the communities were aligned to what they identified as barriers to accessing health services and receiving 'good treatment', particularly access to drugs. Community members also noted the need for access to safe water, mosquito nets and finally more professional and better mannered health personnel who were regularly monitored. HSAs and health personnel noted the need for more and better facilities, housing for health staff, and more ambulances.

Drug shortages

The community members using government facilities were adamant that the need for more drugs was a burning issue. They could tell when drugs arrived by 'seeing the car has come and offloading the medicine', when they 'received drugs that they were not expecting' or by word of mouth from friends who had received drugs at the medical facilities. They felt that these medicines did not last long and added that in the meantime they were given some drugs to delay reaction or ease pain while awaiting the appropriate medication. For example, one respondent noted that if they had high blood pressure, they were 'given other types of drugs just for prevention while waiting for the real drugs to come', revealing the chronic paucity of drugs for non-communicable diseases:⁷⁰

For the past two years [there have been many] drug shortages. [Now we have had] drug shortages for the whole month so for one suffering from malaria [it is] difficult to go to the mission hospital since people rely mostly on government facilities because in mission hospitals one is supposed to pay. This has also mean that children have died due to lack of drugs in government facilities⁷¹.

Most of the time, the drugs are just Panado (paracetamol), LA and ARVs. A woman complained that she had never received penicillin; it is only Panado, LA and ARVs. Are these the only drugs found in the hospital? We always wonder!⁷²

While the drug supplies had improved at facilities delivering drugs through the USAID/UNICEF supply chain process, it was not believed to have improved elsewhere within government facilities. Community members noted that there should be more supervision and visits to the facilities to find out what drugs are found there and they also wanted the drugs in the government facilities to be labelled in a manner so that they can be distinguished from drugs available in the private facilities. They also noted that drugs from the private clinics should be stamped to indicate that they come from private clinics, in order to help the 'auditors'.⁷³

70 FGD, Female, Most Significant Change, Neno.

71 FGD, HSAs, Mchinji.

72 FGD, Female, Community Score Card, Neno.

73 FGD, Male, Community Score Card, Neno.

Clean water

For the ADCs, like those in Neno, Balaka and Nkhotakota, safe water was their highest priority. Equally, some community members felt the need for clean water sources and were advocating for the provision of boreholes.⁷⁴

Insecticide-treated mosquito nets

Community members recognised the importance of mosquito nets for preventing malaria. They perceived that there had been a reduction in malaria cases due to the recent mass distribution of nets to children and pregnant women, as well as the change in malaria treatment (the introduction of LA) and the use of rapid testing kits at the facilities. These perceptions are consistent with official data from UNICEF's Multiple Indicator Cluster Survey and the recent Malawi Malaria Indicator Survey. These found that possession of at least one net had increased from 49.5% in 2006 to approximately 63% in 2010 with utilisation for pregnant women and children under five increasing from 26% to 49% and from 23% to 59%, respectively.^{75 76} However, respondents said that they wanted the government to distribute more nets, such that everyone, not only children and those who were pregnant, could receive them.

Improvement in health facilities and housing for HSAs

Many of the health facilities were perceived to be in need of revamp and maintenance. Lack of resources had meant under-investment in the facilities over a long period of time, against the backdrop of growing population size and demand for services.

Community members regarded the HSAs as important in the delivery of health services to their communities but recognised the deterrent effect of unsuitable accommodation. According to them and indeed to the HSAs themselves, it was a challenge to find housing in the villages that was acceptable to the HSAs and this forced some of them to 'run away because of the problems they were meeting'.⁷⁷ The HSAs interviewed for their part wondered why government teachers (their equivalents in the public education system) working in the same areas received hardship allowances yet they did not.

Finally, another concern was that the HSAs were sometimes provided with bicycles but not the spare parts to repair them when they broke. This further de-motivated some of the HSAs:

*The government gave us bicycles but when it breaks we [have to] buy spare parts ourselves. That is a big problem because [if it happens] mid-month you don't have anything and you [are forced] to go to work [on foot].*⁷⁸

74 KII, Male, Mchinji.

75 National Malaria Control Programme: Malawi National Malaria Indicator Survey, MoH, Lilongwe Malawi, 2010.

76 Mathanga et al. (2011).

77 FGD, HSAs, Rumphu.

78 FGD, HSAs, Balaka.

Professionalism from medical personnel

Community members demanded to have health personnel possessing the right attitude, empathy, work ethic and commitment to their cause. Rude and inconsiderate health workers discouraged patients from seeking health care.

Transport to hospitals in emergencies

The community members participating in FGDs expressed an urgent and dire need for transport services to ferry them, whenever they had acute and severe illnesses, from their home to the medical facilities and in between medical facilities. They regarded this as a high priority. Whenever ambulances broke down or were not available for their use, the community members would send high-level delegations to petition the authorities and have the ambulance services available. Interestingly, even though ambulance services seemed a high priority, whenever the community members were asked to contribute money to buy spare parts for the ambulances and have them repaired, more often than not they were unable to raise the monies:

We [have to] travel long distances... So we are just asking about transport. In other places, we need a motorbike because even cycling can be a big challenge. With a car or a motorbike you reach the destination (hospital) in good time, much better than walking.⁷⁹

4.7 Perception of donor agencies and NGOs

Unsurprisingly the activities of international donors were a world away from these rural communities. Instead, community members' main perceptions of international aid and donor agencies in the health sector were based on their local-level experiences and interaction with international NGOs and to a lesser extent CBOs and FBOs. FGD participants had no apparent awareness and understanding of donor organisations such as NORAD, DFID, or the World Bank as they were not seen as the providers of material benefits to the community, which are often delivered to the communities through NGOs or through direct support to the government or FBOs. Sometimes if the NGOs only work at the health facilities even they are not known to the community members, especially those further away from the clinics. Where NGOs are actively present in the communities during programme implementation they are recognised as the benefactors:

Yes they [NGOs] are available. I am saying that they are available because I often go to the hospital and have seen them there but they do not come to the community. For instance for ARVs drugs, lots of NGOs are taking part [in providing them] but a villager like me here in the village who takes these ARVs, doesn't know any NGOs offering these drugs or what they do in terms of these ARVs. He or she only knows that the government is helping him/her with ARVs but does not know the organisations. But these organisations do exist and we do see them at the hospital.⁸⁰

⁷⁹ FGD, Male, Institutional Mapping, Mchinji.

⁸⁰ FGD, Female, Balaka.

This was confirmed in an institutional mapping analysis by FGD participants, during which donors were rarely identified as important for the health care. Donors were only mentioned twice by the respondents. In one instance the programme related to education and in another a school feeding programme. This point is illustrated in Figure 5, an institutional mapping analysis in Balaka District. Here the FGD participants selected the World Bank as an important institution but placed it (along with MPs) in the margins of the circle, signifying social distance from community members.

Figure 5 – Institutional mapping analysis in Chenda Usiku catchment area, Balaka

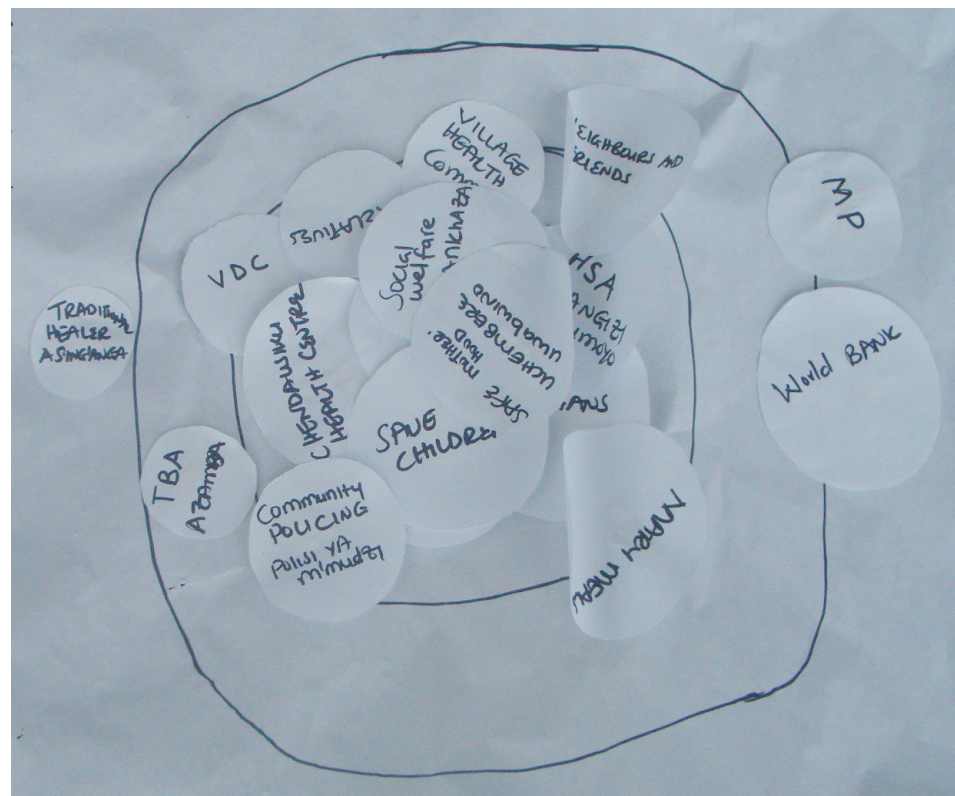


Photo: McDafton Bellos

NGOs were heavily involved within the health sector and implemented a number of programmes in the research communities. The perception of community members and their interaction with the NGOs are described in further detail in Section 5.4.

4.8 Conclusions

An important finding in this analysis of community perceptions of health services is that, across all study sites, community members understood what they were entitled to receive from their health facilities. Community members showed themselves to be well informed on health issues and showed high levels of satisfaction with the amount of information provided to them by health workers. Their sense of entitlement was expressed in terms of good medical treatment and the right to be respected. However, these rights were seldom claimed.

Respondents were knowledgeable about the causes of, and treatments for, the commonly mentioned health problems, which were similar across the regions and catchment areas: malaria, diarrhoea, respiratory infections and malnutrition. AIDS was seldom mentioned as a common disease without probing, but when it was mentioned respondents were knowledgeable about its consequences and the modes of prevention.

The common health problems were not perceived to vary by gender, ethnicity or religion, but they were perceived to vary by age and socioeconomic status. Children under five and the elderly were reported to be the most vulnerable to illness, especially diarrhoea for the children and respiratory tract infections for the elderly. Poor households were seen as disproportionately affected by malnutrition and contagious diseases, which were said to be associated with poor access to clean water and their damp and dark living conditions. The poor were also perceived as having insufficient concern for their health. AIDS and diabetes were both perceived to be disproportionately illnesses of the rich, AIDS because it was associated with men buying, and women selling, sex, and diabetes because the rich could afford to buy sweets and foreign foods.

Formal health facilities, both public and private, were at the top of the list of institutions considered to be important for health. For almost all health problems, people sought treatment by modern medicine. Only when the treatment failed or for a small set of illnesses did people turn to traditional healers, sometimes at the recommendation of facility staff. Most went to the facility nearest to them: government facilities if they lived in a government catchment area and the private CHAM facilities when they lived in a CHAM catchment area. There were several perceived barriers to access including geographical distance, costs, access to drugs and staff behaviour.

Although there was little difference in the perception of the value of treatment and respectful services or the common illnesses across the three districts compared in this study, there were significant differences in the perceptions of the quality of treatment and services at public and private facilities. A major distinction was cost, which is very important for poor communities. At government facilities, both drugs and services were free; at CHAM, users paid for both. Cost was perceived to have implications for both treatment and services. Community members in the catchment areas of government facilities were accustomed to finding that drugs, mosquito nets and nutritional supplements were unavailable; they had also experienced verbal and/or physical abuse or had heard about the poor service from others. The perception of CHAM facilities was that, because of the fees, the facilities were like a business: drugs would be available and staff would be polite, attentive and respectful, in order to retain the customers.

From the perspective of community members, the ideal conditions for good health would be to live in a community with access to clean water and to attend a facility where treatment and services were free and their rights to effective treatment and respectful services were upheld.

5. Participation in policy, planning, budgeting and programme design

This chapter presents the findings on community participation in the policy, planning, budgeting and programme design processes. Section 5.1 outlines the main features of these processes as they are perceived to operate in the decentralised health sector. Section 5.2 discusses constraints on decentralisation. Section 5.3 presents the study findings on participation in planning and budgeting. Section 5.4 examines community participation in the planning and design of NGO programmes. Section 5.5 summarises the findings.

5.1 The planning and budgeting process

As discussed above, the process of decentralisation in Malawi since 1994 resulted in the establishment of elected and consultative structures at district level, and a process of delegating responsibility for the management and delivery of services from the centre to the district level. This process has thus enhanced opportunities for participation and for a strengthening of community voice in the planning and budgeting process.

Within the structure set out above in Figure 5, the District Council is responsible for budgets and planning decisions, in response to proposals developed by the VDC and ADC.⁸¹ Implementation of the District Council's decisions is under the control of the District Executive Committee (DEC) and, for the health sector, of the DHMT. There are two levels of the planning and budgeting process: the production of a medium-term district plan and the preparation of an annual District Implementation Plan (DIP) and budget.

The first involves the periodic production of the District Development Plan (DDP), to cover a four-year period, for which the preparation process is set down in the Development Planning System Handbook for District Assemblies. The initial step is the preparation of a socioeconomic profile. This process is designed to be a participatory one, managed by the District Director of Planning, and with review provided by the MoLGRD.

⁸¹ In line with the Decentralisation Policy (1996) and the Local Government Act (1999), the VDC and ADC sub-district structures at area and community levels respectively provide the platform for the local population to participate in the formulation and implementation of DDPs. The ADC and VDC have come to be recognised as the 'formal' mechanisms through which communities participate in decision making on matters affecting their communities (Chiweza 2010).

Other inputs into the preparation of the DDP come from Area Development Plans (ADPs) that are prepared by ADCs. These focus principally on identifying priorities for investment projects within the area. These are in turn developed through consultation with the VDCs who produce Village Action Plans (VAPs). The final DDP is supposed to be prepared by the DEC and agreed by the District Council.

The annual budget and planning process follows a similar process, with ADCs identifying priorities which are communicated to the DEC as part of the process of preparation of the DIP. In the health sector, district health staff also conduct annual consultation meetings with health centres and communities in December and January. The objective of this consultation process is to determine the burden of disease in each area and establish their related needs and priorities.

In addition to the budget for services provided through the MoLGRD (but earmarked for particular activities) the main sources of discretionary funding at district level are the district's locally generated revenues, the Local Development Fund (LDF) and the Constituency Development Fund (CDF). In general, locally generated revenues are too small (typically much less than 5% of total revenues) to make a significant contribution to meeting expenditure needs. The LDF was introduced as a transfer from central government in 2009 to provide:

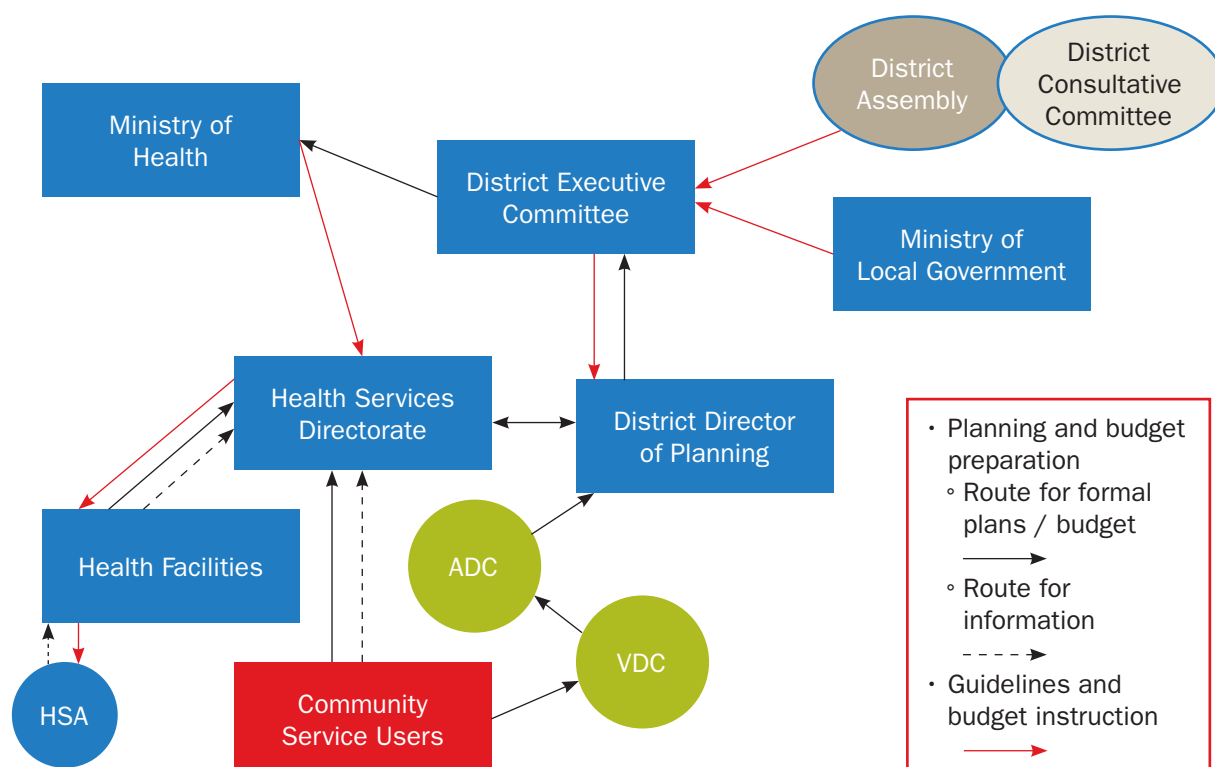
a nation-wide, harmonized, transparent and sustainable local development financing mechanism for poverty reduction at Local Council and Community levels.⁸²

The Community Window of the LDF provides resources for capital investment in line with local priorities (as determined by district councils), and has been used to fund some health projects. However, the bulk of the investment funds under this window are earmarked for the education sector, specifically for staff housing. The CDF (introduced in the 2006/7 budget) was established "to respond to immediate, short-term community development needs and is a means of ensuring that rural development spreads evenly throughout the country" with implementation overseen by the MP who is "responsible for the launch or handover of all projects under the CDF". While guidelines for operation are supposed to take into account locally determined priorities, in practice the CDF seems to be largely used for projects determined by MPs in order to meet immediate political needs for visible action (Chinsinga 2009).⁸³

⁸² 2011/2 Budget, p. 197.

⁸³ Some of these resources are used for small projects in the health sector. For example, in Mchinji the HCAC came up with an idea to build a bathroom for the maternity ward, produced a proposal that they presented to the ADC, and it is now being funded through the CDF.

Figure 6 – Community participation in policy, planning and budgeting



5.2 Constraints on decentralisation

The process of decentralisation in Malawi has been marked by formal initiatives to strengthen local control over governance but whose implementation has in practice been checked or reversed. The core of decentralisation reforms under the 1994 Constitution was the establishment of elected district councils, linked to sub-district structures (ADCs and VDCs) aimed at fostering bottom-up development planning. Local elections were first held in 2000 and were dominated by the ruling United Democratic Front, which won 612 out of 860 District Council seats. At the same time, a system of state payments to traditional authorities was introduced. However, local government elections were suspended in 2004, and the district councils were dissolved in 2005 and replaced by non-elected District Consultative Councils, as President Muluzi was concerned that the local elections might be a focus of political opposition.

With the 2010 Local Government Act, the president was given authority (through a constitutional amendment) to determine the date of local government elections, with the number of councillors being reduced, and MPs given voting rights in district councils. While local elections were planned for late 2010 they were suspended as political tensions developed between the president and vice-president, and splits developed in the ruling Democratic Progressive Party.

The overall context for effective community participation in decision-making is problematic in several important respects. While there are structures and processes that provide some level of accountability (both through the formal political system and through traditional authorities), these tend strongly to emphasise the provision of patronage rather than effective public services. This is reinforced by popular expectations of the role of political leaders. At the same time, there has been little effective de-concentration of administrative authority at the sector level, so that resources and staffing decisions remain largely determined at the central ministerial level.

Specifically, a review of Malawi's decentralisation experience (Chiweza, 2010) found that:

- The postponement of local elections has undermined the role of district councils, leading to their replacement by non-elected DCCs that lack the authority to approve or enforce by-laws and noted (p. 5) that "a general perception persists ... that the DCC is a toothless mechanism and not capable of ensuring efficient, effective, and accountable operation of the Councils".
- "Line agencies have not been fully integrated into one administrative unit with composite budgeting due to the incomplete nature of the sector devolution process. Sector development budgets are still centralised and many development projects are budgeted and managed by the centre and the districts are used as implementation points".
- District councils lacked an ability to generate their own revenues. As discussed above, two sources of funding were in principle available to support local discretionary activities. The first, the LDF, received only very limited donor support. The second, the CDF (p. 6), "currently operates using parallel political structures and is not connected to the recognised District Planning System structures".
- DECAs, which have been created to advise the district councils, met frequently but largely in response to NGO programmes and needs. It was noted that (p. 7) "there were very limited scheduled meetings to discuss and examine the functionality of the district planning process and review the implementation of the DPP".
- With respect to the sub-district structures (ADCs and VDCs), the review found that (p.7) "except in places where NGOs operate and are willing to support their functioning, the committees' composition is not consistent with the District Development Planning System guidelines and the committees are not functional."

5.3 Participation in planning and budgeting in practice

Formal routes for participation

The main formal routes for community participation in the planning and budgeting process are therefore the VDCs and ADCs (Figure 6). These bodies have a formally mandated membership and cover geographical areas that coincide with those of the traditional authorities, the second highest rank in the

hierarchy of traditional leaders. The chiefs at village level play a role in organising the selection of VDC members from the community, but traditional leaders are excluded from membership of these bodies. ADC membership comprises the chairmen of VDCs, as well as ex officio members from public bodies and representatives of political parties, faith groups, and representatives of youth and women.

Constraints limiting effective participation

The findings from fieldwork for the study⁸⁴ confirmed that the scope for effective community participation in resource allocation and decision-making through the formal planning structures was severely limited by the lack of discretionary control over resources at the district or lower level described above. While the cycle of district-level plan preparation is followed, this was not regarded by district officials as exercising a significant influence over decision-making, given the limited discretion that is available at district level.

There has been some devolution of functions to the district level but not of financial control, as all funds from the centre are earmarked for specific activities. The health sector was regarded by the DEC as better than some other sectors at supplying information and in communication, but DHOs are often relatively young and lack administrative experience. To the extent that discretionary resources were available to the district, there were political pressures (on the DEC) to distribute these resources equally by Traditional Authority area or by parliamentary constituency rather than on the basis of needs or plans.

Health sector budgets (as part of the annual DIP) were developed by DHOs with the MoH, with limited cross-sectoral involvement. There is a process of community involvement in DIP preparation, through community meetings held by health programme coordinators. This is in principle used to help set priorities and objectives. However, it was not clear that the financial resources provided matched the priorities, while the fact that budgeted resources could only be spent when cash was released militated against the effective planning and management of budget resources. During the current financial year, substantial budget cuts (of up to a third of the non-staff budget) were implemented.

Given the lack of discretionary resources, the main planning decisions taken at the district level are related to the location of investments (for instance the establishment of new health facilities), under circumstances where resources for this purpose had been made available centrally. ADCs and VDCs played some part in the mobilisation of community resources (particularly the making of bricks) to assist with such investments.

The ADCs met by the study team appeared to be well motivated and to have memberships in line with guidance provided to them, including the chairs of the VDCs covered by the area and representatives of religious communities, women

84 Involving interviews with ADCs, VDCs, and with members of the DEC and the DHMT in Mchinji and Balaka.

(although female participation was largely restricted to having two designated women's representatives, with no women members in other roles), political parties, and government sectoral bodies. Where VDCs and ADCs are supported by NGOs they are operating more effectively and better understand their roles and responsibilities and have better collaborative relationships with other key institutions.

However, there was a high degree of frustration among the ADCs interviewed by this study team at their lack of influence in resource allocation combined with an absence of communication with, or information from, central or district government. ADCs did not have access to information about spending and projects within their area. Nor were they involved in planning for the use of the CDF, with MPs being accused of claiming they were personally funding CDF projects. The ADCs were, however, able to play some role in facilitating the local resolution of disputes and encouraging cross-sectoral cooperation, and in working with NGOs.

ADC members regarded elected district councillors (during the period up to 2005 when they were in place) as having been effective and locally accountable. But they were pessimistic about the future: they considered that the reduction in the number of councillors, the fact that they would be paid, and the linking of wards to parliamentary constituencies would undermine this accountability in the future, and that the councillors, like MPs, would be motivated by "podyerapo" (just wanting the job to get money). Both traditional authorities and elected politicians (i.e. MPs) were attempting to exert influence over the membership of ADCs and VDCs.

Priorities and links to the health sector

Currently, the main priority of the ADCs we met is access to clean water. Health activities do not feature high on the priorities list of ADCs. ADCs and VDCs had some limited involvement with health sector issues, mainly related to capital investments, and in a few cases as channels for complaints about health staff performance. VDCs had little involvement with VHCs, except when there was a health development project such as the building of a new clinic. In some instances, consultations within the VDCs and ADCs have resulted in the building of shelters or under-five clinics but these have been few in number and very small in scale.

5.4 Participation in NGO programme planning and design

There were a number of NGOs operating in the health sector in the areas where this research was conducted. They distributed resources (in particular mosquito nets), supplied medication to under-five clinics and gave material support for the digging of wells and constructing of clinics and pit latrines in the communities. NGOs also promoted behaviour change through training community members as volunteers, with a particular focus on maternal and child health, family planning and HIV/AIDS.

Generally NGOs were reported as bringing development to their communities. They were perceived as being ‘helpful’ to the community and as having a positive impact on the health, nutrition and sanitation situation in their areas. Moreover, their programmes were seen to be more transparent and effective than government-led programmes.

However, when community members and local-level officials were asked whether they were consulted on the design of the programme and on their needs and priorities, the answer was almost always “No”. The programmes are designed at the headquarters, without the involvement of the community members. Once the programmes are designed, a courtesy visit is made to the district and through the local authority structures communities are notified about the programme. At that stage, the NGOs visit the chief to request permission to work in his/her area and, sometimes, to request that the chief and the community select volunteers for training or to mould bricks for constructing a school:

Most of the time we hear about planning and designing health issues while they have already done that. We people in the villages are not involved.⁸⁵

They just come into our village and say our programme is like this but they don't ask for our view or ideas.⁸⁶

NGOs do sometimes consult with community members about their problems. Whatever the problems the community or the ADC identifies, however, the solutions are likely to be beyond the remit of the NGO. Clean water was perceived as a major problem, identified over and over in our field work, but only a few NGOs actually have a donor mandate to drill boreholes. Communities and district-level officials have become adept at interpreting what the NGO has to supply, and to agree that this is what they need: NGO offers are almost never refused.

In Nkhotakota, a group of village men noted their collaboration in building pit latrines and wells in their community with assistance from an NGO (a Muslim association). Prior to the intervention, water-borne diseases were rife and the community used unprotected, shallow water sources due to lack of alternatives. Although the village was not consulted about the design of the intervention, the communities had themselves brought these issues to the association. As a response the community dug and built wells with material support from the NGO, including cement:

[Were you consulted about the project?] No, they did not come to ask us but they just saw that we had a problem with potable water and we also went to tell them. We discussed it with them right here at the trading centre under this tree. We then asked them and they came to see. They asked us whether we can dig wells on our own so we said we can.⁸⁷

85 FGD, Female, Community Score Cards, Balaka.

86 FGD, HSAs, Balaka.

87 FGD, Male, Most Significant Change, Nkhotakota.

When the HSAs were asked in a FGD whether they were given a sufficient role in designing health programmes, they said they were not consulted even though the health facilities relied on them for outreach to the communities, as well as to work in the facilities. Even when they were not given a role in designing health programmes, they were relied on to implement the programmes. Furthermore, even in the implementation of programmes, the HSAs felt that they were not fully and actively engaged by the NGOs, for example by training in their duties in the new programme (though this might reflect the fact that allowances are provided at trainings):

There is a separation. When they are starting... They go straight [to the community] without even passing through us and work in the community, without us knowing.⁸⁸

It was not just the HSAs who complained about not being consulted by NGOs in the design of programmes: the chiefs also complained. They said that the NGOs would just arrive with a programme, without consulting them or the local community members about their views, experiences and opinions:

When the NGO comes to this village, it outlines all the programmes they want to implement and asks for permission to enter the village. Then I call a meeting of all members of the community.⁸⁹

They don't ask our views. They just come with the number [i.e. of beneficiaries of the programme] they have planned already. They don't come and ask 'if we can do this how will you feel?' They don't ask us what problems we have; they just talk to the chief and explain to them that 'we have this we want to do in the village'. ... World Vision provides goats to the orphans without asking them what they want. Out of two hundred orphans they give goats to three. Sometimes they drill boreholes in the village which the orphans don't need.⁹⁰

The programmes are typically designed by donors, and then an NGO is subcontracted to implement it. Thus, even the NGO itself has little flexibility. In one community the chief noted that the community's priority was more boreholes to provide clean water, which would help prevent contagious diseases such as diarrhoea. When an NGO arrived, community leaders asked if they could drill boreholes. The NGO could not: they said that they were there to distribute free food and would deal with water later.⁹¹

One of the responsibilities of chiefs is to "bring development to the community." Some chiefs are proactive: we observed piles of bricks waiting for a donor. Chiefs described NGOs as knocking on her/his door, asking for permission to work in his/her village, and then moving on:

88 FGD, HSAs, Balaka.

89 KII, Chief, Balaka.

90 FGD, Female, Institutional Mapping, Balaka.

91 KII, chief, Balaka.

*It is not possible to deny development. You are supposed to receive the development that has come. If there are other problems you just tell the organisation that comes that we also have this problem.*⁹²

Generally, accepting whatever NGO programmes are offered, even if it is not aligned with community priorities, is perceived as reasonable. There is an expectation that some benefits will accrue. Only once did we hear of an NGO project being turned down. In Neno, an NGO wanted to construct a library and wanted the ADC to recruit people to mould bricks and gather sand for cement. The ADC refused, saying this was not their priority: *'they want to give us library but we want water'*.

It is important to note that the relationship between NGOs and community volunteers and other fixers at the local level is not always based purely on the developmental interests of the communities but also out of opportunities for personal position and gain. Central to many community-based NGO programmes is training, with allowances that operate as a strong incentive for involvement and participation in the programme. Where these were not evenly distributed or where these benefits were not aligned with allowances provided through the government or other programmes, it created problems.

Although NGOs perceive training volunteers as making a project sustainable, this study, and many others, have shown that induced participation is not sustained: working for free is perceived by community members to be foolish, and most volunteers stop working when no more incentives are provided.

Constraints limiting effective participation in NGO programmes

The design of programmes and the setting of priorities by donors centrally and the sub-contracting of NGOs as delivery agents with detailed specifications and reporting structures militates against the ability of NGOs to show flexibility and respond to needs as identified by communities. Communities are aware of this, and hence engage only to a limited extent in planning and design. The perception of lack of influence noted above means that participation is often restricted to being “informed” rather than being “consulted” or being in “partnership” with NGOs in addressing their problems.

⁹² FGD, Male, Social Mapping, Neno.

5.5 Conclusions

The overall finding from the study is that there is an elaborate and structured planning and budgeting process, which in principle allows for community participation, particularly through the ADCs and VDCs, but also through more ad hoc consultative processes at the sector level. The VDCs and ADCs we met appeared to be motivated and responsive to community needs, although women's representation (particularly at the ADC level) was minimal, which may affect the extent to which health is prioritised.

However, the significance of this system is undermined by the following factors:

- The lack of discretionary resources that can be allocated or controlled at the district or lower level of government;
- Political pressures for the equalised allocation of discretionary resources between geographical areas, which militates against district-level planning on the basis of need; and
- The control of spending through cash releases that has, particularly in recent years, militated against coherent management of spending.

In principle, the scope for community participation in planning and budgeting could be increased by the provision of more discretionary resources to the district and area levels, either through the use of locally raised funds, the channelling of more resources through the LDF or similar instruments, or through some genuine decentralisation of budgeting decisions from line ministries. However, to the extent that genuine resource allocation powers are held at these levels, bodies such as the ADCs would risk becoming a focus of politicisation and rent-seeking. There was also concern from ADC members and others that elections to district assemblies under the arrangements introduced in 2010 would be unlikely to lead to effective or locally accountable bodies.

The main features of community participation in planning and budgeting can therefore be summarised as follows, within the framework of the Participation Matrix:

- The main form of community participation in the planning process for health is through involvement in the medium-term development planning activities of VDCs and ADCs – the production of VAPs and ADPs. There is no structured involvement of communities in the annual budgeting process, although there are consultations organised by district health teams.
- In several cases VDC and ADC members appeared to be active and motivated (which may reflect at least in part engagement with and support provided by NGOs) and to have members with strong community links – while severely under-representing women. It is, however, not known how representative of these bodies these findings are.
- Those participating in these processes are community members who are either selected to be members of VDCs through a community selection process overseen by local chiefs, and who are generally locally regarded as

capable and with an interest in development, or representatives of other local interest groups (FBOs, businessmen, etc.).

- Motivations for participation appear to be largely to contribute to community development. At the moment, involvement in VDCs and ADCs appears to provide little opportunity for material benefit or rent-seeking because of the lack of control of resources that these bodies have. However, this study did not seek to review this issue comprehensively.
- The effectiveness of participation is severely constrained by the continuing centralisation, which means there is little control (even at the district level, much less below this) over the most important budget and resource allocation decisions. Lack of information and transparency in how resources are simply used also constraints on effective participation.
- While the VDC/ADC system appears to have potential to be a relatively effective way of articulating community interests, in practice the level of participation in planning is limited and in the annual budget process it is barely tokenistic. There is, however, some scope for influence over decisions about the use of resources for capital investment. The available funding sources (particularly the LDF, where available resources are largely earmarked for education) do not provide significant resources for the health sector.
- Community participation in the design of NGO programmes is limited to being informed of programmes designed at the central level and in supporting the NGOs in implementing them (generally when motivated by financial incentives), with limited consultations with community members.

The findings from community participation in policy, planning, budgeting and programme design are summarised in Table 3.

Table 3 – Participation in policy, planning, budgeting and programme design

Types of participation	Who participates	Motives for participation	Conditions for effective participation	Level of participation	Results of participation
VDCs – Identification of local needs and priorities through VAPs; transmitting plans to ADCs for consideration in district planning process (DIP).	Representatives from each village within VDC, ward representatives, four women representatives and extension worker representative. Process of community selection/ election of members overseen by Chief.	Nomination by community; improving wellbeing of community; access to resources and patronage; community standing; legitimacy; power.	Availability of resources especially non-earmarked funds; willingness of officials and NGOs to provide information; skills of committee members; political neutrality of committee.	System is designed to provide some level of “delegated power”. However, in practice lack of information and discretionary resources means participation rarely rises above level of “consultation”, and is often tokenistic.	Limited Some allocation of resources for construction of health facilities, mobilisation of self-help through collective community participation in provision of labour (e.g. moulding bricks).
ADCs – Identification of local needs and priorities in the ADPs and transmitting plans for consideration in district planning processes (DIP).	VDC chairperson and vice chairperson, ward representatives of faiths, representatives of youth and women's groups in the area, representatives from the business community and chairperson of area executive committee.	Generally, literacy and good standing in the community is required.			Primary impact on small village projects such as material for building of shelters, pit latrines, bathing areas and boreholes.
NGO programmes – Support in implementation of the programme. Limited role in design and formulation of projects and programmes.	No representation in planning stage. Districts and Traditional Authority notified of presence and project aims. Generally, literacy is required.	Bringing development and material benefit to the community.	NGO activities need to be aligned with priorities of the communities. Need for more consultation and involvement of community members at design stage.	Community perception of lack of influence over NGO priorities means participation often restricted to “informing.”	Support in implementation of NGOs' projects (see Chapter 6).

6. Participation in health service delivery

6.1 Introduction

This chapter explores the nature of community participation in the provision and support of health services in Malawi. The remainder of this chapter is as follows: Section 6.2 introduces the different forms and channels of participation. In Section 6.3 we discuss who within the community volunteers and for what motives. Section 6.4 discusses the necessary conditions for effective participation, before we set out our conclusions in Section 6.5.

6.2 Forms and channels of participation

Community participation in the provision and support to health services in Malawi is primarily through volunteers working within the communities and on occasions in the health facilities. The types of community participation identified during this research included:

- Members of the government-mandated VHC mobilised by HSAs to support outreach activities;
- Community volunteers mobilised by health centres or NGOs for projects;
- Voluntary action mobilised by religious congregations;
- Collective voluntary action mobilised by chiefs; and
- CBOs.

VHCs were established by the MoH to promote primary health care activities and work with (and be supervised) by HSAs to deliver preventative and promotional health services (MoH, 2011). VHC members support the HSAs in disseminating preventative health messages, undertaking immunisation campaigns and distributing health material (See Box 4). They also encourage households to dig pit latrines, use mosquito nets and change health-related behaviour.

Box 4 – FGD with HSAs: The role and importance of VHCs, Nkhata Bay

The VHCs are the first ones to tell the chiefs and the people in their villages that we [HSAs] are coming. Sometimes they gather the community members where we can find them, sometimes we move with them and they show us the houses. These people also help us when we have health campaigns; they go around, spreading the message to the villagers that we are coming for campaigns. They also spread the information once we have left.

While we also go to other areas to do the same thing they keep on telling the people how the village can stay clean and how they can prevent different diseases that have occurred in our area, so we let them continue with that job.

The VHCs are a bridge between the people in the village and the HSAs and hospitals. When there is diarrhoea in the village they get the ORS or HTH (chlorine) from us and give it to the villagers. As an HSA you have limited eyes, you do things alone and if something happens you might not know, but the members of the VHC are free to talk to them since they stay in their villages.

These people are chosen through the HSA and the village head of that area or village. You tell the village head that in this village we want to have a health committee, so the chief calls all the people in the area and tells them that our HSA has come here and wants to help us in choosing the VHC, or the committee was already there and they want to help us form a new committee. After all the explanations they are given the freedom to choose those who they think can lead them in their village.

Community volunteers mobilised by Health Centres or NGOs for projects

Community volunteers are mobilised in response to requests by health centres or inducements by NGOs to support programme implementation. Volunteers provide support to the HSAs in disseminating preventative and promotional health messages or material and contribute to the implementation of NGO projects. Sometimes they also provide direct support to government and CHAM health facilities:

[Volunteers] work with chiefs and HSAs and help in distribution of information, vaccination, helping people who are sick get to health centres, etc. The other roles of a volunteer are to take care of patients, carry the patients on bicycles, repairing houses for the aged, etc.⁹³

The effectiveness of volunteers varies based on their intrinsic motivation for participation, the type of support provided and the process by which they were selected. NGOs encourage volunteers by offering training for specific tasks, such as mobilising their neighbours to use family planning or to change their risky behaviour. The training is inevitably accompanied by per diems and other allowances that provide more money than an individual could earn in several months of small-scale retail, such as selling fritters in the market or by piece-work on a neighbour's land. Because the NGOs typically require that a volunteer be able to read and write, they are selected from among the wealthier

93 FGD, Male, Community Score Cards, Nkhatakota.

community members: in one FGD a woman said “*The rich are selected for committees, the poor are never selected.*”⁹⁴

On a more sporadic basis, volunteers are mobilised by traditional authorities at the behest of health centres (for example, to dig pit latrines at a centre) and HSAs may mobilise volunteers (additional to the VHC volunteers) for a campaign.

In addition, some volunteers help at the health centres, supporting the health personnel with the weighing of children during growth monitoring sessions, distributing vitamins to mothers with children under five and also providing help in cleaning and maintenance of the facility (Figure 7).

Figure 7 – Community volunteer distributing vitamins – Nkhotakota



Photo: Maja Jackobsen

The importance and activeness of volunteers varies from community to community. While VHCs and volunteers were noted as important by community members, they were not deemed socially close in many of the communities (Figure 4). Some respondents explained that the members of the VHC ultimately had no power in treating them: “*they just refer rather than directly assisting*” and “*they don’t give drugs.*” Furthermore:

94 FGD, Female, Wellbeing Analysis, Neno.

Their job isn't much because they work hand in hand with HSAs. They report illness to HSAs. Some are members of the VHC. But they are close because whenever we have a problem we first meet the volunteer, they are people in the village with a good heart, some are also in the VHC.⁹⁵

Volunteering action mobilised through religious congregations

Organic forms of participation occur in the FBOs and schools, and are quite common. Religious institutions play an important role in dealing with health issues within their congregation. Members of religious congregations, such as members of a women's group, are active and effective volunteers. The support goes primarily to members of the congregation, but in an effort to evangelise may also go to the rest of the community. Religious groups often have a committee that visits the sick, cooks their food, fetches water, provides personal care and prays for them.

A pastor's wife said that they take this opportunity to visit a sick relative, bringing food and providing care just as they do for their own members:

When you leave, then he/she starts thinking 'can these people visit me even though I am not a member of their church?' The person who showed most compassion to others was Jesus, so when we are ministering to the sick we feel that we are doing it instead of Jesus and we feel happy about following what he did.

The pastor's wife also said that they are not paid anything, but do this as a ministry and are taught in their church that they have a duty to minister to others without expecting something in return.⁹⁶ The religious groups often consisted mostly of women, although men are also allowed to participate.

Collective action mobilised by chiefs

On occasion the village chief mobilises community members to mould bricks and build under-five clinics, build housing for the HSAs or support the building of extensions to the facilities such as a waiting room, a shelter for pregnant woman or boreholes for the health facility. This activity is often to demonstrate buy-in to an NGO or FBO project known as 'self-help' projects: the community members mould the bricks and build the walls, while the roof and the cement floor are to be provided by the organisations:

We called chiefs and asked with help for bricks and informed them that there was a donor who promised to help with other supplies. The chiefs, health advisory committee members and health workers made a decision. They knew that a guardian shelter is a very important thing, mainly for serious patients who have been admitted to hospital. They involved the community in moulding bricks.⁹⁷

⁹⁵ FGD, Female, Institutional Mapping, Neno.

⁹⁶ KII, Pastor's wife, Neno.

⁹⁷ FGD, HSAs, Rumphi.

The chief also coordinates activities and mobilises resources for members of his/her community in times of difficulty and need:

When people are very sick we help each other in the village. When needed, the chief encourages everybody who can to contribute to the cost of renting a bicycle taxi to transport the sick person to the health clinic. It takes one and a half hours by bike to the health clinic and two and a half on foot.⁹⁸

6.3 Who volunteers and why?

Volunteers are often nominated by fellow community members and/or a chief. The criteria for some types of volunteering are set by the government or an NGO: typically, these are: (1) to be able to read and write (thus limiting the selection to the upper stratum of rural society) and; (2) to be of good character and behaviour. In addition, the chief – who is always present – may have his/her own criteria, such as benefiting a relative or a person of standing in the community from whom he or she can then expect reciprocity. There are individuals who see this as a privilege through which ‘one gains respect’ and something ‘people don’t turn down’. However, there are those who are less interested in taking on this responsibility but do so out of obligation and duty and because ‘it is not good to be turning down the chief and the community’s requests’. Community members are also required to contribute to self-help projects, although undertaking the moulding of bricks and provision of labour is the task of the poor:

The rich never volunteer for self-help projects; that’s for the poor.⁹⁹

Thus, the main motivations for volunteering are: (i) the expectation of immediate benefits, usually in the form of allowances; (ii) the expectation that volunteering will enhance opportunities for obtaining subsequent paid employment; (iii) social, religious and other altruistic motives; and (iv) compulsion and community pressure.

Volunteers for government-mandated village committees are not paid but NGOs pay people to attend training that will provide them with information and/or skills that they are then expected to disseminate to others in the community. In the context of rural Malawi where employment opportunities and prospects of a salaried job are very limited and largely confined to public servants and those with staff positions at NGOs, these perks and incentives are attractive. Thus, when a community meeting is organised by the chief to select volunteers at the request of an NGO, community members put themselves forward and vie for nomination, with the expectation of workshops and allowances to follow.

⁹⁸ KII, Female Chief, Nkhotakota.

⁹⁹

Those volunteering for the health facilities or on behalf of HSAs are also provided with allowances from time to time and especially when the programme or campaigns undertaken are financed by donor organisations. In Malawi, where patron–client relationships are prevalent, volunteering can also open up new opportunities for control and access to resources and services for themselves and their friends and relatives. Volunteers may have access to materials meant for community members such as mosquito nets, drugs, condoms, etc. and may also receive better treatment when accessing health services.

Many young people who have finished secondary school but cannot find a salaried job are keen to volunteer for NGOs. A volunteer in a youth club said:

Yes, I had a hope I would receive something because I work hard. I come and concentrate on this even after working hard in the field. I can say that I have already benefited because I know more information on HIV. I know that one day I will receive something or go far because of this. [What benefits do you see in the future?] I don't see any benefit in the future – sometimes I go to training and receive some money.

100

A similar comment was made by an HSA:

Some volunteer because they are not employed but are well educated; they just work there and if an opportunity arises at the hospital – [for example] they may be looking for someone to do the slashing [cutting grass and brush]. We inform that person and we also write a reference letter for him or her so they are at an advantage when they have been called for the interviews and a lot of them have been employed through these methods. Now we have about three of them at this health centre who started as volunteers and when others see this they are motivated to become volunteers as well.¹⁰¹

While the perception that volunteers are in it for themselves rather than others is widespread, many clearly have mixed motives:

[What is the reason that you are on the VHC?] I know that one day I will get a job because many people are getting jobs through this, and God rewards those people who are working hard. But sometimes I feel happy because I know that I am developing our community.¹⁰²

[People volunteer without receiving anything because] they wish to develop their skills; others know that during campaigns there are allowances which are received; and others who are educated hope that one day if there are vacancies at the hospital they will be first to receive the information about the vacancy and they can easily apply since they are already working as volunteers. They feel they will be the first to be considered if they have good qualifications.¹⁰³

100 KII, Youth club volunteer, Balaka.

101 FGD, HSAs, Nkhata Bay.

102 KII, VHC member, Neno.

103 FGD, Male, Institutional Mapping, Mchinji.

*I just volunteer because I want to build a good future for the children. I feel happy because I know that these children are benefiting from me. [Do you have any expectations from this job?] Yes, I know that one day I will go for training and I will have money for soap.*¹⁰⁴

Some community members also volunteer their services out of the 'goodness of their hearts'. These individuals have often volunteered for a great number of years and are well known in their communities as 'good', 'honest' people:

*What encourages [some people to volunteer] is a loving heart. We often see a volunteer who doesn't receive anything. You should have a heart, rather than wanting to be paid for what you have done.*¹⁰⁵

Just as there are incentives for participation, however, there are also disincentives. For one, they are spending time that might be more profitably used growing maize for themselves or their family. For another, volunteers are often mocked and seen as "fools" for working for the government or a rich NGO without pay:

*Since there is no pay for the work that we do, when we are moving around in the village some people do mock us. They say 'I cannot do work without pay.' When we are working there, some people do say to us, 'who do you imagine you will be?'*¹⁰⁶

Finally, community members also participate in collective action within communities – i.e. the above-mentioned 'self-help' projects – out of their own conviction, social expectation and fear of sanctions. Collective action requires strong local leadership in order to be effective. If community members, including the local leadership, are not convinced by a particular project they may refuse to collaborate: *'we don't want to do unpaid work for a project we don't value'*.

Although some community members appreciate the need for contributing to public goods that will be of great benefit to their community, many are reluctant to participate in collective action and to contribute in this way. They only get involved because they are 'told to do so by the chief' or sometimes for fear of sanctions:

*We participate in health issues, [because of] the vote of the chief, and because we are the ones who will be benefiting from that and not other people. But mostly we do this work because it is the law of the chief. The chief often takes part and leads by example – and if the chief is working, what about us?*¹⁰⁷

*Even if they don't want to they are called by the village headman [and if they don't come] they are punished. They are charged money, maybe K500. So to avoid paying the K500 people do the development work.*¹⁰⁸

104 KII, Secretary of Community-Based Child Care, Neno.

105 FGD, Male, Community Score Card, Neno.

106 KII, VHC member, Neno.

107 FGD, Female, Institutional Mapping, Balaka.

108 FGD, Female, Institutional Mapping, Mchinji.

There was evidence of some communities refusing to participate in collective action, for instance the moulding of bricks. In a number of accessible catchment areas in Nkotakota district, communities were meant to build an under-five clinic and housing for their HSAs and in turn Save the Children would provide the HSA with a supply of drugs and other necessary equipment. However, two years after the project was initiated only 31% of the clinics had been constructed and a further 7% had moulded bricks. The remaining catchment areas had not undertaken any activities.¹⁰⁹

Typically, motivations for volunteering mix several of these motives, as illustrated in the example in Box 2.

Gender and participation

There was no clear evidence on whether men or women were more likely to participate or not. Some argued that women were more likely to participate out of the ‘goodness of their heart’ and continue doing so despite a lack of financial remuneration, while others noted that women were more likely to drop out due to family obligations and the requests of their husbands.¹¹⁰ Analysis of the findings suggests that motivations relating to financial gain or the prospects of future employment may be more important for men than for women. Moreover, in relation to group participation in self-help projects, the roles within the community are sometimes divided along traditional gender roles (e.g. ‘women fetching water’ and ‘men moulding bricks’) but both were reported to take part in voluntary work.

6.4 Conditions for effective participation

Factors contributing to effective and sustained participation through volunteering included how deeply rooted the organisation promoting volunteering was in the local society, whether the expectations of volunteers in regard to obtaining benefits were met and sustained, and the capacity of community leadership (particularly chiefs).

Although there was much variation, the field research generally found that forms of participation through FBOs were more deeply rooted and longer-lasting, thus providing more collective goods and more satisfaction for the participants. In these forms of participation altruistic motivations for participation were of more significance than perceived notions of material benefit.

¹⁰⁹ KII, Save the Children staff, Nkhotakota.

¹¹⁰ KII, Female Chief, Mchinji.

Box 5 – Story of a volunteer in Nkhotakota

Peter started volunteering in 2008, out of his own will to serve people in his community. He just went to the health clinic one morning and told to the medical officer that he wanted to volunteer at the clinic, and then he was considered. He had the ambition of working in the hospital when he was at school and after he dropped out of school when he was in form three he thought volunteering was the other alternative that could help him get work in the hospital. In 2009, the village had to choose a volunteer but since Peter was already doing the work they said he should continue doing this work. He knew how to read and write and therefore had the qualities they wanted in a volunteer. There were two volunteers but the other one did not work for long, going instead to Lilongwe to work at a company.

Peter goes to the clinic and helps to record the weights of children under five. He also helps in spreading information during vaccination campaigns when he tells the chief to tell the people about the venue and time of vaccination. On the day, while the HSAs are giving the vaccines, he helps in peace keeping and maintaining order while people queue. Peter has never gone for any training except when they have to give vaccines, on which they are trained for two to three hours. The last time they had to be trained for such an activity was last month. In his own time Peter farms to make a living for himself. When asked why he volunteers, Peter says 'It is a good idea to help your own community in terms of health and a volunteer teams up with the other health personnel, meaning together the work is done faster'. He also hopes for a job opportunity in the future and has been to a few interviews. He also gets an allowance whenever there is some activity happening in which they are involved, such as training for some vaccinations. Finally, he noted that he is also referred to as a doctor in the community, which gives them good social standing.

Nevertheless, allowances matter to them. They are given K300 lunch allowance which they feel is not enough and also creates a huge difference between them and those people who are fully employed by the government who are given K2000 to K4000 (HSAs). The other set back is that of non-employment where one works as a volunteer for many years in hope of a job that does not materialise. The community also despises the volunteers and mocks them sarcastically. As a volunteer, he reports to the person in charge of the clinic but so far the only problems he has reported are his concerns about the allowances and the job prospects. In regard to the latter, the person in charge of the clinic told him to be patient and that he would be considered in due course.

Other people who want to volunteer are discouraged due to the lunch allowance being inadequate, but the fact that one is supposed to know how to read and write to be a volunteer at this health facility is also a problem. Peter feels that as a result of his work the workload [of the facility staff] has been minimised, especially at the under-five clinic.

An example from Neno provides a comparison of participation in an organic group and participation in an induced group. When we asked a pastor about participation he described how he attended a meeting on AIDS in Lilongwe, and on his return formed an AIDS committee in his church. The pastor's wife was also interviewed. When we asked her about participation, she talked about her denomination's health ministry, which began in the 19th century. The pastor's AIDS committee quickly collapsed within three months, with members leaving because they did not receive allowances; the pastor's wife's group of 50 women meet every Thursday, share information about sick members, and then visit them, providing care and praying with them.

Within the church structure a distinction should be made between members who volunteer to visit the sick or for congregational committees and those under CHAM structures. The latter are selected through the community by the same processes that select other community volunteers. They can therefore be influenced by non-altruistic motives such as material benefit; however, the oversight of these structures was deemed more effective in ensuring more active participation compared to similar types of volunteering within government and NGO structures.

While many of the volunteers selected by the community, especially through NGOs, did not seem to be very effective, in large part because of high attrition, the VHC and other volunteers selected to support the HSAs do appear to be more effective. At least some are individuals who have been engaged in helping their communities for a very long time and are driven not by material but by altruistic motives, as well as by an interest in gaining new knowledge. The effectiveness of HSA volunteers depends on the activeness and level of engagement from the HSAs themselves. Where HSAs lived in their assigned village and were highly visible and active in the community, so too were the volunteers supporting them. This is also true of the VHCs, but this committee was found to be dormant and inactive in many of the communities visited by the research team. Where they did operate, VHCs undertook similar roles to individual volunteers; in some instances, volunteers were also members of the VHC.

A key constraint on the active and effective participation of volunteers and VHCs selected through the community is the process and conditions for selection itself. As noted earlier, in most cases individuals themselves cannot choose to participate – they cannot ‘*wake up one day and decide to participate*’ – but have to be nominated by the community. The conditions for nomination were the behaviour of the individual, their ability to read and write and their physical strength. Beyond these aspects, nomination is also likely to be influenced to a greater or lesser degree by the chiefs and sometimes HSAs who may nominate their friends and relatives:

*You can only become a volunteer if you are selected by the community. You cannot just wake up one day and do volunteering. If one wants to help the sick they have to go and get permission from the chief, because we have the Home Based Care and it is their role to undertake this activity.*¹¹¹

*The person is chosen on the basis of wisdom, ability to speak and those with the spirit of helping the people. ... There is also a culture of choosing people from near the health centres.*¹¹²

This selection process results in some individuals being selected who have little motivation or interest in participating but who do so at the behest of the community or in the hope of some material benefit. Although we heard that some nominated individuals did decline, this did not appear to be common, probably because it would be considered an insult to those who made the nomination:

111 KII, Group Village Headman, Mchinji.

112 FGD, Male, Most Significant Change, Nkhotakota.

*VHCs are active in some places and not in others. It depends on the people and really on the process of selection. Some people say yes but they can't really do anything. When these groups are selected they complain, 'why should I do it when I don't get paid?' It depends on your heart and kindness which you will have when you are born. Some people don't have that element in them.*¹¹³

While communities had to formally select individuals who wanted to volunteer, this did not stop some individuals going to health facilities to work as volunteers or individuals supporting their neighbours and friends in times of need.

The effectiveness of community collective action depended on the strength and behaviour of the local leadership. A strong and active chief carries a community and ensures that more collective action is undertaken by community members, volunteers and VHC members:

*If the chief is not leading people in development activities and is just showing people, people cannot go. These chiefs have children and if their children do not take part in any of these activities [e.g. the construction of health clinics] whose children can go there to work? This makes people fall behind on health development issues. If the chiefs and their families stand up, who can remain seated?*¹¹⁴

The chiefs are instrumental in mobilising their communities to undertake collective action and where chiefs are not willing to participate projects do not get off the ground. In one of the areas in Nkotakota, we learned that the chiefs were of the belief that the construction of the clinic should be done through the government and in this area we found limited forms of community participation. Several chiefs reported that they took the lead in mobilising support: members who did not contribute their time might be fined or, in the extreme, their land might be taken away.

The most important cause of ineffective participation was that volunteers mobilised in response to NGO demand were motivated at least in part by expectations of material benefit that was either not fulfilled or not sustained. Thus, in the absence of sustained support by the NGOs in the form of refresher trainings or resources such as bicycles, t-shirts, and food, they drifted away:

*Yes, many drop out because when joining voluntarily they expect to get something like a salary but as time goes by and they don't receive anything then they drop out.*¹¹⁵

*No other woman has continued to provide the "services" that the MaiMwana group provided. The group is dead. In fact, I am the only volunteer in the village. The others did not continue to be engaged as the NGO left and they stopped receiving money from the project. The NGO had left saying 'the HSA should do your work now that we are going'.*¹¹⁶

¹¹³ KII, Chairman of HCAC, Mchinji.

¹¹⁴ FGD, Male, Institutional Mapping, Rumphi.

¹¹⁵ KII, VDC Vice chairman, Neno

¹¹⁶ KII, Former HSA volunteer and former MaiMwana volunteer.

Members of the VHC (and of other community bodies such as HCACs and VDCs) often complained that they had not been orientated on their roles and responsibilities and did not have sufficient resources to undertake their responsibilities effectively. Moreover, they noted that they required allowances from time to time to provide them with sufficient motivation to continue their work:

Many people do say we are just working without pay, but our friends are benefiting from our work. Sometimes when the Traditional Authority comes to the meeting we have to fund the transport for him. We are only three women in our committee and we are more active because most of the men are very busy. The biggest problem we have is transport; whenever we want to go to visit some villages in our catchment area we have problems with transport. Some volunteers stopped because they said they were tired of volunteer work and just wasting time.¹¹⁷

6.5 Outcomes of participation

Community participation in the health sector provides immediate and tangible benefits to community members. Chiefs mobilise their people to mould bricks, collect grass thatching, build shelters at the maternity ward, construct houses for the HSAs and dig pit latrines. Community volunteers help the HSAs and NGOs with growth monitoring activities, immunisation campaigns, dissemination of health information, and distribution of plumpy nuts, chlorine, mosquito nets and condoms. They encourage women to give birth at the health clinics, people to dig and use pit latrines, couples to practice safer sex and those suspected of having HIV/AIDS to get tested and use ARVs. Religious support groups and home-based care volunteers visit the sick and provide them with food, water and general psychosocial support through prayer and counselling.

Through these activities, health clinics are built, pit latrines purportedly dug and more HSAs reside within their designated communities. Moreover, more children are weighed and immunised, mosquito nets and chlorine are distributed to greater numbers of people and the sick and pregnant mothers within the community are encouraged and helped in accessing the health care and are better cared for subsequently by the community members.

To the extent that the participation is effective, it is likely to contribute to the improvement of health outcomes. This research does not allow for a rigorous assessment of the impact of community participation on health outcomes. There is, however, evidence from a recent systematic review that suggests that lay or community health workers in primary health care have a positive impact on maternal and child health and TB outcomes. It found that the use of lay health workers in maternal and child health probably leads to an increase in the number of woman breastfeeding and children immunised, and may lead to fewer deaths amongst children under five. The authors also speculated that participation may reduce the number of children suffering from fever, diarrhoea

¹¹⁷ KII, VHC member, Neno.

and pneumonia and may increase the number of parents who seek help for their sick children.¹¹⁸

While improving service delivery and project implementation at the margins and at the community level, community participation is less effective in shaping and forming the way in which health services are provided by the health facilities and systems are operated.

6.6 Conclusions

There was active involvement in health service delivery and related activities (focused on prevention) across all the communities visited, through different forms of volunteering. This form of participation tended to involve neither the richest nor the poorest members of communities (who lack time, resources and sometimes social standing).

Some participatory activities are entrenched in the traditions of reciprocity within rural communities: these are undertaken organically by people with 'a good heart' and/or members of religious congregations who answer the call of compassion. Other participatory activities are mandated by the government and under the authority of chiefs who have the power to sanction non-participation. A third, and more problematic category of participation, is induced by NGOs with incentives to offer which are, however, often not fully realised or not sustainable. Motivations for participation vary markedly across these different types of activity, depending on the prospects either of immediate reward or of enhancing the prospects of subsequently obtaining employment.

Conditions for effective participation depend in particular on the extent to which HSAs (for direct involvement in community health activities) and chiefs (for organising collective action) act effectively to motivate and organise participation.

Community participation in the prevention activities and health service delivery appears to provide immediate and tangible benefits to community members.

The findings from this chapter are summarised in Table 4.

118 Flotorp S, Glenton C, and Lewin S. Do lay or community health workers in primary health care improve maternal and child health and tuberculosis outcomes? A support summary of a systematic review. 2011. www.support-collaboration.org/summaries

Table 4 – Participation in service delivery

Types of participation	Who participates	Motives for participation	Conditions for effective participation	Level of participation	Results of participation?
VHCs – Support to HSAs in dissemination of information and health campaigns.	Selected by the community with oversight by chiefs and HSA. Literacy may be a requirement.	Nomination by community; financial and material benefits; better access to services; community standing; acquiring new skills and training; future job prospects; community obligation; altruism; religious calling and beliefs; lack of alternatives.	Skills and motivation of members; support and direction from HSA and chiefs.	Degree of participation varies from “informing” and “consultation” where VHCs are active to “partnership” (where there is effective community mobilisation).	Expanding coverage of programme and better access within communities.
HSA volunteers – Supporting HSAs in campaign for digging pit latrines; helping during vaccination campaigns; scaling of children under five; dissemination of general information and health material (mosquito net, chlorine, etc.).	Same as VHCs.	Same as VHCs.	HSA support and supervision, motivations of individual volunteers, those volunteering out of ‘goodness of heart’ and for long periods of time more effective.	At best, can achieve “partnership” in service delivery and prevention.	Expanded coverage of programmes and better access within communities.
NGO/CBO volunteers – Support in implementation of the programme. Part of committees introduced through the programme and undertaking activities aligned with the objectives of the programme, for example talking about safe motherhood and encouraging women to deliver in health facilities.	Those nominated by community based on NGO/CBO criteria, which will often include literacy. Those willing to participate (see motivation).	Same as above.	NGO activities need to be aligned with the priorities of communities. Need for more consultation and involvement of community members at design stage. Material and financial incentives play a larger role in motivation for participation. Sustainability depends on how aligned it is with existing local structures.	“Consultation” and “informing” during design and planning are tokenistic. However, may rise to level of “partnership” during monitoring and implementation, but this is often not sustained.	Support in implementation of NGO projects. Often stop once NGO support comes to an end.

Types of participation	Who participates	Motives for participation	Conditions for effective participation	Level of participation	Results of participation?
Home-based care/ Support to orphans and vulnerable children/ community-based child care services – Home visits and support to chronically ill, elderly and orphans; identification of HIV positive people to support them to live a normal life integrated into the community.	Same as above.	Similar motivations as volunteers.	Access to financial resources. CBOs arising from and addressing genuine community needs and concerns more effective than those established in response to accessing additional resources.	At best, can achieve “partnership” in service delivery and prevention.	Visits made to vulnerable groups within society and support in meeting their needs.
Religious support groups – Home visits to the chronically ill, elderly, orphans (e.g. washing clothes, cleaning households, providing nutritional and psychosocial support).	Members of religious organisations – often mainly women.	Religious calling and beliefs.	Organisational persistence; consistent messages; administrative and financial support for organisation; Individual faith and belief system.	Generally based on sustainable community initiative.	Support to material and psychosocial wellbeing of those in need.
Tradition-based collective action at community level – Moulding bricks for construction of village clinics, maternity or guardian shelter at the health centre, sanitation facilities (toilets, bathrooms, etc.); financial contributions; provision of labour.	Community members – mostly the poor (the rich are expected to provide financial contributions).	Instructions from chief; threat of sanctions; conviction on need for support.	Strong local leadership; relevance of collective action to community needs and priorities.	Partnership, where there is effective community mobilisation.	Moulding of bricks, construction of clinics.

7. Monitoring, accountability and health services

This chapter examines participation in monitoring including the expression of voice in relation to complaints and concerns about health services, and makes an assessment of the extent and nature of accountability in the health system. It identifies the main structures and processes that play a role in accountability to service users, and examines how and to what extent service users exercise voice (as a form of participation) to deal with problems and concerns about service delivery. It is structured as follows. Section 7.1 lists the bodies that play (or potentially play) a role in accountability to service users, and presents a diagrammatic summary of the main route through which complaints and concerns are voiced. Section 7.2 examines how voice is used as a means to raise concerns. Section 7.3 discusses factors that constrain the use of voice. Section 7.4 provides an assessment of the effectiveness of accountability to service users. The conclusions are summarised in Section 7.5.

7.1 Monitoring and accountability structures at the district level

There are two main types of formal local accountability structures in the health sector: the first is meant to receive complaints about service provision while the second concerns community roles in monitoring the flow and use of drugs and other resources.

The only significant monitoring activities were in relation to the supply of drugs.¹¹⁹ This was done either through the HCACs (see below), one of whose functions was to co-sign with health staff for drugs delivered to the facility, or through drugs committees initiated by NGOs in some areas. The main responsibility of the drugs committee is to counter-sign the 'kit box' together with HSAs at the health centre. During the opening hours of the village clinic, members are expected to monitor the prescription of drugs by the HSA.

The study did not obtain sufficient evidence to make an assessment of the effectiveness of this type of community monitoring, so the discussion in this chapter focuses principally on how complaints about services were voiced and to what extent this led to effective accountability in the form of a response from service providers.

119 ADCs interviewed in Mchinji and Balaka expressed a strong interest in playing a role in monitoring the implementation of projects in their area and the flow of resources for these projects, but complained that they were not provided with the information to allow them to take on this role.

Figure 8 identifies the main routes through which concerns about services can be voiced, and the accountability relationships among the main stakeholders in the system:

- Line management arrangements for staff provide the most direct form of accountability. The main elements of the hierarchy from the MoH are Zonal officials, the District officials (the DHO), the DHMT, and the District Environmental Health Officer (DEHO), the person in-charge of a health facility, the supervisor of the HSAs, HSAs, and the volunteers who the HSAs may supervise.
- The effectiveness of line management depends on the ability of managers to monitor the activities of their subordinates and their ability to apply sanctions and to provide incentives. With the current decentralisation arrangements, DHOs have dual reporting channels. In addition to the MoH, DHOs also report to the DEC – the executive branch of local government, headed by the DC. The DEC in turn is accountable to the elected district assembly. However, as noted above, district assemblies have been in abeyance since 2005 and the district assembly has been replaced by the DCC or District Consultative Forum. As noted in Section 5.2 the DCC has no legal mandate for decision-making and plays no supervisory or monitoring role.
- HCACs act as a link between communities and health facilities. The HCAC has three main roles: i) to deal with complaints made by patients against the health facility and concerns of health staff; ii) to co-sign for drugs delivered to the clinic; and iii) to provide a forum for discussion of any other matters arising from the interaction between health personnel and community members.
- VHCs are mostly involved in service delivery (including prevention activities). However, they also occasionally served as the initial channel for complaints.
- A recent innovation has been the appointment of a District Health Ombudsman. The ombudsman is meant to receive and adjudicate complaints from the public and from the health personnel. While ombudsmen have been appointed in most (but not all) districts, they received little or no guidance or training and were dealing with extremely small numbers of complaints. Communities were not aware of the existence of this role, since it has not been widely publicised at the community level.
- Rights-based activities are supported in some areas by NGOs and human rights groups. They primarily rely on citizen score cards and use of media (radio and newspapers) to monitor the activities of service providers and to highlight cases of mistreatment and incompetence.
- Active traditional leaders (particularly at the lower level, i.e. village headmen and group village headmen) play a central role in dealing with the concerns of their communities, acting as a link between communities and authorities, both bureaucratic and political, and deploying their authority for the benefit of their community.

- Several potential routes to hold service providers accountable are notable by their absence. First, as noted above, there are currently no formally elected officials of any kind below the level of MP, who were perceived as unavailable and/or unapproachable in our institutional mapping analysis (see Section 4.5). Second, legal or judicial channels were not being used or regarded as available as a way of raising concerns or seeking redress. Third, while there are recent examples of medical staff being disciplined or barred from practice by their professional associations on the grounds of malpractice, there are no practical routes available for complaints to be made to this level, while rural communities have very little access to or engagement with individuals from such bodies. Fourth, collective action to address health sector concerns, to the extent that it existed, operated through existing bodies and social networks.

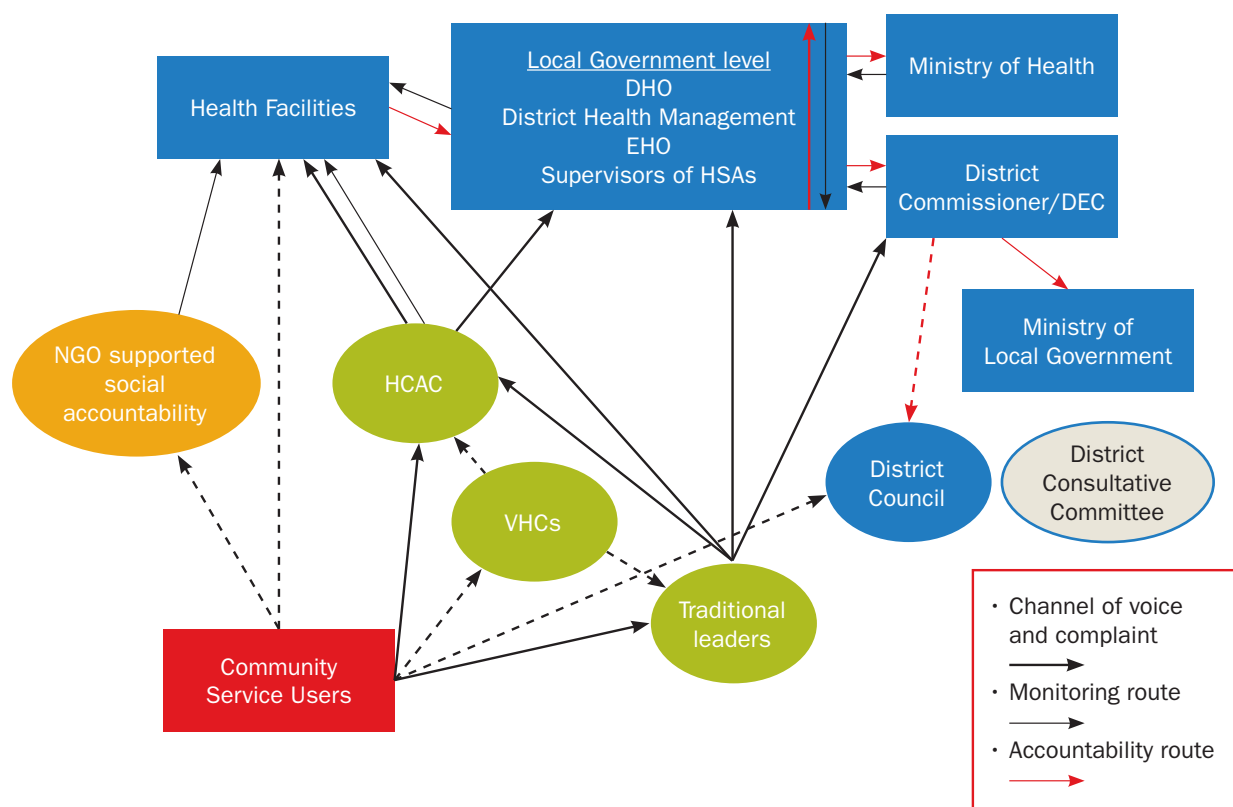
The potential routes through which service users at the community level can voice their concerns, and the channels through which service providers are monitored and held to account, are depicted in Figure 8 below.

The figure shows that users can raise their concerns through HCAC, the Traditional Authority, the VHCs or directly at the health facility. Concerns raised through the Traditional Authority are channelled to the health facilities, MoH staff – including HSA supervisors, the DEHO and DHO – or raised with the DC. The HCAC appears to be main interface between service users and providers, and channels concerns to the health facility or in serious cases to the management structure at the MoH. The ombudsman in principle provides a direct route for complaints for service users but this is almost never used in practice. The potential routes currently absent are depicted with broken arrows.

In practice, a complaint may skip one or more of the steps in the process: for example, a person of high standing may take a complaint directly to the DHO, and a community member may take a complaint to a relative who is thought to have some form of influence (for instance, a guard at the health centre).

Rural Malawians complain about the health sector informally and formally. They grumble in their informal social networks about the treatment they received at the health centre that day but do not seek accountability; it is only when they perceive serious mistreatment that they lodge a formal complaint through the government's accountability structures — mainly the HCAS — or through a traditional leader. Only on rare occasions do they complain directly at the health facility.

Figure 8 – Channels for expressing voice on health services



Monitoring is also both informal and formal. When community members see government drugs, mosquito nets or nutritional supplements for sale at a shop, they spread the word through informal social networks. The formal monitoring activities are largely limited to monitoring the arrival of drugs at the health clinic and distribution by HSAs at village under-five clinics. A community member of the HCAC is meant to co-sign the delivery of drugs to the health facility and other community members (sometimes a member of VHC) monitor drug distribution by the HSAs at the village under-five clinics when the drugs are provided through NGO programmes.

In addition to the limited monitoring activities noted above, some NGOs are also supporting accountability initiatives through citizen report cards. In 2006, for instance, with support from World Vision the DHMT placed a suggestion box at a health facility in Nkhata Bay district. Subsequently the health personnel and community members were brought together and the results of the process were discussed and proposals were put forward for improvement. However, although this enabled communities to truthfully table their complaints to the health facility and improve services it also resulted in subsequent tension between community members and health personnel (see Box 6).

Box 6 – Results of a citizen score card process: Narrative of a group of women in Nkhata Bay

There was a suggestion box so that everybody who has a problem could write his or her complaint on paper and put it in the suggestion box. The box was placed right there at the hospital. People put their complaints in the box and the box was taken to Nkhata Bay district hospital where they looked at the complaints. After proper analysis of the problems, the assigned committee at Nkhata Bay came here with those problems at the hall at World Vision and the people were called to hear for themselves the problems they faced and how they will be dealt with. The problems included problems that women face in maternity, for example a nurse might throw away a chitenje (cloth) that is old but being used by a pregnant woman – the nurse wanted a pregnant woman who will give birth to have four chitenje (pieces of cloth), but how can you have four chitenje if you are poor? We really had problems.

So when they were disciplined at World Vision we have seen that things have changed. People really came in large numbers and everybody talked about their problems without fear in front of doctors and nurses. The morning of the next day after the meeting when the people went to the hospital, they were told to go to Nkhata Bay hospital to be treated there. They said, 'you have got us in trouble and now you come here for us to help you. Why do you want to come here? Go to Nkhata Bay to be treated.'

That story took time to be resolved and those nurses are not working here now. They have been transferred.

These rights-based community initiatives are currently supported by donor programmes and projects.

7.2 Exercising voice: complaints and their outcomes

Type of Complaints and outcomes

During FGDs, participants distinguished between bad service and bad medical treatment. Bad service related to the behaviour of the medical staff towards patients. This might include the doctors and nurses arriving late for work, shouting at patients, not listening to them or inadequately examining them. In these instances, FGD participants explained that patients often do not seek out authorities with their complaint. In such cases, they may grumble to their friends or neighbours or complain 'in their hearts' but nothing more.

In some cases, when service is outstandingly bad it becomes intolerable and people voice their complaints and the doctors often apologise. For example, at a health facility in Neno one day a man came with a seriously ill patient and instead of assisting the seriously ill patient the 'doctor' started chatting with a teacher. This episode made people angry and the guard went to complain to the HCAC and the VHC. They addressed the issue by criticising 'the doctor' the same day and he has since changed his behaviour:¹²⁰

There came a certain nurse and a person went there. I don't know what they disagreed upon but it was found that she threw a passport book at that person. She went to complain to the committee. The committee said that it shouldn't be difficult;

¹²⁰ KII VDC Vice Chairman, Neno.

*we will go and talk to her. They talked to the person and things changed. She did not do it again to another person until she was transferred. Never again did she throw a passport book at another person.*¹²¹

The research found formal complaints due to bad medical treatment (or lack thereof) to be more common. Our findings revealed shared perceptions of the same muted response for some aspects of what patients perceived as bad medical treatment, such as prescribing paracetamol (Panado) instead of a ‘*strong and more appropriate medicine*’. In these cases people voiced their complaints only to friends, relatives and neighbours and sometimes to the VHCs. However, complaints were more pronounced and vociferous where patients were severely maltreated and when this resulted in serious adverse health outcomes. Examples cited of severe maltreatment included a woman delivering outside the clinic or a patient dying unexpectedly. In these circumstances complaints were made to the authorities.

In this and in similar cases, the likely outcome was that the staff member disappeared – ‘*we notice later that the nurse is no longer there*’ – which suggests that the health worker was transferred or fired:

*Yes, here [at this health facility] there was this doctor working here and the patient died while waiting. The community encouraged the relatives to take the issue to the HCAC. [Subsequently] they didn’t discuss [the outcome with] the HCAC, but they saw that the doctor was not there anymore, having been transferred to Phimbi [health centre]. Now they are hearing that he is at the Balaka District Hospital. In fact it was the influence of the community to complain because many were concerned. Everyone saw what that doctor did.*¹²²

There was, however, no concrete evidence from the KIIs or the FGDs that staff were fired. Probably because there are staff shortages in the rural areas, strong unions in the health sector, a weak administration that is unable or unwilling to exert authority and a general reluctance to sanction misbehaviour by dismissal, we conclude that dismissal is extremely rare, occurring primarily in cases where the patient died from unambiguous maltreatment.

Indeed, interviews with DEHOs and DHOs suggested that dismissals were indeed very rare as cases needed to be dealt with through the human resources department at the MoH, so they could only refer individuals for dismissal rather than sanctioning it.¹²³ Moreover, KIIs confirmed that staff transfers are not necessarily due to misbehaviour but more often a routine departmental action, sometimes even as promotion or at the behest of the health worker. It is relevant for communities’ perceptions of accountability, however, that those in the accountability structures did not inform the complainants that there had been a response.

¹²¹ FGD, Female, Community Score Card, Balaka.

¹²² KII VHC member, Balaka.

¹²³ KII, DEHO, Mchinji.

The fieldwork showed that a great proportion of complaints were directed through the HCACs (if they were functioning), especially when related to medical personnel and experiences while seeking treatment at health facilities. These committees were successful in dealing with small instances where doctors and nurses shouted at patients or when they turned up late. In these instances they would talk to the individuals involved and they would apologise to the patients. However, more serious cases had to be referred to the higher authorities and in particular to the DHO.

FGD participants explained that community members were more likely to complain about HSAs than medical staff.

Role of collective versus individual complaints

FGD analysis revealed that collective action was perceived to be more effective in garnering a positive response, compared to individual complaints, although in practice this did not often happen. People were generally reluctant to make individual complaints as they felt these would not be taken seriously and might be viewed as disruptive:

*I can face a problem and go and complain to the chiefs, but they won't take my case seriously. It carries weight if it is a group, so because of this you just keep the issue to yourself.*¹²⁴

A group of women in Rumphu, for example, noted that a person could complain to NGOs dealing with human rights issues or a women's forum group and other organisations. But even there they found it difficult to complain as an individual and felt collective action was more effective:

*It is difficult. You cannot complain on your own. We need a collective voice. When you go to the group and complain on your own it means that you are abusing the health worker's rights. No one will support you. No witnesses. You can say that I was with such and such person, but the person will discourage you, saying "you are just wasting your time; I do not want to be involved in your issue." That is why we do not go there to complain.*¹²⁵

We heard of no examples of a collective appeal for accountability through protest. In the rare examples we found of collective action, group discussion was the mode of action, and the issue was more likely to concern the HSAs than the medical staff.

Role of individuals of higher standing

The effectiveness of complaints was perceived to be further enhanced if the complaints were supported or endorsed by individuals or institutions with power and clout known personally by the complainant (e.g. chiefs, medical staff, DHO, Traditional Authority, etc.).

¹²⁴ FGD, Female, Wellbeing Analysis, Mchinji.

¹²⁵ FGD, Female, Wellbeing Analysis, Rumphu.

A community member who is relatively uneducated and thus has little status will strategically seek an intermediary who is perceived to be influential, to help them navigate the accountability process and who is willing to support the complaint. Participants in FGDs spoke of many types of intermediary (and there may be more than one). These include a 'good chief', the priest in a CHAM catchment area, a relative who is a nurse or a guard at the facility, an important businessman or a ward leader. The intermediary then may take it to the HCAC or, based on personal ties or a patron–client relationship, the DHO.

In the institutional mapping exercises, when participants were asked whether the local accountability structures (the VHC or the HCAC) would respond to their complaint, the typical answer was '*no, because we do not know them.*' While many did not know that the HCAC existed, they do know that there is a VHC, although they may not know its members. Thus, when they say 'we do not know them, they mean they do not know the members personally.

7.3 Constraints on the expression of voice

Unwillingness to complain was perceived by FGD participants and interviewees to stem from the expectation that the health system would be non-responsive, with people saying '*nothing gets done*' and '*things stay the same*'. There was an accompanying perception that local people of higher standing who were expected to be intermediaries did not always pass messages to the health officials:

*... but sometimes when we complain we complain to local leaders in the hope that they will take the issue somewhere but the local leaders don't take the complaints to the authorities. We don't have powers to go straight to those institutions to complain because we don't know where these institutions operate and we have to follow the right channel to direct our complaints.*¹²⁶

In addition to the perceived non-responsiveness of the accountability structures in place, the low levels of willingness to exercise voice was also attributed to other factors, including:

- Partial awareness of rights and formal channels of accountability;
- Fear of (collective or individual) retaliation by medical staff;
- Lack of choice – people go to the nearest facility if possible in order to avoid the costs of transportation; and
- Unequal power relations between the 'educated' medical staff in control of resources and the 'uneducated' patient in need of treatment and resources.

These are described in turn below.

Awareness of rights and channels of accountability

As noted in Section 3.2, community members understand their basic rights to effective treatment and respectful service but had limited knowledge of channels of accountability and capacity to exercise them. Although there are structures through which complaints should progress to the top health officials (see Figure

¹²⁶ FGD, Male, Wellbeing Analysis, Nkhotakota.

8 above), many said they were not aware of where to complain, especially within those communities far from the health facilities:

*Some are aware of the committee and others are not. Those who are do go and complain. And the committee does go and talk to them (doctors). They discuss the issues raised saying 'people are not being helped'. However, the victims do not follow up to know whether their complaints have been attended to or not. We go and complain to the committee that looks after the hospital. We cannot complain to the doctor since he/she is the one who has done wrong.'*¹²⁷

There was, however, a greater recognition that complaints could be taken to the HCACs. Compared to HCACs, the VHCs were less recognised as a channel of complaint and more as a committee responsible for supporting the activities of the HSAs:

*Most of the time we [members of the VHC] are the ones who solve the problems at the hospital, for example when the doctors have problems with patients and sometimes we go and sign for the medication when it comes to the hospital. ... We also solve the problems of people in terms of medication. Whenever people complain that they do not receive appropriate medication and are only given Panado we explain to them that this because drugs are not available. In our committee we have a rule that we tell people in the village 'if you have a problem don't go straight to the health centre, you should first come to us and we will solve the problem with you'.*¹²⁸

However, some VHCs did not seem to be aware of this and rarely dealt with complaints from community members. In fact, VHCs were found to be one of the least functioning accountability structures in the health sector and were not active in many of the communities visited during this research.

Fear of (individual or collective) retaliation by medical staff

Fear of retaliation appeared to be the greatest barrier to lodging a complaint. Rural Malawians perceived that their life depended on the doctors and nurses, and that if they complained they might not receive good treatment in subsequent visits or worse be purposefully harmed:

*They know our health problems very well and they treat us when we are ill, so they can easily do something to you the next time you visit them.*¹²⁹

*We are afraid of complaining because when you do that the issue is tabled and when the issue is tabled your name is mentioned there. Once mentioned, when you go to the hospital you do not receive drugs. They say 'you are the one who reported us to be fired from our work' and they even inject a poison injection to your child so that he will die. That's why people don't report.'*¹³⁰

¹²⁷ FGD, Male, Most Significant Change, Nkhotakota.

¹²⁸ KII, VHC member, Neno.

¹²⁹ KII, VHC chairman, Nkhotakota.

¹³⁰ FGD, Female, Wellbeing Analysis, Neno.

Moreover, people have seen or heard about staff members who became angry at a patient and told him/her to just go elsewhere: 'why did you complain about me? Are you trying to get me sacked? You know I'm the one who is treating you'.

In addition to personal retribution, people perceived the possibility of collective retribution: that if one patient from a village was seen as disruptive, the staff would remember the name of the village and cause problems for the other members of that village. At a government health facility in Rumphu, we heard that an entire village was banned for two years from getting treatment at the health centre because they had once questioned the medical assistant's competence by accusing him of prematurely declaring one of their own as dead. The medical assistant, in retaliation, decided to 'discipline' that community and barred them from accessing any sort of service at the health centre. While they stood in the waiting line at the health centre, these community members would be identified from the data in their health passports and sent home. The district administration and the DHMT were unaware of this.

Lack of alternative sources of health care

Research participants explained that one of the reasons why community members do not complain is due to the limited availability of alternative health care services. Some communities were only serviced by one health facility and do not have sufficient funds to seek treatment in health centres further away. As a result, many villagers were hesitant to make complaints against the health personnel for fear of being refused treatment:

If there is bad treatment you just have to accept that it may be a bad day for you and that you should just accept it and let it go. Of course it hurts when you are not treated well but you still have to get your drugs so you have to keep it to yourself.¹³¹

If more alternative health services were available, community members would be more inclined to complain, as part of the fear of retaliation mentioned above derives from this lack of choice. Furthermore, people were more likely to complain at district hospitals because of the multiple number of staff and avenues for complaints and because they are often not from that area and do not personally know the health staff.

Unequal power relations

Fear of reprisal and lack of choice and alternatives accentuate the unequal power relation between the 'educated' medical staff in control of resources and the 'uneducated' patients in need of treatment and resources. Medical staff are highly respected within communities and viewed as very important individuals. The power and position of health centre staff is further enhanced by the great demand for their services and this, in some cases, created a pervasive culture of impunity and invincibility amongst health workers. This is well founded because they know that they could, at worst, only be transferred from their current duty station to another if they did something wrong:

¹³¹ KII VHC chairmen, Nkhotakota.

*There are many [problems at the health centre] as we have already said. When you go there as a sick person you find that they have not started working yet and when you speak they say, 'it's my work, don't command me! You can't fire me I was employed by the government, it's my work'*¹³²

*We can complain to the chiefs and there are some health workers who do not respect the chiefs. They say, 'We are here because of work'. When the chiefs are misbehaving the medical personnel will leave the place. These other chiefs are not strong minded and when we complain to them they warn us that we will end up not having any medical personnel in the health centres, so we do not know where else we can complain.*¹³³

In general, community members with very low levels of education felt inferior to the medical staff and did not see themselves as capable or worthy of officially complaining and especially not about the staff. Significantly, they found it easier to complain about HSAs (who are not as highly educated as the health staff) rather than the medical personnel. As one person put it: *'even the president doesn't complain about the doctors.'*¹³⁴

Additionally, community members perceived the health workers as educated government employees who were accountable to the government and not to them as 'villagers':

*The other reason why people do not complain is that they feel the health workers are accountable to the government. They are government employees and it is only the government that can hold them accountable.*¹³⁵

Many community members noted that the 'educated' people received better treatment because they knew where to complain, unlike the uneducated ones who had nowhere to go with complaints:

*I can say I did not go far with this [complaint]; I called one of the health workers and complained about the attitude of the health worker who did this [i.e. threw the health passport at him and refused him treatment]. And I told them that they will meet educated people, who know where to complain, and you will accuse that one that she is the causer of your job termination.*¹³⁶

7.4 Constraints on accountability

The research indicated strongly that accountability to service users and communities is not effective within the rural health system in Malawi, for a number of reasons. In addition to the constraints on the expression of voice listed above, the management structures and oversight committees do not have the sufficient institutional capacity and resources to monitor activities at the

132 FGD, Female, Community Score Card, Balaka.

133 FGD, Male, Community Score Cards, Rumphi.

134 Ibid.

135 KII, Volunteer, Mchinji.

136 FGD, Male, Community Score Card, Rumphi.

district, sub-district and village level. Moreover, where cases of poor performance are identified, sanctions are rarely applied.

Institutional capacity

Accountability depends upon the willingness of those in positions of authority to accept that they are responsible to communities. It also requires well-functioning systems where rules, processes and procedures are well established and followed, bureaucrats who have sufficient skills and training, sufficient resources allocated for systematic supervisions and spot checks, and the ability and willingness of higher-level officials to sanction the non-compliance of lower-level staff.

The civil service in Malawi, as in many other poor countries, has weak institutional capacity and thus is often ineffective. The limited availability of financial resources curtails the ability of district officials to visit health facilities on a regular basis and monitor their activities. Moreover, staff at the health facilities are also unable to undertake their duties and responsibilities properly. Compounding this is a weak civil service with weak institutional capacity. The management accountability structures within the health sector are perceived as weak and ineffective. Activities are not undertaken in a timely manner, rules and procedures are not strictly adhered to and sanctions are rarely used:

Supervision is there but it's not effective. It is difficult [dealing with an HSA that is not performing]. When I see that one is not performing, my duty is to get him back on track. I used to reason with him or her and tell them that they need to improve in some areas and I do it the way we are chatting here. I also tell them that I am there to point out their mistakes to them but to get them on track. This was done in the past but, now, no.¹³⁷

In principle, HSAs are required to live in the communities they serve but many HSAs do not, preferring to reside in a town. Health officials are unable to enforce these rules and non-compliance is rarely penalised. Sanctions against medical personnel with higher levels of education are rarer still, in part due to the limited supply of health workers in the country, making suspension or firing of health workers a measure of last resort.

Health workers are aware of this and know that the worse that can happen is for them to be transferred to other health facilities; as a result, some behave disrespectfully towards their patients and do not perform their duties with due diligence.

Unsurprisingly and astutely, many respondents noted that there should be more supervision of the health workers to '*monitor how they are working and treating patients*' so that '*they may be afraid and come in good time*'. Moreover, some noted that '*some powerful people should also take part and criticise the health workers in the system*'.¹³⁸

¹³⁷ KII, HSA, Nkhata Bay.

¹³⁸ Ibid.

*There must be a supervisor monitoring them because this job involves people's lives. It must be well taken care of because in failing you can destroy the future of a child or the life of a person.*¹³⁹

Capacity of oversight committees

The capacity of oversight committees – i.e. the local accountability structures – as well as their willingness is important in ensuring that the complaints of people are heard, resolved, and the outcomes reported to those who seek accountability.

There was recognition that complaints can be taken to the HCACs, but there was also considerable variation across catchment areas and districts with regard to the extent to which these were functional. While in some catchment areas the HCAC met regularly and dealt with numerous complaints and issues, others met less regularly. For example, in Balaka District the explanations given by DHOs and health centre in-charges for not meeting were that no community member/group has complained, that members of the committee were “too busy” to attend, or that they refused to attend meetings without allowances:

*Yes [we know we can complain to the village committee]. They take four people who are near to the hospital and other members from other villages that are also close to the hospital and people choose them. Whenever they have meetings we see them, and we tell each other that if you have problems those are the people who can help you.*¹⁴⁰

HCACs were found to be more active in dealing with community concerns at CHAM health centres, perhaps due to better oversight and support in terms of incentives and resources:

*It [i.e. the HCAC at a CHAM clinic] receives some money while here [i.e. a government clinic] they are like government volunteers. ...It is a private hospital which earns some money so its committee can be more functional since it is hopeful that it will receive something, while here there cannot be more effort because they are volunteers. You are aware that the work of a volunteer is different from somebody who receives some money. I don't know, but they [committee members at CHAM] appreciate the important task that the committee does.*¹⁴¹

Nevertheless, there was sufficient evidence to show that the HCACs were able to deal with a number of cases and playing an instrumental role in resolving them:

We are fully satisfied because when there is a problem at the health centre we are able to tell that committee. When there was something wrong on the part of doctors

139 FGD, Male, Community Score Card, Neno.

140 FGD, Female, Institutional Mapping, Neno.

141 FGD, Male, MSC, Nkotakota.

*(health workers) the committee quickly reprimands them. So, we are fully satisfied because the committee is quick. They hear our problem.*¹⁴²

Where the HCAs and VHC were operating in an environment with closer supervision and support (for example, from CHAM management structures or NGOs), they were found to be more active and effective in dealing with the problems of community members.

7.5 Conclusions

Complaints about treatment and services are the main way in which voice is exercised and accountability sought. Both the expression of voice and the response in the form of accountability to users, however, are constrained in the context of health service delivery in Malawi. When formal complaints were made they were much more likely to be against bad medical treatment rather than bad service, which was tolerated for longer. The results of these complaints ranged from no action to apologies made by health staff and in more serious cases to the transfer of health personnel to other health facilities.

The exercise of voice is impeded by: (1) perception of ineffective response; (2) a hierarchy of power based largely on education, such that the educated perceive that they can, with impunity, condescend to or even mistreat the uneducated; (3) insufficient distribution of information on the availability of formal accountability channels and how to use them; (4) the perception by community members that their complaints will be met with retribution by the health personnel on whom they depend (except in urban areas); and (5) a lack of choice of a health provider due to distance and the monetary and opportunity cost of travel.

The effectiveness of accountability is also constrained by the institutional capacity and incentives of health management structures and oversight committees – which limit the internal mechanisms for monitoring of activities and sanctions against poor performance – and the lack of elected local representatives at district level to provide oversight and demand accountability.

Formal complaints were found to be more effective if they were made collectively, in response to serious maltreatment (e.g. patient death, chronic negligence, etc.) and when championed by people of higher standing and significance in communities, such as the village headman, councillors or members of health committees (i.e. VHC and HCAC).

Table 5 summarises the types and routes of accountability found and their conditions for effective response.

¹⁴² FGD, Female, Community Score Card, Balaka.

Table 5 – Types of complaints, routes for expressing voice and conditions for responsiveness

Type of complaint/protests	Channel/route for expressing voice	Frequency	Outcome	Conditions for responsiveness
Complaint about bad treatment/ behaviour of medical staff	Village chief, HCAC, Medical Assistant, VHC	Infrequent	Limited impact often ending in apologies. Higher responsiveness in CHAM clinics due to more management oversight	Availability of alternative options, improved power relations, stronger institutions with robust monitoring and accountability structures, increased demand for accountability from local population and awareness of rights. Functionality of oversight committees
Complaint about gross negligence (e.g. death of patient)	Village chief, HCAC, district officials (DHO)	Infrequent	Transfer of medical staff, dismissal (very rare)	Severity of negligence, collective action and engagement of local power structures (e.g. chiefs), responsiveness of government structures
Complaint about drug availability	Health facility, HSAs.	Infrequent	No response	Stronger institutions with robust monitoring and accountability structures, appetite and demand for accountability by senior personnel and citizens
Complaint about absence of HSAs in the catchment area	Chief, HSA supervisors	More frequent	Discussion with HSAs, construction of HSA housing, sanctions and transfers (seldom)	Enforceability of system rules and procedures, pro-activeness of chiefs
Complaint about behaviour of HSAs	Same as above	Same as above	Same as above	Same as above

8. Conclusions and implications

8.1 Summary of main findings

This study has found that rural communities in Malawi are generally well informed about their rights, have expectations of good treatment and have improving access to health information. Communities regard the formal health system as their principal point of call for most common health problems. Facilities run by the CHAM are regarded as generally providing a somewhat higher quality of care than government facilities but not all provide the free healthcare available from government facilities, which means that government facilities are preferred by the poor. HSAs are the most immediate point of contact for communities. Private clinics were generally inaccessible either because of distance or cost for the rural communities interviewed. Traditional health providers are resorted to only for a subset of health problems which are not regarded as within the province of the formal health system, or if treatment through the formal health system does not yield results.

However, despite an awareness of their rights and expectations in regard to services and treatment, community members lack effective channels for communicating their priorities, exercising rights and ensuring accountability within the health system. Communities do not have access to information about the performance of the local health system, the resources available to it, and how these resources are used. The weakness of monitoring and supervision within the government health system and the lack of effective sanctions over poorly performing staff (in part reflecting the continuing shortage of qualified medical staff) limit the effectiveness and responsiveness of service provision. Management appears to be somewhat stronger within CHAM facilities, accounting for the general preference for the use of these facilities where they are available, and among those able to afford CHAM services .

Radio stations appear to have played an important role in reaching communities and in providing health information and fostering discussion of rights. Informal social networks play a particularly important role in the dissemination and sharing of health information. The study design was intended to identify any major differences between different parts of the country in terms of perceptions or engagement with the health system, as well as with regard to access to information about it. In practice, there did not appear to be significant regional variations, with local factors (e.g. the presence or absence of CHAM facilities, the quality and motivations of staff and community leaders, etc.) appearing more important in explaining any observed differences than any systematic differences based on regional, ethnic or cultural factors. The nature of social

differentiation also appeared (keeping in mind the constraints of this study) to be generally uniform, with significant distinctions relating to gender, education, wealth, access to persons of influence, and local social standing and reputation. Other ethnic, social or religious factors did not appear to be of major significance in explaining access to services or perceived influence over service providers. Those at the favoured end of each spectrum (male, educated, relatively wealthy, politically connected and with a good local reputation) could generally expect better treatment and to exert more influence.

One motivation for this study was to assess how development aid was perceived at the local community level, and to what extent perceptions of aid and priorities expressed “from below” might differ from those expressed in dialogue between aid donors and national government. A further objective was to assess to what extent local perceptions of priorities and health problems differed from those based on official data.

In relation to the first point, it appeared that development aid (and the donor community) is effectively invisible at community level. Resources are seen as coming from government or NGOs who deliver in the field and not from the donors providing ultimate funding, although there is awareness of the dependence of government spending on donor support. This invisibility is the result of the alignment of much aid on the use of government and other national systems. In relation to the second point, it was not found to be feasible to make any systematic comparison between official data on health problems and health outcomes and the perceptions of communities, although the diseases and health problems identified by communities appeared broadly in line with those emphasised in public health service provision. A specific constraint on making such a comparison is that no data are available at any level lower than the district – and even district-level data has significant weaknesses from the point of view of making comparisons over time.

Communities regarded public service providers as of central importance for their health, but generally did not feel they were able to exert a strong influence over the behaviour or performance of health workers, except in extreme cases where community anger promoted a response from officials and traditional authorities. Similarly, NGOs were seen as potentially providing benefits for communities but the actions of NGOs were seen largely as an externally-driven process over which communities could not, and did not expect to, exercise control. In both cases, this reflected the deep-rooted inequalities in the formal and informal hierarchies of influence discussed in Section 3.1, particularly relating to education and the lack of forms of collective community action for political or advocacy purposes in rural Malawi. Personal links to sources of official authority (for instance within the district administration), and recourse to traditional leaders who have a perceived need to respond to community concerns, were the main routes of action available, particularly in the absence of any local elected bodies with genuine roots in and links to communities.

Decentralisation has established an institutional framework for community participation in planning through VDCs and ADCs which appears, when functioning well, to have the potential to express community priorities, with the large exception of the under-representation of women. However, the lack of genuine decentralisation of authority – in terms of the level of resources that can be programmed, or significant decisions that can be made, either at district or sub-district level – rendered participation through these bodies of generally limited significance. While they also have a potential role in the monitoring of the use of resources and the performance of government service provision, they lacked either the access to information or the authority to perform this role. Community influence over NGO programmes was limited by the lack of flexibility in NGO funding to respond to community needs (rather than those determined by the funding source), as well as the status inequality between educated NGO staff with access to funding sources and external links, and community members.

The absence of any elected officials below the level of MPs limits the prospects for one potential channel of accountability. Changes to the system of district assembly elections which have increased the size of electoral wards and introduced payment for assembly members were expected to undermine the community links and responsiveness of elected assembly members when district elections do occur, compared to the situation before 2005.

While community participation in planning, budgeting and programme design was consequently judged to be limited in terms of the level of participation achieved, there was community involvement in the form of support to service provision, prevention activities, and community mobilisation for tasks such as building under-five clinics and other small works. There are many sustainable and well-established networks of voluntary action in the health sector, operating through faith-based and other community organisations, as well as through initiatives organised by HSAs. Although NGOs can play an important role in developing local capacity (for instance in VDCs and ADCs), much NGO-induced participation is unsustainable and driven by donor and NGO objectives rather than those of communities.

The extent and effectiveness of community participation around government programmes depends in part on the motivation and capability of HSAs, who vary greatly in terms of their presence and effectiveness in communities. As the first point of contact for communities, the HSA plays a significant role both in promoting local participation and in the provision of information and services.

The effectiveness of community mobilisation for collective action depends on chiefs, who generally hold their office on a hereditary basis and who also vary greatly in their motivation and effectiveness.

In relation to the three underlying hypotheses outlined in Section 1.2, the study has found that access to information has improved the ability of communities to engage and participate in the health sector, but that information alone is not

sufficient to ensure accountability and effective participation. In relation to the second and third hypotheses, these cannot be assessed in relation to the effects of community participation in planning or monitoring, since genuine community involvement in either was very limited. Community involvement in service delivery (including prevention activities) did appear to improve service access to some extent, although the nature of this study means it cannot yield definitive conclusions.

8.2 Constraints on participation and their implications

The main findings on constraints affecting participation and their likely implications for service delivery can be summarised as follows:

- Effective participation in the planning and budgeting of public services is constrained by the lack of genuine decentralisation of decision-making and of locally elected democratic institutions, as well as the very limited representation of women. This is likely to make service provision less well tailored and responsive to local needs than a more effectively participatory or representative system.
- Effective participation in the design of NGO programmes is limited by the lack of flexibility in donor programmes, which limits the extent to which programmes can respond to locally expressed needs, as well as an imbalance of power between educated, externally linked NGO staff and local communities.
- Constraints on more effective participation in service delivery and prevention activities generally relate to the varying levels of motivation and competence of local health staff (particularly HSAs) and traditional authorities who play a major role in community mobilisation, as well as the limited resources (financial and equipment) available to be used at this level.
- Effective participation in monitoring (including the ability to voice and hold health sector workers accountable in relation to grievances) is constrained by power imbalances at the local level (which may be offset by active and competent local traditional authorities), but most significantly by the weakness of supervision and lack of effective sanctions for poor performance within the public health system.
- Information on financial or other resource flows is not provided (for instance to ADCs) or published. Nor is there information on service provision performance. Again the absence of locally elected bodies is a limit on the capacity for effective monitoring and the ability to ensure accountability.

The areas where action to overcome these constraints are likely to be most immediately effective in terms of the probable impact on the quality of service delivery relate to strengthening supervision and management within the public health system, and to the enhanced provision of information to local communities and community bodies. These are both areas where donor support to strengthen public management and accountability systems could have a

positive impact on participation and service quality, and these issues need to be given prominence in the development of policies on participation in health.

It should be noted that this study has not established empirically that improved community participation does lead to positive effects in terms of service quality and relevance to users. This is partly because the design of the study was not specifically focused on this objective. This would have required a quite different type of study, ideally focused on statistically rigorous comparison of levels of participation and impacts on services, which would have demanded much more in the way of resources and time, although this study could be seen as in part a scoping exercise for such a study. A second reason is that, in fact, the level of participation at least in planning and accountability functions appears on the basis of the study evidence to be universally limited. There is therefore insufficient variation to allow such a study to be done in this context. However, there are plausible reasons why enhanced participation could be expected to improve services, and such participation is central to the logic of decentralisation that Malawi is following.

8.3 Implications of the findings

The findings of this study, despite its limitations in terms of scope and depth, present several significant challenges for the current practice of the Malawian government, donors providing support to the health sector, and to NGOs.

Implications for Government of Malawi

1. The findings suggest that the limited progress that has been made in the decentralisation of public resource allocation decisions undermines the value of the local planning structures (here, the VDCs and ADCs) that have been created. However, in some cases they appear to have the motivation and capacity to play an enhanced role in planning and budgeting that could lead to greater local ownership and a closer matching of resource use to needs in the sector and more generally.
2. These structures may also have the potential to play a role in monitoring the use of public resources and the quality of services, both in the health sector and more generally. This is currently largely unexploited.
3. In addition, effective accountability to service users, including responsiveness to concerns about service quality or treatment, is constrained by the weakness of supervision and management in the public health sector, including the lack of effective and credible sanctions for poor performance by staff. There is also an apparent lack of systematic and regular monitoring and supervision of facilities, which would include close oversight of, and the provision of feedback on and response to, data from facilities. Strengthening accountability requires enabling community members to act on their rights to services and good treatment, as well as improving the flow of information on how public resources for health are allocated and used.

4. Four types of organisation and avenues may have a role in this process of strengthening accountability – and it is probably necessary that all are enhanced to strengthen checks and balances:
 - a. **Formally mandated structures (such as the HCACs, ADCs and VDCs)**, which require access to more information (particularly about the use of public resources), a clearer definition and understanding of their roles, and potentially support to the building of their capacity (to the extent that they demonstrate a commitment to playing an effective role).
 - b. **Community-led initiatives** (particularly through FBOs and community mobilisation through chiefs), which may also be able to play an enhanced role in monitoring services and the use of resources.
 - c. **Local radio stations** have played a particularly important role in providing information about health and rights and that there may be scope for enhancing this further, for instance by encouraging programmes that provide information on how to enforce rights and address problems of bad or disrespectful treatment.
 - d. **The quality of supervision and monitoring** needs to be enhanced within the public health system and more effective sanctions on poor treatment need to be applied. This needs to include some process by which the performance of frontline health staff is monitored at the community level.
5. These weaknesses are fundamentally challenges to the way in which government planning, budgeting and management functions are performed in the health sector (and probably more widely). This study has not comprehensively assessed the performance of these functions and their wider implications, focusing just on the (negative) implications for effective community participation.
6. A further challenge relates to enhancing the role of women in planning and accountability processes. At the moment, women's participation is mainly restricted to serving as health volunteers. Women thus have a valuable role in service provision and prevention, including information dissemination, but one that provides little scope for ensuring service provision meets women's needs. It is vital that the articulation of community priorities reflects women's interests and perspectives, as well as men's.
7. Finally HSAs represent the main point of contact between rural communities and the health system. Ensuring that they are resident in the communities that they serve seems to be of particular importance. This should become a condition of service enforced by their line managers, and be monitored by community structures such as VHCs and VDCs. Access to training or other opportunities for HSAs should be dependent on how their performance is assessed by the communities they serve.

Implications for Donors and NGOs

8. The above findings are also a challenge for donor action, since sector support from donors to the HSSP largely operates through existing government systems and processes which this study suggests are biased against effective community participation in several ways. This support is therefore likely to reinforce these biases, unless it is specifically designed to counter them.
9. It may be tempting for donors to respond to the challenges highlighted above by bypassing what are currently relatively ineffective official processes in order to work directly with communities. In practice, this would generally involve working through NGOs as service providers and as an interface between donors and communities. However, a further significant challenge for donors comes from the findings about NGO programmes and participation. In reality, many attempts to foster participation through NGO programmes create expectations that cannot be sustained and that risk undermining other forms of community participation.
10. There were examples found where NGO support had strengthened planning and participation (although with doubts about sustainability). However, there is a persistent problem that priority setting for (donor-supported) NGO programmes leads in practice to a situation where local priorities are over-ridden (and are clearly perceived to be over-ridden) by the incentives facing NGOs to implement programmes in line with the instructions and interests of their funding agencies. The fact that this can happen is also a reflection of the weakness of the local planning system, which is not empowered or resourced to determine priorities to guide funding (either public or provided through NGOs).
11. Donor priority setting and NGO programme design should be more closely aligned to the needs of the community. This requires a better understanding of what these needs are and the flexibility to respond to them. In the first instance this means more consultation at community level, prior to any intervention and allowing for greater flexibility when programmes are designed to adapt to emerging needs.
12. This may require separation of NGO support to capacity building or the facilitation of community decision-making from the provision of resources to avoid a conflict in incentives. However, any process that does not work through existing formal or informal structures is likely to face severe challenges related to sustainability.
13. Many community members heard about their rights to better services through local radio stations. There may be scope for enhancing this further by encouraging further information on how to enforce these rights and to address problems of maltreatment and wider issues of effective service delivery.

8.4 Guiding principles for policy on participation

The findings from this study, together with a broader perspective on lessons from experience for achieving aid effectiveness, suggest a set of principles to guide initiatives that are better aligned to the needs of the community and for strengthening community participation in the health system:

- I. Support provided through NGOs needs to be carefully designed to reinforce local participation and ownership and to build capacity, in order to avoid a situation where programmes that may not match a community's objectives are imposed on them.
- II. More interaction and engagement with communities requires a better understanding of the formal and informal structures through which communities engage and participate in programmes. The analysis of participation (for instance using the framework and tools that have been developed for this study) should be a standard part of the process of programme design and evaluation, since the strength and form of community participation is likely to have implications for the level of ownership and effectiveness of accountability. At the very least, questions about participation should be asked, and addressed using a more systematic and comprehensive approach than appears generally to have been the case in international experience.
- III. Sustainable participation is likely to be rooted in existing social organisations and networks, as well as in the formal structures of budgeting and planning. Initiatives outside these will generally be unsustainable. Poorly designed support may risk undermining these organisations.
- IV. Strengthening participation in planning and budgetary processes requires the provision of additional discretionary financial resources at the district level and enhanced oversight of how these resources are used, including through existing structures such as VDCs and ADCs. There may be scope for donors to support pilot initiatives of this kind.
- V. Initiatives that provide more resources to be controlled at a decentralised level, while in principle having scope to improve ownership and effectiveness, need to be carefully designed so as to ensure that accountability is enhanced along with the resources provided.
- VI. Strengthening participation in service delivery should wherever possible build on existing community-led structures and initiatives (particularly through FBOs and community mobilisation through chiefs). Direct NGO involvement in the formation of new participation structures and the selection of volunteers are unsustainable and risk undermining the existing structures and should be avoided.
- VII. Improving the effectiveness and accountability of health service provision requires strengthened management (supervision, monitoring, and sanctions) within the public system (particularly for HSAs and health facility staff). Community led initiatives without any attention to this is unlikely to yield significant changes to the way in which services are delivered. The strengthening of line management arrangements and accountability should be a central objective of donor support.

VIII. Improving the ability of communities to monitor the effective use of resources and to ensure accountability requires greatly increased transparency in access to information.

These principles could, if accepted in their current or an adapted form, provide a structure for the main elements of a policy or guidelines on participation in health.

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Annexes



Annex A – Selected health indicators by district, 2012

District	Expected delivery by trained health workers	Full immunisation of children under one	Under-five diarrhoea non- bloody inpatient death rate/1,000 new cases
North			
Nkhata Bay	57.1	74.4	2.4
Karonga	54.1	74.9	1.2
Mzimba	57.7	77.3	1.0
Rumphi	84.9	94.3	1.5
Chitipa	76.4	84.2	1.7
Likoma	78.7	63.6	2.8
Central			
Salima	71.1	87.7	1.9
Dowa	69.0	88.4	0.2
Ntchisi	72.5	87.6	0.7
Lilongwe	63.0	80.1	0.8
Ntcheu	82.6	83.4	0.7
Nkhotakota	64.1	85.2	1.5
Dedza	71.4	79.2	2.2
Kasungu	49.6	76.4	0.5
Mchinji	78.3	74.0	1.6
South			
Zomba	79.9	97.7	0.1
Neno	64.4	81.5	1.1
Phalombe	67.1	107.9	1.6
Thyolo	77.2	82.9	2.2
Machinga	90.2	109.3	0.4
Chiradzulu	93.0	109.6	0.5
Balaka	78.4	89.9	N/A
Nsanje	76.1	92.3	1.6
Mangochi	79.3	82.8	1.9
Mulanje	77.8	106.5	0.5
Chikwawa	69.8	95.2	2.6
Mwanza	89.3	99.9	0.8

Source: Draft health bulletin, 2012, MoH, Government of Malawi

Annex B - Research hypothesis and questions for fieldwork

B.1 Introduction

The objectives of the fieldwork at the community level is to capture the perceptions of different community members, men and women, on health status and outcomes, health seeking behaviour, quality and availability of service provision, and participation, voice and accountability in the health sector. A community consists of heterogeneous groups of people from different social, economic, ethnic groups and of different ages, both men and woman. All these groups and individuals may have different views and perceptions of health service provision, participation and accountability which this study aimed to understand and capture.

The remainder of this section sets out the key research hypothesis and questions.

B.2 Research hypothesis

The key research hypotheses of this study are summarised in Table 6 below.

Table 6 – Research hypothesis and underlying assumption

Hypothesis	Underlying Assumption
I. Access to information improves the ability of communities and different social groups within communities to engage with and participate in the health sector.	Depending on the skills and capability of the individuals, opportunities and channels for engagement, cultural norms, habits, politics and individual's expectations and ability to claim rights.
II. Community participation in health service planning, delivery and monitoring improves the type, acceptability and quality of services delivered.	Depending on the channels of accountability, their functionality and effectiveness and the incentives and responsiveness of state and service providers to formalised complaints and monitoring. It also depends on the meaningfulness of established channels of participation and expression of voice, including opportunities for <i>collective</i> voice and action.
III. Community participation in health service planning, delivery and monitoring improves the access to and uptake of health services by local population.	Provided other social (including gender), economic, cultural and geographical barriers are also removed and that power and status differences between health providers and communities can be negotiated. And provided that households develop a better understanding of services available and change health seeking behaviour.

B.3 Research questions

To test the hypotheses and underlying assumptions stated above a number of key research questions were designed for the study. These are summarised below:

A. Situation of health outcomes and services provision (to be asked of both community members and service providers)

- I. What is the health situation in this district/catchment area/community/village? What are the major illnesses and health trends?
- II. What are the health facilities available in the area? What is the quality of these services?
- III. What are the main institutional and political economy constraints in health service provision and access in the area? How does this differ for men and women, boys and girls? How does it differ by other social factors, including ethnicity, power and social status?
- IV. What are the perceptions of different groups within the local population on the type of health provider and the quality of health services provided? Do perceptions differ by sex?
- V. What are the differences in the health services provided by different types of service providers? (e.g. Government clinics, faith based organisations, private sector and traditional healers). Do preferences differ for men and women?

B. Information dissemination and knowledge sharing

- VI. What type of information dissemination or sensitisation activities have been undertaken in the community? And through which channels?
- VII. What are the outcomes of these activities, if any, on the knowledge of different individuals and groups within the communities and their ability and willingness to participate in the health sector?

C. Participation and accountability (to be asked of both community members and service providers)

- I. What are the informal 'demand driven' mechanisms through which different individuals and groups within the community participate in the health sector? Do men and women use different mechanisms?
- II. What are the formal 'invited' accountability channels in the health sector? What is the level of demand for these? How widely are these known? How frequently are these used? How effective are they?
- III. Who participates in these formal and informal mechanisms? And for what purpose or motive?
- IV. What are the views on community participation and its effectiveness?
- V. What are the conditions for effective participation? What are the cultural, social, political and economic barriers to participation in the health sector? Do women face different barriers than men?

VI. What is the impact of participation and accountability on health sector outcomes?

These key research questions were further elaborated in a series of probing questions that the research used for gathering information during the field research.

Annex C - Participatory tools for the study

This section provides details of the participatory tools used for this study.

C.1 Participatory tools - Social mapping

This is a group activity to be undertaken with the **Health Surveillance Assistants (HSA)**.

Objectives: (i) to map and analyse local social and physical infrastructure, particularly the health services; (ii) to understand the characteristics of wellbeing in the community and perceptions of differences in well-being amongst the population including as it relates to access to health services; (iii) to prompt broader discussion on the community level health problems, availability & characteristics of health facilities, services and other related interventions.

Materials: flip chart paper, pens

Step-by-step guidance: After introducing the purpose of the research and explaining your presence in the community, proceed broadly along the following steps, while using your own best judgement at all times. Work in pairs with one facilitator and one note taker.

Step 1. Working with your group first decide **what area the map will show in relation to the ‘community’**. This may be the health catchment area. Social maps begin as physical maps of the residential area of a community.

Ask the local analysts to **start by preparing the outline or boundary of the map**. Another option is to ask the analysts to draw a simple health catchment area map showing some features such as roads, paths, and watercourses for orientation.

Ask the analysts to **identify and draw on the map other institutions and landmarks** that are important to them. This could include main markets, schools, health centres, bus depots, NGO offices, child care centres, chief's house, etc.

For health institutions probe for all types of facilities and organisations involved including: **government clinics, CHAM facilities, Banja, private clinics, village clinics, Village Health Committees (VHC), Health Surveillance Assistance (HSAs), Home Based Care, pharmacies and Traditional Healers.**

Once completed then *ask for the location of the different communities in the catchment area* and ask the analysts to mark each as a small empty square. Try and explore about different well-being categories across communities (*such as rich, better-off, poor, and very poor*).

Explore whether some of the communities have particularly different social categories or ethnicity than others. Ensure that the criteria used by local analysts to distinguish different well-being criteria are noted on the map and that they all have the same understanding of the criteria and characteristics.

Step 2: Analyse the Social Map. As the map is being produced (or perhaps once it has been completed), *facilitate a group discussion on the health and social characteristics and differences in the community, including differences in what they feel should be provided to their communities (entitlements); access to health resources and social networks (the individuals they know they can go to for help)*. Explore the following areas and ask prompting questions to encourage analytical discussions around the research themes:

- Ask about the community **poverty profile** including:
 1. **Income** streams-livelihood strategies (How and where do different people in the community earn an income, why?);
 2. **Expenditures and assets** (what is the living condition of different community members and groups? Do they have different expenditures?);
 3. **Socioeconomic characteristics** (the health status of community members, schooling, HH conditions and other);
- Ask about **patterns and differences** across the community:
 1. What are the differences between **men and women, boys and girls**?
 2. Are there particular **household types** (female headed households? Child headed households? Polygamous households) or **distinct social, ethnic or religious groups** (Muslims/Christians, Zionists, Traditional African churches; Yaos, Chewa, Tumbuka) with **different access** to resources, assets, income and power? Which groups are wealthier than others and why?
- Ask in relation to these different types of groups:
 1. Who are the powerful members of the community?
 2. Who are the more marginalised and vulnerable groups?
 3. Do **different community groups** have different types of **illnesses or health problems**? Why? How? What are the **causes** of these? (In particular explore this in relation to the health services).

- Ask about trends in the community:
 1. Have there been any **changes in people's living standards** in the past 2-3 years? How? Why?
 2. Have there been any **changes** in the **type and quality of health services** delivered? How? Why?
- Ask about the ability of the different community members to:
 1. **Access** health services and meet health requirements?
 2. **Seek alternative** health services?
 3. **Complain** about services they receive and hold health service providers and health personnel to account?
 4. **Participate** in health processes including designing programmes and policies, implementing programmes or monitoring services provided.

Step 3: Bring the discussion to an end. Ask participants if anything has been left out? If not ask what the participants have learned from their analysis. Ask them what they themselves can do to change the situation in their community based on their analysis.

C.2 Participatory tools - Community well-being analysis (using 100 seeds proportional piling)

This is a group activity.

Objectives: (i) To understand the characteristics of wellbeing in the community and perceptions of differences in well-being amongst the population; (ii) to elicit estimates of the distribution of well-being; (iii) to understand perceptions of the characteristics of the most vulnerable in the community (iv) explore issues around health outcomes for each of well-being groups.

Materials: flip chart paper, pens, seeds

Step-by-step guidance: After introducing the purpose of the research and explaining your presence in the community, proceed broadly along the following steps, while using your own best judgement at all times. Work in pairs with one facilitator and one note taker.

Step 1. Working with your group (e.g. a group of key informants), place a piece of flip chart paper on the floor with two symbols of houses: once bigger one with a *corrugated* iron roofing, a very small thatched house. These represented those in the community that are very well off and those that are very poor.

Ask the community whether there are any other groups in between these two (for example those that are not poor or rich or those that are poor but not very poor)? Once all the groups are established, draw a symbol representing their housing structure and ask the group to describe the characteristics of each of these groups one by one.

Step 2. When asking analysts to list the characteristics of the different groups probe and seek clarification and consensus. Make careful notes. Note any controversial characteristics that the group cannot agree on. Only prompt on unmentioned issues once the group has completed its listing. Once this is done you can probe or explore the following questions:

- What are the **assets** (e.g. household items, agriculture inputs and implements, etc.) and characteristics (health status, clothing, type of household, number of children, number of meals a days, etc.)
- What are the **risks** (e.g. shocks to income sources, illness and diseases) and vulnerabilities (chronically ill, orphaned, female headed households, poverty, landlessness) faced by each group?
- What are **health problems faced by the community**? Are these different for **different groups**? How and why?
- Do these different groups have different strategies (**different ways of seeking treatment**) in times of illness? What are these strategies? Why?
- What are the **differences in these well-being groups in their ability to**:
 - **Access health services**, get good treatment, be treated well by health staff and meet health requirements? (go to ANC, get kids immunized, etc.)
 - Seek alternative health services? (e.g. go to private clinic, borrow money for private care? Go to clinic further away?)
 - **Participate in health processes** including designing programmes and policies, volunteering in implementing programmes or volunteer to monitoring services
 - **Complain** about services (to VHC, to nurse directly, in charge, HSA, facility health committee, an NGO, the chief, MP, etc.) they receive and hold health service providers and health personnel to account? (*for example through monitoring their activities*).

Step 3. Once discussion is finished place a pile of 100 seeds or stones on the flip sheet. Tell the community that this pile of stones represents the entire community, ask the group to estimate the proportion of stones for each group. Don't worry too much about the accuracy of their estimation at this point (Note: they do not need to count each and every stone).

Step 4. Ask the participants if we have covered everything or whether there is anything else they would like to discuss? If not ask what the participants have learned from their analysis. Ask them what they themselves can do to change the situation in their community based on their analysis.

Step 5. Thank the group, distribute drinks/snacks and close the session.

Figure 9 – Introducing 3 well being categories and encouraging an initial allocation of seeds, Agona Abrim community, Central Region, Ghana



Photo: Jeremy Holland

C.3 Participatory tools - Institutional mapping (Venn diagramming)

This is a group activity that can be conducted with groups of (male or female separately).

Objectives: (i) to understand the importance and value attached to key institutions in the key community; (ii) to understand the nature and importance of social connectedness/exclusion among different groupings in relation to health; and (iii) to analyse social relations, networks/coalitions and motivations for civic engagement (or lack of civic engagement) with service providers.

Materials: flip chart paper, pens, cards (rectangular or circular, in three sizes).

Step-by-step guidance: After introducing the purpose of the research and explaining your presence in the community, proceed broadly along the following steps, while using your own best judgement at all times. Work in pairs with one facilitator and one note taker.

Step 1. Begin by asking the community members to list the important individuals and institutions involved in health care in the community/traditional authority.

Importance means individuals, groups or institutions

- that have **knowledge**, **experiences** and **resources** to **help and treat people** in the community when they are sick or to **keep the community healthy** (for example by immunizing your children or teaching you about cleaning your latrines).
- who are also **involved in making decisions** that **affect health programmes, policies** or types of **resources distributed** at the community.

Explain that these actors could be physically present in the area or could be associated directly or indirectly (such as district officials or politicians) and could be individuals, groups, or organisations/institutions. Ask the group to list the actors. Probe and make sure that they include **formal and informal institutions and individual** involved in the health sector, examples that you may want to probe on include (this list is not exhaustive):

- Health Surveillance Assistance (HSA)
- Community Health Workers
- Volunteers
- Doctors, nurses
- Village Health Committees (VHC)
- Ombudsmen
- Chief
- MP
- Friends, relatives, neighbours
- Traditional Healer, Traditional Birth Attendant
- Donors
- Health facilities, NGOs, FBOs, church

Step 2. Next, introduce cards (rectangular or circular) in three sizes (small, medium and large) and ask the analysts to write the name of each 'actor' on a card, with the size of the card relating to the relative importance of that actor in their lives (i.e. large cards are most important and small cards least important).

Ensure that everyone participates in the discussion regarding the size of circle. Note also the basis for the analysts determining the relative importance.

Step 3. Now working with your group draw a large circle on large sheet of paper to represent their community. Draw two rings inside the circle so that you have an 'archery target'. Place a small circle in the middle. This represents them as community members (this is the group within the focus group and not the entire population). Ask the analysts to put the cards representing actors onto the large circle drawn earlier that represents the community. The placement of the cards in relation to the archery target rings provides a scale of 1-3 representing *social distance* factors such as accessibility and cooperation/contact with the health actors.

Social connectedness/closeness means they are people that this group can:

- Reach when they have a problem
- They can rely and depend on
- They know will take care of them

For example, actors that are viewed to be very inaccessible or not trusted should be placed farther away (on the outer ring or middle ring) than the actors that are felt to be very accessible and trusted (who would be placed on the inner ring). Emphasise that the ***distance*** of a paper disc from the circle that represents the village ***does not necessarily mean geographical distance***.

An individual and institution can be important in making decision on health issues or treating people but it may not be close. Alternatively an individual or institution can be less important but people have access to them for example the volunteer or church leader may be very close to them and they can rely on them but they may not have the power, resources to treat people or make decision.

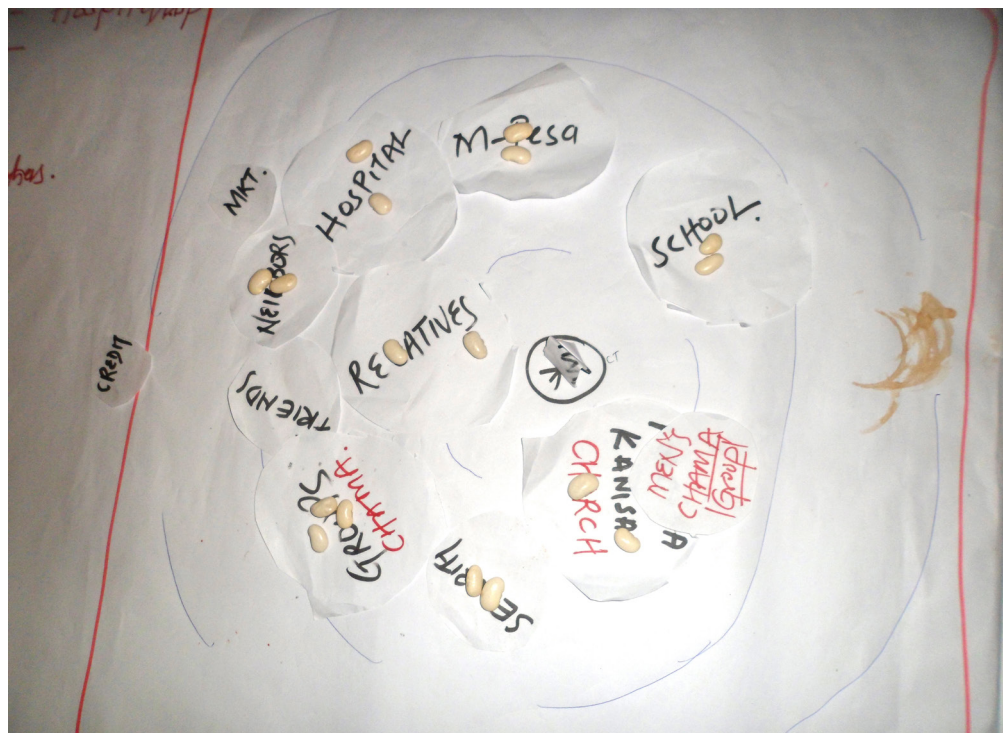
The actors can be related to each other through overlaps where these exist, through incorporation where one institution lies entirely within another, and through separate locations where there is no overlap. For example, actors with no or very little contact or cooperation should be placed farther apart from each other than those with closer contact or cooperation, which should overlap to some degree.

The analysts should change the position of the paper discs if desired (for example, after a second round of discussion) until they are happy with the diagram. Check that the basic diagram is correct and ask the analysts to reproduce a clean version on another sheet of paper or to paste the discs on the paper sheet (alternatively take a photo of this tool).

Step 4. Analyse the institutional map. Many aspects of the relationships between actors and community members can be explored using the institutional map (for example, power and influence, flows of money or information, social or cultural bonds or constraints, legal or institutional mandate, fear, mutually beneficial collaboration, altruism). Ask questions to the whole group to encourage further analytical discussions around the research themes:

- What are the ***main health issues*** and ***illnesses*** in the community?
- Where do people go to when they are ill? Why?
- Who are the ***services providers near this community***? Do they meet the ***health needs of this community***?
- Who are the most ***powerful stakeholders within the health sector***? How is the ***relationship*** of the community members with these groups?
- Are there any ***NGO health programmes*** too? Do these meet the needs of the community? When the NGO came, did it ask people what they needed or did they just come with food or to build a building, or to train volunteers? Was anyone in your community involved in this? how? Why not?

Figure 10 – Venn diagramming with male non beneficiaries, Ngoleni sub-location, Kangundo district, Kenya



Note: seeds are used here only as weights to stop paper blowing away

Photo: Jeremy Holland

- What are the **key barriers and constraints to accessing** formal health care services? Why?
- What are the reasons for **difference in the quality of health services provided** by different health providers? How can this be improved?
- Why do community members **participate** (not participate) in the health care planning, delivery or monitoring of services? What are **the barriers or reasons** for not participating? How can these change or improve?
- What are the **mechanisms for participation in the community**? Are they useful? Who participates in these? Why (probe about the various motives such as monetary, faith or social standing)?
- Are health service providers **accountable to the community**? Why? Why not? What are the forms of accountability? Are they effective? Why? Why not?
- Where do the community members go when they have any **complaints** related to health service providers? Why? Why not? Is this useful? What has the results been of the complaints?
- Have there been any **changes in the health sector** in the past 2-3 years? Why? why not?

Ask about any other issue that may have been forgotten or left out.

Step 8. Thank the group, distribute drinks/snacks and close the session.

C.4 Participatory tools - Community score cards

This is a group activity that can be conducted with groups of individuals.

A community score card (CSC) is an interactive monitoring tool used to increase accountability of service providers by soliciting male and female user perceptions on the quality, accessibility and relevance of various public services. The CSC is conducted in a focus group setting with a stratified sample of 6-12 service users.

The CSC is described as a “mixed method” tool because it generates both quantitative and qualitative data and analysis. The quantitative data comprise perception scores of specific qualities of service provision, usually scored on a 4 or 5 point scale. These scores can then be aggregated from all the focus group discussions held and compared across groups and over time. But the aim of the tool is not to elicit scores as an end in themselves but rather to generate discussions around defining the problems/issues, diagnosing them and identifying priorities for service improvement and elaborating on solutions.¹⁴³

Objectives: (i) To understand the satisfaction of health users with the services provided; (ii) ease of access to health facilities and treatment; (iii) level of participation, transparency and accountability within the health sector; (iv) issues and challenges in the health sector; and (v) likely solutions and areas of improvement.

Materials: flip chart paper, pens and normal paper. Make sure that there are **enough copies** of the score card so each participant has their own copy.

Step-by-step guidance: After introducing the purpose of the research and explaining your presence in the community, proceed broadly along the following steps, while using your own best judgement at all times. Work in pairs with one facilitator and one note taker.

Step 1. Ask each individual to fill in the score cards provided to them separately. Provide any clarification or help requested but without directing the individual in his/her choice of score. Explain to the group that following the completion of the individual exercise, the group will discuss each question and provide a group score too. The individual exercise should not take more than 10-15 minutes to complete. At this stage we only collect the scores and will **NOT** have in-depth discussions. Collect the score cards and put them to one side without further comment.

Assist those who cannot read, or need help or further explanations.

¹⁴³ Ibid.

Table 7 – Template for the Community Score Card for health facilities

Date:	Type of respondents
Start time:	District:
End Time:	Traditional Authority:
Moderator:	Health Facility:

Question	Score	Response	Discussion	Way to improve things/ By whom
During your last visit to a health clinic, approximately how long did you see the health worker?	Record in minutes (3 digits) Write 998 if time is not known			
Approximately how long did you wait before seeing the health worker?	Record in minutes (3 digits) Write 998 if time is not known			
Were you given a clear explanation of your problem and the treatment by the health worker?	1= Very clear 2= Quite clear 3= Not very clear 4= Very unclear			
Overall, how satisfactory was the service that you received today?	1 = Fully satisfactory 2 = Mostly satisfactory 3 = Not fully satisfactory 4 = Not at all satisfactory 8 = Don't know			
In your opinion, how satisfactory was the behaviour of the health worker towards you?	1 = Fully satisfactory 2 = Mostly satisfactory 3 = Not fully satisfactory 4 = Not at all satisfactory 8 = Don't know			
How satisfied were you with the overall quality of health services near your community?	1 = Fully satisfactory 2 = Mostly satisfactory 3 = Not fully satisfactory 4 = Not at all satisfactory 8 = Don't know			
How satisfied are you with the costs of the medical treatment at the health centres?	1 = Fully satisfactory 2 = Mostly satisfactory 3 = Not fully satisfactory 4 = Not at all satisfactory 8 = Don't know			
How satisfied are you with the availability of medicines at your health facilities?	1 = Fully satisfactory 2 = Mostly satisfactory 3 = Not fully satisfactory 4 = Not at all satisfactory 8 = Don't know			

How accessible is this health facility to the people of your community?	1= health centre is very accessible 2= health centre is accessible 3= health centre is not fully accessible 4=health centre is not accessible at all			
How satisfied are you with the level of information provided to you and your community by the health workers and facilities?	1 = Fully satisfactory 2 = Mostly satisfactory 3 = Not fully satisfactory 4 = Not at all satisfactory 8 = Don't know			
How satisfied are you with the involvement of people from your community in the design and planning of health activities and programmes?	1 = Fully satisfactory 2 = Mostly satisfactory 3 = Not fully satisfactory 4 = Not at all satisfactory 8 = Don't know			
How satisfied are you with the honesty and transparency of health workers and the clinic?	1 = Fully satisfactory 2 = Mostly satisfactory 3 = Not fully satisfactory 4 = Not at all satisfactory 8 = Don't know			
How satisfied are you with the work of the Village Health Committees?	1 = Fully satisfactory 2 = Mostly satisfactory 3 = Not fully satisfactory 4 = Not at all satisfactory 8 = Don't know			
How satisfied are you with the work and involvement of the Health Centre Committees?	1 = Fully satisfactory 2 = Mostly satisfactory 3 = Not fully satisfactory 4 = Not at all satisfactory 8 = Don't know			
How satisfied are you with the Health Surveillance Assistance in your community?	1 = Fully satisfactory 2 = Mostly satisfactory 3 = Not fully satisfactory 4 = Not at all satisfactory 8 = Don't know			
How satisfied are you by the response of health NGOs in your community?	1 = Fully satisfactory 2 = Mostly satisfactory 3 = Not fully satisfactory 4 = Not at all satisfactory 8 = Don't know			
How satisfied are you with the Government's response to the health problems in your community?	1 = Fully satisfactory 2 = Mostly satisfactory 3 = Not fully satisfactory 4 = Not at all satisfactory 8 = Don't know			

How satisfied are you by the services provided by non-government health facilities such as CHAM or the private sector?	1 = Fully satisfactory 2 = Mostly satisfactory 3 = Not fully satisfactory 4 = Not at all satisfactory 8 = Don't know			
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Step 2. Participants then come together and score each question as a group on a flipchart. Make **bullet point notes of comments** made by participants on a separate flipchart against each question.

Keep probing participants' comments by asking:

- “why do you say that?”
- “why is that happening?”
- “what causes that?”
- Ask participants for their perception of trends: how have things changed, why and for whom?
- **Step 3.** During the group scoring process and after the scoring, ask questions to the whole group to **encourage further analytical discussions** around the research hypothesis and questions:
 - What are the **main health issues and illnesses** in the community?
 - Where do people go to when they are ill? Why? Who are the **services providers** near this community? Do they meet the **health needs** of this community?
 - Are there any **NGO health programmes** too? Do these **meet the needs** of the community? Was the **community engaged the design and development** of these programmes? Were they consulted? how? Why not?
 - What are the **mechanisms for participation** in the community? For example:
 - serving on village committees like the village development committee or the VHC; being in a group that visits the sick (e.g. HBC, child care group early childhood education, but also church groups).
 - a group that helps orphans (e.g. an orphan care CBO).

Probe about these mechanisms of participation:

- Are they **useful**? If “no”, why not?
- If “yes”, how are they useful, what have they done that **improves** things?
- **Who participates** in these? Why (probe about the various **motives** such as monetary, faith or social standing?)

- What are the key barriers and constraints to accessing formal health care services? Why? Why might people not go to get treatment at a government clinic or hospital?
- **Probes** about these key barriers and constraints:
 - Distance?
 - They know they will be shouted at?
 - They prefer a TBA to a birth in the hospital?
 - They know there aren't drugs and they don't have money?
 - It's an emergency and they don't have transport?
 - What else?
- What are the reasons for **difference in the quality** of health services provided **by different health providers**? How can this be improved?
 - Who gets better treatment--, those who go to the government health centres and hospitals? To CHAM? To a private hospital? Banja? To a traditional healer?
- Why do community members **participate** (not participate) in the health care **planning, delivery or monitoring of services**? What are the **barriers or reasons for not participating**? How can these change or improve?
- Are health service providers **accountable to** the community? Why? Why not? What are the forms of accountability? Are they effective? Why? Why not?
- **Where** do the community members go when they have any **complaints** related to health service providers? Why? Why not? Is this useful?

Step 4. At the end of the discussion, ask the participants what **action they think should be taken** to improve the service being discussed. Moreover ask the participants what actions they as **individuals or in groups can take to change things**. Some examples of how the CSC activity might **stimulate some local reflection and action**:

- Would they start to communicate with service providers through meetings?
- Would they, for example, try to get more information on services provided?
- Would they consider establishing health provider-patient user groups or seek to make more effective use of existing community structures?

Step 5. Ask whether any key issues or themes have been left out and whether they should be included in to the score card. If there some, write these down and discuss with the group.

Step 6. Once the session is closed make sure that you have a complete set of quantitative and qualitative data. The quantitative data will comprise:

- (i) the **individually** completed **score cards**.
- (ii) the **group score card** (flip chart).

Step 7. Thank the group, distribute drinks/snacks/soap and close the session

C.5 Participatory tools - Most Significant Change¹⁴⁴

C.5.1 Procedures

C.5.1.1 Time, Materials, and Skills Needed

Allow between 1.5 to two hours to generate significant change stories and to ensure that a full discussion occurs with local analysts. The discussion group will include a facilitator, observer/note-taker, and selected local analysts. The facilitator and observer/note-taker should be experienced in both the principles behind the use of participatory tools and methods as well as in their practical use.

Objective: Capture mini case studies ('typical' rather than sensational/journalistic) of accountability processes in a research community to provide illustration (with analysis) of the (positive, negative and mix of both) relationship between social accountability and health service delivery and outcomes.

C.5.1.2 Approach

MSC can be implemented in different ways. The following approach is an adapted approach to MSC based on the context and objectives of this study.

Step 1: Select group participants. Identify the groups of people to talk to about their perceptions of social and economic change in their community. These social stratifies are summarised in Table 4.1 above. A group of 8-10 participants will generate 4-5 change stories. If there is time for pairs to swap roles to tell their stories (see Step 4 below) then this size group will generate 10-12 change stories.

Step 2: Provide introductions and explanations.

Step 3: Identify 'domains' of change and time period. The next step is to identify the domains of change to be monitored over a specified time period that covers the process of participation and accountability in the health sector. The three domains in this research are: (i) changing accountability relationships around health service delivery (at community, health catchment and district level), (ii) change or contribution to changing health outcomes and (iii) changes in broader outcomes in terms of individual or collective empowerment of those without voice or power.¹⁴⁵

¹⁴⁴ Davies, R. and Dart, J. (2005) 'The Most Significant Change Technique: A Guide to Its Use.' Funded by CARE International UK; Oxfam Community Aid Abroad, Australia; Learning to Learn, Government of South Australia; Oxfam New Zealand; Christian Aid, UK; Exchange, UK; Ibis, Denmark; Mellemfolkeligt Samvirke (MS), Denmark; Lutheran World Relief, USA. Available at <http://www.mande.co.uk/docs/MSCGuide.pdf>

¹⁴⁵ To what extent did health delivery accountability spill over into broader institutional change within households and communities around social (including gender roles and relations), political and economic empowerment?

Step 4: Collect the stories. The next step is to invite participants to share their most significant stories of change. This can be initiated with prompting the following questions:

Tell me a story about how someone/some group you know who got involved in volunteering in health related issues or health care provision or monitoring.

'Tell me a story about how someone/some group in your community complained about the health services they received? How did they do it and what was the result of this?'

Moderator should also ask where they went and whom did they complain too and what happen?

The method for eliciting the stories is to pair up participants, with one of the pair being the story teller and one the story collector. One by one, the story collectors will then recount their partners' stories to the rest of the group, with prompting from the facilitator if necessary, while the group observer/note taker will take careful notes of each story.

Please note that this can be positive, negative or a mix.

Step 5: Vote on the most significant change story. Once all the stories have been told and documented, the group will be asked to vote for the *most significant* change story. This voting process will prompt an in depth evaluative discussion in defence of the different change stories. It will also ensure that the stories told by the group are meaningful and 'typical' rather than being an exaggeration or one-off process. This analytical discussion will need to be captured by the observer/note taker.

Step 6. During the group discussion, ask questions to the whole group to encourage further analytical discussions around the research hypothesis and questions:

- What are the **formal and informal mechanisms for participation** in the health sector in the community? (in health care planning, delivery or monitoring of services).
 - Are there people in your community who are **involved in decisions and policies government** makes? Or in deciding what the health needs of the community are?
 - Have you heard of **people volunteering in the health centre** (e.g. volunteers, HTC counsellors, etc.) What about volunteers helping the HSAs? If so, why? What about HBCs? What help do they provide? Why? What about church groups, do they provide help when you are sick?
 - **Probe for:** What is that help? What about NGOs, do they provide help when people are sick? What is that help? Are there any other groups?

- **Do community members participate** (not participate) in these? Who does? Why?
 - **Probe** about the **various motives** such as monetary, faith or social standing/why not? Are these mechanisms useful?
- Would you **like to be involved any of these forms of participation**? For example would you like to be a volunteer for an NGO? Why/why not?
- What are the key **barriers and constraints to accessing** formal health care services? Why?
- What are the reasons for **difference in the quality** of health services provided by different health providers? How can this be **improved**?
- Are **health service providers accountable to the community**? Why? Why not? What are the **forms of accountability**? Are they **effective**? Why? Why not?
- Where do the community members **go when they have any complaints** related to health service providers? Why? Why not? Is this useful?
- Do people ever **protest** about health issues? Why? Why not?

Step 7: Conclude the Activity. Check again that the participants know how the information will be used. Ask the participants to reflect on the advantages, disadvantages, and the analytical potential of the tool. Thank the participants for their time and effort.

C.5.1.3 Points to Remember

Good facilitation skills and note taking are key. The participants need to be confident and probing in sharing and recounting their stories. The approach outlined above is a general guide; be flexible and adapt the tool and approach to local contexts and needs.

C.6 Participatory tools - Social accountability and participation process tracing¹⁴⁶

C.6.1 Procedures

C.6.1.1 Time, Materials, and Skills Needed

Allow between 1-2 hours to produce and analyse a process tracing diagram and to ensure that a full discussion occurs with local analysts. Markers and large sheets of paper are required. Notebooks/paper and pens will be needed to make a copy of the diagram and for the note-taker to record the discussion generated during the diagram development. The process tracing diagram can also be drawn on the ground; if this is the case, then a large area will be needed as well as a large supply of objects such as stones or beans.

¹⁴⁶ Adapted from Holland, Jeremy (2007), Tools for Institutional, Political, and Social Analysis of Policy Reform.

The discussion group will include a facilitator, observer/note-taker, and selected local analysts. The facilitator and observer/note-taker should be experienced in both the principles behind the use of participatory tools and methods as well as in their practical use.

Objectives: (i) To understand the processes and steps taken in seeking and receiving health treatment; (ii) the relationship between participation and accountability and service delivery within the health sector; (iv) issues and challenges in the health sector when seeking treatment, and in participating and holding service providers to account; and (v) likely solutions and areas of improvement.

C.6.2 Approach

The following approach is a general example that can be adapted to suit the local context, views of local analysts, and the research objectives.

Step 1: Select local analysts. Identify the groups of people to talk to about their perceptions of local institutions. Once stratified, select six to eight local analysts to participate. This will be manageable size for a process tracing exercise and analytical discussion.

Step 2: Provide introductions and explanations. When working with each group, the facilitator and observer/note-taker should begin by introducing themselves and explaining carefully and clearly the objectives of the discussion. Process tracing can follow the path of services, products, money, decisions and information, identifying actual or ideal paths, revealing problem areas of risk and potential solutions. In this research, we will use it to help understand (and visualise) the process of seeking treatment, receiving treatment and medication, and the opportunities and processes for participation and social accountability mechanisms with the health sector and resultant effect of these forms of participation and social accountability. Check that the local analysts understand and feel comfortable with what will be discussed.

Step 3: Identify 'domains' of research. The next step is to identify the domains of interest in which cause-effect flows will be identified as a result of seeking treatment, receiving it, participation in the health sector and processes for social accountability. The three domains in the case of this research are: (i) community members. (ii) the health catchment area and (iii) the district.

Step 4: Produce a process tracing diagram for the following scenarios:

- a. Ask the local analysts to draw a symbol of a person during the period of illness on a piece of paper on a large sheet of paper. Ask the local analysts to identify the opportunities and processes for seeking treatment for this individual using arrows (to show the necessary steps for seeking treatment) and circled actions (to show the type of changes). Encourage the analysts to annotate the flow diagram using "bubbles" or coloured post it notes to highlight particular risks or challenges emerging from, or

influencing, the process of seeking treatment. This process tracing will explore the options available and steps taken from development of illness to reaching formal or informal health service providers.

- b. Ask the local analysts to draw a symbol of an ill person at a clinic on a piece of paper on new large sheet of paper. Ask the analyst to trace the typical steps taken in receiving treatment from time of arrival to time of treatment and procurement of medicine. At each step of the process ask the respondents to highlight the challenges and opportunities emerging from, or influencing the process of treatment by medical staff. Once process map is completed explore whether these step differ across different types of health service users (young women, men of working age, the elderly and boys and girls), types of illness and the socio-economic status of the users. Also explore the difference across different service providers (Government run, private, NGO run and traditional healers).
- c. Ask the analyst to draw a symbol showing a complaint or dissatisfaction with a particular service provided (or lack of). Ask the analyst to map the typical mechanisms available for holding the service providers to account or the process for making complaints or voicing their views or opinions on the matter (If these mechanisms are different, explore them separately). The process tracing should explore what happens at each of these stages and the challenges and opportunities affecting this process and why? Ask about who participates in this process, why and the outcome of these processes?

Step 5: Analyse the process tracing diagram under each scenario. The process of completing the exercise and subsequent discussion will generate a rich narrative of the process of seeking health treatment and the impact of participation and social accountability on service delivery within the health sector. This discussion should be carefully facilitated to ensure that any inconsistencies are resolved, processes fully explained and contribution of participation and accountability fully discussed. Use developed question guides to help facilitate the discussion. Make a record of the discussion as the information is provided. Some of the broad questions to explore include:

- What are the main health issues and illnesses in the community?
- Where do people go to when they are ill? Why? Who are the services providers near this community? Do they meet the health needs of this community?
- Are there any NGO health programmes too? Do these meet the needs of the community? Was the community engaged the design and development of these programmes? Were they consulted? how? Why not?

- What are the mechanisms for participation in the community? Are they useful? Who participates in these? Why (probe about the various motives such as monetary, faith or social standing?)
- What are the key barriers and constraints to accessing formal health care services? Why?
- What are the reasons for difference in the quality of health services provided by different health providers? How can this be improved?
- Why do community members participate (not participate) in the health care planning, delivery or monitoring of services? What are the barriers or reasons for not participating? How can these change or improve?
- Are health service providers accountable to the community? Why? Why not? What are the forms of accountability? Are they effective? Why? Why not?
- Where do the community members go when they have any complaints related to health service providers? Why? Why not? Is this useful?

Step 6: Conclude the Activity. Ensure that the diagramming results have been recorded and that the local analysts have a copy if they wish. Check again that the local analysts know how the information they have discussed and provided will be used. Ask them to reflect on the advantages, disadvantages, and the analytical potential of the tool. Thank the local analysts for their time and effort.

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