

Strengthening Community - Health Centre Partnership and Accountability in Zambia

A Participatory Research Report



Equity Gauge Zambia with the Regional Network for Equity in Health in East and South Africa (EQUINET)



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Through institutions in the region, EQUINET has been involved since 2000 in a range of capacity building activities, from formal modular training in Masters courses, specific skills courses, student grants and mentoring. The capacity building activities in EQUINET are integrated within the existing areas of work of the network or build cross cutting skills demanded across themes by institutions in the network. This report has been produced within the capacity building programme on participatory research and action and is disseminated in this context. It is not a formal EQUINET discussion or policy paper.

Executive summary

The need for community partnership and participation in the provision of equitable and people-centred health system has been recognized in Zambia through the most recent health reforms initiated in the early 1990s with a vision "...to provide equity of access to cost-effective quality health care as close to the family as possible". The strategies for these reforms are centred on the principles of *leadership, accountability, partnerships and sustainability (affordability)* at all levels of the health system.

The principles of partnership and sustainability, assume the need to engage and involve communities using established governance structures such as the Neighbourhood Health Committees, as these were developed to specifically enhance accountability and community participation in planning, budgeting and implementation of health activities. Although most communities have been involved in the planning and budgeting of health activities on an annual basis, the evidence showed that there was little or no incorporation and implementation of these community plans by health centres. The perception was that the choice of activities to be implemented was often not done objectively by the health centres staff. The inadequate knowledge by stakeholders on the available resources, their disbursement and utilization at health centre and community levels led to tensions and misunderstandings between health workers and the local communities they served.

The researchers therefore proposed to use the Participatory Reflection and Action (PRA) approach as a pilot intervention to address the above problems working with two district health management teams (DHMTs) in Zambia, one urban (Lusaka) and the other rural (Chama). The PRA approach was based on the training programme initiated by the Regional Network for Equity in Health in Southern Africa, EQUINET through the Training and Research Support Centre (TARSC) and Ifakara Health Research and Development Centre Tanzania (Ifakara). The choice of these DHMTs also took into consideration the existence of pilot Equity Gauges in the two districts.

Major findings

There were 24 out of the 25 recruited participants that completed the PRA intervention out of which 12 were health workers (HWs) and 12 were community members (CMs).

The findings from the pre and post-test questionnaires showed that there had been a shift in thinking and action by both (HWs) and (CMs) on their perceived their involvement in the planning process and allocation of funds at the health centre (HC) level. HWs were more likely to report high levels of community participation than CMs both at the pre and post-test. CMs were more enlightened after the PRA intervention but still unsatisfied with their participation in planning.

Whereas only 80% of the participants agreed that HWs provided information on planning to CMs at the pretest, all of the participants agreed at the post-test. The assessment of whether CMs were working together with HWs in developing the action plans increased between the pre and post-test with no respondent reporting *no participation*. The intervention appears to have enabled the two groups to obtain the necessary information and act together.

However when one compares the baseline pretest findings on planning with what emerged during the PRA workshop, one observes some slight contradictions. For example whereas high levels of collaboration and information sharing on planning were reported in the pre-test, poor communication between HWs and CMs in the planning process was identified as one of

the priority problems during the PRA workshops together with the lack of information, needing urgent attention.

In the pretest two thirds of respondents felt that communities had little say in the allocation of funds at HCs. This feeling was more pronounced in CMs in Lusaka district. Although at the end of the project some progress had been made towards understanding how the funds flowed and how the budget allocations were done for their health centres, the monitoring meetings particularly in Lusaka, suggested that most participants felt the information gap still remained on resource allocation. Participants also raised their frustrations at the constant non-availability of funds from the district and central levels to implement planned activities.

From the focus group discussions and evaluations, information sharing and communication were found to be the most important factors in enhancing community partnership. The project findings showed that both community members and health providers acquired adequate skills in the PRA methodology to be able to use the tools and share them with their colleagues for the planning process. The Wheel Chart was identified by both groups as one of the most useful tools for sharing information on planning. Participants were able to use the Charts to review and monitor their activities and the progress they had made. Some participants suggested using the wheel charts for monitoring other areas of their work.

The findings further revealed positive changes after the PRA intervention in the attitude of health providers towards the community members. The health providers were able to open up enough to allow the community members to penetrate their territory and view them as necessary partners with valuable contributions in the planning, resource allocation and implementation process. On the other hand the community members were able to participate with more confidence in the HC activities particularly in information gathering and sharing for planning and activity implementation.

In conclusion the Zambia PRA project has shown that the Participatory Reflection and Action methodology is replicable in other health centres of Zambia operating under district health management teams, be it in a rural setting like Chama or an urban district like Lusaka. The Participatory Reflection and Action methodology can also be used to improve communication and interaction between community members and health providers in attaining a people-centred health system in resource limited settings such as Zambia.

Recommendations

- There is need to maintain the momentum of PRA activities started in the pilot health centres as well as advocate for the scale up of PRA methods to other health centres by including them in the district action plans as routine programme activities so as to improve information and communication on the district planning and implementation process.
- The DHMT members who were part of the research team need to continue to work with the participants oriented in PRA methodology not only to assist them to maintain the activities started, but also with the view of using some of them as trainers of trainers in the future.
- The research team recommends that further work be done with DHMTs in the use of the PRA approach in problematic areas of health service delivery that are cardinal in promoting people-centred health systems such as resource allocation and take up some of the proposals from the participants on ways to reduce information gaps in this area.
- There is need to advocate and source for funds to support the PRA methodology from within allocated district funding and from other stakeholders interested in promoting community participation in health service delivery and in assisting DHMTs to incorporate PRA trainings in district action plans.

1. Introduction

1.1 Background

The Regional Network for Equity in Health in Southern Africa, EQUINET through the Training and Research Support Centre (TARSC) and Ifakara Health Research and Development Centre Tanzania (Ifakara), has developed materials and begun a programme of training on participatory training and research for community based mechanisms to strengthen their voice in planning and implementing primary health care and health services at primary care level. Research, implemented in a participatory manner, can itself raise community voice and strengthen more collective forms of community analysis and organization to take up their interests in health. Further evidence from the research demonstrated clear gains to primary health care uptake and in the community knowledge and use of health systems when such methods are used. TARSC and Ifakara, with peer review from Centre for Health, Science and Social research (CHESSORE), have initiated work in 2005 to develop this programme of capacity support for research and programme implementation.

CHESSORE undertakes equity work in four districts including Chama and Lusaka, where Equity Gauges exist. The work examines the national health reform policy focusing on equity and governance issues in health at district level. CHESSORE has also undertaken other specific governance work in collaboration with partners such as EQUINET, to assess the factors contributing to the current inequities in the Zambian health services. Some of the factors have included problems with information and information flow, use of power and power relations in planning and budgeting for primary health care services. In order to redress some of these shortcomings CHESSORE with EQUINET have proposed a PRA approach in their next phase of work and it is anticipated that the findings from this proposed Zambia PRA project will feed into this work.

The Zambia PRA project was initiated in February 2006 after the TARSC/Ifakara training programme in Bagamoyo Tanzania where participants submitted proposals to EQUINET on specific areas where PRA skills could be built to build a learning network on the use of these methods in health. Participants from Zambia submitted a proposal through the Zambia Equity Gauge aimed at reducing some existing misunderstandings and enhancing the community voice through more proactive participation in planning, budgeting and implementation of activities at health centre (HC) and community levels in line with the country's health reforms and vision.

1.2 Overview of problem

The most recent Zambian health reforms from the early 1990s aim "to provide equity of access to cost-effective quality health care as close to the family as possible". The strategies are centred on the principles of *leadership, accountability, partnerships and sustainability (affordability)* at all levels of the health system.

As outlined above, two of the key principles of the health reforms are partnership and sustainability, which assumes the need to engage and involve communities. In addition community governance structures such as the Neighbourhood Health Committees (NHCs) were developed to specifically enhance accountability and community participation in planning, budgeting and implementation of health activities.

However despite development of policies for this, implementation at the health centre and community level has not been smooth, with frequent misunderstandings between health workers and local communities. The underlying causes for these tensions are obviously numerous and vary from community to community, but one possible reason that stands out

is the inadequate knowledge by stakeholders on available resources, their disbursement and utilization at health centre and community levels.

In addition, although most communities have been involved in the planning and budgeting of health activities on annual basis, evidence shows that there is little or no incorporation and implementation of these community plans by health centres. The perception is that the choice of activities implemented by the health centres is often not objective. This situation has led to ineffective partnerships with the community.

The researchers identified two of the factors contributing to this situation as follows:

- The conventional basic training of health care providers that seems to emphasize the concept of 'health provider knows better than the patient'. This does not always promote participation, which is key in the 'bottom-up approach' proposed in the health reforms.
- The inadequate advocacy and communication skills of community members, which often results in their ideas not being taken up by the health providers.

The project therefore proposed to use the Participatory Reflection and Action (PRA) approach as a pilot intervention to address the above problems working with two district health management teams (DHMTs) in Zambia, one urban (Lusaka) and the other rural (Chama). The choice of these DHMTs also took into consideration the existence of pilot Equity Gauges in the two districts.

1.3 District Profile - Lusaka

Lusaka district, which is also the capital city of Zambia, is situated in Lusaka Province in the central part of Zambia and covers an area of 360 square kilometers with a District population for 2006 estimated at 1,676,321 (CSO, 2000). Lusaka as a province is the most urbanized in the country and within the southern region and has a population density of 65.4 persons per square kilometers. It has a good road and rail network and an international airport. The telecommunication and mass media system is well developed. All twenty-five (25) health centres under Lusaka DHMT have radio communication as well as the Voice Over the Internet Project (VOIP).

Lusaka, as capital city, is a hive of trade and commercial investments and industries include manufacturing, farming and construction. Lusaka is also the headquarters of all government departments and ministries, who are also the country's largest employers. Poverty continues to affect the majority of households in Lusaka with an estimated 70% of the population classified as the poor. Employment opportunities in formal sector are limited resulting in most of the people being involved in informal self-employment.

Lusaka has the largest number of learning and training institutions in Zambia. However, the introduction of school fees and increase in poverty has reduced enrolment. Despite advocacy for gender equity, there are still gaps between men and women in the distribution of education attainment, employment distribution and access to social services and health care.

LDHMT is responsible for the provision of primary health care services. The District is subdivided into four operational areas known as sub-districts to facilitate the administration and provision of the district health care package. LDHMT supervises 25 Health Centres, 3 sub-centers and 3 Health Posts providing preventive, promotive and curative services. Although the district has a 500 in-patient bed capacity with a ten large health centers offering maternity services, twelve health centres with laboratories, two health centres with X-ray facilities, it unfortunately does not have a district hospital yet and uses the tertiary University Teaching Hospital (UTH) as the first referral hospital.

1.4 District Profile – Chama

Chama district, is situated in the northern part of Eastern Province and has a surface area of 17,630 square kilometers and shares its eastern border with Malawi. The District has a population for 2006 estimated at 91,280 people (CSO, 2000) with a population density of 4 persons per square kilometers. The district lies in a valley and is divided into two by the Luangwa River, a tributary of the Zambezi River and is generally classified as a hard to reach area. It includes national Park and wildlife areas that pose risks to people from the animals themselves or from the game rangers when they are mistaken for poachers. These features result in most parts of the district being inaccessible during the rainy season and add to the challenges of trying to render health services to a scattered population.

Access to Chama district is via Lundazi road from the south and Muyombe road from the north, however the roads are not all weather roads. Chama town is 331km from the provincial capital Chipata and 902km from Lusaka the national capital city. The district has a radio, land and mobile phone network with access to internet facilities and television access via satellite network. Although all nineteen health centres under Chama DHMT have radio communication, general communication to most parts of the district remains poor. There is no airport or airstrip therefore air access is only by helicopter.

Chama district is currently under developed with cotton farming offering the only few opportunities for employment in the commercial sector. The majority of people are poor and are engaged in subsistence farming, with the area being renowned for its tasty rice produce. Most people in formal employment are civil servants working for various government departments especially teachers. The district has limited financial services, is not yet connected to the national electricity grid and relies on diesel generators for its electrical power. There are plans underway to connect Chama to the Malawi grid, as this would be cheaper than connecting to the Zambian grid. Chama has one boarding high school, one day high school, sixty four (64) basic schools up to grade nine, and forty three (43) community schools which are mostly initiated and supported by local communities. This scenario has had a direct bearing on the literacy levels of the people.

Chama DHMT is responsible for the provision of primary health care services and supervises the 19 government health centres. The district has a small hospital with a theatre, laboratory and X-ray facilities that is still under equipped both in terms of equipment and human resource whilst the first referral hospital is situated in Lundazi about 156km away. This situation including the unfavourable demo-geographical status makes the delivery of quality health services to the community challenging.

For both districts the unique challenges posed require prudent and rational planning that involves the affected communities in order to maximize on the limited resources available for the implementation of optimum people-centred health activities and services.

2. Methods

The project used both quantitative & qualitative methods. The Quantitative methods involved the use of a pre and post-test questionnaire on the same individuals. The qualitative methods were based on the PRA and Outcome Mapping methods for which progress markers were developed to achieve an Outcome Challenge. The questionnaire was used to obtain baseline information and to monitor change in information exchange between communities and health centres on planning and resource allocation. A detailed guide was developed for the PRA workshop to support the local meetings with communities and HCCs, as well as a guide for the focus group discussions and selected PRA tools for the mid term review meetings on progress on community- health worker exchange in health planning.

The Outcome Challenge was to see positive change in the attitude of health providers towards community members as mutual partners; and for community members to participate and respond to this partnership with confidence that they are invaluable to people-centred health services. The qualitative methods were also used to assess the facilitator teams own learning on PRA methods and ability to use these in health programmes.

The pilot project was targeted at health providers and community members from 2 selected health centres under the DHMTs of two districts in Zambia. One of the districts was urban (Lusaka) and the other rural (Chama) to provide some comparison for the project. The health centres in both pilot districts were selected for convenience and easy access as well as their prior exposure and involvement in the Zambia Equity Gauge activities.

The health workers and community health volunteers were targeted for the intervention as they were considered key players in the delivery of health services. The selection of the individual participants was left to the respective health centres but criteria were given. Each health centre was asked to select health workers from the HC in-charge or their deputies, community health coordinators, departmental in-charges, environmental officers, MCH nurses, and nutritionists, or HWs involved in the Equity Gauge activities. Community members were to be selected from members of the Health Centre Committees (HCC) and Neighbourhood Health Committees (NHC), community health volunteers (CHV) and Equity Gauge members. Health centres were also requested to balance their groups by gender.

The resources available for the project determined the number of participants for both districts. A total of 26 people were selected and 25 participated in the intervention as one health worker from Chama was unable to join the group due to an expected commitment. There were 9 from Chama (4 females & 5 males); and 16 from Lusaka (7 males & 9 females).

The 3 facilitators for each district were drawn from the three who had participated in the TARSC/Ifakara regional PRA training (Chama Mr Payi Mtonga; Lusaka, Mr Moses Lungu and Dr Clara Mbwili-Muleya. who was also the team leader). The other three (Mr Lameck Ngulube, Mr Geston Moyo and Mr Leigh Chilala) had some experience with PRA methods and received further 'on the job' training during the preparatory meeting and workshops.

The Lusaka team, including the team leader, assist in the facilitation of the first Chama PRA workshop and thereafter each team worked independently with their groups. The teams maintained communication and feedback mostly by telephone, fax and e-mail although this was a challenge as the rural district of Chama had very unreliable electrical power supply and very few internet access points. The pilot project was undertaken between April and July and the reports from the two district activities were consolidated into one final report.

Preparatory and review meetings were held for facilitators before and after each intervention activity, followed by the two PRA workshops (1 in each district); two monitoring meetings by each team in each district; data analysis and compilation & writing of reports. The PRA tools used were drawn from the TARSC; IFAKARA Training Tool Kit on : Participatory Methods for a People Centred Health System. (2006).

The final report was disseminated to the participating DHMTs and project participants, to EQUINET the funding agent of the project, and to CHESSORE as national coordinators of the Zambia Equity Gauge.

The PRA meetings aimed to

- provide baseline data on perceived information exchange between health workers and communities
- list and prioritise perceived problems and identify their causes
- find out involvement of communities in resolving health problems
- determine how communication is happening between stakeholders in health
- identify stakeholders roles in planning & health service delivery and determine how health system engages communities; barriers to participation and options for overcoming them
- empower groups to participate in health budgeting, get consensus on identified issues

The monitoring meetings aimed to

- identify progress markers for the outcome challenge, evaluate the workshop and monitor progress markers of project
- To review changes in levels of participation and discuss barriers

The process of the PRA meetings and the specifics of how the tools were used can be obtained from the research team. The meetings included interactive introduction of participants; official opening from invited guests (in Chama the District Commissioner and the District Director of Health and Medical Officer in Charge of the local Hospital and in Lusaka the District health manager on behalf of the District Director of Health).

In Chama the event received a very high profile perhaps because the community is small and close knit with fewer events happening in the town in comparison to Lusaka which is a capital city. In both cases the guests emphasized the importance of health workers and communities working together in the provision of health services. After the introductions the pre-test questionnaire was administered, and participants outlined their expectations. These were referred to at the end of the workshop during the wrap-ups to see which ones had been achieved.

The pre and post questionnaire was administered to the same individuals and although there were no names recorded on the questionnaire forms, the participant number from the first workshop registration forms was used to link and trace the respondents for follow up post - test.

The workshops then worked through the methods to assist the participants build on their experiences from each tool used previously using the principles of sharing, using different methods, and drawing on existing behaviours & perceptions.

Intepreting the Johari's Window at Chama workshop

Some tools, like the wheel chart, were identified as useful and will be used to monitor the progress of the group in the areas identified as priorities for participation by repeating the Wheel Chart exercise after a period of time. The Wheel Chart tool also opened up the discussion on monitoring indicators and introduced the topic on progress markers for Outcome Mapping.



Facilitator drawing a wheel chart at the Lusaka workshop

The progress markers needed to achieve the Outcome Challenge aimed to assess

- positive change in the attitude of health providers towards the community members as mutual partners and for the community members to participate and respond to this partnership with confidence that they are invaluable to people-centred health services; and
- facilitators own learning on PRA methods and ability to use these in health programmes

The participants would use the progress markers to monitor any levels of change in behaviour after being exposed to the PRA methodology. The participants also evaluated the workshop itself.



Evaluating the workshop in Chama

3. Findings

3.1 Expectations

The participants expected to gain knowledge, to know the roles the community members and stakeholders would play and to know how to narrow the gaps between community members and health workers. Other expectations were to obtain certificates and to know more about the Equity Gauge. In Chama out of the 12 expectations listed, 3 were in line with the workshop objectives. However in Lusaka it appears that the distribution of the workshop programme before this session biased the participants' responses, whereas in Chama the programme was only given after the Pre-Test had been done. Almost all the expectations at the Lusaka workshop mentioned knowledge gain in PRA and planning as well as improving communication and narrowing the gap between health workers and the community members. In future workshops it will be advisable to avoid biasing participants with project expectations and discuss the specific PRA objectives after their expectations have been heard.

Overall it appeared from the expectations from both districts that the community members (CM) and health workers (HW) were not collaborating very well and therefore that the PRA workshops were timely to address this.

The three facilitators trained in Bagamoyo were uncertain about whether the other three facilitators co-opted into the teams would be able to comprehend the PRA approach in the short time available. However the preparatory meeting before the workshops and the participatory way in which the workshops were conducted allowed for quick learning and team facilitation and encouraged the new team to confidently assimilate the methods. The facilitators also expected participants to have difficulties in grasping the PRA concept and tools particularly that the workshop period was reduced from the proposed three to two days due to logistical constraints. But again the fears were unfounded as the participatory approach also encouraged participants to assist fellow group members to understand using local language, phrases and examples. For example in Chama the word *ntowa* was brought in which translated locally into ‘a way or means of doing things’.

The facilitators were also pleasantly surprised by the enthusiasm of the participants to learn and unravel the jigsaw puzzle that the PRA approach had brought. It was overwhelming to see how the groups opened up as they were exposed to more of the PRA steps almost like buds blossoming into flowers. The enthusiasm was again shown by the fact that all but one participant [he had a bereavement in the family] completed the project.

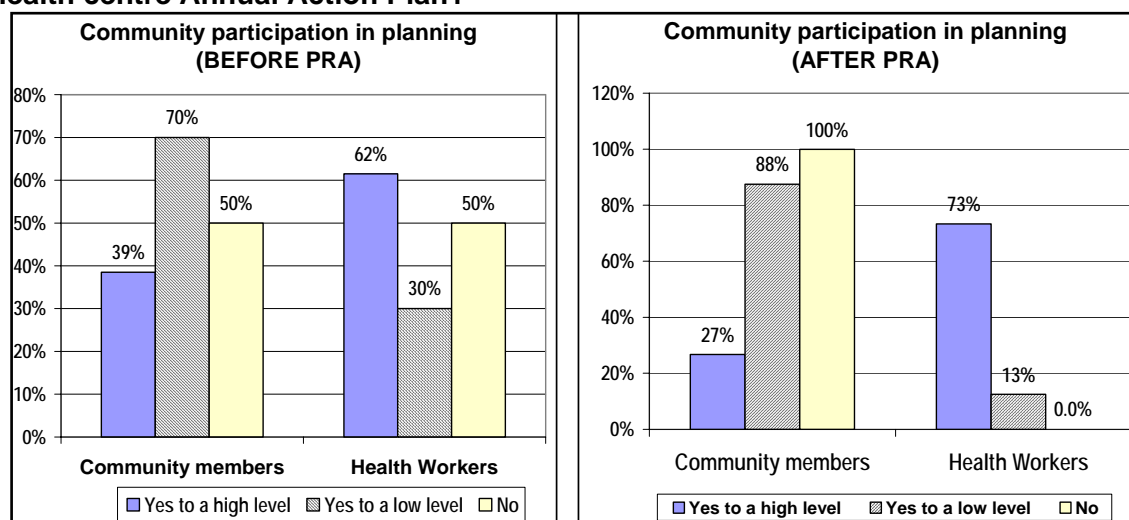
3.2 Pre- and post-test findings

The total number of respondents for the pre-test from both districts was 25, with 12 health workers (48%) and 13 (52%) community members. There were 9 respondents from Chama, 5 male and 4 female (44%), whilst Lusaka had 16 respondents out of which 9 were female (56%) and 7 male. For the post-test the total number of respondents was 24, with 12 health workers (50%) and 12 (50%) community members. There were 9 respondents from Chama, 5 male and 4 female (44%), whilst Lusaka had 15 respondents out of which 9 were female (60%) and 6 male.

Responses on Planning

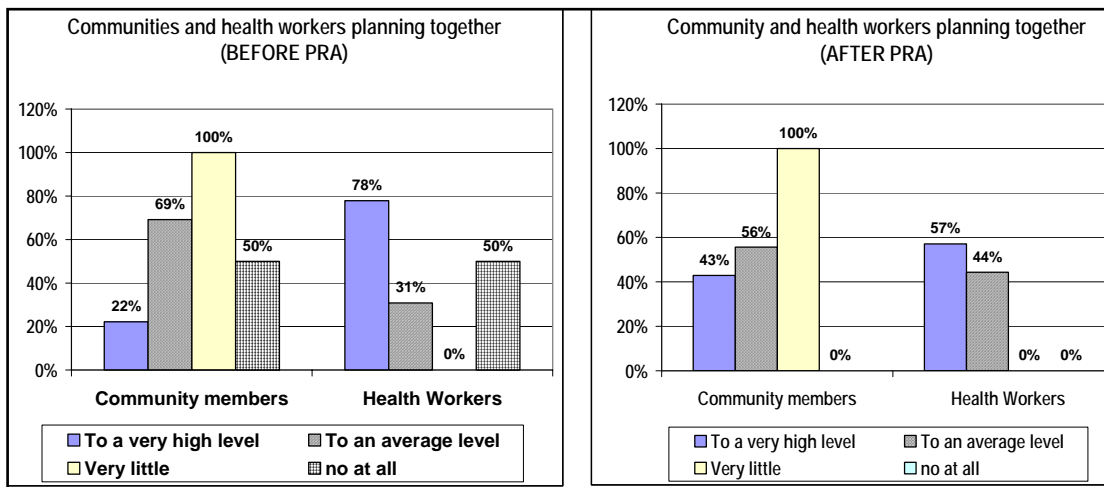
On the question of community participating in annual action planning, HWs were more likely to report high levels of community participation than CMs both at the pre and post-test with no HW reporting *no community participation* at the post-test. This finding was significant (*Fischer exact test at p= 0.027*) when compared with CMs responses at the post-test. See Figure 1 below.

Figure 1: Question 1 - Does the community participate in the development of the health centre Annual Action Plan?



On levels of collaboration in developing the HC action plans **before** the PRA intervention, 88% (22/25) reported average (13/25) to very high levels (9/25) of working together, with only 12% (2/25) reporting very little or no collaboration. However **after** the PRA intervention all but 1 respondent (CM) reported average to high levels of collaboration in developing annual plans. **See figure 2.**

Figure 2: Question 2 - How much do CMs and HWs work together in developing the health action plan?

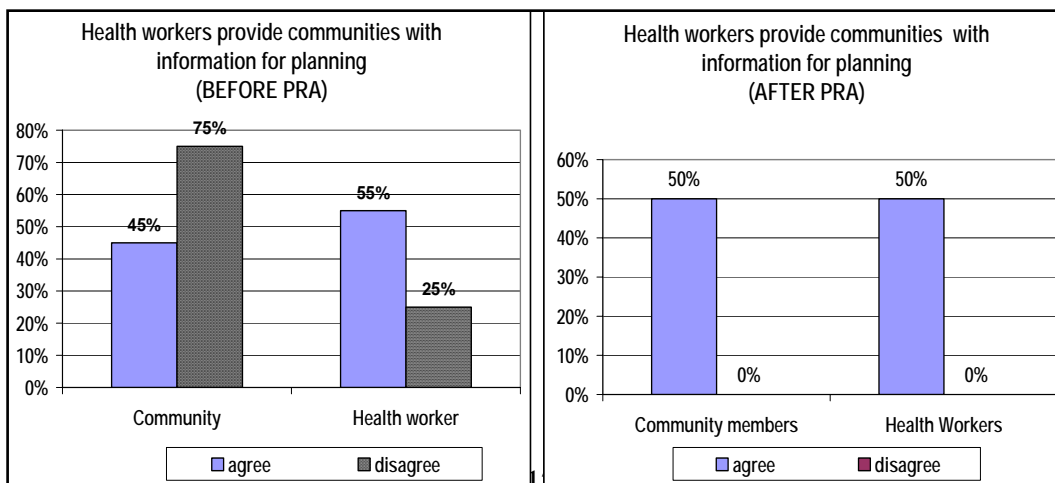


From the pretest questionnaires both CMs and HWs 84% (21/25) valued community opinions on planning and similarly at the posttest 23/24 (95.8%) of CMs and HWs valued community opinion.

On HWs providing CMs with information for planning at the pretest 80% (20/25) of respondents agreed whilst at the posttest this rose to 100% (24/24). (See figure 3 below).

For CMs providing information for plans to HWs, at the pretest again 80% (20/25) agreed and this figure rose at the posttest to 95.8% (23/24) with the respondent that disagreed being a CM from Lusaka. Overall 80% at the pretest and 95% at the posttest of both CMs and HWs reported receiving and providing information.

Figure 3: Question 5 - Health workers give communities information to help them be involved in health planning



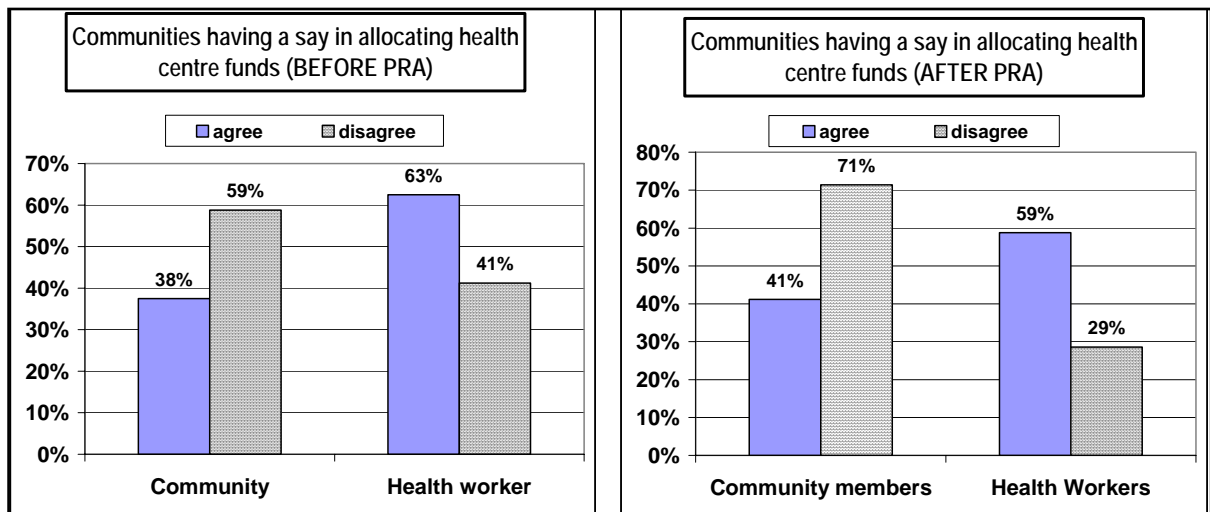
Pretest 80% (20/25 %) of participants said communities find it easy to raise views with health workers and this increased to 100% (24/24) at the posttest.

Responses on Resources

On whether communities had a say in allocation of funds at HCs, 68% (17/25) of respondents disagreed, 58.8% (10/17) of these were CMs; only 25% (2/8) of CMs agreed to participating in resource allocation.

At the posttest however, the proportion of those agreeing to having a say in the allocation of funds at HCs rose to 70.8% (17/24) out of which 41.1% (7/17) were CMs. Of the 29.1% (7/24) respondents who disagreed, all were from Lusaka district and of these 71.4% (5/7) were CMs. See figure 4.

Figure 4: Question 10 - Community members have a say in how funds for health are allocated to the health centre



At the pretest 68% (17/25) of respondents reported that communities know the various resources available for health at the HC level; but of these only 29.4% (5/17) were CMs. In Lusaka all (100%) HWs agreed to knowing the resources available compared to 37.5% (3/8) CMs and were all NHC members.

At the posttest 62.5% (15/25) reported that communities know the various resources available; but of these still only 29.4% (5/15) were CMs. For Lusaka at the posttest the proportion decreased to 75% (6/8) of HWs agreeing to the statement compared to 14.2% (1/7) of CMs. The CM was a chairperson for the NHC.

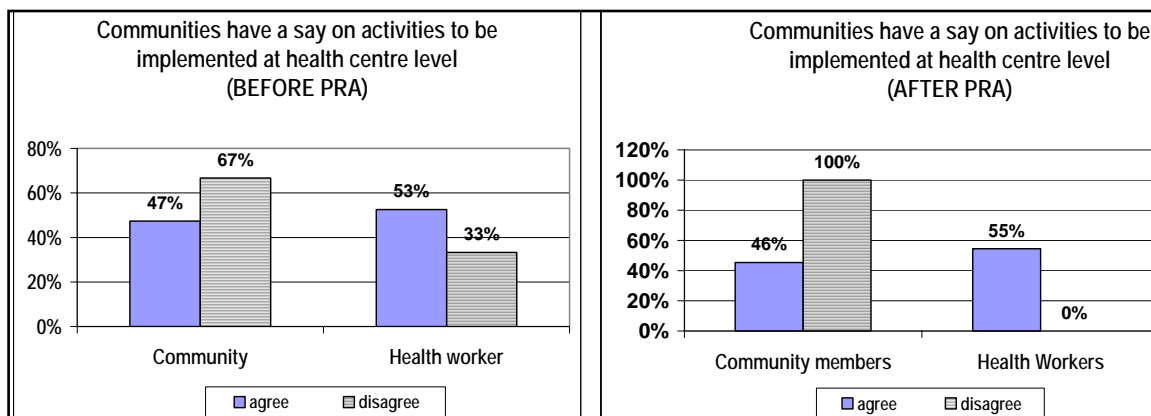
These findings seem to imply that although through the PRA intervention the participants had managed to increase their knowledge on how funds were being disbursed at their respective HCs, this same newly acquired knowledge helped them realize that there was still a gap in the information and involvement of stakeholders in resource allocation.

Responses on Activity Implementation

At the pretest 76% (19/25) respondents agreed that communities have a say on which health activities should be implemented from the action plan, out of which 42.1% (8/19) were CMs.

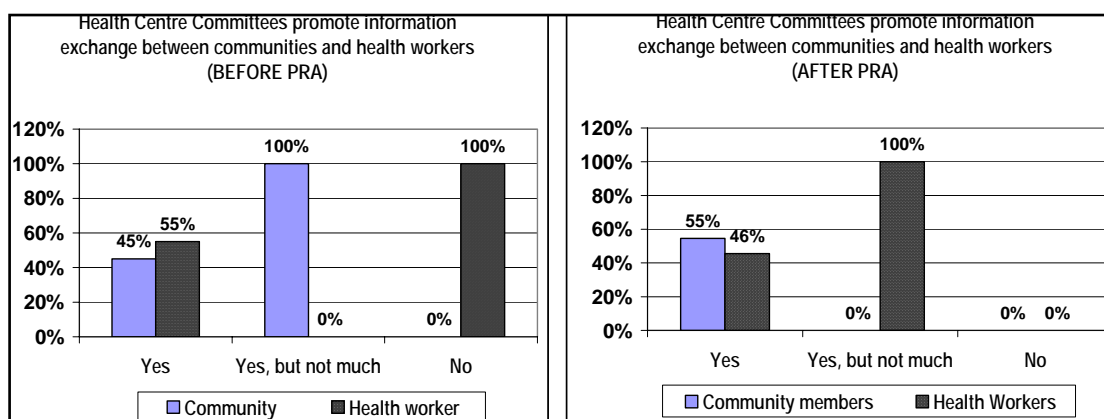
The figure increased at posttest to 91.6% (22/24) of respondents agreeing that communities have a say on which health activities should be implemented from the action plan, out of which 10 were CMs. All HWs in posttest agreed that CMs have a say on which activities are to be implemented (**figure 5**).

Figure 5: Question 11 - Community members have a say on which activities should be carried out from the Action Plan



At the pretest 23/25 (92%) reported that their Health Centre Committees (HCC) were active with all (100%) of CMs and HWs in Lusaka agreeing. Then at the posttest no participant said *no* in the posttest as shown in Figure 6.

Figure 6: Question 14 - Is the Health Centre Committee useful for exchange of information between HWs and CMs?



3.3 Findings of the PRA meetings

The brainstorming brought out participant perceptions of the current problems in the planning process, resource allocation and activity implementation as separate groups of HWs and CMs. The groups shared their problem lists in a plenary session and the two lists were then consolidated into one problem list. This method was very good for identifying different perceptions on issues between stakeholders but it also forced the two groups to work

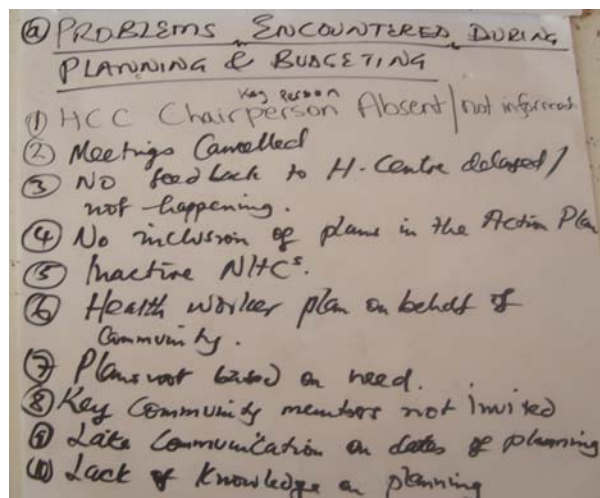
together as they had to merge their problems into a common list that they could both then identify with.

At this stage we were really encouraging the two groups to 'let out their steam' and bring out their perceived problems without being influenced by each other as well as to see if there were any common problems identified.

Despite Chama being very rural and small and Lusaka urban and large the perceived problems in planning at health centre level were very similar.

Problems identified in Chama were:

- Low community knowledge and skills on planning health issues
- HWs plan on behalf of community
- Inadequate staff does not allow for consultations with communities
- Community does not appreciate planning process / importance of planning
- Inactive NHCs
- CMs are passengers in planning process
- Key CMs not available during planning activities
- Inadequate resources to carry out plans
- Community plans included in Action plans not need-based
- Community has difficulties implementing activities planned on their behalf
- Ineffective communication between HWs and CMs
- Inadequate information by community on planning process eg cycle schedule, formats etc.
- Inactive community volunteers to provide planning information to NHCs & HWs



Problems identified in Lusaka were:

- Planned activities not implemented due to no funding
- Final approved action plan & budget takes too long to be returned from district level
- Inadequate knowledge & skills on planning process & formats for both community & HWs
- Inadequate feedback (on activity planning/budgeting, resource allocation & implementation) between community groups,.
- Most HWs and CMs never see a copy of the final Action Plans for the health centres
- Health Centre Committees (HCCs) are not effective in disseminating information on the 3 areas of planning, resource allocation & implementation
- Some HWs and community groups do not want to be involved in planning process
- CMs & HWs do not always plan together
- District level not giving enough support, guidelines etc on planning & resource allocation to HC level therefore HCs not able to pass on anything to community
- Inadequate feedback (on activity planning/budgeting, resource allocation & implementation) from HC management meetings to other staff members.
- Community not involved in allocation of funds at the health centre
- Inadequate representation of staff on the HCC since only the in-charge is in attendance

The common problem list was weighted using the Ranking and Scoring method in order to find the top three priority problems. These are shown in Table 2 for each district, as shown in the Table 1.

Table 1: Prioritised problem lists for Chama and Lusaka Districts

	Chama		Lusaka
1	Ineffective communication between HWs and CMs	1	CMs & HWs do not always plan together
2	Inadequate staffing levels do not allow for consultations with communities	2	Inadequate information, knowledge, skills & District level support on planning process for both community & HWs
3	Low levels of community knowledge and skills on planning health issues	3	Inadequate feedback on activity planning/budgeting, resource allocation & implementation at all levels:- between community groups, between HWs & between HWs and CMs

Looking at the priorities from both districts, it appeared that most of the problems hinged on communication and information flow between the HWs and the CMs, although the issue of health worker shortage was also felt to be an important factor that hampered the consultation process. Interesting again was that these findings were common for both the Chama and Lusaka participants.

During the discussions the participants explained their criteria used for ranking the problems. The group said they took into account problems that they felt they could resolve either through advocacy; those that they felt were achievable and sustainable; and those for which the community could easily be mobilized to tackle.

Both groups found this exercise empowering and a fair way to resolve difficult decisions even in other areas of their work. It was also interesting to see groups come up with different ways of resolving listed problems with tying votes. One group had ties for the 2nd and 3rd place problems and so redistributed all the 3 counters again for the group to re-vote on the two. The process was repeated until the 2nd and 3rd placed problems were identified. Then when each group had presented their priority list, the priority lists were merged into one list of three priority problems ranking the highest scoring problem as the highest priority. It was these prioritized problems that were also used for the activity plans and to identify progress markers later.



Ranking & Scoring in Lusaka

The two previous tools had already started to improve the participation of the group members and some level of trust was developing between the CMs and HWs. Participants were broken into mixed groups of HWs and CMs to allow for deeper reflection on the possible reasons underlying their problems and who was responsible for them. The process needed substantial guidance by the facilitators. Eventually the participants were able to find at least one root cause to their selected problem and realized that even at their level they had some power to act and change some of the situations. The findings from a discussion of the problem of 'not planning together' are shown in the figure below and they appear to identify that from immediate causes in the community, deeper underlying causes stemmed more from higher levels of the health and political system. This pattern was the same with most of the other problems tackled by the groups.



Figure 1 Problem tree analysis, Lusaka

Problem: Community members & health workers not planning together			
Level	Underlying Cause	Whose Problem	Who Can Act
Immediate →	Lack of communication ↓	Community/HC	HC
↓ Environmental →	Because of the system ↓	District /MOH	HC
↓ Environmental →	No guidelines ↓	District /MOH	HC/District /MOH
↓ Structural →	Not considered to be important ↓	MOH	MOH
↓ Political system & values →	No knowledge by Minister ↓	MOH	Government
↓ Political system & values →	No policy	Government	Government

By the end of the session the concept was well understood and it was found that some aspects of discussion would be useful later during other exercises eg Stepping Stone and Role Play. The tool was one of the most popular during the workshop with participants teasing each other with the words 'but why?' when a colleague said something that was unclear. The facilitators felt the method needed a lot of time.

Having started the process of analysing causes of the perceived problems, a role play was used to probe further into the aspect of who had the power to resolve the problems using a real life scenario.

The selected players were given a scenario where a community was facing a problem of the health centre only distributing ITNs (impregnated bed nets) to under five children and pregnant women leading to complaints from the rest of the community members. The players were asked to show how they would resolve the problem. In both districts in the role plays, the community summoned the district director through the health centre in-charge to come and discuss the problem.

In Chama the problem was resolved with the director agreeing with the community's suggestion to allocate part of the 10% district funding for community activities to go towards buying ITNs that the general population could buy at a reduced rate.

In Lusaka the director explained the scientific reasons behind targeting the pregnant women and children but did not commit himself to providing the ITNs to the whole community. Instead he promised to lobby other donors and partners to extend the distribution of ITNs to the general population at a subsidized fee.

The role plays as interpreted by the participants displayed a process of a community being empowered to respond to the health system in demanding for services they required and perceived important. In the discussion the CMs highlighted the fact that they were able to summon the director [or HC in-charge] to come down to their community to listen to their grievances because they were united and felt they had the right to do so. They also highlighted that the process was one of negotiation for both sides to give and take so that both parties benefit. This outcome was an eye opener for the facilitators as they realized that the role play was a powerful participatory tool that could be used to achieve many of the project objectives. Through the role plays the facilitators emphasized that a problem can be tackled in different ways depending on how the stakeholders see the problem and how they participate in resolving the perceived problem. As a follow up to the role plays, the facilitators introduced the Incomplete Stories tool to make the participants think even deeper on their role in the problem solving process as stakeholders of the health system.

The series of pictures used were depicting an intervention involving the siting and installation of a hand pump water well for the community.

The final interpretation of the story was similar by all the groups although the 'journeys' to the end of the story varied by group and district. All the groups agreed that it was important to involve all stakeholders from the beginning when implementing any health intervention, to ensure full participation and consensus. However in the discussions one of the issues raised was that of who was making the decisions in the story. Some groups saw a community leader such as a head man, political leader or a health worker trying to push their personal agendas, without considering how people may see things differently. It was said that often, influential people could mislead communities and that it was important to sensitise communities before an intervention is carried out.

In Lusaka the exercise was altered slightly by providing only 2 out of the 3 pictures and asking the groups to complete the story. When the first incomplete stories were shared, the final picture was added to the story and again the groups were asked to tell the new story.



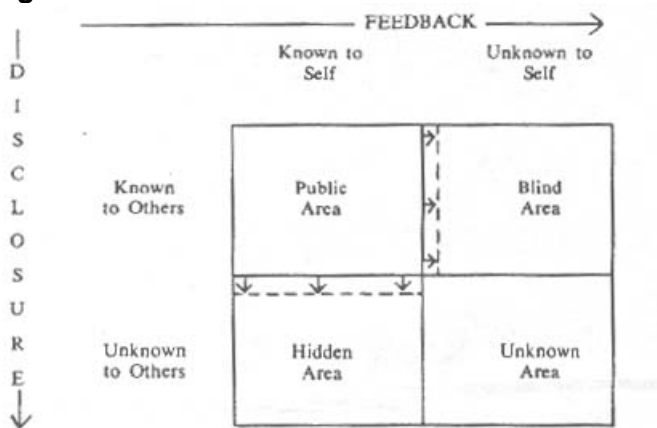
Completing the Story by Lusaka Groups

One Lusaka group interpreted the first story as a scene of a funeral gathering with the people trying to site where to put a tombstone and the women walking away from the site in fear of a snake! As facilitators we realized that Lusaka being an urban area, there would be fewer instances where siting of a hand water well would be an issue. However due to the higher incidence of death in light of the population and possibly the HIV pandemic, funerals are more common place in urban Lusaka.

After the addition of the third picture the group arrived at conclusions similar to those in chama. However when participants added their own final picture it showed how people see their own social and economic environment affecting health practice. The tool brought about much discussion amongst participants and increased interaction and communication between the CMs and the HWs. While the Incomplete Stories helped to draw out community perceptions, facilitators felt that generic pictures may not always be appropriate and there is need to design pictures that are relevant or common to the local environment.

The Joharis Window method (see PRA toolkit) was used to help participants reflect a little more in depth into how they themselves as stakeholders communicate on health issues. This tool was helpful to promote self-reflection and to bring out and overcome prejudice. As the group opened up so the public window in Figure 2 below grew, opening the issues around which participants share and exchange views and experiences more freely.

Figure 8: Johari's Window



Source: <http://www.augsburg.edu/education/edc210/johari.html>

The tool was however proved a little difficult as a concept even for some facilitators and needed more in-depth explanation.

Once the participants had discovered how they themselves communicate it was easier to realise the potential in themselves and others. The Spider diagram was used to encourage them to go a step further and begin to take action towards fulfilling their identified roles. Participants identified the following as their roles in the delivery of health services.

- Community to identify their felt needs on health.
 - HWs to sensitise and inform all stakeholders on planning through workshops & meetings.
 - CMs to hold meetings on regular basis to review their strengths and weaknesses.
- Other roles existed but time constraints meant that these could not all be discussed.

A stepping stones method was selected to show how the health system engages communities and embraces their roles.

The participants were given a scenario of Malaria as a health problem, and eliminating Malaria as the goal.

Chama group identifying the stepping stones



The participants brain stormed on the possible steps and who takes them and identified the measures below (C= community, H = Health workers):

- calling for a meeting (C)
- sharing technical knowledge (H)
- identify strategies (C&H)
- share experiences (C&H)
- early recognition of treatment (C)
- have right drugs to treat with (H)
- use of traditional treatment (C)
- burn local herbs (C)
- remove stagnant water (C)
- in-door residual spraying (C&H)
- environmental clean up (C&H)
- use of ITNs (C)
- monitoring and evaluation of activities (C&H)

It became clear in the method how each needed the other. The technique effective to mobilize the community and for increasing partnership between HWs and the CMs. At the end of the exercise both groups said that they needed each other as partners in health service delivery and if they worked together more often they would resolve many of the problems that appeared impossible. It also further strengthened communication between the HWs and CMs and encouraged team work.

The wheel chart was used to measure how involved the HWs and CMs were in the planning process, resource allocation and activity implementation from the beginning to the end of the project.

Generally both groups felt their current levels of participation at the beginning of the intervention were unsatisfactory and could be improved. After seeing and discussing the existing levels, the groups agreed that during monitoring meetings, the Wheel Chart should be included to see progress made.

The participants were also asked to complete individual Wheel Charts that they could monitor for their own levels of participation. This allowed individual participants to reflect on their own levels of participation and adjusting to where they would like to be. One HW working as a departmental in-charge in Lusaka realized that she wanted to reduce her level of participation in planning by ensuring that others in her HC increased their participation, thus relieving some of her burden.



Lusaka health workers drawing the Wheel Charts at the meetings

Some HWs suggested ways of quantifying the levels to match the lines in the chart to percentages. It was also felt however that methods were needed that could be used easily by all especially CMs. The participants also said that the tool was easy to use and interpret even in local language, as it was very visual. Most participants also said they would continue to monitor their progress using the Wheel Chart even in other areas of their work.

During the first meeting, all the group wheel charts produced showed high levels of increased participation on 'access to planning information' and 'participating in the planning activities';

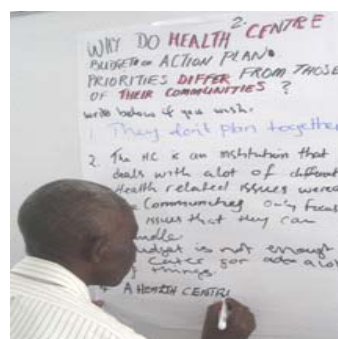
slightly lower levels of increase in 'activity implementation', and very minimal to no increase in levels of participation in 'resource allocation'.

During the second meeting, information sharing continued to show the highest levels of increase for both HWs and CMs at all health centres. Using a scale of 1 to 10 the participants reported increases from about 2 or 3 to about 6 to 8. However participation in resource allocation remained low in all Wheel Charts.

During the same meeting, participants were asked to volunteer and present their individual charts to share their 'journeys'. This session was very uplifting for the facilitators as almost everyone wanted to show off their progress. One of the HWs -clinical officer, was voted the highest achiever by the group for having moved from being a 'passenger' with almost no knowledge on planning at the beginning of the intervention to spearheading the current planning cycle in her department. Also elating was to see one of the CMs who had a little difficulty with the English language come forward proudly to share her 'journey' in the local language and finished by saying 'as in the Johari's window, I was blind but now I see'. A thunderous 'parliamentary clap' (one of the many participatory claps the facilitators learnt from the participants) of course followed the presentations.

A Market Place method was used in the Lusaka workshop to probe further into why communities were not participating optimally in budgeting and resource allocation.

Community member contributing to the Market place Discussion in Lusaka



The points raised are shown in Table 2 below:

Table 2: Market place responses

<p>Why do health centre budgets or action plan priorities differ from those of their communities?</p> <ul style="list-style-type: none"> •We differ in the way we perceive things. •What is important to one may not be important to another. •They don't plan together •Health centre deals with treatment while the community deals with identification of problems •The Health Centre is an institution that deals with a lot of different health related issues whereas the community only focuses on issues they can handle. •Budget is not enough to cater for a lot of things. •A health Centre has got more activities as compared to the community. •Health Centre action plan is statistical based while community deals with reality or situation existing. <p>How can the community monitor that health centre expenditure is in line with agreed action plan priorities?</p> <ul style="list-style-type: none"> •By reviewing the budget monthly. •By reviewing the budget quarterly. •By participating in the allocation of funds to priority areas. •By consulting each other.

- By involving them in resource allocation.
- By receiving reports through the HCC meetings monthly basis without fail!
- By communicating every end of the month.
- By feedback from the HC to the community.
- By comparing with the plan of action.
- By involving them in activity implementation.

In summary after the group discussion what emerged was the need for both groups to interact for a common purpose and that this purpose must be clear and be known by both CMs and HWs if budget priorities are to be harmonized. It was felt that HCs and communities 'don't plan together' and 'perceive things differently.' The community had a responsibility to identify community interests and factor them into the plans and participate in monitoring to ensure that planned activities were done. However the limited budget was also seen to be a major hindrance to accommodating community priorities as HWs seemed to feel the HC based activities should take precedence as they were 'evidence-based' "...*Health Centre action plan is statistical based while community deals with reality or situation existing*". Suggestions on how communities could participate, basically hinged on regular feedback and communication. It was said that communities should '*receive reports through the HCC meetings on monthly basis without fail!*'

3.4 Progress markers

Progress markers that were identified in the two districts for what CM expect to see and would like to see at each of the monitoring meetings. These tracked progress to an outcome of:

- seeing positive change in the attitude of health providers towards the community members as mutual partners and for the community members to participate and respond to this partnership with confidence that they are invaluable to people-centred health services.
- seeing facilitator teams' own learning on PRA methods and ability in using these in health programmes

At the first monitoring meeting progress had been made on all the progress markers. The participants reported having held meetings with the HC management and had met with their NHC members to explain about the PRA methods they had learnt and the task of participating actively in the planning process as well as in resource allocation. It was interesting to note that the PRA groups took advantage of HC planned meetings and requested to be included on the agenda in order to share what they had learnt. Orientation had been initiated on the format for planning, but it was noted that this needed practice and more time.

All the participants reported having seen the action planning handbook and guidelines, which they had obtained from the HC in-charges. The participants organised at least two joint meetings as HWs and CMs to monitor their activity plan update each other on progress. Minutes of meetings were brought as evidence of the meetings.

By the second and final monitoring meeting all HCs in Lusaka had achieved the 'expect to see progress markers' (See Table 3). On the 'like to see', the 4th progress marker that involved funding and resource allocation, had not been achieved by most HCs whilst the 2nd progress marker on drafting the annual plan was partially done or had started. In Chama all the progress markers had been achieved within the time planned. The drafting of the annual action plan was delayed because the district level had not received the planning updates and budget ceilings from the central level by the time the 2nd meetings were being held.

Table 3: Lusaka Progress Markers

Expect To See Progress Markers		Done
1	HC receive formats and guidelines on next year's plan	Yes
2	HC Management Committees give HCCs and departments feedback on planning guidelines	Yes
3	HC & community hold planning meetings together for next year's plan	Yes
4	Participants present able to explain planning format to others	In progress
Like To See Progress Markers		Done
1	Agree on priority activities for next year's plan	Yes
2	Draft Action Plan done together with community	In progress
3	Feedback on planning activities through regular meetings between HWs and CMs	Yes
4	HCC & departments receive a quarterly financial report	No
5	Participants present able to write a plan as per format	In progress

Table 4: Chama - Expect To See Progress Markers

Expect To See Progress Markers		Done
1	Improved sharing of information on resources & resource utilization for HCs & community	Yes
2	Hold regular meetings between the HWs & NHCs	Yes
3	Involvement of communities in the planning process in good time	Yes
Like To See Progress Markers		Done
1	Know the planning format	Yes
2	Develop an action plan using the format	Yes
3	Hold follow-up meetings to discuss and review the plan	Yes

3.5 Findings from the focus group discussions

During the first follow up meeting the focus group discussions (FGDs) were done in separate groups of CMs and HWs. It was evident that progress was being made especially in the area of information sharing and feedback. The CM groups were also more confident to approach the HC staff for information they needed to engage in the planning process. They were also able to sensitise other NHC members on how to participate even in a small way in planning.

"We held two meetings with neighbourhood health committees within first and second week of the PRA workshop. We also had a combined meeting with the HC staff on the PRA, which coincided with the receipt of the HC typed action plan from the DHO. We plan a big meeting soon. We also met NHC and briefed them. They tasked the Top ten to talk to zones about the activities they can do as community members. They encouraged us to have more confidence to bring our planned activities to the HC and to plan with the HC staff. They were also going to include PRA as an agenda item for the next HCC meetings"

Lusaka CM

Some of the feedback is shown in Box 2 below:

Box 2: FGD Responses from the Lusaka Groups at first Monitoring Meeting

<p>What have been your experiences during this period since the PRA workshop in relation to the planning and budgeting process? HWs: The PRA orientation has brought a new approach to planning and changed our attitudes</p>
--

about planning. We have been able to share the new skills in planning although some health workers have a very negative attitude toward planning.

CMs:

The working relationship has improved with Chipata HC. HC staff is taking our opinions into consideration.

Matero HC:

- Working together better as shown during Child Health Week (CHWeek) activities.
- HC staff is giving us knowledge to carry out our work eg Health education information.
- CMs were involved in handling the cash during CHWeek showing increased confidence in them by HWs.
- CMs were involved in selecting the community participants in CHWeek and allowed to involve even ordinary community members who were willing to help.
- MCH department stands out in giving out of skills to CMs especially in report writing.

What barriers or difficulties did you encounter?

HWs:

The negative attitudes of some staff. The community members need a drink each time a meeting is organised. There are many clashing programmes at the HC. New staff lacks planning skills. There is late reviewing of the previous action plan, and receipt of budget ceiling and guidelines from the district and central level.

CMs:

- The limited project time to carry out the activity plan.
- The erratic or inadequate Basket funds from higher level.
- The final typed Progress markers were not received from PRA facilitators as expected before the follow-up meeting.
- Some PRA group members had to attend to personal issues and were therefore not able to participate fully in implementing the PRA activities.

During the second follow up meeting the FGD was done as one combined group and was aimed at identifying where sustainable change had been introduced and what barriers still needed to be addressed. Both CMs and HWs reported positive changes in how they related with each other not only in the planning activities but in implementation of other activities e.g. at Chipata HC the CMs were now being involved in carrying out exit interviews to monitor patient satisfaction.

Information sharing was said to be the key to improving the interaction between CMs and HWs at all levels. It was emphasized that just as the HC needed to share information on how funds are allocated, so too the district level should send information on how moneys received are spent through different means such as financial bulletins or news letters. One HC reported having made progress in this area saying the HC had shared information with the HCC on how the fundraising account operated at the HC.

On the barriers still hampering progress in the four areas the participants were considering, most were linked to availability of resources to implement the planned activities. Another barrier identified was the negative attitudes of some community members and health workers. It was said that many people in the community were misinformed about most health services but that it was up to those CMs with accurate information to assist the health centres in clarifying issues. On health workers it was said that some had no interest in HC issues and many were more preoccupied with personal things.

3.6 Evaluation of the workshops

In general the responses were very positive from both Chama and Lusaka districts with participants affirming that they appreciated HWs being brought together with CMs as they learnt a lot about each other. To quote one response: *“The whole workshop was superb and an eye opener for me. God bless”*.

The participants were impressed at the PRA methodology and tools. Several participants reported the ‘problem tree as the most useful whilst the wheel chart was the most relevant’. However many complained that the number of days for the workshop should be increased to ensure all participants were confident with the tools. As summarized by one participant, *‘...there was little time to grasp everything therefore [there is need to] increase on the duration’*.

The research team has acknowledged this point and proposes to reduce the number of tools to be used in future PRA workshops addressing the district planning and budget process.

One participant asked *“How long will this programme stay?”*

A Ballot in the Box at the last monitoring meeting was used to explore :

1. Which PRA method was the most useful or relevant
2. What to change or do differently to improve information sharing in areas of planning and resource allocation
3. Any questions, suggestions or comments about the PRA project

In summary half of the participants wrote that the Wheel Chart was the most useful or relevant tool they had learnt saying that it was user-friendly, easy to understand and to explain to others and had helped to them to see how much they had improved.

The Stepping Stones was considered the next most useful and this tool was said to have helped bridge the gap between the HWs and CMs and made the groups realize that they needed each other to improve health of the people. Some participants were pleased to have had the opportunity to learn and review the planning process as this empowered them to teach others more confidently. The Market Place was said to have been useful in encouraging peoples’ views on issues; whilst knowing about the three pillars of PRA had helped participants change their behaviour from ‘them and us’ to ‘we’. From the Chama team both HWs and CMs reported that the most useful thing they had learnt was the need to work hand in hand to have a healthy community.

On the question of power and what participants could change, most responses were related to resource allocation. Most participants would ensure that there was adequate and timely information on available resources for carrying out at least 75% of planned activities; they would develop brochures, organise general meetings to share information on resources allocation processes and how much had been received from the DHMT.

Other participants reported that if they had the power they would ensure that there were regular refresher trainings and on going meetings on the planning process to ensure information was disseminated and ensure that everyone was involved and found planning important. Another participant would use meetings and trainings for HW and CM transformation leading to behaviour change. There were also two participants that referred to encouraging more use of vernacular at the health centres and more drama performances in communities to improve on information sharing with those that did not understand English.

In summary issues raised related to:

- information sharing,
- increased knowledge on planning,
- personal transformation in terms of changed perceptions and behaviours on planning and related issues, and
- expanding or rolling out of the PRA intervention to all the health centres and other levels (continuity issues).

Some participants from both Lusaka and Chama commented on the need to have adequate funds for the planning process and to provide allowances for those actively involved in developing and writing up the plans.

Then one participant simply asked why resource allocation was so difficult in our country. This seems to imply that this area is an area of concern even beyond the PRA project.

The positive impact that the PRA intervention appeared to have had was highlighted at the final monitoring meeting in Lusaka where the HC in-charge of Chipata HC where the meeting was held decided to join the meeting. In her closing remarks she explained that she had decided to find time to participate in the meeting and to experience for herself what this PRA was that had brought her conservative clinical officers out of their shells to a point of demanding to see the health centre action plan in order to review their activities:

“...I was surprised when my CO [clinical officer] who had never shown any interest before in planning, knocked on my door to ask for the health centre action plan because he wanted to begin writing the next year’s plan for his department!”

The in-charge also praised the PRA intervention and expressed joy and surprise that the participants were motivated enough to carry out their activity plan and hold their meetings despite not having funds even to buy refreshments. She hoped the PRA methodology could be integrated into the district activities so that all the health centres could benefit.



Chipata HC in charge giving her closing remarks.

Facilitators burning midnight oil reviewing the Chama workshop.



4. Discussion

This project proposed to use the Participatory Reflection and Action (PRA) methodology to impart participatory communication skills to the two target groups that is, the health providers and community health volunteers involved in health activities at the HC level. The project further proposed to reduce the information gap on the availability and utilization of the health resources, as well as build the confidence of communities to speak out on health issues that affect them.

Despite the pilot project being able to cover only two health centres in each district and a total of 25 participants for the intervention, the project brought out important issues that influence the planning and resource allocation process for district health services in resource limited settings.

4.1 Pre and post-test questionnaire findings

The pre and post-test questionnaires assessed the levels of participation in planning, financing and implementation of activities at health centres by the two groups before and after the intervention.

The results indicated

- Significantly increased reporting of community participation in annual action planning between the pre and post test.
- Higher CM expectations of participation in annual planning than amongst health workers
- Average levels of collaboration in developing the HC action plans reported in both the pre test, with increased reporting of high levels of collaboration after the PRA training, suggesting a shift in thinking and behaviour where both groups are more proactive with the new acquired knowledge and skills.
- An increase from pre to post test of **HWs reported provision of CMs with information** and of report of communities finding it easy to raise views with health workers.

In the pre test many areas rated as high contradicted the reports of poor communication and information flow and suggest that there may have been biases in the pretest or misinterpretation or misunderstanding of the questions. On the other hand the open and frank discussions during the workshop allowed participants to bring out true opinions and gave the participants a chance to have more in depth understanding of the questions.

Between the pre and post- test report of communities having a say in the allocation of funds at HCs rose, but still remained relatively low, especially in Lusaka district.

Although by the end of the PRA intervention participants reported having made progress during the FGDs towards understanding how the funds flowed and how the budget allocations were done for their health centres, the questionnaire and Wheel Chart findings during the follow up monitoring meetings revealed particularly in Lusaka, that most participants felt the information gap still remained large on resource allocation. Some participants also raised their frustrations at the constant non-availability of funds from the district and central levels to implement planned activities.

While all participants appeared to generally agreed that communities have a say on which activities to implement from the action plans, the share of HW support for this increased after

the PRA. This may imply that they had now accepted the community as partners with a voice and valuable contributions. Further after the PRA meetings all participants regarded the Health Centre Committee as a useful channel for information sharing and enhancing community voice.

4.2 Other findings

The project findings showed that both community members and health providers acquired knowledge and skills in the PRA methodology and were able to use the tools and share them with their colleagues for the planning process. The Wheel Chart was one of the tools which both groups identified and used to share information on planning and levels of participation in implementation of activities. Participants were able to use the Charts to review and monitor their activities and the progress they had made. Some participants had even gone further to suggest they use wheel charts for implementing and monitoring other areas of their work.

It was interesting to find that health providers were just as likely to be misinformed and have no knowledge on the planning and resource allocation of their respective health centres as their community partners

There was clear evidence produced during the project of increased information exchange between community members and health providers on planning and resource allocation for health centre (HC) and community activities in the target areas. The two groups were able to not only organise and hold meetings amongst each other as PRA cohort groups, but they were also able to take opportunities to have their agendas included in other planned HC and community meetings to share their acquired knowledge on PRA methods and the planning process. Both groups produced minutes and activity plans from the meetings they had held with HC staff, HCCs and NHCs.

The participants were able to explain some of the formats for planning, as they had started the orientations on the planning cycle using the handbooks and guidelines they had obtained from their HCs. However it was noted that mastering all the different sections of the documents would take practice and more than the three months of the project life. This was no mean achievement considering many of the participants both amongst health providers and community members had never seen or heard of these documents before.

The project revealed that the information gap on the the planning process and resource allocation was not only between HWs and CMs, but also between HWs themselves, as noted from the FGDs and individual wheel charts produced before and during the monitoring meetings. As one health worker said '*...the PRA workshop has really made me achanged person because I used to say that it [planning] is done only by the managers and not anybody else*'. Another health worker said that PRA was an eye opener *...'I have learnt the importance of sharing information as it reduces the workload by having others involved*'.

The participants acquired sufficient knowledge and skills to develop 'expect to see' and 'like to see' progress markers that they followed up to the end of the project period. By the end of the three months monitoring period, all the progress markers were achieved by both districts except for the progress marker relating to 'like to see involvement in funding and resource allocation'. The progress marker on drafting of the action plan was also only partially achieved because of the delays in feedback information from the district and central level about the new HC budget ceilings and any updates to be considered in the new plans.

This brought out one of the threats of carrying out a planning process that is top-down. At the HCs where the in-charge or management is not very strong in the planning process, the HWs will sit back and wait for a signal from above to start the planning cycle despite having the documents and mandate to begin reviewing the previous years activities with their communities and begin brainstorming on the following year's plans in good time.

The researchers believe the project went beyond achieving the target **'like to see' progress markers** and in fact achieved **some 'love to see'** progress markers. This is because the project saw participants beginning to take initiatives to find out information beyond that prescribed during the project meetings. Health workers who were previously detached and uninterested in the planning process approached their in-charges to obtain action plans in order to take a lead in reviewing them. Community members were able to contact the district's planning manager for information directly in order to clarify issues that were unclear at the health centre level as well as request for time to share their proposed activities at HC meetings. The change seen was summed up in the words of a pleasantly surprised HC in-charge *"...I was surprised when my CO [clinical officer] who had never shown any interest before in planning, knocked on my door to ask for the health centre action plan because he wanted to begin writing the next year's plan for his department!"*

Other unexpected outputs that pointed towards achieving the 'love to see' outcome, were the positive comments from the participants reflecting a shift in thinking / attitude when they suggested that the PRA project be continuous and be extended to other health centres and communities so that they too could quickly benefit. More than 70% of the responses to the evaluation question on comments or suggestions mentioned the importance of information sharing and the need to extend the project to other areas. One participant wrote *'...My suggestion is we should continue keeping each other informed on the latest info on PRA and that this programme should reach other health centres soonest'.*

Another Lusaka participant wrote *'...There is need for PRA to expand to other health centres apart from the pilot project health centres. We have found it to be very, very useful and helpful and as such we need our friends also to know something about PRA.'* Another said *'...It has been an eye opener & very educative. I suggest that this should continue so that each and everyone in the community and health centre know how to go about in planning as well as participate in the planning, implementation, [sharing] information on planning and allocating resources.'* Finally one sums it up and writes *'...Include this program in the DHMT planning cycle.'*

There was another important issue that emerged from the intervention and that was the need to use appropriate language for effective communication even by health providers at the health centres, to improve participation and partnership-building between the HWs and CMs. Participants noted in the final evaluation of the project for example, that they would make the following changes at health centres

- *'To promote vernacular speaking at health centres'.*
- *'I would change the system by encouraging more community participation and encourage drama groups in my area so that even those that don't understand English would get to know what is going on'.*

The findings did not show significant differences between rural Chama and urban Lusaka although there was greater need to make explanations in the local language in Chama than in Lusaka and this may have disadvantaged some participants in understanding the questionnaire.

During the project period the research teams found it necessary to review the progress of their work after the PRA workshops were held in the two target districts. The facilitators learnt

valuable lessons from the project and the opportunity to increase their knowledge and competency in using the participatory, reflection and action methods since all of them were carrying out the PRA intervention for the first time. As reported by Hofnie-//Hoebes K (2006) one does not need formal education to participate in PRA methods. What one needs are skills to listen and respect different views – these are essential in facilitating the process. Facilitators should also always be ready for unexpected outcomes.

The pilot project revealed that this PRA intervention is replicable in other HCs of Zambia operating under district health management teams, be it in a rural setting like Chama or an urban district like Lusaka as reported from the positive evaluation findings.

4.3 Lessons learnt from the PRA intervention

There were a number of challenges faced:

The distance between the 2 districts led to less time and opportunity for the two teams to meet before the workshops and disadvantaged the rural district of Chama. Implementing and coordinating the project in two districts was a real challenge particularly that Chama is one of Zambia's hard-to-reach districts with limited communication infrastructure.

The Johari's Window was felt to be difficult to explain for most facilitators as there was insufficient background information on the concept. More time was also needed to explain the concept of Progress Markers as it was done towards the end of the workshop. For effective learning of all the tools used in the Zambia PRA project, the 2 days allocated was too short. The research team acknowledged that the project used too many tools and proposes to reduce the number of tools for future PRA workshops addressing the district planning and budget process.

A number of positive lessons were learned:

The methodology allowed for 'on the job training' with minimal disruption to the workshop proceedings. The facilitators in training felt confident to participate due to the team approach of the trained facilitators. It adapts to the environment and allows facilitators to come to the same level as the participants. For example allowing the use of the local language during the workshop helped to breakdown barriers and raised the confidence of the participants.

The holding of a preparatory meeting ensured that facilitators knew what they were to do and the workshop flowed smoothly. A Field Guide was produced that can now be used for future trainings on Planning using PRA methods. Maintaining a record book during all activities was a new technique for most of the facilitators, however the method proved invaluable when writing the reports and compiling the Field Guide.

It is important to involve the senior managers from DHMT from the inception of the PRA program as was seen from Chama and Lusaka. This helped a lot in information gathering and direct involvement. The concept of involving people in planning creates a sense of ownership to programmes'

All the facilitators agreed that the PRA methodology can help improve the communication between CMs and HWs as well as change attitudes positively in both groups in the long term as it facilitated dialogue between the two groups. The positive results achieved by the project were commendable considering the short intervention period which was a challenge especially as activities were done in two districts with a phase of monitoring included. Both teams and participants were however very enthusiastic to see that the project succeeded.

5. Conclusion and recommendations

In conclusion the ZambiaPRA project has shown that the Participatory Reflection and Action methodology can be used to improve communication and interaction between community members and health providers in attaining a people-centred health system in resource limited settings such as Zambia. The project findings revealed positive changes in the attitude of health providers towards the community members as reported in the findings section of this report. The health providers were able to open up enough to allow the community members to penetrate their territory and viewed them as a necessary piece of the puzzle in the planning, activity implementation and resource allocation process. On the other hand the community members were able to participate with more confidence in the HC activities particularly in information gathering and sharing for planning and activity implementation.

The DHMT members, who were part of the research team will continue to work with the participants oriented in PRA methodology not only to assist them to maintain the activities started, but also with the hope of using some of them as trainers of trainers in the future. The PRA methodology should be scaled up to other HC and communities to improve information and communication on district planning process by integrating it as an activity in the DHMT programs.

PRA training should be targeted at health centre in-charges and district officers / managers as well as specific cadres of health workers such as clinical officers who do not seem to participate easily in HC planning activities despite being a critical cadre in health care delivery. The research team recommends that further work be done in the use of the PRA approach in problematic areas of health service delivery such as resource allocation that are cardinal in promoting people-centred health systems. There is thus need to identify and engage other stakeholders interested in promoting community participation in health service delivery that are able to fund or assist DHMTs to incorporate PRA trainings in district action plans.

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Participants from the PRA workshop

Equity in health implies addressing differences in health status that are unnecessary, avoidable and unfair. In southern Africa, these typically relate to disparities across racial groups, rural/urban status, socio-economic status, gender, age and geographical region. EQUINET is primarily concerned with equity motivated interventions that seek to allocate resources preferentially to those with the worst health status (vertical equity). EQUINET seeks to understand and influence the redistribution of social and economic resources for equity oriented interventions, EQUINET also seeks to understand and inform the power and ability people (and social groups) have to make choices over health inputs and their capacity to use these choices towards health.

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- Distribution and migration of health personnel
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