LESSONS AND EXPERIENCES FROM LOCAL INITIATIVES FOR HEALTH (LIFH) PROJECT

FINAL EVALUATION REPORT

CARE MALAWI

LIFH Project
May 2005

Summary

Since establishing a presence in Malawi, CARE Malawi has piloted a number of initiatives and engaged in several processes of ongoing reflection and lesson learning. In 2002 CARE Malawi launched the Local Initiatives for Health (LIFH) Project, funded by DFID via CARE UK. The LIFH Project, with its various rights based approaches, aimed to develop innovative and sustainable models that sought to resolve issues of poor health service and access amongst rural communities.

The LIFH Project has been working at the community and district level to discover how best they can meet the needs of communities with respect to the provision of preventive and curative services designed to meet the most critical health needs and rights of rural communities, especially women and disadvantaged groups. The project has been building collaboration between communities and health service providers through the adoption of participatory methodologies that consider the practical aspects of rights, equity and accountability, by empowering individuals and the institutions that support them in their communities to analyze their situation and take decisions about their lives, rather than being passive objects of choices made on their behalf.

In April 2005, at the end of the Project's 3 year lifespan (March 2002 – February 2005), an end-of-project evaluation was conducted by LIFH Project. This report compiles what the LIFH Project was about and the successes and impacts of the Project. The first part of the report gives a background to the LIFH Project – it brings out the context of the LIFH Project within the setup of CARE Malawi Country Office and poverty and health service delivery in Malawi. The first part also recounts the goals and outputs, as well as the lifecycle of the LIFH Project, most prominently featuring the scorecard process.

Part II of the report recounts the processes in the run up to the LIFH Project's impact assessment and outlines the tools and processes that were employed in the process. The Project's OVIs, RBA Framework and the Interagency RBA Framework together form the framework that was developed to measure the impact of the LIFH Project.

Part III of the report recounts the findings of the impact evaluation. In this part, the findings from the evaluation are grouped into the pillars of the framework that was used in the evaluation. Part III outlines the LIFH Project's impact on promoting voice, participation and accountability; relationships and linkages; as well as institutional response. It also outlines what sustainable changes have been achieved by the LIFH Project.

The last part of the report contains details of the report compiled as annexes.

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List of acronyms used:

A-LIFH:	Advocating for Local Initiatives for Health
CO:	(CARE) Country Office
CRLSP:	Central Region Livelihood Security Program
DFID:	(British) Department for International Development
DHO:	District Health Office/District Health Officer
DHMT:	District Health Management Team
FGD:	Focus Group Discussion
GVH:	Group Village Headman
HCC:	Health Centre Committee
HMIS:	Health Management Information Systems
LIFH:	Local Initiatives for Health
MoH:	Ministry of Health
NGO:	Non-Governmental Organisation
OPR:	Output-to-Purpose Review
PACE:	Partnership and Capacity Building in Education
SSI:	Semi-Structured Interview
SRH:	Sexual and Reproductive Health
SWAp:	Sector Wide Approach
VHC:	Village Health Committee

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PART I: BACKGROUND

1.1 CARE Malawi

CARE Malawi Country Office explores and develops the potential of partnerships that bring together civil society, government, donors and the private sector. As a result of this, the Country Office has shifted from an organization that 'implements projects' to one that 'facilitates and negotiates processes'.

CARE Malawi opened its doors in December 1998 as a dynamic learning organization with unique approaches to programming that seek to demonstrate impact. The Country Office presence is of a manner that is both *'light'* and *'flexible'* with the ability to build effective and strategic partnerships. CARE Malawi's vision is one of 'being recognized as a dynamic learning organization, with unique approaches to programming that demonstrate impact, and the ability to build and nurture strategic partnerships, in the advancement of people's rights to secure livelihoods'.

CARE Malawi supports the improvement of livelihoods and capacities of poor and marginalized households through:

- Understanding and addressing the root causes of poverty.
- Promoting participatory development, which ensures equal rights and opportunities for all and brokering an innovative range of partnerships that influence policies, strategies and practices.
- Demonstrating and advocating replicable development approaches.
- Mainstreaming HIV/AIDS activities in all programs by developing innovative and sustainable models that will help build the capacity of communities and service providers to mitigate against the devastating effects of the pandemic.

CARE Malawi has over the years shifted from an organization that predominantly implements to one that increasingly facilitates and addresses the underlying causes of poverty. CARE Malawi has identified the following five underlying causes of poverty in the context of Malawi.

i. Social Exclusion defined as people's inability to fulfil rights and responsibilities due to inequality and discrimination;
ii. Inequitable access to resources and services due to differences in economic, social and political status;
iii. Weak governance because of the failure of formal and informal political processes;
iv. Gender inequity leading to discrimination, exploitation, vulnerability of women; and
v. Poor Macro and Micro economic environment.

Learning and Design Unit and the thematic teams
CARE Malawi made a commitment to learning and will be consistently committed to improving and adopting innovative approaches and models based on lessons learnt. The

vehicle for being 'a learning organization' is the Learning and Design Unit (LEDU) within the Country Office structure. LEDU was established some three years ago and has since taken responsibility for developing a range of coherent and consistent information systems and procedures, as well as coordinating and leading the organizations reflective learning agenda. LEDU has a strategic role on reflective learning and the generation of learning and strategic positions on addressing the underlying causes of poverty in Malawi. This includes the dissemination and sharing of CARE Malawi's lessons learnt and strategic positions with a range of stakeholders, including; government, non-government and donor partners.

In September 2003, a program quality audit exercise was conducted to establish the extent to which learning and reflective practice was taking place and being utilized to generate change and promote learning throughout the organization. This process led to the establishment of a series of thematic teams[1] – the theme teams continue to meet on a set day every month and include participation from all Country Office staff. Regular theme team meetings have led to the development of a number of programmatic models and principles of good practice that are critical for the different Country Office projects and programs.

In line with the growing understanding and focus on the underlying causes of poverty in Malawi, several of the thematic teams are aligned with the underlying causes of poverty groups. For example, the Gender Equity and Diversity Thematic Team is focusing on CARE Malawi's attempts to address gender inequity and diversity issues. Likewise the District and Community Institutional Strategies Theme Team has aligned itself so as to pay greater attention to opportunities for promoting more inclusive governance. The role of the thematic teams therefore is to generate learning on understanding the nature of particular underlying causes, and to share experiences on strategic attempts to address the complex issues surrounding poverty in Malawi.

1.2 Poverty in Malawi

Malawi is one of the most densely populated countries in Southern Africa with a population of some 12 million people, nearly half of which is below the age of 15. According to UNDP's Human Development Index, Malawi is one of the poorest countries in the world ranked 163rd out of 174 counties. More than 65% of the population lives in chronic poverty. The current level of poverty is widespread, severe and characterised by deep inequality. The richest 20% of the population in Malawi consumes nearly half of all goods and services, whereas the poorest 20% consumes only 6.3%.[2]

The country has one of the highest rates of HIV infection[3] in the Region and life expectancy at birth presently stands at less than 40 years. Malawi's national literacy rate is 42%, one of the lowest in Africa, with a literacy rate for women of only 34%[4]. The country also has some of the worst child malnutrition and mortality rates in Africa. HIV/AIDS is playing a major role in accentuating the chronic decline in rural livelihoods in most parts of Malawi, impacting on households' labour capacity and utilisation of scarce assets for medical care and

[1] The Theme Teams include: Rights Based Approaches, Gender Equity and Diversity, HIV/AIDS, District and Community Institutional Strategies, Effective Partnerships, and Reflective Learning.
[2] UNDP, 2000
[3] Conservative estimates put the HIV infection rate at around 14.4% for the 15 - 49 age groups.
[4] Malawi Government & UNESCO, *Education for All 2000 Assessment*, Malawi 2000.

funerals. Denial, fatalism and stigma dominate rural dwellers' attitudes towards HIV/AIDS. Malawians are willing to talk about HIV/AIDS in the abstract, but when speaking about themselves or their family, they prefer to speak of "chronic illness". This stigma forces affected families to cope on their own and become excluded from health service delivery. Families suffer in silence with a deepening sense of shame and fear.

This situation continues to worsen as access to basic services, such as health, falls far below even the most minimum standards of quality and quantity, with rural areas suffering most from the lack of services and resources. Access to basic health services remain beyond the reach of the poorest and most vulnerable members of Malawian society. Only 10% of the health facilities operating in Malawi are able to fulfil government's requirements on availability of services, resources and staff levels[5].

1.3 Health service delivery in Malawi

Health services in Malawi are provided at three levels: primary, secondary and tertiary. At primary level, services are delivered through rural hospitals, health centres, out reach clinics and community health initiatives such as Drug Revolving Funds (DRFs). The health centres are supposed to be under the leadership of a medical assistant and have at least three nurses, but the reality is that most of the rural health centres have either a nurse or a medical assistant, but not both. For example, almost all[6] of the primary health care facilities in Ntchisi District have either a medical assistant or a nurse running all the services at the facilities. Two[7] health centres in the district do not even have a nurse or a medical assistant and are run by HSAs.

District Hospitals provide the secondary level of health care such as surgical back up services, mostly for obstetric emergencies and general medical and paediatric in patient care for common acute conditions. The district hospital is supposed to have at least one medical doctor, several clinical officers and nurses and several other cadres of health workers. They act as referral hospitals for the districts. The District Health Officer (DHO), heading the District Health Management Team (DHMT), who is the overall managers for all health services and activities for the district, are based at the district hospital.[8]

The tertiary hospitals (central hospitals) act as regional and national referral hospitals, to which district hospitals send their difficult cases. There are four central hospitals in Malawi, namely, Queen Elizabeth (in Blantyre in the Southern Region), Zomba (in Zomba in the Eastern Region), Kamuzu (in Lilongwe in the Central Region) and Mzuzu (In Mzuzu in the Northern Region). The central hospitals have several medical doctors, nurses, clinical officers and several other cadres of health workers and are headed by a director. The central hospital director reports to the Principal Secretary for the Ministry of Health on management issues, but sometimes report to specific directors of services in the Ministry for specific issues.[9] The central hospitals are as autonomous as the district health offices.

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[5] Ministry of Health, *Joint Program of Work,* Malawi 2004

[6] Except the village of Malomo, which is a rural hospital

[7] Mndinda and Nthondo

[8] Lilongwe is a unique case since it does not have a district hospital, but has the Bottom Hospital, which serves as referral hospital for the district.

[9] For example, the Director reports to the Ministry of Health Director of Curative Services on issues of curative services, and to the Director of Nursing Services should the issues be about nursing services, etc.

The health system is intended to work through a referral network. Patients are expected first to contact one of the points at the primary level of the system – usually at the health centre. If the staff at the health centre feel the patient needs more complicated treatment than they can offer, the patient should be referred to the district hospital. Subsequently, if the district hospital cannot cope, the patient should be sent to central hospital. The services at all government health facilities at tertiary, secondary and primary levels are provided free of charge. However, there are some wards at district and central hospitals that are considered "private" wards and clients have to pay a small fee in order to use this facility. The reason for the small fee is to ensure autonomy of the wards, so that they become self sustaining, instead of banking on scarce government resources. The "private" facility only applies to admissions, and the rest of the services are free.

Overall, Malawi suffers from a chronic shortage of drugs, medical supplies and human resource whereby the rural poor people suffer the most. It is these vulnerable households who don't have access to resources and services. As resources for the health sector continues to dwindle, dissatisfaction continues to grow among the rural poor health service users. Poor working conditions for health workers aggravate the health workers' poor attitudes towards executing their duties professionally and, in doing so, contribute to a continued disconnect between the communities and the service providers. The communities have no forum where they can voice and express their views and opinions on health services. Nor do they have access to knowledge and are often excluded from structures and channels of information flows which could provide them with the basis for contributing towards improving health services.

Over the years there have been a variety of health initiatives in Malawi and its neighbouring countries with a few resources to spend on health and other social services. The initiatives have had some impact on general health statistics and the increases in the availability and quality of health service. Nevertheless, the greater problem of poor health due to social and economic forces faced by the poorest households remains largely unchallenged. The LIFH Project explicitly aimed at developing sustainable models that ensure the empowerment of communities. Models that promote voice, participation, transparency, equity and accountability that enable communities to exercise their right to health by demanding quality health services, as well as empowering health service providers to provide such quality services. The Project aimed at fostering a mutual understanding through dialogue between service providers and users to ensure joint participation and decision-making in the planning, management and evaluation of health services.

2. LIFH Project

In 2002 CARE Malawi launched the LIFH project. LIFH project, funded by DFID via CARE UK, with its various rights based approaches, aimed at developing innovative and sustainable models that sought to resolve issues of poor health service and access amongst rural communities.

The LIFH project has been empowering individuals and the institutions that support them in their communities to analyse their situation and take decisions about their lives, rather than being passive objects of choices made on their behalf. The LIFH project is working at

community and district level to see how best service providers can meet the needs of communities, with respect to the provision of preventive and curative services designed to meet the most critical health needs and rights of rural communities, especially women and other disadvantaged groups.

2.1 Goal, purpose, outputs and coverage

LIFH's goal:

- To contribute towards the improvement of the household health and livelihood security of rural households in the central region of Malawi.

LIFH's purpose:

- To improve the ability of rural households in the central region of Malawi to address their basic rights to health.

The Project formulated the following outputs:

i. Partnerships established with appropriate health service organisations
ii. Participatory rights based assessment methodology developed that allows communities, and particularly women and disadvantaged groups to identify and implement pilot initiatives that address priority health related issues
iii. Developed organisations of informed rural consumers of health care that, as advocates of their own welfare, and in partnership with service providers, are able to identify and where relevant address priority health issues, as well as access and/or develop more appropriate forms of quality health services
iv. Methods of addressing community identified health priorities developed, tested, monitored and lessons learnt documented and disseminated particularly within on going health SWAp development process.

The LIFH Project was implemented in Lilongwe and Ntchisi districts. In Lilongwe, the project has been working in 4 government health centres and their surrounding catchments areas, and with 7 health centres in Ntchisi district. The Project established a Sub-District Model in Chileka Health Area of Lilongwe District, from where lessons were replicated in the District Model established in Ntchisi District.[10]

i. Partnerships

LIFH project established formal partnerships with Ntchisi and Lilongwe DHMTs. Partnerships were also established with a total of 11 health centres in Ntchisi and Lilongwe and agreed upon through the signing of memoranda of understanding (MOUs). The MOUs set out the principles and commitments of both the LIFH Project and the DHMTs in the ensuing project processes. Among other things, the DHMTs committed to supporting health centre staff needs through supervision and management; facilitating and supporting LIFH Project's activities through a client-oriented care delivery model; and playing an advocacy role for the community demanded needs that are beyond their attention.

[10] Discussion on District Model and Sub-District Model follows later on page 15 and 18.

On its part, the LIFH Project committed to facilitating strategies that promote regular dialogue and interface between healthcare providers and community groups; supporting the DHMT in strengthening the SWAp by providing technical support and/or relevant capacity building; and building capacity of community health institutions (VHCs and HCCs) to enable them to advocate for their health needs. The Project then agreed with the DHMTs on the working areas, and these had to be health facilities that were not already being covered by other NGO initiatives, and where there was existing CARE Malawi projects (for the case of Lilongwe) and all health centres in Ntchisi.[11]

MOUs were also developed and signed with all health centres that the LIFH Project worked with. They also set out a declaration of principles and commitments for both parties. In general, the MOUs governed the processes and activities that the Project carried out with the parties it signed the MOUs with.

ii. Using Rights Based Approach (RBA)

CARE Malawi has made a commitment to using rights based approaches (RBA) to address underlying causes of poverty. Thus the Country Office committed to mainstreaming RBA in all its projects and programs. LIFH was designed as an RBA project. With its design, using RBA in the LIFH Project entailed a number of things, including:

- Working with different levels of governments to see how best basic rights to health can be addressed;
- Working with rural government health centres as duty bearers in fulfilling rights of service users through provision of quality services;
- Working with community based health institutions to help them identify their health issues, analysing them and take decisions of their own choice;
- Working jointly with communities and service providers to define quality health services and identify barriers to the provision of the quality services; and
- Working with communities to promote responsibility and mutual accountability.

The LIFH Project operationalised RBA by using five main principles:

1. Participation and inclusion of voice
2. Accountability and transparency
3. Non-discrimination
4. Equity
5. Shared responsibility.

A framework was developed in order to contextualise these five RBA principles in the LIFH environment (see Annex 1 for the original LIFH Project RBA Framework).

a. Putting RBA into practice: The Scorecard process

The LIFH Project used a range of participatory approaches in applying RBA, most notably the scorecard and social mapping processes. The Project also facilitated dialogue between various levels of service providers and service users, in addition to provision of capacity building to both the service providers and service users.

[11] 2 health centres in Ntchisi, Mndinda and Nthondo were subsequently left out due to lack of staff at the facilities, which posed problems for the Project to work with the facilities.

The Project facilitated regular interfacing between communities and health centre staff and DHMTs to identify and map ways of addressing priority health needs. Dialogue and review sessions were conducted on a quarterly basis with the aim of tracking progress against planned activities by all the stakeholders, and encourage one another to implement the planned activities. It further extended the interfacing to the Central Medical Stores, a Government structure responsible for procurement of drugs for the Country and distribution to health facilities in the Country, with the aim of enforcing mechanisms for ensuring timely and consistent supply of drugs to the health facilities.

The Scorecard is a tool to help service users' claim and achieve their human rights while holding duty bearers accountable. The scorecard process was conducted at both the service user level and the service provider level – thus there was a community scorecard and a service provider scorecard. The scorecard process aimed at identifying barriers to provision of quality and equitable health services and identifying the priority health concerns of the communities, by both the communities and the healthcare providers (see Annex 2 for a diagrammatic illustration of the scorecard process).

b. The scorecard process:

Step 1: Community level

At community level a meeting with all community members in the village[12] is facilitated by the Project staff. Groups of men and women each conduct an assessment of the services provided at their health facility. Each group identifies the burning issues at the health facility in each of the following four categories:

- Conduct of health staff;
- Management of health services;
- Access to and quality of health services;
- Equipment and infrastructure for supporting healthcare delivery.

Then indicators are developed and each indicator scores out of a maximum 100,[13] giving reasons and justifications for each of the scores. The reasons behind each score are discussed and suggestions for improvement are then generated and a complete scorecard for the village is developed[14]. An important element that comprises the community process is the brainstorm of what the community knows about rights followed by a subsequent discussion on health rights.

Step 2: Cluster Review

The HSAs, VHC and HCC members have been present at the community scorecard process and observed the process. They then brief and facilitate a similar process in six neighbouring villages and come up with complete scorecards for each of the villages. The seven villages form one cluster. For each health centre, two clusters participate in the scorecard process – one cluster being close to the health centre, and another being far from the health centre.

[12] Men, women, youth, community and religious leaders, HSAs, political leaders, village and health centre committee members, e.t.c.

[13] A score of zero (0) meant the service/indicator is poorest and a score of 100 meant the service/indicator is excellent.

[14] See Annex 3 for an example of the community scorecard.

The scorecards for each of the villages in each cluster are consolidated at a cluster [15]centre point and a consolidated scorecard, which is representative of all the villages in the cluster. The consolidated cluster scorecard thus consists of indicators scored out of a maximum 100, with reason for each of the scores and suggestions for improvement.

Step 3: Health centre level

At the health centre, another scorecard is developed with the health centre staff. A general assessment of health services is conducted and indicators for assessing and tracking performance and services is developed and scored out of a maximum 100, with reasons given for each of the scores.[16] Then the reasons for each of the scores are discussed and suggestions for improvement are generated (see Annex 5 for an example of a health centre scorecard).

During the health centre scorecard, the facilitators also prepare the health centre staff for the interface meeting to avoid unnecessary confrontation with the community members. A behaviour and attitude change "form of training" is facilitated. The facilitators ensure that the health centre staff understands the objective behind the evaluation process (i.e. trying to find ways of improving performance and therefore service delivery). They are encouraged to take the criticism from the community members objectively and make constructive resolutions.

Step 4: The interface meeting

The interface meeting marks the final stage of the scorecard process. The community members at large, VHC and HCC members, community leaders, health centre staff, DHMT members and religious and political leaders, as well as LIFH Project staff are present at the interface meetings. The communities and the health centre staff present their findings from their scorecards and discussions ensue from the findings, where each of the stakeholders present has the opportunity to make contributions and suggestions of what should be prioritised. The suggestions are then prioritised and isolated – these are suggestion for addressing burning health issues. The DHMT plays an active role in the interface, especially when there were issues beyond the mandate of the health centre staff.

Step 5: Action planning

The prioritised suggestions are then fed into an agreed and negotiated joint action plan. The suggested activities are mapped into action points and assigned as responsibilities to relevant and appropriate stakeholders. Finally a timeframe within which the activities are to be conducted is developed (see Annex 6 for an example of a joint action plan). The Scorecards are then publicly displayed in each health centre.

Thus a complete scorecard process ends at the action planning stage, after which, all the stakeholders set out to implement the activities on the action plan. The scorecard process has to be repeated after six months, where the same indicators are scored again and

[15] See Annex 4 for an example of a cluster scorecard matrix.

[16] It must be noted that even though this was a self assessment for the health workers and the possibility of being defensive was extremely high, the process enabled the health centre staff to voice out their deepest concerns and scored the indicators objectively. They understood that the process would help them improve their own performance and were willing to be honest in the exercise.

comparisons are made to see if there had been any changes, desirable or undesirable in the provision of health services at the respective health facilities. Increases and/or decreases in scores for the indicators are scrutinised to understand the circumstances that led to the changes in the indicators.[17] The previous action plan is reviewed to track what had been achieved and why, and what had not been achieved, and outstanding issues then will be redrafted into the new action plan, and so on.

iii. Developed organisations of informed rural consumers of health care

As part of implementing the joint action plans, LIFH Project developed appropriate training modules for both the service providers and the community health organisations (the VHCs and HCCs). The subsequent trainings ensured that the community organisations are aware of their roles and responsibilities as community health representatives, and empowered them to support health service provision. Among other things, the trainings comprised of such topics as: roles and responsibilities; human rights; community mobilisation; village inspection; gender and HIV/AIDS.

Subsequently, communities in the targeted health centres implemented various health initiatives. Some of the health initiatives included: use of notice boards to list available drugs and equipment; use of numbering and queuing system for patients at the health centres; continued dialogue between service users and providers through village health committees and health centre committees; construction of pit latrines in their households, staff houses and guardian shelters at health centres; and encouraging community members to use the health services at their health facilities.

The trainings for the health service providers comprised of such topics as human rights; HIV/AIDS and gender; the scorecard and social mapping processes; proposal development; community mobilisation; as well as community mobilisation and inspection. The staff from health centres also underwent a series of behaviour and attitude change training. In addition, staff from the health centres from the two districts underwent training in the Health Management Information Systems (HMIS), which were facilitated by key people from the two DHMTs in collaboration with focal HMIS person from the MoH Headquarters. The trainings and capacity building activities for the health workers empowered them to improve their own performance and provide better services to the communities, who had concurrently been empowered to demand better services.

2.2 The LIFH Project Cycle

a. The Pilot phase: The Sub-District Model

Between May 2002 and April 2003, LIFH project was implemented on a pilot basis. The main purpose of the pilot was to provide sufficient time for trials that could lead to developing a model, which would be replicated at scale in the subsequent phases of the Project. During this period, a number of initiatives contained in the original LIFH project document were tried and tested leading to a number of lessons learnt on 'what worked well and what did not work so well'. Through various platforms and groups, LIFH's lessons and experiences were shared with others.

[17] See Annex 7 for an example of a repeat scorecard.

In May 2002, the LIFH Project established a partnership with the District Health Management Team in Lilongwe for the pilot phase, and two health centres were selected, namely, Nthondo and Chileka. During this period LIFH worked closely with the Lilongwe DHMT, staff at the two health centres (Chileka and Nthondo), as well as the communities served by them, in order to develop a Sub-District Model for introducing a rights based approach in the delivery of health services.

The Sub-District Model rolled out with the first community assessment, which comprised of the scorecard and social mapping processes. After the first joint action plan was drawn, the stakeholders set out to implement it. Among the major activities from the action plans were the trainings and other capacity building activities for health centre staff and VHCs and HCCs. After each of the trainings for the VHCs and HCCs, further more detailed and specific action plans were drawn for each of the VHCs and the HCCs, which they were going to implement in their respective villages and health centres.

Some of the highlights from the action plans of the VHCs included community inspection and head-counting of under-five children, and subsequently ensuring that all under-five children were attending Under-Five Clinics. At the health centres, the HCCs introduced the numbering and queuing systems for patients to enforce the first-come-first-served policy.

The Project staff held regular (at least on a monthly basis during the first 12 months) review meetings with the VHCs and HCCs in the company of HSAs. This was done to regularly monitor the progress made by the VHCs and HCCs. During the review meetings, the action plans were scrutinised and readjusted and fine-tuned where necessary.

Another important characteristic of the Sub-District Model was the dialogue sessions, which had all the stakeholders in the Project participating. Representatives from both the community and the service providers shared what progress they had made in contributing towards the improvement of health service delivery.

Six months after the first scorecard process, the communities and the health centres underwent a repeat of the scorecard process (in August 2002). This was done with the aim of evaluating the impact of the first scorecard process. What came out from the second round was that attitudes of the health workers had improved tremendously, which had subsequently boosted the communities' willingness to participate in the management of health services.

b. First Output to Purpose Review (OPR):

In May 2003 the first annual review, the OPR was conducted by consultants commissioned by the Project's funding partner, DFID, in order to access the Project's progress against its outputs in the first year. What had worked, and what had not worked so well work was identified and recommendations for the second phase of the project were made.

The first OPR acknowledged that the LIFH Project had made headway in its attempts to involve all the stakeholders in improving health service delivery at the pilot health centres.

"Despite only 8 months of field operations, this project has already achieved clear and quantifiable results: the establishment and revitalisation of committees at the village and health centre level, the introduction and successful piloting of the scorecard methodology, and the early identification and completion of various community proposed initiatives. These were demonstrated to the OPR team. The efforts of the CARE implementation team should be commended and noted at this early stage of the project".

Excerpts from the first OPR Report – May 2003

i. Participatory Rights Based Assessment Methodology (PRAM)

The LIFH Project had adopted a PRAM, which comprised of the scorecard and its associated processes, as well as the continued dialogue between the various levels of rights holders and the duty bearers.

The OPR noted that the adoption had been quite successful, but pointed out that it lacked some critical elements in order to fully be called a "true PRAMs" approach.

"Whilst there was a consensus that effective participatory methods have been developed (particularly the community score card) and that the project had successfully fostered a degree of empowerment and accountability, there was also agreement that the approach did not include all the elements necessary to be considered a true PRAMS approach. It was suggested that a PRAMS approach should also include an explicit linkage to rights and a focus on issues of equity (non-discrimination and vulnerable groups)".

Excerpts from the first OPR Report – May 2003

ii. Equity

The OPR further noted that the LIFH Project had been addressing inequalities relating to wealth ranks of the households in the communities it had been working with. It however recommended the Project should consider exploring other inequalities relating to gender, HIV/AIDS and orphanage.

"The scorecard methodology addressed some issues of wealth inequity, but it was agreed that other potentially disadvantaged groups should be identified and efforts made to ensure their active participation in the LIFH process and that means are devised to provide verification and objectively verifiable indicators demonstrating that such groups are beneficiaries of the project. It was suggested that such groups might include female-headed households, orphan-headed households, people living with AIDS, the elderly, and people with disabilities".

Excerpts from the first OPR Report – May 2003

iii. Linkages to Rights

In its RBA, the LIFH Project addressed issues in a non-confrontational manner by working with both the "supply" side and the "demand" side of rights. The Project worked to facilitate an environment where people's right to health would be met.

However, while acknowledging that overt linkage to rights in a politically sensitive environment might prove counter-productive, the OPR recommended that the project should explore ways of introducing explicit rights to the communities, for example by brainstorming on health rights as stipulated by the Malawi Constitution.

"However, it was agreed that time and thought should be given to brainstorming and planning initiatives that would address the need for such linkages. It was suggested that such activities should include, in some way,

education and dissemination of Malawi's Constitution, especially the Human Rights Chapter and articles relevant to the right to a high standard of health and equality (which is also expressly stated in international treaties to which Malawi is a state party)".

Excerpts from the first OPR Report – May 2003

c. Consolidation phase

Following the first OPR, the LIFH Project reflected upon and made decisions on the recommendations made from the first OPR. The Project explored ways in which it could address issues of explicit linkage to rights, equity and mechanisms for provision of mini grants.

i. The Equity Study

In September 2003, an equity study was commissioned to help identify vulnerable groups, analyse the vulnerable groups' links with aspects of intervention, particularly access, inclusion, participation and representativeness in community health institutions. Equi-TB Knowledge Program, in collaboration with LIFH Project staff carried out the study in the two pilot health centres in Lilongwe District.

The study identified several groups that were vulnerable in terms of accessing health services and participating in community health activities. These groups included the orphans, single-headed households (female headed households and households with single fathers looking after children), the aged, the chronically ill, those living with disabilities (especially physical disabilities), and the destitute.

Out of the Equity Study, an equity mainstreaming strategy was developed, and it included, among other things, institutionalising the social mapping process and follow-up visits for the vulnerable people at the health centre level; and strengthening advocacy skills and capacity for health workers and LIFH staff.

d. Scale up

After successful completion of the consolidation phase, the LIFH Project then rolled out its activities to Ntchisi District in September – October 2003, where it set out to establish a district model (see annex 14 for District model illustration). The Project established a partnership with the DHMT for Ntchisi, and the DHMT advised the Project on how roll-up activities could best be carried out.

Subsequently, the Project initially started its activities in four health centres in Ntchisi, namely, Kamsonga, Mkhuzi, Khuwi and Chinguluwe. The first rounds of the scorecard were conducted in October – November 2003, and the first action plans were drawn. In January – February 2004, the first trainings for the health centre staff and community institutions were conducted.

Towards the end of February, running into March 2004, the Project further scaled up to 2 more health centres in Lilongwe and 3 more in Ntchisi. This entailed steps towards

completion of the Sub-District and the District models.[18] Here too, the first rounds of the scorecard and trainings followed.

The exit strategy workshop:
Towards the end of the second year, the LIFH Project conducted a review workshop with its partners from the pilot health centres in Lilongwe District, with the aim of developing indicators and preparing the partners for exit in the District. The workshop, which was conducted in April 2004, identified what successes the Project and its partners had made in the two years, and what changes had been experienced.

Among the successes highlighted by the partners, there was mention of dialogue which had been initiated between the health service users and the healthcare providers, which ensured transparency and a working relationship between the two sides. The partners also applauded the capacity building for both the health workers and the community institutions, which they claimed enable them to jointly participate in activities that promoted improvement of health service delivery. The partners were quick, however, to point out that it would have added a lot of value had the capacity building extended to all communities in the catchment areas of the pilot health centres, so that the sense of ownership for the health facilities and services that had been installed in them could extend to everyone.

As for indicators for exit, the workshop agreed that achievements of the LIFH Project would manifest themselves in the sustainability of initiatives in the health centres, namely, among others:

- When there is continued interfacing between the service providers and the service users, without the intervention of the LIFH Project staff:
- When there is continued dialogue and sharing between various levels of the service users and the service providers;
- When the community institutions continuously perform their duties without the support of the LIFH Project.

The partners committed to continuing using the scorecard process and interfacing in order to check and maintain quality of health services. The partners also committed to continue working together in planning, management and evaluation of health services in the health centres.

The Project then developed an exit strategy, based on what the partners had said at the exit strategy workshop (See Annex 7 for LIFH Project Exit Strategy).

e. The Second OPR

In September 2004, the LIFH Project underwent its second annual review (OPR) by its donors, DFID. The review aimed at assessing progress the Project had made in its outputs, as well as how it had addressed issues arising from the First OPR.

[18] The Project aimed at reaching out to all government health centres in Ntchisi District and Chileka Health Area. However, 2 health centres in Ntchisi (Mndinda and Nthondo) were dropped due to unavailability of staff. 1 health centre in Chileka Health Area (Ndaula) was dropped due to continued uncooperativeness of staff at the facility.

The Second OPR also acknowledged considerable strides had been made in advancing both the Project's outputs and the recommendations made from the First OPR.

> *"Considerable milestones have been registered by the LIFH project in the past two years. Good progress has been made under most of the four outputs that the project set out to achieve. The rights based methodology adopted has enhanced the involvement of both duty bearers and rights holders in the project process leading to improved transparency, accountability, improved dialogue and collaboration, joint planning and improved health service delivery in terms of quality, equity and access. All the current project processes have ensured that people of different social groups have benefited from the improvements registered so far by the project. The project has also enhanced dialogue and collaboration among duty bearers at different levels. The subsequent scorecard processes undertaken bear evidence to the strides made by the project so far".*

Extracts from the second LIFH project OPR –September 2004

> *"The project is very appropriate especially given the current environment in Malawi where development initiatives need to be viewed through a rights lens and the need to transition from direct implementation to that of catalysts for change. Considerable lessons have been generated during the pilot phase which have already been shared with partners and used as the basis for scaling up and the development of a district wide model".*

Extracts from the second LIFH project OPR –September 2004

The Second OPR, however, regretted that, while the LIFH Project had taken such strides in advancing RBA in the healthcare delivery system, there was lack of demonstration of evidence of impact. The OPR recommended that, if the Project was to influence the policy through the SWAp, there was need for having quantifiable evidence of impact.

> *"In order to strengthen LIFH's potential role throughout the SWAp, the project's existing qualitative and quantitative indicators, particularly on issues of vulnerability, need to be refined. Areas that could immediately be strengthened include indicators of vulnerability at intra-household level (e.g. the role of gatekeepers such as mothers'-in-law, husbands etc. in controlling women's access to health care); determinants of vulnerability that cut across economic/social status (e.g. vulnerability by gender or age); specific indicators of poverty (e.g. by income, livelihood, gender, ownership/access to assets etc.); ethnicity etc. to enable disaggregating data".*
>
> *"Investment by the LIFH project in collecting (where still possible) baseline data by household on barriers to, uptake of, and perceptions of health services. Qualitative and quantitative information at this level, followed by routine M&E based on these determinants will be essential if project achievements are to be evidence-based and convince policy makers of the efficacy and validity of a rights based approach".*

Extracts from the second LIFH project OPR recommendations –September 2004

f. The Second OPR follow-up activities:

Following the September 2004 OPR, the Project set out to implement the activities that had been recommended by the OPR Team. These included supporting DHMTs in training health workers in the HMIS; strengthening the participatory formulation of the DIPs; as well as strengthening dialogue between the DHMTs and the Central Medical Stores. The Project further prepared all partners in Lilongwe for exit. This preparation included extensively training the health workers in the use of the scorecard; proposal development; as well as rights issues.

g. The final evaluation phase

Towards the end of the Project in February 2005, the LIFH Project set out on a journey for consolidating its lessons and experiences in order to demonstrate its evidence of impact. The process coincided with the Lesson Learning Exercise that was being undertaken by the Interagency RBA Group (herein referred to as the Interagency Group), a grouping of UK international NGOs, which aimed at assessing the impact of RBA against the impact of non-RBA interventions.

The Interagency Group developed a framework that comprised of all aspects of rights based development (RBD). The framework looked at RBA from the lens of equity and participation, obligation and inclusion. It has three main pillars in which it measures RBA impact, namely: voice, participation and accountability; changing relationships and linkages; and institutional response. The three pillars feed their results into a fourth dimension of impact, which looks at the gains and benefits towards achieving the Millennium Development Goals (MDGs), leading to a fifth pillar, sustainable change.

The LIFH Project took advantage of the Interagency RBA Framework and made modifications, and redefined the indicators in the framework. The new framework developed was used to retrospectively generate baseline information and measure the impact of the LIFH Project. The section following recounts the process referred to herein.

2.3 Learning and sharing

Being a pilot learning project, LIFH continuously generated lessons and experiences on using RBA and shared these lessons and experiences with partners, government, donors and the civil society.

Through a wide range of avenues, the Project continuously involved its partners in participatory monitoring and evaluation of its programs. The scorecard process became an important tool that the Project and its partners at the community, health centre and district levels used to monitor and evaluate progress made in improving delivery of health services. The quarterly review meetings that the Project held with its partners also helped review the progress all the partners had made against the commitments in the joint action plans developed, at the same time encouraging and reinforcing commitment among the Project's partners. The LIFH Project also shared its lessons and experiences with district, health centre and community partners during the quarterly dialogue sessions that it facilitated. This was also a forum where each of the partners also shared their lessons and experiences.

From time to time throughout the course of the Project, opportunity arose for LIFH to share its experiences with other players in health, rights, as well as development. Avenues for such sharing included meetings, workshops, conferences, presentations, field visits, evaluations and reports. Among the players who had this opportunity to learn from the LIFH Project included: DFID, World Bank, OXFAM, MASAF, White Ribbon Alliance for Safe Motherhood and other CARE projects within and outside CARE Malawi. A good number of these have adopted LIFH Project's scorecard tool, examples being OXFAM, MASAF and CARE Malawi's ILTPWP.

The Project continuously participated in forums that enabled it to share its lessons at local, national and global levels. For example, the Project was a member of the Malawi Health

Equity Network (MHEN), a civil society grouping that advocated for policies that promoted equity and good governance in the health sector. Through the MHEN, LIFH Project was able to share its experiences with the Parliamentary Committee on Health (PCH) in August 2003; and participated in the Equity in Health Conference spearheaded by EQUINET Africa in South Africa. It is also through the MHEN that LIFH Project participated in the development and refinement of the yet-to-be-launched Patients' Bill of Rights and Responsibilities, a charter that declares and outlines rights and responsibilities that health service users have, and is expected to foster delivery of quality and equitable health services. The Project also shared its lessons and experiences at a conference organised by the CIVICUS World Assembly in Botswana, a civil society network promoting rights related issues through capacity building.

The RBA Synergy Group

In 2003 LIFH initiated the RBA Synergy Group in order to learn with others on rights-based approaches, share lessons and experiences on implementing RBA and discuss strategies and ideas for further operationalising RBA in Malawi. Initially the Group consisted of DFID, LIFH and the Shire Livelihoods Security Program (OXFAM) but soon it became clear that there was a greater need for sharing and collaboration and the group expanded through inviting other organisations to join.

In March 2004 LIFH hosted the first meeting with a wider group e.g. White Ribbon Alliance, Every Child, Women in Law in Southern Africa (WLSA), Council Universal, Action Aid Malawi, Norwegian Church Aid, CARE Malawi's PACE Project, Democracy Consolidation Program and Malawi Centre for Advise Research and Rights (Malawi CARER). The group currently meets once every quarter and after sharing and getting acquainted with each others' several approaches and experiences, the group is currently developing an advocacy strategy.

The current agenda is set to advocate towards higher levels of government on the adoption of right-based approaches and operationalising equity and rights in policy formulation and implementation. In Malawi, the LIFH Project has been recognized as a pioneer and therefore many projects were keen on learning from LIFH. For CARE Malawi, and more specifically for the LIFH project, the RBA Synergy Group is of great importance because it has challenged LIFH to deepen its understanding of RBA and further explore how to operationalize RBA. With the RBA Synergy Group, the LIFH Project shared its successes and shortcomings and challenges, especially in monitoring and demonstrating impact, which turned out to be a common problem in all rights' based work.

Learning and sharing of LIFH's RBA methodologies with others

During the LIFH project there has been a significant uptake of the RBA methodologies and processes by health service providers, other CARE projects and NGOs. In August 2003, LIFH was invited to assist World Bank during an international workshop held in Malawi in orienting staff of the Malawi Social Action Fund (MASAF) and its governmental partners on the use of the scorecard in social accountability and transparency in public services.

In 2004 LIFH was consulted again twice to train MASAF staff, government officials and community partners in use of the scorecard to monitor and track performances of public services. MASAF now adopted and is using the scorecard method. Furthermore in July 2004,

LIFH was invited by OXFAM to train staff on operationalising RBA using the scorecard process. LIFH facilitated a three day training whereby OXFAM modified and adopted the scorecard to monitor and evaluate the Shire-Livelihoods Security Program performance and progress.

Between 2003 and 2004, projects within CARE Malawi were trained on operationalising RBA and adopted and built in the scorecard methodology into their project processes. Examples are the Partnerships and Collaboration in the Education Sector (PACE) and Improving Livelihoods through Public Works Program (ILTPWP).

Learning visit on explicit linkage to rights:
As part of the process on learning how other players are explicitly linking to rights in the RBA work, the LIFH Project visited several organisations that are using RBA.

The Project firstly visited WLSA and Malawi CARER, who are implementing rights sensitisation activities for OXFAM's Shire Highlands Livelihood Security Program. However, the LIFH Project learnt that the two organisations were mostly working on sensitisation about rights, but did not complement the rights awareness with any intervention and action, which LIFH's RBA focuses on.

The Project also had a chance to try out processes that explicitly talked about rights with the community representatives at Chileka Health Centre in October 2003 with the guidance of the First LIFH OPR Team Leader, Daniel Alberman. However, it was evident from the process that explicitly talking about rights diverted people's attention from the health issues and begin to take on political undertones.

The Project then visited CARE Bangladesh's HIV/AIDS and Rights program in April 2004, but also found out that the focus of the program was more on empowering women to protect themselves against HIV and AIDS, than the explicit rights linkage.

However, following the visits and various other dialogues with DFID and other stakeholders, the Project revised the topic guide for generating indicators for the scorecard and included a session on rights brainstorm and discussion on rights. The scorecard was also revised to make explicit mention of rights issues.

Video documentary and other materials
In addition to the above, the LIFH Project produced two video documentaries on using RBA. The first one was produced in around February 2004, which was a 7 minute video that was cut for the BBC's *Earth Report* by a freelance journalist, Kate Kennedy White. White came back a year later as an independent media consultant to cut the second video, which was a double video pack (one abridged version that lasts 10 minutes and another one that lasts 25 minutes), that captured the key processes of the LIFH Project, including the scorecard process. It also captures the Project's impact as told by the Project's partners a year later. The new video pack has already been shared widely with donors and other development partners at the global level, including the World Bank and CARE International. The Project (through its imminent sequel project – the A-LIFH) intends to translate the video into the local (Chichewa) language and embark on a nationwide dissemination campaign of the LIFH Project's experiences.

The Project also produced two brochures: one on how it was addressing HIV/AIDS issues that was part of CARE Malawi's HIV/AIDS Open Day in October 2003; and another one on how RBA is used, which was part of the information package for two conferences: the Global Health and Human Rights Conference held in Atlanta, USA in April 2005; and the African Citizen engagement in Accountability held in Accra in May, 2005. In addition, LIFH Project regularly contributed to *The Informa*, CARE Malawi's quarterly newsletter.

PART II: THE END EVALUATION

1. PROCESS AND STUDY DESIGN

Between February and April 2005, the LIFH Project went through a process of consolidating evidence of impact. The process was carried out in collaboration with the UK RBA Interagency Group and its in-country consultants (Miriam Chalimba and Desmond Kaunda).[19] The process involved several workshops, consultations, reviewing of documentation, interviewing partners and staff from LIFH Project and DFID.

The study design involved the formulation for a research framework that would be able to collect both baseline information as well as evaluative information. A barrier to overcome was that LIFH project did not make good enough use of a baseline and that the monitoring and evaluation model itself did not fully permit conclusions about impact. What was learned during the LIFH project is that while using a rights-based approach, it is crucial to specify and clarify approaches to rights-based monitoring and evaluation, beyond awareness that a high degree of participatory M&E is necessary. The measuring impact framework therefore required to be rights' based, with due appreciation to the rights' based nature of the Project. Since there had not been any models to learn from for evaluating the impact of RBA, LIFH Project collected various tools as ingredients for the formulation of the framework:

1. The objectively verifiable indicators (OVIs)
2. The RBA framework that the Project had developed for taking stock of its rights work (herein referred to as "LIFH's RBA Framework")
3. The RBA framework developed by the UK RBA Interagency Group (herein referred to as "the Interagency Framework").

To integrate the three tools and frameworks, the LIFH Project underwent several steps in a series of workshops:

- Defining the pillars of the LIFH measurement impact framework;
- Redefining the broad indicators of the UK RBA Interagency Group framework to fit into LIFH Project's context;
- Defining specific indicators;
- Formulating indicative questions;
- Identifying information sources;
- Sourcing existing baseline information; and
- Defining participatory tools and topic guides

The integration and consolidation of the three frameworks referred to above produced a viable framework that was used to measure the impact of the LIFH Project with an RBA lens. Following is an analysis of the three frameworks.

[19] The two consultants were expected to run a parallel review to assess impact of RBA using the LIFH Project as a case study, but it was later conceded that it would be more productive to minimise inputs and maximise outcomes by having the LIFH team and the consultants working together.

1.1 The OVIs

The LIFH project formulated the following OVIs during its design phase:

- Participating household demonstrate improved uptake of health services,
- Rural communities, especially women and vulnerable households, participating in decision making processes around health issues and health services,
- Rural health centres providing equitable access and improved quality of health service,
- Health service providers and rural communities interacting and collaborating with respect to planning, management, implementation and assessment of priority health initiatives,
- Community organisation and service providers demonstrating ability to sustain health initiatives; and
- Strong linkages to health SWAP process established

1.2 LIFH Project's RBA framework

In May 2004, the LIFH Project developed an RBA framework which focused on the key principles of RBA: access to information, participation in decision making, accountability, transparency, equity, linkage to rights and shared responsibility. The framework took stock of how RBA was being applied in the Project, and isolated the major activities and achievements under each element of RBA. The framework only acted as part of the documentation for the LIFH Project, but did not necessarily form part of the M&E Framework (See Annex 1 for LIFH Project's RBA Framework).

1.3 The Interagency RBA Framework

The UK RBA Interagency Group developed a framework to compare the impacts of RBA against those of non-RBA interventions. The framework is based on the assumption that "increased freedom and equity are prerequisites for reducing poverty", and contextualises RBA within participation, inclusion and obligation. (See annex 8 For UK RBA Interagency Group Framework)

The Interagency framework has 5 pillars or concepts which the LIFH project identified as complementary to its RBA framework. The 5 pillars are:

1. Voice, participation and accountability
2. Changing relationships
3. Institutional responses
4. Gains and Benefits towards the MDG's
5. Sustainable change

1.4 LIFH RBA Framework versus Interagency Framework

There were several similarities that were observed between the Interagency RBA Framework and LIFH Project's original RBA Framework. The pillars in the Interagency Framework are centred on measuring all possible impacts of RBA, since they are centred on tracking impacts on equity and participation; inclusion and obligation – which are essentially all areas that RBD intends to impact on. The table overleaf demonstrates how the two frameworks complement each other and why the LIFH Project deemed it imperative to adopt the Interagency Framework.

Interagency RBA Framework measures	LIFH RBA Framework measures
1. Voice, participation and accountability	Participation in decision making processes, accountability, transparency
2. Changing relationships	Participation in decision making processes, access to information, transparency, shared responsibility, access to information
3. Institutional response	Opening up of doors of decision making service provider levels to community voice, transparency, accountability, shared responsibility

Table 1: Relationship between LIFH RBA Framework and Interagency Framework

1.5 Redefining the pillars of the Interagency Framework

The pillars of the Interagency RBA Framework were redefined to provide a context for the LIFH Project. The table below illustrates what each of the pillars means to the LIFH Project:

No.	Pillar	Definition
1	**Voice, participation and accountability**	Focus on how the service users are responding to the services and service providers (health seeking behaviour, utilisation e.t.c.) and how the service providers are responding to communities. Focus on how the health structures and institutions are strengthening their partnerships to promote empowerment of service users in claiming their health rights. Participation of all stakeholders in decision making processes around health issues.
2	**Changing relationships**	How relationships are changing between and within the institutions involved in provision of and supporting health services – a glance at the linkages between and within the institutions
3	**Institutional response**	A look at how the institutions are responding to each other and to each other's needs. How central levels are responding to the needs of the grassroots, and if there are any changes in the mechanisms used within and between the institutions.
4	**Gains and benefits towards the MDGs**	This pillar explores how program outcomes and impacts relate to empirical data for MDGs, and changes in how the Project participants apply skills and competencies outside the program. The pillar also explores how they perceive the gains and losses from participating in the Project; and if there are nay long tem impacts in inclusion and equity within the program area.
5	**Sustainable change**	This pillar looks at the extent of uptake of the used approaches at health centre and district levels, and any changes in the perceived future vision and reputation of the Project's partners. Sustainable change also looks at whether there have been any power relations between the service users and the service providers.

Table 2: Interagency RBA Framework pillars defined for LIFH Project

1.6 Defining broad indicators

The LIFH Project team then defined indicators for each of the five pillars. The team formulated broad indicators that would be measured to generate contribution to the four pillars. The table below shows the broad indicators that were formulated:

No	Pillar	Broad indicators
1	**Voice, participation and accountability**	▪ Changes in the response of health workers towards service users ▪ Changes in the response of communities to health services and health service providers ▪ Changes in the way HCCs, VHCs, DHMTs and health centres strengthen partnerships with each other ▪ Changes in the way HCC and VHC are fulfilling their roles and responsibilities ▪ Shifts in the way service users demonstrate empowerment leading to the claiming of rights
2	**Changing relationships and linkages**	▪ Changes in linkages between community, health centre, district and ministry level ▪ Changes in relationships between community, health centre staff and DHMT ▪ Changes in the access to policy making/implementation processes by community voices at district and national level ▪ Changes in cultural practices in relation to health services delivery and consumption ▪ Changes in information flows among service providers and users
3	**Institutional response**	▪ Changes in the way drugs, medical supplies and equipment are being allocated between the DHMT, health centre, health post, DHO, communities (Allocation: managed distribution administration) ▪ More innovative and appropriate responses from health service providers towards the health needs of the communities ▪ Changes in processes and mechanisms used within DHMTs, Health centres, VHCs, HCCs and between them. ▪ Influence on programming and processes within and outside of CARE ▪ Initiatives translated into action by VHCs, HCCs, HC Staff and DHMTs
4	**Gains and benefits towards the MDGs**	▪ Trends analysis of programme outcomes and impacts in relation to MDG empirical data ▪ Change in capacity of poor and most marginalised people to apply skills and competencies outside programme ▪ Perspectives of poor and most marginalised people on the benefits, gains and losses from the project ▪ Ability of projects to maximise resource take-up in relation to targets. ▪ Likely long – term impacts, positive or negative on inclusion and equity within the programme area and on the achievement of the

		MDGs
5	**Sustainability of achievements**	▪ Extent of institutionalisation of mechanisms and processes of transparency and accountability at community health centre and district levels ▪ Changes in LIFH's contribution to strengthening the SWAp at national level ▪ Changes in the perceived vision of the future of Health services by communities, HCCs, health staff and DHMT ▪ Changes in the perceived image /reputation of health services by communities, HCCs , health staff and DHMT ▪ Shifts in power relationships between health staff, service users and other social groups

Table 3: LIFH Project new framework broad indicators

1.7 Defining specific indicators:

The LIFH team then generated specific indicators from the broad indicators for measuring impact. These were the smallest units of measurement of the impact of the LIFH Project. The findings from the specific indicators were meant to contribute to the measurement of the broad indicators, and ultimately, to the measure of the Project's impact on each of the four pillars (see Annex 9 for illustration of the hierarchy of the indicators in the new LIFH Project framework for measuring impact)

1.8 Formulating indicative questions:

Indicative questions were generated for collection of data for measuring the indicators. The questions were designed to collect baseline information (the before-LIFH-situation) and the evaluation information (the now/after-LIFH situation). The indicative questions fed into the topic guides for discussions with the various group/sources of information (see Annex 10 for topic guides).

1.9 Identifying information sources:

The information sources for the impact assessment process for the LIFH project were identified as:

- Community members
- Community institutions (VHCs and HCCs)
- Health centre staff
- District Health Management Teams
- LIFH Project staff
- DFID staff

1.10 Sourcing existing baseline information:

A desk review of literature and information on the initial baseline was conducted by the LIFH Team. This involved looking through the reports and documents that the Project had produced, including scorecards, interface meeting reports, dialogue session reports and quarterly reports. This review came up with a substantial amount of existing baseline data. However, the baseline information that was sourced during this process also lacked quantification, which necessitated that the imminent review also sources out baseline information.

1.11 Defining participatory tools and guidelines

Participatory tools and guidelines were developed and defined and refined to suit the data demands of the review in questions, and the process involved the LIFH Team and one of the Interagency In-Country Consultant, Miriam Chalimba. Among other tools, the review used the group discussion and interviews with selected households. Within the discussions and the interviews, other participatory tools, such as "the Busometer" and "the Road" were introduced, which helped the respondent groups and households track the extents of impact the LIFH Project had made upon health services and their lives (see Annex 11 for the participatory tools used in the review).

1.12 Target groups and coverage:

This study was conducted in the both Lilongwe and Ntchisi districts, where the LIFH Project was implemented. Specifically, the review covered 3 of the 11 health centres that the LIFH Project had been working in, 1 of them being Chileka in Lilongwe, and the remaining 2 being Mzandu and Mkhuzi in Ntchisi, representing a 30% sample of the total number of the health centres.[20] In each of these health centres, two villages were randomly sampled as case studies. The study also focused on DHMTs from each of the districts, as well as LIFH Project staff and DFID key staff (see Annex 12 for details on data collection program).

DHMTs:

One group discussion each was held with members of the 2 DHMTs from Lilongwe and Ntchisi to get information on their perception of the LIFH Project's impact using extracts from the framework (see Annex 10 for Topic guide/checklist for discussions with DHMT members).

HC staff:

One group discussion each was held with staff from all the 3 health centres under discussion in order to extract information on their perceptions of the impact of the LIFH Project on the staff, the communities and to the health service delivery system in general (see Annex 10 for Topic guide/checklist for discussions with health centre staff).

HCCs:

A total of 3 group discussions were held with each of the HCCs for the health centres under discussion (see Annex 10 for Topic guide/checklist for discussions with HCCs).

VHCs:

A total of 6 group discussions were facilitated with members of the village health committees from Kaziputa and Chiziko (under Chileka HC); Ngwewa and Ndendele (Mzandu HC); and Thengeza and Malama (Mkhuzi HC) to get an impression of the impact the LIFH Project has had on the communities and in their respective HCs (see Annex 10 for Topic guide/checklist for discussions with VHCs).

[20] The LIFH Project had been working with Chileka, Mkhuzi and Mzandu health centres since May 2002, October 2003 and March 2004 respectively.

Men and women:
A total of 6 group discussions each for men and women were facilitated for men and women in the 6 villages under discussion above, with the aim of getting information on the impact of the LIFH Project on the communities, at their respective HCs and in their households.

Household interviews:
A total of 120 households (20 from each village) were interviewed in each of the 6 villages under discussion above. Specifically, for each village, 4 interviews each were conducted for each of the following marginalised[21] social groups (at household level): the chronically ill (including HIV+ patients), the elderly/aged, the disabled, orphans and female headed households. The interviews were held with the household heads, and where the household head was not available, a proxy responded (who was a reasonably mature person) from the same household was interviewed (see Annex 10 for topic guide for discussions with men, women and the marginalised social groups).

[21] The term "marginalised groups" is used to refer to those groups of people who normally have difficulties accessing health services in a normal environment, and also have difficulties participating in regular community health-related activities.

PART III: LIFH PROJECT'S IMPACT

1. The findings:

The review focused on four main areas stipulated in the impact measurement framework, namely: voice and accountability; changing relationships, institutional response and sustainability of achievements. Findings from the information sources will be categorised into the four areas (See Annex 12 for the findings from various groups).[22]

a). Voice, participation and accountability:

The groups who participated in this review indicated that there had been tremendous changes brought about by the LIFH Project in promoting their voice and enforcing mutual accountability of the service providers and the service users. There are indications that there have been favourable changes in response of both the service users and the service providers towards each other. They also all indicated that the VHCs and HCCs are now fulfilling their responsibilities of linking with the service providers both at health centre and at district levels as illustrated below:

Before the LIFH Project	After the LIFH Project	Changes
▪ Hostile relationships between health workers and community	▪ Favourable response of both the service users and the service providers towards each other.	▪ Changes in relationships between health service providers and service users
▪ VHC/HCC not active in fulfilling their responsibilities at both HC and district levels.	▪ VHCs and HCCs are now fulfilling their responsibilities of linking with the service providers both at health centre and at district levels.	▪ Roles and responsibilities changed redefined and including linkages
▪ Communities indicated not to be empowered in taking up things with various levels of service providers	▪ Communities indicated to be empowered and taking things up with the various levels of the service providers.	▪ Communication systems between communities and service providers strengthened.
▪ There was bad attitude of staff towards clients in all health centres	▪ 16% of the VHCs complained about undesirable changes in health workers due to poor working conditions and shortage of ▪ 83% of the VHCs indicated that there had been tremendous improvements in the attitude of the health workers towards clients utilising the health facilities.	▪ Behaviour change of health workers and improved relationships between service users and service providers
▪ None of the health workers were committed to their work and were punctual for work.	▪ 83% indicated that health centre staff is now more committed to their work than before the LIFH Project's intervention, and report for work on time.	▪ Accountability of health workers promoted
▪ None of the health workers used to listen to patients' problems and there	▪ 83% indicates that health workers now listens to patient's problems and give	▪ Improvements in relationship between health workers and

[22] It must be noted here that the LIFH Project still faced the challenge of measuring its impact; i.e. putting all the impact in figures and percentages. Firstly because some of the concepts, such as behaviour and attitude change are difficult to translate into numbers and percentages. Secondly, because baseline information was partly collected in retrospect whereby it was very difficult for the respondents to recollect reliable measures of "the before LIFH" situation.

was hostile reception of patients. ▪ None of the VHCs and HCCs were active and fulfilling responsibilities of supporting improvements in health service delivery ▪ No VHC and HCC used to take up issues from communities to the HC staff and the DHMTs ▪ There was no indication from the respondents of being involved in DIP process	proper prescription and are receive well ▪ 100% of the VHCs and HCCs promote understanding and appreciation of the constraints affecting health service delivery and help reduce discontentment among the service users in the communities ▪ 67% of the HCCs now taking up issues with DHMTs – go directly to DHMTs to make requests on behalf of the communities ▪ HCC indicated that HCC's participation in the formulation of the DIPs was also a good step towards ensuring that community voices are heard at the district level.	community members promoted ▪ Community representatives empowered to complement efforts in improving health service delivery ▪ Community representatives empowered to advocate for the voices of the communities; partnership between service providers and service users facilitated and promoted ▪ Community voice heard at district level; participation of community members in planning processes promoted

Table 4: Impact on voice, participation and accountability

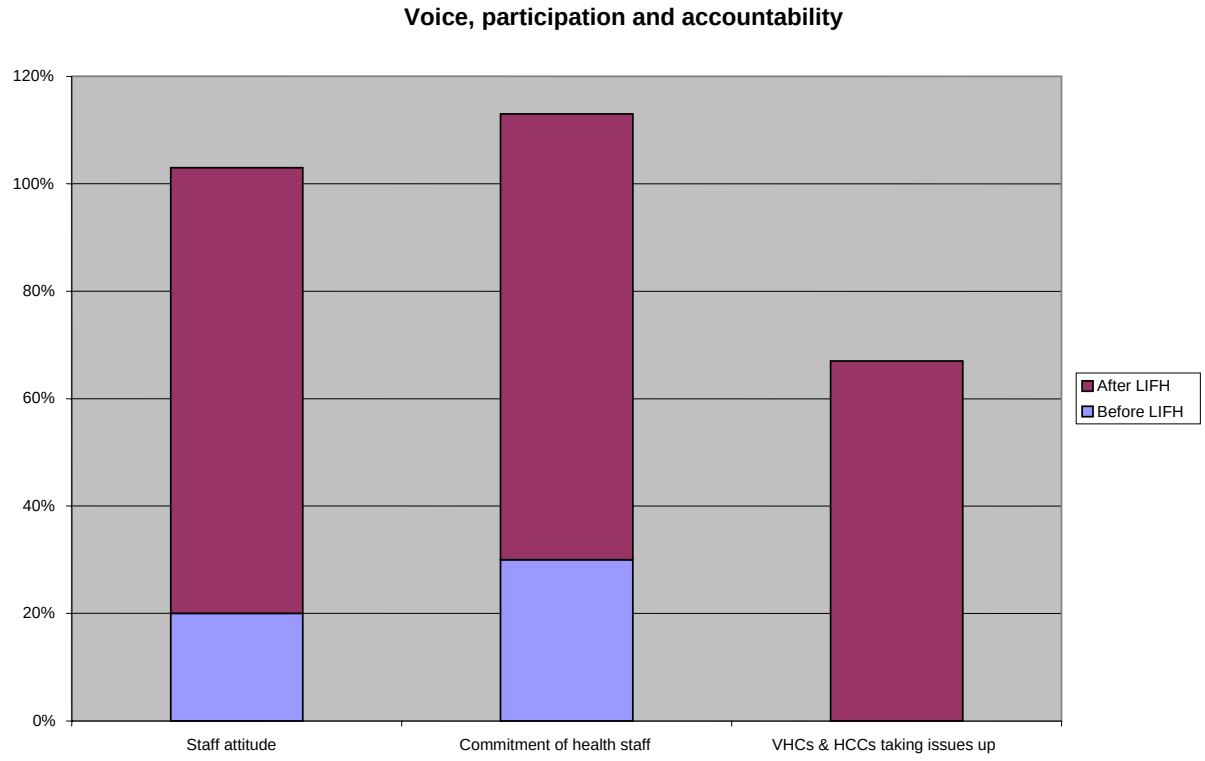


Figure 1: Impact on voice, participation and accountability

"At first, the medical assistant would not even look up and listen to a patient when you were explaining your ailment, and, before you finished explaining, he would have already finished scribbling in your notebook [health passport] and given you drugs. But now he faces you, listens to you while you explain, and asks you if you have finished explaining. He then writes something in the notebook and directs you to the dispenser for drugs…" (A man from Kaziputa Village explaining about staff at Chileka Health Centre)

"At first the district was responsible for making plans for us, but they never asked us what we wanted. But they have asked us what we want in the next year, and this will ensure that they do what we want, instead of making plans in their offices…" (HCC member from Mzandu Health Centre)

b). Changing relationships and linkages:

All the groups that participated in this study indicated that there had been improvements in the relationships between the health service providers and the service users, leading to stronger linkages between the various institutions involved in the provision and support of health services through the introduction of joint planning and the opening up of the service providers' doors to the voices of the community. There has also been a shift towards better information flows and cultural practices between the service providers and service users. The illustrations below summarises the impact on relationships and linkages.

Before the LIFH Project	After the LIFH Project	Changes
▪ There were no proper communication channels between the health service providers and the service users (communication on *ad hoc* basis)	▪ 100% of the VHCs acknowledged that there are now communication channels between the VHCs, HCCs and the service providers. ▪ All the HCCs indicated that there had been a shift from communication with the communities by word of mouth and on ad hoc basis to a more formal and effective communication system, where letters are used for communication and done on a more regular basis. ▪ The HCCs meet with the health centre staff at least on monthly basis. With the VHCs, community leaders and the health centre staff, the HCCs are now making joint plans. The HCCs have access to higher level processes, such as their participation in the formulation of the DIPs and interacting directly with the DHMT members.	▪ Communication channels between service providers and service users facilitated, promoted and institutionalised at health centre and district levels
▪ None of the community members or their representatives in the VHCs and HCCs used call on the health workers to address any pertinent issues	▪ 80% of the respondents indicated that people now communicate through VHC /HCC and sometimes directly through the HSAs. VHCs call on the HSAs whenever they need them, and the entire communities are aware of whatever is discussed with the HSAs because there is constant feedback to the communities given by VHCs.	▪ Changes in linkages – switch from "push" system (reactive) to "pull" system (proactive), where "open-doors" have been introduced by those in authority
▪ Planning of health services was done centrally at the district level, with little or no consultation at all from the service users	▪ 67% of the health centres have involved community and health centre representatives in formulation of the 2005/06 DIP formulation.	▪ Local voices heard at district level.
▪ No HCC respondent indicated to have been raising issues to the DHMT	▪ The DHMTs indicated that they had effected an open-door-policy and welcome members of the HCCs to their offices should there be any issues they HCCs want to raise with them. The HCCs can meet the DHMTs anytime they want to complain about health centre staff conduct,	▪ Flexible communication systems and channels between district and local level promoted; changes in relationships – access of community voices to higher levels.

	availability and indeed any other issues. ▪ 67 of HCCs have had meetings with DHMTs on an issues arising from communities (ambulance, more staff)	

Table 5: Impact on relationships and linkages

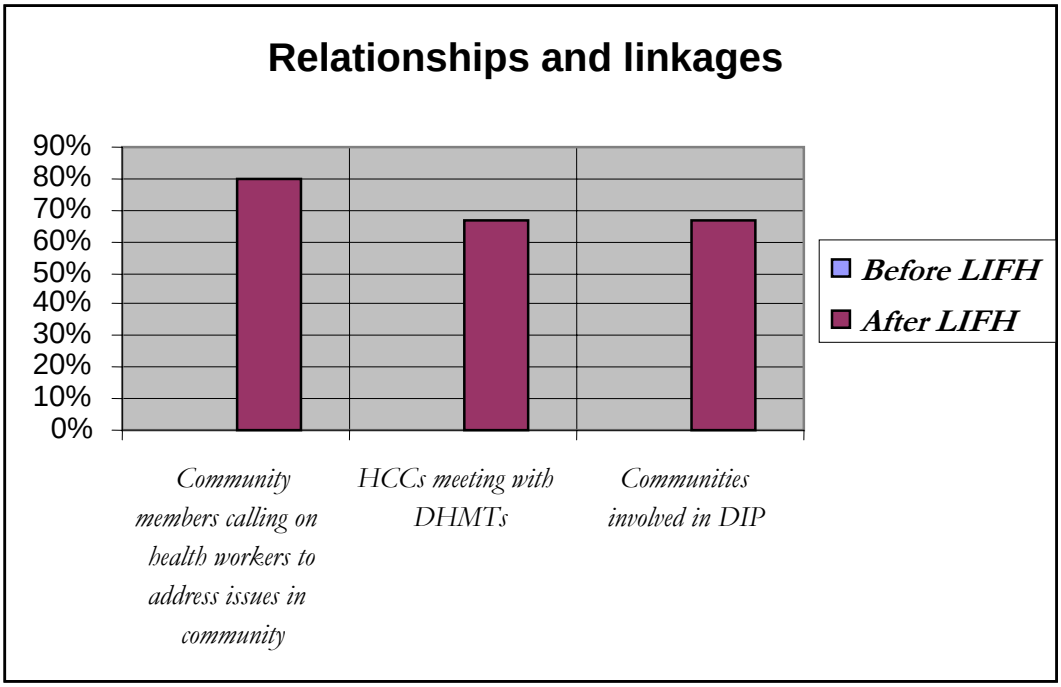


Figure 2: Impact on relationships and linkages

"When our nurse went on leave, our Health Centre was on the verge of closing, so we went to the District and complained to the DHMT. Look now we have a nurse working on relief basis…"
An HCC member from Mzandu

c). Institutional response:

The respondents to this review indicated that both the community health institutions and the service providing institutions have responded well to the interventions that have been taking place with the LIFH Project. They indicated that there is now transparency promoted among the service providers on drugs, supplies and equipment allocated to the health facilities. The community institutions are now democratically elected by the communities voting, and are now able to respond to a diversity of health issues in their communities in contrast to their initial preoccupation with hygiene and sanitation issues.

Before the LIFH Project	After the LIFH Project	Changes
▪ None of the health service providers transparent on the use of drugs, supplies and equipment	▪ 100% of the health service providers are transparent and involve community health institutions in monitoring and endorsing receipt of drugs, supplies and equipment	▪ 100% in shift towards transparency in drugs and supplies by health service providers
▪ Poor utilisation of health services per incidences of illness (30% of cases of illness treated at health centres)	▪ Utilisation of services at the health centres per incidence of illness (70% of illnesses treated at health centres)	▪ Changes in health seeking behaviour per incidence of illness

▪ Less pregnant women delivering at the health centres (30% of pregnant women delivering at health centres)	▪ Increase in pregnant women delivering at the health centres (more than 90% of pregnant women delivering at the health centres)	
▪ Undemocratically elected community health institutions (HCC appointed by TAs while VHCs appointed by village heads and HSAs) responding to a narrow array of health problems i.e. hygiene and sanitation issues	▪ 100% of VHCs and HCCs elected democratically and responding to a diversity of health issues in the community including representation, advocacy and lobbying.	▪ Democratic election VHCs and HCCs; VHCs and HCCs responsive to health issues
▪ Communities (service users) were not informed of drug availability	▪ Communities health institutions post drug availability information on drug utilisation boards for service users	▪ The Right to information for health service users is achieved ▪ Improved representativeness of HCCs
▪ HCCs comprised of individuals from villages closest to the Health Facility	▪ 100% of the HCCs comprise of individuals from across the entire health centre catchments	

Table 6: Impact on institutional response

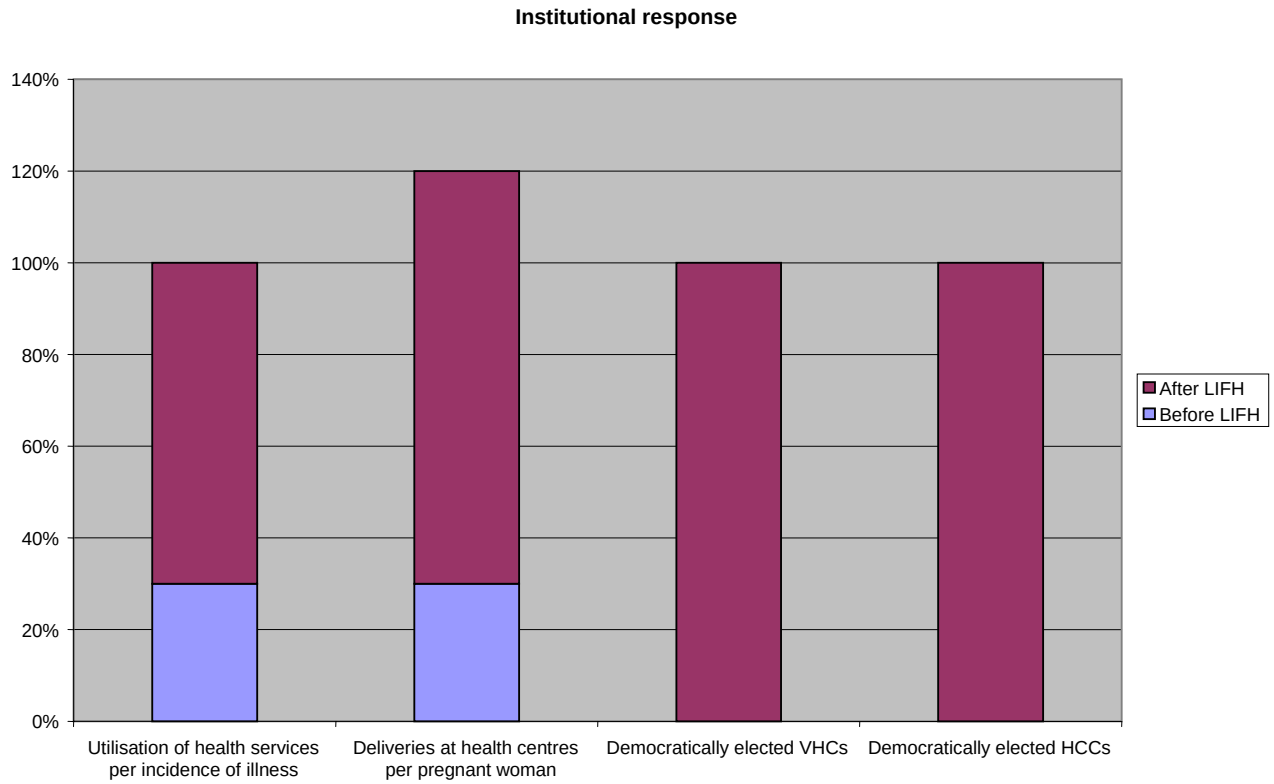


Figure 3: Impact on institutional response

d). Sustainability of achievements:

The LIFH Project has brought an understanding among both the service providers and the service users up to the district level on processes that foster mutual understanding between the two parties, leading to a collective appreciation of and collective shift of focus to activities that aim to improve health service delivery. Both the community institutions and the healthcare providers have appreciated and are willing to institutionalise key processes

that promote transparency and accountability; and share a common vision of health services, which is that that bases on a sustainable and working relationship between the two parties. The service providers are also willing to change and surrender some of their responsibilities and power to the empowered communities so that they can complement each other in improving health service delivery. However, even though the LIFH Project has been able to influence policies at the community, health centre and district levels, more needs to be done in advocating for the health priorities of the communities at levels higher than the district level.

Before the LIFH Project	After the LIFH Project	Changes
▪ Lack of common and shared vision of health service delivery by health providers, community health institutions and service users	▪ Shared vision of health service delivery between service providers and users ▪ Willingness to institutionalise key processes that promote transparency and accountability ▪ Service providers are aware of the scorecard and social mapping and are using them in evaluating health service performance by allowing communities and service users to score their health services	▪ Changes in vision and reputation of both the health service providers and the service users on definition of quality health services

Table 7: Impact on sustainable change

2. Successes of the LIFH Project:

The LIFH Project registered a number of successes in its RBA work. Among other things, Project ensured that communities participated in decision making processes; promoted access to information, transparency and accountability and equity in the health service delivery system. More specifically, the LIFH Project's major successes are as follows:

Element	Before the LIFH Project	After the LIFH Project	Changes
Participation in decision making processes	▪ District level planning was done by district officials with little or no input from health centre staff, let alone community members	▪ Community and local level service providers involved in identification and prioritisation of issues to be included in the DIPs.	▪ The voice of the community is now being heard at the district levels and incorporated into the DIPs
	▪ The health committees comprised of people related to the village heads and was not based on merit. Women were mostly "ordinary" committee members, never chairpersons or treasurers	▪ Women and other vulnerable groups encouraged and taking leadership roles in health committees and scorecards.	▪ Representation of various social groups in the health committees enforced
	▪ The HSAs hardly ever used to orient the health committees on their roles and responsibilities; in the few cases where did, the health committees were oriented on being agents of sanitation and hygiene activities	▪ Topics of leadership and participation included in meetings and trainings with health committees and in dialogue sessions.	▪ Knowledge gaps in leadership and participation identified and addressed
	▪ The ratios of men to women in the health committees ranged from 7:3 to 9:1	▪ Equal membership ratios of men to women in health committees enforced.	▪ Gender representation in health committees addressed

Access to information	▪ Only general notice boards were present at the health centres, and were updated at the discretion of the health centre staff; communities had no knowledge about drug availability status at the health centres	▪ Use of general notice and drug utilisation boards in all health centres enforced to constantly give information to communities.	▪ Provision of information from service providers to the users facilitated and on going
	▪ The HCCs had no authority to access any information at the health centres.	▪ Health centre committees accessing utilisation registers and other documents and inventories in the health centres.	▪ Health workers have become transparent towards the communities
	▪ Little or no training provided to communities or their institutions.	▪ Trainings and capacity building activities providing knowledge and information to communities.	▪ Knowledge gaps identified and addressed
	▪ No interfacing between community members or their representatives. Issues dealt with only on as-is-basis between health workers and "aggrieved" individuals – which often ended up being confrontational.	▪ Quarterly and other meetings between healthcare providers and community people to share and discuss all pertinent issues.	▪ Dialoguing between service providers and service users promoted
Transparency and accountability	▪ No community representation in monitoring of drug utilisation; no community involvement in management and evaluation of health services	▪ Health centre committees participating in drug monitoring and other activities planning, management and evaluation of health services	▪ Community representation in transparency mechanisms promoted
	▪ No information on drugs provided to communities.	▪ Use of drug utilisation boards in the health centres.	▪ Transparent management of drugs promoted
	▪ No discussion and/or agreement on quality of health services – each party complained on their own and accused each other of not supporting improvement of service delivery.	▪ Interfacing between the service providers and service users to share and discuss quality health service delivery in a more open and direct manner.	▪ Dialoguing between service users and service providers promoted
	▪ Health service providers acting as "know-it-alls" and making all decisions on their own; community members taking health service provision as a "favour" from the service providers, and not as a "right"	▪ Health centre and district level service providers readily accepting responsibility over issues identified and raised by the community and applying a human face in addressing the issues – accepting to be held accountable by service users over the services.	▪ Health service provider accountability for health services promoted.
Equity	▪ Preferential treatment given to friends, relatives and famous/popular and prominent people at the health centres – the poor and infamous people treated last	▪ Use of numbering and queuing systems to enforce and reinforce the first-come-first-served practice.	▪ Equal treatment of service users promoted
	▪ (Perception) poor people given "light" drugs such as	▪ Dispensing drugs according to illness for every social group of	▪ Change in perception of fairness of service

	Aspirins while friends, relatives and prominent people given the "stronger" and more effective drugs ▪ Everyone taking care of themselves (except family members) – "only the strong survive" mentality reigned in communities ▪ "Everyone is poor" mentality – everyone took care of themselves, whether they were ill or aged or not ▪ No collaboration between the medical suppliers and the consumers – CMS and DHMT accused each other of delaying drug distribution	people utilising health centres (perceived change) ▪ Identification of vulnerable people through the social mapping process and follow-up mechanisms in communities. ▪ Promotion of village support systems that link up with and support vulnerable people in communities. ▪ Facilitated dialogue between districts and Central Medical Stores to ensure timely and equitable availability of drugs in districts and health centres.	providers facilitated ▪ Identification of vulnerable groups in communities facilitated ▪ Promotion of community support systems for vulnerable people facilitated ▪ Fair treatment of districts on drug allocation facilitated and promoted

Table 8: Successes of the LIFH Project

3. Major challenges:

While the LIFH Project achieved considerable successes in the three years that it was in existence, the Project also faced several challenges and constraints in applying RBA in the health sector. The following are the major challenges faced:

i. **Evidence of impact:** With RBA being a fairly new approach, there were no role models to learn from. Consequently, it was difficult for the LIFH Project to install an effective and effective monitoring system that continuously monitored the impacts of the RBA work that it was doing. This made demonstration of evidence of impact an arduous task for the LIFH Project.

ii. **Linking into the Health SWAp:** The LIFH Project's learning objective was to feed lessons into the wider health sector through the Health SWAp. However, both the Project's staff and its district partners were not sufficiently informed about the SWAp process and demands. This made it difficult for the Project to find entry points into the SWAp process.

iii. Equity and addressing social exclusion: It was difficult for the Project to isolate who was socially excluded and who was not, as criteria for social exclusion changed from one scenario to another. Thus the Project could only identify who was vulnerable in terms of accessing health services and participating community-based health activities.

Major lessons learnt:

i. Influence of partner responsibilities on project activities; and effective partnership development in relation to partnership goals.

ii. Incremental capacity building as a catalyst to translation of learning into action

iii. Open dialogue has promoted collaboration and working relationships between all levels of service providers and service users

iv. Interfacing has promoted joint vision of quality health services and has fostered joint planning towards achieving quality services, resulting into enhanced ownership of health facilities and services by the communities and their institutions

v. Provision of information has promoted trust between various levels of service providers and service users
vi. Working through partners (capacity building) has increased coverage – small input resulting into big results
vii. The scorecard is an efficient vehicle for promoting mutual transparency and accountability between the service providers and the service users
viii. Scorecard process as a tool for addressing human rights (assessment, evaluation, participation).

Conclusion:
From the preceding discussion, it is evident that the LIFH Project took considerable strides in attempting to address issues of poor health among the rural communities of where it worked. Having improved the relationship between the various levels of service providers and service users, the Project empowered both parties to work towards providing and supporting quality services respectively. This has enhanced ownership of the health services by the communities, thereby improving user satisfaction.

The scorecard process became an effective vehicle for advancing rights related issues by bringing together the rights holders and the duty bearers. The less confrontational manner of tackling rights issues in the scorecard ensured that both the healthcare providers and the communities identify barriers to quality health services and understand and prioritise issues and map a joint plan to address the issues. Facilitating the DIP process to become a consultative one has enabled the district levels to incorporate views from the communities as priorities for the districts.

It is also evident that the LIFH Project's approach did not only prove successful for the LIFH Project alone, but was also seen as a potential methodology for mainstreaming rights approaches into new and existing livelihood programs. This is evidenced by the several other organisations and institutions that learnt from and adopted and adapted the scorecard process. The organisations include OXFAM's SHSLP, MASAF and CARE Malawi's PACE and CRLSP projects. The DHMTs from Lilongwe and Ntchisi are also selling the approach to other development partners.[23]

However, the LIFH Project did not do enough to feed its approaches, successes, lessons and experiences into the wider health sector through the Health SWAp[24] as it was originally planned. While the SWAp provides clear mandate for initiatives like the LIFH Project to participate in developing, implementing and evaluating the SWAp, the LIFH Project did not come across any entry points into the SWAp processes. While the Project facilitated processes at the community and district level that directly related to the SWAp outline, the

[23] Ntchisi DHMT intends to use the scorecard and its associated processes (dialogue and interface meetings) in collaboration with World Vision International/Malawi at one of the health facilities that was not covered by the LIFH Project – Nthondo; and Lilongwe DHMT intends to use the scorecards and the dialoguing processes in the remaining health areas of the district, piloting with Nathenje Health Area, which is the southern part of the district.
[24] The MoH led the Health SWAp consists of the MOU between the Ministry and donors for the Health Sector; a Joint Program of Work (POW) for all partners in the Health Sector and the Essential Health Package (EHP). The POW stipulates, among other things, direct budget support into the health sector; rolling out the EHP; and joint planning at district level, including voices of the most poor.

disconnect between the Central Government level and the district and community levels remains unchanged but crucial to an effective and efficient health sector in the country. This is partly because the Health SWAp has for a long time been a closed process involving the donors and MoH Central Level, and has been still a mystery to the civil society and district levels; and also because the Health Sector's civil society remains fragmented, thereby not organised enough to present itself as one voice into the SWAp processes.

Ambitions and way forward for the future: A-LIFH

Having successfully applied RBA in the health sector at community level, health centre and district level, it was only logical and proper for the LIFH Project to move to the next level. LIFH Project generated lessons on how participation of communities in district processes can be enhanced to feed into the district level processes. It also generated lessons on empowering both the demand and supply sides of the health service delivery systems. The LIFH Project strengthened the links between the local and middle levels in the health sector and played an advocacy role at the local and middle levels. Therefore it was logical and the ambition of the LIFH Project to move into its next phase. Thus LIFH's sequel project: the A-LIFH is the complimentary continuation of the LIFH Project, as it takes off from where the LIFH Project stopped.

A-LIFH is funded by CARE UK and started on June 1st, 2005. It is a learning initiative on negotiated development that builds linkages between civil society and the state through their engagement in SWAps. A-LIFH primary engages with The Ministry of Health, District Health Management Teams and civil society based networks such as the Malawi Health Equity Network and other like-minder partners. At the district level A-LIFH is engaging in the eastern health zone, which includes the districts of Ntchisi, Salima, Dowa, Nkothakotka, and Kasungu.

A-LIFH is advocating for a more transparent, equitable, representative and accountable health system. A-LIFH is linking district and central levels of government in the implementation of the Malawian Health Sector Wide Approach (SWAp). In order for a successful roll-out of the SWAp it has to become more inclusive of civil society and represent the voice of the most vulnerable rural households. A-LIFH is exploring and learning from the political engagement of civil society in SWAps, by using RBA as an advocacy strategy, operationalising the language of rights, accountability and equity into political discussion.

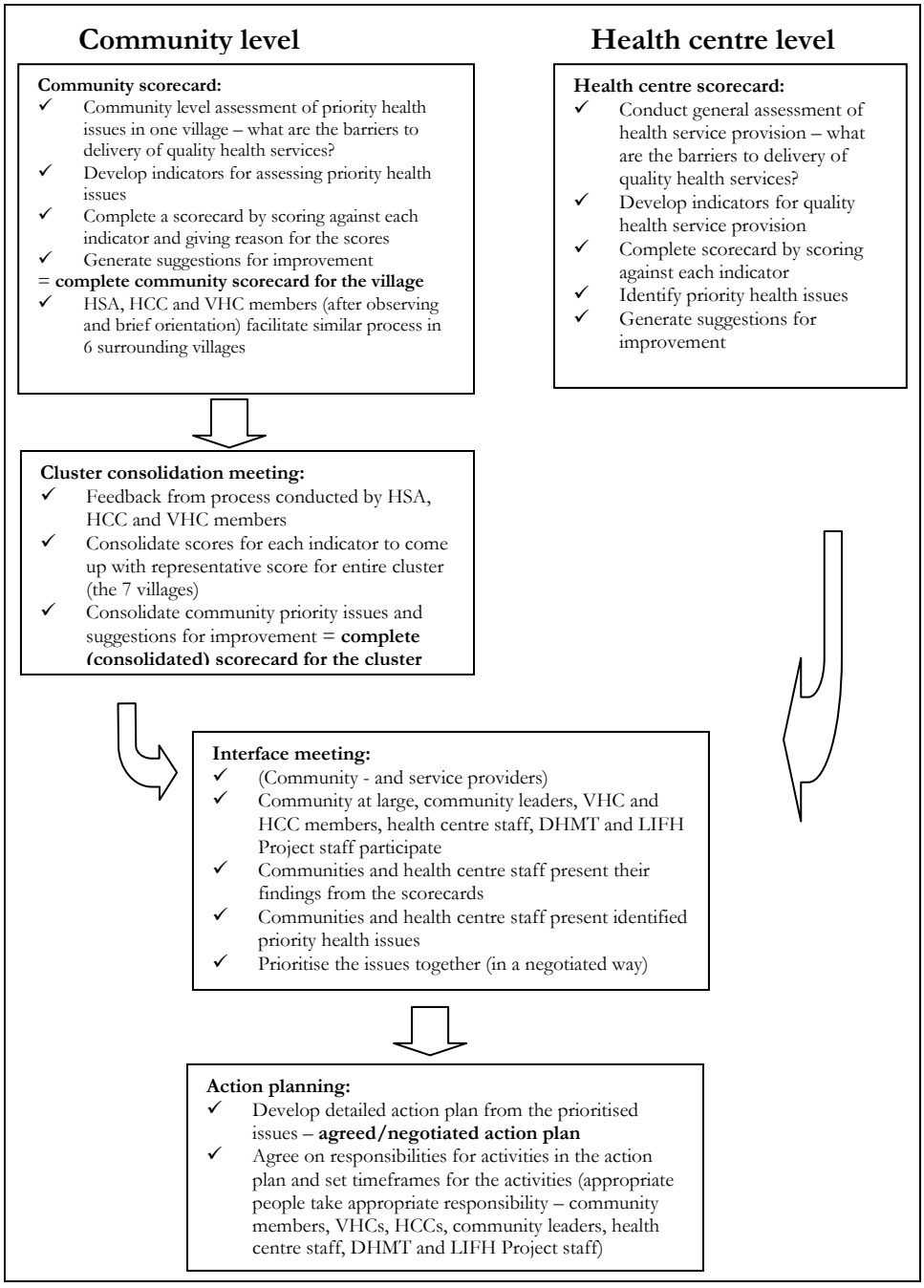
A-LIFH empowers Malawian civil society to have effective strategies and structures in order to be an essential partner to government and donors and hold them to account. A-LIFH is advocating for accountability, equity and transparency mechanisms within SWAPs to improve the appropriate use of resources, service delivery and establish service user satisfaction.

PART IV: REFERENCES AND ANNEXES

Annex 1: LIFH Project's original RBA Framework:

	KEY ELEMENTS	ACTIVITIES RELATING TO THE KEY ELEMENTS
1.	Access to information	▪ Drug monitoring ▪ Use of notice boards in health centres ▪ Frequent meetings between health centre staff and community members
2.	Participation in decision making	▪ Establishment and inclusion of a cross-section of community members in VHCs and HCCs ▪ Involvement of community representatives in making the action plans
3.	Accountability	▪ Drug monitoring activities ▪ Record keeping
4.	Transparency	▪ Use of notice boards ▪ Involvement of a cross section of partners at the Interface meetings
5.	Equity	▪ Social mapping process ▪ Scorecard process
6.	Shared responsibility	▪ Establishment of committees ▪ Involvement of all partners in implementation of planned activities ▪ Channelling issues through committees

Annex 2: Diagrammatic illustration of the scorecard process:



Annex 3: An example of a community scorecard:

A repeat scorecard completed with men from Mwanjema Village accessing Chitedze Health Centre in Lilongwe District

1.0 Staff conduct:

Indicator		Score out of 100		Reasons for the score
		APR '04	DEC '04	
1.1	Observing official working hours	**60**	**70**	There is some improvement
1.2	Attitude and behaviour towards patients (respect, listening e.t.c.)	**65**	**70**	Some improvement
1.3	Reception of patients	**50**	**50**	some staff are rude
1.4	Maintaining patients' privacy	**0**	**100**	They try their best
1.5	Honesty and transparency in staff members	**0**	**50**	They are trying but on some thing like drugs availability should improve
Overall Score		**20**	**75**	

2.0 Management of health services:

Indicator		Score out of 100		Reasons for the score
		APR '04	DEC '04	
2.1	Cleanliness of the health facility	**85**	**90**	It is clean most times
2.2	Maintaining first come first served basis	**75**	**75**	No much has changed
2.3	Prioritising serious cases	**100**	**100**	They do
2.4	Link and collaboration with community members and VHCs	**-**	**50**	There is now some link
2.5	Link and collaboration with HCC	**-**	**80?**	We know of the existence of a HCC
2.6	Link and collaboration between HSA and community	**0**	**90**	It is there and good
2.7	Link and collaboration between HCC and VHCs	**-**	**0**	Not good
Overall Score		**40**	**85**	

3.0 Right to access Quality health services:

Indicator		Score out of 100		Reasons for the score
		APR '04	DEC '04	
3.1	No preferential treatment	**42**	**42**	Not much has changed
3.2	Availability of drugs at the health facility	**75**	**85**	There is some improvement
3.3	Availability of adequate staff members	**90**	**50**	There is still need for more staff like nurses and MA
3.4	Availability of multiple services (dental, optical, e.t.c.)	**-**	**0**	Not available
3.5	Availability of qualified and competent staff	**50**	**50**	Some are qualified some are doing duties that they are not trained for
3.6	Access to emergency services	**50**	**75**	During the day it is good but not during the night
3.7	Quality of under-five services	**95**	**100**	good
3.8	Quality of rehabilitation services	**0**	**85**	Advice available but Need for nutritional support
3.9	Quality of family planning and reproductive health services	**90**	**100**	good
Overall Score		**80**	**90**	

4.0 Infrastructure and equipment:

Indicator		Score out of 100		Reasons for the score
		APR '04	DEC '04	
4.1	Availability of infrastructure such as (electricity, water, toilets, kitchen, guardian shelter, beds and mattresses for pregnant women)	**45**	**45**	No change
4.2	Availability of separate holding rooms for men and women	**0**	**0**	No separate rooms
4.3	Availability of adequate diagnostic and medical equipment	**30**	**50**	Most are available others we don't know
4.4	Availability of communication means (wireless message, telephone, e.t.c)	**0**	**75**	Available but the phone fails often
4.5	Availability of transport	**0**	**75**	
Overall Score		**20**	**60**	

Suggestions for improvement:

- Health centre staff members should observe working hours
- Staff members should be able to welcome patients in a friendly and quick manner
- The health centre needs to have separate waiting rooms for men and women
- The health centre should have more toilets
- Need for a two way communication between the health centre and the HCC as well as the VHC
- The staff should advise patients calmly and not shout at them
- Medication should be prescribed according to illness
- Need to have some kind of relief for malnourished children
- The health centre should have its own ambulance
- The health centre should have a dental section
- Need for water supply in or near the kitchen
- Patients should not get into the MA's office in groups

Annex 4: An example of a cluster scorecard matrix:

Scores for Chakuzamutu cluster accessing Chileka Health Centre in Lilongwe District

1.0 Attitude of Health Centre Staff

No	**Indicator**	**Score out of 100**																										
		Chimwaza				**Mselu**				**Kaziputa**				**Chaola**				**Mizati**				**Chakuzamutu**				**Cluster**		
		Mar '03		**Jan '04**		**Mar '03**		**Jan '04**		**Mar '03**		**Jan '04**		**Mar '03**		**Jan '04**		**Mar '03**		**Jan '04**		**Mar '03**		**Jan '04**		**Aug '02**	**Mar '03**	**Jan '04**
		M	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**			
1.1	Punctuality of staff	75	50	80	80	80	80	90	90	45	80	70	90	85	80	90	90	75	50	80	80	95	20	65	10*	50	**60**	**75**
1.2	Polite behaviour	75	80	85	90	85	60	75	40	65	60	80	70	90	45	80	40	80	10	40	60	90	50	55	100	40	**50**	**65**
1.3	Listening to patients' problems	60	90	95	95	100	100	100	100	95	90	95	100	100	100	100	100	50	20	100	50*	80	100	100	100	50	**85**	**95**
1.4	Respect for patients	50	90	30	95	50	90	50	100	50	70	60	80	100	100	100	100	80	10	90	70	95	90	90	100	25	**95**	**85**
1.5	Respect for patients' privacy	90	100	100	100	100	100	100	100	100	100	100	100	75	100	100	100	100	50	100	80	100	100	100	100	70	**75**	**100**
1.6	Honest and transparent staff (in terms of dealing with drugs, food, etc.)	50	50	50	40	50	50	85	100	50	50	80	40	50	50	75	20	25	50	30	20	0	20	50	100	2	**45**	**60**
Overall		**85**	**70**	**90**	**95**	**75**	**50**	**80**	**60**	**50**	**50**	**85**	**70**	**50**	**60**	**75**	**80**	**50**	**50**	**60**	**70**	**50**	**30**	–	**75**	**45**	**50**	**65**

Annex 5: An example of a health centre scorecard

A scorecard completed with staff from Khuwi Health Centre in Ntchisi in October 2003

1.0 Conduct of Health Centre Staff Members

No.	Indicator	Score out of 100	Reasons
1.1	Observing official working hours	80	Some staff members report for work early, while others report late
1.2	Respect of health centre staff members	95	There have never been any complaints from any quarters
1.3	Two-way communication among health centre staff members	100	There are frequent meetings among staff members
1.4	Openness among health centre staff members	80	There is openness, but sometimes there is uncalled for speculation
	Overall Score	**90**	

2.0 Management of health centre

No.	Indicator	Score out of 100	Reasons
2.1	Cleanliness and tidiness of health centre and its surroundings	60	The surroundings are clean, but there are times that the office walls and roof even have cobwebs
2.2	Availability of rules and regulations to govern operations at the Health Centre	70	There are no rules and regulations set by the Health Centre; but there are rules that have just come from the district headquarters
	Overall Score	**60**	

3.0 Quality of Services

No.	Indicator	Score out of 100	Reasons
3.1	Availability of sufficient drugs	75	There are enough drugs for three weeks in every month
3.2	Prescription of drugs according to ailment	100	Everyone gets drugs appropriate to ailment
3.3	Availability of enough staff members	60	There are some posts that are vacant, for example, medical assistant
3.4	Availability of appropriate staff members	75	Some staff members perform duties in which they were not trained
3.5	Provision of appropriate services to patients	100	Everyone gets appropriate services
3.6	Number of people accessing services in relation to population of catchment area	80	There are some people from the catchments of Mponela who access health services at Khuwi Health

			Centre
3.7	Availability of food for patients	0	There is no food for any patient
	Overall Score	**80**	

4.0 Relationship with Health Service Users

No.	Indicator	Score out of 100	Reasons
4.1	Reception of patients	90	There have never been complaints pertaining to reception raised by the service users
4.2	Meetings between health centre staff members and VHC and HCC	40	There are no meetings except in cases where HCC has concerns to address with the Health Centre
4.3	Relationship between the Health Centre and its service users	50	• Most of the community members have no clear understanding of official working hours. They mostly come to the Health Centre late – when the staff members are knocking off. • Sometimes, patients expect and insist to have an injection for inappropriate ailments.
	Overall Score	**60**	

5.0 Infrastructure and Tool/Instruments for Use at the Health Centre

No.	Indicator	Score out of 100	Reasons
5.1	Availability of good water	90	There is only one borehole
5.2	Availability of transport	10	Most of the times, patients die before the ambulance arrives at the Health Centre
5.3	Availability of staff houses	50	There are only three staff houses
5.4	Availability of toilets, kitchen and guardian shelter	80	• There are insufficient toilets • Kitchen available • Guardian shelter available
5.5	Availability of beds, mattresses and bedding	60	Only a few available
5.6	Availability of space for use at the Health Centre – working rooms	50	Insufficient – there are no offices
5.7	Availability of communication means	90	Wireless message available, but sometimes dysfunctional because of flat batteries
	Overall Score	**70**	

6.0 Staff Development

No.	Indicator	Score out of 100	Reasons
6.1	Promotions offered to health centre staff members	0	No one has ever been promoted
6.2	Provision of allowances to health centre staff members	0	"Junior" (health centre) staff members never get allowances – it takes a long time for them to process the allowances – sometimes never, whereas it is quicker done for "senior" staff.
	Overall Score	**0**	

Suggestions for Improvement

1. Provision of additional staff members to the Health Centre
2. Health centre staff members should get [appropriate] promotions
3. Allowances should be given to health centre staff members [at appropriate times]
4. The Health Centre should have [its own] ambulance
5. Health centre staff members should be given additional and refresher trainings
6. Construction of more houses fro staff members
7. Provision of more beds, mattresses and bedding
8. Provision of supplementary feeding materials to the Health Centre
9. Provision of additional scales for Under Five Clinic services
10. Provision of [additional] protective clothing, such as uniforms

Annex 6: An example of a joint action plan

A joint action plan drawn at Ming'ongo Health Centre in Lilongwe in March 2004

	ACTIVITY	PROCESS	RESP. PERSON	TIME FRAME
1	Provide more staff such as HSAs cleaners and nurse	- DHO to follow up on this issue	- DHO	August 2004
2	Constructing outreach clinic shelters	- HCC to meet with chiefs - HCC and MA to apply for funds from MASAF	- MA - HCC - Chiefs	June 2004
3	Informing villagers of activities at health centre	- LIFH to provide notice boards - HSAs to write on the boards	- LIFH - Senior HSAs	July 2004
4.	Informing villagers about drugs at health centre	- HCC, Drug committee to meet with MA - Drug committee to be present during drug delivery - HCC should inform VHCs of drugs available - VHCs to inform villagers	- HCC chairman - MA - Drug committee - VHCs	June 2004

Annex 7: LIFH Project exit strategy

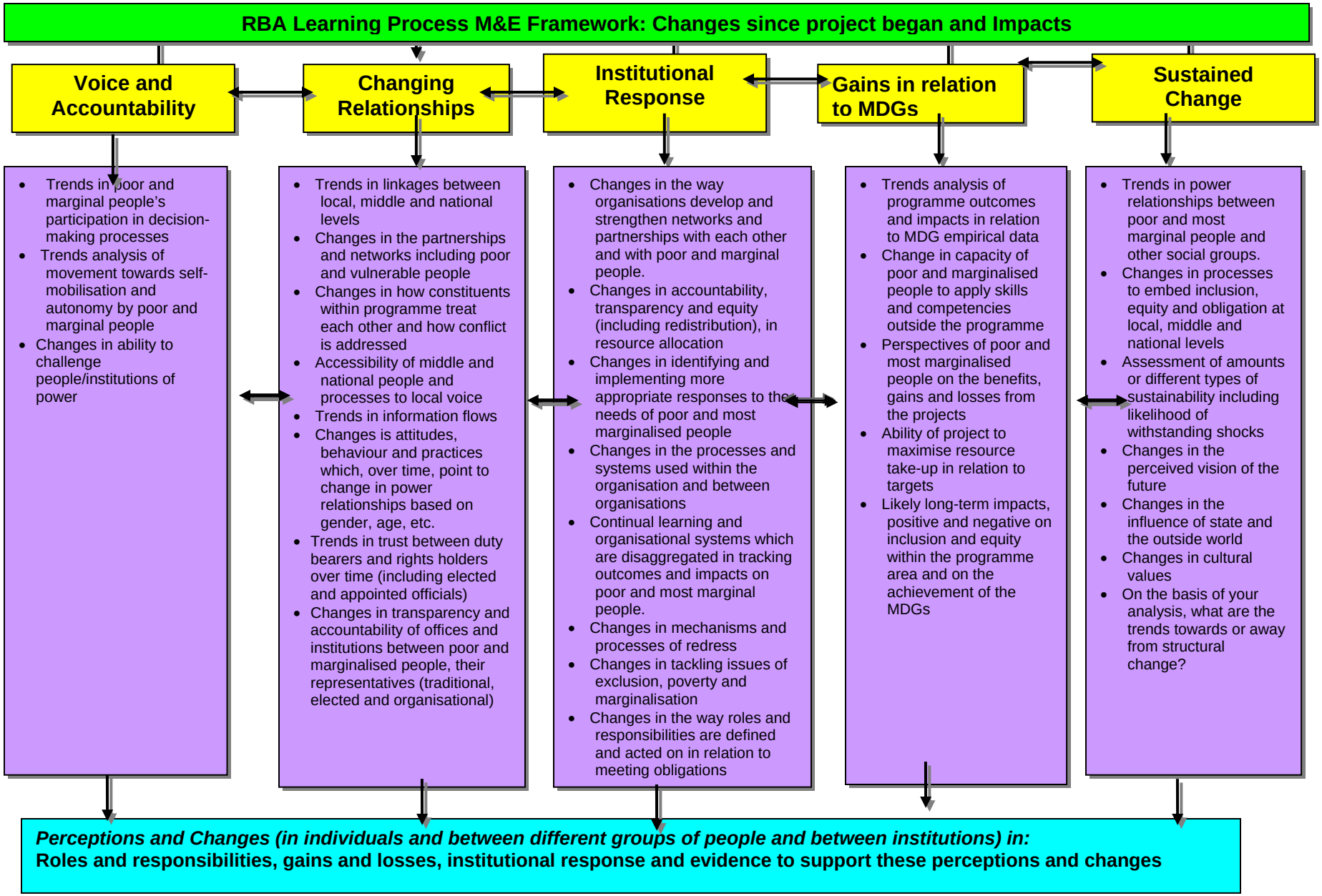
Necessary steps towards sustaining the processes and activities

Issue	Steps	Underpinning Rationale	Targets	Responsibility
1. Institutionalization of the community scorecard and health centre self assessment process	▪ Undertake a review of the functionality of the VHCs and HCCs and revamp non-functional ones ▪ Conduct training of VHC, HCC and health centre staff on the process ▪ Map out the management of each and every step of the process by assigning responsibility to specific institutions/offices ▪ Agree on the most feasible frequency of the process	▪ The scorecard process has been implemented several times in the catchment area(s). However, not all VHC, HCC, health centre members have participated in all steps of the process. In order to institutionalize the process, there is need for all concerned stakeholders to get acquainted to the entire process	▪	▪
2. In putting into the DIPs	▪ Familiarize with the current practice on annual planning and budgeting (including the structure and content of the DIP) ▪ Ascertain the relevance and practicality of the annual planning and budgeting cycle/calendar prepared by the MOHP ▪ Explore the possibilities of aligning the scorecard process with the cycle ▪ Negotiate, if necessary, with the DHMT on extent of involvement by health centre staff in the planning and budgeting process	▪ The joint action planning process provides an opportunity to instil the principles of a SWAp and at the same time, a practical step towards decentralization. However, the elements of the action plans have not explicitly been fed into the annual planning and budgeting process at the district level. On the other hand, participation and influence of lower level health personnel is not consistent. The planning processes at the local level could be more meaningful if they are synchronized with the centrally controlled processes.	▪	▪
3.Participatory monitoring system	▪ Disseminate the developed participatory monitoring framework ▪ Seek consensus from all concerned partners on the practicality of the framework ▪ Revise the community monitoring registers ▪ Orient all partners on the reporting processes and channels	▪ Much as the project has used the community scorecard and health centre self evaluation process to monitor health service delivery and other health system issues, routine reporting has not been consistent. This is also apparent at the community level where community	▪	▪

Issue	Steps	Underpinning Rationale	Targets	Responsibility
		monitoring registers had been introduced, but were not effectively utilized		
4. Drug monitoring	▪ Acquaint all stakeholders on the new drug distribution system ▪ Review the role of HCCs in drug monitoring and modalities for information dissemination to the community	▪ The Ministry of Health and Population has recently championed a number of reforms at the Central Medical Stores. However, the processes and procedures of such reforms have not been effectively communicated to the lower level service providers, not least the service users. This creates an information vacuum and unnecessary mistrust between service providers and users on one hand, as well as within the supply chain. It is also rumoured that there is intended creation of drug monitoring committees. The relevance of such a move in the presence of HCCs, who are already charged with a similar responsibility, is subject to clarity.	▪	▪
5. Patient numbering system	▪ Review the current processes followed in implementing the patient's numbering system ▪ Devise mechanisms (if necessary) to manage the system	▪ The system has been in place since project inception. Nonetheless, there has been turn over of key staff at the health centres, which could lead to weakening of such a system. This therefore, calls for reinforcement of the system.	▪	▪
6. Use of notice boards	▪ Review the current processes followed in utilizing the notice boards (types of information, responsible people, frequency, etc) ▪ Devise mechanisms (if necessary) to manage the system	▪ The validity of having permanent boards for scorecards is subject to review. It appears little attention is paid to these boards by service users as well as providers over time. Similarly, the drug inventory boards are not regularly update, either due to diffusion of	▪	▪

Issue	Steps	Underpinning Rationale	Targets	Responsibility
		responsibility or lack of commitment by those charged with the responsibility. The responsibility and frequency for the same needs to be clarified further and where necessary, reorient the concerned parties		

Annex 8: Interagency RBA Framework



Annex 9: Illustration of the hierarchy of indicators for LIFH Project's new RBA framework

LIFH PROJECT FRAMEWORK FOR MEASURING IMPACT!

Broad indicators	Specific indicators	Indicative questions (Ask: *How was it before? How is it now?* for every question)	Sources of information	Tools for collection	Information / findings	
					Baseline	Now/evaluation
1. Voice, participation and accountability						
1. Changes in the response of health workers towards service users	Response of health centre staff to health service users: 1. Reception of service users by staff (first come, first serve, queuing and numbering, prioritizing emergencies / acute health problems,) 2. Perception of privacy of service users (confidentiality, waiting room, consultation)	1. How do health service providers receive their health service users? What mechanisms are in place for the reception of patients? 2. Do you feel that the service user's privacy is respected? Can you explain how?	Use disaggregated data (age, gender, social group, etc) VHC, HCC How to measure equity, equitable access? Who are we talking about? Define who are service users: *Social excluded* *Vulnerable groups* *Marginalised* *The poor*	*Bear in mind, be aware that some will get lost, change, differ once we 'translate' this into Chichewa* 1. Interviews; group discussions; the road/river	1. Service users are not welcomed in a friendly and polite manner, they are threatened and kept for long periods of time without being informed of whether services are available or not (assessment reports, site reports) None 2. Service user's privacy was not respected. Consultations done in groups, shouting to patients at maternity ward (assessment reports, site reports)	

	3. Perception of respect of health staff towards service users (listen to the patient, no shouting, hearing them out) 4. Perception of health service users on respecting punctuality/flexibility of working hours of health staff	3. Do you feel that health centre staff respects service users? Can you explain? 4. Do you feel that health centre staff is observing / respecting working hours? Can you explain?			3. No , they are unwelcoming , unfriendly. Treat service users as their beneficiaries and not people with rights to good health service. They behave as if they are doing a favour for the people (assessment reports) 4. No, Often start duties late, take more than an hour during lunch break, do not work during weekends, sometimes close health centre when they don't feel like working (assessment reports)	
2. Changes in the response of communities to health services and health service providers	Response of communities to health services 1. Utilization of health services, health seeking behaviour, Response of communities to health service providers 2. Perception of respect of health service users towards	1. Did you or any member of your household seek medical attention in the last 12 months? Where did you seek help? Why? 2. Do health centre staff feel that service users respect	Use disaggregate data	1. FGD; theatre; HMIS; interviews	1. (equity study 1 & 2, Site reports) 2. No, service users demand	

	health staff (no shouting, attitudes) 3. Perception of trust between the service user and the health staff (rights and responsibility, willingness, obligation, instead of demanding, more trust on responsibilities)	them? 3. Do service providers and users trust each other?			services disrespectfully, want their choice of treatment only, accuse health workers of theft without evidence, speak disrespectfully, verbal abuse. (site reports, scorecard reports, assessment reports) 3. No, each side considers the other in the wrong and with hidden agenda (site reports, scorecard, assessment reports)	
3. Changes in the way HCC', VHC's, DHMTs and health centres strengthen partnerships with each other	The way HCC's, VHC's, DHMTs and health centres strengthen partnerships (networks) with each other - planning, management, linkages, *Bear in mind that by partnerships we mean to include networks*	1. How do the institutions and different groups work together? 2. Do they work together during planning, management etc.? Can you give examples	Measure between HCC VHC DHMT Health centre - staff 4 levels: 8 different responses	Relationship & power relationship mapping; Venn Diagrams; FGDs; interviews	1. There is no coordination whatsoever. VHCs and HCC s not well established in most cases. No link with DHMT and between themselves and health staff (scorecard results, assessment reports) 2. No, except for DHMT and health staff who have	

		or share stories?			monthly meetings at HAMT level	
4. Changes in the way HCC and VHC are fulfilling their roles and responsibilities	Types of roles and responsibilities that HCC's and VHC's are fulfilling and to what extent. Expecting: - drug monitoring - joint planning - joint management - joint assessment of priorities - expressing voice How, quality and frequency Perception of the representativeness of the HCC's and the VHC's by the communities	1. What roles and responsibilities are the VHC's and HCC's fulfilling? How? 2. What roles and responsibilities are VHC's and HCC's supposed to fulfil in the community? How? 3. Are you satisfied with the level of representation VHC's and HCC's? Why?	HCC's and VHC's perception of the different groups in the community towards the committees Cross checking	Group discussions; trend analysis; ranking & scoring	1. Village inspection, promoting sanitation at H/H level. By house to house visits 2. Health education on U5, FP, sanitation, disease prevention, representing the people at health centre, work together with HSA, link with HCC. By holding village meetings, meetings with HCC and HC staff 3. No. Most are old and are chiefs who are not in tune or in contact with the younger generation and do not frequently use the health centre and also do not allow villager to express their views	
5. Shifts in the way service users demonstrate empowerment leading to the	1. Number and type of issues/concerns taken up to health centre by community representatives 2. Number and type of	1. What issues/concerns were taken up to the health centre in the last 12 months? How many? 2. What issues/concerns were	VHCs; HCCs; HC staff, DHMT	FGDs; participation spoke;	1.None	

claiming of rights	issues/concerns taken up to DHMT by community representatives 3. Proportion of institutions (VHC's, HCC's) that are able to take up issues to DHMT 4. Availability of support systems and informal safety-nets for different groups	taken up to the DHMT in the last 12 months? How many? On what and how many issues did you get a response 3. What support systems and informal safety-nets are available? Who is included and who is excluded from these systems and why?			2.None 3. Mostly none. Some have orphan care groups and VACs or rely on traditional ways of supporting each other in the community i.e. support during a funeral ceremony. Mostly the disabled, the elderly, orphans and the CI	
2. Changing relationships and linkages						
1. Changes in linkages between community, health centre, district and ministry level	1. Frequency and type of communication between community and health centres 2. Frequency and type of communication between health centres and DHMTs	1. What communication channels do you use to communicate on health issues? 2. How many times have you communicated with … in the past 12 months?	VHC, HCC, HC staff, DHMT	Power relations & Relationship mapping; group discussions; brainstorm *Secondary Data will be used to collect information on frequency and types of communication used in influencing Decentralization by LIFH.*	1. Verbal messages through the HSAs, written memos especially from DHO to HC, Verbal messages in meetings through HAMT parent, written memos to and from DHO and MoH 2. Meetings and memos mostly planned for monthly but not achieved. No consistent meetings held	

	3. Frequency and type of communication between DHMTs and Ministry of Health Headquarters 4. Frequency and type of communication between VHC's/HCC's and community members	3. Why have you been using these channels?			No particular frequency but depended on the pressing need at a particular time 3. They are the easiest and the ones that are institutionalised in the health process	
2. Changes in relationships between community, health centre staff and DHMT	1. Number and type of plans developed and implemented jointly by communities, VHC's, HCC's, HC's and DHMTs 2. Uptake / acceptance of responsibilities in improving health services by community (number and type, for example drug monitoring) 3. Responsibilities in improving health services accepted by health centre staff 4. Responsibilities in improving health services accepted by DHMTs (for example: supervision of staff, relocation of staff and resources)	1. What do you understand by joint planning, how would you define that? 2. How many plans have been developed jointly? 3. How many action plans that have been developed jointly, have been implemented in the past 12 months? 4. What were your responsibilities in the joint planning processes? 5. What responsibilities did you accept in improving the health services? In the joint planning process?	Community, VHC, HCC, HC staff, DHMT	FGD, Relationship mapping; trend analysis	1. 2. None 3.None 4. N/A 5. Assisting or working together with the HSA, volunteering at U5 clinics In the plan its none	
3. Changes in the access to policy	1. Level of participation of communities in planning	1. Are communities participating in planning	Community, VHC, HCC, HC	FGDs, Participation	1.No, because they do not know	

making/implementation processes by community voices at district and national level	processes 2. Level of participation of communities in implementation processes 3. Proportion of community priorities incorporated in the DIP's 4. Proportion of community priorities reflected in NHP's	processes? How? 2. Are communities participating in implementing activities? What activities? How? 3. Are community priorities incorporated in the DIPs? What activities? How many? How? 4. Are community priorities reflected in the NHP? What priorities? How many? How?	staff	spokes, spider web diagram	anything about planning processes 2. They participate but passively. Instructions largely come from the health centre. Examples are campaigns launched by DHO, by providing what is required of them eg. Children for vaccinations, nets for medication e.t.c 3. No. Mostly DIP is compiled from HAMT to DHMT levels with no community contribution 4.	
4. Changes in cultural practices in relation to health services delivery and consumption	Proportion of women and men in leadership positions Trends in health seeking behaviour	1. How many men, how many women are present in the VHC? HCC? HC? DHMT? 2. How many men, how many women hold leadership positions in these institutions? 3. Add a question on health seeking behaviour (when does one seek attention at the health centre? Why?)	VHCs, HCCs, HC staff, community	Observation (count), records; FGD (Health seeking behaviour)	1. 2. 3.	

5. Changes in information flows among service providers and users	The way information flows between districts, health centres and communities. Availability of information on drugs and supplies in the health centre The accessibility of information channels provided by the health centre for the communities The level of response of health centres to information provided by communities	1. Is information being shared? Among whom? Do the district and health facilities share information with one another? Do communities or their institutions and health facilities share information with each other? How? 2. Do the communities have information about drugs and supplies available at the health centre? How do they get this information? Is it enough? 3. Are the information channels accessible to the communities? How? To what extent? 4. What does the health centre do when it gets information from communities? How?	HC, DHMT, HCC, VHC, community	FGDs, Relationship mapping, interviews	1. Information generally moves from top to bottom but there not from bottom to top. There is however no horizontal sharing from community to community or institution to institution 2. No, it is supposed to be collected and shared by HCCs but it does not happen since HCCs are not functional 3. No. There are no links between VHC s and HCCs and VHCs do not really give feedback to their communities 4. If its information about disease outbreak the health centre dispatches HSAs to contain the matter. Not much information however has been brought to health centres by communities apart	

					from that of disease out breaks	
3) Institutional response						
1) Changes in the way drugs, medical supplies and equipment are being allocated between the DHMT, health centre, health post, DHO, communities. Allocation: managed distribution administration	1 The extent to which the process of allocating medical supplies from DHO to health centre is transparent and equitable. 2. The extent to which service users are aware / or have access to information on the allocation process and allocated amount of drugs, medical supplies and equipment. 3. The (perception) proportion of available drugs in the health centre meeting the demands from the service users. 4. The extent to which drugs, medical supplies and equipment are being equitable distributed by health service providers among users.	1. How are drugs/ medical supplies allocated to health centres? 2. How do you know this, where do you find this information? 3. Do you think that the drugs/ medical supplies received by the health centre are adequate, to cover the health centre needs? 4. What is the process of drug allocation to the health centre like? How did you know this? 5. Do you feel drugs/medical	Who do we ask? Community members, VHCs, HCCs, HC staff, DHMT *At all three levels?*	FGDs, ranking & scoring *Number/proportion of households accessing health services*	1. Districts collect requisitions from HCs and order from CMS. Drugs are allocated to districts, who distribute to health centres as and when they please. 2. Only district knows how much drugs are allocated, but no one knows what process/criteria is used. 3. The drugs are not enough. They are hardly enough to satisfy the catchments of the health centres for 2 weeks. In every month. 4. The district decides how much drugs to allocate to health centres. Only the district officials know the process, not the HC or the community representatives. 5. The health	

		supplies are equitably dispensed by health centre staff and health surveillance assistant?			workers favour their relatives and friends, and other officials and students/pupils. They do not give the poor people in the village adequate drugs. They also do not give drugs to the aged people, because "they say it is a waste of scarce resources" to treat old people, who are already going to die anyway.	
2) More innovative and appropriate responses from health service providers towards the health needs of the communities	1. The type of responses by VHC's to the health needs of the communities 2. The type of responses by HCC's to the health needs of the communities 3. The type of responses by Health centres to the health needs of the communities	1. How does the VHC, HCC, HC staff respond to the health needs of the community?	Communities, VHCs, HCCs, HC staff	FGDs, ranking & scoring, power relations mapping, theatre	1. Either there is no VHC, or the VHC does not know its responsibilities; the community does not know the VHC's responsibilities. No community member goes to the VHC for any issues. The VHC only distributes Chlorine if and when it is available. 2. Either there is no HCC, or the HCC does not	

					know its responsibilities. It comprises of chiefs and is not representative for the entire HC catchment.	
3) Changes in processes and mechanisms used within DHMTs, Health centres, VHC's, HCC's and between them.	1. Number and type of accountability and transparency mechanisms and processes used within and between these institutions 2. Election procedures for establishing the VHC's and HCC's.	1. How was your committee established? 2. How do you or your committee inform the all stakeholders at all levels about your activities? 3. What kind of activities do you report on? To whom and how do you report? 4. How often do you provide information to each other? Why?	VHC, HCC, HC staff, DHMT, community	FGDs	1. The chief/HSA chose people to be in the VHC. The medical assistant chose people to be in the HCC 2. The medical assistant gives a message to a patient to give to their chief, for the whole village. Sometimes it is not necessary to tell the community about everything. 3. We do not have to report on anything to anyone. Everyone just performs their functions in their own respect. 4. The health centre puts up a notice on the board and gives messages to churches when there are visiting specialists coming	

					to the facility.	
4) Influence on programming and processes within and outside of CARE	1. The number of organisations (NGO's) that adopted LIFH's accountability and transparency mechanism and processes 2. The number of projects within CARE that adopted LIFH's accountability and transparency mechanisms and processes	1. What organizations have approached LIFH to learn about the social mapping and scorecard processes so as to employ them in their work? 2. What organizations have adopted LIFH's approach and processes? 3. Which CARE projects have approached LIFH to learn about the rights-based participatory methodologies and processes so as to employ them in their projects? Which CARE projects have adopted LIFH's processes?	LIFH, CARE staff, DHMT, HC	Interviews, FGDs	1. No one knows about the LIFH Project's rights' based approach and the scorecard process. The LIFH Project is the pioneer of the process.	
5) Initiatives translated into action by VHCs, HCCs, HC Staff and DHMT	1. Proportion of initiatives translated into action by VHCs 2. Proportion of initiatives translated into action by HCCs 3. Proportion of initiatives translated into action by HC staff 4. Proportion of initiatives translated into action by DHMT	1. How many initiatives were planned by the VHC/HCC/HC/DHMT over the last 12 months? 2. How many of the planned initiatives have been implemented?	Community, VHCs, HCCs, HCs, DHMTs	FGDs, road/river, (monitoring registers)	1. The Ministry of Health Headquarters plans what should happen in each and every district. The district plans what should be implemented in the rural health centres. They are the ones who decide what is important and implement only those plans.	
4. Sustainability of achievements						
1) Extent of institutionalisation of mechanisms and processes of	1.Proportion of VHCs/HCCs demonstrating understanding of key processes (scorecard and social mapping)	1. Do you know the social mapping and scorecard processes? (VHC,HCC,HC) If yes, describe (i) social	VHCs, HCCs, HC staff, DHMT	FGDs, road/river/bus	1. We have never heard about the scorecard or social mapping	

transparency and accountability at community health centre and district levels	2. Proportion of health centres demonstrating understanding of key processes (scorecard and social mapping) 3.Proportion of health centres using the processes (scorecard and social mapping) 4. Proportion of VHCs/HCCs using key processes (scorecard and social mapping) 5. Proportion of villages in which the Health Centre is using the key processes and mechanisms. 6. Proportion of health centres using key processes (scorecard and social mapping) 7. Proportion of VHCs/HCCs that have adopted key processes (scorecard and social mapping) 8. Proportion of health centres that have adopted key processes (scorecard and social mapping)	mapping process (ii) scorecard process. 2. Have you ever used the processes? 3. If yes, when and how many times have you used each of the processes? And how have you used each of the processes? 4. Where have you used the processes? (HC) 5. Do you feel comfortable or capable of using the processes by yourself without the support of LIFH Project?			processes. We are seeing this for the first time. We have never used the processes.	
2) Changes in LIFH's contribution to strengthening the SWAp at national level	1. LIFH's understanding of the SWAp process	1. How does the LIFH Project understand the SWAp process?	LIFH staff, DHMT, DFID, MoH	Interviews, secondary data, participation spokes	1. The LIFH Project looks at the SWAp as a harmonised approach or plan or perspective for the health sector	

					in the country, drawing lessons from all stakeholders in the health sector.	
	2. LIFH's effort of linking into the SWAp	2. What has the LIFH Project done in linking to the SWAp process? How much has the LIFH Project done in linking to the SWAp? Is it enough? Why?			2. The LIFH Project has chosen to advocate for the realisation of the EHP, which is one of the pillars of the SWAp.	
	3. Donor's contribution towards supporting LIFH's linkages into the SWAp	3. What have the donors done in supporting the LIFH Project's linkages to the SWAp? Is it enough? Why?			3. Nothing yet!	
	4. LIFH's expertise on advocacy strategies and policy influencing	4. What skills and expertise does the LIFH Project staff have in advocacy and policy influence? Is it enough? Why?			4. Some of the LIFH Project staff have skills in advocacy at local and community levels, but still need to sharpen their skills to be able to influence national policies.	
	5. Participation in relevant/strategic partnerships	5. What strategic/relevant partnerships for the SWAp are there in the health sector? In which of these partnerships is the LIFH Project participating? Is it enough? Why?			5. The LIFH Project can link into the SWAp using its membership in the MHEN. The MHEN is a civil society organisation that brings together various players and advocate for	

					policy changes that reflect on equity in health in the country	
3) Changes in the perceived vision of the future of Health services by communities, HCCs , health staff and DHMT	1.Perceived vision of health services among communities 2. Perceived vision of health services among VHCs 3.Perceived vision of health services among HCCs 4. Perceived vision of health services among Health centre staff 5. Perceived vision of health services among DHMT members	1. How do communities want their health services in their facilities to look like? Why? 2. How do the VHCs want health services in their facilities to look like? Why? 3. How do the HCCs want health services in their facilities to look like? Why?	Community, VHCs, HCCs, HCs, DHMT	FGD, Road, river, busometer	1. The communities want a bigger health centre that has drugs throughout the year. They also want a health centre right in or close to their village. They want to have at least a borehole in each and every village. They want to the government to have san plats. 2. The VHCs (if they are there at all) want to have HSAs at least in every 3 or 4 villages. They want to have chlorine for their shallow wells all year round. 3. The HCCs (if and where they are there at all) want the health centre to have adequate drugs. They want bicycles for each one of the	

		4. How do health centre staff want health services in their facilities to look like? Why? 5. How do DHMT members want health services in health facilities in their district to look like? Why?			members in order to reach out to the entire health centre catchment area. They also want to have a bigger health centre, where they should have all the health services (including surgical and admissions). 4. The HC staff want to have more staff in the facility. They want to have new and adequate equipment and infrastructure. They want to have a community that listens to what they say. They want a community that come to the facility in good time, not nearing closing hours. They want a community that understands the health workers and does not "demand" excellent service. 5. The DHMT wants to receive good and timely reports from all	

					health facilities. They do not expect the health facility workers or the communities to question what they say and do. They want the MoH Headquarters to allocate funds to the districts as much as they requested for. They do not want to have any drug stock outs in the district.	
4) Changes in the perceived image /reputation of health services by communities, HCCs , health staff and DHMT	1.Perceived image/reputation of health centre and services among communities 2. Perceived image/reputation of health centre and services among VHCs 3.Perceived image/reputation of health centre and services among HCCs 4. Perceived image/reputation of health centre and services among Health centre staff 5. Perceived image/reputation of health services among DHMT members	1. What do the communities think that the other stakeholders (VHCs, HCCs, HC staff, DHMT) think about them in relation to contribution to the improvement of health service delivery? Why? 2. What do the VHCs think that the other stakeholders (communities, HCCs, HC staff, DHMT) think about them in relation to contribution to the improvement of health service	Community, VHCs, HCCs, HCs, DHMT	FGD, Road, river, busometer	1. The communities think that their fellow community members understand them, but the HCC, HC and DHMT does not care about them, and think that they cannot make any contribution towards improving health services. 2. The VHC (if and where it exists at all) thinks that it all it needs to do is to encourage sanitation and	

		delivery? Why? 3. What do the HCCs think that the other stakeholders (communities, VHCs, HC staff, DHMT) think about them in relation to contribution to the improvement of health service delivery? Why? 4. What does the health centre staff think that the other stakeholders (communities, VHCs, HCCs, DHMT) think about them in relation to contribution to the improvement of health service delivery? Why?			hygiene activities in their village. It does not have to be accountable to anyone since they are just volunteers 3. The HCC (if and where it exists) thinks that all it has to do is encourage the same activities that the VHCs does. It also does not see any need to be accountable to anyone. 4. The HC staff feel that they are knowledgeable since they went for professional training and does not have to be accountable to anyone. They know what every patient needs and decides what to give them without any explanations. The communities are rude and it is not necessary to listen to them. The DHMT should know about all the problems about the health centre,	

		5. What do the DHMTs think that the other stakeholders (communities, VHCs, HCCs and HC staff,) think about them in relation to contribution to the improvement of health service delivery? Why?			therefore no need for reminding them to do what they are already supposed to do. 5. The government does not have money, and everyone can see that, so why should anyone ask for explanations when there is shortage of resources to health centres? We will give them more resources when "government" gives us more resources. It is not necessary to go and get views from communities because decisions should be made by "government"	
5) Shifts in power relationships between health staff, service users and other social groups	1. Participation of 'service users' in decision making processes (DIPs, Scorecard, Joint planning) 2. Participation of 'other social groups' in decision making processes(DIPs, Scorecard, Joint planning) 3. Participation of 'health staff' in decision making processes (DIPs, Scorecard,	1. Do community members or their representatives participate in DIP, scorecard and joint planning processes around health issues? How? To what extent? 2. Do 'other social groups' of people participate in DIP, scorecard and joint planning processes around health issues? How? To what extent?	Disaggregated data Who? - women, female headed households, child headed households, orphans, elderly, the chronically ill, health staff,	FGD, Power relationship mapping, participation spokes, trends analysis,	1. It is not necessary to involve communities and health centres in planning and DIPs. The DHMT knows all the problems and needs in the district and will	

	Joint planning)	3. Do health staff participate in DIP, scorecard and joint planning processes around health issues? How? To what extent?	DHMT, Ministry of health, members of parliament		include all the priorities in the DIP. If and when government gives the district money, the DHMT will decide what to use the money for	

Annex 10: topic guides

a. Topic guide/checklist for discussions with district health management team members

(For each of the questions, ask for "how was before the LIFH Project; and how is it today?")

1. How do you work together with VHCs, HCCs and HC staff? Do you work together during planning, management? Explain and share stories.

2. What roles and responsibilities are VHCs and HCCs fulfilling? How? What roles and responsibilities are they supposed to fulfil? How? Are you satisfied with the way VHCs and HCCs are fulfilling their roles and responsibilities? Explain and give stories.

3. Do the VHCs, HCCs and HC staff bring up any issues from the community? What kind of issues? How often? What are the responses that you give? Do you take up any issues from the community/HCs to the headquarters? What kind of issues? How often? What kind of responses do you get/have you got?

4. What communication channels do you use to communicate on health issues? How many times have you communicated with VHCs, HCCs, and HC staff in the past 12 months? Why have you been using these channels?

5. What do you understand by joint planning, how would you define that? How many plans have been developed jointly? How many action plans that have been developed jointly, have been implemented in the past 12 months? What were your responsibilities in the joint planning processes? What responsibilities did you accept in improving the health services in the joint planning process?

6. Do communities participate in planning processes? How? Do communities participate in implementing activities? What activities? How? Are community priorities incorporated in the DIPs? What activities? How many? How? Are community priorities reflected in the NHP? What priorities? How many? How?

7. How many men, how many women are present in the VHC? HCC? HC? DHMT? How many men, how many women hold leadership positions in these institutions? When does one seek attention at the health centre? Why?

8. Do you share information? With whom? Do share information with the district? Do you share information with communities and VHCs and the HCC? How? Do the communities have information about drugs and supplies available at the health centre? How do they get this information? Is it enough? Are the information channels accessible to the communities? How? To what extent? What does the health centre do when it gets information from communities? How?

9. How are drugs/medical supplies allocated to this health centre? How do you know this/where do you find this information? Do you think that the drugs/medical supplies received by the health centre are adequate, to cover the health centre needs? What is the process of drug allocation to the health centre like? How did you know this? Do you feel drugs/medical supplies are equitably dispensed by health centre staff and health surveillance assistant?

10. How do you respond to the health needs of the community?

11. How were your VHCs and HCC established? How do your VHC and HCC inform the all stakeholders at all levels about your activities? What kind of activities do your VHC and HCC report on? To whom and how do the VHC and HCC report? How often do they provide information to each other? Why?

12. How many initiatives were planned by the HC/HCC/HC/DHMT over the last 12 months? How many of the planned initiatives have been implemented?

13. Do you know social mapping and scorecard processes? If yes, describe (i) social mapping process (ii) scorecard process. Have you ever used the processes? If yes, when and how many times have you used each of the processes? And how have you used each of the processes? Where have you used the processes? Do you feel comfortable or capable of using the processes by yourself without the support of LIFH Project?

14. How do you want services in your health facility to look like? Why?

15. What do you think that the other stakeholders (communities, VHCs, HCCs, DHMT) think about you in relation to your contribution to the improvement of health service delivery? Why?

16. Do you participate in DIP, scorecard and joint planning processes around health issues? How? To what extent?

b. Topic guide/checklist for discussions with health workers

(For each of the questions, ask for "how was before the LIFH Project; and how is it today?")

1. How do you work together with VHCs, HCCs and DHMTs?

2. Do you work together during planning, management? Explain and share stories.

3. Do the VHCs & HCCs bring up any issues from the community? What kind of issues? How often? What are the responses that you give? Do you take up any issues from the community to the DHMT? What kind of issues? How often? What kind of responses do you get/have you got? Are there any support systems that you know of/created?

4. What communication channels do you use to communicate on health issues? How many times have you communicated with VHCs, HCCs, and DHMT in the past 12 months? Why have you been using these channels?

5. What do you understand by joint planning, how would you define that? How many plans have been developed jointly? How many action plans that have been developed jointly, have been implemented in the past 12 months? What were your responsibilities in the joint planning processes? What responsibilities did you accept in improving the health services? In the joint planning process?

6. Do communities participate in planning processes? How? Do communities participate in implementing activities? What activities? How? Are community priorities incorporated in the DIPs? What activities? How many? How? Are community priorities reflected in the NHP? What priorities? How many? How?

7. How many men, how many women are present in the VHC? HCC? HC? DHMT? How many men, how many women hold leadership positions in these institutions? When does one seek attention at the health centre? Why?

8. Do you share information? With whom? Do share information with the district? Do you share information with communities and VHCs and the HCC? How? Do the communities have information about drugs and supplies available at the health centre? How do they get this information? Is it enough? Are the information channels accessible to the communities? How? To what extent? What does the health centre do when it gets information from communities? How?

9. How are drugs/medical supplies allocated to this health centre? How do you know this/where do you find this information? Do you think that the drugs/medical supplies received by the health centre are adequate, to cover the health centre needs? What is the process of drug allocation to the health centre like? How did you know this? Do you feel drugs/medical supplies are equitably dispensed by health centre staff and health surveillance assistant?

10. How do you respond to the health needs of the community?

11. How were your VHCs and HCC established? How do your VHC and HCC inform the all stakeholders at all levels about your activities? What kind of activities do your VHC and HCC report on? To whom and how do the VHC and HCC report? How often do they provide information to each other? Why?

12. How many initiatives were planned by the HC/HCC/HC/DHMT over the last 12 months? How many of the planned initiatives have been implemented?

13. Do you know social mapping and scorecard processes? If yes, describe (i) social mapping process (ii) scorecard process. Have you ever used the processes? If yes, when and how many times have you used each of the processes? And how have you used each of the processes? Where have you used the processes? Do you feel comfortable or capable of using the processes by yourself without the support of LIFH Project?

14. How do you want services in your health facility to look like? Why?

15. What do you think that the other stakeholders (communities, VHCs, HCCs, DHMT) think about you in relation to your contribution to the improvement of health service delivery? Why?

16. Do you participate in DIP, scorecard and joint planning processes around health issues? How? To what extent?

c. Topic guide/checklist for discussions with health centre committees

(For each of the questions, ask for "how was before the LIFH Project; and how is it today?")

1. How do the health workers receive you? What mechanisms are there for reception of patients? Do you feel do you feel respected by health workers? Do you feel that your privacy is respected? Explain.

2. Do you feel that health staff observes official working hours? Explain.

3. Did you or any member of your household seek medical attention in the last 12 months? Where did you seek help? Why? Do you respect the health workers? Do you trust the health workers? Explain

4. Do you trust the health workers at your health centre? Do you think they trust you?

5. How do you work with VHCs, HC staff and DHMT? Do you work together in planning and management? How? Explain and share stories/examples.

6. What roles and responsibilities are you fulfilling? How? What roles and responsibilities are you supposed to fulfil in the community? How? Are you satisfied with your level of representation? Why?

7. Do you take up any issues from the community to the health centre? What kind of issues? How often? What are the responses that you give? Do you take up any issues from the community up to the HC staff/DHMT? What kind of issues? How often? What kind of responses do you get/have you got? Are there any support systems that you know of/created?

8. What communication channels do you use to communicate on health issues? How many times have you communicated with HC staff, VHCs, and DHMT in the past 12 months? Why have you been using these channels?

9. What do you understand by joint planning, how would you define that? How many plans have been developed jointly? How many action plans that have been developed jointly, have been implemented in the past 12 months? What were your responsibilities in the joint planning processes? What responsibilities did you accept in improving the health services? In the joint planning process?

10. Do you participate in planning processes? Do communities participate in planning processes? How? Do communities participate in implementing activities? What activities? How? Are community priorities incorporated in the DIPs? What activities? How many? How? Are community priorities reflected in the NHP? What priorities? How many? How?

11. How many men, how many women are present in the VHC? HCC? HC? DHMT? How many men, how many women hold leadership positions in these institutions? When does one seek attention at the health centre? Why?

12. Do you share information? With whom? Do you share information with the communities, VHCs, HC staff and DHMT? How? Do the communities have information about drugs and supplies available at the health centre? How do they get this information? Is it enough? Are the information channels accessible to the communities? How? To what extent? What does the health centre do when it gets information from you or the communities? How?

13. How are drugs/medical supplies allocated to your health centre? How do you know this/where do you find this information? Do you think that the drugs/medical supplies received by the health centre

are adequate, to cover the health centre needs? What is the process of drug allocation to the health centre like? How did you know this? Do you feel drugs/medical supplies are equitably dispensed by health centre staff and health surveillance assistant?

14. How do you respond to the health needs of the community?

15. How was your HCC established? How does your HCC inform the all stakeholders at all levels about your activities? What kind of activities does your report on? To whom and how does the HCC report? How often do you, your VHC and HC staff provide information to one another? Why?

16. How many initiatives did you plan with the VHCs/HC/DHMT over the last 12 months? How many of the planned initiatives have been implemented?

17. Do you know social mapping and scorecard processes? If yes, describe (i) social mapping process (ii) scorecard process. Have you ever used the processes? If yes, when and how many times have you used each of the processes? And how have you used each of the processes? Where have you used the processes? Do you feel comfortable or capable of using the processes by yourself without the support of LIFH Project?

18. How do you want services in your health facility to look like? Why?

19. What do you think that the other stakeholders (communities, VHCs, HC staff, DHMT) think about you in relation to your contribution to the improvement of health service delivery? Why?

20. Do you participate in DIP, scorecard and joint planning processes around health issues? How? To what extent?

d. Topic guide/checklist for discussions with village health committees

(For each of the questions, ask for "how was before the LIFH Project; and how is it today?")

1. How do the health workers receive you? What mechanisms are there for reception of patients? Do you feel do you feel respected by health workers? Do you feel that your privacy is respected? Explain.

2. Do you feel that health staff observes official working hours? Explain.

3. Did you or any member of your household seek medical attention in the last 12 months? Where did you seek help? Why? Do you respect the health workers? Do you trust the health workers? Explain

4. Do you trust the health workers at your health centre? Do you think they trust you?

5. How do you work with HCC, HC staff and DHMT? Do you work together in planning and management? How? Explain and share stories/examples.

6. What roles and responsibilities are you fulfilling? How? What roles and responsibilities are you supposed to fulfil in the community? How? Are you satisfied with your level of representation? Why?

7. Do you take up any issues from the community to the health centre? What kind of issues? How often? What are the responses that you give? Do you take up any issues from the community up to the HCC/HC staff/DHMT? What kind of issues? How often? What kind of responses do you get/have you got? Are there any support systems that you know of/created?

8. What communication channels do you use to communicate on health issues? How many times have you communicated with HC staff, HCCs, and DHMT in the past 12 months? Why have you been using these channels?

9. What do you understand by joint planning, how would you define that? How many plans have been developed jointly? How many action plans that have been developed jointly, have been implemented in the past 12 months? What were your responsibilities in the joint planning processes? What responsibilities did you accept in improving the health services? In the joint planning process?

10. Do you participate in planning processes? Do communities participate in planning processes? How? Do communities participate in implementing activities? What activities? How? Are community priorities incorporated in the DIPs? What activities? How many? How? Are community priorities reflected in the NHP? What priorities? How many? How?

11. How many men, how many women are present in the VHC? HCC? HC? DHMT? How many men, how many women hold leadership positions in these institutions? When does one seek attention at the health centre? Why?

12. Do you share information? With whom? Do you share information with the HCC and HC staff? How? Do the communities have information about drugs and supplies available at the health centre? How do they get this information? Is it enough? Are the information channels accessible to the communities? How? To what extent? What does the health centre do when it gets information from you or the communities? How?

13. How are drugs/medical supplies allocated to your health centre? How do you know this/where do you find this information? Do you think that the drugs/medical supplies received by the health centre are adequate, to cover the health centre needs? What is the process of drug allocation to the health centre like? How did you know this? Do you feel drugs/medical supplies are equitably dispensed by health centre staff and health surveillance assistant?

14. How do you respond to the health needs of the community?

15. How was your VHC established? How does your VHC inform the all stakeholders at all levels about your activities? What kind of activities does your report on? To whom and how does the VHC report? How often do you and your HCC provide information to each other? Why?

16. How many initiatives did you plan with the HCC/HC/DHMT over the last 12 months? How many of the planned initiatives have been implemented?

17. Do you know social mapping and scorecard processes? If yes, describe (i) social mapping process (ii) scorecard process. Have you ever used the processes? If yes, when and how many times have you used each of the processes? And how have you used each of the processes? Where have you used the

processes? Do you feel comfortable or capable of using the processes by yourself without the support of LIFH Project?

18. How do you want services in your health facility to look like? Why?

19. What do you think that the other stakeholders (communities, HCCs, HC staff, DHMT) think about you in relation to your contribution to the improvement of health service delivery? Why?

20. Do you participate in DIP, scorecard and joint planning processes around health issues? How? To what extent?

e. Topic guide/checklist for discussions with service users (Men, women, boys and girls, aged, disabled, chronically ill, female-headed households, child-headed households, orphans and other social groups)

(For each of the questions, ask for "how was before the LIFH Project; and how is it today?")

1. How do the health workers receive you? What mechanisms are there for reception of patients? Do you feel do you feel respected by health workers? Do you feel that your privacy is respected? Explain.

2. Do you feel that health staff observes official working hours? Explain.

3. Did you or any member of your household seek medical attention in the last 12 months? Where did you seek help? Why? Do you respect the health workers? Do you trust the health workers? Explain

4. What roles and responsibilities are the VHC's and HCC's fulfilling? How? What roles and responsibilities are VHC's and HCC's supposed to fulfil in the community? How? Are you satisfied with the level of representation VHC's and HCC's? Why?

5. Have you taken up any issues to the VHC/HCC/health centre/DHMT in the last 12 months? What issues? What was the response? Explain.

6. Are there any support systems and/or informal safety-nets available? Who is included and who is excluded from these systems, and why?

7. What communication channels do you use to communicate on health issues? How many times have you communicated with VHC/HCC/HC staff/DHMT in the past 12 months? Why have you been using these channels?

8. What do you understand by joint planning, how would you define that? How many plans have been developed jointly? How many action plans that have been developed jointly, have been implemented in the past 12 months? What were your responsibilities in the joint planning processes? What responsibilities did you accept in improving the health services? In the joint planning process?

9. Do you participate in planning processes? How? Do you participate in implementing activities? What activities? How? Are your priorities incorporated in the DIPs? What activities? How many? How? Are your priorities reflected in the NHP? What priorities? How many? How?

10. How many men, how many women are present in the VHC? HCC? HC? DHMT?

11. When does one seek attention at the health centre? Why?

12. Do you share information? With whom? Do you think the district and health facilities share information with each another? Do you or your VHC and health facilities share information with one another? How? Do you have information about drugs and supplies available at the health centre? How do you get this information? Is it enough? Are the information channels accessible to you? How? To what extent? What does the health centre do when it gets information from you? How?

13. Do you know how drugs/medical supplies are allocated to health centres? How do you know this, where do you find this information? Do you think that the drugs/medical supplies received by the health centre are adequate, to cover the health centre needs? What is the process of drug allocation to the health centre like? How did you know this? Do you feel drugs/medical supplies are equitably dispensed by health centre staff and health surveillance assistant?

14. How does the VHC, HCC and HC staff respond to your health needs?

15. How were your VHC and HCC established? How do your VHC and HCC inform the all stakeholders at all levels about your activities? What kind of activities do your VHC and HCC report on? To whom and how do the VHC and HCC report? How often do they provide information to each other? Why?

16. How many initiatives were planned by the VHC/HCC/HC/DHMT over the last 12 months? How many of the planned initiatives have been implemented?

17. How do you want services in your health centre to look like? Why?

18. What do the you think that the other stakeholders (VHCs, HCCs, HC staff, DHMT) think about you in relation to your contribution to the improvement of health service delivery? Why?

19. Do you or your representatives participate in DIP, scorecard and joint planning processes around health issues? How? To what extent?

Annex 11: Participatory tools used

1) Interviews *(individual household interviews)*
2) Group discussions *(with men, women, VHCs, HCCs, HC staff, DHMTs)*
3) Social mapping *(to identify various households for interviews)*
4) Power relationship mapping *(to identify shifts in power relations between service providers and users)*
5) Busometer *(to map out extent of change/improvement in health service delivery)*
6) River/road *(same as the Busometer above)*
7) Venn diagram *(to map out linkages and relationships between and among institutions)*
8) Ranking & scoring *(to map out strength of change)*
9) Participations spokes *(to measure the level of participation)*
10) Direct observation
11) Trend analysis
12) Literature review

Annex 12: Program for fieldwork

Program for fieldwork for LIFH Project's RBA and M&E Consolidation Process:

No.	Date	Time	Activity	Location	Who
1	Thursday 7th April 2005	13.00 – 15.00	Meeting with VHC and community 1; identify various social groups in village 1	Chileka	2 people
		13.00 – 15.00	Meeting with VHC and community 2; identify various social groups in village 2	Chileka	2 people
		13.00 – 15.00	Meeting with HCC	Chileka	2 people
2	Friday 8th April 2005	09.00 – 11.00	Meeting with HC staff	Chileka	1 person
		09.00 – 11.00	Meeting with DHMT	Lilongwe	2 people
		11.30 – 13.30	Meet various social groups in village 1	Chileka	2 people
		11.30 – 13.30	Meet various social groups in village 2	Chileka	2 people
		11.00 – 12.00	*Meeting with HAMT?*	Chileka	1 person
		14.30 – 16.30	Debriefing	CARE Office	Team
3	Monday 11th April 2005	09.00 – 11.00	Meeting with HC staff	Mzandu	1 person
		09.00 – 11.00	Meeting with HCC	Mzandu	1 person
		09.00 – 12.00	Meeting with VHC and community 1; identify various social groups in village 1	Ngwewa (Mzandu)	2 people
		09.00 – 12.00	Meeting with VHC and community 2; identify various social groups in village 2	Njolo (Mzandu)	2 people
4	Tuesday 12th April 2005	09.00 – 12.00	Meet various social groups in village 1	Ngwewa	2 people
		09.00 – 12.00	Meet various social groups in village 2	Njolo	2 people
		09.00 – 11.00	Meeting with HCC	Mkhuzi	1 person
5	Wednesday 13th April 2005	09.00 – 11.00	Meeting with HC staff	Mkhuzi	2 people
		09.00 – 12.00	Meeting with VHC and community 1; identify various social groups in village 1	Thengeza (Mkhuzi)	2 people
		09.00 – 12.00	Meeting with VHC and community 2; identify various social groups in village 2	Mtachira (Mkhuzi)	2 people
6	Thursday 14th April	09.00 – 12.00	Meet various social groups in village 1	Thengeza	3 people
		09.00 – 12.00	Meet various social groups in village 2	Mtachira	3 people
7	Friday 15th April	09.00 – 11.00	Meeting with DHMT	Ntchisi	2 people

Annex 13: Some of the findings from various groups

1. **Health Centre Committee findings:**

	Indicator	Analysis/Synthesis
1.0 Voice and accountability		
1.1	Response of health workers towards community	✓ Reception of patients, which used to be very poor, has improved: ▪ Introduction of numbering and queuing system, which ensures adherence to first-come-first-served policy ▪ No more shouting at patients.[25] ✓ Staff punctuality has improved. Health workers now report to work on time (at least early); and "really" report for work after lunch. The health centres also now offer emergency services (services after normal working hours) and on Saturdays.[26] ✓ There has not been very positive attitude in some health workers, such as cleaners (specific for Chileka) and some HSAs towards community member and HCCs especially when dealing with supplementary feeding materials such as Soya
1.2	Response of communities to services and providers	✓ Initially, the HCC did not participate in any activities at the HC, but now participate in monitoring drugs and supplies at the HC – they have accepted the responsibility to represent the community and ensure transparency and accountability among the health workers, and improve trust between the service users and service providers
1.3	Strengthening partnerships with other institutions	✓ There were no working relationships between HCCs and VHCs and HC staff – the HCCs did not know their roles and responsibilities. but there is now a strengthened relationship between VHCs and HCCs, such that issues from the communities come to the HCC through the VHCs ✓ HCC is strengthening networks with communities through the VHCs and community leaders to contribute to development activities at the HCs (such as construction of a carport for the ambulance at Chileka; and construction of guardian shelter at Mzandu HC)
1.4	Fulfilling responsibilities	✓ Initially, HCCs comprised of community leaders from lose to the HC, because they were there to discipline HC staff that misbehaved – there were no regular meetings with the HC staff. But now, HCC members are drawn from a cross-section of the HC catchment and comprise a diversity of groups of people. ✓ HCCs are now involved in witnessing receipt of drugs at the HC, as entities representing the entire community ✓ HCCs are now involved in monitoring drugs and medical supplies through updating of notice boards on quantities of available stocks ✓ The HCCs report to community leaders on progress of development

[25] And the dentist at Chileka HC does not send people (those who have not cleaned their mouths) back anymore. He gives treatment to everyone.

[26] However, community members from Mkhuzi HC catchment complained that the HC is no longer providing services on Saturdays due to an agreement that the HCC made with the HC staff.

		activities taking place at the HC ✓ The HCCs check on selling of illegal drugs ✓ The HCCs encourage hygiene and sanitation activities in the communities
1.5	Demonstration of empowerment	✓ Initially, the HCC did not work with the DHMT at all, thus they did not take any issues up with the DHMT. There is a working relationship between the HCCs and the DHMTs as the latter have introduced an open-door policy[27] ✓ HCCs have been receiving complaints from the communities and VHCs on issues such as prescription of a "inadequate" drugs, and HCCs have discussed the issue with HC staff and provided some civic education on the use and appropriateness of prescriptions of drugs[28] ✓ HCCs have been taking up issues concerning their HCs and communities directly to the DHMT and the DHMTs have responded accordingly by offering what they can.
2.0 Changing relationships		
2.1	Linkages between institutions	✓ Initially, communication was done by word of mouth and on ad hoc basis, which made commitment difficult as there were no reference points. But at present, communication to and from DHMT, HC staff, traditional/community leaders, VHCs and community members is done through the use of letters, wireless message and meetings ✓ The HCCs communicate with DHMTs at least quarterly, and more frequently with the HC staff, VHCs and communities, whenever need for such communication arises
2.2	Relationships between institutions	✓ Initially, the HCC did not make any joint plans with other institutions. They only carried out activities on ad hoc basis, and in isolation. They are now involved in formulation and implementation of joint action plans with VHCs, HC staff, DHMTs, community leaders, community members ✓ The HCCs have been involved in formulation of joint plans for at least twice (utmost thrice) each during the interface meetings held with DHMTs, HC staff, VHCs, CARE and community members
2.3	Access to higher levels	✓ Initially, the HCC was never involved in DIP processes. The HCCs are now involved in formulation of DIPs, and are expected to participate in implementation, monitoring and evaluation of the DIPs
2.4	Cultural practices	✓ HCCs used to compose of mostly chiefs, but now has a diversity of social groups, and women now occupy such influential positions as

[27] For example, Chileka HCC directly went to Lilongwe DHMT and lobbied for an ambulance to be based/operate from Chileka HC, which they were later given; One HSA at Mkhuzi HC was trained in VCT but VCT services were not being offered due to lack of test kits. The HCC took the issue up with DHMT and managed to get the VCT test kits to the HC, and the VCT services are now being provided at the HC.

[28] Mzandu HC has a nurse working on relief basis because the regular nurse is on leave. Community members raised a concern that the relief nurse was not prescribing adequate drugs as their regular nurse used to, and the HCC took the matter up with the HC staff, and then had audience with the nurse, who explained what criteria she uses when prescribing drugs. The HCC, after understanding the position of the nurse, went on to civic educate the community on the appropriateness and relevance of prescriptions, which the community understood.

		Secretary (the proportion of men to women in the HCCs is now 1 to 1, or at least 3 to 2) ✓ There used to be a high occurrence of deliveries done at TBAs (at least 50% of the pregnancies), but that has reduced now as more women have started using the HCs for deliveries (up to 70% of the deliveries)
2.5	Information flows between institutions	✓ There used to be no forum for sharing information, both from other institutions to HCCs and from the HCCs to the other institutions. The HC now shares information on drug availability with the HCC through the drug monitoring, and the HCCs share this information with the community members through meetings with the VHCs, notice boards, and also directly to the community members in one-to-one conversations whenever interested people ask the HCC members
3.0 Institutional response		
3.1	Allocation of drugs, supplies and equipment	✓ The HCCs did (and still do) not know how drugs are allocated to their HCs, but suspect that the drugs are allocated basing on the catchment populations of the HC. Drug availability is not adequate because drugs are only available 75% of the times (3 weeks in a month), and in Ntchisi (Mzandu and Mkhuzi), it is about 50% of the time because of the irregular deliveries of the drugs.
3.2	Responses to the health needs of communities	✓ The HCCs receive reports (and often complaints) from VHCs and community members on issues regarding the HC, and when they take the issues up and discuss with HC staff or DHMT, they give feedback to the communities through meetings with the VHCs
3.3	Processes and mechanisms used within institutions	✓ The HCCs are not aware of how the former HCCs were formed, but are aware that most of the members were chiefs. All the current HCCs were elected by chiefs from the catchments of the HCs, and comprise of a diversity of professionals, including religious leaders, traditional leaders, councillors and HC staff, among others. ✓ All the current VHCs report to the people who use the HCs on activities taking place at the HC through meetings with the VHCs and the chiefs
3.5	Initiatives translated into action	✓ Initially, the HCCs did not advance any initiatives. But at present, all the HCCs are now busy taking initiatives to develop their HCs by various construction works.[29] ✓ One of the HCCs (Chileka) is also lobbying with the DHMT to reintroduce mobile clinics to reduce congestion at the HC
4.0 Sustainability of achievements		
4.1	Institutionalisation of processes and mechanisms of transparency and	✓ Initially, none of the HCCs never knew the scorecard nor the social mapping processes ✓ All the HCCs now know the social mapping and scorecard processes as they have watched LIFH staff facilitate the process

[29] Chileka HCC is in the process of constructing a carport, a ward and a fence around the HC (already moulded bricks enough for carport, but moulding the extra bricks for ward and fence); Mzandu HCC is spearheading the construction of a guardian shelter, pit latrines and a kitchen for the maternity at the HC; and Mkhuzi HCC is in the finalisation process constructing bathrooms for guardians, a staff house and a holding shelter for dead bodies before they are taken to the village or the mortuary (for Mkhuzi HCC, initiatives were requests to DHMT and were granted)

	accountability	✓ Only 1 of the HCCs (Chileka) has ever facilitated the scorecard process (twice) ✓ All the HCCs feel confident that they can comfortably facilitate the scorecard process on their own ✓ All the HCCs feel they would need proper orientation in order to facilitate the social mapping process
4.3	Perceived vision of the future	✓ Initially, the HCCs did not have a vision. ✓ All the HCCs envision quality health services that are achieved through: ▪ Availability of adequate drugs and equipment ▪ Availability of enough and hardworking staff ▪ Availability of pit latrines and safe water in the communities ▪ Availability of training for VHCs and the HCCs
4.4	Perceived image/reputation	✓ Not clear about their image/reputation!!!
4.5	Shifts in power relations	✓ HCCs never used to participate in any decision making processes, except when there was need to discipline staff members. ✓ HCCs are now spearheading community participation in management of health services at the HCs. They are involved in formulation of joint action plans during the interface sessions with HC staff, DHMT, VHCs and CARE ✓ 2 of the HCCs (Mkhuzi and Mzandu) have already been part of the DIP formulation processes (identification of issues/plans/priorities and consolidation), and will also participate in implementation, monitoring and evaluation of the DIPs

2. Findings from LIFH Project staff

Indicator	**Findings**		**Comments**
	Baseline	*Evaluation*	
Changes in LIFH's contribution to strengthening the Health Sector SWAp at national level			Data collected from: LIFH team DFID
1. LIFH staff's understanding of the SWAp process	1. SWAp is a process to harmonize all stakeholders working and present within the health sector 2. Based on Basket funding 3. Besides the health sector, other sectors are developing sector wide approaches. 4. Extensive work plan, for	1. SWAp is an approach, based on basket funding, to support the whole health system whereby the MoH has full responsibility for management and implementation 2. A process that finalized in February 2004 of various stakeholders (donors, MoH,	> LIFH staff experiences on regular bases that health staff, DHMTs and DHO's don't have understanding of the SWAp and what it is about. They are under the impression that CARE is more

	the next 10 years. 5. A process to reduce the overlapping of the several stakeholders with their different approaches, projects, etc. 6. Aware of the fact that the process was taking place and that as LIFH project we were supposed to link into it and work with others. 7. Lot of confusion on how, where, who's leading it.	civil society) agreeing at how to the health sector can be improved 3. Very closed process. Unclear how civil society, DHMTs, DHO's and NGO's participated in this process. 4. Products are the Agreed Program of Work; Essential Health Packages; SWAp document 5. SWAp aims at bringing the MoH into a leading, central role of the health sector. Before there was no co-ordination, lot of overlap, repetition and different people doing different programs, initiatives. 6. Unclear if the SWAp is launched, kick off. Did the SWAp actually start? Aware that some parts of the SWAp have started, for example several trainings on the essential health packages have been conducted.	advanced in linking into the SWAp then them. > There seems to be a time gap between the development of the Program of Work and the actual signing of the memorandum that is supposed to put the Program of Work into action. This presumably contributes to the unclearity of the process. > It seems that the SWAp has been developed by DFID, Norad, JICA, others and the MoH. The 'money people' hold and dominate the process. > LIFH and others are still waiting for the official kick off, information dissemination meeting whereby all the different stakeholders within the health process will be informed on the SWAp.
2. LIFH's effort of linking into the SWAp	1. Unclear understanding of what direction, what focus LIFH is taking and what linking into the SWAp means and at what level? Reasons: - Developing advocacy strategy was not seen as a priority > unaware that a strategy needed to be developed due to the lack of a holistic view and focus	1. Different ideas on what 'linking into the SWAp' means 3. Several, on many occasions, request towards DFID were made to support LIFH with its linkage into the SWAp with very poor results. 4. Several knocks on the MoH's door were held, with very poor results.	*Important to note that none of LIFH staff, except one, was present at the designing table of LIFH project.* Different understandings of what 'linking into the SWAp' actually means to us: - linking into the

	on what direction LIFH was going. - Emphasis was on community work, developing the scorecard and other participatory methodologies - Advocacy was not in the picture and perceived 'as somebody else's business, e.g. the PM	5. Linking into the SWAp at district level is successful 5. Difficulties because: - no advocacy strategy developed - insufficient planning of linking into the process - no sufficient M&E framework installed - no specific learning indicators formulated. ,6. Not enough efforts were made by LIFH on planning and developing an advocacy strategy because: - not seen as a priority - understanding of the SWAp grew during the project - understanding of LIFH's focus, level of impact grew during project - Focus, vision of the future on where LIFH's is going grew during the project Not enough efforts were made to understand, be aware of the agenda's of the several stakeholders, for example SWAp secretariat, taking place of the Health Sector Review	MoH, but at what level? - Participation in the development and implementation of an monitoring and evaluation framework for the Agreed Program of Work (this to ensure the voice and participation of civil society and install accountability processes) - Establish learning processes together with the MoH. LIFH did not make enough efforts in terms of planning - After the PM left, a gap occurred and the bigger picture and the gap between LIFH's ground work and impact at national level became clear. Then the focus, direction that LIFH was supposed to take became clear.
3. DFID's contribution towards supporting LIFH's linkages into the SWAp at national level	1. Fund LIFH project 2. During the design of LIFH it was negotiated by DFID that 'linking into the SWAp' is part of LIFH project	1. Several promises were made to support LIFH's linking into the SWAp (knocking on doors, establish relationships, etc). It is unclear if DFID ever did a follow up, carried its promises out.	LIFH: Understanding that DFID would support LIFH with linking into the SWAp. For example by conducting forums with SWAp secretariat, civil society actors, donors, health workers, health officials and LIFH. - LIFH expected DFID to promote the sharing between all the different

			stakeholders. Co-operate with the involvement of LIFH into the SWAp - Unclear if a conversation between DFID and LIFH ever took place on how both partners expected the linking into the SWAp would take place and on what level and roles in that process.
4. LIFH's expertise on advocacy strategies and policy influencing	Staff has always pointed out their need of advocacy training	Decision was never made for staff to actually receive training	
5. Participation in relevant/strategic partnerships on national level.		- Malawi Health Equity Network - Management Sciences for Health SWAp secretariat - District Health Network - Parliamentary Committee on Health	> Unclear if MHEN has been part of the development of the SWAp. CARE now part of steering committee. At first, MHEN very skeptical towards LIFH project because of the RBA approach it has taken.

3. SESSION 2: SEMI STRUCTURED INTERVIEWS WITH ELDERLY WOMEN CHIZIKO VILLAGE, GVH MTALI, CHILEKA HC, LILONGWE

Broad indicators	Specific indicators	Now/evaluation
		4 aged women: Nelesi Mbingwani (age= was 12yrs by 1949, approx 68 yrs old) Abineli Buliyani 64 yrs old Naomi Jasi 63 yrs old (morbid) Deliya wayiti May be 70 + (walks with difficulties) <u>Scene setting Qs/Context</u> Who composes your household? Nelesi Mbingwanier 2 grand sons, Bineli Buliyani one grand son + 5 orphans: 2 girls married and 3 boys also married Naomi Jasi one daughter Deliya wayiti one grand son Are there committees, organizations, institutions working in this village or you know of? *Micah, Gabriel, Namitondo mission, Inter Aid, CARE, Herbalist, VH, VHC*
1) Changes in response of health workers towards the service users	**Response of health staff to health service users:** 1. Reception of service users by staff (first come, first serve, queuing and numbering, prioritizing emergencies / acute health problems,) 2. Perception of privacy of service users (confidentiality, waiting room, consultation) 3. Perception of respect of health staff towards service users (listen to the patient, no shouting, hearing them out) 4. Perception of health service users on respecting punctuality / flexibility of working hours of health staff	<u>Q 3 Did you seek medical attention over the last 12 months?</u> <u>How many times? Where?</u> All 4 sought medical care at the HC and St. Gabriel mission hospital. When they are very sick, have money to pay they prefer to go to St. Gabriel hospital to Chileka HC. Reasons: They are sure of availability of medicines. Problem is congestion; they stay the whole day on the queue. The HC is second option because very often they return without receiving medicines due to short supply. <u>Q1. How HWers receive patients</u> <u>Changes at the HC</u>: Queue system, HC staff disperses adequate medicines to all without distinction when medicines are available. , Consultation is private you enter one person at a time and you are allowed to explain what you are suffering; <u>Do they do physical examination?</u> No. They prescribe treatment after you explain your illness while in the past they sometimes just gave out half a tablet, or aspirin, iron or a vitamin tablet and told you to go before you explained. There is a dental clinician who is inhuman, cruel and sends back patients most of the time. I was sent back to wash my teeth with Colgate (tooth paste) for one week before going back to seek treatment from him. Many people also have been told the same. At other times he says he has no grooves.
2) Changes in response of communities to health services and the health service providers	**Response of communities to health services** Utilization of health	<u>Q 2 Time keeping</u>

	services, health seeking behaviour, **Response of communities to health service providers** 1. Perception of respect of health service users towards health staff (no shouting, attitudes) 2. Perception of trust between the service user and the health staff (rights and responsibility, willingness, obligation, In stead of demanding, more trust on responsibilities)	CO at the HC keeps time and does not like patients to wait for a long time. But the dental clinician, most of the time he is not available for patients he gets drunk even in early morning hours. Another member of staff who is feared is elderly cleaner she is always cursing and saying cruel words to patients
3) Changes in the way HCC', VHC's, DHMTs, Health centre strengthen partnerships with each other	**The way HCC, VHC, DHMT, Health centre strengthen partnerships (networks) with each other - planning, management, linkages,** **(how is this done now, how was this done before?)**	**Q3 Healthy seeking behaviour Q 11 seeking attention of HC** When we fall sick, firstly prepare some herbs (basil) and ask a boy to buy pain relievers. We lie down but if illness is severe or persists over weeks, we go to the HC. We rarely go to St. Gabriel because there you pay for everything. **Q 4 Roles and responsibilities of VHC** Village Health Committee is very active. When there is an outbreak of diarrhoea or cholera, they issue out drugs to put in drinking. When one falls sick suddenly, they rush to get ambulance, or carry oxcart get to the HC. **Q 5 Voicing concerns** **Earlier on you mentioned about the dental clinician at the HC, have ever taken up an issues to the VHC, HC? No.** **Q 7 communication** The VHC calls for meetings through the VH, in some cases we do attend Village headman's meetings at other times we hear from those who attended the meeting when they are charting. At another meeting they told us about vaccine for chickens.
4) Changes in the way HCC and VHC are fulfilling their roles and responsibilities	**Types of roles and responsibilities that HCC's and VHC's are fulfilling and to what extent.** **Expecting:** - drug monitoring - joint planning - joint management - joint assessment of health priorities - expressing voice - etc.	**Q 6 Support system/ informal safety nets on health matters** **There is an herbalist who serves when one cannot manage to reach HC service.** **Neighbours do assist when they notice that you have been lying down which is unusual.** **Q 8 & 9; 16, 17, 19: Participation in planning** We have no idea about how VHC makes plans. But they do hold committee meetings. **Q 17:** Medicines should be available and dental clinician need to change and treat people. **Q 10 Gender membership in committees** VHC has 10 members 5 men and 5 women.

	How, quality and frequency How where they meeting their roles and responsibilities before, and how now? Perception of the representativeness of the HCC's and the VHC's by the communities	
Shifts in the demonstration of empowerment, leading to the claiming of rights by service users. (expressing, claiming and using of rights)	The way communities take up issues Empowerment - the type of concerns that service users are expressing users expressing their needs, concerns Expressing voice External response	**Q 12 Information sharing Q 13 information about drugs** When people return from HC without medicines, they talk about it and when we hear that, we stay without making a journey to the HC in vain. In that way we get information.
5) Changes in tackling issues of exclusion, poverty and marginalisation in access to health services		**Q15 How VHC was constituted and when** In 1994 the VHC was elected at a village meeting. People voted 5 men and 5 women. The same committee is working until now because there are no complaints.
1) Changes in linkages between community, health centre, district and ministry level		**Q18 NA no clue**
2) Changes in relationships between community, health centre staff and DHMT		**Q 8,9,16,17,19, Grouped together Participatory planning process who participates** VHC inform community at a village meeting about health plans and what they expect people to do. Usually to implement e.g. household hygiene, water chlorination, construction of shall wells (two now).

4. Session 3: Semi Structured Interview (SSI) with women with disabilities

Tekila Siveliano (Physical disability)
Maliana Mbingwani (Physical disability and morbid, Lenisa's guardian)
Edna Masapi (guardian of epileptic Yasinta (7 yrs old)
Mrs Lenisa James (Mental illness)

Q 3 Medical attention sought over the past 12 months, where, why, what is your opinion on health workers at the HC?

All the four members of the group said they had sought medical service at both St. Gabriel and Chileka Health Centre during the past year.
Drawbacks at st. Gabriel are long waiting time due to congestion and not well organised queues; and fee paying. Otherwise they supply adequate medicines all the time.
At Chileka HC, There are organised queues, free medicines and the CO is very kind and good to patients.

Q Have you ever felt discriminated against on the account of your disability?
No. We get treated like everybody else. Sometimes when you go there while very ill, the CO asks the other people if it is alright to attend to those who are very ill first. So we get priority treatment.
When medicines are available, we get full course on home treatment, sometimes a course for five days.

Qs Using the Bus and road tool

VHC is seen as driving the bus. VHC would be said to have moved 50% of the journey towards reaching our aspired state well being, committee roles and responsibility bearing. The VH plays a key role of coordinating all activities and running the village. Men and women in the village co-operate in implementing various development activities such as: MICA, Food & livelihood security, crop diversification, seed multiplication and revolving clubs, community and personal woodlots. The VH is over 50% through the journey to our aspired leadership roles and responsibilities.
The dental clinician is not in the bus, if only he could stop getting drunk may be he would change his attitude towards us, and treat us as human beings- (ngati anthu).
The CO is 75% on the road to our aspired role execution
The two women with physical disabilities said they were 25% through the journey to wellbeing because availability of medicines at the HC is still a big problem. When they hear that medicines have arrived, it takes only a week there after; the HC has no medicines for several weeks. During this time we look for herbal medicines and drugs from hawkers.

Yasinta the epileptic girl
Edna Masapi the mother of Yasinta said that her child has been epileptic since early childhood. During early days of Yasinta's illness she tried different herbalists but her condition did not change, she continued to have several (6 -10) attacks per a day. When she was advised to stick to conventional medicine, at first she could come worse, but after using the medicine for a long time there has been some improvement. There is reduced frequency

of attacks (from 10 times to once a day, sometimes ones a week) which is a very significant change.

In terms of the care and quality of service I get from the HC, I would say the bus is 75% through its journey to desired support service because there is a big difference between now and before CARE's participatory research (Kafuku-fuku). Nowadays the CO knows and treats her case separately. We always get medicines for a month while before that sometimes we used to stay the whole day waiting for medicine just to be told when you reach the end of the queue that there is no medicine.

Edna and Mr Chikalipo her husband are, in most cases exempted from community roles in committees so that they attend to Yasinta who requires full time attention.

Problem areas:

- Edna and her husband live in continual fear of road accident because Yasinta sometimes dives into the road that passes very close to their house.
- Absence of a drug to cure epilepsy, because the medicine Yasinta gets just controls the condition.
- Yansinta plays with her fellow children but sometimes they beat her due to their failure to understand why she behaves in a strange way.
- Although Yasinta is 7 she cannot attend school because even when she is not under epileptic attach, she is mentally defected.
- Voiceless comes in because she does not know where else they can obtain other forms of assistance for Yasinta.

Lenisa James (Mrs) Mental illness

Lenisa get mentally ill as a result of anaesthetic. From birth up until her early adolescence in 1986, she was normal. She was operated on at Kamuzu Central Hospital (KCN), and she lost her mind as she woke up from anaesthetic. Hospital treatment did not work and they reverted to herbal medicines from different herbalists but failed. Since 1996 they have been getting treatment from Chileka HC. As long as she takes here daily medicine, she stays normally.

For the past one and a half years, Lenisa's mother has noted the following improvements at Chileka HC which she attributes to the participatory research which CARE facilitated:
The CO communicates more with patients. In her case she is able to leave Lenisa to collect her monthly medicines by herself unless she is sick.
The CO notifies them when there is a visiting doctor to examine people like Lenisa.
She also said, *"One time they changed Lenisa's medicine. The CO explained that the medicine which was given to her previously was not the correct type (the previous visiting CO prescribed a drug used to treat epilepsy). His expression indicated concern and it helped me to administer the medicine confidently and I trusted the CO more. This behaviour is very different from the past when CO used to prescribe treatment before you finished explaining your illness. Now they take time to talk to the patient. Lenisa is not scared of the CO because of the way he approaches her".*

5. WOMEN'S GROUP CHIZIKO VILLAGE COMMUNITY, GVH MTALI, CHILEKA HC, LILONGWE

Broad indicators	Specific indicators	Now/evaluation
6) Changes in response of health workers towards the service users	**Response of health staff to health service users:** 1. Reception of service users by staff (first come, first serve, queuing and numbering, prioritizing emergencies / acute health problems,) 2. Perception of privacy of service users (confidentiality, waiting room, consultation) 3. Perception of respect of health staff towards service users (listen to the patient, no shouting, hearing them out) 4. Perception of health service users on respecting punctuality / flexibility of working hours of health staff	19 women Scene setting Qs/Context Who composes households in this village? What are the interest groups, committees, organizations, institutions with whom you relate in health development issues? (*Men, women, girls, boys, kids, babies, grandchildren, in-laws, orphans, aged, pple with disabilities,) Organisations and committees Micah, Gabriel, Namitondo mission, Inter Aid, CARE, Youth club, TBA, Hebalist, VH, VHC, HCC, Counsellor, MP*
7) Changes in response of communities to health services and the health service providers	**Response of communities to health services** Utilization of health services, health seeking behaviour, **Response of communities to health service providers** 1. Perception of respect of health service users towards health staff (no shouting, attitudes) 2. Perception of trust between the service user and the health staff (rights and responsibility, willingness, obligation, In stead of demanding, more trust on responsibilities)	Q1. How health workers receive patients Overall, there are new procedures: -Patients stand on the Queue, first come first save - Consultation is private: one person at a time, door closed -Patient is allowed to explain what s/he feels; -When the Co notices a very sick patient, he presents him or her to the whole group and asks for their opinion whether they could permit him to beat the queue. This makes the other patients to accept without pain. It increases our confidence that he is a kind and loving concerned doctor. Q 2 Time keeping Overall CO keeps time and now serves two roles: consultations and dispersing drugs so that patients do not wait too long with their prescriptions in the hands. **But there are some three individuals Hws at the HC who are disrespectful** Dental clinician, elderly cleaner, and middle age nurse. They are scornful, cruel and defiant to warnings. **When one tries to explain her illness, they shout and say, "*Just tell me one illness or just tell me what you feeling and not Nyamakazi (rheumatism)*" then he just prescribes Iron tabulate for you.** **If one seeks treatment on <5 clinic days the nurse stops the Co from treating women saying they are just pretending to be sick just because they are here for the <5 clinic. These other HWers are feared, hated.**

8) Changes in the way HCC', VHC's, DHMT's, Health centre strengthen partnerships with each other	**The way HCC, VHC, DHMT, Health centre strengthen partnerships (networks) with each other - planning, management, linkages,** **(how is this done now, how was this done before?)**	**Q3 Healthy seeking behaviour Q 11 seeking attention of HC** When one falls sick, firstly you buy pain relievers if it fails, you go to the HC. Committee when there is an outbreak of diarrhoea or cholera There is also a herbalist who treats some ailments, people seek treatment from him. <u>Do children, elderly, girls, boys as well as men and women seek treatment equally?</u> No. Explain. They all laughed. Children of 6 to 10 years old are least considered for treatment seeking, mothers pay more attention to babies. Girls and boys shy away from seeking health service more than adults. Boys go to get condoms more these days than before (2001, 02) **Q 4 Roles and responsibilities of VHC and HCC and Q 7 communication** VHC is very hard working. They monitor household and community hygiene, promote basis household infrastructure construction, maintenance and clearing of bush, sweeping; When there is diarrhoea or cholera they report to HCC and bring back water treatment chemical and distribute to HHs. When one falls sick suddenly, we report to them and they rush to get ambulance. They also link the village to HCC through meetings and feedback meetings to the village. The VHC gets invitations from HCC for these meetings. When we have complaints like about the dental clinician, the cleaner and the nurse we talked about, they present our complaints to the HCC. **Q5** But when the HCC tried to reprimand the nurse, she became worse and dangerous to patients. She would say, *"The people here are sending evil reports about me. What can they achieve? I still get my pay intact? Because of your evil reports, I will not serve you, and when a child walks to touch a chair, she reaches out to stop the child saying go away your mother was reporting me. As a result, fear creeps in that she my give us wrong treatment deliberately. We have resolved to be silent for the sake of peace.*
9) Changes in the way HCC and VHC are fulfilling their roles and responsibilities	**Types of roles and responsibilities that HCC's and VHC's are fulfilling and to what extent.** **Expecting:** - drug monitoring - joint planning - joint management - joint assessment of health priorities - expressing voice - etc.	**Q 6 Support system/ informal safety nets on health matters** **B There is a herbalist and a TBA who serve us when one cannot readily access HC service.** **Q 8 & 9participation in Joint planning** VHC makes plans and calls for a meeting to tell us the plan and we all participate in implementation construction related works. Beyond VHC there are no known planning bodies we know about.

	How, quality and frequency How where they meeting their roles and responsibilities before, and how now? Perception of the representativeness of the HCC's and the VHC's by the communities	But Inter Aid called a village meeting where they asked questions what we would like to do. We suggested and planned together with them water projects. We made agreement on roles to play between us as a village and interAid. This was in 2003 and last planning meeting was held in march 2005 **Q 10 Gender membership in committees** VHC has 10 members 5 men and 5 women. We don't know HCC and other health committees beyond our community.
Shifts in the demonstration of empowerment, leading to the claiming of rights by service users. (expressing, claiming and using of rights)	The way communities take up issues Empowerment - the type of concerns that service users are expressing users expressing their needs, concerns Expressing voice External response	**Q 12 Information sharing Q 13 information about drugs** What has changed significantly over the past two years is information sharing especially from the HC staff and patients. Before Co would let you toil for hours on the queue and tell you very late that the health center has no medicines. Nowadays, they apologise to patients and announce about drug shortage and give a date when they are expecting to receive them. There is a bill board where they give information about drugs and other things for patients to be informed. When drugs come VHCs are informed. Although individual differences are still prevalent. Some women are prescribed adequate medicines while others come back with panado or just iron tablets.
10) Changes in tackling issues of exclusion, poverty and marginalisation in access to health services		**Q15 How VHC was constituted and when** VHC was elected at a village meeting by voting. 5 men and 5 women. In 1994 few members were co-opted in 2000 since then there has not been new or regular elections.
3) Changes in linkages between community, health centre, district and ministry level		**Q18 NA for women group**
4) Changes in relationships between community, health centre staff and DHMT		**Q 8,9,16,17,19, Grouped together Participatory planning process who participates**
5) Changes in the access to policy making/implem entation		**<u>INTEREST GROUP IDENTIFICATION</u>** CHHs Mizeke Lester, Joyce Nyankha and Loyd

processes by community voices at district and national level		Chronically ill: Msolola Aged women: Alen, Enelesi(Anasiluma); men Mr Chiwala/ herbalist, A kadammanja, and wife tekila Disabilities: Maliama, Yusuf/ wife accompany, Divason Poorest: Chale Yakobe, Chimphanje, Nachisale, Chimwala, Nazaleti, Osina

6. HC Staff findings

	Indicator	Findings		Comments
		Baseline	**Evaluation**	
1.0 Voice and accountability				
1.3	Strengthening partnerships with other institutions	It was difficult to work with VHC because most VHCs were untrained, some were not yet established and very few were briefed on their roles and responsibilities(Mkhuzi HC)	VHCs are established, trained and empowered- they complement well efforts of Health centre staff and HSAs VHCs have been useful in making communities understand that health workers are few hence need for patience by communities when they seek treatment at the health centre	Previously, when communities had concerns on how services are being run at the health – they would just come and shout at health centre staff- but now all concerns are go through the VHCs who either report straight health centre or to HCC Today –13/04/05 HCC was actually counting received drug quantities and recording the same on the notice boards(Mkhuzi HC)
		Only very few VHCs and the HCC existed before the LIFH project (mzandu HC)	HC staff interact with HCC frequently, through usual monthly meetings and emergency meeting called upon by either HC staff or HCC	
		HCC was untrained and dormant(Mkhuzi HC) Very few meetings were done between HC staff and HCC No drug monitoring were done by HCC (Mzandu HC)	Interaction with DHMT has increased, however requested items are sometimes not provided to HC, despite improved interaction (may be because the requested items are not available) All Health Centers including HCC VHCs and communities are involved in the planning process	
		Interaction with DHMT was low	The interface meeting which is part of the scorecard brings together VHcs, HCCs and DHMT	
		Planning was done by DHMT with the involvement of one HC staff torepresent all health centres	Communities and HC staff have been consulted during the 2005/06 DIP planning process	
		No meeting brought	Monthly joint meetings	

		together VHCs, HCC, DHMT Communities and health centre staff were not consulted during DIP planning Monthly joint meetings between HC and HCC were not done	between HCC and HC staff are being done	
1.5	Demonstration of empowerment	VHCs and HCC could not bring up issues from the community (mkhuzi HC) VHCs only encouraged community members to dig up latrines and other sanitary facilities Only VHCs that have an HSA would demand for outreach clinics to be conducted in their area (Mzandu) Taking up issues from the community to DHMT was limited to wireless message and during supervisory meetings	VHCs and HCC are able to bring to Health issues from community such as Demands for treating /chrolinating water in certain villages Complaints on the number of drugs prescribed by service users (Mkhuzi HC) VHCs have become more proactive in demanding for services- such as requesting for HTH/chlorine for treating water to prevent Cholera and other water borne infections VHCs report any suspected outbreaks in their community Even VHCs that have no HSAs leading them, are also demanding for out reach clinics in their areas (especially those that are far from health centre) Issues are taken up from the community to DHMT through: Interface meetings Submissions of emergency reports Monthly reports Wireless message DHMT supervisory visit	
2.0 Changing relationships				
2.1	Linkages between institutions	Use of radio message is used to communicate to	Use of radio message and supervisory meetings to	These methods were used because

		DHMT Word of mouth is used to communicate to HCC and VHC	communicate with DHMT Letters and word of mouth used to communicate to VHCs and HCC	they are the only means available for communication
2.2	Relationships between institutions	No joint planning was done, except by having one heath centre staff representing all health centres (mkhuzi HC) Most plans were developed at DHMT level with little involvement of health centre incharge(s)	Joint planning is done through: Interface meetings Supervisory meetings were done twice but were supposed to be done four times DIP meetings were done once (mkhuzi HC) Plans are now developed together with communities and health centre staff Over the past 12 months, several plans have been developed, with HCC, VHCs and DHMT. Some of the said action plans are the two action plans developed during the interface meetings. HSAs,VHCs and HCC are involved in soliciting views from the community for incorporation into DIP Community views were solicited and submitted for consolidation and incorporation into the DIP	
2.3	Access to higher levels	Communities were not involved in any planning process	Communities are involved in planning process through ; interface meeting and DIP consultations All activities for developing an action plan during the interface meeting come from communities and health centre	
2.4	Cultural practices	VHCs used to have on average 9 men and 1 woman (Mkhuzi HC) Most VHcs had 9 men	VHCs now have an average of 5 men and 5 women HCCs have 9 men and 2 women, one of whom holds a	On average 1 or 2 of the women in VHCs hold leadership position

		and 1 or zero women The one woman in the VHC would in most cases play the role of secretary	leadership position At the health centre, the nurse is a woman and she leads the institution. The rest of the women are HSAs Most VHCs have a minimum of 4 women and 6 men, while some men have 5 men and 5 women One or two of the 4 or 5 women in the VHC would play a leadership role ie chairperson or vice (Mzandu HC)	
2.5	Information flows between institutions	Information from health centre to communities was taken by VHCs by word of mouth	Information from the health centre is available through VHCs or is written on notice boards Information about drugs is also available on drug notice boards (mzandu HC)	
3.0 Institutional respons				
3.1	Allocation of drugs, supplies and equipment	Drugs are allocated to health centre based on the population of people using the health facility and the drug request order submitted (mkhuzi HC and mzandu HC) Drugs received are adequate and stock outs are rarely experienced Drugs are equitably dispensed by health centre staff	The process of drug allocation has remained the same, what has changed is the system of delivery –drugs are delivered straight from the Central Medical Stores (mkhuzi HC) Allocation of drugs is based on average number of patients seeking treatment at health centre and also on the prevalent diseases in the area plus availability of required drugs from Central Medical Stores or Regional Medical Stores Drug stock outs are more frequently experienced Drugs are equitably dispensed by health centre staff.	One HSA explained 'All people are given the right type and quantities of drugs regardless of their social status' Of late however, the relief nurse is dispensing very few aspirin tablets per day(8 aspirin tablets instead of the recommended 18 tablets per person). This pattern in prescription is bad because it will be reflected in monthly reports and that will

				reduce the amount of aspirin tablets to be received by the health centre in future.
3.2	Responses to the health needs of communities			
3.3	Processes and mechanisms used within institutions	VHC members were nominated into the committee by Village headmen or HSAs Only the villages close to the health centre were asked involved in choosing HCC members – hence poor representation for villages living far from the health centre VHCs were mostly involved in encouraging households to dig up toilets HCC were mostly involved in disciplining health centre staff (Mkhuzi HC) Some VHCs were chosen by Village headmen without any community involvement HCC was formed by traditional authority (TA) who appointed various group village headmen to serve in the HCC VHCs and HCC do not meet each other	VHC members are voted by community to serve in this committee All the village headmen that fall in the catchment area of the health centre are represented in the HCC VHCs are doing much more and linking with HC staff, HCC and local leaders such as Group village headmen and Counsillors on various issues VHC members voted into position by community members The HCC has a variety of members including ordinary community members, HC staff and businessmen VHCs and HCC meet each other at least quarterly. HCC members visit specific VHcs and report back in a bigger HCC meeting (Mzandu HCC)	HCC on the other hand is also linking with VHCs, HCC, DHMT and local leaders including member of parliament for the area- who(the MP) at one time was requested for support and donated blankets to the health centre
3.5	Initiatives translated into action		Initiatives planned by HCC include: Construction of a house at the health centre for a member of staff Construction of bathrooms for guardian shelter	Delta Construction were already approached and they accepted the proposal by HCC. The one on

			Request Delta construction company , who are doing renovation and expansion of the facility to donate their shelter, so it can be used to house the dead while waiting for their relatives to collect the dead body	construction of bathrooms for guardian shelter is not yet done.
4.0 Sustainability of achievements				
4.1	Institutionalisation of processes and mechanisms of transparency and accountability	Do not know scorecard or social mapping	Staff explained the scorecard as a tool for evaluating health service performance by allowing communities and service users to score their health services They were unable to explain social mapping Staff explained that they feel more capable to use scorecard than social maps They are familiar with scorecard and social mapping – and are using social mapping in own villages	
4.3	Perceived vision of the future		Health centre should have adequate equipment, staff and infrastructure including more staff houses The health centre should not experience frequent and persistent drug shortages and should have its own ambulance	

Annex 14: District model

LIFH District Model- proposed steps

Village/community level	HC level	District level
❖ Preliminary village assessments ❖ Finalise indicators ❖ Ist scorecards ❖ Cluster scorecards	❖ MOU ❖ Behaviour and attitude training ❖ Self-evaluation scorecard	❖ MOU ❖ Dialogue to explain the process ❖ Invitation to monthly DHMT meetings
First interface	***First interface***	***First interface***
❖ Implement action plan ❖ Train VHC ❖ DRF ❖ Monthly/health campaigns ❖ Monitoring	❖ Implement action plan ❖ Train HSAs ❖ Monitoring	❖ Implement action plan ❖ Monitoring ❖ Preparation for including HC action plans in the DIP – invite the HCs to present their plans, inform likely schedule well in advance, as well as the district budget
❖ Repeat scorecard ❖ Second interface	❖ Repeat scorecard ❖ Second interface	❖ Repeat scorecard ❖ Second interface
Joint review of progress		
❖ Further training, if necessary ❖ Implement action plan ❖ Continue with regular activities	❖ Preparation to present action plan for inclusion in DIP	❖ Continue regular activities
❖ Repeat scorecard ❖ Third interface	❖ Repeat scorecard ❖ Third interface	❖ Repeat scorecard ❖ Third interface
		❖ Incorporate HC plans in the DIP