

Local Initiatives for Health: Malawi

CONTEXT: Malawian citizens suffer from a weak and low-capacity health sector. National health indicators paint a worrying picture of health provision, with life expectancy dropping from 43 years to 39 between 1996 and 2000, and infant and under-five mortality rates in 2000 of 104 and 189 deaths per 1,000 live births, respectively. Maternal mortality rates are particularly high, with 1,120 per 100,000 live births in 2000 (MRSP). Access to basic services such as health care remains far beyond the reach of the poorest and most vulnerable Malawians as evidenced by a low percentage of births attended by health workers of 43 percent (MPRSP). The Local Initiative for Health (LIFH) project aimed to address these severe shortcomings within the health sector through improving citizen monitoring and planning of service provision at the local level.

OBJECTIVE: To contribute towards the improvement of the household health and livelihood security of rural households and to improve the ability of rural households in the central region of Malawi to address their basic rights to health

APPROACH: LIFH adopted a rights-based approach to improving health services in Malawi, drawing on DFID's three RBA operational principles: participation, equity and obligation. The project aimed to establish direct partnerships with local service providers and to promote partnerships between informed rural service-users and health providers. Through the CSC social accountability mechanism, LIFH aimed to allow communities – particularly women and disadvantaged groups – to implement and monitor the delivery of improved health services.

During the project's pilot phase, CARE led the facilitation and implementation of the CSC process. This served as an opportunity to train community facilitators prior to the project's scale-up.



INTERVENTION: LIFH was designed in 2001 in partnership with DFID. The CSC process was implemented between 2003 and 2005. Between 2003 and 2003 the CSC was implemented on a pilot basis in Lilongwe District. From September 2003, the LIFH expanded activities to Ntchisi District; in February and March 2004, the project further scaled up to include two more health centres in Lilongwe and three more in Ntchisi. The CSC was implemented in five phases:

Planning and Preparation: CARE staff were trained on the CSC process. Introductory meetings were held, and MoUs signed, with all project partners, wherein respective roles and responsibilities were outlined. Village clusters were determined, based on their proximity to their local health centre.

Conducting the Scorecard with Community: Two-day meetings were held with target communities, facilitated by project staff. Discussions focused on health issues relating to access to/quality of local health service provision. From this, a total of 22 indicators were generated, falling under the categories of: staff attitudes; health centre management; quality of services; and equitable access to services. Separate groups of men and women were then invited to implement the CSC in every village, with participants awarding each the 22 indicators a score of between 1 and 100. Indicators with lower scores were discussed and suggestions given for their improvement. Village scores were consolidated in clusters, with seven villages to every cluster and two clusters per health centre.

Conducting the Scorecard with Service Providers: This process was repeated with health centre staff. Indicators were grouped under six categories: staff attitudes; health centre management; service quality; user-provider relationship; infrastructure and equipment; and staff incentives. During the discussions, facilitators prepared participants for the interface meeting in order to avoid unproductive confrontation with community members.

Interface Meeting and Action Planning: Community members, health staff, and relevant community and political stakeholders participated, with both users and providers presenting their findings, identifying priority areas and then developing shared action plans. The Department of Health helped in determining what could/could not realistically be implemented by local health centre staff. Once action plans had been developed, they were displayed in the local health centres, alongside both sets of CSCs. Examples of Action Plan activities included: community inspection programme; head-counting of children at 'Under 5' clinics; introduction of numbering and queuing systems at clinics.

Action Plan Implementation and M&E: The CSC process was repeated after 6 months using the same set of indicators. Increased/decreased scores were scrutinised and previous action plans reviewed to track what changes had occurred and why. Outstanding issues were assessed in terms of attainability and as to whether they should be included in next

DISABLING FACTORS

Commitment of service users and providers: Both community institutions and members and healthcare providers were willing to institutionalise key processes that promote accountability and a working relationship between service users and providers

Willingness to share authority: service providers were compliant in granting a degree of responsibility and power to community-level service users.

DISABLING FACTORS

- **Disconnect between government levels:** LIFH struggled to influence health priorities and policy making at levels higher than the District. The disconnect between District and Central government is a crucial barrier to the effective implementation of SWAp for health, however this remains unchanged.
- **Lack of integration into SWAp:** Outcomes of the CSC were intended to feed into the ongoing SWAp to health care improvement. However, LIFH staff and partners lacked understanding of, and strategic entry points in the SWAp process. CSC findings thus remain somewhat separate to wider reform processes.
- **Challenges in monitoring progress:** LIFH experienced difficulties in developing a monitoring system that continuously documented progress on often-intangible indicators such as empowerment and behavioural change. This made demonstrating impact a difficult and time-consuming task.



SUCCESSSES:

Gradual capacity building: Learning opportunities should be ongoing and closely linked to project activities. This is particularly important for facilitators, who play a crucial role in ensuring CSC effectiveness and action plan implementation.

Joint vision and planning: In promoting dialogue, joint planning and mutual trust and respect between service users and providers, the CSC can generate enhanced ownership over health facilities and services for both staff and community members.

Partnership: Working with and through local partners can significantly increase the coverage of project outcomes

SUCCESSSES:

- **Increased use of health centres:** Prior to LIFH, only 30% of illnesses, and 30% of child deliveries, were handled at health centres. The former subsequently increased to 70% and the latter to over 90%. Relationships between health service users and providers improved due to improved communication and mutual understanding. Health staff, previously described as unprofessional and disrespectful, had notably improved by the second CSC round.
- **Equality and transparency:** Before LIFH, male-female ratios on health committees ranged from 7:3 to 9:1; after, equal representation was enforced. Concerns surrounding the preferential treatment offered at health centres, in terms of waiting time and service quality, were combated through measures such as queuing systems and improved transparency in areas such as drug allocation and availability.
- **Communication:** Traditionally, communication between local service providers and community members has been limited to the expression of grievances. Communication channels have now been institutionalized, with letters and monthly meetings, providing a formal space for service-user dialogue. Health staff were noted as operating an open-door policy, whereby users were able to register complaints and suggestions on an ongoing basis.
- **Empowered communities and representative** Community members reportedly gained confidence in expressing concerns to and engaging in dialogue with service providers. Community representatives of Village Health Committees become more vocal in expressing community concerns at the District level.

CONTACT: