Local Initiatives for Health: Malawi

NTEXT: Malawian citizens suffer from a weak and low-capacity health sector. National health indicators paint a worryi ture of health provision, with life expectancy dropping from 43 years to 39 between 1996 and 2000, and infant ar der-five mortality rates in 2000 of 104 and 189 deaths per 1,000 live births, respectively. Maternal mortality rates a ually high, with 1,120 per 100,000 live births in 2000 (MRSP). Access to basic services such as health care remains f yond the reach of the poorest and most vulnerable Malawians as evidenced by a low percentage of births attended l alth workers of 43 percent (MPRSP). The Local Initiative for Health (LIFH) project aimed to address these seve ortcomings within the health sector through improving citizen monitoring and planning of service provision at the loc el.

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

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

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

TERVENTION: LIFH was designed in 2001 in partnership with DFID. The CSC process was implemented between 20 d 2005. Between 2003 and 2003 the CSC was implemented on a pilot basis in Lilongwe District. From September tober 2003, the LIFH expanded activities to Ntchisi District; in February and March 2004, the project further scaled up clude 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 Mo signed, with all project partners, wherein respective roles and responsibilities were outlined. Village clusters we determined, based on their proximity to their local health centre.

Conducting the Scorecard with Community: Two-day meetings were held with target communities, facilitated project staff. Discussions focused on health issues relating to access to/quality of local health service provision. Fr this, a total of 22 indicators were generated, falling under the categories of: staff attitudes; health centre manageme quality of services; and equitable access to services. Separate groups of men and women were then invited to impleme the CSC in every village, with participants awarding each the 22 indicators a score of between 1 and 100. Indicators w lower scores were discussed and suggestions given for their improvement. Village scores were consolidated i 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. Indicat were grouped under six categories: staff attitudes; health centre management; service quality; user-provi relationship; infrastructure and equipment; and staff incentives. During the discussions, facilitators prepar 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 politi stakeholders participated, with both users and providers presenting their findings, identifying priority areas and th developing shared action plans. The Department of Health helped in determining what could/could not realistically implemented by local health centre staff. Once action plans had been developed, they were displayed in the local hea centres, alongside both sets of CSCs. Examples of Action Plan activities included: community inspection programm 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 indicato Increased/decreased scores were scrutinised and previous action plans reviewed to track what changes had occurr and why. Outstanding issues were assessed in terms of attainability and on whether they should be included in acti

ABLING 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**: LI struggled to influence health priorities and polic making at levels higher than the District. The disconnect between District and Central government is crucial barrier to the effective implementation of SWAp for health, however this remains unchanged.
- **Lack of integration into SWAp**: Outcomes of the C were intended to feed into the ongoing SWAp to heal care improvement. However, LIFH staff and partne 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 experienc difficulties in developing a monitoring system th continuously documented progress on often-intangib indicators such as empowerment and behaviour change. This made demonstrating impact a difficult a time-consuming task.

UCCESSES:

- **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

SUCCESSES:

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

NTACT: