LEARNING SERIES

HEALTH CENTRE IMPROVEMENT GRANTS
A pilot study with Health Centre Advisory Committees

Introduction

Health centres in Malawi do not have ring-fenced budgets and often do not have the resources for basic maintenance and repairs. The situation was similar in Malawi's primary schools until Primary School Improvement Grants (SIGs) were rolled out in 2010. Each school is given at least MK 600,000 per year to be spent through School Management Committees, which comprise community members and senior school staff. There is an emphasis on transparency and accountability.

From June 2016 to September 2018, the UKAid-funded Malawi Health Sector Programme – Technical Assistance component (MHSP-TA) designed and implemented a community based accountability pilot study with Health Centre Advisory Committees (HCAC) as the entry point. The objectives were to strengthen HCACs' functionality and effectiveness, improve facility functionality, increase drug accountability, improve duty bearers' and government responsiveness, as well as embedding HCACs within the decentralised health system.

MHSP-TA developed a draft HCAC terms of reference and comprehensive training manual. Eleven HCACs in three Districts (Mwanza, Mulanje and Rumphi) were revitalised, participated in a five-day training and monthly mentoring for six months[1]. HCACs comprise community members and health workers. Community members are voluntary and receive no benefits or allowances. HCACs have no access to any resources other than those they raise from benefactors and their communities. Very positive mid-term evaluation results[2] showed that HCAC functionality and effectiveness significantly increased after the training and all HCACs had raised and managed significant resources which they used to make improvements to their facility.

The health centre improvement grant pilot

Malawi's Health Sector Strategic Plan II (HSSP2), Objective 8[3] identifies the allocation of funding directly to peripheral health activities as a key activity. Additionally, the HCAC mid-term evaluation showed that trained HCACs have the capacity to manage small amounts of money. This provided an opportunity to investigate if a similar approach to SIG would be appropriate. The findings would then inform national level discussions on how HCIGs can be introduced into the health sector.

Mwanza District has three health centres, all of which participated in the HCAC pilot study. The District Health Officer of Mwanza was keen that these HCACs participate in the HCIG pilot following the Department of Planning and Policy Development's approval of the study design, so from December 2017 to June 2018 MHSP-TA implemented the pilot with Kunenekude, Thambani and Tulonkhondo HCACs.

Method

HCIG draft guidelines (Box 1) were prepared in consultation with the education and health sectors. The guidelines are based on SIG financial management guidelines and tie in with the draft HCAC TOR.

Box 1: HCIG draft guidelines

The draft guidelines cover all aspects of HCIG preparation including:

- HCIG roles and responsibilities within the HCAC – including establishment of planning, procurement, and finance sub-committees
- Opening and managing the bank account
- Budgeting for how the grant will be spent
- Financial management and procurement
- Transparent management of the HCIG e.g. posting financial reports on notice boards

Each HCAC was given a HCIG of Mk 500,000. This is in line with the SIG and was appropriate for the six-month duration of the pilot as, for M&E purposes, all HCIG expenditure and activities had to be completed by the end of the pilot.

Local communities, the DHO and local government authority (LGA) members were sensitised about the pilot. Six DHO and LGA representatives were selected for training of trainers. The HCAC training on HCIGs

1 MHSP (2017) 'Drug accountability, Health Centre Advisory Committees and Enhancing Community participation in Health
2 CDM (2018) Endline evaluation of MHSP-TA HCAC capacity development and mentoring pilot programme
3 MoH (2018) Health Sector Strategic Plan II 2017-2022

lasted two days. Some local chiefs including Area Development Committee members also attended the training, at the end of which each HCAC had agreed and finalised plans on how to spend their MK 500,000.

Each HCAC then received weekly mentoring and monitoring from the MHSP-TA trainer and a monthly visit from a DHO representative.

Results

At the end of the pilot study, all three HCACs had substantially completed their planned purchases and constructions (Box 2) and had less than MK 1,000 left in their accounts. Most of the projects had been completed within one and a half months of receipt of the grant funds from MHSP-TA.

Box 2: Examples of how HCACs used their grants

- Tulonkhondo built 3 toilets including one for the maternity ward. They budgeted Mk500,000 and spent MK 470,000.
- Kunenekude completed a maternity unit toilet and bathroom (Figure 1). They spent MK 410,000. The remainder was used to build an access ramp to the outpatients' department.
- Thambani bought minor medical equipment and stationery. Purchases included a blood pressure machine, buckets, torches and rechargeable batteries.
- The HCACs also spent small amounts on minor maintenance of the health facilities, such as fixing door handles and locks to enhance security.

A 10% budget limit was placed on administration costs.

Fig 1: Kunenekude maternity unit bathroom and toilet

Each HCAC put a copy of the HCIG budget onto notice boards within the community (Figure 2) and shared grant information in other ways, including:

- Meetings with group village heads
- Community gatherings such as funerals
- At opening ceremonies/presentations for HCIG funded constructions and purchases

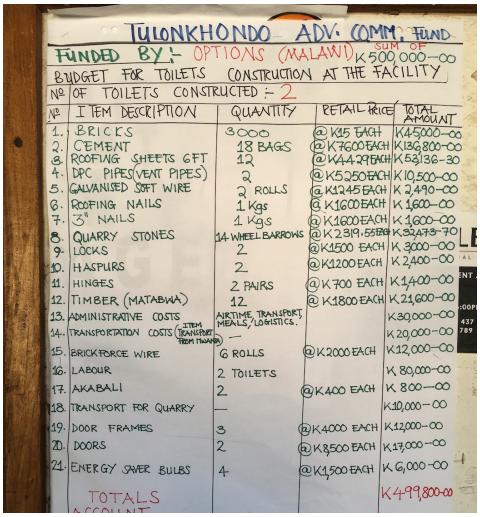

Figure 2: Displayed breakdown of a HCIG budget

Benefits of the grant

In addition to the direct benefits of the grant, there were a number of other advantages as a result of HCACs having direct control of a budget:

- All the HCACs spent their grant on things that had previously been requested from the DHO but had not been received. HCACs were able to act rapidly and got quick results. Most expenditure was completed within two months of receiving the HCIG.
- HCACs found cost effective ways of achieving their outcomes. They had direct control over contractors and negotiated prices. Control over quality and cost led to high standard products.
- The transparency of HCAC expenditure, and public access to information meant there was little opportunity for abuse of resources. This was complemented by the sense of ownership generated by the HCIG process, whereas abuse of other recurrent transactions is widely recognised in the MHSP-TA (2015) Health Efficiencies Report.
- A strength of the HCAC and HCIG model is that communities have control over health spending and are empowered to fulfil their responsibilities.

Recommendations

The benefits of HCIGs appear to outweigh the costs and risks, and SIGs confirm that HCIGs are likely to be a win-win for all stake-holders.

The key recommendation is to scale up HCIGs to national level, although the pace of scale-up should be dependent on strong HCACs. This is essential before giving a grant. Mentoring and supervision of HCACs is also a critical factor. Mentoring from District Offices seems most appropriate.

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