

Health Systems in Africa

*Community Perceptions
and Perspectives*

The Report of a Multi-Country Study

June 2012



**World Health
Organization**

REGIONAL OFFICE FOR

Africa

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This publication contains the report of an international study team on the perceptions and perspectives of populations on the health systems in ten African countries and does not necessarily represent the decisions or the policies of the World Health Organization nor those of the governments concerned

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List of abbreviations

AFRO	WHO Regional Office for Africa
ANC	Antenatal Care
APOC	African Programme for Onchocerciasis Control
ARVs	Antiretrovirals
BCC	Behaviour Change Communication
BCG	Bacille-Calmette-Guérin
CAR	Central African Republic
CBHI	Community-Based Health Insurance
CBO	Community-Based Organization
CDTI	Community-Directed Treatment with Ivermectin
CSO	Civil Society Organization
DHS	Demographic and Health Survey
DPT3	Diphtheria Pertussis Tetanus (three doses)
DRC	Democratic Republic of the Congo
FGD	Focus Group Discussion
HHH	Head of Household
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
IDI	In-depth Interview
IGA	Income-generating Activity
IRB	Institutional Review Board
LGA	Local Government Area
MDGR	Millennium Development Goals Report
MDG	Millennium Development Goal
MOU	Memorandum of Understanding
NCD	Noncommunicable Disease
NGO	Non-governmental Organization
NID	National Immunization Day
PHC	Primary Health Care
PMTCT	Prevention of Mother-to-Child Transmission
RC	Regional Committee
SPSS	Statistical Package for Social Sciences
SSA	Sub-Saharan Africa
TB	Tuberculosis
TDR	UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases
UN	United Nations
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Report writing team

Listed in alphabetical order

Dr Uche Amazigo	Prof Peter Ndumbe
Dr Mary Amuyunzu-Nyamongo	Dr Richard Ndyomugyenye
Dr Tieman Diarra	Dr Ngozi Njepuome
Prof S. J. H. Hendricks	Prof Martin Oka Obono
Dr Tarcisse Elongo Lokombe	Prof Joseph Okeibunor
Prof Paul-Samson Lusamba-Dikassa	Dr Luis G. Sambo
Prof Pascal Lutumba	Ms Yolande F. Longang Tchounkeu
Dr Leonard Mukenge	Mr Honorat G. M. Zouré.

Foreword

During my address to the Sixty-fourth World Health Assembly on 16th May 2011, I made the point that all of our debates and discussions in the health arena only have meaning when they improve the health of people and relieve their suffering. I therefore urged delegates at the assembly to “remember the people”.

I am pleased to commend the research team that sought the community perceptions and perspectives regarding health systems in the WHO African Region in order to provide the evidence base for more relevant, responsive and equitable services that meet people’s expectations and respond adequately to their needs.

The inequalities in the health status of people between and within countries have been a cause for concern for health managers and providers over time. They led to the Alma-Ata Declaration and its other reiterations such as the Ouagadougou Declaration.

When we compare the key health indicators in the world, for example those related to the Millennium Development Goals, we are struck with the uneven distribution of health across countries, within countries, and between population sub-groups, e.g. rich and poor, men and women. Further, there are differences between rural and urban areas in coverage of key health services such as skilled attendance at birth, immunization, and diagnosis and treatment of common diseases. These inequities can be avoided through the adoption and implementation of relevant health and development policies that seek to minimize variations of health indicators associated with socioeconomic status.

In essence, the attainment of an acceptable level of health requires, in addition to the health

sector, the participation of all related sectors as well as the participation of the community in the planning, organization, operation and monitoring of health delivery mechanisms. Since health care delivery mechanisms are intended for the community, the non-participation of communities may result in irrelevant interventions.

The results of this study are enlightening and revealing. Communities had clear perceptions of health and service delivery. They included the physical, mental, emotional, spiritual, social and economic well-being in their definition of health and underlined the necessity of our health services to be more responsive to all of the health needs of the community and not only to focus on some of them. These findings are worthy of our attention.

The respondents in this study also identified areas in which their participation could improve the overall governance of the health delivery systems. There is evidence that governance and accountability issues, if properly addressed, would contribute to ensuring the achievement of positive outcomes of the different health interventions.

I hope that the results of this study will be discussed with all national stakeholders so that policies and strategies are developed to respond appropriately to our people’s needs. This will lead us towards universal coverage and the attainment of the highest level of health that our countries and populations can afford.



Dr Margaret Chan
WHO Director-General

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The team thanks the research and academic institutions of the participating countries and their staff for in-country support, and the WHO Regional Office for Africa and the African Programme for Onchocerciasis Control staff for their assistance.

The research team is particularly grateful to the ministers of health of the participating countries for their feedback on the briefing presented by the study initiators (20 May 2012 in Geneva, Switzerland) and their consent to publish the study results.

The WHO Regional Office for Africa and the African Programme for Onchocerciasis Control provided the funding for this study.

Executive summary

“In all hospitals, even in clinics, there is no love. When you arrive at the hospital, they give you the patient form. He holds his pen. You tell him: Papa, write, my child is dying; he will answer, pay the money. He even crosses his legs; you are anxious, fidgeting and he will insist that you pay the money. Before the money arrives, the child dies. There is no love there. To use the hospital, it is money in full or you’ll die if you do not have the money” (Focus Group Discussion women).

BACKGROUND

1. Every decade since the 1940s, health policy makers, professionals and providers have launched new global and national initiatives in an attempt to address the health challenges and needs of populations, particularly those living in sub-Saharan Africa. However, few reforms have been successful.
2. Recent debates have emphasized how to make progress in strengthening the health systems, achieving universal health coverage and making progress towards meeting the Millennium Development Goals (MDGs). However, the perspectives of health professionals and providers fundamentally drive the majority of these debates with little attention to the end-users’ perceptions and views. While it remains essential in many sub-Saharan African countries to continue advocacy for increased investments in health, there is substantial untapped potential residing in the human capital and indigenous knowledge of the end-users.
3. Improving the delivery capacity of national health services in Africa goes beyond declarations and increased financing. It also requires the input of communities. In view of this, we engaged people in urban, peri-urban and rural areas in this study with the objective of understanding their perceptions and perspectives on health and health service delivery.
4. The study sought to answer six research questions: (i) how are health and health care perceived by African communities; (ii) how is health care implemented in selected urban, peri-urban and rural health districts; (iii) to what extent are existing health service delivery systems responsive to community needs; (iv) what is the existing potential and capacity of communities to contribute to and engage in health service delivery; (v) how can people and groups in urban, peri-urban and rural communities be empowered in community health development and how can their capacity be increased; and (vi) what are the perspectives of the communities on the delivery of health care.
5. This multi-country, multidisciplinary cross-sectional study was therefore designed to investigate the issues articulated above with a view to gain in-depth understanding of the interface between communities and health services and yield new knowledge on ways through which communities could be empowered to better contribute to health

reforms together with other key stakeholders—governments, partners, private sector, among others.

6. The study was conducted in 13 sites in ten African countries selected through a multi-stage sampling process. First, the countries were clustered into three subregions (Central, East and Southern, and West) according to criteria of the WHO Regional Office for Africa. Within each subregion, three or four countries were selected on the basis of demographic, language, geographic and existing capacity for research. The ten countries (Algeria, Cameroon, Central African Republic, Democratic Republic of the Congo, Kenya, Niger, Nigeria, Senegal, South Africa and Uganda) reflect a wide variety of health system models represented in the African Region. In addition, they constitute 26% of the 46 Member States and represent over 52% of the population of the Region.
7. In each study site, two health regions were randomly selected in two stages based on the most recent demographic and health survey (DHS) reports as well as maternal, infant, neonatal mortality and immunization coverage data. The regions were grouped into two clusters of high-performing and low-performing based on the health indicators.
8. The study combined biomedical and social science research methods: cross-sectional surveys, qualitative inquiry and case study research. Workshops were held to standardize the methodology and implementation of the study protocol to ensure the collection of comparable data.
9. The study was conducted in urban, peri-urban and rural areas. Eligible respondents were randomly drawn from 24 communities in six health districts in each site (a total of 240 communities). The study participants per site ranged from 799 in CAR to 980 in Kenya. The quantitative data were collected using an interviewer-administered household questionnaire. A total of 10 932 heads of households (HHHs) or their representatives were interviewed. The qualitative data collection was based on in-depth interviews (IDIs) and focus group discussions (FGDs) with various stakeholders including community members, and health personnel at

frontline, district and national health provision levels. A total of 24 FGDs were conducted per study site giving a total of 312 FGDs and 816 IDIs; 78 case studies were conducted.

KEY FINDINGS

10. The mean age of the 10 932 respondents was 43.9 years with a range between 38.7 and 54.6 years. Males comprised 53.2% of the sample. The distribution of sampled households in urban, peri-urban and rural areas was 33.8%, 33.1% and 33.1%, respectively. Most respondents had lived in the study areas for more than 25 years.
11. The study results provide important information on people's perspectives of being in good health and health system components that require leveraging to better respond to their expectations. The communities' definitions of health include "physical, mental, emotional, spiritual, social and economic well-being." This definition, which goes beyond the WHO definition of health¹, is illustrated by the quote below:

"What I think « agh » I would not be wrong, but the conceptualization I have of good health should be spiritual as well as physical. You can be physically in good health but not well spiritually. The most important thing is to be in good health spiritually and physically" (FGD, male adults, urban).
12. About 23% of respondents mentioned *the ability to work* (21.5%) as what constitutes good health. Other characteristics of good health mentioned included *movement* (19%) and *engagement in vigorous activities* (10.3%). According to most respondents, a good health system should be people-centred (at the individual and household levels), with policies, knowledge sharing, infrastructure, access to essential health services and strong community involvement. The respondents' perspectives identify the key components of

1 The World Health Organization defines health as follows: "Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (source: <https://apps.who.int/aboutwho/en/definition.html>).

- a health system to include: health and health-related policies, knowledge, medicines, health facilities, health personnel, delivery of health services within a framework of leadership, governance, stewardship, and community involvement.
13. The respondents recognized the high burden of communicable and noncommunicable diseases (NCDs) in their communities. Malaria was the most commonly reported health problem in 11 of the 13 sites, the exceptions being in Algeria and South Africa. Malaria and fever (mentioned by 69% and 53% of the respondents, respectively) were the most common health problems of children. For older people, the most commonly reported health problems were arthritis (42%), followed by hypertension (41.3%), malaria and eye problems (each at 35.9%). It is noteworthy that HIV/AIDS was not among the most commonly cited diseases across all the sites even in countries with known high prevalence.
 14. The level of awareness of NCDs was high across the study sites, especially hypertension, diabetes and mental health problems albeit with some site differences. In the East and Southern subregion, 63.2% and 41.1% of respondents mentioned malaria and fever as common ailments. Hypertension and diabetes received more mention in the East and Southern subregion (26.8% and 23.9%, respectively) and the West subregion (33.3% and 23.3%, respectively) compared to the Central subregion (22.5% and 12.2%). Algeria, DRC West, Nigeria South East, Senegal and South Africa reported high levels of awareness of diabetes as a common health problem.
 15. In all study sites, 85–90% of the respondents cited public sector health facilities as the main sources of health care. This was followed by private health facilities in urban areas (55.9%) and traditional healers (17.9%).
 16. In urban areas, respondents mentioned non-public sector such as faith-based health facilities (14.7%) and informal medicine vendors (13.8%) as alternative sources of health care. In the West subregion, the use of faith-based health facilities was mentioned by 5% of respondents compared to 22.3% in the East and Southern subregion and 17.5% in the Central subregion. Informal medicine vendors were mentioned as important sources of health care in the Central subregion by 18.1% of respondents and 15% of respondents in the West subregion. These findings have implications on the stewardship, regulatory, oversight and convening role of government in health system leadership and management.
 17. Though public sector health facilities were cited by 90% of respondents as the main sources of health care, the facilities were perceived and described by the people, in particular, those in the West subregion, “as centres for child immunization, and antenatal care and delivery for women.” In the three subregions, treatment of ailments was the commonest service offered in public health sector facilities as mentioned by 80.2% of the respondents in the West subregion, 79.9% in Central, and 54% in the East and Southern subregion. This was followed by services for children and women.
 18. On people’s rating of the responsiveness of the health services delivery, more than two thirds of the 10 932 respondents rated the services at public sector facilities as inadequate with the only exception being South Africa. The main reasons cited for the poor rating were: unavailability of drugs and equipment (39.1%); poor attitude of health providers (27.7%); and delays in the provision of care and long waiting time (13.1%). This perception is captured in the quote below:

“Previously, when I arrived at the health centre, I was welcomed. Before asking me for money they treated the child and only after that they gave me the bill. Now, what we see, you bring a sick child, the child is in coma but they ask you to bring medicines, blood and transfusion supplies. By the time you go through all these steps the child’s condition deteriorates” (FGD, male adults, rural).
 19. In general, the main factors influencing the rating of health facility services in the study were: health personnel attitudes towards users; insufficiency of medicines and other supplies; and the friendliness of the environment. There were differences by locations and subregions. Concerns and dissatisfaction

were more in the Central subregion (69%) followed by the West subregion (67%). The people's sentiments are captured in the quotes below:

"The health workers are not friendly. They are rude to patients" (FGD, female adults, urban).

"Only people who have relation(s) in the health centre have the opportunity to have good care and are well received. Those who have no relations in the hospital are ignored and nobody cares about them even if you are dying alone" (FGD, female youth, urban).

20. An adult male described the environment in public sector health facilities as unfriendly to the newborn, noting that:

"A newborn baby will be delivered well and before day dawn about 10 mosquitoes have already bitten him and this is before he leaves the hospital. How do you expect such a child to be fine? In such a case would you still want to go to the hospital or would you prefer another place?" (FGD, males, urban).

21. In contrast, the respondents who reported that the services were good attributed this mainly to health personnel responsiveness to users (42.7%), friendly environment (18.9%) and availability of medicines (14%).

22. Across localities (whether urban, peri-urban or rural), the responses present a description of a health system in which the greatest expectations by the beneficiaries are medicines, facilities and human resources. Where the health providers were responsive, people also expressed positive appreciation of the service: "We see in our centre, health personnel walking long distances on foot to get medicines" (Female FGD).

23. There are ailments for which people prefer to seek care from alternative sources due to their cultures and beliefs. About 25% of the respondents mentioned fever, malaria and arthritis as health conditions not taken to the nearest health facilities. Other ailments cited included depression and respiratory problems.

24. Traditional and spiritual healers constitute the main providers of health care for ailments not taken to conventional health facilities. Of the respondents who mentioned

traditional healers as the main recipients of ailments which they do not take to the hospital, 67.1% were from peri-urban communities. Other providers of care mentioned spiritual healers (21.1%) and informal medicine vendors (16.2%).

25. On access to health services, over 90% of the respondents knew where to seek health care. However, financial barrier was cited by 34.1% of the respondents as the main constraint to accessing health care. Other constraints included transport (11%), inadequate drugs (6.7%) and the perception that the health condition was not serious enough (5.4%). The study showed that 2.8% of the respondents were discouraged from seeking care in public sector health facilities as a result of the poor attitude of the health workers despite this being mentioned by 27.7% of the respondents as one of the reasons for rating these facilities as poor.

26. Three out of the ten participating countries have formal health insurance (Algeria, Cameroon and South Africa). The majority of the respondents in the three subregions did not have health insurance and had limited reimbursement of the money they spent on treatment. About 12% of the respondents had health insurance in the Central subregion, 9.1% in the East and Southern subregion and 2.5% in the West subregion. In CAR, respondents reported that the government, with resources from development partners, provided subsidies, while in Senegal the model was based on community financing. Exceptionally, in Algeria, the insurance companies provide 99.3% reimbursement for medicine for those in rural areas, 96.4% for those in urban areas and 98.9% for those in peri-urban areas. Respondents in some sites, particularly in South Africa, recognized access to free government health services. However, the overall proportion of the respondents who had free government health services was less than 14%.

27. Communities contribute to health service delivery in numerous ways: providing assistance in managing and maintaining the health facilities (20.9%), appointing volunteers (10.7%) and training community volunteers (10.5%). In some study sites, communities built the facilities (6.3%) or provided the

necessary labour for the construction (5.6%). Across localities, individuals' contributions to the delivery of community health services were highest in caring for patients as cited by more than 30% of respondents.

28. The results show that across the subregions, individuals are contributing to health care delivery. The highest proportion of those making contributions to health care delivery (37.7%) was in rural areas, followed by peri-urban (36.4%) and urban (34.0%) areas. However, as many as 26.2% of the respondents did not know how or if their communities contributed to health care and 64% had never made contributions.
29. It is noteworthy that a higher proportion of the respondents reported willingness to contribute to health service delivery in the future: 70.9% in the West, 66.2% in East and Southern, and 62.3% in the Central subregion.
30. Some of the respondents (40.5%) trusted that the government would do the right thing for the communities all the time but 13.8% reported that they did not trust government to act in their interest. The statement below captures the perspectives and some of the reasons people distrust governments:

“We acquired land some time ago to build residential quarters for the health personnel so that they would work well. In fact, we had started moulding the blocks and pouring sand at the site. Then the local government chairman, at that time, said that we should not build the residential quarters because the government would do it. As we speak now, the quarters have not been built and all the blocks and sand have been wasted” (IDI, community leader, peri-urban).
31. The level of involvement of communities in decision-making about how health services could be delivered was rated as poor in East and Southern (48.8%), West (44.0%) and Central subregion (41.8%). These proportions indicate the insufficient inclusion of community members in decision-making within the health reform agenda.
32. On ways to improve the delivery of essential health services, participants suggested improving the supply of medicines as the most significant aspect in which health

services should be improved. This was followed by improved quality of health staff and the construction of health facilities. The participants involved in the FGDs expressed similar views, as illustrated below:

“You know why we are asking for the staff to be increased? If you're just here at 11pm and you are sick, whatever the gravity of your illness, you will wait until the next day. There is nobody who will be here to put a drip on you because they will say that there will be no personnel to take care of you during the night. This is what they will tell you” (FGD male, peri-urban).

CONCLUSIONS

33. This study has shown that people's perceptions of health and health service delivery provide valuable insights that could help to improve health systems' responsiveness and effectiveness in the African Region. The results indicate that communities understand the dynamics and interactions that often influence the delivery of health care and the outcomes at the community level. The study provides useful insights into the determinants of health including the physical, mental, emotional, spiritual, social and economic well-being dimensions. People are concerned about malaria, fever and NCDs that require additional investments at the district and community levels. The respondents were equally concerned about the shortage of medicines in the public sector health facilities and the poor attitude of health personnel, in particular during emergency situations.
34. In spite of government and partner efforts to strengthen health service provision in most countries in the Region, the users still find the health care and facilities inadequate. The findings show that local and community health services are under-resourced and require more investments to boost their capacity to deliver quality care and increase access for the poor and vulnerable members of society including older persons. Services in district public sector health facilities should not be limited or perceived by the people to be limited to only children (immunization)

and women of child-bearing age (antenatal and delivery care) but should be expanded to other interventions that respond to broad community needs.

35. The gaps in social protection and the challenges highlighted by this study call for the establishment of more effective mechanisms that would spare households from catastrophic out-of-pocket expenditures and lead to the use of both public and non-public sector health facilities. The study also illustrates the importance of community involvement in the governance of health services.
36. The overriding observation is that more is required: more funds, staff, medicines, facilities and efforts towards improving the performance of national health services. Moreover, efficient management of existing resources is critical.
37. The perceived non-inclusion of community members in decision-making is an issue of concern. Although the findings show that a high proportion of the respondents trust that their governments will act in their best interest, a key challenge is government ability to meet the high demand for essential health services despite being signatories to numerous commitment and declarations.
38. The contribution and significant role that individuals and communities can play in providing information on the local health situation and the potential role they could have in the delivery of health services are underscored by the results of this study. Engaging the users of services will not only improve access but will also lead to innovative mechanisms for tapping resources and leveraging people's potential. This will contribute to improved health system performance, and provide solutions to efficient use of resources. In addition, it will provide effective delivery of health services to the broadest possible population.
39. As the global health architecture is undergoing structural changes, which include an emphasis on "smart spending", there is a need for new designs and frameworks on the delivery of health services to generate creative models that are more responsive to improved health outcomes without necessarily waiting for huge financial investments. The expectation of this study is that

the results will sensitize policy-makers about new ways of designing health systems in recognition of the huge untapped potential of communities in Africa in the process of national and regional health development.

RECOMMENDATIONS

40. In light of the findings, governments, communities and partners should consider the following recommendations:
 - (a) Establish mechanisms to increase providers' awareness on the multi-dimensional and complex nature of health that is perceived by the communities as a state of *physical, mental, emotional, spiritual, social and economic well-being*. Health stakeholders should consider people's knowledge in their analysis, policy formulation and practice in a broader context of health reforms guided by scientific evidence and normative work;
 - (b) Enhance the quality of health care through reforms that improve infrastructure, in particular health facilities, qualified staff, essential medicines and financing that will result in universal health coverage and improved user satisfaction; these measures would benefit from effective use of guidelines and supportive supervision;
 - (c) Establish community-based surveillance systems for detecting and reporting the most common health problems, including communicable and noncommunicable diseases, facilitate awareness of risk factors associated to these conditions and institutionalize community-based case management;
 - (d) Expand the range of health interventions to address, in addition to children and women of child-bearing age, the needs of adolescents and older persons as well as other vulnerable groups;
 - (e) Establish appropriate health financing mechanisms including social health insurance, taxation, community financing and other options towards universal health coverage;
 - (f) Design health reforms that would be implemented through innovative approaches that enhance effective

community representation, ownership and participation in health service policy formulation, planning, organization and operations;

- (g) Support the conduct of social, epidemiological and health service research and the documentation and sharing of public health best practices in order to promote and support the scaling up of essential public health interventions in the African Region and accelerate progress towards the achievement of national and internationally agreed health goals.

It is a typical village story. Households live on less than one dollar a day. To access basic health care services, community members—women, men and children—walk for 20 kilometres or more to the nearest health facility,

sometimes to find no health worker and no drugs. When drugs are available in the village medicine store, they may be expired or fake. In this village, there is no doctor. For children, malaria, fever, diarrhoea, and vomiting are frequent; adults suffer from hypertension. But health information is scarce. Heads of households and village leaders have good ideas on resolving health issues but the health providers who visit the village assume falsely that local input does not count. They think for the leaders and community members. They plan health initiatives for the village without asking for the consent or views of the local people. They say the community is the “heart-beat” of the health system, but the people are involved neither in decision-making nor planning.

I Introduction

In recognition of the fact that health services all over the world were not responding to the needs of the populations they served, the World Health Organization (WHO), through the Alma-Ata Declaration of 1978 (WHO and UNICEF, 1978; Lawn et al, 2008), launched the Primary Health Care (PHC) approach which focused on the key role of shared commitment and community participation in the delivery of health services. The fact that people in urban, peri-urban and rural communities potentially make valuable contributions to the design and organization of effective health services was again underscored in the Addis Ababa Declaration (WHO, 2006), the World Health Report (WHO, 2008e) and the Ouagadougou Declaration (WHO, 2008a). In these declarations, the WHO revisited the PHC model and emphasized the principles of people-centred approaches and universal coverage.

Member countries' financial obligations to address what is considered a public health crisis in the continent (WHO, 2003) were identified by African Heads of State in the Abuja declarations of both 2000 and 2006, the latter calling for universal coverage of health interventions mainly for malaria, tuberculosis and HIV/AIDS. However, the actions suggested mainly target countries and governments without identifying roles for communities or community-based organizations.

In the past few years, the global health community has broadly placed renewed focus on strengthening health systems (G8 Health Experts Group, 2008; Reich et al, 2008), acknowledging that systemic weaknesses are major reasons

for the delays in achieving the Millennium Development Goals (MDGs). Despite national and international efforts, health interventions are not adequately meeting the health needs of the people, especially those living in poor and marginalized communities.

Improving the health workforce, increasing funding for strengthening health systems and expanding the knowledge base about how to make health systems work better would greatly benefit the over 800 million people living in the WHO African Region (WHO, 2008f). However, increased finances, expanded inputs in health service delivery (including the construction and location of health facilities) and improved availability of health technology or medicines do not necessarily lead to better health outcomes (Travis et al, 2004; WHO, 2000).

In the last two decades, African governments and the global health community have formulated policies, designed programmes and allocated funding for the delivery of health services, health system strengthening and monitoring of MDG indicators based on their perceptions of the characteristics of a good health system. What is missing in all these efforts is the voice and contribution of the end-users of the health system.

This omission may be due to the fact that high-level decision-makers do not always listen to the views of populations in the lowest socio-economic quintiles; in addition, some decision-makers may lack the mechanisms for engaging communities in policy formulation, planning, implementation, monitoring and evaluation. In order to significantly improve the health of

populations, it is necessary that end-users (particularly the poor and marginalized) design and plan the health services target for them.

RATIONALE

Recent reviews by WHO (2011) indicate that most countries in the Region are unlikely to achieve MDGs 4, 5 and 6. The slow progress in health development and in the realization of global and national targets has been related to weak health systems of which there are six key elements: (i) service delivery; (ii) health workforce; (iii) information; (iv) medical products, vaccines and technologies; (v) financing; (vi) leadership and governance (WHO, 2007; WHO, 2006; Sambo and Kirigia, 2011).

The current Regional Office focus on strengthening health systems, which is based on the PHC approach towards universal health coverage, is an excellent opportunity for implementing health interventions that are responsive to people's needs. Such interventions would be better placed to utilize locally available human and financial resources to effectively, efficiently and sustainably improve health outcomes in Member States (WHO 2008a, b, c). However, the main barriers to improved health outcomes

include ineffective governance, inadequate workforce, and limited and uneven resource allocation.

Several health system strengthening approaches implemented in the Region such as Reaching Every District (RED) and Community-Directed Treatment with Ivermectin (CDTI) have demonstrated that when governments and communities take responsibility, health programmes can be successfully implemented and result in better health outcomes. However, the implementation of these interventions requires building effective partnerships with communities and other stakeholders to achieve a comprehensive response.

Information on health systems strengthening for the African Region is primarily based on the views of health providers, with little input from the clients. This gap exists despite the increasing recognition of the role of communities in the delivery of health care, particularly in developing countries where the health infrastructure remains weak.

This study was undertaken to provide evidence on how best to formulate a health systems strengthening framework that responds to the needs of communities by considering people's perceptions and perspectives of health and health service delivery.

2 Research Questions and Objectives

2.1 OVERALL RESEARCH QUESTIONS

The research was guided by six key questions:

- (a) How are health and health care delivery perceived by African communities?
- (b) How is health care implemented in selected urban, peri-urban and rural health districts?
- (c) To what extent are existing health service delivery systems responsive to community needs?
- (d) What is the existing potential and capacity of communities to contribute to and engage in health service delivery?
- (e) How can people and groups in urban, peri-urban and rural communities be empowered in community health development and how can their capacity be increased?
- (f) What are the perspectives of the communities on the delivery of health care?

2.2 RESEARCH OBJECTIVES

The main research objective was to describe the realities of essential health care in Africa and assess community² perceptions and perspectives

on essential health service delivery in order to develop more appropriate mechanisms for health service delivery through community participation.

The specific research objectives were to:

- (a) Describe community perceptions of health and health service delivery in selected African communities;
- (b) Describe and analyse the implementation of essential health service delivery at the level of health districts (urban, peri-urban and rural), documenting experiences with community engagement in health care service delivery;
- (c) Assess community expectations regarding patient- and community-responsive health services;
- (d) Assess community readiness (ability, willingness and capacity) and constraints for participating in health service delivery;
- (e) Recommend measures for effective community engagement and improved essential health service delivery mechanisms by taking into consideration community perspectives.

² **Community:** A group of people who occupy a defined territory under common leadership, with access to shared local resources, as the base for carrying out the greatest share of their daily activities. Such a group may vary by country to include villages, quarters, groups of hamlets, peri-urban, urban, rural and mobile populations, and temporary settlements.

3 Methodology

3.1 STUDY DESIGN AND METHODS

This is a multi-country, multidisciplinary cross-sectional study designed to describe and analyse community perceptions and expectations of health and health care in the context of district-based health systems in the WHO African Region. The main aim of the study was to determine key factors for community engagement and empowerment in the governance, management and implementation of PHC. The study combined both quantitative and qualitative analytical methods as well as case studies originating from public health and social science research.

The quantitative data were collected by use of an interviewer-administered household questionnaire aimed at heads of households. In the absence of the household head, a representative was interviewed based on his/her position in the household. The qualitative inquiry was based on in-depth interviews (IDIs) and focus group discussions (FGDs) with various stakeholders including community members, opinion leaders and health personnel. Case studies aimed at collecting detailed information from the district/LGA health facilities by use of records reviews, checklists and in-depth interview guides with facility managers.

3.2 STUDY SITES AND POPULATION

The study was conducted in 13 sites in ten countries selected through a multi-stage sampling process. First, the countries were clustered into three subregions according to the WHO African

Region organizational structure: West, Central, East and Southern subregions. Within each subregion, three to four countries were selected. The ten countries represent 26% of the Member States (46) and 52% of the Region's total population. The ten countries were Cameroon, Central African Republic and Democratic Republic of the Congo in the Central Africa subregion; Kenya, South Africa and Uganda in the East and Southern Africa subregion; and Algeria, Niger, Nigeria and Senegal in West Africa subregion. Given the vastness of DRC and Nigeria, multiple sites were selected (three in Nigeria and two in the DRC). The study population comprised of heads of households or their representatives, community leaders, community-based organizations, community health volunteers and health personnel at peripheral, district and national levels.

3.3 SAMPLING

Selection of health regions and districts

Owing to variability of PHC development at regional and district levels, two health regions³ were randomly selected in two stages. First, the health regions were grouped into two clusters of high-performing and low-performing using the most recent Demographic and Health Survey (DHS) reports, datasets on maternal, infant, neonatal mortality and immunization cover-

³ A health "region" may be defined differently in various countries, e.g., as "province", "state", or "health district."

age. Intermediate indicators such as delivery under skilled personnel and/or DPT3 coverage were also used. Secondly, one health region was randomly selected from each cluster of health regions.

The health districts in each of the two selected health regions were classified and grouped into clusters of urban, peri-urban and rural. One urban, one peri-urban and one rural health district were randomly selected from each sampled health region.

Selection of communities within districts

From the list of communities in each selected district, four communities were selected using a simple random process to form the sampling clusters from which eligible respondents were drawn. This gave a total of 24 communities in six health districts drawn from two health regions in each country site.

Household sample selection

Using a 50% assumed rate of awareness of health services in the communities and a confidence interval of 95% with an estimated 3.5% error margin, a sample size of 770 ± 27 was computed using the following formula:

$$Z^2 \times (p) \times (1 - p) / c^2$$

where:

$$Z \text{ value for 95\% confidence level} = 1.96$$

$$p \text{ (\% household heads awareness of the PHC system)} = 0.5$$

$$c = \text{confidence interval} = 0.5$$

The sample size was, however, rounded up to 840 households per country site, taking into account a 5% contingency rate. Each country site team interviewed about 35 households in each of the 24 communities.

To select the households, a central location in each of the randomly selected communities was identified, and this served as the starting point for data collection. Two research assistants were assigned to cover each community cluster. The research assistants moved in opposite directions from the identified starting point in each community and continued to turn right at any

junction until the desired number of respondents was attained. On occasions where the number required in a cluster was not reached, interviewers moved into an adjacent community to complete the sample.

3.4 RESEARCH INSTRUMENTS

Ten research assistants with local language knowledge drawn from universities and research institutions in the selected health regions were trained in each country site on the objectives and data collection techniques. A training manual was developed to guide the teams to ensure the collection of standardized quality data. Four different types of research instruments⁴ were used, each targeting different sources of information to investigate the research questions. The research instruments are described briefly below.

The household survey questionnaire was administered by an interviewer to about 35 heads of households or their representatives and provided information on the health service experiences, perceptions and expectations from the perspectives of respondents. Information on the demographic characteristics, lifestyle and environmental risk factors was also collected. This instrument also investigated the willingness and capability of respondents to participate in the delivery of essential health care services in the communities.

There were three types of guides for in-depth interviews (IDIs). The IDIs were used for collecting information from 816 key informants that provided qualitative data on the delivery of essential health services in the study communities; the willingness and capability of communities and health volunteers to continue to participate in their provision roles; and the perceptions and expectations about health services. The three main groups interviewed included community leaders and representatives of community-based organizations (CBOs); community health volunteers; and health personnel at frontline health facilities.

The third research instrument was the guide for focus group discussions (FGDs) with community groups. A total of 24 FGDs comprising 8-10 participants were held at each site with separate

4 Refer to <http://www.who.int/apoc> for the study tools.

groups of adult females, adult males, adolescent females and adolescent males. This resulted in 312 FGDs in all the 13 sites. As with the IDIs, the FGDs elicited information on people's experiences, perceptions and expectations of health services as well as the communities' willingness and capability to continue participating in the delivery of essential health services.

Guidelines for case study research on district-based essential health services were provided for generating detailed contextual case studies on the delivery of essential health services in the catchment areas. This instrument guided the principal investigator for each site who conducted the interviews with health policy-makers, opinion leaders and health workers in the health district. Documents were also reviewed to ascertain funding and the availability of other resources (e.g. health commodities, equipment, personnel and technology) at the health facility.

Pilot study and standardization of instruments

Each team pre-tested the instruments in health districts outside the districts selected for the study. Districts selected for the pilot studies were purposively selected. Data from the pilot study were analysed and used to refine the data collection instruments before the teams embarked on the main study.

3.5 DATA ANALYSIS

Quantitative data

The data collected were double checked by field supervisors before computer entry using EPI-Info by trained data entry personnel. All data files were continuously checked and cleaned by data entry supervisors and rechecked by a senior statistician before their use for analysis in SPSS. Descriptive statistics were used to characterize the respondents. Frequency distribution tables and illustrative graphs were used in presenting the data.

Qualitative data

All interviews were tape-recorded, and detailed notes were simultaneously taken of non-verbal cues and verbal citations. Tape-recorded

interviews were transcribed according to standard rules (MacLean, Meyer and Estable 2004) and translated into French and English by the country teams. Detailed minutes were taken from all stakeholder consultations and carefully transcribed soon afterwards. All textual data were entered into the AtlasTi software and coded according to a code-list established by the project team. Citations by code and memos were analysed in accordance with emerging themes using the network visualization abilities of the AtlasTi software for qualitative analysis (www.atlasti.com).

Case studies

The case studies enabled in-depth assessments of the realities of essential health care delivery in the study sites. The results of the interviews with health managers have been presented in this report in the form of boxes.

3.6 ETHICAL CONSIDERATIONS

The following were steps taken to ensure compliance of the study with standard ethical rules.

- (a) The core research proposal was submitted for ethical clearance through the WHO Research Ethics Review Committee.
- (b) Each of the 13 participating research teams obtained national IRB approval and government clearance as appropriate, except in Democratic Republic of the Congo where only one set of documents was made for the two sites.
- (c) All team members were carefully briefed to ensure respect, protection and promotion of the rights of study participants.

Informed consent was sought from all study participants and anonymity was assured with respect to recorded and reproduced interview data. The consent form contained information on the purpose of the study, study team composition, expected duration of the study and expected length of the interviews and discussions. It also described the right of the participant to decline participation in the study or not to respond to specific questions without prejudice; measures taken to ensure confidentiality and to contact person in case of need for further information. The information sheet and

consent processes were developed for each type of respondent to ensure clarity of the study terms and conditions.

3.7 THE STUDY PROCESS

Pre-testing of the data collection tools was undertaken in May-June 2010 and the data collection was carried out between July 2010 and March 2011 in all the study sites. In view of the multi-country nature of the study, which entailed the involvement of scientists from diverse disciplines and backgrounds, nine workshops were held to ensure standard implementation of the study protocol, collection of valid and comparable data, and interpretation of results.

- Development of the draft study protocol, Brazzaville, Republic of Congo, October 2009.
 - Finalization of the study protocol with scientists from the participating countries, Brazzaville, April 2010.
 - Workshop to standardize the study instruments after pre-testing, Ouagadougou, Burkina Faso, August 2010.
 - Training of data managers and social scientists on Atlas.Ti, Epi-Info and SPSS, Ouagadougou, November 2010.
 - Training of data managers and social scientists on Atlas.Ti, Epi-Info and SPSS, Ibadan, Nigeria, January 2011.
 - Preliminary analysis of data, Brazzaville, June 2011.
 - Final analysis workshop and report writing, Ouagadougou, October 2011.
- Peer review meeting, Brazzaville, May 2012.
 - Final peer review meeting, Brazzaville, June 2012.
 - Briefing session for ministers of health of participating countries, Geneva, Switzerland, May 2012.

3.8 STUDY LIMITATIONS

The study had three main limitations that should be taken into account when interpreting the results. Firstly, the study focused on perceptions and awareness but did not measure disease prevalence. Therefore, the results on health problems should be interpreted with this understanding.

The two regions selected per site may not be representative of the entire country although they were selected randomly. To mitigate this limitation, the data were corroborated by interviews with health providers at all levels (from community to national levels), and there was an extensive review of literature to validate the results.

There is a possibility of bias by the research teams and the study respondents that could have influenced the responses to the study questions. To address this shortcoming, several measures were put in place to ensure standardized collection of data (including the development of a training manual) and detailed training sessions with the study team per site. The investigators were also involved in several training workshops to ensure that the effect of any individual bias was minimized.

Triangulation of data from the various data collection tools has been done to minimize the weaknesses of the three methods used in this process.

4 Results

4.1 SOCIO-DEMOGRAPHIC INFORMATION

A survey of 10 932 heads of households (HHHs) or their representatives was conducted in 13 sites in ten countries: Algeria, Cameroon, Central African Republic (CAR), Democratic Republic of the Congo (DRC East, DRC West), Kenya, Niger, Nigeria (North West, South East, South West), Senegal, South Africa and Uganda. The participants per site ranged from 799 in CAR to 980 in Kenya. The distribution of sampled households in urban, peri-urban, and rural areas was 33.8%, 33.1% and 33.1%, respectively. Most respondents had lived in the study area for more than 25 years except in Nigeria South West where the majority had lived in the

study community for 5-10 years. The overall sample of HHHs or their representatives comprised slightly more males (53.2%) than females although this trend was reversed in six sites where the majority of respondents were females. This latter group of sites included South Africa (67.3%), Uganda (63.9%), DRC East (55.1%), Kenya (54.5%), Senegal (53.3%), and Nigeria South West (51.5%). The sex distribution of the respondents across the three geographic areas (urban, peri-urban and rural) was similar in all sites, except in South West Nigeria where the urban sample had more male respondents. Figure 1 displays the mean age of the respondents in the 13 sites.

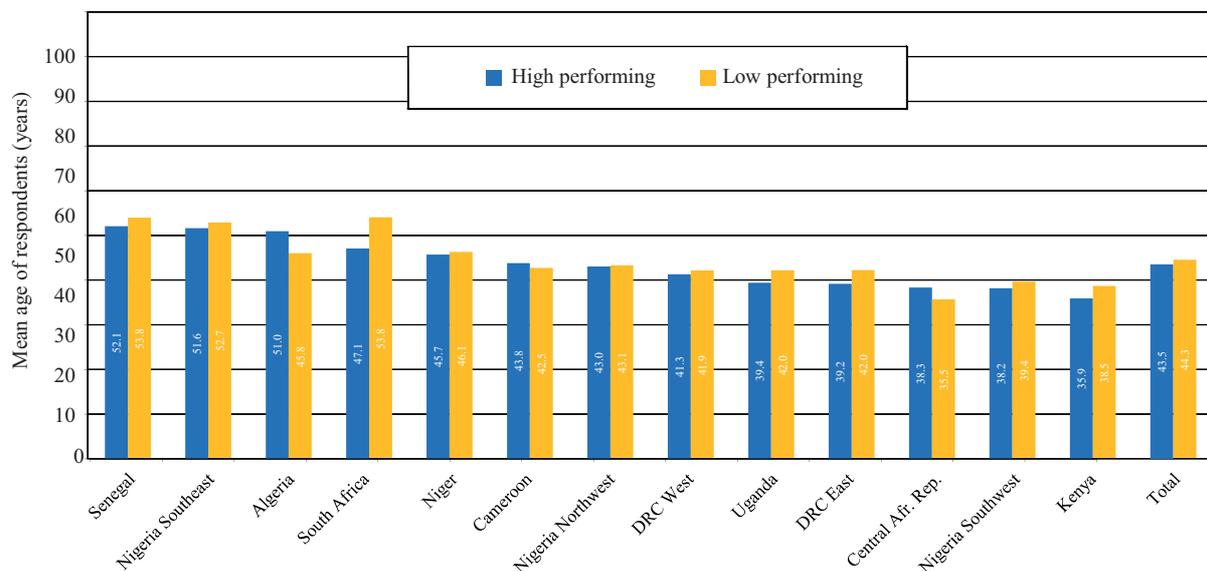


Figure 1 Mean age distribution of respondents by high- and low-performing regions

The mean age of respondents per site was 43.9 years with a range from 38.7 to 54.6 years (Annex 2). Males in the sample were, on average, older (45.7 years) than females (41.7 years). The mean age of respondents was 43.4, 44.1, 44.2 years for urban, peri-urban and rural locations, respectively.

Marital status

The proportion of the respondents currently married was 72%. The rest belonged to the following categories: never-married (15%), widowed (8.6%), divorced (2.3%) and separated (1.4%). Among married respondents, 26.9% were aged 35-44 years, while 31.7% of the proportion never-married were aged 25-34 years. Of the male respondents, 81% were married compared to 63.3% of the females.

The proportion of married respondents in the 25-34 age group by site was as follows: North West Nigeria (94.6%), Uganda (81.2%), Cameroon (67.2%), and CAR (45.4%). The majority of married respondents aged 35-44 years were in Algeria (89.2%), DRC East

(84.3%), DRC West (80.9%), Kenya (83.2%), Niger (94.2%) and Nigeria South West (69.9%).

Religion

Figure 2 shows the distribution of respondents by religious affiliation. In nine of the 13 sites (Cameroon, CAR, DRC East, DRC West, Kenya, Nigeria North West, Nigeria South West, South Africa and Uganda), the respondents were predominantly Christian, while Islam was the main religion in Algeria (100%), Niger (99.4%) and Senegal (98.2%).

School attendance

The proportion of respondents who ever attended school in all sites was 79.6%, ranging from 57% in Niger to 92% in Cameroon. A high proportion of respondents in Niger (49.4%), Nigeria North West (32.7%) and Senegal (52.3%) had religious or non-formal education (Figure 3). More males (83.8%) than females (74.8%) had ever attended school.

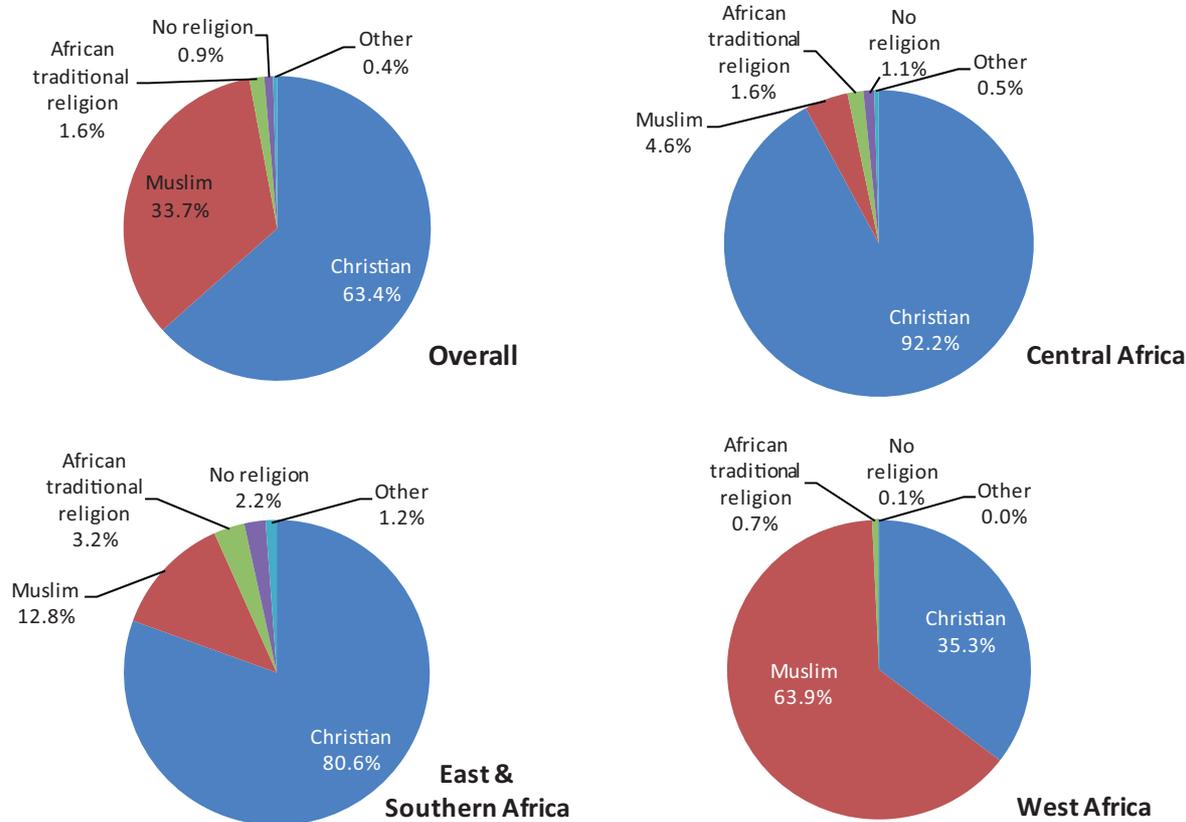


Figure 2 Distribution of respondents' religious affiliation, overall and by subregions

Figure 4 shows that in eight sites (Algeria, Cameroon, CAR, DRC West, Niger, Nigeria South East, Nigeria North West, and Senegal), more than 50% of respondents who had ever attended school were males, and in five of the

sites (DRC East, Kenya, Nigeria South West, South Africa and Uganda) more than 50% who had ever attended school were females (Figure 4 and Annex 3).

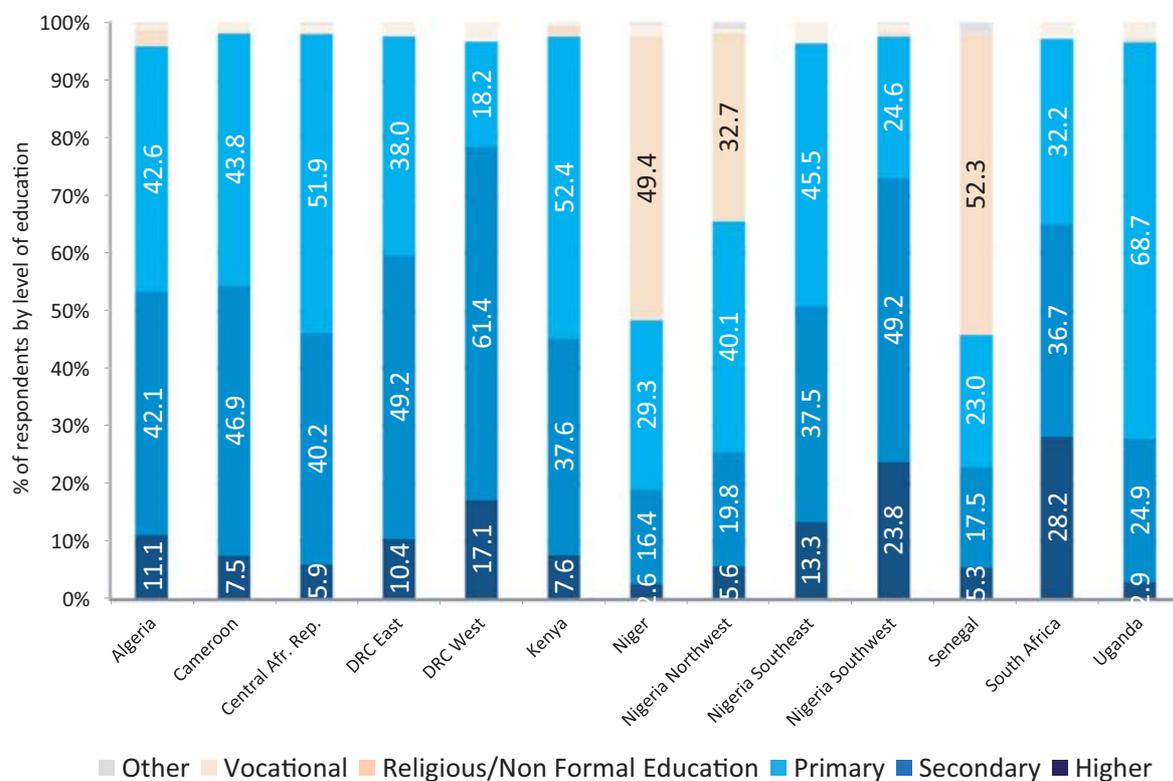


Figure 3 Distribution of the highest level of education of respondents by site

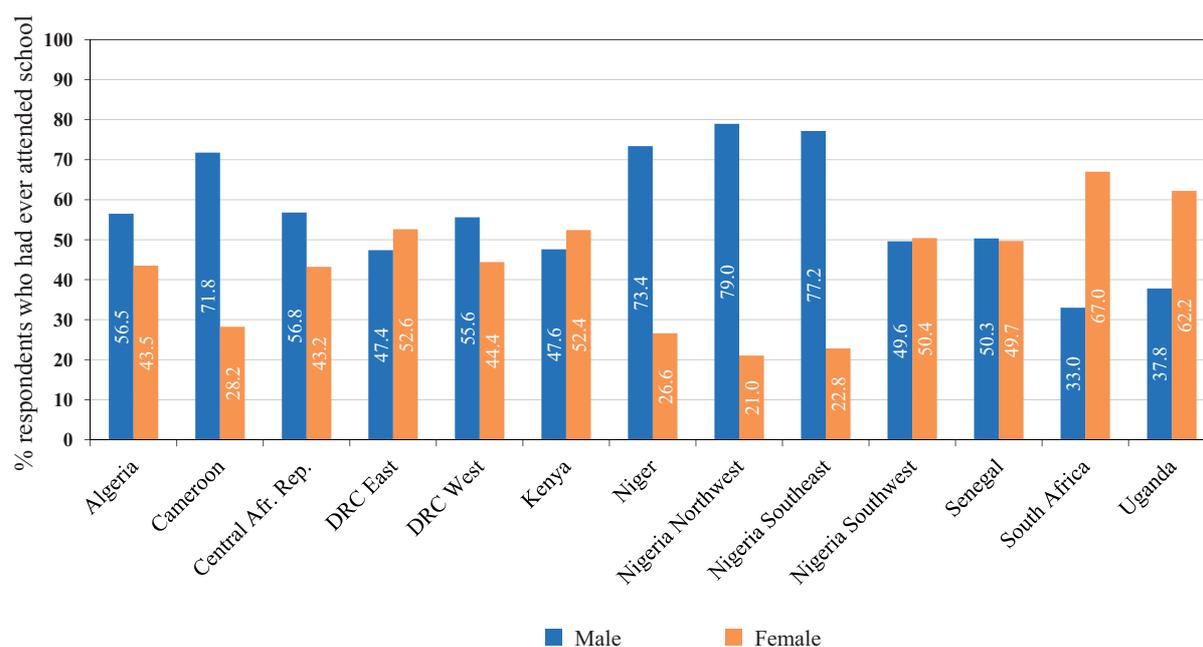


Figure 4 Distribution of respondents who had ever attended school by site

Engagement in income-generating activities

More than 60% of respondents were engaged in income-generating activities (IGAs)⁵, with the exception of South Africa where only 41.3% earned an income. Of those who had ever attended school, more than 60% were engaged in IGAs, the highest proportion being in Nigeria South West (89.1%) and the lowest in South Africa (43.5%). Of those who never attended school but engaged in IGAs, the highest level was similarly reported in Nigeria South West (88.4%) and the lowest in South Africa (32.9%).

With regard to gender distribution by site, 84.1% of the males and 68.4% of the females were engaged in IGAs. Males in Nigeria North West (95.4%) are more engaged in income-generating activities while South Africa (49.5%) reported the lowest proportion. Among females, the highest proportion was reported in Nigeria North West (88.6%), while the lowest was reported in South Africa (37.3%). In the high-performing regions, 79.4% of respondents indicated that they were involved in IGAs, while in low-performing regions, 74% of the participants were involved ($p < 0.001$). Analysis by site showed that Nigeria North West had the highest proportion of respondents engaged in IGAs in both high- (95%) and low- (91.9%) performing regions.

The distribution of IGAs in postconflict countries (CAR, DRC East and West study sites) for high-performing regions were 83.2%,

5 Income-generating activities include farming, hunting, fishing, livestock breeding, small-scale trading, paid/salaried employment, artisans and business.

76% and 72.9%, respectively, while low-performing regions reported 87.6%, 65.5% and 74%, respectively.

4.2 COMMUNITY PERCEPTIONS OF HEALTH AND HEALTH CARE DELIVERY

The community concept of health derived from the qualitative data includes spiritual well-being. Respondents described good health as the ability to work and move around as well as the emotional, psychological, economic, mental and spiritual aspects of health. A representation and reconstruction of people's perception is presented in the discussion section.

Signs and definition of good health according to the views of respondents

The respondents were asked to mention what they considered signs of good health. Physical signs were cited most frequently as an indicator of good health: ability to work; movement; engagement in vigorous activities; and absence of aches and pains. Although anxiety and depression were also mentioned, they ranked lower as shown in Table 1.

The "ability to work" ranked high in DRC (urban, 72%; peri-urban, 90%; and rural, 85.2%); and Northwest Nigeria (urban, 96.1%; peri-urban, 87.9%; and rural, 94.6%). In Algeria ability to work was reported by 73.2% in peri-urban, 58.8% in rural and 55.4% in urban areas.

The community members articulated what they considered signs of good health through FGDs as illustrated in the following quotes.

Table 1 Signs of good health by locality

Signs	Urban		Peri-urban		Rural	
	Number of mentions	% of respondents	Number of mentions	% of respondents	Number of mentions	% of respondents
Ability to work	2786	23.1	2791	21.8	2838	21.5
Movement	2336	19.3	2440	19.1	2445	18.5
Engagement in vigorous activities	1208	10.0	1351	10.6	1369	10.4
Absence of aches and pains	1161	9.6	1231	9.6	1177	8.9
Ability to sleep and wake up	854	7.1	1015	7.9	1022	7.8
Ability to care for self	793	6.6	883	6.9	910	6.9
Absence of sadness and depression	613	5.1	640	5.0	636	4.8
Absence of anxiety and worry	595	4.9	540	4.2	450	3.4

“When I say someone is healthy it means that person is not suffering from any sickness. He or she is moving around well and in strength. Somebody who is healthy cannot be lying down. He will be moving about, performing his normal functions and duties. He does not complain of headache” (FGD, males, urban).

Income status was also seen as a measure of good health:

“Without any money to cater for our needs we cannot be healthy . . . for example people without money are very weak and unhealthy . . . but people who are rich are healthy because they can afford the basics Poverty is the underlying cause of ill-health. It causes high birth rates consequently leading to malnutrition and ill-health. So, saying one is healthy means he is economically able to meet his basic needs” (FGD, adult males, rural).

In other discussions, the opinions were more elaborate.

“Health is life. It is the protection of the body against all the diseases. Having a healthy body is to have good sight, and an excellent perceptibility of the ears, eats good food because that allows the person to carry out his duties well and gives him power to participate in society issue. That is health” (FGD, female youth, rural).

The spiritual dimension of health was repeatedly mentioned by study participants. A sample

of quotes from various countries represents this dimension.

“What I think « agh » I would not be wrong, but the conceptualization I have of good health should be spiritual as well as physical. You can be physically in good health and not well spiritually. The most important thing is to be in good health spiritually and physically. This is what I wanted to say” (FGD, adult males).

“When I go to church I worship my God peacefully, my heart is at rest, on my part I am in good health. Nothing disturbs my heart, I have no anxiety then I know I am in good health” (FGD, adult males).

“We have got categories - mental health, physical health and spiritual health. I tend to think such a person is healthy” (FGD, male youth, urban).

“You can be healthy biologically or healthy spiritually” (FGD, male youth, urban).

“It means that the person will be both physically, mentally, spiritually and otherwise, the person is fit” (FGD, female youth, peri-urban).

Common health problems as perceived by the communities

Malaria was cited as the most common health problem in all the sites, except Algeria and South Africa (Figure 5). Nearly three quarters of all the respondents (73.3% in the urban, 76.3% in

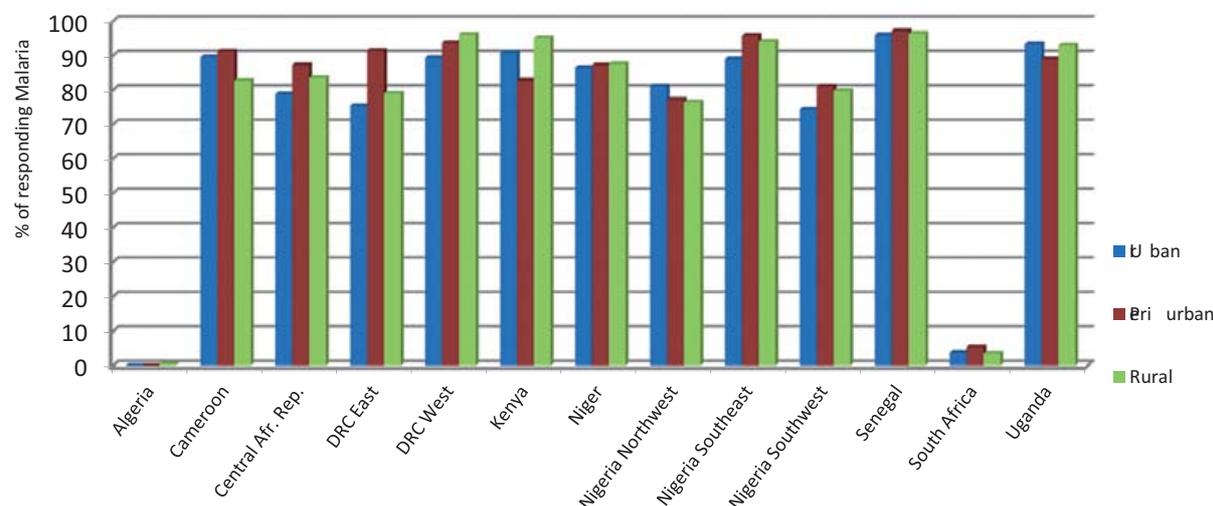


Figure 5: Proportion reporting malaria as a common health problem per site

Box 1: Common health problems in study sites—views of health workers (case studies)

- 1.1 “Malaria naturally is endemic in Nigeria and . . . it cannot be an exception (here) but also I know that the environment accounts for the high rate of malaria in the local government area (LGA). Like we are here, there are many bushes around and we are not yet aware of the use of insecticide-treated nets which has been advocated in Nigeria and the world as a whole. If we had treated bednets, probably the rate would be down” (head of district health).
- 1.2 “The district manages the following diseases: malaria, onchocerciasis, diarrhoea, dysentery, cholera, tuberculosis, Buruli ulcer, HIV/AIDS (PMTCT); supplies commodities such as vaccine, insecticide-treated bednets, fight against worms in the medical units and schools. The district is also in charge of the supervision of activities and of the progress reports of health areas that are submitted to the regional level” (district medical officer).
- 1.3 “About 50% of them (indigenes) resort to traditional medicine. . . . the indigenes of this community are predominantly farmers so they don’t have money to go to the private hospitals we have around, so they resort to traditional medicine even in childbirth. It is a very bad experience, even in childbirth they resort to traditional medicine. That is what they do because the health centre is located very far from here and government hospitals when you go there, you need some money, you need a lot of money to pay to get health services there . . .” (community leader).

Table 2 Leading 10 most common health problems as perceived by locality

Health problem	Urban		Peri-urban		Rural	
	Number of mentions	% of respondents	Number of mentions	% of respondents	Number of mentions	% of respondents
Malaria	2683	73.3	2748	76.3	2700	74.9
Fever	1711	46.8	1712	47.5	1793	49.7
Diarrhoea	741	20.3	965	26.8	1037	28.8
Hypertension	1055	28.8	1060	29.4	1000	27.7
Respiratory problems	818	22.4	949	26.3	989	27.4
Arthritis	702	19.2	868	24.1	842	23.3
Diabetes	761	20.8	710	19.7	727	20.2
Eye problems	576	15.7	753	20.9	826	22.9
Pain	597	16.3	745	20.7	763	21.2
Vomiting in children	495	13.5	653	18.1	685	19.0

peri-urban and 74.9% in the rural areas) reported malaria as the overall leading health problem in their households. The leading health problems reported in households from all of the sites are presented in Table 2. It is noteworthy that although respondents mentioned HIV/AIDS as a common health problem, it was mentioned by less than 15% of the respondents.

The proportions of households that reported malaria as an important health problem among the localities are shown in Figure 5. Malaria ranked high in 11 of the 13 sites with DRC West, Nigeria South East, Senegal and Uganda reporting the highest levels. Information provided by

the FGD and IDI participants and case studies with health workers corroborated the quantitative results.

Noncommunicable diseases: hypertension

Hypertension was reported in all 13 sites with some remarkable differences between and within the sites. Respondents in peri-urban areas of Algeria and DRC West reported hypertension as being common while rural areas in Niger, Nigeria South East, Senegal, South Africa and

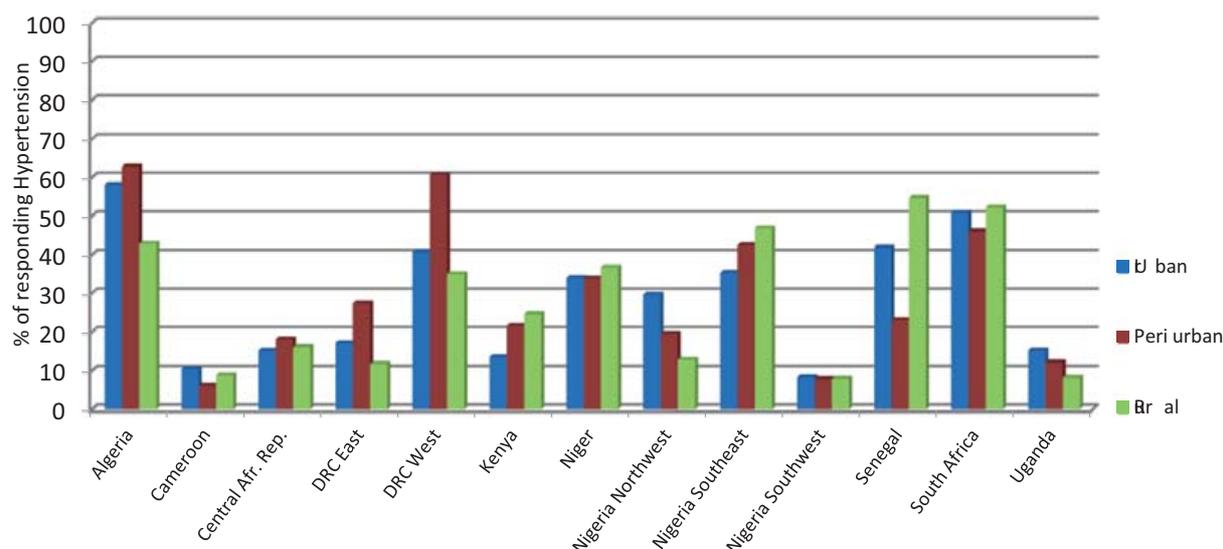


Figure 6: Proportion of respondents reporting hypertension as a common health problem per site

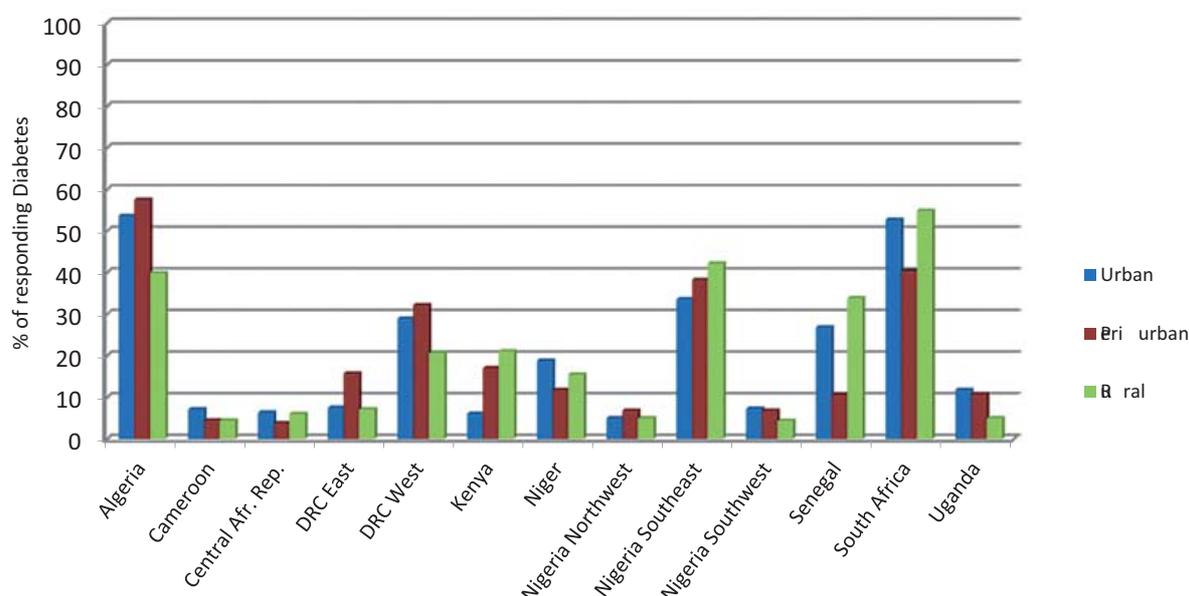


Figure 7: Proportion of respondents reporting diabetes as a common health problem per site

Kenya reported higher levels than the urban and peri-urban areas, as shown in Figure 6.

Noncommunicable diseases as perceived by respondents: diabetes

Results on diabetes closely followed the pattern of hypertension with Algeria, DRC West, Nigeria South East, Senegal and South Africa recording high levels of awareness, as shown in Figure 7 and Annex 4.

The subregions revealed differences in the mention of different health problems. Figure 8 shows the regional differences for the four

commonly mentioned conditions, namely, fever, malaria, diabetes and hypertension.

Common health problems among children as perceived by respondents

Malaria and fever were the most commonly cited health problems of children in all locations (urban, peri-urban and rural) as shown in Figure 9 and in the three subregions (Figure 10). Almost a third (32.5%) of the respondents mentioned anaemia as a common health problem of children in Central Africa while only 6.7% and 5.8% identified the same in the East

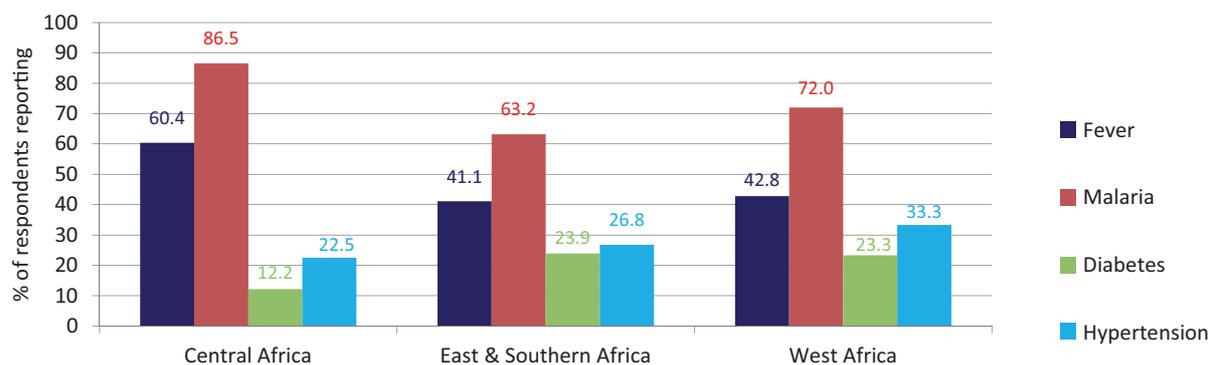


Figure 8: Common health problems in subregions as reported by respondents

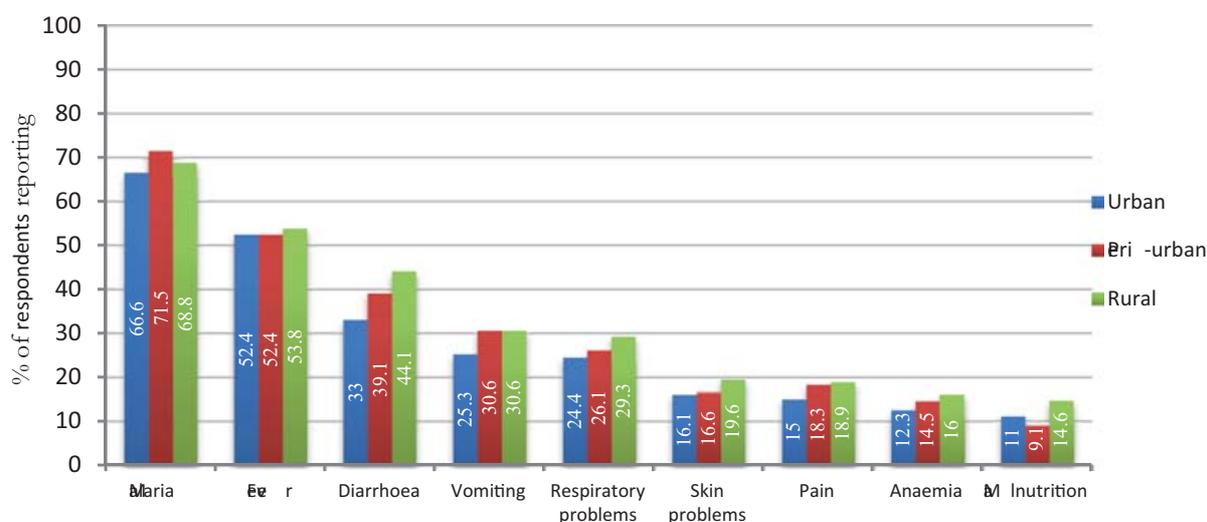


Figure 9: Common health problems among children by locality

and Southern and West subregions, respectively. The reported childhood illness pattern closely followed that of the general population shown in Table 2. However, there were significant differences among subregions ($p < 0.0001$) as shown in Figure 10.

Common health problems of women (15–49 years) by locality and subregion

For women of child-bearing age (15–49 years), the most common health problem cited was malaria, followed by pain and fever. It is important to note the rising recognition of hypertension and diabetes among urban, peri-urban and rural respondents as shown in Figure 11.

There were also differences among the subregions ($p < 0.001$). With respect to malaria, 64%, 52.7% and 50.7% of respondents in Central subregion, West, and East and Southern subregions, respectively, mentioned malaria as the most common problem. Similar to the trend in

the general population, the NCDs (diabetes and hypertension) received more mention in West and East and Southern than Central subregions, as shown in Figure 12.

Common health problems in older persons by locality and subregion

For older people hypertension was reported as the most common health problem followed by diabetes and malaria. Eye problems and diabetes were also commonly reported as shown in Annex 5.

The health problems among the older persons showed shifts toward NCDs irrespective of subregions. This is particularly so in the case of the respondents from the East and Southern and West subregions (Figure 13).

In the East and Southern subregion, both diabetes and hypertension received higher mention than malaria and fever in older persons. In Central subregion, malaria remained the number

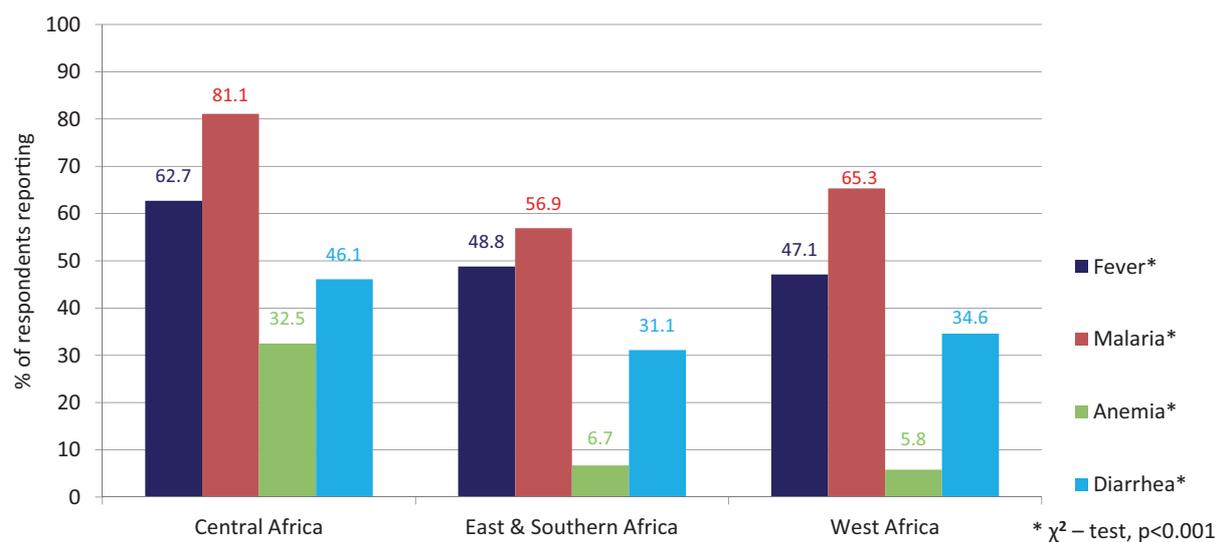


Figure 10: Common health problems of children in subregions

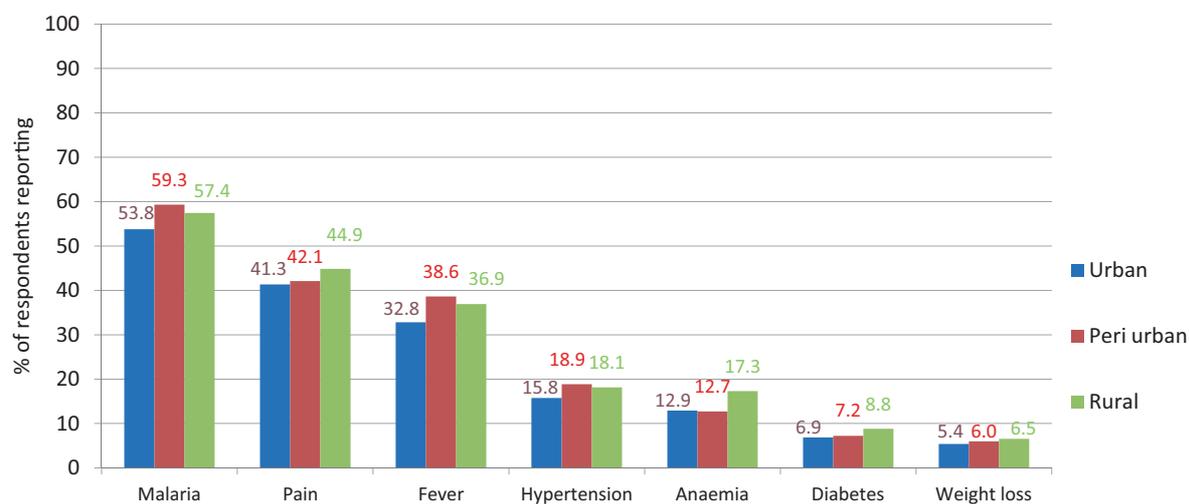


Figure 11: Common health problems of women (15–49 years) by locality

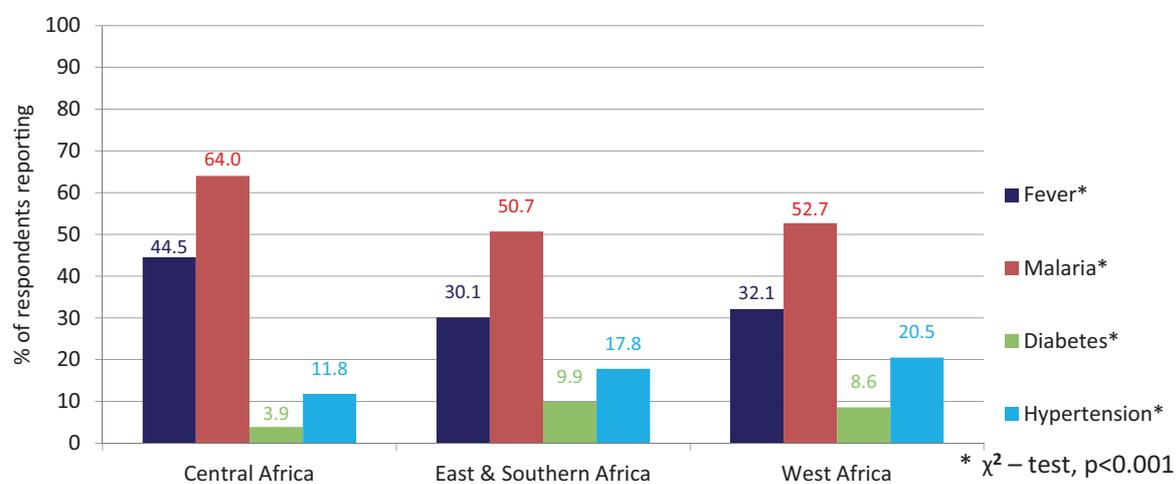


Figure 12: Common health problems of women (15–49 years) by subregions

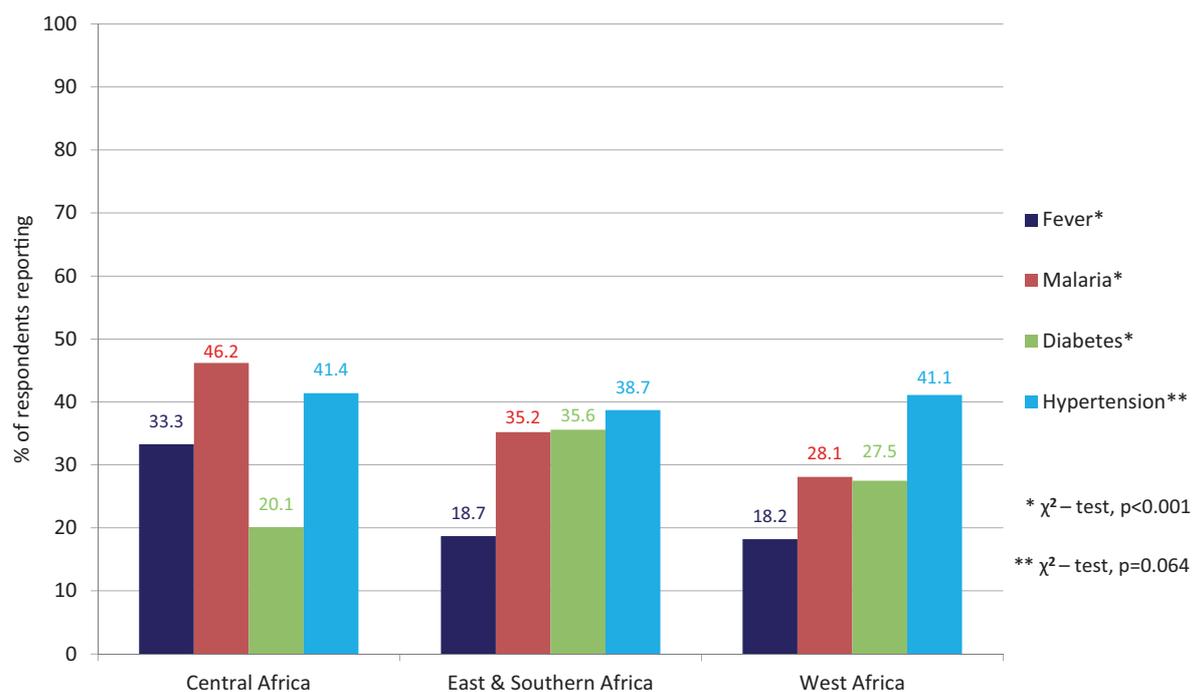


Figure 13: Common health problems of older persons in subregions

one health problem for the older persons with 46.2% of the respondents mentioning it. As shown in Figure 13, in the East and Southern subregion as well as the West subregion, hypertension was the most commonly mentioned health problem of older persons with 38.7% and 41.1% mentioning it, respectively. In the Central subregion the leading health problem was malaria (46.3%) followed by hypertension (41.4%). For malaria and diabetes, there were significant differences between the subregions ($p < 0.001$) while for hypertension, there was no difference ($p = 0.064$).

Anaemia and diarrhoea however displaced the NCDs noticed among the women (15-49 years). Next to fever was diarrhoea, which was mentioned by 46.1%, 31.1% and 34.6% of the respondents in Central, East and Southern, and West subregions, respectively.

Some of the health problems identified through the household interviews were confirmed during the IDIs and FGDs. However, there were some conditions identified in the FGDs that were not commonly mentioned through interviews with the community members and health personnel, for example:

“Elephantiasis – the community members don’t know what causes the disease. Most of them would associate it with eating

specific types of some food or engaging in specific chores” (IDI, health provider, rural).

“You see the most important health problem in our communities is the way we are producing children without proper planning. . . . Their age difference is close and they have no adequate food. This has led to malnutrition. There is virtually no disease that kills them other than hunger and starvation. Malnutrition is the biggest killer in our communities. . . . They suffer from worms and their mothers don’t take them to health centres for medication” (FGD, male adults, rural).

Perceptions about disease causation

Community level discussions identified the perceived causes of the common illnesses as illustrated in the quotes below.

“We are living near marshy areas where mosquitoes breed and it is just now that people are realizing that the cases they thought were (due to) witchcraft were just caused by malaria and by the anopheles mosquitoes. They now have some knowledge of signs and symptoms of

malaria” (IDI, community implementer, peri-urban).

“These diseases are caused by lack of hygiene, wind and dust. So, in my opinion, in order to avoid these diseases people must follow and promote hygiene. People must be clean, sweep, wash regularly and look after the cleanliness of their children” (IDI, adult female CBO leader, urban).

“The cause of these diseases is the lack of cleanliness. There is too much litter lying around and there is sexual promiscuity” (FGD, adult male, peri-urban).

Measures people take to stay in good health

Most of the respondents cited healthy eating, followed by hygiene practices and prompt health-seeking behaviour as measures people take to stay healthy. Although avoidance of risky behaviour and engaging in physical exercise were also mentioned, they did not rank high among the respondents. The results are summarized in Table 3.

Several site differences were noted. In Algeria, engaging in regular exercise was high especially in the peri-urban areas at 35%. For Cameroon, the most cited measure was hygiene—urban areas (65%) and peri-urban (54%). In Uganda, healthy eating ranked highest in rural areas (24.7%). It is notable that in Uganda, avoidance of risk ranked low in urban (6.4%), peri-urban (8.2%) and rural areas (4.9%).

The qualitative data illustrated participants’ views on measures important to ensure health:

“When somebody says that he is in good health, it is when he eats well. And then he must work as his health allows him. He must have a good life. He must have money to enable him to take care of his children” (FGD, adult male, urban).

Perceptions towards state of personal and household health

The participants were asked: in general how do you rate your health today and how would you rate the health of your household today? Figure 14 illustrates the answers to these two questions.

A higher proportion of household members in the urban and peri-urban areas reported being in good health compared to the rural areas. The rating of individual and household health showed that the respondents rated household health better than their personal health (Figure 14). Moreover, there were differences across the subregions with the highest rating for both individual and household recorded in the East and Southern region, followed by West subregion.

Responsibility for assuring people good health

The communities view the provision of health as the responsibility of the household heads (HHHs), followed by the government and then community leaders. From the perspective of respondents in the different sites, there were some differences between localities (Figure 15).

Table 3: Measures people take to stay in good health

Measure	Urban		Peri-urban		Rural	
	Number of mentions	% of respondents	Number of mentions	% of respondents	Number of mentions	% of respondents
Healthy eating	2375	65.0	2292	64.1	2300	64.2
Appropriate hygiene	2154	58.9	2150	60.1	2095	58.5
Regular health check-ups	1220	33.4	1144	32.0	1145	32.0
Prompt health seeking	899	24.6	991	27.7	1097	30.6
Avoidance of risk behaviours	857	23.4	1057	29.6	992	27.7
Engaging in physical exercise	491	13.4	507	14.2	481	13.4
Don't know	82	2.2	97	2.7	102	2.8

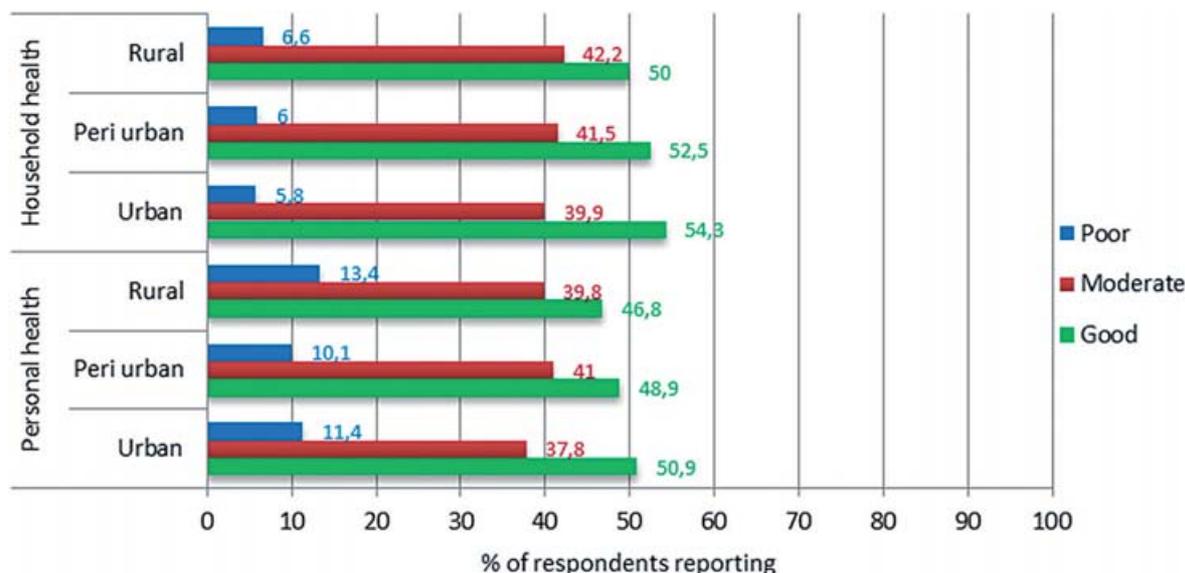


Figure 14: Rating of personal and household health status at the time of the study

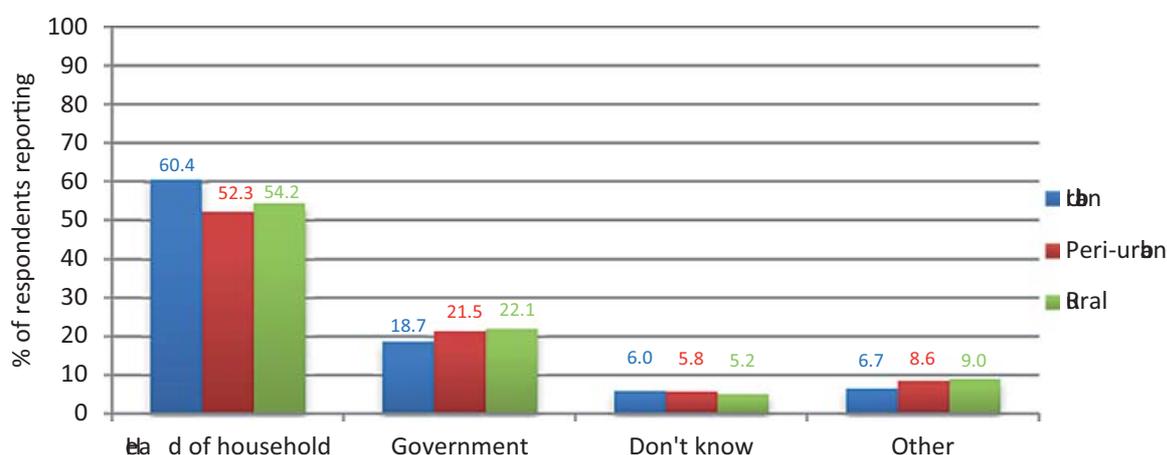


Figure 15: Responsibility to ensure that people stay in good health by locality

Knowledge of availability of health services

Almost all respondents (93.5%) were aware of where to access health care with differences (χ^2 -test, $p < 0.001$) between the high- and low-performing provinces, with the former reporting 94.9% awareness while the latter reported 92.2%. Public sector health facilities were the main sources of health services. These were followed by private health facilities in urban (55.9%), peri-urban (46.7%) and rural (44.2%) areas. Other significant sources of care were traditional healers (17.9%), faith-based facilities (14.7%) and informal drug sellers/vendors (13.8%) in urban areas as illustrated in Table 4.

In all the subregions, public health sector facilities and private health facilities are mentioned as the main sources of health services (Table 5). In the West subregion, the use of faith-based health centres is relatively marginal (5%) compared to the East and Southern region (22.3%) and Central subregion (17.5%). In Central and West subregions, 18.1% and 15% of respondents, respectively, mentioned informal drug sellers.

The qualitative results support the findings reported in Tables 4 and 5. For instance, a young woman in Nigeria North East observed that “When somebody is ill we take him or her to the government health facility for treatment” while an adult male participant in the same site

Table 4 Sources of health care by locality

Source	Urban		Peri-urban		Rural		Total number of mentions
	Number of mentions	% of respondents	Number of mentions	% of respondents	Number of mentions	% of respondents	
Public sector health facilities	2933	85.2	3009	90.1	2893	85.3	8835
Private clinics/hospitals	1926	55.9	1560	46.7	1500	44.2	4986
Faith-based health centres	505	14.7	426	12.8	433	12.8	1364
Traditional healers	616	17.9	653	19.6	726	21.4	1995
Spiritual healers	305	8.9	383	11.5	326	9.6	1014
Informal drug sellers	476	13.8	496	14.9	489	14.4	1462
Other	96	2.7	120	3.6	155	4.6	368
Don't know	15	0.4	17	0.5	13	0.4	45

Table 5: Sources of health care in subregions

Source	Central sub-region		East & Southern sub-region		West sub-region		Total number of mentions
	Number of mentions	% of respondents	Number of mentions	% of respondents	Number of mentions	% of respondents	
Public sector health facilities	2381	77.1	2293	94.0	4162	89.6	8836
Private clinics/hospitals	1603	51.9	1367	56.0	2017	43.4	4987
Faith-based health centres	690	22.3	426	17.5	248	5.3	1364
Traditional healers	711	23.3	352	14.4	932	20.1	1995
Spiritual healers	410	13.3	215	8.8	389	8.4	1014
Informal drug sellers	558	18.1	210	8.6	695	15.0	1463
Other	241	7.8	23	0.9	104	2.2	368
Don't know	27	0.9	9	0.4	9	0.2	45

stated that, “Apart from the hospital, we also go to the traditional healers to cure our illnesses.” Other participants observed that:

“As for me, if I'm sick and if the sickness is not too strong, I will not go first to the hospital, I'll just buy medicine from roadside vendors and if after two or three days I'm not feeling fine, then I can go to the hospital” (FGD, female youth, urban).

“People still have old practices, which lead to keeping patients at home, such as using traditional medicines. If it succeeds, it is better and if it fails, then they bring weakened patients to the health facility. This practice is rare in towns but more frequent in rural areas” (FGD, male adults, urban).

Services provided by frontline health facilities

The respondents were asked to identify the types of services accessible to them from their nearest

public health facility. Treatment of ailments was the commonest service offered in the health facilities nearest to the respondents at 79.9% in Central subregion, 54% in East and Southern Africa and 80.2% in West subregion, as shown in Table 6.

Other services identified included prescription of medicines (56.7%), immunization (46.8%) and delivery care (45.8%). Delivery care ranked higher than antenatal care. The peri-urban and rural communities mentioned delivery care at 52.5% and 43.9%, respectively. Similarly, more peri-urban (57%) and rural respondents (51.1%) compared to urban respondents (42.5%) mentioned immunization services. Health education and HIV/AIDS screening scored low (9.1% and 1.8%, respectively).

Types of health problems treated using alternative health care providers

An important proportion of respondents identified mainly fever (16.9–25.1% of respondents),

Box 2: Implementation of essential health service—views of health workers

- 2.1 “I would say that the country does not suffer from systems, but it suffers from how to make the systems to function. The programmes are there but do not have the support of the policy. As we work, we find it difficult to maintain health service satisfaction at any time. Our services are not stable because they depend on the support we receive. I give you a trivial example: we completed the BCG campaign and should achieve coverage of over 88%; today we are at 48% coverage simply because we lack syringes. The vaccine is there but there are no syringes. You have a series of events like this that come up during the year. With tuberculosis, the annual review was not held due to lack of funding and supervision is not supported yet it was the best programme in the country. If it continues like this, it will sink in the meantime and TB will continue to rise with HIV/AIDS. You find many packages on the HIV side, but there is almost nothing on the TB side. The structures are there, but we lack the means” (health officer).
- 2.2 “I can confidently say today that there has never been an adequate supply of drugs, and in some instances if faced with stockouts we have been forced to buy the medicines ourselves or refer the patients to purchase the drugs at the local chemists in town, but the good thing is we have never run out of essentials like ARVs and vaccines” (medical officer).
- 2.3 “You have district health services where we are now; then we have the district hospital which is our referral level, and then you have the health centre. There is a leading health centre that takes care of a health area and inside some health areas you have satellite health units that also offer health care. Hence, cases that cannot be managed at the level of the health unit and health centre are referred to the district hospital where they will be attended to by a medical doctor and cases which are still difficult we refer to the regional hospital” (district medical officer).
- 2.4 “There are no in-patient services in this hospital; we refer the patients to the Moi Teaching and Referral Hospital. The only in-patient service that we offer is the maternity wing. For cases of HIV and AIDS we have a counselling and testing area and a place where they get their ARVs. Tuberculosis drugs are also issued but we do not have wards for the patients. The demand for services at the facility is higher than what we can meet; for example, demand for medicine cannot be met by the supply that we have” (medical health officer).
- 2.5 “Gunduma system is to ensure efficient and effective delivery of health services and the ministry of health on the other hand is charged with the responsibility of general oversight of the entire system; like issues to do with policy and regulation licences and also collaborating with the donor funded programmes. Coming directly from Federal Ministry of Health to the State, the state Ministry of Health addresses issues like HIV/AIDS, malaria, TB, PHC, all issues that have direct support from Federal Ministry of Health or donors or memoranda of understanding (MOU) between government or any other organization outside the state, all are rooted from the department of programme support in the Ministry of Health” (Deputy Director, Programme Support and Regulation).
- 2.6 “Sometimes we face shortage of funds and it becomes a challenge, the clients or the community have to chip in” (health worker).
- 2.7 “The user fee is the main means of generating funds for the facility” (health worker).

malaria (11–12.5%), arthritis (8.4–12.4%) and pain (7.3–10.2%) as health problems not taken to the health facilities as shown in Table 7.

Table 8 shows that depression and respiratory problems in Central and depression in East and Southern subregions were mentioned by more than 10% of the respondents as not treated at the nearest health facilities.

The responses revealed that fever, malaria, arthritis, pain and depression were the commonest problems not taken to health facilities. This behaviour is commonest for fever in the urban and for arthritis in the rural communities at 25% and 12.4%, respectively. Higher proportions of diseases not taken to health facilities were reported among the low-performing regions

Table 6: Services offered in frontline health facilities in subregions

Service	Central sub-region		East & Southern sub-region		West sub-region		Total number of mentions
	Number of mentions	% of respondents	Number of mentions	% of respondents	Number of mentions	% of respondents	
Treatment of ailments	2460	79.9	1328	54.0	3825	80.2	7613
Prescription of medicine	1915	62.2	1404	57.1	2531	53.1	5850
Immunization	1205	39.1	1070	43.5	2549	53.4	4824
Delivery care	1738	56.5	838	34.1	2147	45.0	4723
Antenatal care	1001	32.5	771	31.4	2131	44.7	3903
Diagnosis/medical tests	1345	43.7	776	31.6	1245	26.1	3366
Dispensation of drugs	777	25.2	1107	45.1	1358	28.5	3242
Referral to higher facilities	677	22.0	864	35.2	1268	26.6	2809
Malaria treatment and prevention	781	25.4	740	30.1	1282	26.9	2803
Counselling patients	810	26.3	776	31.6	864	18.1	2450
Post-natal care	689	22.4	496	20.2	1262	26.5	2447
Infant/child care	786	25.5	423	17.2	1035	21.7	2244
HIV/AIDS screening	513	16.7	948	38.6	88	1.8	1549
TB diagnosis treatment	439	14.3	663	27.0	149	3.1	1251
Health education	236	7.7	490	19.9	214	4.5	940
Nutritional care	255	8.3	289	11.8	298	6.2	842
Other	164	5.3	74	3.0	112	2.3	350
Don't know	94	3.1	30	1.2	48	1.0	172
Nothing	9	0.3	8	0.3	6	0.1	23

Table 7: Leading health problems reported by respondents as not treated in health facilities by locality

Source	Urban		Peri-urban		Rural		Total number of mentions
	Number of mentions	% of respondents	Number of mentions	% of respondents	Number of mentions	% of respondents	
Fever	453	25.1	297	17.5	295	16.9	1045
Malaria	225	12.5	187	11.0	217	12.4	629
Arthritis	151	8.4	154	9.1	217	12.4	522
Pain	131	7.3	139	8.2	178	10.2	448
Depression	142	7.9	115	6.8	164	9.4	421
Respiratory problems	128	7.1	109	6.4	111	6.4	348
Eye problems	90	5.0	104	6.1	118	6.8	312
Diarrhoea	120	6.6	72	4.3	90	5.2	282
Weakness	66	3.7	66	3.9	81	4.6	213
Vomiting in children	56	3.1	68	4.0	73	4.2	197

for fever and arthritis at 20.4% and 11%, respectively compared to high-performing regions at 19.5% and 8.9%, respectively. Malaria (12.6%) was higher in the high-performing compared to low-performing regions (11.4%). A participant during an FDG noted that:

“There are some diseases for which people do not need to go to health facilities such as headaches, abdominal pain (light) or fevers. These diseases are not brought directly to the health facility and they could be treated with traditional medicine.

Some fevers could be healed by God using known traditional products but other diseases we have to bring patients to health facilities” (FDG, male adults, rural).

Some disorders including mental health conditions were perceived by both the community respondents and health professions to be better managed outside conventional health systems.

“When somebody is suffering from a mental disease, people think first of witchcraft. In this case, you have first to see a

Table 8: Leading health problems reported by respondents as not treated in health facilities in subregions

Source	Central sub-region		East & Southern sub-region		West sub-region		Total number of mentions
	Number of mentions	% of respondents	Number of mentions	% of respondents	Number of mentions	% of respondents	
Fever	469	23.0	157	20.2	419	17.2	1045
Malaria	352	17.3	78	10.0	199	8.2	629
Arthritis	128	6.3	50	6.4	344	14.2	522
Pain	190	9.3	70	9.0	188	7.7	448
Depression	53	2.6	96	12.4	272	11.2	421
Respiratory problems	58	2.8	102	13.1	188	7.7	348
Eye problems	79	3.9	50	6.4	183	7.5	312
Diarrhoea	201	9.9	15	1.9	66	2.7	282
Weakness	77	3.8	49	6.3	87	3.6	213
Vomiting in children	148	7.3	14	1.8	35	1.4	197

traditional healer and even we, when we receive a case for which we lose hope, whereby we do not know what to do, we advise the parents to go and see a traditional health practitioner who may have the solution” (IDI, male health provider).

Awareness of alternative sources of health care

Traditional healers constitute the main source of advice for health problems that were not taken to health centres with the peri-urban communities accounting for the most mention of the traditional healing options (67.1%). Other options mentioned included spiritual healers (21.1%) and informal medicine vendors (16.2%) as presented in Figure 16.

Low-performing regions cited the use of traditional healers (69.1%) and the spiritual healers (22.1%) more than the respondents in the high-performing regions.

Statements by the qualitative study participants confirmed the reports on use of alternative health care avenues as illustrated below.

“There are people who, for certain diseases, they use herbs as treatment. When the traditional medicines fail then they bring the patients to the hospital. If the local hospital fails, they refer them to the higher level hospital” (IDI, community leader, urban).

“Many people now go to see the doctor and nurses at the health centre. Although there are other private medical houses around, many people still go to the health centre.

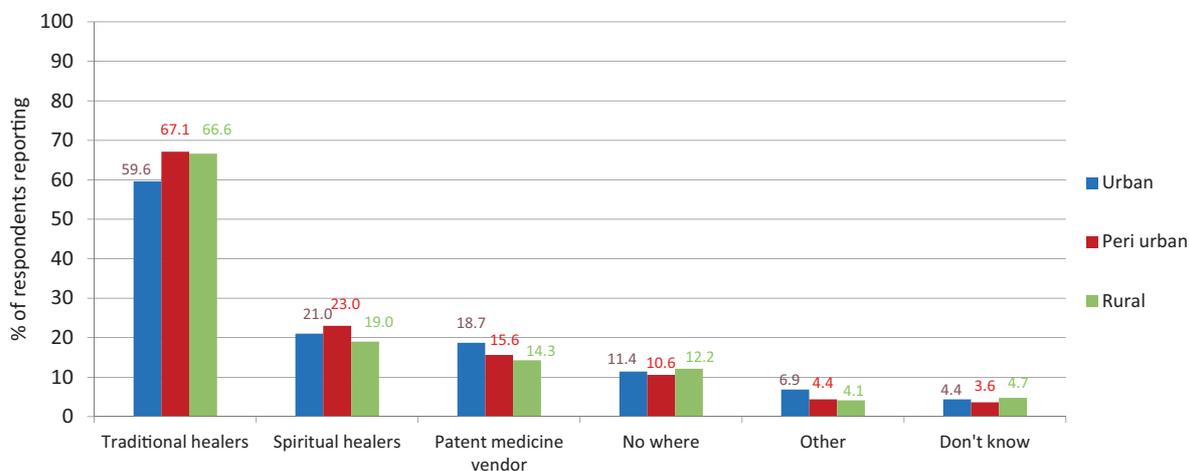


Figure 16: Where solutions for health problems not taken to health facilities are sought

Maybe because the services they provide are very affordable compared to the ones in private hospitals. There are other people who go to the mission houses, especially for delivery. Women who want to give birth patronize them a lot. They go for prayers and sometimes they live in those mission houses, especially when they are near the delivery date” (IDI, community leader, urban).

Perceptions on health service provision

Respondents were asked their views regarding the type of services provided by public health facilities. Almost half of the respondents cited child immunization and the provision of health facilities as shown in Table 9.

A participant in a discussion stated that:

“The only health programme that arrives in our area is the immunization programme.

But the HIV/AIDS programme is not implemented. Apart from the immunization programme, the other programmes do not reach the community needs. Because we are abandoned, the traditional healers, Elim Church and the matron help people to solve their health problems” (FGD, adult male, peri-urban).

Rating of health services provided in their communities

When asked to rate the health services provided in their communities, most of the respondents indicated that they were grossly inadequate. The rating for poor provision is presented in Figure 17 together with the reasons for the rating. Inadequacy of drugs and attitude of health providers ranked high across the urban, peri-urban and rural areas. Inadequacy of drugs was ranked slightly higher among rural respondents.

Table 9: Services provided by the government by locality

Health care provisioning	Urban		Peri-urban		Rural	
	Number of mentions	% of respondents	Number of mentions	% of respondents	Number of mentions	% of respondents
Child immunization	1618	44.3	1685	47.0	1691	47.9
Provision of health facilities	1635	44.8	1630	45.0	1641	46.5
Provision of medicine	1064	29.1	1162	32.4	1015	28.8
Provision of health personnel	961	26.3	1146	32.0	992	28.1
Provision of Antenatal Care (ANC)	734	20.1	808	22.5	752	21.3
Health awareness	502	13.7	511	14.3	484	13.7
Provide free health services	499	13.7	435	12.1	476	13.5
Train community health volunteer	341	9.3	281	7.8	401	11.4
Care for older people	257	7.0	182	5.1	240	6.8
Cost recovery	81	2.2	81	2.3	284	8.0

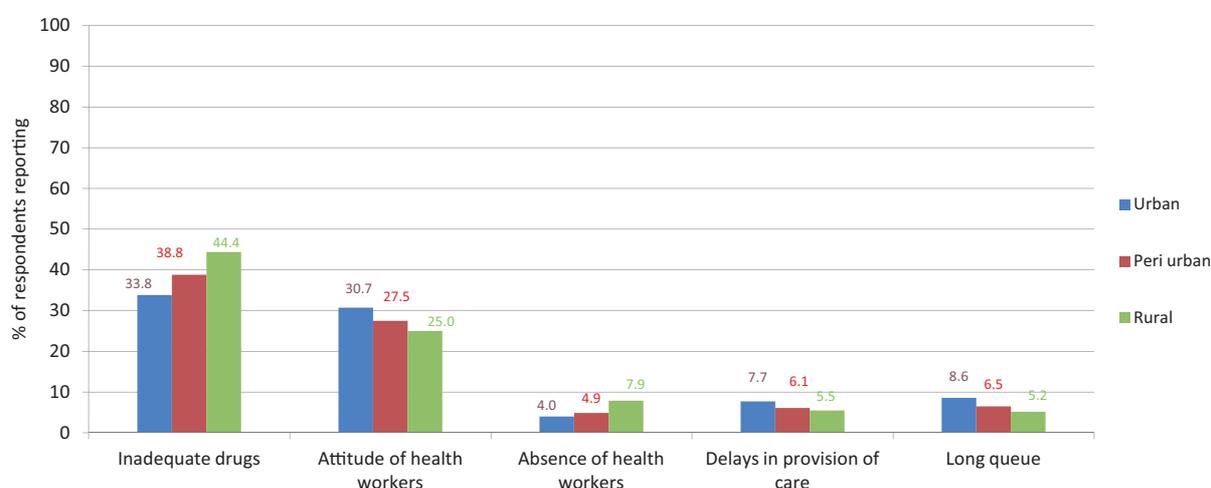


Figure 17: Rating of government services and the reasons for the rating by locality

The respondents who reported that the services were good attributed this mainly to the “responsiveness to clients” and “friendly environment” as shown in Figure 18.

From the qualitative data, a participant noted that:

“Previously, when I arrived at the health centre, I was welcomed. Before asking me for money they had to treat the child and only after that they gave me the bill. Now, what we see, you bring a sick child, the child is in coma but they ask you to bring drugs, blood and transfusion supplies. By the time you go through all these steps the child’s condition deteriorates” (FGD, male adults, rural).

Level of satisfaction with the health services provided by the government

Over two thirds of the respondents across all sites stated that they were dissatisfied with the public health services. The overall level of dissatisfaction was 64.3%: urban–66.7%; peri-urban–62.7 %; and rural–64.6 % as shown in Figure 19.

In DRC West, the overall level of dissatisfaction with government services was high. By locality it was highest in peri-urban areas (84.6%). The level of dissatisfaction in rural and urban areas was 79.6% and 68.6%, respectively. Similarly, in DRC East, 81.1% of those in peri-urban areas were dissatisfied, relative to 66.8% and 61.4% of those in the urban and rural areas, respectively.

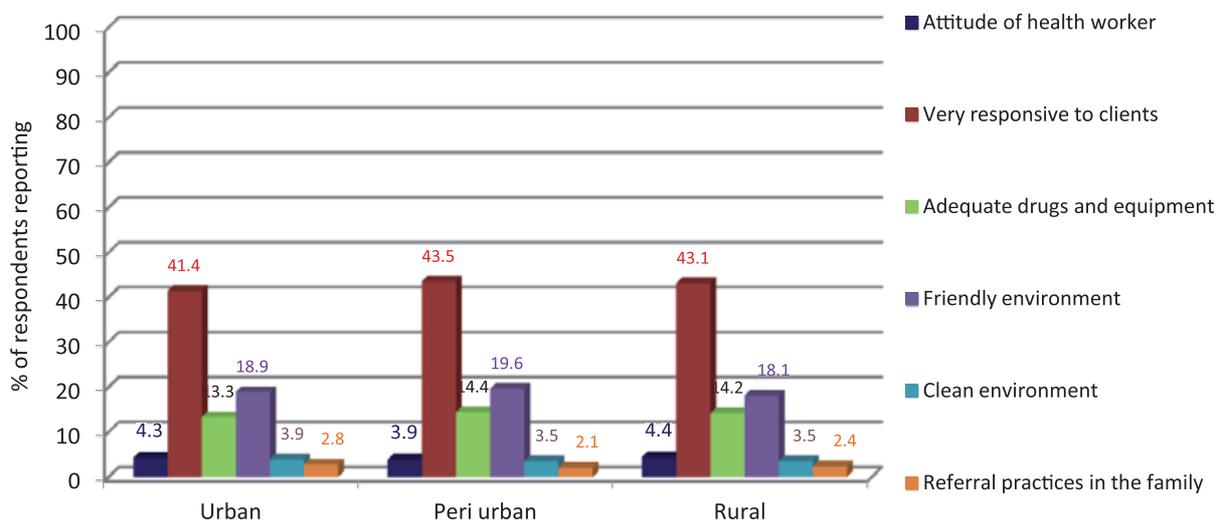


Figure 18: Reasons for rating health service as good by locality

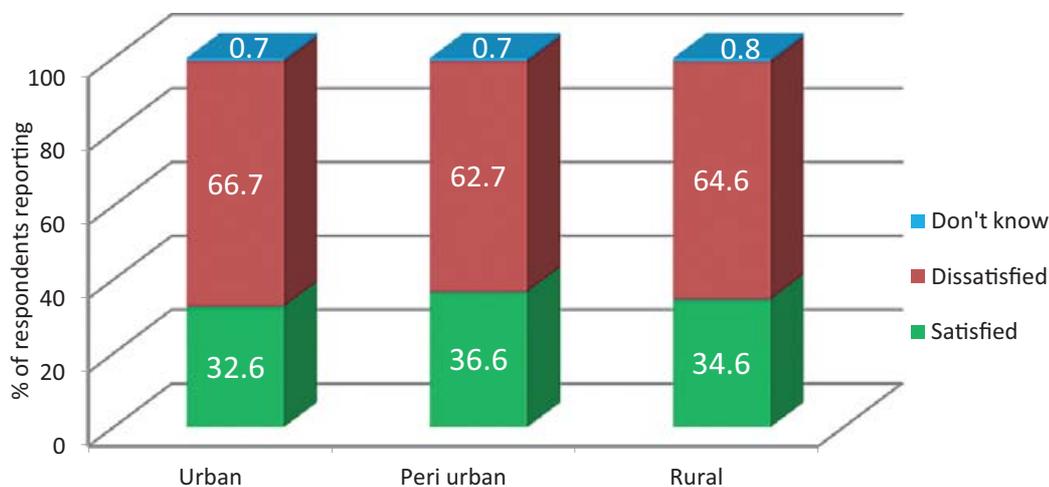


Figure 19: Rating of public sector health facilities by locality

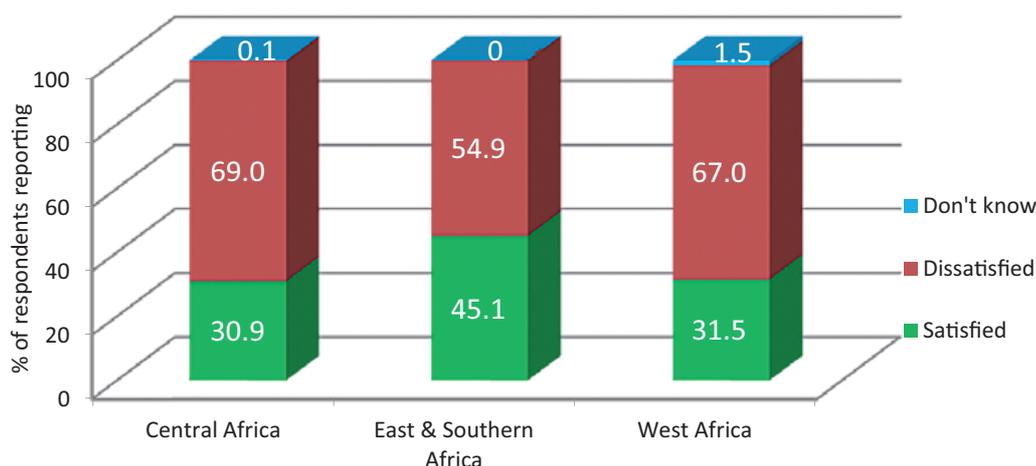


Figure 20: Levels of satisfaction with the way health care is provided by government by locality

In Niger, 65.6% of the respondents were dissatisfied with the services. The urban areas reported the highest level of dissatisfaction (76.2%). This was followed by rural (63.6%) and peri-urban areas (57.0%). Conversely, the highest level of dissatisfaction in CAR was in the urban areas at 77.3%. The peri-urban and rural communities reported levels of 67.2% and 62.8%, respectively.

Figure 20 reveals high levels of dissatisfaction with the way health care is provided by government in the communities. This feeling of dissatisfaction was more in Central subregion with 69%, followed by West subregion (67%). However, small proportions of the respondents in Central and West subregions were undecided about the way health care is provided in the communities.

Study participants expressed general dissatisfaction with the health services. The attitude of the health providers was cited across the sites as a deterrent factor to accessing health care in public sector health facilities. Terms used to describe health providers included “lazy nurses, shortage of doctors, rude clerks.”

A selection of quotes from the discussions with community members is provided below.

“Another problem we have when we go to the clinic is the attitude of the health workers; they can be very impatient and intolerant with us because we are villagers. They used to complain that we delay in taking our ill ones to the hospital” (FGD, adult males, rural).

“The nurses were rude. Can you imagine them telling me to follow others who were

queuing and my problems will be solved? That made me angry and when I waited the doctors went out to have lunch” (FGD, female youth, urban).

“The health workers are not friendly. They are rude to patients. . . . For example, there was a man I saw who had brought a sick child to the health centre. Another man had come with a child in critical condition and decided to directly take the child for treatment without following the queue; the health worker told him, ‘go back, go back, all these people you see there are patients, go and sit there. Don’t you know that all these people are sick and want medical care?’” (FGD, female adults, urban).

“People that you find at the entrance (the guard) of the hospital, the way they look at you discourages you to the point you could go back to the house without care” (FGD, female youth, urban).

Several people complained about high costs, corruption and nepotism in public health facilities as cited below.

“It is the doctors and government that cause these things. Most doctors have private hospitals; they take government drugs and equipment to their private clinics. When you visit government hospitals, they usually refer you to their private clinics” (FGD, adult males, rural).

“Only people who have relations in the health centre have the opportunity to have

good care and are well received. Those who have no relative in the hospital are ignored and nobody cares about them even if they are dying alone” (FGD, female youth, urban).

Public sector health facilities tended to have qualified personnel, which was one of the reasons people sought care from them. Where people felt that the health providers were responsive, there was better appreciation of the services. The personal efforts made by some of the health providers were also recognized. A female FGD participant in an urban area observed that: “We see in our health centre health personnel walking long distances on foot to get medicine.”

Discussions with health service providers indicated that community members contributed to some of the challenges encountered with access to services from government facilities. Some of the health providers expressed frustration with communities’ high expectations. In their view:

“The communities expect to find medicines all the time and if the medicines are not available then the perception is that health workers have stolen the drugs. Whenever there are no drugs the information flows into the community and you will get a reduced number of the patients that turn up to the health facility unless the case is an emergency. You will not get even more than 10 patients” (IDI, health provider, urban).

“They are very much aware of the facility in place and are taking advantage of it. The only problem we have is that they don’t come on time. Most of them come to the Primary Health Centre by 11am when personnel have gone to attend to other people elsewhere (for outreach services)” (IDI, health provider, urban).

“Regarding antenatal care, most women come to the clinic around the third or second trimester. You hardly see a woman coming to the clinic in the first trimester. They come in the sixth or seventh month (of pregnancy)” (IDI, health provider, urban).

Some study participants made positive comments about government efforts to provide health care, as illustrated below:

“My view is that the government has tried to help the people to eliminate early disease. We want to ask health centre providers to please bring more free treatment or gifts like drugs and equipment. All community members make use of the services available” (IDI, health provider, urban).

Sometimes, culture is a key deterrent to the use of health facilities:

“The difficulties concern the persistence of tradition that inhibits the activities of health promotion. People are illiterate and are attached to tradition. Pharmacopoeia and traditional practices still polarize the attention of patients who come to the clinic when it is too late” (FGD, male adults, urban).

Perspectives on the role of communities in decision-making on service provision

Almost half of the respondents reported poor involvement of communities in health decision-making: urban (46.6%), peri-urban (43.3%), and rural (43.5%). However, 20% of the respondents did not rate their engagement in decision-making (Annex 6).

In Nigeria North West, respondents in peri-urban communities rated the involvement of community higher (50.4%) than those in urban (37.1%) and rural (32.9%) areas. In Senegal, 62.9% of urban dwellers rated the involvement of the communities in decision-making as poor, while only 32.7% and 41.2% of the rural and peri-urban, respectively, considered it poor. In Uganda, almost three quarters of the respondents felt community involvement in decision-making was poor: in the urban areas (76.8%), peri-urban (68.6%) and rural (77.9%).

The qualitative data showed that the constraints reported for poor involvement of communities in decision-making revolved around high poverty levels, culture, lack of supplies for those willing to participate, and other responsibilities that limit the capacity of local people to contribute to decision-making.

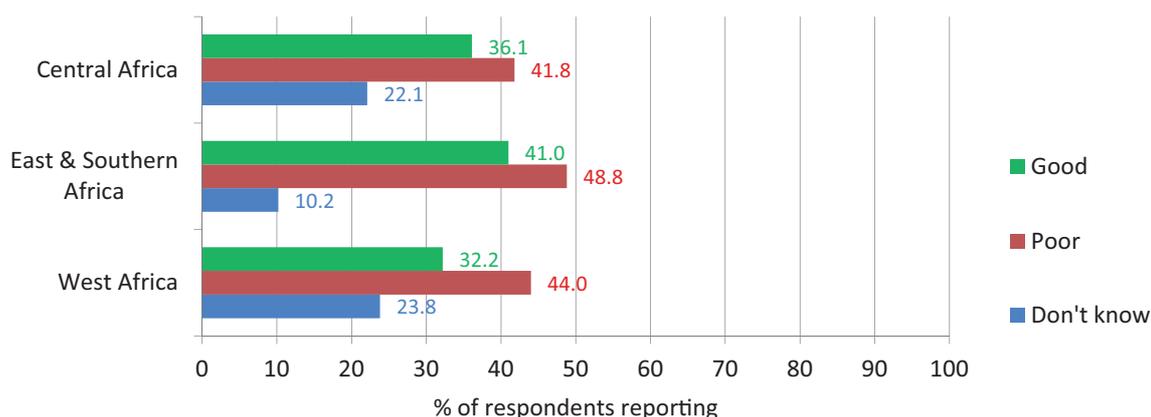


Figure 21: Rating of involvement of communities in decision-making in Central, East and Southern, and West subregions

Figure 21 shows that, irrespective of the subregions, a higher proportion of respondents rated the level of involvement of communities in decision-making on how health services could be delivered as “poor”. The negative rating appeared more in the East and Southern sub-region (48.8%) than the West subregion (44%).

Sources of information on matters of health

Sources of health information varied across the countries, but the most commonly cited was radio, followed by community announcements as shown in Table 10.

For Algeria, the main source of health information was television (54%) distributed as follows: urban 46.1%, peri-urban 64.6% and rural 51.4%. Community announcements ranked very low in Algeria (0.8%) contrary to what was obtained in other sites. In Cameroon,

community announcements were cited most in urban, peri-urban and rural areas at 40.1%, 43% and 38%, respectively.

The quotations below illustrate the availability of multiple channels of information in the different sites:

“The public is informed through the public announcements we do. We also use media such as radio to announce immunization. There are also mosques, with the cooperation of imams” (IDI, community leader, rural).

“The community gets information through the district head who is informed by the LG. He, in turn, passes the information to the ward heads, leaders and development committee who inform community leaders through errand boys. They also get information through the radio” (IDI, community leader, urban).

Table 10: Main sources of health information by locality

Source of information	Urban		Peri-urban		Rural		Total	
	Number of mentions	% of respondents						
Radio stations	1717	46.5	1574	43.6	1482	41.0	4773	47.3
Television	467	12.6	409	11.3	359	9.9	1235	11.3
Pamphlets	43	1.2	27	0.7	27	0.7	97	0.9
Bill boards	29	0.8	24	0.7	20	0.6	73	0.7
Community announcement	730	19.8	919	25.5	995	27.5	2644	24.2
Friends and relatives	259	7.0	233	6.5	247	6.8	739	6.8
Other	329	8.9	350	9.7	370	10.2	1049	9.6
Cannot say	122	3.3	75	2.1	116	3.2	313	2.9
Total	3696	100	3611	100	3616	100	10923	100

Health information flows through religious leaders (imams at the mosque, pastors and priests and traditional religious leaders), from door-to-door and through community leaders, town criers, posters, telephone, television and community radio.

4.3 EXPERIENCE WITH HEALTH SERVICES

This section presents the responses to questions about people’s experiences with health care services. The first part presents household needs for health care; the second part presents experiences with prescriptions and availability of drugs.

Household needs for health care

Most people surveyed had sought health care within the last 30 days (50.9%) and 36.1% between one month and 12 months ago. This implies that 87% of people had sought health care within a year, a reflection of the high demand for functional health services. As shown in Annex 7, the highest proportion of respondents seeking health care in the last 30 days was in the rural communities (51.1%), the least being in urban communities (50.8%) (Figure 22).

Among the low-performing regions, 52.3% of the households needed care in the last 30 days preceding the interview compared to 49.5 % in the high-performing regions (Annex 8).

The urban respondents in the 13 sites had greater options regarding the availability of

health facilities. About half (50.8%) of the urban households had two or more health facilities to choose from while 46.7% of rural households had two or more facilities ($p < 0.001$). However, in six study sites (Algeria, Cameroon, CAR, DRC East, DRC West and Nigeria North West), more than 56% of the households had no option regarding which health facility to visit for health care; they had only one or none.

The gross inadequacy of health facilities is highlighted in statements made by some informants in the qualitative reports across the sites. In the North West site in Nigeria, an adult female observed:

“We must tell you that we are not satisfied at all, because we don’t have the health facility here and most of us go to the private clinics for treatment, so all government health interventions do not reach us. For example, if someone is very sick or a woman is in labour, we have to carry her on a local bed to the river bank where a canoe will cross over with her, or a bike will carry her to the private clinic at Jagindi Tasha which is easier for us” (FGD, adult females).

A man from Cameroon described the health facility’s environment as unfriendly to the newborn, noting:

“A newborn baby will be delivered well and before dawn about 10 mosquitoes have already bitten him and this is before he leaves the hospital. How do you expect

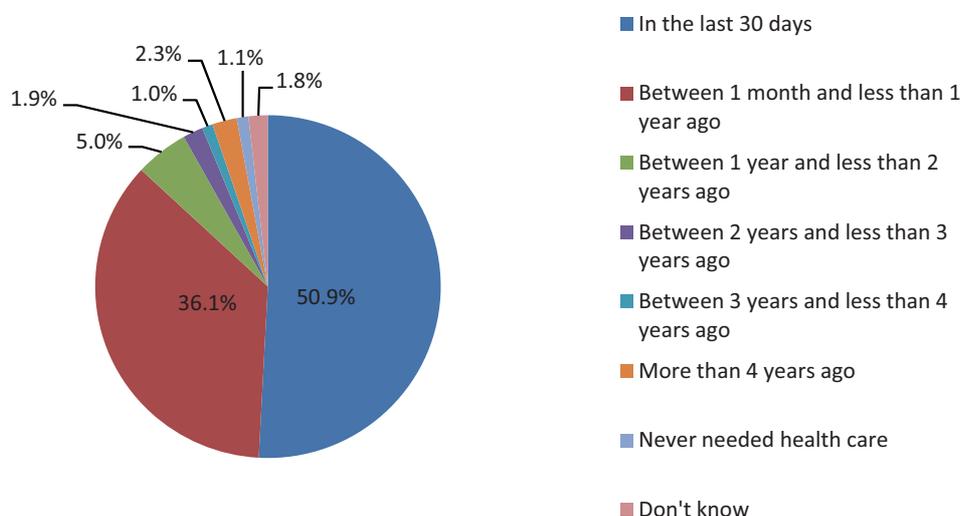


Figure 22: Households needing health care within a given timeframe

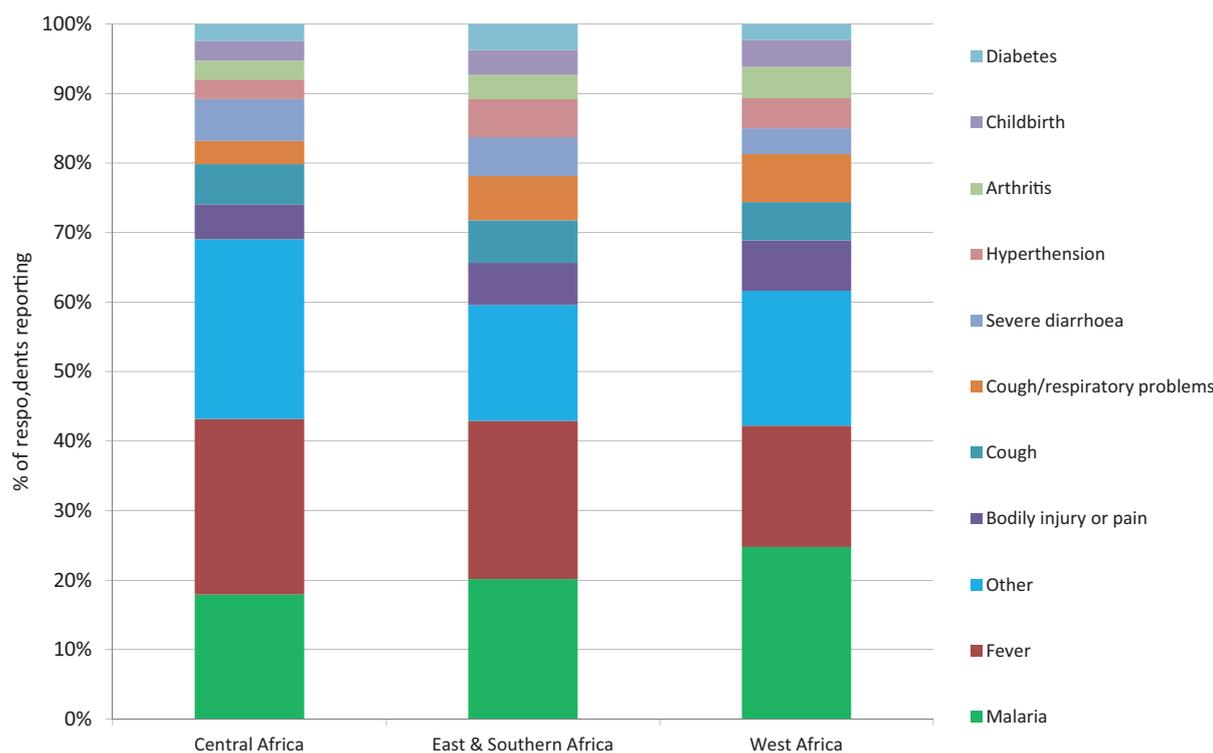


Figure 23: Top ten most common reasons why health care was sought by subregions

such a child to be fine? In such a case would you still like to go to the hospital or would you prefer another place?” (FGD, adult males).

This view was supported by another statement:

“Due to the distance between this community and the health facility, sometimes people lose their life before getting any medical attention” (FGD, adult males).

A youth in a rural area narrated his experience:

“Tombel municipality . . . should have 102 doctors here and I wonder if we have 5 . . . I have a friend who is in Munyong in western Bakossi. It is about 20 km from Nyadong and there is no motorable road. Her daughter had hot water poured on her, so she got burnt at about 6pm and he had to cover those 20km to Nyadong which took some 4 or 5 hours, in the night on a rocky terrain in the bush to get first aid, and by the time they wanted to pull the dress from the daughter in Nyadong, it (the dress) came out with the skin. But Nyadong doesn’t have a medical doctor, it just has a health post, you see” (rural youth).

Generally, malaria and fever were the main reasons for seeking health care (Annex 9), irrespective of locality or region (17.6% and 17.2%, respectively) except in South Africa and Algeria where hypertension and diabetes mellitus ranked first and second highest, respectively. Malaria was higher in West subregion (20.3%) than in the other subregions (Annex 9).

Among the top ten reasons why health care was sought, malaria and fever accounted for more than 40% (Figure 23). There were also other medical problems like body injury or pain and respiratory infections. In a nutshell, a majority of the respondents (92%), received health care the last time they needed it. The percentage that received health care was least in the low-performing and rural areas (91.1% and 90.6%, respectively).

The main reasons why community members in the study districts did not receive health care included the cost of health care (34.1%), transport problems (11%), inadequate drugs (6.7%), and the perception that the health condition was not serious enough (5.4%).

The qualitative results accorded more responsibility for this trend to the health system and highlighted the role of poor attitude of health workers:

“In all hospitals, even in clinics, there is no love. When you arrive to the hospital, they give you the patient form. He holds his pen. You tell him: ‘Papa, write, my child is dying’; he will answer, ‘Pay the money.’ He even crosses his legs; you are anxious, fidgeting and he will insist that you pay the money. Before the money arrives, the child dies. There is no love there. To use the hospital, it is money in full or you’ll die if you do not have money” (FGD, women, rural).

According to female discussants:

“The drugs are not available anytime. Very often health personnel send patients to get the drugs outside the hospital. For this purpose, some doctors who have their own clinics or pharmacies have the advantage of sending patients to buy drugs or for a transfer (to their facilities). This is a way for them to recover money” (FGD, female rural).

A female respondent from Niger commented on being treated with less than absolute dignity. She had experienced and observed:

“Indifference towards patients . . . During my last visit to the clinic, the health personnel looked at us as if we were not human beings . . . they only take good care of those who have money and their relatives” (FGD, peri-urban women).

One woman drew attention to the power of a positive attitude:

“Yes, when I was pregnant, I came here to the hospital. I was doing my consultation in another health centre and when I heard that there was a health centre here, I decided to continue here. It is a big hospital and it is clean, midwives are very kind and sensitive” (IDI, peri-urban women).

Prescription and availability of medicines

The majority of the respondents (90.2%) said medicines were prescribed for them during the last time they needed health care. Analysis by regions showed no difference in the level of

prescription by health care providers, as 90.1% in the high-performing areas and 90.4% in the low-performing areas received their prescriptions.

In high-performing areas, the analysis by site showed that most of the sites exceeded 90% except for four sites, namely South Africa (86.2%), Nigeria South West (84.2%), DRC East (80.2%) and Niger (71.7%). Low-performing areas in all sites showed that over 90% of those who needed care received prescriptions except for seven sites: DRC West (89.5%), CAR (89.2%), Cameroon (88%), DRC East (85%), Senegal (85%), Nigeria South West (82.7%) and South Africa (77.6%).

Of the medicines prescribed in the health facilities, 60.2% of the respondents reported getting all of them, 19.9% got some of them, 17.8% got none, and 2.2% of respondents did not remember if they received the medicines. Across regions the responses were similar with 60.2% and 60.1% in the high- and low-performing areas, respectively, reporting that they got all the medicines. There were differences in five sites. In Algeria, the values were low in both regions. All medicines were received 40% of the time in the high-performing and 8.2% of the time in low-performing areas. In the other four countries (DRC East, DRC West, South Africa and Uganda), respondents in low-performing areas received all the drugs more often than those in high-performing areas.

Reasons for not getting the prescribed medicines

Up to 73.5% of the respondents reported that they could not find prescribed medicines. The proportions ranged from 75.6% in high-performing areas to 71.7% in low-performing areas. A female FGD participant in a rural area observed:

“When we go to the hospital for treatment we don’t get drugs, the providers only ask us to go and buy the drugs from their chemists, so we need medicine” (FGD, female community member, rural).

In Uganda, a male FGD participant noted “In most cases there are no medicines in that facility. When you get there they tell you, ‘go to a clinic’— they just prescribe for you drugs to go and buy.” For another participant in the West

subregion: “It is heart breaking that when a sick person gets to the health centre, he or she will not get the drugs he needs.” A young man observed:

“There are no drugs in the centre to cure different ailments or to give patients when they seek for medical treatment, although the nurses there are trying their best but they lack adequate drugs to complement their work so there is a total need to supply them enough drugs of different types that can heal different ailments so as to motivate people to patronize them very well” (FGD, female adult, rural).

According to a respondent in Central African Republic the cost of medicines can change even while the patient is still consulting at the health centre:

“A female participant experienced an unfortunate situation. I was not welcome in the clinic with my child. I left the clinic at night for another in Ngoulapalo and there the temperature of my child was very high. At Ngoulapalo, I called the nursing staff in vain. When a health worker came out, he said that the consultation fees had increased from 100 FCFA to 250 FCFA. We were forced to go to Bangassou for medical care. What is this kind of behaviour? But in Bangassou the staff receives people badly and he approaches the patient as if he (the patient) has a problem with him. The prices of drugs

increase quickly in the presence of the patient” (FGD, female adult, peri-urban).

Payment for medicines

As Figure 24 shows, respondents paid for medicines their households received from the health facilities. Payment for medicines by respondents was highest in the West subregion (85.3%), followed by Central (77.9%) and the East and Southern subregion sites (61%). The frequency of payment for drugs varied by subregion as shown in Figure 24.

From the qualitative data, there seemed to be agreement across sites that patients had to pay for treatment. A student in Cameroon shared his experience:

“I had a case out there in the hospital. I had a sore tooth . . . I had 1500 CFA Francs. When I arrived at the hospital, the man (health personnel) asked me to pay for a form, I spent 100 CFA Francs for the consultation. He (health personnel) said I should pay 600 F. I gave 600 and all the money I had left was 1500 . . . the bill was already 700 FCFA. So when I saw the health personnel, I showed her 800 FCFA and she said that the bill was 3000 FCFA. I told the lady that I was a student . . . I did not have enough money, and asked her to give me at least a drug for 800 FCFA. She said no. I returned home sad. I was a loser, losing 700 FCFA in total and without treatment” (FGD, young male, rural).

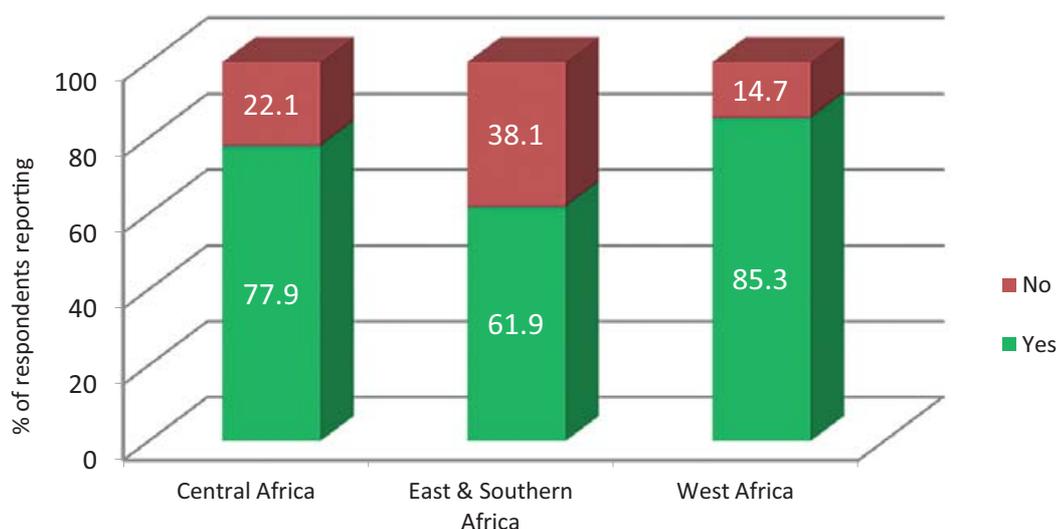


Figure 24: Payment for medicines by subregion

The rate of reimbursement of money paid for medicines was very low, with reimbursement occurring in as little as 3.7% of the cases in Central subregion (Annex 10). There was no reimbursement in 96.3% of the cases in the Central subregion, 90.2% of cases in the East and Southern subregion and 86.1% of the cases in the West subregion.

According to a community member in the low-performing region in Enugu, Nigeria South East, by contrast:

“We don’t have any health financing here. The only thing we have here is those free drugs like Mectizan® that are given to us to distribute to the people otherwise you are on your own” (FGD, community member).

The spike in the West subregion reimbursement rate (13.9%) is the result of the Algerian data (Annex 10). In Algeria, insurance companies provide those in rural areas (99.3%) reimbursement for medicine, which is the highest compared to the urban and peri-urban which rank 96.4% and 98.9%, respectively. Among the urban communities, Cameroon ranked highest providing nearly 100% of health financing. However, the health insurance scheme in Cameroon was perceived as not functioning well.

“There is (reimbursement) almost in all health areas. They had signed an agreement with the Tombel health areas. They have some cards that they give to patients

with photos and the patient registers and must have at least four people in a family. The fee is approximately 14 000 or 15 000 FCFA, yes 15 000 FCFA per year, coverage year. Assistance can be up to 100 000 francs. And the patient benefits from 75% of these expenses. Mutual Health supports 75% while the patient meets 25% of the expenses. People appreciate and they are registering gradually” (IDI, health officer).

Figure 25 shows that the overwhelming majority of the respondents in the subregions did not have health insurance. Only 11.8% had health insurance in the Central subregion, 9.1% in the East and Southern subregion, and 2.5% in the West subregion.

When asked if there were other ways people got health subsidies, 16% of the respondents responded in the affirmative. This was highest in the urban areas and among people in the high-performing areas (21.7%).

Insurance is not available for a large majority of people in the three subregions and especially for those in the low-performing areas (among 65% of the respondents). In general, 20.6% of the people interviewed did not know if there were other subsidies available. In DRC East, some NGOs provide subsidies for pregnant women and children. The results presented by subregion in Figure 26 show that except for the Central subregion, the government was the main source of health subsidies. In the Central

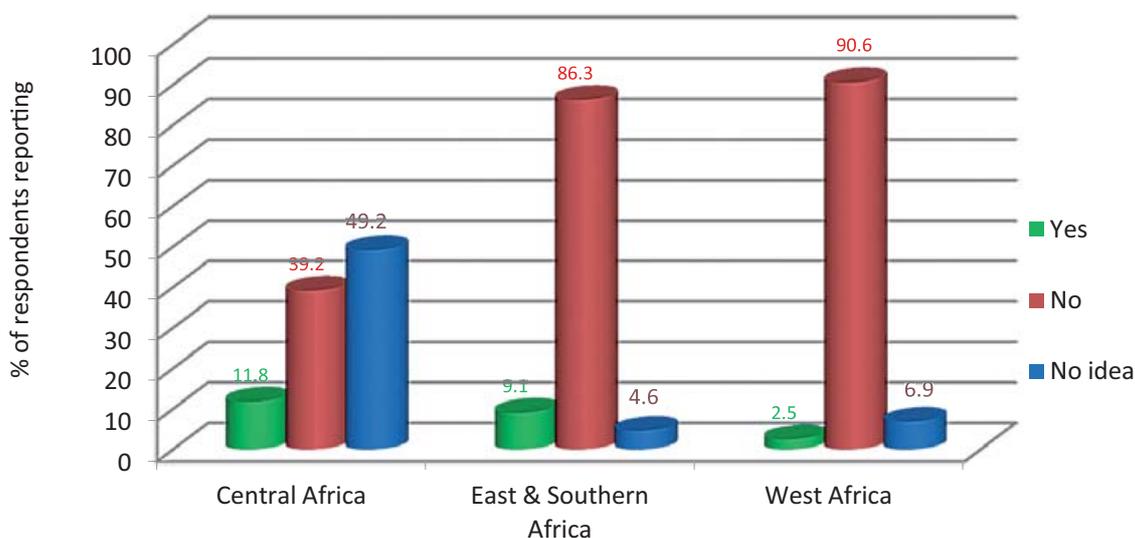


Figure 25: Proportion having health insurance by subregion

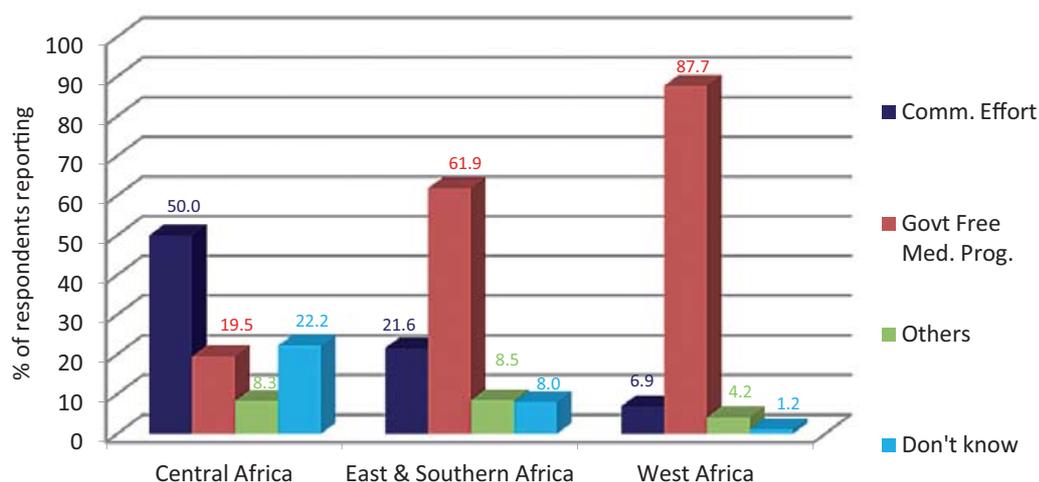


Figure 26: Other ways people get subsidies for health cost by subregion

subregion, subsidies were through community effort (50% of the respondents).

Free government health services are well recognized in South Africa. According to a male adult community implementer in a rural setting, “The Government decided that people should be helped freely.” In Senegal, community effort was mentioned by a health staff as important:

“At the health centre, there is what we call groups. These are people who often cannot pay their bills, pay for their prescription and so on. I think at this point . . . it’s the social case. It is planned that if one is considered a social case, the service is free of charge” (IDI, health provider, urban).

Box 3: Community expectations—views of health workers

- 3.1 “The government should step up its support to the facility. More resources are needed; more money should be allocated because the quarterly allocation is below the actual amount required for a level 4 facility to run” (Medical Superintendent).
- 3.2 “The government should increase the allocation to the facility since the allocation we get is very little and is half our budget, such that we survive on deficits” (health programme officer).
- 3.3 “There is a problem with our referral system, because referring patients from dispensary to the district hospital is hectic” (health officer).
- 3.4 “With the new constitutional dispensation, the government should provide equal access to quality health care services and should strengthen human resources to enhance capacity building” (health officer).
- 3.5 “Some of the constraints we have in this health centre include poor patronage from the people especially the enlightened ones. They are not ready to come because there are no basic amenities like a toilet to use when the patients come. The environment is very dirty, there is no security and it’s possible for people to steal the remaining things in the health centre, even children can be stolen because our doors are spoilt and the main gate is bad” (health worker).
- 3.6 “At times, if we want to take care of ailments some people will be saying they want to see doctor, they want the doctor and at times they want to do scanning and we don’t have scanning machine here. We then refer them to Afao Health Centre. They will now be saying, ‘Is it only Afao Health Centre that is supposed to have scanning machine?’ That is not good” (health worker).

4.4 COMMUNITY PERCEPTIONS OF HEALTH CARE FINANCING

Community perceptions of government contributions

This section presents the results of the study describing expectations and contributions of governments and communities to the delivery of essential health services. The government contribution to the delivery of health services was uniform across localities. It was concentrated in the provision of health facilities, workers and drugs (Figure 27). The spike in immunization

reflects programme focus and provision of free immunization as a component of maternal and child health care.

When asked to rate the provision of health services by the government, most (64.3%) of the respondents indicated that they were inadequate as shown in Figure 28. The responses ranged from 63.3% in peri-urban areas to 65.6% in the rural sample.

These patterns did not vary across low-performing and high-performing regions in all the sites. The results are consistent with earlier

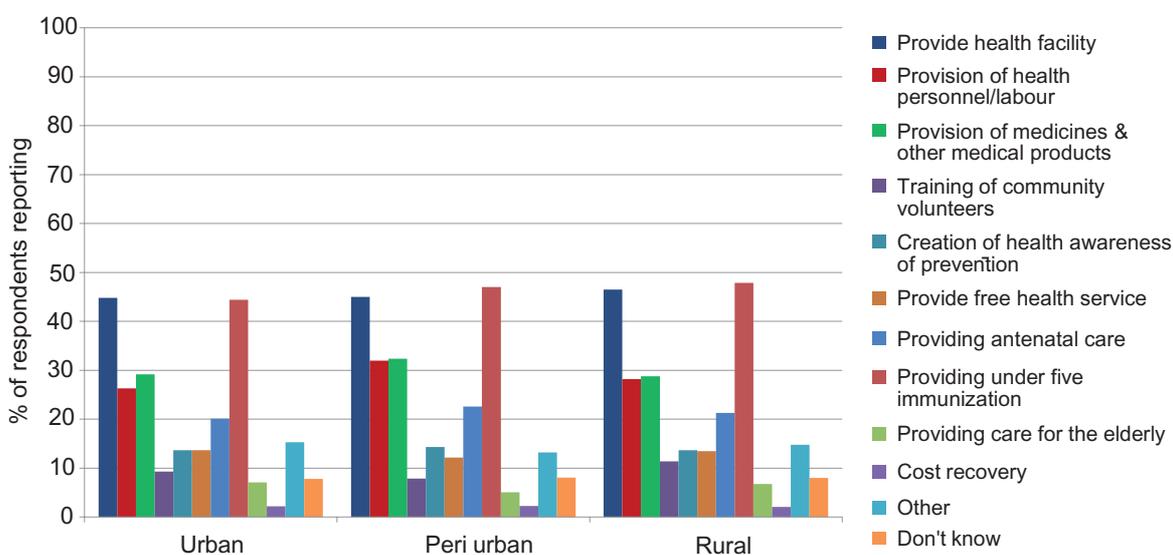


Figure 27: Health services provided by the public health sector by locality

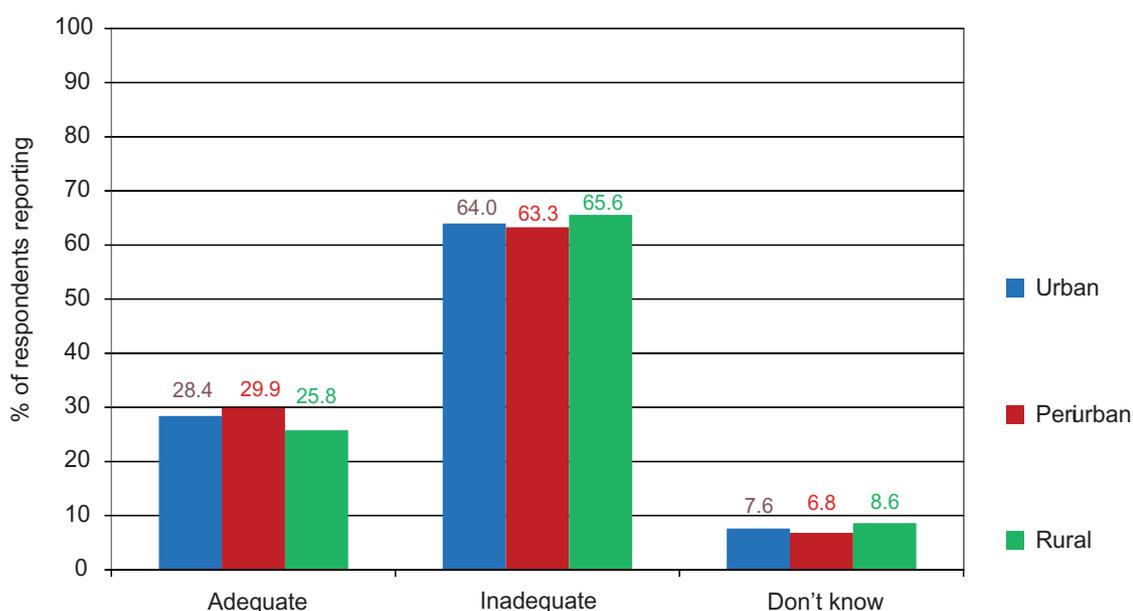


Figure 28: Perceptions of government contributions to delivery of essential health services by locality

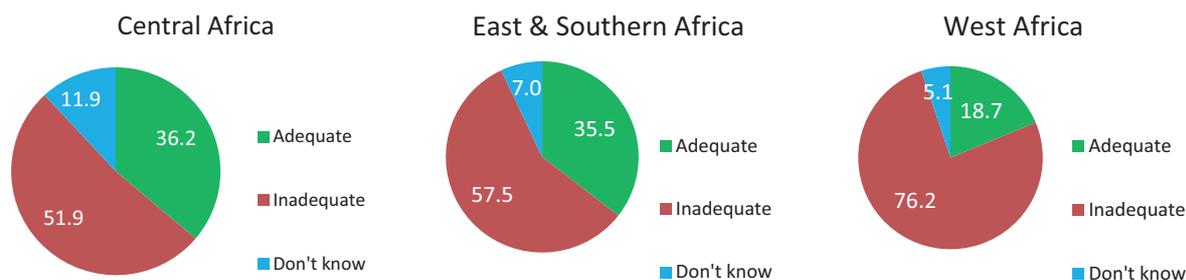


Figure 29: Perceptions of government contributions to delivery of essential health services by subregion

rural patterns showing distrust of government involvement in the provision of health care.

The results show that 65.5% of respondents in high-performing regions view government efforts as inadequate, and in low-performing regions 63.2% of the respondents view government efforts as inadequate. Figure 29 shows that this perception is consistent across the subregions.

There were however differences ($p < 0.001$) in terms of the negative ratings across the subregions. For instance, while 76.2% of the respondents from the West subregion rated government contributions as inadequate, only slightly more than half (57.5% and 51.9%) of the respondents

in East and Southern and Central subregions, respectively, rated the services as inadequate.

Rural male discussants in the Central African Republic (CAR) expressed deep-seated distrust of government and disappointment with its performance in the delivery of essential health services. “Does the Central African State worry about the rural populations?” they ask. “Why are infrastructure abandoned? Why are essential drugs not available for emergency cases? Why is it only first-aid workers that are sent to us whereas qualified personnel are trained in Bangui?”

Figure 30 illustrates communities’ perspectives on the ways in which the contributions of

Box 4: Readiness and constraints of communities to participate in delivery of health services—views of health workers

- 4.1 “People are willing to participate according to the observations. For example, when we were looking for volunteers to be involved in this home pack exercise, people were really fighting to participate in this exercise. People normally come to participate” (health officer).
- 4.2 “Sometimes, the people go to the chairman of (the) local government to complain, but most times their complaints are not addressed . . . This is not surprising as the rural communities in this local government have not galvanized themselves into health committees through which they can articulate their wants and aspirations and then forward to government agencies” (health officer).
- 4.3 “Gender disparity in terms of decision-making in health matters is still prevalent in terms of decision-making” (health officer).
- 4.4 “The majority of health personnel and the population are excluded from any form of participation in the design, the conception of the social and health activities in the public frontline health facilities. They are not stakeholders in the decision-making process which is at the central level in the Ministry of Health, of Population and Hospital Reform. The actors see themselves as « doing what has been decided without them », in their proper words” (health worker).
- 4.5 “The people around this place are not happy because they feel that the government took their land and did not do anything for them. Even those they took as voluntary workers were not compensated” (health officer).
- 4.6 “The community is willing e.g. the community came up in a big way to mobilize drug addicts which has been overwhelming and it has been supportive” (health officer).

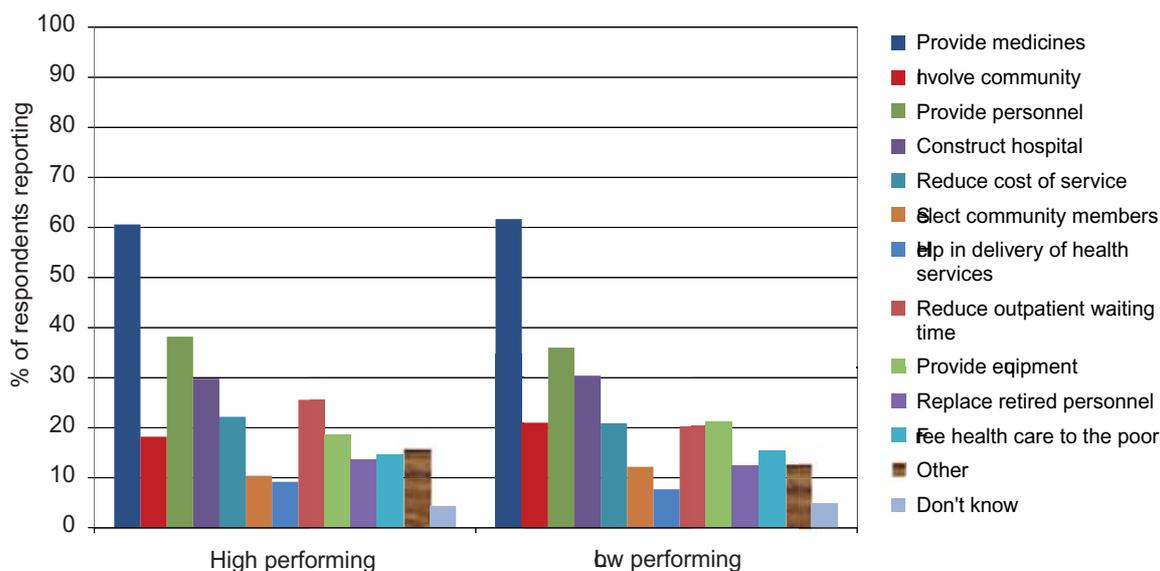


Figure 30: How to improve delivery of health care services

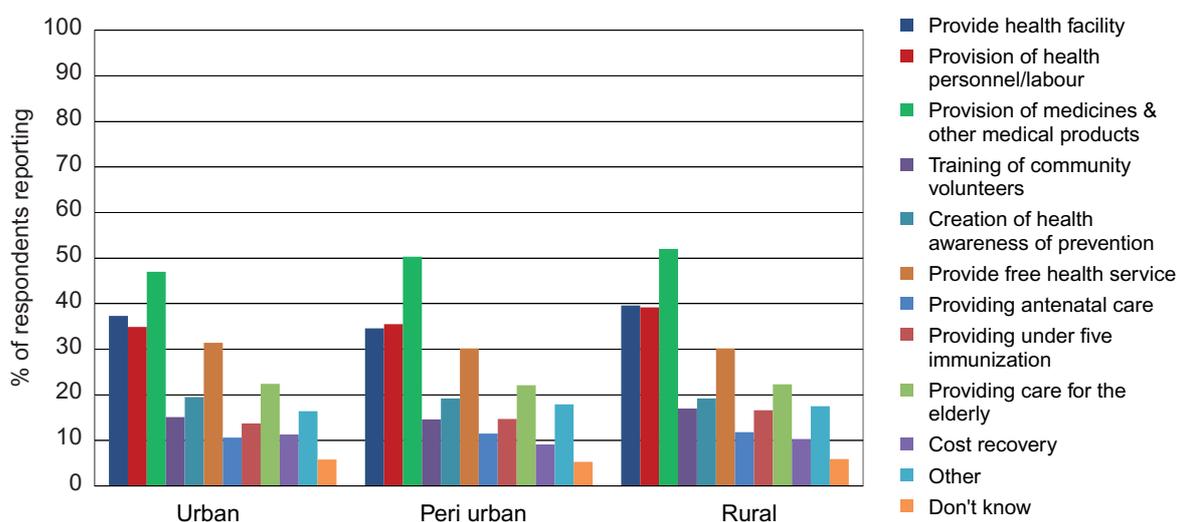


Figure 31: Community expectations of government contributions to health by locality

government to the delivery of essential health services in high-performing and low-performing regions can be improved. The majority of respondents felt that the supply of drugs was the most significant area in which health services could be improved. This was followed by the provision of well-trained staff to manage the facilities and the construction of hospitals in both high-performing and low-performing regions.

Across localities (i.e. whether urban, peri-urban or rural), the responses in Figure 31 present a disheartening portrait of a health system in which the unmet expectations of its beneficiaries are the very drugs, facilities and human resources

which should be at its centre. Figure 31 shows the expectations respondents have of government contributions to health.

The demand for medicines, health personnel and facilities was stated by qualitative study participants to be high and urgent. In Senegal, a young male in a peri-urban locality cites reasons for the urgency:

“You know why we are asking to increase the staff? If you’re just here at 11p.m. when you are sick, whatever the gravity of your illness, you will wait until the next day. There is nobody who will be

there to put a drip on you because they will say that there will be no personnel to take care of you during the night. This is what they will tell you” (FGD, young male rural).

According to this young man, the problem is complex. It combines poor staffing with inadequate facilities to aggravate patients’ health conditions.

“For the beds we’re talking about, sometimes it is possible that a patient comes and can feel pain in his body because he sleeps in a rough bed and the disease may worsen. People also need to think about this” (FGD, young male, rural).

Despite this awareness, study participants seem to recognize that the crisis in the health sector is sometimes a product of extraneous factors such as broader systemic instability. This situation is reported in CAR where a group of adult men suggested that “The main difficulties lie at the cultural level,” explaining that the country’s post-conflict situation made proper health management difficult, especially in remote areas where atrocities and local dislocations may have been common. A key informant observed that:

“This is an isolated area which has suffered for a long time the atrocities committed by rebels and bandits. Valid people gave up their village for other communities. The health station suffered the impact of abuse and abandonment of the village. No medical activity can be applied in accordance with the principles set” (FGD, adult males, urban).

Community contributions

The contribution of communities to health is mostly in the area of maintenance of facilities (20.9%), and providing assistance in caring for patients (18.1%). Figure 32 shows that individuals are uniformly contributing to health care delivery across the subregions.

Communities also contribute to service delivery by selecting volunteers (10.7%), training them (10.5%), and providing help in managing facilities (10.4%). In some cases, they build or provide the facility (6.3%), labour (5.6%), commodities (5.8%), and compensation for the health providers (5%). As many as 26.2% of the respondents did not know how or if their communities contributed to health care.

On average, 64% of individuals had never made contributions to community health care delivery for the three types of localities, most of these being in the urban areas (66%). The patterns may reflect greater levels of infrastructural neglect in rural communities.

Across localities, individuals’ contributions to the delivery of community health services were highest in caring for patients. This was the most frequent form of contribution, occurring in over 30% of the responses in the three localities (Figure 33).

At least twice as many individuals were willing to make contributions to service delivery: 68.1%, 66.6%, 66.7% in urban, peri-urban and rural sites, respectively. Over 65% of respondents in all localities expressed willingness to contribute to community health care delivery in the future. These data show variation by age or occupation and are consistent for all sites.

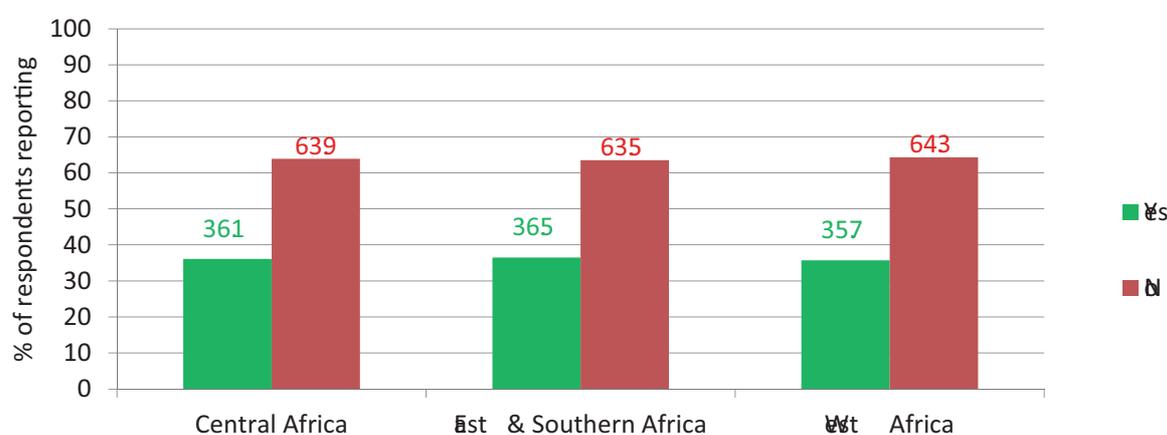


Figure 32: Contribution of individuals to the health of their community in the subregions

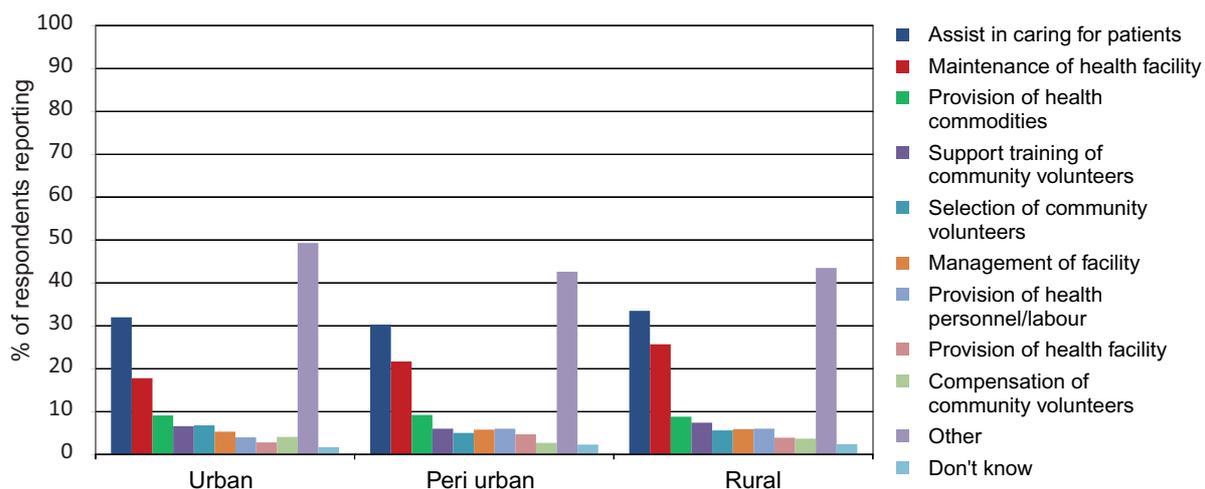


Figure 33: Individual contributions to community health by locality

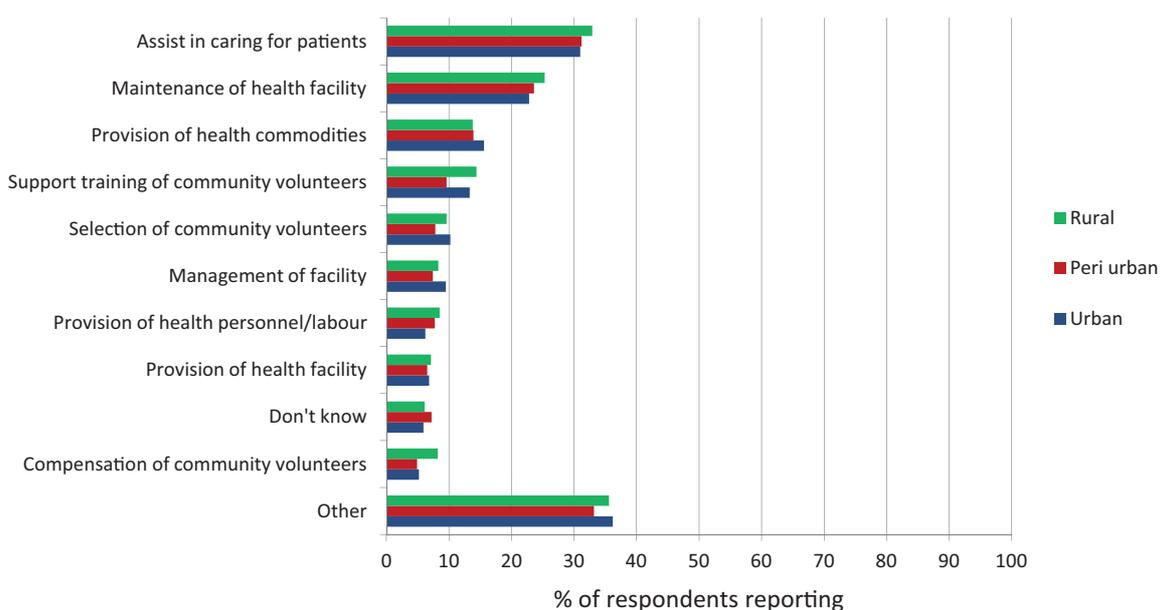


Figure 34: Forms of individual contributions to health in the community by locality

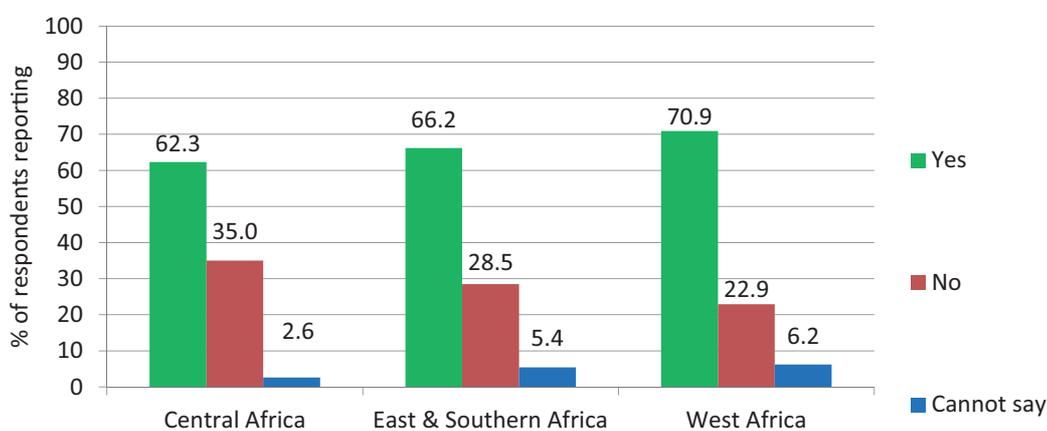


Figure 35: Willingness to make contributions in future in the subregion

Figure 34 displays the forms of contributions individuals are willing to make to health care delivery in their communities. Across the sites, they are also willing to help maintain facilities and provide commodities.

When asked about their willingness to contribute to health care in the future, the respondents in sites in the West subregion ranked higher as shown in Figure 35.

The reasons for lack of willingness to contribute to health care delivery differed across the subregions (Figure 36). In Central and West subregions, the lack of money was reported as the major reason, 59.8% and 41.1%, respectively.

Unemployment was second in both subregions and tied with financial constraints in East and Southern subregion.

When asked why they were not willing to contribute to the delivery of health services in their communities, lack of money was the predominant reason across the localities, followed by the perception that it is the government's responsibility and because of unemployment (Figure 37).

From the IDIs and FGDs across the locations, financial considerations were the leading constraints to individual contributions to the delivery of essential health services. Discussions with

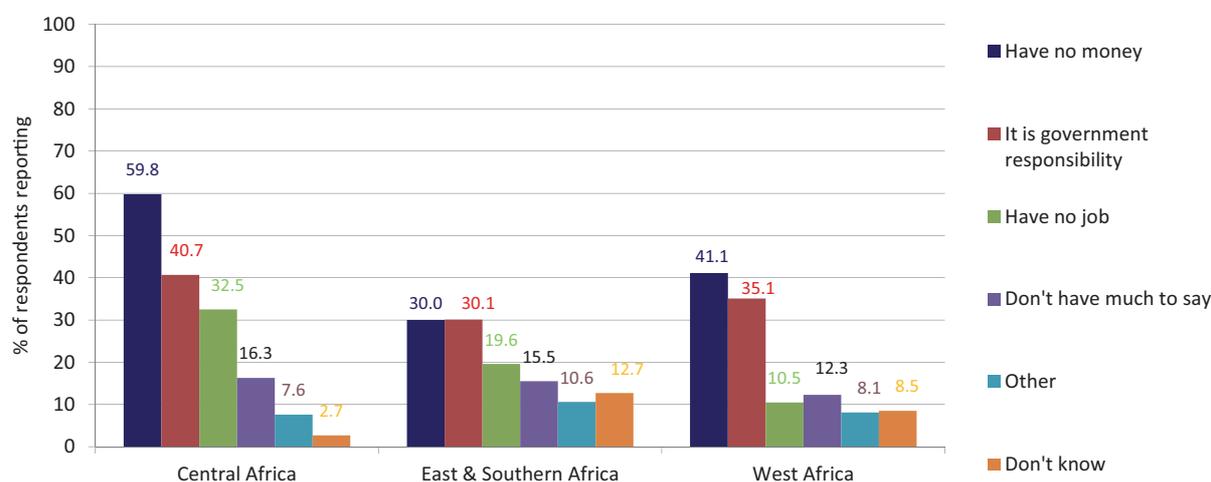


Figure 36: Reason for lack of willingness to contribute to health care delivery in the subregion

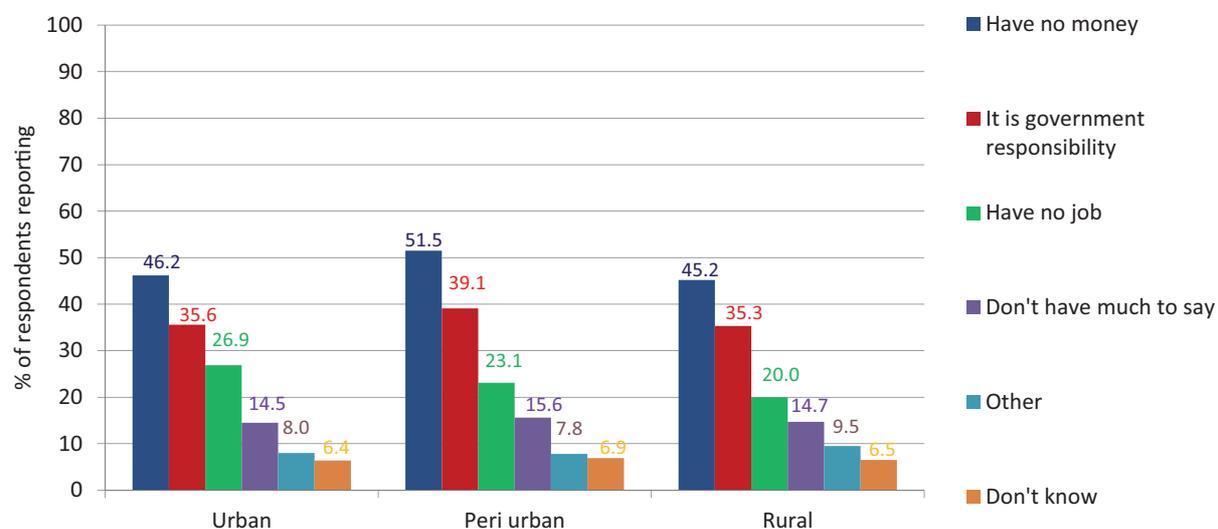


Figure 37: Reasons for the lack of willingness to contribute by subregion

participants show a diversity of reasons for non-participation which include economic reasons. Adult urban women explained:

“What prevents us from doing it (participating) is that you cannot help it where you do not have means. If you do not have means, you will not be able to help. What we can do is sensitize people” (FGD, adult women, urban).

For a female community leader, exclusion results from programme focus. Government was

perceived as not doing enough for people’s health because its attention was on immunization.

Community expectations

Figure 38 illustrates community perspectives on what can be done to improve the way health care services are delivered. In both high-performing and low-performing regions, the provision of drugs ranked highest. Respondents also indicated the importance of reducing waiting time at facilities.

Box 5: Utilization of health services—views of health workers

- 5.1 “They are very much aware of the facility in place and are taking advantage of it, the only problem we have is that they don’t come on time, most of them come to the primary health centre by 11am when personnel have gone to attend to other people elsewhere (for outreach services)” (health worker).
- 5.2 “Most times when the health facilities are placed in areas where they are inaccessible, it becomes difficult for the communities to access it. If it is too far, they’ll not be able to access it. They will always go to a place that is close to them no matter the level than going to the one that is far” (Head of district health).
- 5.3 “This local government lacks skilled manpower and this affects the people’s readiness to access health care in these facilities. They keep people that are working unhappy. They even write to them not to pay the people that are working here. For instance, this lady here has been working since yesterday. She will work morning, afternoon, and night and after everything they will not pay her. Lack of manpower is also another problem I have with them here because they have refused to employ more people” (HOD, health).

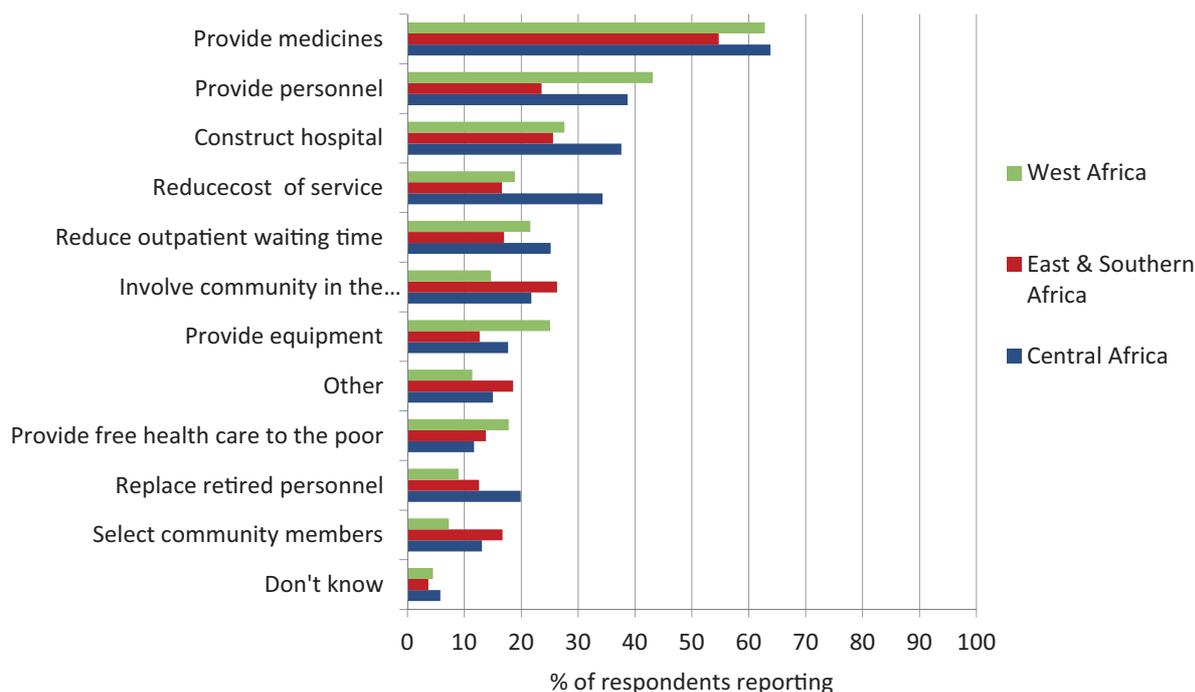


Figure 38: Ways of improving the community health system in subregions

Box 6: Emerging issues—views of health workers

- 6.1 “Distance from residential homes to this facility is also one of the major challenges we face. Due to this, those who stay far from the facility cannot access our services at all. Means of transport to the facility is something of the past i.e. we only have two vehicles which transport people from this shopping centre at 6.00am and 6.30am and will then come back at 5.00pm. So what happens when you fall sick at midday?” (health officer).
- 6.2 “The lack of power supply in the zone is a handicap for the activities of the centre and the communities. Nevertheless, the health areas without power supply have a generator for the storage of vaccines. It was noted that in spite of the absence of power supply in some health areas, all these structures have a refrigerator for the storage of vaccines” (district medical officer).
- 6.3 “When you get them involved in delivery of services, they always want remuneration. Like when we are doing campaigns such as immunization campaigns (NID campaigns), anyone you get involved would be demanding something. If you don’t give them something, they don’t like it and when you call them severally for meetings, any meeting they come, they want something and no health care provider can always sponsor such meetings. Even at the state level, if you call for a meeting of the ward development committee, only a few would come and they would demand for something afterwards like transport and other things . . .” (Health of district health).
- 6.4 “As it is mentioned in the minimum package of activities, in the field of financing, the head of health district initiates the creation of a mutual insurance in the catchment area. The latter found it useful to create a health mutual insurance that could help the poor people to pay for health care” (district medical officer).
- 6.5 “They should facilitate us with funds to meet the demands of the community. The PHC fund should be increased and sometimes they take long to release the funds; therefore time management should also be put into consideration” (health officer).
- 6.6 “We don’t have the capacity to handle emergencies and every time a patient comes to us we always pray that there are no emergencies because if it happens we don’t know what we will do” (medical officer).

Views towards improvement of health services

Figure 39 shows that community members would like officials and health workers to focus on improving the delivery of health services.

Across sites, more than 65% of the respondents viewed the services provided as needing much improvement. Only about 10% felt the services were good. The results reinforce earlier data reflecting high levels of dissatisfaction and the opinion that services were inadequate.

4.5 HEALTH SYSTEM GOALS AND SOCIAL CAPITAL

Results in this section are organized and presented according to the following: (i) people’s rights to demand health services from the

government; (ii) people’s trust in government to meet their health needs; (iii) people’s rights in getting the government to address issues that affect them; and (iv) freedom of the people to express themselves on health matters without fear of government reprisal.

Rights of people to demand health service delivery from the government

Community members were perceived to have different levels of say in getting governments to address issues of interest to them in their communities. Overall, politicians (55.1%), community leaders (51.4%) and religious leaders (46.8%) were perceived to have more rights and thus able to hold governments accountable compared to groups of people in their respective communities (Figure 40).

Further analysis was done by study site on people’s right to demand health service delivery from government. Community leaders were perceived to have a lot of influence in Senegal,

Cameroon, Niger and Nigeria North West in all the study regions (urban, peri-urban and rural). In Kenya, they were perceived to have more influence in urban than in other areas. As shown

Table II: Perceived community leaders’ rights to demand for health service delivery from the government

Study Site	Urban		Peri-urban		Rural	
	Number of mentions	% of respondents	Number of mentions	% of respondents	Number of mentions	% of respondents
Algeria	56	20.0	59	21.1	68	24.3
Cameroon	187	70.0	172	63.2	170	62.7
Central African Republic	136	50.9	143	54.0	156	58.9
DRC East	137	48.9	175	26.8	62	22.1
DRC West	111	39.6	121	43.2	126	45.0
Kenya	227	65.4	164	49.8	162	53.7
Niger	173	63.6	172	63.5	176	64.9
Nigeria North West	189	67.5	189	67.5	125	44.6
Nigeria South East	119	42.5	152	54.3	147	52.5
Nigeria South West	108	39.1	111	39.8	125	41.7
Senegal	240	88.2	208	76.5	248	91.2
South Africa	180	58.1	103	46.4	158	57.5
Uganda	32	11.4	41	14.7	49	17.5

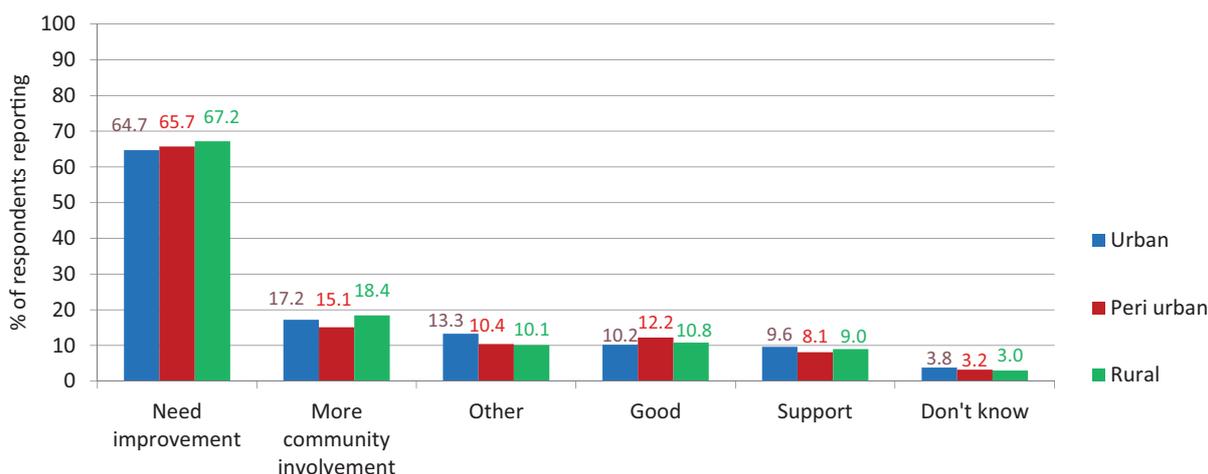


Figure 39: Respondent perceptions of status of health system by locality

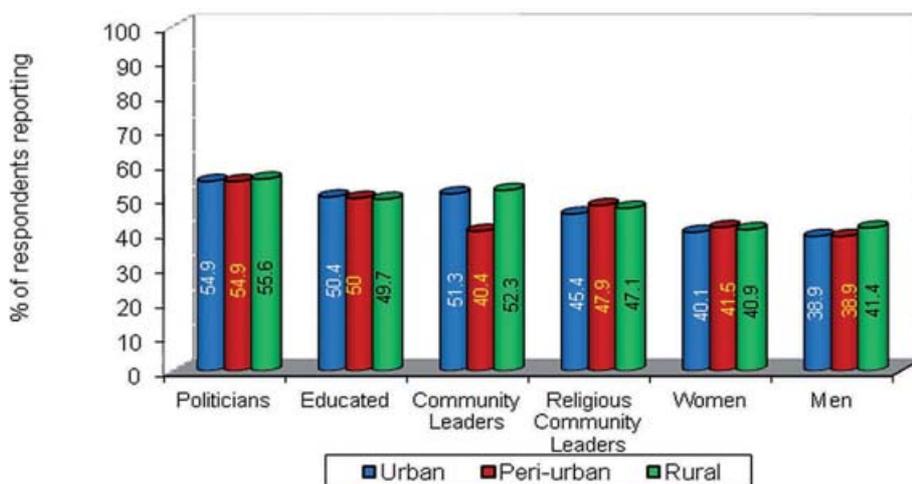


Figure 40: Perceived rights of people to demand health service delivery from government

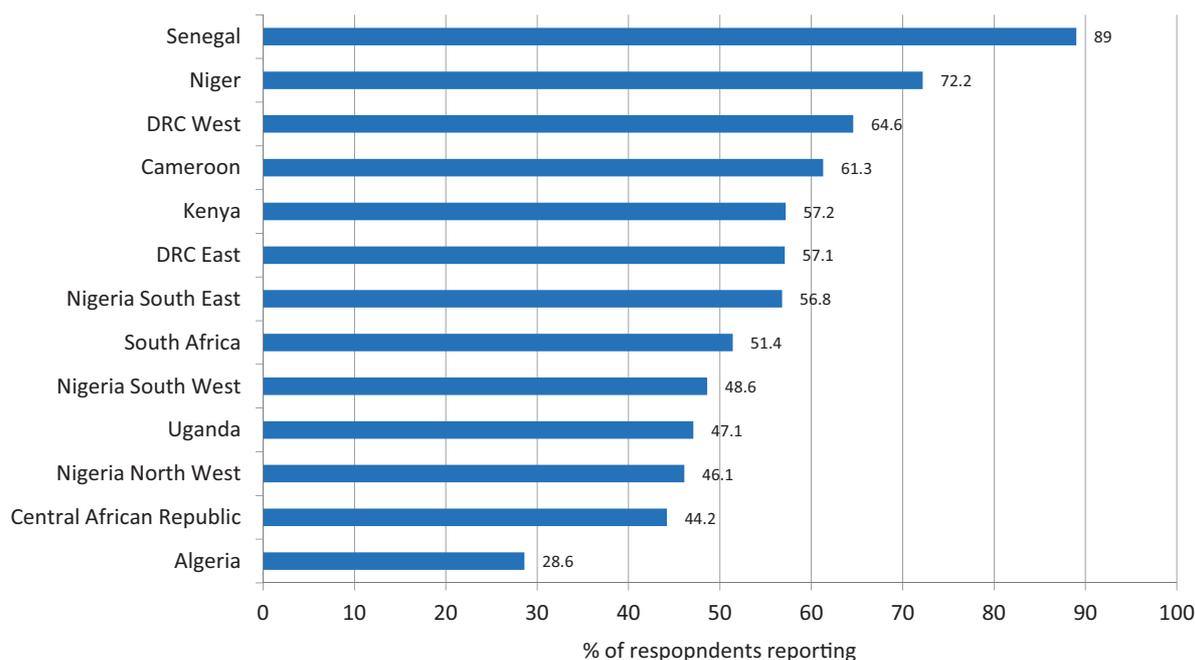


Figure 41: Perceived rights of politicians to demand health service delivery from government in rural areas

in Table 11, community leaders were least perceived to have a lot of influence in Algeria and Uganda in the subregions.

As regards politicians, they were perceived to have a lot of influence in urban, peri-urban and rural areas in Senegal, Kenya, Niger and Cameroon, but not in Algeria and Uganda. Specifically for rural areas, politicians were perceived to have considerably more influence in Senegal and Niger than in all the other study sites as shown in Figure 41.

Religious leaders were perceived to have a lot of influence in all localities in Senegal, Niger, DRC East, and Central African Republic with more than 50% of the respondents in each area citing their influence. They were also perceived to have a lot of influence ($\geq 50\%$) in Cameroon, DRC East, Kenya, Nigeria North West and Senegal in peri-urban areas. Public officials with experience in working with government and communities reiterated the importance of educating and sensitizing people on their rights to demand effective health service delivery:

“Sensitizing people about their rights and what they ought to receive is very important . . . our people have not reached that level where they can freely demand for services from the duty bearers especially the government . . . When they don’t have water, they do not go to the water office

and demand for clean and safe water . . . Even when we go away from health to other sectors, it is still hard for people to go, for example, to the marketing officer and say ‘We have this kind of business here, can you help us learn how to manage it?’ So I think the population has not learnt to maximize benefits from the expertise that is available” (IDI, health provider, rural).

People’s trust in government response to health needs

Overall, 40.5% of the respondents indicated that they always trusted the government to respond to their needs. Of those, 37.5%, 41.7% and 42.4% were urban, peri-urban and rural respondents, respectively. About two fifths (41.1%) of the respondents indicated that they sometimes trusted the government to deliver health services correctly. However, 13.8% mentioned that they never trusted government to act correctly in the interest of the people. Site analysis showed that the proportion of respondents who always trusted the government to do the right thing was higher in rural areas than urban and peri-urban areas except in Algeria and DRC West where it was higher in urban areas. Nigeria North West, Senegal and South Africa recorded higher levels of trust in peri-urban areas than in rural areas (Table 12).

Table 12: Trust in government to always respond to human health rights by locality

Study site	Urban		Peri-urban		Rural	
	Number of mentions	% of respondents	Number of mentions	% of respondents	Number of mentions	% of respondents
Algeria	139	56.2	139	49.6	146	52.1
Cameroon	150	56.2	162	59.6	168	62.0
CAR	180	67.2	193	72.8	206	78.3
DRC East	106	37.9	110	39.3	163	58.2
DRC West	93	35.4	49	17.5	89	31.8
Kenya	113	32.6	151	45.9	144	47.4
Niger	65	23.9	96	35.3	78	28.8
Nigeria North West	142	50.7	162	57.9	99	35.4
Nigeria South East	68	24.3	40	14.3	76	27.1
Nigeria South West	52	18.8	67	24.0	65	23.6
Senegal	67	24.6	93	34.2	52	19.1
South Africa	76	24.7	104	45.6	100	36.9
Uganda	125	44.6	127	45.5	143	51.1

Mistrust in the government to do the right thing for the public was partly due to persistent shortage of drugs and health personnel in the public health sector. Overall, 74% of the respondents reported that they could not receive all the medicines prescribed to them during the previous illness prior to the study. Of those, 72%, 73.9% and 74.9% were residents in urban, peri-urban and rural areas, respectively. A community leader stated:

“Are we not part of this country? They should give us a doctor, they should give us drugs, now tomorrow again they will send some other people to come and ask us our needs and interview us. We have managed to build this health centre. The government, we are not sure whether this is still functioning, tomorrow they will come and ask for our votes” (IDI, community leader, rural).

High cost of treatment and negative attitudes of health workers to patients in public sector health facilities were also a source of mistrust of the government to deliver health services. This was frequently echoed in focus group discussions across all study sites:

“I would say that the country is not suffering because of the health system. It is because of lack of means to make the system function. The programmes exist but they don’t have means for implementation of their policy” (IDI, health provider).

Some respondents were of the opinion that there is inequity in the distribution of health care serv-

ices by government because of more provision of amenities in the cities.

“I would like to ask government authorities to honour their commitment regarding their financial contribution to the health facilities to ensure free health care for children. If they don’t do so, health facilities will be closed because they lose a lot of money by paying for drugs and treating children for free. As the government does not pay for children, the health facilities’ money decreases every time so the health facilities will be closed” (IDI, community leader, rural).

“My own question to government is that we are all citizens of this country whether we live in the village or town, why is it that government does not provide us with the amenities that will ease our lives like they do for people in the city?” (FGD, adult males, rural).

People’s awareness of rights to get government to address health issues

Overall, 80.6% of the respondents were aware of their rights in getting government to address health issues that interest them. Of those, 77.5%, 82.6% and 81.9% were urban, peri-urban and rural residents, respectively. Site analysis showed a similar pattern across all study sites except in Uganda (67%) and South Africa (53.7%) where awareness was lowest among urban respondents. Some community members were indeed using this awareness to lobby for government health interventions for their communities.

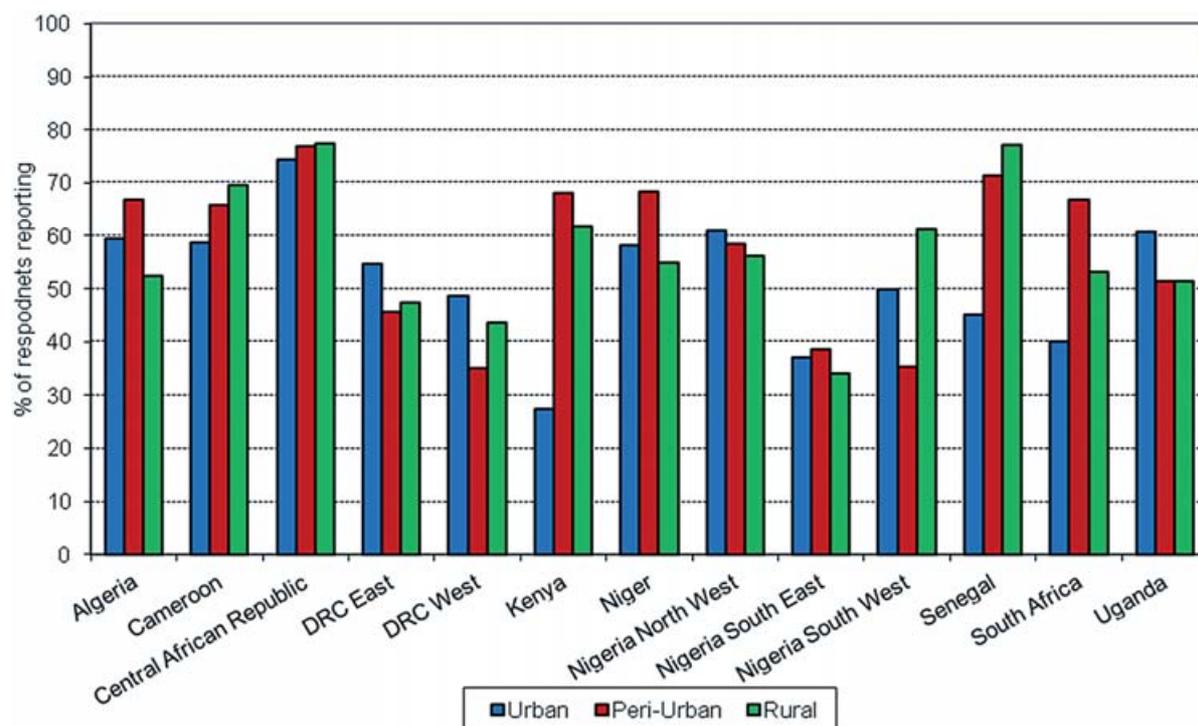


Figure 42: Freedom of people to express themselves on health matters without government reprisal

Despite people's awareness of their rights in getting the government to address health issues that interest them, government unresponsiveness to community efforts was a discouragement to communities.

“A health structure was built to the roof level through community effort, but the government could not help the communities with funds for roofing and the structure collapsed” (FGD, adult male, rural).

In another instance, through community mobilization, a project aimed at providing accommodation for health personnel was stopped by a chairman because he felt it was not appropriate for the community to do so:

“We got a piece of land sometime ago to build residential quarters for the health personnel, so that they can work well. In fact we have started moulding the blocks and putting sand there. Then the local government chairman at that time said that we should not build the residential quarters and that the government will build it. As we speak now, the quarters have not been built and all the blocks and sand are wasted” (IDI, community leader, peri-urban).

Freedom of expression on health matters without fear of government reprisal

Respondents were more likely to report that they were completely free to express themselves without fear of government reprisal in peri-urban and rural areas than in urban areas, with the exception of DRC East, DRC West and Nigeria North West and Uganda where it was higher in urban areas than peri-urban and rural areas (Figure 42). Overall, 55.7% of the respondents stated that they were completely free to express themselves and 51.4%, 59% and 56.9% were from urban, peri-urban and rural areas, respectively (Annex 11). All three subregions reported more than 85% of respondents having some freedom (either complete or moderate) to express themselves. Notably, in the West subregion only 11% of respondents felt there were no freedoms (Annex 12).

Overall, males (53.3%) were more likely to indicate that they were completely free to express themselves without fear of government reprisal than females (46.7%), and the pattern was the same in urban, peri-urban and rural areas.

5 Discussion

The results presented in this report are based on a large sample of respondents drawn from diverse countries, representing over 52% of the population and a significant proportion (26%) of the countries in the Region. The large sample size of 10 932 provides a basis upon which the discussion is based to draw out the implications of the results on community perceptions and perspectives on health service delivery.

National governments, development partners, civil society organizations (CSOs) and communities are confronted with the challenge of providing health care to the people in Africa. Preventive and curative services as well as health promotion activities have been intensified since the formulation of the MDGs and in line with national health goals and targets. This increased focus on health system strengthening in the last five years has presented opportunity for health actors in the WHO African Region to assess the capacity of national health systems to deliver essential health care to the people.

Member States have been urged at various forums⁶ to strengthen health systems and fund

research that promotes evidence-based programming and policies. The model in wide use identifies six building blocks of an effective and efficient health system. It places people at the centre of the system, served by responsive leadership and governance, a trained health workforce, funding, medical products, service delivery, and information (WHO 2010; Swanson et al, 2010).

This study addresses several recommendations for research made in various regional agreements and declarations aimed at providing better understanding of how to position urban, peri-urban and rural communities more integrally as part of a strengthened health system. It documents perceptions and perspectives of people on health, health service delivery and health systems. It describes the realities of essential health care in order to develop more appropriate mechanisms for community participation and responsive health service delivery.

Community perceptions and awareness of health

Perceptions of what constitutes good health: Respondents overwhelmingly focus on the ability to work, move around and “be strong” when considering what constitutes good health, with important emphasis on the emotional, psychological, economic, mental and spiritual aspects of health. The prominence of physical strength in community views derives from agrarian production systems in which farming is labour-intensive and not mechanized. The interface between health and financial ability is

6 Key meetings and agreements include: The Algiers Declaration 2008 (Ministerial Conference on Research for Health in the African Region); Abuja Declaration on Health Research (March 2006); Accra Declaration on Health Research for Disease Control and Development (June 2006); Ouagadougou Declaration on Primary Health Care and Health Systems (April 2008); and The Brazzaville Declaration on Noncommunicable Diseases Prevention and Control in the WHO African Region (April 2011).

captured by and Ugandan study participant who observed: “If you do not have money you cannot be healthy.” The community concept of health which includes a dimension of spiritual well-being is an important contribution to this study on the definition of health. This spiritual dimension is significant from the viewpoint of community health training and practice because it is a formal indication of the antecedents of health-seeking behaviour. For respondents in the study, health is both personal and relational and is also indicated by the health status and well-being of those around an individual, denoted by “peace” in the qualitative data.

An analysis of community notions of what constitutes health and the standard, original WHO definition of health as “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity” (WHO, 1946; WHO, 2006) shows that there is a convergence of understanding albeit with an additional component of health that has been recognized but not fully integrated in health discourse. Figure 43 illustrates that community perspectives of health incorporate elements of economic, emotional and spiritual well-being.

At the centre of people’s conceptions of the world is their idea of the spiritual and the inter-relationships among all persons. This construct is a more robust conception of wholeness and “completeness” which extends the understanding of health to the body of one’s interpersonal relationships and how these have implications for mental, emotional, economic and physical well-being. This explains why respondents tended to rank household or group-level well-being higher than personal or individual health. The perspective has implications for health worker training which should include curricula containing ethnographic knowledge and cultural sensitivity. This would bring health service provision closer to the people, and community members and health workers could discuss health problems in language and ideology that are mutually comprehensible.

The emphasis on physical ability and the ability to work, move around and “be strong” is based on the agrarian background of most of the study communities where production systems are labour-intensive and not mechanized. In addition, increased rural-urban migration causes rural food production to come under pressure,

making physical ability a primary measure of individual health. Reinforced by high youth unemployment rates, the idea that health has an economic dimension, that is, saying one is healthy means he is economically able to meet his basic needs, is sensible from the perspective of poor communities.

Community perspectives of health systems are related to their overall perspectives of good health. According to the respondents, a good health system should be people-centred (individual and household) with strong community involvement; good leadership, governance and stewardship; and within an environment that is conducive as depicted in Figure 44⁷.

It is important to recognize that when people visit health facilities they are more concerned about the services available and how the providers treat them. Although financing is an important component of a health system, the people’s focus is on the end result—whether it translates into the availability of equipment and supplies and whether there are sufficient personnel who are friendly to them.

Common health problems: There are high levels of awareness of both communicable diseases and NCDs across the study sites. Malaria was cited as the most common illness, which is in line with the latest estimates from WHO (2010b). The estimates indicate that 250 million cases of malaria occur each year, with an associated annual toll of about 781 000 deaths (WHO, 2010b). Most of the burden of disease caused by malaria is borne by the populations living in the highly endemic areas of sub-Saharan Africa where the populations at highest risk are pregnant women and children under five years of age (Akweongo, 2011; Okeibunor et al, 2011; Heggenhougen, Hackethal and Vivek 2003). The two countries involved in the study that reported very low malaria levels were Algeria and South Africa. Algeria is one of the ten countries in the malaria elimination phase (WHO, 2010b). Although South Africa has some regions that are malaria endemic, the study was conducted in Gauteng and Eastern regions where the prevalence of malaria is generally low.

7 This figure is a construction by the research team to illustrate the key elements of a health system as articulated by the respondents through both the quantitative and qualitative data.

COMMUNITY CONCEPT OF INDIVIDUAL HEALTH

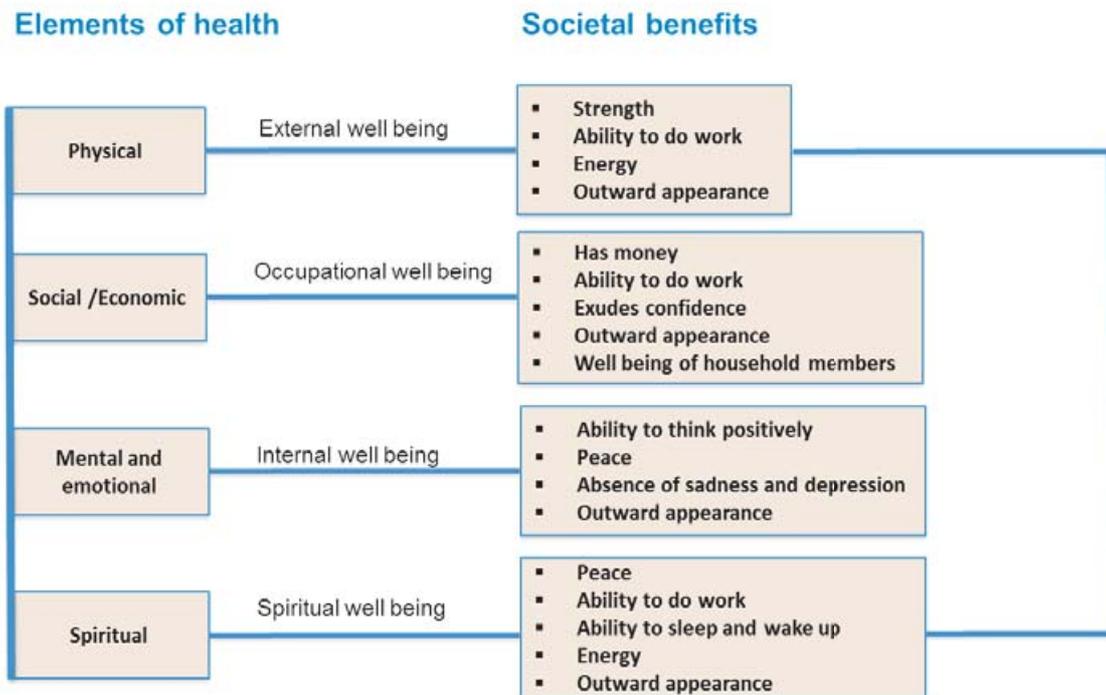


Figure 43: Conceptualization of individual health based on respondent perceptions of health

COMMUNITY PERCEPTIONS OF HEALTH SYSTEMS COMPONENTS

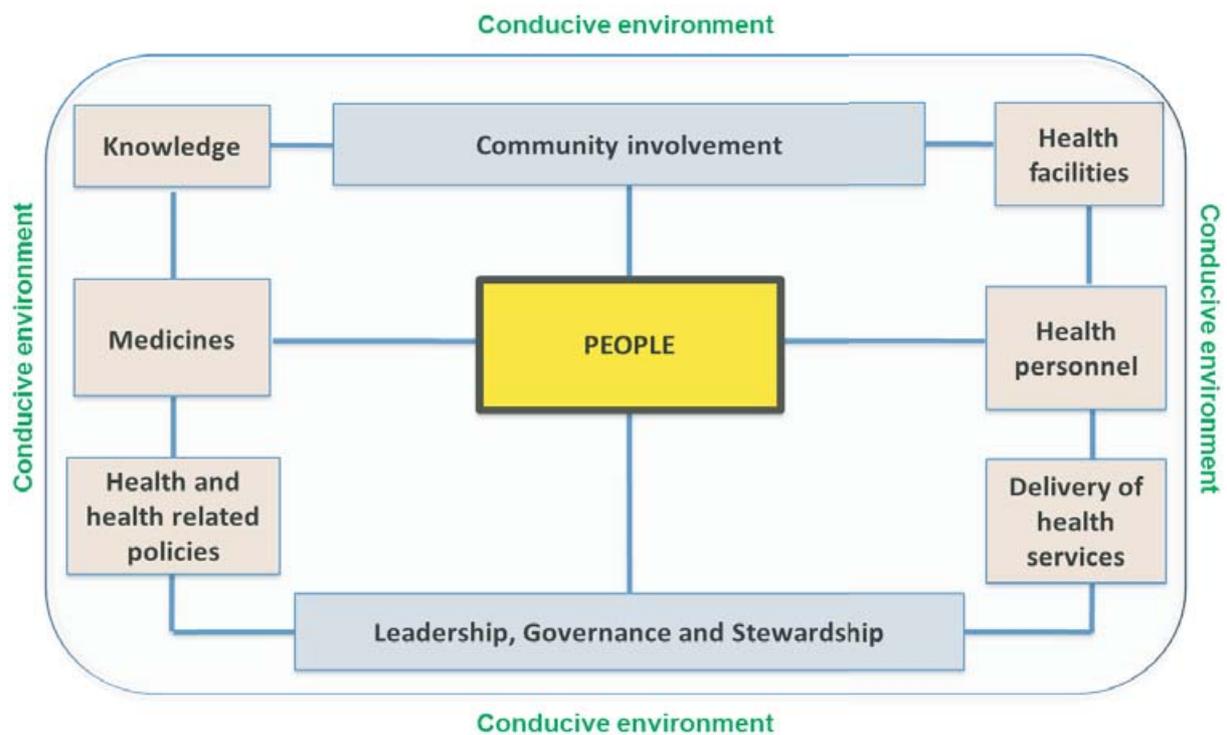


Figure 44: Community perspectives of a good health system

Malaria in children under five years has been frequently over-diagnosed in many endemic countries (Koram, Molyneux, 2007). Therefore, respondents' mention of malaria as the most common health problem needs to be interpreted with care.

Awareness of noncommunicable diseases: The results show high levels of awareness of hypertension and diabetes and other NCDs including mental health. Although all sites reported the presence of such diseases, it is notable that Algeria, DRC, Nigeria (some parts), Senegal and South Africa had higher levels of awareness. It is estimated that the global prevalence of hypertension in adults (25 years and above) was at 40% in 2008 (Mensah, Bakris 2011) although the prevalence rates in most African countries remain unknown (Bosu, 2010). It is imperative to understand the double burden of communicable and noncommunicable diseases in order to structure health services to respond appropriately (WHO, 2011). NCDs in particular can be chronic and necessitate long-term management in a community setting. In this regard, the political declaration adopted by the UN High Level Summit on NCDs (2011) recognized the critical role of strengthening health systems with the active engagement of civil society, private sector and communities (the users of health services) to address these diseases in a context-appropriate way and avoid unnecessary health centre visits.

Actions for maintaining good health: Hygiene was identified in this study as a key measure of maintaining health and is an important concern given that most health problems in the Region are preventable through measures such as improving personal and community hygiene. Access to clean and safe drinking water is still low for most countries in the Region (UN, 2010). Measures such as prompt seeking of health care, regular check-ups, regular exercise, and avoidance of risky behaviour are important for disease prevention and control. Prompt health care is critical in situations of acute illnesses such as malaria and pneumonia among children as well as for asymptomatic health problems (including NCDs). Surprisingly, avoidance of risky behaviour ranked low despite the fact that there have been great efforts in the last three decades to educate communities in urban, peri-urban and

rural locations on behaviour change, particularly in response to the HIV/AIDS pandemic.

Perceptions on sources of health care: Public health facilities were the most commonly cited sources of health care. However, these facilities were perceived to target mainly children and women of childbearing age at the expense of older persons, men and youth (Rosato et al, 2008). Consequently, to a majority of the respondents, the government's main role in health care provisioning is seen as immunization and provision of health services targeted at women and children. This perception needs to be addressed because male involvement is important for the management of ill-health, particularly in Africa where they make most household decisions (UNICEF, 2006). In fact, this observation has influenced the substantial shift in practice by agencies working on reproductive health towards promoting male involvement in their programmes.

Health facilities: The unavailability of drugs, poor attitude of health providers and long waiting times were the main reasons cited for the poor rating of public health facilities. Satisfaction is one of the key guiding principles of health systems strengthening (Swanson et al, 2010), but it continues to be a challenge in the Region. For those respondents who were satisfied with the services, the main factors contributing to this positive opinion included responsive health providers and friendly environment.

Responsibility for maintaining household health: The household head was reported to be the one responsible for providing health care services. This might reflect the source of health expenditures for many households which depend on household members rather than health insurance or any form of subsidy. The fact that household heads were seen as the ones responsible for health implies that they have to be "strong" to do so. The need to be healthy is clearly illustrated in HIV/AIDS literature, where the death of a household head disenfranchises households and throws them deep into poverty (Desmonda, Michaela and Gowb, 2000).

Community participation in health decision-making: Involvement of community members in health decision-making, a critical factor in

health system strengthening, was generally low across and within all the sites. This observation was mainly related to operational issues such as lack of material support for such engagement and limited capacity of the community members to engage. The feeling of deliberate exclusion from decision-making by the health system was also reported. The Heads of Governments at the 2011 Rio Conference on Social Determinants of Health underscored the importance of participatory approaches in policy and implementation.

Main sources of health information: Radio and community announcements were the major sources of information on health as reported by study participants. Although pamphlets and billboards are used extensively for social marketing, the results show that these modes of communication may not be effective in delivering health messages. This could be due to limited involvement of communities in developing such health education materials despite evidence that integrating people's beliefs in the design of communication materials is a key to ensuring the success of health interventions (Escott and Walley, 2005). Swanson et al (2010) call for particular attention to knowledge generation and application at the household and community levels through formative research and behaviour change communication (BCC) strategies which can lead to stronger health systems in the long term. Such capacity enhancement is critical to enable effective community, district and national ownership of health programmes.

People's experiences with health services

The perceptions and perspectives of people are influenced and shaped by individual and community encounters with the health system. The interaction between the health care providers and the people is important in shaping people's experiences with health delivery. It also determines how community members utilize the health care services, where they access care and the extent to which they participate in the delivery of health services. These experiences differ by location (rural, urban, peri-urban settings as well as post-conflict settings) and by type of health facility (primary, secondary, tertiary, private, traditional, etc).

Access to health care: The key obstacles to accessing care cited in the study were cost of health care, long distances to facilities, inadequate and unaffordable transport systems, poor quality of care and poor attitude of health service providers. The African Programme for Onchocerciasis Control reported that in DRC 20% of onchocerciasis endemic communities were located 11 to 20 kilometres from the nearest health facility (WHO, 2008g). The shortage of skilled health workers, discrimination against those who cannot pay and poor referral are critical challenges to accessing health services. This issue points to inequitable access to health care, a key concern when addressing the social determinants of health (WHO, 2008f).

Several health problems are not taken to health facilities immediately they occur yet prompt care seeking is a key measure for effective prevention and management of illnesses. Fever, malaria, arthritis and mental health problems were seen in many sites as diseases to be treated outside the health system. For such illnesses, some people sought care from traditional healers, spiritualists and patent medicine vendors and only visited the health facilities when the preferred sources of care failed (Ibidapo, 2005). Delayed health care seeking, a phenomenon extensively discussed in literature, has repercussions on health outcomes (Amuyunzu-Nyamongo and Nyamongo, 2006; Okeibunor 2007a,b). This partly explains the high level of child mortality associated with malaria and other acute illnesses. Delay in the seeking of health care is seen as a key challenge to effectively addressing NCDs in the Region (UN, 2011).

Poor quality of services and lack of information underlie the poor perception of public health facilities voiced by the users. Characteristics of poor quality of services include poor infrastructure, poor staff attitudes towards patients and lack of drugs. These factors are key determinants of poor health outcomes as well as poor perceptions. The study results are clearly illustrative of the practical aspects of the Health Belief Model (Rosenstock, 1974). The utilization of public sector health facilities depends on the value that clients place on the health care services as well as their estimation of the goal of achieving good health. The values placed on the available options often evolve from long-term experiences and socialization. Clients with negative

experiences with the health facilities, in the form of “out of stock” syndrome and poor attitude of the health workers, will definitely place lower value on the public sector health facilities (Frost and Reich, 2008).

Resulting factors of people’s poor experiences with health care is that communities resort to self-treatment, seek ineffective alternatives, or report late for care, often with poor health outcomes. Many resort to traditional healers. Although traditional healing is a key element of health care seeking in the Region, it leads to delay in accessing care in a timely manner (Hatchett et al, 2004). The search for alternative sources of health care indicates that if people had money they would spend it elsewhere. It is also noted that some of the private sector facilities, such as patent medicine vendors, are more likely to defer payment, thereby providing patients with care when it is most needed. These observations should however be interpreted within the understanding that people’s use of health care facilities is determined by multiple reasons, including religion and belief systems.

Sources of health care: Health care was sought mainly from public health facilities. This was despite the fact that most of the respondents felt the services were inadequate. The main factor associated with this contradiction is an acknowledgement that public sector health facilities are run by qualified personnel (Rutebemberwa et al, 2009; Rubel and Garro, 1992; Pathania, Almeida and Kochi, 1997, Auer et al, 2000; Konde-Lule et al, 2008, Ajayi et al, 2008; Abuya, 2010). This indicates that improving health facilities and services is a key measure of increasing their use. Private health facilities, including those operated by faith-based institutions and CSOs, complement these public health services but they too need strengthening so as to provide quality health care.

Prescription of medicines: The results show that people who used public health facilities were given prescriptions but were not always able to obtain the medicines prescribed. In some cases they visited prescription facilities knowing they were unable to buy the medicines. This illustrates the need to improve this aspect of health service delivery. The medical and social implications of receiving fewer medicines (than prescribed)

and non-treatment due to “not finding any of the drugs” include deterioration of health, drug resistance, non-compliance with treatment as well as loss of confidence in the public health system, among others. Medical supplies are recognized as a key component of an effective health system (WHO, 2008f).

The results of the study suggest an overall inadequacy of drug supply. A surprising finding of this study is the marked regional differences in DRC West, Kenya, South Africa and Uganda indicating greater availability of drugs in the low-performing regions. In South Africa, the drug depots are located in the low-performing region (Eastern Cape) while in Kenya the area differences observed could be due to the availability of partner-supported programmes addressing HIV/AIDS, reproductive health and malaria at the coast. This may also suggest that the low-performing settings utilize drugs less due to minimal pressure on consumption. Access to drugs is also affected by willingness and ability to pay (TDR, 1996). This is a factor needing further research.

Payment for health services: The results show limited reimbursement of the money spent on medicines across the study sites. Communities are, however, finding ways of addressing health financing. In some countries including Senegal, Niger and Nigeria, communities have established associations to handle the expenses related to major illnesses, death and funerals (Amuyunzu-Nyamongo and Ezech, 2006). Health care charges, in the form of administrative and treatment costs, as well as other out-of-pocket expenditures place heavy financial burdens on poor clients and their households. Many fail to access care in public sector health facilities when they need it most while others fail to obtain the necessary referral for more skilled care. The qualitative data revealed that people do not always know what they are supposed to pay for, and which payment demands are legitimate or how to get waivers. Both the official and unofficial charges seemed unaffordable to a majority of the study participants. Exemptions and waivers not obtained as health insurance remain at the rudimentary stages of development in the Region. In countries where user fees are charged, there is limited evidence that quality of care has improved even with the additional funds generated from such fees.

In most countries, health insurance applies only to people in formal employment. Community health insurance is characterized by geographical inequality and shallowness of benefit package (Roberts et al, 2004). In Nigeria, Onwujekwe et al. (2010) noted that less than 40% of the people were willing to pay for Community-Based Health Insurance (CBHI) schemes for themselves or other household members. The proportions of people who were willing to pay were much lower in the rural communities. The cost and the ability to pay are critical issues in health policy which calls for the establishment of a strong system that supports access to health care through multiple mechanisms such as reimbursements, subsidies, waivers or social health insurance ensuring equitable access to care. Financing is one of the six building blocks of a good health system (WHO, 2010a). Policies to address the concerns of people who are unable to pay are therefore critical and urgent.

Health financing: The results show that health financing is a challenge in most of the sites. Resources at the frontline health facilities are limited and this affects service provision. The limited allocation of resources for operational costs to frontline health facilities is a reflection of the national budgetary allocations. Although the Member States agreed to allocate at least 15% of their national budgets to health (The Abuja Declaration), only five countries in the Region have been able to do so (including South Africa). Furthermore, donor funding, which augments national resources, does not always go towards strengthening health systems, is often uncoordinated and operates in a vertical manner. Countries that have implemented the Paris Declaration (2005) on harmonized funding are better able to direct funding to strengthening health systems rather than project funding. However, these countries are few and far between in the Region.

Community expectations and contributions to essential health service delivery

Expectations of governments: The results across sites show that government contributions to the delivery of health services are uniform across localities, i.e. urban, peri-urban and rural. The

services are, however, concentrated on the provision of health workforce, facilities and drugs. The delivery of essential health services was rated inadequate among two thirds of the study population.

Communities expect greater transparency and want governments to contribute more to health. In recent times, it has been observed that a major gap exists between the development of new health intervention tools and their delivery to communities in the developing world including the African Region (Madon et al, 2007). Many potentially effective disease control products have had limited impact on the burden of disease because of inadequate implementation which leads to poor access even to very simple and affordable products (TDR, 2003). There is therefore an urgent need for more effective strategies that can ensure improved access to existing health interventions. One such strategy, CDTI, has been used very successfully in onchocerciasis control in Africa over the last decade (Amazigo and Boatman, 2006).

Community participation in health service delivery: The success of disease control through PHC is predicated on a high level of community involvement and participation (Amazigo et al, 2007). Increasingly, there is recognition of the critical role of community participation in health service delivery (Njebuome et al, 2009). This could indicate a shift in power and decision-making which allows communities to play more substantive roles with support from the health system and other facilitators. It has been argued that community involvement and participation form the anchor around which a new paradigm for disease control efforts in the Region must revolve. For health care systems to be successful, a majority of those affected must feel themselves to be in charge rather than being passive recipients of others' decisions. This also recognizes the inherent relationship between the infusion of individuals with a sense of their own self-worth and their empowerment to tackle problems within their communities (TDR, 2008).

Human resources: Because of major workforce gaps, it is necessary to increase the numbers and quality of health service personnel. This is a serious problem in most countries in the Region and has been worsened by a huge brain drain

as a consequence of internal conflicts and better opportunities in foreign lands. The human resource deficit could be addressed by bringing communities around the table to develop mechanisms for redress in which task-shifting is a possibility. An increased involvement of community members in the delivery of essential health services to the public will engender an understanding of the health facilities including the type of services offered and community expectations. Such an understanding would facilitate community engagement in service delivery. For instance, community health workers could bridge the capacity gap in health education, service delivery and home-based care.

How health system goals are experienced in the African Region

Ability to demand health care: Politicians, community leaders and religious leaders were perceived to have more rights to demand health services than women who use the facilities most. The observed limited rights for women to demand health service delivery from the government could be due to lack of awareness of their rights. Lack of understanding of service charters and rights remains a key challenge in the Region despite the acknowledgement that a good health system should deliver quality services to all people, when and where needed. National health systems in some African countries remain weak and under-resourced, and health services are skewed heavily in favour of urban areas which tend to account for the largest proportion of trained personnel (WHO, 2008).

Understanding the right to health: People are central to the health system, but before they can meaningfully contribute, they must be aware of their rights including holding governments accountable to them. The findings show that 80% of the respondents were aware of their right to access health care from government, and indeed some communities were exercising this right. However, the unresponsiveness of governments to these needs frustrates those seeking redress. The main challenge is to actualize the role of clients in demanding and holding health providers accountable. Some people mistrust government because of frustrations with the health system, inequities in delivery

of public health services, negative attitude of health personnel towards patients, high cost of treatment and inadequate facilities. Given the reliance on person-to-person communication, one individual's poor experience can be escalated and influence others who have not had similar experiences. It is important, however, to note the contradictions in the results. Most of the respondents identified public health facilities as the most commonly used although they found them inadequate. Furthermore, even if the attitude of the health providers was often-times viewed negatively, there is a sense that if the facilities were well-equipped, communities would prefer their use to private health facilities that tend to be more expensive and sometimes suspect. For strengthening health systems, health planners and researchers should address these contradictions.

Trust in the government to provide health care: The proportion of people indicating that they always trusted the government to do the right thing was higher in rural areas than urban and peri-urban areas in most of the study sites. This could be due to relatively low levels of expectations of governments to provide care by urban and peri-urban dwellers who appear to have more access to private health facilities. They also have relatively higher levels of education and could therefore be more informed about their rights to services.

The capacity of people to support each other in times of crisis is a key strength of African communities. However, there is evidence that the traditional mechanism of social support has increasingly come under strain due to changing socioeconomic contexts in the Region. With increasing poverty and migration, governments are more frequently being asked to support the poor and vulnerable who normally cannot access public services. The drive towards formulation of social protection policies in the Region is based on this premise (Taylor, 2008).

There is a need to look at the determinants of health more broadly. The fact that respondents from urban, peri-urban and rural areas had similar perceptions and experiences with the health system is indicative of the narrowing of differences in the various sites. Access to education, water, sanitation and other social services are essential for people to enjoy healthy lives.

6 Conclusions

This study has shown that peoples' perceptions of health and health service delivery contain valuable information that could help to improve and increase health systems reach, responsiveness and effectiveness in the African Region. The results show that communities astutely understand health, describe the health service situations and comprehend the dynamics that often act as barriers to achieving better health in cities and rural communities. The study participants provided useful insights into the determinants of health; their definition of health includes the spiritual dimension. They were concerned about malaria and NCDs, especially hypertension and diabetes that require additional health expenditure. Regarding health services provision, study participants were particularly concerned about inadequacy of drugs at health facilities, poor attitude of health personnel, and health workers' attitudes to the emergency situations mentioned by respondents in many countries.

In spite of government and donor efforts to strengthen health service provision in most countries, the users still find provision including facilities grossly inadequate. The study findings suggest that to improve the delivery of health services in the African Region, countries need to substantially increase access to services by the poor and the majority of people living in peri-urban and urban areas, deliberately including those services that target men and older people. Services at peripheral and district health facilities should not be limited (or perceived by people to be limited) to only children (immunization)

and women of child-bearing age (antenatal and delivery care), as perceived by study participants.

The gaps in social protection and the challenges highlighted by this study are the result of the broader need for health system strengthening. Establishing more effective financing policies will save households from paying huge out-of-pocket expenses for health care which discourage people from using available health services, public or private. Respondents complained about high costs of health services and the importance of improving community involvement in the governance of health systems.

Thus, the overriding observation is that more is needed—more funds, staff and facilities as well as more efforts towards improving the attitudes of health workers. However, existing domestic funds and human resources also need to be used more effectively.

The study participants perceived that health systems deliberately exclude community members from decision-making. The fact that respondents from urban, peri-urban and rural areas had similar perceptions and experiences with the health system is indicative of the narrowing of differences in the various locations. National governments have made numerous commitments to meet targets. Although the findings show that a sizeable proportion of respondents trust their governments to do what is right for the people, a key lesson from the study is the importance of governments meeting commitments to basic needs as a vital tool to increase people's trust.

Another important point is the contribution and significant role that individuals and communities have in providing information on the local health situation and their potential role as true partners in the delivery of health services. Engaging the users of services will improve access; however, innovative mechanisms for tapping resources and leveraging people's potential in the ways described in this report will contribute to improving health system performance and provide solutions for efficient and effective

delivery of health services to the broadest possible population.

As the global health architecture undergoes structural changes and emphasizes "smart spending", new strategic frameworks for the delivery of health services should help decision-making about changes for improved health outcomes without requiring huge new financial investments. The hope is that policy-makers will also recognize the urgency with which some Africans require transformations in their health systems.

7 Recommendations

This study has shown that community perceptions of health systems contain valuable information that could, if acted upon, help increase the reach, responsiveness and cost-effectiveness of health systems.

The study findings suggest that with the support of WHO and partners, countries should:

- (a) establish mechanisms to increase providers' awareness on the multi-dimensional and complex nature of health that is perceived by communities to constitute physical, mental, emotional, spiritual, social and economic well-being; health stakeholders should consider people's knowledge in their analysis, policy formulation and practice in a broader context of health reforms guided by scientific evidence and normative work;
- (b) enhance the quality of health care through reforms that improve infrastructure, in particular health facilities, qualified staff, essential medicines and financing that will result in universal health coverage and improved user satisfaction; these measures would benefit from effective use of guidelines and supportive supervision;
- (c) establish community-based surveillance systems for detecting and reporting the most common health problems, including communicable and noncommunicable diseases; facilitate awareness of risk factors associated with these conditions and institutionalize community-based case management.
- (d) expand the range of health interventions to address, in addition to children and women of child-bearing age, the needs of adolescents and older persons as well as other vulnerable groups;
- (e) establish appropriate health financing mechanisms including social health insurance, taxation, community financing and other options towards universal health coverage;
- (f) design health reforms that would be implemented through innovative approaches that enhance effective community representation, ownership and participation in health service policy formulation, planning, organization and operations;
- (g) support the conduct of social, epidemiological and health service research and the documentation and sharing of public health best practices in order to promote and support the scaling up of essential public health interventions in the African Region and accelerate progress towards the achievement of national and internationally agreed health goals.

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Annexes

ANNEX I: DESCRIPTION OF TERMS USED

Attitudes: An expressed way of feeling that people and groups have towards health, health services and the health system. Individual or community attitudes are feelings that may be influenced by perception, experience, knowledge and awareness. Provider attitudes are feelings which health workers and other suppliers of health services have towards patients, community members, health services and the health system. These feelings may influence individual- and community-level perceptions of health services.

Catastrophic health expenditure: Paying more than 40% of the household income directly on health care after basic needs have been met (The World Health Report 2010). In some cases households forego their basic needs to meet their health expenditures.

Community: A group of people who occupy a defined territory under common leadership with access to shared local resources as the base for carrying out the greatest share of their daily activities. Such a group may vary by country to include villages, quarters, groups of hamlets, peri-urban, urban, rural and mobile populations, and temporary settlements.

Community expectations: Opinions that people have about the roles and outcomes of responsive health systems.

Community participation: The process by which people are enabled to become actively

and genuinely involved in defining the issues of concern to them, in making decisions about factors that affect their lives, in formulating and implementing policies, developing and delivering services and in taking action to achieve change.

Community perception: The view that individuals and communities have about health services. It can be influenced by outcomes of previous health care experiences.

Community perspectives: The sum of collective knowledge, attitudes, valuation, awareness, perceptions and experience of the community with respect to health and the delivery of essential health services.

Conventional health facilities: These are health facilities that diagnose and treat using modern (western) medical practices.

Delivery of essential health services: The system for making basic curative, preventive and promotional care available at peripheral levels in a manner acceptable to the community.

Essential health services: Basic curative, preventive and promotional health services at all levels of the health system.

Frontline health facility: The health facilities closest to the people. In some countries these are referred to as health posts, dispensaries, health centres, etc.

Head of household: Person who is responsible for household welfare and who makes decisions for the well-being of household members. If the

head was absent, a household was represented by a consenting adult known as the representative of the head of household.

Health: A state of complete physical, mental, and social well-being and not merely the absence of disease.

Health awareness: Consciousness of the value of health and the existence of health opportunities and resources, including the right to health, individual and collective responsibility for health, healthy lifestyles, disease prevention and health promotion.

Health care experience: Previous encounters with health services and the related consciousness developed through them.

Health district: A defined geographical and operational zone for the local implementation of health services. Health districts can have different denominations in different countries, such as *préfecture sanitaire* (CAR), local government area (Nigeria), *zone de santé* (DRC), *district de santé* (Cameroon and Senegal) or *service de santé de cercle* (Mali).

Health knowledge: Accurate information about conditions that promote or militate against the achievement of a state of complete physical, mental, and social well-being of an individual or community.

Health system: All the organizations, institutions and resources whose primary purpose is to improve health. A health system needs staff, funds, information, supplies, transport, communications, guidance and direction. It needs to provide services that are responsive and financially fair while treating people.

Health zone: Unit of a health district offering Primary Health Care to defined communities through a frontline health facility.

High-performing regions: Areas with better health outcomes in the study sites.

Locality: The urban, peri-urban and rural areas where the study was conducted.

Low-performing regions: In the study sites, areas with poor health outcomes

Primary Health Care: “Essential health care based on practical, scientifically sound, and socially acceptable methods and technology made accessible to individual and families in the community through their full participation and at a cost that the community and country can afford to maintain in the spirit of self-reliance and self-determination” (WHO, 1978, Alma-Ata Declaration).

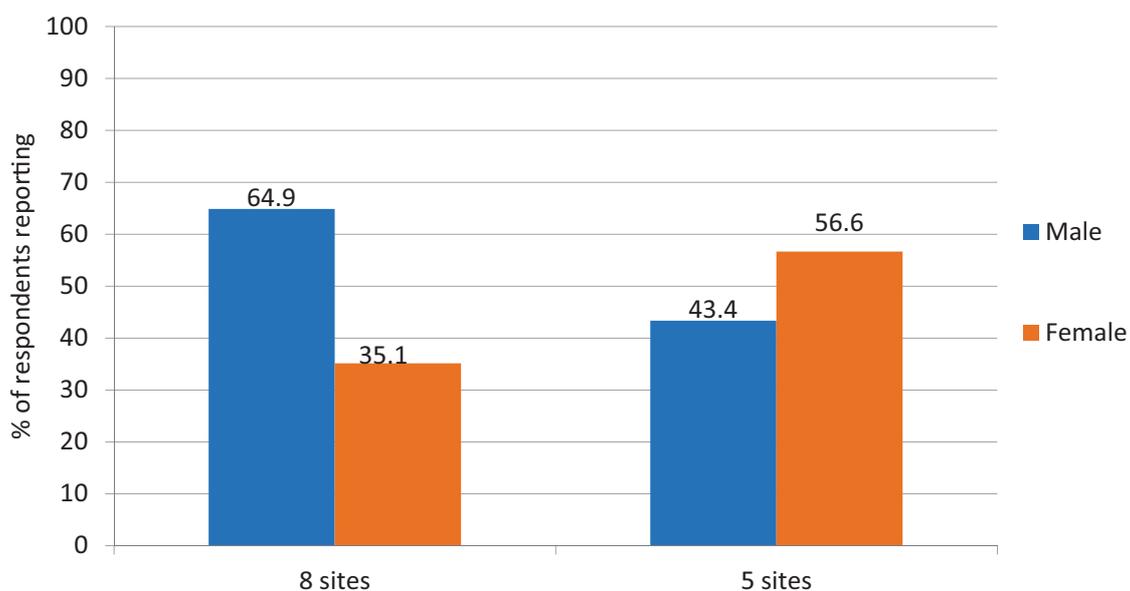
Public health region: A defined geographical zone at the intermediary level for the regional planning and administration of health care and health services. It encompasses different health districts and can have different denominations in different countries, such as state (Nigeria) and *région médicale* (Senegal).

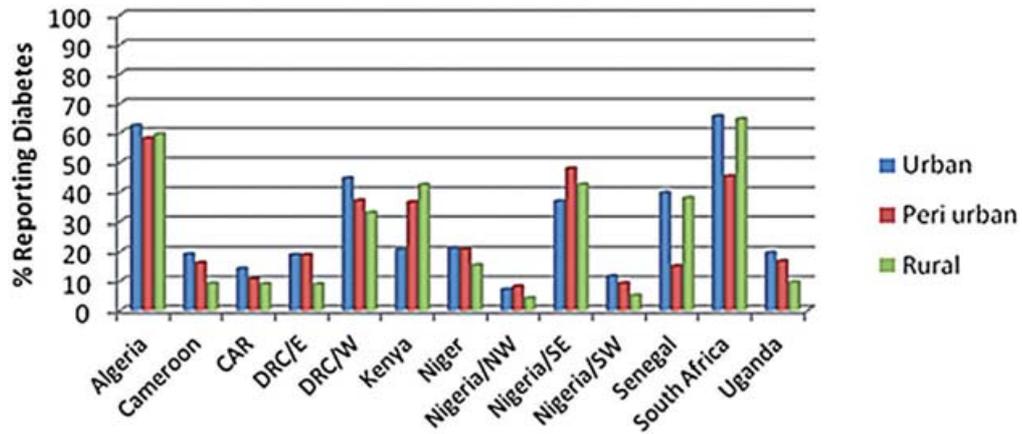
Readiness to participate (RTP): The capacity and willingness of individuals and community groups to become actively and genuinely involved in the governance, management, financing, and supervision of the delivery of essential health care in their communities.

Smart spending: A philosophy for achieving financial security without depriving oneself.

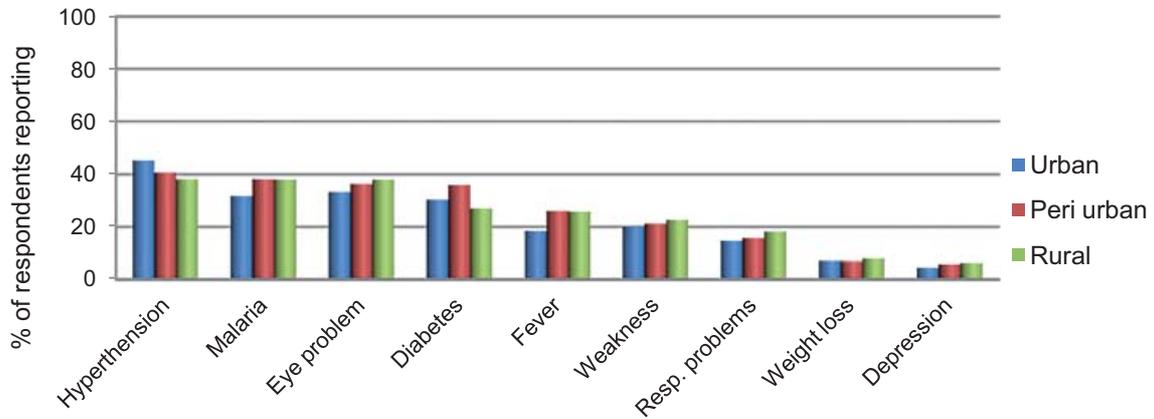
Annex 2: Distribution of mean age by site

SITE		Urban	Peri urban	Rural	Total
Algeria	N	280	280	280	840
	Mean	49.5	50.9	44.7	48.4
Cameroon	N	267	272	271	810
	Mean	44.3	41.1	44.1	43.1
Central Afr. Rep.	N	268	265	266	799
	Mean	36.4	36.6	37.8	36.9
DRC East	N	280	280	280	840
	Mean	41.0	41.1	39.7	40.6
DRC West	N	280	280	280	840
	Mean	40.4	41.5	42.8	41.6
Kenya	N	347	329	304	980
	Mean	35.5	38.8	37.5	37.2
Niger	N	272	272	272	816
	Mean	49.3	44.2	44.2	45.9
Nigeria Northwest	N	280	280	280	840
	Mean	41.2	44.7	43.3	43.0
Nigeria Southeast	N	280	280	280	840
	Mean	49.1	53.3	54.1	52.1
Nigeria Southwest	N	276	279	276	831
	Mean	38.7	39.7	38.0	38.8
Senegal	N	272	272	272	816
	Mean	53.2	50.6	54.9	52.9
South Africa	N	315	245	280	840
	Mean	48.2	52.8	50.9	50.4
Uganda	N	280	279	281	840
	Mean	38.4	40.1	43.5	40.7
Total	N	3697	3613	3622	10932
	Mean	43.4	44.1	44.2	43.9

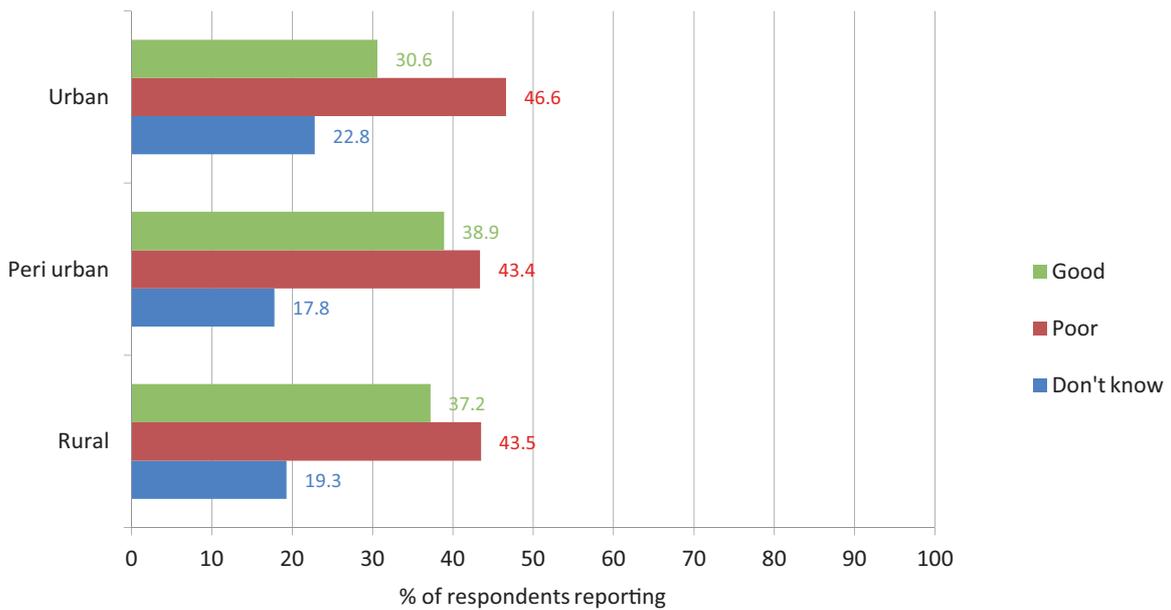
**Annex 3:** Distribution of respondents who had ever attended school by sex



Annex 4: Proportion reporting diabetes as a common health problem per site



Annex 5: Common health problems of older persons by locality



Annex 6: Rating of involvement of communities in decision making by locality

Annex 7: Households needing health care by locality

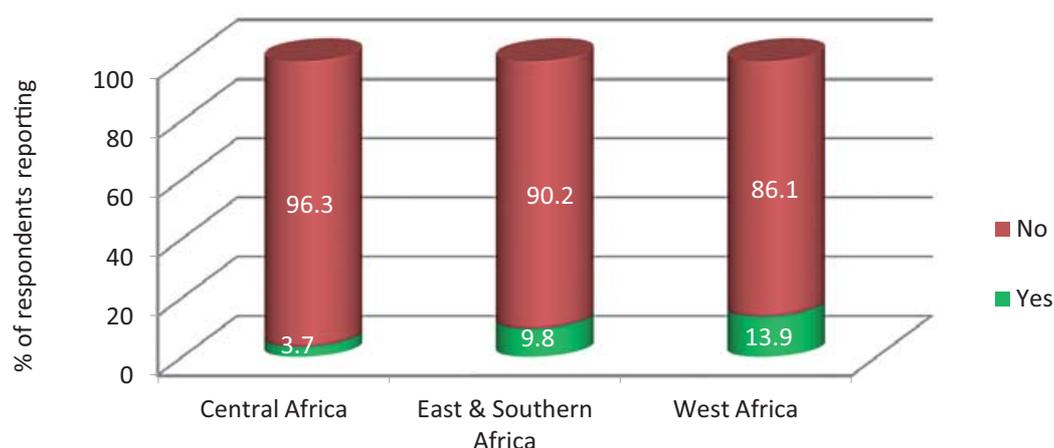
	Locality						Total	
	Urban		Peri urban		Rural			
	Number of respondents	% of respondents						
In the last 30 days	1877	50.8	1837	50.9	1849	51.1	5563	50.9
Between 1 month and less than 1 year ago	1308	35.4	1341	37.2	1289	35.6	3938	36.1
Between 1 year and less than 2 years ago	205	5.5	162	4.5	179	4.9	546	5.0
Between 2 years and less than 3 years ago	77	2.1	61	1.7	67	1.9	205	1.9
Between 3 years and less than 4 years ago	38	1.0	38	1.1	31	0.9	107	1.0
More than 4 years ago	92	2.5	75	2.1	79	2.2	246	2.3
Never needed health care	36	1.0	39	1.1	44	1.2	119	1.1
Don't know	63	1.7	56	1.6	80	2.2	199	1.8
Total	3696	100.0	3609	100.0	3618	100.0	10923	100.0

Annex 8: Households needing health care by performance of district

	Performance of district				Total	
	High performing		Low performing			
	Number of respondents	% of respondents	Number of respondents	% of respondents	Number of respondents	% of respondents
In the last 30 days	2703	49.5	2860	52.3	5563	50.9
Between 1 month and less than 1 year ago	2071	37.9	1867	34.2	3938	36.1
Between 1 year and less than 2 years ago	277	5.1	269	4.9	546	5.0
Between 2 years and less than 3 years ago	99	1.8	106	1.9	205	1.9
Between 3 years and less than 4 years ago	51	0.9	56	1.0	107	1.0
More than 4 years ago	106	1.9	140	2.6	246	2.3
Never needed health care	56	1.0	63	1.2	119	1.1
Don't know	95	1.7	104	1.9	199	1.8
Total	5458	100.0	5465	100.0	10923	100.0

Annex 9: Most common reasons why health care was sought by sub-region

	Sub-region						Total	
	Central sub-region		East sub-region		West sub-region			
	Count	% within sub-region	Count	% within sub-region	Count	% within sub-region	Count	% within sub-region
Malaria	487	14.8	421	15.9	1004	20.3	1912	17.6
Fever	686	20.9	476	18.0	708	14.3	1870	17.2
Other	702	21.4	348	13.2	786	15.9	1836	16.9
Bodily injury or pain	137	4.2	127	4.8	294	5.9	558	5.1
Cough	157	4.8	128	4.8	224	4.5	509	4.7
Cough/respiratory problems	91	2.8	133	5.0	280	5.7	504	4.6
Severe diarrhoea	163	5.0	117	4.4	150	3.0	430	4.0
Hypertension	77	2.3	114	4.3	176	3.6	367	3.4
Arthritis	73	2.2	73	2.8	182	3.7	328	3.0
Childbirth	78	2.4	75	2.8	156	3.2	309	2.8
Diabetes	65	2.0	78	3.0	94	1.9	237	2.2
Skin diseases/itching	56	1.7	49	1.9	117	2.4	222	2.0
Vomiting	70	2.1	53	2.0	96	1.9	219	2.0
Don't know	86	2.6	34	1.3	86	1.7	206	1.9
Antenatal consultation	57	1.7	44	1.7	97	2.0	198	1.8
Sight problem	48	1.5	29	1.1	120	2.4	197	1.8
Immunization	32	1.0	48	1.8	113	2.3	193	1.8
Asthma	38	1.2	67	2.5	64	1.3	169	1.6
Dental care	45	1.4	57	2.2	62	1.3	164	1.5
Minor surgery	46	1.4	27	1.0	53	1.1	126	1.2
Heart disease	31	.9	23	.9	57	1.2	111	1.0
Tuberculosis	35	1.1	61	2.3	8	.2	104	1.0
Family planning	13	.4	28	1.1	17	.3	58	.5
HIV/AIDS	15	.5	34	1.3	4	.1	53	.5
Total	3288	100.0	2644	100.0	4948	100.0	10880	100.0



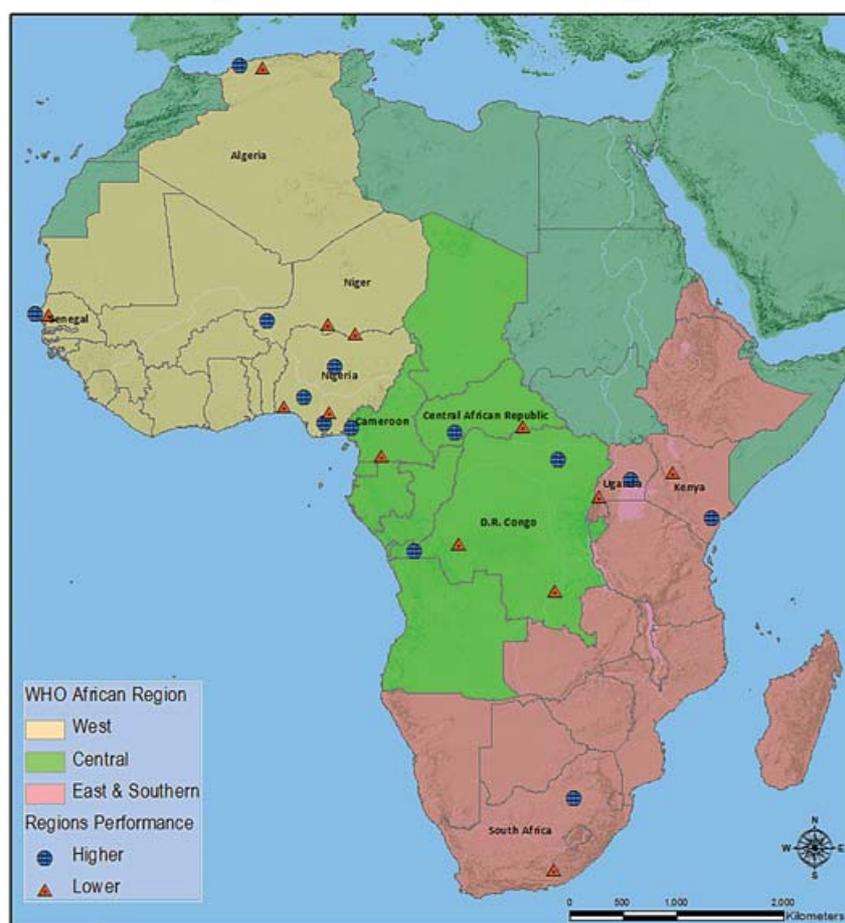
Annex 10: Reimbursement of money paid for drugs in sub-region

Annex 11: Freedom of expression by locality

	Location						Total	
	Urban		Peri urban		Rural			
	Number of respondents	% of respondents						
Completely	1892	51.4	2120	59.0	2053	56.9	6065	55.7
Moderately free	1258	34.1	1078	30.0	1070	29.6	3406	31.3
Not free at all	534	14.5	396	11.0	488	13.5	1418	13.0
Total	3684	100.0	3594	100.0	3611	100.0	10889	100.0

Annex 12: Freedom of expression on health matters by sub-region

	Subregion						Total	
	Central subregion		East sub region		West subregion			
	Number of respondents	% of respondents						
Completely	1903	57.9	1381	52.7	2781	55.8	6065	55.7
Moderately free	906	27.6	847	32.3	1653	33.2	3406	31.3
Not free at all	479	14.6	391	14.9	548	11.0	1418	13.0
Total	3288	100.0	2619	100.0	4982	100.0	10889	100.0

Study selected countries and regions**Health Systems in Africa: views from communities****Annex 13:** Location of the study sites

ANNEX 14: RESEARCH TEAM

Dr Luis Gomes Sambo, MD, PhD
Public Health Specialist
WHO Regional Office for Africa
Initiator and Principal Investigator

Dr Uche Amazigo, PhD
Former Director
African Programme for Onchocerciasis Control
Initiator and Principal Investigator

Algeria

Prof Mohamed Metboul
Social Scientist
University of Oran
Principal Investigator

Prof Nori Nidoum
Epidemiologist
University of Oran
Qualitative Study Supervisor

Dr Ouassila Salemi
Social Scientist
University of Oran
Qualitative Study Supervisor

Dr Kamel Daheur
Social Scientist
University of Oran
Qualitative Study Supervisor

Prof. Mohamed Sayah
Data Manager
University of Oran
Responsible for transcription of qualitative data

Dr Lakhdar Zemmour
Epidemiologist
University of Oran
Qualitative Study Supervisor

Dr Abderhamane Derkaoui
Epidemiologist
University of Oran
Qualitative Study Supervisor

Cameroon

Dr Anne Cécile Zoung-Kanyi Bissek, MD
Dermato Venereologist
Faculté de Médecine et de Sciences de la
Santém Université de Yaoundé I
Principal Investigator

Ms Yolande Flore Longang Tchounkeu
Social Scientist
Research Foundation in Tropical Disease and
Environment
Co-Investigator and Sociologist

Mr Emmanuel Betsi
Social Scientist
Ministry of Health
Study Sociologist

Dr Nicolas Tendongfor
Epidemiologist
University of Buea
Study Epidemiologist

Dr Emmanuel Yenshu
Anthropologist
University of Buea
Research Foundation in Tropical Disease

Dr Ernest Njih Tabah
Epidemiologist
University of Yaounde I
Study Epidemiologist

Mr Fabrice Datchoua Pountcheu
Anthropologist
Study Sociologist

Mr Theobald Nji
Anthropologist
Research Foundation in Tropical Disease and
Environment

Central African Republic

Dr François Banyombo
Social Scientist
University of Bangui
Principal Investigator

Mr Jean Faustin Piamale
Demographer
Ministry of Planning
Study Data Manager

Dr Rosine Fioboy
Clinician
Ministry of Health
Study Public Health Specialist

Dr Josué Ndolombaye
Anthropologist
University of Bangui
Study Anthropologist

Dr Noure Moukadas
Social Scientist
University of Bangui
Study Social Scientist

Dr Jean De Dieu Longo
Epidemiologist
Ministry of Health
Study Epidemiologist

Democratic Republic of the Congo (East)

Prof Pascal Lutumba, MD, MSc, PhD
Epidemiologist
University of Kinshasa
Principal Investigator

Dr Adélard Nkuanzala, PhD
Social Scientist
University of Lubumbashi
Study Sociologist

Dr Alain Mpanya, MD, MPH
Epidemiologist
Ministry of Health
Study Epidemiologist

Mrs Mimy Vuna, BA
Social Scientist
Ministry of Health
Study Social Scientist

Mr Sylvain Baloji, BSc (Community Health)
Ministry of Health
Study Epidemiologist

Dr Tarcisse Elongo, MD, MPH
Public Health Specialist
Ministry of Health
Study Health Systems Expert

Mr Hercule Kalonji, BSc (Mathematician and
Information)
Technology Specialist
Ministry of Health
Study Data Manager

Democratic Republic of the Congo (West)

Prof Bruno Lapika, PhD
Sociologist and Anthropologist
University of Kinshasa
Principal Investigator

Prof Barthelemy Kalambayi, PhD
Demographer
University of Kinshasa
Study Co-Investigator

Prof Gudjjjiga Gikapa, PhD
Sociologist and Anthropologist
University of Kinshasa
Study Co-Investigator

Dr Tarcisse Elongo, MD, MPH
Public Health Specialist
Ministry of Health
Study Health Systems Expert

Mr Bertin Nzambi, BA
International Relations Specialist
Ministry of Health
Study Research Assistant

Mr Joseph Musiki, BSc
Sociologist-Anthropologist
University of Kinshasa
Study Research Assistant

Mr Serge Kapanga
Lawyer
Ministry of Health
Study Research Assistant

Mr Lusengi Wade, BA
Anthropologist
Ministry of Health
Study Social Scientist

Kenya

Dr Mary Amuyunzu-Nyamongo, PhD
Social Anthropologist
Executive Director
African Institute for Health and Development,
Nairobi
Principal Investigator

Dr Stephen Muleshe, MBChB, MPH
Director, Medical Officer
Central and Southern Africa Health, Arusha,
Tanzania
Co-Principal Investigator

Dr Yeri Kombe, MBChB, PMH
Epidemiologist, Information Technology
Director
Centre for Public Health Research, Kenya
Medical Research Institute
Co-Principal Investigator

Dr John Odoni, MBChB (Surg)
Public Health Specialist
Head, Department of Public Health
Ministry of Public Health and Sanitation
Co-Principal Investigator

Mr Jared Owuor, BSc (Nursing)
Programme Officer
African Institute for Health and Management
Data Manager

Ms Monica Wabuke, BA (Sociology, Political
Science)
Programme Officer
African Institute for Health and Development
Study Data Manager

Niger

Dr Abdoulaye, PhD
Social Scientist
University Abdou Moumouni, Niamey
Principal Investigator

Dr Amadou, PhD
Social Scientist
University Abdou Moumouni, Niamey
Study Social Scientist

Dr Hadiza, PhD
Social Scientist
University Abdou Moumouni, Niamey
Study Social Scientist

Dr Zilahatou Tohon, MD MPH
Epidemiologist
Centre de Recherches Médicales et Sanitaires
(CERMES)
Study Epidemiologist

Dr Maimouna Guero, MD, MPH
Public Health Specialist
University Abdou Moumouni, Niamey
Study Health Systems Expert

Mr Moussa Haladou, MSc
Biostatistician
Ministry of Health
Study Data Manager

Nigeria South East

Prof Joseph Okeibunor
Social Scientist
University of Nigeria, Nsukka
Principal Investigator

Dr Ngozi Njebuome
Medical Doctor
Reggia Resources Int. LTD, Abuja
Co-Principal Investigator and Public Health
Specialist

Prof Obioma Nwaorgu
Parasitologist
Nnamdi Azikiwe University
Co-Principal Investigator and Public Health
Specialist

Dr Nkechi Onyeneho
Social Scientist
University of Nigeria, Nsukka
Co-Principal Investigator and Study Social
Scientist

Dr Ngozi l'Aronu
Social Scientist
University of Nigeria, Nsukka
Study Social Scientist

Ms Ijeoma Okoye
Social Scientist and Demographer
University of Nigeria, Nsukka
Study Social Scientist

Mr Chidi Ugwu
Anthropologist
University of Nigeria, Nsukka
Study Anthropologist

Mr Nnabuike Osadebe
Social Scientist
University of Nigeria, Nsukka
Study Social Scientist

Mr Clinton Ezirike
Engineer
University of Nigeria, Nsukka
Study Data Manager and Public Health
Specialist

Dr Bona Nwakeoma
Parasitologist
Nnamdi Azikiwe University
Co-Principal Investigator and Public Health
Specialist

Mr Cyril Ugwuoke
Social Scientist
Enugu State University of Science
Study Social Scientist

Nigeria South West

Dr Oka Obono
Sociologist/Anthropologist
University of Ibadan
Principal Investigator

Dr Eme Owoaje
Public Health Physician
University of Ibadan
Co-Principal Investigator

Dr Ezebunwa Nwokocho
Sociologist/Demographer
University of Ibadan
Study Social Scientist

Dr Kobblowe Arikpo
Sociologist/Communication Specialist
University of Ibadan
Study Social Scientist

Mr Joachim Nwachukwu
Sociologist/MBA
University of Ibadan
Research Assistant

Ms Abosede Odunlami MSc (Sociology)
University of Ibadan
Study Research Assistant

Mr Sylavanus Otikwu MSc (Sociology)
University of Ibadan
Study Research Assistant

Mr David Akeju MSc (Sociology)
University of Ibadan
Study Research Assistant and Data Manager

Ms Charity Umeokoro MSc (Sociology)
University of Ibadan
Study Research Assistant

Ms Opeyemi Balogun MSc (Geography)
Obafemi Awolowo University, Ife

Ms Bolatito Murele MSc (Sociology)
University of Ibadan
Study Research Assistant and Data Manager

Nigeria North West

Dr Elizabeth Elhassan
Parasitologist
Sightsavers
Principal investigator

Mr Tosin Adekeye
Social Scientist
Ahmadu Bello University
Study Social Scientist

Dr Felicia Anumah
Medical Doctor
University of Abuja, Nigeria
Study Public Health Specialist

Mr Sunday Isiyaku
Entomologist
Sightsavers
Study Public Health Specialist

Dr Felicia Enwezor
Parasitologist
Nigerian Institution for Trypanosomiasis
Research
Study Public Health Specialist

Dr Hafsat Kontagora
Social Scientist
Kaduna Polytechnic
Study Social Scientist

Mrs Tinuola Olumehen
Social Scientist
Kaduna Polytechnic, Nigeria

Ms Folake Ibrahim
Statistician
Sightsavers
Study Data Manager

Mrs Eunice Ohidah
Social Scientist
Kaduna Polytechnic
Study Social Scientist

Mrs Maimuna Abdulrahman
Social Scientist
Kaduna State Media Cooperation

Mr Margaret Luther
Social Scientist Consultant

Mr Femi Folorunsho
Economist Consultant
Study Public Health Specialist

Senegal

Mr Salif Ndiaye
Demographer
Centre de Recherche et Développement
Humain (CRDH)
Principal Investigator

Mrs Hélène Benga
Social Scientist
Centre de Recherche et Développement
Humain (CRDH)
Co-investigator

Mr Alpha Missidé Diallo
Statistician
Centre de Recherche et Développement
Humain (CRDH)
Research Assistant

Dr Mame Cor Ndour
Clinician
Abt Associate
Study Resource Person

Mr Ibrahim Seye
Information Technology Officer
Centre de Recherche et Développement
Humain (CRDH)
Study Data Manager

Mr Amadou Hassane Sylla
Demographer
Centre de Recherche et Développement
Humain (CRDH)
Study Technical Assistant

Mr Abdel Kader Diarra
Logistician
Centre de Recherche et Développement
Humain (CRDH)
Study Research Assistant

Dr Issa Wone
Clinician
ISED
Study Public Health Specialist

South Africa

Prof Stephen Hendricks
Public Health Specialist, Epidemiologist
University of Pretoria
Principal Investigator

Dr Amusaa Inambao
Physician, Epidemiologist
Public Health Researcher
Consultant

Ms Chipso Mwetwa
Social Scientist
Public Health Researcher
Consultant

Dr Inonge Kamungoma-Dada
Physician
Public Health Researcher
Consultant

Prof Eric Buch
Physician
University of Pretoria
Public Health Policy Specialist

Mr Eric Maimela
Epidemiologist
Limpopo Department of Health
Data Manager

Ms Belinda Lourens
Social Scientist
Project Manager
Consultant

Uganda

Dr Richard Ndyomugenyi
Medical Doctor
Vector Control Division, Ministry of Health
Principal Investigator

Mr Asaph Turinde Kabali
Social Scientist
Institute of Social Research, Makerere
University
Study Social Scientist

Mr Alfred Etywom
Statistician
Joint Clinical Research Centre, Kampala
Study Data Manager

Dr Fred Ntoni Nuwaha
Medical Doctor
School of Public Health, Makerere University
Study Public Health Specialist

Mr Firminus Mugumya
Social Scientist
School of Social Sciences, Makerere University
Study Social Scientist

WHO Secretariat

Prof Paul-Samson Lusamba-Dikassa
Mr Honorat G.M. Zouré (Overall Data Manager
and Analyst)
Dr Johannes Sommerfeld
Dr Leonard T. Mukenge
Ms Patricia Mensah



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