



**College of Medicine**

**ASSESSING THE IMPACT OF HEALTH CENTRE MANAGEMENT COMMITTEES  
IN CURBING DRUG PILFERAGE AND PROMOTING PUBLIC SERVICE  
DELIVERY; A CASE OF CHITIPA DISTRICT**

**BY**

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*(Bachelor of Medicine Bachelor of Surgery)*

**A Thesis Submitted in Partial Fulfillment for the Degree of Master in Public Health**

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## DECLARATION

I, **TED BANDAWE**, hereby declare that this submission is my own work towards the Master of Public Health and that, to the best of my knowledge, it contains no material previously published by another person nor material which has been accepted for the award of any other degree of the University of Malawi or any other university elsewhere, except where due acknowledgement has been made in the document.

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## **CERTIFICATE OF APPROVAL**

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## **DEDICATION**

To my wife, Mercy, and my beautiful daughter, Deborah: thank you for enduring those long periods I would forget my fatherly roles so as to concentrate on this project. That endurance in itself was reason enough to make me work diligently in this project for your sake. You had done it on numerous occasions before and you did it again this time. I owe all my achievements to your tolerance and understanding. God bless you.

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In addition, am greatly indebted to the Government of Malawi for the partial scholarship and allowing me time off for the Masters programme. I owe many thanks to ACEPHEM for partnering with College of Medicine for the programme and as postgraduate students we were able to study in dignified classrooms because of your support. The additional support in terms of workshops have assisted us to come up with remarkable work. Special thanks should also go to all professors and lecturers in the department of public health for their dedication during and after course work.

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## **ABSTRACT**

Chitipa District Hospital registers high numbers of drug cases due to pilferage despite the availability of Health Centre Management Committees (HCMC). One of the key responsibilities of HCMCs is to monitor drug and supply chain at both facility and community level. This comes against the background that 15% of the stock outs at Chitipa District Hospital were due to drug pilferage in 2018[1]. At national level, millions of drug funds are lost every year due to drug pilferage. However, since the introduction of the national drug investigation unit (DTIU) in 2017, drug theft cases have declined and most perpetrators were apprehended. Focus Group Discussions and Key Informant interviews were used to collect data in five facilities in Chitipa. A total of 100 (48 males, 52 females) participated in the study. Of these thirty (11 males, 19 females) were members of Health Centre Management Committee and ten (4 males, 6 females) were local leaders. The rest that took part in the focus group discussions were community members affiliated to HCMC committees. Lack of Information among community members is one factor contributing to poor functionality of the Health Centre management committees. What is clearly emanating from this research is that grassroots' participation in Chitipa District council is a farfetched idea because local elites are exploiting the new found window of opportunity in the decentralization initiative to promote patronage and neopatriotism at the expense of the grassroots participation in decision-making. The study could not establish strength of association between the factors identified and the functionality of the HCMCs. The findings highlight the importance of using the socio-ecological model in community engagement so as to identify and address factors at every level.

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## **LIST OF ABBREVIATIONS AND ACRONYMS**

<b>LGA</b>	Local Government Authority
<b>MoH</b>	Ministry of Health
<b>NCHS</b>	National Community Health Strategy
<b>SDC</b>	Sub Drug Committee
<b>CAGs</b>	Community Action Groups
<b>CBD</b>	Central Business District xxxddd
<b>CBO</b>	Community Based Organizations
<b>CHAM</b>	Christian Health Association of Malawi
<b>COMREC</b>	College of Medicine's Research Ethics Committee
<b>DHO</b>	District Health Office(r)
<b>DIP</b>	District Implementation Plan
<b>FGD</b>	Focus Group Discussion
<b>HCPs</b>	Health Care Providers
<b>HIV</b>	Human Immunodeficiency Virus
<b>HSAs</b>	Health Surveillance Assistants
<b>IDI</b>	In-Depth Interviews
<b>KII</b>	Key Informant interviews

<b>MDHS</b>	Malawi Demographic and Health Survey
<b>NGOs</b>	Non-Governmental Organizations
<b>NSW</b>	National Surveys of Women
<b>SSDI</b>	Support for Service Delivery Integration
<b>T/A</b>	Traditional authority
<b>TRA</b>	Theory of Reasoned Action
<b>USA</b>	United States of America
<b>USAID</b>	United States Agency for International Development

## DEFINITIONS OF CONCEPTS AND TERMS

**Content analysis** : A systematic, replicable technique for compressing many words of text into fewer content categories based on explicit rules of coding.

**Socio-ecological model** : A theory-based framework for understanding the multifaceted and interactive effects of personal and environmental factors that determine behaviors.

**Systems thinking** : A method of critical thinking by which you analyze the relationships between the system's parts in order to understand a situation for better decision-making.

**Health Belief Model** : A psychological model that attempts to explain and predict health behaviors by focusing on the attitudes and beliefs of individuals.

**Theory of Reasoned Action** : A theory of behavior change which suggests that stronger intentions, which are determined by attitudes and subjective norms, lead to increased effort to perform the behavior, which also increases the likelihood for the behavior to be performed.

# CHAPTER 1: INTRODUCTION

## 1.1 Background

This study investigates the impact of Health Centre management Committees in reducing community drug pilferage and promoting public service delivery. Among other things it seeks to analyze level of participation by various key actors in the community reform initiatives and the mechanisms for ensuring accountability of both health workers and the community at large in order to understand the effectiveness of community engagement on public health service delivery at local level in Malawi. The present chapter provides an introduction, background, problem statement and objectives.

The government of Malawi lost k900 million to drug theft in 2016 [1]. Reports indicate that most of these drugs are stolen with the help of health worker. In most instances, communities suspect involvement of health workers in the malpractice, unfortunately, they choose not to take any action. Most of the drugs stolen from health facilities find their way into the community or across the border especially in Chitipa. In 2018, Chitipa district health office reported more than 12 cases of drug pilferage according to the office of the ombudsman at the district [2]. In almost all health facilities, there are Health Centre Management Committees whose role is to monitor the drug supply chain and promote community participation in service delivery.

The majority of Malawians access health services from government owned facilities Known as a free at point of access health system [3]. Community Engagement as a policy reform is one of the common reform trajectories in Malawi championed to enhance grass-roots participation and accountability in service delivery at the local level [4]. Since 1989, community engagement

through decentralization has been highly ranked on the policy agenda that focuses on development, democratization and public sector reforms. The country adopted a Local Government Act (LGA) which stipulates the aims of community engagement such as that of ‘furthering democratic principles, accountability, transparency and participation of the people in decision making especially in health service delivery.

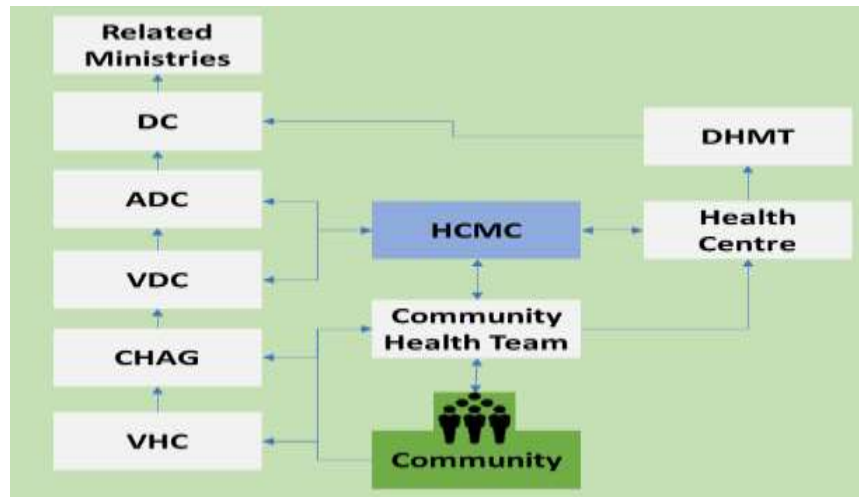
In view of the above, the adoption and implementation of decentralized health services in Malawi has taken place in the context and environment where the community has been given the mandate to decide for their own health choices. This means people have the power to demand health services needed at a particular time besides individual health seeking behaviours. It still remains at the discretion of the policy holders to implement the services in demand. The use of powerful stakeholders in the community has had positive impact for anti-corruption strategies and improving health service delivery [5]. The health policy and health sector strategic plan (2017-2022) are policy tools that are advocating for decentralization of health services to local councils and thus participation, accountability and equity issues are at the centre stage of public service delivery. A number of health sector reforms have been initiated by the Ministry of Health with a view to improving efficiency and providing quality health services). However, despite the efforts in Malawi the central government apart from retaining some powers to control district activities through policy direction is also seen in the equation of the power struggle when it is still controlling the drug budget, recruitment, promotion, internal training and development of health workers as far as decentralization of health services is concerned.

The Government of Malawi is committed to improving health and livelihoods through the provision of basic health services in rural and urban communities. Community National Strategy entails the provision of basic health services in rural and urban communities with the participation of people who live there and it is essential in improving health and livelihoods of Malawians. Community engagement involves but not limited to use of HCMCs for service delivery, involvement of Local authorities in decision making and all other decentralized decisions that involves the grassroots. Community health activities have contributed to historical improvements in Malawi's health outcomes, especially for women and children, such as the decline in child mortality and malaria fatality rates. Community engagement builds sustainable and resilient community health systems which contribute to optimal health outcomes. Historically, Community Health has significantly contributed to improvements in Malawi's health outcomes in particular attainment of MDG4 [6]. However, the community health system faces resource constraints and inconsistencies around quality of service – which negatively affect health outcomes. Further, effective and efficient community engagement relies on active, capable and committed community health structures such as Village Health Committees (VHCs), Community Health Action Groups (CHAGs) and Health Centre Management Committees (HCMCs) which were formerly known as Health Centre Advisory Committees (HCACs).

Health Centre Management Committees have been proven to be effective in addressing a number of grassroots inequalities in low income countries. A systematic review of the literature for evidence on health facility committees in low- and middle-income countries [7] provided convincing evidence of significant benefits of Health facility committees. A number of studies done in South Africa, Kenya, India showed the impact was sizeable and impressive.

Preston et al.'s review of various forms of community participation in rural primary health care found evidence that community participation can result in beneficial health outcomes and increased uptake of services [8]. However, Community participation is a complex social process that is situation specific. What works in one community should not be expected to work in the same way or with the same effect elsewhere. The studies also indicated that when it comes to the determinants of the effectiveness of HFCs, there are a number of systems and interacting factors, operating at a variety of levels. The compelling evidence from a number of studies have prompted African countries to decentralize various services through the use of local structures.

In the early 90s, the Government of Malawi tried various forms of engagement to empower people in various communities. Ministry of Health in Malawi utilized the HCMCs in 2013 through the department of HIV to follow up HIV patients on ART within their localities. In Luzi Health Centre in the Northern part of Malawi, in Mzimba, five committee members were trained in prevention of vertical transmission (PMTCT) of HIV in early 2014, and it significantly reduced HIV prevalence [3]. There is no one size fit all approach to community intervention but through diversification and integration of services gains are realized. The outburst of community committees prompted government to standardize and formulate terms of references for various local structures. The MOH entrusted the Health Centre Management Committees with the responsibility of bringing health services closer to the community. Failure to decentralize power to local structures lead to slow uptake and development of the HCMCs [9]. The HCMCs provide a platform for community engagement for improved service delivery and reduction is stock outs of supplies and medicines.



**Figure 1:** Diagrammatic flow of command at community level (*source: National Community Health Strategy Malawi 2017-2022*).

The community health strategy has a reporting hierarchy at council level. The District commissioner is now the president of the local assembly and oversees all the activities at council level. From the grassroots to the higher authorities, the community forms community health teams which is now an entity of Health Centre Management Committees. These committees report to the District Health Management Committees which directly reports to the District Commissioner. On the other hand, the Village Health Committees and Community Health Action groups report to the Village Development Committees. The VDCs form part of the Area Development Committees which is responsible for developmental issues at community level. The ADC feeds to the DC through Councilors and the DC reports to Local Government headquarters and other related ministries.

Some of the roles and responsibilities of HCMCs are; ensuring adherence to the service charter, promoting utilization of health service, to enhance mutual accountability, Supporting the development of health centre business/improvement plans, mobilizing resources to improve health facility functionality and to advocate for availability of essential drugs and medical

supplies. The committees have been mandated to witness, verify and sign-off delivery notes for drugs and supplies.

## **1.2 Research Question**

What has been the impact of Health Centre Management Committees in curbing drug pilferage and promote service delivery in Chitipa district?

## **1.3 Statement of the Problem**

In Malawi, provision of health services has been decentralized and it's the responsibility of the community to take a proactive role. In the context of decentralization, the Ministry of Health in Malawi has put in place structures to facilitate community ownership and participation. However, available evidence does not confirm that decentralized governments perform better in delivering services to the poor [10]. Districts have since been given greater responsibility for managing health services at district and lower levels. Drug and Other Recurrent Transaction budget are also devolved to the full control of the district councils and it is expected that the accountability and participatory mechanisms at district council levels will be in charge of the public health service delivery system [11]. Day in day out, public health service delivery image to provide safe, quality and compassionate care continues to go down evidenced by unprofessional conduct, shortage of drug and becoming the mainstream news headline of a failed system [9].

The general public continues to complain about health service delivery in general and yet decentralization allows community members total participation and rightfully claims that citizens

demand accountability for public goods and services [7]. With the alarming rates of drug pilferage in the country it could be that there is little ownership of public health facilities by communities or the community health governance structures are frail and do not have the full capacity to mobilize communities in community led health initiatives and leaving everything to district health office or the district commissioner. The other reason could be that there is a long chain in the flow of information on health issues from the health facility to the communities. For instance, from health facility to Health Centre management Committee to Village Development Committees (VDC) to chiefs to communities and back. This gives room for distortion of information and delayed action thereby fueling up public concerns. This therefore leads to the problematic phenomenon that this study wants to analyze: the impact of Health Centre Management Committees on public health service delivery in particular drug supply monitoring and community participation. This is the case because the present studies do not provide enough data especially in Malawi that can explain the extent to which these committees help to address drug pilferage and improve community livelihoods.

## **1.4 Literature Review**

This chapter covers the work that was reviewed in order to have an understanding of other studies that have been done in relation to the topic under investigation. The review provided an insight into the explanations that have already been done on some factors associated with functionality of the HCMCs and the gaps that are there so far.

### **1.4.1 Effectiveness of Health Centre Management Committees and their functionality**

The health policy and health sector strategic plan of 2016 are policy tools that are advocating for

decentralization of health services to local councils and thus participation, accountability and equity issues are at the centre stage of public service delivery. The Ministry of Health is implementing public health policies that are guided by a number of documents, including the Constitution of the Republic of Malawi, the Public Health Act and vision 2020 for the health sector in Malawi. A number of health sector reforms have been initiated by the Ministry of Health with a view to improving efficiency and providing quality health services. The major policy reforms include: decentralization of the management of health services to local government; hospital reform and public-private partnerships [6,12]. However, many African Countries including Kenya, Uganda and Tanzania have also reported operational challenges facing the implementation of health sector decentralization. The most significant challenge is that in most of these countries, decentralization has not achieved its intended goal of increasing the power of the local authorities because many governments have often implemented concentration or delegation forms of decentralization rather than devolution [9]. Likewise, in Tanzania, a study revealed that decentralization has expanded participation at grassroots level by allowing citizens to participate in the planning process to determine their health needs and priorities. However, the planning process at LGAs faces the challenge of political interference, particularly from local leaders who want their constituencies to be given top consideration when prioritizing councils' health plans. Such political interference distorts the whole process of planning and resource allocation in the councils [10]. Most of the HCMCs fail to operate fully because the mandate is still with other high authorities and there is little influence from above.

#### **1.4.2 The Bottlenecks and Quality Improvement Initiatives Associated with HCMC**

The central government apart from retaining some powers to control district activities through policy direction is also seen in the equation of the power struggle when it is still controlling the drug budget and development of health workers as far as decentralization of health services is concerned. This has a bearing on how much goes to the grassroots in terms of medicines and supplies. The general public continues to complain about health service delivery in general and yet democratic decentralization allows community members total participation and rightfully claims that citizens demand accountability for public goods and services [8,12]. The Health Centre Management Committees are to bridge the community and health facilities but the gap is evident. Decentralization brings decision-making closer to the people and therefore yields programs and services that better address local needs. The challenge is to ensure that all stakeholders can and will voice their opinions. As part of the decentralization process, policy makers and politicians are integrating programs to address citizen participation, promote advocacy groups, incorporate women and the poor in policy decisions, aid in poverty reduction and environmental initiatives at the local level, and encourage sub national autonomy and creativity in addressing local needs [13]. Participation is important to health service delivery because it opens a window of opportunity through which local people can be in charge of their own local governance, a forum through which they can influence decisions that affect their livelihood and community [3,7,14]. One of the priority strategies in implementing primary health care is community participation because community members know about their own health situation and they are also in a position to determine what to do about it and take appropriate action. The role of the health system is to facilitate self-discovery in health matters among communities. Community members should participate in planning and be given the power to

change their situation for better services. Multi-sectoral structures for coordinating health service planning and implementation at community level are also not well established and sustained [6]. The link between HMCM, ADC, VDC, CHAGS is a good avenue for report sharing and integration of services at grass root level.

Further to this, health promotion activities in Malawi have not been implemented in a coordinated manner considering the diversity and emerging health-related issues such as Covid 19, gender based violence and non-communicable diseases. Substantial progress has been made in Malawi and many health indicators have improved. However, health for all is far from reality, malaria, HIV/AIDS, TB, pregnancy related problems, acute respiratory infections, diarrhoeal diseases and malnutrition are still the main causes of child mortality and morbidity [15]. The general argument for decentralizing health care is that greater local participation in health policy and local accountability can lead to improved quantity (including coverage) and quality of service. Improved health coverage starts with availability of resources and key amenities like drugs and treatment.

In Malawi, procurement of drugs is done through the National local government finance committee and the districts are able to access the funds from the central level and are only allowed to buy from Central Medical Stores Trust (CMST). Drug budget is also formulated centrally without the input of district health offices. This often result in stock out of essential drugs and district health management teams have often complained that this monopoly of the market leads them to run out of drug budget funds as the price of drugs are quiet exorbitant. Monitoring of drug funds is also problematic because the consumers are not provided with

timely feedback and the system provides a fertile ground for corruption and pilferage of drugs. This is not in tandem with new public sector management arrangements that promote decentralization and grass root participation [16].

## **1.5 Justification of the Study**

In light of the aforementioned, the study seeks to find out the answer to the following main research question: Does community engagement initiatives (HCMC) improve the effectiveness of community health service delivery to people's expectations? The background research questions would attempt to explore theoretical/conceptual underpinnings, problematic and contextual issues and seeks to deal with: How does the health Centre Management Committee initiatives bring sanity to health service delivery in Malawi? What is the effectiveness of their participation in public health service delivery? What's the perception of the people on the type of health service that they receive? What are the community perceived challenges in drugs and supply monitoring system? Many organizations have implemented different interventions in Chitipa district since 2010 but their impact on reducing drug pilferage in the district has been minimal. The organizations that have implemented interventions aimed at improving availability of drugs and supplies in the district include: CHEMONCs, Support for Service Delivery Integration (SSDI), ONSE, FOCUS, and of course, Chitipa District Health Office.

Studies have been conducted to show the significance of community interventions but no research has been conducted to establish the impact of HCMCs in Malawi on improved service delivery. The findings from this study will be used to shape and design the policy formulation and advocacy on how best to strengthen the community structures or propose alternative

approaches to community initiatives. The qualitative data will guide the maximum impact at community level on whether HCMCs are a way to go or not. The FDGS and KIIs ideas from the horse's mouth are strategies likely to work better when implemented other than imposing on what the community has no knowledge of.

## **CHAPTER TWO: STUDY OBJECTIVES**

### **2.1 The Broad Objective**

To establish the impact of Health Center Management Committees in reducing drug pilferage and promotion of service delivery in Chitipa district.

### **2.2 Specific Objectives**

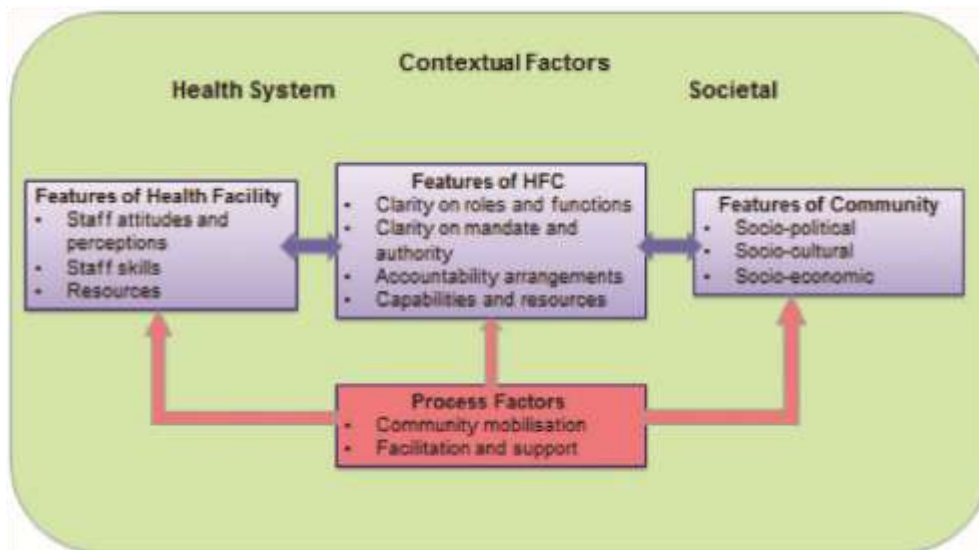
Specific objectives were:

1. To explore knowledge and understanding levels of health centre management committee roles and responsibility in drug and supply monitoring.
2. To establish the community perception towards health centre management committee's vigilance and accountability.
3. To establish community perceived benefits towards participation in health service delivery and drug monitoring.
4. To explore the challenges that health advisory committees experience in executing their roles in public health service delivery.

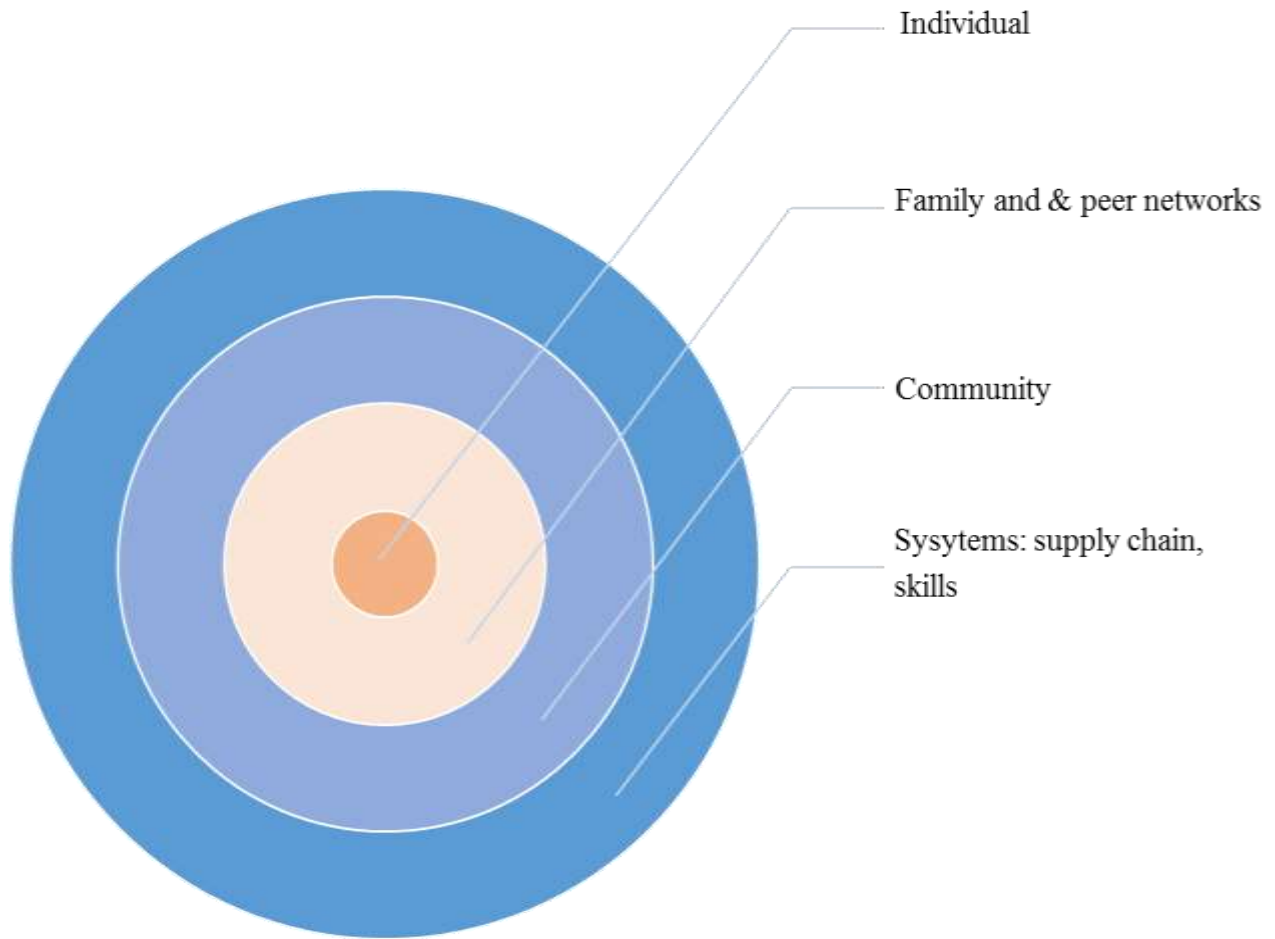
## CHAPTER 3: STUDY METHODS

### 3.1 Type of Research Study

This was an exploratory cross-sectional qualitative study. Focus Group Discussions (FGD) and Key informant interviews (KII). The study used a modified socio-ecological model as the framework of analysis 11. This approach is most suitable for the study because it explores the factors at all levels and dissect the root cases for policy change using a modified model, the study was aimed at exploring motivators and barriers to functionality of HCMC in curbing drug pilferage and promoting service delivery at four levels. The levels were individual, family and peer networks; and the community. However, the society level in the original socio-ecological model was replaced by system level (see *Figure 3*). At this level, drug participatory budgeting was one of the key factors that was explored. The unmodified socio ecological model related to Community structure upon which modifications were later made was as presented below.



**Figure 2: The un-modified socio-ecological model.**



**Figure 3: A Socio-ecological model that has been modified for the purposes of this study.**  
Source: [www.heart-resources.org](http://www.heart-resources.org)

### **3.2 Study Location**

The study was conducted in Chitipa District; northern region of Malawi (formerly known as Fort Hill). Chitipa is located at a distance of about 640 km to the north of Mzuzu city. Chitipa district has a referral hospital for 12 health centres of which the farthest is 120km from the district hospital (Nthalire). The district covers an area of 4,288Km square with a population of 240,789

according to the District Health Information System data. Of these, 127,613 are women of child bearing age. Health services in the district are coordinated by the Ministry of Health through the Chitipa District Health Office.

Chitipa District Council was purposively chosen as a study site because is one of the typical rural district that has a moderate level of socio-economic development and a fairly accessible in terms of transport and communication networks. Furthermore, the district has a diverse cultural background and there are 22 languages that are spoken in Chitipa. It is also one of the districts reported to have vibrant HCMCs. The study took place at and around one urban and four rural health facilities in Chitipa district. The urban facility was the Chitipa Distric Hospital whereas the rural facilities were Misuku, Wenya, Nthalire and Kameme health centres. Chitipa Distric Hospital was chosen because among all facilities it has the highest catchment population of 50,191 which represents about 20% of the total population in Chitipa. The remaining population is shared among the rest 12 health facilities. All of these health facilities are run by the Ministry of Health through Chitipa District Health Office. The four facilities were therefore chosen as a befitting representative of the rural views while the Chitipa Distric Hospital's catchment population represented the urban views.

### **3.3 Study Population**

The study population included: women and men (15-60 years, local leaders, health centre workers and members of HCMCs. A total of 45 women and 30 men participated in focus group discussions (FGDs) while other 15 women and 10 men were interviewed individually. The focus groups had an average of 15 participants. A total of 18 health workers from the facilities

participated in the study. A total of 10 local leaders also participated in the study. Three church leaders and two members of community based organization were among the interviewees in this study. All the participants were purposively selected. A detailed explanation on how the data was collected among the study participants is presented in the data collection section below.

### **3.4 Study Period**

Data collection took place in July-August 2020, data transcription; theme generation and coding were running concurrently with data collection and the final report was written in December 2020.

### **3.5 Sample Size**

A consensus on the appropriate sample size for qualitative research is yet to be reached by researchers. Different researchers have indicated that there is a point of diminishing return to a qualitative sample as more data does not necessarily lead to more information (data saturation). This is because one occurrence of a piece of data, or a code, is all that is necessary to ensure that it becomes part of the analysis framework [17]. Therefore, the five FGDs and twenty five key informant interviews that were conducted in this study were considered to be enough to reach data saturation.

### **3.6 Data Collection**

Data was collected at all levels of the socio-ecological model indicated. From the sampled health facilities, five focus group discussion comprising of at least fifteen people each and twenty-five key informant interviews were conducted. The key informants included the chiefs, the chair for

HCMC, the health workers, religious leaders; and the community based organizations leaders. A uniform FGD guide was developed for all the age group categories.

Messages were sent to the communities beforehand to ask the participants to be available and to participate in the study. Health workers were prepared in advance to make shifts as others would be attending to interviews and focus group discussions. Key informant interview guide was developed for each category of interviewees. Fifteen women and ten men were interviewed at and/or around each health facility as part of the KII (See table 1).

Eight data collectors were recruited and trained for three days. The data collectors were told the uniform translation of the technical words into local language. Four of the eight data collectors conducted FGDs others, conducted the key informant interviews. One uniform Focus Group Discussion guide was developed to avoid interviewer bias. The key informant interview and FGD guides were first translated into the local language (Tumbuka), pre-tested and modified before they were finally used to collect the data. Voice recorders were used for recording both the KII and the FGDs.

All participants not affiliated to HCMC committees were excluded from the study. This was validated through registers and minutes of their previous meetings.

**Table 1:** Participant Data Segregation According to Age and Location

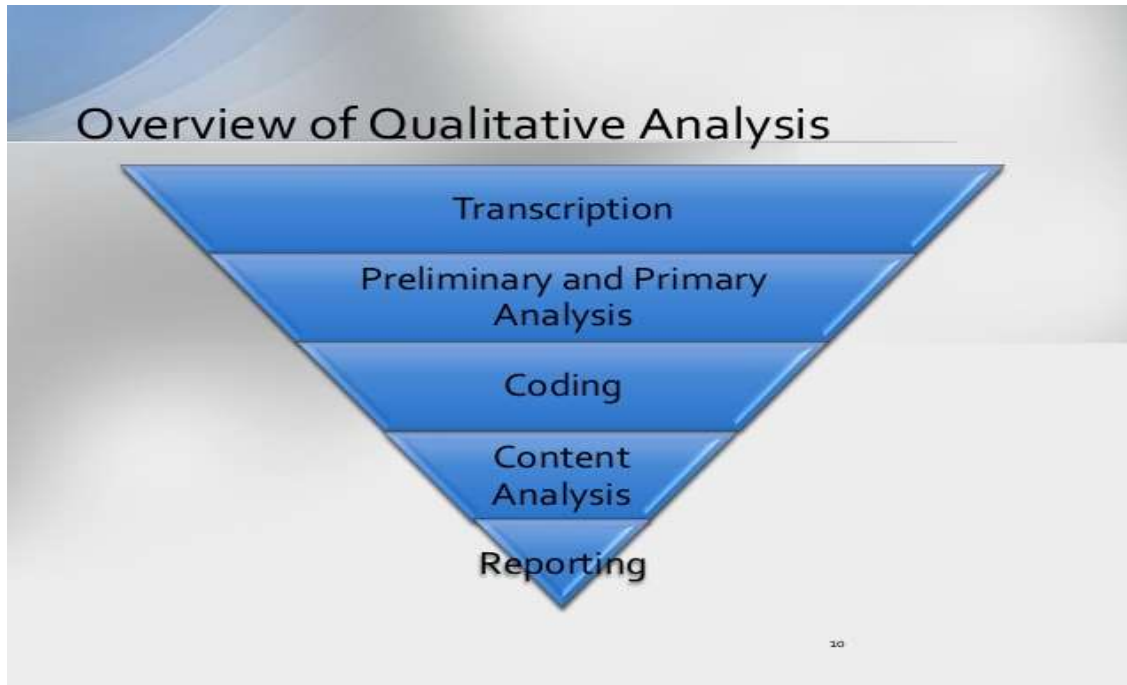
<b>AGE</b>	<b>RURAL</b> (Nthalire, Misuku, Kameme, Wenya)	<b>URBAN</b> (Chitipa Distric Hospital)	<b>TOTAL</b>
<b>FOCUS GROUP DISCUSSIONS (FGD)</b>			
15-60 years	15		
15-60 years	15		
15-60 years	15		
15-60 years	15	15	<b>75</b>
<b>KEY INFORMANT INTERVIEWS</b>			
Men	5	5	<b>10</b>
Women	10	5	<b>15</b>
<b>SUM TOTAL</b>			<b>100</b>

### **3.7 Data Management and Analysis**

Different authors have quoted Spradley’s work published in 1979 as having referred to analysis as a systematic examination of something to determine its parts, the relationship among parts, and their relationship to the whole [18,19]. There are many ways of analyzing qualitative data and several approaches such as hermeneutics, content analysis and semiotics [18,20–22]

In this study, raw data was kept in soft copies on the computer, flash disks and recorders while transcribed data was kept in both printed hard copies and on the computer. Content analysis was used in which the recordings of the FGDs and the key informant interviews were manually analyzed

by transcribing the data, identifying the major themes, coding the data under each theme and identifying the pattern of the data. The data analysis process followed the steps: Transcription, preliminary and primary analysis, coding and content analysis before this final report was written (see *figure 4*) [23,24]. The content analysis was complemented by framework analysis method in which the socio-ecological model was used [25]. Using this frame wok, the study findings have been categorized under the four levels of the social ecological model: individual, family and peer networks; the community and the systems level.



**Figure 4:** The Process of Qualitative Data Analysis

*Source: David Filiberto-conducting, analyzing and reporting in-depth interviews (internet)*

### **3.8 Study Strengths and Limitations**

By basing on the socio-ecological model, the study holistically explored the factors that promotes functionality of the HCMCs in service delivery thereby making it possible to design interventions

addressing the factors at each level. However, the study being qualitative in nature, could not establish strength of association of the factors identified and the direct cause of drug pilferage in relation to HCMC roles and responsibilities. The study could also not establish the causal relationship between the identified factors and the community structures. Other socio-ecological factors associated with drug pilferage and not necessary HCMC could be potential motivators or barriers. Chitipa is a boarder district and as such provides a good market for drugs and supplies especially to boarder traders. This is itself is an indirect factor why drug pilferage is high in the district.

### **3.9 Ethical Considerations**

The study demanded the participants' time; as such, consent was first sought from the Chitipa District Health Office, the community leaders and all participants. Interviewees were administered a consent before data collection. Confidentiality was assured to the participants by not recording the names of the participants. Furthermore, the proposal was submitted to the College of Medicine's Research Ethics Committee (COMREC) for approval and it was duly approved (see *Appendix 10*). The study only involved FDGS and interviews and no invasive procedures were conducted on the participants. The process through which the participants were chosen into the study was explained to the participants so as to remove any element of mistrust in the health system regarding the security of the data obtained from clients.

## **CHAPTER 4: FINDINGS**

### **4.1 Introduction**

This chapter presents the findings of the study according to the levels of the socio-ecological model where the respective factors operate. There were more educated participants in the FGD and the key informant interviews in the urban area (where the education level ranged from standard 8 to Bachelor's degree) than in the rural area (where the education level ranged from no education to standard 8). Almost all participants (both men and women) in the rural areas reported to be subsistence farmers. In the urban communities some of the women said they were housewives, others tailors, teachers, business women and school leavers. While among the men there were chiefs, tailors, farmers, faith leaders, teachers and school leavers.

Two themes were developed following the data analysis and these were: Potential motivators and barriers to HCMC functionality and delivery of health services. Each factor was identified as being either a potential motivator or a barrier.

### **4.2 Potential Motivators to HCMC Functionality**

#### **4.2.1 At Individual Level**

##### *i. High Education Level*

All the key informants interviewed both in the urban and rural health facilities were of the opinion that higher education level positively influences one's choice to voluntarily take part in HCMC activities.

*We understand the need to protect our own community and making sure drugs and supplies are closely monitored. We have a role to inform our communities which drugs and supplies available and which ones are out of stock.*

HCMC member from Chitipa Distric Hospital

**ii. Perceived Gain**

Most community members and key informants expressed satisfaction of having to go home healed when all the required resources are available.

*I have been to the facility more than ten times and I have never felt better when I am told the sickness is gone and discharged. Very few times I had gone back home without being given medications. I volunteer to make sure drugs are available and no one steals from us.*

Male participant in Misuku Health Centre

**iii. Incentives**

Most key informants acknowledged that the package they receive from partners at times is force being their commitment to uphold to the roles and responsibilities of community structures:

*Last year I received a t-shirt, cap, backpack and money in one of our meetings and since that day, I have felt compelled to come and supervise drug delivery at the health centre.*

Female respondent (27 years) key informant, Nthalire Health Centre.

**iv. Age**

The findings revealed that older people are likely to participate in voluntary community work than the younger generation. Most of the chairpersons of HCMC in most facilities were 40 years above.

*I have done my part and what's left now is to be a responsible citizen. I have attended almost every monthly meeting because there isn't much to do at home. As we age, we pass time in making meaningful decisions to prepare a good future for the next generation.*

Old male participant in an FGD, Kameme Health Centre

**4.2.2 At Family and Peer Networks Level**

**i. Family's Health Status**

At family level, the potential driver from most members was how often they visited the hospital due to sickness of a family member.

*Most of my children suffered various forms of sickness the past two years ranging from mild to severe illness. Having being at the hospital several times I realized the facility is facing a lot of drug stick outs. This prompted us in our family to voluntary be part of the HCMC and help fight drug pilferage at our health centre.*

Male participant in an FGD, Nthalire HC.

**ii. Peer Influence**

Most of the female community members have been part of community developments because of influence from their peer families.

*My neighbor visited me the other and told me that she is a member of HCMC and that they are mandated to go out in the community Sensitizing people on the need to report those that are involved in drug theft and illegal medical supplies. She also said that it is our responsibility to inform the community which drugs have been delivered and those out of stock. I made a decision to join the committee the following the day as there were few female representatives in the committee.*

Female participant at Chitipa Distric Hospital.

#### **4.2.3 At Community Level**

##### ***i. Health Worker's Commitment***

At community level, most members were compassionate and motivated with the commitment of health workers in the facilities.

*It is really pathetic, these health workers work day and night and sometimes we really feel sorry for them when we wake them up in the middle of the night with a sick child who has fever. There is a need for either two or three doctors. That means one can work during the day and the other one during the night. That means everyone that comes like, for example in the middle of the night, his or her problem will be dealt with by the one on night duty. That means they won't be sending us back and they won't be shouting at us again. That means the shouting would have decreased because they will have shifts. But because there is only one, he sees that he has been working during the whole day up to the evening. So, for him he takes evening as time for resting, but illnesses do not see*

*that this is the morning, this is the afternoon, and this is the night. They just come any time and they need our support.*

Male participant in an FGD, Chitipa Distric Hospital.

#### **4.2.4 At Systems Level**

##### ***i. Government Drug Budget Support***

Health workers and community members praised the government for the system in place that each health centre gets its own share of drugs and medical supplies unlike in the past when they used to order from the district hospital. The increase in the drug funding is also a motivator to many members of the HCMC.

*The CMST van delivers medicines every month and this sustains the continuum of care for our patients. The committee has an oversight role to monitor and supervise availability of drugs and informs the community. We commend the government and we are willing to support in whatever form to improve health service delivery.*

Health worker from Misuku Health Centre.

### **4.3 Potential Barriers to HCMC Functionality**

#### **4.3.1 At Individual Level**

##### ***i. Distance to the Facility***

Distance from home to the health centre was one of the factors reported as being barriers to many community member's participations in HCMC activities. Chitipa has a hilly topography and households are far from each. Most of the roads are impassable especially during rainy season and

this proves difficult for most community members to actively execute their duties. For those that have bicycles fail to cycle because of the terrain and this renders these committees less functional.

**ii. Perception Towards Health Workers**

While the reasons given by many participants for their lack of participation in community health interventions, it was clear that some had a bad perception towards health workers. Much as some acknowledged the support and commitment from the health workers, some had reservations that health workers steal drugs and sell them in private clinics in town.

*They tell us that some drugs are out of stock and that we must go buy in pharmacies and the next day you find the very same health worker operating in those private pharmacies and clinics. We feel this is a syndicate and they agree to steal drugs from the facilities for their personal gains. This is slowing us backwards as our efforts to curb drug pilferage proves futile. We are calling upon the government to deal with such malpractice to energize us for more action.*

Male participant in FDG at Chitipa Distric Hospital

**iii. Time Factor**

Time was another factor that was identified as a barrier for most community members to take part in health service delivery in the communities where the study was done. Some participants, both male and female, in the rural community explained that it is more justifiable for those that are well to do to participate in voluntary activities than the impoverished.

*I live at 6am for farming to find food for my big family and normally I knock off at 6pm almost every day. I have no any other source of income and as such I depend on farming for survival. I rarely find time to participate in most of these voluntary work especially the health centre management committee meetings.*

Male participant in an FGD, Wenya Health Centre.

#### **4.3.2 At Family and Peer Networks Level**

##### *i. Lack of Knowledge*

In communities where the HCMCs were operating in an environment with closer supervision and support, they were found to be more active and effective in dealing with the problems of community members. In most cases, the HCMCs do not reach out to the communities and as such they are not known to the community. One of the challenges is that these committees have not been effective because the elected members have not been oriented on their functions. The last formal trainings were in 2015 but since then many members have left and this significantly contributed to the knowledge gap both from the committee members transcending to the communities.

*I had never heard of HCMC until this discussion was called for by my friend who lives close to the health centre. I decided to come and take part in the discussion and I have heard a lot of which am willing to be part of this committee.*

Young female participant at Wenya Health Centre

### **4.3.3 At Community Level**

#### *i. Poor Leadership of Community Duty Bearers*

The capacity of oversight leadership – i.e. the chiefs and councilors –as well as their willingness is important in ensuring that the complaints of people are heard, resolved, and the outcomes reported to those who seek accountability. There was recognition that complaints can be taken to the HCMCs, but there was also considerable variation across catchment areas of Misuku, Nthalire and Chitipa district with regard to the extent to which these were functional. While in Nthalire catchment area the HCMC met regularly and dealt with numerous complaints and issues, in Misuku they met less regularly. Councilors and chiefs are supposed to provide leadership and support to these small pertinent structures for improved health service delivery but most of them do not show up for meetings.

HCMCs are supposed to be meeting every month to discuss issues and grievances from the community. Just like most important meetings, refreshments and food to keep up the energy is an integral part of such key meetings. More often members starve to get the agendas discussed and as such they are not motivated to meet often.

### **4.3.4 At Systems Level**

#### *i. In Adequate Drug Budget*

This observation was shared by health workers and chiefs mainly from the urban setting. They indicated that many clients are sent away from the public facilities telling them in the process that they have to buy medicines from private facilities.

## **CHAPTER 5: DISCUSSION**

### **5.1 Introduction**

This chapter discusses the findings presented above. Parallels have been drawn with other studies and the implication of the findings on program designs have been discussed. Some factors were identified as being a motivator to HCMC functionality if they were present and they would be a barrier if they were absent or vice-versa. However, if the factor was considered by the respondent/interviewee to be stronger in one aspect - for example, as being more of a barrier than a motivator- it was categorized as perceived by the respondents; i.e. as a barrier.

### **5.2 The Motivators**

In this study, at individual level: education level, age, perceived gain side and incentives attached were identified as potential motivators for HCMC functionality.

The HCMC in urban setting was more proactive than the committees in the rural set up though the sample size for urban setting was low depending with the geographical set up of chitipa. According to the 2010 Malawi Demographic and Health survey, there are more educated people in the urban areas than in the rural areas in Malawi [15]. This influences the level of commitment and participants from different community stakeholders. Education opens up the reasoning ability and the need to take ownership for the greater good.

Motivating factors specific to the family and peer networks level were: family exposure to sicknesses and peer pressure. Most families who had a direct impact of the health care system in the facilities were more likely to understand and take part in community health committees. The

hurdles faced when seeking health care forced them to better the situation in their respective communities.

Health worker's commitment is a community motivating factor towards taking a part in developmental issues. Most chiefs and religious leaders commended the level of commitment of the health workers in the facilities. The staffing level does not meet the minimum standard norms in most health facilities but the team is able to operate through out day in day out. The community felt obliged to support the health workers in making sure all perpetrators of drug pilferage are brought to books. Health service delivery is a complex system that requires concerted efforts to curb down drug pilferage and increase stock levels for improved life expectancy.

At systems level, the little support that comes from the government towards drugs and medicines is an insuating factor towards many community members to join hands and fight drug pilferage. Members are obliged to take part in public service delivery activities if the officer bearers show commitment. Much as funds for procuring drugs and medicines are limited but the political will exercised by the current regime has a push effect for the commitment to do more. This is a chicken and egg situation as it acts both as a motivator and the barrier at the same time, depending on how the community perceived it. The current system of central procurement of drugs needs to be decentralized to give more power to the locals. This will motivate them further and enhance ownership of health facilities and work towards bringing all perpetrators of drug pilferage to justice.

### **5.3 The Barriers**

At individual level perception towards health workers, distance from the health facility and time factor were some of the contributing factors towards dysfunctional HCMCs. Perception in the sense that public health service delivery has ineffective accountability mechanisms which may orchestrate drug pilferage at local level. Based on this finding, it can be safely concluded that public health service delivery has deep unintended long-term impacts on the functionality of HCMCs. It can further be argued that because of the dysfunctional community structures and weak democratic decentralized institutions at local level that has resulted in the manifestation of serious malaise whereby communities take the law in their own hands. Bad Perception towards health workers has serious consequences and it hinders developmental agendas.

Universal health coverage promotes easy access of services to all. Most of our facilities are beyond a radius of 8kms. This goes against health equity which is probably the most fundamental principle underlying public health service delivery. It is the principle that emphasizes that health should be for all people and not just for a few privileged ones. Distance is a key barrier to satisfactory performance of HCMCs in curbing drug pilferage and service delivery. The cost of health care encompasses transport and time spent in seeking/participating in health care/deliverables.

Lack of knowledge on functionality of HCMCs at family and peer level was one of the significant barriers to community participation hence the increase in drug pilferage cases. These is not a good sign in a democratic decentralization set up where local political representation, participatory and accountability avenues are supposed to be functionally sound in the public health service

delivery. Firstly it could be that there is little ownership of public health facilities by communities or the community health governance structures are frail and do not have the full capacity to mobilize communities in community led health initiatives and leaving everything to health workers; secondly the information on effective participation is not accessible to the public through their local elected leaders or finally it could be that there is a long chain in the flow of information on health issues from the health facility to the communities. For instance, from health facility to HCMC to ADC to VDC to chiefs to communities and back. This gives room for distortion of information and delayed action thereby fueling up concerns and giving wrong information.

Lack of leadership at community is a strong factor hindering community progress and especially functionality of HCMCs in Chitipa. What is clearly emanating from this research is that grassroots' participation in the Chitipa District council is a farfetched idea because local elites are exploiting the new found window of opportunity in the democratic decentralization initiative to promote patronage and neopatrimonism at the expense of the grassroots participation in decision-making. Hence, participation of community members in public health service delivery is not satisfactory because in most cases their participation is in form of contributions and not the actual decision making. As a consequence, most reform initiatives appear to dismally fail to promote and consolidate local governance institutions such as HCMC. On the other hand, the effectiveness of community mobilization for collective action depends on chiefs, who generally hold their office on a hereditary basis, and who also vary greatly in their motivation and effectiveness.

In adequate funding towards drug budget is a setback to community development. Chitipa's health system faces absolute and relative inadequacy of financing resources to adequately fund essential health package services e.g. drugs and supplies. Despite the development of a resource allocation formula, there appears to be no criteria for allocation of resources between health centres and the council at large. The current resource allocation formula is based on population, number of facilities and existing resources and not on disease burden and prevailing poverty. There is a need to review the resource allocation formula in order to ensure equity in the allocation of resources at different levels because this is an obvious contradiction when health spending practices in some countries is compared with the burden of disease. This may lead to inequality as there are differences in life expectancy at birth, infant and child mortality, nutrition status (for example the prevalence of stunting), maternal mortality and age-specific adult mortality. This demotivates those that are willing to take an extra mile to promote health service delivery and curb drug pilferage. Our communities are more empowered than before with the birth of several human rights groups. We have seen scenarios where health workers have been tortured thinking they are behind some of the drug pilferage cases when in fact it's just normal scarcity of drugs due to stock outs. These challenges when not addressed in the right time can lead to mob justice in the end crippling health service delivery to those that need it.

## **CHAPTER 6: CONCLUSION AND RECOMMENDATIONS**

### **6.1 Conclusion**

In this study, we identified factors such as education level, availability of incentives, time, level of commitment by both health workers and central government as potential motivators to HCMC functionality for improved service delivery. Factors such as distance to the health facility, lack of knowledge, poor health drug funding, poor community leadership as and perception of health care at all levels as potential barriers to HCMC functionality for improved service delivery.

- The identification of the factors at different levels highlight the importance of using the socio-ecological model in community programming so as to identify and address the factors underlying rampant drug pilferage and poor health service delivery. Nonetheless, this study exposes the weakness of implementing the socio-ecological approach with no regard to the systems thinking approach in implementing community health interventions. The strong emphasis on the need for HCMCs to be empowered to make transforming community decisions without looking for approval from higher authority.

### **6.2 Recommendations**

We recommend that in order to promote the motivators and reduce the barriers to HCMC functionality and service delivery in Chitipa district the following should be done:

1. The socio-ecological model should be used with an incorporation of the systems thinking approach. Even if a health belief model is used as some studies have

advocated, [26] the systems thinking approach should be incorporated within the program design.

2. It should be emphasized that councilors and chiefs must be members of HCMC and take a key role in monitoring drug supply chain and promote equitable health service delivery in the communities.
3. there is need to fasten loopholes in as far as participatory strategies and community mechanisms are concerned in public health services delivery. This study suggests that more training is required to build the capacity of the established decentralized bodies, particularly, HCMC, health and environment service committees at council level and to enable them to contribute effectively towards improving the quality of health service delivery
4. The central government needs to adhere to the principles guiding the implementation of the decentralization policy. The government should grant more financial powers to the local citizenry to levy local taxes as well as provide them with adequate and unconditional grants to be able to implement social and economic development activities. The drug budget must be generated and controlled at council and community level to address issues of drug stock outs and promote ownership.

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## APPENDICES

### Appendix 1: Informed Consent Form to Participate in a Research Study [English version]

**Title of the study:** Assessing the impact of Health Centre Management Committees in curbing drug pilferage; A case of Chitipa district.

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#### Part a: Introduction

You are being asked to participate in the research study mentioned above. This study involves assessing the impact of Health Centre Management Committees in curbing drug pilferage; A case of Chitipa district

Before you decide whether or not to participate in this study, you should know the purpose of the study, the risks and benefits of the study. We will answer all questions that you may have. After the study has been explained to you, you can decide whether to participate in the study or not. When you understand everything about the study, and you accept to participate in the study, you will be asked to sign to give consent or put a mark.

You have to note the following things:

- a) Taking part in this study is voluntary

- b) You can decide not to take part in the study, or to stop the interview at any time without losing your benefits or work.
- c) If you do not want to take part in the study, you are free to do so without any implication.

### **Purpose of the study**

The purpose of this study is to assess the impact of Health Centre Management Committees in curbing drug pilferage; A case of Chitipa district

### **Procedure**

If you accept to participate in this study, a study guide will be administered and it will take approximately one hour. The discussions will be taped or recorded so that we do not lose anything. The recordings will be kept with maximum confidentiality so that the discussion is not linked to you, your family or any other person.

### **Risks or other issues**

There are no potential risks associated with this study. However, if you are not comfortable with some questions, you are allowed to defer the questions or may stop at any time. Any information which may lead to your identity will not be collected or shared with any person outside the study.

### **Potential Benefits**

You may not receive any benefits from this study. However, the knowledge that will be obtained from this study could help the Government of Malawi and other development partners in improving community monitoring and curb drug pilferage in public health facilities.

### **Participating for another reason**

You don't have to participate in this study if you don't want to. If you are not enrolled into the study you will not lose any benefits.

## **Confidentiality**

The study team will keep all your information and recordings as confidential as possible. You will not be identified by any other means. None of your personal information will be released without your written permission. You will not be identified in any publications from this study. Your information can be reviewed by the Principal Investigator and the study team and other authorized agents such as the College of Medicine Research and Ethics Committee.

## **Individuals to contact for questions**

If you have any questions related to the study or if you have any issues as a result of participating in this study, you should contact **Ted Bandawe** on 0993929147, [tbandawe@gmail.com](mailto:tbandawe@gmail.com), P. O Box 95 Chitipa, or Dr Sue, Supervisor on 0888224630. You may also contact the chairperson College of Medicine Research and Ethics Committee (COMREC), Private Bag 360, Chichiri, Blantyre 3 or call COMREC secretariat on 01871911.

## **Part b: Statement of content**

I have read (or someone has read and explained to me) this consent form. I understand the purpose of the research study, how it will be conducted, risks, benefits and procedures involved.

I agree voluntarily to participate in this study (tick in the appropriate box):

I agree to participate in this study

I do not agree to participate in this study

---

Interviewee Name (print)

Thumb Print

---

Signature

---

Date

IF AVAILABLE:

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---

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Legally representative person (print)

Signature

Date

Thumb Print

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---

Interviewer's name (print)

Signature

Date

## **Appendix 2: Informed Consent Form to Participate in a Research Study [Chichewa version]**

**Mutu wa kafukufuk:** Kufufuza kufunika ndi ubwino okhala ndi Health Centre Management Committee ku Mudzi: Chitsanzo cha pa Chitipa

**Dzina lamkulu wakafukuku:** Ted Bandawe

Keyala : P.O Bokosi 95, Chitipa

Nambala ya foni: : +265 1 871 911; foni ya mmanja: +265 993929147

Email adilesi : [tbandawe@gmail.com](mailto:tbandawe@gmail.com)

### **Mbali yoyamba: Mau oyamba**

Muli kupemphedwa mosakakamiza kutengapo mbali pakafukufuku amene wanenedwa pamwambapa. Kafukufuku ameneyu akukhudza Kufufuza kufunika ndi ubwino okhala ndi Health Centre Management Committee ku Mudzi: Chitsanzo cha pa Chitipa.

Musanapange Chisankho chotenga mbali pa kafukufuku ameneyu , mukufunika mudziwe zolinga za kafukufuku, zoopsa zake komaso ubwino wake potenga mbali mukafukufuku ameneyu. Tikuyankhani mafunso omwe muli nawo. Tikamaliza kukufotokozelani za kafukufuku ameneyu, zili kwa inu kutenga mbali kapena ai. Mukamevtsetsa zakafukufuku ameneyu, komaso ndikuvomeleza kutenga mbali, muzapemphedwa kuti musainile pamunsipa kapena kuika chidindo cha dzanja.

Mwayenela kuzindikila zinthu izi:

- a) Kutenga mbali mukafukufuku uyu ndikosakakamiza

b) Mukhoza kusankha kusatenga mbali, kapenaso kusankha kusiya kafukufuku nthawi iliyonse yomwe inu mungafune.

c) Ngati simukufuna kutenga mbali, ndi ufulu wanu kutero popanda choletsa chilichonse.

### **Zolinga zakafukufuku**

Kufufuza kufunika ndi ubwino okhala ndi Health Centre Management Committee ku Mudzi: Chitsanzo cha pa Chitipa

### **Ndondomeko**

Mukavomeleza kutengambo mbali tizakufunsani mafunso angapo and kucheza kwathu kutenga ola limodzi. Zokambilana zathu tizikopela pakaseti kuti tizataye zinthu zonse takambilana. Zokambilana zimenezi zomwe zili pakanemazi tizisunga mosamala kuti inuyo musadziwike komaso zisakhudze banja lanu.

### **Zoopsa zokhudza kafukufuku**

Palibe zoopsa zokhudza kafukufuku. Ngati simukuwamvetsa bwino mafusowa muli oloedwa kusayankha mafunso. Zokambilana zokhudza kwambiri inuyo monga ngati otenga mbali sizizaululika kupita kwa munthu wina kapena banja lanu.

### **Zabwino zokhudza kafukufuku ameneyu**

Palibe zomwe muzalandire potenga mbali pakafukufuku ameneyu. Kafukufuku ameneyu azathandiza kupeza ndondomeko zina zomwe boma likhoza kugwilitsa ntchitio kuti mankhwala asamabedwe.

### **Kusankha kutenga mbali**

Simuli okakamizidwa kutenga mbali ngati simukufuna. Ngati simutenga mbali simutaya mwayi uliwonse okhudzana ndikafukufuku ameneyu.

### **Chinsinsi chakafukufuku**

Zonse zomwe titakambilane panopa zizasungidwa mosamalika .Inuyo simudzadziwika kuti munatenga nawo mbali. Zonse zokhudza inuyo mukafukufuku ameneyu zizagawidwa pokhapokha inuyo mutauzidwa. Dzina lanu silidzatchulidwa mukafukufuku wina aliyense pokhapokha mutauzidwa. Zonse zomwe mwatiuza zizaunikidwaso ndi amene akuyang'anila kafukufuku ameneyu ndionse omwe akupangitsa kafukufuku ameneyu komaso anzathu amene aloleza kuti kafukufuku ameneyu achitike aku College of Medicine Research and Ethics Committee.

### **Mukakhala muli ndi mafunso or zovuta zina**

Ngati muli ndimafuso ena okhudzana ndi kafukufuku ameneyu mukhoza kuwaoeza a **Ted Bandawe** pa 0993929147, [tbandawe@gmail.com](mailto:tbandawe@gmail.com), P. O Box 95 Chitipa, kapena adokotala akulu Sue, amene akuyang'anila ntchito zonse pa 0888224630. Komaso mukhoza kuwauza apa mpando amene amayang'anila bungwe la College of Medicine Research and Ethics Committee (COMREC), Private Bag 360, Chichiri, Blantyre 3 kapenaso mukhoza kuimba ku mlembi COMREC pa 01871911.

### **Mbali yachiwiri: mawu ovomeleza**

Ineyo ndawerenga (kapena andithandizila) ndondomeko imeneyi. Ineyo ndamvetsetsa zolinga zakafukufuku ameneyu, mmene itapangidwile, zoopsa zake, ubwino wake komaso ndondomeko yonse mmene itayendele. Ndavomeleza kutenga mbali mosakamiza (chongani mukabokosi):

Ndavomeleza kutenga mbali

Ndakana kutenga mbali

---

Dzina la ofunsidwa (print)

Sayini

tsiku

Ikani chala

Ngati chidindo chilipo:

---

Owimilira otenga mbali

Sayini

tsiku

Ikani chala

---

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Dizna laopangitsa kafukufuku (lembani)

Sayini

tsiku

### **Appendix 3: Informed consent form to participate in a research study [Tumbuka version]**

**Mutu wa Kafukufuku:** Assessing the impact of Health Centre Management Committees in curbing drug pilferage; A case of Chitipa district

**Zina la mlongozgi wa kafukufuku:** Ted Bandawe

**Keyala** : P. O Box 95, Chitipa

**Nambala ya foni** : +265 1 871 911; Foni ya m'mawoko: +265 993929147

Email address : [tbandawe@gmail.com](mailto:tbandawe@gmail.com)

#### **Chigaba Chakwamba: mazgu gha kwamba**

Tikumupemphani kuti mutolepo lwande pa kafukufuku uyu talongosola pachanya apa. Kafukufuku uyu wakukhwaska awo wakapokera lwande pala tikulongola pa nkhani za umoyo muchikaya.

Pambere mundaghanaghane vya kutolapo lwande pakafukufuku uyu, mukwenera kumanya ulato wake, vyakofya vyake na chandulo chake cha kafukufuku uyu. Tizgolenge mafumbo yose agho muli nagho. Pala mwalongosolereka vyose vya kukhwaska kafukufuku uyu, mukupasika mwawi wakutorapo lwande pakafukufuku uyu panji chara. Para mwapulikiska makola za kafukufuku uyu, ndipo mwazomera kutorapo lwande, mupemphekenge kulemba zina linu na kusayina panji kudinda na chigung'u kuti mwazomerezga.

Mukwenera kumanya vinthu ivi:

- a) Kutorapo lwande pa kafukufuku uyu nkhwakujipereka.

- b) Para mwakhumba, mungakana kutorapo lwande pa kafukufuku uyu, panji kulekerathu kuzgola mafumbo nyengo yili yose uku kafukufuku wali mkati ndipo kuti mutayenge vya wanangwa chara panji kumlekeskani ntchito yinu.
- c) Pala mukukhumba chara kutorapo lwande pa kafukufuku uyu, muli wanangwa kuchita nthaura kwambula suzgo liri lose.

### **Ulato waka kafukufuku**

Ulato wa kafukufuku uyu ni kusanga maunono agho nthambi ya vya umoyo na masambilo wakasangana navyo pa kugwira ntchito yakupereka katemera kweniso na vinthu ivyo vingapangiska kuti katemera uyu wende makola.

### **Ndondomeko ya kafukufuku**

Para mwazomera kutorapo lwande pa kafukufuku uyu, tichezgenge namwe pafupi-fupi ola limoza. Vya kudumbirana vithu tijambulenge kuti tileke kutaya chinthu chili chose cha kukhumbikwa. Vya kudumbilana vithu ivyo tijambulenge tivisungenge mwa chisisi ndipo vya kudumbirana ivi kuti viphalikenge kwa wali yose chara nga ndi mbumba yinu panji munthu wali yose.

### **Vyafopya Panji msuzgo ghankhe ya kukhwaska kafukufuku**

Palije vyakofya vya kukhwaska kafukufuku uyu. Kweni para muli wakumasuka chara na mafumbo ghanyake, muli wakuzomerezgeka kulijumpha fumbo ilo panji kulirekerathu kuzgola. Para vya kudubirana vithu vikulongola chimanyikwiro chinu, fundo izo zilembekenge chara panji kulongoleka kwa uyo wali mu kafukufuku uyu chara.

### **Chandulo cha kafukufuku**

Kutorapo lwande pa kafukufuku uyu chikung'amula kuti musangengepo chandulo chara. Nanga uli, ivyo visangikenge mukafukufuku uyu vivwilenge Boma la Malawi na mabungwe yanyake munthazi pa ndondomeko ya kendeskeru ka ntchito ya kupereka katemera wa kachibungu ako kakwambiska matenda ya kansa ya mulyango wa chibabilo.

### **Kutorapo lwande pa vifukwa**

Kutorapo lwande pa kafukufuku uyu chara para mundakhumbe. Para mundatorepo lwande pakafukufuku uyu kuti mwataya chandulo chilichose chara.

### **Kusunga chisisi**

Wupu wa kafukufuku wusungenge vyose ivyo tadumbirana pano na vya kujambula mwa chisisi. Imwe kuti mumanyikwenge mwa nthowa yili yose chara. Paliye uyo wamanyenge za imwe kwambula kuti mwalemba chikalata cha kuzomerezga. Zina linu kuti lamkulembeka mu mabuku gha kuphalazga za kafukufuku uyu chala. Uyo wangamanya za imwe ni uyo wakuona za kafukufuku uyu na wupu wake na wanthu wanyake wakuzomerezgeka nga ni nthambi ya kuona vya kafukufuku ya College of Medicine.

### **Wanthu awo mungakhwasna nawo para muli na masuzgo panji mafumbo**

Para muli na mafumbo ya kukhwaska kafukufuku uyu panji vinthu vinyake chifukwa chakutorapo lwande pa kafukufuku uyu, kumanani na wadada wa **Ted Bandawe** pa nambala iyi:

0993929147, P. O Box 95, Chitipa, Dr Sue, Project supervisor on 0888224630. Kweniso mungaimbangha kwa wapampando wa College of Medicine Research and Ethics Committee

(COMREC) kweniso kwa secretary COMREC pa 01871911, Private Bag 360, Chichiri, Blantyre  
3.

**Chigawa cha chiwiri: Dongosolo la zomera kutolapo lwande pa kafukufuku**

Nawerenga (waniwerengera na kunilongosolera) za chikalata ichi. Napulikiska ulato wa kafukufuku, katemera wa wasungwana wa kachibungu ako kakwambiska mtenda ya kansa ya mulyango wa chibabilo na vyakofya, chandulo and ndondomeko yake. Nkhuzomera kwambula kuchichizgika kutorapo lwande pa kafukufuku uyu.

Nkhuzomera kutorapo lwande pa kafukufuku

Nkhuzomera chara kutorapo lwande pa kafukufuku

---

Zina la dada/mama

Sayini

Zuwa

(Panji kudinda na chigung'u)

PANJI

---

Mwimiliri wakuzomerezgeka

Sayini

Zuwa

(Panji kudinda na chigung'u)

---

Zina la wakufumba mafumbo

Sayini

Zuwa

**Appendix 4: Interview Guide for Key Informants (Agents)**

Interview No.....District.....

Date of interview: ..... Place of Work.....

Occupation: ..... Position .....

Qualification:..... Experience.....

**Section a: Understanding the concept of HCMC**

1. How do you define the roles of HCMC?

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.....

2. What could you say about the participation of community in health service delivery according to MOH policy?

.....  
.....

3. How did you come to get involved in HCMC activities?

.....  
.....

4. What kind of decisions are you able to make at your level regarding health management management Committee.....e)

Procurement of drugs and medical supplies.....

6. The ministry of health has devolved drug monitoring to HCMCs. What are

Your views on this?

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.....

**Section b: Participation**

8. How do you assess public health service delivery in terms of participation of the people at the grassroots? *Explain your answer*

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9. The health centre management committee (HCMC) is one of the community structures which is deliberately put in place by government to encourage citizen participation in public health service delivery. What roles do they play at the health facility?

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.....

10. May you also explain whether or not HCMC undermines other decentralized structures for participation such as the Area Development Committees and Village Development Committees?

*Explain your answer*

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.....

.....

.....

.....  
.....

**Section c: Accountability**

12. May you explain the mechanisms that have been put in place in the local public health service delivery to ensure accountability of health service providers to :

a) The District Council?

.....  
.....  
.....

b) The people on the grassroots?

.....  
.....

13. In the present set up of decentralized health services, how possible is it for local masses to demand accountability from service providers? i.e. how drugs have been used.

.....  
.....  
.....  
.....  
.....

14. Are there any systems of supervision, monitoring and annual evaluations of your performance by the district council in the past 4 years? If yes how are the findings /feedback sent to you?

.....  
.....  
.....  
.....

15. To what extent have these (supervision, monitoring and annual evaluations) influence your delivery of services?

If no,why?

16. How is your performance appreciated in the community?

.....  
.....  
.....  
.....  
.....

**Section d: Benefits and risks**

17. Do you think there are any benefits and risks to the work that HCMC do in the community?

*Explain your answer*

.....  
.....  
.....

.....  
.....

18. DO benefits outweigh the risks? Explain *your answer*

.....  
.....  
.....

**Section E: Perception and challenges experienced**

20. How do you perceive the effectiveness of the service you deliver in producing the desired results in the decentralization set up? *Please explain your answer*

.....  
.....  
.....

21. How do you know that beneficiaries are satisfied with the services you provide? *Please explain your answer*

.....  
.....  
.....  
.....

22. What sanctions are leveled against members of the HCMCs who do not perform?

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.....

23. Do you think decentralization of health services would improve the delivery of health in your area? Which things would improve and how? If no, why?

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.....  
.....  
.....

25. What are some of the challenges faced when implementing supply chain of drugs in the community.

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.....  
.....

26. Do local leaders or community structures that are in place support service delivery?

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**Appendix 5: Key Informant Interview Guide for Key Informant (Agent) [Tumbuka version]**

*Assessing the impact of HCMC in curbing drug pilferage for improved health service delivery.*

**INSTRUCTIONS:** Administer a written consent to the interviewee for participation. Once the written consent has been granted, you can proceed with the introduction.

**NAME OF INTERVIEWER.....**

**DATE:.....**

Tikumupemphani kuti mutolepo lwande pa kafukufuku uyu talongosola pachanya apa. Kafukufuku uyu wakukhwaska awo wakapokera lwande pala tikulongola pa nkhani za umoyo muchikaya.

Pambere mundaghanaghane vya kutolapo lwande pakafukufuku uyu, mukwenera kumanya ulato wake, vyakofya vyake na chandulo chake cha kafukufuku uyu. Tizgolenge mafumbo yose agho muli nagho. Pala mwalongosolereka vyose vya kukhwaska kafukufuku uyu, mukupasika mwawi wakutorapo lwande pakafukufuku uyu panji chara. Para mwapulikiska makola za kafukufuku uyu, ndipo mwazomera kutorapo lwande, mupemphekenge kulemba zina linu na kusayina panji kudinda na chigung'u kuti mwazomerezga.

**A. Understanding HCMC**

1. Kasi mungatilongosolera za udindo winu pakovwirapo pa vya umoyo na ndondomeko ya HCMC muchikaya chinu panji mu muzi winu?

**[Probe: Kasi mukovwirapo uli?]**

## **B. Participation**

2. Kasi mukughanaghana kuti chipatala chinu chikawa na wanthu wa za umoyo wakukwana pakugwira ntchito zawo makola pa nyengo iyo paka perekekanga katemera wa kachibungu ka kwambiska kansa ya mulyango wa chibabilo?
3. Kasi pa chipatala chinu wakatumapo wa za umoyo wakusazgirapo pakovwira kupereka katemera wa kachibungu ka kwambiska kansa ya mulyango wa chibabilo?

[**Probe:** Kasi wakatumapo walinga?]

4. Kasi kusazgirapo kwa ntchito ya katemera uyu kukawa na suzgo liri lose pa kagwiliro ka ntchito zinyake za umoyo pa chipatala chinu?

[Para ENYA, **probe:** Kasi kagwiliro ka ntchito zinyake kakakhwaskika wuli?]

## **C. Accountability**

5. Kasi ni udingo wuli uwo imwe mukatorapo lwande pa kumema wanthu pa vya katemera wa kachibungu ka kwambiska kansa ya mulyango wa chibabilo?

[**Probe:** Kasi wanthu mukawamemanga uli mu chikaya chinu? Kasi wanthu wakanozgekera uli pa vya katemera? Kasi mukawa na mafumbo ghali ghose pa katemera uyu? Kasi mafumbo ghakawa ghakuti uli?] [*Note to interviewer: Ask one probing question at a time.*]

6. Kasi ni ntchito uli za kumema wanthu izo mukaziwona zikuchitika?

[**Probe:** Kasi ni njani uyo wakanozgera ntchito izi? Kasi ni njani uyo wakamemanga nawo? Kasi wakachitanga uli?] [*Note to interviewer: Ask one probing question at a time.*]

7. Kasi ghakawapo mawupu agho ghakovwirangapo pa ntchito ya kumema wanthu?

[**Probe:** Para ENYA, Kasi ni mauwupu nga agho ghakovwirangapo pa ntchito ya kumema wanthu? Kasi ni ntchito uli zakumema wanthu izo wakachitanga?] [*Note to interviewer: Ask one probing question at a time*]

8. Kasi ni mauthenga wuli ghakulembeka agho imwe mukaghawona kuti gha kugwiriskika ntchito?

[**Probe:** Kasi ni uthenga wuli uwo ukawa wakuwuska nkumbi wasungwana na wapapi wawo kuti wazomerezge wana wasungwana kuti kapokere katemera? Chifukwa uli? Kasi ni ntchito uli za kumema wanthu izo imwe mukughanaghana kuti zikachiska wasungwana na wapapi wawo kuti wazomere kupokera katemera?] [*Note to interviewer: Ask one probing question at a time*]

9. Kasi mukughanaghana kuti ntchito ya kumema wanthu yikapereka uthenga wakukwanira, ku wasungwana na wapapi wawo kuti waghanaghane kuti wana wawo wasungwana wapoke katemera?

10. Kasi imwe mukatorapo lwande pakumema wasungwana kuti wakapoke katemera wa kachibungu ka kwambiska kansa ya mulyango wa chibabilo?

[**Probe:** Para ENYA, kasi ni ntchito uli iyo imwe mukachita kuti mumeme wasungwana makola kuti wapokere katemera wa kachibungu ka kwambiska kansa ya mulyango wa chibabilo? Kasi ni njani munyake uyo wakatorapo lwande pa kumema wasungwana kuti wapokere katemera? [*Note to interviewer: Ask one probing question at a time*]

#### **D. Benefits and risks**

11. Kasi pakawa kukoleranako kuwemi pakati pa nthambi ya vya umoyo na nthambi ya vya masambiro?

[Para ENYA, **probe:** Kasi kukoleranako uku kukawa uli? Kasi mungatiphilirako viyeleze gelo vya umo wakagwiliranga ntchito pamoza? Para CHARA, kasi ni vimphindikwa uli ivyo mukaviwona kuti waleke kukoleranako?] *[Note to interviewer: Ask one probing question at a time]*

#### **E. Perception and challenges experienced**

12. Kuyana na ivyo mukaviwona pa katamera uyu mu masukulu, kasi ni ntchito uli izo mukaziwona mukughanaghana kuti zingizakawerezgeka munthazi kovwira kupereka uviri wa HCMC mu masukulu?

**[Probe:** Kasi ntchito izo zikavwira uli pakupereka katamera? Kasi chifukwa uli ntchito izo zikwenera kuwerezgeka? Kasi ni ntchito uli izo zikwenera kuwerezgeka chara? Kasi chifukwa uli zikwenera kuwerezgeka chara? *[Note to interviewer: Ask one probing question at a time]*

13. Kasi mungalongosola ntchito izo zikawa makola na izo zikawa makola chara pakendeskeru ka katamera uyu?

**[Probe:** Kasi ni ntchito uli izo zikawa makola? Zikawa makola pa chifukwa uli? Kasi ni ntchito uli zikawa makola chara? Zikawa makola chara pa chifukwa uli?] *[Note to interviewer: Ask one probing question at a time]*

14. Kasi mukughanaghana kuti katamera wa kachibungu ka kwambiska kansa ya mulyango wa chibabulo ni ndondomeko yiweme kuti Boma la Malawi liyambiske mu maboma ghanyakhe?

**[Probe:** Kasi chifukwa uli panji chifukwa uli lingayambiskanga chara? *[Note to interviewer: Ask one probing question at a time]*

15. Kasi mukughanaghana kuti ni nthowa wuli yiweme yakaperekero ka katemera uyu kwa wana wasungwana: mu masukulu yawo panji mu vipatala panji mu vikaya vyawo?

**[Probe:** Kasi pa chifukwa uli?

16. Kasi muli na maghanoghano ghanyake kuti tidumbirane pa mutu uwu?

**Interviewer's summary:**

**[Note any key points that have come out of this interview in the box below]**

*Umaliro wa kucheza kwithu, yewo chomene chifukwa cha kutorapo lwande pa kafukufuku uyu*

**Appendix 6: Interview Guide for FDGS**

Interview No:..... District:.....

Date of Interview: ..... Place of Interview.....

Name of ADC, VDC, HAC..... Ward.....

Section a: Interview guide for FDGs

Interview Questions Guide for community members (Principals)

**Section a: participation**

1. How do you assess public health service delivery in terms of participation of the people at the grassroots? *Explain your answer*

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2. May you describe the criteria used in selecting the health advisory committee (HCMC)?.....

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4. May you also explain whether or not HCMC undermines other decentralized structures for participation such as the Area Development Committees and Village Development Committees?

.....  
.....  
.....  
.....

**Section c: Accountability**

6. May you explain the mechanisms that have been put in place in the local public health service delivery to ensure accountability of health service providers to :

a) The District Council?

.....  
.....  
.....

b) The people on the grassroots?

.....  
.....

7. In the present set up of decentralized health services, how possible is it for your (local masses) to demand accountability from service providers? i.e. how drugs have been used.

157

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8. What could be other channels which community members can use to demand accountability from both service providers and councilors?

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9. Are you aware of any supervision, monitoring and annual evaluations of the performance of the facility or your committees by the district council in the past 4 years? If yes, how are the findings /feedback sent to you?

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.....  
.....  
.....  
.....  
.....

11. To what extent have these (supervision, monitoring and annual evaluations) influenced the delivery of services. If no, why?

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.....  
.....

12. How is your performance appreciated in the community?

.....  
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15. In your view ,do you think HCMCs are making any difference in the delivery of health services?.....

.....  
.....  
.....  
.....

**Section e: Perception of the community**

16. How do you perceive the effectiveness of the public health service you receive in the community?

*Please explain your answer*

.....  
.....  
.....

21) How do you know that community members are satisfied with the health services that they receive? *Please explain your answer*

.....  
.....  
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22) What sanctions are leveled against HCMCs members that are not performing?

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23) Do you think HCMC services would improve the delivery of health in your area? Which things would improve and how?

If no, why?

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24) What do you view as challenges in your line of duties? What would be the benefits? What would be the obstacles to the process?

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6) Do local leaders or community structures that are in place support you?

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.....

THANK YOU PARTICIPATING

### Appendix 7: Events Planning Matrix

Activity	Time Frame											
	July '20			August'20			September '20			December'20		
Training of data collectors	█											
Pre-testing and refining of data collection tools		█										
Data collection and transcription			█	█								
Data coding and analysis					█	█						
Narrative writing							█	█				
Submission to the college											█	█

## Appendix 8: Study Budget

Item	Description	Unit	Persons	Days	Rate (MK)	Total (MK)
<b>A. Subsistence allowance during data collection</b>						
	Research Assistants	Person days	8	8	5,000	320,000
<b>Sub-Total</b>						<b>320,000</b>
<b>B. Subsistence allowance during data transcription</b>						
	Research Assistants	Person days	8	5	5,000	200,000
<b>Sub-Total</b>						<b>200,000</b>
<b>C. Fuel</b>						
	Fuel to Nthalire through wenya, mahowe and Misuku	Litres per day	25/day litres	4	730	73,000
<b>Sub-Total</b>						<b>73,000</b>
<b>D. Communication</b>						
	Air time for the PI and the research assistants	Airtime per person/day	9	8	250	50,000
<b>Sub-Total</b>						<b>50,000</b>

Item	Description	Unit	Persons	Days	Rate (MK)	Total (MK)
<b>E. Printing, Stationery and recorders</b>						
	Hard cover notebooks	Each	8	1	2,000	16,000
	Pens	Each	9	1	100	900
	Hiring recorders	Each/day	4	8	1,000	32,000
	Batteries	Each/person	4	4	1,000	16,000
<b>Sub-Total</b>						<b>64,900</b>
<b>GRAND TOTAL</b>						<b>707,900</b>

## Appendix 9: Letter of Confirmation for Study Support



Acting Director of Health & Social Services  
Chitipa  
P.O. Box 95  
Malawi  
Email: [tbandawe@gmail.com](mailto:tbandawe@gmail.com)  
Cell +265 993929147/888224630  
30<sup>th</sup> October, 2019

**TO: COLLEGE OF MEDICINE RESEARCH AND ETHICAL COMMITTEE**

### **LETTER OF CONFIRMATION FOR STUDY SUPPORT**

This letter confirms support for the study that Ted Bandawe who is a Malawian health professional and studies at Malawi College of Medicine intends to lead and conduct in Chitipa District. The district authorities are aware of the planned study and will support the processes involved. However, Chitipa District authorities are also aware that prior to any data collection process, the study will make a formal application to the College of Medicine Research Ethics Committee. This application will ensure that the study complies with the established and acceptable health research standards and practices in Malawi. Therefore, this letter of support also confirms to the authorities that might be reviewing the ethical application that the study is of relevance to the interventions delivered in Chitipa District. The study findings would provide further knowledge to the district on strengthening health system, especially in the integration of health services at the community level.

Therefore, any assistance rendered to the study and consideration of the ethical application would be greatly appreciated.

Your Faithfully

A handwritten signature in blue ink, appearing to read 'Dr Victor Matumbo'.

Dr Victor Matumbo  
Ag Director Of Health and Social Services

Appendix 10: COMREC Approval Certificate



## CERTIFICATE OF ETHICS APPROVAL

This is to certify that the College of Medicine Research and Ethics Committee (COMREC) has reviewed and approved a study entitled:

P.11/19/2853 - Assessing the impact of Health Centre Management Committees in curbing drug pilferage; A case of Chitipa district. by Ted Bandawe

*On 13-Dec-19*

*As you proceed with the implementation of your study, we would like you to adhere to international ethical guidelines, national guidelines and all requirements by COMREC some of which are indicated on the next page for your study*

A handwritten signature in blue ink, appearing to read "YB Mlombe".

Dr. YB. Mlombe - Chairperson (COMREC)

13-Dec-19

Date

Approved by  
College of Medicine

13-Dec-2019

(COMREC)  
Research and Ethics Committee