

**Documentation of the Community Capacity
Building Experience in
Uganda**

GOU-UNICEF COUNTRY PROGRAMME, 1995-2000

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*Submitted by Sandra Wilcox and Jonathan Gaifuba to UNICEF
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Sandra Wilcox and Jonathan Gaifuba

Authors

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ACRONYMS

AIDS	Acquired Immuno-Deficiency Syndrome
ARI	Acute Respiratory Infection
BCC	Behavior Change Communication
CBHC	Community Based Health Care
CBMIS	Community Based Management Information System
CCB	Community Capacity Building
CDD	Control of Diarrheal Diseases
DHE	District Health Educator
DDHS	District Director of Health Services
DMO	District Medical Officer
DOTS	Directly Observed Therapy
EPI	Expanded Program on Immunizations
FP	Family Planning
GOU	Government of Uganda
HIV	Human Immune-Deficiency Virus
HC	Health Center
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Illness
LC I	Local Council – Level 1- community
LCII	Local Council – Level 2- parish
LCIII	Local Council – Level 3 – sub-county
LCV	Local Council – Level 5 - district
MOH	Ministry of Health
NGO	Non-Government Organization
ORS	Oral Rehydration Salt
ORT	Oral Rehydration Therapy
PDC	Parish Development Committee
PHC	Primary Health Care
RH	Reproductive Health
S/C	Sub-County
STD	Sexually Transmitted Disease
TB	Tuberculosis
TBA	Traditional Birth Attendant
UNICEF	United Nations Children’s Fund
UPE	Universal Primary Education

EXECUTIVE SUMMARY

For many years organizations and development agencies have struggled with how to empower communities to manage their development processes. This paper documents how UNICEF and the Ugandan Ministry of Health have built the capacity of Ugandan communities to understand, document, prioritize and develop solutions for their problems. It describes how UNICEF and the MOH established Parish Development Committees (PDCs) at the parish or ward level, as the basic capacity building structure. These PDCs were composed of members of local government from parish councils as well as members from the communities in the parishes, with equal male and female representation. Trainers who worked at the sub-county level trained the PDC members and district level trainers, in turn, trained them. The training consisted of topics that covered: community organization for development; decentralization; gender; behavior change communication; adult learning principles; report writing; planning; problem identification and solving; and how to develop a Community Based Management Information System (CBMIS). This training targeted employees from the district levels down to representatives at the village level and the purpose was to reorient their development strategy from a top-down to a bottom-up approach. The PDCs were also structured in a way that integrated them with the decentralized system of local governing councils, in order to encourage political support for their community based development strategies.

As a first task, the PDCs were asked to collect data about each of the communities in their parish (CBMIS). These data generally included information about the populations, broken down by age and sex, numbers of children attending school, immunization levels, numbers of latrines and information about the quality of water sources. This information is then used to educate the communities about their general status and lead to discussions about solutions for the problems identified. The documentation process revealed that in addition to serving as a basis for community development activities, the CBMIS has also created a realistic basis for parish development plans. Because the PDCs are directly linked with the local governing councils, there is greater likelihood for their development priorities and plans to be accepted and funded.

Other accomplishments noted in the documentation included the strengthening of women's roles in development activities. Because of the gender equity policy, women are well represented on the PDCs and those who are active tend to take on leadership roles in areas related to the home and children such as food production, nutritional status, sanitation and child health. Generally women's participation in preventive health activities is much higher in the PDC communities. Examples include: infant nutrition meetings; growth monitoring sessions; immunization clinics; attendance at family planning and antenatal clinics.

Other interesting accomplishments include how the PDCs have interfaced between the service delivery system and the communities. In fact the PDCs have become the entry point to the community. They are viewed by the district medical officers (DMOs) as their "first line health workers" and have been the key organizers for dynamic community participation in immunization campaigns, malaria control and cholera eradication. In fact the major problem, according to district officials, has been meeting the dramatically increased demand for preventive services. Since the PDCs have become active, community data systems report immunization levels that have increased from coverage levels of 20% to 30% to levels above 80%. District data also

shows general increases in preventive health indicators, depending on the number of active PDCs in the district. In addition, there is evidence of good collaboration between the Health Unit Management Committees and the PDCs with the two groups usually attending each other's organizational meetings and sharing information about community health problems being seen at the health units. In some parishes the PDCs are used to follow-up on individuals seen at the health units and assure that they are followed in the community outreach clinics.

It was found that all the PDC members interviewed understood their role as volunteers. Many commented on the importance of their work noting the elevated self-esteem they felt from being regarded as trained knowledgeable leaders in their communities who could collect data about the condition of their communities and parish and inform others about what they could do to improve their situations. Some of these volunteers commented that their payment for their work was seeing healthier communities with more latrines, cleaner houses and healthier children. They also noted that because they were volunteers, people were less suspicious of their motives for collecting data and trying to improve their communities.

Because of the status they've achieved from having the knowledge and skills to diagnose community problems and suggest solutions for resolving them, the PDCs are very interested in expanding their abilities and many have received training in other development areas such as agriculture, planning, adult literacy, animal vaccination programs etc. PDCs are recognized as the entry points to the communities and many organizations contact them when they want to implement programs at the community level. PDCs are also having success in requesting tax revenues from the local governing councils for their prioritized development projects. To this end, several PDCs have convinced the sub-county and parish councils to allocate specific budgets for their development initiatives.

The documentation concludes that there are several potential resources for sustaining PDC activities. The key seems to be the foundation of a capable PDC that has internalized the ability to understand its needs and assert its rights. Once a PDC is aware of its needs and is able to document them then they can develop a plan to address them. Many are also using their newly acquired skills to create income-generating project.

INTRODUCTION

This is a documentation of how UNICEF and the Ugandan Ministry of Health have built the capacity of Ugandan communities to understand, document, prioritize and develop solutions for their problems. It describes the steps taken in establishing a basic capacity building structure at the Parish or Ward level of the government structure. These structures are labeled parish development committees (PDCs). This report also presents some of the key activities and unique methodologies that the Parish Development Committees of four districts have employed to improve the living conditions in its parishes and sub-counties and documents the results of these efforts. Finally, the document notes some of the important lessons learned in the PDC process as well as some of the constraints and challenges that it faces in the future.

In order to conduct this documentation, the consultants, Sandra Wilcox and Jonathan Gaifuba visited parish development committees in the four districts where the project was initiated: Jinja, Iganga, Mukono and Kiboga (See Program in Annex ____). The consultants also reviewed project documents and interviewed personnel at UNICEF and the central and district offices of the Ministry of health. The objectives of the consultancy are to:

1. Document Uganda's experience with community capacity building through the establishment of parish development committees.
2. Identify lessons learned from this process that may be useful in the 2001-2005 Country Program.
3. To share Uganda's experience of CCB with other people.

This report is organized in accordance with the categories outlined in the terms of reference for this consultancy.

It is important for readers of this document to realize that this is not an evaluation of the PDC program but rather documentation of how it developed and some of the key program elements that have contributed to its success.

1. (a) HISTORICAL BACKGROUND

Throughout its colonial and the early part of its post colonial period, Uganda's health care system has evolved from that of traditional medical practices to a system based on modern curative methods to the current one which is based on primary health care priorities. That is to say, a system in which the role of individuals and their communities is emphasized.

The focus on primary health care (PHC) was given impetus in 1978 with the Alma Ata declaration emphasizing a PHC strategy of "health for all." However, between 1978 and 1994 it was primarily the non government sector which focused on achieving meaningful community participation through a Community Based Health Care (CBHC) strategy. Though these efforts were not comprehensive, they did achieve some results in mobilizing communities to participate in immunization campaigns, nutritional improvement efforts and water and sanitation projects. During this period a few government staff associated with non government agencies (NGOs) were involved with CBHC as trainers, facilitators and program managers. These staff were able to gain useful experience in mobilizing communities and stimulating members to take responsibility for their own health care.

During the 1980s and early 1990s the government assumed that the poor health status of Ugandans was due to a lack of sufficient service delivery sites, a lack of sufficient knowledge and skills on the part of service providers, and a lack of sufficient supplies and equipment. Therefore, this period saw a considerable investment by the government in the areas of curative, preventive, promotional and rehabilitative services. Heavy investments were made in the purchase of drugs, supplies and equipment. In addition, facilities were constructed and/or rehabilitated. Health providers who had been trained in conventional curative care were oriented to primary health care with the hope that they would stimulate greater community participation in health. The results of these efforts indicated that although some improvements in health had been achieved, they were not on a level with what had been expected. In addition, it was felt that the government strategy had not sufficiently mobilized the communities to take a role in their own health care. The criticism was that because the programs were implemented vertically in a top-down fashion, they did not build community capacity and take root and therefore the efforts were not sustainable.

By 1991 about 49% of the population was living within 5 kilometers of a health facility, the infant mortality rate was 122 per 1000 live births, and the under five mortality rate was 203 per 1000 live births. The maternal mortality ratio was 506 per 100,000 live births.¹ According to the Burden of Disease study in Uganda (Ministry of Health, 1995) over 75% of premature deaths were due to preventable diseases. Perinatal and maternal complications (20.4%); diarrheal disease (15.4%); malaria (15.4%); acute lower respiratory tract infections (10.5%); and HIV/AIDS (9.1%) together account for over 70% of deaths.

By the mid 1990s the government realized that its focus on the supply side of the healthcare system without a corresponding stimulation of the demand side from people needing services, did not result in the desired improvements in the health of the Ugandan people. With this in mind, the 1995-2000 UNICEF Country Program was designed with the intent of building community capacity to respond to and manage their primary health care needs. The program designers realized that most of the previous actions taken had been directed towards filling gaps in the supply of health services. Not much had been done to generate demand for the services in the way of promotional activities that targeted individuals at the community level. The result was a low utilization of these services and only a marginal improvement of the nation's health indicators.

At this time members of inter-sector working groups from the Ministry of Health, Local Government, Gender and social Welfare, Planning, UCBHCA, and UNICEF recognized that in order to reach PHC goals and create sustainable programs, communities would need to be capable of making informed decisions about their own healthcare. The decisions needed to be based on an accurate analysis of the causes of their problems and an ability to take appropriate action. The groups realized that real behavior change among community members can only occur through this kind of process. It was further postulated that once this happens, then people will more fully utilize available services and demand other services that they need. Service providers at the various levels of the health care system would then more appropriately be able to respond to these demands.

¹ The National Health Policy 1999

After a year of research and deliberation regarding how to best reach the community, the small working group designed a unique model, which had its roots in the methodology which had previously been used by NGOs and isolated government employees. This approach was baptized as the *Community Capacity Building Process*. However, operationalizing this strategy proved to be a real challenge. The group held many meetings in order to define, clarify and internalize the entire process and finally agreed on the implementation steps noted in sections c and d of this report. Although the objective was to have these steps carried out in all Uganda's 45 districts, it was decided to start with a pilot phase of a few districts so that the process could be evaluated and modified before expanding throughout the country.

It was concluded that if the health status of people in Uganda was to improve, two things would have to happen: 1) Individuals and communities have to be able to access services such as immunizations, early consultation for illness, family planning etc.; and 2) individuals and communities needed to be capable of taking the initial steps to care for their own health. It was felt that people weren't taking care of themselves because they were isolated and did not have the awareness or the skills to access the health care system. Therefore it was considered necessary to strengthen the capacity of individuals and communities to manage their own health.

The focus of community capacity building in Uganda has been to:

- Facilitate communities to become better organized and initiate sustainable local development. This was to be done through a newly created structure, the Parish Development Committees (PDC) and it was anticipated that these PDCs would be established in all the country's parishes (about 4000) by the year 2000.
- Empower the PDCs by helping them attain the necessary knowledge and skills to conduct regular analysis of their development issues and take appropriate action.
- Create an enabling social and political environment for PDCs and their trainers.
- Increase the community's ability to mobilize and manage resources locally.
- Stimulate and sustain community demand for social services through the catalytic role of PDCs.

1. (b) THE RATIONALE FOR COMMUNITY CAPACITY BUILDING IN UGANDA.

As mentioned above, prior to introducing the inter group Community Capacity Building concept, both government and non-government agencies (NGOs) had implemented a number of community based health care (CBHC) projects, investing large amounts of resources in these efforts. However, the traditional approaches used in these projects such as the training of community health workers to deliver specific services like nutrition education, immunizations, sanitation improvement etc., did not yield the expected outcomes. Communities did not own these programs since they were usually provided to them by donor organizations and were not linked to a decentralized political structure that encouraged people to participate in health. Hence, the community remained a passive recipient of services without becoming involved in the process. As a result, sustainability of these Programs/projects became unrealistic from the perspective of the service providers.

It is only when communities are organized to make informed decisions, based on an analysis of their specific problems and an understanding of the causes of these problems that they can take appropriate action. It is then that necessary behavior change can take place. Once this happens, people are able to more fully utilize available services provided by the various social sectors and are able to demand the services that they feel they need. This demand driven approach (DDA) ensures ownership of services as well as their sustainability. But in order for the community to demand services and take pride in what they can accomplish with minimal support, they need to acquire the ability to assess situations and organize a response to the problems they've identified. Once a community acquires these skills, then their capacity is built.

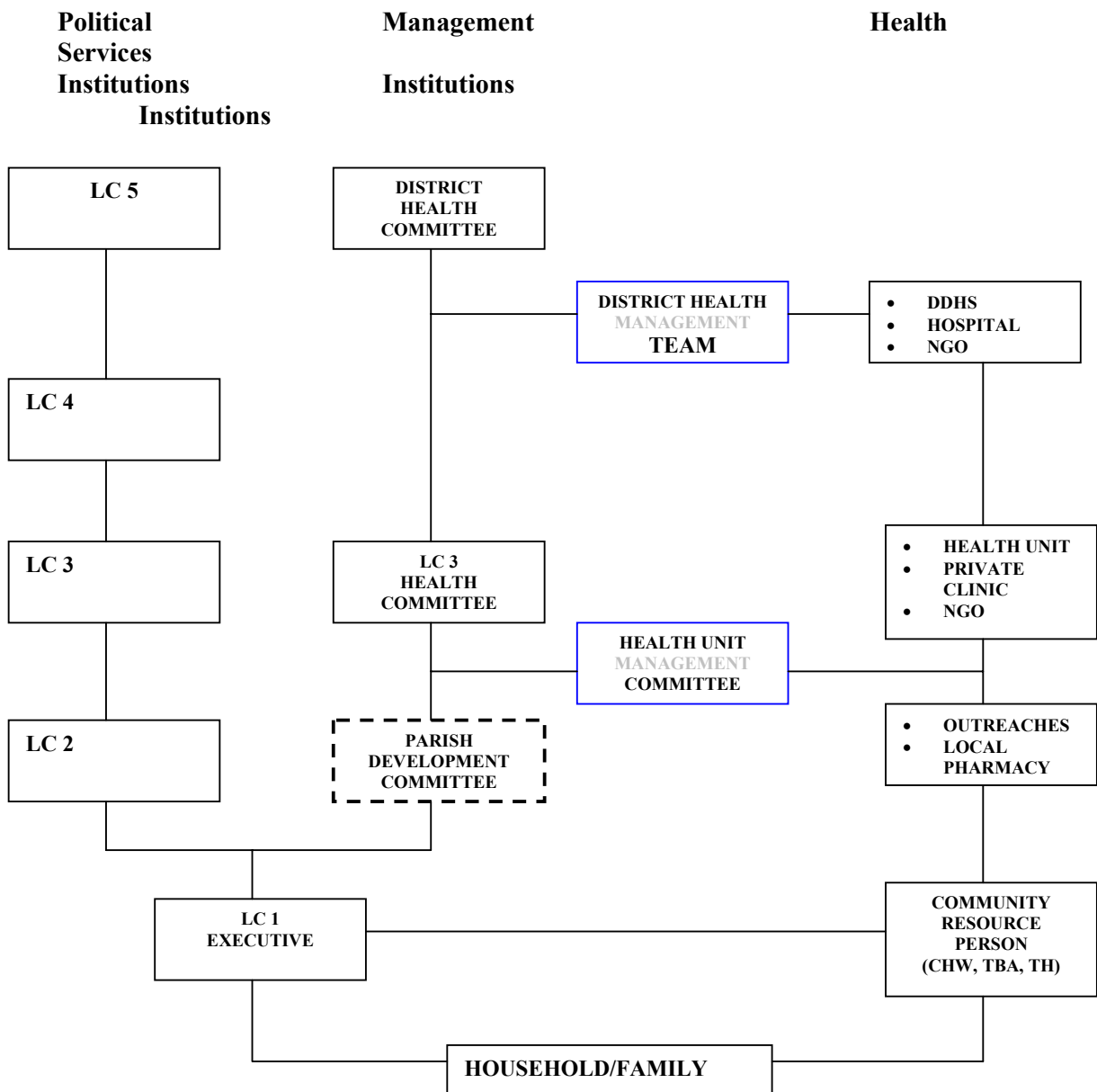
The community capacity building process is centered around the Parish Development Committees which are the driving force in this entire process.

In addition to the local council government structure (figure 1), the capacity building work group considered it necessary to form the PDC for several reasons. The first reason was because it would be an apolitical body. Next, it would minimize the need for having several sectoral committees such as Village Health Committees, Water Source Committees etc. (often with the same people on all of them). It was also thought that the PDCs would focus on the development issues facing their communities and thus strengthen the planning and resource mobilization capacity of the local council II, or parish level governing structure. Unlike the CBHC structures of the past, the PDCs were directly linked to the decentralized political structure through the inclusion of LCII and LCI members in the PDCs, thus providing them with needed political support and networks. Furthermore, it was decided that the parish was the most logical level at which to establish a development committee because of it's positioning between the village level and the sub-county level, where there existed a network of administrative and technical government staff as well as resources. (It was also deemed unrealistic to try to establish, train and manage a large number of development committees at the village level).

For the Ministry of health the idea of building community capacity was perceived as a key step in making Primary Health Care a practical reality as well as building on positive experiences of the previous decade. This direction was further strengthened by existing government policies such as the PHC Policy of the Ministry of Health and the Decentralization Policy of the Ministry of Local government, as well as the policies on Gender, including Affirmative Action. The MOH therefore found it necessary to design the CCB process in a way that would strengthen these policies. In line with the Gender and decentralization directives which provide for representation of women on the local councils, the CCB process sought to strengthen women's capacity to influence decision making in health at community and household levels.

Community capacity building (CCB) was understood to be a process. As a process it was expected to take some time and require constant support and follow-up. However, in the design of the process certain results/outcomes were expected at each stage. Sustainability considerations also greatly influenced the decision to adopt a stepwise approach in the CCB process. To facilitate this process a series of activities have been carried out at the central and district levels beginning in 1995. These included orientation of politicians at various levels of government, training of trainers at district and sub-county levels, follow up of trainees, forming, training and follow up of members of parish development committees (PDCs) and district support for the process, etc. One of the first activities undertaken by the PDCs is to collect

Figure 1: DISTRICT HEALTH SERVICES MANAGEMENT STRUCTURE



- LC Local Council
- TBA Traditional Birth Attendant
- CHW Community Health Worker
- DDHS District Director of Health Services
- TH Traditional Healer
- NGO Non-Governmental Organisation

Note: At various levels, health providers deliver services for which resources have been allocated by management institutions.

Parish Development Committee is proposed as a sub-committee of the LC 2. The decision whether or not to have such a committee is left to the LC 2 executive.

community-based data about the population in the parish. This population-based data usually also includes information about the parish's general health status, utilization of preventive services, status of sanitation and clean water supply services and information about numbers of children attending and not attending school. It was foreseen that this data would be very useful to the LCII and LCIII councils who have to plan for the sub-county and parish development needs.

So far the CCB process has been introduced in 44 out of 45 districts in the country. These various districts are at different stages in the CCB process. Districts that have functional PDCS have reported numerous positive experiences and outcomes in relation to the CCB process. For this reason it was thought that this would be an appropriate moment to document Uganda's experience in Community Capacity Building. It will also allow the Government of Uganda, UNICEF and the government's other development partners to build on this positive strategy during the coming year. Finally, documenting this experience will allow Uganda to share it with the rest of the world.

1. (c) THE FORMATION AND TRAINING OF PARISH DEVELOPMENT COMMITTEES (PDCs)

In the community capacity building process, the objective of training district trainers and sub-county trainers is to ensure the establishment of functional parish development committees (PDCs). The purpose of the training is to prepare the trainers for this important task. This is accomplished through two workshops of two weeks duration each, followed by field assignments where trainees implement what they learned. As they are implementing activities in their respective sub-counties and parishes, they receive technical follow-up support from their trainers and produce some tangible results as outputs of the CCB process.

The entire training program, from the district level down to the parish level is based on the Community Based Health Care (CBHC) model used in Uganda during the 1980s and early 1990s and is meant to develop; the capacity of trainees to:

- Facilitate adult learning
- Assess and critically analyze any given problem as a basis for making decisions about actions that need to be taken to address the problem.
- Advocate for the CCB process in the sub-countys and parishes in which they are working
- Motivate local councils (LCs) to desire, form value and support PDCs.
- Monitor and evaluate the development of capacity at the community level and the outcomes of such capacity especially in terms of behavior change and social development at the household and community levels.

As mentioned above, the Community Capacity Building process consists of a series of logical steps that are followed during implementation. The formation and training of the Parish Development Committees consists of the following activities:

1. The sub-county trainers meet the chief executive of the Local Council II (LCII – Parish level) to advocate for Community Capacity building and arrange for an orientation of the LCII Council members;
2. The sub-county trainers conduct the orientation of the LCII Council and are supervised by the district trainers. During this process, they also facilitate the selection of 5 members to the Parish Development Committee (PDC);

3. The sub-county trainers meet the Local Council I (LCI – village level) Chairman and his executive to advocate for Community Capacity Building and arrange for an orientation of the LCI Council (the whole village). This process is conducted in each of the villages in the parish;
4. The sub-county trainers conduct orientations of the LCI Councils and facilitate the selection of members from each village to the Parish Development Committees. The criteria for being selected as a PDC member include that he or she must be:
 - A resident of the parish.
 - Interested in the development of their village and parish.
 - Mature and respected in the community.
 - A good mobilizer and motivator.
 - Trainable (meaning that they have some education and the ability to grasp CCB concepts).
 - Able to devote voluntary time to PDC work

Please note that among the original criteria for selection of PDC members, it was stipulated that they not be chairpersons of either the LC1 or LC2. However, in practice it has been found that where the situation permits, it can be useful to involve these persons in the PDCs. Their political leadership is often useful in convincing communities to follow the development interests of PDCs and in some parishes they are helpful in garnering resources.

The PDC consists of the following members:

- 5 members from the LC2
- 2 members from each LC1 in the parish. Consistent with gender equity priorities, one of these members is to be a man and the other a woman.
- 1 or 2 specially selected members who may be deemed useful or facilitate the PDC in carrying out its work.

The size of the PDC may vary in accordance with the number of villages in the parish. It may have as many as 45 members or as few as 12.

5. Once formed the PDC members meet and elect from among themselves a chairman, vice chairperson and a secretary. A sub-county trainer should be present to guide this process and to ensure that fair representation of both males and females in leadership positions of the PDC is considered. The trainers also explain the roles and responsibilities of PDC members;
6. The sub-county trainers with the support of the district trainers meet the community leaders, LCIII (sub-county level), II and I Chairmen, and sub-county and Parish chiefs to discuss and plan the training of the PDCs;
7. The sub-county trainers conduct the training of PDCs and are supervised by the district trainers, and monitored by the National facilitators. During training their roles and responsibilities in social and economic development is emphasized, as is community diagnosis, participatory planning, and establishment of a Community Based Management Information system (CBMIS).

The steps they go through after completion of their training before they start work in the various parishes are contained in Annex II.

1.(d) THE ROLES AND RESPONSIBILITIES OF A PARISH DEVELOPMENT COMMITTEE

A PDC is expected to carry out the following tasks:

1. Initiate a community-based management information system (CBMIS). Collect the information in a participatory way with members of the different parish communities through meetings with individuals and groups. Record the information in a designated workbook.
2. Draw a Parish MAP that shows the communities and indicates where the needs and problems are.
3. Prioritize the problems identified by the PDC (Committee to decide on ranking criteria during the process, e.g. ease of mobilization).
4. Develop a realistic parish plan of action for implementation by the parish communities.
5. Mobilize the communities to address the issues and problems identified in the parish action plan. Continue to mobilize about on-going health/ development problems.
6. Facilitate communities to mobilize local resources to address their priority health and development problems.
7. Liaise closely with the LCI and LCII Councils and also any NGOs operating in the parish so as to assure their support and collaboration in the development activities.
8. Submit plans and reports to the LCII Executive.
9. Maintain a high level of awareness within the community through meetings and home visits about on-going health and development activities.
10. Strengthen and maintain the Community Based Information System (CBMIS) and manage it as a tool that the Parish inhabitants can use to better understand their problems and justify local action to address them.
11. Facilitate the identification, selection and training of the Community Own Resource people (CORPs).
12. Monitor the Health and development efforts in the parish and record that information in the CBMIS.
13. Manage resources received from LCIII for the implementation of the priority activities identified in the plans.

14. In consultation with community leaders conduct regular meetings with the community to review progress in on-going programs.
15. Write reports and keep records.

The legal status of a PDC.

At the beginning of the CCB process, there were supporters and non supporters of the PDC structure. There were questions about what this new structure had to offer that was different from what the existing political structures offered and what its relationship would be to them. But the PDCs were confirmed as legal entities according to the Local Government Act of 1997. Since their membership includes 5 members from the LCII Council and 2 members from the LCI Councils, they are directly linked to these Councils and support them. Therefore, they were formed using the existing structures of the Decentralization Policy. Finally, the district council V and the sub- county council III support PDCs in most of their activities because of the important role they play in community mobilization and development. At the National level, the Ministry of Local government has endorsed their existence and urges all districts to use the PDCs as community level entry points for Social and Economic development. This is because this Ministry, which is responsible for the decentralization process, encourages a bottom-up approach to Community Empowerment and sees PDCs as structures that can make this happen.

2. (a) ACHIEVEMENTS AND OUTCOMES OF THE CCB PROCESS AT COMMUNITY AND HOUSEHOLD LEVELS

The Composition and Function of the PDCs

Once formed a PDC should be able to start performing its functions right away. Whether this happens or not depends very much on the support provided by its sub-county trainers, which in turn depends on the support they receive from their district trainers.

As mentioned above, the PDC is composed of 5 members from the local council 2 executive, at least one of whom is a woman, and two members from each village, one man and one woman. In general women constitute over 40% of the membership. The primary purpose of the PDCs as non statutory management structures created by the LCII, is to initiate and promote development activities with full participation and involvement of community members within the parishes.

The criteria for a functioning PDC are that it

- Has established a Community Based Management Information System (CBMIS).
- Uses the CBMIS for decision making, planning and monitoring of activities.
- Has developed a Parish Plan of Action.
- Implements and monitors that Parish Plan of Action.
- Holds regular (monthly) meetings that result in concrete decisions about activities and follow-up actions.

Experiences from functioning PDCs in several districts, including those visited by the consultants, indicate that the PDCs can be a very useful arm of the Local Council II (LCII) and is therefore a useful structure for stimulating bottom up decision making,

planning and local development action on a sustainable basis. This is consistent with Uganda's decentralization policy.

In districts such as Mukono, Iganga, Jinja and Kiboga where PDCs are being supported by the district and sub-county councils they have had a commendable impact on improving the standard of living. The PDCs have initiated realistic development plans for their parishes. The successes of the PDCs include the mobilization of parents and child caretakers for the National Immunization Days (NIDs) and routine immunizations; improvement of environmental sanitation, especially in the construction of pit latrines, home hygiene and protection of water sources; construction of classroom blocks and teachers houses; encouraging children to attend school (in line with the Universal Primary Education policy); and initiating income generating activities.

One of the first key activities that all the PDCs undertake is to set up their Community Based Management Information Systems (CBMIS) in each of the parish communities. They have initiated and established simple Community Record keeping on vital information e.g. the parish population broken down by sex, age and location, number of children not going to school, location and condition of water sources, village pathways, etc. Of note is that they collect all this information for their own use and report writing, which testifies to the extent of their involvement in the process. Some of them have rich databases, which are very enlightening about the condition of their parishes. Communities in the parishes are being educated about the specific kinds of problems affecting their standard of living and this makes them dissatisfied and motivates them to undertake actions to overcome them.

The PDCs vigorously monitor and supervise development activities in the parish and have become a focal point for any activity. In many cases, PDCs have transformed the communities as evidenced by the activities they have initiated and their impact on peoples' standard of living. An example is the cleaner households observed in PDC communities, there's no evidence of garbage or children's feces in the yards and they're using latrines. Other examples include the dramatic drop in morbidity and mortality from immunizable diseases such as measles and polio in the PDC communities. They have moved programs along which were static such as immunization and water programs. Most program leaders, government or non-government are using them to help implement their projects, recognizing the PDCs knowledge of the communities and skills in convincing people to adopt improved behaviors. An example that many PDCs noted during interviews is how they've helped the DOT (Directly Observed Treatment of TB) program identify a community person who can oversee treatment of a community member who has TB.

They are spearheading many initiatives for social and economic change in the parishes.

In some cases, like the Waibuga sub-district of Iganga district, where the PDCs are funding a sustainable school lunch program at minimal cost. Others have mobilized women, youth and men into various categories of income generating activities without external resources. Many of these are increasing the standard of living of families and individuals in the villages.

They have also strengthened linkages with other structures, such as the Health Unit Management Committees, schools and other services being provided by government

and NGOs. The consultants observed that most of the PDCs visited included members of the health unit management committees.

In times of epidemic diseases, the PDCs have played a vital role in preventing the spread of the disease in question. An example includes how the PDCs promoted hygiene, hand washing and water purifying techniques in communities exposed to Cholera. As a result the epidemic was controlled within a very short period of time, hence saving many lives in the affected areas. This was done by conducting house-to-house mobilization and education of everyone, adults and children.

The Role Played by Women Members of the Parish Development Committees

Due to the gender equity policy being implemented in PDC member selection, women are becoming active in community capacity building efforts. The PDCs require that at least one member from each community be a woman and usually at least one leadership position is filled by a woman.

All of the PDCs visited in the four districts of Jinja, Iganga, Mukono and Kiboga, commented that through the PDC process women have become involved and actively speak out about issues. They are also much more likely to be listened to by the men than in the past. It was noted that due to household duties, it is sometimes more difficult for women to be active but those that find the time to participate tend to be very successful.

The trainers and PDCs in Mukono noted that women tend to be the most successful PDC members. They are more committed to data collection efforts and more effective in educating families in their homes. In the PDCs, women are often given responsibility for money management and for activities related to children and food production. In PDC activities, women tend to take leadership roles in areas related to food production, nutritional status, sanitation and child health because women are viewed as the key stakeholders in these areas (i.e. mothers are more effective at convincing other mothers to bring their children for immunizations). In addition women PDC members are more readily welcomed in homes than men and people are more willing to share their household data with them.

In general as a result of community capacity building activities, one sees a much higher level of women participating in preventive health activities, such as attendance at infant nutrition meetings, growth monitoring sessions, taking children for immunizations, attendance at antenatal care clinics etc. In the districts visited, immunization rates have increased by 30% to 40% and the district officials credit the PDCs for this improvement. Some of the PDCs also commented that there were now more shared responsibilities between men and women with men helping out more with household and childcare responsibilities.

Capacity of PDCs to use CBMIS for Assessment, Analysis and Action

In all the parish development committees interviewed, development of, use and maintenance of their community management information systems (CBMIS) was viewed as a priority activity. All the parishes displayed their data collection books as well as data summaries. In fact Mukono district had developed a parish data

summary form that could be used for planning purposes at the monthly meetings (see Annex). Once this information was collected, it often served as a revelation to the communities when they discovered the extent of their problems. This realization then stimulated the communities and parishes to want to address these problems and CBMIS has continued to be a motivational tool that is regularly used to assess and analyze the status of the communities. These data have served as a basis for the parish development plans, which outline actions to be taken that will address the identified problems.

In general the PDCs begin by collecting data about the populations in the parish communities. There is a description of the total population broken down by age range and sex. Next information about the household is collected, such as whether they have a pit latrine, the condition of the water source, the number of children attending school, numbers of immunizations received, whether there is a home garden, and other items decided by the community. In general, most PDCs are guided by the district and sub-county trainers to begin their data collection efforts focusing on the areas noted above (population description, sanitation, immunizations, water condition). However, later on many communities decide they want to collect information about other areas. For example, many are collecting data on the numbers of disabled persons in their villages as the government is trying to address this area. Many are also collecting information about the numbers of orphans in the communities and the number of elderly citizens.

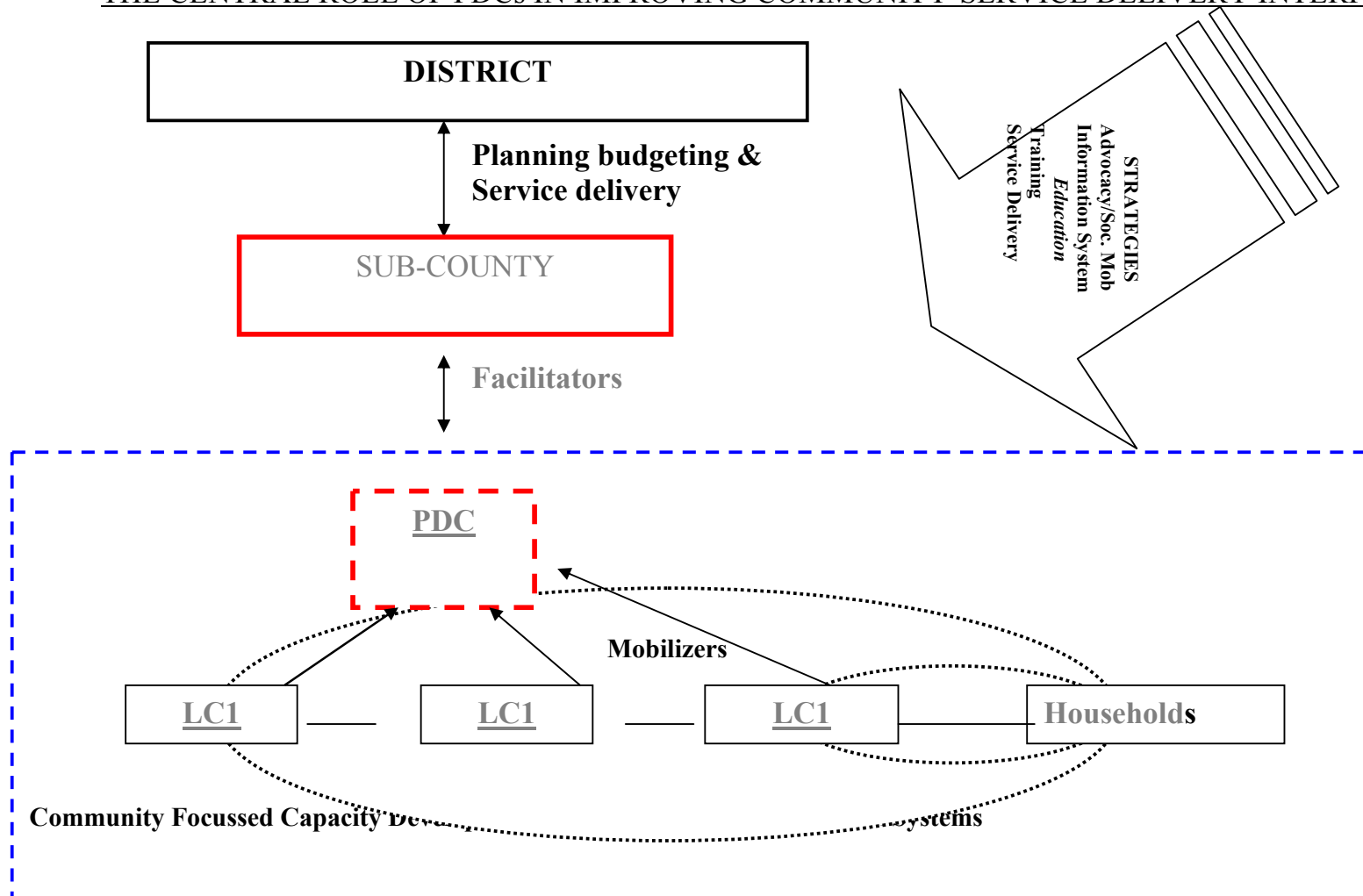
These data have served multiple purposes. In addition to being a tool for making the community aware of their problems and stimulating them to take action to remedy them, they also serve as a basis for larger scale development priorities at the parish and sub-county levels. After seeing the data presented to him by the PDCs, one parish council member said, “today I realize what my role is.” Prior to that he had no data from which to make decisions about what activities he should undertake to improve the situation in his parish. Many sub-county and district level officials that were interviewed commented on the importance of the data collected in the parishes and the subsequent action plans developed that targeted well defined and prioritized problems. These plans and corresponding data have gone a long way in convincing sub-county and district level officials to allocate resources to address the identified priorities.

Interface between the Health Service Delivery System and the Community

In every PDC and district visited there were many examples given of how the PDC process has strengthened the health delivery system. Their being integrated into and effective functioning within the District Local Government structure (figure 2) has largely enabled this to happen. District medical officers (DMO) in all four districts referred to the PDCs as their “first line health workers.” The director in Jinja noted that because of PDC mobilization they now have health units in every parish in his district. These have been constructed in partnership with the MOH through which the community provides the local materials for health unit construction. He and the other DMOs also noted a remarkable increase in attendance for preventive health efforts such as immunizations, growth monitoring and nutrition education sessions, family planning services and antenatal care. Commenting on this same trend in Iganga, the DMO noted that they are now overwhelmed by people demanding preventive services, particularly for immunizations. In fact, planning for this increased demand has become an issue. PDC groups in Kiboga were complaining

Figure 2:

THE CENTRAL ROLE OF PDCs IN IMPROVING COMMUNITY-SERVICE DELIVERY INTERFACE



that they had only had two immunization campaigns this year and were demanding more. The DMO commented that they did not have enough resources to deliver the immunization services being requested and that some PDCs had raised funds to pay the costs for workers to deliver them. The DMOs also commented that there has been a great increase in demand for family planning services. This is particularly evident since they have increased mobilizations concerning the responsibility of having a small number of “quality children,” which means being able to attend to their needs for good health and education. One PDC visited in Kiboga district, which is keeping track of births through its CBMIS system, noted that the numbers of births in their communities were decreasing dramatically. One community that regularly had 30 births per year, only had one birth during the past year, which they explained as being the result of their educational efforts and demand for family planning services.

All of the PDCs visited noted the close coordination between themselves and the health units. In fact many of the health unit personnel attended the PDC meetings. PDCs regularly monitor the health service utilization, particularly for preventive services. They monitor immunization campaigns to make sure that all eligible children that are documented in their CBMIS, receive immunizations. If some children are not brought in, the PDCs follow up with the families. District officials believe that this is the reason for the dramatic increase in immunization coverage (polio coverage is over 100% in these districts and other immunization levels have increased 30 to 40%).

Dr. David Kitimbo, the DMO in Jinja, also noted the effectiveness of PDCs in transmitting preventive health messages to the communities. As an example he described an educational flyer that his office developed to inform people about malaria prevention which he gave to the PDCs and asked them to educate their communities about it. Three months later when they held a workshop about it, the people from the communities demanded that they be given bednets. He noted that the political leaders now use the same health messages that he has given the PDCs because they know it’s a hot issue. He also used this strategy when cholera broke out in his district. The PDCs spread messages about proper sanitation and latrine building and within two months the epidemic had stopped. He said that before the CCB work of the PDCs, some people had latrines but didn’t use them. Afterwards, when the PDCs convinced people to build latrines and use them there was 100% usage. Also he has documented that during the cholera outbreak in 1997-98, latrine construction rose from 76% to 90.4%. In addition knowledge of cholera was raised to 80% of respondents and use of pit latrines was the most common prevention message remembered (82%). A high proportion of respondents (96.7%) believed cholera was associated with poor sanitation and 98% believed that cholera could be prevented through improvement of sanitation in their homes.² Dr. Kitimbo (DMO) believed this was all due to the work of the PDCs.

Level of Utilization of Available Health Services

All the district health officers interviewed noted that there has been a dramatic increase in the utilization of services in their districts. Some of their findings have already been noted in other sections of this report (see above section on interface

² Lukwiya M., Kitimbo DW, Wagoleire C, Murru M, Lamunu M, Najjemba R. “Sanitation Status in Mafubira Subcounty, Jinja District, After the Cholera Epidemic Campaign.” Paper 26. UNACOH’s 8th Annual Scientific Conference. 15-16 September, 1999.

between health system and the community). They all noted how the PDCs are really extending government programs in the villages. As they receive more training, they become more knowledgeable about different preventive health practices and services and do a tremendous job of conveying this information in their communities.

As noted above, latrine coverage rose dramatically through PDC efforts in Jinja district. It was noted in the other districts visited (Iganga, Mukono and Kiboga) that latrine coverage was usually over 90%, according to data recorded in the PDC workbooks.

Other data from Jinja district noted that the contraceptive prevalence rate has increased from 13.3% to 34% between 1995 and 1999. The percentage of women receiving their first prenatal visit between 4 and 7 months rose from 46% to 70% between 1995 and 1999. The percent of health facility deliveries as opposed to home deliveries rose from 54% to 92% between 1995 and 1999. The percent of men using condoms to prevent HIV rose from 38% in 1995 to 50% in 1997.³ The district officials believe these increases are in great part due to PDC mobilization efforts. It should be pointed out that presently PDCs are active in only 31 out of 40 sub-counties (77%). The DMO also noted that they are presently working with the PDCs to do a maternal mortality audit in three sub-counties. PDCs are being trained to conduct verbal autopsies and to describe what the people believe were the causes of death. From this the health workers will be able to interpret the medical cause. As part of this effort, the DMO is encouraging the PDCs to collect birth and death data. He noted that in most PDC communities, people know the causes of death. PDCs are now being trained to implement community base IMCI, so that they will be able to advise villagers about what to do when a child has diarrhea, fever, respiratory infections etc.

As noted above all the districts commented on their increased immunization coverage which they attribute to the work of PDCs. The PDCs not only help with organization of the campaigns but they also keep track through their CBMIS of whether all the eligible children get immunized, and if they don't come in, the PDCs follow-up. The PDCs visited during this documentation demonstrated coverage levels above 85%, according to their CBMIS workbooks.

Dr. Humphrey Megere, the DMO for Kiboga district, noted how much easier it is to mobilize people for health initiatives. PDCs mobilized over 100% of children for polio immunizations. He also noted that with regard to routine coverage, they had had a coverage rate of 49% (1997) and it is now at 65%. He said the PDCs have been distributing ORS and educating about care of diarrheal disease and now they see few cases of dehydration. In general there is a much greater demand for services, in fact sometimes community organizations have funded health workers to go and deliver them when the district doesn't have the resources.

In all the districts interviewed, the PDCs have been working with the Ministry of health to implement Direct Observed treatment of Tuberculosis (DOT). After the patient has been treated in the hospital for two weeks, they leave and the PDCs help them to identify someone in the community who will oversee that the patient takes his/her medication. This is quite an undertaking because the patient has to undergo eight months of treatment. However, the PDCs have been very resourceful in setting

³ Data presented at DISH II-Jinja District Work Plan Meeting. 1999. Jinja.

up these kinds of arrangements in the communities and are relied on by health personnel to assure that these treatments are successful.

Working Relationships between PDCs and Other Committees such as Health Unit Management Committees (HUMC)

In general all the PDCs visited have developed collaborative relationships with the Health Unit Management Committees. In fact the Health Unit In charge and/or other health service personnel were usually present at the meetings which attests to the positive working relationship between the PDCs and the health Units.

There was a particularly strong relationship between the Health Unit Management Committee and the PDC in Bunya sub-county in Iganga district in which the president of the PDC is regularly invited to their meetings. The HUMC is especially interested in village follow-up. They contact the PDC about patients that have been seen at the Health Unit and arrange for them to oversee the patient's attendance at outreach clinics.

In the other parishes the Health Unit Management Committees viewed PDCs as people who were more knowledgeable about what was happening in the communities and asked them to do more health education concerning the problems they were seeing in the health units. In general, there seemed to be good collaboration between the two systems as evidenced by attendance at each other's meetings. The Health Assistant at Nakasuzi parish in Kiboga noted that before they had the PDCs, there were seeing a lot of diarrhea cases and infections due to poor sanitation but now that has decreased due to the regular home visits and education provided by PDCs. He said in home visits, the PDCs did things he isn't able to do, such as making observations about the house and educating families about latrines, drying racks, the need to immunize children etc. He said that because of all the home surveillance and education, now he only has one case of T.B to monitor.

The DMO in Iganga, James Baguma noted that the PDCs and HUMCs have formed good working relationships in Iganga. He notes that the PDCs have collected data and identified gaps in services that are needed at the local levels. This information is then sent to the sub-county councils who know the gaps need to be filled, so they work with the HUMC who can help collect funds to pay for the needed services through user fees. He's seen an increasing trend of the PDCs and HUMCs working together to mobilize resources in order to fill service needs.

Potential for Sustaining the PDCs

All of the PDCs interviewed understand their role as community volunteers. This was explained to them when they agreed to do the work and they accepted it. Many of the PDCs commented on the value of being volunteers. They felt they had learned a lot through training and believed the training was the key to their success. Once they learned how to collect information about their communities and then use the information to convince other villagers to improve their lives, they really became motivated. Being viewed as knowledgeable resource people in the communities really elevated their sense of self worth and standing in the community. For this

reason, many of them expressed a continuing desire for more training. They see their improved status as being directly linked to the knowledge and skills that they bring to the other members of their community, so they would like to receive new training on a regular basis. Many of the PDCs stated that their payment for their services was seeing healthier communities, seeing more latrines built or cleaner houses or not having so many children die of preventable diseases. The PDCs in Bunya (Iganga district) stated that one of the advantages of being volunteers was that the community did not look at them with suspicion when they tried to introduce new health or development practices. They knew that the PDCs did not have a monetary or political interest in their PDC work and therefore the villagers were more likely to trust them and believe that they really were doing their work for the benefit of the community. In turn, the people reasoned, “if these PDCs care so much about their communities and their neighbor’s lives, then maybe we should listen to them and try to improve our lifestyle!” This was viewed as one of the reasons that people were accepting the new development initiatives so readily.

Although these PDCs are very successful as volunteers, they do need regular support to maintain their enthusiasm. In every district they asked for more training and wanted to be involved in more development related activities. Many of the successful PDCs are already working with other development areas. Some of the groups mentioned were: the Planning Unit which is particularly interested in the CBMIS information; animal vaccination programs, tree planting projects; Direct Observation Therapy (DOT) for tuberculosis control; adult literacy program; universal primary education (UPE) and the District Development Program (roads). The Chief Executive Officer for Jinja district noted the importance of PDCs as gatekeepers to the communities when he commented that “the districts have greatly benefited from the PDCs because they have done most of the groundwork for development activities.” Because the PDCs are becoming recognized as the key entry point into the communities, many organizations are interested in working with them in order to implement programs. The PDCs in turn, are also interested in being involved in new activities and receiving more training, so this appears to be a workable strategy for sustaining the program. But other efforts for additional refresher training and follow-up should also be pursued.

Another resource area that the PDCs are having some success with is in requesting tax revenues from the LC councils for development projects prioritized by PDCs. Many of the PDCs have specific budgets allocated to them in the sub-county budgets. One of the oldest PDCs, Namiganda in Bulanku sub-county (Iganga) discussed how they have created a coordinating committee for all the PDCs in their sub-county and regularly share information about their development needs and data findings. Since 5% of the sub-county tax revenue goes to the PDCs, this group assigns priorities for these funds based on their combined plans and interests. Actually the decision to return 5% of the tax revenue to the parish was due to the work of this PDC in lobbying the government to make separate funds available for PDCs. They were invited by the national government to present their data and achievements at a national decentralization conference. From this experience the government decided to award PDCs the 5% of the s/c budgets. They then commented that some of the PDCs have been successful in combining the 5% for PDCs with the 25% of local tax revenue, which LC1s (communities) receive to be used for community purposes. With these additional funds, they have been able to do even more of their prioritized activities. It should be noted though, that even though the laws provide for these funds to go back to the sub-county and community levels, the resources are not

always available and even when they are, they may not be enough to meet PDC needs. This was particularly true in Kiboga where the PDCs expressed great concern about how to claim these resources (see section C of this report for further discussion).

In general, there are several potential resources for sustaining PDCs. The key seems to lie with the foundation of a capable PDC that has internalized the ability to develop its communities and assert their rights. Once the PDCs are aware of their needs and have the ability to document and plan for their development needs, they can then approach resources to fund them, either within the government structure or outside it. Many are also using their organizing abilities to bring in income generating activities and lobby for more resources for their communities.

2B. LESSON LEARNED

- One of the key lessons learned in the few years that the PDCs have been operating, is that the community capacity building process is primarily a district-driven activity that depends largely on the commitment of each district. Their success really depends on the extent to which the district advocates for PDCs, allocates resources to them, provides them with supportive supervision and generally provides political and administrative commitment to the process.
- With the establishment of functional Parish Development Committees (PDCs), communities are realizing the goals of the community capacity building process. These are the ability to: 1) identify the prevailing community problems through data collection and analysis; 2) form a simple plan of action in accord with identified problem priorities; 3) mobilize the required resources needed to address the problems; 4) mobilize communities for health and other development activities such as universal primary education, protection of water sources, environmental sanitation, food production and storage, environmental protection (tree planting), children's rights (particularly in regard for orphans), adult literacy campaigns and road construction.
- The understanding and support of the CCB process by district and sub-county officials is key to the success of these interventions. For example, in Iganga, Mukono and Kiboga (all very active PDC districts) the districts have purchased bicycles and other job-related materials for sub-county trainers. Therefore, it is important for there to be continuing efforts by the center and donor agencies to regularly orient and retrain district and sub-county officials.
- At the beginning there was some concern that the LCs might be threatened by the creation of PDCs. So care was taken to assure that PDCs be created and desired by LCs and that LCs maintain involvement in the PDC process. It was recognized that for this relationship to function, the LCs must be informed about what to expect and what not to expect from PDCs. It was stressed that they should form the PDCs only when they clearly understand and agree with the roles and responsibilities stipulated as well as the anticipated requirements and limitations of their functions. These steps have helped to avoid mistrust and conflicts that might have resulted from confusion over the different roles and responsibilities of the two entities. In instances where the PDCs are becoming popular and risk the envy of the LCs, the district and sub-county trainers have played an important part in clarifying roles. They use the situation as an opportunity to explain to the LC II executive that the PDCs are actually helping him do his work and therefore, the LC II should identify with the successes rather than be threatened by them. This has been a very successful approach and is probably responsible for the close working relationships observed between successful PDCs and LCs. The original PDC selection criteria stipulated that they should not be chairpersons of LC1s or LC II. However, it has been observed that some of the strongest PDCs include these LC chairpersons and that these individuals have actually been very helpful to PDC functioning through their abilities to attract resources and political support.
- Some observers have seen the issue of volunteerism as an obstacle to successful functioning of PDCs. As stated in section 2A of this report, the consultants did not find this to be the case with the PDCs that were interviewed. When asked,

many of them responded that their payment was to see the village standard of living improved. Others mentioned that the recognition they received from the villagers as community workers with important knowledge and skills to share was reward enough for them. These individuals see themselves as being appreciated and respected as important community members. They are invited to important occasions and always asked to speak at public gatherings. The effective PDCs really have a good understanding of their roles and this is largely due to the work performed by the sub-county trainers in preparing them to carry out their responsibilities as well as the supportive supervision the trainers have provided. The creation of a functioning PDC is an involved and often slow process and it needs constant nurturing if it is to be successful. For this reason, it is necessary that some kind of in-service training for district and sub-county trainers be provided at regular intervals. It would also be useful to create a forum in which PDCs from different areas could share their experiences.

- One of the obvious lessons is that even though this is a capacity building process that is supposed to shift responsibility for development to the community level and create a bottom up approach, in actuality it is a long involved process and requires a lot of top-down support. This means that once the PDCs have been trained and have internalized their roles, they still need on-going support from higher levels in order to learn how to manage the political system and apply their skills. Even though the governing structure is decentralized, there is still a lot of learning and positioning that needs to take place if PDCs are to be effective. For this reason, the PDCs really need to be able to work in partnership with the higher levels in order to become established and fulfill their community development roles.
- Another lesson learned in the process of capacity building was that it was not sufficient to provide the basic training and then send the PDCs out to collect the CBMIS data. The district and sub-county trainers interviewed pointed out that it was very important to follow-up with the PDCs after the data was collected, help them analyze it and set priorities. Then it was necessary to guide them in developing their plans of action and often accompany them through the implementation process in the communities. Essentially, there needs to be a lot of top-down input in order to get the bottom-up process moving. Some of the PDCs that were formed early in the process that did not have this hands on follow-up support from their trainers found that although collecting data and talking to villagers did cause some villagers to improve their living status, it did not occur to the extent that the CCB staff expected. For this reason, the trainers stressed that it is important that there not be delays in the PDC training process. Once formed, it is important to go right to work so that the PDCs and trainers do not lose their momentum. The Mukono district trainers came up with an interesting solution for dealing with delays that can be applied between the different phases of PDC training. They developed a case study of a parish and presented it as an example to the PDCs being trained before they went off to collect their data. The case study showed an example of how data was collected from a fictitious community and then proceeded with the steps the PDC went through to analyze the data, decide on priorities and then implement a plan of action. Many of the PDCs being trained were excited about this case study example and rather than wait for the next phase of training, they went ahead developing and implementing their own plans, with the intent of bettering the results achieved in the case study! These kinds of creative solutions from trainers and other district personnel need to be

encouraged. CCB is still a process in formation that depends on many linkages between government, communities, NGOs and other structures to be successful. This example demonstrates how important it is to not lose sight of the CCB goals, to encourage flexibility and alternative approaches in order to reach them, and to not get sidetracked by the process.

2. (C) CONSTRAINTS AND CHALLENGES

Despite the successes of the PDCs, they and their trainers are continuing to face some challenges. Most of the challenges have to do with the slow pace of the CCB process, how to best support PDC needs for material support and how to sustain volunteers and the CCB process.

- All of the district, sub-county and parish leaders as well as the program managers interviewed by the consultants reported that they believed PDCs were very useful and appropriate structures for reaching communities. Ideally all the parishes in the country should have formed functional PDCs. To date only 1,543 out of a possible 4,156 have been formed. The challenge is how to expedite this process. By design, the process was expected to be slow since grass roots capacity building takes time but other factors have contributed to slowing it further. These factors include delays in requisitioning funds from the central level, delays in disbursing funds from central and district levels, other competing priority activities in the districts, delays in accounting for funds, inability of local governments (districts and sub-counties) to support the trainers during field practice periods and inability to fund PDC training. These problems indicate that a large part of the success of the CCB process depends on the ability of district and sub-county officials to make rational development plans, as well as mobilize, utilize and account for resources in a timely manner. So in order to strengthen PDC capacity, it will also be necessary to improve the decentralized districts' administrative capacities.
- There also needs to be a method for continuously motivating PDC members. Every PDC we interviewed mentioned that they needed the following items to carry out their work: bicycles, stationary (mainly record books), rain coats, umbrellas, gum boots, rubber gloves, rainproof bags and a training certificate. Secondly, they requested that they be given additional training on new programs so that they can keep abreast of what is happening in their communities. The issue here is who should provide these badly needed items? Some sub-county officials have provided bicycles to the sub-county trainers and chairmen of some of the PDCs. In one district NGOs have provided the sub-county trainers with bicycles, but the larger problem remains unsolved. Clearly there is a need for district leaders to address the PDC demands, which are not unreasonable considering the work they are doing for the districts! It is important for district officials to respond to these demands in a timely manner in order to sustain PDC motivation.
- At all levels there needs to be continuous technical support, supervision and follow-up. Most of the members of the PDCs that were interviewed emphasized that the visits by sub-county trainers and technical staff as well as by district trainers were very necessary to update technical skills and boost their morale. However, due to lack of transportation resources, the sub-counties are not able to carry out this function as regularly as required. The challenge is how to assure that this important task is sustained with more regularity.

ANNEX

Terms of Reference for Consultancy

Individuals and Groups Interviewed

GOU-UNICEF COUNTRY PROGRAMME
TERMS OF REFERENCE FOR THE CONSULTANT TO DOCUMENT THE
EXPERIENCE OF
COMMUNITY CAPACITY BUILDING IN UGANDA

Background

Uganda's health care delivery system has evolved from the informal, predominantly traditional medicine through predominantly curative services especially during the colonial and part of the post-colonial era to the current one where primary health care – and thus the role of individuals and communities - is emphasized. Since the Alma Ata Declaration of Primary Health Care as a strategy for achieving 'health for all' the only period when a conscious effort by government to aggressively work with communities all over the country to improve their health conditions has been from 1995 to the present time. Between 1978 and 1994 it was predominantly the Non-Governmental Organizations (NGOs) who were actively promoting the Community Based Health Care (CBHC) approach in an effort to realize meaningful community participation, but on small scale in some districts. Few government staff, mainly those associated with NGO supported programs were involved in CBHC as trainers, facilitators and program managers and thus had useful experience in working with communities from the point of view of enabling community participation.

During the late 1980s and early 1990s the government assumed that the poor health status of the people of Uganda was mainly a result of insufficient service delivery points, lack of knowledge and skills on the part of personnel and in lack of supplies and equipment. This period therefore saw considerable investment in health by government in terms of curative, preventive, promotive and rehabilitative services. Heavy investments were made in procurement of drugs, supplies and equipment and physical structures were rehabilitated. Health providers who had undergone conventional training were orientated to Primary Health Care in the hope of increasing community participation in health care. New initiatives such as health education, social mobilization and community co-management of services emerged. The result of these various interventions and approaches were that some improvements in health status of the population occurred but were less significant than expected.

By 1991 about 49% of the population were living within 5 kilometers of a health unit, the infant mortality rate was 122 per 1,000 live births, and the under 5 mortality rate was 203 per 1,000 live births. Maternal mortality ratio was 506 per 100,000 live births.⁴ According to the Burden of Disease study in Uganda (Ministry of Health, 1995) over 75% premature deaths were due to preventable diseases. Perinatal and maternal conditions (20.4%), malaria (15.4%) acute lower respiratory tract infections (10.5%) AIDS (9.1%) and diarrhea (15.4%) together accounted for over 60% of the death burden.⁵

Realizing that a focus on the supply side of health care at the expense of the demand side does not result into significant changes the design of the current Government of Uganda - UNICEF Country Program (1995-2000) was made with an emphasis on building community capacity in the first place. It was recognized that most of the

⁴ The National Health Policy 1999.

⁵ Ibid.

actions taken had been directed towards correcting the ill affecting the supply of health services. Not very much had been done to generate demand for these services. In particular promotive and preventive aspects of health services, and especially the roles and capacities of individuals and communities were less emphasized. The result was a low uptake of these services such that the health indicators were only marginally affected.

From the above analysis it seemed inevitable that if health status of the people was to improve, and if health indicators were to improve two things ought to happen:

- Individuals and communities must be able to utilize the existing services such as take children for immunization, consult early when they are sick, use family planning services, etc.
- Individuals and communities must in the first place take some action by themselves in respect to their health, and only seek assistance where necessary.

These things were happening only to a limited extent, not because of ill-will on the part of individuals and communities but rather due to certain inhibitions. These inhibitions were largely associated with lack of knowledge, skills, information and resources. It was thus considered necessary to build the capacity of individuals and communities to be to perform their roles in respect to their own health.

The focus of community capacity building in Uganda has therefore been to

- enable communities to get better organized to initiate and sustain local development – hence the need to establish a new structure namely Parish Development Committees (PDC) in all the parishes (about 4,000 in the country by end 1999);
- enable the PDC to acquire the knowledge, attitudes, skills and resources for continuous assessment, analysis, and action in relation to improving their own situations;
- create an enabling social and political environment for PDCs and their trainers to practice;
- improve mobilization and management of resources at community level;
- stimulate and sustain community demand for social services through the catalytic role of the PDCs.

The PDC was considered a necessary structure to have in addition to the local councils for several reasons. First, it would be apolitical. Secondly, this would minimize having several sectoral committees such as Village Health Committees, Water Source Committees, etc., all using more or less the same persons to constitute them. Thirdly, the PDC would focus on development issues and concerns of their communities and thus strengthen the planning and resource mobilization capacity of the local council 2 as provided for in Section 38 (1) and (4) of the Local Government Act, 1997. The parish was chosen as the level at which to have the development committee because it is a level near enough to the community and also near enough to the sub-county where a network of administrative and technical staff are placed. For the PDCs to be able to regularly carry out assessment and analysis of their local situations and make informed decisions and plans they were to acquire knowledge and skills in establishing and using Community Based Information System (CBMIS).

For the health program the idea of building community capacity was perceived as a step in the right direction in making Primary Health Care a practical reality, building on the positive experiences of CBHC in the country over the previous one decade. A

positive environment for this initiative was the then existing Government Policies such as the PHC Policy of the Ministry of Health and the Decentralization Policy of the Ministry of Local government, as well as the policies on gender, including affirmative action.

The health program therefore found it necessary to design the CCB process in such a way as to contribute towards and strengthen these policies. In line with the gender and decentralization policies which provided for representation of women on the local councils the CCB process sought to strengthen the capacity of women to influence decision making in respect to health at community and household level.

Community capacity building (CCB) was perceived to be a process. As a process it was expected to take some time and require constant support. However, in the design of the process certain results or outcomes were expected at each stage. Sustainability considerations also greatly influenced the decision to adopt a stepwise approach in the CCB process. To facilitate this process a series of activities have been carried out at central level and in the districts since 1995. These have included sensitization of politicians at various levels, training of trainers, follow up of trainees, training and follow up of members of the parish development committees (PDCs).

The CCB process has so far been introduced to 40 out of 45 districts in the country. The various districts are at different stages in the CCB process. Some districts, which currently have functional PDCs, have started reporting some positive experiences and outcomes of the CCB process. It is thus considered that this is an appropriate moment to document the experience of Community Capacity Building in Uganda, which appear to be quite positive. This will enable the Government of Uganda, UNICEF and other development partners of the government to consolidate on this positive experience in the coming years. Documenting this experience would also enable sharing Uganda' experience with the rest of the world.

Objectives of the Consultancy

1. To document Uganda's experience with community capacity building through the establishment and functioning of parish development committees.
2. To share Uganda's experience of CCB with other people.

Terms of Reference

1. Review available documents and reports and synthesize the available information to write
 - (a) the historical background to the CCB process in Uganda,
 - (b) the rationale of Community Capacity Building (CCB) in Uganda,
 - (c) the process of formation and training of Parish Development Committees (PDCs) and the rationale behind this process,
 - (d) the roles and responsibilities of a PDC,
 - (e) the legal status of a PDC.
2. Review available documents and reports, and make some field visits to document the experiences of districts, CCB trainers, PDC members and communities in respect to the CCB process. This documentation should clearly bring out
 - (a) achievements/current situation, especially in terms of the outcomes of the CCB process at community and household level. Focus should be on
 - the composition and functionality of the PDCs;
 - the role played by women members on the PDCs;

- capacity of the PDCs to use CBMIS for routine Assessment, Analysis and Action;
 - interface between the health service delivery system and the community;
 - level of utilization of available health services;
 - working relationships between PDCs and other committees such as Health Unit Management Committees (HUMC) and Sub-county Health Committees (SCHC);
 - potentials for sustaining the existence and functioning of PDCs;
- (b) lessons learnt;
- (c) constraints and challenges.
3. Organize the materials written into chapters with appropriate headings and sub-headings.
 4. Produce the first draft of the document by 14 October 2000 and the final draft by 20 October 2000. The submission will include a diskette copy of the document on each of the two occasions.

Final Product

- A draft document of not more than 30-40 pages on the experience of Community Capacity Building in Uganda. This may be finalized and forwarded to the Chief, Health section UNICEF, KAMPALA within a period of one month after the consultancy.
- A diskette copy of the first draft of the document.

Duration of the Consultancy

This consultancy will last for a period of 19 workdays. The consultant will spend 16 days of work in Uganda and 3 days of work in her home country/station finalizing the document.

Remuneration

UNICEF will pay to the consultant professional fees at the rate of US\$ 325 per day of work; and Day Subsistence Allowance (DSA) at the current UNICEF rates for the various stations in Uganda where she will be travelling for the work.

Transport

UNICEF will provide transport to the consultant and her team of local counterparts for the period of the consultancy.

DOCUMENTATION OF CCB EXPERIENE IN UGANDA

INDIVIDUALS AND GROUPS DISCUSSED WITH

UNICEF KAMPALA

- | | |
|----------------------------|--|
| 1. Mr. V. Lukyamuzi Mbidde | Project Officer, Health |
| 2. Mr. Thomas Odong | Assistant Project Officer, Health |
| 3. Dr. Iyorlumun Uhaa | Section Chief, Health |
| 4. Mr. Keith Wright | Section Chief, Coordination Communication and Advocacy |

MINISTRY OF HEALTH KAMPALA

- | | |
|--------------------|--|
| 5. Dr. Sam Okware | Commissioner of Health Services (Community Health) |
| 6. Mr. Paul Kagwa | Assistant Commissioner of Health Services (Health Promotion & Education) |
| 7. Mr. Sam Enginyu | Senior Health Educator |
| 8. Mr. John Wakida | Health Educator |

JINJA DISTRICT

- | | |
|---------------------------------------|--------------------------------------|
| 9. Dr. David Kitimbo | District Director of Health Services |
| 10. Mr. Boniface Ntalo | District Health Educator |
| 11. Mr. W. Edimu | District CCB Trainer |
| 12. Mr. Sam Muwumba | LCV Chairman |
| 13. Mr. C. Isanga | LCV Vice Chairman |
| 14. Mr. Galabuzi | Chief Administrative Officer |
| 15. Ms D. Nampala | Deputy Speaker, Jinja DLC |
| 16. Mr. Balidawa | LC III Chairman |
| 17. Mr. G. Kabambe | Sub-county Chief |
| 18. Mr. Kwoba | Sub-county CCB trainer |
| 19. Mr. Sam Kyakulaga | Sub-county CCB trainer |
| 20. Mr. Patrick Mukasa | Sub-county CCB trainer |
| 21. Ms Harriet Nabirya | Sub-county CCB trainer |
| 22. Mr. Wandera Muzamu | PDC Coordinator |
| 23. Mr. John Kaluya | PDC Chairman |
| 24. Mr. Charles Musingo | PDC Secretary |
| 25. 25 PDC members of Namagera parish | |
| 26. 23 PDC members of Lubanyi parish | |

IGANAGA DISTRICT

- | | |
|---|--------------------------------------|
| 27. Dr. James Baguma | District Director of Health Services |
| 28. Dr. Jennifer Kyewalyanga | i/c Bunya West Health Sub-district |
| 29. Ms Bukyabubi | District CCB Trainer |
| 30. Mr. Richard Gidudu | District CCB Trainer |
| 31. Ms Maria Najjemba | District CCB Trainer |
| 32. Mr. Fred Tagaghe | District CCB Trainer |
| 33. Ms Ritta Mirembe | Sub-county CCB Trainer |
| 34. Ms Jennifer Otama | Sub-county CCB Trainer |
| 35. Mr. Wako Ikona | PDC Chairman, Ndaiga parish |
| 36. Mr. Christopher Babi | PDC Vice-chairman, Ndaiga parish |
| 37. Mr Naluswa Makubo | General Secretary PDC |
| 38. Hangi Majabu Abasa | PDC Chairman, Namiganda parish |
| 39. Mr. Isabirye | PDC Secretary, Namiganda parish |
| 40. Hajati Hadija Mutesi | Sub-county CCB Trainer |
| 41. Met 14 PDC members of Ndaiga parish | |
| 42. Met 8 PDC members of Namiganda parish | |

MUKONO DISTRICT

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|-----------------|--------------------------------------|
| 43. Dr. Tushabe | District Director of Health Services |
|-----------------|--------------------------------------|

- 44. Mr. Akimu Kalungi District CCB Coordinator/Trainer
- 45. Mr. J. Kasirye Secretary for Health, Mukono DLC
- 46. Ms Harriet Namuddu District CCB Trainer
- 47. Ms Jane Namubiru Sub-county CCB Trainer
- 48. Ms Serunjogi Sub-county CCB Trainer
- 49. Ms Ruth Tamale Sub-county CCB Trainer
- 50. Met 14 members of PDC, Bulika parish
- 51. Met 8 PDC members of Kabanga parish

KIBOGA DISTRICT

- 52. Dr. Humphry Megere District Director of Health Services
- 53. Mr. Charles Walakira District CCB Coordinator/Trainer
- 54. Ms. Agnes Namugenyi District Health Educator
- 55. Mr. Kayongo Chief administrative Officer
- 56. Mr. Grace sendabagizi Resident District Commissioner (RDC)
- 57. Mr. Job Namakula Assistant RDC
- 58. Mr. S. Okello World Vision International
- 59. Met 18 PDC members of Kigando parish
- 60. Met 8 PDC members of Nakasongola parish