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# **Strengthening Community Participation in Health: Final Evaluation**

Summary Report

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## Preface

This report provides **a summary of the final report** of the evaluation of the ‘Strengthening Community Participation in Health’ (SCPH) programme in Zimbabwe, a pilot programme funded by the UK Department for International Development (DFID) and the European Union (EU). Oxford Policy Management (OPM) also produced a baseline report at the start of programme implementation which is available on request.

The final report is made up of two volumes. Volume I is a descriptive report, which presents the findings of the evaluation. Volume II is intended to provide further supporting technical information about the evaluation approach and methodology, as well as the evaluation process. In Volume II we also present the original Terms of Reference, and the full set of results tables, figures and graphs that the evaluation produced.

The programme is being implemented by Save the Children and the Community Working Group on Health (CWGH) in 166 health facilities in 21 districts across eight out of Zimbabwe’s 10 provinces (Harare and Bulawayo are excluded). 14 districts are funded by DFID and the remaining seven by the EU. The programme is part of DFID’s broader Maternal, Newborn and Child Health (MNCH) Programme in Zimbabwe.

## List of abbreviations

ANC	Antenatal care
CDC	Centers for Disease Control and Prevention
CM	Community Monitor
CWGH	Community Working Group on Health
DAC	Development Assistance Community (OECD)
DFID	Department for International Development (UK)
DHE	District Health Executive
DHIS	District Health Information System
DHS	Demographic and Health Survey
DMO	District Medical Officer
DNO	District Nursing Officer
EPI	Expanded Programme on Immunisation
EU	European Union
FGD	Focus group discussion
HCC	Health Centre Committee
HLF	Health Literacy Facilitator
HMIS	Health management information system
HTF	Health Transition Fund
ISP	Integrated Support Programme
MDGs	Millennium Development Goals
MNCH	Maternal, newborn and child health
MoHCC	Ministry of Health and Child Care
MOU	Memorandum of understanding
NGO	Non-governmental organisation
NIHFA	National Integrated Health Facility Assessment
OPD	Outpatients per month
OPM	Oxford Policy Management
PICES	Poverty, Income, Consumption, Expenditure Survey

PEC	Provincial Engagement Coordinator
PNC	Postnatal care
RBF	Results-based financing
SCPH	Strengthening Community Participation in Health programme
ToC	Theory of change
UNICEF	UN Children's Fund
USAID	US Agency for International Development
U5s	Children under the age of five
VHWs	Village health workers
WHO	World Health Organization
ZDHS	Zimbabwe Demographic and Health Survey

# 1 Introduction

Zimbabwe has seen a steady improvement in the provision and availability of health services since 2010. Greater economic stability and increased overseas development assistance have contributed towards improving health service delivery in the country. This improvement followed a period of constrained health spending and limited development of health services in the previous decade, conflated by an economic downturn, a rise in HIV prevalence and extensive out-migration of skilled health personnel.

## The Strengthening Community Participation in Health programme

In 2013, the UK Department for International Development (DFID) and the European Union (EU) began funding the 'Strengthening Community Participation in Health' programme (SCPH) in Zimbabwe. The pilot programme provided an opportunity for citizen engagement in health services, in order to increase the quality and utilisation of health services, with the final aim of improving health outcomes for women of reproductive age and children in rural Zimbabwe. Designed to complement the supply-side support to the health sector provided through the Health Transition Fund (HTF), which subsequently became the Health Development Fund, the programme focused on increasing the demand for quality health services at the community level. The underlying concept behind the programme was that greater collaboration between the community and government health service providers would serve to improve feedback mechanisms in the health system, reflecting users' views on the quality of the services they receive, thereby creating a health system that responds more effectively to the needs of its users.

The programme was ambitious in its reach, covering eight out of Zimbabwe's 10 provinces (Harare and Bulawayo are excluded), together with an advocacy plan that worked at the national level. The programme established Health Centre Committees (HCCs) where they did not already exist, and trained and supported HCCs to facilitate the feedback mechanisms created by the programme, and to raise community awareness about their patient rights and their ability to register complaints. The programme encouraged the use of three main feedback mechanisms: community scorecards, suggestion boxes and HCC feedback forms. It also provided training to a cadre of volunteers called Health Literacy Facilitators (HLFs) on how to educate community members about maternal, newborn and child health (MNCH) issues and patient rights, and to Community Monitors (CMs) on how to administer community scorecards. To support these aims at the community level, the programme also implemented a national advocacy strategy focused on large reforms, such as passing the Public Health Act Amendment bill, advocating for increased national spending on health care and improving health resources (especially staff). The strategy also included advocating for some smaller but important changes, such as the removal of user fees at the primary health care level and legitimising the role of HCCs in the health system.



## 2 Evaluation questions and methods

The main focus of the evaluation, conducted by Oxford Policy Management (OPM), in partnership with Jimat Development Consultants, is on assessing the impact of SCPH. In addition to this, we present reasons for the findings, and assess the relevance, effectiveness, sustainability and value for money provided by the programme. We also draw lessons for future programmes that seek to increase voice and accountability, with the aim of improving public service delivery.

DAC criteria	Key evaluation questions
Impact	What was the causal effect and contribution of the programme on/to the expected outputs, outcomes and impact along its ToC?
Relevance	To what extent are the objectives of the programme still valid? Are the activities and outputs of the programme consistent with the overall goal and the attainment of its objectives? Are the activities and outputs of the programme consistent with its intended impacts and effects?
Effectiveness	What worked well and what worked less well, and why? What were the major factors influencing the achievement or non-achievement of the objectives?
Efficiency	Was it good value for money? How could value for money have been improved?
Sustainability	To what extent and how do programme strategies support the long-term sustainability of achievements, and should anything be done to strengthen these strategies?

### Methodology

This evaluation employs a theory-based, mixed methods approach to assess the impact of the programme. The evaluation is theory-based in that it makes explicit use of the programme's Theory of Change (ToC) to understand its impact, and our approach involves the integration of qualitative and quantitative study components.

The evaluation comprises a baseline and an endline. The baseline measured the situation on the ground before the programme started, while the endline measures the impact of the programme after it has been operational for two years. The dates of key activities are summarised in the table below:

Date	Activity
Feb 2014 – Jun 2014	Development of ToC and evaluation design
Jul 2014 – Aug 2014	Quantitative and qualitative baseline data collection
Sep 2014 – Feb 2015	Baseline report
Jul 2016 – Dec 2016	Quantitative and qualitative endline data collection
Sep 2016 – Feb 2017	Endline (final) evaluation report

Source: OPM

The quantitative component of the evaluation uses a quasi-experimental design to allow us to estimate the causal effect of the programme by constructing a comparison group. This is done using propensity score matching to identify comparison facilities (where the programme is not operating) that were similar to the intervention facilities before the implementation of SCPH. The impact of the programme is then estimated by comparing intervention and comparison facilities at the end of the programme. We report that the programme had an 'impact' on a particular outcome when the comparison between intervention and comparison facilities is statistically significant. The

qualitative component takes a case-based approach to provide deeper contextual understanding and explanations for what happened as a result of this programme and why.

We used data from a health facility survey that we conducted and secondary data from the MoHCC and other organisations working in the health sector.

The impact of the programme is measured by comparing outcomes from the facilities that received the intervention with those which did not. Factors that affect both the intervention and comparison groups, such as the roll-out of the RBF programme, do not interfere with our evaluation because the influence of RBF is the same on average across both our intervention and comparison groups. By drawing this comparison between intervention and non-intervention groups, the evaluation is assessing the additional impact of SCPH over and above any other support that facilities may be receiving.

The evaluation presents findings on the effectiveness and impact of SCPH in the following areas, based on the programme's Theory of Change (ToC):

- 1. The quality and functionality of HCCs**, who were trained to fulfil their roles more effectively, establish feedback mechanisms at health facilities, and engage with communities to ensure their inclusion in decision-making processes.
- 2. The public's knowledge of their rights and entitlement to health care**, which the programme aimed to increase by training HLFs and HCCs to raise awareness of these areas. Community awareness of rights and entitlements was expected to lead to their increased participation in health, through a greater understanding of the services and treatment they should be entitled to at health facilities, and their empowerment to be able to claim those rights.
- 3. The complaints and monitoring mechanisms at health facilities**, which the programme sought to establish and strengthen.
- 4. The inclusivity of the decision-making processes regarding community and health facility resources**, which was expected to increase due to the increased ability of HCCs to act as representatives of the community in decision-making processes, and the increased participation of community members in the available channels for providing complaints and feedback, and awareness of their rights to do so.
- 5. The quality of health facilities (actual and perceived)**, which was expected to increase as a result of decision-making processes that were more responsive to actual community needs and priorities.
- 6. The utilisation of MNCH services**, which was expected to increase as a result of improved quality of services and community satisfaction with the services provided.

## Limitations

This section outlines a summary of the main limitations of the evaluation, and describes how these limitations affected the findings and conclusions presented in this report.

**The primary survey data collection was a health facility survey and so we did not interview people who do not use health facilities.**

- This means that our survey does not allow us to gain insights from those who do not visit clinics as regards the reasons why they do not do so.
- The qualitative research was intended to consult with non-users of facilities, or people who use clinics very rarely. However in practice it sometimes proved difficult to obtain these

interviews, and the qualitative study did not complete as many such interviews as was hoped.

**The programme implementation began in October 2013 and ran until June 2016. Therefore, the programme roll-out began before the baseline data were collected in July/August 2014.**

- The risk arising due to having baseline data collection after the programme began is that the baseline may not accurately measure the pre-intervention outcomes.
- However, given the nature of the gradual roll-out of the programme across and within districts, there was very little likelihood of the programme influencing key indicators in the four months between the start of operations and collection of the baseline data.

**For the quantitative surveys of facility Head Nurses and HCCs the effect size that we are able to measure with statistical confidence is relatively large.**

- According to our sample size calculations, any differences of less than 23 percentage points between intervention and comparison facilities for a facility- or HCC-level indicator (for example the percentage of HCCs that collect feedback from the community) would not be expected to show up as statistically significant.

**There is a risk of spillovers affecting the comparison group.**

- Spillovers occur when the comparison group is somehow affected by the implementation of SCPH among the intervention group.
- We do find some evidence of limited spillovers due to actions taken at the district level, in response to the implementation of this programme. Several of the DHE representatives interviewed reported having taken some actions to try to ensure that any positive outcomes of the programme were also achieved in the comparison facilities.
- However, although this finding does present some concern that our findings may underestimate the true impact of the programme, DHEs also noted that their ability to support the comparison facilities in these respects was severely restricted because they do not have funding to roll out SCPH activities in comparison facilities.

**The evaluation did not have access to the required spending data from SCPH so our ability to comment on the value for money is very limited.**

- We only provide a light-touch assessment of the value for money provided by SCPH, based mainly on qualitative interviews with programme implementers and the total cost of the programme from the perspective of its funders. The evaluation did not have access to the costs of the programme incurred by its implementers, or a breakdown of how these costs were distributed across different activities. Therefore our ability to comment on what was achieved in relation to the resources provided is very limited.

**The time period of the intervention and evaluation is relatively short to assess changes on some outcomes**

- The evaluation measured results over a two year period, (with baseline data collection in July and August 2014, when the programme was in its inception phase, and endline data collection in July and August 2016, when the programme was closing in most districts).

- This time period may be considered relatively short to observe changes in some of the outcomes and impacts identified in the ToC. In particular, outcomes around behaviour change may be expected to shift more slowly than this. Therefore the evaluation period may not have been long enough to draw firm conclusions on issues relating to behaviour change.

### 3 Key findings

#### 3.1 Impact of SCPH on HCC performance

SCPH had a small effect on improving the HCCs’ understanding of their role. However, we found HCCs were not easily able to articulate their role in sufficient detail, so there is still scope to improve on this. SCPH did not affect the likelihood of HCCs undertaking initiatives such as providing in-kind contributions to the facility, infrastructure development and repairs, including the construction of mothers’ waiting shelters, or the likelihood that HCCs raised funds.

SCPH has had some impact in the extent of HCC engagement with communities, as reported by the HCCs themselves, with intervention HCCs being significantly more likely to report meeting with the community than in the comparison group. Yet despite the HCCs’ stated intention to work within communities and the impact of SCPH on the proportion of HCCs that reported meeting with their community, we find that the communities are not well aware of the HCC. The overall visibility of each HCC across the whole community remains limited, with less than a quarter of all patients surveyed having heard of the HCC.

There are several reasons that explain the relative lack of awareness of the HCCs. Firstly, HCCs lack a platform of their own. They primarily engage with the community during ward meetings or wider community meetings that are organised by local leadership groups; and do not call community meetings of their own. HCC members are known by the other roles they perform in the community, such as traditional leaders, health workers or volunteers. As a result, when they do address the community, they may seem to be doing so in their traditional role, and not as part of the HCC. Additionally, not all community members may attend meetings. Finally, HCCs often lack of funds or means of transport to travel to villages that are further away in the facility’s catchment area.

SCPH did not impact the level of engagement of the HCCs with facility staff. At baseline it was found that the degree of partnership between HCCs and health facility staff was close, and this has remained. But SCPH did have a positive impact on the level of interaction between DHEs and HCCs, and extent to which HCCs reported that they were kept up to date with developments at the district level.

**Table 1: Key results on quality and functionality of HCCs from quantitative data**

Quality and functionality of HCCs					
	Data source		Comparison mean	Intervention mean	Treatment effect
<b>Proportion of HCCs that met with the community at least once in the past 12 months</b>	OPM HCC survey	<i>Endline mean</i>	76.25	95.65	<b>19.4***</b>
		<i>N</i>	80	69	149
		<i>Baseline mean</i>	81.01	90.91	
		<i>N</i>	79	66	
<b>Proportion of HCCs that implemented any new initiatives in the past 12 months (HCC perspective)</b>	OPM HCC survey	<i>Endline mean</i>	78.75	81.16	2.41
		<i>N</i>	80	69	149
		<i>Baseline mean</i>	65.38	66.67	
		<i>N</i>	79	66	
<b>Proportion of HCCs that participate in meetings with the DHE</b>	OPM HCC survey	<i>Endline mean</i>	71.25	91.3	<b>20.05***</b>
		<i>N</i>	80	69	149
		<i>Baseline mean</i>	53.16	63.64	
		<i>N</i>	79	66	
		<i>Endline mean</i>	22.13	22.15	.02

Quality and functionality of HCCs					
	Data source		Comparison mean	Intervention mean	Treatment effect
<b>Proportion of ANC and U5 patients that are aware of the HCC</b>	OPM ANC and U5 surveys	<i>N</i>	1464	1255	2719
		<i>Baseline mean</i>	23.22	26.3	
		<i>N</i>	1559	1370	
1. Treatment effects for HCC outcomes are estimated using the OLS regression: $Y_j = \alpha + \beta_1 T_j + \varepsilon_{ij}$ where $Y_j$ is the outcome for HCC $j$ , and $T_j$ is equal to 1 if the facility is covered by the intervention. 2. Treatment effects for patient level outcomes are estimated using the regression $Y_{ij} = \alpha + \beta_1 T_j + \varepsilon_{ij}$ where $Y_{ij}$ is the outcome for individual $i$ in the catchment area of facility $j$ . For these regressions we present results from the pooled sample of ANC and U5 samples together. 3. An array of estimation models and robustness checks for these results, as well as the additional outcomes that were tested, are presented in Volume 2. 4. Standard errors are clustered at the level of the health facility (at which the intervention was assigned) 5. * = $p < 0.1$ , ** = $p < 0.05$ , *** = $p < 0.001$					

### 3.2 Impact of SCPH on patient knowledge of rights, entitlements and responsibilities for health

SCPH has had some success in raising community members’ awareness about patients’ rights. Though awareness of the Patients’ Charter (the government document that sets out patient rights) remains low in both intervention and comparison facilities, there has been some improvement due to SCPH in raising people’s awareness that they have any patient rights at all, and that MNCH services should be free of charge.

Nonetheless, there is still considerable scope to raise people’s knowledge and understanding of the full range of rights contained in the Charter. The majority of people can still only name the most basic right. We also found that the training provided on rights to community members had a limited reach. Partly, this was because HCC members tended to train the community in their patient rights at the inception of the programme and during meetings at which there were several other agenda items. An additional issue is the relatively low coverage of SCPH-trained HLFs across catchment areas. Only 2-3 HLFs were trained in each catchment area, some of which covered several wards and thousands of people, and HLFs did not in general have ready access to transport (though SCPH was able to provide bicycles for some).

SCPH did not have an impact on the level of awareness and knowledge about healthy behaviours for promoting MNCH. In both intervention and comparison facilities, levels of knowledge were high.

**Table 2: Key results on patient knowledge of rights and entitlements from quantitative data**

Patient knowledge of rights and entitlements					
	Data source		Comparison mean	Intervention mean	Treatment effect
<b>Proportion of ANC and U5 patients aware of the Patients Charter</b>	OPM ANC and U5 surveys	<i>Endline mean</i>	3.35	7.81	<b>4.46***</b>
		<i>N</i>	1464	1255	2719
		<i>Baseline mean</i>	5.4	7.46	
<b>Proportion of ANC and U5 patients aware of free services for pregnant women and carers of under 5s</b>	OPM ANC and U5 surveys	<i>Endline mean</i>	80.26	85.98	<b>5.72**</b>
		<i>N</i>	1464	1255	2719
		<i>Baseline mean</i>	74.63	73.54	
<b>Proportion of ANC and U5 patients aware of any patients’ rights</b>	OPM ANC and U5 surveys	<i>Endline mean</i>	50.68	54.42	3.74
		<i>N</i>	1464	1255	2719

Patient knowledge of rights and entitlements					
	Data source		Comparison mean	Intervention mean	Treatment effect
		<i>Baseline mean</i>	39.96	43.21	
		<i>N</i>	1559	1370	
<b>Proportion of ANC and U5 patients that received any training on patient rights and entitlements in the past 12 months</b>	OPM ANC and U5 surveys	<i>Endline mean</i>	24.53	25.33	.8
		<i>N</i>	742	683	1425
		<i>Baseline mean</i>	20.87	21.69	
		<i>N</i>	623	592	

1. Treatment effects for patient level outcomes are estimated using the regression  $Y_{ij} = \alpha + \beta_1 T_j + \varepsilon_{ij}$  where  $Y_{ij}$  is the outcome for individual  $i$  in the catchment area of facility  $j$ . For these regressions we present results from the pooled sample of ANC and U5 samples together.
2. An array of estimation models and robustness checks for these results, as well as the additional outcomes that were tested, are presented in Volume 2.
3. Standard errors are clustered at the level of the health facility (at which the intervention was assigned)
4. \* =  $p < 0.1$ , \*\* =  $p < 0.05$ , \*\*\* =  $p < 0.001$

### 3.3 Impact of SCPH on the operation of complaints mechanisms

We find that SCPH did not have a positive impact on whether HCCs do anything to capture information about patient opinion (as nearly all committees do this anyway), but it did have an impact on how this information is collected and communicated within the health system. Intervention HCCs were found report using the mechanisms supported by the programme to collect feedback (scorecards and suggestion boxes), and significantly more likely than comparison HCCs to report having educated community members on how and where to report complaints. We also found a positive impact on HCCs and health facility staff reporting that a mechanism exists for the HCC to inform facilities about patient opinion, suggesting that information is being escalated to appropriate decision makers.

However, despite the wide availability of feedback mechanisms in both intervention and comparison facilities, which SCPH was able to improve even further, community engagement with these mechanisms does not appear to have improved as a result of the programme, and is low. Few complaints are made, and SCPH did not affect the proportion of patients who would be likely to report a complaint about the health facility, should they ever feel unsatisfied. We also find that SCPH did not have an impact on the proportion of people who say that they would complain to the HCC if ever unsatisfied.

The main reasons that people do not complain are fear of reporting, lack of knowledge about where and how to report, low coverage and availability of SCPH-trained volunteers, and being tolerant of the circumstances.

**Table 3: Key results on the establishment of complaints mechanisms from quantitative data**

Complaints mechanisms					
	Data source		Comparison mean	Intervention mean	Treatment effect
<b>Proportion of HCCs that collect quality of care information about patients</b>	OPM HCC survey	<i>Endline mean</i>	98.75	98.55	-.2
		<i>N</i>	80	69	149
		<i>Baseline mean</i>	89.74	95.45	
		<i>N</i>	79	66	
<b>Proportion of HCCs that keep a record of complaints from community members</b>	OPM HCC survey	<i>Endline mean</i>	42.5	72.46	<b>29.96***</b>
		<i>N</i>	80	69	149

Complaints mechanisms					
	Data source		Comparison mean	Intervention mean	Treatment effect
		Baseline mean	49.37	53.03	
		N	79	66	
Proportion of HCCs that have educated the community in how and where to register their complaints	OPM HCC survey	Endline mean	57.5	95.65	<b>38.15***</b>
		N	80	69	149
		Baseline mean	(No baseline data available)		
		N	(No baseline data available)		
Proportion of HCCs in which a mechanism exists to inform health facility staff of patient complaints	OPM Head Nurse survey	Endline mean	67.9	94.2	<b>26.3***</b>
		N	81	69	150
		Baseline mean	60.61	45	
		N	66	80	
Proportion of ANC and U5 patients who reported any complaints (among those who were unhappy with the facility in the past 12 months)	OPM ANC and U5 surveys	Endline mean	18.97	16.6	-2.37
		N	253	241	494
		Baseline mean	9.27	13.04	
		N	151	138	
Proportion of ANC and U5 patients who would complain if not satisfied with the health facility	OPM ANC and U5 surveys	Endline mean	61.83	65.46	3.64
		N	1464	1255	2702
		Baseline mean	59.97	57.59	
		N	1559	1370	

1. Treatment effects for facility and HCC-level outcomes are estimated using the OLS regression:  $Y_j = \alpha + \beta_1 T_j + \varepsilon_{ij}$  where  $Y_j$  is the outcome for facility (or HCC)  $j$ , and  $T_j$  is equal to 1 if the facility is covered by the intervention.
2. Treatment effects for patient level outcomes are estimated using the regression  $Y_{ij} = \alpha + \beta_1 T_j + \varepsilon_{ij}$  where  $Y_{ij}$  is the outcome for individual  $i$  in the catchment area of facility  $j$ . For these regressions we present results from the pooled sample of ANC and U5 samples together.
3. An array of estimation models and robustness checks for these results, as well as the additional outcomes that were tested, are presented in Volume 2.
4. Standard errors are clustered at the level of the health facility (at which the intervention was assigned)
5. \* =  $p < 0.1$ , \*\* =  $p < 0.05$ , \*\*\* =  $p < 0.001$

### 3.4 Impact of SCPH on the responsiveness of decision makers

SCPH has had a somewhat positive impact in increasing decision-making that is directly responsive to community feedback. We find a large and positive impact on the proportion of facilities who report making any changes due to patient opinion.

Although this is promising, qualitative research revealed that while facilities do try to respond to complaints, and sometimes do make changes where they can, in many cases they are only able to partially respond, or are not able to respond at all. This means that there are still relatively few clear examples of the anticipated feedback loop working as intended – where community members raise a concern, issue or piece of feedback, and decision-makers actively address it. We find that decision-makers face considerable resource constraints in their ability to respond to the feedback that they receive.

Moreover, as reported above, the fact that community members still do not widely engage with the available complaints and feedback mechanisms also acts as another immediate limitation on the ability of decision-makers to respond.

**Table 4: Key results on the responsiveness of decision makers from quantitative data**

Responsiveness of decision makers					
	Data source		Comparison mean	Intervention mean	Treatment effect
<b>Proportion of facilities in which changes have occurred as a result of patient opinion shared by the HCC with facility staff in the past 12 months</b>	OPM Head Nurse survey	<i>Endline mean</i>	58.02	79.41	<b>21.39***</b>
		<i>N</i>	81	68	149
		<i>Baseline mean</i>	80	57.35	
		<i>N</i>	55	68	
1. Treatment effects for facility-level outcomes are estimated using the OLS regression: $Y_j = \alpha + \beta_1 T_j + \varepsilon_{ij}$ where $Y_j$ is the outcome for facility (or HCC) $j$ , and $T_j$ is equal to 1 if the facility is covered by the intervention. 2. An array of estimation models and robustness checks for these results, as well as the additional outcomes that were tested, are presented in Volume 2. 3. Standard errors are clustered at the level of the health facility (at which the intervention was assigned) 4. * = $p < 0.1$ , ** = $p < 0.05$ , *** = $p < 0.001$					

### 3.5 Impact of SCPH on inclusive decision making

We find that there are generally high levels of collaboration between nurses and the HCC in both intervention and comparison facilities. SCPH was able to strengthen this in some limited respects, but the partnership between HCCs and facilities is in any case generally strong.

However we do not find evidence of meaningful and ongoing inclusion of community voices in the decision making process. As reported above, there are individual examples of decision makers seeking to make changes at some facilities to respond to patient opinion, but we do not find that communities are engaged in decision making in a sustained way. Facility head nurses report that community members are rarely directly involved in the decision-making processes, and SCPH did not improve this. This may not, in and of itself, be a problem if the HCCs were strongly engaged with the community and could represent the community views in the decision-making process. However, as reported above the HCCs are not as strongly engaged with the community as they could be.

**Table 5: Key results on inclusive decision making from quantitative data**

Inclusive decision making					
	Data source		Comparison mean	Intervention mean	Treatment effect
<b>Proportion of facilities with an operational plan for the current year</b>	OPM Head Nurse survey	<i>Endline mean</i>	95.06	94.2	-.86
		<i>N</i>	81	69	150
		<i>Baseline mean</i>	87.69	93.75	
		<i>N</i>	67	80	
<b>Among facilities with an operational plan, proportion of HCCs reporting that they were consulted in its development</b>	OPM HCC survey	<i>Endline mean</i>	96.05	98.53	2.48
		<i>N</i>	76	68	144
		<i>Baseline mean</i>	98.59	96.55	
		<i>N</i>	71	58	
<b>Among facilities that received money from RBF in the past 12 months, proportion of HCCs reporting that the spending was 'fully' in line with their priorities</b>	OPM HCC survey	<i>Endline mean</i>	83.33	89.55	6.22
		<i>N</i>	78	67	145
		<i>Baseline mean</i>	81.82	80.95	
		<i>N</i>	77	63	
1. Treatment effects for facility-level outcomes are estimated using the OLS regression: $Y_j = \alpha + \beta_1 T_j + \varepsilon_{ij}$ where $Y_j$ is the outcome for facility (or HCC) $j$ , and $T_j$ is equal to 1 if the facility is covered by the intervention. 2. An array of estimation models and robustness checks for these results, as well as the additional outcomes that were tested, are presented in Volume 2. 3. Standard errors are clustered at the level of the health facility (at which the intervention was assigned) 4. * = $p < 0.1$ , ** = $p < 0.05$ , *** = $p < 0.001$					

### 3.6 Impact of SCPH on health services quality

The quantitative evidence shows no impact of SCPH on overall service quality, as measured by the MoHCC Quality of Care checklist. We measured both the overall composite scores awarded to health facilities each quarter, and the 18 underlying scores that are used to calculate the overall score. While the data show that there have been increases in service quality over time, these are not any greater in the SCPH intervention facilities.

In contrast, the qualitative interviews suggest that there have been some meaningful improvements in some cases due to the feedback mechanisms supported by SCPH. This was reported to be particularly the case in terms of improvements in staff attitudes and the relationship between facility staff and community members. However the quantitative survey of patients did not show any evidence that satisfaction with health facility staff has increased due to SCPH.

Our view is that SCPH may have had some small effects on improving the quality of services in some places, but that these are isolated changes, which have not been large enough to translate into overall increases in the measured quality of services according to the MoHCC checklist scores.

**Table 6: Key results on the quality of health services results from quantitative data**

Quality of health services					
	Data source		Comparison mean	Intervention mean	Treatment effect
<b>Average MoHCC Quality of Care checklist composite score per facility per quarter</b>	MoHCC Quality of Care checklist data	<i>Endline mean</i>	83.19	83.22	0.034
		<i>N</i>	426	450	876
		<i>Baseline mean</i>	67.21	67.27	
		<i>N</i>	141	150	
<b>Average RBF disbursement amount per facility per quarter</b>	Crown Agents RBF disbursement data	<i>Endline mean</i>	1953.44	1993.07	39.627
		<i>N</i>	423	444	867
		<i>Baseline mean</i>	902.44	840.96	
		<i>N</i>	131	139	

1. Treatment effects for facility-level outcomes are estimated using the OLS regression:  $Y_j = \alpha + \beta_1 T_j + \varepsilon_{ij}$  where  $Y_j$  is the outcome for facility (or HCC)  $j$ , and  $T_j$  is equal to 1 if the facility is covered by the intervention.
2. An array of estimation models and robustness checks for these results, as well as the additional outcomes that were tested, are presented in Volume 2.
3. For the MoHCC and RBF results, the baseline period is considered to be quarter 3 (July – September) 2014 (the first quarter for which data is available), and the endline period is considered to be quarters 1, 2 and 3 (January – September) 2016.
4. Standard errors are clustered at the level of the health facility (at which the intervention was assigned)
5. \* =  $p < 0.1$ , \*\* =  $p < 0.05$ , \*\*\* =  $p < 0.001$

### 3.7 Impact of SCPH on patient satisfaction

We find that SCPH did not have any effect on patient satisfaction. Patient satisfaction with the quality of the health facility and its staff was very high at baseline in both intervention and comparison facilities, and has remained so over the lifetime of SCPH. Given that satisfaction was already very high at baseline there was little opportunity for the programme to change this, without significantly altering people’s expectations of quality. We find the assumption that this programme could increase the utilisation of health facilities by increasing people’s satisfaction with facilities to be a significant failing in the programme’s ToC or intervention logic, given the observed high levels of satisfaction at baseline.

**Table 7: Key results on patient satisfaction from quantitative data**

Perceived quality of health services					
	Data source		Comparison mean	Intervention mean	Treatment effect
<b>ANC and U5 patients overall satisfaction with the health workers at the facility. (Average score out of 3)</b>	OPM ANC and U5 surveys	<i>Endline mean</i>	2.33	2.38	.04
		<i>N</i>	1465	1256	2721
		<i>Baseline mean</i>	2.55	2.52	
		<i>N</i>	1557	1370	
<b>ANC and U5 patients overall satisfaction with the health workers at the facility. (Average score out of 3)</b>	OPM ANC and U5 surveys	<i>Endline mean</i>	2.09	2.09	0
		<i>N</i>	1464	1255	2719
		<i>Baseline mean</i>	2.41	2.35	
		<i>N</i>	1557	1368	

1. Treatment effects for patient level outcomes are estimated using the regression  $Y_{ij} = \alpha + \beta_1 T_j + \varepsilon_{ij}$  where  $Y_{ij}$  is the outcome for individual  $i$  in the catchment area of facility  $j$ . For these regressions we present results from the pooled sample of ANC and U5 samples together.
2. An array of estimation models and robustness checks for these results, as well as the additional outcomes that were tested, are presented in Volume 2.
3. Standard errors are clustered at the level of the health facility (at which the intervention was assigned)
4. \* =  $p < 0.1$ , \*\* =  $p < 0.05$ , \*\*\* =  $p < 0.001$
5. Satisfaction is measured using an average score out of 3 on a range of questions relating to satisfaction with health workers and health facility, based on the following scoring system: 0 = very dissatisfied, 1 = somewhat dissatisfied, 2 = somewhat satisfied, 3 = very satisfied

### 3.8 Impact of SCPH on utilisation of health facilities

We find that there was no impact of SCPH on the utilisation of health facilities for MNCH services, as measured by ANC (first visits, second visits, third visits and fourth or more visits), PNC (at three days, seven days and six weeks), immunisations, and the total number of new outpatients per month (OPD).

Qualitatively, respondents in both intervention and comparison facilities testified that there have been recent increases in the volumes of women using health facilities for MNCH services. However, we also do not find increases in the overall use of MNCH health services since the baseline period in either intervention or comparison sites over the evaluation period (2014–2016). We therefore infer that the increases which people referred to occurred before the start of the intervention period, and can be primarily attributed to the introduction of HTF. HTF brought more money to facilities than they were receiving before, and injected much-needed resources into the health system, allowing health facilities to support greater numbers of patients. We find that SCPH has not been successful in raising utilisation further.

Among the reasons for limited impact at this level are that the use of health facilities is already quite high for some MNCH services. Non-use of services appears to be concentrated among specific groups rather than being a widespread issue across the rural communities covered by the intervention. The one key group who consistently do not use health facilities are those belonging to a specific kind of Apostolic religion, whose beliefs prohibit them from doing so. Among others who do not use health services as much as they should, the key barriers relate to the distance to travel to health facilities and associated costs of reaching the clinic, as well as people being unable to attend if they are working.

**Table 8: Key results on facility utilisation from quantitative data**

Utilisation					
	Data source		Comparison mean	Intervention mean	Treatment effect
		<i>Endline mean</i>	69.19	71.60	2.41

Utilisation					
	Data source		Comparison mean	Intervention mean	Treatment effect
Average total ANC visits per facility per quarter	OPM T5 verification survey	<i>N</i>	81	69	150
		<i>Baseline mean</i>	68.22	66.83	
		<i>N</i>	80	67	
Average total PNC visits per facility per quarter	OPM T5 verification survey	<i>Endline mean</i>	33.69	33.13	-0.57
		<i>N</i>	81	69	150
		<i>Baseline mean</i>	28.99	26.36	
Average total new outpatient visits per facility per quarter	OPM T5 verification survey	<i>Endline mean</i>	464.45	494.21	29.77
		<i>N</i>	81	69	150
		<i>Baseline mean</i>	644.55	686.51	
Average total immunisations per facility per quarter	OPM T5 verification survey	<i>Endline mean</i>	135.07	142.31	7.25
		<i>N</i>	81	69	150
		<i>Baseline mean</i>	140.56	142.93	
		<i>N</i>	80	67	

1. Treatment effects for facility-level outcomes are estimated using the OLS regression:  $Y_j = \alpha + \beta_1 T_j + \varepsilon_{ij}$  where  $Y_j$  is the outcome for facility (or HCC)  $j$ , and  $T_j$  is equal to 1 if the facility is covered by the intervention.
2. An array of estimation models and robustness checks for these results, as well as the additional outcomes that were tested, are presented in Volume 2.
3. For the utilisation results we consider the baseline period to be 6 months of data between January and July 2014, and the endline period to be 6 months of data between January and July 2016.
4. Standard errors are clustered at the level of the health facility (at which the intervention was assigned)
5. \* =  $p < 0.1$ , \*\* =  $p < 0.05$ , \*\*\* =  $p < 0.001$

### 3.9 Impact of SCPH on MNCH policy

The advocacy strategy was well conducted overall. The conferences that it facilitated were well organised and brought together the relevant stakeholders to address the policy issues on which the strategy focused. The strategy culminated in significant progress in the adoption of the Public Health Act Amendment bill, which is set to be passed this year after long delays. Without the continued momentum that this advocacy work supported, it is likely that this bill would have been delayed even further.

Some of the higher goals of the strategy were not achieved, which can be attributed largely to a challenging economic environment that was not conducive to some of the strategy’s broader goals, especially those around improving human resourcing for health and financing. There are also some recommendations for improving the strategy. These include a greater focus on using evidence to make the strategy’s case, and further efforts to follow up after events to ensure that commitments and decisions were followed through.

## 4 Summary of how the evaluation findings relate to the programme ToC

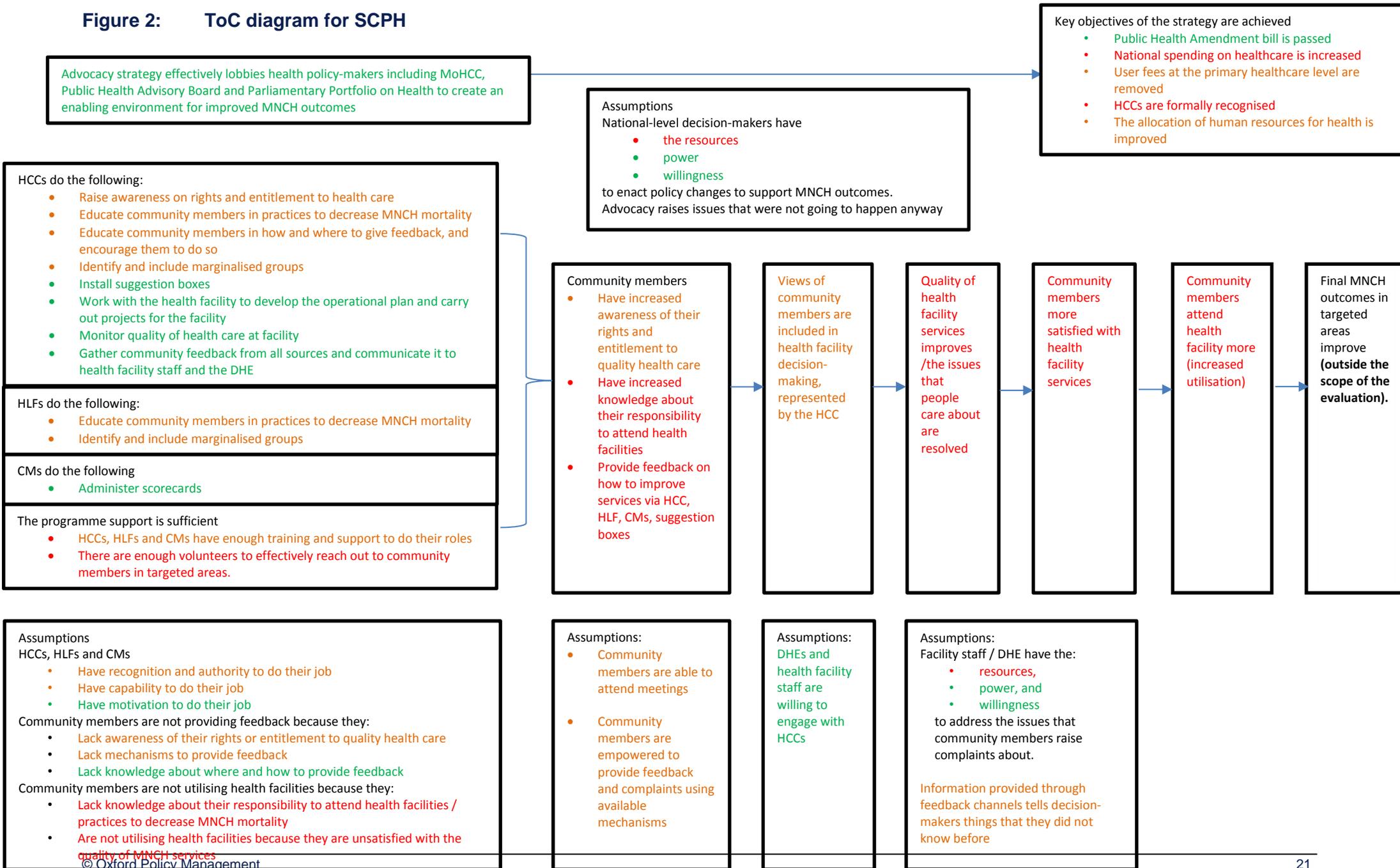
Figure 2 shows the evaluation team's understanding of the ToC for SCPH. This represents our understanding of how the programme was intended to work in theory, and the basis on which our theory-based evaluation was designed. The diagram depicts the main outputs delivered by the programme, followed by its intermediate outcomes, and the final outcomes and impacts that the programme aimed to achieve. These are underpinned by a set of assumptions that relate to each part of the results chain.

It is colour-coded in line with evaluation findings to show whether or not each component was achieved, and whether or not the assumptions underpinning them were met.

- Green: indicates that the component was achieved or that the assumption held.
- Amber: indicates that the component, or assumption was partially achieved
- Red: indicates that the component was not achieved or that the assumption did not hold.

A summary and discussion of these results is presented in the next section.

**Figure 2: ToC diagram for SCPH**



## 5 Conclusions, lessons and recommendations

In the following section we discuss what the results imply for the success of the programme in terms of its relevance, effectiveness, impact, value for money, and sustainability. We then outline some lessons and recommendations that may be drawn from the evaluation and its findings, for future programmes.

### 5.1 Summary of the evaluation findings

Below we summarise our key findings, which are structured around the DAC criteria.

#### Relevance

SCPH's aimed to address key problems relevant to the provision and use of quality MNCH services, but there were some weaknesses in the programme's design.

Trying to increase participation through HCCs has the potential to be effective because HCCs are an already existing link between health facilities and the community. However, HCCs still lack their own platform in the communities that they service so this needs to be changed in order for them to be effective. Also, as currently set up HCCs are expected to cover wide catchment areas so they need means to reach their areas physically, and they also need a larger pool of people to cover the catchment areas. Furthermore, people are reluctant to voice complaints for fear of reprisals so local leaders need to be engaged to encourage and reassure community members that reprisals will not be tolerated. The most relevant programme activities are those that focus on strengthening the profile and capacity of HCCs, and establishing monitoring and feedback mechanisms systems that are currently weak or not in place.

A weakness in the design was the assumption that decision-makers have raised, or will be able to raise, the resources to be able make the required changes to the quality of services. Additionally, in order to increase utilisation it would be more effective to focus on the key reasons for non-use rather than try to improve the quality of health services as users generally report high levels of satisfaction despite the shortfalls in services.

#### Effectiveness and impact

SCPH did deliver its key intended outputs in regard to establishing mechanisms for community members to raise complaints, and encouraging decision-makers to review, escalate and respond to those complaints as necessary. However, the intervention did not manage to increase community participation in a meaningful way, in terms of ensuring that community voices were truly represented in decision-making processes. Whilst there were some instances of decision-makers responding to complaints, we did not find evidence of systematic inclusion of community members in the decision-making process. We found that there remain key barriers to community members being able to raise their voices to provide complaints. HCCs are also not yet working extensively enough within communities, or using engagement strategies that go deep enough, to allow them to act as genuine representatives of the community in decision-making.

SCPH did not achieve its final intended outcomes of improving the quality and utilisation of MNCH services. The reasons why these final outcomes were not attained are attributed to limitations both in the implementation of the programme and in the theory behind it. The implementation of the programme is considered to have been too light to deliver the ambitious changes that were anticipated, due to the short intervention period, low coverage of volunteers and short duration of

training to deliver their roles. However, there were also some failures in the assumptions underpinning the ToC, as discussed above under relevance, meaning that even if the implementation had been delivered with greater intensity it could not have been expected to achieve its higher-level goals under the current conditions.

The programme achieved some successes in its other key objective of shaping the wider policy environment to support improved MNCH outcomes. Though the adoption of an advocacy strategy, it was able to secure some marked progress in the adoption of the Public Health Act Amendment bill, which was its major goal. Some of the other goals of the strategy were not fully achieved.

The table below summarises the key findings on the effectiveness and impact of SCPH, structured around the key elements of the programme’s ToC. We use the following colour scheme, to illustrate the extent to which the programme had a significant impact on each key outcome:

- Green: SCPH had a significant impact on improving the outcome, in line with its objectives
- Orange: SCPH had some impact on improving the outcome, but it did not improve as much as anticipated.
- Red: SCPH had no impact, or a very limited impact, on improving the outcome.

Summary of key findings on the effectiveness and impact of SCPH in the following areas, based on the programmes ToC	
	<p><b>1. Limited impact of SCPH on HCC performance</b></p> <p>SCPH had a small effect on improving the HCCs’ understanding of their role. However, members of HCCs who were interviewed were still often not easily able to articulate their role in detail. Community members were generally not aware of the HCC or their role – in part this is because the HCCs often lack a platform of their own and use wider community meetings to interact with the community. As HCC members assumed other roles in the community, they were known in their traditional roles and not as part of the HCC.</p>
	<p><b>2. Modest impact of SCPH on patients’ knowledge of rights and entitlements, and no impact on patients’ knowledge of their health responsibilities</b></p> <p>SCPH has had some success in raising awareness about patient rights. Though awareness of the government document that sets out patient rights (the Patients’ Charter) remains low in both intervention and comparison facilities, there has been some improvement due to SCPH in people’s awareness that they have any patient rights at all, and that MNCH services should be free. However, there is still considerable scope to raise people’s knowledge and understanding of the full range of rights contained in the Charter. The majority of people can still only name the most basic right.</p> <p>Patients’ knowledge about healthy behaviours was high in both intervention and comparison facilities, and SCPH had no impact on increasing such awareness.</p>

	<p><b>3. Limited impact on the operation of complaint mechanisms</b></p> <p>SCPH improved the availability of feedback mechanisms in intervention facilities, and the HCCs' use of feedback mechanisms to gather complaints. However, despite improved availability of channels for providing feedback, the community often do not use these mechanisms for fear of retribution, lack of knowledge about where to complain, or because they are tolerant of the facilities' constraints.</p>
	<p><b>4. Modest yet positive impact of SCPH on increasing decision-making that is inclusive and responsive to community feedback</b></p> <p>We find a large and significant impact on the proportion of health facilities reporting that changes have occurred in the facility as a result of patient complaints. However, there are few complaints made to facilities in the first place, and resolution of those was often only partially achieved, owing to limited resources at the disposal of decision-makers.</p>
	<p><b>5. Very limited impact of SCPH on the quality of health services</b></p> <p>According to the Ministry of Health and Child Care (MoHCC) Quality of Care checklist there has been no overall improvement in health service quality in intervention facilities compared with comparison facilities. The qualitative endline study, on the other hand, did find evidence of small, but important, improvements in the quality of health service – especially in improving the understanding between facility staff and community members towards each other.</p>
	<p><b>6. No impact of SCPH on patient satisfaction with health services</b></p> <p>We find that SCPH did not have any effect on patient satisfaction, and that this was already high before the programme began. At both baseline and endline patients from both intervention and comparison facilities reported high levels of satisfaction with the health services, including opening hours, cleanliness, access to privacy, availability of medicines, facility staff, waiting times, and facility infrastructure.</p>
	<p><b>7. No impact of SCPH on utilisation of MNCH services</b></p> <p>We find that there is no impact of SCPH on the utilisation of health facilities for MNCH services as measured by antenatal care (ANC) (first visits, second visits, third visits and fourth or more visits), postnatal care (PNC) (at three days, seven days and six weeks), immunisations, and the total number of new outpatients per month (OPD).</p>
	<p><b>8. Positive impact of SCPH on MNCH policy</b></p> <p>Despite long delays in the adoption of the Public Health Act Amendment bill, the programme's advocacy strategy contributed to the progress of the bill, which is set to be passed this year. Advocacy efforts had limited impact on improving human resourcing for health and financing.</p>

## Sustainability

The discussion of the sustainability of SCPH focuses on the areas where SCPH had a significant effect. The strengthened role of HCCs within the health system is likely to continue while existing members are in post. HCC members expressed a high level of commitment and demonstrated intrinsic motivation to undertake their roles after the support from Save the Children or CWGH ends, and are due to receive legal recognition for their roles in the new PHA Act when this is (likely) passed. Additionally, the recognition given to HCCs as representatives of community members in the new Public Health Act Amendment bill when it is (likely) passed is one successful implication of the SCPH advocacy strategy, and this should help make some formal provisions for the continuation of community accountability structures within the Zimbabwean health system. However, the ability of the HCC to meet internally, and with the district, and to collect feedback, in particular using scorecards, will be limited by a shortage of funds. The training provided to HLFs and CMs will continue to benefit the community through the fact that the programme chose in many cases to train those who were already working as VHWs. However, crucially, as the existing volunteers filling roles on the HCCs and the VHWs who were trained by SCPH leave their posts the effects of the programme will be lost.

## Efficiency / value for money

Judged against final objectives of increasing the quality and utilisation of health facilities, the value for money provided by the programme is limited since these goals were not achieved.

The programme did achieve some progress in outcomes relating to participation, even though this was not fully realised. However we find that this programme was relatively expensive to deliver these changes. We also found that the programme suffered from a shortage of budget to fully implement all planned activities. Therefore, given that even more resources would be likely to be needed for this programme to have really brought about change in the inclusion of community voices, we do not feel that the programme represents value for money if the objective is to raise participation.

## 5.2 Lessons

This section presents the key lessons and recommendations from the evaluation. We structure this section into lessons learned about the achievement of the three goals of SCPH: increase community participation in health, increased quality of health services and increased utilisation of MNCH services.

### Lessons around increasing community participation in health

We believe that this programme does have the potential to lead to improved participation outcomes if it had more time for implementation and more resources (explained further below). However, we also find that the mode of delivery of this programme is already relatively expensive. Therefore given our view that even more resources would be required to achieve meaningful improvements in participation and inclusive decision making, we do not feel that investing further in this programme would be of value compared to other investments that could be made instead.

Community participation is identified as key objective in the MoHCC 2016 – 2020 National Health Sector Strategy, which emphasises the importance of linking community systems and health

service delivery<sup>1</sup>. We recognise that there is intrinsic value in empowering local communities to share feedback and contribute to decisions that affect them, and that inclusion of community voices is indeed important in ensuring the longer term strength of health systems. Yet we feel that at this time in the development of the health sector in Zimbabwe, these benefits need to be balanced against the potentially high cost required to achieve them, in view of the other uses that investment in the health system could be directed toward.

If the goal is to achieve participation, rather than continuing to invest in this mode of delivery it would be worth exploring more cost-effective alternatives. One less expensive option could be to integrate training on community participation into the standard training package that HCC members receive as part of the RBF scheme.

Some other specific lessons emerging from the evaluation in relation to achieving greater community participation are as follows:

- **Volunteers can be effective in engaging with community members, but more are needed to cover the facility catchment areas, and this can be costly.**

The evidence suggests that volunteers are, in the main, highly motivated to perform their roles and are held in high regard by community members for the roles they perform. This means that they have the potential to be effective in raising awareness about rights and entitlements, and to become ambassadors for the health facility that community members feel they can approach. However, volunteers struggled to reach all communities within their catchment area due to large distances between them and a lack of transport links. This implies that more would be needed for volunteers to be able to engage deeply with community members, which has implied costs since training them is expensive. The programme could also consider varying the number of volunteers trained according to the size of the catchment area, rather than having a fixed number per facility

- **The decision to target the intervention at HCCs was appropriate, but HCCs still need a lot of support.** HCCs are recognised for the important role they play in the health sector, and were suitable for the programme to work with given its aims. Committees were mostly already in existence before the start of this programme, have been found to generally work well with facility and MoHCC staff, and already had a mandate that placed a strong focus on community participation. However, we found that SCPH-supported HCCs were variable in how effective they were in their roles, and are not yet all performing at a consistent level, compounded by frequent changes in membership. This implies that further, targeted support to HCCs is still required before they can function as effective conduits between the community and the facility. Providing the level of support required for all HCCs to function at a consistent level is likely to be expensive.
- **The programme may have had more of an impact on changing people's expectations and levels of satisfaction with health services if it increased the quality of information on MNCH results in the local area that was shared with community members.**

The emphasis of the programme in terms of community feedback was strengthening a flow of information from community members upwards toward the relevant decision-makers. A similar community accountability programme implemented in Uganda achieved stronger results by focusing to a greater extent on the feedback that flowed back to the community

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<sup>1</sup> 'Community Systems Strengthening Framework for Health in Zimbabwe' (Draft 1), Ministry of Health and Child Care, 19<sup>th</sup> October 2016.

level, including communicating MNCH results in the local area to community members to raise their awareness of local health outcomes. A complementary focus on communicating actual health outcomes back to the community level may be able to raise people's expectations of quality service delivery more effectively than delivering training on patients' rights in the abstract.

- **The effectiveness of the programme could have been improved by greater efforts to engage local leadership, including religious leaders, to encourage community members to voice complaints and to create awareness about the existence and role of the HCC.**

The inclusion of local leadership has the potential to ease two key constraints we observed in the propensity of community members to raise their complaints: lack of awareness about where to report, and fear of reporting. Encouragement by local leadership to seek out and participate in decision-making processes would raise awareness among community members more effectively than could individual volunteers with a more limited platform, and this would also reassure community members that they can do so without fear of reprisal.

The programme did begin to include local leadership to a greater extent during the scale-up to Rushinga and Guruve, and noted promising results in doing this. Inclusion of local leadership in the programme is also important for the effectiveness of HCCs. HCCs are in many cases reliant on local leadership in order to convene meetings with the community, and the support of leaders can also help the HCC to mobilise resources for their planned activities.

- **Given the fact that the programme's mandate is ambitious in its attempt to change social norms around voicing grievances, increasing the duration of the intervention would increase the chance that these changes could occur.**

The context for the intervention is an environment in which people report overall satisfaction with the quality of services provided at health facilities. Among those who are unsatisfied, the primary reason for not reporting anything is fear of the repercussions of speaking out. The programme sought to shift these prevailing attitudes, first by raising people's expectations about the quality of services that they should be entitled to, and second by encouraging a culture in which people feel able and empowered to raise their concerns. These are departures from the norm in terms of people's attitudes and behaviours, which may require more time to change than this programme allowed for. Since we observed some changes in awareness of patients' rights during the period, it is possible that a more sustained intervention that worked more intensively within communities to instil this culture of participation would have achieved greater results in doing so.

## **Lessons around increasing the quality of health services**

The route that this programme sought to take to improve the quality of MNCH services was flawed given the current stage in the development of health facilities in Zimbabwe. At present the main challenges affecting health service delivery are well known to both community members and decision makers (staff at the health facility, district, province and national policy levels). The main reason why they are not being overcome is a persistent shortage of resources rather than a lack of accurate information or accountability structures.

This programme anticipated that when community members are consulted over their main issues and priorities for health, and have a strengthened ability to monitor service quality and hold

decision makers to account, the decision making process will become more responsive to service users. However the assumption underpinning this mechanism is that decision makers will have the capacity to make the required changes, and that it is the absence of sufficient accountability or information about what changes are needed that prevents them from doing so in the first place. In this context, this assumption is not met. Therefore it would not have been possible to achieve substantial changes in service quality through this route.

If the end goal of the programme is to improve service quality, we believe that resources would be more effectively spent in directly targeting the recognised resource challenges that health facilities experience, particularly around shortages of staff and waiting times.

This is not to say that the community participation route to improving facility quality could not be valid in other contexts, or could not work over the longer term to improve responsive decision making when the supply side constraints are less urgent. But under current conditions this channel is not appropriate to try and bring about the changes that are most needed to improve service quality in Zimbabwe.

### **Lessons around increasing the utilisation of MNCH services**

There were flaws in the underlying theory behind how SCPH was expected to bring about increased utilisation of MNCH services. This theory anticipated that higher utilisation could be achieved by raising patient satisfaction in services (through initiating a more inclusive and responsive decision making process) and also by raising awareness about the importance of attending clinics (through the education provided by HLFs).

Yet satisfaction levels and knowledge were not found to be key barriers to utilisation in this context. Patient satisfaction and knowledge and awareness of key MNCH issues were both found to be high. The level of service utilisation, at least for some sorts of services, is in fact already relatively high in Zimbabwe compared to other countries in the region. The non-use, or limited use, of services is therefore not a widespread problem, but tends to affect specific groups of people. The particular barriers faced by those who do not often use clinics include religious objection, for those belonging to the Marange Apostolic sect, and the distance and cost to reach clinics for communities who live in remote areas.

Therefore if the final objective of the programme is to increase utilisation, it would be more cost-effective to work with these particular groups and target resources towards overcoming these barriers. Seeking to raise utilisation by improving patient satisfaction is not effective in this context because dissatisfaction is not a key reason why people don't use clinics.

SCPH did include some components that partially addressed distance and cost barriers, for example in promoting the construction of mothers' waiting shelters and removing user fees from clinics still charging users for MNCH services. However, these were not its main areas of focus. Outreach services, which are commonly used to increase access to health care when distances to facilities are high, were not prioritised by this programme and should be considered for future programming. The programme did attempt to deepen its engagement with Apostolic communities during implementation, with some reported success. However this was not its main area of focus, so emphasising a strategy for engaging with these groups should be a focus for future programmes seeking to raise utilisation.

## 5.3 Recommendations

The following section outlines the recommendations arising from our evaluation findings and lessons. In this section we distinguish between recommendations applying to each of the key identified intended users of the evaluation.

### Recommendations for the development partners financing this programme and MoHCC:

1. SCPH sought to goals of improve community participation, health service quality *and* health service utilisation. However, in the current context in Zimbabwe, the goals of improving community participation, health service quality and health service utilisation outcomes require different types of investments and strategies. It is recommended for development partners to determine what the primary objective of programming in this area is, and tailor investments accordingly.
  - If the main goal is to **increase utilisation**, we recommend that future programming should focus on targeted investment that more directly seeks to alleviate the primary barriers to utilisation. In the current context, these are distances and costs to reach clinics, and religious objection among certain groups. Alleviating distance barriers may be achieved through continued investment in outreach services, mothers waiting homes and investments in transport services such as ambulances. Alleviating barriers around religious objection requires that a targeted strategy be developed for working with Marange communities.
  - If the main goal is to **increase health services quality**, we recommend focusing investments directly in supporting the weaknesses and gaps that exist in health service delivery, in particular staff and medicine shortages which are frequently cited as a constraint to the quality of health services in Zimbabwe.
  - If the main goal is to **increase community participation in health**, we believe that a continuation of the strategies pursued by SCPH can achieve this, but recommend that more cost-effective means of delivering the programme be sought as the current model, of using a standalone NGO implemented programme, is expensive. Closer integration of community participation objectives into existing programmes and activities could help to achieve efficiency. For example, including training around community participation and complaints mechanisms in the training that HCC members and facility staff already receive under the RBF scheme. Ongoing support to HCCs is appropriate as part of such a strategy, since committees are under-resourced and are a natural platform through which to bring community voices into decision making. However, strategies for increasing the reach and usefulness of training and other support provided could be considered. This could include ways to improve retention of committee members, and how to build cost effective mechanisms for ongoing capacity building and support, to ensure that skills are sustainability built and maintained throughout committees.

### Recommendations for the development partners financing this programme:

Overall, we find that the expectations for this programme were disproportionate to its budget and design. We believe that it could have been possible to anticipate the ultimate failure of SCPH to achieve its higher level goals, to some extent, in advance. The business case for DFID's overall MNCH programme suggests that the accountability intervention was modelled on related intervention implemented in Uganda. As described in section 1.2.2 of Volume 1 of this final

evaluation, an evaluation of this programme in 2004-5 using a randomised design found positive results<sup>[1]</sup>. Our understanding is that SCPH was designed, at least in part, with these impressive results in mind.

Whilst it is appropriate to have drawn lessons from a previous evaluation to shape the design and targets established for this programme, we believe that some further attention could have been paid to the potential sensitivity of the Uganda results to their context. There may have been some indications at the design phase of this programme that the likelihood of witnessing similarly positive findings in the Zimbabwean context would be lower. For example, the 2010/11 Demographic and Health survey had indicated that the major barriers to health service utilisation by women of reproductive age were distance to health facilities and the cost of obtaining treatment, rather than the quality of services. This evidence could have been drawn on to question the assumptions underpinning the ToC for SCPH, and establish more feasible targets from the start.

Related to the above, even if the indications at the inception phase of this programme suggested that the intervention could achieve comparable success to the Uganda model, the programme could perhaps have paid closer attention to monitoring the key assumptions underpinning it over time. This includes paying attention to the financing situation for health facilities during this period, which was integral to the ability of decision makers to meaningfully respond to complaints. According to the business case, expectations at the time were that the HTF would provide sufficient resources to health facilities to enable responsiveness to feedback. Yet over time it became increasingly apparent that the HTF alone did not provide enough resources to meet financing deficit and persistent shortages remained. The OPM baseline evaluation report also provided some indications that the programme may not be likely to achieve its projected results.

### **Recommendations for the implementers of this programme:**

Below we make a number of operational recommendations for programme implementers with regard to how programme delivery could be made more effective. We recognise that many of these observations have already been taken on board by programme staff, but we reiterate them here as a record of the lessons emerging from the implementation of this programme.

1. We recommend continuing to invest in accessible materials for communicating patient rights and entitlements to community members. This is because messages about patient rights are not yet found to have permeated widely among community members, and the Patients Charter is a dense document. Wider distribution of pictorial and/or local language guides to health facility staff and community health workers could help to increase the impact of training around rights and entitlements. We also recommend that health facilities be encouraged to display these local language or pictorial guides to patient rights in communal areas of the health facility, where they may be easily seen by patients who are waiting.
2. Continue to work with traditional and local leadership to seek support for promoting community participation, and to help encourage community members that speaking up is safe and that their feedback is welcomed.
3. Make some refinements to the manner in which HCCs are supported, to increase the impact of their engagement with local communities. The programme should consider ways to help make HCCs better known amongst communities in their capacity as a committee on health.

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[1] M. Björkman and J. Svensson (2009) 'Power to the People: Evidence from a Randomized Field Experiment on Community-Based Monitoring in Uganda'. *The Quarterly Journal of Economics* (2009) 124 (2): 735-769. Available from [https://staffstream.hhs.se/public/streamdocument.ashx?dl=02557\\_003](https://staffstream.hhs.se/public/streamdocument.ashx?dl=02557_003)

The programme should also focus on strategies for incentivising HCC members and community health volunteers appropriately, to ensure that they are motivated to continue in their roles and rates of turnover are minimised.

4. Make some improvements to suggestion boxes:
  - Move suggestion boxes to a more discreet location in the facility, where it is out of sight of the nurses.
  - Educate community members about its purpose and location.
  - Ensure that the box is in good repair and remains locked.
5. Aim to relay information back to the community as much as possible, as well as seeking their feedback. This includes communicating what the outcome or progress of any complaints that were raised has been, developments and trends in services provided by the facilities and decisions that are being made at the clinic.
6. As outlined above, implementers should consider how to incorporate community participation elements into other existing health programmes and strategies, rather than carrying out a separate programme with this as its focus. This might include developing training modules and materials that can be easily incorporated into other training programmes, working with the MoHCC on incorporating these approaches and supporting the MoHCC and its partners to develop the capability for undertaking this work.

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