Strengthening Community Participation in Health: Final Evaluation

Volume I: Descriptive Report

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Preface

This report constitutes 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 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.

Executive summary

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 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 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.

The evaluation

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.

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 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 identity 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.

The evaluation presents findings on the effectiveness and impact of SCPH in the following areas, based on the programme's 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 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.

Key findings

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	
🟠	**1. Limited impact of SCPH on HCC performance** 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.
🟠	**2. Modest impact of SCPH on patients' knowledge of rights and entitlements, and no impact on patients' knowledge of their health responsibilities** 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. Patients' knowledge about healthy behaviours was high in both intervention and comparison facilities, and SCPH had no impact on increasing such awareness.
🟠	**3. Limited impact on the operation of complaint mechanisms** 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.
	4. Modest yet positive impact of SCPH on increasing decision-making that is inclusive and responsive to community feedback

○	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.
○ / 🚫	**5. Very limited impact of SCPH on the quality of health services** 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.
🚫	**6. No impact of SCPH on patient satisfaction with health services** 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.
🚫	**7. No impact of SCPH on utilisation of MNCH services** 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).
✚	**8. Positive impact of SCPH on MNCH policy** 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.

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.

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[1]. 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

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

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 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.

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, an evaluation of this programme in 2004-5 using a randomised design found positive results[1]. 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

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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

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. 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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List of figures, tables and boxes

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

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1 Introduction

1.1 Background to SCPH

1.1.1 Aims of the programme

SCPH in Zimbabwe was a pilot programme that aimed to strengthen citizen engagement in the monitoring of MNCH services in order to improve their quality and utilisation, and hence improve MNCH outcomes. The programme also contributed to national-level advocacy to strengthen accountability mechanisms and increase the visibility of MNCH issues.

The programme was intended to complement the supply-side support to the health sector provided through the HTF, a multi-donor pooled fund, the overall purpose of which is to improve MNCH in Zimbabwe, which provided support from 2012 to 2015. It also has links to the overall MoHCC strategy for community participation in health, as enshrined in the 2016 – 2020 National Health Sector Strategy, which identifies linking community systems and health service delivery as a key objective[2].

1.1.2 Coverage of the programme

The programme covered eight out of Zimbabwe's 10 provinces (Harare and Bulawayo were excluded), while the advocacy worked at the national level. Within these eight provinces, the programme operated in 21 of the 59 districts. In total, the programme operated in 166 facilities. Figure 1 depicts the programme's geographic coverage.

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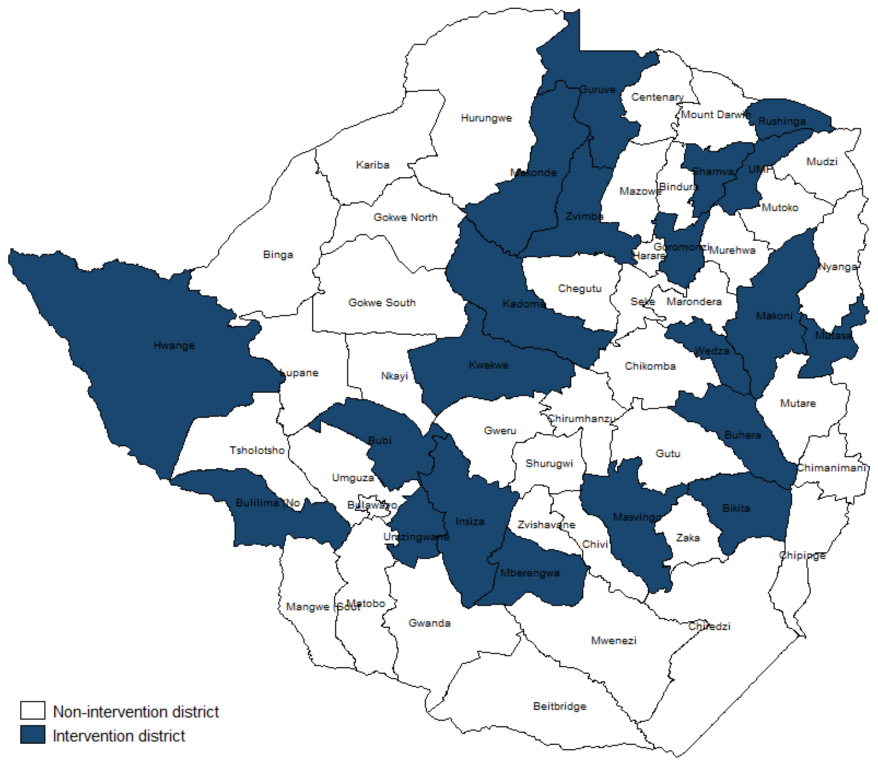
[2] 'Community Systems Strengthening Framework for Health in Zimbabwe' (Draft 1), Ministry of Health and Child Care, 19th October 2016.

Figure 1: Map of districts supported by the SCPH intervention

Map of districts supported by the SCPH intervention



Source: SC/ CWGH project implementation information

SCPH was funded by DFID and the EU. The implementation of SCPH in 14 districts, plus the evaluation, was funded by DFID and implementation in the remaining seven districts was funded by the EU. The programme was implemented by Save the Children and CWGH, and was part of DFID's broader MNCH Programme in Zimbabwe, which ran from 2012 to 2016.

1.1.3 Key activities of the programme

The programme's work centred on establishing HCCs where they did not already exist, and training and providing ongoing support to the HCCs. It also provided training to HLFs on how to educate community members about MNCH issues, and to CMs on how to administer community scorecards.

As described by the training manual used by Save the Children and CWGH:

> *HCCs were originally proposed by the MoHCW* [now MoHCC] *in the 1980s to assist communities to identify their priority health problems, plan how to raise their own resources, organise and manage community contributions, and tap available resources for community development. The HCC is the mechanism by which people get involved in health service planning at a local level. HCCs report on community grievances about quality of health services, and discuss community health issues with health workers. It is a joint community-health service structure linked to the clinic and covering the catchment area of a clinic (usually a ward or more).*

The programme focused specifically on HCCs and not Ward Health Teams/Committees or Sub-Health Committees. The government transferred responsibilities from Ward Health

Teams/Committees and Sub-Health Committees to HCCs around the time SCPH began. In some cases this merely involved a name change, but in other cases the change affected operations as well. This change was driven by the introduction of an RBF model, which imposed requirements regarding the way a committee was formed and operated, including the need to elect committee members, which was not always required by Ward Health Teams/Committees or Sub-Health Committees.

The HCC training manual used by the programme, which outlined the roles and responsibilities of the HCC, was adapted from the one used in CWGH's prior work. Under SCPH, two additional modules were added. In the first of these additional modules, HCCs and HLFs were taught actions and practices to reduce maternal, newborn and child mortality. In the second, additional module HCCs were trained to identify vulnerable and marginalised groups in their communities and to explore ways of addressing their MNCH needs.

The programme promoted the establishment and use of mechanisms for the community to provide feedback to the health facilities. The programme encouraged the use of three main feedback mechanisms:

1. **Community scorecards**. The programme provided training and ongoing support in the use of community scorecards, by which the health services could be rated by the local community. The community scorecards were developed by the programme and roughly two CMs per health facility were trained to administer these on a quarterly basis. The programme also trained HCCs to analyse data from community scorecards.

2. **Suggestion boxes**. HCCs were trained to install suggestion boxes, which community members could use to suggest new ideas or to raise concerns, and to review the feedback.

3. **HCC feedback forms**. HCCs were trained to collect data on community perceptions of access to, and provision of, MNCH services, and to analyse the data using HCC feedback forms.

The HCCs were trained to produce a report using all information sources. The report was then intended to be shared with stakeholders at the community and district level.

The HLFs were trained to educate communities on their health entitlements using the '*rights and responsibilities approach'*. The rights and responsibilities approach is captured in a community-produced checklist, which is set out in pictorial form, with images or photos produced by the community. The checklist is divided into two parts, one showing the community's rights and entitlement to quality MNCH services (which can be used in discussions with health providers) and the other side showing the responsibilities that the community has accepted, showing their commitment towards adopting healthy behaviours and practices to improve MNCH outcomes. It was intended that any possible solutions or strategies for change that could improve MNCH services that might arise during the development of the checklist would be fed back directly to HCC members, who would then engage in dialogue with health care providers. HCC members were then meant to collect feedback from health care providers and to provide responses to community members. However, the programme implementers indicated that they believe that, due to budget constraints, the full rights and responsibilities approach was not implemented with the necessary depth and quality to influence behaviour relating to access and utilisation, particularly among those who held strong beliefs against using services.

In each district the programme usually began with the establishment of the HCC, if one did not exist, and then followed the training of the HCCs. Following this, the HLFs and CMs were trained and the programme worked with the HCCs to establish community feedback mechanisms (suggestion boxes, community scorecards and HCC feedback forms). The programme also trained the HCCs to hold community- and district-level advocacy meetings and to arrange HCC 'exchange visits' to share learning.

1.1.4 Advocacy component of the programme

A distinct part of the SCPH was an advocacy strategy, designed to influence the policy environment for health in Zimbabwe in such a way as to support an improvement in MNCH outcomes.

Strengthening community involvement in health is already identified as a key objective in the National Health Strategy 2016 – 20, which defines community systems for health as 'community-led structures and mechanisms used by communities through which community members and community-based organisations and groups interact, coordinate and deliver their responses to the challenges and needs affecting their communities'[3]. The MoHCC document on Community Systems Strengthening outlines a number of key principles related to achieving this aim, including the need to ensure 'active community participation in all aspects of health programme planning, design, implementation and monitoring', as well as 'programming informed by evidence and responsive to community experience and knowledge'. These principles are closely aligned with the spirit of SCPH, and therefore the wider objectives of SCPH are in some respects already linked to government priorities[4].

To support the achievement of its goals, the advocacy strategy component of SCPH focused on a set of specific objectives around health policy reform. These were as follows:

To pass the Public Health Act Amendment bill

The Public Health Act is the central piece of legislation that determines health policy in Zimbabwe. Attempts to revise the Act have been made since 2010, when the Public Health Advisory Board was established to review the provisions of the Act. However the Public Health Act Amendment bill has faced a number of delays in reaching parliament. The SCPH advocacy strategy sought to accelerate the process of enshrining the Amendment into policy. The specific provisions of the Amendment which are of highest priority for the advocacy strategy are the removal of user fees across primary health facilities in Zimbabwe, an updated allocation of staff, and renewed Health Financing Policy, all of which are also separate objectives of the advocacy strategy.

To advocate for increased national spending on health care

The proportion of the national budget allocated to health care has remained low relative to the recommendations of the 'Abuja declaration'[5], which state that 15% of the national budget should be reserved for health. The proportion in Zimbabwe has fluctuated between 6% and 10% over the past few years. The strategy aimed to try and bring about increased spending on health care.

To ensure the removal of user fees at the primary health care level

Zimbabwe has had an official policy on user fees since 1981. Under this policy, primary health centres are not permitted to charge user fees to pregnant women, carers of under-fives and over-65s, though council- and mission-run clinics are formally exempt from this ban. Yet despite the

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[3] Quoted from 'Community Systems Strengthening Framework for Health in Zimbabwe' (Draft 1), Ministry of Health and Child Care, 19th October 2016.

[4] Ibid.

[5] See World Health Organisation (WHO) 'The Abuja Declaration: Ten years On' (August, 2011), available at www.who.int/healthsystems/publications/abuja_report_aug_2011.pdf?ua=1

existence of a formal policy, user fees have continued to be applied at the primary level in order to cover facilities' costs. The introduction of results-based financing RBF in 2012 improved the situation greatly, since the removal of user fees was a condition attached to the receipt of RBF disbursements. However council- and mission-run clinics have continued to charge user fees, and there are isolated cases of government-run clinics doing the same. The levy of even a small charge for facility users to access services at the clinic acts as a severe barrier to facility utilisation in economically-deprived areas. The advocacy strategy sought to bring about a legally-binding policy on user fees to address this.

A statutory instrument for HCCs

The importance of HCCs in the Zimbabwean health sector has received a boost in recent years, most notably through the introduction of RBF, which gave renewed importance to the role of HCCs in helping to manage the new funds that facilities were receiving. Development agencies and non-governmental organisations (NGOs) have also increasingly invested in HCCs. However, there is no formal legislative recognition of HCCs. The advocacy strategy sought to implement a statutory instrument for HCCs, in the event that the Public Health Act Amendment bill was not passed (which separately included recognition for HCCs).

Improved human resources for health

A shortage of qualified health staff has been among the major challenges at the primary health care level. This shortage emanates in part from an outdated allocation of staff, as well as difficulties in the retention of qualified personnel and the extent to which outgoing staff are replaced. As demand for services has increased, the lack of staff has placed services under great strain. The advocacy strategy sought to alleviate this situation.

The approach to achieving the objectives laid out above began with a situation analysis, to better understand the current situation of health care policy in Zimbabwe and strategies through which the planned objectives might be best realised. The actual strategy was then launched around a year after SCPH began. It was developed with the support of an external consultant, and was designed to build on the approaches that CWGH already take in their work, as well as to strongly reflect the community participation emphasis of SCPH. The strategy therefore marked some continuation with CWGH's regular operations, but narrowed the focus down to a set of key objectives (described below).

The main element of the strategy activities was the organisation of large advocacy conferences and events each year, with the aim of bringing together all relevant stakeholders in shaping the policy agenda for health. The strategy also included provision for programme staff to attend key strategic meetings and to circulate pre- and post-budget position papers containing analysis of the budget proposals and implications of changes.

1.2 The SCPH evaluation

1.2.1 Objective of the evaluation

DFID commissioned an evaluation of SCPH because there was limited evidence on the impact and value for money of community accountability programmes. The evaluation assesses the impact of the programme on the quality and functionality of HCCs, the public's knowledge of their rights and entitlement to health care, the decision-making processes regarding community and health facility resources, the complaints and monitoring mechanisms at health facilities, and the quality of health facilities (actual and perceived). Ultimately, the evaluation aims to understand if the programme increases the utilisation of MNCH services. The main objective of the evaluation is therefore to estimate the impact of the programme, but we also consider the other Organisation for Economic Co-operation and Development (OECD) Development Assistance Committee (DAC) evaluation criteria of the relevance, effectiveness, efficiency (including value for money) and sustainability of the programme[6].

1.2.2 Background of the evaluation

SCPH was reviewed by DFID's annual review team for the DFID's MNCH programme in Zimbabwe. The team scored the SCPH output an 'A' for the final annual review in 2016. We note that the scope of the annual review was narrower than that of this evaluation, because the annual review team focused mainly on the function of the HCCs, rather than the full community feedback loop, and it did not consider the effect of SCPH on its higher levels outcomes and impacts (namely the quality and utilisation of health services).

This evaluation is to our knowledge the first to causally assess the effect of a programme like SCPH in Zimbabwe. Prior to this programme, there has been ongoing work looking at HCCs and their impact on health systems in Zimbabwe. Between 1989 and 2002, CWGH set up or revitalised HCCs, and by 2001 the organisation covered 21 districts. Studies provide evidence of better service delivery and better quality of services in Rural Health Centres with an HCC than in those without.[7] For example, in three districts with well-functioning HCCs, clinics with HCCs on average had more staff, a larger allocation of funding from MoHCC, more Expanded Programme on Immunisation (EPI) campaigns, and greater drug availability (even if overall availability of drugs was low) than clinics without HCCs. However, these studies neither investigate whether this relationship is causal, nor do they provide a clear hypothesis of change that connects the presence of HCCs in communities and improved health outcomes in those same communities. As described in Section 5 below, this evaluation will aim to address this issue.

To date we are aware of two other completed studies that use a counterfactual design to estimate the impact of community accountability interventions in the health sector.

Firstly, Björkman and Svensson (2009)[8] conducted a randomised field experiment on community-based monitoring intervention in the health sector in Uganda. The randomised control trial took place in 50 communities across nine districts from 2004 to 2005. The intervention differed significantly from the SCPH intervention in that the implementers of the interventions directly facilitated village and staff meetings in which members of the communities discussed the status of health service delivery and encouraged community members to develop a plan identifying key problems and steps the providers should take to improve health service provision. On the other hand, in SCPH the intervention worked with HCCs, HLFs and CMs, who were then tasked with engaging with community members. Björkman and Svensson found that after one year treatment communities were more involved in monitoring the provider, health workers serving treatment communities appeared to exert higher efforts to serve the community and there were large increases in utilisation and improved health outcomes (reduced child mortality and increased child weight).

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[6] At the time of preparing the final evaluation report, DFID Zimbabwe's health programme 2017-20 had already been designed and it was already decided not to provide support to HCCs through a standalone programme (which is among our recommendations). DFID Zimbabwe provide funding for the HDF, so to the extent that the HDF incorporates elements around community participation then this evaluation is expected to help inform those decisions.

[7] Training and Research Support Centre (TARSC)/CWGH (2004) 'Assessing the impact of Health Centre Committees on health system performance and resource allocation'.

[8] 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

Secondly, Jean-Benoît Falisse (2016)[9] studied an intervention that worked with Health Facility Committees (similar to Zimbabwe's HCCs) in Burundi and South Kivu, Democratic Republic of the Congo. The study looked at 251 Health Facility Committees in Burundi and 79 in South Kivu. The intervention consisted of an information session on the intended official functioning of these committees and a follow-up meeting. The author found that the intervention strengthened the committees and led to changes in health facility management in South Kivu, but not in Burundi. It is argued that the difference in results came from dissimilar management structures and people's relationships to service providers. The intervention had no effect on service provision.

There is also an ongoing study in Tanzania and Indonesia which is evaluating an intervention similar to that in Björkman and Svensson (2009). The study is called Transparency for Development (T4D)[10]. Baseline data were collected in 2015 and endline data will be collected in 2018, so results are not yet available.

1.2.3 Intended users of the evaluation

The primary intended users of the report are the funders of this programme, to help them understand what results this programme has led to and inform decisions over whether to adapt, continue or expand the programme. The secondary users of the report are the programme implementers, to help them learn what has worked well or less well during implementation and to inform future programming decisions. Also included in the secondary intended users of the report are MoHCC staff, to inform their decisions on the health strategy in Zimbabwe, particularly around MNCH and community participation. Other users of the report include civil society; the research community in Zimbabwe (and indeed globally); and the donor community who are interested in the provision and use of MNCH services and the role of the community in improving those services.

1.2.4 Engagement of the evaluation team with key intended users of the evaluation

The evaluation team sought to work closely with DFID partners, as well as Save the Children and CWGH project staff throughout the evaluation. We aimed to ensure that the primary intended evaluation stakeholders and users were well informed of the evaluation's objectives, methodology and timeline, and had the opportunity to provide feedback, seek clarification or raise concerns. Draft reports, survey instruments and research guides were shared with all stakeholders ahead of finalisation to seek comments. The evaluation team met with Save the Children, CWGH and DFID staff in Zimbabwe and in the UK on several occasions throughout the evaluation process to provide updates.

Dissemination events were held in Harare to communicate the results of the baseline and endline findings to a wide audience, including representatives from DFID, Save the Children, CWGH, MoHCC staff and a range of other donors and partners working in the Zimbabwe health sector. In addition to these wider events, we also met with programme staff in London and Zimbabwe, and with DFID, in smaller meetings to discuss the findings and comments on those findings and how they were interpreted.

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[9] J.B. Falisse (2016) 'The community governance of basic social services in fragile states: Health facility committees in Burundi and South Kivu, DR Congo'. Thesis submitted for the degree of Doctor of Philosophy, University of Oxford. Unpublished. Available from jb.falisse@ed.ac.uk.

[10] http://t4d.ash.harvard.edu/.

1.2.5 Description of evaluation products

This report constitutes the final report of the evaluation of SCPH in Zimbabwe. This report is presented as Volume I of the two-volume Final Evaluation Report. While Volume I is intended to be accessible to a wide audience, and avoids technical language, Volume II contains detailed discussions of methodological issues and presents detailed results in support of our findings. The two volumes complement each other and represent a single analytical product. A baseline report, produced at the start of SCPH, is also available. The Terms of Reference for the evaluation are included in Volume 2.

1.3 Structure of the remainder of this report

The report is organised into 18 sections. Sections 2 to 5 provide the background to the programme and the evaluation, Sections 6 to 17 discuss the findings of the endline study, and Section 18 concludes.

Section 2 presents the background of the health sector in Zimbabwe, including trends in key health indicators and the contribution of RBF and other programmes towards improving health outcomes.

Section 3 describes how SCPH was implemented.

Section 4 details the ToC for the programme that directed the evaluation study.

Section 5 discusses the overall design of the evaluation, including the design and methodology of the quantitative and qualitative components. The limitations of the design and its risks are also discussed in this section.

Section 6 presents the impact of the programme on the HCC's understanding of their role and responsibilities, their engagement with the community and District Health Executives (DHEs), frequency of meetings and improving record-keeping at facilities.

Section 7 reports on the programme's impact on patients' knowledge of their rights and entitlements.

Section 8 details the impact of SCPH on encouraging feedback within the community, especially the community's ability to register complaints and use feedback mechanisms designed by the programme

Section 9 goes on to record how these complaints were responded to, capturing instances of complaints that have and have not been responded to, and offering an explanation for the lack of responsiveness where relevant.

Section 10 presents findings on the involvement of different stakeholders in making decisions at the facility, including HCC involvement in the operational plan.

Section 11 highlights the impact on health services quality.

Section 12 records satisfaction with services and Section 1**3** changes in utilisation of the facility, and reasons why the community uses the facilities, when they do so, and barriers towards use.

Section 14 unpicks the complex policy environment within which the programme was working to report on the contribution of the advocacy strategy towards policy change.

Section 15 discusses all the findings from Sections 6 to 14 and how they relate to the programme's ToC.

Section 16 assesses the programme's value for money by analysing the programme's economy, efficiency and effectiveness.

Section 17 reflects on how sustainable the programme will be based on the sustainability of structures developed by the programme, continued government support after the programme implementation is complete, and, finally, the sustainability of health outcomes.

Section 18 presents our conclusions and lessons for future programmes.

The report concludes with a list of references.

2 Background on the health sector in Zimbabwe

2.1 Trends in health indicators

Economic challenges through the late-1990s and into the last decade contributed to a massive reduction in health spending in Zimbabwe, from approximately $42 per capita in 1992 to just over $6 per capita in 2009. The late-1990s saw a rise in HIV prevalence to a peak of between 27% and 30% in 1999. The economic challenges precipitated extensive out-migration – a 'brain drain' – especially of skilled health personnel, mostly to the UK and to neighbouring countries such as South Africa and Botswana. Such was the extent of this brain drain that a study estimated that in 2006, 24% of nurses and 51% of doctors were working abroad.[11]

The result of all these, and other, challenges has translated into a rapid deterioration in most key health indicators, notably MNCH indicators. Since 2010, a combination of economic stability, a greater commitment towards providing basic health services and increased donor funding in Zimbabwe has seen an improvement in the availability of essential health services, and subsequently in key health indicators. Shortages of highly skilled personnel still persist, although there has been an increase in midwife, nurse and doctor attendance at primary health care facilities. Table 1 below shows the trends in some of the main MNCH and health indicators in Zimbabwe over the past decade.

Table 1: Trends in key health indicators in Zimbabwe, 2004–2014

Health indicator	2004/2005	2009/2010	2013/2014
Life expectancy at birth[12]	43	51	58
Adult HIV prevalence[13]	19%	15%	15%
TB incidence[12]	800/100,000	633/100,000	600/100,000
Malaria incidence[14] (suspected cases)	153/1,000	58/1,000	21/1,000
Maternal mortality ratio	830/100,000[12]	960/100,000[15]	614/100,000[16]
Infant mortality rate	60/1,000[17]	57/1,000[15]	55/1,000[16]
Under-five mortality rate	74/1,000[18]	84/1000[15]	75/1000[16]
Proportion of deliveries with skilled birth attendant/in facility		66%[15]	80%[16]
Percentage infants fully immunised	53%	65%[15]	69%[16]
Proportion of pregnant women attending at least four PNC visits		65%[15]	70%[16]
Percentage of health facilities with over 70% of essential medicines available[19]		25%	88%

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[11] Clemens, M. and Pettersson, G. (2008) 'New data on African health professionals abroad'. *Human Resources for Health,* 6(1).
[12] Word Development indicators, World Bank: http://data.worldbank.org/country/zimbabwe.
[13] UNAIDS indicators: http://data.unaids.org/Publications/fact-sheets01/zimbabwe_en.pdf.
[14] UN Development Programme, May 2013
[15] Demographic and Health Survey (DHS) 2010–11.
[16] Multiple Indicator Cluster Survey (MICS), 2014.
[17] ZimStat 2010/2011.
[18] www.childmortality.org/index.php?r=site/graph#ID=ZWE_Zimbabwe.
[19] Vital Medicines Availability and Health Service Survey (VMAHS) rounds 6 and 21.

There has been a notable improvement in many of the indicators between 2009 and 2014, as Table 1 above shows. Despite these improvements, a number of key challenges in health remain, and these include:

1. the sustainability of health funding (more than 35% of health funding in 2014 was from official development assistance);
2. health-seeking behaviour among the poor remains lower than among the better off, regardless of service availability and quality;[20]
3. institutional capacity to plan and formulate clear policies remains weak in some areas;
4. most health indicators are still below the levels required for Zimbabwe to achieve health-related Millennium Development Goals (MDGs);
5. weak referral and patient management systems;[21]
6. quality gaps in the delivery of best practices for routine MNCH services; and
7. no national-level focused and measurable process of measuring care quality.

2.2 Overseas development assistance for health in Zimbabwe

Table 2 shows the donor contributions to health in 2015. Expenditure on health by donors has increased since 2009, with the Global Fund being the largest single contributor to health interventions in Zimbabwe.

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[20] According to the Poverty, Income, Consumption, Expenditure Survey (PICES), 38.5% of the non-poor did not seek care when sick, compared to 45.8% of the extremely poor (PICES survey, 2011/12). According to the Zimbabwe Demographic and Health Survey (ZDHS) 2010/11, 51.7% of the poorest households did not send their lastborn to a health facility in case of diarrhoea, compared to 54.3% from the richest households

[21] Mutasa, R and the Zimbabwe Health Team (World Bank) (2013) ‘RBF in Zimbabwe-Design Evidence and Early Lessons on Pay-for-Quality’.

Table 2: Contributions towards health initiatives by main donors in Zimbabwe (2015 budget)

Donor	(USD millions)	% of health donor funding	Main health initiatives funded
UN Development Programme /Global Fund	119.8	32.6%	HIV/AIDS, malaria and TB commodities procurement and health systems strengthening initiatives
United States Agency for International Development (USAID)	85.7	23.3%	HIV/AIDS, malaria, TB prevention activities, behaviour change communication, technical support to health systems strengthening
UN Children's Fund (UNICEF)	44.9	12.2%	HTF – human resources in health retention, health commodities and equipment, training of midwives and outreach support
Centers for Disease Control and Prevention (CDC)	31.9	8.7%	Infection prevention and control, epidemiological surveys, health data dissemination and use (District Health Information System (DHIS) 2), male circumcision, antiretroviral therapy (ART) initiation
EU	31.6	8.6%	$28 million towards HTF, and community accountability for health,
DFID	27.0	7.3%	Contribution to HTF (through the broader MNCH programme of which the SCPH intervention is a part), sexual reproductive health services commodities and integrated services, monitoring and evaluation, community accountability
Embassy of Switzerland	10.9	3.0%	Child protection fund, psychosocial support, HIV/AIDS prevention programme, policy and legal environment for sexual reproductive health
Embassy of Sweden	10.7	2.9%	$7 million contribution to HTF, Integrated Support Programme (ISP) for sexual reproductive health, cervical cancer, HIV, gender-based violence services
Irish Aid	3.4	0.9%	$2.5 million contribution to HTF, ISP
Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ)	1.0	0.3%	HIV prevention
Norway	0.7	0.2%	HTF contribution
Total	**367.53**		

* There may be some duplication, especially where multiple bilateral donors have contributed to a multilateral-led activity, such as the HTF.

2.3 RBF

The World Bank and UNICEF, through funding from the HTF (Now the Health Development Fund) a multi-donor trust fund, are helping the Government of Zimbabwe to implement a national RBF programme. The transition of the HTF to a RBF model was initially scheduled for June 2014. There were some delays, however, and this deadline could not be achieved, but health facilities received their final payments under HTF in late 2014. Subsequent quarterly disbursements of funds to health facilities, from January 2015, took place under the RBF model.[22]

The RBF model is structured around three primary design components: results-based contracting; management and capacity building; and monitoring and documentation. The RBF model has the following key features:

1. health facilities receive financial incentives for performing according to pre-agreed standards and quantity of services – with HCCs playing an important role in community participation and involvement;[23]
2. financing is decentralised so that health facilities purchase equipment/commodities, verify service utilisation and engage in strategic management of the facilities. It requires improved health facility governance to enable effective planning for use of resources generated under the programme; and
3. health facilities are monitored on a quarterly basis using a quality of care checklist administered by MoHCC staff and a client satisfaction survey administered by community-based organisations. The quantity of services is being measured using the HMIS, which is being regularly verified by Crown Agents.

One of the implications of the RBF model is that there is a closer focus on results. The RBF model creates a need for much improved financial auditing and monitoring, and health statistics quality is being strengthened to ensure the system works effectively. There are various initiatives to address some of these challenges: for example, the United States CDC is working with government to finalise the new DHIS 2.

Under an RBF model, poorly performing health facilities could create health service provision gaps among vulnerable populations, as future resources/budgets are based on past performance. An RBF model can lead to disparities in levels of service and quality of health care across the country, with poorly performing health facilities failing to get additional funds with which they can provide adequate health care services.

The introduction of RBF has led to a change in the relative importance of some of the HCC roles. One of the main roles of HCCs is community mobilisation, and, in the context of very limited resources and irregular cash disbursements from the Government of Zimbabwe to health facilities before the RBF (and the outgoing HTF/HTF-plus), HCCs had to mobilise financing from the communities to be able to cover some running costs, such as the cost of security guards, maternity feeding shelters, improvement of toilet facilities etc. With the introduction of RBF, some of this work may no longer be as important, as most facilities are expected to perform at a level that will guarantee adequate funding for at least the most basic services and provisions.

Under the RBF model, HCCs have a responsibility to prioritise expenditure at health facilities. This role therefore affects how effectively the RBF funds are used. HCCs are responsible for deciding how the money received at the health facility is spent and if the HCCs are well governed: use of funds is prioritised according to community health needs. HCCs thus have an instrumental role in improving the allocation of RBF funds – with funds prioritised according to the specific needs of a

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[22] Actual payment will depend on when the specific health facility is able to meet the RBF conditions for disbursement, which include submitting complete financial reconciliation records for the previous quarter (acquittals). As the system transitions to the RBF, health facilities not fully compliant with RBF requirements may experience a delay in payments, which could affect the quality and scope of services provided in the short term.

[23] The Government of Zimbabwe recognises the importance of community participation in the improvement of health outcomes, and one of the objectives of the National Health Strategy (2009–2013) is to 'Enhance community participation and involvement in improving health and quality of life' (Government of Zimbabwe, ‘The National Health Strategy for Zimbabwe 2009–2013. Equity and Quality in Health: A People’s Right’.)

community. Conversely, poorly governed/working HCCs results in inefficient allocation of RBF funding if their prioritisation of expenditure is not aligned to that of the communities they serve. HCCs thus have an allocative role in the spending of RBF finances.

Another key role of the HCCs, in the context of the RBF, is improved health governance. RBF requires that health facilities develop annual operating plans and HCCs are an integral part of this planning process. The involvement of HCCs in planning can be expected to help communities understand better what the RBF is, how it works, and some of its benefits. If understanding the nature of interventions in a particular community is linked to greater ownership and support for such programmes then HCCs may well serve as a communication and dissemination platform for the RBF, and could lead to stronger engagement by communities.

3 Implementation of SCPH

In this section we describe the main activities undertaken by SCPH, and the support provided. We also comment on some of the challenges experienced during the implementation period, and the implications that these may have had on the final attainment of results.

3.1 Inception period

The programme began with an inception phase in July 2013 to December 2014. During this time the main activities were: negotiating the signing of MOUs in all districts; carrying out HCC assessments to understand the functioning of HCCs before SCPH training started; and training HCCs, HLFs and CMs

Before embarking on any activities the programme needed to establish MOUs. Delays were faced in getting all of these agreed in both the EU- and DFID-funded districts. These delays were attributed to a transition period following presidential, parliamentary and council elections. These delays may not have left the intervention with as much time as was needed to stimulate changes at the community level in levels of participation, or to allow decision-makers the time needed to respond to new information received through feedback channels.

> *'Given the coverage of programme and nature of intervention which is to create social accountability, the time is much limited to educate the community and to instil behaviour change. By the second year we started implementation but then year three we have to already wrap up and had to rush the component of HCC exchange visits.'*
> PEC

3.2 Support provided by SCPH to PECs

In each province the PEC was responsible for implementing the programme. His/her specific roles were: to conduct training for HCCs, HLFs and CMs; to monitor them in their roles and provide supportive supervision or retraining as necessary during the implementation period; to act as the main point of contact for the programme with provincial level staff such as the Provincial Medical Director (PMD), and the Province Administrator (PA) as well as the DHE and District Administrator offices; and to engage with the President's Office to clear protocols ahead of the start of the programme.

PECs received initial training lasting for about one week and then participated in a further three-day training course, called the Training of Trainers. This was intended to provide the necessary skills and knowledge for PECs to conduct training for HCC members, HLFs and CMs within their provinces.

No additional training was provided for the PECs through SCPH, although they acquired further support through meetings held between PECs and Save the Children and CWGH once a year to discuss best practice. Overall, the training and support to PECs was sufficient to equip them to implement their roles.

The main challenge faced was that there was only one PEC per province, and they had a large degree of responsibility in regard to conducting all training and monitoring the implementation of the programme throughout the province. PECs we met noted that covering the whole province was difficult due to restricted availability of transport and resources to conduct frequent field visits. As a result of the PECs being overstretched, they did not interact directly with communities but rather relied on volunteers for this.

3.3 Training provided by SCPH to CMs, HCCs and HLFs

HCCs, CMs and HLFs were trained by the PEC in each province, together with representatives from Save the Children or CWGH (depending on the district), and members of the MoHCC and Rural District Council. Training for HCCs was originally planned to last for five days but was reduced to two to three days to keep within the budgeted amount, and training for HLFs and CMs lasted for two days.

In general, there was no retraining scheduled for volunteers, although Save the Children did source funds to conduct one additional refresher training session for HCCs during the course of implementation. Generally, though, PECs were relied on to identify gaps and provide further targeted support to volunteers as needed.

The training provided to HCCs, HLFs and CMs was well conducted. We found that HLFs and CMs were both significantly better informed about the Patients' Charter and its contents than the VHWs interviewed in comparison areas, and qualitative interviews with volunteers showed that the training had been found to be useful.

However, the training provided was relatively short given the aims of the programme. The vast majority of all HCC members, CMs and HLFs interviewed reported that further training was still needed to help them implement their roles effectively. Moreover, some members of the HCCs did not receive any training under the programme. Again due to budget limitations SCPH could only provide training to a few members of the HCC (around five), rather than to the entire committee. This normally included the chairperson, sister in charge, treasurer and two other committee members. Even among the intended participants there were some who did not receive their training, since poor turn-out was an issue for some of the HCC training session.[24] Nearly all HCCs, HLFs and CMs we interviewed reported the need for further training to implement their roles.

Added to this, interviews with programme staff also highlighted challenges in retaining volunteers over the life of the intervention. This was partly due to difficult economic circumstances, which meant that volunteers who found paid work elsewhere were liable to vacate their roles. There were also instances of *ad hoc* disturbances within HCCs, in which some trained members were removed from the HCC or in some cases the entire HCCs was dissolved. Our survey found 77% of the HCC chairpersons in SCPH-supported facilities that we interviewed reported that they had been trained by Save the Children or CWGH.

> *'The budget wouldn't permit continuous retraining, so we would do a training for new volunteers during our routine monitoring visits instead, maybe just for half a day. It may not have been enough.'*
> Programme staff member

> *'The issue is not the topics of training or amount of training received – this is all sufficient for the role. The only issue is that new members need training to get up to speed.'*
> DHE representative

The training guides and communications materials provided to volunteers were widely reported to be useful (by 100% of all HLFs and CMs interviewed who had been issued with one). However, the programme was not able to finance the printing and distribution of as many materials as were perceived to be needed. This included the facilitators' guides for HCCs, HLFs and CMs, and the Patients' Charter and 'MNCH flyer', which were used during sessions with community members.

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[24] This was attributed to some training being conducted during the onset of rains, with some would-be participants engaged in looking after their fields

The programme also faced a lack of funds to translate training materials into local languages, meaning that some volunteers without strong literacy in English were not able to make use of them.

> *'We need more flyers or patients' charters to give communities when conducting meetings.'*
> CM, Masvingo

> *'We could have done better at translating materials into local languages. We failed to meet the budget for translation, e.g. of the facilitators' guide.'*
> Programme staff member

3.4 Coverage of HCCs, HLFs and CMs

An average of two HLFs and two CMs per district were active in DFID-funded districts, and three HLFs and four CMs in the EU-funded districts.

Table 3: Coverage of HLFs and CMs

	DFID-funded districts	EU-funded districts	Total
Number of districts	14	7	21
Number of facilities covered by the intervention	102	64	166
Total number of HLFs	199	188	387
Total number of CMs	199	244	443
Average number of HLFs per facility	1.97	2.94	2.36
Average number of CMs per facility	1.99	3.81	2.72
Average population covered by an HLF	4464	2235	3533
Average population covered by a CM	4373	1640	3273
Number of districts	14	7	21

Source: Save the Children and CWGH data on volunteer numbers and catchment population

Given the large population sizes covered by some facilities, the number of volunteers supported through the programme was relatively modest. Under some assumptions about the number of people that volunteers can meet on a given day, a rough indication of the number of people that a volunteer could feasibly meet within one year is about 600.[25] This is lower than the total catchment population per volunteer in both DFID and EU districts, meaning that even if volunteers were able to meet with a different group of people every day they would not on average be likely to be able to reach the whole targeted catchment population in one year.

In addition to large population sizes, a related issue facing many SCPH-trained volunteers was the large distances they were required to travel in some catchment areas to reach communities. SCPH was able to provide some bicycles to assist volunteers with transport, but long distances remained a challenge.

Altogether, the limited number of volunteers per catchment area combined with large catchment population sizes and poor transport links across catchment areas meant that the coverage of the

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[25] Assuming that volunteers can meet 10 people per day, work for 5 days a month and 12 months a year (10 x 5 x 12 = 600 people) The OPM HLF and CM surveys found that volunteers work an average of 5 days a month (6 for HLFs and 4 for CMs).

programme (in terms of the number of people that volunteers were able to meet with) was limited. This was noted as a key issue by several respondents and volunteers.

> *‘The success of our implementation lies in community education, for which we relied on HLFs. But there are only two per facility in DFID-funded districts, which is not enough when catchment areas might be up to 8,000. There are lots of pockets not being reached by the intervention and no finances to cover more.’*
> Programme staff member

> *‘Luvuluma is the furthest village, which is 20km from where I stay and I have to walk, and have limited access to bicycles.’*
> HLF, Bulilima

The limited coverage of volunteers is also among the key findings of the final project report to the EU[26], which states the following:

> *‘A higher number of volunteers in a smaller project catchment area would have built capacity of the community structures as a whole, and would have furthered the overall, recorded impact. In the two districts where the SCUK [Save the Children] 2016 breakthrough funding allowed scaling up to five HLFs per village, early indicators are showing significant improvements in both motivation and impact. For improved learning and impact, it is also recommended to increase the number of PECs from one to three per province, as they proved an invaluable link to the community cadres.’*

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[26] Save the Children, CWGH (2016) ‘Final Narrative Report to the European Commission’.

4 SCPH ToC

In this section we present a revised diagram depicting the programme ToC. 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. We have collected data across all areas of the ToC and the diagram below indicates the section numbers of our report where we present evidence for each point in the diagram, drawing on all our quantitative, qualitative, primary and secondary data sources.

The ToC diagram below is intended as a visual aid to help convey the theory behind this programme. The programme's original ToC, and the comments that OPM made on the ToC during the baseline period, are presented in Volume 2, Annex E.[27]

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.

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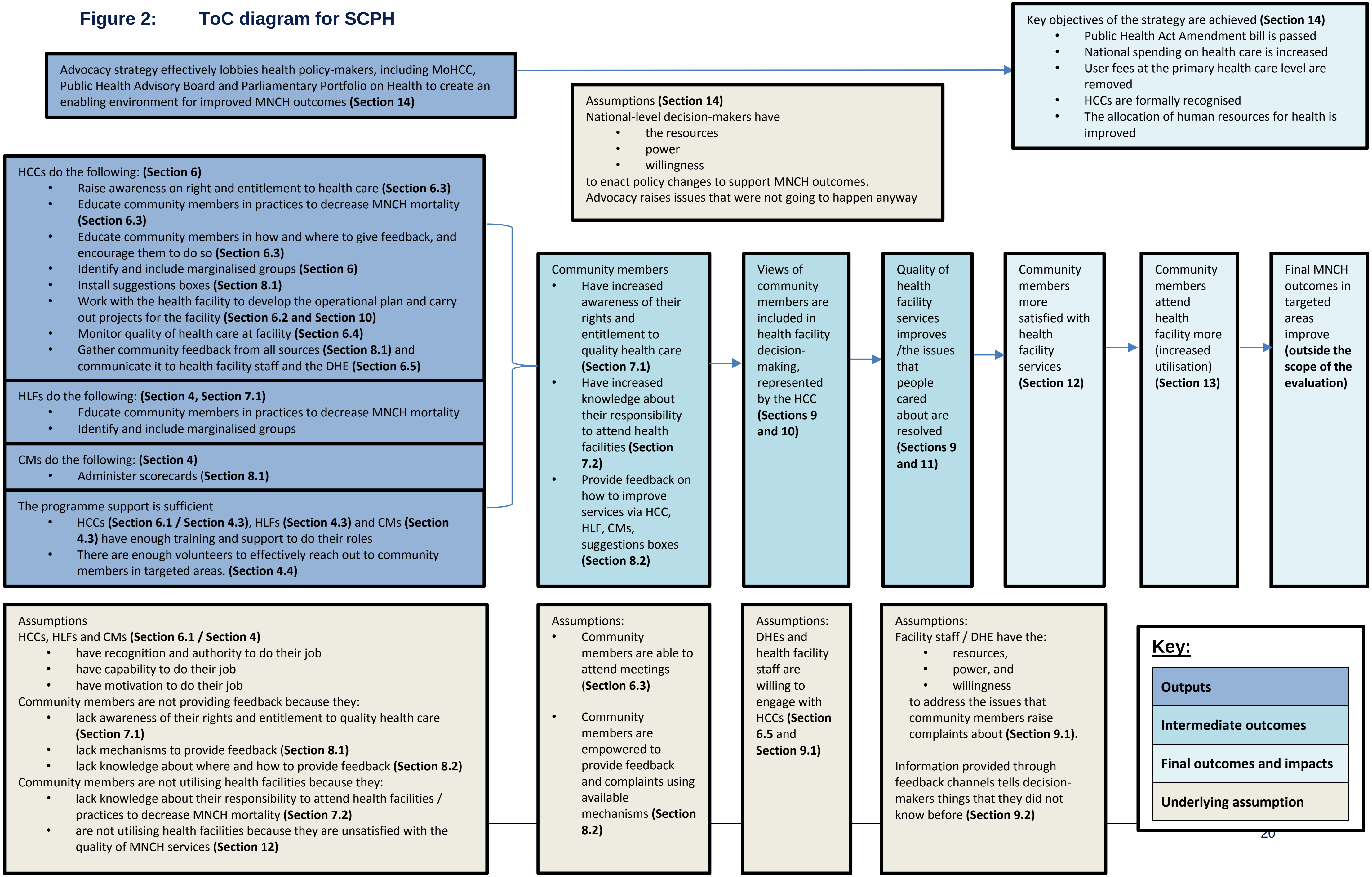
[27] Our representation of the ToC is based on its original programme ToC and its logframe. The logframe identified the key impacts and outcomes of the programme as: contributing to increased utilisation of MNCH services, increased responsiveness to complaints, increased community satisfaction and increased quality of care. The key outputs were identified as greater awareness of the Patients' Charter among community members, increased use of feedback mechanisms, improved quality of HCCs and the proportion of HCCs using community feedback mechanisms. The outputs of the programme's advocacy strategy were identified as increased advocacy for improvements to MNCH services, with the intended outcome being influence over MNCH policy and practices. The programme's logframe and OPMs comments on the logframe are presented in Vol 2, Annex F.

Figure 2: ToC diagram for SCPH



Advocacy strategy effectively lobbies health policy-makers, including MoHCC, Public Health Advisory Board and Parliamentary Portfolio on Health to create an enabling environment for improved MNCH outcomes **(Section 14)**

Key objectives of the strategy are achieved **(Section 14)**
- Public Health Act Amendment bill is passed
- National spending on health care is increased
- User fees at the primary health care level are removed
- HCCs are formally recognised
- The allocation of human resources for health is improved

Assumptions **(Section 14)**
National-level decision-makers have
- the resources
- power
- willingness

to enact policy changes to support MNCH outcomes.
Advocacy raises issues that were not going to happen anyway

HCCs do the following: **(Section 6)**
- Raise awareness on right and entitlement to health care **(Section 6.3)**
- Educate community members in practices to decrease MNCH mortality **(Section 6.3)**
- Educate community members in how and where to give feedback, and encourage them to do so **(Section 6.3)**
- Identify and include marginalised groups **(Section 6)**
- Install suggestions boxes **(Section 8.1)**
- Work with the health facility to develop the operational plan and carry out projects for the facility **(Section 6.2 and Section 10)**
- Monitor quality of health care at facility **(Section 6.4)**
- Gather community feedback from all sources **(Section 8.1)** and communicate it to health facility staff and the DHE **(Section 6.5)**

HLFs do the following: **(Section 4, Section 7.1)**
- Educate community members in practices to decrease MNCH mortality
- Identify and include marginalised groups

CMs do the following: **(Section 4)**
- Administer scorecards **(Section 8.1)**

The programme support is sufficient
- HCCs **(Section 6.1 / Section 4.3)**, HLFs **(Section 4.3)** and CMs **(Section 4.3)** have enough training and support to do their roles
- There are enough volunteers to effectively reach out to community members in targeted areas. **(Section 4.4)**

Community members
- Have increased awareness of their rights and entitlement to quality health care **(Section 7.1)**
- Have increased knowledge about their responsibility to attend health facilities **(Section 7.2)**
- Provide feedback on how to improve services via HCC, HLF, CMs, suggestions boxes **(Section 8.2)**

Views of community members are included in health facility decision-making, represented by the HCC **(Sections 9 and 10)**

Quality of health facility services improves /the issues that people cared about are resolved **(Sections 9 and 11)**

Community members more satisfied with health facility services **(Section 12)**

Community members attend health facility more (increased utilisation) **(Section 13)**

Final MNCH outcomes in targeted areas improve **(outside the scope of the evaluation)**

Assumptions
HCCs, HLFs and CMs **(Section 6.1 / Section 4)**
- have recognition and authority to do their job
- have capability to do their job
- have motivation to do their job

Community members are not providing feedback because they:
- lack awareness of their rights and entitlement to quality health care **(Section 7.1)**
- lack mechanisms to provide feedback **(Section 8.1)**
- lack knowledge about where and how to provide feedback **(Section 8.2)**

Community members are not utilising health facilities because they:
- lack knowledge about their responsibility to attend health facilities / practices to decrease MNCH mortality **(Section 7.2)**
- are not utilising health facilities because they are unsatisfied with the quality of MNCH services **(Section 12)**

Assumptions:
- Community members are able to attend meetings (**Section 6.3)**
- Community members are empowered to provide feedback and complaints using available mechanisms **(Section 8.2)**

Assumptions:
DHEs and health facility staff are willing to engage with HCCs **(Section 6.5 and Section 9.1)**

Assumptions:
Facility staff / DHE have the:
- resources,
- power, and
- willingness

to address the issues that community members raise complaints about **(Section 9.1).**

Information provided through feedback channels tells decision-makers things that they did not know before **(Section 9.2)**

Key:

Outputs
Intermediate outcomes
Final outcomes and impacts
Underlying assumption

5 Methodology

5.1 Key evaluation questions

The main objective of the evaluation is to estimate the overall impact of the programme across the facilities in which it was implemented, whilst also considering the other DAC evaluation criteria of the relevance, effectiveness, efficiency (including value for money) and sustainability of the programme.

Table 4: DAC criteria and key evaluation questions

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?

5.2 Overall evaluation design

The overall evaluation takes a **theory-based approach** and uses **mixed methods**. The theory-based approach makes explicit use of the ToC to draw conclusions about whether and how the intervention has contributed to the observed results. The quantitative research uses a quasi-experimental method to address whether the intervention worked, and the qualitative research looks at how and why the intervention worked, or did not work.

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 Table 5 below:

Table 5: Timeline of the evaluation

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

5.3 Quantitative component

The quantitative component of the endline evaluation provides a statistically robust appraisal of the effect of the intervention on a number of key indicators along the ToC. These indicator areas are: the quality and functionality of HCCs (output); knowledge of patient rights and entitlements, and healthy MNCH practices (output); inclusive decision-making regarding health facility resources (output); complaints mechanisms at the health facilities (output); the quality of health facilities (outcome); perceived quality of care (related to outcome) and service utilisation (impact).

We use a quasi-experimental design to allow us to estimate the causal effect of the programme by constructing a comparison group. Using the comparison group we can assess the question of the counterfactual: ‘what changes in outcomes (if any) occurred as a result of the programme?’

We use a matching design to measure the impact of the programme. In randomised experiments, the randomisation enables an unbiased estimation of the impact of a programme because randomising who receives the intervention and who does not implies that intervention and comparison groups will on average be the same before the intervention begins. The facilities where SCPH was implemented were not selected randomly, and therefore they may not on average share the same characteristics as the facilities that were not chosen. Matching attempts to mimic randomisation by identifying a set of health facilities (and the communities they serve) that did not receive the intervention, but which are comparable with respect to their observed characteristics to the set of health facilities (and the communities they serve) where SCPH was implemented.

We used propensity score nearest neighbour matching to identify one comparison health facility for each intervention facility in our sample. The intervention was rolled out in 21 districts but did not cover all the health facilities in each district of operation. We selected comparison health facilities from the remaining health facilities in these districts that were not covered by SCPH.

The impact of the programme is measured by comparing outcomes from the facilities that received the intervention with those which did not. We consider the programme to have had an impact when the difference between intervention and comparison groups is statistically significant. 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.

For the quantitative component of the evaluation 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.

Our health facility survey covered a sample of health facilities where the programme was operating (intervention facilities) and their matched facilities (comparison facilities). The facilities were first visited in July and August 2014, and these same facilities were revisited again at endline in July and August 2016. The procedure used to sample intervention facilities is described in more detail in Volume 2, Annex G. In these facilities, we interviewed the nurse in charge, the HCC chairperson and a sample of facility users. The facility users we interviewed were ANC patients and carers of children under five years of age (known as ‘U5s’). In addition, for the endline survey we interviewed one HLF and CM in each intervention facility, and one VHW in each comparison facility. We also used facility registers to record the volumes of patients visiting the facility for MNCH services over a six-month period, and interviewed a representative of the DHE in all 21 districts.

In the baseline report we presented the results of a comparison of intervention and comparison groups to determine whether there were any significant differences between them. The results showed that the two groups were well matched, meaning that they had similar characteristics before SCPH started.

At endline, we have conducted two further kinds of test to reconfirm this assumption. First, we repeated the balance tests performed on the HCCs and facility Head Nurses surveys, using the baseline data. The reason for repeating these tests was because there had been some minor changes to the facilities in which SCPH was working since the baseline analysis was carried out. Therefore we needed to check that the two groups were still well balanced under the new, slightly different, assignment of the intervention. We also conducted a new set of balance tests on the samples of ANC and U5 facility users that were interviewed at endline. This was because we did not interview the same facility users at endline as we did at baseline, and therefore we needed to check the balance again in the endline sample. In order to do this we assessed the groups only against characteristics that could not have plausibly been affected in any way by the fact that one group had been exposed to SCPH. This implied comparing the groups in terms of their ‘persistent’ characteristics, such as age, religion and household size.

The results from the two new kinds of balance test are presented in Volume 2, Section 3.1. We found some small differences between intervention and comparison groups, but the overall level of comparability is good across the HCC, facility Head Nurse, ANC and U5 samples. The results are presented in Volume 2, Section 3.1, and are discussed further in Volume 2, Section 2.1.2.

The comparability of the two groups means that we can assess the impact of SCPH by comparing outcomes at endline and be confident that any differences we observe are due to the influence of SCPH. In this report the results presented are derived from comparing the average outcome in the intervention group with the average outcome in the comparison group. In the results section below, we also show some graphs of our main outcome variables that illustrate the average outcome at baseline as well as at endline. These graphs are intended for illustrative purposes, to show how outcomes have evolved over time on average.

There is one key difference between treatment and comparison facilities, which is that the intervention facilities have larger catchment populations than the comparison facilities. This arose due to the way that SCPH selected its facilities to work in and deliberately sought to work in facilities with large catchment areas. In order to ensure that our results were not biased by the difference in catchment populations, we account for this difference in two ways in our additional analysis, which is presented in Volume 2. Firstly, we control for catchment population size in our regressions using the facility Head Nurse and HCC surveys. Secondly, we estimate difference in difference estimates so that any differences in outcomes at baseline are taken into account when comparing differences at endline.

For analysis with secondary data, where possible we use a sample of all the 166 intervention facilities with ‘matched’ comparison facilities.

Table 6: Health facility survey sample sizes

Survey instrument	Total sample size Baseline/endline	Intervention sample size Baseline/endline	Comparison sample size Baseline/Endline
Head of facility	147/150	67/69	80/81
HCC member	145/150	66/69	79/81
Carer of U5	1,514/1,578	684/720	830/858
ANC patient	1,415 /1,175	686/553	729/622
Tallies of registers	147/150	67/69	80/81
HLFs	N/A/64[28]	N/A/64	N/A
CMs	N/A/64	N/A/64	N/A
VHWs	N/A/81	N/A	N/A/81
DHE representatives	N/A/21	N/A	N/A

Note: HLF and CM interviews were only conducted in SCPH facilities because they do not exist in comparison facilities. VHW interviews were only conducted in comparison facilities in order to draw some comparisons with the HLFs.

The secondary data sources used were as follows:

1. **The 2011 needs assessment questionnaire from the National Integrated Health Facility Assessment (NIHFA)**. This is a health facility survey that is designed to provide an analysis of the needs of individual health facilities throughout the country. The 2011 survey covered a total of 1,375 public health facilities countrywide, or 95% of all health facilities. We used these data to identify comparison facilities that were similar to the intervention facilities.
2. **HMISs** are a critical component of well-functioning health care systems, and a key tool for obtaining relevant information on the extent to which a specific population makes use of the health services offered to them. The Zimbabwe HMIS records monthly utilisation of services, by service type and by facility for all facilities. We used these data to identify comparison facilities that were similar to the intervention facilities, and to check the robustness of our register tallies.
3. The quality of the health facilities is measured by the MoHCC as part of the HTF-RBF implementation. The **MoHCC Quality of Care checklist** contains modules relating to general appearance, administration and planning, health information system management, infection control and waste management, outpatient services, family and child health, inpatient services, medicines, sundries and stock management, referral services, community services, and environmental health services. We use these data to measure the impact of the programme on the quality of health facilities
4. Under the HTF-RBF implementation, **the amount disbursed to each health facility** depends on the quantity and the quality of services offered. Facilities received an amount based on their quality score and an amount based on the quantity of patients. The total amount of RBF disbursement is a measure that combines quality and quality. Note, the first RBF disbursement was made in January 2015, and therefore the quality of care composite score is available from the third quarter (Q3) of 2014. We use these data to measure the impact of the programme on the quality of health facilities and service utilisation[29].

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[28] The field teams were not able to interview five HLF and five CM respondents due to those members being unavailable during the team's visit.

[29] Note that this is an evaluation of the SCPH programme, not of RBF, so we do not use this data to draw conclusions about the impact of RBF.

5. Save the Children/CWGH programme implementation and monitoring data (Status of Intervention reports, quarterly and monthly progress reports, list of volunteer numbers and coverage and milestone reports to DFID). We use these data to assess the effectiveness of the programme in terms of what support was provided by the intervention and when. Milestone reports are used for the measurement of value for money.

5.4 Qualitative component

The qualitative component assesses how the programme has contributed to the observed results by examining and explaining the processes that have influenced the observed changes. This element identifies and assesses any significant influencing factors (i.e. assumptions and contextual factors) that have played a role in the causal chain. Beyond looking for evidence on impact and seeking explanations for the results observed through the surveys, this component also explores questions around the relevance of the programme, and the sustainability of the programme beyond the intervention period.

The qualitative component included semi-structured interviews at the national level around the relevance, efficiency and sustainability of the programme, combined with research at the sub-national level primarily focused on impact. At the sub-national level, the focus of the qualitative component was on six health facilities within two districts (five intervention sites and one non-intervention site), together with their surrounding communities, in an attempt to gain a detailed understanding of what happened in those places and why. At the national level, we also conducted a series of interviews to gain perspectives from a range of stakeholders on the effectiveness of the advocacy work conducted by SCPH.

The qualitative evaluation draws on two principal qualitative methods namely: interviews and focus group discussions (FGDs). Key informant interviews were carried out in Harare, in the two districts of Rushinga and Bulilimamangwe (Bulilima), in selected facilities within these districts and in the communities within the catchment areas of each facility. For the FGDs, the team utilised a number of participatory tools, including community and social mapping and proportional piling.

The evaluation team undertook a total of 46 semi-structured interviews and 18 FGDs in Rushinga and Bulilima, and eight interviews at the national level. Additionally, the team undertook six non-participant observations within the facilities, to look for evidence of programme influence (e.g. availability of complaints box, statistics, etc.) and carried out a transect walk within the vicinity of the health facilities.

At the provincial, district and facility level the teams interviewed HCC chairs/ heads; facility heads; DHE members, (District Medical Officers (DMOs); District Nursing Officers (DNOs); Provincial Medical Directors; and Provincial Engagement Coordinators (PECs). At community level, respondents included: facility users, facility non-users or infrequent users (where these could be identified), members of HCCs and/or VHWs; and opinion leaders (including religious and traditional leaders, local business persons etc.).

The complete set of data sources used for the evaluation are summarised in Table 7 below:

Table 7: Data sources used for the evaluation

Evaluation data sources		
Data source	Quantitative or Qualitative data	Primary or secondary data
2011 Needs Assessment questionnaire from the National Integrated Health Facility Assessment (NIHFA)	Quantitative	Secondary
Official HMIS	Quantitative	Secondary
Health Facility Survey – Head of Facility Interview	Quantitative	Primary
Health Facility Survey – Under-Five Exit Interview	Quantitative	Primary
Health Facility Survey – Utilisation Survey	Quantitative	Primary
Health Facility Survey – Village Health Worker, Health Literacy Facilitator and Community Monitor Survey	Quantitative	Primary
Survey of District Health Executive (DHE) members	Quantitative	Primary
MoHCC Quality of Care Checklist	Quantitative	Secondary
Amount of RBF disbursement	Quantitative	Secondary
Save the Children/ CWGH programme implementation and monitoring data – (Status of Intervention reports, quarterly and monthly progress reports, list of volunteer numbers and coverage and milestone reports to DFID)	Quantitative	Secondary
National level interviews	Qualitative	Primary
Provincial level interviews	Qualitative	Primary
District level interviews	Qualitative	Primary
Facility level interviews and focus group discussions	Qualitative	Primary
Community level interviews and focus group discussions	Qualitative	Primary

Source: OPM

5.5 Value for money component

The purpose of the value for money analysis is to understand to what extent SCPH used resources efficiently to achieve its results, and what can be learned from the successes or weaknesses of the programme in managing these resources.

Our analysis is structured against DFID's '3E's framework[30], and consists of the following elements:

Overall costs of the programme:

As agreed with DFID during the inception phase of the evaluation, we measure the overall cost of the programme based on the amount of the funding provided by DFID and the EU, rather than assessing the actual costs incurred by Save the Children and CWGH. Therefore the cost of the programme is considered from the perspective of its funders.

Economy:

This domain considers the cost at which inputs were purchased for programme implementation. As the evaluation does not seek to obtain detailed cost data from Save the Children and CWGH, our assessment of economy is qualitative, and is based on interviews with programme staff, during

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[30] DFID (2011) 'Approach to VFM', DFID, July 2011.

which we seek to determine what the major inputs of the programme were, which were the most costly to purchase, and whether and to what extent efficiencies were sought in buying them.

Efficiency:

Efficiency refers to how well SCPH implementers used resources to convert inputs into outputs. The main quantitative indicator assessed under this domain is the cost per person supported by an HCC. This indicator is reported on in the OPM Annual Review of the DFID MNCH programme. This is supported by qualitative information around the main cost drivers in producing outputs, which became more or less expensive to produce over time, and around what efficiencies were sought in doing so.

Effectiveness:

Effectiveness refers to how well resources were managed in the conversation of outputs into outcomes and impacts. Here we consider the impact of the programme on increasing the quality of services, as measured by the MoHCC Quality of Care checklist composite score.

Data sources for the value for money:

The main data sources for the value for money analysis are the milestone reports submitted by the programme to DFID, data on the main final outcome indicators for the programme (the MoHCC Quality of Care checklist data, HMIS data on facility utilisation and patient satisfaction as measured by OPM's quantitative health facility survey), the cost per person supported by an HCC, as measured by the OPM Annual Review team, and programme data supplied by Save the Children on the number of volunteers working for SCPH in each district.

5.6 Limitations

This section outlines the 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 findings from our survey of patients are not generalisable to the wider population of community members from the 21 districts where SCPH operates, and represent only the impact of the programme on facility users. This is because facility users may be systematically different to facility non-users in their outcomes and how they responded to the programme. For example, they may have relatively higher levels of overall engagement with the clinic and levels of awareness than those in communities who our survey did not reach.
- The qualitative research was intended to consult with non-users of facilities, or people who use clinics very rarely, in order to ensure that their views and perspectives were incorporated into the evaluation. However, in practice it sometimes proved difficult to obtain interviews with non-users of clinics and the qualitative study did not complete as many such interviews as was hoped. This was because we found that there were in fact relatively few distinct groups of community members who did not use clinics at all. We did seek to conduct interviews where possible in communities that engage to a lesser extent with health facilities than others, including for example those that were on the periphery of the catchment area or not well connected by road. Nonetheless, it is a limitation of our

evaluation that we were not able to represent facility non-users to a greater extent through either the quantitative or qualitative research.

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.

- This occurred as a result of a delay in contracting the evaluation team and the programme implementers needing to begin operations in order to meet their own deadlines. 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. The first step in the programme implementation was establishing MOUs with the MoHCC and this was followed by establishing and training HCCs. At the time the survey was carried out, the community feedback mechanism process had not yet been rolled out. Therefore, the outcome that may have been affected by the timing of the data collection is the existence of HCCs. Indicators further along the causal chain, such as those relating to the quality of the health facilities, are very unlikely to have been impacted in such a short time. Moreover, for our measurement of facility utilisation this problem is not relevant as we are able to draw on data dating back to January 2014.

We were not able to attain the full intended sample size of ANC patients for the endline survey, as the volumes of ANC patients at some facilities was lower than anticipated, particularly in Matabeleland.

- The final sample is 1,175, rather than the intended 1,400. Among the reasons for this are conditions of drought and food insecurity during and preceding our survey implementation period, which disproportionately affected southern regions of the country. These challenges led some women to migrate from southern provinces (particularly Matabeleland North and Matabeleland South) to Botswana or South Africa during pregnancy, often coming back to Zimbabwe after delivery to obtain a birth certificate for the child. Other families living in provinces near state borders have migrated altogether to look for work elsewhere. Since average volumes of patients attending facilities for services for children under five are in any case higher than the volumes attending for ANC, these circumstances did not lead to a corresponding issue with regard to obtaining the desired sample size of U5 patients. The lower than anticipated volumes of ANC patients means that there is a risk that our quantitative estimates of impact cannot detect small differences in outcomes with statistical confidence. However, since the intended sample size of 1,400 patients was chosen to detect effect sizes that are already quite small (at 10 percentage points), and the loss of sample is not large, this risk is not too great.

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.

- Sample size calculations were presented in our baseline report, and showed that a sample of 140 health facilities would enable the analysis to detect a minimum effect size (difference between intervention and comparison groups) of 23 percentage points. This means that if the difference between intervention and comparison facilities, for a facility- or HCC-level indicator (for example the percentage of HCCs that collect feedback from the community) is less than 23 percentage points we would not expect it to show up as statistically significant. Since these calculations were done, the sample size of health facilities was increased to

150, so this is a conservative estimate of the minimum effect size. However it is nonetheless quite large, and therefore we need to be mindful in our interpretation of the findings that smaller effects than this may not be detected by our sample size.

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. This means that comparing outcomes between intervention and comparison groups will underestimate the impact of SCPH, because the comparison groups will also have experienced some changes due to the programme.
- We do find some evidence of limited spillovers due to actions taken at the district level, in response to the implementation of this programme. Among the 21 DHE representatives that we interviewed, 13 out of 21 responded that they had taken some actions to try to ensure that any positive outcomes of the programme were also achieved in the comparison facilities. DHEs reported trying to assist comparison facilities by establishing similar feedback mechanisms to the ones strengthened by SCPH, implementing responses to community complaints from the intervention facilities across the district, and encouraging staff and HCCs from comparison facilities to engage more widely with community members.

  'We standardised the feedback policy to all clinics, because the benefits are very good.'
  DHE representative

  'We encouraged health facilities without the fund to engage the community.'
  DHE representative

  "'Most of the facilities in the district are run by the local council, and most positive outcomes from the programme are discussed in the full council meeting and they are implemented in all facilities regardless of whether [they are supported] or not.'
  DHE representative

  'We are also encouraging them to work as a team with health facilities and to install suggestion boxes.'
  DHE representative

- 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 having funding to roll out SCPH activities in comparison facilities.

  'Now we also include some of the [lessons of the programme] in our HCC trainings, but as for training it is still a big challenge in some parts of the district.'
  DHE representative

  'We tried cascading the programme to other facilities but it failed because these sites related are private owned which are run by management which is a barrier in us implementing the programme.'
  DHE representative

We cannot guarantee that there are no unobserved differences between our intervention and comparison groups.

- Our assessment of impact is based on the assumption that there were no systematic differences between intervention and comparison facilities, and the catchment areas that they serve, before the implementation of SCPH. The matching design that the evaluation employs is designed to ensure this by constructing a comparison group that is as similar as possible to the intervention group in all respects, apart from the exposure to the intervention. Yet, while we are able to verify the validity of this assumption for characteristics that we can observe at baseline, we cannot guarantee that there are no such differences in characteristics that were not observed. The fact that the groups were found to be well balanced along observable characteristics raises confidence that they are also comparable in terms of unobserved characteristics, but this risk cannot be ruled out.

There is a risk of self-reporting bias for some outcomes

- Some of our impact measures are based on outcomes that are reported to us by volunteers working for SCPH – the HCCs, CMs and HLFs. For outcomes reported by HCCs that concern their activities, we have the ability to cross-check answers by asking the same questions to facility Head Nurses, though they are also on the HCC and may also be biased. However, we do not have any means of cross-checking the answers given by HLFs and CMs. This may lead to an overstatement of the HCCs', HLFs' and CMs' achievement. To address this, where possible we triangulate responses and reports from the community members that the HCCs, HLFs and CMs serve.

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.

5.7 Evaluation principles and ethical considerations

We sought to conduct our evaluation in line with the following guiding principles:

- **Actively involving key stakeholders throughout all stages of the evaluation**, including the programme implementers and DFID.

- **Communicating and disseminating the findings of our evaluation effectively**, to provide the main intended evaluation users with the opportunity to learn about, discuss and interrogate our findings.

- **Delivering the evaluation to the highest possible quality**, through expert quality assurance of our evaluation design and products, and seeking the critical feedback of key stakeholders.

- **Building the capacity of our partners**. This includes the local researchers who conducted the data collection for this evaluation, for whom we aimed to provide the opportunity to build skills that would continue to be relevant after the evaluation assignment was complete. This meant delivering training in a participatory manner and actively involving the researchers in the design of the fieldwork plan and key research questions. Local researchers also played a pivotal role in the analysis and interpretation of data, through structured daily debriefs during fieldwork to seek their inputs on helping to understand emerging findings and patterns.

- **Ensuring that our evaluation adhered to accepted international good practice standards and ethics**. This includes seeking to deliver the evaluation in line with the Paris Declarations, as well as the OECD-DAC criteria against which our evaluation questions have been structured.

The ethical principles that underpinned our evaluation were taken extremely seriously, and outlined in detail in Volume 2, Annex H. A summary of the specific practices and considerations that we took into account to maintain ethical standards were:

- **Seeking the informed consent of all participants in data collection**. This meant providing potential participants with information about the content of the study and how their data would be used, as well as seeking to make them feel comfortable and empowered to refuse to participate or choose not to answer any questions if they did not want to.

- **Preserving the anonymity of research participants**. This meant ensuring that research participants would not have their personal information shared, or be individually identified as a result of participating in this study. During fieldwork we made every effort to ensure that interviews were always carried out in privacy (such as in a quiet room with no other people present, or in a quiet location outside health facilities or in the community). During data analysis and the write up of our results, we ensured that information was not shared beyond the small analysis team, and that no people were individually identified in our reports.

- **Ensuring the safety of research participants** and respecting cultural sensitivities throughout our interactions with participants.

- **Seeking to minimise any potential disruption to participants’ day to day lives caused by the data collection process**. We employed a range of strategies to seek to minimise this ‘footprint’, including: only conducting interviews with patients at facilities after their consultation was fully complete; maintaining as low a profile as possible during the evaluation teams visit to every health facility, community or other research site; aiming to conduct interviews with participants at a time that was convenient for them; providing health facilities and communities with advance notice of our intention to visit.

- **Ensuring the safety of the local researchers** who conducted data collection.

- **Ensuring the inclusion of women and socially excluded groups in our evaluation**, to the extent possible, to ensure that our findings represent their views.

6 Impact of SCPH on HCC performance

Sections 6 to 14 present the analysis and findings of the evaluation. Our findings are structured along the outputs, outcomes and impacts shown in the ToC diagram in Figure 2. These sections address the evaluation questions around effectiveness and impact. Findings are also presented on relevance, efficiency and sustainability as per the evaluation questions.

In section 6 we assess the impact of the programme on the performance of HCCs and the extent to which they fulfil their expected roles. First we explore how the programme affected HCCs' understanding of their role and what it is that HCCs do in practice. We then assess whether and to what degree there was an improvement, due to the intervention, in HCCs' ability to engage with community members, with the health facilities that they serve and with the DHE. Finally we look at the effect of the programme on HCCs' management and organisation.

Key findings

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. 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 8: Key results on quality and functionality of HCCs from quantitative data

Quality and functionality of HCCs					
	Data source		Comparison mean	Intervention mean	Treatment effect
Proportion of HCCs that met with the community at least once in the past 12 months	OPM HCC survey	*Endline mean*	76.25	95.65	**19.4*** **
		N	80	69	149
		Baseline mean	81.01	90.91	
		N	79	66	
	OPM HCC survey	*Endline mean*	78.75	81.16	2.41
		N	80	69	149

Quality and functionality of HCCs					
	Data source		Comparison mean	Intervention mean	Treatment effect
Proportion of HCCs that implemented any new initiatives in the past 12 months (HCC perspective)					
		Baseline mean	65.38	66.67	
		N	79	66	
Proportion of HCCs that participate in meetings with the DHE	OPM HCC survey	*Endline mean*	71.25	91.3	**20.05*****
		N	80	69	149
		Baseline mean	53.16	63.64	
		N	79	66	
Proportion of ANC and U5 patients that are aware of the HCC	OPM ANC and U5 surveys	*Endline mean*	22.13	22.15	.02
		N	1464	1255	2719
		Baseline mean	23.22	26.3	
		N	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

6.1 Impact of SCPH on HCCs' understanding of their roles and responsibilities

SCPH had a small effect on improving the HCCs' understanding of their role. When SCPH initially began training HCCs the programme's progress reports noted that programme implementers found some HCCs to be unclear on their roles and responsibilities. Evidence from the survey showed that there seems to be a modest improvement in an understanding of their roles among intervention HCCs. Among those saying that they faced challenges in carrying out their roles, the proportion who mentioned knowledge of their roles as one of the main challenges was 23% in the comparison group, as compared to 13% in the intervention group. However, the difference is only weakly statistically significant.

However, we found HCCs were not easily able to articulate their role in sufficient detail, so there is still scope to improve on this. As part of the qualitative study we asked HCCs in the six research sites (five of which were trained by SCPH) to recount what they mainly do as a committee. Since only one of the qualitative sites was not supported by the intervention we do not make any comparison to deduce whether there was any improvement in how readily HCC members knew their roles as a result of SCPH[31]. Overall, the committees did have a reasonable understanding of what is expected of their role, but it was not always front and centre in their minds. In some groups it required a lot of discussion and probing before they could explain their main functions.

By the end of the discussions, all HCCs mentioned aspects of the role related to both working within communities (raising awareness about health issues, mobilising people to attend the facility and conducting outreach services) and working alongside the facility (assisting with planning, carrying out projects or monitoring). The majority also listed helping plan how to spend RBF funds, and some demonstrated an awareness that they should serve as the conduit between the

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[31] The sampling strategy for the qualitative study is described in Volume 2, Section 2.2.2, where we discuss the reasons for not including additional comparison sites in the qualitative sample.

community and the health facility, noting that they spend time on communicating messages and information from one to the other.

HCCs consider engaging with communities to be a key part of their role, and often described their function in terms of being the intermediary between communities and the health facility. They used phrases like ‘bridge’ or ‘idombo’ in connection with their role– the idombo is traditionally someone neutral who negotiates for the bride and groom’s families before the wedding.

The qualitative FGDs with HCC members also provided rich information on how HCC members spend their time. A breakdown of these activities by ‘domain’ is presented in Figure 3. **The breakdown of HCC activities shows that HCC members reported spending most of their HCC time on activities relating to engaging with community members.** Within this, the major activities reported related to providing health education to community members and encouraging women to attend facilities for ANC or delivery. Related to community engagement, some HCCs also reported spending considerable amounts of time on mobilising communities to assist with development projects for the facility (for example, moulding bricks to construct a mothers’ waiting shelter). They placed less focus on raising awareness around rights, and on consulting with the community around feedback or complaints.

After community engagement, FGD respondents spent most time on activities related to conveying information between health facilities and communities, and carrying out projects at the facility level, such as infrastructure development, procuring medication and monitoring.

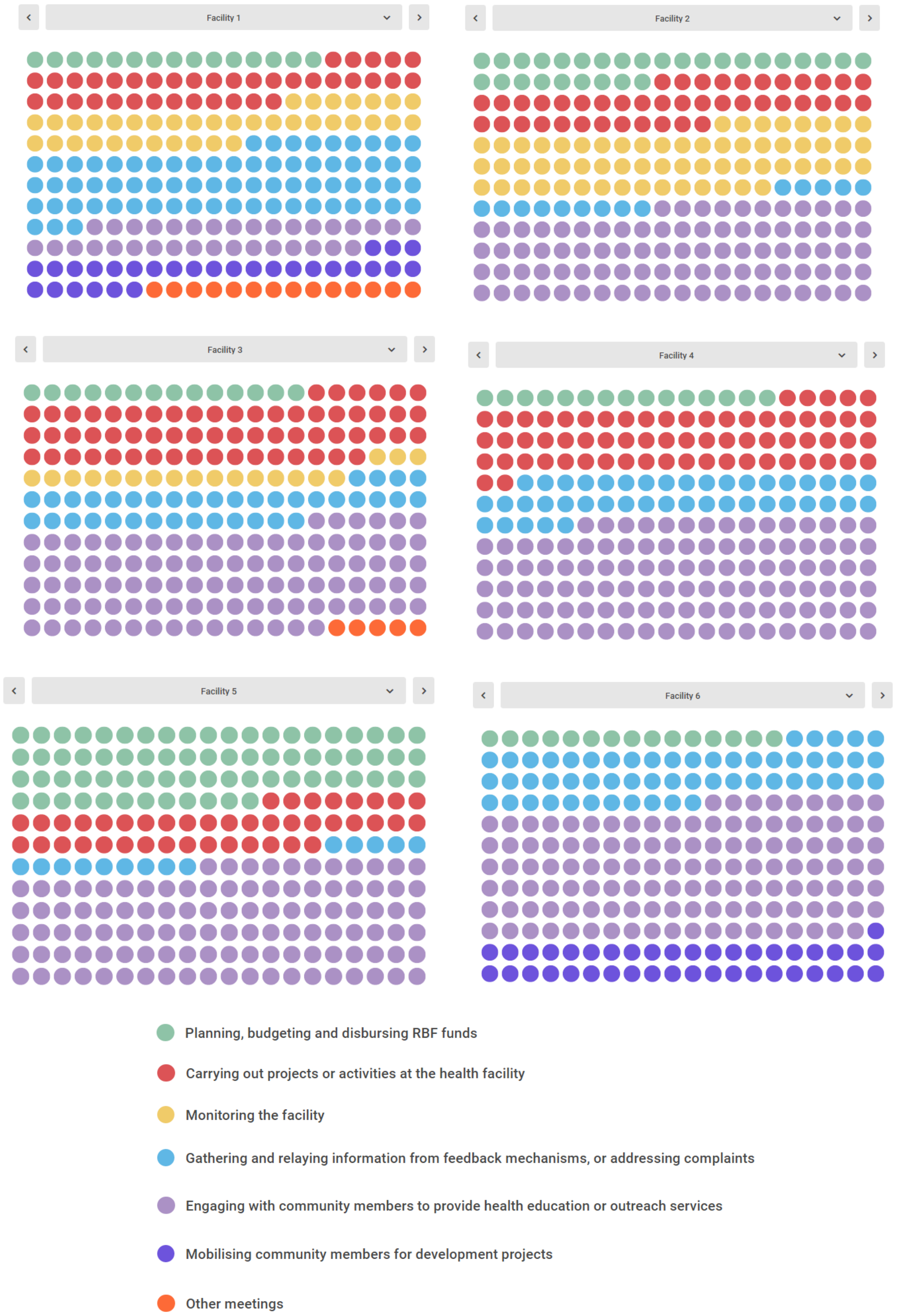
Finally, the FGDs revealed that budgeting for RBF and writing operational plans occupied the least of the HCCs’ time overall (apart from in one facility). This reflects the fact that these activities are done infrequently – only at the start of the year or only when RBF funds become available.

However, the RBF does have an important bearing on what HCCs prioritise and do as HCC members are motivated to act to increase the health facility RBF payment. HCCs that spent time on trying to mobilise community members to attend the facility often did so with the explicit incentive in mind of increasing the RBF disbursement for the facility, which is linked to patient volumes. There is also a separate incentive through RBF that is paid directly to facility staff, some of whom are on the HCC, which provides a compelling personal motivation for facility staff to try to encourage community members to attend the facility. Activities undertaken by the HCC that relate to infrastructure improvement at the facility, and monitoring of quality and supplies, are also tied to RBF incentives, since the disbursement amount is also based on certain specific criteria related to the quality of services.

HCCs that function less well tend to emphasise the elements of their role relating to facility development. The HCCs that were less definitive on their main roles as a committee tended to emphasise to a greater extent activities related to building and repairs at the facility. Amongst these HCCs, the manner in which they interact with community members tends to be limited to delivering education or mobilising them to provide labour or resources for facility projects. This is a shallower form of community engagement than consulting community members in a participatory way to hear their complaints and priorities, and feedback on responses made.

> *‘The well trained ones are knowledgeable and assist us. The less well trained ones focus more on infrastructure.’*
> DHE respondent

Figure 3: **HCCs' reported time use broken, qualitative FGD discussions**



6.2 Impact of SCPH on HCC initiatives and fund-raising

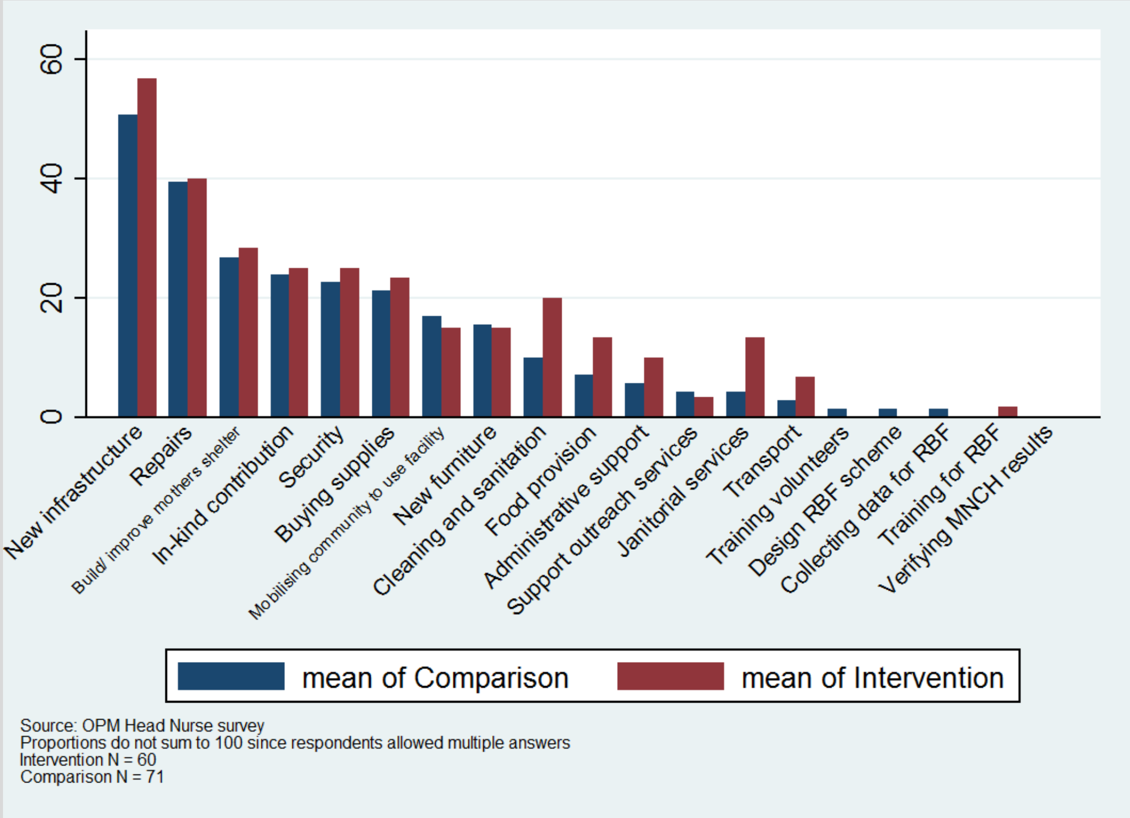
The remainder of the subsections in this section assess whether there has been any impact of SCPH on what HCCs do. First we consider whether there has been any change in the particular projects or initiatives that HCCs may carry out, alongside the main elements of the HCCs' role described above.

The survey finds no impact of SCPH on whether HCCs reported undertaking any new initiatives in the past 12 months, with an average of 80% across the intervention and comparison groups having done so. Among these, the primary activities undertaken were providing in-kind contributions to the facility and infrastructure development. The same question was asked of facility Head Nurses, where again no impact of SCPH was observed on whether any new initiatives were undertaken by the HCC. As shown in Figure 4, the main 'new initiatives' that Head Nurses reported all relate to facility development projects – repairs, infrastructure development and construction of mothers' waiting shelters.

Figure 4: HCC initiatives

Amount of HCCs that implemented a new initiative in the past 12 months, the proportion that implemented the following

Reported by Head Nurse



Source: OPM Head Nurse survey
Proportions do not sum to 100 since respondents allowed multiple answers
Intervention N = 60
Comparison N = 71

Source: OPM Head Nurse survey

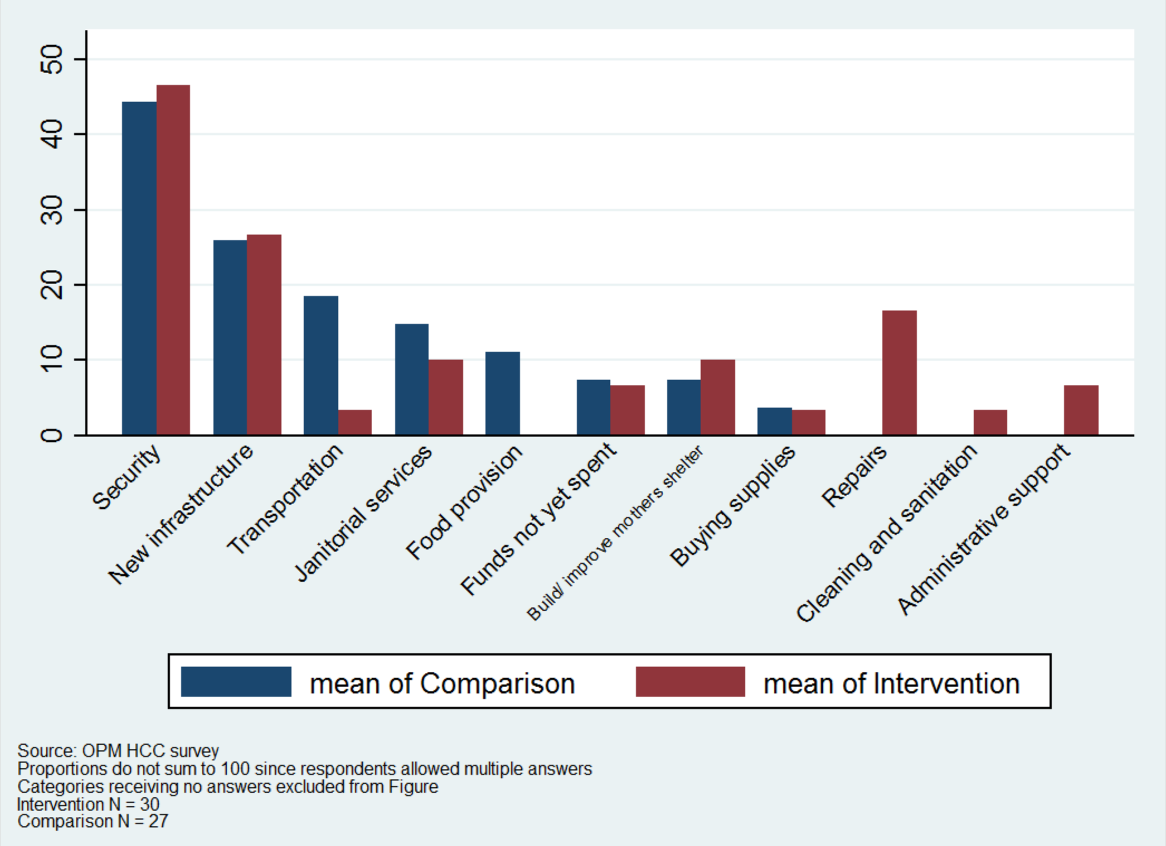
There was no impact of SCPH on fund-raising conducted by HCCs. There is no statistically significant effect in regard to the proportion of HCCs planning or actually raising money in the past 12 months, or the amount raised by HCCs that did. **Around 50% of HCCs had a plan to raise some money in the past 12 months**, with no significant difference between intervention HCCs and comparison HCCs. Of those, 69% of comparison HCCs and 82% of intervention HCCs actually raised some money (though the difference in proportions was not statistically significant with our sample size). The mean amount raised was $695.

Of those that raised money, **the most common use of that money was for security purposes** – for example, building a fence around the facility or hiring a guard. Other common uses across both groups were hiring a janitor and buying new infrastructure. Note that sample sizes for this domain were relatively small so caution should be applied in regard to making inferences regarding differences between intervention and comparison HCCs.

Figure 5: HCCs' use of funds raised

HCCs' use of funds raised

Reported by the HCC chairperson



Source: OPM HCC survey
Proportions do not sum to 100 since respondents allowed multiple answers
Categories receiving no answers excluded from Figure
Intervention N = 30
Comparison N = 27

Source: OPM HCC survey

The qualitative research indicated that the HCCs which were most effective in terms of implementing new initiatives and raising funds tended to be those with many connections in the community to other influential entities, such as local leadership and business groups. The ability to draw on these networks to source resources and help to mobilise community support for projects was crucial for some HCCs in regard to finalising planned projects. Differential access to community resources and local influential networks may provide part of the explanation as to why some HCCs have been able to achieve more than others.

Box 1: Facility case study: HCC support to one facility

This case study looks at a government-owned clinic that is situated in a severely drought-prone region of Zimbabwe. When the qualitative team visited the facility, due to the lack of water the staff were struggling with day-to-day tasks, such as ensuring the facility and its toilets were cleaned, and that the staff had enough water for their personal consumption and for carrying out their medical procedures effectively. Their situation was exacerbated by the fact that their water pump had broken down. As a temporary solution, the community would bring water from the only borehole surrounding the facility according to a duty roster that assigned this responsibility across the catchment area. According to community members, mothers who sought to use the waiting shelter were expected to bring 20 litres of water with them if they wanted to use the services there. Over time, the shortage of water had discouraged people from using the services offered at the facility.

The staff had raised complaints about the water shortage, but there has been no support from the district level owing to the lack of funds. The nurse spoke of feeble attempts by the district to help. On a monitoring visit, the visiting district officers tried to carry water in cans to the facility. Given the bumpy road, most of the cans had run dry by the time they reached the facility.

The HCC at this facility was an active group, but they could not find a solution to the water problem. In the past, the committee's members participated in several infrastructure projects to help improve the facility and often helped the facility staff who were stretched for time and resources. When a transformer stopped working and the facility lost its power supply the HCC chair ensured that a complaint was registered and power was restored immediately. Earlier, when a storm blew the roof off one of the shelters, the staff helped restore it. The HCC mobilised the community to mould bricks and ensured that new toilets were built in the facility. However, the HCC was unable to address the water shortage at the clinic. When they took their complaints to the District Water and Sanitation Sub-Committee for assistance, they were advised to raise money to repair it on their own.

In the case of this facility, the HCC, like the other HCCs observed for the qualitative study, had been instrumental in supporting infrastructure projects both with the RBF and with community contributions. However, when it came to finding a long-term solution to the persistent shortage of water at the facility, the HCC was unable to help.

6.3 Impact of SCPH on HCC engagement with the community

Here we assess the impact of SCPH on how effectively HCCs engage with community members, in terms of the frequency with which they meet with them and how well aware community members are of the HCC as a committee.

We find that SCPH has had some impact on the extent of HCC engagement with communities, as reported by the HCCs themselves. We find a significant impact on the proportion of HCCs that report having met with community members in the last 12 months, from 76% of the comparison group to 96% of the intervention group. Members also report that these meetings are well attended, with over 90% indicating that more than 20 people are normally present at these meetings (across both intervention and comparison groups). Although for HCCs that do report meeting with the community, there is no change in the average number of meetings held in the past 12 months, which is 5.2 across the intervention and comparison groups.

However, despite the HCCs' stated intention to work within communities, and the impact of SCPH on the proportion of HCCs that report meeting with the community, we find that the communities are not well aware of the HCCs and the overall visibility of each HCC across the whole community remains fairly limited. When asked to name and rank the people, institutions and actors who are most important in health care matters in the community, only one of the FGDs out of six included the HCC in their list. Similarly, the survey shows that the proportion of facility users reporting an awareness of any committee that works for health in their community is low, and is no different between intervention and comparison areas, at an average of 22% across ANC and U5 patients.

Some key informants did demonstrate a good understanding of the HCC and what they do, even if they did not know the committee as the 'HCC'. We found that if the HCC is known within the community at all, the HCC is not often referred to by its formal title. Instead, the committee might be known as 'the health committee', the 'hospital committee', 'the purchasing committee', or by another name.

There are several factors that explain the relative lack of awareness of the HCC.

1. **HCCs lack a platform of their own**: HCCs primarily engage with the community during ward meetings or wider community meetings that are organised by local leadership groups. They do not call community meetings of their own. Some indicated that they did not do so in order to respect traditional leadership, and to follow the protocols expected of them. This may mean that the community members who attend do not do so in the knowledge that they are gathering to meet with the HCC.

   During these meetings HCCs are given a slot where they can discuss pressing issues with the community. The time allocated to the HCC may be limited. As described by one HCC interviewed as part of the qualitative study, in these cases they tend to focus on their most immediate priorities for discussion, such as requesting financial support or physical labour from the community for improving the facility.

   As well as working through local leadership structures in order to convene meetings, HCCs may also rely on other entities to help them interact with community members in other respects too. For example, in one of the qualitative sites the HCC said that they were planning to raise awareness about the benefits of attending health facilities to church leaders, so that they could in turn share and spread these messages among congregants. They also planned to work through district-level structures to try and levy a ban on home deliveries in the community. This implied that part of their role involves leveraging the support of others to engage with communities on their behalf, which may also serve to reduce the direct engagement between HCCs and communities.

2. **HCC members are known by the other roles they perform:** HCC members are normally elected into their roles by communities. Those selected are often those who held positions in the community prior to being on the HCC, such as traditional leaders, health workers or volunteers – and they may still hold those positions. 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.

   The findings from the institutional mapping exercise with facility users provided some evidence of this. While 'the HCC' as a committee was only listed by one of the groups as among the important actors for health care and advice on health in their community, individual members of the HCC did appear on most maps in their other roles.

   To help raise the profile of the committee, in some places HCC members said that they would appreciate caps, t-shirts or bicycles to help the community to be more aware of them in their role when they travelled around the catchment area.

3. **Not all community members may attend meetings:** The diversity of people present at meetings with the HCC may in some cases be restricted. The survey found that an average of 20% of HCC members (across intervention and comparison groups) indicated that normally it is the same group of community members that come to meetings, with a further 38% saying that it is usually the same people.

There are a number of reasons why not all community members may attend meetings. The quantitative survey found the most common reason that facility users gave for not attending meetings (among those who were aware of the HCC) was that they did not know where meetings were held, or that they were too busy to attend. The large distances covered by some catchment areas and lack of transport links may also make it difficult for some members to attend. We did not encounter specific evidence of community members mentioning this as a barrier to attending meetings, though distance is a known barrier to utilisation of clinics in general.

The constraints that people face in attending HCC meetings may be expected to vary substantially across regions, depending on cultural and contextual conditions. In some regions temporary migration of some community members during the farming season weakens the ability of HCCs to engage broadly with communities. This was the case in the regions visited for the qualitative research, Rushinga and Bulilima, where it is highly common for community members to migrate across the border (to Mozambique and Botswana) for farming during several months of the year. Propensity to attend meetings is also affected by how strong the culture of local meetings is in each region. For example, in some areas, community attendance at ward-level meetings where the HCCs appear is considered to be almost mandatory apart from for the very sick or infirm, whereas in others people may only attend if they have a specific interest in doing so.

4. **Limited funds for transport**: HCCs often lack funds or means of transport to travel to villages that are further away within the facility's catchment area.

5. **Low coverage of HCC members across catchment areas**. The large catchment population sizes served by some facilities relative to the size of the HCC is an additional barrier to HCC members being able to engage widely with community members in their catchment area.

6.4 Impact of SCPH on HCC engagement with the facility staff

SCPH did not impact the level of engagement by HCCs with facility staff, in terms of how frequently they meet and how favourably the facility regards the role of the HCC. At baseline it was found that the degree of partnership between HCCs and health facility staff was close, and this has remained the case. 79% of facility Head Nurses across both the intervention and comparison groups reported that the HCC was 'very useful' for the facility, and they reported an average of 9.9 meetings held between the facility and the HCC in the past 12 months.

In-depth interviews with the nurses provide supportive evidence that facility staff have responded positively to the HCCs. Nurses in all the facilities visited in Rushinga and Bulilima reported good working relationships and appreciation for the HCCs.

> *'The HCC is useful for the facility. If you talk about construction the chairman can mobilise resources. He can approach heads and chiefs and all stakeholders on the importance of bringing resources to the clinic. Without the HCC it would be difficult for us to do that. If we have any problem we can talk to the HCC, they can talk them to meetings with the VHWs to discuss them. They also tell us issues from the community, and take issues to influential leaders if it needs their participation. They come back with their solutions from the influential leaders.'*
>
> Facility Head Nurse, Rushinga

As well as assisting the facility with its various tasks, HCC members are also expected to conduct **routine monitoring of facilities to check on quality**. **The survey found there was no impact of SCPH on the proportion of HCCs that make visits to health facilities for monitoring, or the number of visits made. Almost all facilities in both the intervention and comparison groups reported making monitoring visits to health facilities (about 95%).** Tasks relating to monitoring also scored relatively highly in the qualitative time-use exercise. Head Nurses reported that the HCCs conduct around 1.7 monitoring visits per month and no impact of the programme is observed on this dimension.

The items that HCCs most commonly reported checking for during monitoring visits to facilities were staff attitudes and how staff treat patients, whether services were being provided, progress against the specific objectives in the operational plan, and the general state of the facility infrastructure and cleanliness. Qualitative interviews showed that HCCs consider monitoring to be an important part of their role, and are fairly systematic in their approach to doing this. Some reported using a physical checklist, while others had informally agreed a set of items that they would routinely check against during monitoring visits. HCCs also reported feeding back any findings of their monitoring visits afterwards, to the rest of the committee and to facility staff.

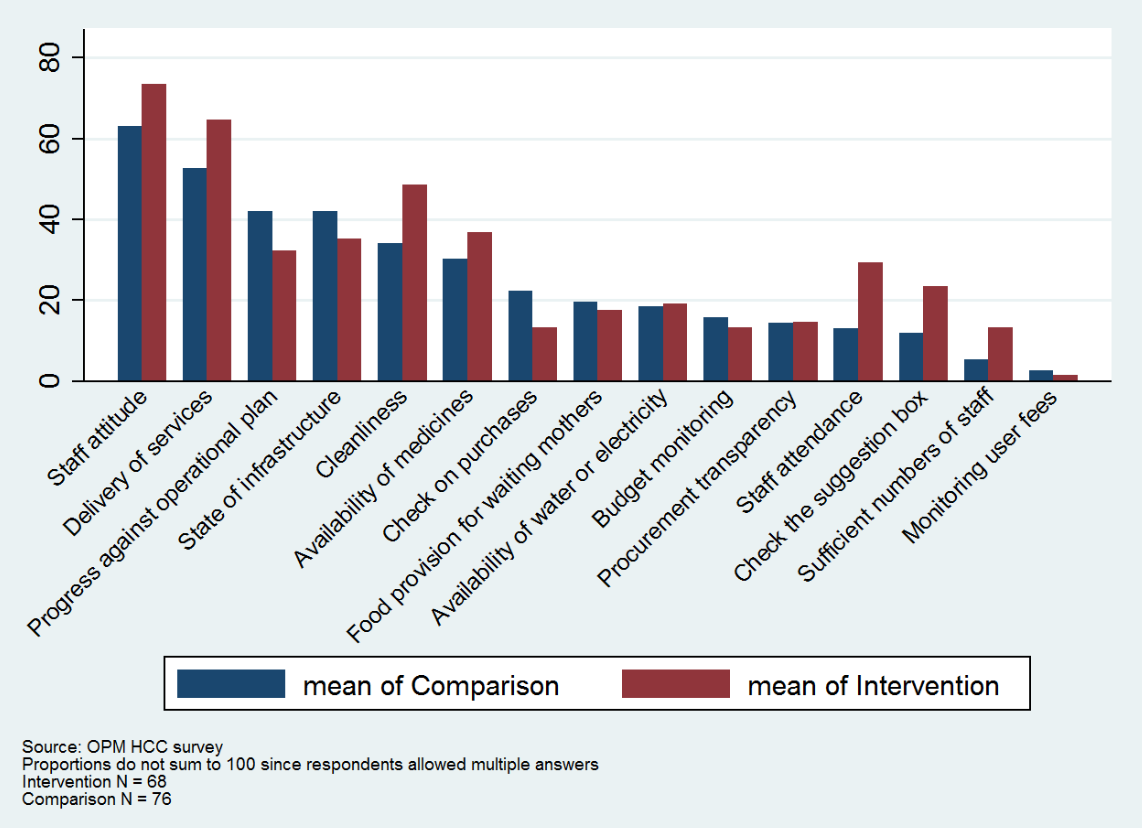
> *'During the monitoring a checklist is used with various indicators especially from the operational plan. It was during the checklist that the increase in the number of home births was noted. During monitoring they also noted that there are some details that the nurse misses when filling in the notes. The individual carrying out the monitoring must politely find out why this is the case and address the issue in a tactful manner so as not to offend the nurse.'*
> HCC chairperson, Bulilima

> *'We have duties, each one of us has two days of monitoring per week. We monitor the opening time of the facility, how the patients are treated, the time the facility is closed, how the staff manage their time when they go for tea or lunch breaks, the staff attitudes, the mothers' shelter, the communication between the community and the staff, and we also handle complaints. When we have monitored we give back feedback to the staff.'*
> HCC chairperson, Rushinga

Figure 6: HCC monitoring visits to clinics

HCC monitoring visits

Among HCCs that visit health facilities for monitoring, list of things commonly checked for



Source: OPM HCC survey
Proportions do not sum to 100 since respondents allowed multiple answers
Intervention N = 68
Comparison N = 76

Source: OPM HCC survey

6.5 Impact of SCPH on HCC interactions with the DHE

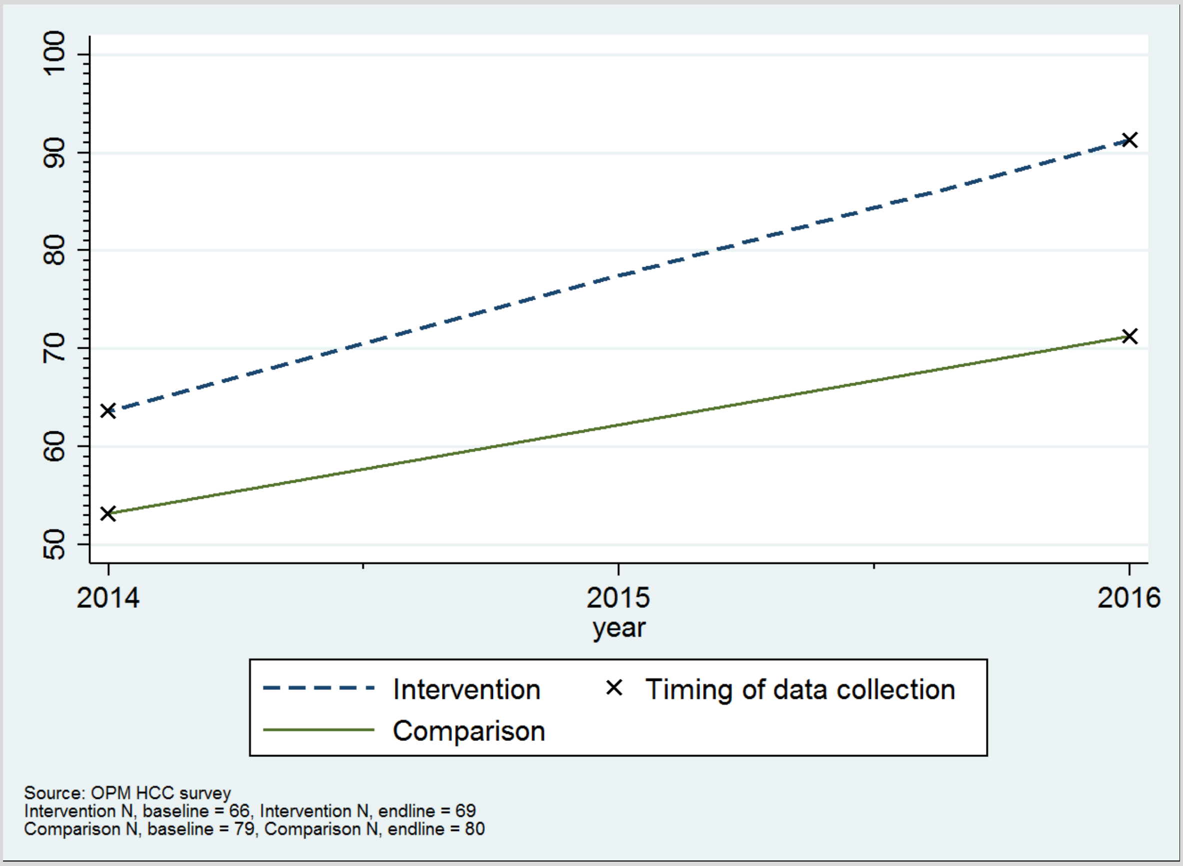
The DHE has responsibility for supervising all heath facilities in their district and for planning and coordinating all district health activities. This team comprises the DMO, the DNO, the District Environmental Health Officer, the District Health Services Administrator, a pharmacist and an accountant. SCPH sought to strengthen the links between HCCs, as representatives of communities, and the DHE in order to ensure that complaints from the community level reach decision-makers at the district and higher levels.

SCPH has had a positive impact on the extent to which HCCs are found to interact with DHE members. The survey with HCC members finds that 91% of intervention HCCs participate in the meetings with the DHE, as compared with 71% of comparison HCCs in the same districts. Among those who have any meetings with the DHE, HCCs in intervention areas met with the DHE an average of 3.6 times in the past 12 months, as compared with 1.8 times for comparison HCCs. Intervention HCCs were also more likely to report being kept up to date on health developments by the DHE.

Figure 7: HCC meetings with the DHE

Proportion of HCCs that attend meetings with the DHE

Reported by HCC chairperson



Source: OPM HCC survey
Intervention N, baseline = 66, Intervention N, endline = 69
Comparison N, baseline = 79, Comparison N, endline = 80

Source: OPM HCC survey

Interviews with representatives from the DHE also testified to fairly close levels of engagement between HCCs and the district health team. Nearly all DHE representatives surveyed for the district-level survey indicated that HCCs in their district provide feedback to the DHE. This is most commonly provided during visits that DHE members make to facilities, when HCCs come to the DHE of their own accord, and scheduled meetings with HCCs (the latter of which have been promoted through SCPH). District-level staff reported high levels of satisfaction with the HCCs, with 95% saying that the feedback received from HCCs is ‘very useful’, and a further 90% saying that the HCC as a whole is ‘very useful’.

> *‘They work hand in hand with staff to make progress in health facilities. They are motivating the community to take actions for health, one example is bringing bricks to build a mothers’ waiting home. They are working together with the staff.’*
> DHE representative

6.6 Impact of SCPH on HCC meetings, management and record-keeping

SCPH did not have an impact on the likelihood of HCCs holding regular internal meetings, as all HCCs do this, at an average of 9.8 times per year. Qualitative discussions with HCCs found that their meetings do not generally follow a fixed schedule, but rather that HCCs arrange to meet when they have something important to discuss. This includes meetings scheduled around

RBF milestones – for example, participating in the RBF budgeting process or supporting procurement of goods from the RBF funds for the facility.

SCPH also did not have an impact on how extensively HCCs keep records of their internal meetings, meetings with the communities and monitoring visits to the facilities. The vast majority of HCCs keep minutes for their internal meetings, and of those 88% of the comparison HCCs could present these to our evaluation team, compared with 96% of intervention HCCs (though the difference is not statistically significant). Minute-keeping for meetings with the community is less consistent, with only 48% of HCCs across the intervention and comparison groups reporting that they do this. There is no impact of the SCPH in this, or in the proportion of HCCs that were able to present these minutes to the evaluation team. Relatively few HCCs are found to keep physical records of monitoring visits that they make to the health facility. An average of 13% of HCCs reported always keeping such records, and 16% reported ‘sometimes’ doing so, with no impact of SCPH. 71% of HCCs in both groups indicated that they never recorded monitoring visits. Qualitative interviews showed that HCCs were more likely to indicate that they provide verbal feedback following monitoring visits.

SCPH did have a somewhat positive effect on the proportion of HCCs that submit written reports about MNCH outcomes and issues in their community to the DHE. 36% of comparison HCCs did this, as compared with 51% of the intervention HCCs (though the difference is only weakly significant). Among HCCs that do submit such reports, the average number submitted in the past 12 months is 7.1 across both the intervention and comparison HCCs.

In terms of documentation kept by the HCC, there is a strongly significant impact on the proportion of HCCs that report having a copy of an HCC handbook and the Patients’ Charter. 40% of comparison HCCs had a copy of the HCC handbook, compared with 79% of intervention HCCs. 45% of comparison HCCs had a copy of the Patients’ Charter, compared with nearly 93% of the intervention HCCs.

SCPH had a positive impact on the likelihood that HCCs would compile and present graphs on MNCH outcomes in health facilities, for example on immunisation rates, which are meant to be updated every month. An example is shown in the photograph below. We found no impact of SCPH on the proportion of HCCs where these statistics were found to be presented for the current month (at about 15% of those surveyed across both groups). However, there was a difference between intervention and comparison facilities in regard to those that reported the statistics for the preceding month, and a significant difference in regard to those not reporting statistics at all, from 73% of the comparison group to 57% of the intervention group HCCs.

Photograph 1: Records in Mukonde Clinic

Example graphs on MNCH outcomes displayed in health facilities

Source: OPM

7 Impact of SCPH on patients' knowledge of rights, entitlement, and responsibilities

Key findings

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, with only 2-3 HLFs having been trained in each catchment area.

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 knowledge levels were high.

Table 9: 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
Proportion of ANC and U5 patients aware of the Patients Charter	OPM ANC and U5 surveys	*Endline mean*	3.35	7.81	**4.46*****
		N	1464	1255	2719
		Baseline mean	5.4	7.46	
		N	1559	1370	
Proportion of ANC and U5 patients aware of free services for pregnant women and carers of under 5s	OPM ANC and U5 surveys	*Endline mean*	80.26	85.98	**5.72****
		N	1464	1255	2719
		Baseline mean	74.63	73.54	
		N	1559	1370	
Proportion of ANC and U5 patients aware of any patients' rights	OPM ANC and U5 surveys	*Endline mean*	50.68	54.42	3.74
		N	1464	1255	2719
		Baseline mean	39.96	43.21	
		N	1559	1370	
Proportion of ANC and U5 patients that received any training on patient rights and entitlements in the past 12 months	OPM ANC and U5 surveys	*Endline mean*	24.53	25.33	.8
		N	742	683	1425
		Baseline mean	20.87	21.69	
		N	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

7.1 Impact of SCPH on awareness of patients' rights

SCPH has had a small but statistically significant impact on the proportion of patients who are aware of the Patients' Charter, who are aware that MNCH services should be free and who report knowing any patient rights at all. As shown in Figure 8, community awareness of the Patients' Charter was slightly higher in the intervention group patients (8% had heard of it), as compared with the comparison group patients (3% had heard of it) (across the U5 and ANC sample). As is also shown in Figure 8, the proportion of people who were aware that MNCH services for pregnant women and carers of under-fives should be free was much higher, at 80% in the comparison group and 86% in the intervention group. The proportion of facility users who report knowing any patient rights at all was 51% in the comparison group and 54% in the intervention group[32].

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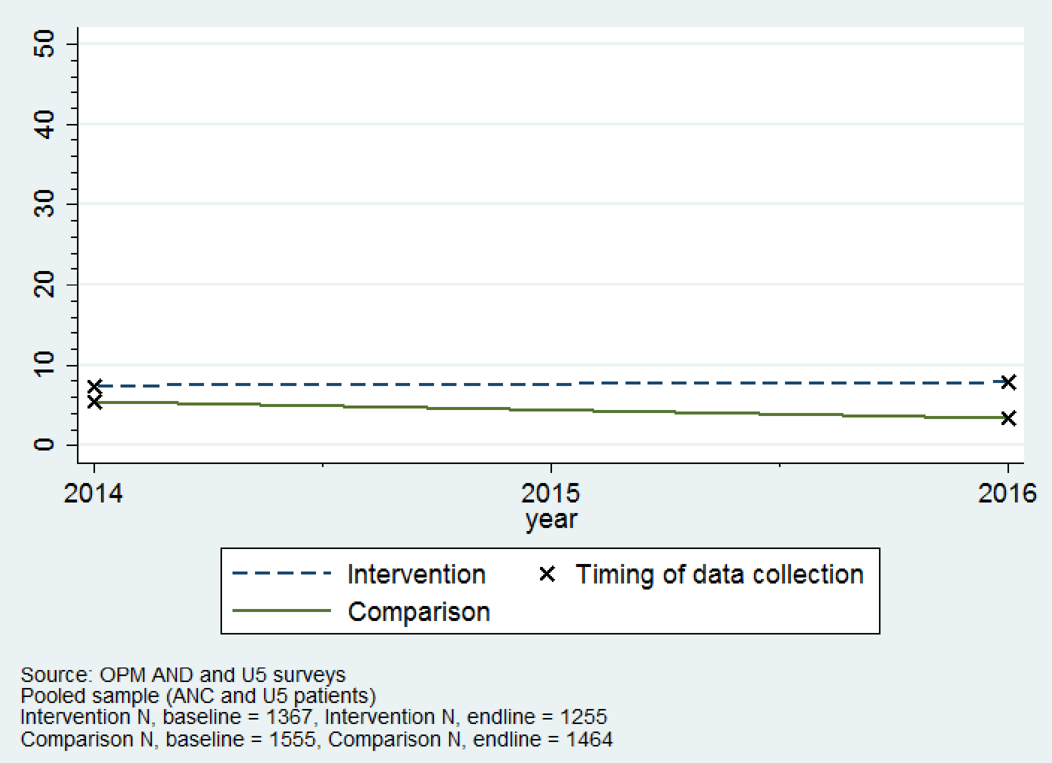
[32] Although the simple difference at endline is not statistically significant, regression specifications that include covariates present significant differences for this outcome.

Figure 8: Knowledge of rights and entitlement of facility users

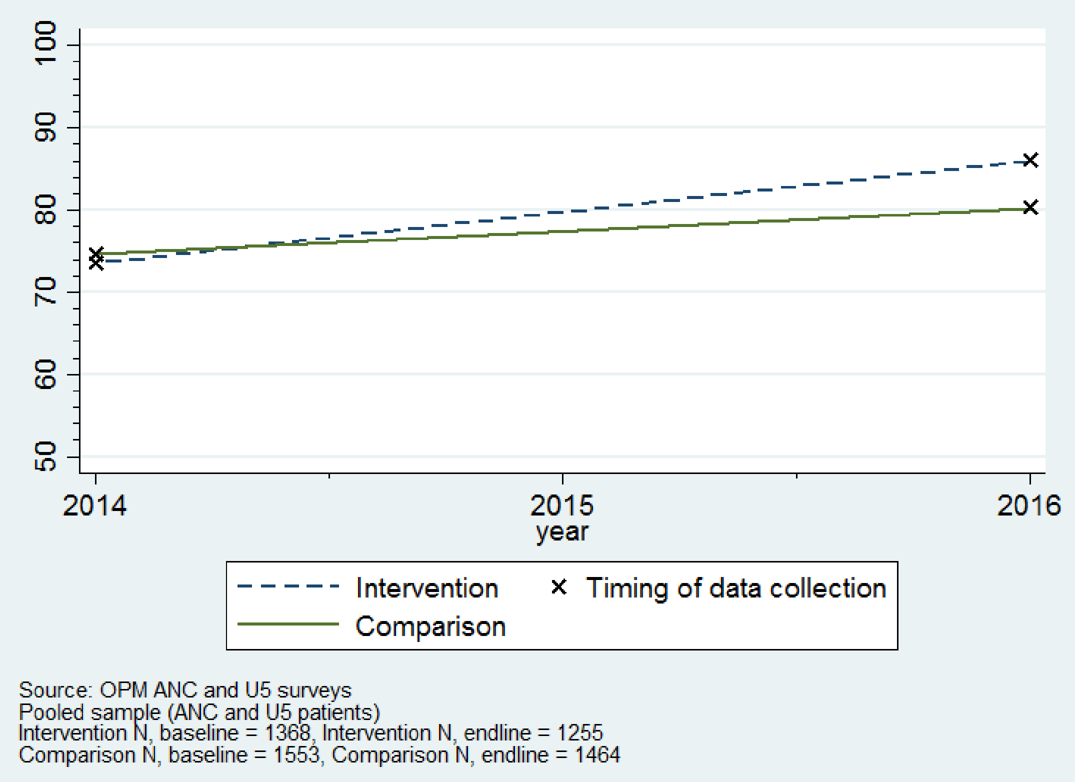
Knowledge of rights and entitlement of facility users

Proportion of facility users who are aware of the Patients' Charter



Source: OPM AND and U5 surveys
Pooled sample (ANC and U5 patients)
Intervention N, baseline = 1367, Intervention N, endline = 1255
Comparison N, baseline = 1555, Comparison N, endline = 1464

Proportion of facility users who are aware that MNCH services should be free



Source: OPM ANC and U5 surveys
Pooled sample (ANC and U5 patients)
Intervention N, baseline = 1368, Intervention N, endline = 1255
Comparison N, baseline = 1553, Comparison N, endline = 1464

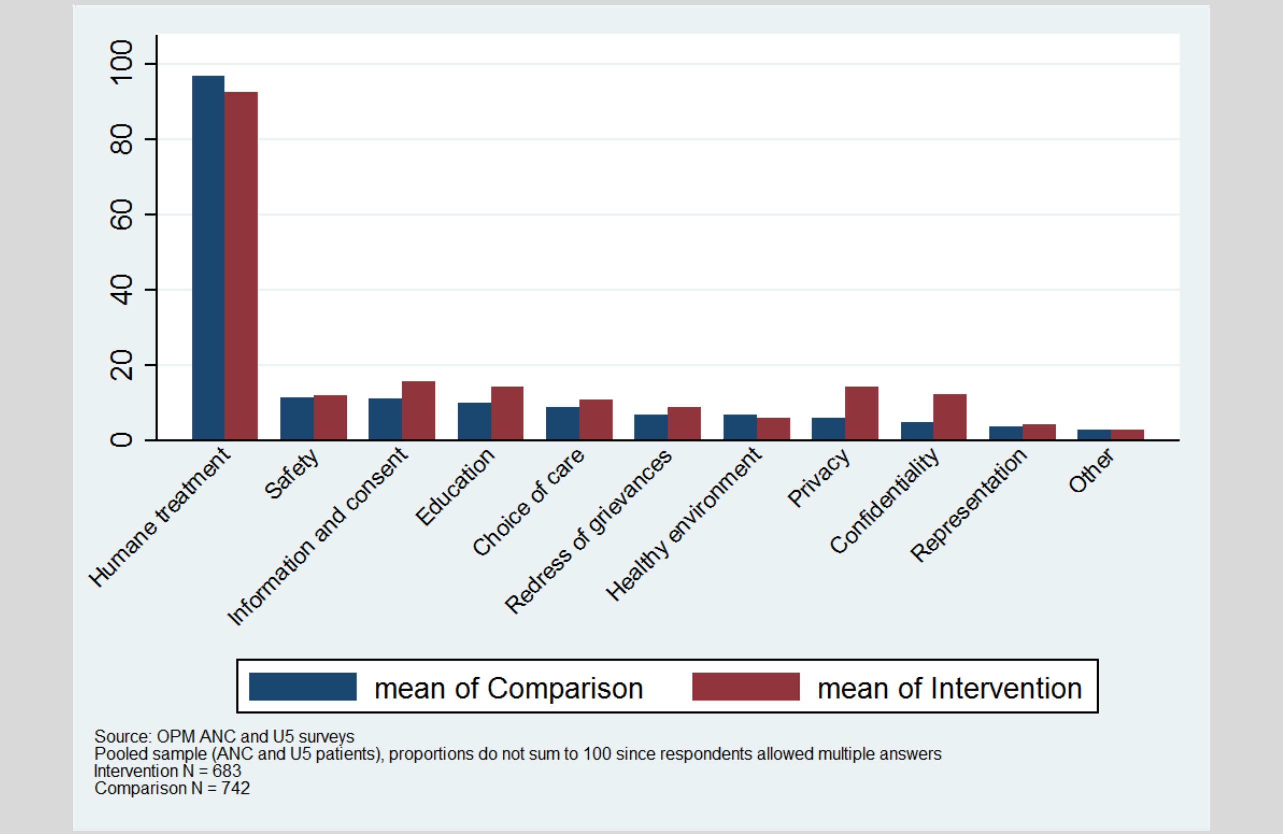
Source: OPM ANC and U5 surveys

However, the findings also indicate that the level of understanding of what these rights are has not improved due to SCPH, and remains quite basic. Among users who know of any rights, there are no significant differences between the intervention and comparison groups in the average number of rights that patients were able to name. Out of the 10 rights enshrined in the Patients' Charter, users could name an average of 1.9 rights in the intervention group and 1.7 rights in the comparison group. By far the most common right that users mentioned is the first and most basic entitlement: the right to health care and humane treatment, as shown in Figure 9. SCPH has not improved understanding of the other rights in the Charter, for reasons that are explained below.

Figure 9: Range of patients' rights that patients are aware of

Range of patients' rights that patients are aware of

Among facility users aware of any rights, the proportion mentioning the following rights



Source: OPM ANC and U5 surveys

Some reasons for the limited impact of the training provided on patients' rights through SCPH are the following:

1. **The training provided on rights to community members only had a limited reach**. As shown in Figure 10, when asked what their main sources of information on patient rights had been, the great majority of patients indicated that information had come from either facility staff or from their own general knowledge, rather than mentioning the sources that SCPH trained to raise awareness on rights (HCCs and HLFs). There are no major differences in reported information sources between the intervention and comparison groups. Furthermore, as shown in Figure 10, only around 13% of facility users reported having received any formal training on rights in the past 12 months, and there was no impact of the programme on this.

The apparently limited penetration of training on patient rights within the community can be attributed to the low coverage of volunteers across facility catchment areas, as described in Section 3.4, which made it difficult for volunteers to access a wide spectrum of the community to raise awareness on rights.

2. **HCC members tended to train the community in their patient rights at the inception of the programme and during meetings in which there were several other agenda items**. When they did address the community during larger, more generic community gatherings they prioritised the most important issues on their agenda, which were not typically rights. Therefore, many HCCs did not establish a space or platform for extensive trainings on patients' rights.

3. **Variable attendance at community meetings.** As discussed in Section 6.3 above, not all community members are always available to attend meetings where rights may have been discussed.

> *'I've never heard of rights in meetings, but I'm not always around. I travel a lot so I can't always attend.'*
> Facility user, Rushinga

4. **The Patients' Charter is not often displayed in an accessible format, in a place where it is easily visible to waiting patients.** While the Charter is displayed in the great majority of health facilities, this is not often in a common area where it can be easily seen. It is usually found inside the nurses' consultation room, which is often cluttered with many other posters, graphs and charts. In addition, the Charter is often displayed in English, rather than in Shona or Ndebele, and the full poster version is very text-heavy.

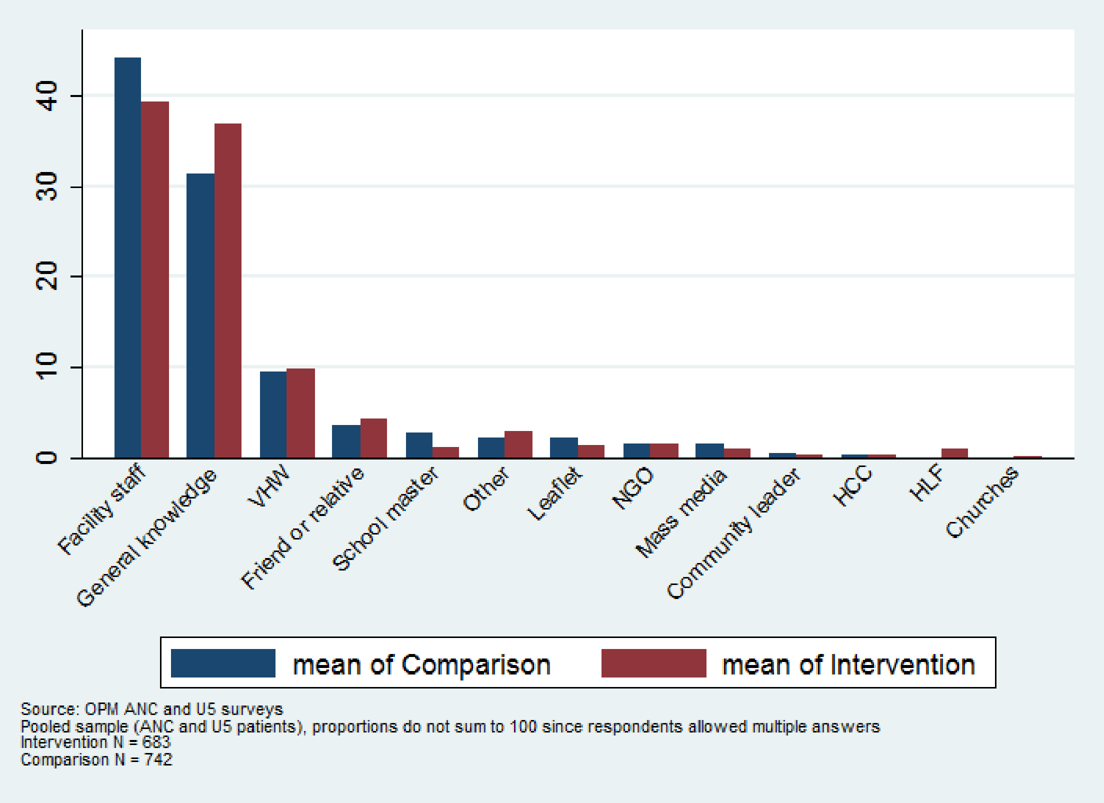
   Ideally, the contents of the Charter would be actively communicated to community members through community meetings or on an individual basis. But for those not exposed to such training, displays of the Charter on the walls of the clinic or through leaflets that they can pick up whilst at the clinic may be the only exposure that they have to it. Therefore to enhance understanding of patient rights, there is scope to improve these communications materials so that more local-language versions and pictorial guides to the Charter are readily available.

   In recognition of this, SCPH has made efforts to develop participatory methods of training on rights and communications materials were updated during the implementation period to try and make messaging around rights more accessible. An example of the updated communications materials produced by SCPH for the scale-up of the programme in Rushinga district is shown in Photograph 2.

Figure 10: Source of information on patients’ rights

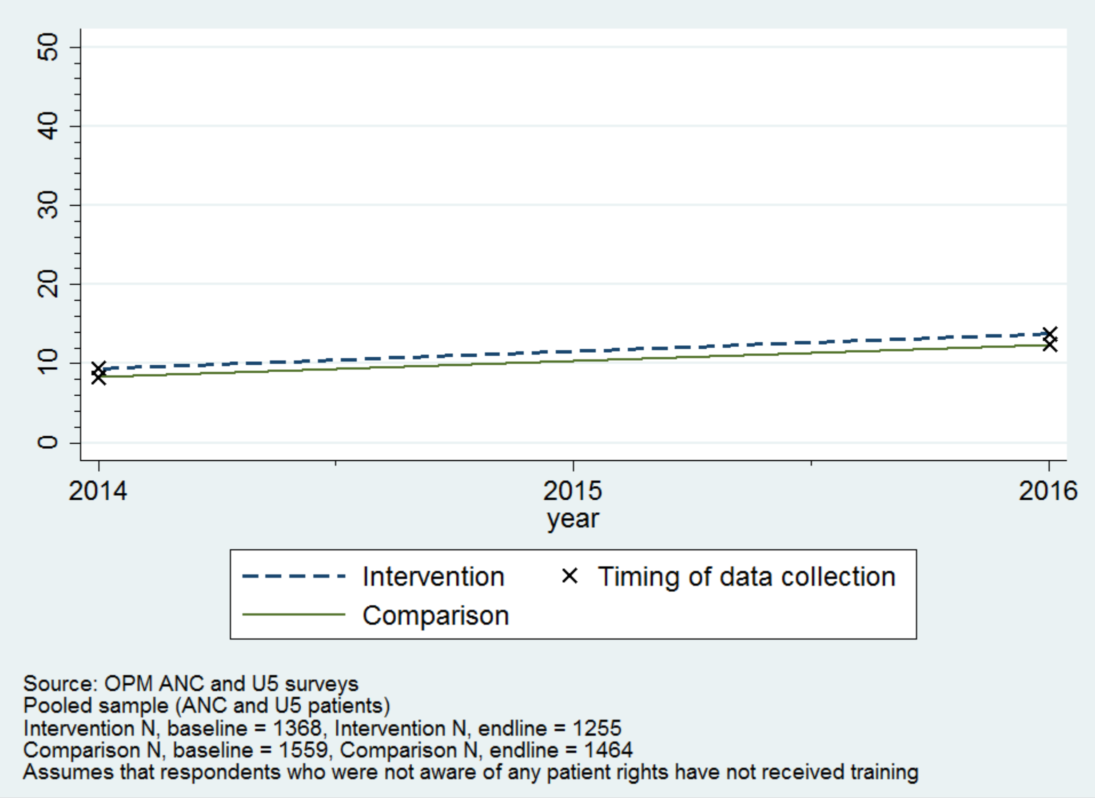
Source of information of patients’ rights

Among facility users aware of any patient rights, proportion mentioning the following sources of information



Source: OPM ANC and U5 surveys
Pooled sample (ANC and U5 patients), proportions do not sum to 100 since respondents allowed multiple answers
Intervention N = 683
Comparison N = 742

Proportion of facility users who received training on patients’ rights in the past 12 months



Source: OPM ANC and U5 surveys
Pooled sample (ANC and U5 patients)
Intervention N, baseline = 1368, Intervention N, endline = 1255
Comparison N, baseline = 1559, Comparison N, endline = 1464
Assumes that respondents who were not aware of any patient rights have not received training

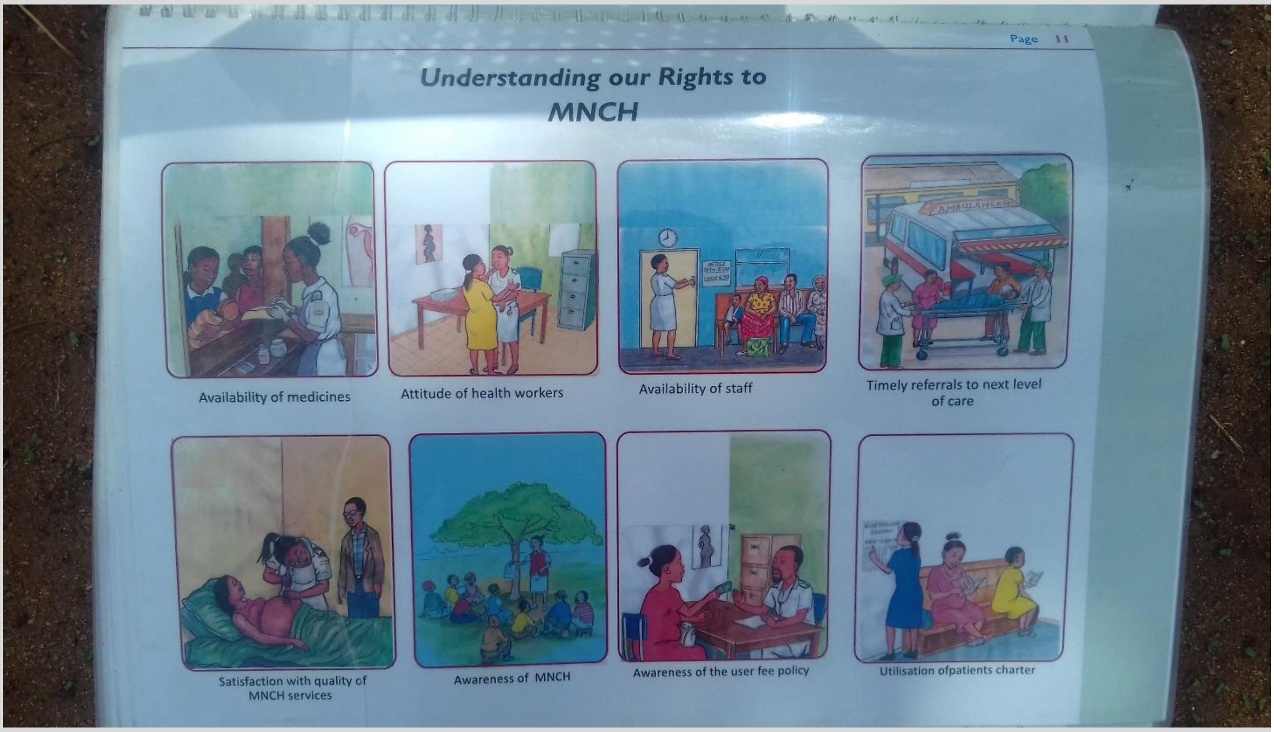
Source: OPM ANC and U5 surveys

Photograph 2: Communications materials for raising awareness on patients' rights

Communications materials for raising awareness on patients' rights

The Patients' Charter displayed at a clinic

Revised communication material by SCPH



Source: OPM ANC and U5 surveys

7.2 Impact of SCPH on awareness of responsibilities for health

The survey results show that SCPH did not impact the level of awareness **and knowledge about healthy behaviours for promoting MNCH, but that in both intervention and comparison facilities knowledge levels are good**. Nearly 100% of patients surveyed recommended ANC visits for pregnant women at a health facility, with a further 88% recommending at least four visits. 85% were aware of the recommended duration of exclusive breastfeeding being six months.

These very high levels of awareness may be due to the fact that Zimbabwe used to have very good health and education systems, so this sort of knowledge may be widely understood. Additionally, the survey targeted users of facilities rather than the general community so the sample is likely to be biased towards those with knowledge about good health-seeking behaviour.

Another reason for high levels of reported knowledge are that there is more training delivered to community members around healthy behaviours than there is around patients' rights. Training on healthy behaviours comes from a range of sources in addition to the HLFs trained by SCPH. Many facility users interviewed during the qualitative research reported hearing health messages from nurses during their consultation, or outside the clinic while they were waiting. As discussed in Section 6.1, we also found that HCCs consider providing information on healthy behaviour to be an important part of their roles and responsibilities, and the government VHWs also provide this kind of training. The survey found that 46% of the comparison group and 49% of the intervention group reported having received training on healthy behaviours in the past 12 months – more than three times as many as said they were trained in patients' rights. The difference between the two groups is not significant. Community members are appreciative of the training they receive, and feel that it has made a difference to health in their community.

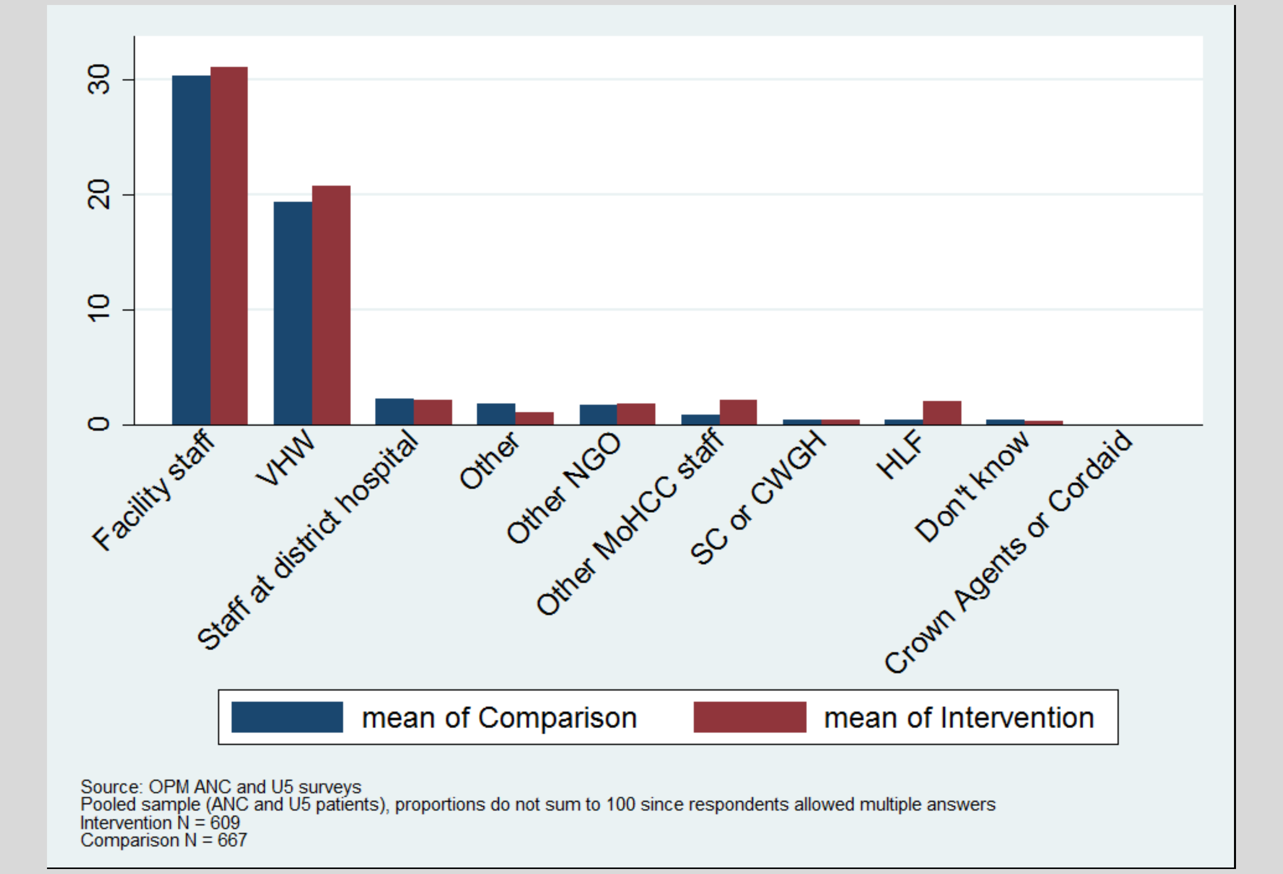
> *'The VHWs just teach us about nutrition of our bodies, balanced diet, and hygiene for breastfeeding mothers. The meetings are useful because some of these things are new and we wouldn't have known.'*
> Facility user, Bulilima:

> *'The information that we get from the nurses and at the (community) meetings is very important because back in the day we did not see the importance of going to the hospital and we always gave the Traditional Healer priority when it came to our health. We lost our children because of lack of knowledge and that some practices did not make a difference to our health. Now we understand these diseases and we know that we should go the clinic and get all the help that we need.'*
> Facility user, Bulilima

As shown in Figure 11, by far the most common source of training around healthy behaviours was reported to be facility staff and VHWs. Although HLFs are not shown to be well represented in the sources of training that people report having received on health, this may be because HLFs very often also work as VHWs and are more commonly known by this (pre-existing) title. However, there is only a small increase in community members mentioning having received training from either VHWs or HLFs in the intervention areas, suggesting that the additional exposure to health messages provided by SCPH was limited.

Figure 11: Source of training in health responsibilities

Proportion of facility users reporting having received training on responsibilities for health from the following sources



Source: OPM ANC and U5 surveys
Pooled sample (ANC and U5 patients), proportions do not sum to 100 since respondents allowed multiple answers
Intervention N = 609
Comparison N = 667

Source: OPM ANC and U5 surveys

8 Impact of SCPH on the operation of complaints mechanisms

Key findings

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 10: Key results on the establishment of complaints mechanisms from quantitative data

Complaints mechanisms					
	Data source		Comparison mean	Intervention mean	Treatment effect
Proportion of HCCs that collect quality of care information about patients	OPM HCC survey	*Endline mean*	98.75	98.55	-.2
		N	80	69	149
		Baseline mean	89.74	95.45	
		N	79	66	
Proportion of HCCs that keep a record of complaints from community members	OPM HCC survey	*Endline mean*	42.5	72.46	**29.96*****
		N	80	69	149
		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	**38.15*****
		N	80	69	149
		Baseline mean	(No baseline data available)		
		N			
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	**26.3*****
		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	

Complaints mechanisms					
	Data source		Comparison mean	Intervention mean	Treatment effect
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

8.1 Impact of SCPH on the establishment of complaints mechanisms

In this section we consider the impact of SCPH on whether channels for community members to provide complaints were available, and the extent to which HCCs and decision-makers systematically gathered and escalated these complaints upwards through the health system as necessary.

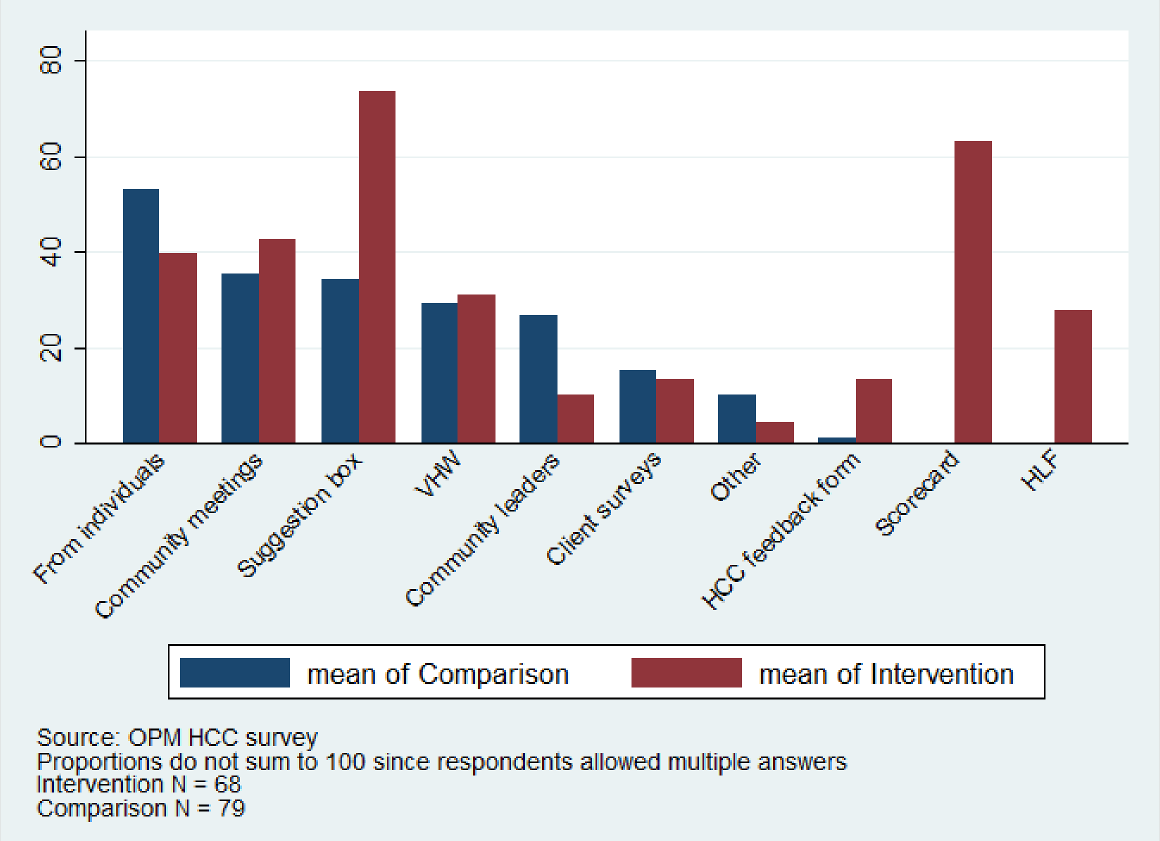
SCPH did not have a significant effect on the proportion of HCCs that were collecting complaints from patients on the quality of care received because nearly all intervention and comparison HCCs were doing this already. However, **we do find a significant impact on the use of the specific channels established by SCPH to collect this information.** Figure 12 summarises the sources of information that HCCs use to hear patient complaints. The figure shows that the main mechanisms for collecting information on patient complaints in intervention-supported facilities are through suggestion boxes and scorecards, both of which were part of the SCPH intervention. This shows that the mechanisms which were established by the programme are being put to use in intervention areas. However, HCC feedback forms, which are intended as a systematic way for HCCs to record patient feedback, are not widely used by either intervention or comparison facilities.

The other most common information sources that HCCs use to receive patient complaints are by speaking with individual community members and through community meetings.

Figure 12: Sources of feedback that HCCs use to gather patient opinions and feedback

Sources of feedback that HCCs use to gather patient opinions and feedback

Among HCCs that gather quality of care information from patients, proportion that use the following sources:



Source: OPM HCC survey

SCPH has had a positive impact in terms of the use of these feedback mechanisms by HCCs to capture information and communicate it to health staff. Intervention HCCs are significantly more likely to report maintaining a record of complaints from the community (43% in the comparison group, as compared with 73% in the intervention group). Significant differences are also observed in the proportion of HCCs and health facilities reporting that there is a mechanism in place for the HCC to inform facility staff of patient opinions. All estimates are strongly significant in the regression specifications. Among HCCs with a mechanism in place to inform staff of patient opinion, this occurred an average of 4 times in the past 12 months. We also find evidence of HCCs cascading complaints upwards to the DHE level, and this was reported by DHE staff to be useful.

> *'The HCC feedback assists them [DHE staff] to know how the nurses are doing their job and if further training is required. The HCCs go through suggestion boxes and give feedback at these [DHE-level] meetings.'*
> DHE representative

> *'The feedback is objective, it contains both strengths and weaknesses. The HCC tells us the perception of community members of health staff, health workers and the availability of medicines. In some instances it does tell us things that we did not know before.'*
> DHE representative

SCPH also had a positive impact on ensuring that decision-makers raise awareness about the availability of complaints mechanisms and encourage people to use them. Nearly all intervention HCCs reported providing education to the community on how and where to register complaints (58% in the comparison group, as compared with 96% of the intervention group). Qualitatively, VHWs, HLFs and CMs also reported raising awareness among community members about how and where to record their complaints.

> *'I encourage people when we have meetings to use the suggestion box as a way of raising complaints about the health facility. Besides the suggestion box they can complain to the village head or the councillor if they are not happy of the way they have been treated by the health facility staff or if they are not happy at all of the clinics.'*
> VHW, Bulilima

8.2 Impact of SCPH on community engagement with complaints mechanisms

8.2.1 To what extent do people complain, and who, or where, do they complain to?

Although decision makers report making greater use of complaints mechanisms to gather information on patient opinion, and a wider variety of complaints channels are available to community members in intervention facilities, we **do not find evidence that community members are actually raising complaints to a greater extent.**

There is no impact of SCPH on the proportion of patients who say they would be likely to report a complaint about the health facility, should they ever feel unsatisfied. 64% of ANC patients and U5 patients in the intervention and comparison groups claimed that they would be likely to report a complaint about the health facility, should they ever feel unsatisfied. The differences between intervention and comparison groups were small and not statistically significant.

Although this represents a high proportion of users indicating that they would be likely to use an available complaints mechanism, when asked about actual complaints made in the past 12 months **the proportion of users who reported ever having raised an issue is low, and SCPH did not have a significant impact on this.** Among facility users who were ever unsatisfied with anything at the clinic in the past 12 months, only around 22% of ANC patients and 15% of U5 patients ever reported their dissatisfaction, in both intervention and comparison facilities.

> *'There is a suggestion box in the community however people do not use it they just grumble amongst themselves and some just end up using the neighbouring clinic but we don't really know why they would have left this clinic.'*
> Support nurse, Bulilima

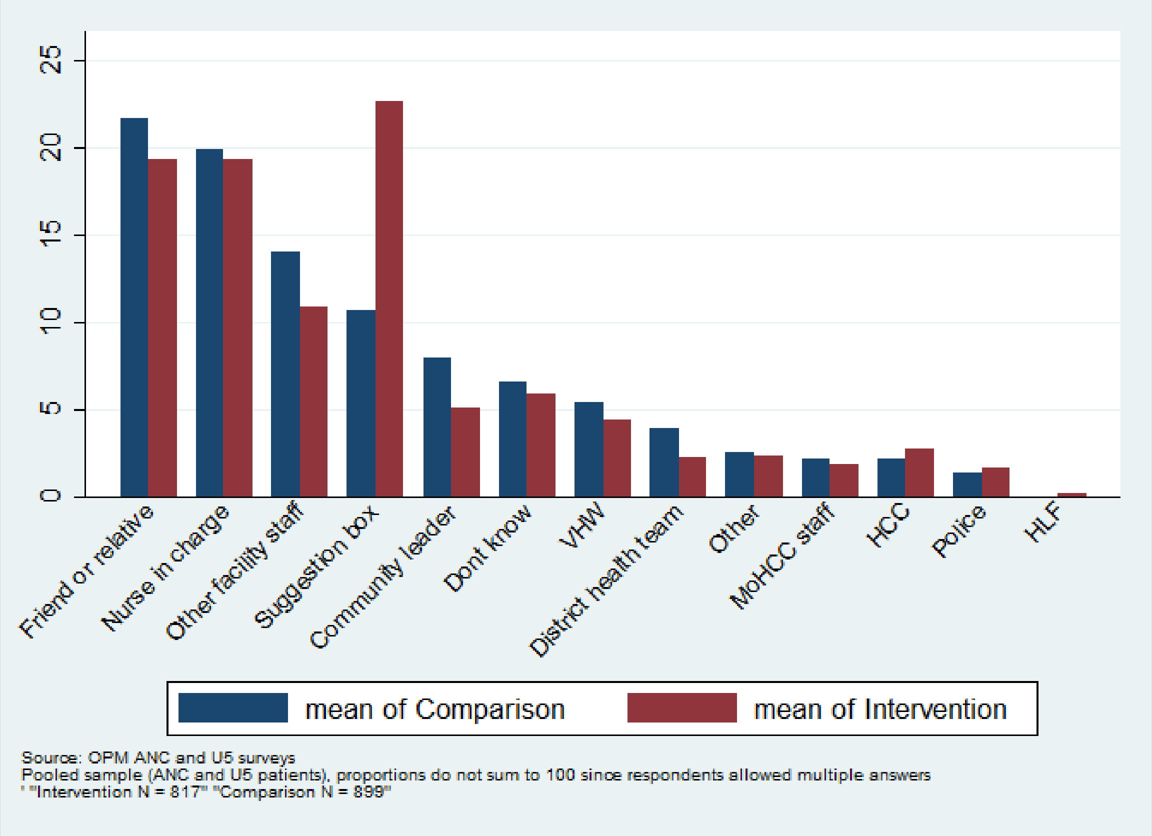
Among those who said that they would complain, there is evidence that SCPH has had an effect on how likely people are to say they would use a suggestion box. This is illustrated in Figure 13 below. **However, in practice the use of suggestion boxes seems to be relatively low, as discussed further in the following section**. The figure also shows that among those who said they would complain it is most common for people to make these complaints to friends and relatives, (and therefore their feedback would not be likely to be picked up by decision-makers). The next most common choice is to complain to facility staff directly. According to the qualitative evidence, many people report that they would approach their VHW or a local health volunteer with their complaints, since these members are well known within the community and may be more accessible than HCC members or facility staff.

We also find no impact of SCPH on the proportion of people who would complain to the HCC. Only around 5% of ANC and U5 patients who knew of the HCC (and recall that less than a quarter of ANC and U5 patients did know of the HCC) reported having ever made a complaint to an HCC member, with no differences between intervention and comparison groups.

Figure 13: Places/people where facility users would register their complaint

Places/people where facility users would register their complaint

Among facility users who say they would report a complaint, proportion citing the following as places/people that they would make their complaint to



Source: OPM ANC and U5 surveys
Pooled sample (ANC and U5 patients), proportions do not sum to 100 since respondents allowed multiple answers
' "Intervention N = 817" "Comparison N = 899"

Source: OPM ANC and U5 surveys

Altogether, the findings around complaints show that although community members are not complaining to a greater degree as a result of SCPH, decision makers are more likely to pick up on and act on the complaints that are made. This implies some improvement in the flow of information reaching decision makers despite the fact that community behaviour regarding the propensity to raise complaints has not shifted.

Box 2: Facility case study: When and how do people complain, if they do have grievances?

In one of the facilities visited for the qualitative study, facility staff, users of the facility services and community members said that in their facility there had been one significant incident that had prompted a community member to register a complaint. This was against a nurse who was known to mistreat her patients at the facility. For example, one respondent remembered her unfavourably: ‘There was a nurse who didn’t treat us well, I once came with my children at 8 am and I saw her at 3 pm and had not been served as yet, so she just looked at me with remorse and said “what are you still doing here with your trailer?” (in reference to her children)’. Another respondent remembers how ‘even the councillor was afraid to approach the nurse (in question). The whole community had to gather together and they got her transferred out of the district.’

We found that a complaint was only registered against the nurse following an incident that generated concern at the district-level hospital. A patient arrived at the clinic late at night due to an emergency. This patient knocked at the nurses’ door but the nurse did not respond. Following this, the patient went to the councillor and was taken to the district hospital. At the district hospital, the staff there asked the patient to write a report about this nurse, following which the nurse was transferred out of the facility. The current nurse in this facility confirmed that the ‘HCC knew of the matter and was involved.’ However, the HCC did not mention this incident when we spoke with them.

This example offers one example of a case where patients only complained when there had been a significant breach of patients’ rights. In this case, complaints were registered with traditional leaders, councillors or directly with district staff, rather than with the HCC.

8.2.2 Why do more people not register complaints?

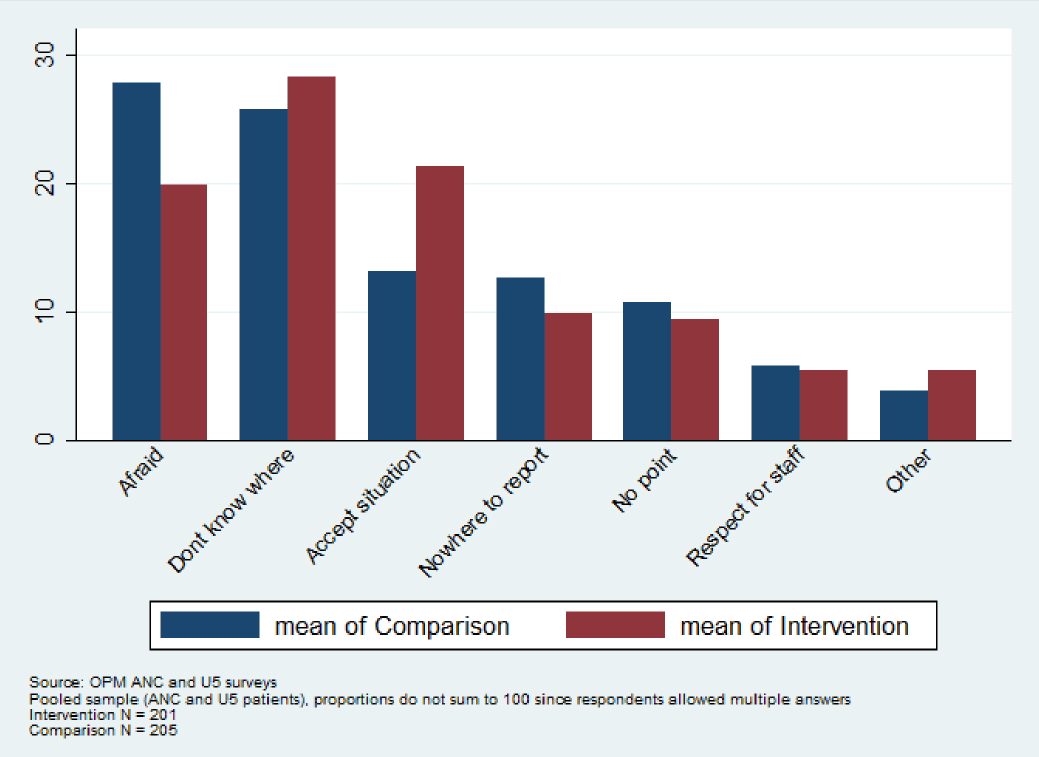
Figure 14 below illustrates the main reasons given by respondents in the survey as to why they did not report any complaints that they had in the past 12 months, or why they think they would not be likely to raise any complaints in future.

Figure 14: Reasons that people do not report complaints

Reasons that people do not report complaints

Actual reason

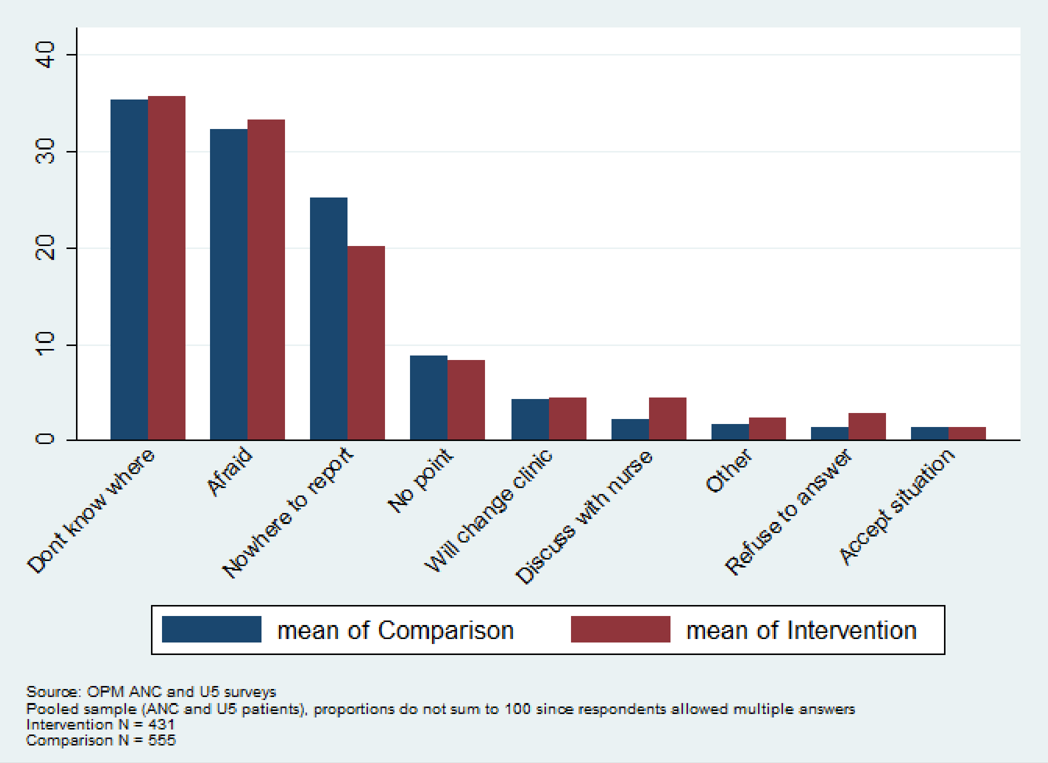
Among facility users who were unsatisfied in the past 12 months but who did not report it, proportion citing the following reasons



Source: OPM ANC and U5 surveys
Pooled sample (ANC and U5 patients), proportions do not sum to 100 since respondents allowed multiple answers
Intervention N = 201
Comparison N = 205

Hypothetical reason

Among facility users who say they would not report if they ever had a complaint, proportion citing the following reason



Source: OPM ANC and U5 surveys
Pooled sample (ANC and U5 patients), proportions do not sum to 100 since respondents allowed multiple answers
Intervention N = 431
Comparison N = 555

Source: OPM ANC and U5 surveys

The qualitative research provided more in-depth understanding of these issues. Overall, the main factors that emerge as continued barriers to complaints and feedback are the following:

Fear of reporting complaints

Fear of potential negative repercussions is shown in Figure 14 to be a key factor in preventing more use of complaints mechanisms. Qualitative interviews with community members also showed this, with people reporting that they are unwilling to make complaints in case they are not treated well the next time they come to the facility. People are also sometimes reluctant to make complaints even if they are assured of privacy in doing so.

> *'I am afraid to complain because this is the only healthy facility that we rely on, if I complain I may be prescribed wrong medication by the nurses if I complain.'*
> Opinion leader, Rushinga
>
> *'There are groups I know in the community, the health workers, CPC [Child Protection Coordinator], VHWs and HBC [Home-based Care]. I might report to those people, but at the same time I am afraid they might distort information. Or they might not deliver information to where it is supposed to go.'*
> Facility user, Rushinga
>
> '*We do not really get one-on-one time with the district staff to discuss our complaints with them, we are not free to raise our complaints in that way but when they come we start discussing in loud voices as we are waiting to be served in the hospital so that the people from the district hear what we are discussing*.'
> Facility user, Bulilima
>
> *'The challenge with using scorecards is that the respondents do not always share their opinions freely because they fear there is no confidentiality.'*
> CM, Bulilima

The fact that community members continue to fear reprisals in case of reporting may imply that there is still a lack of awareness that they have the right to do so.

Lack of knowledge about where and how to report complaints

Even if people feel that they have the right to complain, there remains the issue that some do not know of the available channels for making complaints. This is also shown in Figure 15 to be among the main reasons for not complaining, despite the finding that in the intervention areas the HCCs report being more likely to have educated community members in how and where to register their feedback.

> *'I don't know who to go to for complaining. If something happened to me I would report but I don't know where to go.'*
> Facility user, Rushinga

Low coverage and availability of SCPH-trained volunteers

HCC members, CMs and HLFs are unlikely to be able to regularly visit and communicate with residents across the whole catchment area, due to the low numbers of volunteers relative to the catchment populations that they cover. This means that community members who would have liked to raise complaints through one of these individuals may have been unable to due to limited ability to access them.

Being tolerant of the circumstances

Some people are also reluctant to complain because they appreciate the challenges facing facility staff members. Among facility users who did have complaints in the past 12 months but did not report them, 17% said that the reason for this was that they just accepted the situation. In the qualitative research, the examples given of cases where community members had complained tended to be in areas that were perceived as a significant break from the norm in terms of patient care. For example, community members in one facility in Rushinga did raise a complaint when a new nurse joined the facility who was considered to be abusive towards patients.

The qualitative team heard a similar incident of a nurse mistreating patients at another facility, where the complaint was formally raised at a community meeting only after a number of people became dissatisfied with the treatment they received, including women who had not been attended to during childbirth. In this case the district representatives at the meeting advised people to use the suggestion box to raise their complaint.

Issues with suggestion boxes

Though in general all facilities do have a suggestion box installed, there are a number of issues with how they are used. In two facilities visited for the qualitative study the box was in disrepair, so community members could not use it. In others, the HCC and facility staff reported that they do not often find any complaints in the box.

> ‘*The suggestion box is there, but it is useless. Our community does not have a strong right to complain. The suggestion box is not working, the papers can be easily blown off by the wind, anyone can come and open the box, and we really need a new suggestion box.*’
> Facility user, Bulilima
>
> *‘The nurses treat us well so we don’t have any complaints. Given that we have something to complain about, we don’t know how we are supposed to complain because there is no suggestion box.’*
> Facility user, Bulilima
>
> *‘There is also a suggestion box which they can use. However, we never get anything from the suggestion box which means and shows that the community has nothing to complain about.’*
> HCC chairperson, Rushinga
>
> *‘People are satisfied. No one has ever dropped anything in the suggestion box ever since it was put. They have nothing to complain about.’*
> Local opinion leader, Rushinga

Our observations during fieldwork visits were that the suggestion box is often located near the entrance to the facility, in a place that makes it difficult for people to drop notes in discreetly. Since fear of making complaints is found to be a key deterrent, one suggestion to improve the functionality of suggestion boxes would be to move them to a less public place. Secondly, using the suggestion box also requires having paper and something to write with available. If people are reluctant to be seen to be using the box then they are also not likely to want to ask nurses for a pen to write down their complaint with. Finally, the box is not an appropriate platform for those who are not literate.

8.2.3 Reasons for complaints

As discussed in Section 12, overall satisfaction with health facilities and facility staff is very high. Yet despite this high general satisfaction with the facilities, and the opinions of some HCC members and opinion leaders, the fact that relatively few people voice complaints does not mean that they do not have any to make.

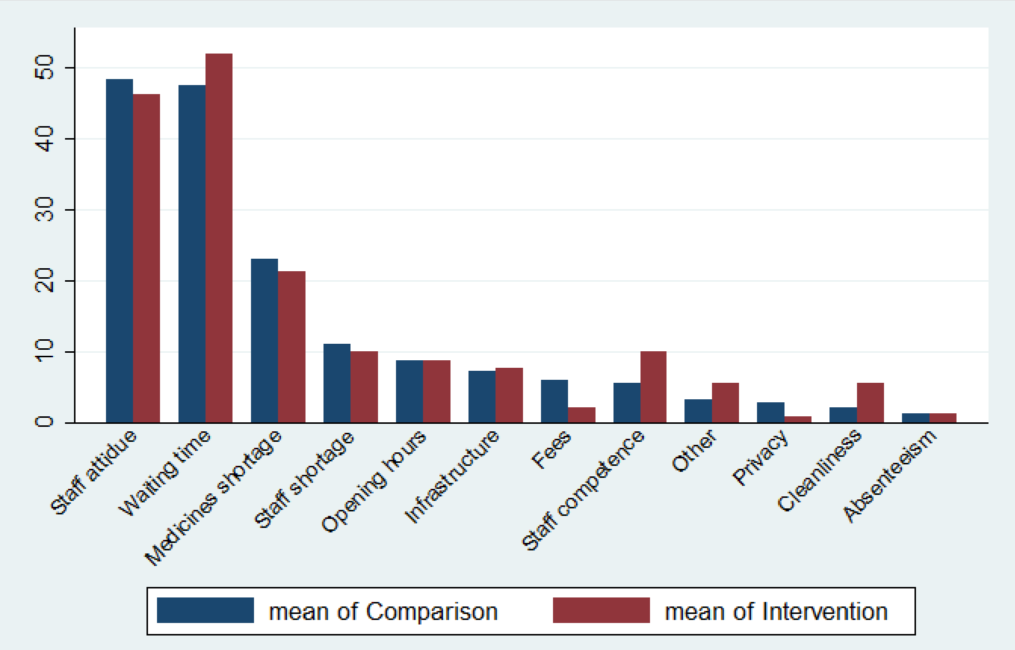
In the survey data, around 18% of ANC and U5 patients reported feeling unsatisfied with something at the health facility in the past 12 months. We asked facility users, facility Head Nurses, HCC members and CMs the main reasons for patient complaints in the past 12 months. The answers given consistently showed that the main complaints were around waiting times at the facility, staff shortages, a lack of medicine and staff attitudes.

Figure 15: Areas that health facility users are dissatisfied with

Areas that health facility users are dissatisfied with

Reported by facility users

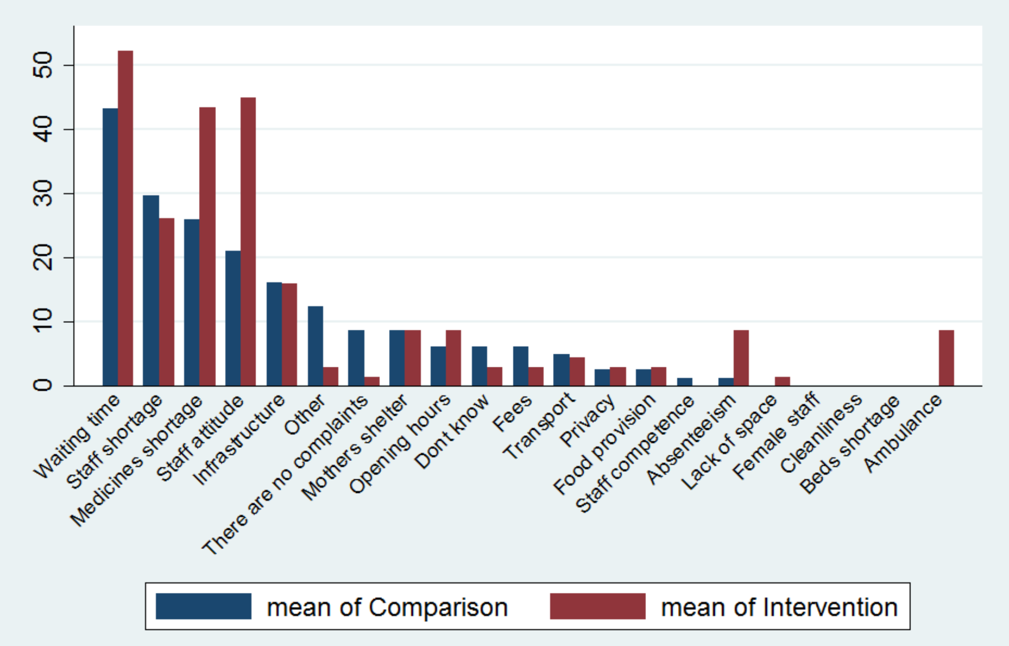
Proportion of facility users reporting the following main reasons for complaints, among those who were ever unsatisfied with services in the past 12 months



Source: OPM ANC and U5 surveys
Pooled sample (ANC and U5 patients), proportions do not sum to 100 since respondents allowed multiple answers
Intervention N = 241
Comparison N = 253

Reported by Head Nurse

Proportion of facility Head Nurses reporting the following main reasons for complaints in the past 12 months



Source: OPM Head Nurse Survey
Proportions do not sum to 100 since respondents allowed multiple answers
Intervention N = 69
Comparison N = 81

Sources: OPM Head Nurse survey, ANC survey, U5 survey

9 Impact of SCPH on the responsiveness of decision-makers

In this section we report our findings on whether or not SCPH has had an impact on the extent to which decision-makers in relation to health service provision are responsive to issues raised by community members.

Key findings

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 11: Key results on the responsiveness of decision makers from quantitative data

Responsiveness of decision makers					
	Data source		Comparison mean	Intervention mean	Treatment effect
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	OPM Head Nurse survey	*Endline mean*	58.02	79.41	**21.39*** **
		N	81	68	149
		Baseline mean	80	57.35	
		N	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

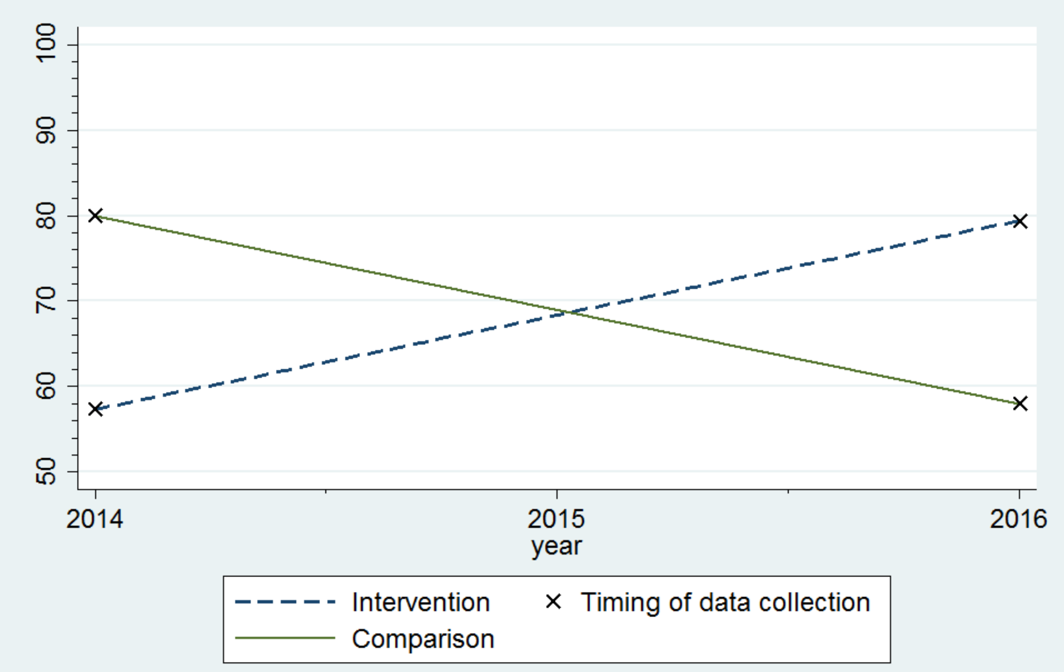
9.1 Impact of SCPH on decisions taken in response to community feedback

The survey data show a **large and strongly significant impact on the proportion of health facilities reporting that changes have occurred in the facility as a result of patient complaints**, from 58% of the comparison group to 79% of facilities in the intervention group. A similar finding obtains in the HCC data (from 80% of comparison group facilities to 93% of intervention group facilities), and in both cases the estimate is significant in the regression specifications.

Figure 16: Proportion of health facilities in which changes occurred as a result of patient opinions in the past 12 months

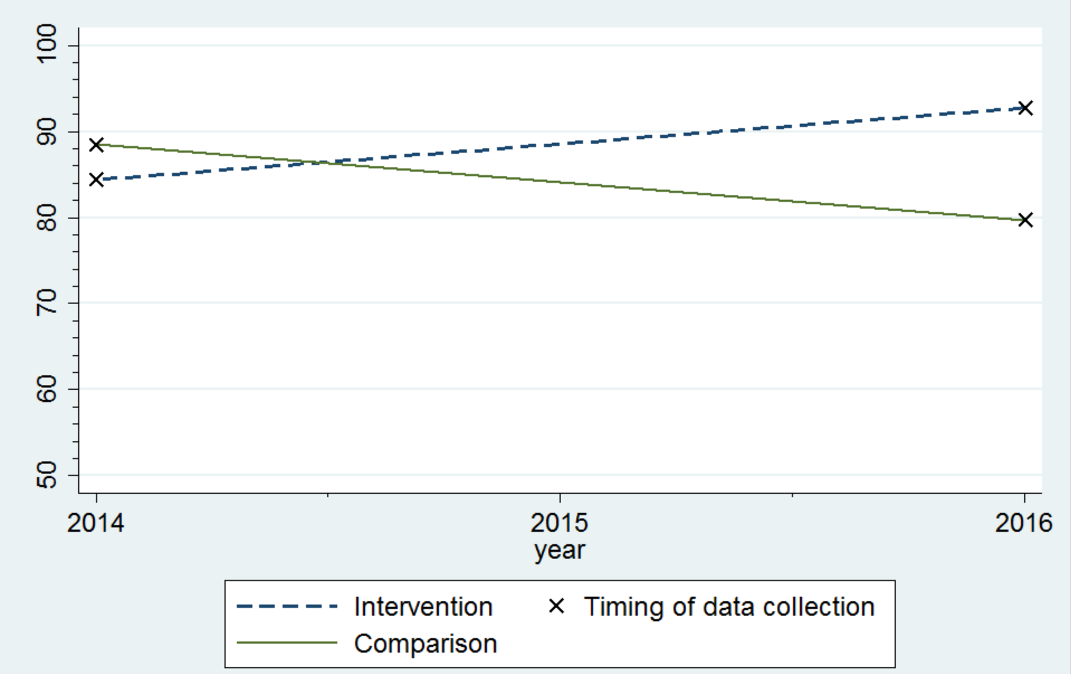
Proportion of health facilities in which changes occurred as a result of patient opinions in the past 12 months

Reported by Head Nurse



Source: OPM Head Nurse survey
Intervention N, baseline = 68, Intervention N, endline = 68
Comparison N, baseline = 55, Comparison N, endline = 81

Reported by HCC chairperson



Source: OPM HCC survey
Intervention N, baseline = 64, Intervention N, endline = 69
Comparison N, baseline = 78, Comparison N, endline = 79

Source: OPM HCC and Head Nurse surveys

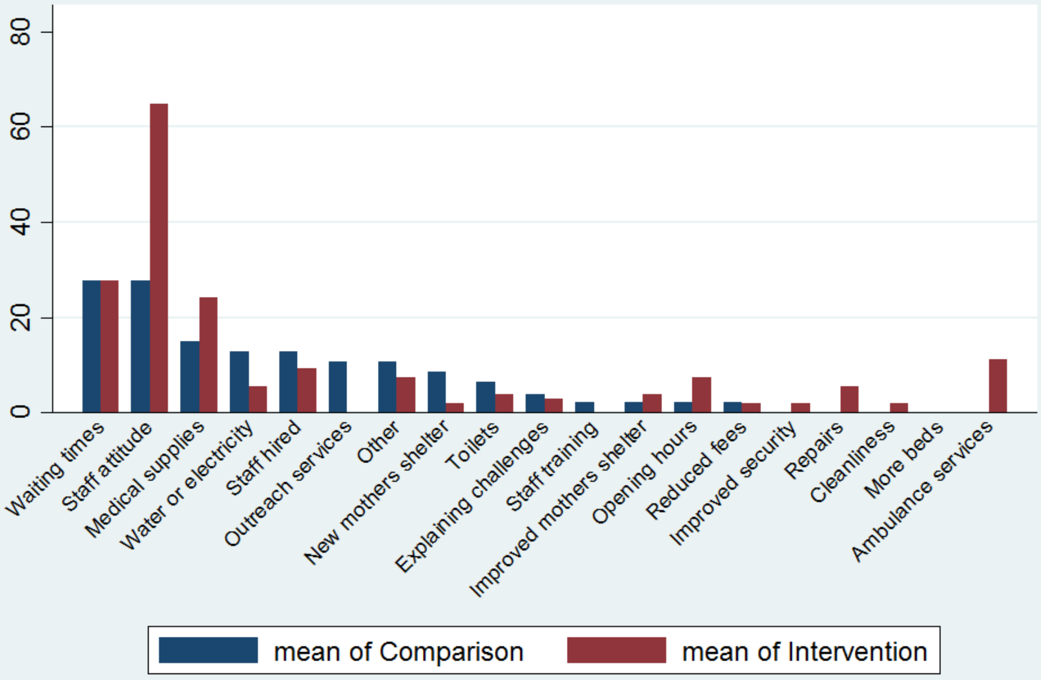
Among facilities reporting that changes have occurred due to patient complaints in the past 12 months, the main changes that were cited in the surveys relate to seeking to decrease waiting times, improve staff attitudes and improve medical supplies and drugs at the facility. This is illustrated in Figure 17 below, which shows the responses of the HCC chairperson and facility Head Nurse, respectively, when asked about changes at the facility in the previous 12 months.

The areas where facilities reported having made changes in the past year line up well with the issues that patients reported being unsatisfied with (illustrated in Figure 15 above).

Figure 17: Changes due to patient opinions

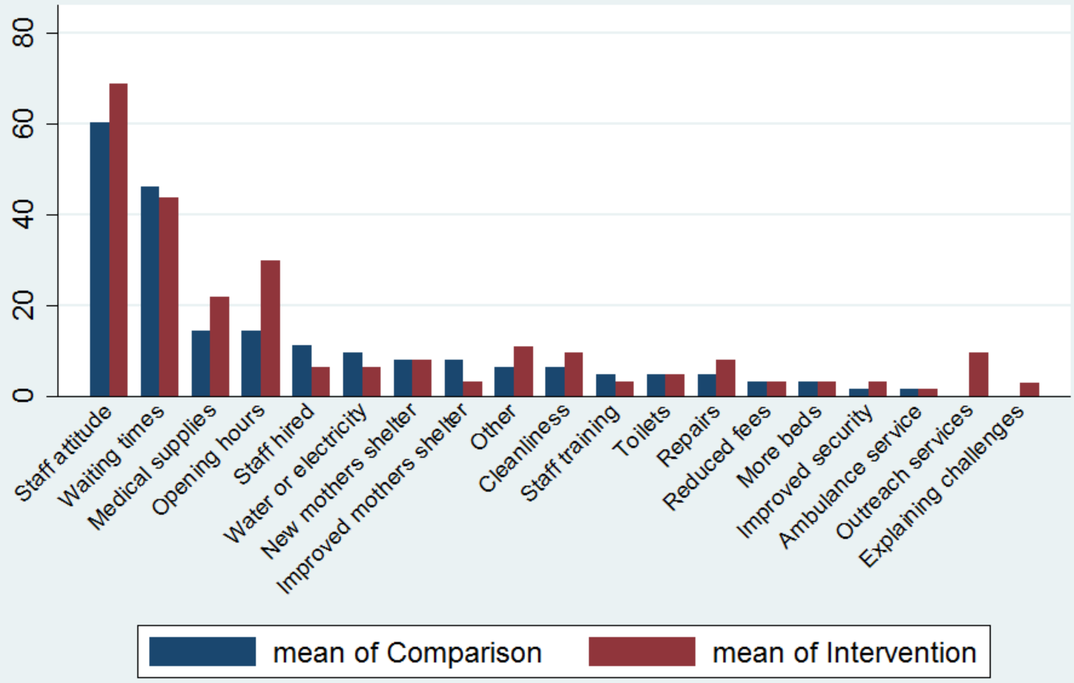
Among HCCs in which changes have occurred as a result of patient opinions, proportion reporting that the following changes occurred

Reported by Head Nurse



Source: OPM Head Nurse survey
Proportions do not sum to 100 since respondents allowed multiple answers
Intervention N = 54
Comparison N = 47

Reported by HCC chairperson



Source: OPM HCC survey
Proportions do not sum to 100 since respondents allowed multiple answers
Intervention N = 64
Comparison N = 63

Source: OPM HCC and Head Nurse surveys

The qualitative research probed further on whether and how HCCs had been successful in resolving complaints. We also find that facility staff and other decision-makers appear to show a genuine motivation to respond to complaints.

> *'At times we take things for granted and so it's useful to get complaints.'*
> Head nurse, Bulilima

However, we did not find very many examples of complaints being resolved effectively. The ones that we did find were the following:

1. We found cases where HCCs had sought to resolve complaints about staff attitudes by speaking with staff on behalf of the community to ask them to greet patients when they visited the clinic. In some instances, staff were willing to participate in the discussion, and to accept and act on feedback:

   > *'The community once complained about staff attitude. When the HCC was informed about these complaints, they sat down with the nurses and the issue was discussed, then we (the nurses and HCC) came up with a solution. The community said we did not greet them before we started work so we discussed that and said "There is no harm in greeting patients".'*
   > Head Nurse, Bulilima

2. We also heard more than one example of issues relating to staff attitudes being escalated to the district level, where the DHE was able to react by speaking with staff directly or assigning community sisters to mentor them.

3. In Rushinga, there were some other examples given of complaints that had been effectively responded to – for example, after community members requested that facility staff sleep at the facility, the district helped to remodel a room in the hospital into a staff home. HCCs also described digging a borehole where there was a water shortage.

9.2 Barriers to responsiveness

We find 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. Indeed, as shown in Figure 16, 21% of intervention facilities did not make any changes as a result of patient opinions in the previous 12 months. **The main barrier to improved responsiveness to community feedback is the capacity constraints that decision-makers face.**

Staff are operating in an extremely resource constrained environment, in which the funds they receive through RBF have become the primary source of income for the facility. These funds are not enough for facilities to provide the levels of service delivery that they would like to provide, and in many cases facilities have experienced delays in these funds arriving. Even the use of the RBF money is restricted to expenditures that can be justified by their relationship to supporting MNCH outcomes. This means that if facilities run short of certain drugs that are provided through the standard package delivered by NatPharm they may not be able to justify spending RBF money on new orders that do not have a clear relationship to MNCH, such as additional rabies vaccines.

The overall shortage of funds means that only the most urgent problems are addressed, but persistent problems around infrastructure and shortages of medicines cannot be dealt with. A further implication is that in some cases, rather than directly addressing the source of complaints, the only possible response is for HCCs and facility staff to simply explain the situation facing the clinic to those who complained. In this way, responses to complaints take the form of trying to make communities more understanding of the reasons for service quality issues, rather than improving the issues.

> *'We don't have resources. This means that normally our solutions are short term. We do respond to feedback but because of lack of resources it takes us longer.'*
> DHE respondent

> *'Before people would complain to VHWs about payments at the clinic. But now there are no complaints at all. The situation was that although the clinic was not charging for treatment, cards were being charged for. People complained because they didn't know the role of the money. They asked VHWs why they had to pay. The HCC called a meeting with headmen. After that the headmen took the info to the community. The charging for cards did not stop but it was explained that they need this charge in order to pay the security guard.'*
> VHW, Rushinga

Box 3: Example of unresolved complaint: Long waiting times

Long queues outside a facility and the long wait before being attended to was a frequently repeated, yet unresolved, complaint recorded by the qualitative study. The reasons why this often remains unresolved are as follows:

1. **Lack of staff at the facility level:** Nurses spoke of the severe shortage of staff in clinics. This meant that they took on additional responsibilities at the clinic, working longer hours, and taking on a greater case load. 'People may complain about waiting times. People are satisfied here, but always talk about staff shortage. They want more nurses so they can be served in time. We are only two (staff). The general hand is on leave and the person on the environment side went for indoor residual spraying. So we now have to do all the cleaning and mopping before we start work. The government froze posts for civil servants so it's difficult to solve that problem.'

2. **Shortage of funds to hire new staff:** The lack of finances and centralised decision-making structure does not enable government officers to respond, even if they want to. An interview with a district-level officer yielded the following statement: 'At a local clinic you are meant to get an RGN [Registered General Nurse], but there are many PCNs [Primary Care Nurses] at these clinics. There are vacancies in this district, I can't say how many. We can't fill these until the Ministry of Finance gives a green light. This is random, sometimes we hear that a post has been opened for us to fill. Most of these things are done at a province level, filling the post. We tell the province if there is a need and vacancies here. Usually it is the issue of finances that prevents us from responding to issues.'

3. **Increase in record-keeping:** In at least one clinic, staff attributed delays in attending to patients due to the many registers that they had to fill. The nurse in charge attributed the increase in records to RBF. Often, the responsibility for filling registers fell on the more experienced nurse in the facility. In this case the respondent said that the registers not only delayed patients, but also halted her career development.

4. **Unwillingness to respond:** A DHE representative mentioned that long waiting times at the facility was one of the complaints heard most often. , but sometimes without clear evidence ('Sometimes people wait for five minutes, but think that they have been waiting for a long time.'). The officer stated that there is not enough evidence to justify complaints around waiting times, and that the district would have a more accurate picture about waiting times if a study was carried out to capture the time from when people arrive to when they are attended to.

Some of the challenges that communities have raised, such as long waiting times and shortages of medicines, are so endemic and well known that feedback does not tell decision-makers anything that they did not already know. Therefore, some of the information received by decision-makers as a result of feedback channels may not actually provide a reason to update their priorities.

10 Impact of SCPH on inclusive decision-making

This section refers to how decisions are made at health facilities around the setting of priorities and the spending of RBF money, and the extent to which HCCs, volunteers and community members are engaged in decision-making processes.

Key findings

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 12: Key results on inclusive decision making from quantitative data

Inclusive decision making					
	Data source		Comparison mean	Intervention mean	Treatment effect
Proportion of facilities with an operational plan for the current year	OPM Head Nurse survey	*Endline mean*	95.06	94.2	-.86
		N	81	69	150
		Baseline mean	87.69	93.75	
		N	67	80	
Among facilities with an operational plan, proportion of HCCs reporting that they were consulted in its development	OPM HCC survey	*Endline mean*	96.05	98.53	2.48
		N	76	68	144
		Baseline mean	98.59	96.55	
		N	71	58	
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	OPM HCC survey	*Endline mean*	83.33	89.55	6.22
		N	78	67	145
		Baseline mean	81.82	80.95	
		N	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

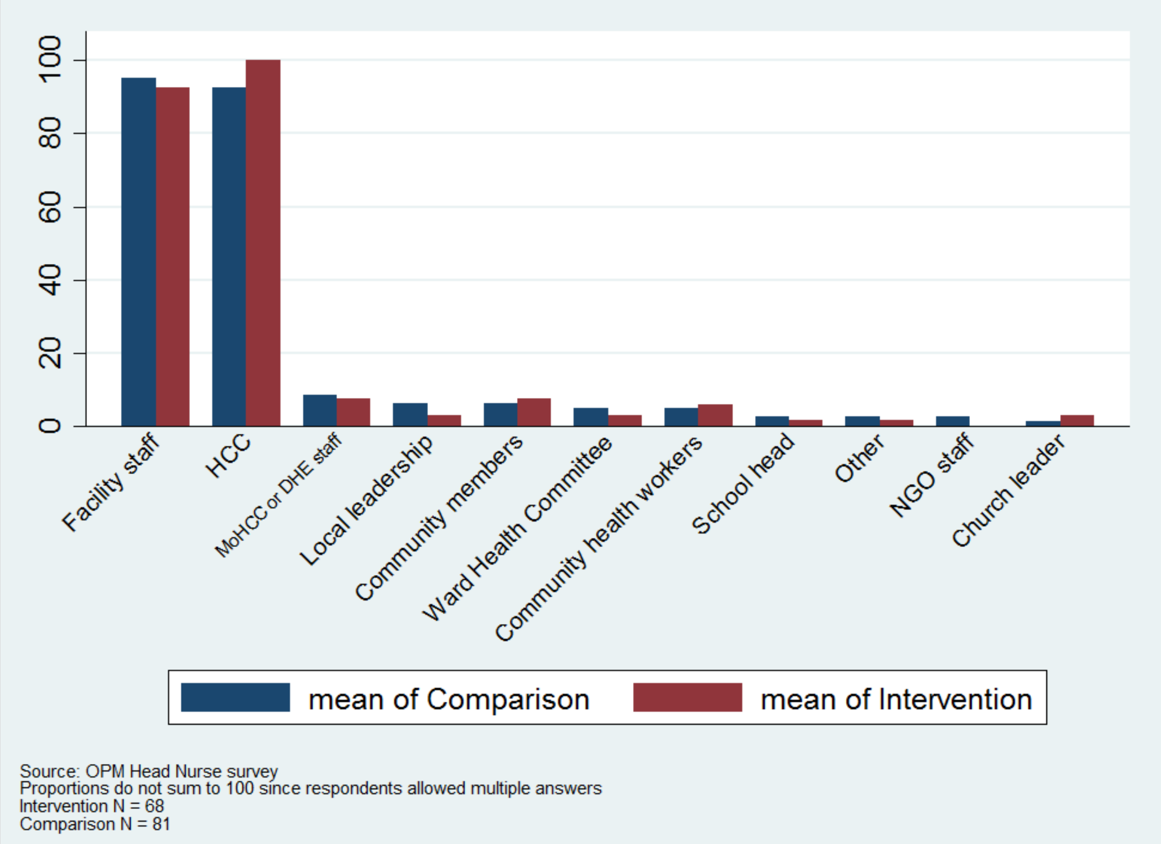
Since the introduction of the RBF payment system the annual operational plan has been the key planning document for determining the direction and priorities for each health facility. Nearly all facilities (around 95% of intervention and comparison facilities) have operational plans. The operational plan is developed by the HCC and the health facility staff, including the nurse in charge.

SCPH had a small positive impact on the involvement of HCCs in the development of the operational plans, as reported by Head Nurses. Head Nurses at intervention facilities were more likely to report that the HCC was involved in the development of the operational plan, though this is a common practice in both intervention and comparison facilities. As shown in Figure 18 below, the HCC was involved in the development of the operational plan in all intervention facilities, as compared with 93% of comparison facilities.

Figure 18: Involvement different groups in the development of the operational plan

Among facilities that have an operational plan, the proportion of Head Nurses reporting that the following were consulted in developing it

Reported by the facility Head Nurse



Source: OPM Head Nurse survey
Proportions do not sum to 100 since respondents allowed multiple answers
Intervention N = 68
Comparison N = 81

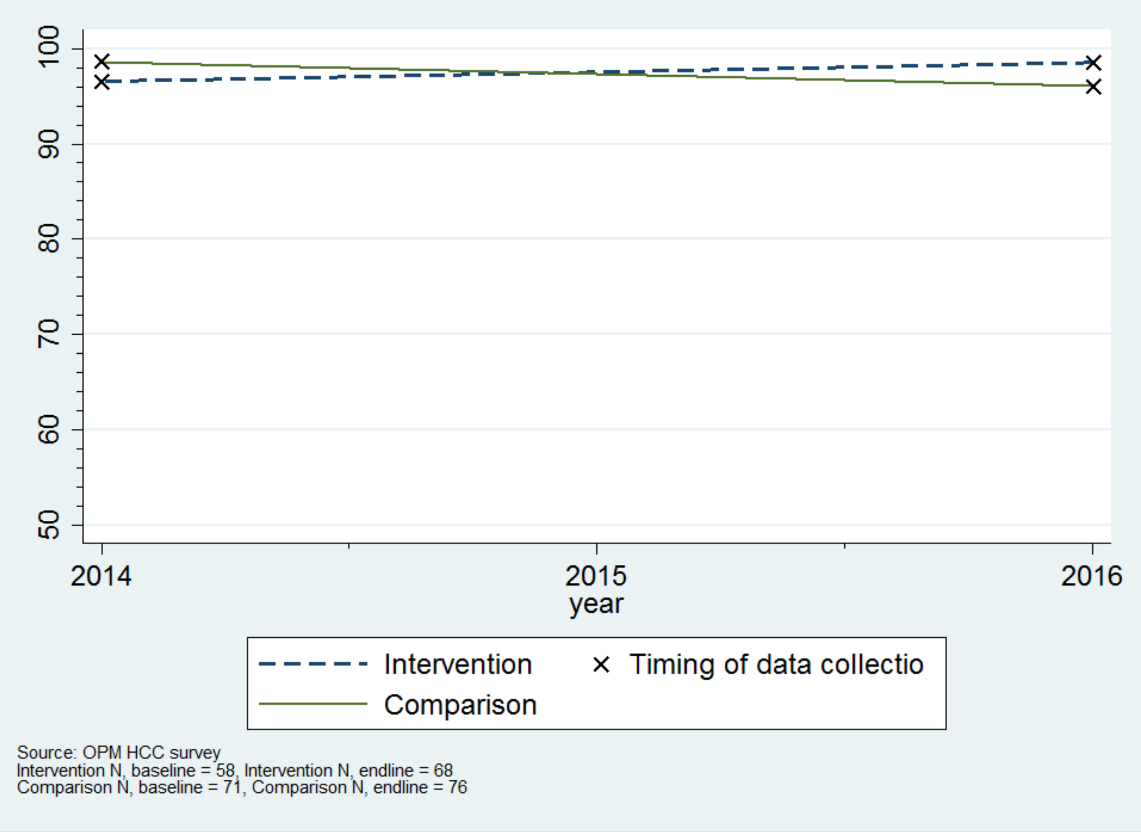
Source: OPM Head Nurse survey

However, there were some discrepancies between what was reported by the Head Nurses as compared with the HCCs: when HCCs themselves were asked if they had been involved in the development of the facility's operational plan, nearly all of them in both intervention and comparison reported that they had been. **Therefore, using the HCC interviews as a data source, we find that SCPH did not affect the involvement of the HCC in the development of the operational plan.**

Figure 19: Involvement of HCC in the development of the operational plan

Among facilities that have an operational plan, the proportion of HCCs who report having been involved in its development

Reported by HCC chairperson



Source: OPM HCC survey

We also find that the SCPH had a positive impact on the likelihood that the Head Nurse was able to produce a hard copy of the plan when requested. (83% of nurses could show us the plan in intervention facilities, compared with 69% in comparison facilities). However, there were no statistically significant differences between intervention and comparison facilities in regard to the proportion of HCCs that could show our teams the operational plan. This indicator is significant because it provides some indication of how much the operational plan is used or how far it is seen as an important document.

SCPH did not affect the proportion of HCCs who are involved in the decision-making over how RBF funds are spent because nearly all HCCs in both intervention and comparison facilities are involved in this process. Intervention and comparison facilities showed similar patterns in terms of how decisions over spending are made. The nurses reported that almost all (97%) of HCCs are involved in decision-making over how RBF money is spent and there was no difference between intervention and comparison facilities (and we received similar information from HCCs themselves). Almost all intervention and comparison HCCs reported that the spending of RBF money was in line with their priorities, and intervention HCCs are no more likely to be a signatory for the facilities' bank accounts. Health facilities in our sample reported receiving an average of $6,249 in the past year from RBF.

Within the HCC, decisions concerning finances and community projects are generally made collaboratively and there are no differences between intervention and comparison facilities.

Overall, the survey findings point to **a good degree of collaboration between HCCs and facilities, and between HCC members, in terms of how decisions are made, but with very little direct involvement of communities in planning at the facility level; SCPH did not improve this**. As shown in Figure 18**Error! Reference source not found.**, only around 7% of nurses reported that community members were directly involved in the development of the operational plan, and there were no differences between intervention and comparison facilities. The weakness in community participation at this level was echoed by the findings of the qualitative research, in which we heard testimony from one key informant that the traditional leaders and the facility staff were perceived to be the ones who are responsible for improving the clinic. In contrast, 'ordinary' people were not perceived to take part in decision-making regarding health priorities in the clinic or attempts to improve services. The respondent felt that the community could not influence the facility, and all they wanted from the hospital was to be treated. According to this respondent, even the VHWs do not make these decisions – they just hold meetings in the facility about health issues.

The lack of direct community involvement may not, in and of itself, be a problem if the HCCs are strongly engaged with the community and can represent the community's views in the decision-making process. However, as shown in Section 6.3, the HCCs are not strongly engaged with the community and therefore the communities' voices are rarely channelled into the decision-making process.

11 Impact of SCPH on health services quality

Key findings

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.

The qualitative interviews do suggest that there have been some meaningful improvements in some facilities 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 13: Key results on the quality of health services results from quantitative data

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

11.1 Evidence from the MoHCC Quality of Care checklist

The Quality of Care checklist is conducted quarterly in each facility to monitor the quality of services provided. The checklist covers a wide range of different domains of health service quality, and is used to construct one overall composite measure of quality every quarter. This composite measure is constructed from 18 ‘underlying’ scores that correspond to different dimensions of quality. The underlying scores are separated into one ‘structural’ domain and one ‘clinical quality of care’ domain.

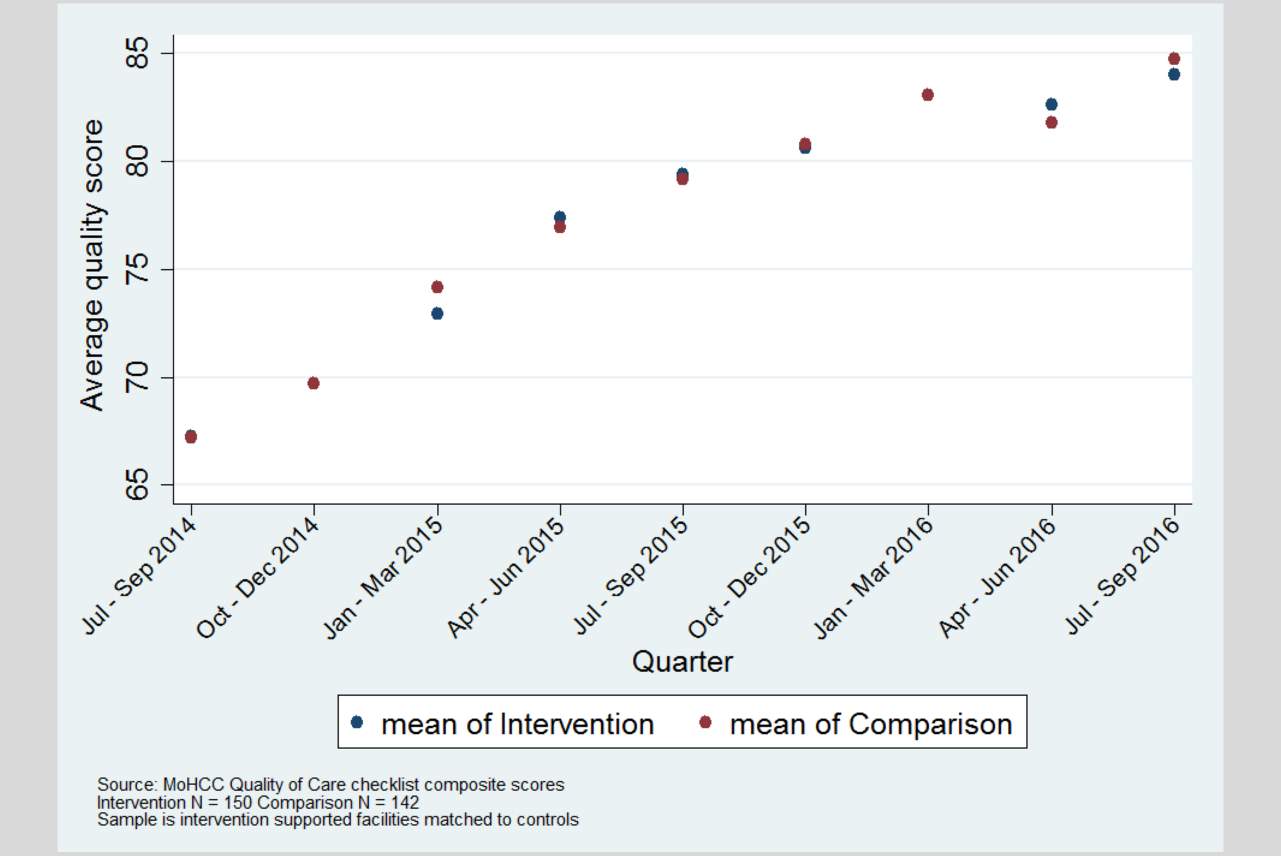
We conducted analysis of both the composite and underlying scores using data from all the intervention facilities, and a sample of comparison facilities selected to ‘match’ the intervention sites in terms of their characteristics in the baseline period, as measured by the NIHFA data[33]. Data are available from the third quarter of 2014 (July–September) to the third quarter of 2016.

Figure 20 below shows that while the scores have increased over time, there are no differences in the trends between the intervention and comparison sites. The corresponding graphs for all the underlying dimensions are presented in Volume 2, Section 4, and also show no overall difference between intervention and comparison facilities.

Regression analysis of the composite scores confirmed that there was no quantitative impact of SCPH on improving these scores in intervention facilities. We also do not find significant differences in the underlying scores[34].

Figure 20: Trends over time in average facility composite quality scores

Facility composite quality scores over time, as measured by the MoHCC Quality of Care checklist



Source: MoHCC Quality of Care checklist composite scores

Although there has been no aggregate increase in service quality due to SCPH, Figure 20 above does indicate that there has been an average improvement in service quality scores across all facilities over time.

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[33] Some intervention facilities were lost from this ‘matched’ sample, due to difficulty in linking them with both the NIHFA data and the MoHCC Quality of Care checklist data. Out of 166 intervention facilities, the final matched sample used for analysis contained 150 of these (matched to comparison sites).

[34] Out of the 18 underlying dimensions, there is only one outcome that is significant at the 10% level, and no outcomes that are significant at the 5% level.

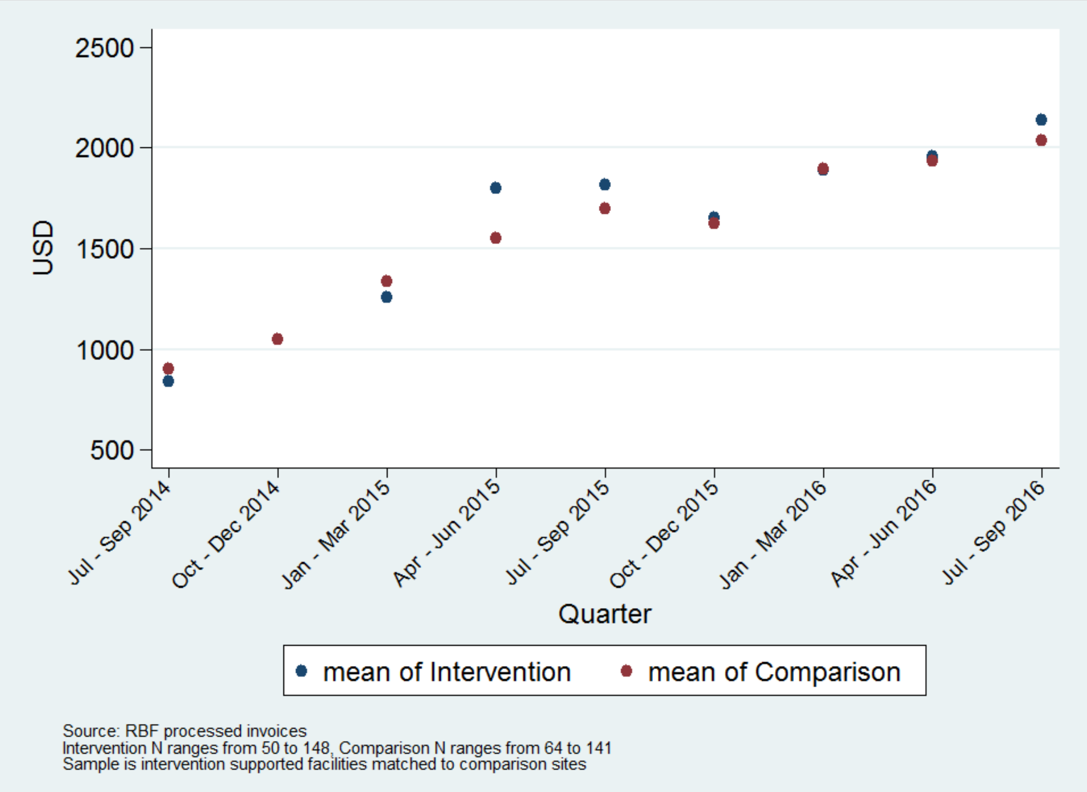
11.2 Evidence from the RBF disbursements data

We posit that these increases in quality have been primarily brought about by the injection of resources brought about by the HTF. Additionally, the introduction of RBF also introduced some specific incentives tied to improving quality along the dimensions measured by the Quality of Care checklist.

A second measure of health service quality can therefore be gauged by assessing the disbursements provided to facilities through the RBF scheme. Figure 21 plots the average total disbursements paid to intervention and comparison facilities over time. This combines both the payment linked to quality of care (based on the MoHCC checklist data presented above), and a payment linked to the quantity of services provided. The figure shows that there has been an increase in average RBF disbursements paid to facilities over time, in line with the increase in quality checklist scores. The figure also shows negligible differences between intervention and comparison sites in average RBF disbursements at the start and end of the intervention period. Intervention sites received a higher average disbursement toward the middle of 2015, but this difference was not sustained into 2016. We also find no impact on RBF disbursement amounts when intervention and comparison facilities are compared through regression analysis.

Figure 21: Trends over time in average total facility RBF disbursements

Average total RBF disbursements paid to facilities over time



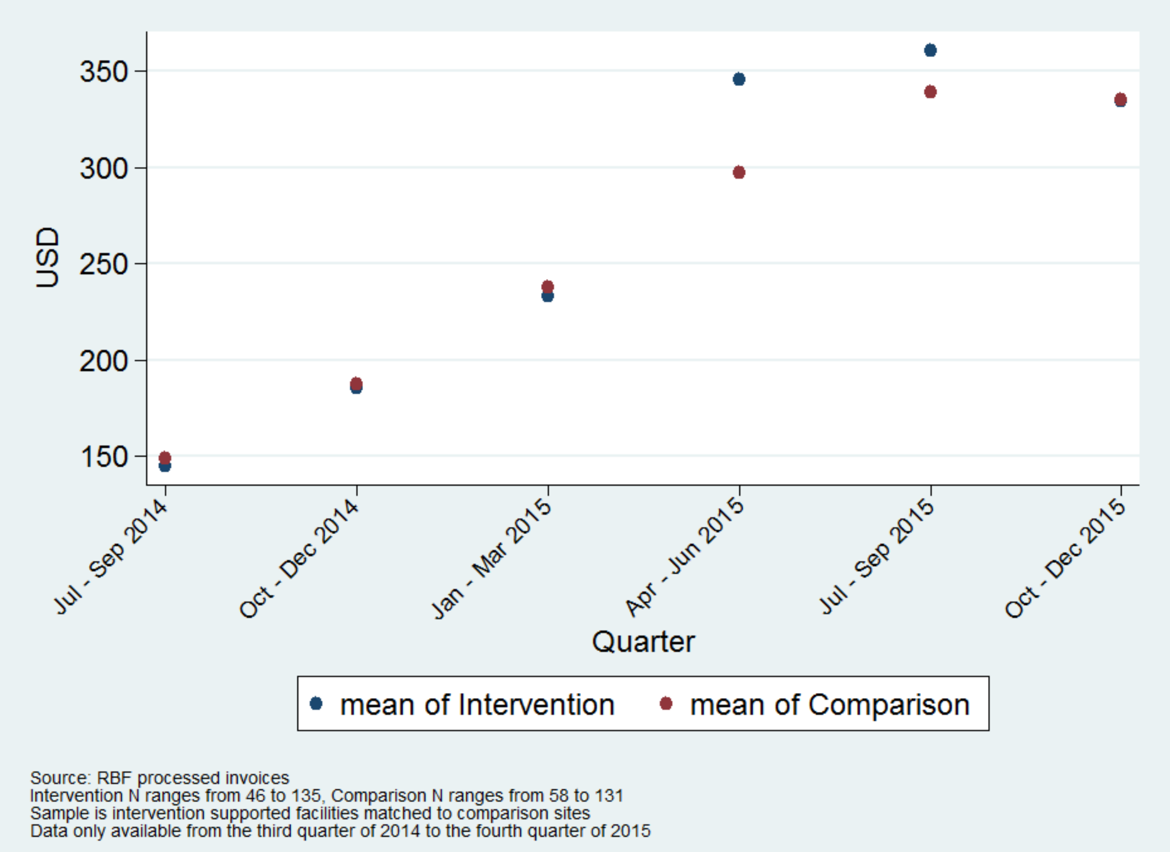
Source: RBF processed invoices
Intervention N ranges from 50 to 148, Comparison N ranges from 64 to 141
Sample is intervention supported facilities matched to comparison sites

Source: RBF processed invoices (supplied by Crown Agents)

It is also possible to separate out the payment that was made to health facilities in respect of the quality scores alone, although unfortunately the data are only available until the end of 2015. Figure 22 shows that intervention facilities attained higher quality-linked RBF payments than comparison facilities towards the middle of 2015. This is consistent with the pattern in the overall RBF disbursement payments shown in Figure 21 above. However the difference seems to have vanished by the end of 2015.

Figure 22: Trends over time in average quality-linked facility RBF disbursements

Average quality-linked RBF disbursement paid to facilities over time



Source: RBF processed invoices
Intervention N ranges from 46 to 135, Comparison N ranges from 58 to 131
Sample is intervention supported facilities matched to comparison sites
Data only available from the third quarter of 2014 to the fourth quarter of 2015

Source: RBF processed invoices (supplied by Crown Agents)

Both sets of secondary data indicate that, overall, the intervention-supported facilities have not attained higher levels of quality than comparison sites over the implementation period as a whole. However, there have been improvements in quality over time. One visible manifestation of this is in the infrastructure of facilities, which has improved since the pre-RBF period. The evaluation team observed that the facilities which were visited during the qualitative and quantitative survey research were generally clean and presentable, and the buildings were sturdy.

> *'Recently they are concentrating more on the structure, painting. For RBF they are assessed on performance, which is partly structural. So they are biased in that whole structural thing. Before RBF everyone was told about availability, but now they think they have to concentrate on appearance too.'*
> DHE respondent

11.3 Evidence from the qualitative and quantitative survey data

The MoHCC composite quality scores represent an aggregate index that captures a large range of factors related to the performance of health facilities. Though our evaluation was purposefully designed not to collect detailed information on health service quality, so as not to replicate already existing data collection efforts, we did still gather some information from the qualitative research and quantitative surveys that provide more depth to the findings on service quality.

Several respondents for the qualitative research indicated that a notable achievement of SCPH has been **improvements in the relationship between community members and facility staff**

due to reinforced feedback and accountability mechanisms at facilities. However this has not translated into any differences in overall patient satisfaction with facility staff according to the quantitative survey (reported in Section 12)

> *'We had serious issues of staff attitude when we started. Then these issues were raised and the community sisters did mentoring sessions with facility staff.'*
> Programme staff member

> *'Now staff are hearing that their attitudes are bad they are changing their behaviour.'*
> District-level staff member

Other respondents also reported that a key respect in which health facilities have improved in recent years is in the removal of user fees. This is described further in Section 13, where it is noted that the main stimulus for the removal of user fees for MNCH services among facilities that were still charging them has been the introduction of RBF. However, not all facilities have been able to remove user fees, and continued efforts to do so are also something that SCPH has emphasised. Therefore, **the qualitative evidence points to some effect of SCPH in promoting the removal of user fees in some facilities that were still charging them even after the introduction of RBF**.

> *'RDC [Rural District Council]-owned clinics were charging user fees before. Through the programme this has now stopped. Clients were complaining, education started so they knew they weren't supposed to be charged. The Ministry intervened.'*
> Programme staff member

We do not have direct evidence on the proportion of facilities charging user fees. However, we do find that the proportion of facility users who reported paying anything for their services at the clinic on the day of interview is slightly lower in the intervention group of U5 patients compared with the comparison group – at 1% of intervention group patients, compared with 4% of comparison group patients. There is no corresponding decrease in the sample of ANC patients.

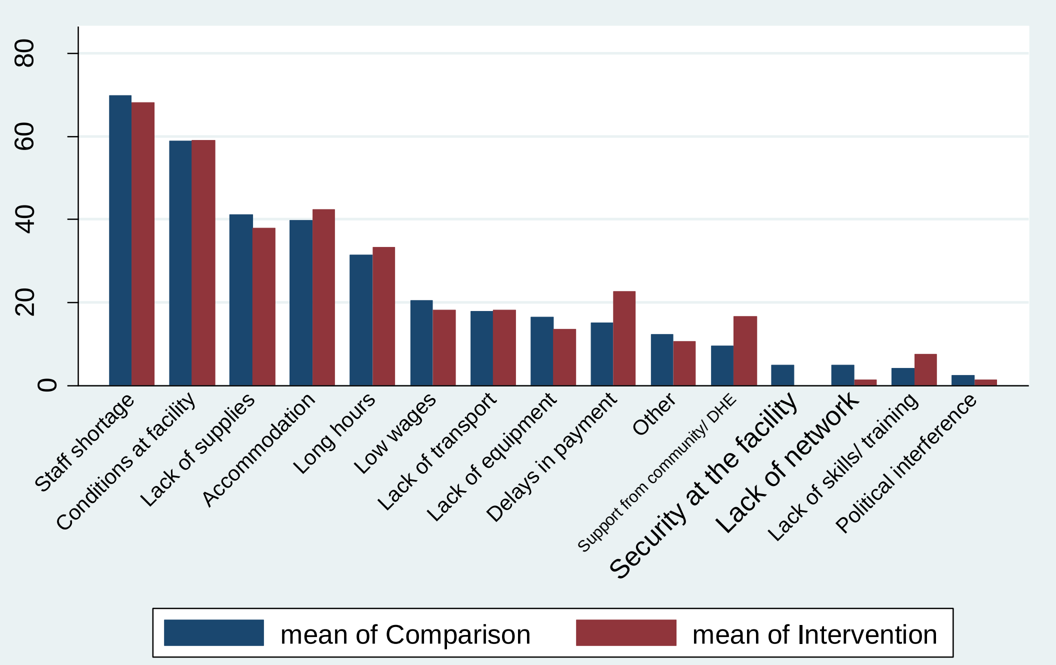
However, we also noted during the qualitative and survey fieldwork that there remain many facilities that are continuing to levy some costs on facility users through other channels. This includes fines for pregnant women who deliver at home, *ad hoc* 'facility development' fees, or fees for patient treatment cards that may be charged.

The results of OPMs health facility survey **do not show any impact of SCPH among other limited measures of health service quality that were collected**. There is no difference in the proportion of facility Head Nurses reporting that health workers face challenges in carrying out their roles, which is in fact higher among the intervention group – at 96% of nurses, compared with 90% in the comparison group (though the difference is not statistically significant). The main challenges reported across both groups are a shortage of staff, lack of supplies, poor working conditions at the facility, lack of accommodation and long working hours. As was the case at baseline, we also find that almost all ANC patients had an ANC card recording their ANC visits.

Figure 23: Challenges facing facility staff

The main challenges facing health staff, among those who reported that staff face any challenges in carrying out their roles

Reported by facility Head Nurse



Source: OPM Head Nurse survey
Proportions do not sum to 100 since respondents allowed multiple answers
Intervention N = 66
Comparison N = 73

Source: OPM Head Nurse survey

12 Impact of SCPH on patient satisfaction

Key findings

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 14: Key results on patient satisfaction from quantitative data

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

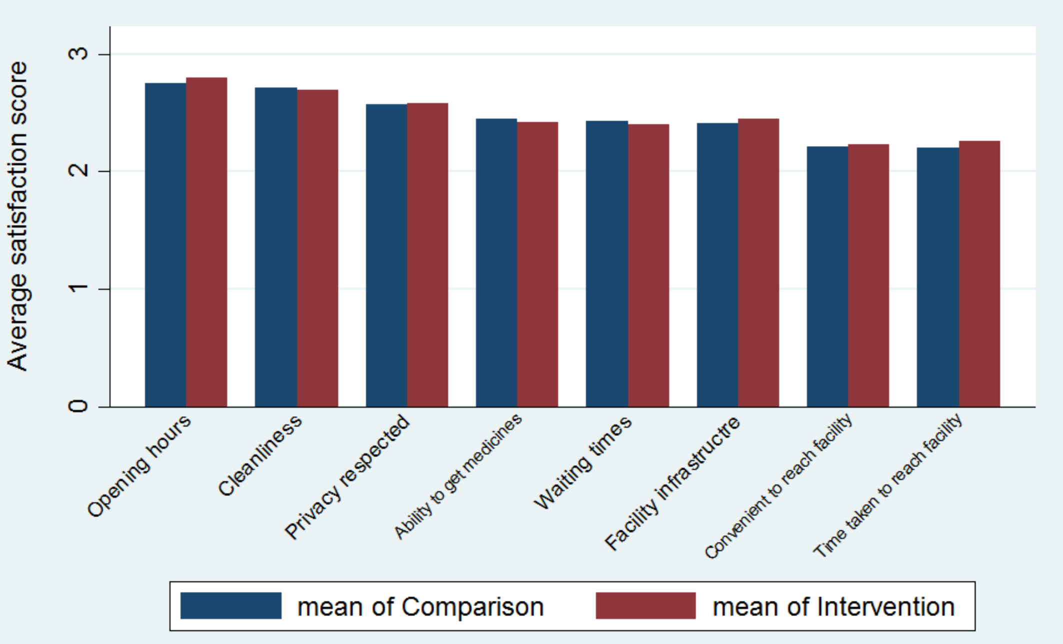
Patient satisfaction was measured in the survey by asking facility users to say how satisfied they were with different questions relating to their treatment and experience using the health facility. We converted these answers into a score ranging from 0 to 3, with the following key: 0 = very dissatisfied, 1 = somewhat dissatisfied, 2 = somewhat satisfied, 3 = very satisfied. Figure 24 below show that average satisfaction across the sample was between 2 and 3 for all dimensions asked, meaning that on average patients reported being quite satisfied or very satisfied with each question asked.

The graphs below show the satisfaction with both characteristics of the health facilities and the health workers using the endline data. As shown, people reported being very satisfied with the quality of both health facilities and the health workers. Although this is not shown here, we found similarly high levels at baseline, and the regression results show that there is no impact of the SCPH on satisfaction (details in Volume 2, Section 3.2.6).

Figure 24: Satisfaction with characteristics of the health facilities

Average satisfaction with the health facility (score out of 3)

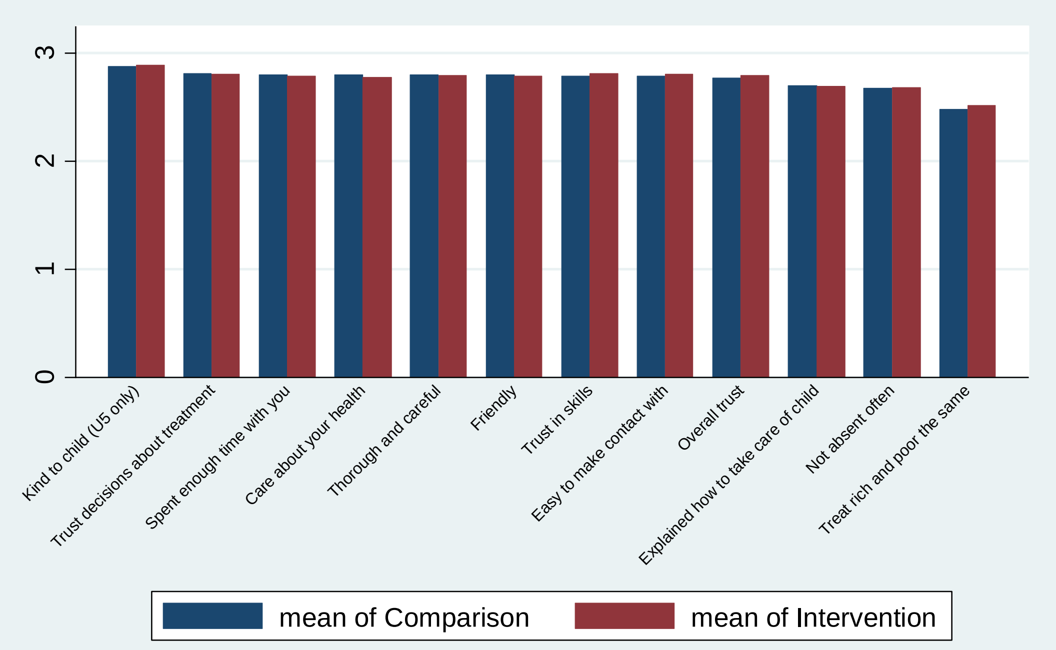
Reported by ANC and U5 patients



Source: OPM ANC and U5 survey, Pooled sample (ANC and U5 patients)
Intervention N ranges from 1232 to 1254
Comparison N ranges from 1434 to 1464
N varies because answers given as 'don't know' are treated as missing
Score out of 3 based on the following system: 0 = very dissatisfied, 1 = somewhat dissatisfied, 2 = somewhat satisfied, 3 = very satisfied
Questions on satisfaction with the cost of transport and fees at the facility excluded due to very small sample sizes of users who paid these costs

Average satisfaction with health workers at the facility (score out of 3)

Reported by ANC and U5 patients



Source: OPM U5 and ANC survey
Intervention N ranges from 1212 to 1255
Comparison N ranges from 1410 to 1464
N varies because answers given as 'don't know' are treated as missing
Score out of 3 based on the following system: 0 = very dissatisfied, 1 = somewhat dissatisfied, 2 = somewhat satisfied, 3 = very satisfied

Source: OPM ANC and U5 surveys

13 Impact of SCPH on the utilisation of health facilities

Key findings

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 15: Key results on facility utilisation from quantitative data

Utilisation					
	Data source		Comparison mean	Intervention mean	Treatment effect
Average total ANC visits per facility per quarter	OPM T5 verification survey	*Endline mean*	69.19	71.60	2.41
		N	81	69	150
		Baseline mean	68.22	66.83	
		N	80	67	
Average total PNC visits per facility per quarter	OPM T5 verification survey	*Endline mean*	33.69	33.13	-0.57
		N	81	69	150
		Baseline mean	28.99	26.36	
		N	80	67	
Average total new outpatient visits per facility per quarter	OPM T5 verification survey	*Endline mean*	464.45	494.21	29.77
		N	81	69	150
		Baseline mean	644.55	686.51	
		N	80	67	
Average total immunisations per facility per quarter	OPM T5 verification survey	*Endline mean*	135.07	142.31	7.25
		N	81	69	150
		Baseline mean	140.56	142.93	
		N	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

13.1 Evidence on volumes of services provided

13.1.1 How impact was assessed using the quantitative data

We measure utilisation of health facilities during the intervention period using the record of patient numbers kept in registers in each facility. For this analysis we concentrate on measures relating to the use of MNCH services. The registers are tallied every month by the facility nurses and are recorded in the facility's 'T5 forms', which give the number of patients per month per facility. When visiting the health facilities our data collection teams recorded the number of people using the facility, as recorded in the T5 forms, for the following MNCH services: 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).

To check the reliability of the data recorded in the T5 forms, our data collection team also tallied the patient numbers in the registers for a six-month period at baseline and endline. We did this for all of the above MNCH services, except for immunisations. In theory, these tallies should match the tallies recorded in the T5 forms.

We also obtained the official HMIS data, but we were only able to obtain these for ANC services. The purpose of gathering data from three separate sources was so that we could carry out a data verification exercise, to check the consistency and quality of these data before using them in analysis. We duly compared the findings for the comparable indicators across all data sources, and found them to be highly consistent. The findings of this quality check are presented in Volume 2, Section 4. This provides some confidence in the quality of the data. We have chosen to present our main analysis using the T5 data, since these data are the most complete in the sense that they cover ANC, PNC, new outpatients and immunisation outcomes.

All data sources were collected for six months over the baseline period (January to June 2014), and gathered again for six months during the intervention period (January to June 2016).

First, we plotted the average patient volumes per service type per facility over time, during six months of the baseline period and six months of the intervention period for both intervention and comparison facilities. The graphs are presented in in Figure 25 and Figure 26 below[35]. We then ran regressions to estimate the impact of SCPH (results are presented in Volume 2). A number of specifications were estimated, including comparing intervention and comparison facilities at endline and using a difference-in-differences approach to account for any difference at baseline. We also ran our regressions using the data from the registers that were collected by our survey teams.

13.1.2 Findings

In the HMIS data, we find that across all measures of utilisation SCPH did not have an impact on the utilisation of health facilities for MNCH services. In some cases small positive differences between intervention and comparison groups are observed, but the differences are small and not statistically significant when estimated using regressions. The graphs below show that intervention and comparison facilities have very similar recorded volumes of patient services. In the regressions, both data sources and the majority of models tested find that SCPH did not have an impact on the utilisation of health facilities.

Although the HMIS shows no evidence of an impact of SCPH on service utilisation, in the qualitative research respondents overwhelmingly reported that there have been recent increases in

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[35] The corresponding graphs for the OPM registry data show similar trends for ANC, PNC and new outpatient volumes, and are presented in Volume 2.

the volumes of women using health facilities for MNCH services. This was the case both in the intervention sites and the one comparison facility we visited for the qualitative study. To assess this claim, we used to the HMIS data to assess whether there have been increases in service utilisation across both intervention and comparison sites together, since the baseline period.

Interestingly, the findings show that overall there have not been increases in service utilisation since 2014 across the sample as a whole. We do see an increase (across both intervention and comparison facilities) in the number of women attending ANC earlier in their pregnancies, before the 16th week. However there is no *overall* increase in the number of women attending ANC visits, since the increase in first visits before 16 weeks is offset by a decrease in first visits after 28 weeks of pregnancy. This means that ANC patients have been coming earlier in their pregnancy, but there have not been more ANC patients overall since 2014. We do find an increase in the average number of women attending facilities for PNC visits, but decreases in the average numbers of immunisation services administered and in the average number of new outpatients. In sum, the HMIS data do not show there to have been any overall increases in the utilisation of MNCH services over the implementation period across both the intervention and comparison sites.

The widespread view among respondents for the qualitative research that service levels have increased, we believe, relates to perceptions of the period since before 2014. The most plausible explanation is the introduction of the HTF since 2012. Prior to the HTF, health facilities in rural areas of Zimbabwe had been experiencing significant shortages. The arrival of new money into the system enabled facilities to be restored to a level of operations that had not been feasible before, and therefore it was possible to increase the volume of services. The qualitative testimonies of increased utilisation therefore do not contradict the qualitative findings based on HMIS data, they simply refer to a different reference period.

Figure 25: Trends over time in total monthly ANC and PNC visits

Average total number of ANC visits per facility per month

Source: HMIS T5 data: OPM
Intervention N, baseline = 67, Comparison N, baseline = 80
Intervention N, endline = 69, Comparison N, endline = 81

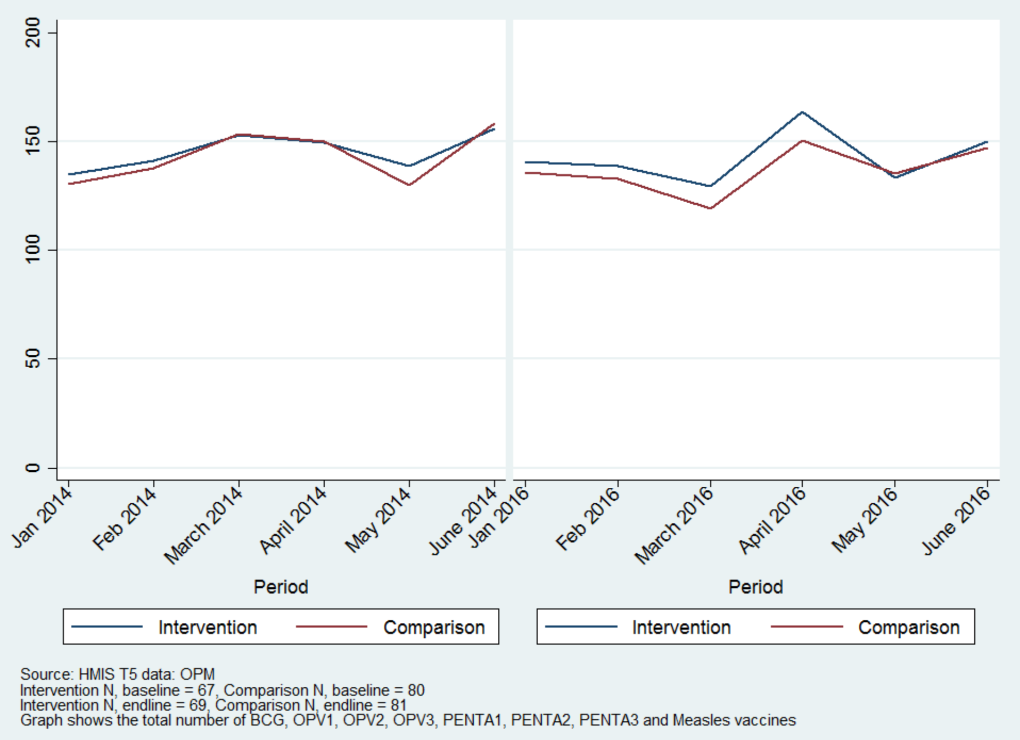
Average total number of PNC visits per facility per month

Source: HMIS T5 data: OPM
Intervention N, baseline = 67, Comparison N, baseline = 80
Intervention N, endline = 69, Comparison N, endline = 81

Source: HMIS T5 data: OPM verification

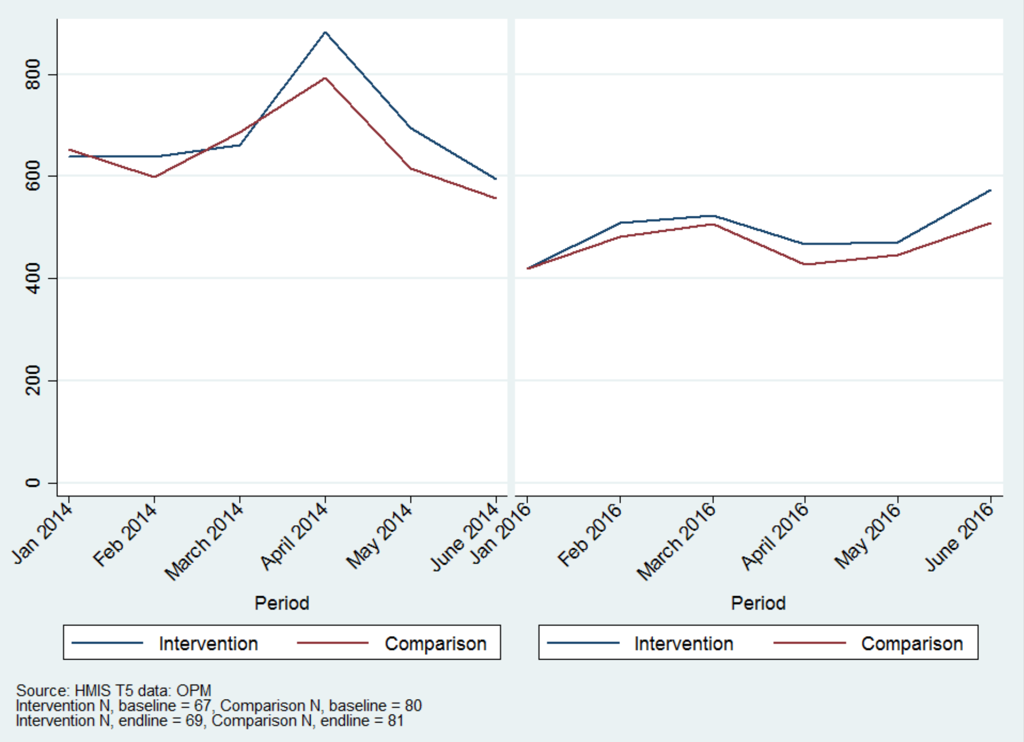
Figure 26: Trends over time in volumes of new outpatients and immunisations administered

Average total number of immunisations administered



Source: HMIS T5 data: OPM
Intervention N, baseline = 67, Comparison N, baseline = 80
Intervention N, endline = 69, Comparison N, endline = 81
Graph shows the total number of BCG, OPV1, OPV2, OPV3, PENTA1, PENTA2, PENTA3 and Measles vaccines

Average total number of new outpatient visits per facility per month



Source: HMIS T5 data: OPM
Intervention N, baseline = 67, Comparison N, baseline = 80
Intervention N, endline = 69, Comparison N, endline = 81

Source: HMIS T5 data: OPM verification

More recently, the phased introduction of the RBF scheme from 2015 onwards has also brought new direct incentives to health facilities to try to increase the volumes of patients. These incentives are in the form of a payment to the facility that is linked to the quantity of services provided and a 25% incentive paid directly to staff. This represents a strong stimulus for facilities to encourage more patients to attend facilities. However, as described above, we do not yet see evidence that there has been an overall increase in utilisation of services since January 2014, apart from for PNC visits.

Nonetheless, in the qualitative research facility staff and HCC members cited RBF incentives as a direct reason for their efforts to mobilise more users to attend facilities: in many cases they directly communicated to communities the fact that the facility would receive more money and would be able to improve if more people made use of it.

> *'I also encourage people to go to the clinic, especially pregnant women so that we get points from RBF because for every live birth we get money.'*
> HLF, Rushinga

> *'There is a committee on health in this community. They encourage pregnant women to book early and come for their review dates so that they get RBF and procure what is needed.'*
> Facility users, Bulilima

The introduction of RBF was also significant because health facilities had to comply with conditions around removing user fees for pregnant women and carers of under-fives in order to receive funds. User fees present a significant barrier to access for poor women in regard to accessing health services, and while a government policy on user fees has existed since the 1980s, many clinics had either continued to charge these fees in order to cover their running costs, or had been forced to reintroduce them under financial strain before RBF was introduced.

A further factor that may have enabled an increase in the number of women giving birth in facilities (an indicator not measured by this evaluation) in recent years is the construction of mothers' waiting shelters at health facilities. These shelters allow greater access to facilities for women who live far away from the clinic or who face high transport costs, by giving them the opportunity to travel to the clinic during their pregnancy and remain there for ANC visits, delivery of the baby and PNC. These shelters have been funded through a variety of sources in intervention and comparison facilities, including HTF/RBF funds, HCC fund-raising and through other NGO/donor programmes.

> *'Pregnant women may prefer to give birth at home before the waiting home was built. Before, the home was at Kalanda or other hospitals which are far away so they couldn't afford to go.'*
> VHW, Rushinga

13.2 Remaining barriers to facility utilisation

Overall, the utilisation of MNCH services is in fact relatively high in Zimbabwe relative to other countries, as reported in the 2015 Zimbabwe Demographic and Health Survey (DHS). In terms of the use of maternal health services, the DHS finds that the proportion of women aged 15 – 49 who received antenatal care for pregnancies in the 5 years preceding the survey is over 90%, and the proportion delivering in health facilities is 77%[36]. The use of services for infant and young child outcomes is also high, with 76% of children aged between 12-23 months included in the survey having received all basic vaccinations at any time before the survey (one dose of BCG, three doses of DPT, three doses of the polio vaccine and one dose of measles).

These figures indicate that although there remains scope to raise the use of health services further to target those who are not yet accessing appropriate care, limited utilisation is not necessarily an entrenched issue for broad segments of the population. Rather, the non-use or limited use of services appears to be a problem that affects particular groups facing specific barriers.

Our qualitative research found that the only group of community members who do not use health facilities at all are those belonging to the Marange Apostolic sect. Among those who use clinics less frequently, we found the following barriers to be reasons for low use:

Distance and cost to reach the clinic: Women often have to travel long distances to reach the clinic, and many do not have access to transport. In the quantitative survey data, 85% of U5 and ANC patients reported having walked to the clinic, and the average distance travelled was 4.8 km. These large distances are widely reported to be a major barrier to facility use. The cost of travelling to the clinic and the additional costs of providing for the pregnant mother and any family members who accompany her is prohibitive for some families. Community leaders in one of the qualitative study sites said that home births were common because families did not have the money required for travel and food if they were to use the health facility. Among facility Head Nurses interviewed for the quantitative survey who reported that women of reproductive age do not come to the clinic as much as they should, 78% indicated that the main reason for this was distance to the clinic or the cost of transport.

> *'Poor transport is another – this is a big catchment area. If they have transport, those living far away can come, but it is limited. But those from the border use motorbikes. Transport is the only main barrier.'*
> Facility Head Nurse, Rushinga

Competing priorities. Many people from the rural catchment areas targeted by SCPH spend much of the year farming, during which time they are busy for long hours during the day and are not able to travel to clinics. It is also common for households in Rushinga and Bulilima to migrate for long periods during the year, preventing them from obtaining services at the clinic during that time.

Religious objection. There are also community groups belonging to certain Apostolic sects, notably the Johanne Maranges, whose religious beliefs mean that they do not visit health facilities. Although we heard some suggestions that some of these communities are gradually relaxing their practices in this respect, with their members beginning to visit facilities for treatment of some conditions, religious objection remains an important barrier for many of these community groups. This does not necessarily mean that these communities are completely unwilling to engage with any form of health education or health behaviours, however. During the qualitative research our team visited one such community, and learned that while their views do not allow them to attend health facilities, they were interested in adopting preventive health care behaviours and were open to attending community meetings on health. This case is explored in **Box 4** below.

Other costs of accessing treatment. Limited services or amenities at clinics mean that there may be costs imposed on facility users to access services, even if they are not directly paying user fees for medical attention. For example, in one facility visited for the qualitative research the lack of

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[36] Zimbabwe Demographic and Health Survey (2015)

water meant that community members had to carry their own water to the clinic if they wanted to use the mothers' waiting shelter. We also found that shortages of certain drugs at clinics also lead to community members needing to raise funds to travel to the district hospital to obtain them instead.

> *'The main barrier is cash. I might come to the clinic and they give me painkillers, but I would need to save money to go to the hospital to get drugs. This happened to me before.'*
> Facility user, Rushinga

Box 4: Facility case study: Exclusion of marginalised groups from health services

In one of the qualitative research sites our team visited a community belonging to the Marange Apostolic group. Prior to our visit, facility staff and others connected to the facility had indicated that this community were very isolated from facility matters due to their religious beliefs, and indeed may not wish to meet us for an interview. On our trip to see if they would receive us we were accompanied by a member of the HCC, in order to help us make an introduction to the community. During the journey we observed that our guide did not know the route to the community at all, suggesting that they had never visited them, or had only done so rarely.

The community welcomed our research team warmly. They indicated that while their views prohibit them from taking pills and medicines, or attending clinics for some services, they are nonetheless interested in receiving health education and practising preventive health care behaviours.

> *'We ask the prophets to pray for us and ask the holy spirit to heal us and if it does not work we then wait for the last minute which is death. I don't take in any drugs whether natural or from the clinic.'*
>
> *'My church does not allow medication but we want all other kinds of help and we want to be involved in the health awareness programmes.'*

It was clear that the community had not received a visit from any health workers for a long time, and had not benefited from a toilet-building programme that had been rolled out elsewhere in the catchment area, or in the residual indoor spraying carried out in other homes to protect inhabitants from malaria. They told our team that they would appreciate such services, and their beliefs did not impose any restrictions in this respect.

The view of the evaluation team was that this community may have been excluded from health programmes and consultation in community health matters due to a perception that they would be difficult to reach, and resistant to efforts to encourage their members to visit clinics. This may demonstrate a tendency for health staff to focus their efforts on those who are thought to be more amenable to using facilities, thereby entrenching the isolation of those who are already marginalised.

14 Impact of SCPH on MNCH policy

Key findings

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.

The role of Save the Children and CWGH in shaping the policy environment cannot be easily disentangled given the myriad influences, processes, barriers, constraints and accountability relations that characterise policy-making. The success of the advocacy strategy is assessed through an evaluative judgement made on the basis of the progress on the objectives outlined above, together with the role that Save the Children and CWGH played and the views of a range of key informants at the national level.

14.1 Were the overall goals of the advocacy strategy achieved?

Table 16 below summarises the progress made on the objectives of the advocacy strategy.

Table 16: Progress made on the objectives of the advocacy strategy

Objective	Progress as at January 2017
To pass the Public Health Act Amendment bill	The bill is scheduled to be tabled before the current parliament, and is anticipated to be passed this year.
To advocate for increased national spending on health care	The proportion of the national budget allocated to health remains short of the Abuja target. A Health Financing Policy has been drafted, based in part on a technical study and costing exercise in respect of the National Health Strategy. This Health Financing Policy is expected to feed into a Health Financing Strategy; its provisions will include an emphasis on seeking to improve the efficiency of spending being made, in view of the projected shrinking of the economy.
To ensure the removal of user fees at the primary health care level	The majority of facilities at the primary level are not charging user fees for services for pregnant women, carers of under-fives and the over-65s. It is not clear whether there have been any changes in the number of facilities continuing to charge user fees during the intervention period.
A statutory instrument for HCCs	Legal recognition of HCCs will be included in the amended Public Health Act, when this is adopted.
Improved human resources for health	There have been some modest achievements in improving the human resources situation. The government pledged in May 2016 to recruit an additional 8,500 nurses[37], and to 'unfreeze' posts for outgoing staff so that a greater proportion of vacant positions can be filled. However, there has not been any move to increase the overall number of staff.

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[37] SCPH final report to the EU.

14.2 Conclusions about the effectiveness of the strategy

The advocacy work was successful in its contribution to the adoption of the Public Health Act Amendment bill

The passing of the Public Health Act Amendment is the major success of the advocacy work, and represented the greatest change in the policy landscape for health to occur during the intervention period. Although political will to pass the bill existed prior to the advocacy work, progress in bringing the bill before parliament had been continually stalled. Delays were caused by competing priorities taking precedence and a lack of momentum to get the bill's provisions agreed and brought before parliament.

In conditions where the reasons for the bill being delayed were not due to a fundamental lack of capacity or disagreement over its content there was an opportunity for advocacy to advance its progress. The advocacy strategy successfully brought together the necessary stakeholders to make sure that the bill was reinstated as a key priority. CWGH were widely regarded as having been active and at the forefront of contributing to the debate around the Public Health Act.

There were also some partial successes in the strategy's goals around improving human resourcing, but this goal and the goal around improving financing for health care were largely not met. The main reason for this was a lack of financial capacity.

During the intervention period there was some progress in improving human resourcing levels for health, through a commitment to unfreeze some vacant posts for health staff. However, the broader issue of an outdated staff establishment and freeze on posts for new staff remains in place, and staff shortages remain a severe challenge. The level of financing for health care also remains at a relatively low level, and below the Abuja target.

The issue with implementing these objectives was not a lack of commitment from the main stakeholders, or awareness that the challenges identified exist or are important. Instead, the binding constraint to enacting reforms to improve staffing levels, supporting the complete removal of user fees in all outstanding facilities, and improving financing, is a lack of funds to do so. In this context the potential effectiveness of advocacy work is somewhat constrained because there is only a limited opportunity to make the changes that were being emphasised.

Although it is important not to lose sight of these longer-term goals around improving health financing and staff allocations, the immediate objectives of the strategy would have benefited from being more clearly defined in relation to the tight fiscal situation. To some extent the strategy did try to elevate arguments around efficiency, but some respondents argued that this this could have been done to a greater extent.

> *'We need more discussion about reallocation and efficiencies, rather than simply pitching for more money which isn't going to be forthcoming.'*
> MoHCC respondent

This is also to some extent true of the strategy concerning user fees. The national policy on user fees is already in place and is clear, so what the advocacy strategy was emphasising was the uniform implementation of the policy rather than any revisions to it. Among the reasons for inconsistent adoption of the user fee policy is that there are insufficient funds to provide facilities with the counterpart funding that RBF was intended to be a complement to. Therefore facilities are in many cases dependent on the disbursements from RBF, which is now the *de facto* financing mechanism for primary-level facilities, though it was not intended as such. The advocacy strategy could have placed greater emphasis on possible approaches to help facilities manage the shortfall that would be left by removing user fees, to increase the possibility that they would be able to do so.

Progress has been made on integrating analysis and technical skills into the advocacy work, but more could still have been done to improve the impact of advocacy

CWGH are increasingly making efforts to promote the use of evidence in their advocacy work. They have established a technical desk to conduct analysis and review evidence, and as part of the advocacy strategy they have disseminated budget analysis papers to the Parliamentary Portfolio Committee since 2013. These analysis papers are presented at workshops, and have been found to be quite effective. Examples were given of cases when recommendations made in these papers were taken up in policy.

However, some observers expressed the opinion that the advocacy strategy would have been strengthened by a greater engagement with evidence to strengthen its arguments. This could have been achieved through a more explicit interaction with existing evidence, both from within Zimbabwe and outside of the country, not necessarily through commissioning a lot of new analyses. Arguments that are backed by evidence would have more traction in entering a policy debate.

More emphasis could have been placed on what happens after each advocacy event

Some key informants indicated the impression that after advocacy conferences more could have been done to ensure that decisions or agreements made by participants were properly followed up on to ensure that commitment was sustained after the events were over.

Provisions have been put in place to safeguard the sustainability of the strategy, but there remain some risks around this.

The influencing power of CWGH and Save the Children seems to reside to a large extent in the recognition of, respect for, and multi-faceted roles of the senior leadership. These are the people who are most widely recognised for the work that they do as individuals, and they are able to leverage personal relationships and access to decision-making platforms to effectively instigate for change. There is therefore a risk that the success of advocacy work is somewhat centralised within these individuals, and may falter should they ever move on. However, there is some evidence of efforts being made to develop staff at lower levels within these institutions to play a similarly active role.

15 Value for money provided by SCPH

Key findings

The extent to which the programme can be said to provide value for money is limited by the fact that it was not able to achieve its higher-level objectives of increasing the quality of health facilities and utilisation of MNCH services.

The programme did achieve some progress toward greater community participation in terms of establishing mechanisms for community members to provide complaints. With regard to the results that were achieved, we find that this programme was a relatively expensive way to do this. On one hand, programme implementation faced a shortage of budget to carry out the full scope of planned activities. Yet the overall costs to fund this programme were still high. A rough estimate of the cost incurred by the programme to support one facility for one year is higher than the average amount that facilities received through RBF – a vital source of funds that facilities rely on and have myriad uses for.

Thus our view is that although spending more money on this programme has the potential to bring about greater improvements in community participation, this would not be considered to represent value for money given the high cost required. At the current time in Zimbabwe there are competing priorities for resources within the health sector where money could be more effectively targeted.

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.

The assessment of the value for money provided by the SCPH programme is based on the value for money framework initially agreed during the inception period (shown in Volume 2, Annex I). To this framework we have added an additional indicator of interest under the efficiency domain – the estimated cost per health facility supported by the programme. This was deemed to be an informative composite measure of the cost of delivering the programme’s activities at the facility level. We do not calculate the indictors listed in the original VFM framework under the effectiveness and cost effectiveness domain, due to the lack of programme impacts arising at this level.

15.1 Costs of the SCPH programme

As agreed during the inception phase of the evaluation, we are considering the cost of the programme from the perspective of its funders, rather than drawing on the actual spending made by the programme because this was not made available to us.

Total programme cost from the perspective of the funders is given by the value of the contract held with the EU, together with the funding provided by DFID[38]. Funding for the EU-funded districts was provided through a grant worth EUR 800,000 ($953,200). DFID’s funding was provided through a milestone contract with Save the Children. Based on the final milestone report presented to DFID (up to the end of quarter 12), the total amount billed was £2,001,095 ($3,052,470). During

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[38] The actual costs to Save the Children in achieving the milestones are not reported to DFID. In view of this it was agreed to consider the costs of the programme from the funders’ perspective.

implementation the programme also sourced an additional £200,000 ($305,080[39]) from Save the Children UK, in 2015[40]. Altogether, this amounts to $4,310,750 of funding.

The cost of the programme is also considered from the perspective of the costs incurred by the volunteers who implemented it. Table 17 presents estimated costs to CMs and HLFs over the life of the programme in terms of their hours worked and out of pocket expenses incurred.

Table 17: Costs incurred by programme volunteers

	Total hours worked over the life of the programme (per volunteer)	Total out of pocket expenses incurred over the life of the programme (per volunteer, USD)
HLFs	483	134
CMs	345	157
Sources: OPM CM and HLF endline surveys Save the Children and CWGH data on volunteer numbers		

1. The average number of hours worked per month is taken from the endline survey, and is estimated at 21 hours for HLFs and 15 hours for CMs. Overall, assuming that the total months of activity is 23 months (from September 2014, when the last of the volunteers were trained, to July 2016), we find that the total number of hours worked by all 387 HLFs and 443 CMs over the duration of the implementation period is estimated at 186,003 total HLF-hours and 153,196 total CM-hours. This is a conservative estimate since some volunteers will have started operating prior to September 2014.
2. The total out of pocket costs incurred by volunteers corresponds to a total cost of $69,591 paid by all CMs, and $50,900 paid by all HLFs. This is estimated by taking the average cost incurred by a CM and HLF in the month before the endline survey ($7 for CMs and $6 for HLFs), and multiplying it by the 23 months of volunteer activity, and finally by the total number of volunteers.

Aside from the out of pocket costs incurred by volunteers, the real cost of interest is the opportunity cost in terms of potential wages or other opportunities that volunteers gave up in order to take part in the programme. It is not possible to readily estimate this cost since local wage data have not been available from which to estimate the outside option faced by volunteers. An indication of the extent to which HLFs and CMs sacrificed significant outside options in order to take part in the programme can be taken from the endline survey. The results show that 14% of HLFs and 33% of CMs reported having a paying job alongside their volunteer work, and among the remainder, an average of 69% of both HLFs and CMs said that they believed they would have another paying job if they were not volunteering. This implies that volunteers did sustain some costs in terms of foregone wages due to participation in the programme.

15.2 Economy – the cost of inputs

The most costly inputs faced by the programme were in staff time, particularly in the design and delivery of training sessions for volunteers, and in ongoing supervision and support. Other key costs were in the production of training and communications materials, (notably the ‘MNCH flier’ that was used by volunteers in meetings with the community and the ‘MNCH Facilitators guide)’, and the organisation of training sessions (including costs of venue-hire, transport, meal allowances, accommodation and stationary).

The programme faced a shortage of funds to fully implement all aspects of the intervention to the degree intended. This was due in part to conditions that were beyond the control of project implementers, including a depreciation in the value of the grant provided by the EU.

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[39] Exchange rates taken from www.imf.org, quoted on 01 Jan 2015 (the end of the programme’s inception phase)

[40] Additional funds were also sourced in 2016 to fund the scale-up of the programme to Rushinga and Guruve, which is outside the scope of the evaluation.

Some of the costs faced by the programme were also higher than anticipated, due to delays in getting MOUs signed in some districts and a higher than expected turnover in HCC membership (leading to higher associated costs of supervision and support for newer members).

The programme sought to achieve efficiencies in a number of ways, particularly through close monitoring of the budget on a monthly basis with technical assistance from SCUK advisors and the Regional Portfolio Officer.

15.3 Efficiency – the cost of delivering outputs

Budget limitations meant that SCPH was not able to deliver all outputs as initially intended. In particular, the training plan for HCCs was shortened from five days to three. Ongoing monitoring of volunteers was also more limited than the programme had hoped for. Monitoring costs were reasonably high due to large distances covered by PECs to travel in order to visit intervention sites, and the turnover rates of volunteers.

The programme was able to seek some efficiencies to manage this shortfall, for example by arranging HCC exchange visits as a means for HCC members to share learning and best practice examples, rather than relying solely on PECs to provide capacity building support. Implementers also took advantage of the fact that costs of running the programme per district varied according to distances, the availability of transport links and accommodation. For some activities the programme faced a unit cost per district, and was therefore able to partially offset the costs of the more expensive districts with the less expensive ones. Nonetheless, it was eventually decided to try and source more funds for implementation, and additional funds from Save the Children UK in 2015 were received to support more supervision and retraining for HCCs.

Turnover within the Save the Children and CWGH implementation team was low throughout the programme, with only one staff member leaving the project during its last six months. Additional efficiencies were sought in the scale-up of the programme to Guruve and Rushinga, building on the experience of the first phase. The content of volunteer and PEC training was largely already designed, so start-up costs were not faced to the same degree as in the first phase (though some changes were made in the mode of delivering training).

The total outputs delivered by the programme during implementation are summarised in Table 18 and Table 19 below.

Table 18: Programme outputs delivered – Training and volunteer activities

	DFID-funded districts	EU-funded districts
Health facilities supported to set up community accountability mechanisms (suggestion boxes, HCC feedback forms, HCC exchange visits organised)	102	64
PECs trained	14	6
HCC committees trained	102	64
HCC members trained	510	294
CMs trained	199	244
HLFs trained	199	188
Community members reached through HLF sessions	69,679	136,736
Source: Save the Children and CWGH data on volunteer numbers and catchment population Save the Children SCPH End of Project Report		

Table 19: Programme materials and resources provided

	DFID-funded districts	EU-funded districts
HCC training manuals	200	372
HLF health literacy manuals	100	212
CM facilitation guides	500	215
Community scorecards	300	480
MNCH facilitators' guide	270	702
PEC training guide	-	22
MNCH flyers	7000	9180
Patients' Charter	24000	7700
T-shirts	296	320
MNCH posters	130	214
CM bags	260	204
Stickers	128	-
Banners	4	4
Bicycles	64	70
Source: Save the Children SCPH End of Project Report		

The main VFM indicators calculated under the efficiency domain are the annual cost per person within the catchment area of a health facility supported by each HCC, in DFID-funded districts, and the estimated cost per facility supported.

The cost per person covered by an SCPH-trained HCC is reported in the OPM MNCH Annual Reviews[41]. The indicator dropped from $1.1/ per person in 2014 to $0.57 in 2015.[42] As reported in the 2016 Annual Review, this indicator was on target for the year under review, and there are no appropriate benchmarks for this[43]. The decrease in costs since 2014 reflects the fact that the first year of implementation involved relatively high start-up costs, in terms of training and production of training materials.

We believe that the usefulness of this indicator is limited by the fact that it is calculated on the basis of the total catchment population of supported facilities, rather than the numbers of people who were actually exposed to HCC activities and meetings. As shown above, the ability of HCCs to meet and engage with people widely across catchment areas was limited by the sometimes large distances and high population sizes. Therefore the total catchment population size represents an overestimate of the numbers of people that HCCs were able to work with in practice.

We also estimate the cost per health facility supported by an HCC, as $10,387 per year of SCPH implementation. This figure is only indicative, and rests on some assumptions about the allocation of costs toward facility-level activities (as opposed to the advocacy strategy activities)[44]. We also recognise that this is higher than the likely running costs of the programme if it were scaled up and implemented over a longer period, since this also captures the start-up costs of instigating activities and initial overhead costs. With these caveats in mind, we nonetheless consider this indicator of interest as it suggests a high cost of implementing this programme, particularly in relation to the average RBF disbursements that health facilities receive over a year. In the year from October 2015 to September 2016, the average RBF disbursement that facilities in the 21 SCPH districts received (both intervention and comparison together) was $7,226 facilities (Crown Agents)[45]. In view of the central importance of the RBF funds to facilities and many uses that they have for this funding, we regard the costs of SCPH as somewhat expensive relative to what was achieved.

Table 20: Estimated costs per person supported by an HCC, and per facility supported

	Estimated cost (USD)
Cost per person supported by an HCC (2014)	$1.1
Cost per person supported by an HCC (2015)	$0.57
Estimated cost per facility supported by an HCC, per year of implementation[1]	$10,387
Source: DFID and EU funding amounts OPM Annual Review of the DFID MNCH programme, 2016	

1. Calculated by taking the overall funding amount provided by the programme, at January 2015 exchange rates ($953,200 + $3,052,470 + $305,080 = $4,310,750), assuming that 80% of funding was allocated toward facility level activities (= $3,448,600), dividing this by the number of supported facilities and 2 years of implementation.

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[41] OPM Annual Review of the DFID MNCH programme, 2016

[42] The cost per person supported by an HCC is calculated by taking the overall cost in each year billed to DFID, divided by the catchment population of each health facility with a well-funded HCC.

[43] There are available data from Bangladesh, but the context is different and even after adjusting for relative prices it is difficult to make concrete recommendations based on those data.

[44] We assume that 80% of the programme's funding was directed towards activities conducted at the facility–level.

[45] We note that the comparison is not like-for-like, since the RBF disbursement amount does not include the overheads associated with administering the funds.

16 Sustainability of SCPH's impact

Key findings

The SCPH programme formally ended in July 2016. The discussion of the sustainability of SCPH focuses on the areas where SCPH has had a significant impact.

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. The contribution of this programme to advancing the PHA Amendment Bill is also likely to help safeguard the role of HCCs through formal legal recognition of their role.

Additionally, 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, 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. Moreover, 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.

Finally, SCPH implementers have secured funding to continue the programme on a small scale and are seeking to integrate the objectives of SCPH into some of their other programmes to try to ensure a continuation of its results.

Our assessment of sustainability is based primarily on the perceptions of programme stakeholders interviewed during the qualitative research and on our own judgements. The timing of the quantitative surveys was intended to coincide with the end of the programme, in order to measure the impact of the programme, but this has meant the survey does not provide a rich source of information as to whether results are be sustained beyond the end of the programme implementation.

The SCPH programme formally ended in July 2016. The end of the programme means that PECs no longer have any responsibility for overseeing HCCs, coordinating HCC exchange visits, or providing *ad hoc* supervision to HLFs, CMs and HCCs. Programme funding for district-level feedback meetings has also ended. The roles of the HLFs and CMs did not exist before SCPH, and therefore these individuals have ceased to operate under these titles. The majority of these continue to work as VHWs (the quantitative survey data showed that 96% of HLFs and 69% of CMs were also VHWs).

The discussion of the sustainability of SCPH focuses on the areas where SCPH has had a significant impact. Our findings show that the programme did not have an impact on the utilisation of the health facilities, the quality of health facilities or the satisfaction of users with the health facility so the discussion on the sustainability of the programme along these dimension is not relevant. Our findings also show that the feedback loop that SCPH intended to set up is not fully working, for two main reasons: firstly, community members do not use it (either because they do not know where/how to complain or they are scared of negative consequences if they do speak up); and, second, the facility staff often do not have the resources required to make the changes to address community concerns. However, the other parts of the feedback loop (complaints mechanisms are set up, HCC checks them and provides feedback to facility staff and DHE, staff are willing to take comments on board and try to address them) are working and SCPH did improve this. Therefore, the discussion of sustainability concerns how sustainable SCPH's impact on these parts of the feedback loop is likely to be.

The role of HCCs as a structure will continue after the end of SCPH. We found that HCC members expressed a high level of commitment to continue functioning. HCC members generally demonstrated a high level of intrinsic motivation to undertake their roles and a wish to continue functioning after the support from Save the Children or CWGH ends. We also found high levels of support for HCCs among health facility and DHE staff, who were generally appreciative of their role. 95% of DHE respondents interviewed reported that they find the HCCs useful. 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.

> *'We started working without any help, so if Save the Children stops we can go on. Some things, like bricks and builders, can be found in our own community. VHWs were there well before the programme came in, so these are some things that we can't stop. This clinic belongs to us; no one will come and do it for us.'*
> HCC members, Rushinga

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. From now on facilities or DHEs will need to finance the printing of scorecards and district-level feedback meetings themselves. Some programme staff thought that limited funds will mean that HCCs will not be able to meet as regularly after SCPH ends everywhere, both for their internal meetings and for meetings at the district level, which SCPH formerly supported by helping to cover transport and logistical costs.

> *'We would like to hold them [district-level feedback meetings with HCCs] once per quarter but there would be a need for more resources to do it, so I'm not sure if we'll achieve it.'*
> DHE representative, Matabeleland North

> '*We heard that the programme is ending in December and then we are going to be in trouble. We won't get the meetings at the district. These people were motivated through the programmes, for example the HLFs and CMs, through being invited to meetings at the clinic*.'
> DHE representative, Rushinga

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. This means that although these individuals will no longer formally work as HLFs and CMs, the skills learned may be carried over into their routine work as VHWs. This includes training around patient rights and entitlements, the use of participatory methods to engage community members, and training in how to identify and engage marginalised community members.

However, crucially, as the existing volunteers filling roles on the HCCs, and the HLFs and CMs who were trained by SCPH, leave their posts the effects of the programme will be lost. Surveys with HCCs, HLFs and CMs revealed that they were intrinsically motivated to perform their roles, with the vast majority reporting their main reasons for taking on the roles as being because they wanted to help the community or to work in health care. However, the HLFs and CMs trained by the programme were on average in their mid-40s and HCC members were in their mid-50s, and so they will one day vacate their roles. When these members move on from their roles the benefits of the training will be lost.

Finally, SCPH implementers have secured funding to continue the programme at a small scale and are seeking to integrate the objectives of SCPH into some of their other programmes to try to ensure a continuation of its results. Save the Children and CWGH secured funding to scale up the programme in Guruve and Rushinga until March 2017. They have also sought to integrate the objectives of SCPH into their other programmes to try to ensure a continuation of its results.

> *‘Though we will no longer be providing resources through this programme, there are other Save the Children programmes that can work through the same feedback channels [so we hope that this will help to sustain them]… We hope that the feedback mechanisms will continue. Previous discussions with the DHE indicate that they will do so. They can ride on existing meetings to bring in the HCCs.’*
> Provincial Engagement Coordinator

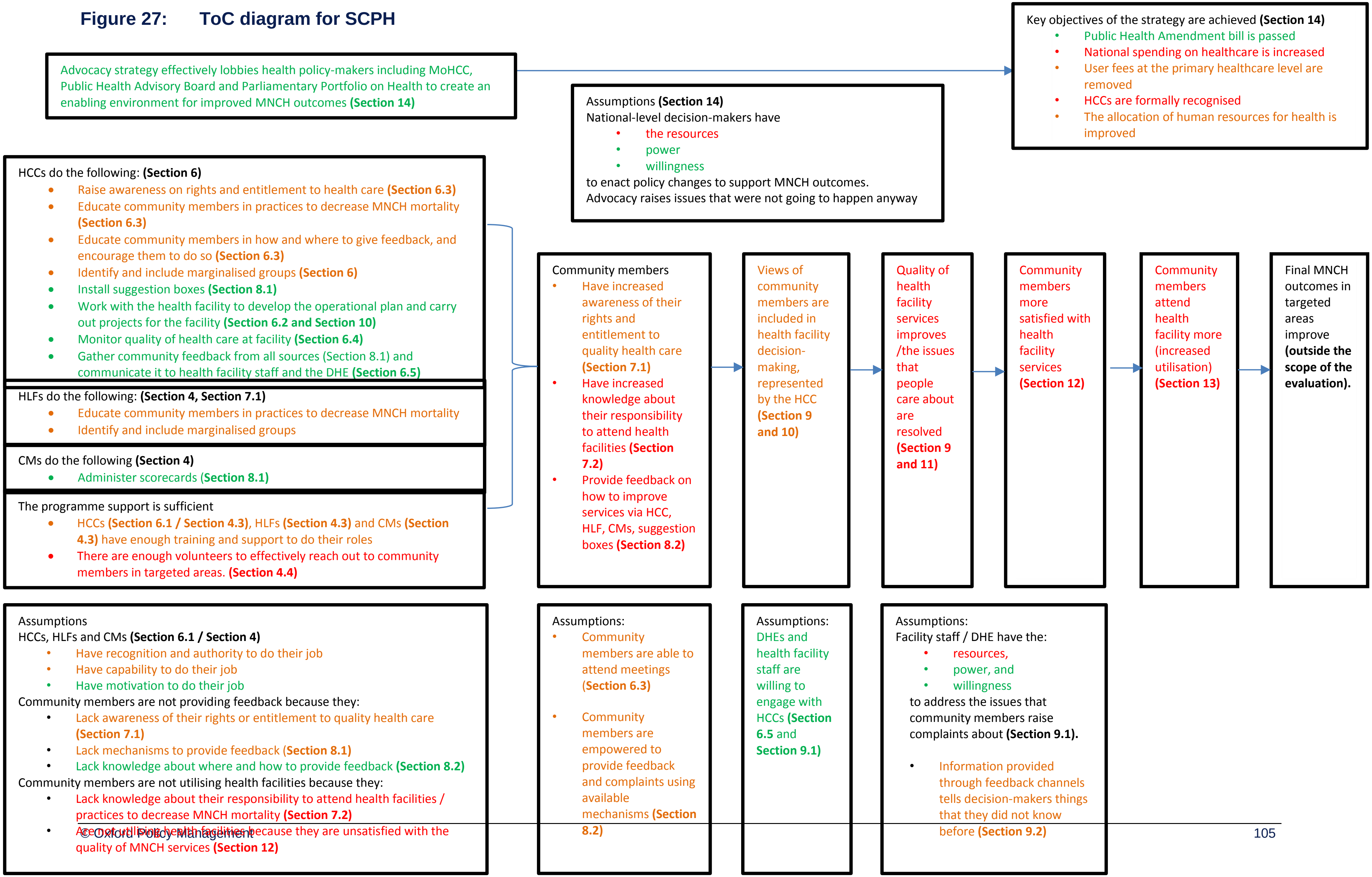
17 Discussion of findings and how they relate to the programme ToC

In this section, we summarise the findings of the evaluation presented in Sections 6 to 14, and we discuss what the findings can tell us about the programme's ToC. Where we found that SCPH did not achieve the intended results we discuss the extent to which this was driven by theory failure or by implementation failure. Theory failure means that there is a fundamental problem with the ToC that the programme was built on, and so no amount of resources could lead to the desired change using this route. Implementation failure implies that it could be possible to achieve the desired results through this route, if the programme implementation had been somehow different (e.g. more time, more intensity etc.).

In Figure 27 we reproduce the ToC diagram shown in Section 4, colour-coded in line with our 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 was partially achieved or that the assumption partially held.
- Red: indicates that the component was not achieved or that the assumption did not hold.

Figure 27: ToC diagram for SCPH



Advocacy strategy effectively lobbies health policy-makers including MoHCC, Public Health Advisory Board and Parliamentary Portfolio on Health to create an enabling environment for improved MNCH outcomes **(Section 14)**

Key objectives of the strategy are achieved **(Section 14)**
- Public Health Amendment bill is passed
- National spending on healthcare is increased
- User fees at the primary healthcare level are removed
- HCCs are formally recognised
- The allocation of human resources for health is improved

Assumptions **(Section 14)**
National-level decision-makers have
- the resources
- power
- willingness

to enact policy changes to support MNCH outcomes.
Advocacy raises issues that were not going to happen anyway

HCCs do the following: **(Section 6)**
- Raise awareness on rights and entitlement to health care **(Section 6.3)**
- Educate community members in practices to decrease MNCH mortality **(Section 6.3)**
- Educate community members in how and where to give feedback, and encourage them to do so **(Section 6.3)**
- Identify and include marginalised groups **(Section 6)**
- Install suggestion boxes **(Section 8.1)**
- Work with the health facility to develop the operational plan and carry out projects for the facility **(Section 6.2 and Section 10)**
- Monitor quality of health care at facility **(Section 6.4)**
- Gather community feedback from all sources (Section 8.1) and communicate it to health facility staff and the DHE **(Section 6.5)**

HLFs do the following: **(Section 4, Section 7.1)**
- Educate community members in practices to decrease MNCH mortality
- Identify and include marginalised groups

CMs do the following **(Section 4)**
- Administer scorecards **(Section 8.1)**

The programme support is sufficient
- HCCs **(Section 6.1 / Section 4.3)**, HLFs **(Section 4.3)** and CMs **(Section 4.3)** have enough training and support to do their roles
- There are enough volunteers to effectively reach out to community members in targeted areas. **(Section 4.4)**

Community members
- Have increased awareness of their rights and entitlement to quality health care **(Section 7.1)**
- Have increased knowledge about their responsibility to attend health facilities **(Section 7.2)**
- Provide feedback on how to improve services via HCC, HLF, CMs, suggestion boxes **(Section 8.2)**

Views of community members are included in health facility decision-making, represented by the HCC **(Section 9 and 10)**

Quality of health facility services improves /the issues that people care about are resolved **(Section 9 and 11)**

Community members more satisfied with health facility services **(Section 12)**

Community members attend health facility more (increased utilisation) **(Section 13)**

Final MNCH outcomes in targeted areas improve **(outside the scope of the evaluation).**

Assumptions
HCCs, HLFs and CMs **(Section 6.1 / Section 4)**
- Have recognition and authority to do their job
- Have capability to do their job
- Have motivation to do their job

Community members are not providing feedback because they:
- Lack awareness of their rights or entitlement to quality health care **(Section 7.1)**
- Lack mechanisms to provide feedback **(Section 8.1)**
- Lack knowledge about where and how to provide feedback **(Section 8.2)**

Community members are not utilising health facilities because they:
- Lack knowledge about their responsibility to attend health facilities / practices to decrease MNCH mortality **(Section 7.2)**
- Are not utilising health facilities because they are unsatisfied with the quality of MNCH services **(Section 12)**

Assumptions:
- Community members are able to attend meetings **(Section 6.3)**
- Community members are empowered to provide feedback and complaints using available mechanisms **(Section 8.2)**

Assumptions:
DHEs and health facility staff are willing to engage with HCCs **(Section 6.5 and Section 9.1)**

Assumptions:
Facility staff / DHE have the:
- resources,
- power, and
- willingness

to address the issues that community members raise complaints about **(Section 9.1).**
- Information provided through feedback channels tells decision-makers things that they did not know before **(Section 9.2)**

17.1 Attainment of programme outputs

17.1.1 Community feedback mechanisms

The start of the results chain for SCPH is the establishment and operation of a community feedback mechanism, from community members to the health facility and DHE. The feedback mechanism was intended to follow the following steps:

1. Complaints mechanisms are established.
2. People use the complaints mechanisms to speak up about what they are dissatisfied with in regards to health service delivery.
3. HCC checks and reviews complaints.
4. HCC reports to health facility staff and the DHE.
5. Health facility staff and the DHE listen, take comments on board, and are willing to try to resolve complaints.
6. Health facility staff and the DHE listen and make the required changes.

Below, for each component of the feedback mechanism, we say whether the goal of getting the component operating well was achieved or not, and we discuss the impact of the programme on this achievement or otherwise.

1. Complaints mechanisms are established – achieved

Though the programme did not affect the existence of feedback mechanisms (as nearly all HCCs in intervention and comparison facilities do something to collect feedback), it did increase the use of suggestion boxes and scorecards, and improve the likelihood that HCCs check the feedback, report it back to health facility staff, and that staff take the feedback on board. We found that intervention facilities are much more likely to use suggestion boxes, scorecards and HLFs as sources of patient feedback, as compared with comparison facilities.

2. People use the complaints mechanisms to speak up about what they are dissatisfied with in regards to health service delivery – mostly not achieved

We found that 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, or the proportion that have done so in the past 12 months. We also found that SCPH did not have an impact on the proportion of people who would complain to the HCC. The main reasons that people do not complain are fear of reprisals, lack of knowledge about where and how to report, and tolerant of the circumstances faced by health facilities.

This partly represents an implementation failure. The number of volunteers per catchment area was too small for them to engage effectively with diverse groups of community members to solicit their feedback, and the intervention did not operate for enough time or at sufficient intensity to bring about the shifts in beliefs and attitudes that would be required for people who are currently afraid to speak out to become empowered to do so. Our evidence suggests that volunteers can be effective in working within communities, since we found that HCCs, HLFs and CMs were generally highly motivated and were held in high regard by community members who were aware of them. This implies that more volunteers, with more support, and over a longer time period could be successful in gaining the trust of community members to voice their complaints.

In addition to more time and resources, we also suggest that some changes to how the programme is implemented would help to generate substantial changes in how community members interact with complaints mechanisms. A key finding of the evaluation was that HCCs are not well known within communities as a committee, even if the individual members are known. In order for HCCs to be able to function effectively, the programme should consider ways to increase their visibility. As well as providing ongoing support to HCCs to help them understand and implement their roles, future programmes could also consider how to elevate their status within communities. One way to do this could be to work with local leadership to try and seek their endorsement and recognition of HCCs, and potentially to provide HCCs with their own platforms for engaging with communities, beyond existing community meetings (which have many other agenda items).

Programme implementers also observed that the effectiveness of community involvement in health care is strengthened when local leaders are involved in what the programme is doing. During the scale-up of the programme to Rushinga and Guruve, the programme invited local leadership and community members to meetings and increasingly sought their support in the programme activities.

> *'They [community leaders] are the gateway to the community. When we started involving them we really started seeing some changes.'*
> PEC

3. HCC checks and reviews complaints – achieved

We found that SCPH did not have a significant effect on the proportion of HCCs that were collecting feedback from patients on the quality of care received because nearly all intervention and comparison HCCs were doing this. However, SCPH did have a positive impact on how this feedback is captured and used by HCCs. There was an impact on the range of sources that HCCs use to obtain feedback, through increased engagement with the community during meetings and the use of scorecards and suggestion boxes. There was also an impact on HCCs reporting feedback to health facilities.

4. HCC reports to health facility staff and the DHE – achieved

We found that there are generally high levels of collaboration between nurses and the HCC in both intervention and comparison facilities anyway, but that across some domains SCPH was able to increase this collaboration even further.

5. Health facility staff and the DHE listen, take comments on board, and are willing to try to resolve complaints – achieved

The survey data show a large and strongly significant impact on the proportion of health facilities reporting that changes have occurred in the facility as a result of patient complaints, from 58% of the comparison group to 79% of facilities in the intervention group. As discussed above, many of these changes that staff were able to address related to staff attitudes.

6. Health facility staff and the DHE make the required changes – partially achieved

We found 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 mechanism working as intended – where community members raise a concern or issue, or provide feedback, and decision-makers actively address it. We found that decision-makers face considerable resource constraints in their ability to respond to the feedback that they receive.

17.1.2 MNCH advocacy strategy

The advocacy strategy was well conducted overall and 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 stalled 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 certain kinds of reform, particularly those around improving human resourcing for health and financing.

Our recommendations for improving the strategy include a greater focus on using evidence to make its case, and further efforts to follow up after events to ensure that commitments and decisions were followed through.

17.2 Attainment of programme outcomes and impacts

Voices of community members are included in health facility decision-making, represented by the HCC - mostly not achieved

We did not find evidence of genuine inclusion of community attitudes in decision-making for health. We also found some limited examples of cases where decision-makers responded to individual complaints that were within their capacity to handle. However, we did not find that community voices were routinely involved in decision-making on an ongoing basis, or that there was a sustained dialogue between the community and health service providers. HCCs are not yet closely involved enough with a diverse range of community members to be able to act fully as their representatives in decision-making platforms.

We believe that the attainment of this outcome could have been strengthened by strategies to deepen the extent and quality of community participation. SCPH provided channels for community members to provide inputs (e.g. through suggestion boxes and scorecards) that could shape decision-making, and trained HCC members to review the information collected. However, the ability of community members to provide these kinds of inputs only represents one dimension of community engagement, and does not in itself equate to meaningful participation in the sense of bringing communities into a conversation around health service delivery in which challenges and issues are resolved through a collaborative approach. Through SCPH, community members had more opportunities to bring evidence to decision-makers to inform what they did, but they did not have the ability to actively participate in decision-making processes, or engage closely enough with HCCs to enable the committees to truly represent them in decision-making processes.

Our recommendation is to support HCCs to work more closely with community members, and to encourage an active dialogue with the community, rather than simply relying on the review of feedback tools such as suggestion boxes. Establishing this culture would be expected to take time, and would require HCCs to focus to a greater extent on actively consulting community members, as well as establishing a more reciprocal line of communication in which local MNCH results and decisions are also fed back to the community, to build an understanding of the local situation for health.

Improved quality of health facility services - mostly not achieved

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.

SCPH has had some small, but important, effects on improving the quality of services in some places, but these changes were not widespread and have not been large enough to translate into overall increases in the measured quality of services according to the MoHCC checklist scores. The improvements were mostly in terms of improvements in staff attitudes and the relationship between facility staff and community members, but SCPH did not significantly affect staff attitudes on a large scale as we found no significant difference between intervention and comparison facilities with respect to satisfaction with staff friendliness/approachability.

The reasons why changes in quality did not obtain to a greater extent were largely due to external resource constraints. We found that the main issues people complained about were waiting times, shortage of staff, shortage of drugs and staff attitudes. Of these, all except staff attitudes require significant resources to resolve, which, despite the introduction of HTF, are not available since the health sector in Zimbabwe is still hugely underfunded, despite large donor contributions. Without the ability to mobilise significant resources this programme could only hope to bring about changes that were low or no cost. Given this, under current conditions it was not possible for this programme to lead to the hiring of more staff or a change in the supply of medicines – which are the main issues that people care about and are the kinds of changes that might bring about changes in utilisation. This is a ToC failure, since one of the key assumptions (that the health facility staff had the resources required to make the necessary changes) is not met.

We do believe that a community participation programme can have the potential to shift service quality given enough time and if decision-makers have sufficient resources to implement changes. To the extent that the programme can facilitate a genuine culture of community inclusion in decisions that affect them, this can contribute to important benefits to health service delivery over the longer term. The changes may be long-lasting if health services are truly underpinned by a participatory decision-making process and monitored by a citizenry that is aware of their rights and that is empowered to exercise them.

Increased satisfaction with the quality of health service delivery - not achieved

We found 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. This is a ToC failure, since the assumption that this programme could increase the utilisation of health facilities by increasing people’s satisfaction is not met.

In order to be able to change people’s satisfaction the programme would have needed to significantly raise people’s expectations, and thereby reduce satisfaction initially. Only then, if expectations were raised, and if people were able to speak out and demand better services, and if quality could then be increased, could satisfaction increase. However, the education on rights and entitlement under SCPH was more focused on explaining people’s basic rights, rather than educating members that the status of health service delivery is low in order to significantly raise people’s expectations of what should be provided by the public health service. Moreover, SCPH only had moderate success in raising awareness about patients’ rights. Awareness of the Patients’ Charter remains low and the majority of people can still only name the most basic right, so there is still considerable scope to raise people’s knowledge and understanding of the full range of rights contained in the Charter.

Increased utilisation - not achieved

We found that SCPH did not increase the utilisation of health facilities for MNCH services, as measurement ANC and PNC visits, outpatients' visits, and vaccinations. The programme ToC assumes that increases in the quality of health services provision will lead to increases in utilisation, primarily through increases in patient satisfaction with the quality of services at health facilities.

However, we found that the main reasons why people do not use facilities are religious reasons, among specific Apostolic groups (mainly the Johanne Marange) – who do not use health facilities at all – and the large distances that many people face to reach the facility, which imposes costs and restrictions in terms of time, effort, and travel expenses. In practice, though, the focus of the programme was not on addressing these key barriers to utilisation of facilities (religion and distance). Rather, the programme's focus was on finding out what people did not like about the existing health service and trying to change these things. There were some ways that the programme tried to address key barriers (religion and distance) marginally, through the construction of mothers' waiting rooms, but distance still remains a big issue for ANC, PNC, OPD, and U5 services. The programme also tried to deal with religious barriers by training HCCs to encourage all community members to attend facilities for MNCH services, but these are entrenched beliefs and the will require a significantly larger investment to shift.

The programme also tried to encourage utilisation by raising awareness of the benefits of using clinics. However, awareness of the benefits of using clinics is not found to be a major constraint to utilisation. The survey showed that awareness of health responsibilities is already high (although the survey sample was biased because it consisted solely of facility users), and in the qualitative research respondents consistently ranked the health facility and nurses as very important people for health. This is a ToC failure, in that the ToC incorrectly identified patient satisfaction and service quality as primary constraints to greater health service utilisation.

In order to have an effect on utilisation, we recommend that greater attention be paid to how to alleviate the persistent barriers to service utilisation around distance and religious objections. These barriers could be eased by lobbying health facilities to provide outreach services. A distinct strategy for engaging with Marange sects should also be considered. Our evidence shows that some members of the Johanne Marange sect are open to being involved in health meetings, engaging in preventive health behaviours and interacting with health service providers in the community, even if their views prevent their members from using modern medicines themselves. This shows that there is scope to engage these groups in dialogue around health to a greater extent than is currently being done.

Although the final objective of raising utilisation was not met, we argue that there is still a value in increasing participation in health decision-making, and that this remains a worthy goal in and of itself. The objective of elevating the voices of community members, enhancing their awareness and empowerment to claim their patient rights, and increasing their inclusion in decision-making that affects them are in themselves achievements that, if fully realised, could be considered intrinsically valuable final outcomes, regardless of any further effects on service utilisation or quality. These are important goals that render community participation interventions worthwhile, even if in this case we believe that the final objectives around increasing use of services were not feasible in this case due to the resource constrained environment.

18 Conclusions, lessons and recommendations

18.1 Summary of the evaluation and its findings

This section presents a summary of our evaluation and its key findings.

The main objective of this evaluation was to understand whether and to what extent the programme had an impact on the outcomes and impacts that it sought to achieve, and the reasons how and why it did or did not achieve these key results. A secondary goal was to comment on the relevance, effectiveness, sustainability and value for money provided by the programme, in accordance with the OECD-DAC criteria for evaluating development assistance programmes.

The key evaluation questions are summarised in Table 21 below.

Table 21: DAC criteria and key evaluation questions

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?

To address these questions the evaluation used a theory-based approach. This meant that we made explicit use of the programme's ToC to test whether the outputs, outcomes and final impacts held, whether the proposed mechanisms for change were as anticipated in the ToC, and to test the validity of the assumptions that underpinned it.

We used a mixed methods approach to gather evidence for the evaluation, combining a quantitative and qualitative component. The quantitative component used a quasi-experimental approach, based on a health facility survey that we carried out in a sample of health facilities supported by the intervention and comparison facilities. The comparison facilities were selected using a matching approach to ensure that they resembled the intervention facilities as closely as possible prior to the start of SCPH. Our quantitative component also drew on a range of secondary data. The qualitative component used a case-based approach to understand outcomes, mechanisms and contextual factors occurring at facilities and within communities. In addition we conducted interviews at the district, province and national level to ensure that our evaluation included the perspectives of a range of stakeholders involved with this programme at all levels of the health sector.

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

18.1.1 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.

18.1.2 Effectiveness

The intervention was found to be generally well implemented. It delivered its key intended outputs around providing training to volunteers, establishing mechanisms for community members to raise complaints, and encouraging decision-makers to review, escalate and respond to those complaints as necessary.

Nonetheless, 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.

18.1.3 Impact

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 both limitations 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. 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 current conditions.

The programme did achieve some successes in its other key objective of shaping the wider policy environment to support improved MNCH outcomes. Through 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.

18.1.4 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.

18.1.5 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.

18.2 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.

18.2.1 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[46]. 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

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[46] 'Community Systems Strengthening Framework for Health in Zimbabwe' (Draft 1), Ministry of Health and Child Care, 19th October 2016.

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 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.

18.2.2 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.

18.2.3 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.

18.3 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, an evaluation of this programme in 2004-5 using a randomised design found positive results[1]. 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. The programme should also focus on strategies for incentivising HCC members and

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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

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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