Strengthening Community Participation in Health

End of project report
Zimbabwe 2013-2016

Save the Children

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EXECUTIVE SUMMARY

Zimbabwe's unacceptably high maternal mortality rate, which peaked at 790/100,000 live births in 2008, is due, in part, to the introduction of service fees in the early 1990s, coupled with the economic downturn over the last decade. The Strengthening Community Participation in Health project, implemented by Save the Children and Community Working Group on Health between 2013 and 2016, aimed to address key barriers to uptake in maternal, newborn and child health (MNCH) services, including service charges; long distances to health facilities; and staff shortages.

By building the capacity of three community cadres, namely health centre committees (HCCs); community monitors (CMs); and health literacy facilitators (HLF), the project equipped these key community health assets with improved knowledge, skills and tools to increase the uptake in MNCH services at 166 selected rural health centres across 21 districts.

Centred around a community feedback mechanism, the project created platforms at village, health centre, and district levels, to raise issues affecting MNCH service provision, and to plan and implement local, participatory solutions to these. At national level, the project advocated for an enabling environment for improved service delivery through lobbying of policymakers and influencers, and by engaging the mass media.

Given the large geographical coverage, the relatively short implementation phase, and the restricted budget, the project achieved remarkable progress and successes. The community cadres advanced considerably in engaging both their communities and district leaders, resulting in communities adopting a participatory approach to develop health centre facilities; staff shortages being resolved; and the removal of service charges. As an immediate result, the majority of the project health centres reported a significant increase in health facility deliveries – the single most important indicator in reducing the maternal mortality rate – as well as other MNCH services, including family planning and immunisation.

At national level, SCPH project partners played a considerable role in lobbying for the development of a standalone HCC statutory instrument; increased budget allocations for universal health coverage; the government's May 2016 pledge to recruit an additional 8,500 nurses; and the universal removal of user fees for MNCH services.

The vast majority of challenges encountered during the project span were due to budget restrictions, coupled with the large geographical coverage. The unanimous appeal across all project partners, staff and participating districts, health centres and community actors, is that the project should be expanded and scaled up to include more health centres per district, and more HLFs per community.

INTRODUCTION

Context

With the introduction of the Economic Structural Adjustment Programme in the early 1990s, public health facilities in Zimbabwe started charging user fees, meant to finance the improvement and expansion of health services. The fees, however, had a highly negative effect on equitable access to health care services, with an increasing number of people failing to access essential services, and played a key role in the alarming increase in the maternal mortality rate (MMR) and the under five mortality rate.

In 1990, the MMR was 390 per 100,000 live births compared to 790/100,000 in 2008, whereas the under five rate increased from 78 per 1,000 live births to 94/1,000[1]. Whilst the 2014 MICS figures showed a marked turn in this trend, noting that the MMR had dropped to 614/100,000 and under five mortality rate down to 75/1,000, the levels are still unacceptably high in relation to the Millennium Development Goals 4 and 5 of reduced child mortality and improved maternal health. As the Sustainable Development Goals have been accepted globally, Zimbabwe too is now making efforts to align many of their national laws and policies to achieving SDG 3, to ensure healthy lives and promote well-being for all.

Due to the economic decline over the last decade, the ensuing infrastructure deficit – from roads and bridges to actual health centre facilities – has hugely compromised maternal, newborn and child health (MNCH) service delivery, especially in the rural areas, where 67% of the population lives[2].

Other main barriers to the uptake of MNCH include the sparse distribution of rural health facilities, and limited outreach services for hard to reach areas, resulting in high transport expenditures for patients; staff shortages at most rural facilities, often leading to long waiting times and poor relations between staff and patients; drug stock outs; and cultural/religious practices that negatively impact on health seeking behaviours.

In this context, and in rural settings in particular, well functioning community structures are essential to achieve marked improvements in the provision of MNCH services. In order to increase access and utilisation, there is a great need to raise awareness amongst communities on their rights and entitlements to quality MNCH services, as well as on their own responsibilities to improve MNCH practices by accessing services at facility level.

Though gravely underfunded, health centre committees (HCCs) play an increasingly pivotal role in advocating for the health needs of the communities they serve. They work with communities to help identify health needs, and monitor the performance of the health centres in their catchment areas, acting as the key point of contact with communities in all health related activities.

There is an unequivocal acceptance by the Zimbabwean government that community participation should be officially facilitated and supported through HCCs. The majority of rural health centres have an established HCC, though the level of engagement and quality of support, to both communities and facilities, varies greatly from one HCC to the next. Nonetheless, this existing structure offers significant opportunities to actively influence the provision of quality of MNCH services in areas where they are needed the most.

Barriers to uptake of MNCH services

- User fees
- Poor infrastructure
- Long distances to facilities
- Staff shortages and perceived negative staff attitudes
- Drugs stock outs
- Cultural/religious practices
- Non-availability of mothers' waiting rooms

[1] WHO/UNICEF/UNFPA/World Bank; 2010 Trends in Maternal Mortality, Zimbabwe

[2] World Bank, 2014

THE STRENGTHENING COMMUNITY PARTICIPATION IN HEALTH PROJECT

The Strengthening Community Participation in Health (SCPH) project was implemented by Save the Children (SC) and Community Working Group on Health (CWGH) in 166 health facilities across 21 districts in Zimbabwe between July 2013 and June 2016.

SCPH PROJECT DISTRICTS

Province	DFID Districts/No of HCCs	EC Districts/No of HCCs
Mashonaland Central	Guruve/7 HCCs, Shamva/6 HCCs	Rushinga/10 HCCs
Mashonaland East	Uzumba-Maramba-Pfungwe/7 HCCs, Goromonzi/5 HCCs	Hwedza/5 HCCs
Mashonaland West	Mhondoro-Ngezi/4 HCCs	Zvimba/8 HCCs, Makonde/13 HCCs
Manicaland	Buhera/8 HCCs, Mutasa/6 HCCs	Makoni/13 HCCs
Matabeleland North	Bubi/4 HCCs	Hwange/10 HCCs
Matabeleland South	Bulilima/8 HCCs, Insia/6 HCCs	Umzingwane/5 HCCs
Midlands	Zibagwe/11 HCCs, Mberengwa/11 HCCs	
Masvingo	Bikita/8 HCCs, Masvingo/9 HCCs	

Funded for the duration by DFID (£2m budget in14 districts) from July 2013, EC funding (€800,00) added seven more districts to the project area in July 2014. Save the Children UK awarded breakthrough funds in 2015 (£200,000) and 2016 (£261,000). The project worked with a total of 166 health centres/HCCs (102/DFID and 64/EC) and aimed to:

- Contribute to increased utilisation of MNCH services
- Strengthen communities' influence for improving quality of MNCH services
- Empower communities with knowledge on their right to free, quality MNCH services
- Strengthen institutionalised community structures to monitor the quality of MNCH care available
- Strengthen community participation in health governance
- Contribute to the creation of an enabling policy environment

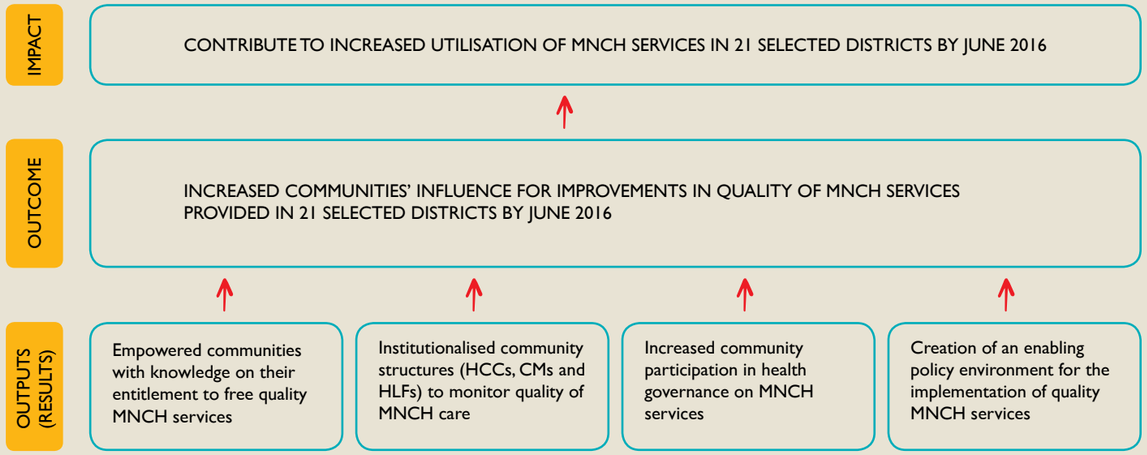
The targeted direct beneficiaries for the project were HCCs, HLFs and CMs, and indirect beneficiaries were pregnant women and children below five years of age. The project focused on building the capacity of HCCs, community monitors (CMs), and health literacy facilitators (HLFs) to achieve these outcomes. HLFs were mostly village health workers, who, as part of the SCPH project, raised awareness on MNCH entitlements and rights, as well as household and community responsibilities to healthy MNCH practices, and provided general education to community members on maternal and child health issues. CMs collected community perceptions on service quality using score card feedback mechanism, and HCC members instituted suggestion boxes at the health facilities, and collected data using feedback forms. The three cadres worked closely together to raise awareness on rights and entitlements, as well as compiling feedback and complaints on service quality to facilitate actions at district, health centre and community levels.

Sarudzai Zulu with her 4-week-old daughter, Hope, who was delivered at the Long Valley Clinic

In addition, the project advocated for a conducive and enabling environment through direct lobbying of policy makers and influencers, as well as through mass media channels. Universal removal of user fees; reviewing of staff establishment, especially at rural health centre level; and legal recognition of HCCs were key advocacy issues raised throughout the project at national, provincial and district levels.

This project was embedded in a theory of change that supports transformational change by encouraging improved institutional capacity, processes and partnerships to support greater accountability in the participating 21 districts and 166 rural health centres and HCCs.

THEORY OF CHANGE



Project targets and deliverables

The overall impact of the SCPH project is measured against the contribution to increased utilisation of MNCH services in the 21 districts (14 DFID /7 EC) by using the following indicators:

IMPACT TARGETS AND INDICATORS

June 2016 Target

Impact indicator 1: Increase in health facility deliveries by a skilled birth attendant compared to control sites

DFID districts	5%
EC districts	5%

Impact indicator 2: Increase in women attending at least four antenatal care visits compared to control sites

DFID districts	10%
EC districts	10%

Impact indicator 3: Increase in children under one year fully immunised compared to control sites

DFID districts	5%
EC districts	5%

Impact indicator 4: Increase in number of new OPD cases compared to control sites

DFID districts	5%
EC districts	5%

Impact indicator 5: Increase in output-based disbursement to health facilities compared to control site facilities

DFID districts	5%
EC districts	5%

The overall projected outcome of the SCPH project is an increase in communities' influence for improved quality of MNCH service provision in the 21 districts (14 DFID/7 EC), measured against the following indicators:

OUTCOME TARGETS AND INDICATORS

June 2016 Target

Outcome indicator 1: %-age of formally recorded complaints fully addressed by the DHE/RDC

DFID districts	70%
EC districts	50%

Outcome indicator 2: %-age of score card respondents reporting satisfaction with quality of MNCH service provision

DFID districts	90%
EC districts	85%

Outcome indicator 3 (DFID): Increase in overall 'quality of care' composite score of RHC Health Services Fund quality assessment compared to control sites

Outcome Indicator 3 (EC): Percentage of targeted RHCs with improved 'quality of care' composite score on Health Services Fund quality assessment

DFID districts	N/A
EC districts	100%

Project implementation

Inception phase activities

Project activities were outlined to achieve the desired impact across the four output areas, and were continuously monitored and evaluated and adjusted where needed to achieve maximum impact.

In the initial project planning period (July-December 2013), a number of inception phase activities took place, including:

- Partner engagement
- Recruiting and training of head office staff and Provincial Engagement Coordinators (PECs), and establishing field sub-offices
- Coordination meetings with Crown Agents (the implementing agency for the results based financing/ RBF side of the project) to identify districts of operation, followed by mapping exercise to select final project and control districts, and MOUs with all participating districts
- Defining project deliverables and key milestones
- Collection of baseline data and finalising of results framework; monitoring plan; advocacy strategy/plan; and media strategy/plan
- Selection of HCCs and HLFs; developing of assessment tools to assess HCCs and HLFs; and community based activities to carry out assessments
- Finalising of detailed implementation plan and budget for implementation period (Jan2014-June2016), including log frame revision, and risk log and risk management process
- Commence training of HCCs and HLFs, with recorded lessons learnt for remaining training sessions

Implementation phase activities

As the implementation phase commenced in January 2014, a number of inception phase activities were ongoing/still being finalised, including MOU signings with districts; materials production; staff, HCC, CM and HLF training. A broad range of implementation activities took place over the course of the project period:

Tools & visibility

To equip the community cadres with the necessary tools, a number of materials was developed, pre-tested, printed, and distributed:

- Training manuals for HLFs, CMs, and HCCs, additional modules for the government's HLF and HCC training manuals, and a Training of Trainer Guide for PECs
- PEC facilitation manual
- Data collection tools, including community score card, suggestion boxes, and HCC feedback forms
- IEC materials, including MNCH flier, Patient's Charter, and posters for health facilities translated into three languages
- Visibility materials including banners and posters, and branded T-shirts, bags and stationary for HLFs and CMs

MATERIALS DEVELOPED AND DISTRIBUTED FOR DFID DISTRICTS

Training Materials	
HCC training manuals	372
HLF health literacy manuals	212
CM facilitation guides	215
PEC training guide	22
Community score cards	480
MNCH facilitators guide	702
IEC materials	
MNCH fliers	9180
Patient's Charter	7700
Visibility materials	
T-shirts	320
MNCH posters	214
CM bags	204
Banners	4
Other	
Bicycles	70

MATERIAL DEVELOPED AND DISTRIBUTED FOR EC DISTRICTS

Training Materials	
HCC training manuals	200
HLF health literacy manuals	100
CM facilitation guides	500
Community score cards	300
MNCH facilitators guide	270
IEC materials	
MNCH fliers	7000
Patient's Charter	24000
Visibility materials	
T-shirts	296
MNCH posters	130
CM bags	260
Banners	4
Other	
Bicycles	64
SCUK BSIF	
Bicycles	80

Training

The majority of the project budget was allocated to training related activities, ranging from developing, translation and production of training, IEC, and monitoring materials, to the physical logistics of conducting the trainings. The overall objective of training activities was to build and strengthen the capacity of three community level cadres: HCCs, CMs, HLFs in order to position them to better serve their communities on MNCH issues.

HLF training sessions objectives were to acquaint these key community health assets with the SCPH project elements, and strengthen their knowledge levels on MNCH issues, with particular focus on clarifying common myths and misconceptions. In addition, the rights and responsibilities of community members were explained in relation to access to and utilisation of health services, with the Patients' Charter covered in full detail.

Two CMs per health facility, selected by the community members, were equipped with skills on how to collect feedback on community perceptions on access to and utilisation of MNCH services by rating eight criteria using the community score card, in order to advocate for improved provision of services. Training included how to administer score cards; conduct focus group discussions; record findings; and dissemination of feedback. In addition, all CMs were trained on key MNCH issues.

Following assessments of HCC capabilities, members were trained on their roles and responsibilities; patients' rights; and HCC composition. Further training included key MNCH issues, and the main causes of preventable morbidity and mortality in women and children under five, as well as working with vulnerable populations. In order to strengthen the functionality of the HCCs, the sessions included practical skills and knowledge on community participation; conducting meetings; preparation of reports and action plans; and communication skills when working with the various layers within the health system, providing feedback to district and community levels, and advocating for health issues. Finally, sustainability issues such as building local alliances and local fundraising initiatives were covered.

The tools and roll out of community feedback mechanisms were covered in detail, including agreed district mechanisms, data collection tools and analysis.

> "In the past, we didn't understand our roles as a HCC – even me, as the chairman. After the training, we reconstituted to bring in more members, including different people from the communities such as businessmen, teachers and the youth. We are now 15 members, and when we discuss issues, we get more diverse ideas and find solutions to wider problems."
>
> *Thomas Kennedy, Chairman, Long Valley clinic HCC, Makonde district*

As an ongoing project activity aimed to further strengthen the HCCs, exchange visits were organised for HCC members to share experiences, challenges faced, and successes achieved, with a particular focus on their roles and responsibilities. Generally, well-functioning HCCs were matched with poor performers, for the latter to increase their reach in to their communities; broaden their accountability to their constituents; standardise their structures and practices; and improve usage of community monitoring tools.

TRAINING AND HEALTH EDUCATION BENEFICIARIES IN DFID DISTRICTS

Training activity	Beneficiaries	Reached
	Male	Female
HCC trainings	214	296
HLF trainings	118	86
CM trainings	129	75
Community members reached through HLF sessions	21176	48503

TRAINING AND HEALTH EDUCATION BENEFICIARIES IN EC DISTRICTS

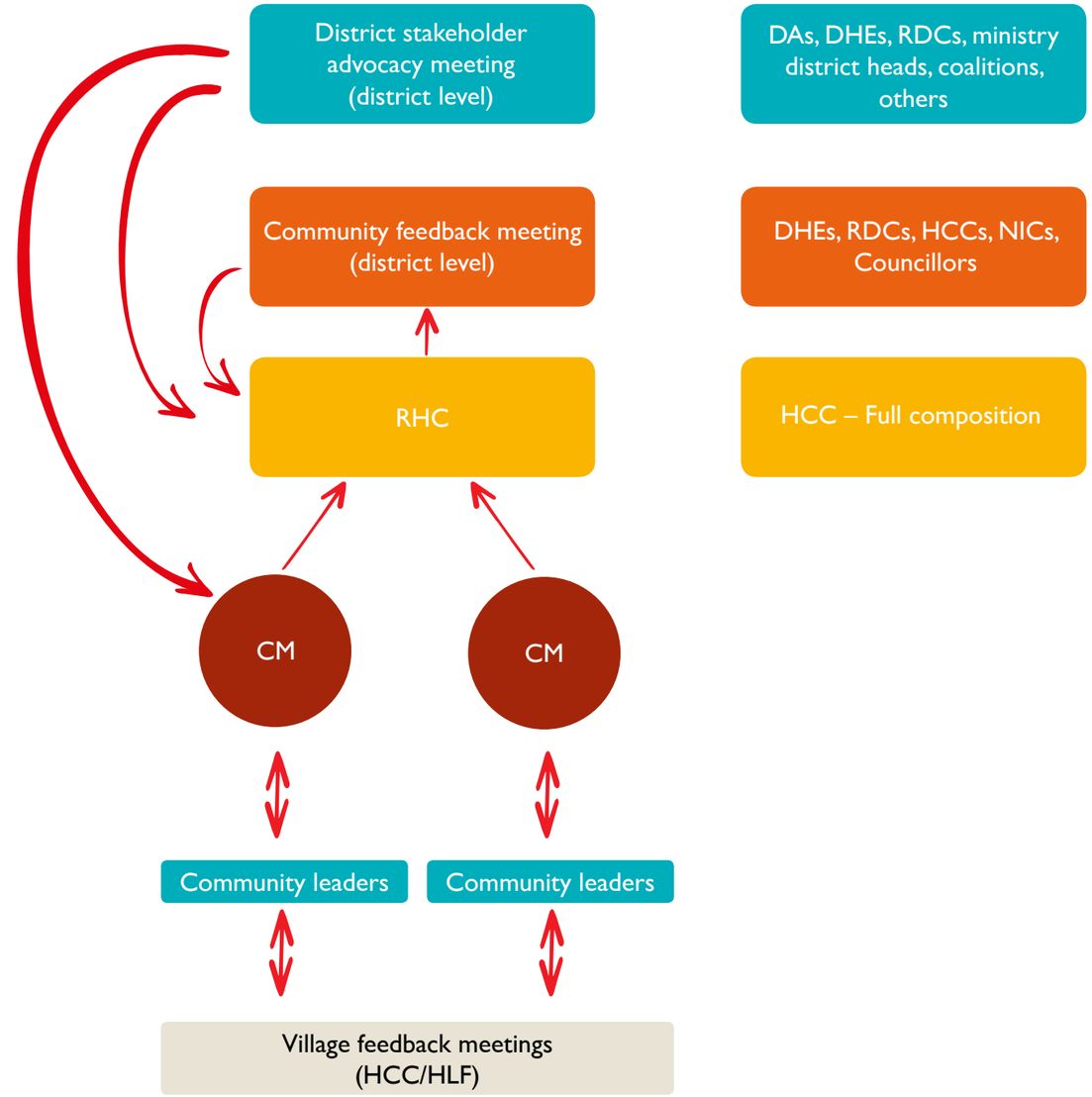
Training activity	Beneficiaries	Reached
	Male	Female
HCC trainings	173	121
HLF trainings	45	145
CM trainings	125	117
Community members reached through HLF sessions	47225	89511

"Now, we use drama and poetry to educate on services, and people like the Long Valley clinic and come for services. Even the husbands got for HIV testing now. They used to see it as 'just for the women' but I show them the photo of the happy family in the brochure, and they now understand testing is for everyone.

"I used to see myself as the one who had the responsibility for everything, but the project has taught me that we all have responsibilities to participate for better health. Now I work with the whole community and the leaders; people like being included, they feel honoured. With teamwork, you get so much done in the community."

Rebecca Mpofu, HLF, Mwanga A village, Makonde district

The community feedback mechanism, designed, developed and revised with active engagement of community stakeholders, was a key tool in the overall design and implementation of the SCPH project. Equipped with the tools and training detailed in above tables, the three community cadres had the capacity to facilitate the flow of information and feedback required for actions at district, health centre and community level.



Platforms

A key component of the project has been to create platforms for dialogue and relationship building at community, district, provincial and national levels. At the onset of implementation phase, a number of meetings were conducted across all levels to ensure buy in with a large number of stakeholders. During project implementation, monthly review meetings were conducted at village and district level.

Village feedback meetings

Data and feedback from score cards, suggestion boxes and HCC forms are collected by the HLFs, CMs and HCCs, who meet and, together, analyse the data and categorise the feedback.

HCC meetings

HCCs receive the score card data from the CMs, and collect feedback from the community using feedback forms and suggestion boxes, from which they prepare a report to present at district level.

A HCC member addresses colleagues at Bezu Clinic in Bulilima district

District community advocacy meetings

The PECs and HCCs meet with representatives from the rural district council (RDC), rural health centre and district health executive (DHE), where HCC members present their feedback reports, and issues that can be resolved at district level are addressed. The HCCs then feed back responses to their respective communities through organised feedback meetings back at village level.

District stakeholder advocacy meetings

District health executive (DHE) teams, rural district councils (RDC), HCCs and other partners including NGOs, CBOs and parastatals, including district development fund (DDF), Zimbabwe Electricity Supply Authority (ZESA), Ministry of Public works meet to discuss progress on access and provision of quality MNCH services, with special focus on social determinants of health and other peripheral issues, such as poor road networks, dilapidated rural health centre (RHC) infrastructure, lacking/ inadequate water supplies, non electrification, geographical distribution of RHCs, unconstitutional dissolving of HCCs and unresolved complaints. A series of advocacy issues that cannot be resolved at this level were taken up to the provincial and national level. These advocacy issues were mostly centred on legal recognition of HCCs, Human Resources for Health, inadequate government spending on health especially for district, provincial and national levels of care since these levels often lack donor funding.

A variety of national level advocacy meetings, conferences and workshops took place to sensitise key decision makers, stakeholders, and engage in national level policy dialogue and influence through a range of platforms. Some events, like the CWGH annual conference, were organised by the SCPH project partners, whereas others were government or INGO meetings, allowing for project representatives to bring MNCH issues raised by the communities to national level influencers and decision makers. In addition, a number of position papers were prepared and presented at national level, such as national health budget meetings.

Also at national level, the project steering committee, representing the Ministry of Health and Child Care (MOHCH), University of Western Cape, UNICEF, and selected community, district and national councils, was formed to serve as an advisory structure for the consortium. The intended roles of the committee included sustainability issues; scale up of the project; support linkages with relevant government and development partners; and lobby and advocate for public accountability in health reforms.

FORMAL ADVOCACY MEETINGS ORGANISED/ATTENDED

	No. organised/ attended	Attendance
National Advocacy Conference	1	135 people
CWGH National Conference	3	160 people each
Pre-budget Meetings	2	50 people each
Post Budget meetings	2	100 people each
Public Discussion Meetings	1	56

Advocacy & media

An advocacy and communications strategy was developed to support programme objectives incorporating a wide range of methodologies to bring feedback collected in the communities to a national advocacy level, namely through above mentioned national platforms. In addition, media engagement, in particular radio and newspapers, has been a key element in reaching diverse audiences, ranging from community members to policy makers, with targeted information to influence policy change and public opinion for improved maternal and child health.

Media conferences and field visits were organised, press releases and articles prepared, and radio spots recorded, with a strong focus on promoting patients' rights, especially with regards to MNHC services, user fees and policies, and to raise key advocacy issues that affect women's and children's access to healthcare. In addition, the media covered all conferences and workshops organised by the project.

Through various national level fora, either organised by project partners or external stakeholders, project representatives used the platforms to advocate for a number of policy issues, including the Public Health Act Amendment Bill, catering for the recognition of HCC and village health workers; the development of a standalone HCC statutory instrument; the Health Financing Policy to ensure universal health coverage, advocating for the government to allocate a minimum of 15% of the national budget to the health sector; the Strengthening Human Resources for Health Situation in Zimbabwe, lobbying for the government to fulfil its May 2016 pledge to recruit an additional 8,500 nurses; and review of the user fee policy, lobbying for a universal removal of user fees for MNCH service.

MEDIA COVERAGE

Type of Media	Number of slots/ Newspaper articles	Readership/ Listenership (Zamps survey)
Radio	13 slots	2,7 million
The Herald Newspaper	5 stories	1,7 million
Daily News Newspaper	3 stories	873 000
NewsDay Newspaper	6 stories	901 100
The Chronicle Newspaper	2 stories	566 700
The Zimbabwean	2	100 000
The Standard	2	203 600
Financial Gazette	3	109 913
ZBC news	2	9% of the market share

M&E/Support & supervision

During the early stages of implementation, a theoretical baseline study was conducted in order to benchmark the project indicators.

The M&E plan clearly outlined objectively verifiable indicators, responsibility, frequency of data collection, and sources of verification in order to monitor progress against expected targets. Targets set for each indicator assisted in measuring performance of the indicators on the objective hierachy.

The community cadres received extensive, ongoing support and supervision from the field based PECs and project M&E specialists and management team, through regular assessments of capacity gaps, and responding coaching and mentoring - particularly with regards to participatory methodologies, feedback mechanisms, data analysis, and documentation and reporting of feedback.

PEC, Mirriam Mutandwa, visits borehole constructed by community members at Long Valley Clinic, Makonde district

Project achievements

The SCPH project achieved a number of highly impressive results, especially considering the relatively brief implementation phase and budget restrictions. Below are the main impact and outcome targets and results, as well as some key achievements, rated according to the RAG status (Red = >10% below target. Amber = within 10% of target. Green = target or above.

IMPACT TARGETS AND INDICATORS

Impact indicator 1: Increase in health facility deliveries by a skilled birth attendant compared to control sites

	June 2016 Target	June 2015 Achievement	End of project achievement
DFID districts	5%	12%	14%
EC districts	5 %	12%	14%

Impact indicator 2: Increase in women attending at least four antenatal care visits compared to control sites

	June 2016 Target	June 2015 Achievement	End of project achievement
DFID districts	10%	8%	15%
EC districts	10 %	8%	15%

Impact indicator 3: Increase in children under one year fully immunised compared to control sites

	June 2016 Target	June 2015 Achievement	End of project achievement
DFID districts	5%	-18%*	29%
EC districts	5 %	-18%*	29%

Impact indicator 4: Increase in number of new OPD cases compared to control sites

	June 2016 Target	June 2015 Achievement	End of project achievement
DFID districts	5%	-4%*	5%
EC districts	5 %	-4%*	5%

Impact indicator 5: Increase in output-based disbursement to health facilities compared to control site facilities

	June 2016 Target	June 2015 Achievement	End of project achievement
DFID districts	5%	N/A	5%
EC districts	5 %	N/A	5%

*Impact indicators 3 and 4 use data from the Results Based Financing project implemented by Crown Agents. We were not able to access 2015 data until January 2016 when the data was made available to Save the Children, hence putting our milestone achievements into negative figures. By the end of project the achievements were back on track.

OUTCOME TARGETS AND INDICATORS

Outcome indicator 1: %-age of formally recorded complaints fully addressed by the DHE/RDC

	June 2016 Target	June 2015 Achievement	End of project achievement
DFID districts	90%	87%	98%
EC districts	50%	25%	81%

Outcome indicator 2: %-age of score card respondents reporting satisfaction with quality of MNCH service provision

	June 2016 Target	June 2015 Achievement	End of project achievement
DFID districts	90%	87%	96%
EC districts	85%	81%	96%

Outcome indicator 3: Increase in overall 'quality of care' composite score of RHC Health Services Fund quality assessment compared to control sites

For the DFID project districts, a 1% increase was noted in the overall 'quality of care' composite score compared to the control sites. For EC districts, all of the health centres showed an improved score, although modest.

KEY OUTPUT ACHIEVEMENTS

Output indicator 1.2: %-age of score card respondents aware of the user fee policy

	Baseline	June 2016 Target	June 2015 Achievement	End of project achievement
DFID districts	74%	85%	83%	95%
EC districts	83%	80%	86%	97%

Output indicator 1.3: Number of MNCH service users utilising the feedback mechanisms

DFID					
Baseline	Q9	Q10	Q11		Q12
5881	4646	5616	6293		6055
EC			Q6	Q7	Q8
			3246	3373	3496

Output indicator 1.4: %-age of score card respondents aware of MNCH services they are entitled to at RHC level

	Baseline	June 2016 Target	June 2015 Achievement	End of project achievement
DFID districts	81%	85%	87%	96%
EC districts	86%	83%	86%	98%

Output indicator 2.4: 5-age of complaints raised and actioned

	Baseline	June 2016 Target	June 2015 Achievement	End of project achievement
DFID districts	N/A	80%	67%	98%
EC districts	N/A	50%	25%	81%

Output indicator 4.1: Number of newspaper publications on removal of user fees, and other MNCH issues

	Baseline	June 2016 Target	June 2015 Achievement	End of project achievement
All 21 districts	N/A	12	7	41

Output indicator 4.2: Number of national level budget meetings to discuss position papers on MNCH

	Baseline	June 2016 Target	June 2015 Achievement	End of project achievement
All 21 districts	N/A	5	1	3

Other indicators for output areas 2 and 3 show that all of the 166 participating HCCs have achieved a government-approved standard of functionality; have an established, functioning complaints and feedback mechanism; are analysing the status on MNCH services using the score card; are updating MNCH services utilisation status on their respective Community Based Management Information (CBMI) boards; and are advocating for issues affecting MNCH services.

PROJECT CLINICS NOTE GREAT INCREASE IN UPTAKE OF MNCH SERVICES

Home deliveries are a key factor in the country's high maternal mortality rate. Main barriers to health facility deliveries recorded through SCPH project surveys include service charges, long distances to clinics, lack of water at the clinics, and religious and cultural objectors to health care services

"Some mothers live up to 20km away," says Sister Shylet Takawira, Mhondoro-Ngezi District Nursing Officer, stressing the importance of space specifically allocated to expecting mothers, commonly referred to as 'waiting mothers' rooms'.

One such mother is Alice Madzvimbo, who lives 20km from her nearest health centre, and is about to have her third child. "I delivered my last child at home because it was an emergency delivery and I didn't have money for transport," explains Alice, who is due in one week and is staying at the Twin Tops clinic's waiting mother's room until the delivery. "I am happy to be here and expect a normal delivery this time, because the nurses are right here."

For Alice's previous delivery, she was assisted by a TBA (traditional birth attendant), which is the norm in many rural communities. "The HLFs and HCCs have explained how dangerous home deliveries can be, so all the TBAs in our villages have now stopped their work." This trend is a significant step towards increasing health facility deliveries. Nurse Benlura from Twin Tops Clinic explains that their HCC has incorporated the TBAs as committee members. "In the past we might have just one delivery at the clinic per month, sometimes none at all. Now, because of the TBAs' involvement, the waiting mothers' rooms, and the water tank, that figure is now eight or nine per month."

When clinics don't have safe water sources, mothers are forced to bring their own from boreholes that are easily several kilometres away. For five years, Nhakiwa Rural Health Centre in Uzumba-Maramba-Pfungwe (UMP) district faced serious water challenges after the engine pump broke down in 2010. Only after their HCC received training through the project, was the water source restored, and their number of deliveries went up from two in January 2014 to 12 in July 2015.

Sister Farai Masunga, a nurse at Nyakapupu Clinic explains how the project has helped increase numbers on antenatal care bookings and deliveries. "We used to charge $5 for ANC and deliveries, but as the communities became more informed on their rights to free services, we scrapped the fees and the numbers increased."

As the HLFs have improved their health education skills and knowledge, they are also reaching key populations that were previously excluded, such as communities that object to modern healthcare services on religious grounds. "Many of these mothers are now bringing in their children, sometimes in secret even, because the information has reached them," says Sister Masunga. As a result, the clinic's immunisation numbers, for example, have nearly doubled during the project implementation phase.

Most project clinics proudly display posters tracking their progress across various MNCH indicators such as deliveries and family planning services. Nurse Majangara is explaining the promising figures on the Long Valley Clinic poster, noting the read line where the project started. He then adds, "I didn't draw a red line here, in June 2016, because we're going to continue the work. We're not going to stop just because the project is stopping."

Alice Madzvimbo preparing for her safe delivery at the Twin Tops Clinic waiting mothers' rooms

The Long Valley Clinic CBMI board

Baby Anthea, delivered at Long Valley Clinic, during postnatal examination

SUCCESSES, CHALLENGES AND RECOMMENDATIONS

Successes

Rights, entitlements and responsibilities

In its relatively short time frame and with considerable budget constraints, the SCPH project has been hugely successful in raising awareness on communities' rights, entitlements and responsibilities amongst the target population. This improved knowledge, combined with the tiered platforms and feedback mechanisms put in place by the project, has sparked a number of significant changes, both within the individual communities, and also at health centre and district level:

- Markedly improved relations between patients and rural health centre staff. With staff shortages resulting in long waiting times, and brief, at times incomplete, consultations; and patients focusing more on their rights rather than on fulfilling their responsibilities, negative attitudes existed on both sides. As communications improved, and community members gained a better understanding of staff challenges and, started fulfilling their own responsibilities, the relationships have improved dramatically through more reciprocal approaches and attitudes.
- With no formalised system of raising and solving issues between the health centres and district level managers, communities were relying on nurses to convey their complaints. With the platforms created by the project, meetings are taking place with a specific view on tackling MNCH issues raised through the feedback mechanisms, and attended by a variety of stakeholders in positions to carry out the necessary changes – including indirect actors such as water, roads and electricity district representatives, other CSOs, and church and traditional leadership.

As a direct result of these changes and improvements in knowledge, structures and communication, a number of long standing issues at the participating health centres have been resolved:

- The majority of clinics now have 'waiting mothers' rooms', free of charge for expecting mothers, jointly funded by community cash contributions and district RBF funds, and constructed by community members. For women, who live long distances from the health centres, these shelters provide a much needed place to prepare for a safe delivery, and have had a direct impact on the recorded reduction in home deliveries.
- A main barrier to facility based deliveries, was the lack of reliable water sources at clinics, requiring women approaching/in labour to bring water themselves. With communities raising this issue through the project feedback mechanisms and platforms, most clinics now have boreholes either constructed or being repaired by the community members with technical and/or financial assistance from the district, or by locally based NGOs or CBOs linked through the district meetings.
- Realising the negative impact from staff shortages and staff's poor living and working conditions, several HCCs successfully lobbied at district level for additional staff members, and undertook construction of proper staff quarters.

Staff housing at Long Valley Clinic constructed by community members

Strengthened community structures

- Equipping the three cadres of community health assets with improved knowledge on MNCH issues; strengthened skills on health education, data collection and communication; and the necessary tools, has had a highly positive impact at community, health centre and district level:
- Communities are more confident to raise complaints and issues, and better informed on how to do so, with the support of the strengthened HLFs, CMs and HCCs.
- The structured and formalised feedback mechanisms, in particular the score cards and HCC feedback forms, have helped to guide the flow of information to and from communities, clinics and districts, providing records of issues raised to prioritise health needs and develop action plans.
- HLFs have improved significantly as health educators, adopting participatory methods such as drama and poetry from project training sessions. As a result, they are now more efficient in mobilising their communities, utilising the various community structures including traditional leaders and the HCCs.
- The continuous capacity building through training and support supervision, with refresher trainings or additional support where gaps were identified, has been hugely motivating for the HLFs, CMs and HCCs in continuing their work as volunteers.

As a result, several changes directly impacting the uptake of MNCH services have been recorded:

- Through the HLFs' improved efforts to raise awareness on free maternal services, complaints of charges were raised from the communities through to district level. Consequently, a number of clinics removed the fees, which markedly improved the uptake of services and, in turn, resulted in a higher score in client satisfaction and quality of services, that meant an increase in funds received from the districts.
- HLFs are now better placed to make decisions in terms of solutions to their communities' health challenges, increasingly using evidence and the structures in place to influence health seeking behaviours.

Testament to the project's overall success is the substantial buy-in from development partners including UNICEF, World Bank, and WHO, as well as the Ministry of Health, who are currently in the process of adopting a client satisfaction survey tool partly based on the SCPH score card and other partners like Crown Agents and CORDAID.

BUILDING BRIDGES FOR LONG LASTING IMPACT

"In the past, all we would see of the council people was their car rushing past us on the road. They never stopped. The car just kept going." This statement, by Nurse Benhura from Twin Tops Clinic in Mhondoro-Ngezi district, is received with much laughter and heads nodding in agreement by a group of HCC members, HLFs and CMs. Partly because this is exactly how these community level health assets used to feel about Nurse Benhura and his colleagues.

In a healthcare system that is underfunded and overstretched, people rarely take the time for niceties. Patients complain, and nothing happens. Health workers complain, and nothing happens. The end result, sadly, is at the expense of essential MNCH service provision.

Morgan Sainayi, an HLF, says that "In the past, people would travel very far to avoid this clinic" because the staff attitudes were very bad. Sister Mpaule, who at that time was the only nurse at the clinic, explains. "It's not that there was a bad attitude before, but I was alone here, and there was too much pressure. You focus only on your work, and getting through the queue of patients. You just don't make the time for nice greetings. People thought I was so rude, but they didn't understand the pressure."

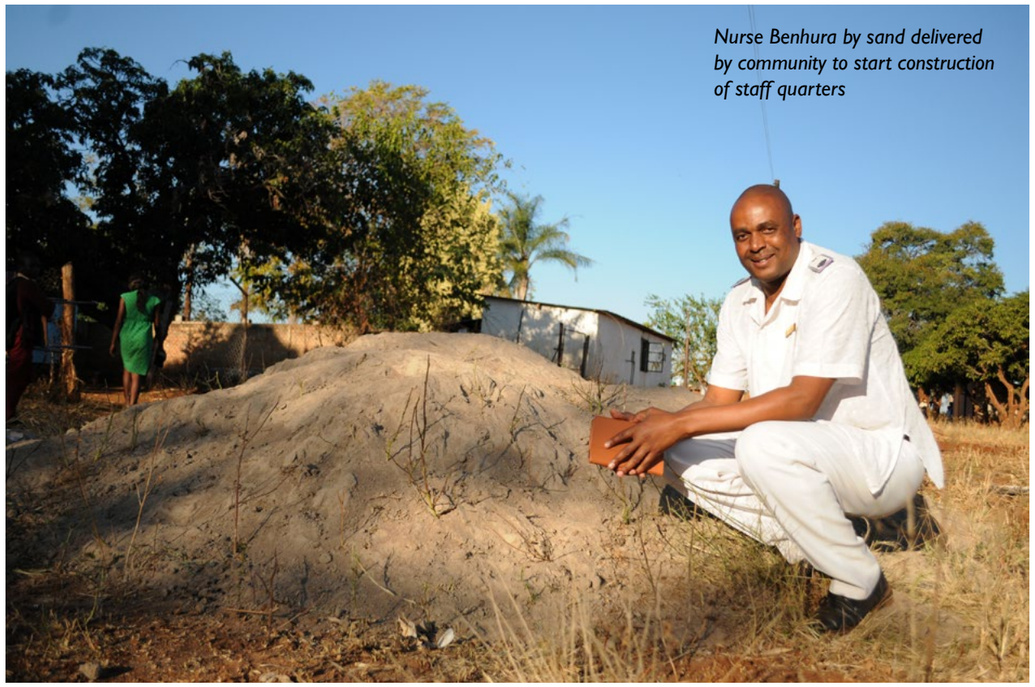
As the project started improving and structuring the dialogue between communities and health workers, people quickly understood the staff challenges. Empowered by the trainings, and equally aware of their own responsibilities, the HCC members addressed the rural district council with issues raised from the communities, including staff shortages and lack of facilities at Twin Tops Clinic.

"In the past, communities would just bring us the problems, never the solutions," says Cletus Matingwina, HR Manager for Mhondoro-Ngezi rural district council. "But with the project, everyone became involved; the HLFs, the HCCs and the district officers. It was very impressive how everyone became involved to participate and contribute." Twin Tops Clinic had water challenges since 2005, but when everyone came together through the project platform, the solution was simple: The council provided the pump, and community members carried out the work.

The HCC successfully lobbied for more staff – the clinic now has three nurses – and waiting mothers' rooms were constructed by the community, with assistance from the council. "It's not difficult to find people to do the work," says Kudakwashe Muketiwa, Chairman of the HCC. "Everyone understands, and everyone wants to help." Currently, the community is in the process of collecting 24,000 bricks for construction of proper housing for the staff, who up till now have been sleeping inside the actual clinic. To more cries of laughter, Mr Muketiwa adds, "This clinic is now state of the art". While still far from "state of the art" the Twin Tops Clinic is undeniably providing more, better and free MNCH services to the community, with everyone benefiting tremendously from the improved conditions and relations.

"I have to be honest," Mr Matingwina continues. "When Save the Children first approached us, I thought to myself, 'this project is going to be useless. They are not giving us money; not giving us anything. It's going to be a waste of time'. But instead, they identified human development; they have really developed our people. And we can now take this approach to other parts of our communities, such as schools. This 'local solution' thing is really very good for our communities."

Sister Mpaule in front of the waiting mothers' rooms



Nurse Benhura by sand delivered by community to start construction of staff quarters

Project installed suggestion box at Long Valley Clinic

Waiting mothers' rooms at Mwanza Clinic, Mashonaland East

Waiting mothers' rooms at Bezu Clinic, Bulilima district

Challenges and recommendations

To achieve greater geographical coverage on the budget, the project was implemented to cover fewer, selected clinics but in more districts, with an anticipated ripple effect to non-participating clinics. This created challenges at district level due to complaints from clinics not part of the project, especially as the difference in quality of services became evident, resulting in better performing clinics receiving more Results Based Financing funds. Whereas the desired ripple effect did take place to some extent, the districts do not have adequate resources and capacity, nor do they have the comprehensive community monitoring tools and platforms to replicate and supervise the project activities.
With limited funds available, it is recommended to scale down the overall geographical coverage, and instead include all health centres per district that qualify according to selected indicators. This approach would ensure all clinics under the same administration would improve at similar rates and pace, thus eliminating a lot of challenges for the district managers, and would likely create a more sustainable impact.

Similarly, and also due to budget restrictions, the number of HLFs and CMs selected and trained were too few to cover the catchment areas. Only two HLFs were trained – out of 8-12 village health workers per RHC catchment population – which not only created a sense of exclusion amongst non-HLFs, but also presented a huge challenge to the trained HLFs to cover great distances. Two CMs per clinic/HCC were also too few to carry out the many duties across the large catchment area. It was furthermore noted that some HCCs needed the support from PECs in community level feedback meetings, and that the HLFs and CMs could have benefited from increased on the job support supervision, which was not possible due to budget restrictions.

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 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 district, as they proved an invaluable link to the community cadres.

Choosing the health centres through which to reach key populations in hard to reach areas, presented further challenges, both in terms of budget restrictions, and the individual districts' preferences.

In choosing future clinics and areas, it is recommended to consider all indicators including hard-to-reach, large catchment, high home delivery rate, and religious and cultural barriers.

As training and capacity building have been key elements to the success of the project, HCC members' terms of office have presented considerable challenges in terms of skills retention and continuity, particularly where the majority of members are replaced during elections.

To minimise efforts and resources on re-training members, it is recommended to introduce limits to the reconstitution, ensuring the skills and knowledge are retained in the committee as a whole.

Budget restrictions furthermore limited the number of national level advocacy meetings organised, as well as the engagement of mass media. Media activities took place throughout the project, however, were only intensified towards the end of the project timeframe.

With a demonstrated impact in raising awareness on key MNCH issues to a variety of target audiences, it is recommended to increase the budget allocation for media engagement. With an established steering committee, especially with such well placed members as for this project, it is recommended to utilise this network to its full potential, particularly with regards to funding shortfalls and advocacy issues.

IEC materials, such as the MNCH flyer and the Patient's Charter, proved an important tool for HLFs in conducting health education, though the limited budget restricted the number distributed.
It is recommended to increase the IEC production budget to cover each household in the catchment area as a minimum.

Due to external and internal issues, the baseline survey suffered significant delays, with final results only released in April 2015, nearly two years after the project inception phase. With a theory based baseline, project implementation started without a true picture of the starting point, making the tracking of progress and assessing of impact challenging.

It is highly recommended to follow the logical programme life cycle for implementation, even if it causes delays to project implementation, for better informed activities and evidence based project design.

As the project had limited monitoring and no evaluation budget there was limited scope for the project team to conduct in-depth monitoring of project activities for performance related learning, and to carry out field validation of data collected through the Crown Agents and PECs. This meant that a lot of challenges, such as the need for increased on the job training for HCCs, were only addressed with the 2015 baseline survey, missing out on opportunities for improved performance. With limited resources for field visits, and the HCCs' complete lack of resources to travel, the data collected on score cards and through other feedback mechanism did not represent 100% of the target populations, and progressively started including repeated complaints as the respondents were the same.

For a project of this type, where approaches and interventions are tested, it is highly recommended that sufficient funds are allocated to carry out in-depth monitoring and evaluation, as well as allowing the flexibility to adapt the project according to continuous findings. With breakthrough funds by SCUK in early 2016, two districts were scaled up to cover all rural health centres, increase trained HLFs from two to five, and to deepen the community mobilisation and feedback mechanisms. The funding was awarded to fill the shortfall in the monitoring budget, to gain 'proof of concept' that will full and proper investment the approaches would achieve a larger impact.

During project implementation, and late into the training process, informal feedback from PECs highlighted a clear need for simplified materials to improve learning. The findings eventually resulted in an in-depth redesign and piloting of more user friendly training materials, in particular for low literacy trainees, for future use by existing and expanded project beneficiaries.
Several of the training materials, in particular the HCC manuals, would have benefited from thorough piloting and testing during the project's inception phase.

CONCLUSION

The SCPH project succeeded in building the capacity of citizens to demand access and provision of quality health services from duty bearers. It was noted that citizens were often socially, politically or economically excluded, to demand increased participation in decision-making structures. These structures were strengthened though capacity building of HCCs and evidence generated from community monitoring tools.

Health centre committees have brought social knowledge, experience, views on health problems and solutions within communities to jointly design and implement the plans and budgets for the health system at primary health care and community levels. This joint role in governance has given the HCCs information, authority and motivation to facilitate dialogue and consultation with communities on action plans; mobilise the community for social and health action, build constructive partnerships and facilitate dialogue with different actors to ensure that problems are addressed; and implement, monitor and evaluate actions related to service improvements and collective community health actions. This has raised the oversight role of HCCs. They are monitors and ensure that plans have been implemented in a manner responsive to their communities, provide feedback to the communities, and discuss with communities and health workers on how to make improvements, in a cycle that again identifies new and further needs to feed into work and action plans,

Effective implementation of these roles has been documented to show a positive impact on advancing the right to health; to improve the performance of the primary health care system, the satisfaction and retention of health personnel at primary care level, and the satisfaction of the communities they serve.

Currently factors affecting access and provision of quality MNCH services are bordering around health policies that are being reviewed, and need to be implemented. Civil society's watchdog role needs to be maintained in pushing finalisation of the following acts and policies:

- The Public Health Act amendment bill, though finalised, needs to be passed into law in Parliament
- Implementation of the health financing policy currently being finalised, that favourably pushes for universal health coverage through sound domestic financing strategies
- Finalisation of the National Health Strategy 2016 to 2020 and the National Social Protection Policy meant to incorporate National Health Insurance Policy

It is the sincere wish of Save the Children Zimbabwe and Community Working Group for Health to continue building on the SCPH project successes to further raise awareness on community rights, entitlements and responsibilities to MNCH; strengthen community capacity and structures; and create an overall enabling environment for the provision, access and utilisation of free, quality MNCH services.

"The communities not involved in the project are really struggling to participate in the development of their clinics. One clinic took one year to construct waiting mothers' rooms, whereas the project clinic did it in four months. I wish the project wasn't ending so soon, but instead continue with other clinics, so that when they leave, every clinic and HCC in the district has the same knowledge on community participation."

Ndaizivei Mwela, Makonde rural district council

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