Learning brief 03 | November 2021

RESULTS AND LEARNING BRIEF ON COMMUNITY-LED MONITORING TO IMPROVE THE QUALITY OF HEALTH SERVICES IN TWO DISTRICTS IN INHAMBANE PROVINCE, MOZAMBIQUE

1. Introduction

N'weti received funding from Amplify Change to facilitate community-led monitoring (CLM) in four health facilities (HF) in Maxixe and Zavala districts in Inhambane province, Mozambique, to improve the quality of HIV and other primary health care services. UNAIDS estimated that in 2020, in Mozambique, 2.1 million people were living with HIV, of whom 68% received antiretroviral treatment (ART). Through its community activities, N'weti has noted several barriers to increasing ART coverage, adherence and retention in care, such as long waiting times to consultations at the HFs, stock-outs of ART, breaches in confidentiality, and low awareness of rights of people living with HIV (PLHIV) among the frontline service providers.

To address these barriers, N'weti implements CLM using the community scorecard (CSC) tool. CLM enables local communities, particularly PLHIV, to engage with frontline health care providers with the aim to improve the quality of and access to public health services. The CLM reported in this results and learning brief had a special focus on HIV services, including prevention of mother-to-child transmission (PMTCT), and maternal and child health (MCH) services.

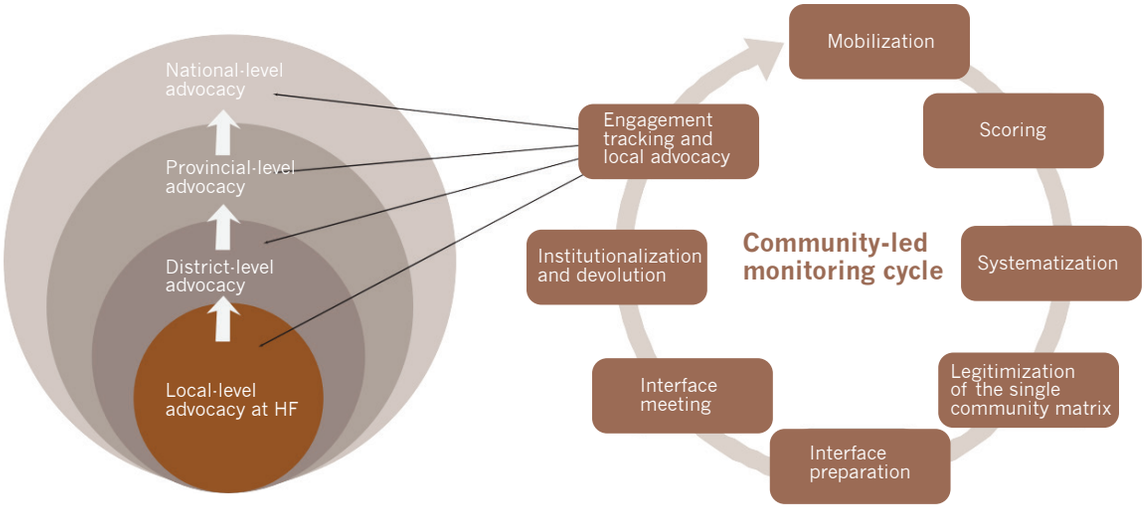
The CLM process has three main objectives: (i) monitoring the quality of public health services; (ii) identification and definition of health priorities from the service users' and providers' perspective for subsequent integration in the HF plans, district plans of the health sector, and in the annual district-level plan and budget (Plano Económico Social e Orçamento do Distrito, PESOD), and, (iii) building a body of evidence to define advocacy actions on public policies in the health sector.

For the CLM activity financed by Amplify Change, an additional objective of evaluating the CLM process and generating learnings from it was established, in order to improve the activity in the future. To this effect, the perceptions of the facility-level co-management and humanization committees were captured. These existing committees, that include both community members and service providers, are the main structures to promote engagement between the communities and HFs. Before the evaluation, a refresher training was provided by N'weti to all co-management and humanization committees, to remind them about the role and responsibilities of the committee in improving the quality of the HF services, including monitoring of the jointly agreed action plans developed as a result of the CLM process, and how to implement advocacy actions.

2. Methods

The CLM activity allows the users of public health services to actively participate, in an organized manner, in monitoring the quality of services provided by HFs. Due to its participatory nature, the CLM process creates conditions for healthy interaction and dialogue between users and providers of public health services, aiming to identify gaps, positive aspects, and concerns that serve as a basis for generating consensus and finding solutions with the aim of improving the quality of the services. N'weti's comprehensive approach to the CLM activity is described in diagram 1 below.

Figure 1. N'weti's community-led monitoring cycle



The CLM process starts with **community mobilization and mapping** of both the services offered by each HF, as well as the existing structures of collaboration between users and providers such as the co-management and humanization committees. The CLM approach and its aims are also presented to district health authorities, HF management, service providers, and to community-based structures. The health service user and provider participants of the CLM are informed about the process, and a **set of indicators on the quality of services is scored** by both groups.

N'weti's adapted methodology requires several groups of service users of each HF to score the same set of indicators. These **scores are systematized** and summarized in a single matrix, which is **legitimized** and validated by service users. Selected representatives of service users are **prepared and trained to participate in the interface meeting** with service providers. During this meeting, representatives of service users and providers discuss their scores, concerns, and propose solutions until priority actions are agreed and included in a joint action plan.

Institutionalization and devolution of the agreed actions to a broader audience is conducted through different PLHIV support groups, and the progress of the agreed solutions is followed up by existing mechanisms for community participation in the management of HFs. Evidence from the CLM is used to inform planning processes at the HF and district levels, and shared with all stakeholders for j**oint follow-up, engagement tracking, and advocacy at different levels.** The CLM is thus used to solicit community members' opinions about the degree of access, satisfaction, and quality of services. By providing an opportunity for direct dialogue between service users and providers, the CLM process empowers citizens to voice their opinions and to demand improved service delivery.

In the CLM activity presented in this document, the services of each HF were evaluated by one group of service providers, and two community groups with participants who had experience of services provided by the evaluated HF. One of the community groups was formed by women living with HIV who had used PMTCT services, while the other group was composed of other community members, including community leaders and members of the collaborative structures for HF management, such as the co-management and humanization committees. They scored pre-defined indicators on four different dimensions of quality of care, namely: 1) Quality of attendance at the HF; 2) Quality of counselling services; 3) Availability of ART and other medicines; and 4) Quality of infrastructure. Each indicator was scored as "bad", "good" or "very good".

After scoring and the interface discussion, joint action plans were developed, and these were monitored together with the co-management and humanization committees. Normally, a subsequent CLM cycle would be undertaken to establish whether there have been any changes in the quality of services. However, as the current report includes results of only one cycle of CLM, the changes in the indicators mentioned below are based on monitoring discussions with the co-management and humanization committees. It should be noted that besides the actions and advocacy implemented as a result of this CLM activity, other parallel processes by the health authorities and partners were on course at the same time, which also influenced the reported changes.

For the additional component of evaluating the CLM process and generating learnings, initially a large dissemination and evaluation workshop was planned to be held, but because of restrictions due to the COVID-19 epidemic, instead, smaller focus group discussions (FGD) were conducted. These enabled capturing different local dynamics that affect community participation and engagement with providers, as well as the providers' motivations to accept the proposals of service users for improvement of the quality of health services. The COVID-19 epidemic caused also other challenges and delays to the activity, which was foreseen to last for one year and be completed in 2020, but was completed only in 2021.

3. Results of community-led monitoring

This section presents the results of the CLM activity, implemented with the CSC tool in four HFs of two districts in Inhambane province, Mozambique, namely: Maxixe Health Centre and Chicuque Rural Hospital in Maxixe district, and Quissico District Hospital, and Zandamela Health Centre in Zavala district. The primary health care services provided by these HFs were evaluated, with a special focus on HIV and MCH services. Altogether 86 health service users (83% of them women), and 34 service providers participated in the CLM activity. The quantitative results provided below reflect the scoring of the service users, which were then discussed together with the providers to find solutions for the identified problems. The results of the above-mentioned evaluation of the CLM process are provided in chapter 4.

3.1. Quality of attendance at the health facility

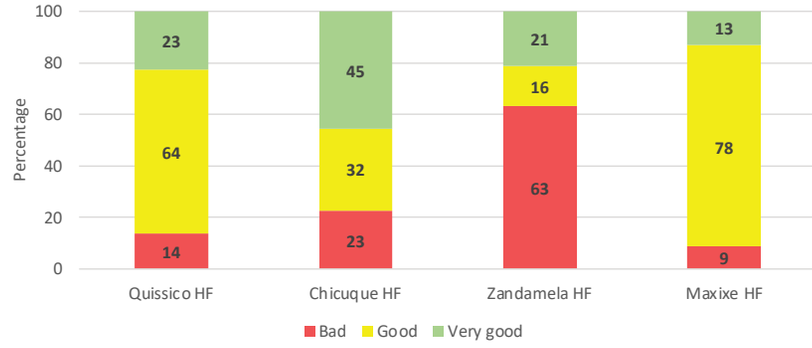
The quality of attendance at the HF was assessed through the following three indicators: 1) Waiting time to receive health services; 2) Availability of health providers during opening hours of the HF; and, 3) Courtesy of providers.

The first indicator on **waiting time** was evaluated very negatively for Zandamela Health Centre. This was due to the HF having too few providers to attend the patients, as mentioned by one of the health service users:

> "We spend a long time in the queue because there is only one technician, attending to several sectors alone." (Community member – Zandamela Health Centre)

This issue was discussed at the HF level and N'weti took it up to the authorities at district level. More personnel were allocated to this HF, which according to the co-management and humanization committee led to reduced waiting times.

Graph 1: Health service users' perception of waiting time



Also Chicuque Rural Hospital had a relatively high negative score for the indicator on waiting time, while it should be noted that it received the highest percentage of "very good" scores for the same indicator. In the interface discussion it became clear that long waiting times in this HF were due to primary health services being provided within the hospital, which meant that the same service providers provided different services and thus were not always available at their consultation rooms. The service providers also pointed out that besides attending to patients, they have

several administrative duties and meetings, and thus are not always able to attend to patients immediately. N'weti advocated with the management of the hospital to separate the primary and secondary health services, with specific staff dedicated to each type of service. This was done, and as a result, according to the co-management and humanization committee the situation in this HF improved. In addition, the providers were reminded of the correct protocol of attending patients, while the users were sensitized about the fact that in addition to attending to patients, the providers have administrative duties. The users of Maxixe Health Centre and Quissico District Hospital showed higher satisfaction with the waiting times than the users of the other two HFs.

Also the indicator on the **availability of service providers during opening hours** of the HF received a relatively high overall negative score, with 43% of users scoring it as "bad" in Maxixe Health Centre. Of the users in Chicuque Rural Hospital, 27% gave a negative score for this indicator and the corresponding percentage for Quissico District Hospital was 23%. On the other hand, only 11% in Zandamela Health Centre gave a negative score for this indicator, while 79% of the users considered the availability of service providers in this HF as "very good". The reasons for the negative scores are reflected in the quotes below:

> "The technicians leave before closing time and are always on their phones." (Community member – Maxixe Health Centre)

> "Because the health providers are always talking to people in the other [HF] sectors. They give priority to family members." (Woman with experience of PMTCT services – Chicuque Rural Hospital)

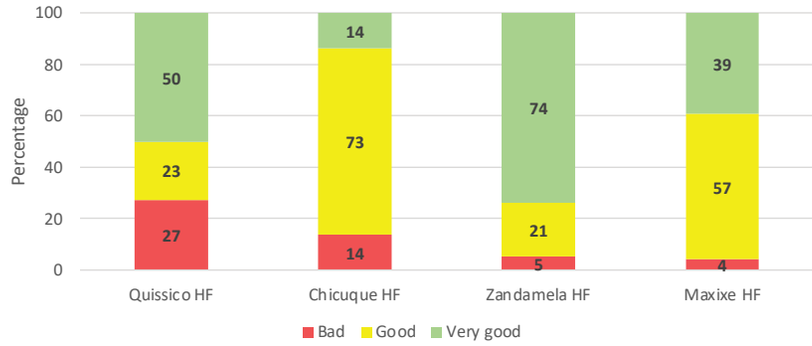
Dedicating specific staff to provide primary health services in Chicuque Rural Hospital, as described above, and allocating more service providers and supervisory staff to Maxixe Health Centre improved the situation in these HFs. In addition, the service providers were sensitized about the correct protocol and hours of attending to patients, and the providers will regularly discuss with the members of the co-management and humanization committees to monitor changes in this and other indicators.

Overall, the third indicator, namely **courtesy of providers**, received overall the highest percentage of positive scores when compared to the other two indicators in this dimension. As shown in graph 2, courtesy of staff was best at Zandamela Health Centre (74% scored it as "very"good" and 21% as "good"), while Quissico District Hospital had most room for improvement (27% scored courtesy as "bad"), as reflected in the following quote.

> "Because some providers are not kind to patients living with HIV." (Community member – Quissico District Hospital)

As a solution, the service providers were sensitized about the rights of health service users and the need to treat the patients well, as well as to have patience while explaining complicated matters. N'weti will continue monitoring this issue together with the co-management and humanization committee of the HF.

Graph 2: Health service users' perception of courtesy of service providers

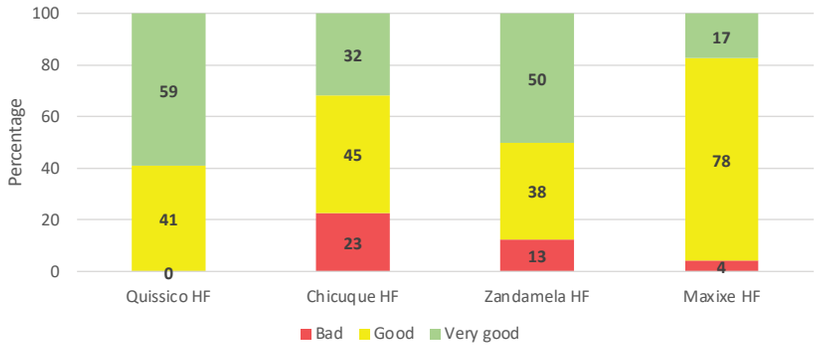


3.2. Quality of counselling services

This dimension consists of four indicators, namely: 1) Respecting the confidentiality of HIV diagnosis or other health conditions by health providers; 2) Quality of counselling on how to take ART or other medicines and how to deal with possible side effects; 3) Quality of counselling on the importance of early infant diagnosis (EID) for HIV-exposed children, and how and when it should be done; and 4) Quality of counselling on the importance of continued ART adherence after delivery, and after cessation of breastfeeding. The last two indicators were scored by the women with experience of PMTCT services, as well as by service providers, but not by the group consisting of other community members. Overall, the quality of the counselling services was evaluated more positively than the quality of attendance.

Regarding the first indicator in this dimension, Quissico District Hospital had the best result with no negative scores, while 23% of the users of Chicuque Rural Hospital were dissatisfied with r**espect shown by service providers for confidentiality of HIV diagnosis or other health conditions**, as shown by graph 3 below.

Graph 3. Health service users' perception of respect for confidentiality of HIV diagnosis or other health conditions by service providers



As mentioned by the CLM participants quoted below, the reason for dissatisfaction among the users of Chicuque Rural Hospital was related to the need to go to different parts of the HF to receive all the necessary HIV services (medical consultation, psychosocial support, pharmacy etc.), and thus other people may suspect that the user is HIV-positive.

> "...because the consultations often take a long time, and we go through many [consultation] rooms, and people easily end up discovering the patients' situation." (Woman with experience of PMTCT services – Chicuque Rural Hospital)

> "Women's care should take place in one [consultation] room, where we can find all HIV services." (Woman with experience of PMTCT services - Chicuque Rural Hospital).

As a solution, it was suggested that all these services should be received in one consultation room ("one-stop shop"). This solution was advocated for by N'weti, as it is also mentioned in the ministry of health policies, and nowadays the HIV-patients of Chicuque Rural Hospital receive all their services in one consultation room. The positive results of Maxixe Health Centre and Quissico Rural Hospital may be related to the fact that these HFs already followed this practice before the implementation of the CLM. N'weti advocated to have the same practice at Zandamela HF, but this is a smaller HF with limited space, and thus as of yet, it was not possible to implement this approach.

The quality of counselling on how to take ART or other medicines and how to deal with possible side effects received an overall positive rating. This indicator received no negative scores in Chicuque Rural Hospital or in Zandamela Health Centre, while 18% and 13% of the users of Quissico District Hospital and Maxixe Health Centre scored the quality of this service as "bad". The quotes below reflect the reasons for the negative scores:

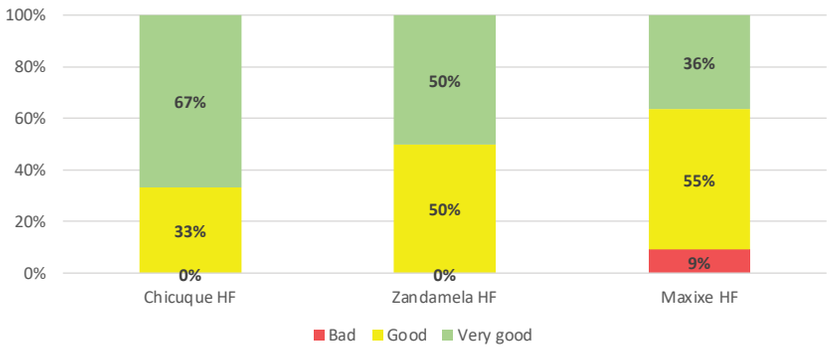
> "Often, we only get an explanation of how to take the medication at the first appointment, but on the days when the medication is collected at the pharmacy, they no longer tell you anything, they just hand over the medication, but this is due to the overflow of people at the pharmacy." (Woman with experience of PMTCT services – Quissico District Hospital)

> "[There is] a lack of patience in the explanation of how we should take the medicines." (Community member – Maxixe Health Centre)

The patients living with HIV should receive counselling on ART also during follow-up psychosocial support consultations, but often lack of time limits this possibility. N'weti therefore advocated for the inclusion of information on the use of ART/other medicines as well as on possible side effects to the health talks provided at the HF, as well as provision of guidance at the pharmacy of the HF or at the one-stop shop, when the patients receive the subsequent dose of ART.

The women with experience of PMTCT services were satisfied with the **quality of counselling on the importance of early infant diagnosis for HIV-exposed children, and how and when it should be done**, as this indicator received no negative scores in any of the three HFs where it was scored. This and the following indicator were not scored in Quissico District Hospital by mistake, as the activity was new for the facilitators. Women who had gone through PMTCT were happy also with the **quality of counselling on the importance of continued ART adherence after delivery, and after cessation of breastfeeding**, which received no negative scores at Chicuque Rural Hospital or Zandamela Health Facility, while only 4% of users of PMTCT services were dissatisfied at Maxixe Health Centre, as shown in graph 4 below.

Graph 4: Health service users' perception of the quality of counselling on the importance of continued ART adherence after delivery, and after cessation of breastfeeding

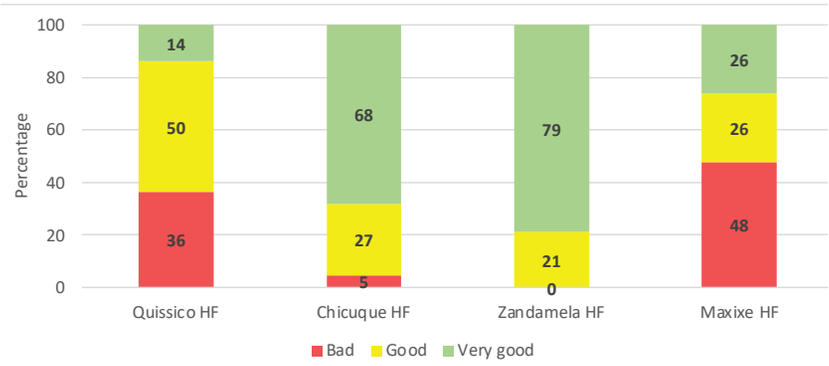


Similar to the indicator on counselling on ART, one reason for dissatisfaction was the lack of follow-up guidance on the importance of life-long use of ART. To resolve this problem, it was agreed to sensitize the service providers about the need to provide good-quality counselling about the importance of continued ART adherence, even after delivery and cessation of breastfeeding, to ensure continued adherence and retention of mothers living with HIV. This was discussed also with the persons responsible for the PMTCT services in the HFs to receive their support for the follow-up.

3.3. Availability of ART and other medicines at the health facility

This dimension included only one indicator, measuring satisfaction with the availability of ART and other medicines at the HF. The users of Zandamela Health Centre were most satisfied, with no negative scores and 79% scoring the availability as very good as shown in graph 5. Also Chicuque Rural Hospital received a positive evaluation, with 68% of user evaluating availability as "very good", while 5% of the users were dissatisfied.

Graph 5: Health service users' perception of availability of ART and other medicines at the HF



However, many of the users of Maxixe Health Centre and Quissico District Hospital gave a negative score to the availability of ART and other medicines (48% and 36%, respectively), as described in the quote below.

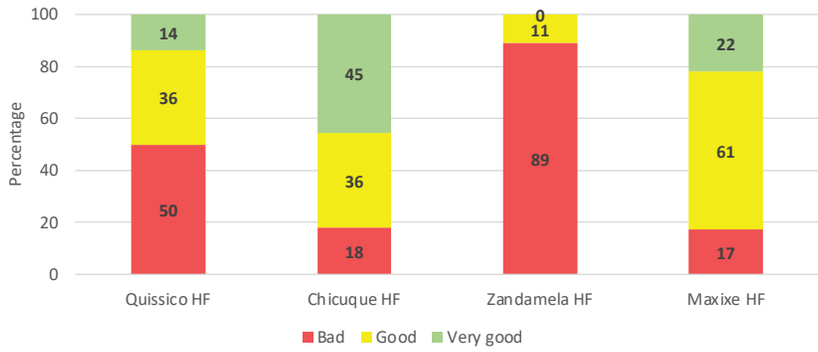
> "There are few pills in the hospital and not enough for everyone, they send us to buy them at an outside pharmacy." (Community member - Maxixe Health Centre)

N'weti discussed this issue at the HF and district levels, and the stock of ART and other medicines has been improved at both levels. This is issue will continue to be monitored to ensure the availability of ART to all those who need it.

3.4. Quality of infrastructure

This dimension contained only one indicator, which combined two aspects, namely the level of hygiene and cleanliness of the HF, and the availability of water. Of all the four evaluated dimensions, this received the worst overall score. Dissatisfaction was especially evident at Zandamela Health Centre, where 89% of the users scored this dimension as "bad" and none as very good, followed by Quissico District Hospital, where half of the service users showed their dissatisfaction, as shown in graph 6 below.

Graph 6: Health service users' perception of level of hygiene and cleanliness of the HF and the availability of water



At Zandamela Health Centre, the very high negative score was mainly due to lack of water and lack of proper toilets. The HF has a water source but there was no no longer a functional mechanism to bump water up. Quissico District Hospital also has a water source, but there was no running water in the toilets or in the maternity waiting home, which led to problems in maintaining cleanliness as described in the quote below:

> "There is a borehole in the hospital, but there is not always water in the bathrooms, and nobody cleans. Our companions [family members who accompany and stay with the pregnant women] in the maternity waiting home have to do the cleaning." (Woman with experience of PMTCT services – Quissico District Hospital)

According to the participants, the unsatisfactory conditions at the maternity waiting home cause them to wait for the delivery at home, instead of coming to the vicinity of the HF, which might put them and their babies at risk.

N'weti discussed the lack of water and proper toilets at Zandamela Health Centre with the district authorities. The water system was rehabilitated and currently the HF has access to running water. Also, two proper toilets were constructed by community members, with material provided by an implementation partner, Centro de Colaboração de Saúde (CCS). On the other hand, the situation in Quissico Rural Hospital was resolved by the district authorities financing the canalization of running water to the maternity ward and maternity waiting home. In addition, new bathrooms were constructed for the HF.

Chicuque Rural Hospital and Maxixe Health Centre had somewhat better results for this indicator, with 18% and 17% of the users of these HFs, respectively, scoring this dimension negatively. However, the high number of problems in the availability of water and in cleanliness of HFs, identified in the current and earlier CLM activities, has led N'weti and partners to establish an advocacy agenda towards improving coordination between the ministries of health and public works, and to appeal to national authorities and cooperation partners for greater investment in this field.

4. Evaluation of the CLM process and lessons learnt

This section details the results of the evaluation process of the CLM activity to generate lessons learnt in order to improve the activity in the future. As mentioned above, FGDs were performed with the HF-level co-management and humanization committees that include members from the community and the HF. Altogether in the two districts, eight community members and 15 service providers participated in this evaluation process.

This evaluation revealed that the CLM, through monitoring the quality of health services, brings the community and the HF closer together. For this process to be effective, the providers and the community participation mechanisms (such as co-management and humanization committees, health committees, and the user offices that receive feedback from health service users), must be aware of the problems presented by the service users, and be able to respond to the identified concerns in a timely manner. For example, in addition to having medical knowledge, the health service providers have to show compassion and provide humane care.

In the Mozambican context, good results in some dimensions, such as maintaining the HFs clean, are only possible if the community and the HF work hand in hand. Cleaning campaigns have played a crucial role in mobilizing everyone to make the user experience in the facility enjoyable. The feeling of belonging is a motivating factor for joint learning and action by the communities and the HF staff towards common good. To this end, as some of the participants in the focus groups mentioned, individual responsibility and initiative are keys to success. There was a recognition that resources exist, but waiting for the government to do everything shows lack of proactivity and active citizenship.

Thus, the current CLM process added a great value to the existing relations between the communities and the HFs, above all because it allowed users to get to know the challenges of HFs and vice versa, thus promoting a gradual process of inclusion and involvement of all. Although one of the challenges of the CLM activity is the fear of reprisals from providers directed at community members who publicly expose problems, the service providers themselves recognized that improving the quality of services depends on honest discussion on identified problems, as this alone can yield gains for both parties. However, one of the provider participants admitted that the providers have different behaviour in different situations: for example, they might not show courtesy towards the patients, while during the co-management committee meetings and the CLM sessions they behave as equals to the other members and show courtesy. The suggested way to solve this is awareness that, regardless of roles, community members and service providers are all equal, as reflected in a comment by a health provider below:

> "We are part of the community, the difference is that I'm in a nurse's attire during the consultation hours, but when I leave from there, I'm just like them [community members]. I live my day-to-day with them in the community, with no water. I never leave my house to go to the hospital to "ask for help to light a fire", I go to my neighbours. This is what we are lacking, first we have to understand that we are all equal, regardless of the different roles we have." (Health provider participant of the FGDs)

Some participants of the FGDs reiterated the importance of providing more information to community members about the objectives and role of the CLM activity in addressing the challenges at the HFs, and also asked for expansion of the CLM activity to further HFs. The FGDs also confirmed the CLM results described above, which point to a lack of staff in the facilities, especially personnel to assist with maintenance of cleanliness and hygiene. Stakeholders recognized the value of the CLM as a process to raise issues, and assist in the resolution of problems ranging from waiting times to lack of alignment between HF and national level planning.

The line of thinking presented in the FGDs suggests that local economic actors should be involved in the CLM process and support resolution of problems as part of their social responsibility actions. Also the staff of the District Services for Economic Activities (Serviço Distrital de Actividades Económicas, SDAE) could be involved, so that at the time of planning and budgeting, they could take into account the problems of the HFs identified and discussed during the CLM activity. This would also improve alignment between the planning processes at the district and HF levels. In addition, the FGD participants were concerned about the current decentralization process, and asked for the co-management and humanization committees to be informed and involved in this process.

Given that many members of the co-management and humanization committees belong simultaneously to other mechanisms of collaboration, such as the health committees, user offices, municipal and even the provincial assemblies, the CLM could evaluate also these other mechanisms, as there seems to be some complementarity between the different spaces for participation and problem solving, as shown in the quote below:

> "...even in matters related to some problems detected in the hospital, they are never considered as criminal matters before they pass through the committee, because in some matters we are the ones who discover and investigate them. There are disciplinary procedures, there are also criminal procedures in other cases; we have participated in the reception of medications. I myself am a member of the user's office. We have so much to do, this work in the HFs where we have provided lectures. It is what our facilitator was saying about how the providers should behave in the HFs, in fact, our challenge is to transmit our experiences to the FGDs." (Community member participant of the FGDss)

Ownership of the challenges and solutions identified during the implementation of the CLM seems to be another factor of concern. One of the FGD participants emphasized the need for all stakeholders to be aware of the outcome of the CLM process, so that the identified solutions and actions can be implemented in a coordinated manner at the district, provincial, or even at the level of the ministry of health, depending on the complexity of the problem. The N'weti CLM cycle includes this component through the steps of institutionalization and devolution of the agreed actions to a broader audience, as well as through sharing the evidence from the CLM with all stakeholders to inform planning processes, joint follow-up, and advocacy actions at different levels.

The health service users who participated in the FGDs mentioned that we all depend on each other and need to work together to obtain the best possible results, and the CLM activity has an important role in this. On the other hand, the providers felt that the CLM supports them in the detection and correction of problems and gaps, which ultimately contribute to changes in behaviour, and improvement in the quality of services. The CLM was considered by the participants to be the main resource, not only for bringing the community and the HF closer together, but also as a space where the service users give their point of view about how the HF is being managed.

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