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State responsiveness to communities' quality health service delivery demands:The Case of Zimbabwe, Shamva District.

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Abstract

Thisstudy examined whether the state (health officials) responded to communities demands of having quality health service delivery in Shamva district. The study sought tounderstandhow the health officials in Shamvadistrict responded to issues raised by communities. The study was guided by interpretive paradigm and utilised qualitative research methodology. The data generating instruments used by the study were individual interviews with community members who visited the health centres during the presence of the research team, focus group discussions, key informant interviews and participant observation.The key finding was that health officials in Shamva district partially responded to communities' complaints of poor-quality service delivery. The study concluded that lack of adequate budgets and full autonomy to Shamva district hindered health officials to respond to communities' demands of quality health services. The major recommendation is that government should fully decentralise health services and provide resources for districts to respond to poor health service delivery concerns.

Key words: state responsiveness, Community's demands, Health services,

1 Introduction

The study was conducted in Shamva district to assess whether the state under this study health officials respondedto communities' demands of having quality health service delivery. The paper covers the back ground to the problem, statement of the problem, the purpose of the study, objectives of the study and research questions. The paper further covers the methodology, data analysis, discussion and presentation. The

major findings, conclusions and recommendations are also given. The background to the problem is given below.

1.1 Background to the problem

Globally people are suffering from preventable diseases and too many are dying prematurely (United Nations, 2018). In 2016, 1.5 billion people required mass or individual treatment and care for neglected tropical diseases(United Nations, 2018). Unsafe drinking water, unsafe sanitation and lack of hygiene are major contributors to global mortality, resulting in about 870,000 deaths in 2016 (World Health Organisation, 2017).Maternal mortality ratio in developing regions is 14 times higher than in the developed regions (World Health Organisation, 2014).

The health sector in Zimbabwe, particularly in Shamva district is not spared from the global health challenges. Save the Children Report (2016) highlights barriers that rural communities in Zimbabwe are facing in accessing provisions of quality Maternal, Neonatal and Child Health Services (MNCH). These barriers include, charging of user fees at Rural District hospitals; Council managed health institutions (RHC level) and at referral hospitals under the management of the Ministry of Health and Child Care (MoHCC). This excludes the poor people who cannot afford to pay the user fees. There were high levels of commercialisation and unregulated service provision that led to high out of pocket payments by clients to enable them to access health services (Ministry of Health and Child Care, Health Finance Policy 2017).

In addition, the nature of decentralisation in Zimbabwe kept on changing from administrative to elected local authorities. There has been policy gaps between rhetoric and reality (Chakaipa, 2001; Government of Zimbabwe Constitution, 1999; Makumbe, 1998; Gasper, 1997; Wekwete & de Valk, 1990). There has been lack of decentralisation of power because of various reasons that include unwillingness of national institutions to relinquish power (Conyers, 2003). This aligns with Shah (2016), that experience has shown that local government accountability is largely oriented upwards and has rarely attained the kind of social accountability, responsibility and responsiveness that was envisaged by decentralisation reform outcomes

The implementation of structural adjustments programmes in the mid-1990s seriously undermined accountability of African states to their citizens (Friis-Hansens, 2000). The World Bank, Department for International Development and other donors pro-actively promoted social accountability (SAcc) as conditionalities of development assistance (DIIS, 2013). This led to the rise of social accountability strategies that focused on demand side of good governance that strengthened the voice of citizens to demand greater accountability and responsiveness directly from public officials and service providers (Joshi & Houtzager, 2012). Reforms associated with social accountability in Africa are sometimes called second generation reforms as they were introduced as a follow up to improve institutional arrangements that were implemented by structural adjustment programmes in the mid- 1990s. It is worth to note that Zimbabwe also went through the same journey with other African countries after mid-1990s.

In all these phases, the government of Zimbabwe emphasised efficiency and effectiveness in delivering public services. There is lack of financial support to improve the health centres and the district staff lack full autonomy to make decisions that might help the rural health centres.

The above-mentioned challenges of poor-quality service delivery became a concern to the government and interested partners in health. This led the Ministry of Health and Child Care (MoHCC) to sign a Memorandum of Understanding with donors and some Civil Society Organisations (CSOs) to help address some of the challenges in the health sector through implementing different social accountability (SAcc) programmes. The above problems and challenges in Zimbabwe prompted the researcher to examine whether the state is responding to the demands that are raised by communities of improving quality health service delivery.

1.2 Statement of the problem

HIV and Sexually Transmitted Infections (STIs) levels in Shamva district were high due to illegal mining activities in the district, resulting in high mobile population or immigrants. The government of Zimbabwe passed a user fee policy in 1980 that was fully enforced in December 2017. At all sixteen Shamva district rural health centres, all the patients did not pay for health services. Shamva district hospital incurred expenses ranging from $1500 to $2000 per month for non-paying patients while the hospital collects $5000 to $8000 from user fees resulting in a funding gap of $3000 for the administration expenses of the hospital. The budget shortfall impacted badly on the quality of services offered at the district hospital. The user fee policy also distorted the referral system and the district hospital was clogged by non-paying

patients. In addition, The National Health Surveys conducted by Ministry of Health and Child Care acknowledges poor health services delivery in rural communities.

However, there is lack of evidence on the responsiveness of health officials to communities' demands on improving quality health services in Zimbabwe. Furthermore, it is not clear whether the statethrough its health officials, isready and has the capacity to respond to demands tabled by the citizens. Therefore, the study sought to bridge the perceived knowledge gaps by writing this paper.

1.2.1 Purpose of the Study

The purpose of this study was to examine whether the health officials respond to communities' demands of having quality health services in Shamva district.

1.2.2 Objectives of the Study

The objectives of the study were to:

- establish the extent to which health officials respond to communities' health demands; and
- analyse the rate at which the state is responding to communities' complaints of poor service delivery.

2 Review of Related Studies

The need for state responsiveness has been alluded to by many authors includingJoshi (2013); and Fox (2015). Responsiveness translates into changes in health provider behaviour, involving concrete action to improve service provision in line with citizens' concerns (Lodestein, Ingemann, Molenaar, Dieleman, & Broerse, (2017). Dasputa (2011) and Coe (2013) added that the responsiveness of providers is likely to depend on whether they perceive users of health services as patients, recipients,

beneficiaries, clients, consumers, citizens or holders of rights. This view can be strengthened by common societal beliefs that not everyone has equal rights makingdenial of rights accepted as the natural order of things (Schuurman &Mahmud, 2009). This is also the same where patients bend low because health workers are more equal than they are.The patients are expected to be grateful for services regardless of perceived quality (Wendland, 2010).

Political and government actors including public service providers are held to account for their actions and decisions by citizens (Molyneux, Mulupi, Mbabu & Marsh, 2012). Public providers are expected to respond to the citizens demands requiring a behavioural change towards more openness to discussing poor performance and willingness to improve the power of service users and accountability and adapt service delivery practices (Mc Neil and Malema, 2010, Molyneux et al. 2012; Joshi 2013). Citizens across the globe are increasingly challenging their governments citing lack of accountability, responsiveness and transparency, especially in relation to disadvantaged groups (Commonwealth Foundation, 1999, Narayan, Raj, Schafft, Rademachacher and Kock-Schulte, 2000).

"The impact of nonresponsive and unaccountable governance is most harshly felt by people in Africa, where corruption and governance failures are broadly acknowledged as major obstacles to achieving critical poverty reduction and human development goals" (Malena & Mc Neil, 2010, p.1). Unless the CSOs and other actors demand government's transparency, responsiveness and accountability, current governance failures are unlikely to be resolved.

Therefore, the state must know that "citizens' trust in governments grows when they feel they have a say in government decisions and an eye on government's activities and when government listens and responds to their concerns"(Malena & Mc Neil, 2010, p.15). While improving responsiveness of service providers can be a real challenge because public services mostly are provided at local level where implementation and enforcement is hampered by resource constraints or institutional bottlenecks (Camargo& Jacobs, 2013). Therkildsen, (2014), added that provider responsiveness to the public may be constrained if the health professional's careers depends on the good will of direct supervisors or political connections.

Berlan and Shiffman, (2012) concur with the above notions citing three broad contextual domains that influence health provider responsiveness to social demands. These include nature of competition between health providers, the level of provider autonomy, the relative importance of community priorities and relative importance of social accountability vis-a-vis internal accountability (Lodestein et al., 2017). This goes hand in hand with Joshi (2014), who stresses that social accountability components are such as information collection, demand articulation and presentation can influence responsiveness differently.

In addition, in countries where there is good legal environment for citizens to mobilise themselves and the redress channels are clear, health officials are more likely to respect citizen groups; decisions and respond to their actions (Mukhopadhyay, 2003; Ngulube, Mdhululi, Gondwe & Njobvu, 2004). Thisis different in cases where the health committees have poor capacities as they are voted into power because of their socio-economic or political rather than their knowledge in health care (Ngulube

et al, 2004). Usually the providers look down upon these individuals and rarely respond to their needs (Williams, 2007; Mukhopadhyay and Meer, 2004).

Furthermore, social accountability may generate state responsiveness when it triggers fear of repercussions for poor performance (Lodenstein et al., 2017). Women's organisations in India used the media to publicise testimonies of poor or denial of services, in a way of putting pressure to health providers to respond to quality services (Dasgupta, 2011). This is the same where journalists are particularly important in generating responsiveness of service providers (Mukhopadhyay, 2003). Furthermore, feedback from social actors can raise health workers awareness of the importance of the relational aspects of care, need to engage and chat with users and to treat them equally (Lodenstein et al., 2016).

3. Site of the study and population

The study was conducted in Shamva district. In February 2018 Shamva District had a population of about 130 000 and these were serviced by 16 rural health centres (District Medical Officer, 2018). The study generated data from five health centres that were referred to as A, B, C, D and E.The current study's data were generated from five rural health centres. Health centre A had six (6) nurses who served seventeen thousand and seven hundred (17700) people from three wards. Health centre B had a catchment area of forty-one thousand eight hundred and forty-eight (41848) people that covered nine (9) wards and serviced by four (4) nurses. Health Centre C served four thousand eight hundred and one (4801) people from two (2) wards and serviced by four (4) nurses. Health centre D had seven thousand two hundred and eighty (7280) people, it covered three (3) wards and it had three (3)

nurses. Last, but not least, health centre E served eight thousand three hundred and forty-four (8344) people.

4. Data Generation Instruments

The researcher used existing records that included reports from implementing partners such as CWGH, Save the Children, Training and Research Support Centre (TARSC), Crown Agents and government to understand the context and social accountability of Shamva district. This was supplemented using data generating tools which were semi-structured interviews that were administered to community members who visited five health centres during data generation process. Participant observation was also used by the researcher, focus group discussions (FGDs) and key informant interviews (KIIs) were used to ascertain whether health officials responded to communities' demands of quality health services in Shamva district.

5. Respondents biograph

The interviewees of the study were 204 community members from five health centres, 127 participants of thirteen focus group discussions and 27 key informants. Pseudo names were used to keep the confidentiality of the participants and respondents. There were more women than men who participated in the data generating process. Figure 4.1 shows gender disaggregation for all the participants and respondent for the study. There were 358 people who generated data for the study. 118 were men who represent 33% and 240 were women who represent 67%.

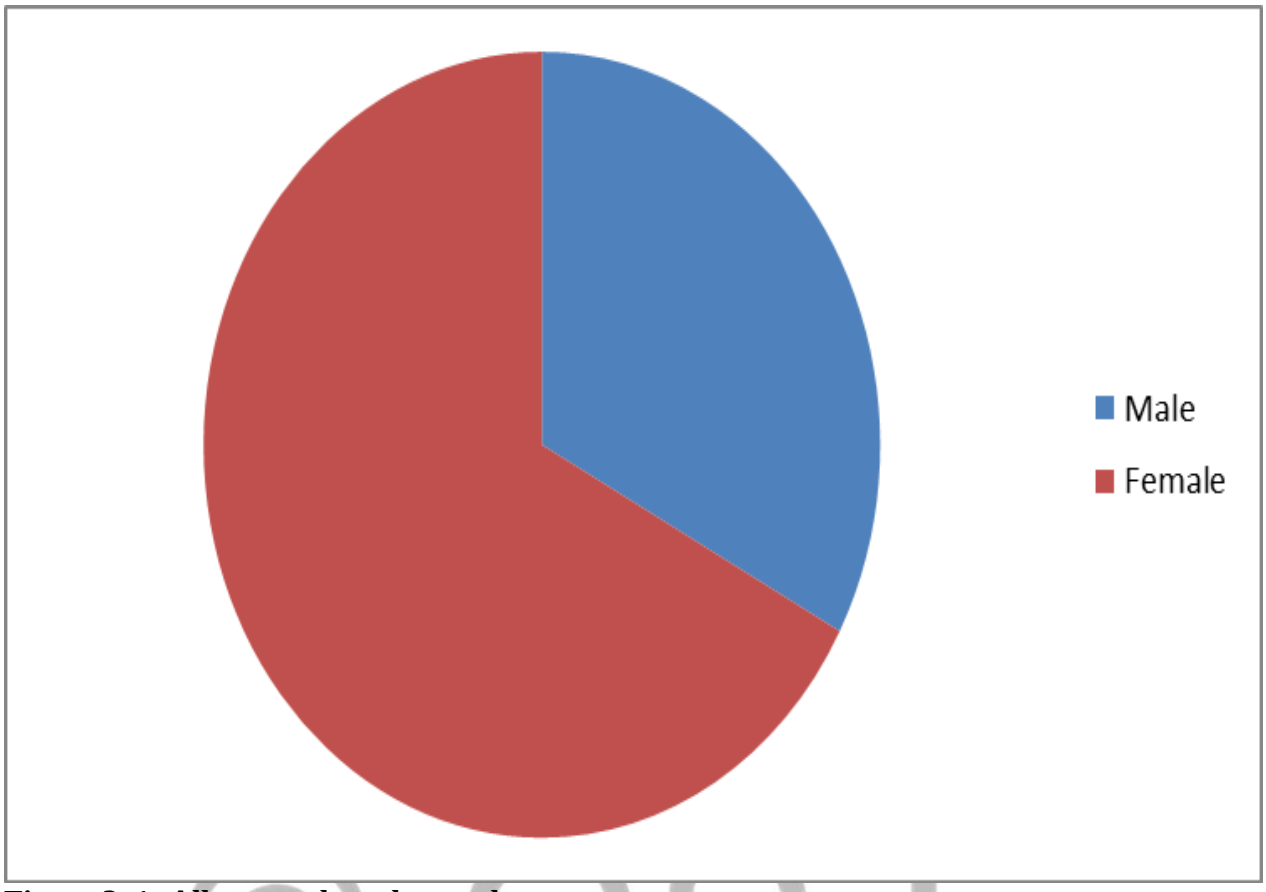

Figure 3. 1: All respondents by gender

4 6. Findings

The findings of the study are presented in the following sub themes:

1. Evidence of issues raised by communities on quality health services
2. Issues that were responded to by the health officials
3. Issues not responded to by health officials.

6.1 Evidence of issues raised by communities on quality services

To measure whether state (health officials) responded to communities' demands, the evidence of issues raised by the citizens, issues resolved, and issues not resolved were discussed. The evidence of issues that were raised by communities was captured at health centres A, C, D and E by the community monitors while carrying out community score cards. At health centre B the issues raised were given to the researcher by communities who took part in individual interviews and in focus group

discussions. Figure 4.2 shows issues that were raised by communities. There were more than 20 issues and the researcher consolidated them to 16 major issues.

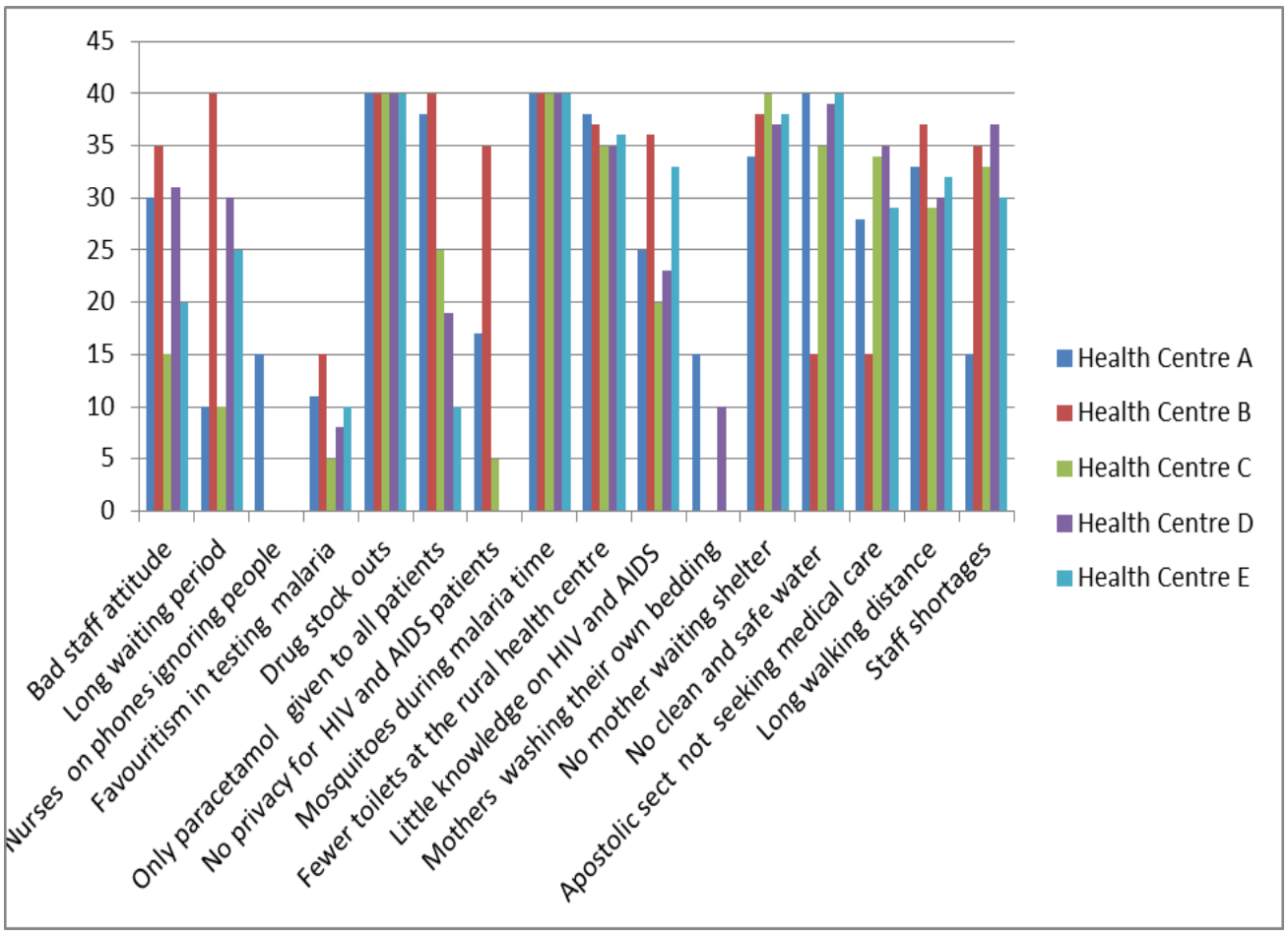

Figure :4. 2 Health issues raised by communities

Common critical issues raised at all the health centres were drug stock outs, mosquitoes during malaria time, walking long distance, staff shortages and bad staff attitude. Brief description of bad or ruthless staff attitude is given below.

6.1.1 Bad staff attitude

Ruthless staff attitude seemed to be prevalent in the district. It tallied with the observations made by the researcher at the district hospital as well. The ruthless staff attitude could be because of work overload that the nurses had since they serviced more than one ward at each health centre. One interviewee indicated that, "*They were afraid of the nurses because they shouted at them and they were not friendly*". It was

difficult for patients to ask for an explanation on the treatment they got from nurses if they were afraid of them. The bad staff attitude was also raised at all the case studies under related literature chapter.

6.1.2 Nurses concentrating on phones

Nurses concentrating on their phones was another issue that was raised by communities. Interviewees complained that some nurses ignored patients while they were using their phones. The nurses paid too much attention to their phones while neglecting patients. This was against their mandate. A district health executive member indicated that he was aware of this problem. He said, "*Because of the social media many nurses were tempted to spend more time on their phones while forgetting their critical role of treating the patients*". Another interviewee said, "*Unotosvika pachipatara vana mbuya wese vari pamafoni awo havatombocheuke kuti papinda munhu*" (You get into the clinic, but the nurses do not even notice that there is someone who got it while on their phones).

6.1.3 Not all patients are tested for malaria

Not all patients were tested for malaria was also an issue raised by communities. One community representative indicated that some patients complained that nurses did not test them for malaria. The nurses gave excuses that malaria kits were out of stock. A community member highlighted that immediately after that giving an excuse to one patient the same nurse tested malaria to their favourite patients. This favouritism was a bad attitude in the sense that nurses were denying all the patients right to be tested malaria while living in a malaria prone area.

6.1.4 Long waiting period

Another issue raised was long waiting period before being served at health centres. One nurse in charge indicated that serving big catchment areas contributed to long

waiting periods at the health centre. About 80% of the communities who took part in answering open-ended questionnaires indicated that they walked about 10 kilometres to the health centres. That means they arrived at health centres when they were already tired. The researcher also noticed long waiting periods at the District Hospital, especially at maternity sections because many women preferred to give birth at a hospital where there were doctors. One interviewee noted that some people who stayed about 15 kilometres from the health centre opted to use the witch doctors who were close by than walking long distances to health centres where they would wait for a long time before being served.

6.1.5 Lack of infrastructure

A community monitor pointed out that the infrastructures in the district were too small for the population that is why patients walked long distances to health centres. At the district level, the district health executive member indicated that female, male and maternity wards were always full. After giving normal birth, mothers were discharged the same day to pave way for other waiting mothers. The district health executive member went on to say, "*We are no longer keeping mothers in the ward for us to examine them and the baby for two days as prescribed in our policies because we are oversubscribed*". The researcher also observed about 50 mothers who were waiting to give birth who were seated outside under a tree because the maternity ward was full. At health centres B and D the patients complained that they were few toilets and there were no sheds for HIV and AIDS patients who came to collect their drugs. At health centres B and E there were no mother waiting shelters. The national policy director agreed with the patients he stated that, "*That the government is behind in building new health centres, due to financial constraints*".

6.1.6 Staff shortages

Staff shortages were an issue given by communities. Shortage of nurses was a challenge that was identified mainly at health centres B and D. The district health executivemember pointed out that both health centres had three nurses so if the other one was on leave and another one attended district meetings there was only one nurse at the health centre to attend to patients. During the data generating process, the researcher could not interview the Nurse-In-Charge at health centre D the first day she visited because there was only one nurse who was attending all patients. It was further worsened that it was a Monday which was the busiest day at the health centre. The policy director explained that, "*The staff shortages were necessitated by the freeze of position for civil servants that was passed by the government in 2014*". The MoHCC must get the Treasury consent for it to hire or replace a vacant position. An implementing officer from one civil society organisation also indicated that, "*The health establishments in the Ministry of Health and Child Care were done before independence when there were fewer people and less disease burden which was different with the current population which significantly increased and the disease burden*".

The policy director further indicated that the World Health Organisation in collaboration with the MoHCC conducted a workload indicator study that showed that the sector was short staffed with more than 600 positions nationwide. This situation affected the way the nurses treated patients at the health centres. When there were a lot of people as witnessed by the researcher at health centre D it meant the nurse could not spend quality time with one patient. Thus, affecting real dialogue that results in compromised health service delivery. However, at health centre A additional primary care nurses were assigned in 2016 so they had five nurses.

In addition, there were no general hand personnel who did the laundry for delivered mothers. PG-A complained that there were no general hand workers who did the laundry after the mothers gave birth. The patient who gave birth or the people who had accompanied the patients were the ones who washed the linen used during labour or child birth. The researcher had a conversation with a mother who was washing the linen at health centre D. She said, "*My daughter gave birth, but there is no one here at the health centre who is supposed to wash linen that was used when she was giving birth that is why I am doing the laundry, if I was not around, she was going to do it herself*". This forced women to do extra work at the health centres after giving birth.

6.1.7 Drug stock outs

The major issue that was talked about by 98% of community members who were individually interviewed, and participants of focus group discussions was drug stock outs. Drug stock outs is unavailability of adequate drugs at health centres. A community member pointed out that the drug stock outs were leading to high out of pocket expenses for the patients and community at large. Out of pocket expenses are the costs that were incurred by communities besides consultation fees, these include money to buy drugs and other medical requirements and transport costs to and from the pharmacies. Implementing officer from a civil society organisation supported this, he indicated that, "*The health centres and the district hospital ran out of drugs despite them ordering the drugs from Natpharm*".

Another programme officer clarified that Natpharm was a parastatal responsible for distributing drugs to health centres, delayed distributing the medicines to the centres. He also indicated that the parastatal was failing to supply the required drugs needed by the health centres. The district health executives (DHEs) and nurses in charge(NICs) indicated that they sent their requests to Natpharm on time however, the drugs were not delivered on time. The Community health director highlighted that the delay was caused by some factors that included lack of foreign currency by the

government to buy the drugs outside the country and lack of operational budget to stock adequate drugs required in the sector. He added that the government was relying on donors to supply the drug which was not sustainable. The global economic recession affected donors who were reducing their funding to the country. He further said, "*The main contributors who were supporting the drugs were the United States government and the British government who had since cut down their budgets due to recession and change of foreign policy from their countries*".

One councillor thought the drug stock outs were influenced by the user fee policy that made it mandatory for the patients to access free services at the health centres and at hospitals. An interviewee highlighted that, before the user fee policy drugs were usually available at their health centre pharmacy. A community literacy facilitator thought that drug stock outs were a result of non-availability of money to buy the drugs at health centre level. This notion could be an indication of lack of adequate consultation of citizens on the enactment of user fee policy.

Constant drug stock outs were leading communities to ask questions on whether free health services were free because the major element of services was not given. A programme officer from a CSO highlighted that, "*Patients were complaining that they were only receiving paracetamol for all ailments, there were no other drugs that were being administered at the health centres hence, and patients, were losing faith with the health centres*". Figure 4.3 shows that shortages of drugs have been highlighted by almost 99% of participants of the study and the issue was linked to many shortages in Shamva district.

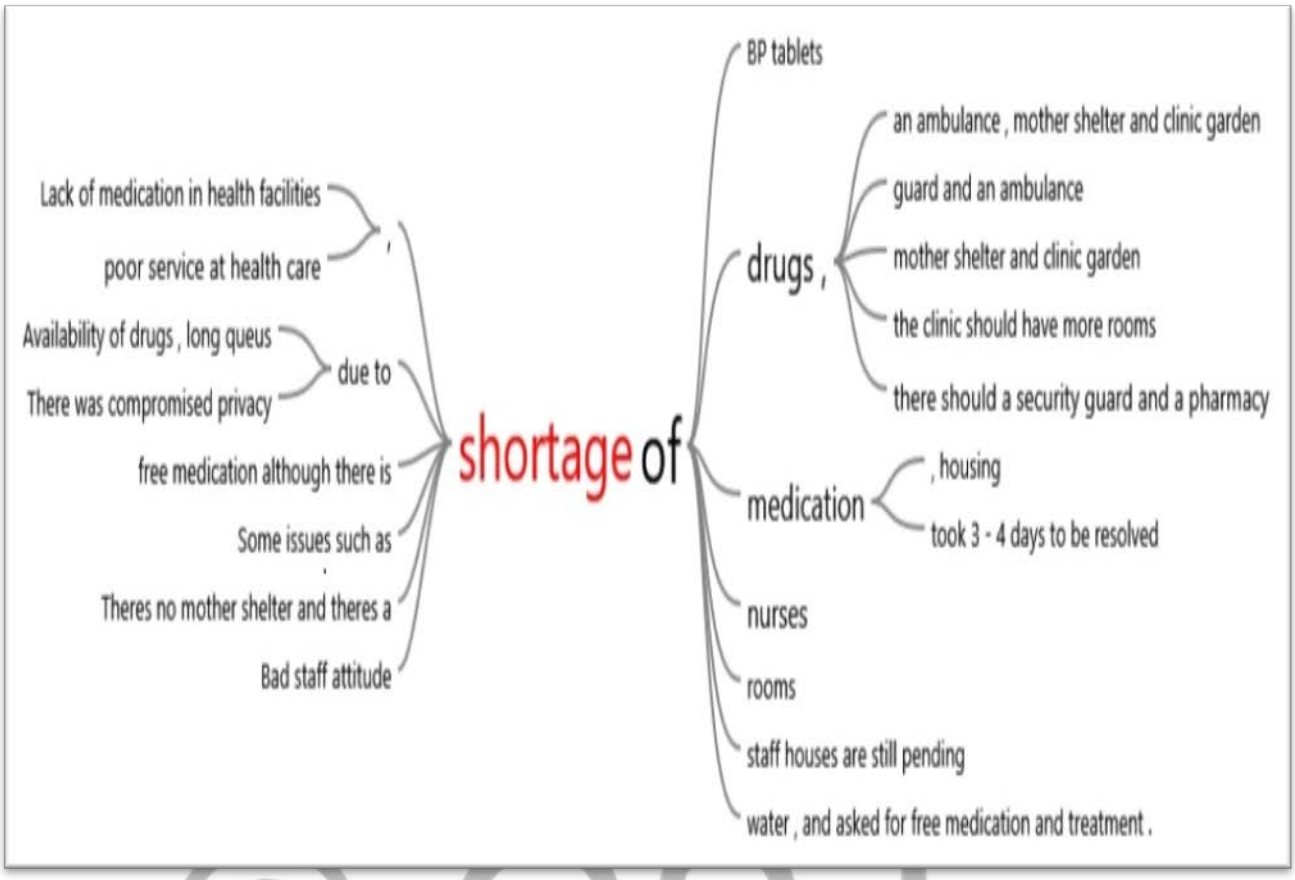

Figure 4. 3: Word tree of shortage of drugs

Another key informant indicated that unavailability of drugs was making many people hesitant to visit the health centres because they knew that they were going to get prescriptions for them to go and buy drugs at Shamva town pharmacies. A programme officer of CSO said that meant communities were failing to buy drugs after getting free consultation.

This information led the researcher to conclude that there were free, but not free services at health centres in Shamva district. The services were referred to as free at policy level while in practice consultation only was free and other related costs were paid for by patients. One key informant agreed with the current researcher that Zimbabwe has good policies on paper that were not implemented well. That meant the

patients in rural areas were not actually getting the free services that were popularised by administrators and politicians.

6.1.8 Religious objectors

The communities highlighted that there were religions such as Vapostori (White garment Church) that did not allow their followers to seek treatment at health centres. One FGD respondent said, "*Tiri kurasikirwa nemadzimai akazvitakura nevana vadiki nekuti havabvumidzwe nechechi yavo kuenda kuchipatara dai vehutano vatibatsirawo ipapo*" (We are losing pregnant mothers and babies because they are not allowed to seek treatment at health centres, we want health officials to help us to resolve this issue). The communities wanted the local leaders and health officials to address this issue to avoid and reduce unnecessary deaths. District health executive member pointed out the issue also and indicated that they were failing to do outreach campaigns that could resolve some of these issues. On the other hand, the VHW model was winning at some areas where they managed to penetrate these religious populations. Table 4.1 shows the issues that were resolved and not resolved by the health officials. Table 4.1 gives a summary of the rate of state responsiveness to the issues that the communities raised.

Table 4.1: Evidence of raised, resolved and unresolved issues

Issues raised by communities by Dec 2017	Resolved Issues by Dec 2017	Unresolved issues as at March 2018
Bad staff attitude,	Resolved to a certain extent during the SCPH program	There is still bad staff attitude towards patients
Long waiting period		Not yet resolved
Nurses concentrating on phones ignoring people	Partially resolved	
Not all patients who wanted to be tested malaria are being tested	Partially resolved when the test kits are available	
Drug stock outs		Not yet fully resolved
Only paracetamol drug was being given to all patients		Not yet resolved
No privacy for HIV and AIDS patients	The patients now have their own shed for collection of tablets	
Mosquitoes during malaria time	Spraying of houses and availability of tablets during malaria prevalent time	
Fewer toilets at the rural health centre	Two more toilets buit at health centre A	Not resolved at other 4 health centres
Little knowledge on HIV and AIDS since the area has high HIV and AIDS prevalence	Resolved , VHWs are spreading the word	
Mothers who have delivered at the centre are washing their own bedding.		It is still an issue at all health centres
No mother waiting shelter at the health centre	Resolved at health centre A,D and E	Still pending although the materials to build are there at health centres C and not yet on raddar for health centre B
No clean and safe water at the health centre	All the health Centres have piped clean water	
Members of the apostolic sect do not seek medical care.	Partially resolved at all the centres	
Long walking distance to the health centres		Not resolved at all health centres
Staff shortages	Partially resolved at all the health centres	

Not all the issues that were raised by community members were resolved at local level and these were referred to the district level.

6.2 Issuesresponded to by health officials

The key informants, focus, individual interviewees and group discussion participants all indicated that some issues were resolved at local level by the community and the health officials. These issues were on ruthless staff attitude, building of HIV and AIDS patients' sheds, supply of clean water, and building of toilets at the health

centres. They also added that there were issues that were partially resolved at some health centres these included the construction of mother waiting shelters and staff shortages.

6.2.1 Ruthless staff attitude

The community monitors and Health centre committees (HCC) members indicated that they had lengthy discussions with the Nurses-In-Charge at the treatment sites for their staff members to handle patients with respect as well as to respect patients' rights. HCC member at health centre A indicated that the staff attitudes changed during the community scorecard programme. Some interviewees pointed out that at health centres A and C the nurses' attitude changed during the community score card programme, but some nurses were reverting to their bad attitude because the community monitors were no longer administering community score cards. Interviewees testified that at health centres D and E the health officials had good attitude and patients were enjoying the outcomes of health official's responsiveness.

However, at health centre B most issues were not resolved because both the citizens and health officials were not taught about patients' charter and service charter in detail as what transpired at the four health centres where the community score card was implemented. One interviewee at health centre B said *"Unototya kuuya kuchipatara nekuti vanaMbuya nana Sekuru wepano vanopopota"*(We hesitate to come to the clinic because the nurses here shout a lot). This was a clear sign that bad staff attitude was not resolved at all at health centre B and was partially resolved at health centre A and health centre C. Not resolving issues raised by communities does

not consider the citizens' rights or views but gives the public administrator the autonomy to act independently without accounting to elected officials.

6.2.2 Availability of safe clean water

Availability of safe clean water was another issue that has been resolved. A member of district health executive indicated that the district steering committee managed to drill boreholes for all health centres by December 2017. All the health centres had access to piped water which is safe, but he acknowledged that it was a big challenge before the borehole drilling. Pregnant mothers testified that they were were no longer bringing water to use at the health centre. One pregnant mother went on to say, "*We used to bring 2 litres of water every time you visit the health centre for treatment because there was no safe water even to use for drinking with drugs*" Another woman also said, " P*ano paitonetsa kugarira kubatsirwa nenhau yekushaikwa kwemvura asi iye zvino hatichazezi kugarira nekuti mvura yawapo pamatepi"* (It was difficult to come and stay at the mother waiting shelter because there was no water but now we are no longer hesitant to come and stay because there is tapped water available). Community sister at district hospital also indicated that nurses who stay at health centres were no longer walking long distances to go and fetch water for their households, it means they were now spending more time at health centres treating patients.

6.2.3 Improvement of health centre infrastructure

Improvement of health centre infrastructure was partially resolved. HCC at health centre A indicated that they managed to build two additional toilets at their health centre in July 2016 through the contributions from communities. At health centres A, D and E the mother waiting shelters were also built in 2017 using resources from the

community and RBF. HCC at health centres A ang B highlighted that they constructed HIV and AIDS patients' waiting sheds at health centres A and B using RBF finances in 2017 also. This improved privacy on how these patients were treated. Their privacy rights were upheld.

6.3 Issues not responded to by health officials

District Medical Officer and CSOs implementing officers indicated that the issues that were not responded to included drug stocks, no mother waiting shelters at health the centres B and E, fewer toilets at the health centres B, C, D and E, ruthless staff attitudes as earlier mentioned and long waiting periods by patients. The HCCs members at health centre D and B highlighted that some issues such as shortage of staff houses were still pending because of lack of enough budgets to embark on building new infrastructure. Lack of enough budget to resolve challenges at health centres was indicated due to low budgets that are allocated to the Ministry of health.

Furthermore, persistence of drug stock outs showed that the dialogues between the communities and service providers were failing to find a solution to this challenge which was not supposed to happen when conducting effective dialogues. During the data generation process all 204 individual interviewees highlighted drug stock out as a perennial issue that was not resolved. This showed that either demand or supply side was not functioning well, hence, compromising the quality of service delivery.

District health executive member indicated that most of the issues raised by the communities were partially resolved because of lack of full autonomy and financial support at the district level. During the district steering committee meeting that the

researcher observed, the government officials who presented at the meeting highlighted that financial constraints was the major hindrance for them to respond to community's demands. This led to inadequate service delivery.

7. Results

The health officials' responsiveness had some positive impact on the quality of health services in Shamva District. The description of the results that emerged are given in the next sub sections.

7.1Provision of free health services

Provision of free health service wasa positive impact that emerged from the study. Due to complaints of high health fees from communities the state responded by offering free access to primary health care. District health executive member indicated at all at rural health centres the patients accessed free health services. CSO programme officer point out that, "*They believed that the social accountability programmes that empowered communities with rights education led to the enforcement of user fee policy that enabled rural people to have access to free primary health care*". Another interviewee also indicated that women were getting family planning contraceptives for free. All the patients at the rural health centres got free services, although inaccessibility of drugs was still a challenge. This made this researcher to be hesitant to call this free health services.

7.2 Health centres improved infrastructure

State responsiveness led to some improved infrastructure at health centres. All the HCCs indicated that that the health centres used some RBF earnings and community's

contributions to renovate the existing structures and building of new infrastructure. The communities had a say in how the income was used and this proffered good relationship between the communities and health officials. A member of district health executive said, "*The construction and refurbishment of the health centres translated to clean health centres, increase in clinic deliveries since many pregnant mothers were using mother waiting shelters*".

7.3 Improved health services

The health official's responsiveness to communities' issues such as decentralisation of ante natal services and voluntary HIV testing led to improved health services offered in the district. Nurse in charge at health centre C indicated that, "*Our responsiveness led to early bookings for pregnant mothers, increased number of people tested for HIV, especially males, which was a breakthrough because there were less men who were willing to be tested before*". Communities acknowledged that there was polite and treatment of patients by health care workers and citizens felt empowered because they recognized practical results in improved provision of public goods.

District medical officer pointed out that prevention of malaria and diarrhoea was prevalent in the district because, the village health workers (VHWs)were testing malaria in villages and giving the malaria tablets to patients. VHW at health centre E acknowledged that by saying, "*Our door to door visits broke a barrier for some apostolic sect people who are now going to the health centres with their children for immunisation and growth monitoring which was unheard of*".

8. Challenges

There were challenges that were identified during the study that hindered the state responsiveness in Shamva district. These are given in next sub section.

8.1 Lack of decentralisation

The decentralised health structures were in place, but they lacked full autonomy and budget to implement their programmes hence hindering the health official's responsiveness to communities' demands. The district health executive (DHE) members indicated that they relied on the centre for financial resources and authority to make some decisions. The DHE member went on to say, "*it is very difficult to operate at district level while waiting for decisions to be made at national level*". This was hampering their immediate response to quality service demands needed by communities.

8.2 Lack of funding

Lack of funding was another challenge that hampered the responsiveness of the health officials. The director of planning highlighted that, "*Late and non-disbursements of national budget allocations to the line ministries affected institutionalisation of responsiveness plans that wererelevant and important to the district*". A member of DHE pointed out that line ministries were failing to build new health centres in areas where patients were walking more than 10 kilometrers to the health centres. This complaint came out at all the health centres since they served two (2) or more wards. The district medical officer indicated that short falls of government's budget allocations affected the administration of the hospital resulting in poor health service delivery because there would be less equipment to use. He went on to say, "*Some Line Ministries that were supposed to pay for bills of war veterans, elderly people,*

workers injured at work did not own up to their debts, creating a budget deficit on the part of the hospital administration budget".

8.3 Conflict brought by political interference

The national programme manager of one CSO highlighted that Mashonaland Central Province was known for political patronage and had a record of intimidating civil servants towards election period. He further indicated that this compromised the way health officials conduct their duties during the election period. This was supported by one nurse in charge she said, "*We were not free to be engaged in dialogues with communities towards or during election period because the possibilities of being misinterpreted and became political victims were very high*". One CSO officer indicated that despite the calls by the government that civil servants were protected, this was not a reality on the ground, the health workers were targeted by politicians. Health officials' responsiveness during election period was less effective since people were afraid to share their views which can misinterpreted. HCC from health centre E shared the same sentiments saying, "*Political victimisation discouraged open dialogues which were important for SAcc and therefore rating of service provision during election time was viewed more as a witch hunt programme or manipulated as a political campaign gimmick*".

9. Discussion

State responsiveness is an accountability role that the state is expected to perform. In Shamva district communities managed to share their views and raised complaints of poor service delivery to their health officials. The health officials partially responded to the demands because of some constraints such as lack of budget and slow

implementation of decentralisation. The social accountability programmes such as community score card mobilised communities to be able to demand quality services from health officials in an organised way. State responsiveness raises confidence and trust to communities.

10. Conclusions

The conclusions of the study are given in the next sections.

10.1State capacity to respond to citizens' demands

1) The SAcc programmes fostered engagements between the communities' representatives and health officials. Many grievances that were raised by communities were resolved at local level. These included change in staff behaviour and attitude towards patients. The HCCs also encouraged communities to contribute resources that were used to build some waiting shelters for expecting mothers.

2) Issues that were not resolved at health centre level were referred to the district level. Most infrastructure issues such as building of new health centres were not resolved. Lack of finances due to government allocating inadequate budgets to line ministries was the major impediment.

3) Non-responsiveness on infrastructure and increase in health staff demands led community members to doubt the capacity of the state to respond to their demands.

11. Recommendations

The researcher proposes recommendations to health sector stakeholders in Shamva District. These are given below.

I. Resourcing the state responsiveness plans

It is recommended that the government and donors should avail adequate resources such as financial and human resources to enhancestate responsiveness to communities' demands in Shamva district health sector.

II. Full implementation of Decentralisation

It is recommended that the government should implement full decentralisation for Shamva District officials to make decisions that affect them quicker and have fiscal autonomy.

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