POTENCIAR

UKaid
from the British people

Grievance Redress Mechanisms in the Health Sector

February 2023

Table of Contents

1. Executive Summary

Context: This research stemmed from learning and changes that occurred in the intervention strategy and budget of the POTENCIAR programme. In consultations and meetings between the Programme Management Unit (UGP) and various actors operating in this area, POTENCIAR's partners identified — in a participatory and inclusive manner — the issue of grievance redress mechanisms as a problem that they can intervene on within the context of Pro-Accountability Initiatives (PAIs). Taking this perspective, POTENCIAR conceived the present research on mechanisms for complaining about and denouncing poor standards in maternity services.

Objectives: The objective of this study was to understand the complaints and grievances management system available to users in the health sector. The insights gained from this study will subsequently feed back into revisions to POTENCIAR's theory of change and theory of action. The research included mapping the flow of the complaint channeling process;

identifying the motives, capacities, and opportunities for the health authorities to implement the system of mechanisms for redressing complaints; an analysis of how the perspectives of users are perceived, considered, and rejected by health authorities; and, finally, an analysis of the extent to which existing grievance mechanisms are used, including the opportunities, capacities, and motivations for using them.

Methodology: The study was an action-research-learning collaboration aimed at stimulating the production of evidence about and for action through collective processes, which involve the participation of actors who work directly on the issues in question and encourage collaboration. In terms of data collection, the study combined primary data (using qualitative and quantitative techniques) and secondary data (based on a documentary and literature review, including lessons learned from case studies in South Sudan and Pakistan). POTENCIAR carried out 15 semi-structured in-depth interviews and three focus group discussions with key informants at the health unit level, covering users, providers, managers, and health policy makers. At the health unit level, POTENCIAR also interviewed members of the co-management and humanisation committees. The team used a questionnaire to survey existing grievance redress mechanisms for providers and health authorities, and at the health unit level (10 in Nampula district and 16 in Monapo district). Finally, we undertook non-participant observation at the health unit level and observed the existing grievance redress mechanisms, particularly the User Assistance Office, as well as the complaints and suggestions boxes and complaints books.

Results: The dominant perception about the role of co-management committees is that they serve to monitor the activities of the health unit and the behaviour of health providers and call people to use health services in the health unit. The study found that user health offices only exist in 3 of the 26 health units covered by the study. All health units covered in Monapo district and most in Nampula district indicated that they had a box and a complaints book. However, these mechanisms are unknown to most users, even though they are located in strategic and visible places in the health unit.

We found a mechanism for assessing user satisfaction with the services received (the satisfaction meter) in maternity hospitals and youth-friendly services (SAAJs), in some health centres, in the districts of Monapo and Nampula. Some health units have a satisfaction meter, but people don't use them. With regard to telephone numbers, most health units covered by this study are unaware of the existence of helplines for users or have doubts about their role, possibly because the existing lines are nationwide. Our data indicates that users tend to present their complaints during visits by authorities at higher levels, because they believe this could influence the improvement of health services, and because they lack confidence in existing mechanisms at the health unit level.

Conclusions: This study sought to understand the complaints and grievances management system of health centre users, through an analysis of the complaints circuit from the moment they are made by users. However, this was not possible, as there is no formally designed and executed circuit articulated with other levels of the system. On the contrary, we identified a set of informal practices — similar to each other — that aim, above all, to protect the health unit

from “external attacks” and expose those who complain. Authorities and health providers are aware that users do not feel comfortable making a complaint to health providers in person, and both users and providers recognize the importance and need for functional and reliable grievance redress mechanisms. We managed, however, to capture the extent to which users use the existing grievance redress mechanisms; to understand how user complaints and grievances are inserted in the SNS (National Health System); to map the capabilities, motivations, and opportunities for health authorities to identify and manage complaints from users; and also to analyse how users' perspectives are perceived, considered, and rejected by health authorities.

Recommendations: We recommend supporting the government in clarifying the responsibilities of the different departments in managing user complaints, clarifying the user complaints management circuit, and planning the production of collection instruments on the number and type of complaints received and resolved. We also recommend promoting the exchange of experiences and mutual learning at local, national, and international levels; establishing a system for managing grievance redress mechanisms; supporting the training of actors in the health sector on the management of complaints; promoting greater interaction between actors within the health sector; and developing a sanctions/rewards system to incentivise accountability. Finally, we recommend strengthening grievance mechanisms and taking advantage of the local context to improve the promotion and implementation of these mechanisms.

2. Introduction

POTENCIAR is a programme that addresses accountability and governance issues undermining the delivery of quality basic services in Mozambique. POTENCIAR aims to contribute to individual, collective, and institutional changes that increase government transparency, accountability, and responsiveness through better resource allocation, more inclusive planning, and decision-making.

Collaborating with various actors — including citizens, civil society, communities, service users and providers, and local, provincial, and national government authorities — POTENCIAR supports Pro-Accountability Initiatives (PAIs), guided by specific issues/problems, aimed at strengthening civic engagement and supporting coalitions of actors to improve the provision and quality of basic services. Three PAIs of the programme focus on the health sector, particularly the maternal and child health sub-service, one of which focuses on the issue of grievance redress mechanisms in delivery services.

Research has been one of the pillars of POTENCIAR since the beginning of its implementation, to ensure the design, implementation and monitoring of programme interventions are evidence-based. This area of work is guided by the Programme's Analytical Work Strategy and is part of the Monitoring, Research, Evidence, Accountability, and Learning system.

This research stems from the lessons learned and changes that have taken place in the intervention strategy and budget of the programme. Its starting point is the seminar on theory of action held with actors from the health sector in Nampula province and Maputo City on the 8th of September 2022. In consultations and meetings between the POTENCIAR Programme Management Unit (PMU) and various actors operating in this area, we verified that while the main complaints and claims of citizens have been mapped within the scope of various monitoring programmes for the provision of health services,[1] and there is already some

[1] Yao, J., Agadjanian, V. (2018), "Bypassing health facilities in rural Mozambique: spatial, institutional, and individual determinants", *BMC Health Serv Res* (**18**) 1006. https://doi.org/10.1186/s12913-018-3834-y accessed on 29.03.21; Galle, A., Manaharlal, H., Griffin, S. et al. (2020), "A qualitative study on midwives' identity and perspectives on the occurrence of disrespect and abuse in Maputo city", *BMC Pregnancy Childbirth* **20**, 629. https://doi.org/10.1186/s12884-020-03320-0 accessed on 29.03.21; Bomfim, E., Mupueleque, M. A., Dos Santos, D., Abdirazak, A., Bernardo, R. A., Zakus, D., Pires, P., Siemens, R., & Belo, C. F. (2020), "Quality assessment in primary health care: Adolescent and Youth Friendly Service, a Mozambican case study", *The Pan African medical journal, 37*, 1. https://doi.org/10.11604/pamj.2020.37.1.22983 accessed on 29.03.21; Galle, A., Manaharlal, H., Cumbane, E. et al (2019), "Disrespect and abuse during facility-based childbirth in southern Mozambique: a cross-sectional study", BMC Pregnancy Childbirth **19**, 369. https://doi.org/10.1186/s12884-019-2532-z accessed on 29.03.21; Wagenaar, B. et al. (2016), "Wait and consult times for primary healthcare services in

knowledge about citizens' perceptions of existing grievance mechanisms (particularly on the complaints box), little is known about the existing complaints system in the health sector and how it can be strengthened and influenced to better respond to the demands of citizens.

Particularly important was the fact that POTENCIAR partners identified grievance redress mechanisms as a problem that they can intervene on within the scope of PAIs. With this in mind, POTENCIAR conceived the present research on the mechanisms for reporting and complaining about poor care in maternity services.

2.1 Objectives

This study aims to understand the complaints and grievance management system in the health sector, through an analysis of the complaints circuit from the moment service users make complaints.

Specific objectives:

- ✓ Map the flow of the process for channelling complaints from users of maternity services and how this process fits into the National Health System.
- ✓ Understand the motivations, capacities, and opportunities for health authorities to implement the complaints management system.
- ✓ Analyse how users' perspectives are perceived, considered, and rejected by health authorities — at the level of health units, District Services for Health, Women, Social Action (SDSMAS — *Serviço Distrital de Saúde Mulher e Acção Social*), Provincial Health Division (DPS — *Direcção Provincial de Saúde*), Provincial Health Service (SPS — *Servico Provincial de Saúde)* and Ministry of Health (MISAU — *Ministerio de Saúde*).
- ✓ Capture the extent to which users use existing grievance redress mechanisms, including users' motivations, abilities, and opportunities to do so.

2.2 Analytical framework

In line with the Actor Based Change Framework[2,3] that guides POTENCIAR's Theory of Change and Theory of Action, we seek to explore the capacities, motivations, and opportunities for

central Mozambique: a time-motion study", Global Health Action, 9:1, 10.3402/gha.v9.31980 accessed on 29.03.21.

[2] Koleros, A., Mulkerne, S., Oldenbeuving, M., & Stein, D. (2020). The Actor-Based Change Framework: A Pragmatic Approach to Developing Program Theory for Interventions in Complex Systems. American Journal of Evaluation, 41(1), 34–53. https://doi.org/10.1177/1098214018786462

[3] The ABC framework is an approach that focuses on the actors within a system as a pragmatic way of modeling how change happens in situations of complexity. This framework allows practitioners to effectively develop an evaluable program theory for interventions aimed at facilitating change in complex systems.

health authorities (including service providers) to respond to complaints from citizens and users, and for the latter to demand a response and responsiveness from the system.

the ABC framework is well-equipped to examine the complex environment in which the POTENCIAR programme is implemented, as the framework is based on the premise that problems or issues arise from interactions between different actors operating within a complex system. Development problems are therefore macro-level outcomes of multiple interactions between the actors in this system. If we are to address the development problem, the actors associated with the problem must be identified and the relationship with each other and with their environment must be studied. In addition, both the institutional arrangements that define the (in)formal rules of the game, and the behavioural conditions that guide the practices and relationships between them must be taken into account.[4]

We believe that a better understanding of the determinants of behaviour and interactions between actors makes it possible to identify both the conditions that must be changed, as well as opportunities and entry points for interventions to change these determinants. and, in this way, contribute to institutional and systemic change.

Analytically, we are also inspired by a specific framework to analyse the dynamics of complaints and their resolution, proposed by Pande and Hossain (2022). Drawing on a literature review on grievance redress mechanisms, Pande and Hossain identify three main elements that allow complaints, facilitate resolution, and improve policy design and implementation. These are: citizens' ability to complain, the state's ability to respond, and proactive transparency[5]. We provide more details on this analytical framework in Section 2 (the national guiding framework).

2.3 Methodology

This was a collaborative action-learning research exercise. It aimed to stimulate the production of evidence about and for action through collective processes, which involve the participation of actors who work directly on the issues at hand and foster collaboration (McGill and Beaty 1985). Action-learning research is aligned with the emerging learning approach of the POTENTIAR programme — an approach which privileges the exploration and continuous analysis of what emerges in any given action arena, through intentional and iterative testing, via learning processes.

Action-learning research is also appropriate due to its applied and operational nature and the dialectical relationship between research, action/intervention, and learning, which makes it possible to act while researching, because the focus of research is precisely on action. The

[4] Sustained behavioural change requires three necessary and sufficient conditions to be met: capability, opportunity, and motivation.

[5] Proactive transparency is when information is immediately made public at the initiative of public bodies, without a request being filed by information seekers.

distinction that Coghlan and Coughlan (2010: 193) make between action learning and action learning research is relevant to this study:

"Action learning research is a related but different form of activity from action learning. The key to understanding the difference lies in the distinction between learning and actionable knowledge (Argyris 1993). When engaging in action learning, two commitments are relevant: commitment to action and commitment to learning (Marquardt 2004). There is no expectation, however, that, in carrying out these commitments, there will be a redistribution of this learning beyond the group. Following this logic, then, action learning research requires a new, related, commitment – a commitment to add to the available actionable knowledge pool."

It is important to emphasise, as Coghlan and Coughlan (2010: 196) argue, that collaborative action learning research:

"Does not impose specialist knowledge, but rather creates collaborative environments where research experts and local actors share and work with different types of knowledge and share the resulting intellectual property. The collaborative process between researchers and local actors involves asking shared questions, collecting data, analysing data and testing/adapting action (...) If we are all involved in action, then we are all involved in learning, and we can be involved in adding to the body of knowledge for application by others."

In line with POTENCIAR's collaborative spirit, this methodology contributed to the strengthening of collaboration between organisations located at various levels (district, provincial, and national) with experience in the area.[6] POTENCIAR actively involved partner organisations in the design and implementation of the research, including the collection, interpretation, and systematisation of data. By doing so, we fostered a space for learning and action around grievance redress mechanisms in maternity services,[7] and for the appropriation of research results by these organisations — so increasing their legitimacy to lead advocacy actions, as they are the primary claimants of the intended changes/reforms.

The following organisations were directly involved in this research: Rede HOPEM, Niiwanane, and Watana (based in Nampula); and CIP, Saber Nascer, Namati, and Observatório do Cidadão para a Saúde (based in Maputo). While organisations based in Nampula participated throughout the process, as Nampula is the focus province of POTENCIAR, they were responsible for administering the questionnaire (REDE HOPEM and Watana in Monapo district and Niiwanane in Nampula district).

[6] POTENCIAR Programme (2022), Annual Report - Year 1, Maputo.

[7] Although the focus of the study was on grievance redress mechanisms within maternity services, the grievance redress mechanisms identified are applicable throughout the health sector.

Photo 1: Reflection session with local partners at the end of the pilot in Nampula city, 18 February 2021

Partner organisations Watana, Niwanane, and Rede Hopem took part in the preparation of the study, specifically in 5 discussion sessions — two face-to-face and three online via Microsoft Teams. The online sessions discussed the terms of reference, induction, and socialisation about the nature and objectives of the research and the roles of each research participant. The face-to-face sessions enabled practical tests, training, and simulation or testing of the data collection instruments in the health units, for possible tests and changes. Testing the surveys made it possible to measure the average survey length per respondent, as well as to identify measures to mitigate possible risks resulting from the surveys. Maputo-based organisations also took part, but only in the design of the research instruments and in the interviews themselves.

At the beginning of the fieldwork, we ran a pilot to test the interview guides and questionnaires. This included two work sessions on the application of the questionnaire — one before and one at the end of the pilot. The second session (see Photo 1) was to identify any necessary changes to the script, discuss the profile of the questioners, and analyse the emerging results of the questionnaires and interviewees carried out during the pilot.

Data collection instruments

Data collection for the study combined primary data (using qualitative and quantitative techniques) and secondary data (based on a document and literature review).

We conducted in-depth semi-structured interviews with key informants at the level of the health unit, SDSMAS, DPS, SPS — covering users, providers, managers, and health policy makers. At the health unit level, we interviewed members of the co-management and humanisation committees.

Interviews explored these people's perceptions of grievance redress mechanisms and their resolution cycle — as well as how to strengthen their capacities, motivations, and opportunities for resolving user complaints and grievances and strengthening the effectiveness of existing

mechanisms. We conducted a total of 15 in-depth semi-structured interviews and 3 focus group discussions.

We used a questionnaire to survey the existing grievance redress mechanisms used to seek redress from health providers and health. We used the same questionnaire at health unit level to find out the extent to which these are available and how they work to provide services as close as possible to citizens. The data available to us indicated that there were about 242 health units in Nampula province — 25 of them in Nampula district and 17 in Monapo district. All health units in Monapo district had maternity services, while in Nampula district only 13 had maternity services.[8]

We also distributed the questionnaire at the level of the SDSMAS, DPS, and SPS to:

i) Understand the complaint circuit and the role of each of these levels in a complaint's resolution and/or referral to other levels.
ii) Identify which specific mechanisms exist at each of these levels, particularly if there are mechanisms that users can activate directly, if they do not find an answer at the health unit level or previous level. In total, 26 questionnaires were applied to health units — 10 in Nampula and 16 in Monapo. Health units in the sample were selected based on:
    a. The presence of a maternity ward
    b. The presence of co-management committees
    c. The presence of a user office
    d. Established grievance mechanisms such as a satisfaction meter or a complaints box/book, to ask users if they were aware of grievance redress mechanisms.

During data collection, POTENCIAR's partners raised the issue of the inaccessibility constraining the selection of some health units — such as the health centre in Namiconha in Nampula district, the health centre in Ituculo in Monapo, and other centres in Monapo. Cyclones have destroyed bridges and roads, affecting access to some health units. Despite this limitation, the team was still able to interview respondents in most health centres in each district and obtain geographically diverse perspectives.

Finally, we did non-participant observation at the health unit level and observed the existing grievance redress mechanisms, particularly the User Assistance Office, as well as the complaints and suggestions boxes (as illustrated in photos in Section 3.4) and complaints books. Our goal was to observe the conditions of the grievance redress mechanisms in all the health units where we distributed the questionnaire.

[8] This data was presented by the Provincial Director of Health of Nampula province during the presentation seminar of the POTENTIAR Programme, held on 2 June 2021 in Nampula City.

2.4 Report structure

This report is organised into six parts. In Section 3 we present the national guidance framework for grievance redress mechanisms, highlighting the relevant documents and what they say about them, as well as the roles and responsibilities of different departments at the level of Mozambique's Ministry of Health (MISAU). Section 4 looks at mechanisms available at the health unit level in terms of the grievance redress mechanisms identified in the guidance framework. In Section 5 we systematise the capacities, motivations, and opportunities for strengthening grievance redress mechanisms. Section 6 presents a brief conclusion and the main recommendations.

3. Grievance Redress Mechanisms: Lessons from other countries and the literature

'To complain is an act of citizenship … Through these institutionalized acts, citizens call on the authority of the state at the same time that they challenge the state in light of perceived rights violations or deficiencies in service provision.'

(Kruks-Wisner Citation, 2021)

This short review summarises the evidence on the implementation of grievance redress mechanisms in the Global South. It draws upon two recent literature reviews: The first review was supported by the Action for Empowerment and Accountability (A4EA) programme at the Institute of Development Studies and by the Open Government Partnership (Pande and Hossain, 2022; Hossain et al, 2023). The second unpublished review was undertaken to support the design of a GRM for the World Bank funded Provision of Essential Health Services Project in South Sudan.

This review begins by outlining a framework for understanding the scope of initiatives that are referred to as GRMs before narrowing to focus on subset. It then overviews what the literature suggests supports effective GRMs and what prevents them from achieving their aims. The review ends with gaps in the literature and pressing questions for researchers.

Although GRMs are often categorized into three common types - (a) within government or administrative; (b) independent redress institutions such as ombuds offices; and (c) legal redress through courts – the review focuses on mechanisms that exist within governments or administrative GRMs. It also confines itself to GRMs in implemented in the Global South.

What are GRMs?

GRMs are often associated with the act of citizens complaining about the poor provision of a service, public good or duty. For example, citizens may take issue with the way they receive medicine in a health facility, the state of roads in a neighbourhood or the disinterest of a policeman in protecting particular groups. However, GRMs do more than give citizens opportunities to complain. In addition, they provide systematised processes for resolving complaints. This may be done immediately by righting a wrong, communicating what actions

will be taken in the future or explaining why something cannot be resolved to the citizens satisfaction due to wider circumstances beyond the control of those receiving the complaint.

This process is often referred to as 'closing the loop'. It supposes that GRMs consist of two-way interactions between citizens and duty bearers, and that a resolution of raised issues will be arrived at or information as to why it can't be imparted. This distinguishes GRMs from other types of citizen voice raising or action that do not necessarily entail a response, such as providing feedback, advocacy or protesting. Indeed, GRMs require duty bearers, such as frontline service providers, their managers in ministries or the politicians that govern them, to respond. This is why GRMs often draw upon policies or laws that establish principles for citizens to raise complaints and authorities to respond.

In the development literature, GRMs – such as complaints boxes, help desks, community forums and call centres – are often seen as tools of social accountability initiatives. Social Accountability (SA) is concerned with empowering people to raise their voices, with the goal of realising their rights, eliciting responsive governance, improving service delivery, and state-society relations. Much of the literature suggests that with better information, and regular and equitable opportunities to engage duty bearers, people can raise demands, co-produce services and, in some cases, select those that govern them based on their performance (WB, 2003; Fox, 2015). Some commentators, therefore, argue that social accountability is a fundamental component of democratic deepening and widening.

GRMs are also increasingly recommended as part of Accountability to Affected Populations (APP) initiatives in humanitarian settings. AAP is defined as 'an active commitment by humanitarian actors to use power responsibly by taking account of, giving account to, and being held to account by the people they seek to assist (ISAC, 2011).' The Transformative Agenda, the World Humanitarian Summit and the Grand Bargain's 'participation revolution' arguably gave AAP its 'moment' (Chalet and Sattler, 2019). These agenda setting moments demonstrated the humanitarian sector's commitment to enabling programmes' beneficiaries to be heard and responded to. GRMs in humanitarian settings also help to monitor projects' progress and to show host governments and donors that implementers are learning from feedback.

In recent years, many governments in the global south have implemented GRMs to monitor and improve the provision of services, with some professing the goal of strengthening citizen-state relations. This is in no small part due to spread of principles espoused by proponents of New Public Management, transparency and accountability agendas, and the use of data to effectively govern. Hossain and colleagues (2023) point out that this has paradoxically occurred at the same time as the space for other types of civic action has been closing. This raises the spectre that GRMs may be used to spot and quell dissent by regimes more interested in retaining control than addressing grievances.

What supports effective GRMs?

Whatever the motivations for their implementation, GRMs have garnered attention from researchers excited about their potential to change power relations by making governance

more efficient, equitable and inclusive. This section turns to what the literature suggests about the conditions under which they are effective.

Most of the literature on GRMs in descriptive in nature, with little information on how collected complaints are used, nor the impacts and outcomes of responses to them. Furthermore, it tends to be in donor funded project documents rather than governmental reports or academic studies. It is also from the last 2 decades. Hossain and colleagues (2023), therefore, describe the evidence on whether and how formal GRMs work as 'thin'. Similarly, Metcalfe-Hough and colleagues (2019) conclude that it is difficult to know whether GRMs are contributing to commitments made by humanitarians.

GRMs embedded in specific services or projects can be good at spotting and solving technical problems. These types of GRMs can help managers and service providers to spot recurring implementation or technical issues, especially if they are used en masse by citizens and issues are not about the design of the initiative or policies underpinning it.

GRMs that are staffed by and linked to community members and existing community organizations can trust. This suggests that, where possible, GRMs should seek to employ local community members or be integrated within existing structures, such as civil society organizations and functioning service users' groups. This may require training them to understand the purpose and operation of new GRMs.

GRMs can benefit from regular informal contact between citizens and staff. Although ideally systematising the process of complaint raise, collection and handling, GRMs often also benefit from informal contacts between focal points, citizens and their representative bodies. This can build trust in the GRM and allow for the flow of information, spotting of issues and, in some cases, the safe delivery of sensitive complaints.

Expectation setting as to the GRM's purpose among citizens is crucial. GRMs often require socialisation among community members that would otherwise be unaware of their existence or purpose, and that may actively distrust them. This is particularly important in places where there are not strong cultures of complaining or where complaints tend to be made through representatives rather than by individuals.

GRMs require multiple routes for raising complaints. In some contexts, citizens do not have the capacity or means of lodging complaints through common methods such as writing, telephone helplines or internet platforms. Furthermore, they may actively fear face-to-face meetings with service providers or users' committees made up of local authorities. Accordingly, GRMs should offer multiple ways to lodge complaints, ensuring that they are inclusive of a diverse capacities and hidden power structures.

GRMs must offer anonymity and safety. Connected to issue of safety and power inequalities, inclusive GRMs should offer anonymous routes to lodge complaints that do not require the collection of personal information that may identify complainants. They should also consider

safety when registering complaints, handling information and responding to it. This is particularly important in contexts with a weak rule of law of authoritarian governance systems.

GRMs must secure the buy-in of frontline staff. Those on the front line of service delivery are also often responsible for handling complaints. They can perceive GRMs as an extra burden to workloads or as unwanted surveillance mechanisms. Accordingly, it is important that they are properly trained and the benefits of GRMs explained to them. This may include incentives to collect and respond to complaints.

GRMs require escalation mechanisms to resolve policy-level problems. Those that contain mechanisms that allow problems that are unresolvable at local or project-level to be escalated to duty bearers higher up governance hierarchies, such as policy makers and politicians, can go beyond the resolution of implementation and technical issues. Where programmes and governments are responsive and adhere to adaptive management principles, this can result in significant changes of policy that have impacts at scale.

GRMs benefit from support from powerful authorities. The literature suggests that responsive GRMs are often backed by senior duty bearers – including politicians - that have committed to their operation. This can extend to policies and laws that require the establishment of routes for citizens to complain and authorities to respond to them, and that give the latter the 'teeth' to reform or sanction underperforming institutions (Fox, 2015). This suggests that the motivation of those governing GRMs and the projects or services they are attached to is key.

What hinders GRMs Effectiveness?

Ignoring the wider ecosystem. The literature suggests that GRMs should be designed with existing cultures of and community structures for complaint raising, and the capacities and means of citizens, taken into account. They should also be designed to accord with existing governance institutions and policies or laws that support citizen engagement and responsive duty bearers. This requires research on the context and potential users to inform the design of systems. It may also necessitate adjacent initiatives that work on creating an ecosystem conducive to GRMs before mechanism are put in place.

Hidden or perverse motivations of citizens, implementers, and duty bearers. For example, mistrustful or discontent citizens may use GRMs to attack or carry out conflicts with service providers, donors and governments. Existing community or users' groups engaged by GRMs and front-line staff may use the contact they provide with citizens to engage in corruption or to silence citizens by ignoring complaints or threatening those registering them. Implementers, duty bearers and politicians may only be interested in GRMs as box ticking exercises, to monitor service providers or to give the appearance of accountability. At worse, they may use them to identify and quell dissent among citizens.

Failing to close the loop. The literature suggests that GRMs that fail to provide information to citizens on how complaints are being handled risk raising expectations and losing trust. This includes transparently providing information on the overall performance of GRMs alongside

regular communications with individual complainants. This can lead to virtuous cycles in which citizen-state relationships deteriorate.

Conclusion

This summary of the literature on GRMs in the global south has outlined the factors that have been identified as supporting their effectiveness and hindering them. It suggests that GRMs should not be implemented without robust research on and understandings of the wider ecosystems in which they reside, and the motivation of users and duty bearers. However, the review is limited by the lack of data on GRMs outcomes or impacts and remains descriptive in nature.

4. The national guiding framework

In this section we analyse what health sector policies, strategies, and guidelines say about complaints and grievance mechanisms, including monitoring their efficiency (timely responses and conclusions) and effectiveness (satisfaction of users and the community at large).

Guiding documents for the health sector establish a relationship between improving primary health care and valuing all stakeholders, including users, workers, managers, and the community. Specifically, the first strategic objective of the Strategic Plan for the Health Sector (2013-2019, subsequently extended until 2024) refers to the intention to *"improve the quality of the services provided, through the guarantee of humanisation in care based on user-oriented services".* The sector recognises the importance of citizen participation to improve the quality and humanisation of health care and defends the social participation of citizens with a view to improving health services. Citizen participation is seen as a way of exercising social control over health services (MISAU, 2017).

The Organic Statute of the Ministry of Health, approved by Resolution 4/2017,[9] establishes as part of the competencies of MISAU, in the area of primary health care, *"to ensure that primary health care is the entry point into the health system (...) and are organised around people's needs and expectations not on disease (p.58)."* To this end, the sector has established a set of instruments and formal mechanisms aimed at promoting citizen involvement in the management of the health sector. Among them are the National Strategy for Quality Improvement and Humanisation 2017-2023, the National Strategy for the Prevention and Combat of Illicit Collections 2017-2023, the Strategic Plan for Health Inspection 2018-2022, and the Charter of Rights and Duties of the Patient, among others. In particular, the Charter on the Rights and Duties of the Patient, made explicit through Resolution 73/2007 of 18 December 2007, states, in Article 12, that *"the patient has the right for himself or for those representing him (organisations included), to submit suggestions or complaints about health services".*

The Quality Improvement and Humanisation Strategy and the Inspection Strategic Plan are the most explicit guiding documents about the sector's vision regarding the grievance redress mechanisms.

[9] Bulletin of the Republic, Series I, Number 82, of 26 May 2017.

Quality Improvement and Humanisation Strategy

References to grievance redress mechanisms appear in the context of strengthening *"the participation and valorisation of users and the community in improving the quality and humanisation of services and assessment of the quality of care offered in health units"*. Linked to this, it sets out strategies to *"strengthen and expand the mechanisms for presenting and handling user issues"*, namely:

- Make available and publicise the tools for presenting users' questions: Complaints and Suggestions Book and Box; Green Line;[10] designated individuals and processes, etc.
- Create/revitalise user offices
- Train a team of health technicians in the collection/registration and handling of user queries

The strategy also provides for *"quarterly sessions/meetings to listen to the opinion of users and the community on the quality of services and feedback on the results of the handling of complaints"*, as well as *"the dissemination in the health unit (HU) of the rules on free delivery of and payment for services and medicines (including penalties)"* and *"carrying out surveillance actions to identify and deal with illicit charges"*.

The Strategic Plan of the Health Inspection 2018-2022 defines, among others, the *"strengthening of partnerships and relationships with the user, society, MISAU and other actors"* (Strategic Axis C), in order to *"improve the management of the relationship with the users and society in general"* (C.1) and, in this way, *"contribute to the satisfaction of users of health institutions, through the **improvement of the complaints management process**"* (C.1.1). The document defines as an indicator for this objective the ***"percentage of complaints, grievances and petitions investigated, resolved and communicated to users within the pre-established deadlines"***. Annual targets for the period range from 30% in 2018 to 60% in 2022. Among the planned activities (summarised in the table below) are the systematisation and implementation of the complaints management model, but details are not provided on its characteristics or on the complaint resolution lifecycle.

MAIN ACTIVITIES

- Systematise the model for managing complaints, grievances, petitions, and contributions on compliance with the functioning of the National Health System, including its level of service, in accordance with its mandate.
- Implement the complaints, claims, petitions and contributions management model, incorporating the actions in the respective Strategic Plan of the Health Inspection.
- Publicise the grievance redress mechanisms in health institutions through the media.
- Publicise the level of service of the Health Inspectorate in a transparent manner.

Source: Strategic Plan of the Health Inspection 2018-2022, p.76.

[10] Emergency helpline for issues related to health care services in Mozambique.

When read together, the two strategies indicate the close relationship between strengthening the management of user complaints and the humanisation of health care. However, in general, the guiding instruments are vague about the complaints management system — not going beyond the description of the existing mechanisms (especially at the health unit level) and the need to improve the management of complaints. Furthermore, the model for managing complaints, grievances, petitions and user contributions is not clear — nor is the relationship between the various bodies in the sector (directorates, departments, and offices) with powers in the management of complaints (see table below).

For example, the Health Inspectorate identifies itself in its Strategic Plan 2018-2022 as *"(...) a gateway to the system for your concerns, complaints and denunciations"* (p.42). This organic unit of MISAU is responsible for the supervision, inspection, and auditing of the health sector.[11] One of its functions is *"to investigate complaints from the public and users about the functioning of the Ministry, its subordinate and supervised institutions, the National Health Service and private institutions and propose appropriate measures for their correction"*.[12] However, none of the guiding documents, which we consulted when developing the list of institutions working with grievance redress mechanisms in Table 1, explain what the link is (at central level) between other instiutions, i.e. the Inspection Department of Curative and Preventive Care of the Health Inspectorate with the User Satisfaction Department of the Department of Continuous Quality Improvement, or with the Department of Humanisation of Health Care, of the National Directorate of Medical Assistance, or even with the User Support Department and the Co-Management Committees of the Department of Humanisation of Health Care (also of the National Directorate of Medical Assistance).[13]

Table 1 — The relationship between the health sector's various institutions with attributions in the management of complaints

National Health Sector (NHS) institutions	Responsibilities related to grievance redress mechanisms

[11] The Health Inspection is structured by a) Health Care Inspection Department; b) Pharmaceutical Inspection Department: Department of Inspection and Inspection of Supply, Import and Export of Pharmaceutical Products; Department of Inspection and Inspection of Pharmaceutical Industry; c) Inspection Department for Training of Health Professionals: Department of Inspection for Training of Health Professionals and Continuing Training; Academic Administration Office; d) Administrative Inspection Department.

[12] Republic Bulletin, Series I, Number 82, of May 26, 2017, p.509.

[13] The National Strategy for Quality Improvement and Humanisation indicates that "the articulation between the National and Provincial Directorates and Programs with the Central Department of Quality and Humanisation is carried out through "focal points" indicated by the respective National and Provincial Directors. The Focal Points must participate in the processes of discussion, elaboration, and implementation of the work agenda of the Central Department of Quality and Humanisation, and report quarterly on the performance of their programs through reports" (p.16-17).

Primary Health Care Inspection Department, Health Care Inspection Department, Health Inspection	• Investigate complaints from the public related to the service provided to users in institutions in the public and private sectors. • Prepare reports of facts likely to be part of an administrative offence. For crimes of a criminal and civil nature, copies will be extracted and sent to the Public Prosecutor's Office or National Criminal Investigation Service (SERNIC).
Administrative Inspection Division, Administrative Inspection Department[14] of the Health Inspection, within the Nampula Provincial Health Directorate	• Investigate complaints from the public and users about the functioning of the institutions of the Ministry of Health and the National Health Service. • Verify that requests from health personnel and users are answered within the legally established deadlines.
Patient Satisfaction Division, in the Continuous Quality Improvement Department of the Quality Assurance Management Directorate	Control compliance and promote: • Holding of monthly and quarterly consultation meetings with users and workers on the quality of services and feedback on health issues, including the results of complaints handled. • Strengthening and expansion of mechanisms for submitting, collecting, and dealing with users' questions in health units. • Development and implementation of mechanisms to prevent and combat illegal charges. • Development and improvement of the work of user offices as an indispensable tool for the evaluation of the process of Continuous Quality Improvement in Health Units. • Sharing of information regarding the state of opinions of users and the community about the services provided and the corrective measures applied to solve the problems.
Patient Support Department and Co-Management Committees, Department of Humanisation of	• Ensure that users and health professionals are valued. • Ensure the promotion of user health at community level. • Guarantee the process of changing the culture in the service, promoting respect for human dignity. • Ensure the monitoring and evaluation and dissemination of the results of Humanisation.

[14] The Health Care Inspection Department is responsible, among other things, for carrying out ordinary inspections, in accordance with the plan, and extraordinary and occasional inspections (when determined by the hierarchical superior), in the health units of the public and private sectors. This department is structured into a) Primary Health Care Division and b) Curative and Preventive Care Division. Both departments are responsible for "investigating complaints from the public related to the service provided to users in Public and Private Sector institutions" and "drawing up reports of facts likely to be part of the illicit of a clinical or administrative nature." In this study we focus on the Primary Health Care Division.

Health Care[15], National Directorate of Medical Assistance)	• Ensure the functioning of health care co-management and humanisation committees.

Source: Author´s outline of institutions within the framework of the Ministry of Health. https://www.misau.gov.mz/

[15] The Department of Humanisation of Health Care is structured into a) Division for Humanisation of Health Providers and b) Division of User Support and Co-management Committees.

5. Main grievance redress mechanisms described in the NHS's guiding instruments

According to the National Strategy for Quality Improvement and Humanisation, the User Assistance Offices (GAUs — *Gabinetes de Atendimento ao Utente*) — with instruments such as complaints books and boxes, user helplines/Green Line, and social action agents for listening, recording, and forwarding questions and complaints from users — are responsible for managing user complaints. They do so with the direction of the health unit, and in collaboration with community leaders via health committees, co-management committees, and quality and humanisation committees.

The GAUs are managed by the Department of Quality and Humanisation and are expected to exist at provincial, district, and health facility levels. At the health unit level, the GAU is made up of the health unit director (as coordinator and person responsible for the GAU), a social action technician, and a member of the Community Health Committee. Complaints and grievances can be forwarded to the GAU through face-to-face contact, complaints/suggestions book or box or by telephone via the attorney's office line or by contacting the health unit managers (health unit director, clinical director, head nurse, inspector and/or head of the GAU). Complaints are handled at the health unit or are forwarded to higher levels, including the Health Inspectorate.

It was not possible to obtain information on the national coverage of the grievance redress mechanisms or on their level of use (number, type, origin of cases, trends). However, the National Strategy for Quality and Humanisation indicates *"by the end of 2014 about 500 (10%) of health institutions were covered by at least one (1)"* of the mechanisms described above, pointing to the need to *"reactivate and consolidate the functioning of the User's Office at all levels of the SNS"*. Interviews with health authorities in Nampula City and quantitative data collected at health facilities in Nampula and Monapo districts provide an illustration of their coverage (this information is presented in the next section).

Quality and Humanisation Committees

The Quality and Humanisation Committees are a mechanism composed of health workers and managers and community members who work together in the planning, execution, follow-up, and monitoring of activities including analysis and decision-making about the life of the health unit. There are quality and humanisation committees at national, provincial, district, and health unit levels. There is also a National Technical Secretariat, the body that executes the decisions of the National and Support Committees made up of MISAU cooperation and implementation partners.

At the level of the health unit, these committees are called Co-Management, Quality and Humanisation Committees) and their role is *"liaising between the community and the Health Sector, as well as coordinating and supporting the process of implementing quality improvement and humanisation activities within the scope of the Health Units."* Among the specific objectives of the co-management committees related to the complaint mechanisms, although vaguely defined, are:

- Participate in the identification, analysis, and resolution of health unit problems (such as infrastructure maintenance, security, medication control, liaison between the HU and the community, etc.).
- Support in the planning, implementation, and follow-up/monitoring of activities to improve the quality and humanisation of health care in the health unit (e.g., cleaning, organisation of users, management of the satisfaction meter[16] / assessment of user satisfaction, and aspects related to poor service, illicit charges or other defined in partnership).

In addition, the committee members will use a set of tools to monitor the degree of user satisfaction, such as satisfaction meters and questionnaires, to be completed anonymously or with the help of a member of the committee. These tools used both to measure patient satisfaction are both identified within the scope of initiatives to improve maternal and child health, such as Maternity Model.

"The satisfaction meter should be placed in a place where users feel free to leave their opinion. Using the voting process, 3 anonymous cards of different colours (pink/red, yellow and green) must be distributed to users who, at the time of discharge, rated the service received by depositing the corresponding card in the satisfaction meter (pink/red if they did not like the service received, yellow - if they liked it a little, and green, if they liked the service received). It is recommended to open and analyse the satisfaction meter on a monthly basis and to discuss its results within the Co-Management Committee and provide feedback to the communities."

Source: Terms of Reference for the Establishment and Operation of Health Units Co-Management Committees (MISAU, 2012)

[16] A method of measuring user satisfaction using a 'traffic-light' approach to providing feedback, with each of the three colours representing a corresponding level of service experienced.

The GAUs are operationalised in the light of Decree 30/2001 of 15 October which approves the operating rules of the public administration — specifically, the articles on public service and suggestions and complaints. Specifically, article 45 establishes that *"the public administration services are obliged to adopt a book of suggestions and complaints in places where public service is carried out, and its existence must be disclosed to users"* (p.224-7), while articles 46-51 indicate how suggestions and complaints received should be handled, forwarded, inspected, and accounted for, distinguishing the procedure for suggestions (and complaints) delivered locally from those delivered to central level.

This decree establishes a chain of information sharing that goes from the local offices of public administration bodies to the provincial director, permanent secretary, provincial governor, and the Minister of State Administration. The information to be provided includes the measures taken or the proposed measures to be taken. On the other hand, suggestions (and complaints) presented to central bodies and institutions subordinated to them must be reported to the director of the body to take measures and this, in turn, must present a biweekly report to the permanent secretary who, in turn, must send a quarterly report to the minister of state administration who must also periodically submit written information to the Council of Ministers on suggestions and complaints received and dealt with.

Article 49 provides that *"citizens who do not know or cannot write in the official language may use the services of an official or any other person free of charge to formulate their suggestion or complaint in writing"*. Article 50 establishes that *"the inspection services must obligatorily analyse the suggestion and complaint books and verify the measures taken"*. The decree includes a draft for submitting a complaint/suggestion, which requests information about the ministry and body concerned, the name, address, telephone, fax, postal and electronic address of the complainant, the reason for the complaint or suggestion, the date and time, the signature of the complainant and, finally, a note indicating that *"under the terms of the legislation in force, this complaint can be answered within a maximum period of 30 days"* (p.224-13).

6. What mechanisms exist at the level of health units?

In this section we present our findings at the level of health units, based on primary data collected from health authorities, health providers, members of the quality and humanisation co-management committees, and users. The following quote, by the director of the Health Centre in Nampula district, illustrates the existence of a range of grievance redress mechanisms and tools to assess user satisfaction with the care received at the health units:

"As a HU, we are prepared in the following way: the GAU [User Service Office] where the patient can go in any situation. (...) Not all expectant mothers know it because it is far away, because of the place where the GAU is located, it is just an impromptu space. As a HU we put our phone numbers, for any situation so that the patient has no doubts. Fortunately. We have received some calls in case of bad service, delay in service and other situations. We also have the satisfaction meter in the maternity sector and the expectant mothers and women put [their assessment of the service received] on the satisfaction meter. Every month we take out the satisfaction meter and count how many bad ones and how many good ones. Monthly, we take stock of how many complaints, illegal charges [we receive]. HU works with CCQH and day-to-day members who liaise with the community; we meet on the 28th of each month, as long as it doesn't fall on Saturday or Sunday. We also have the first morning consultation, the first consultation in this health unit is a meeting where the patients are, where there is a talk given related to all these issues that we are dealing with. In the morning meetings we let users know about these instruments that exist here. It is in the meetings that we show that we have the numbers." [17]

However, the health centre above is one of the most organised that we found in this study — a fact we believe is related to the importance attributed to these mechanisms by the institution's leadership and the existence of both a GAU (with clear purposes) and a functional co-management committee, with regular monthly meetings, in which complaints received are reported and discussed.

More broadly, the picture was very mixed. **Table 2** below shows the main grievance redress mechanisms identified in health care units that we visited. Of the 16 health centres contacted (16 in Monapo district and 10 in Nampula district), most indicated they had complaint and suggestion boxes (all in Monapo district and six in Nampula district) and quality and humanisation co-management committees (all in Monapo district and nine in Nampula district). All the respondents in the district of Monapo indicated that the telephone contacts of the managers of the health unit are available for users. However, in the district of Nampula it was

[17] Director, Health Centre, Nampula district.

only mentioned in three health units. We also noticed a significant difference regarding the complaint books, with all health units in Monapo district indicating they have this document, while only 3 in the Nampula district did so. The User/Green Line phone numbers were mentioned in only 2 health units in Monapo district. Only three health units in Nampula district and one in Monapo district reported having a User Attention Office (GAU — *Gabinetes de Atendimento ao Utente*). Only two health units in Monapo district and three in Nampula district reported having a satisfaction meter.[18]

Some of the 26 health units reported having only one grievance redress mechanism — usually the co-management committee or the complaints and suggestions box. For example, one of the health units in Nampula district indicated that it only had a complaints and suggestions box and a complaints book; of the 26 health units covered, this was the only one that indicated that it did not have a co-management committee. Another health unit indicated that it only had one co-management committee and that it had been recently created.

Table 2 - Main grievance redress mechanisms identified in health units

MAIN GRIEVANCE REDRESS MECHANISMS IDENTIFIED IN HEALTHCARE UNITS		
Grievance redress mechanisms	**Monapo district**	**Nampula district**
Complaint and suggestion boxes	16	6
Complaint books	16	3
User Line / Green Helpline	2	0
Customer Service Office	1	3
Social Welfare Agents in User Offices	0	1
Co-management Committee for Quality and Humanisation	16	9
Telephone contact of health unit managers	14	3
Satisfaction meter	3	2

Source: Author's own data

[18] The satisfaction meter may exist in more health facilities than indicated, as it was not part of the mechanisms listed in the questionnaire, having been mentioned as part of the question about other mechanisms.

6.1 User Attention Offices (GAUs)

As mentioned in Section 4, all health facilities are expected to have User Attention Offices or GAUs. However, we found that they only exist in three of the 26 health units covered by the study. In one health unit, it is one of the most used mechanisms, along with the co-management committees. In another health unit, the respondents had the impression that the GAU *"was in a state of abandonment".* They stated that *"the fact that the person in charge was on vacation at the moment and that the person inquired knew very little did not allow us to adequately capture the level operation of this mechanism"*. Overall, the survey and interviews indicated that GAUs and its purpose are little known by health providers in health units where it does not exist.

Where GAUs exist, respondents mentioned that they serve to *"inform patients about their rights",* and that *"users lodge their complaints in relation to the provision of services offered by the health unit".* In a health unit with a GAU, we noticed some confusion between the GAU and what was called *"social action"*. When asked what grievance redress mechanisms existed in her health unit, one respondent replied that the GAU exists, but it was not used, and that people only used *"social action"*. When asked what the patient should do when he/she has a complaint or complaint about the services he/she has received, the respondent replied that *"he/she should go to the Social Action Office and expose the case"*, indicating that the GAU *"serves to lead users to the social action office".* This confusion may be because GAU has a social action agent.

At another health centre with a GAU, a staff member responsible for nurses mentioned, during an interview, receiving *"informal complaints"* and that the *"GAU responds when we cannot do [answer] in an informal way".* In the same health centre, most of the users interviewed said they did not know the GAU, while the user who did know about it indicated that they did not trust this mechanism because it is managed by health providers who tend to defend their colleagues. The director of a health centre without a GAU indicated that this mechanism could help improve the capacity to manage and respond to complaints from users, but that it was important that this *"not be in the [health] centre in order to create privacy and trust for those who are going to report, as not everyone wants to be exposed at the time of reporting".*

6.2 Quality and Humanisation Co-Management Committees

"A user may be afraid to write in the complaints book. If you are an informed person who knows the health unit, you can go to the co-management committee or the health unit management. Because there is always a member of the co-management committee during the day, and he is an easier person to approach." [19]

"I have been here for 7 years, in that period no one has ever come to file a complaint. I believe that users are more connected to the co-management committee, with us they cannot open up. Maybe they chose that way, maybe because they are the leaders of the neighborhoods." [20]

Health authorities (district and provincial levels) and health providers (health unit level) identified co-management committees as the main mechanism used by users to present complaints and grievances about the health services received. We sought to better understand the perceptions of different actors (district health authorities, providers, users, and the members of the co-management committees themselves) about their role. Table 3 below systematises the answers we got from the health providers in the health units, in the multiple-choice questionnaire, to the question: what is the co-management committee for?

Table 3: Health providers' perceptions of the role of the co-management committee

To help providers do their jobs	To call people to use health services in the health unit (HU)	To monitor HU activities and the behaviour of health care providers	To inform users about their rights in the HU	To make users fulfil their duties at the HU	For users to talk about their health problems
5	20	21	15	12	12

Source: Author's own data.

The dominant perceptions are that the co-management committee serves to *"monitor the activities of the HU and the behaviour of health providers"* (21 respondents) and *"to call people to use the health services in the HU"* (20 respondents), articulated by many providers as the

[19] Technician, SDSMAS from Nampula district
[20] Health Technician, HC Nampula district

promotion of health services in the community. These two roles are illustrated in the two statements below, respectively:

"They [the co-management committee] have been watching over the care of the health professional, when they hear a complaint from the community, they end up probing to see if the complaint really is to build the hospital (improve) or destroy the professional. The health and co-management committee has been closer to the community, they become our link to the community. And we keep improving anyway". [21]

"[The co-management committee] serves to mobilise the community, as in the case of the time when there were many births outside the maternity ward. The co-management committee helped a lot because there was a lot of marginalities as cases of aggression against users on the way to the HU, which culminated in the reduction of the same cases". [22]

Fifteen respondents spoke of the co-management committee's role in *"informing users about their rights in the HU"*, while 12 respondents said it serves to *"make users fulfil their duties at the HU and to talk about their health problems"*. Very few respondents (5) indicated that the co-management committee serves *"to help the providers to do their work"*; those who thought so mentioned that they support various activities of the health unit, including the organisation of service queues and the mobilisation of community resources for the construction of health infrastructure (e.g., overnight lodging facilities for expectant mothers who live far from the HU). In some health units that we visited, we observed that they acted mainly as "helpers" of health professionals, almost confusing themselves with the staff. This perception was reinforced by the co-management committee members' descriptions of some of the activities they carry out: *"for example, when COVID started, we formed rosters of three people to work per week at the HU, transport water and clean the HU".*

Photo 3: Collective interview with members of the co-management committee, Mizerpane HC district of Monapo (Photo by Valerio Ussene, 10 March 2022)

Despite this, there is, in general, an understanding of the main roles of a co-management committee, particularly among its members. When Murutho's co-management committee was formed, its members were told that it serves, among other things, to *"listen to users about the quality of care, see the difficulties of the HU and report the instances to the HU director".* It would

[21] Staff member responsible for nurses, Muhala Expansão HC, Nampula district
[22] Nurse, Muhala Expansão HC, Nampula district

also be responsible for *"bringing community concerns to the HU"*, and *"correcting errors of nurses and users". "For example, if a nurse treats a patient badly, she corrects him by saying that this should not be done".*

Often their action goes beyond a call to raise awareness. When asked about how they collect information about users' complaints, committee members replied that some people communicated to them and told them about cases that came to them related to gifts made to thank health staff/unlawful charges. Below we present two such reports on the role of the committees and their relationship with users in two health facilities in Monapo district. In both health centres, members of the co-management committee give talks in the communities; however, in the first health centre, the members of the co-management committee have a more direct relationship with the users, while in the second they rarely receive direct complaints.

"The Committee gives talks on poor service. It informs users that, in case of bad service, there is a place where the user can feel free to complain and, in turn, the Co-Management and Humanisation Committee (CCGH - Comité de Co-Gestão e Humanização) will take the problem and then solve it. For example, between 2020 and 2021, it took place at the postpartum consultation where a member of the CCGH was giving a talk on illicit fees and [informing about] which service sector is paid and how much is paid. Then a lady who was there reported that she was charged a cash amount during childbirth. In turn, the CCGH member recorded the information about the day this happened, and we went to check the birth register book to see the person who was attending that day. We were able to identify the nurse who was there that day, she confirmed and confessed the charge and promised to return the amount she had received, which was 300Mt, to the person who had been charged. The director [of the health unit] at the time, called her colleague not to do the same again. The amount was given to the CCGH member to send to the owner." [23]

"Users never came directly to the committee to complain about poor service. Only the members of the committee hear rumours outside, in the village, and come to inform the director of the HU. And in turn, the board brings together nurses and staff and makes them aware of what the community says.

For example, we once heard in the neighbourhood that the mother-and-child health nurse called X [nurse's name] was not treating the population well, she was mistreating them. So, we went to the director, and he talked to her about changing her behaviour. We were never told anyone was charged, just bad service. Committee members give talks in the neighbourhoods [say] that there is a complaint box, and anyone can write and put it in the box. We inform you that there is a record book of cases of quality of care. We also inform the population that in case of being poorly served, they can write in this book. It also has numbers of employees, director and CCGH members pasted. But people don't use it, we never get a call". [24]

[23] Chairman of the Co-management Committee, Carapira HC, 9 March 2022, Monapo district,
[24] Member of the Co-management Committee, Metocheria HC, district of Monapo, 10 March 2022

Authorities and health providers claim that co-management committees are the link between the health facility and the community and make many assumptions about the liaison of co-management committees with the community. Despite some common elements in terms of the type of interaction between the members of the co-management committee and the community, the nature of the link varies greatly from facility to facility, as evidenced by the reports above.

Interviews with users reveal a lack of knowledge and distrust of the members of the co-management committees. Although some users want to file a formal complaint, they do not trust the co-management committees due to the proximity of the health unit members with service providers and the fact that they do not understand the capacity they have to forward their complaints to the health unit and exert pressure to resolve the problems raised. Therefore, they usually comment or complain among themselves, or those who can use other ways to reach higher levels of the SNS. Some members of the co-management committees are aware of this. At the end of a press conference with members of a co-management committee in Monapo, one of them asked the interviewer: *"for the community to trust us as members of CCGH, what should we do? Because until now, since 2020, the population does not trust us very much about the work we do at HU".* [25]

Mistrust seems to be associated with a lack of clarity about what information will be passed on to the health unit, particularly whether the complaint will be treated as anonymous or not. There is also some concern about what might happen to providers who have provided poor service.

"(...) I have already held meetings with the population of Metocheria, Napupulo, Calili asking why they don't use these mechanisms instead of whispering. The population replied that they are afraid to make a complaint, and that then when they come to the health unit, they will not be attended to". [26]

"In the talks that CCGH members give, when they ask users why they don't use it and they just mumble, they also say that they think that when they complain, the members [of the co-management committee] will hit or hurt the targeted technicians. That's why they're afraid to report it directly, they prefer to whisper." [27]

"Usually when people are charged, they don't speak, they only speak in the neighbourhood. When we listen, we seek to know with the person who says they were charged, but when people know that we are members of the committee, they don't want to talk or say who charged them because they are afraid of not being treated in the hospital. So, we just report the case to the board and warn them not to continue because in the neighbourhood they say there are charges". [28]

Several co-management committees covered indicated that the main form of interaction with users is through talks and meetings held in neighbourhoods and villages, during which people

[25] Member of the co-management committee, from HC in Metocheria, Monapo district. 10 March 2022.
[26] Member of the co-management committee, from HC in Metocheria, Monapo district. 10 March 2022.
[27] Member of the co-management committee, from HC in Metocheria, Monapo district. 10 March 2022.
[28] Member of the co-management committee, Mizerpane HC, Monapo district, 10 March 2022.

are informed that there are CCGH members in the village to whom people can submit their complaints. Some of these meetings are held together with the leadership of the health units.

"Last year the CCGH planned an activity, in Nova Familia neighbourhood, a delegation between the Director, some members of the CGH, PAV went and had a meeting with the population, where the director said that when they have issues, complaints can be presented, which is to improve the quality of services in our HU". [29]

"When I entered, I tried to talk to the members of the co-management committees, we made a plan of visits to the surrounding neighbourhoods, to have consultation meetings. Unfortunately, we were only able to do it in one neighbourhood because the members of the co-management committee have been busy with other activities". [30]

"We listen to the communities. It is there that we take the opportunity to explain what we are doing so that they feel free to report it. HU works with CCQHs and day-to-day members who liaise with the community. The committee is there in the community, but it is also in the health unit". [31]

A community leader, a member of a Monapo district co-management committee, reported that after having meetings with people he seeks to bring the health unit's leadership to listen to people's concerns first-hand and encourage people to report poor care, but unsuccessfully.

"After talking to the villages, I held another meeting, convened all the communities, and invited the director, for people to present their concerns. But the populations were still afraid. The director told people that if someone complains, it's not because they won't be seen tomorrow but it's for us to improve services to users. But even so, people continued not to report it." [32]

It is important to point out that it is not just users who are afraid to report due to the possible consequences. The members of the co-management committee are also worried and afraid of losing health personnel in a context of lack of human resources, as illustrated by the speech below by a member of the CCGH from a health centre in the district of Monapo:

"For example, we don't know you [referring to the interviewer], so we're afraid, we're afraid to say things because you can take it and then we hear that coach X and Y was transferred from here or expelled. For example, there was a nurse who treated users poorly, insulted them. CCGH members spoke with the director of district services, they met, and he was reprimanded. After that he had improved his behaviour, he was already taking good care of people. But then he was transferred. That was in 2019. After being reprimanded, he was a good person, the whole population liked him, but then he was transferred. Today we miss him. He was transferred in 2021". [33]

This member linked the transfer of the nurse/health unit director to the complaint they had made to the director of District Services. The quote above suggests an awareness of the scarcity

[29] Member of the co-management committee, Mizerpane HC, Monapo district, 10 March 2022.
[30] Health centre Director, Anchilo HC, Nampula district, 17 February 2022.
[31] Health centre Director, Muhala Expansão HC, Nampula district.
[32] Member of the co-management committee, Mizerpane HC, Monapo district, 10 March 2022.
[33] Member of the co-management committee, Mizerpane HC, Monapo district, 10 March 2022.

of human resources and an attempt to prevent health units from losing the few resources they have, even if their performance is problematic. Awareness of the challenges facing health units emerges from participation in meetings; most of the co-management committees that we contacted said they hold meetings at least once a month; meetings include the health centre staff who are also part of the co-management committee, including the unit director.

According to a member of the Nampula district co-management committee, these meetings discuss *"HU matters, information sharing on adherence to prenatal consultations, institutional deliveries, cases of complaints of poor care, and other issues that users talk about when they arrive in their villages from the HU"*. Users' complaints are part of the agenda of the meetings of the co-management committees, on the other hand, there is a lack of feedback from the participants on the follow-up and decisions made about the complaints made; the members of the co-management committee do not participate in the investigations and deliberations made by the health personnel, as evidenced by the two statements below by a member of a committee in the district of Monapo.

"They meet among themselves; only once did they invite a community leader from X [district name]. But the Directorate also does not provide information on the decisions taken on the reported cases, we only notice the change in the behaviour of technicians and technicians in the form of service to users. Committee members, when they bring a problem from the neighbourhood to the management, the members who brought the problem need to be invited to participate in the meeting, to hear what the technicians will answer and take the decision to the village. But now what happens is that we do not participate in the discussion of the issues, and we are not informed of the answer. And we can't say anything to the people who spoke to us in the village about it. That way people would gain confidence and they would know that we have addressed their concerns." [34]

If management committees are to play a stronger role in identifying, forwarding, and resolving user complaints, it will be crucial to strengthen their connection with users, build trust between members and the community (anonymous complaint raising), clarify their relationship with health units, create links to specific parts of the community (e.g., women and youth), and reinforce their role and responsibilities in the complaints management process.

6.3 Telephone numbers

Most of the health units we contacted are unaware of the existence of the Green Helplines for users, possibly because the existing lines are at the national level. We note that there is some confusion about the distinction between the hotline and telephone contacts of providers and health authorities available at the health unit, as shown in the photo below. Most respondents (14 out of 16) in Monapo district indicated that the health facility leadership telephone contacts

[34] Member of the co-management committee, Metocheria HC, Monapo district, 10 March 2022.

are available for clients to call and file complaints. In Nampula district, only three of the 10 health units mentioned the existence of telephone contacts.

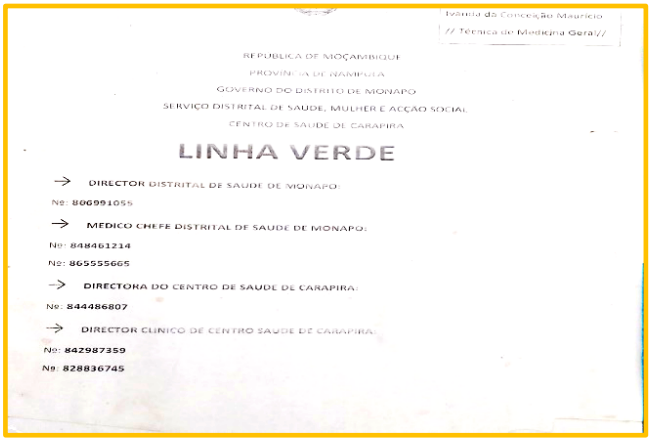


Photo 4: Example of Green Line poster (linha verde)

In one of the health units in Nampula district visited by the report's author, we found telephone contacts posted on a wall, albeit behind a grate and barely visible, near the secretariat. The paper posted had a reference to the GAU and said: *"health unit managers to contact in case of important and urgent matters, such as: reporting poor performance, complaints and compliments"*. At the bottom it had the cell phone numbers of the director of the health centre, the head of the GAU, the clinical director, and the head of administration. However, responses to the questionnaire given by the person responsible for the SMI (Maternal and Child Health) who has worked in this health centre for three years, did not mention its existence.

We suspect that this type of situation may also have happened in some of the other health centres. For example, in another health centre (not visited by the author), the SMI nurse interviewed indicated that the contact details of the manager are not available in all places, only at the desk. She mentioned that there seems to be a "secret" telephone contact, as they have already noticed that certain patients are given a paper with contacts, that is, they assume that there is a clandestine line for complaints that is unknown to the nurses. In a third health unit, the interviewed SMI nurse, who had worked there for two years, replied that *"the numbers of managers exist, but they are not exposed to the entire public"*. In a fourth health unit, the respondent (director of the health centre) said that *"the placement of contact on the walls is in process"*.

In some of the health facilities that we visited in Monapo, the list of available contacts included the number of the district health director, the district chief physician, and the director of the health centre. In one of the health centres, the list was posted next to the complaint box, as shown in the photo below (left).[35] In some centres, the list includes contacts from the local police station for users there to report poor service; other health centres, provide contact details for other providers (for example, maternity manager, pharmacy, expanded vaccination programme, and multipurpose health workers) without, however, being explicit that the

[35] Photo by Valerio Ussene

numbers can be used to report complaints or file grievances, as shown in the photo below (right).[36]

Photo 5: posters with contact details of the health unit and a complaint box.

No one mentioned the contact of the Health Inspectorate, which had a telephone line for complaints but was deactivated two years ago due to a change of inspectorate office.

"We had the phone to receive calls on the Green Line. It's been two years and it's not working. We were working with three networks: Vodacom, Mcel, Movitel. Now those who know me use my personal phone number. We requested a phone account and reactivation of the numbers. We worked with the health units but at some point, as we were making the change, we stopped. And at some point, the colleagues who worked in that area were changed and the work stopped. The boxes and books are there but there is no one to take over; we don't have information because we don't have colleagues. When we left there, we were told everything we had had to move elsewhere, and now we are organising everything from scratch". [37]

Currently the few calls they receive are made to the personal number of provincial inspectors. In addition, users and providers also call the provincial director. Some of these calls directly to the provincial director led to extraordinary inspections (i.e. unplanned) — usually because of a report that was rated as serious.

[36] Photo by Valerio Ussene
[37] Focus group with health inspectors, DPS Nampula.

"This year we have already made an extraordinary one for [name of the district] due to a report of theft of medicines in the warehouse of the health centre. The [health centre] management wrote to alert the provincial management and the provincial director saw fit to send a team". [38]

Generally, people send messages or call anonymously to the numbers provided and/or to people they consider close to the health authorities.

"We have been answering the calls, they call the numbers stamped on all services. There are people who come to me at the maternity ward and first aid bank, only when the service is good. But when it's bad service, they've been calling". [39]

"People prefer to text someone they know rather than say that they were not well attended and ask for an opinion on what they should do, instead of writing in the complaint box. They might be afraid to put it in the box, maybe if it was something you can put it in at night, they would get a full box. Many times, people prefer to record on social media and spread it to all levels. These are the new options that exist, but they are not better because within the health unit we have other options, such as the complaints box". [40]

People mentioned the use of social networks, particularly at the district and provincial level, as a mean increasingly used by users, particularly by the more educated. According to respondents, people use social media with the intention of "spreading information" about poor service, as they believe that this leads to faster responses, as they cause scandal and — as a technician from the district services said — *"stain the institution".*

"For us as a [district] administration, we may think they are not good, but for users, information would spread quickly, and the solution could be quick (e.g., video of a teacher who was asking a student for money at the Universidade Cátolica de Moçambique). That same week, the professor was dismissed, because she brought the institution into disrepute". [41]

[38] Focus group with health inspectors, DPS – Provincial Health Directorate, Nampula.
[39] Responsible for nurses, health centre, Nampula district.
[40] SDSMAS technician from Nampula district.
[41] SDSMAS Technician from Nampula district.

To summarise, although it is positive that the telephone contacts of the health centre leadership are available, this is still an informal mechanism. There are four main reasons for this:

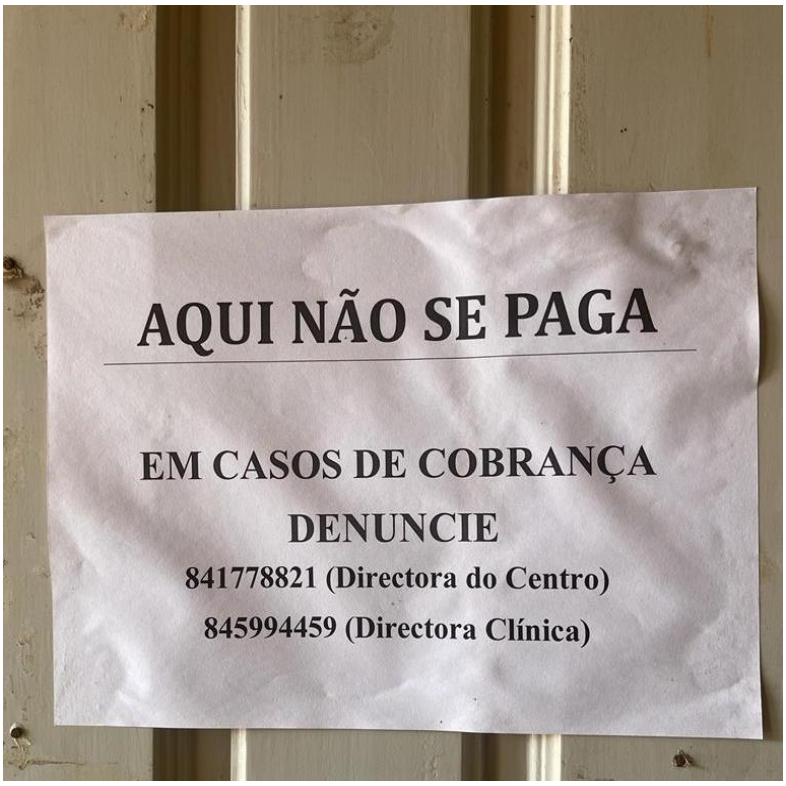


Photo 6: Titled 'Here you do not pay' with the contact details of the Director of a Health Centre

1. Users feel that providers protect each other and they doubt that when they call someone at the health centre, their problem will be treated properly. Hence, those who can, prefer to call the level above the health unit, (i.e. the district services), due to the lack of a specific hotline for complaints, claims, and complaints.

"Once the district administration called me [because] a user called to complain that she had been waiting for a long time and thought that the nurse was not paying attention to her. Her illness was not that serious: we rate them according to seriousness. The patient sat for 4 hours [waiting to be seen]. It was a misunderstanding, lack of information because they didn't know that they wouldn't get priority care because it wasn't a serious case". [42]

In one of the health centres we visited in Nampula district, a user told us that she had suffered an illicit charge at another health unit and therefore decided not to go back there. She said she didn't feel comfortable making the complaint there because she thinks there is a network of corruption — she called it a "savings group" — involving the highest to the lowest level of the health unit hierarchy, including interns. This user highlighted the need for a hotline to make anonymous complaints.

2. Because people call the personal numbers of health care providers, which is not comfortable for some providers, they end up having a second number so they can have a little more privacy.

3. There is no procedure to handle and route these calls. Even when people call anonymously, they are asked to personally identify the person they are reporting.

"They call anonymously to complain and we ask them to point out the person who answered". [43]

4. Numbers are not registered and, therefore, it is not possible to quantify the number and type of complaints made, nor their routing.

[42] Responsible for nurses, health centre, Nampula district
[43] Staff member responsible for nurses, Health centre, Nampula district

6.4 Complaints and suggestions boxes and books

"No, we do not know [that there is a complaint box in the health unit], we were not told. Maybe they announced it on a day when none of us were there. But we never listen, even with our friends". [44]

"As a nurse in charge, I end up going in and talking to ask how the care is. But mothers and companions end up closing themselves off or speaking with fear. [They think] if we are talking, they will treat us very badly". [45]

All health units covered in Monapo district indicated having a box and complaints book. In the Nampula district, eight indicated having a complaint box and only three indicated having complaint books. However, these mechanisms are unknown to most users, even though they are located in strategic and visible places in the health unit (e.g., at the entrance to the pharmacy, ward, or maternity hospital, as in the adjacent photo).

Photo 7: Anchilo HC, Nampula district, 16 March 2022

But it is not just users who have doubts about the boxes and complaints books. In some health units we found that the providers we spoke to did not know if there is any formal procedure for opening the boxes.

"I think that this issue of complaints boxes seems to have been a guideline, which all public institutions should have, it is not a matter of now, it has been going on for years.

I think it's to try in the public service to assess how satisfied the public services are. I started seeing the box a long time ago, but I didn't know how it works. I never opened it. It was an orientation

[44] User, Metocheria HC, Monapo district, 10 March 2022.
[45] Staff member responsible for nurses, health centre, Nampula district.

towards fighting corruption. An attempt to give means to a person who is afraid to speak". [46]As providers keep the keys to the boxes, where there are GAUs, the keys to the complaint boxes stay with a director of the health unit or with the person responsible for the GAU. In health units with more than one complaint box, the keys stay with the person in charge of the department where the box was placed. The boxes are rarely opened because, according to staff, people don't use them.

In a health centre in Nampula district, an SMI official stated that the boxes are only opened when a visitor arrives: *"In past years, it was the director and the visitor who arrived, in this case the administrator who was responsible for opening the boxes".* When we were in the health units, the directors offered to open the boxes: all boxes opened during our visit were empty.

Photo 8: A health unit director in Nampula district opens a complaints box to reveal that it is empty. Anchilo HC, Nampula district, 16.02.2022

Complaint boxes and books are considered the most problematic mechanisms for two main reasons: they require users to know how to write; and they are located in plain sight, meaning users cannot submit complaints privately or anonymously. Of the health units that claimed to have a complaint book, we were only able to see one. SDSMAS users and technicians said they suspect that health providers can secretly open the complaint box and, when they find information that could harm them, they destroy it. They suspect the same happens with complaint books, as the quote below illustrates:

"Another situation [to improve the management of complaints from users] is to ensure the existence of this complaints book, which sometimes is not in the health unit, or is located in a place that the patient does not have access to. Sometimes a week goes by without the book coming out of the drawers, for fear of patients writing a complaint. (...) Sometimes the complaints book has pages torn out, the clinical director or nurse reads it and sees that it will harm him, so he tears out the page. A strategy is needed so that every user can write something without any hesitation". [47]

[46] Health centre director, Anchilo HC, Nampula district.
[47] SDSMAS technician from Nampula.

6.5 Satisfaction meter

In the maternity and adolescent and youth friendly services (SAAJs) within three health centres in Monapo district and two in Nampula district, we found a mechanism for evaluating user satisfaction with the services received using a 'traffic light' approach — known as the satisfaction meter. This tool subjectively assesses patient satisfaction using a box according to their perception of the care they are receiving in the ward during their hospitalisation (Paiva dos Santos, 2013).

Customers receive paper in three different colors (green, yellow and red) at the time of discharge to classify the services received in terms of good, acceptable, and bad — and then deposit the corresponding paper in the box.[48] In addition, there is an auxiliary booklet for the satisfaction meter where users can elaborate on the classification given and providers can record how many good, acceptable and bad reviews they receive daily.

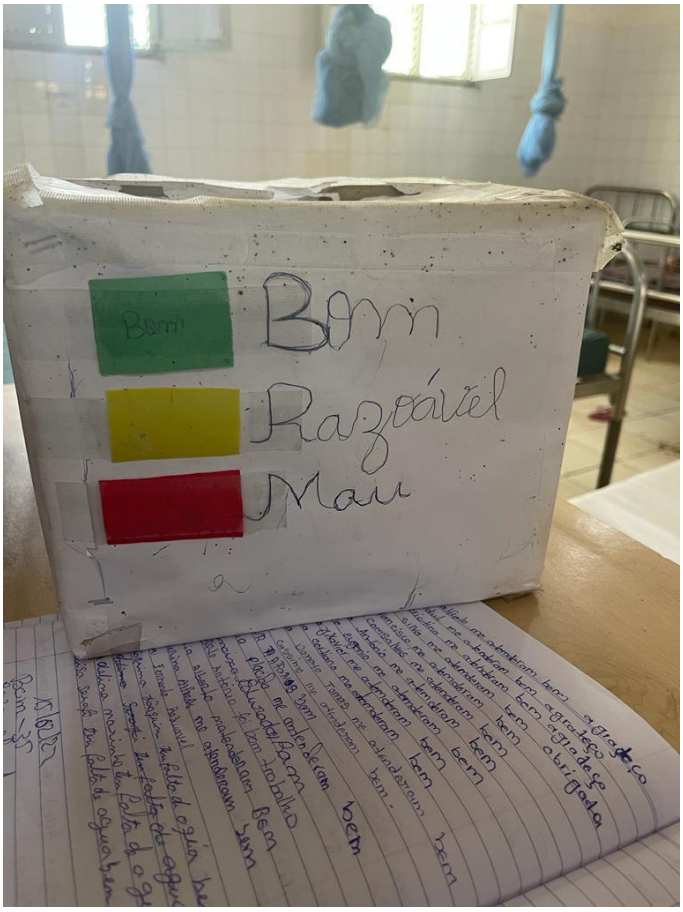


Photo 9: A satisfaction meter box*, 17.02.2022*

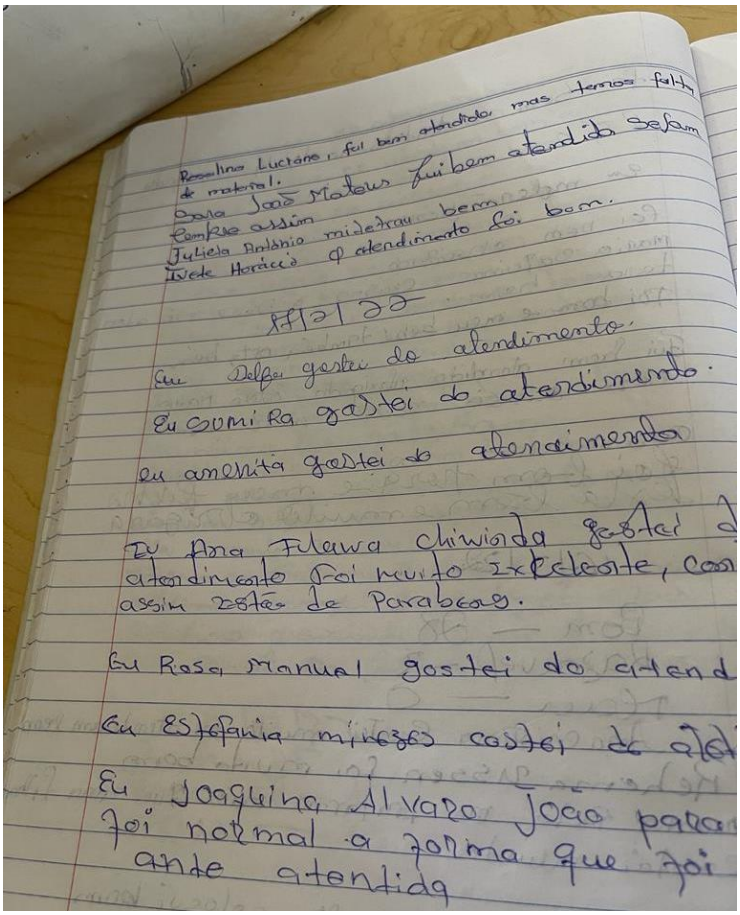
The Terms of Reference for the Establishment and Operation of Co-Management Committees for Health Units (MISAU 2012) indicate that units should use tools such as the satisfaction meter to assess the level of user satisfaction with the services but this study did not identify any co-management committee using this tool.

This mechanism is different from the others mentioned previously, but it also does not offer privacy and anonymity to those who use it unless placed in a location where users feel free to leave their opinion.

The photo shows one of the pages of this notebook, which indicates that all patients who used the notebook on 17 March 2022 (the date we visited the health facility) were satisfied with the service received. In that health centre, the satisfaction meter was on a table, inside the maternity ward, and next to it was the nurse who kindly showed us the notebook proudly. In another health unit we visited, the satisfaction meter was inside the SAAJ, at the entrance of the

[48] MISAU. *Terms of Reference for the establishment and functioning of co-management committees of health units.* (Maputo: Ministry of Health of Mozambique, 2012)

space, close to where the health provider sits thus leaving little privacy for users to leave feedback.



Some health units have a satisfaction meter but it is not used, as indicated by the statement from this provider from a health centre in the district of Monapo: *"before there was a satisfaction meter that ended in 2020, since then we have never used it again".* We do not understand how the satisfaction meter could have ended but we believe that its use had been promoted within the scope of some project or initiative (e.g., Safe Maternity) that has ended. This assumption is based on the fact that the maternity hospital where we photographed the satisfaction meter notebook is part of the Safe Motherhood initiative and the nurses on duty told us that they had been awarded for the quality of the services provided. In that same unit (in the district of Nampula), one of the nurses told us *"there is no great flow of complaints, so the satisfaction meter is the most used"*, suggesting that where users are satisfied with the services, they complain less, and are more predisposed to use the satisfaction meter. However, it also focuses on positive comments, as if they never received negative comments — which does not seem unlikely, given that users are afraid of reprisals.

Most providers could not say what happens to the information collected in the auxiliary booklet of the satisfaction meter but one of them, in a health centre in Nampula district, said: *"the head of social action makes a report and it is shared, but not sure who this information is shared with, simply knowing that there is a team that takes the report".* We assume that the head of social action is in charge of the GAU.

6.6 Meetings and interactions with higher level authorities

The data collected indicate that users tend to favour visits to higher level authorities to present their complaints — both because of the lack of trust in the existing mechanisms at the health unit level and because of the belief that they have some power to influence the improvement of health services. The extract from the interview with a user of a health centre in the district of Monapo shows how "waiting" for these visits to learn about complaints is part of a deliberate strategy.

Interviewer: *How do you think about the treatment you had when you came to give birth?*

User: *I was treated well. Women who refuse to go to the hospital are not treated well.*

Interviewer: *And what do you usually do when you are not treated well?*

User: *When we are treated badly, we go home, wait for a meeting with the administrator or someone else from the government, and complain that when we go to the hospital, we are treated this way and that.*

Interviewer: *But do you know that there is a committee here at the health centre, where you can file a complaint or complain?*

User: *We don't talk to the committee because we don't know how to talk, it's because we're afraid of reprisals. That's why we prefer to talk at home and wait for a visit. And we also hope to hear if more people talk about the same issue. That's when we also talk.*

This strategy was also mentioned by members of co-management committees.

"There is a complaint box, but in the complaint box they rarely find anything because people choose to speak rather than write. For example, two months ago the population complained to the CCGH member and during the visit of district authorities, where the population denounced poor service and charges with the names of health professionals, and said that they no longer wanted those technicians in this HU. The visit met with the management and technicians and advised. Weeks later one of the technicians was transferred to another HU".[49]

According to providers and health authorities, the complaints must begin — and, preferably, remain and end — at the level of the health unit. When we asked health providers about the number of complaints received from users and then resolved and forwarded to other levels, they stated that they receive very few complaints – with the 26 health units receiving between 0 and 4 complaints in the last 12 months prior to the application of the questionnaire. Of those

[49] President Co-management Committee, CS of the district of Nampula

received, it was not necessary to escalate them, they said, especially because many of the complaints received ended up being "misunderstandings".

However, several health providers and authorities also mentioned that people do not respect hierarchy and tend to resort to higher levels, especially district and, in some cases, provincial; they rarely reach the national level, except when staff from the Ministry of Health travel to the health unit.

"There are users who, if the health unit does not do as they wants, escalates it immediately and calls the provincial administration or provincial services directly. The information comes from top to bottom, it starts to decrease...provincial director, district director until it reaches the level of the health unit". [50]

"Something happens and go straight to the radio or wait for inspection? You should first speak with the health facility staff or health facility director. It's not to complain, but to clarify what you saw. First you have to look for the local structures of the health unit. That would be the first step. It's just a matter of following that whole hierarchy. It is never too much to interact with the community leadership and then the community leader interacts with the co-management president who takes the information to the directorate of the health unit. It's a matter of hierarchy. Of course, whoever does this is an informed person. But for a person who is not informed how to do it? You can ask for an audience with the director of the health unit". [51]

"We have a public health and medical care office (of the SDSMAS) where all of our programmes are there. It's not running to talk to the district director, but talking to the person responsible for public health or the person responsible for medical assistance. Therefore, these two figures lead to the District Chief Physician. If he doesn't answer ... if the last person at our level, the district director, can't [answer], we can go to the provincial directorate."[52]

These statements presuppose three things. First, the processes for submitting, forwarding and responding to complaints are clearly defined and functional. Second, that users have access to this information and understand what steps they should follow and/or what is the process for managing their complaints. Third, that users trust that their complaint will be handled appropriately at the health unit level without reprisal and that action will be taken. However, both premises are wrong, as there is no formal process for managing complaints that can be followed by users, providers and health authorities. This lack of clarity is visible in the inspection role, as user complaints do not seem to be part of the aspects that are analysed in ordinary visits to health units, as illustrated in the speech below. Paradoxically, complaints from users are usually what trigger extraordinary visits from inspectors.

"A little while ago last week we had the SDSMAS and DPS, and last week we had the SDSMAS. They seldom look at complaints, they are much more on the technical side, every now and then when the

[50] SDSMAS technician from Nampula.
[51] Technician SDSMAS Nampula.
[52] SDSMAS technician from Nampula.

alarming subject they look at – if there was a problem that reached their superiors from the SDSMAS or DPS. When it's a notification that gets there, but most complaints don't get to be a notification." [53]

Below we quote extensively a description of the work of health inspectors when they go to the health unit. It illustrates, on the one hand, the extent to which the grievance redress mechanisms existing in health centres are analysed and, on the other hand, the nature of interactions with users.

"Inspector means observation mechanism, so we observe in all dynamics. If we go to a health unit, we first look at the facilities, at the technician, how he is in terms of attendance, aplomb and behaviour. Then how he deals with people (health has a physical, mental, spiritual and psychic component); the pedagogical component also enters into training. Where the person graduated, did the institute that trained him/her give him/her the necessary skills, we monitor the quality of training received at the training institutes.

Facilities: we check the space if it is compatible with the activity you are carrying out. Then we will see if there is material available to perform various procedures and how it deals with medical-surgical material for PCI [infection prevention and control] and biosafety; we evaluate the area of sterilization, laundry and waste treatment in all sectors. Then, as he talks to the sick, the sick come to seek the good, not the bad. How the technician places himself before the patient, his way of expressing himself. All this we observe.

Then there's the part where he records. Does he record well? Does he fill in all the fields that the instrument sends? At some point we do an interview, so the person can also say. A person who is contacting the health unit for the first time and may omit some things. The mother needs to have a prenatal consultation, the obstetric component of accessing the delivery room (registers and instruments) to check in case of problems who were to blame. From the professional? Did the patient come late? Was there a lack of material? We see if there was compliance with clinical standards, monitoring of labor, evaluation of the provision of medical care for pregnant women, from prenatal consultation, maternity and postpartum consultation.

In the maternity ward, we check the existence of medicines in the kit for the newborn and the mother. Also in the first aid bank, we check if there are essential medicines for serious cases. We also work in the wards, we look at the hospitalisation processes, how the patient entered, with what diagnosis, after the treatment what happened. If in fact the nurse treated well according to what he learned. We assess whether the processes and procedures are being respected — tidiness, organisation and hygiene of the health unit.

In terms of waste, we assess waste management, from the production site to its disposal/at the terminal. Sanitary units without landfills. There are rules on how to segregate waste and we assess whether colleagues follow these rules. We also evaluate PPE — personal protective equipment — if the colleagues responsible for cleaning have this material and use it correctly. We evaluated whether

[53] Responsible for nurses, CS district of Nampula

there are alcohol dispensers in the screenings. The norm is that each patient who is observed by the nurse, if they do not have water to wash their hands, must have alcohol.

When we arrived here, we produced the report with findings on what we found on the ground. Then we send it to the institution to respond, they have 10 days to respond and we have a 30 day period to monitor the recommendations — ideally we would have to go back but we do telephone monitoring and we ask for the letter to verify if they implemented it or not. This means that the following year, when we go to the field, we see that nothing has changed". [54]

This long quote suggests an emphasis on quality and less attention to issues related to humanisation. There is some interaction with users, but almost none with the co-management committees during inspection visits.

"We don't have a script like that for interacting with users, but in our area there's no way not to interact with users. We are in the ward, we ask if she took the medication, if the delivery went well, if she paid or thanked her (actually I thanked the nurse for so much. While we are talking to her and checking her file, to identify contradictions. She says that she came in at 5 pm, but the record says she came in at 8 pm It means that the nurse when you came in, the nurse did not observe you when she came in. (...) Even at the pharmacy, we also talked to people to assess the waiting time. But we also need to do an analysis, I can't say he's taking too long when the colleague is alone". [55]

"We don't have direct contact with the co-management committees, but when we arrive at the HU we check whether or not it exists and confirm it on the basis of some reports. We don't have direct contact, because we don't know the people, only when they happen to be there when we're going to do an activity". [56]

The inspectors believe that it would be an added value to interact more with the co-management committees as a way of better understanding the problems of the health units.

[54] Focus group with DPS health inspectors.
[55] Focus group with provincial inspectors, DPS Nampula.
[56] Focus group with provincial inspectors, DPS Nampula.

7. Capacities, motivations, and opportunities for strengthening grievance redress mechanisms

The previous sections allowed a glimpse of some of the existing challenges in the health sector. In Section 6, we seek to summarise what we have identified in terms of existing and missing capabilities, motivations, and opportunities that can contribute to improving grievance redress mechanisms. We pay more attention to the supply side, as, like Pande and Hossain, we understand that *"in general, studies on grievance redress mechanisms have focused less on the capacity of state actors to respond, or on their independence, authority, and resources to execute resolutions than on citizens' ability to complain. Therefore, they failed to excavate the dynamics that generate reactive responses or policy feedback"* (2022:23).[57]

Capabilities

- Existence of provincial inspectors with clarity about the nature of their work and knowledge of what quality standards health centres should have, but less preparation on humanised services and user satisfaction.
- There is some knowledge among health providers about the purpose of grievance mechanisms, but some confusion about their scope. For example, a health provider responsible for nurses[58] thought that the GAU was to address both the concerns of users and health providers (including problems between colleagues).
- Absence of guidelines on the management of complaints and claims from users gives rise to practices that violate anonymity and expose users to reprisals. For example, staff might seek to identify the person who reported the complaint in order to resolve amicably and/or ascertain the seriousness of the complaint, ask the complainant to identify the person who provided bad service/made a wrongful charge, and file the case as a misunderstanding.

[57] "Overall, GRM studies focused less on the capacities of state actors to respond, or on their independence, authority, or resources to enforce resolutions, than they did on citizen capacity to complain. Thus, they failed to unearth the dynamics that generate reactive responses or policy feedback". (Pande and Hossain, 2022:23)

[58] The health unit director suggested we talk to this provider in place of the person responsible for the GAU, who was on vacation at the time.

COMPLAINTS AND COMPLAINT MANAGEMENT PRACTICES

Try to identify the person who reported the complaint in order to resolve it amicably and/or ascertain the seriousness of the complaint.

"We sit down as the HU team. If we think there is a need to call the patient, we call the patient and if then necessary we call the colleague, and the patient has to forgive". [59]

Ask the complainant to identify the person who provided poor service/made a wrongful charge.

"They call anonymously to complain, and we ask them to point out the person who answered. In the maternity ward, a nurse did not respond well. They took the patient to the infirmary to show who had treated her badly. To avoid slander, people who want to take away the bread of the other, because they have bad faith. The woman identified the nurse, who was later found to have social problems outside, and we spoke to her. Since then, we have never heard a single complaint from her." [60]

Treat and file as a misunderstanding.

"We also have a lot of unfinished open cases, either because [the patient] changed her mind, or because we called, and they don't show up. People say I've changed my mind, I don't want to pursue the matter anymore, it was a misunderstanding. But we don't know why that happens." [61]

- We note that there is a lack of guidance and training. This translates into poor information and knowledge — particularly at the level of health centres — on how grievance redress mechanisms should be managed even at the level of unit leadership. For example, the newly appointed director of a health centre indicated that he had worked in other centres where there were complaint boxes but he did not know how they worked and that he still did not know. In other health units, we found that there is a great lack of knowledge about the guiding framework of the health sector with regard to grievance redress mechanisms. We did not find anyone who was able to identify a relevant health sector policy, strategy, or standard.

  "Here we have serious problems with human resources. Maybe if you send someone it could be someone who knows more about the laws, statutes, human resources. Because we are many and sometimes we don't even know our rights and duties. So there is an informed person here who at some point will gather the employees and clarify [things to] us". [62]

  "We have trained people for over 5 years, one person from each SDSMAS and some health units. At the time our goal was to cover all health units, but it never happened. Every year we made requests for training, but that didn't happen. We had instructed the districts that had

[59] Health centre director, Muhala Expansão HC, Nampula district
[60] Responsible for nurses, health centre, Nampula district
[61] Health centre director, Nampula district
[62] Health centre director, Nampula district.

been formed to replicate, but we did not monitor. Really not all health units have information because they were not trained".[63]

- The existing human, material and financial capacity does not allow for an efficient complaints management system. The health inspection and the quality and humanisation department are among those with the lowest budget.

  "A lot depends on the dance of financing. All USAID partners have a quality component. The funding dries up and the quality and humanisation department is then left unsupported. The partners that finance quality and humanisation have a clinical perspective (UNICEF, World Bank, JHPEIGO, USAID). In humanisation we have N'weti, Namati, and Ireland (the only international one). The quality and humanisation programme does not even exist in the ministry, it is a smaller programme; something that doesn't even get you five thousand dollars a year. You say that to the minister, he won't even know it exists. The volume of funding determines how important a programme is to the ministry. You will see from the technicians who are in the department, they are very weak".[64]

  The inspection's material and financial difficulties are also illustrative. The lack of training and monitoring of the co-management committees is also a reflection of this lack of resources.

"Here we simply have one computer for all the teams, not a single report." [65]

"It seems that there is something here that we are dodging. Inspections take place here in Nampula district until March. But to go to other districts there are no funds. The inspector cannot go for two days, because it is a complex job. And the whole team goes and has to see everything, it's not something that can be done in one day, at least it has to be 4 days." [66]

"The inspector is the one who is a firefighter (extraordinary inspections) — someone dies in Moma, we have to go. Extraordinary situations affect the district, so they need us. If that's not it, we're just sitting here. We only get to sit here until 15:30 [end of working day]. And we are evaluated by ordinary and non-extraordinary inspections. Inspection is important when it comes to safeguarding DPS interests. Excessive extraordinary inspections are because the inspection is not working. [We had] 15 inspections planned for the districts, but we couldn't do any for the districts, we just did the Nampula district. What will they base it on when they're evaluating us, if we can't stick to our plan, when it's not even our fault." [67]

"We left here without money to go to work, and we overloaded the district. Last time we went to Cabaceira Grande without five hundred in our pocket. We appealed to the director, and she said

[63] Focus group with health inspectors, DPS Nampula.
[64] This quote is taken from an interview with an NGO with an office in Nampula and headquarters in Maputo, as part of the study on collaboration in the health sector, which preceded the present study.
[65] Focus group with provincial inspectors, DPS Nampula
[66] Focus group with provincial inspectors, DPS Nampula
[67] Focus group with provincial inspectors, DPS Nampula

I'm evacuating patients with the money from my pocket, it's already 10 thousand meticais (...) I, as an employee, don't have the obligation to owe the loan shark in order to go on a mission. This ends up creating demotivation". [68]

- The statistics collected at the level of the health centres and systematised by the SDSMAS do not include information on the level of satisfaction of users with the health services or on the complaints and claims received, which makes it impossible to get a real picture on the subject or properly manage the information. In addition, the inspection spoke about the systematisation of information regarding the petitions received and resolved, but not regarding the complaints. When we asked if they knew what was being done with the information they sent, they replied: *"we find out through parliament".* We also noticed that petitions and complaints were treated as synonymous by some inspectors.

  "Usually petitions come under the guidance of the provincial director. The user requests an audience with him and submits the petition. We have others that are sent directly to us. When complaints are made to us, we respond, the time it takes depends on a case-by-case basis. Monthly we send the information to the general inspection of the civil service (IGAP - Inspeção Geral da Administração Pública) in the ministry of administration. When we collect all petitions at the DPS level, we forward them to IGAPE and from there they forward them to the petitions commission of the Assembly of the Republic." [69]

- Work overload and lack of material in the health facility is a source of additional pressure for health providers that affects the quality of care provided. Sometimes providers feel undervalued, as the quality of care provided is evaluated without taking into account the conditions in which they work. They complained particularly about the provincial and national inspection, and less about the district inspection, as it knows better the difficulties they face.

  "Work overload makes nurses forget to inform people when they have priority or are entitled to emergency care. This includes the verbal part as well as the technical part. Saying that we have little material and we are prioritizing. You can buy a syringe because we don't have it so they don't think we're extorting the patient or wanting to take some value from them. There are also ways, such as talking to the patient, we have to attend to the social and professional part, we arrive stressed and we are not careful with the tone of the voice, the way of speaking. We have to psychologically prepare the person, explain why he needs to sting several times because the person has a thin vein. If I don't talk to the person and I just say lie down here, the person will say: I'm not a dummy!

  Whenever they complain, we can see that it really has to do with overload. We are trying to allocate more health professionals, so we can see if it is overload or character. If we add more

[68] Focus group with provincial inspectors, DPS Nampula
[69] Focus group with health inspectors, DPS Nampula

professionals, complaints will be reduced and the work will be more efficient. Even when we follow the professional we see that he did it once in a year and that is not part of his character. If we allocate more professionals, we will have more effective work".[70]

"When they [SDSMAS] try to demand things in a superficial way, they know our reality, they know how we work, they know the positives and negatives, they end up taking it a little lighter. The SDSMAS see that we are doing our best. DPS, they demand things even though we know we can't satisfy the customer. They demand things — for example we have a material shortage (nurse decontaminated a used glove and wanted to use it on the same patient, but they don't accept it) — they say no, this is an antiseptic thing. The glove is disposable, if I do that, I'll have to use my hands anyway. So, what happens, the nurse ends up taking the money from the salary to buy gloves and attend the DPS. The DPS, they come with everything. The ministry is even worse. When they come here, they want to see everything". [71]

Motivations

We found several health providers and authorities who understand the need to improve both the humanisation of health services and the mechanisms for managing complaints, including ways of interacting with users to capture their perception of the services. The leaders of the health centres and members of the co-management committees expressed particular interest in acquiring more training and learning from the experience of other health units in the country.

However, despite the interest in improving the existing grievance redress mechanisms, we noticed a certain fear on the part of the providers — that more complaints and grievances come without their ability to offer improved services, as if the humanised service depended only on the personal attitude and had nothing to do with structural problems that affect the national health system, as articulated in the speech above by the head of nurses at a health centre in Nampula district.

We also note the pressure that providers feel, combined with the awareness that health centres are not meeting the expectations of either the people or themselves, and the tendency to protect themselves from what they perceive as attacks on themselves and the health unit. Some health providers have the perception that some users have bad faith and that when they make a complaint of bad service or illicit charges, they are *"wanting to take away the bread"* of nurses, (i.e. make them lose their jobs), as illustrated in the words of this nurse discussing the work of the members of the management committee:

"They have been watching over the care provided by the health professional. When they hear a complaint from the community, they end up probing to see if the complaint really is about building the hospital or destroying the professional. Did the complaint really happen or the person is just doing it because they received a service they didn't like." [72]

[70] Staff member responsible for nurses, CS district of Nampula.
[71] Nurses in charge, CS district of Nampula.
[72] Staff member responsible for nurses, CS Nampula district.

Similarly, the director of the same health unit spoke of being "tested" by users (i.e., to see how complaints react). This test can also come from health authorities as a way of evaluating performance:

"That person [user] says he arrived at 4:00 am and by 8:00 am he still hadn't been seen; we were changing shifts. He called me. Because it was a call, we need to see the person and have the person's data. He didn't show up. So, we were left with a lot of thoughts... if he was testing." .[73]

Aware that there is a perception that the identification of failures in the health centre aims to "test" or "destroy" certain health providers, a health inspector stated: *"inspection is a pedagogical exercise, no one ever lost bread because of the inspection".* We understand that providers' poor attention to grievance redress mechanisms relates to the fact that they are blamed for most problems in health centres. Complaints from users and the mechanisms for their management are not perceived as exercises that can contribute to improving both the conditions in which they work, the quality of service provided, and the level of satisfaction of users with the services received. Therefore, if at the level of the SDSMAS there is interest in including complaints and grievances from users in the statistics sent by the health units, as illustrated in the quote below about the relevance of these data for the SDSMAS, the tendency of the health units is to camouflage and minimize the number of complaints received.

"If we had monthly statistics and measured to what extent the level of complaints related to a certain area, we would be helping to boost some of the macro health indicators. At the provincial level, births outside the maternity ward are not doing well, we are being champions. When we receive a complaint from a woman who says, "I was poorly attended", she will not come back, she will prefer to give birth at home or what is happening in X [name of health centre] will happen, because we have a midwife who is going serve people at home. If we don't have evidence, we don't have the basis, evidence to confront the health units/providers in the debriefing meetings, with evidence of a complaint, things will improve. Our focus is on improving indicators to improve the health status of pregnant women in the community. It is feasible, we can implement a form and the health unit or person responsible for human resources, or the clinical director can collect this information, enter this form, and put it in the report". .[74]

Finally, we consider it particularly important that members of some co-management committees are aware of the difficulties in interacting with users and to have more confidence in them so that they can do more.

Opportunities

- We understand that the current health sector guiding framework provides a strong foundation for improving complaints management mechanisms. Among others, although the issue of complaints and grievances does not enter the monitoring and

[73] Director, CS Nampula district.
[74] SDSMAS technician, Nampula district.

statistics system at the district level, the quality and humanisation strategy has an indicator referring to the number of complaints processed and resolved.

- The policy framework is very thorough and demonstrates a senior-level bureaucratic will to improve performance. The challenge arises in the implementation of that policy at the level of service delivery. At that level, health authorities are key but appear to be very deficient. For the implementation of this guiding framework to be successful, those who are meant to operate it in practice need to become more aware of the relational and power-related obstacles to users utilising it, as well as the issues occurring on the 'supply side'.

  Furthermore, they should be supported with adaptation of the mechanisms to make them more amenable and user-friendly for the most marginalised and powerless users. This includes improving and publicly offering anonymity and confidentiality; introducing 'arms-length' mechanisms where an intermediator independent of the health service (e.g., NGO) receives, processes, and channels the complaints; relying less on the written word and more on mediums the non-literate can access, etc.
- The existence of initiatives to promote social accountability and monitoring of the quality of health services led by civil society organisations constitutes a strong basis for strengthening existing complaints management mechanisms. However, these initiatives will need to go beyond the identification of problems/complaints from users and start to include the monitoring of what happens with the complaints that are made, (i.e. how they circulate internally in the health institutions and what information is returned to the user/complainant). If health centres can improve the degree of feedback and responsiveness of grievance redress mechanisms, users will gain more trust in the system and will be inspired to use it more frequently.
- In practice, 'closing the loop' can be quite a challenge. CSOs typically focus their efforts on the 'front-end' because making grievance redress mechanisms more accessible and complaints easier to submit is feasible, but there is little understanding on the issues being faced on the supply side and scant evidence on how to resolve those issues (Pande and Hossain, 2022). In addition, it is difficult to independently monitor the process which complaints undergo within the system, let alone sanction staff should they not address the complaints adequately. Political will has to come from the top to enforce staff to follow up on the process.
- The Theory of Change of the Investment Case that seeks to improve the utilisation and quality of reproductive, maternal, neonatal, child and adolescent health and nutrition (financed by the Global Financing Mechanism and managed by the World Bank), identifies low quality of care as one of the main challenges of the health sector. It seeks to encourage the improvement of the quality of care through results-based financing, (i.e. disbursements associated with the achievement of certain indicators). Indicators 8 and 9 concern monitoring the quality of services through social accountability initiatives, namely: the community scorecard and the balanced scorecard. The World Bank has a citizen engagement strategy, whose areas of intervention include complaints

management mechanisms.[75] In this regard, World Bank-financed health projects also have an obligation to establish functional grievance redress mechanisms. The Ministry of Health builds on the existing mechanisms discussed here. The World Bank is therefore a strategic partner interested in improving existing mechanisms beyond the Investment Case.

- The issue of grievance redress mechanisms goes beyond the health sector, covering public administration as a whole, and is also part of the fight against corruption — opening doors to partnerships with institutions such as the anti-corruption office, who is an important actor in this matter.

[75] Le, Ha, Rachel Nadelman, Anjali Sah, and Ian Evans. 2019. "Citizen Engagement: An Independent Review of the World Bank's Commitments in Mozambique." Accountability Research Center.

8. Conclusion and recommendations

This study sought to understand the complaints and grievance management system of users of health centres through an analysis of the complaints circuit from the moment they are made by users. However, this was not possible, as there is no formally designed and executed process articulated with other levels of the system. On the contrary, we identified a set of similar informal practices that mainly aim to protect the health unit from "external attacks". These informal practices expose those who complain. Authorities and healthcare providers are aware that clients are not comfortable making a complaint to healthcare providers face-to-face, and both clients and providers recognise the importance and need for functional and reliable grievance redress mechanisms.

Despite these issues, we have achieved specific objectives, namely:

- To capture the extent to which users use the existing grievance redress mechanisms,
- To understand how complaints and grievances from users are included in the SNS,
- To map the capacities, motivations, capacities, and opportunities for health authorities to identify and manage user complaints, as well as analyse how user perspectives are perceived, considered, and rejected by health authorities.

The table below presents some structured recommendations around capabilities, motivations and opportunities that can be discussed and refined together with POTENCIAR.

Recommendations for POTENCIAR

In addition to the recommendations which have come out of the study conducted by POTENCIAR, the project has also included recommendations relevant to POTENCIAR from two other similar projects:

1. The Empowerment, Voice & Accountability Project in Pakistan 2014-2018 (funded by UK-Aid)[76]
2. The Provision of Essential Health Services Project in South Sudan 2019 – 2021 (funded by World Bank)[77]

Capabilities

- ✓ Promote the exchange of experiences and mutual learning — from other experiences within Mozambique and internationally — with Green Lines and other mechanisms that do not require high levels of literacy, assertiveness, or self-confidence on the part of complainants.
- ✓ Advocate for the establishment of a complaints management mechanism to be implemented and possibly overseen by civil society organisations. However, the state itself should still be primarily responsible for overall management of the mechanisms, in order to retain a sense of ownership.
- ✓ Support the training of providers and health authorities on the management of complaints from users, particularly in registration, referral, return, and feedback to complainants, as well as in how to guarantee — and proactively offer, and assure — anonymity and confidentiality to potential complainants.
- ✓ Facilitate the systematisation and dissemination of information regarding the guiding framework for citizen engagement in the health sector, particularly on complaints, grievances, and avenues for seeking sanction when complaints are not addressed.
- ✓ Promote greater interaction between the health inspectorate, the GAUs, and with the co-management committees at the local level.
- ✓ In partnership with local civil society organisations, support the testing of the application of the satisfaction meter by the co-management committees, creating spaces for its use beyond those under the responsibility of health personnel (e.g., SMI nurses in the maternity ward). It is important that users couple the sharing of their levels of satisfaction with a recommendation on the service that should be provided, so that committees reviewing the scores in the satisfaction meter can understand the scores that users provide.

Experience from similar projects in Pakistan and South Sudan:

- ✓ Conduct research on the existing cultures of and community structures for complaint raising, and the capacities and means of citizens to access existing GRMs.
- ✓ Consider establishing multiple routes for raising complaints that take into account the results of the aforementioned research, safety and anonymity.

[76] https://assets.publishing.service.gov.uk/media/5e5d340686650c53a363f7ad/Wp497_Online.pdf
[77] https://projects.worldbank.org/en/projects-operations/project-detail/P168926

Opportunities

- ✓ Support the Ministry of Health in clarifying the roles and responsibilities of different departments regarding the management of user complaints. This includes the systems for ensuring complaints management takes place by relevant staff in a timely manner and that 'closing the loop' takes place, with feedback to complainants.
- ✓ Support the health sector in clarifying the process for managing complaints from users and drawing up guidelines covering the various levels of the SNS, guiding how complaints should be dealt with, within the scope of the operationalisation of both the quality improvement strategy and humanisation, as well as the inspection's strategic plan.
- ✓ Support district and provincial planning departments in the production of tools for collecting and forwarding statistics on the number and type of complaints received and resolved and feedback to complainants.
- ✓ Explore options to strengthen ways for service providers and health authorities to be held to account from other parts of the system through sanction/reward.

Experience from similar projects in Pakistan and South Sudan:

- ✓ Look for opportunities to link GRMs operations and standards to existing policies and legislation.
- ✓ Identify GRM champions at different levels of governance able to oversee their operations.
- ✓ Publish regular overviews of the performance of GRMs for use by other state and citizen organisations.

Motivations

- ✓ The promotion of mutual learning with other contexts should include experiences that show how the strengthening of grievance redress mechanisms may have contributed both to the improvement of working conditions of health providers and to an increase in the level of user satisfaction with the quality of the services received.
- ✓ In partnership with civil society organisations, government authorities, and private sector actors, promote the improvement of grievance redress mechanisms within the framework of dialogue processes between users and health providers as a way of improving providers' perception of complaints and grievances from users.
- ✓ In partnership with civil society organisations, advocate for the anonymisation of information collected and for protection mechanisms for colleagues who denounce other colleagues, in association with complaints and claims made by users.
- ✓ Support the Ministry of Health to adapt existing performance management processes within health authorities, government, and service providers to include responsibilities and sanctions for complaint redressal and feedback to complainants.
- ✓ Explore the reasons why grievance mechanisms in the health sector, such as complaints boxes and complaints books, are not being used by patients, and identify ways to strengthen them.

- ✓ Understand how the structure of co-management committees and the context of decentralisation can influence the quality of promotion and implementation of grievance mechanisms and leverage this knowledge to strengthen committees and improve the use of grievance mechanisms.

Experience from similar projects in Pakistan and South Sudan:

- ✓ Conduct research on the motivations of existing community bodies and users' groups engaged by GRMs to ascertain reasons for mistrust and possible reforms.
- ✓ Incentivise front-line providers to respond the raised complaints in equitable and transparent ways.

References

Argyris, Chris. *Knowledge for Action. A Guide to Overcoming Barriers to Organisational Change*. (San Francisco: Jossey-Bass Publishers, 1993).

Bomfim, E., Mupueleque, M. A., Dos Santos, D., Abdirazak, A., Bernardo, R. A., Zakus, D., Pires, P., Siemens, R., and Belo, C. F., "Quality assessment in primary health care: Adolescent and Youth Friendly Service, a Mozambican case study", *The Pan African Medical Journal* 3(1) (September 2020). https://doi.org/10.11604/pamj.2020.37.1.22983 accessed on 29 March 2021.

Bonino, F., Jean, I. and Knox Clarke, P. (2014) Humanitarian feedback mechanisms: research, evidence and guidance. ALNAP Study. Overseas Development Institute.

Chalet, A. and Sattler, M. (2019) Coordinating a revolution: the critical role of response leadership in improving collective community engagement. *Humanitarian Exchange*. 74.

Coghlan, David, and Coughlan, Paul. (2010). "Notes toward a philosophy of action learning research." *Action Learning: Research and Practice*. 7(2) (August 2010): 193-203. 10.1080/14767333.2010.488330.

Fox, J. A. (2015) Social Accountability: What Does the Evidence Really Say? *World Development*: 72346–361.

Galle, A., Manaharlal, H., Cumbane, E. Picardo, J., Griffin, S., Osman, N., Roelens, K., and Degomme, O., "Disrespect and abuse during facility-based childbirth in southern Mozambique: a cross-sectional study", *BMC Pregnancy Childbirth* 19 (October 2019): 369. https://doi.org/10.1186/s12884-019-2532-z accessed 29.03.21.

Galle, A., Manaharlal, H., Griffin, S., Osman, N., Roelens, K., and Degomme, O., "A qualitative study on midwives' identity and perspectives on the occurrence of disrespect and abuse in Maputo city", *BMC Pregnancy Childbirth* 20 (October 2020): 629. https://doi.org/10.1186/s12884-020-03320-0 accessed 29 March 2021.

HE (2019) Special feature Communication and community engagement in humanitarian response. *Humanitarian Exchange*. 74.

Hossain, N., Joshi, A. and Suchi, P. (2023) The politics of complaint: a review of the literature on grievance redress mechanisms in the global South. *Policy Studies*, DOI: 10.1080/01442872.2023.2193387

IASC (2011) 'IASC Transformative Agenda'. Inter-Agency Standing committee.

Koleros, A., Mulkerne, S., Oldenbeuving, M., & Stein, D. (2018). "The Actor-Based Change Framework: A Pragmatic Approach to Developing Programme Theory for Interventions in

Complex Systems." *American Journal of Evaluation* 41:1 (August 2018). https://doi.org/10.1177/1098214018786462 accessed 24 February 2023.

Kruks-Wisner, G. (2021). Great Expectations, Great Grievances: The Politics of Citizens' Complaints in India. *Comparative Politics* (January), doi:10.5129/001041521X16106633880914.

Le, Ha, Rachel Nadelman, Anjali Sah, and Ian Evans. *Citizen Engagement: An Independent Review of the World Bank's Commitments in Mozambique*. Washington D.C., Accountability Research Center, 2019.

Marquardt, Michael J. *Optimizing the Power of Action Learning*. (Palo Alto, CA: Davies-Black Publishing, 2004).

McGill, Ian, and Beaty, Liz. *Action Learning: A Practitioner's Guide* (1st ed.). (London: Routledge, 2001). https://doi.org/10.4324/9781315042480

Metcalfe-Hough, V., Fenton, W. and Poole, L. (2019) Grand Bargain annual independent report 2019. Humanitarian Practice Network and Overseas Development Institute.

Michie, S., M., Stralen, M.v., and West, R. (2011). "The behaviour change wheel: A new method for characterising and designing behaviour change interventions." *Implementation Science* 6(42) (April 2011): 11.

Paiva dos Santos, Adriana de Cassia. (2013). Promoção da qualidade, controle de infecção e avaliação de resultados finais no Hospital Central de Maputo em Moçambique. Tesis de doutorado inédito, Universidade Estadual de Campinas, São Palo, Brasil. https://t.ly/sbnd accessed on 09.01.2023.

República de Moçambique. Ministério da Saúde. (2012). Termos de Referência para o Estabelecimento e Funcionamento dos Comités de Co-Gestão das Unidades Sanitárias. Direcção Nacional de Saúde Pública. Departamento de Promoção da Saúde.

República de Moçambique. Ministério da Saúde. (2018). Plano Estratégico da Inspecção de Saúde 2018-2022. Inspecção de Saúde.

República de Moçambique. Ministério da Saúde. (2019). Regulamento Interno do Ministério da Saúde. Diploma Ministerial N° 79/2019. Boletim da República, I Série - N°154.

República de Moçambique. Ministério da Saúde. Estratégia de Inclusão de Género no Sector da Saúde 2018-2023. Unidade de Género.

República de Moçambique. Ministério da Saúde. Regulamento Interno da Inspecção-Geral da Saude. Diploma Ministerial N°297/2011, Boletim da República, I Série - N°52.

República de Moçambique. Ministério da Saúde. Estratégia Nacional para a Melhoria da Qualidade e Humanização dos Cuidados de Saúde 2015-2019. Programmea Nacional para a Melhoria da Qualidade e Humanização dos Cuidados de Saúde.

República de Moçambique. Ministério da Saúde. Plano Estratégico do Sector da Saúde 2014-2019-2024.

República de Moçambique. Ministério da Saúde. Estratégia Nacional Contra Cobranças Ilícitas 2016-2019. Direcção Nacional de Assistência Médica.

República de Moçambique. Comissão Interministerial da Reforma da Administração Pública. Funções Específicas do Gabinete Central de Combate a Corrupção. Resolução N°46/2020, I Série - N°250.

República de Moçambique. Comissão Interministerial da Reforma da Administração Pública. Estatuto Orgânico do Ministério da Saúde. Resolução N°4/2017, I Série - N°82.

Suchi, Pande, and Hossain, Naomi. "Grievance Redress Mechanisms in the Public Sector: A Literature Review." Open Government Partnership and Accountability Research Center, 2022.

Wagenaar, Bradley H., Gimbel, Sarah, Hoek, Roxanne, and Sherr, Kenneth. "Wait and consult times for primary healthcare services in central Mozambique: a time-motion study", *Global Health Action*, 9:1, 2016, 10.3402/gha.v9.31980 accessed on 29 March 2021.

WB (2003) Making Services Work for Poor People. Washington, DC: World Bank.

Wood, A. (2015). Interagency Study on Child-Friendly Feedback and Complaint Mechanisms Within NGO Programmes. Phase One Report: Survey findings - children's access to feedback and complaint mechanisms.

Yao, J., Agadjanian, V. (2018), "Bypassing health facilities in rural Mozambique: spatial, institutional, and individual determinants", *BMC Health Services Research* (18) 1006. https://doi.org/10.1186/s12913-018-3834-y accessed on 29 March 2021.

Annex 1: List of Health Units Covered – Districts of Nampula and Monapo

	Questionnaire	Interviews	Focus Group
Nampula district			
Muala-Expansion Health Centre	**X**	- Interview with the director of the health unit	

		- Interview with the interim manager of the GAU - Collective interview with 5 users	
Namiepe Health Centre	**X**		
25th of September Health Centre	**X**		
Marrerre Health Centre	**X**		
Mucuache Health Centre	**X**		
Anchilo Health Centre	**X**	- Interview with director of the health unit - Collective interview with president and vice-president of the co-management committee	
Niarro Health Centre	**X**		
Namichilo Health Centre	**X**		
Mutava Rex Health Centre	**X**		
Marratane Health Centre	**X**		
District Services for Health, Women and Social Action		- Collective interview with 4 technicians	
Health Inspection - DPS			Focus group with 8 health inspectors
Health Inspection - SPS		- Individual interview with health inspector	
Monapo district			
Mecuco Health Centre	**X**		
Mucujua Health Centre	**X**		
Murutho Health Centre	**X**	- Collective interview with 3 members of the co-management committee - Individual interview with a user	
Jagaia Health Centre	**X**		

Carapira Health Centre	**X**	X - Interview with Chairman of the co-management committee	
Metocheria Health Centre	**X**	- Interview with two users	14 members of the co-management committee
Meserepane Health Centre	**X**		
Monapo Health Centre	**X**		
Monapo-Rio Health Centre	**X**		
Itoculo Health Centre	**X**		
Mizeroane Health Centre			15 members of the co-management committee
District Hospital of Monapo	**X**		

Annex 2: Questionnaire for HU - survey of reporting mechanisms

Health Unit Name			
Health Unit District			
Location	Urban	Peri-urban	Rural
Health Unit Village			
Position/Function of respondent			
How long has the respondent worked at the health unit?			
Respondent's gender			
Age of respondent			
Date of application of the questionnaire			
DATA ABOUT THE RESPONDENT			
Name of the interviewer			
Organisation of the interviewer			
Position/Function of the Enquirer			
How long has the respondent worked at/with the partner organisation?			
Interviewer's gender			
Age of the interviewer			

What should the patient do when he/she has a complaint or report about the services he/she received?

Talk to the nurse

Talk to the co-management and humanisation committee

Leave your concern in the complaint box

Write your concern in the complaint book

Talk to the Multipurpose Elementary Agent

Go to community radio

Inform the neighborhood or municipality structures

Present the district or province inspection when they come to supervise the health facility

Does this health unit have?

User Assistance Office (GAU)

Book of complaints/suggestions

Complaint/suggestion box

Co-management and humanisation committee

Telephone contact of health unit managers.[78]

Email from health unit managers

Provincial attorney or inspectorate telephone contact

Green line

Mobile and tablet application developed by MISAU.[79]

Elementary Multipipurpose Agents

Others (eg local mechanisms)

What is the User Assistance Office used for?

Inform users about their US rights

Make users fulfill their US duties

For users to talk about their health problems

For users to say how US can improve

For users to complain about the behaviour of a healthcare provider

What is the use of the complaints/suggestions box?

For users to talk about their health problems

For users to say how US can improve

For users to say what they like about US

For users to complain about the behaviour of a healthcare provider

5. What is the purpose of the Co-management and Humanisation Committee?

To help providers do their job

To call people to use health services in the HU

[78] US Director, Clinical Director, Head Nurse, Inspector and Head of GAU
[79] Containing the GAU claim form

To monitor HU activities and healthcare provider behaviour

To inform users of their US rights

Making users fulfill their US duties

For users to talk about their health problems

Which of these mechanisms is the most used?

User's office

Complaint box

Co-management and humanisation committee

Community Health Committee

Who has the key to the complaints/suggestions box? Why?

Nurse

Doctor/the boss

Member of the co-management committee

Community health committee member

Why?

Do you know the procedure for opening the complaints/suggestions box?

YES. If yes, why?

NO

Is there a record of complaints/suggestions from users?

If yes, how?

If no, why?

What do you do with the registered information? complaints/suggestions from users?

We analyse internally

We deliver to the US director

We speak at meetings with the CGQH

We hold a meeting with the users

We ship to the SDSMAS

We ship to DPS

We ship to the SPS

We send it to the Provincial Health Inspectorate

Others

If yes, explain?

What is the follow-up of complaints made by users?

We try to identify the user who filed the complaint

We see internally (health unit) how to deal with the matter

We met with the co-management and humanisation committee to try to solve the problem

We met with the community health committee to try to resolve the issue

We forward to other levels (SDSMAS, DPS/SPS, MISAU)

We send it to the Health Inspection at the level of (SDSMAS, DPS/SPS, MISAU)

The matter was too difficult to resolve, so we did nothing

Others

If yes, which?

How many complaints have you received in the last 12 months?

0

1 – 4

5 - 9

10 - 19

20 - 29

30 – 39

40 - 49

+ 50

Of the complaints received, how many managed to resolve at the level of the health unit?

0

1 – 4

5 - 9

10 - 19

20 - 29

30 – 39

40 - 49

+ 50

Of the complaints received, how many were forwarded to the District Services for Health, Women and Social Action?

0

1 – 4

5 - 9

10 - 19

20 - 29

30 – 39

40 - 49

+ 50

Of the complaints received, how many were forwarded to the Provincial Health Directorate or to the Provincial Health Services?

0

1 – 4

5 - 9

10 - 19

20 - 29

30 – 39

40 - 49

+ 50

Of the complaints received, how many were forwarded to the Ministry of Health?

0

1 – 4

5 - 9

10 - 19

20 - 29

30 – 39

40 - 49

+ 50

Of the X [see answer to question 6] complaints received, how many have already been resolved?

What to do after resolving a complaint?

Inform users

They inform the members of the co-management and humanisation committee to inform users

Report to the community health committee

Inform Multipurpose Health Agents

Do nothing

Other

If option 1 was chosen, ask question 19. If not, go to question 20.

How do you inform users?

In writing, post the information on the window/showcase of the health unit

Verbally, during meetings with users

Others

And when they can't solve it or are still dealing with it??

Inform users

They inform the members of the co-management and humanisation committee to inform users

Report to the community health committee

Inform Multipurpose Health Agents

Do nothing

Other

Se a opção 1 foi escolhida, fazer a pergunta 21. Se não, passar para a pergunta 22.

How do you inform users?

In writing, post the information on the window/showcase of the health unit

Verbally, during meetings with users

Others

Is there any guideline, rule or guideline on how user complaints should be handled until they are resolved and the complainant is satisfied?

If yes, please name the document and explain what it says.

---

23. What can be done to improve your ability to manage and respond to user complaints?

Annex 3: In-depth interview/focus group guide with Health Inspection

Can you tell us a little about yourself and the work you do?

What is the organic structure of the Provincial Health Inspection and how it is organised at district level.

The internal regulations of the General Health Inspectorate, approved by Ministerial Diploma n.297/2011. However, the document indicates that the exercise of supervisory and inspection activity at the level of Provincial Health Inspections is subject to its own regulations. Can you tell us which instrument/document regulates the Provincial Health Inspections? Can you share the document with us?

What is the role of this institution in managing complaints from users of health services? Within the General Health Inspection, who manages complaints from users of health services? Is it the Department of Health Care Inspection and Training?

The Organic Statute of the Ministry of Health indicates that one of the functions of the Health Inspection (paragraph g) is "to investigate complaints from the public and users about the functioning of the Ministry, its subordinate and supervised institutions, the National Health Service and private institutions and propose appropriate measures for their correction". Can you tell us how you go about investigating complaints from the public and users?

Is there any guideline, rule or guideline on how user complaints should be handled until they are resolved and the complainant is satisfied? For example: does the inspection guide say anything about this?

The internal regulation of the General Health Inspection, approved by Ministerial Diploma n.297/2011, indicates that among the attributions of the Department of Administrative Inspection and Internal Audit, specifically of the Office of Administrative Inspection is: b) to investigate public complaints and users on the functioning of the institutions of the Ministry of Health and the National Health Service and f) verify that requests from health personnel and users are answered within the legally established deadlines.

Does the Health Inspection have a role in improving the humanisation and quality of health care in health units?

What is your connection with the User Assistance Offices that exist at provincial, district and health unit level?

Is there any way for citizens to present directly to the Health Inspection the concerns/complaints/complaints they may have about the health services received by the health units?

Can you give us an example of any situation in which the Health Inspection has been called to intervene to investigate any complaints from the public or users about the health services?

What are the biggest obstacles that the Health Inspection faces in this component of investigating complaints from the public and users?

What can be done to improve your ability to manage and respond to user complaints?

Annex 4: Guide for interviews with health providers

What should the patient do when he/she has a complaint or report about the services he/she received?

What is the follow-up of complaints made by users?

What is the nature of the complaints/complaints presented by users?

Is there any guideline, rule or recommendation on how user complaints should be handled until they are resolved and the complainant is satisfied?

Does this health facility have a co-management committee in place and functioning? If yes, what is the role of the co-management committee in the management of user complaints and complaints?

Is there any regulation that guides the constitution of the co-management committee and how is a quota guaranteed for the inclusion of the most vulnerable, who are the ones who have the most difficulties in accessing health services?

What kind of support do health providers in particular, and the health facility in general, need to deal with complaints made by users?

Annex 5: In-depth interview/focus group guide with members of the co-management committee

How and when did the co-management committee come about?

Who are your members?

Is there any regulation that guides the constitution of the co-management committee and how is a quota guaranteed for the inclusion of the most vulnerable, who are the ones who have the most difficulties in accessing health services?

What are your tasks/responsibilities? What is the role of the co-management committee in managing user complaints and complaints?

How do you collect information about user complaints, especially in the maternity ward? Do people/users usually approach the co-management committee to present complaints?

And what do they do with the collected information?

Does the committee usually meet? If so, what do they talk about at these meetings? Are user complaints discussed at these meetings?

Have you ever been asked or notified by the HC management to resolve a case reported by users using these numbers pasted on the walls?

What do you think needs to be done to make people feel more comfortable making complaints?

Annex 6: Guide for in-depth interviews with users

Where did you give birth? At home or in the maternity ward? Why?

If you did it in the maternity ward, why did you give birth in the maternity ward and not at home?

How was the treatment you received when you came to give birth?

Did you give the midwife anything before or after the birth? If so, do you think this is normal, paying the nurse to deliver?

And what do you usually do when you are not treated well?

Do you know that there are ways to complain if you feel that you have been treated poorly here at the hospital?

Do you know that there is a complaint box?

Have you ever approached a provider to present a complaint of poor service? If yes, what happened? If not, why?

Do you know the members of the Co-Management Committee? If so, do you know that you can file a claim or complaint with them?

What do you think should be done to improve care here at the health center?