# Strengthening Inclusive, Gender-Responsive and Accountable Community Health Governance Through Health Centre Committees in Masvingo District, Zimbabwe

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## ABSTRACT

Background: Health Centre Committees (HCCs) are intended to strengthen community participation, social accountability and local primary health care governance, yet many remain weakly constituted and insufficiently inclusive. This paper examines programme-associated changes in HCC functionality and other outcomes following structured capacity strengthening in Masvingo District, Zimbabwe. Methods: A comparative descriptive design used programme monitoring data from 18 Pangaea Zimbabwe ZIMACE-supported focus clinics assessed at baseline in July 2024 and during post-implementation monitoring in 2025, together with 18 non-focus clinics assessed as a comparison benchmark. Indicators included HCC membership size, gender composition, women in leadership, youth and persons with disabilities (PWD) representation, availability of feedback mechanisms and HCC meeting documentation and action plans. Results: HCC membership in focus clinics increased from 156 members at baseline to 200 post-implementation, exceeding the expected minimum of 198 members across 18 clinics; non-focus clinics had 111 members. Women's membership increased from 43.6% to 51.5% in focus clinics, compared with 42.3% in non-focus clinics. Youth and PWD representation increased from 22% to 66% in focus clinics, compared with 28% in non-focus clinics. Feedback mechanisms increased from 78% to 100% in focus clinics, compared with 72% in non-focus clinics. Women's leadership combining chairperson and vice-chairperson representation changed modestly from 33% to 35%, indicating that leadership transformation remains incomplete. Conclusion: Structured training, advocacy, mentorship and supportive supervision were associated with rapid strengthening of HCC functionality, inclusion and accountability. However, HCC strengthening must move from representation to influence by institutionalising women's leadership, youth and PWD participation, feedback-response loops, documentation quality and links to district decision-making.

**Keywords**: Community participation; disability inclusion; gender-responsive governance; Health Centre Committees; primary health care; social accountability; Zimbabwe.

## INTRODUCTION

Health Centre Committees (HCCs) are local health governance structures intended to link communities, health workers and district health authorities. They provide a platform for community voice, dialogue and oversight on primary health care, service access, patient rights, service responsiveness and local health priorities. In Zimbabwe, HCCs are legally recognised community health governance structures under Section 17 of the Public Health Act (2018), but many remain constrained by weak functionality, incomplete membership, limited inclusivity, irregular meetings, weak documentation and poor representation of socially excluded groups.

Community participation has long been central to primary health care. The Alma-Ata Declaration of 1978 located participation as both a right and a duty, stating that people have the right and responsibility to participate individually and collectively in the planning and implementation of their health care (WHO & UNICEF, 1978). The Astana Declaration of 2018 reaffirmed primary health care as the foundation for universal health coverage

and stressed that people and communities should be empowered as owners, advocates and co-developers of health and social services (World Health Organization, 2018).

HCCs are therefore not merely administrative health committees. They are mechanisms for social participation, community agency and co-determination in health systems. EQUINET regional evidence describes HCCs as common community and primary-care level mechanisms through which health systems can address community needs, become responsive and accountable, and create opportunities for social participation (Loewenson et al., 2014). Evidence from Zimbabwe suggests that communities in areas with HCCs have better knowledge of health-service organisation, stronger links with health workers and improved primary-care performance even in under-resourced settings (Loewenson et al., 2004).

Despite this potential, HCCs often exist in policy but vary widely in practice. Regional reviews show that HCCs differ in legal status, authority, resourcing, composition, capacities and monitoring arrangements, and that vague mandates and weak support can undermine their legitimacy and functioning (Loewenson et al., 2014; Karuga et al., 2022). This paper contributes programme evidence from the Pangaea Zimbabwe ZIMACE Project in Masvingo District on changes associated with structured HCC capacity strengthening and how these changes may inform more inclusive, gender-responsive and accountable local governance platforms.

### Objectives

The paper has five objectives: to assess the baseline status of HCC composition and functionality among ZIMACE focus clinics before implementation; to describe post-implementation changes in HCC membership, gender balance, leadership, youth/PWD inclusion and accountability mechanisms; to compare focus clinics with non-focus clinics as a programme learning benchmark; to interpret the findings in relation to evidence on community participation, gender equity, disability inclusion, youth engagement and social accountability; and to generate recommendations for HCC strengthening, institutionalisation and scale-up.

## LITERATURE REVIEW AND THEORETICAL FRAMEWORK

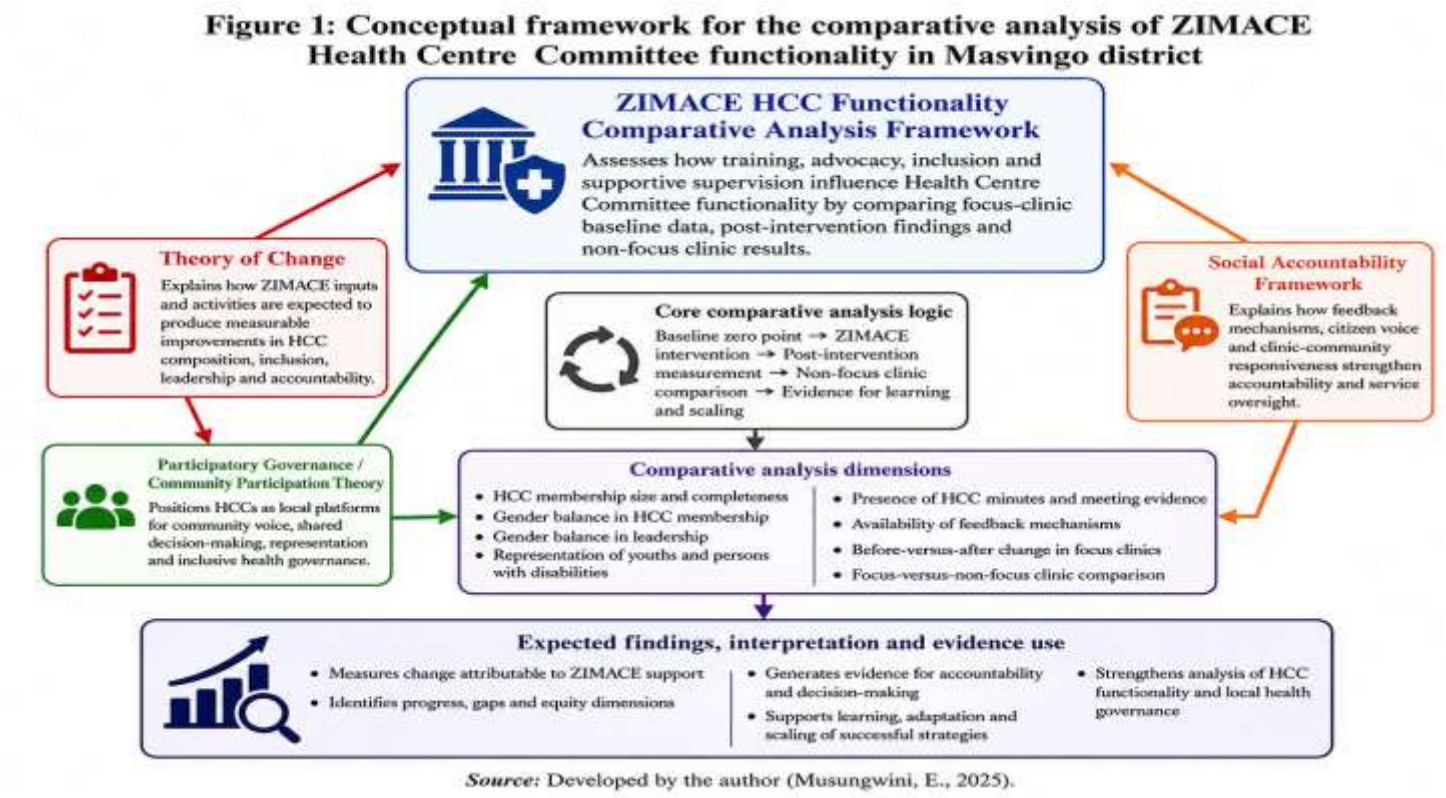


**Figure 1. Conceptual framework for the comparative analysis of ZIMACE Health Centre Committee functionality in Masvingo District. Source: Developed by the author (Musungwini, E., 2025).**

## HCCs, community participation and primary health care

Community participation is both a democratic value and a practical health-system strategy. HCCs operationalise participation at clinic and catchment-area level by enabling communities to identify needs, share experiences, raise concerns, contribute to planning and hold service providers accountable. Mulumba et al. (2018) argue that health committees can promote community participation as a social determinant of the right to health where they are recognised, capacitated and linked to decision-making. Haricharan et al. (2021b) similarly show that health committees can support primary health care participation, although their effectiveness depends on the quality and depth of participation.

For this paper, HCC functionality is understood not only as committee existence, but as a combination of membership completeness, inclusion, leadership diversity, meeting documentation, action planning and feedback-response capacity. This approach is consistent with EQUINET's framing of HCCs as vehicles for social participation in people-centred health systems (Loewenson et al., 2014).

## Social Accountability Framework

Social accountability refers to approaches through which citizens, communities or civil society organisations participate directly or indirectly in demanding accountability from public officials and service providers (Malena et al., 2004). In the ZIMACE context, suggestion boxes, Community Health Rights Champions, HCC minutes and clinic-community dialogue are treated as social accountability mechanisms. Evidence from Tanzania, Bangladesh and Kenya indicates that facility committees and feedback systems can strengthen responsiveness and accountability when feedback is captured, discussed, acted upon and communicated back to communities (San Sebastian et al., 2023; Mirzoev et al., 2021; Kagwanja et al., 2024).

## Participatory Governance and Community Participation Theory

Participatory governance refers to arrangements that enable citizens and non-state actors to participate in decision-making, priority setting, monitoring and service oversight. Arnstein's (1969) ladder of citizen participation shows that participation can range from token consultation to meaningful power-sharing. Contemporary governance literature links participation to legitimacy, accountability and more responsive public services (Fung, 2006; Gaventa & Barrett, 2012). HCCs operationalise participatory governance at local health-system level. In this paper, membership completeness, gender balance, youth/PWD inclusion and leadership diversity are treated as indicators of whether participation is broad, inclusive and meaningful.

## Gender, Equity and Inclusive Representation Lens

Committees can reproduce existing social hierarchies unless representation and leadership are intentionally addressed. WHO's gender and leadership analysis shows that women constitute about 70% of the global health and social workforce but hold only about 25% of senior roles, illustrating a persistent pattern in which health is delivered by women but led by men (WHO Gender Equity Hub, 2020). Hay et al. (2019) further argue that gender norms shape whose voices are heard, whose work is valued and whose priorities influence health agendas. These insights are relevant to HCCs because improving women's membership is necessary but insufficient unless women also influence leadership, agenda-setting and decisions.

The inclusion lens also extends to youths and PWDs. Youth engagement literature shows that meaningful youth participation can improve relevance, acceptability and uptake of health interventions, including HIV and sexual and reproductive health programmes in sub-Saharan Africa and Zimbabwe (Denison et al., 2017; Mackworth-Young et al., 2022; Melles & Ricker, 2018).

Disability inclusion is equally central to equity and universal health coverage. WHO's global report on health equity for persons with disabilities and a global scoping review show that PWDs face persistent barriers in healthcare access, while Zimbabwe-specific evidence highlights physical, communication, attitudinal and system barriers to disability-inclusive health care (World Health Organization, 2022; Greaux et al., 2023; Smythe et al., 2022).

### Theory of Change

The ZIMACE Theory of Change assumes that structured HCC training, advocacy, inclusion support, mentorship and supportive supervision improve knowledge, confidence, representation and operational functioning of HCCs. These changes are expected to strengthen community voice, accountability and responsiveness at clinic level. Theory of Change approaches are useful in implementation and evaluation because they make explicit the assumptions linking activities, outputs and outcomes (Weiss, 1995; Goodrich et al., 2020).

## METHODS

### Study design

The paper uses a comparative descriptive design based on project monitoring data (Aggarwal & Ranganathan, 2019). It compares three groups: focus clinics before ZIMACE implementation, the same focus clinics after ZIMACE support, and non-focus clinics assessed as a comparison benchmark. The analysis is designed for programme learning, accountability and evidence-informed decision-making rather than formal causal inference because it is a non-experimental design that identifies similarities, differences and patterns in programme-associated outcomes (Cantrell, 2011). For this reason, the paper uses cautious language such as observed change, programme-associated improvement and post-implementation difference rather than attributing changes solely to ZIMACE.

### Setting and sampling

The assessment was conducted in Masvingo District, Zimbabwe. Eighteen focus clinics were purposively selected for ZIMACE intervention in consultation with the District Health Executive, particularly the District Medical Officer and District Nursing Officer, and project stakeholders. Selection considered geographic balance across the north, south, east and west of the district, catchment area coverage, urban-rural mix and potential community reach. The focus clinics comprised four urban and fourteen rural facilities. Purposeful selection was appropriate for implementation because the clinics were selected for operational relevance rather than statistical representativeness (Palinkas et al., 2015). Eighteen non-focus clinics were also assessed to provide a comparison benchmark, not a randomised control group.

### Intervention description

The ZIMACE intervention combined structured HCC training, quarterly mentorship, supportive supervision, advocacy for inclusive membership, promotion of women's participation and leadership, inclusion of youths and PWDs, and strengthening of community feedback mechanisms. The main HCC training was delivered over three half-day sessions from 2 to 4 September 2024, with the 18 HCCs divided into three groups because of participant numbers and geography. Training content covered introduction to Pangaea Zimbabwe and the ZIMACE Project, HCC composition, roles and responsibilities, how HCCs work with communities, HCC roles in ZIMACE and safeguarding, documentation and reporting, resource mobilisation, financial management and procurement. Mentorship and supportive supervision were conducted quarterly and included observing HCC meeting proceedings where possible, reviewing previous meeting minutes, checking whether action plans were developed and followed up, encouraging inclusion of youth and PWD representatives, and strengthening feedback-response mechanisms. The intervention also promoted local problem-solving and collaboration between Nurses-in-Charge, HCC members, Community Health Rights Champions and community leaders.

### Indicators and analysis

Indicators assessed included presence of an HCC; number of HCC members; sex distribution of members; availability of HCC meeting minutes; representation of youths and PWDs; availability of feedback mechanisms; and sex distribution of chairperson and vice-chairperson roles. Counts, percentages and denominators were calculated and displayed using tables and figures. Where appropriate, 95% Wilson confidence intervals were calculated for proportions and simple exploratory comparisons were conducted using Fisher's exact tests for clinic-level binary indicators and two-proportion tests for person-level or leadership proportions (Wilson, 1927;

Fisher, 1922; Newcombe, 1998). These statistical comparisons were treated as descriptive and exploratory because the focus clinics were purposively selected, the sample size was small and the before-after design was not randomised. Leadership indicators were interpreted cautiously because some records had missing or inconsistent denominators, particularly for vice-chairperson positions.

### Data Collection, Verification and Ethics-Linked Implementation Approvals

Baseline data collection was conducted in July 2024 across the 18 focus facilities using the ZIMACE Project Health Facility Baseline Data Collection Checklist uploaded into Kobo Collect. Data were collected by Pangaea Zimbabwe programme staff, supported by an external/strategic information resource person for data quality and analysis, and accompanied by Ministry of Health and Child Care representatives: the District Nursing Officer's office supported rural clinic visits, while the Masvingo City Health Department Matron's office supported urban clinic visits. Data were obtained through face-to-face interviews with Nurses-in-Charge and HCC chairpersons, review of HCC minutes, action plans and monthly reports, and verification against facility records. Post-implementation monitoring data were compiled during 2025 after the September 2024 HCC training and quarterly mentorship/supportive supervision visits. Data quality was strengthened through triangulation of interview responses with documentary evidence, review of meeting minutes and registers, verification by programme and district health personnel, and consistency checks during aggregation. The non-focus clinic assessment used the same core indicator categories to provide a practical district comparison benchmark.

## RESULTS

**Table 1. Comparative summary of HCC functionality indicators.**

| Indicator | Focus baseline | Focus post-intervention | Non-focus clinics | Interpretation |
|---|---|---|---|---|
| Total HCC members | 156 | 200 | 111 | Observed increase in focus clinics; non-focus clinics remained under-established. |
| Average HCC members per clinic | 9 | 11 | 6 | Focus clinics reached the expected average membership after support. |
| Female HCC membership | 43.6% | 51.5% | 42.3% | Women's representation increased in focus clinics and exceeded non-focus clinics. |
| Female combined leadership | 33% | 35% | 27% | Leadership inclusion changed modestly and remains an implementation gap. |
| Clinics with youth/PWD representation | 22% | 66% | 28% | Important programme-associated inclusion gain, but representation is not yet universal. |
| Clinics with feedback mechanisms | 78% | 100% | 72% | All focus clinics had documented feedback channels post-implementation. |
| Clinics with HCC minutes available | 89% | 100% | 100% | Documentation availability increased; frequency and quality still require audit. |

**Table 2. Indicator denominators and data completeness used for the comparative analysis.**

| Indicator | Focus baseline numerator/ denominator | Focus post-implementation numerator/denominator | Non-focus numerator/ denominator | Denominator note |
|---|---|---|---|---|
| Total HCC members | 156 members / 198 expected | 200 members / 198 expected | 111 members / 198 expected | Expected minimum based on 11 members per clinic across 18 clinics. |
| Female HCC membership | 68 / 156 | 103 / 200 | 47 / 111 | Person-level denominator: total recorded HCC members. |
| Women in chairperson roles | 4 / 18 | 4 / 18 | 2 / 18 | Clinic-level denominator: expected one chairperson per clinic. |
| Women in vice-chairperson roles | 7 / 18 recorded/expected | 8 / 18 recorded/expected | 7 / 18 recorded/expected | Vice-chairperson records had missing/inconsistent entries; interpreted cautiously. |
| Women in combined chairperson and vice-chairperson roles | 12 / 36 expected positions | 12 / 34 complete/usable records | 9 / 33 complete/usable records | Combined leadership denominator varies because some leadership records were missing or inconsistent. |
| Clinics with youth/PWD representation | 4 / 18 | 12 / 18 | 5 / 18 | Clinic-level denominator: all assessed clinics. |
| Clinics with feedback mechanisms | 14 / 18 | 18 / 18 | 13 / 18 | Clinic-level denominator: all assessed clinics. |
| Clinics with HCC minutes available | 16 / 18 | 18 / 18 | 18 / 18 | Clinic-level denominator: all assessed clinics; frequency and quality varied. |

**Table 3. Exploratory confidence intervals and simple comparisons for selected focus-clinic indicators.**

| Indicator | Baseline % (95% CI) | Post-implementation % (95% CI) | Exploratory p-value | Interpretation |
|---|---|---|---|---|
| Female HCC membership | 43.6% (36.1-51.4) | 51.5% (44.6-58.3) | 0.138 | Directionally improved, but not statistically significant in this descriptive dataset. |

| | | | | |
|---|---|---|---|---|
| Female combined leadership | 33.3% (20.2-49.7) | 35.3% (21.5-52.1) | 0.863 | Leadership change was modest and uncertain. |
| Clinics with youth/PWD representation | 22.2% (9.0-45.2) | 66.7% (43.7-83.7) | 0.018 | Strongest observed inclusion signal; interpret cautiously due to small sample. |
| Clinics with feedback mechanisms | 77.8% (54.8-91.0) | 100.0% (82.4-100.0) | 0.104 | Observed improvement; small sample limits inference. |
| Clinics with HCC minutes available | 88.9% (67.2-96.9) | 100.0% (82.4-100.0) | 0.486 | Documentation availability improved; quality still requires audit. |

Note: Confidence intervals are Wilson 95% confidence intervals. P-values are exploratory only and were calculated using two-proportion tests for person-level/leadership proportions and Fisher's exact tests for clinic-level binary indicators. They are not intended to establish causal effects.

**HCC membership strength**

The results below report counts, percentages and denominators to improve transparency. Because the design is descriptive and non-randomised, statistical comparisons are presented only as exploratory summaries of uncertainty rather than as causal evidence.

HCC membership increased in focus clinics during the implementation period. Total membership changed from 156 members at baseline to 200 members post-implementation, exceeding the expected 198 members across 18 clinics. Non-focus clinics had 111 members, equivalent to 56% of the expected minimum. This suggests better membership completeness in ZIMACE-supported clinics, although the descriptive design does not permit attribution to the intervention alone.

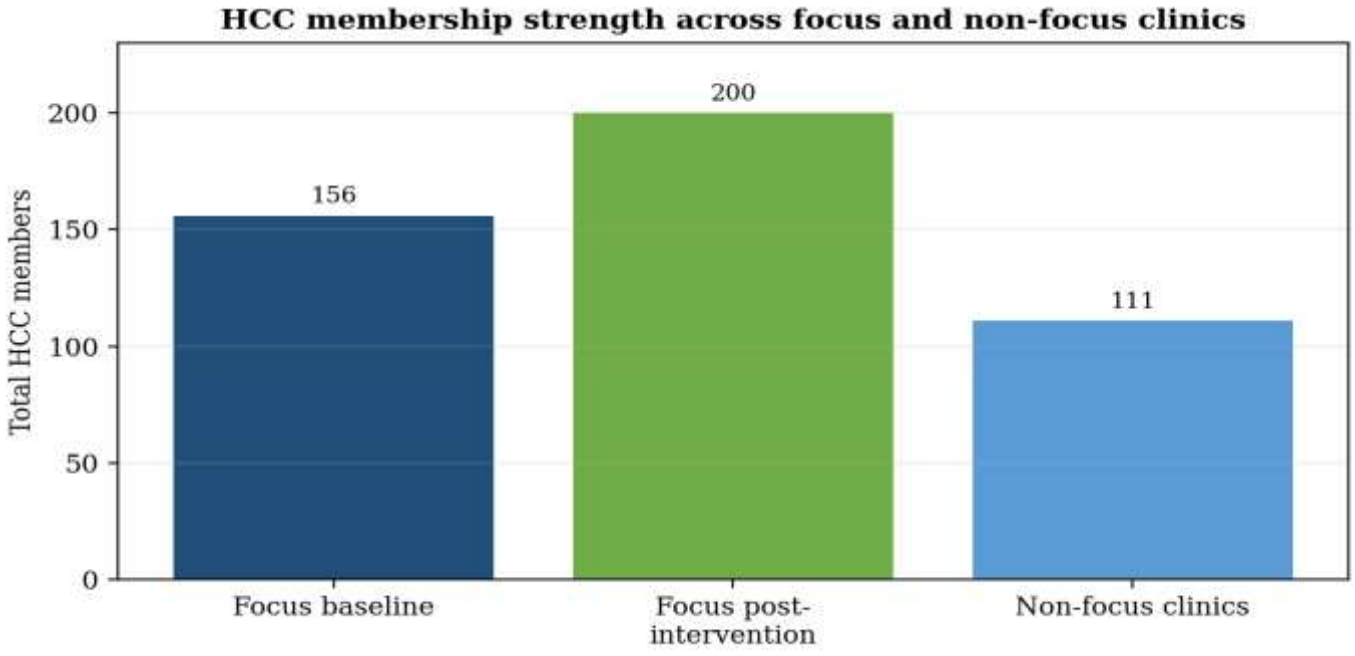


**Figure 2. HCC membership strength across focus baseline, focus post-intervention and non-focus clinics.**

**Gender balance in HCC membership**

Women's representation among HCC members increased from 43.6% at baseline to 51.5% post-implementation. Non-focus clinics remained male-dominated, with women representing 42.3% of members. The exploratory comparison for female membership was not statistically significant, but the direction of change is consistent with the programme focus on gender-responsive HCC strengthening.

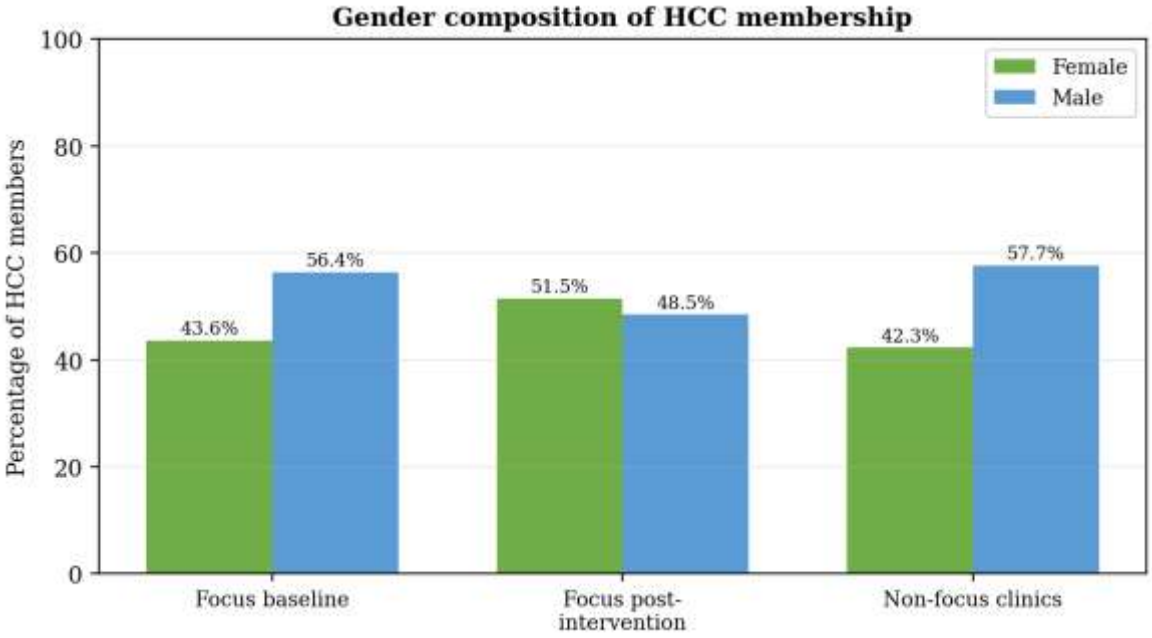


**Figure 3. Gender composition of HCC membership in focus and non-focus clinics.**

**Gender representation in HCC leadership**

Women's representation in combined HCC chairperson and vice-chairperson roles changed modestly from approximately 33% to 35%, compared with 27% in non-focus clinics. This indicator should be interpreted cautiously because some vice-chairperson records had missing or inconsistent denominators. The finding suggests that improvements in general membership representation did not automatically translate into leadership transformation.

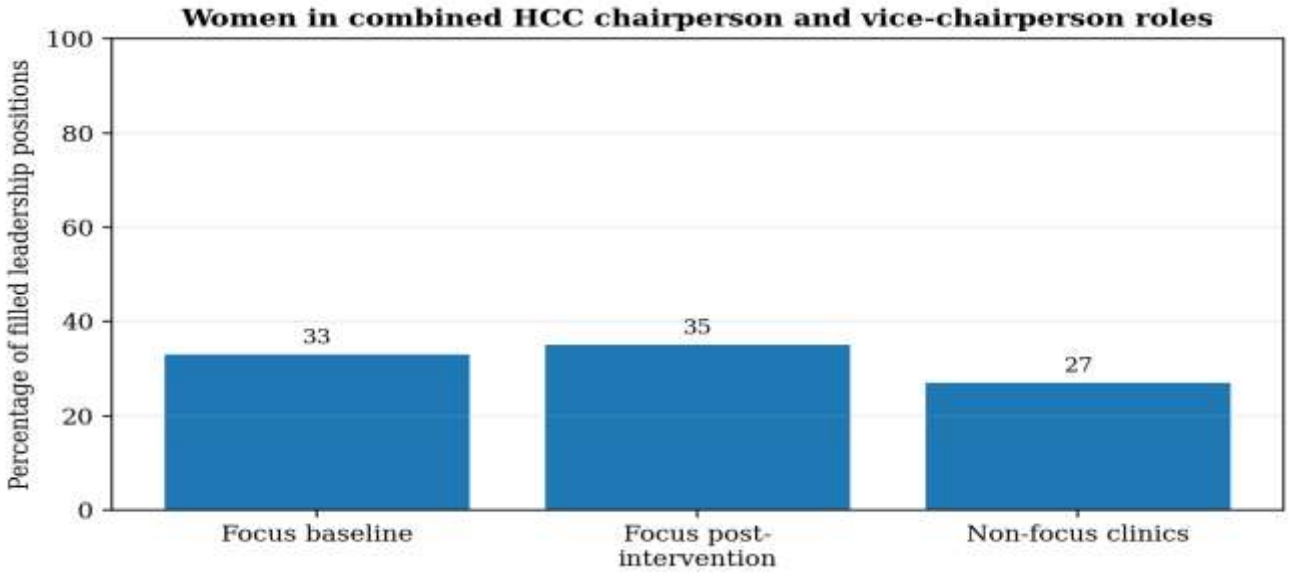


**Figure 4. Women in combined HCC chairperson and vice-chairperson roles**.

**Inclusion of youths and persons with disabilities**

Representation of youths and PWDs increased markedly in focus clinics, rising from 22% to 66%, compared with 28% in non-focus clinics. This was the strongest observed programme-associated improvement and is consistent with intentional ZIMACE advocacy for inclusive community health governance. However, 34% of focus clinics still lacked youth/PWD representation, indicating the need to continue support until inclusion becomes universal.

**Feedback mechanisms and accountability**

Feedback mechanisms improved from 78% at baseline to 100% among focus clinics. This indicates that every focus clinic had at least one documented feedback channel, such as suggestion boxes or Community Health Rights Champions. Non-focus clinics stood at 72%. The improvement strengthens social accountability and the ability of women, girls, youths, PWDs and community members to raise concerns on health rights, access and service quality.

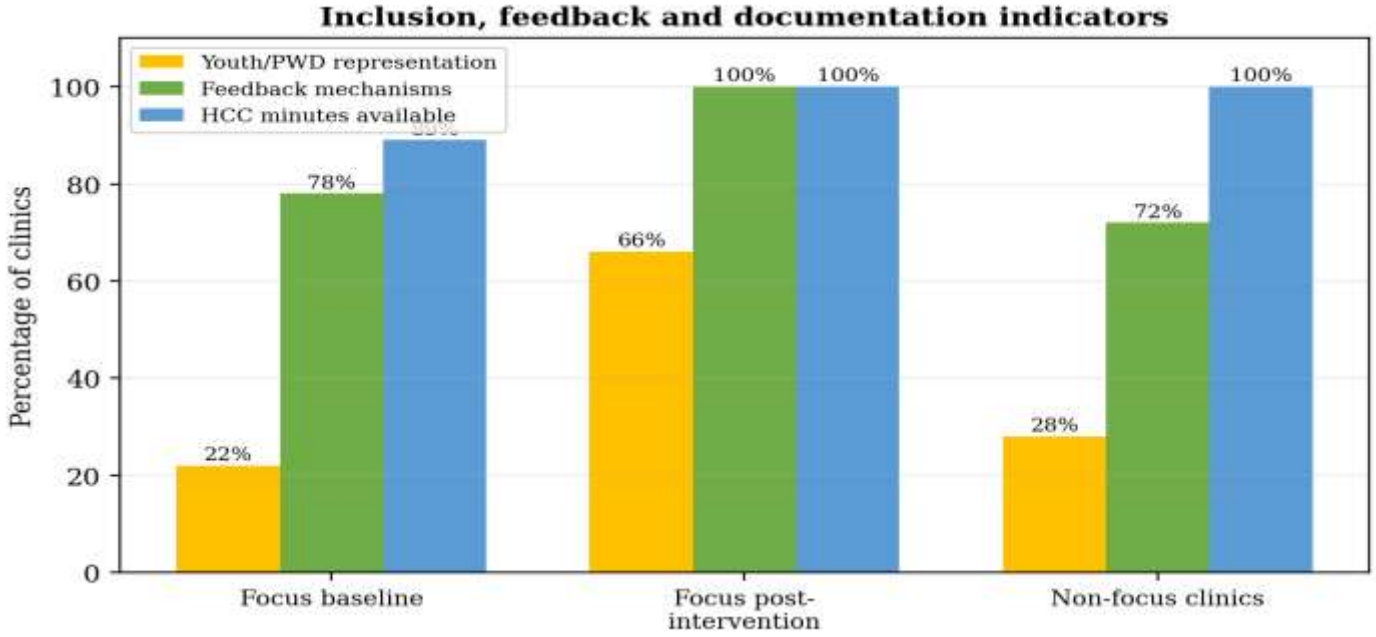


**Figure 5. Inclusion, feedback and documentation indicators across focus and non-focus clinics.**

**HCC documentation and meeting minutes**

Documentation improved among focus clinics, with availability of HCC minutes increasing from 89% at baseline to 100% post-intervention. Non-focus clinics also reported availability of minutes in all facilities, although frequency and quality varied. Future monitoring should assess whether minutes capture attendance, agenda items, action points, responsible persons, timelines and follow-up decisions.

## DISCUSSION

The findings support the view that HCCs are a vital link between communities and health facilities. In ZIMACE-supported clinics, membership increased, feedback mechanisms became universal across focus clinics and inclusive representation improved after training and mentorship. Given the non-experimental programme monitoring design, these changes should be interpreted as programme-associated improvements rather than definitive causal effects. The findings suggest that functional HCCs can convert the principle of community participation into practical local governance arrangements. They also align with Zimbabwean evidence showing that HCCs are associated with improved health resources, primary health care performance, community knowledge of service organisation and links between communities and health workers (Loewenson et al., 2004).

The improvement in women's HCC membership from 43.6% to 51.5% is a significant equity gain. Gender-balanced HCCs are more likely to make visible issues affecting women and girls, including respectful care, privacy, sexual and reproductive health needs, HIV prevention and care barriers, waiting times, safety and affordability. However, the modest increase in women's combined leadership from 33% to 35% shows that representation does not automatically translate into power. This mirrors global health leadership patterns in which women deliver much of health and social care but remain underrepresented in senior decision-making roles (WHO Gender Equity Hub, 2020).

The increase in youth and PWD representation from 22% to 66% of focus clinics is one of the most important programme-associated changes. It shows that general community representation is not enough; inclusion must be intentional, monitored and supported. The exploratory Fisher's exact comparison suggested that this was the clearest statistical signal among the clinic-level indicators, although it should still be interpreted cautiously because of small sample size and purposive site selection. Youth participation can improve relevance and acceptability of health interventions, while PWD representation can help identify practical barriers at clinic level and advocate for reasonable accommodation, respectful care and accessible feedback systems (Mackworth-Young et al., 2022; Greaux et al., 2023; Smythe et al., 2022).

The increase in feedback mechanisms from 78% to 100% in focus clinics is a central social accountability gain. Feedback systems are important because participation is weak if communities can speak but receive no response. In the ZIMACE model, feedback mechanisms such as suggestion boxes and Community Health Rights Champions were linked to HCCs and Nurses-in-Charge. However, the baseline findings also showed that feedback channels can be sub-optimally used where suggestion boxes are not opened regularly, keys are kept at the facility or anonymity is not trusted. This matters because feedback systems require an institutional pathway for discussion, documentation, response and communication back to communities (Mirzoev et al., 2021; Isangula et al., 2023; Kagwanja et al., 2024).

The findings also show that HCCs require more than legal recognition or appointment of members. They need capacity strengthening, mentoring, documentation tools, role clarity and supervision. Regional work has identified HCC capacity gaps in representing community needs, planning, budgeting, networking, monitoring services, documentation and feeding back to communities (Loewenson et al., 2014). The ZIMACE intervention addressed these issues through training, advocacy and supportive supervision, and the monitoring data show programme-associated gains in membership completeness, youth/PWD representation, feedback mechanisms and documentation.

### Policy And Programme Implications

HCC strengthening should be treated as a health equity intervention, not merely as a community mobilisation activity. Inclusive HCCs can make visible the concerns of women, youths, PWDs and other groups whose barriers to care may otherwise remain hidden.

HCCs need clear roles, operational tools and recognition within district health systems. Feedback mechanisms should be institutionalised as feedback-response loops because suggestion boxes and community reporting channels only strengthen accountability when concerns are documented, discussed, acted upon and communicated back to communities. Gender balance in HCC membership should be accompanied by leadership transformation. Youth and disability inclusion should be monitored as core functionality indicators, with representation supported by accessible meeting arrangements, orientation and links to youth and disability networks. HCC data should become part of routine district monitoring, with standard tools covering membership, meetings, minutes, action plans, feedback and inclusion indicators.

## RECOMMENDATIONS

Consolidate HCC membership and functionality by maintaining routine tracking of HCC composition, vacancies, meeting frequency, minutes and action plans. Each clinic should maintain the expected minimum number of HCC members and ensure that HCCs meet at least quarterly.

Move from gender representation to gender-responsive leadership by providing targeted leadership mentoring for women HCC members, promoting women's nomination and election into chairperson and vice-chairperson roles, and tracking leadership by sex in routine reporting.

Institutionalise youth and PWD representation by requiring every HCC to include youth and PWD representatives and ensuring that their participation is meaningful through orientation, accessible meeting arrangements, inclusive communication and support from local disability and youth networks.

Standardise feedback and response mechanisms so that every clinic has at least one functional feedback channel and a documented process for receiving, reviewing, acting on and reporting back on community feedback. HCC minutes should include feedback received, actions agreed, responsible persons and status of resolution.

Strengthen HCC capacity building through standardised training materials covering HCC roles, health rights, gender-responsive governance, disability inclusion, youth participation, meeting management, minute taking, action planning, safeguarding, resource mobilisation and social accountability.

Scale the model to non-focus clinics using ZIMACE-supported clinics as learning sites, prioritising facilities with low membership, weak inclusion and limited feedback mechanisms.

### Limitations

The analysis is descriptive and based on programme monitoring data, so findings should be interpreted as programme learning evidence rather than definitive causal proof. Focus clinics were purposively selected in consultation with district stakeholders; this was appropriate for programme implementation but limits statistical generalisability. The non-focus clinic group provides a practical benchmark but was not randomly selected and should not be interpreted as a controlled counterfactual. Several indicators are based on clinic-level counts across only 18 focus clinics, limiting precision and statistical power. Leadership indicators contained some missing or inconsistent denominators, particularly for vice-chairperson positions, and therefore required cautious interpretation. The analysis also relied mainly on documented records and aggregate monitoring data; it did not include qualitative interviews with HCC members, community members, women and girls, youths or PWD representatives to assess participation quality or influence. Future studies should examine whether stronger HCC functionality leads to measurable changes in service uptake, complaint resolution, facility responsiveness, health literacy and community trust.

## CONCLUSION

The ZIMACE Project provides programme evidence that deliberate investment in HCC capacity strengthening is associated with rapid improvements in inclusive community health governance at primary care level. Focus clinics changed from 156 to 200 HCC members, exceeded expected membership levels, improved women's representation, increased youth and PWD inclusion and achieved universal availability of feedback mechanisms. Compared with non-focus clinics, ZIMACE-supported clinics performed better across most functionality and inclusion indicators, although these findings should be interpreted in light of the descriptive non-randomised design.

The results are consistent with regional and global literature showing that community participation, social accountability and inclusive local governance are essential to people-centred primary health care. They also show that legal recognition of HCCs is not enough. HCCs need training, mentorship, role clarity, documentation tools, feedback-response systems, inclusive representation and links to district decision-making. The next stage should focus on deepening leadership inclusion, especially for women, youths and PWDs; strengthening feedback loops; improving data quality; and scaling effective practices to non-focus clinics.

### Ethical Considerations

This manuscript uses aggregated programme monitoring data collected for implementation learning and quality improvement. No individual patient records, names or personal identifiers are reported. Formal research ethics

review was not sought because the manuscript analyses routine programme monitoring and quality improvement data rather than human-subject clinical research. The ZIMACE Project was introduced to, and implemented with, relevant provincial and district health and other authorities, including the Ministry of Health and Child Care Provincial Medical Director, District Medical Officer, District Health Executive, Masvingo City Health Services, Provincial and District Development Coordination structures and local authority stakeholders. The project approval and clearance process included letters and support from health and local government authorities permitting Pangaea Zimbabwe to operate in Masvingo Province and District. Data use followed programme accountability, confidentiality, safeguarding and aggregate reporting principles, and all analysis is reported at facility or programme level.

## FUNDING

The ZIMACE Project was supported through the DAI/ZIMACE Project Grant. The funder did not determine the interpretation presented in this manuscript.

### Conflict of Interest

The authors declare no competing interests.

### Data Availability

Aggregated data underlying the analysis may be made available by the corresponding author on reasonable request, subject to Pangaea Zimbabwe and district stakeholder approval.

### Author Contributions

Enock Musungwini conceptualised the paper, led analysis and drafted the manuscript. Belinda Magarira, Rudo Shantel Mutyasira and Sophie Mudzingwa contributed to implementation documentation, field learning, data verification and manuscript review. All authors approved the submission version.

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