An exploration of the perceptions of Community Health Workers on the enablers and barriers to providing services in Nyanga District, Zimbabwe

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of

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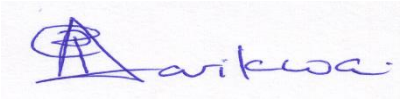
DECLARATION

I, Patricia Darikwa declare that this research report is my own work. It is being submitted in part fulfillment of the requirements for the degree Master in Public Health at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at this or any other University.



6 June 2016

DEDICATION

This work is dedicated to my family for your continued support and understanding. Special dedication to my daughter Mazvita who kept asking me to finish my studies, I finally made it my love. To my work colleagues who covered the work at the office when I was doing my school work, Dr Anna Miller, Dr Davies Dhlakama and Dr Assaye Kassie, thank you. To my mum for bearing with me, you did not complain when you did not see me for months on end. To Tunga, Marian and sis Charlotte for being excellent hosts during my visits to South Africa for my studies .To all the Community Health Workers who give a different meaning to work.

ABSTRACT

Background: The work of Community Health Workers is appreciated in most setups in both developing and developed countries. In Zimbabwe there are a number of cadres who are working to bridge the health services and the community. There has however been limited documentation on the perspectives of Community Health Workers on what enables them to do their work and also barriers they face in providing their services.

Aim: The study aimed to explore the perceptions of CHWs on the enablers and barriers to providing services in Nyanga district in Zimbabwe.

Method: The study used a qualitative methods of in-depth interviews with Community Health Workers and key informants and document reviews. A thematic content analysis was used to identify key themes. The themes were then further analysed to identify the enablers and barriers to community health work.

Results and Conclusion: The major enablers of the CHW work were perceived to be the benefits which have accrued to the communities the CHWs were working with, the benefits which the CHWs had gained and the support given by the hospital, NGO and the community leadership. The following were perceived to be the major barriers to CHW work: limited access to health services by the communities from the health facilities driven by the weak macroeconomic conditions in the country, gaps in support services, workload and geographical coverage. The recommendations include improving the motivation of the CHWs through efficient payment system, improving on quality of care and processes in the service provision. The results provide insights into CHW work which can assist policy makers and managers in making informed decisions on the investments they make for the CHW programmes in Nyanga district and Zimbabwe in general.

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ABBREVIATIONS

AIDS	Acquired Immuno-deficiency Syndrome
ART	Anti-retroviral Therapy
ARVs	Anti-retroviral drugs
BCF	Behaviour change facilitator
CBO	Community Based Organization
CHBC	Community Home Based Care
CHWs	Community Health Workers
CIDA	Canadian International Development Agency
DFID	Department of International Development
DMO	District Medical Officer
EHT	Environmental Health Officer
EPI	Expanded Programme on Immunisation
FP	Funding Partner
GFTAM	Global Fund against Tuberculosis AIDS & Malaria
HIV	Human Immuno-deficiency Virus
HRH	Human Resources for Health
HTC	HIV testing and counseling
HTF	Health Transition Fund
IMCI	Integrated management of Childhood Illnesses
JRM	Joint Review Mission
MCHIP	Maternal and Child Health Integrated Programme
MICS	Multiple Indicator Cluster Survey

MOHCW	Ministry of Health & Child Welfare
MOHCC	Ministry of Health and Child Care
MUAC	Middle Upper Arm Circumference
NAC	National AIDS Council
NATF	National AIDS Trust Fund
NCD	Non-Communicable Disease
NGO	Non-Governmental Organization
NIHFA	National Integrated Health Facility Assessment
OECD	Organisation for Economic Cooperation and Development
OI	Opportunistic Infections
OVC	Orphans and vulnerable Children
PC	Primary Counsellor
PHC	Primary Health Care
PMD	Provincial Medical Director
RDT	Rapid Diagnostic Testing
TB	Tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations Fund for Children
UNFPA	United Nations Population Fund
VHW	Village Health Worker
VMAHS	Vital Medicines Availability and Health Services Survey
WHO	World Health Organisation
ZIMSTAT	Zimbabwe National Statistics Agency

CHAPTER ONE: INTRODUCTION

1.1 Background

The Zimbabwe National Health Strategy 2009-2015 mission statement is equity and quality in health: a people's right (Ministry of Health and Child Welfare 2013). In this strategy one of the goals is enhancement of community participation through revitalization of the Village Health Worker (VHW) and other Community Health Workers (CHWs) (The Global Fund to Fight Against AIDS, TB & Malaria 2012).

Like most sub-Saharan African countries, Zimbabwe is suffering from a severe human resources shortage which has been worsened by the economic crisis which has seen many qualified Zimbabweans migrating from the country to work across borders and internationally (Vujicic et al. 2004). The country has had to deal with the HIV and AIDS pandemic and like most Southern African countries, it has also been in the race to meet the Millennium Development Goals (MDGs) public health targets before the end of 2015 (Campbell & Scott 2011). With an HIV prevalence of 14.26% in 2009 (National AIDS Council 2011) and maternal mortality ratio of 614 per 100,000 births, and under 5 mortality rate of 75 per 1000 live births in 2010, a lot of work still needs to be done (ZIMSTAT & Key Findings MICS 2014) (Ministry of Health and Child Welfare 2012).

Zimbabwe socio-economic and political context

According to the 2011 census for Zimbabwe, the total population of Zimbabwe is 13,061,239, with 67% of this population being rural based (Zimstats, 2012). Over 72% of the population is living below the poverty datum line with poverty levels relatively higher in rural areas (84.3%) especially in households that are solely dependent on subsistence farming for their livelihood (Demographic Health Survey, 2010/11).

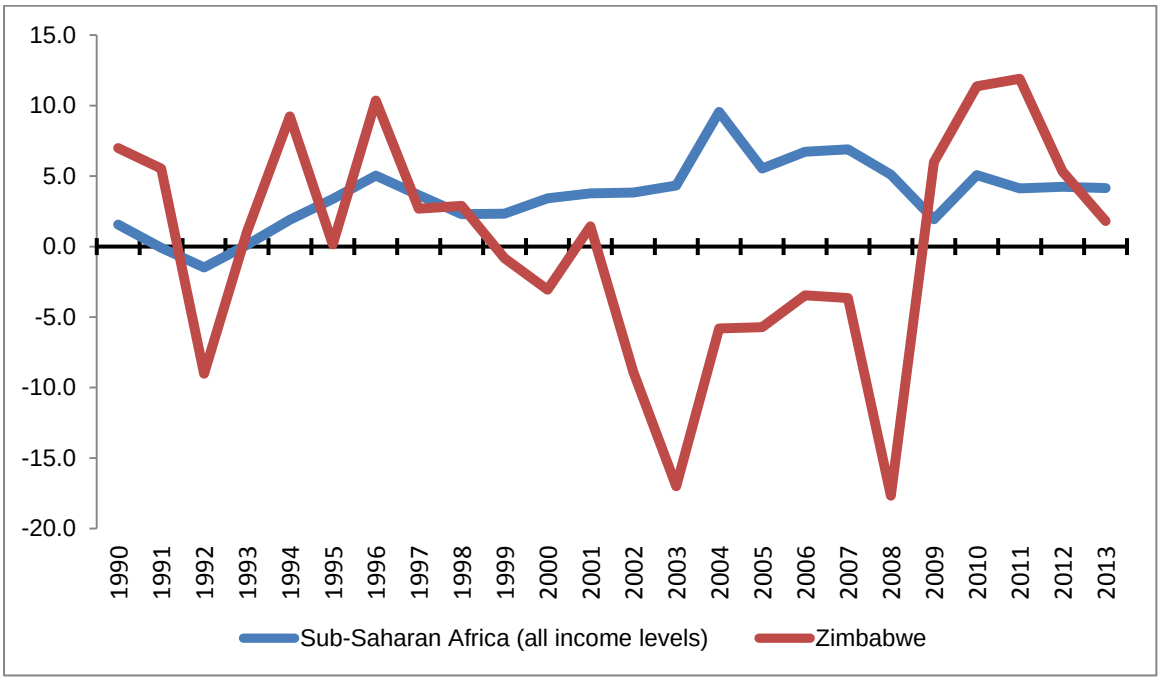
The Zimbabwe Health Transition Fund document states that, during the 1980s and the 1990s, a highly effective health system was in place in Zimbabwe. Key characteristics were: Efficacy of organizational structure based on national governance, provincial leadership, and district management of the health system; adequate public expenditure on health (in excess of US$40 per capita); public/community support for health interventions by a well-educated population; well prepared and supervised health professional staff; and functioning information and logistical support systems (Ministry of Health and Child Care, 2011).

Zimbabwe witnessed sharp political polarization, economic and social deterioration between 2000 and 2008 resulting in a deep economic and social crisis characterized by a hyperinflationary environment and low industrial capacity utilization, leading to the overall decline in Gross Domestic Product (GDP) by 50% in 2008 as shown in figure 1 below (Government of Zimbabwe, 2013). This was at the backdrop of a radical Fast Track Land Reform Program (FTLRP) and deindustrialization.

This economic phenomenon resulted in the replacement of the Zimbabwean dollar with multicurrency in 2009 and the establishment of the Government of National Unity (GNU). The multicurrency system helped to restore confidence in the economy resulting in notable economic growth from -14.3% in 2008 to growth rate of 5.4% in 2009, 11.4% in 2010 and 11.9% in 2011 (Figure 1). This though started to decline with the end of the Government of National Unity (GNU) in 2012 (Ministry of Health and Child Care, 2013). The recovery remained fragile, which is indicative of incomplete economic transformation (UNICEF, 2015). The budget allocation to health stagnated at 8-9% of the total government budget between 2009 and 2013 which is below the Abuja Declaration (2001) benchmark of 15% of the total government budget.

The figure 1 below summarises the performance of the Zimbabwe Gross Domestic Product from 1990 to 2013 against the average for sub-Saharan Africa.

Figure 1: GDP Trends, Zimbabwe and Sub-Saharan Africa, 1990-2013



UNICEF, Zimbabwe Situational Analysis, 2014

Given this situation the health sector has not managed to retain skilled personnel and the required resources for adequate health service delivery. In addition due to this the, central government froze staff appointments which made it difficult for the public health to fill vacant posts thereby compromising health service delivery. In the 2013 Zimbabwe Health profile, the country had 1034 doctors for the 13 million population and 15,539 nurses in the public institutions, translating to doctor density of 0.081/1000 population while nurses were 1.189/1000 population. This was below the WHO recommended 0.2/1000 doctors density and 2.5/1,000 for nurses (WHO, 2014). The vacancy rate for doctors in 2009 was at 52% and for nurses it was at 16% (Health Services Board, 2013).

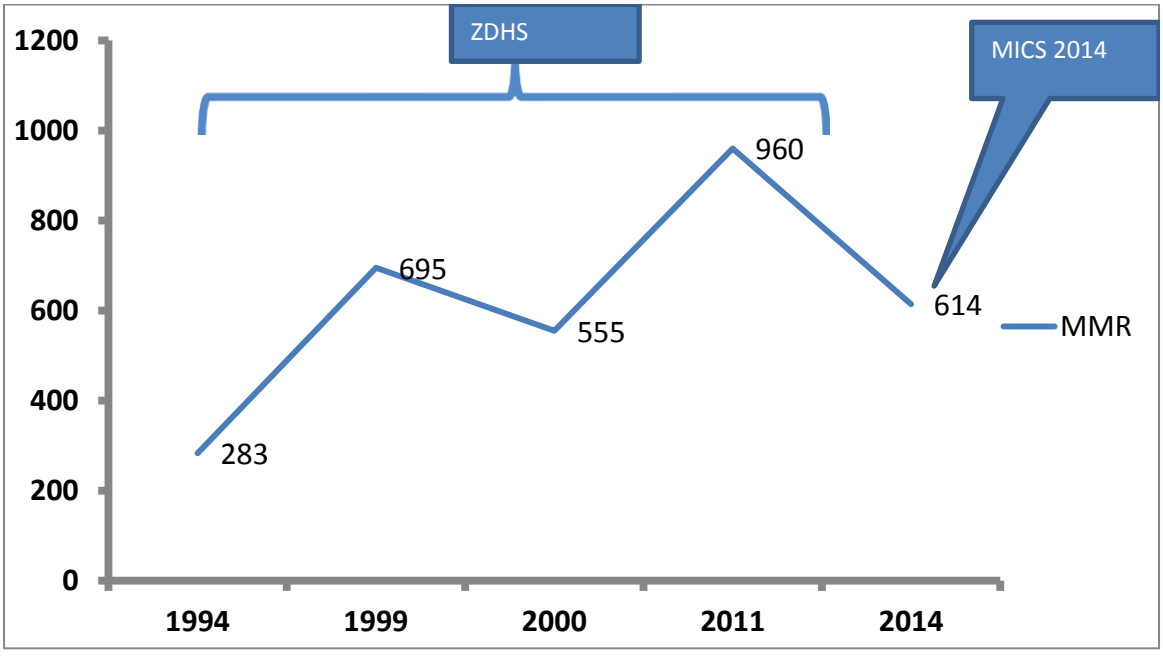
Coverage of most basic services stagnated and most health indicators deteriorated as the economy ground to a near halt. Maternal deaths increased and child mortality rates rose as access to quality health services

became difficult for the most vulnerable of the population, (Ministry of Health and Child Care, 2012). According to the Zimbabwe Demographic Health Survey (ZDHS), 2010/2011 maternal mortality ratio was 960 deaths per 100,000 live births for the period, 2007-2014, (ZimStats, 2010/11). The Multiple Indicator Cluster Survey (MICS) results of 2014 gave an improved figure of 614 maternal deaths per 100,000 live births, an improvement from 2010 but far from meeting the 2015 Millennium development goal target of 174 deaths per 100,000 live births and far below the 1994 (20 years earlier) figure of 283 maternal deaths per 100,000 live births.

Maternal mortality ratio is one indicator which depicts the performance of a health

System and the graph below (Fig 2) summarises how the health sector has been performing in the last twenty years.

Figure 2 Maternal mortality trends for Zimbabwe (1994-2014)



Source, Zimstats Multiple Indicator Cluster Survey, 2014

A number of funding mechanisms from development partners had been established to support and revitalize Zimbabwe's health sector. The major ones were the Health Transition Fund, and the Global Fund for HIV, TB and Malaria, and a notable increase in government spending to 24 USD per capita was noted. The 82% of government contribution was absorbed by the wage bill.

Community Health Workers in Zimbabwe

The issue of the CHW is not a recent phenomenon to Zimbabwe, as the country has been focusing on primary health care as a principle for public health delivery (Zimbabwe Ministry of Health and Child Welfare 2012).

As soon as the country adopted the primary health care approach in 1980, it immediately started to work on the concept of CHWs. According to the Zimbabwe Village Health Worker Handbook, the Village Health Worker dates back to 1981 (Ministry of Health and Child Care, 2013). This was the first CHW followed by the Community Home Based Care Givers who became prominent at the peak of the HIV epidemic in 2003. The BCFs came on board in 2006 (National AIDS Council, 2011).

The table below is from a mapping exercise done on the CHWs in Zimbabwe in 2015. It gives the six most widely functional cadres in the country with the highest coverage being given by the VHW.

Table 1.1 Main Community Health Workers in Zimbabwe

Cadre Title	No. of Agencies Managing that Cadre Type	Cadre Total	Functions
Behaviour Change Facilitator (BCF)	17	4 081	Advocacy work on HIV related activities, gender based violence and sexual rights

Cadre Title	No. of Agencies Managing that Cadre Type	Cadre Total	Functions
Community and Home Based Care Giver (C&HBC)	16	6 801	Caring for the terminally ill in the community and drug adherence monitoring
Community Child Care Worker (CCCW)	12	9 122	Advocacy work on how to tend to the new born and children under the age of 5 years
Peer Educator-ASRHR	9	4 297	Peer education on adolescence sexual reproductive and health rights
Sanitation Action Group (SAGs)	1	4 102	Advocacy and education of communities of water and sanitation activities, including management of water points and construction of toilets
Village Health Worker (VHW)	20	13 490	Link between health facilities and the communities, advocacy work on good health seeking behaviour for all and training of communities of water borne diseases, early booking for Antenatal care and treatment of minor ailments and malaria

Adapted from MoHCC/UNFPA 2016 Report

The mapping report indicated that there were 77 different cadres and a total of 87,000. However some of these cadres are only found in one ward while others are not available in other districts at all. The Behavior Change Facilitators and the Village Health Workers have a wider geographical coverage and have a wider scope in their responsibilities, (MoHCC, 2016). In the same mapping exercise it is stated that all the other cadres tend to have linkages with the VHWs who are also the main link to the health facilities, (MoHCC, 2016). My research focused on the main CHW cadres in Zimbabwe, the Village Health Workers (VHWs) and the Behaviour Change Facilitators (BCFs).

The new pressures have certainly rekindled the interest in the CHW for the country. This has resulted in the revitalisation of the Village Health Worker (VHW) programmes which coincided with the 2008/9 cholera

outbreak (The Global Fund to Fight AIDS, TB & Malaria 2012). The interest and the pivotal role of the CHW has resulted in funding being set aside for CHW work in three major investments into the country: The Global Fund to Fight AIDS, TB and Malaria (GFTAM), the multi donor pooled Health Transition Fund for Health (HTF), (Ministry of Health and Child Welfare, 2012) and the Maternal and Child Health Integrated Programme (MCHIP) all have an investment into CHWs. Success has been recorded in the HIV response resulting in a decrease in HIV prevalence with partial attribution to CHWs (GFATM, 2012).

There are an estimated 87,000 CHWs available in the country who have been trained by the government and some non-governmental organisations (Zimbabwe Ministry of Health and Child Welfare, 2016). These can be village health workers, community home based care givers, community based distributors, behavior change facilitators or peer educators to name but a few. Apart from the training, some have been given bicycles, uniforms, badges and kits to use during their work (GFATM, 2012).

The VHW handbook gives the following as the areas which the VHW should attend to at the primary health care level: Sexual and Reproductive Health, Adolescent Sexual and Reproductive health, STIs including HIV and AIDS, PMTCT, VCT and Counselling, Nutrition, Infant and Young Child Feeding, IMNCI including the community IMNCI, Expanded Programme on Immunisation (EPI), Environmental Health, Hygiene, Water and Sanitation, Diarrhoeal diseases; cholera, typhoid and dysentery, Malaria, Epidemic prone diseases such influenzas, Tuberculosis, Anthrax and Rabies, Communicable Diseases and Non-Communicable Diseases, Oral Health Education, Diabetes, Strokes and Male Circumcision (Zimbabwe Ministry of Health and Child Welfare, 2012). They are expected to educate, advocate and in some cases take part in giving treatment in these different components. The Community Home Based Care (CHBC) givers are expected to provide similar work but more inclined to caring for the sick in their homes (GFATM 2012).

It is against this background that this research explored the perceptions of CHWs on the enablers and barriers in carrying out their work as more expectations are placed on them to deliver. This information will

increase the knowledge base that is available in Zimbabwe on the needs of the Community Health Worker. It can influence the investment case for the support being given in the country to the community component of most development programmes. It will contribute to informing the government, the community and the funding partners as they are all seeking more efficiency in the use of resources.

1.2 Problem Statement

Health care provision faces many challenges manifesting from human resource for health. For Zimbabwe this has mainly been because there is a severe shortage of health professionals who are leaving the country (Vujicic et al. 2004). In a study conducted to assess the health facilities and services in the country in 2011, it was reported that doctor population ratio was one doctor to 15,473 population, nurse population ratio was 1 nurse to 1,136 population and the vacancy rate for doctors was at 44% (Ministry of Health and Child Welfare, 2012). There is need to ensure that services continue to reach the most remote areas of the country with basic primary health care services. The few health professionals that are available are found in the clinics where they are short staffed and are not able to go into the community and perform outreach primary health care tasks (World Bank 2006). There is hope and expectation on the Community Health Worker to be able to conduct some of the primary health care tasks as outlined in the Village Health Worker Handbook, 2013. (Zimbabwe Ministry of Health and Child Welfare, 2012).

Access to health services in the country is limited and this is often attributed to costs of health services, distances to the health facilities and transport to get to health facilities (MoHCC, 2012). Poor access to health services is more acute in poor populations with women and children being more adversely affected. Loewenson, (2010) reported that there are inequities in access to services between urban and rural populations and between the wealthiest and the poorest. She indicated that between 1994 and 2009, the proportion of women in the wealthiest fifth of the population whose babies were delivered by a health professional remained at around 92%, but the figure fell from 55% to 38% among women in the poorest fifth of the population during the same period (Loewenson, 2010).

In the National Assessment of Health Facilities, it was recommended that CHWs should assist to improve health care access (Ministry of Health and Child Welfare 2012). There is evidence that CHWs can influence the availability and acceptability of health services. It is however necessary to get a better understanding from the CHWs, on their perceptions of the enablers and barriers that they face in carrying out their work in light of the increasing expectations from the stakeholders.

1.3 Justification

The human resource challenge in Zimbabwe in the health care system cannot be overstated. This has made the system unresponsive to the needs of the patients (Ministry of Health and Child Welfare 2012). In the Zimbabwe National Integrated Health Facility Assessment (2012), it was recommended that more numbers of VHW be deployed after adequate training and support systems have been established to bring health care closer to the households (Ministry of Health and Child Welfare, 2012). The fact that CHWs have been assisting communities to access minimum health care services have been alluded to in a number of programme evaluations (GFATM 2012). There is evidence of political commitment for the cadre hence it is in the national strategic plan (Ministry of Health and Child Welfare, 2013). There is some funding which has been made available to assist in ensuring that the CHWs contribute to meeting the health targets for the country (Zimbabwe Ministry of Health and Child Welfare, 2011). There is however no information or research exploring the enablers and barriers to CHWs work in Zimbabwe in the Nyanga district. All investments especially in health care are expected to demonstrate results and this also applies to the inputs into CHWs, but there is no evidence that what is provided to CHWs is what they need and will enable them to deliver. This research therefore sought to explore the perceptions of CHWs and related stakeholders on the enablers and barriers to them carrying out their work.

1.4 Literature Review

1.4.1 Human Resources for Health

The six health systems building blocks given by the World Health Organisation, (2007) include human resources for health as one of the critical components of the framework (WHO, 2007). Human resources play the critical role of delivering services to the population. The other components of the building blocks are like cogs in a wheel and for them to turn and be a system that provides a service, there needs to be human resources to oil them. In 2013, the district hospitals which were meant to be the highest level of primary health care were operating at less than half the doctors required at this level and mainly depended on doctors who were doing their first year of community service after finishing training as doctors (UNICEF, 2013).

The 2013 Zimbabwe Health profile showed that the country had 1034 doctors for the 13 million population and 15,539 nurses working in the public institutions, translating to a doctor density of 0.081/1000 population while nurses were 1.189/1000 population. This was below the WHO recommended 0.2/1000 doctors density and 2.5/1,000 for nurses (WHO, 2014). The vacancy rate for doctors in 2009 was at 52% and for nurses it was at 16% (Health Services Board, 2013). These were some of the results of the political and economic fragility of the country (Ministry of Health and Child Care, 2014). This left the health care system unable to provide the services which were critically required more so as the country was trying to meet the MDG health targets (Ministry of Health and Child Welfare, 2012). Apart from the high vacancy rates against the establishment, the situational analysis for Zimbabwe for the 2016-2020 strategy (Ministry of Health and Child Care & Zimbabwe, 2015) indicated that the establishment for staff was last revised immediately after independence of Zimbabwe in the early 1980s. Thereafter the revisions have been fragmented. This is despite the change in the disease burden, the changes in the population and change in health procedures to manage health care services.

1.4.2 Equity in Accessing Health Services

The Alma Ata Declaration (1978) stressed the need for countries to enhance primary health care (World Health Organisation, 2000). Zimbabwe adopted this strategy in 1980 (Zimbabwe Ministry of Health and Child Welfare, 2012). There was never a time when Zimbabwe was actually able to meet immediate needs of its population with regard to health services, but between 1980 and 1990 most of the health indicators had improved. Zimbabwe offered one of the best primary health care services in Africa in the early 1990s (Zimbabwe Ministry of Health and Child Welfare, 2011). The maternal mortality ratio in 1990 was 390 and in the Zimbabwe Multiple Indicator Cluster Survey 2014 it is reported at 614 per one hundred thousand live births (Zimbabwe Zimstats, 2015). The country is currently struggling to meet the standards that it had in set in 1990 let alone the MDG targets (Zimbabwe Ministry of Health and Child Welfare, 2011). The brain drain left the country with a skeletal staff to provide health services. Those who have remained are only in those areas which have good public amenities, thus leaving the majority of the people residing in rural areas with no or very limited access to professional staff (World Bank,2006) of which about 67% population lives in the rural areas (Zimstats, 2013).

1.4.3 Roles and Responsibilities of CHWs

Originally CHWs were seen as change agents who act between the health care system and the community for community empowerment, with their origins dating as far back as 50 years ago (Lehmann & Sanders, 2007). Interest in Community Health Workers (CHWs) had slowed down but was renewed by the Millennium Development Goals and the HIV pandemic which brought new demands on the health care system. This also brought new interests and new cadres into the arena (Hermann et al. 2009). The human resource crisis in poor resource settings has always been a major driver of the interest in Community Health Workers (Campbell & Scott, 2011). In South Africa, in a study to look at the historical perspective of CHWs, the Community Health Worker is seen as an important contributor to change and development as well as an important contributor to primary health (van Ginneken et al. 2010).

WHO defines a Community Health Worker as an umbrella term that embraces a variety of community health aides, selected, trained and working in the communities from which they come (Lehmann & Sanders 2007), they should be answerable to the community for their activities and supported by the health system but not necessarily be a part of its organization (Lehmann & Sanders, 2007) The following conditions are recommended as necessary for CHW programmes to succeed: strong management, suitable training, appropriate selection criteria, adequate incentives and good relations with other health care workers (Lehmann & Sanders 2007). Campbell & Scott (2011) also indicate that the need for community embeddedness is critical for the success of community health worker programmes.

In most African countries, the CHW is seen as an answer to the human resources for health challenges and a way to strengthen health systems, with South Africa giving the CHW an important role in the primary health care reengineering (Nsibande et al. 2013). This has brought with it confusion over their roles and responsibilities. CHWs are noted for doing preventive, curative and or developmental work in most countries (Lehmann & Sanders, 2007).

1.4.4 Successes and Failures of CHW Supported Programmes

1.4.4.1 Volunteerism

In a study conducted in Kenya, Takasugi and Lee (2012) examined the reasons why CHWs volunteer do home based care, prevention and management of minor ailments. They concluded that the sustainability of volunteer CHWs was questionable and it is associated with poor quality and high attrition (Takasugi & Lee, 2012). Hermann et al (2009) stress the point that without sufficient remuneration CHWs cannot be retained over a long period of time, In a study in Kwa-Zulu Natal in South Africa, Thabethe (2011) argues that most of the care work is being left to NGOs who work with volunteers and a new thinking which addresses the care work by Community Home Based Care (CHBC) should be seen as work and should be paid (Thabethe, 2011).

1.4.4.2 Training

Ruiz et al (2012) state that while there are others who have indicated the low contribution of CHWs to health outcomes, it is mainly because they have not been trained properly and in their conclusions they advocate for core competency training for the CHW (Ruiz et al. 2012). They state that CHWs have basically been given piece meal training. A systematic review conducted by Gogia and Sachdev (2010) showed that there was reduced risk of neonatal death and still births and a significant improvement in Antenatal and Neonatal practice indicators through CHWs visitations after training of the CHWs (Gogia & Sachdev, 2010). A similar study in Kwa-Zulu Natal, South Africa came up with similar results on uptake of neonatal and young infant referrals by CHWs to public health facilities (Nsibande et al. 2013).

1.4.4.3 Health System Support

A study in Malawi showed that health systems have to be functional for the CHWs to deliver. It details the delays in trainings and the delivery of kits in community case management of childhood illnesses (Callaghan-Koru et al. 2013). It showed the need for support of CHWs. Similar challenges were encountered in Senegal where the logistics of getting the malaria test and treatment was delayed and resulted in the programme not giving the results expected (Blanas et al. 2013).

1.4.4.4 Motivational factors

In a study done in Zimbabwe on the motivation of Community Facilitators (CFs) the appreciation by the rural community, the hope to create a chance for a career path for the CF and managerial support were seen as the major drivers for CF to doing their work (Osawa et al. 2010). In a study conducted in Iran, supervision and high work load were presented as barriers to the work for the CHWs (Jaskiewicz & Tulenko, 2012). In a World Health Organisation (2007) report, it is highlighted that there is no tidy package which will ensure that CHWs are motivated. The report urged programme planners to recognize the social

complexity of communities and that different CHWs will have different incentive requirements (Lehmann & Sanders, 2007). In the study conducted by George et al (2012), they conclude their study by indicating that while contexts are indeed different, there is still much more work that needs to be done on research to gain the full potential of CHWs (George et al. 2012).

The World Bank report, Priorities in Health (2006) state that in Thailand, the introduction of the Community Health Program coincided with the drop in child malnutrition and this was attributed to the programme (World Bank, 2006). The report gives three main success factors: supervisory level which should be at least one supervisor to 20 CHWs (the supervision need not be in the clinics as this tends to overburden the clinics), the community work has to be hinged on the community practices (Thailand used church based organisations and NGOs) and linking the health care system and the community work for sustainability (World Bank, 2006).

In filling a gap in the literature, this research therefore sought to address the question:

What are the perceptions of CHWs on the enablers and barriers in carrying out their work in Nyanga district in Zimbabwe?

1.5 Study Aim and Objectives

The study aimed to explore the perceptions of CHWs on the enablers and barriers to providing services in Nyanga district in Zimbabwe.

The specific objectives were:

I. To examine how CHWs perceive their roles and responsibilities.
II. To explore what the CHW perceive as enablers and/or barriers in carrying out their work
III. To explore what stakeholders (Ministry of Health and Child Care, NGOs, Donors, the Community leaders) perceive as enablers and/or barriers for CHW work
IV. To compare the perceptions of the stakeholders and the CHWs on enablers and/or barriers to CHW work.

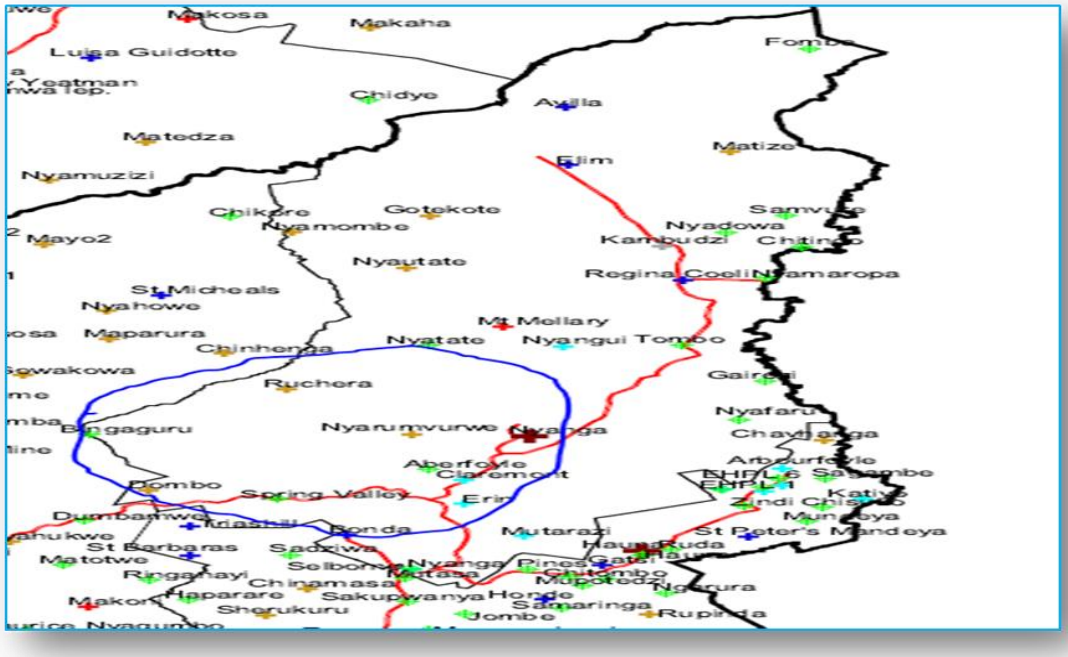
CHAPTER TWO: RESEARCH METHODS

2.1 Study Design

The study was an exploratory study which used qualitative methods. These included in depth interviews, key informant interviews and document reviews. Qualitative methods were chosen as they were most ideal for seeking perspectives of a group of people in order to understand the behaviours of CHWs and their opinions and attitudes. According to Hancock, et al (2009), in health and social care settings qualitative methods are particularly useful in research that seeks to explore views or concepts, real life contexts and on sensitive topics (Hancock et al, 2009).

2.2 Study Site

Figure 3: Study site: Nyanga District



Key	
Study site demarcation	
Road network	
District boundary	

The study was conducted in Nyanga district of Zimbabwe (as marked with the blue circle in the map). It covers 3 wards: Dombo, Bingaguru, and Nyarumvurwe; one district hospital; the Nyanga district hospital. Nyanga district is one of seven districts in the Manicaland province. It has a population of 126,599 people divided into 60,461 males and 66,138 females, (Zimbabwe Census, 2012). Nyanga district has an urban and a rural population but the study focused on the rural side of the district. This location was chosen on the basis that it had consistently retained the VHWs since 1983.

Nyanga district has 29 primary health care facilities, four secondary health facilities and one district hospital. These serve as referral hospitals for the district. These are not evenly distributed in the district and neither do they follow the disease burden in the population, thus one finds there is a skew of more health facilities in the northern end of the district. The road network to reach primary health care facilities is weak and is difficult to use for most of the population especially when they are sick. The road network to referral facilities was in good condition and transport was available, however the challenge was the high fares of transport. Most of the health indicators are in the Province are lower than the average indicators for the country and they are the worst for malaria in Nyanga district.

2.3 Study Population

The study population was made up of the CHWs working in Nyanga District, Zimbabwe. The key informants, were mainly stakeholders working to facilitate the activities under the CHW programme in the country. This included: Ministry of Health and Child Care (MOHCC), directors of NGOs working in the district, the Provincial Health Executive of the province of Manicaland, the District Health Executive of Nyanga district, and the supervising nurses in the clinics and the local leadership in the district.

2.4 Sampling and Selection Criteria

The CHWs were purposively sampled from two health facilities and one NGO in the district. Seven Village Health Workers (VHWs) were identified from the health facilities and five Behavior Change Facilitators were identified from the database at the NGO. In total, twelve CHWs were interviewed. Both men and women were considered from a list compiled from the health facilities and the NGO including all the names of the VHWs they worked with. The key informants were purposively sampled from the stakeholders in the clinics, community leadership and national decision makers.

Where available, both genders were welcome to take part in the exercise. The research covered Village Health Workers and Behaviour Change Facilitators only. These cadres make up the majority of the CHWs in the country and can be given additional functions by the community.

In order to have a mix of different experiences, six of the CHW had worked for more than five years and the others had worked for more than one year and less than five years as presented in Table 2.1.

Table 2.1 Criteria for sampling CHWs

Years of experience	Clinics	NGOs
More than 5	6	3
More than 1 and less than 5	1	2

The CHWs who participated in the study were from three wards in Nyanga district ward 20, 22 and 23. These are neighbouring each other on the North Eastern side of the district. Each of the VHWs and BCFs were working in a separate villages in the area. The community can choose to have the same cadre taking on the role of another cadre but serving the same community, for example one VHW could also be selected to be a BCF or as a peer educator. This tends to make the CHW have more than one role in the same village. The VHWs were appointed by the clinic and the BCFs were appointed by the NGO.

The main partners who have invested in CHWs were interviewed. This included the MoHCC where most decisions on VHWs are made; one community nurse from the two health facilities, one community leader in the district and some development partners.

The table below summarises the stakeholders who were interviewed:

Table 2.2 Stakeholders interviewed

Stakeholder	Number of Stakeholders interviewed
Community leader	1
Health institution nurse	1
NGO manager	1
Donor representative	2
CHW national activist	1

2.5 Data Collection and Analysis

The data collection for this research was done using a document review, in depth interviews of the CHWs and key informant interviews of the stakeholders in order to answer the questions embedded in the research objectives.

2.6 Document Review

The initial document review was conducted as part of the literature review on Zimbabwe and its context on the CHW sector. The second document review was to check and reaffirm some of the information given during the interviews. Some of the stakeholders offered these documents as information to the researcher during the interviews.

Where the documents were not provided during the interviews, they were looked up in the Ministry of Health and Child Care library or from the internet and some of the stakeholders emailed the documents after the interviews. This was done to ensure completeness of some of the information they had shared. Most of

the documents were strategies for the Ministry of Health and Child Care, implementation guides, annual reports and reviews of programmes and evaluations as shown in the table 2.2 below:

Table 2.3 Documents reviewed

Strategies, Policies and Implementation Guidelines	**Reports**	**Reviews, Evaluations and Surveys**
• **National Health Strategy for Zimbabwe 2009-2015** • **Interpersonal Communication tool, UNFPA, 2014d Child Care, 2011** • **Community home based care givers policy, Ministry of Health, 2014** • **Village Health Worker Manual, 2014**	• Manicaland Province Monthly Generic Report, August 2014	• Joint Review Mission Report, Ministry of Health and Child Care, 2014 • Vital medicines and Health Services Survey, 2014 • SWOT Analysis for the development of National Health Strategy 2016-2020 • Zimbabwe Multiple Indicator Cluster Survey, 2014 • National Health Facility Assessment 2010 • Zimbabwe Demographic Health Survey, 2010/2011

However not all the documents which were referred to during the interviews were reviewed as some could not be found during the research.

2.7 In depth Interviews and Key Informant Interviews

In order to get information that would inform the objectives a structured interview guide was designed to guide discussions with the CHWs (Appendix 2). The interviews took place in Nyanga district. The CHWs were interviewed either n their homesteads, at the local shops and one of the schools in the local area. In all instances the privacy of the discussion was maintained.

The interviews explored the actual activities which the CHWS conducted, discussed their perceptions on what enabled and the barriers to their work. The interviews probed into such areas as motivation, why they had not left and done something else, what could have enhanced their work and improvements which they desired.

Stakeholders were also interviewed for their perceptions of CHWs work as key informants. They were interviewed in their offices after appointments were arranged with them. A semi structured interview guide (Appendix 3) was used during the interview. The discussion with stakeholders included their investments into CHWs programmes, if they were convinced they were getting what they needed and they were putting enough resources for the expected outputs. These in depth interviews were conducted in English except for the community leader who was interviewed in Shona.

Permission to conduct the research among the CHWs was requested from the Ministry of Health and Child Care (Appendix 4) before the study could be conducted. Permission was granted from national office, through the Permanent Secretary for Health (Appendix 10) to the Provincial Medical Director's (PMD) office. The office of the PMD permission was given through correspondence to District Medical Director's office of Nyanga district (Appendix 11). The DMO then facilitated the meetings with respective health institutions and a local NGO using the information sheets (Appendix 5 and 6). An information sheet which briefly described the study was provided to the study participant prior to the interview (Appendix 5). Informed consent was received from the study participants through a signed consent form for audio recording (Appendix 7) and another consent form to agree be interviewed (Appendix 8) All interviews except for one stakeholder were audio recorded and in addition notes were taken during the interviews to substantiate the audio recordings. The interviews for the CHWs were conducted over three days with the first interview being the longest (two and half hours); however on average the interviews took one and half hours. The interviews with the stakeholders took on average two hours, and the interviews were spread over

two months as it was difficult to secure appointments with some of the stakeholders. The data collection for the research was conducted in the months of July and August 2014.

2.8 Piloting of Interview Guides

In order to check on the soundness of the guides, the in depth interview tool was pre-tested in Mhondoro Ngezi district to check on appropriateness of the tool for the CHWs. A few adjustments were made to the flow of the guide and some questions were removed completely. This was done as the participants gave the information as soon as there was good dialogue with the researcher.

2.9 Data Analysis and Data management

From the transcribed data from the interviews and field notes, I used a thematic analysis to identify the pre-determined themes and emerging themes on the perceptions of enablers and barriers to CHW work. These were collated and coded. Themes are abstract constructs that link not only expressions found in texts but also expressions found in images, sounds, and objects (Ryan & Bernard, 2003). These themes as they started to appear during data collection and transcribing of data, were analysed by considering, similarities, differences, repetitions and some metaphors from the local language. From the themes, sub-themes were identified. To ensure reliability, rigour and quality of data, the researcher reverted back to the transcribed information to ensure that any contradicting information was cross checked with the transcripts. According to Thomas et al, (1998) reverting to source data improves the quality of data transcribed (Thomas et al. 1998).

The themes and sub themes were further analysed against the themes from the key informant interviews to also identify gaps, similarities and differences between the perceptions of the decision makers and the funders of CHW programmes and those of the CHWs.

The researcher ensured that the transcribed material was stored in a safe place and was only accessible to the researcher and the supervisor.

2.10 Ethical Consideration

Ethical approval was obtained from the University of the Witwatersrand Committee for Research on Human Subjects Medical (Certificate number: M131173) (Appendix 9). Collection of data on the participants and from the participants was in compliance within ethical standards and observed the following**:** Informed consent to participate in the interviews was obtained from the study participants. In a separate format, one consent form was to be interviewed and the other was to be audio recorded. Participation was voluntary with no consequence for not agreeing to take part. Each participant was given an information sheet which explained the purpose and value of the study as well as information on consent and who to contact if one had questions on the interview prior the interview. In order to undertake the research, the researcher sought clearance from the Ministry of Health and Child Care, (Appendix 4). Ministry of Health and Child Care, (MoHCC) gave written permission to undertake the study in the district through the province (Appendix 10) the province then gave clearance to the district to allow the researcher to conduct the research (Appendix.11) . The study participants were given assurance that their names would not be used anywhere in the study or the research report. The respondents were therefore referred to by their categories such as VHW 1, Stakeholder 2, etc.

To ensure confidentiality, data and audio recordings were kept in a computer and could be accessed by the researcher via a password. The tapes will be kept under lock and key for six years, after which they will be destroyed.

2.11 Researcher's Position

The researcher played an insider role in the health sector and this might have been known to the CHWs and the stakeholders who were interviewed. In order to avoid the effect of power and positionality during the interviews, the researcher explained in her introduction that she was conducting the research for educational purposes and the information gathered would not be used in any way to influence her position nor that of the stakeholders and the CHWs involved in the research. The researcher used reflexivity strategy in order to increase the credibility of the data she collected. Reflexivity refers to assessment of the influence of the investigator's own background, perceptions, and interests on the qualitative research process (Krefting, 1991). The research would have benefited more if the researcher would have worked with an outsider to bring the advantages which come with conducting policy research with both an insider and an outsider. Walt (2008) indicates that both insiders and outsiders in qualitative research have both advantages and disadvantages. She recommends that qualitative studies can benefit from team formations which have insiders and outsiders, (Walt, 2008). The involvement of a supervisor outside the context assisted in ensuring that the researcher did not carry her knowledge of the sector ahead of the expressions of the CHWs and the stakeholders interviewed.

CHAPTER 3: RESULTS

This chapter presents the results of an exploratory study conducted to find out about the perceptions of Community Health Workers and their stakeholders on the enablers and barriers to providing services in Nyanga district in Zimbabwe. It will give a description of the characteristics of the study participants, then dwell on the findings of the study using the following themes in line with the stated objectives of the study: roles and responsibilities of CHWs, enablers for CHW work and barriers to CHW work. Detail of sub themes under these main themes will also be given.

3.1 Description of participants

A total of eighteen interviews were conducted. Twelve were in-depth interviews with CHWs and six were key informant interviews with stakeholders who are involved or work with CHWs. Tables 3.1 and 3.2 below give a description of the interviewees.

Table 3.1*:* Demographic information of the CHWs

Category	Number	Male	Female	Age
VHW	7	0	7	25-55
BCF	5	2	3	25-40

Table 3.2*:* Demographic information of stakeholders

Occupation	Number	Male	Female
Medical doctors	2	2	0
Community leader	1	1	0
Development specialists	2	2	0
Sister in Charge	1	0	1

The study looked at two categories of Community Health Workers: Village Health Workers (VHWs) and Behaviour Change Facilitators (BCFs). Of the twelve CHWs interviewed, seven were VHWs and were all females. Five of the CHWs were BCFs. One was a pastor in a local church and the other was running a barbershop at the local shops in the area he was working in. He also highlighted that he was a community worker for an agricultural programme. The rest of the CHWs were not formally employed elsewhere. The BCFs on average were younger than the VHWs. The age range for the VHWs was 25 years to 55 years with most of them being above 45 years of age. The BCFs age range was 25 years to 40 years of age with most of them aged between 30 years and 35 years of age. All the CHWs interviewed had worked for more than a year in some form of community work.

Of the six stakeholders interviewed, five were male and one was female. Two were medical doctors and senior advisors on health policy and donor support. One was a nurse by profession, two were development specialists working with NGOs and one was a community leader. The medical doctors were working at the national level of the European Union and the Global Fund. The development specialists were employed in leading local NGOs in the country. The nurse was in charge of a department in a district hospital and the community leader was a community chief in Nyanga district.

3.2 Roles and Responsibilities of CHWs

The CHWs explained that they perceived their primary function to be that of bringing health services closer to the communities. They perceived their roles as those of providing primary health care and information to the communities they served from the technical institutions such as NGOs and the health facilities. They did this through provision of basic care, information dissemination, health promotion and advocacy. The stakeholders concurred with most of these roles and responsibilities as defined by the CHWs. Below are the themes that represent the different views on the roles and responsibilities:

3.2.1 Bridge between the hospital and the Community

The CHWs were of the opinion that one of their major roles was to create a bridge between the health institutions and the people in the community they served. They saw themselves as the ones who ensured that the people in the communities access services. They explained how they travelled between the hospital and the village bringing in knowledge and medicines for the benefit of the community. One of them said had this to say:

> "*We bring medication and information to the people from the hospital, thus bridging the community and the hospital services" (VHW 3)*

They highlighted that planning and reporting to the clinic and NGO was part of their work and this was done on a monthly basis. This was the way their work was monitored. During these reporting sessions, observations on any new disease burdens and abnormal challenges in the community would be highlighted. The staff in the clinic and NGO would take note of these. One of the VHWs highlighted this and said:

> "*We see children when they come for weighing and we notice that children are not well or not feeding properly, we inform the clinic. Even when we see some rash which we are not used to, we report this to the clinic". (VHW 7).*

The CHWs saw their role as ensuring that what happens in the community is relayed to the clinics, hospitals and NGOs for better planning and decision-making processes.

Some of the stakeholders though, differed on this, as they felt that the information taken to the clinics and NGOs was not being given the attention it deserved and should be improved. One stakeholder said:

"I believe there are a lot of observations which are made by the CHWs on disease patterns even on health systems which the public health system is not collecting and if they collect it they are not making use of it" (stakeholder 4)

3.2.2 Treatment of Minor Ailments and provision of basic care

The VHWs highlighted that they treat minor ailments, injuries and malaria. They also offered counselling and visited people in their homes. In some instances they had helped with doing some of the chores when there was no immediate family to help. This was explained by two of the VHW who said:

"*We have people from the community come to consult us when they fall ill, and normally it's for headaches, diarrhea and flu and like this season we can also have malaria. We can treat these when we have the medication" (VHW 3)*

"We also visit the sick in the homes, sometimes you get there and you find the house dirty or there is no firewood or the fire has not been lit, we then assist in doing this for the patient"(VHW 5)

The VHWs mentioned that they also enjoyed doing community child growth monitoring. They reported that they had scales to weigh children and had days which were confirmed with the mothers to meet at one point in the village. Here they would weigh the children and record on the growth monitoring cards. One of the VHWs highlighted that growth monitoring was an important activity as it was assisting the mothers to reduce the time spent at the clinic or travelling to the clinic for growth monitoring. She said:

"I conduct growth monitoring and the mothers bring their children here at the end of each month and I weigh the children and record. And if I notice that there is something wrong with the child, I refer the mother to the hospital so that the baby can be attended to by nurses" (VHW 4)

The CHWs also felt that their role was to ensure that those who need hospital care are transferred to the hospital early. They stressed the link that they had with hospitals and clinics and were clear that they did not do their work independently of these facilities. They also ensured that only those needing clinic services would be referred to the clinic, while they attended to those whom they could manage in the village. This was meant to reduce the burden at the clinic. It also reduced the cost of securing transport to the clinic and the time consumed through travel for the communities. One of the VHW explained this as follows:

> *"We watch out for danger signs then refer to clinic or hospital, this way only those who really need to go to the hospital go and thus save the person bus fare and reduce congestion at the hospital" (VHW 6)*

The issue of referrals was also mentioned at the hospital by one of the stakeholders. She indicated that the CHWs were assisting in the screening of patients and therefore reduced the number of patients going to the hospital.

> "*VHWs screen patients for us at the village level and especially now with the malaria season upon us, only the critical patients need to come to us" (Stakeholder 2)*

Referral was mentioned by both the staff at the clinic and the VHWs, but there was no documentation that was available to show how they were being done. It would seem that the referral was by word of mouth. This would agree with an observation made in the MoHCC 2014 Joint Review Mission report which indicated that referrals even from hospital to hospital were weak and proving to be a bottleneck, specifically for maternity cases (Joint Review Mission, 2014.)

In addition, one of the stakeholders complained about the referral system. He thought it was weak and not building on the work the CHWs were doing. He said:

> "*VHW can refer patients to the clinic but the clinic does not take into consideration the fact that the patient has already been seen and now needs urgent care, this is mainly because the patients will not have any documentation from the VHW. Let us not even discuss the referrals back to the CHW from the clinic, this does not exist" (Stakeholder 6)*

The stakeholders agreed to some extent on the role of the CHWs. They however had reservations regarding some tasks which they felt should not be provided by CHWs, as this would create unreasonable expectations by the community. The concern for the stakeholders was the workload of the VHWs. They felt that it was too much for a cadre that was expected to work for only 2 hours in a day. The second issue was on the level of work they were meant to do; both for the BCFs and the VHWs. Regarding the VHWs it concerned the issue of treatment and whether some of the treatment they were expected to provide was at their level or beyond their capacity. The concern for the BCFs was the expectation of them to address issues related to gender based violence in communities where they resided in. An issue which some of the stakeholders felt required more training than that given to the BCFs.

There was concern about work overload and too many expectations on the CHW. This was seen as taking them away from their focal area of prevention and also a displacement of other cadres who were part of the system who should continue to do their work as per their role in the system, for example the Environmental Health Technician (EHT). One stakeholder complained about the CHWs' treatment role as follows:

> "*Do not make them little doctors but rather make them work on the household dynamics which influence the social determinants of health and focus on prevention." (Stakeholder 4*)

On the displacement of other health cadres, one stakeholder complained as follows:

"*The environmental health technicians (EHTs) are now bystanders with the CHWs having taken over the work on toilet construction and drilling of boreholes. The EHT needs to be capacitated to do his work and the CHW compliments the work he does. An EHT might just need a motorbike to get round the village and he already has the technical knowhow on boreholes and toilet construction" (Stakeholder 6)*

3.2.3 Information Dissemination, Health Promotion and Advocacy

The CHWs highlighted that most of the information and technical expertise existed in NGOs and in clinics and hospitals, but it needed to find its way into the community in order for it to make a difference for the people. They defined their role as that of developing the capacity of the people in the community, including the community leaders, so that they are able to make informed health decisions through education, promotions and advocacy using the information from the health institutions and NGOs. One of the BCF emphasized this view and said:

"*We are there to help people to know that there is help out there and others are being helped. We inform people on where to get services, from the police, social welfare, and hospitals" (BCF 3).*

The community leaders were seen as key in information dissemination as they could utilise more community events to repeat and reiterate the same messages. A BCF had this to say regarding their role with the community leadership:

"The community leaders need to know the information we give to the people they lead. This works like this, when we get the information we take it to the community leader who has to understand it

and then creates platforms for us to give the information, when we are not there he can even give the information on his own and also he refers people to us", (BCF3)

This was confirmed by a community leader who highlighted the importance of him being knowledgeable about what the CHWs know. He also highlighted that it is his responsibility to create opportunities for the CHWs to speak to the people mainly at community gatherings that he organised. He said:

"*I am proud of the work that the VHWs are doing in my community, when they come from the hospital, they come first to me and explain to me the information that they will have heard from the clinic, I then work with them to ensure that the idea is accepted by the community without causing any friction between them and the villagers" (Stakeholder 1)*

A number of areas for health promotion were highlighted but encouraging pregnant women to register early for antenatal care was mentioned by most of the VHWs. They emphasized the need for early booking as it was related to HIV and it showed their keen interest to address challenges related to HIV. One CHW highlighted this by saying:

"*We have to inform pregnant women to go to hospital and register early as there are programmes which are there these days which can help the mother and baby pair; especially if there is a danger of HIV" (VHW 4)*.

The VHW indicated that they were also meant to promote hygiene and cleanliness and to teach on the importance of these in the homes. They promoted the construction of safe water points, toilets and worked with the community to ensure that waste management is properly done in the homes. One VHW summarized this by describing the names they were given in the local language which speak to health and good hygiene;

"We are known as grandma hygiene or grandma health, because that is what we are there for…. Cleanliness and good health" (VHW 1).

The BCFs highlighted that they worked mainly on gender based violence, HIV and AIDS, non-communicable diseases such as cervical cancer, diabetes and hypertension. They indicated that they had created demand for services at hospitals and clinics and had brought awareness of the services which health institutions want the community to come and seek, for example male circumcision and cervical cancer screening. They were trained on the health challenges the communities are likely to face and how to identify these. They accessed the community at family and household level and using an interpersonal communication tool[I], raised awareness of the diseases. They would then advocate for the communities to visit the clinics and hospital to have these checked and attended to. One BCF said this about their work:

"*We talk to people in their families and depending on the exposure they are likely to be facing, we refer them to the hospitals. When we started people did not even know about cervical cancer and how it can be prevented", (BCF 1)*

One of the stakeholders explained that most of the BCFs roles was training groups of people identified from the community either by age group or sex and also taking into consideration cultural factors. Such groups form one cohort and are taken through eight weeks of training on basic information on HIV. It had been observed that some of the issues needed to be discussed in a family setup for individuals to be able to make decisions. This made them change the interpersonal communication tool to encourage more of a discussion at household level with the BCF leading the exercise. The stakeholder said:

[I] In order to guide the BCF in information gathering and dissemination on Gender Based Violence, HIV and Non Communicable diseases, a communication tool which takes the BCF on step by step guide to the discussion with the household to encourage them to open up and get assistance should any of the areas pertain to the households. It is designed in such a manner that it has carbon copy which remains in the guide and the top copy is submitted to the NGO for data analysis.

"We changed from the group model of teaching on HIV to family setup as the evaluation of what we used to do showed that information from the group teaching was not influencing the decision in the household as the decision making power was in the home not in the group. Children were still not HIV tested as the father or the mother would not agree to take that step. Now we work with the family to see it we can influence behavior change from within". (Stakeholder 3)

All the stakeholders saw information dissemination, education and awareness creation as the main function of the CHWs. One of the stakeholders was very excited that CHWs were taking the lead in bringing information to the people on Non-Communicable Diseases (NCDs). He highlighted this by saying:

"We have only recently established the structure for managing NCDs, but the CHWs are advocating for screening of patients and they have already generated a huge demand for this service and it is in line with the extended National Strategic Plan for Health." (Stakeholder 4)

There was consistency in the understanding of the roles and responsibilities amongst the CHWs. It was also interesting to note that the stakeholders and CHWs agreed in a lot of respects on the roles and responsibilities. The descriptions of roles and responsibilities given by the VHW and the stakeholders also matched those outlined in the Village Health Worker manual and the national policy for the VHW which were shared by stakeholder 6. These documents were however not available within the hospital nor with the VHWs. Some of the stakeholders though, raised concerns about the excessive expectations on CHWs and on the overlaps they thought existed with other cadres such as the EHTs. No further review was conducted during this research to compare the job descriptions of the EHTs and that of the VHWs to confirm whether indeed the VHWs were conducting roles that were specific to the EHTs

3.3 Enablers to conduct CHW work

The CHWs expressed a lot of satisfaction derived from doing their work. They indicated that they loved their work as it had brought positive change among the people they lived with. They also shared some of the experiences that made them sincerely proud to have done CHW work. They felt that the community trusted them and they had also accrued some benefits for doing community work. The CHWs and the stakeholders perceived that the community members who had become CHWs had changed in the way they perceived themselves and their role in society. The CHW felt that they had been empowered, had become a voice for the voiceless in their community and felt their self-worth had increased. The CHWs appreciated the support that they received from the community leadership, hospital and NGO which they worked with enabled them to do their work. Below are sub themes on the enablers for CHW work identified during the research:

3.3.1 Benefits realized by the Community

The first thing that was mentioned by most of the CHWs about what motivates them in their work was that they enjoyed what they did as CHWs. They indicated that they felt good from being associated with the improvements that had occurred especially for the people affected by HIV/AIDS in the community. They were convinced that their work had reduced bed-ridden patients in the homes and that people were no longer dying from HIV/AIDS. With the introduction of ARVs the work had changed and people that were infected by HIV were now able to return to their work and look after their families. This was confirmed by one VHW who had this to say on the introduction of treatment for HIV:

> "*We have worked as Community Home Based Care givers. We looked after people whom the hospitals could not help. People died during that time. But now people do not die, families are now stable again with children going to school. This has actually changed most of our work from caring work to support work. I now focus more on drug adherence than watching members of the community die."(VHW 1)*

Another VHW echoed this on the improved lives of the people in the community she was working in by referring to the access to treatment of malaria. The CHWs were testing for malaria using rapid diagnostic testing and giving the treatment. These roles had recently being introduced to the CHWs and they indicated that they were happy to be assisting their communities to avoid loss of lives due to lack of access to treatment for malaria. She said:

> "*And I am also doing RDT for malaria. Malaria used to be a killer disease in Nyanga but with RDT it will soon be a thing of the past and communities do not have to travel long distances to get the treatment as we can now offer the treatment. As you can see, this place is far from the clinic and the people can just come here at my house and I assist them" (VHW 6)*

Interestingly, the stakeholders agreed with the CHWs and highlighted the self-drive of the CHWs and the love they had for the work. This was seen as the major enabler to do their work even in difficult circumstances. To express this one stakeholder said:

> *" CHWs have it in them to do this work, they have a passion to serve their community, that is what gets them to do the work and this is one of the things that we look for when we recruit them. We look for a person who can be send around to do different errands without complaining" (Stakeholder 1)*

3.3.2 Benefits for the Community Health Workers

Apart from the gains made by the community, the CHWs also indicated that they had gained in a number of ways from the work they did. This had also motivated them to do the community work. Their lives changed in a positive manner through the knowledge gained and the exposure to new skills and knowledge which had

transformed the lives of people. They felt that they had endured a lot doing CHW work over the years but things were improving for the better. One VHW gave a short comment[II]. She said:

> *"We have come a long way to be where we are today. When we started to do this work, it was pure volunteer work, we were helping the community because we felt you could change someone's life using your meagre resources. Then support came and we were chosen to be trained, still with no additional benefits. We started doing care work during the pandemic of HIV, then support came for some allowances and some consumables that we would receive from the clinic, like soap and gloves. Remember this was also the time we did not even have anything to share with the community from our households because of the challenges the country was facing, you might want to recall the 2007/8 period. Things have continued to improve now where we have bicycles and cell phones to use to do our work". (VHW 6)*

In this way she was reflecting on the improvements in the benefits they received for the work they were doing. She then went on to explain how they had started the VHW work with nothing to use other than the desire to assist those who were suffering in the community. She therefore welcomed the input provided as it made the job manageable.

In order to be a CHW one needed to be chosen by the people first, with endorsement of the local leadership. Only after this, then technical knowledge on the job would be considered and assessed through an oral interview in order to qualify for the job. This was described by both the BCF and the VHW. It was observed that this was described with an element of pride that the whole community trusted the one individual to do the job out of the many who had volunteered. To explain this one BCF commented:

[II] on observation, her facial expression was one of gratefulness for her current circumstances".

"*I had to be interviewed for this work by the people from the NGO but before we got there, the community had to choose me first and the village head had to agree to my being chosen. Now I feel that I have to ensure that I deliver as the community trusted me to do the work for them". (BCF 4)*

Being trusted by the community reportedly brought about a certain degree of responsibility. The CHWs felt that they could not let down the community and the leadership that believed in them. This was a driver to perform the work. This was confirmed by one of the stakeholders who explained that the work the CHWs do was driven by community cohesion and the appreciation of the work they do by the people in the community. This compounds their desire to do their work. One stakeholder commented:

"*These people work where they see immediate impact of their work on people whom they know and care about, some of them are immediate family to them. In addition to this, they are appreciated by the community that they work with. There is self-worth in this work" (Stakeholder 4)*

There was a sense of empowerment which came with being selected as a CHW. The training and the position that one is given in the community made the CHWs feel important and it had also led some of them to be driven to improve themselves. One VHW had only a grade seven certificate[III] when she was hired. She was now doing the same work that is done by Ordinary level certificate[IV] holders and she was even performing better than some of them. She highlighted that her competency had improved, commenting that:

"*I can now stand among and compete with 'Ordinary levels certificate holders in the work that I am doing though I am only a grade 7 certificate[1]holder. I can even do the work better than them. Doing this work has made me discover more of what I can do for myself and others. I became a VHW after I lost my husband, I was withdrawn and did not want to speak to people. This has changed, I have to have people around me and helping each other" (VHW 1)*

[III] Grade 7: highest level of primary education achieved after 7 years of primary education
[IV] Ordinary level certificate: Qualification acquired after four years of secondary education. Secondary education is done after seven years of primary education

All the CHWs expressed their appreciation of the education and knowledge gained through working as a CHW. One VHW said:

> "*This has now changed the way I raise my own children and grandchildren. I inform my own family on these issues. I teach them on HIV. I teach them on proper nutrition. I teach them on the importance of hygiene. I did not know about these before and would not have managed to do this without the training I received", (VHW 4).*

There were also individual advantages accrued by being a VHW. Some were getting treatment, others counselling and easier access to treatment for their relatives as they were better informed about the health system. This would not have been possible if one was not a VHW. One VHW indicated that she was a patient and because of her work she was accessing treatment more easily than if she was not a CHW. She commented:

> "*I am a patient myself and being a CHW helps me to easily access medicines." (VHW 2)*

3.3.3 Support provided to the CHWs

The CHWs were supported by either the hospital or an NGO. The support included training, feedback meetings, supervision and mentoring and some items to use for their work. The CHWs expressed their appreciation for this and during the interviews highlighted how this support enabled them to their work.

3.3.3.1 *Training*

The CHWs all reported having received some form of induction into the work through workshops after being recruited. A VHW said:

"*You don't choose yourself to be a CHW, you volunteer and then the community has to choose one among those volunteering and after you are chosen you have to be trained to do the work" (VHW 3).*

The most recent and most remembered training for the VHW was the training on malaria. The workshop was seen from three perspectives. Firstly it was increasing their responsibilities which was interpreted to mean there was more trust in them to do the work. One VHW said:

"*Here in Nyanga we also do RDTs, and we are the first group that has been trained, others are still to be trained" (VHW 1)*

Secondly, the workshop was seen as one way of addressing the bottlenecks faced by the community as Nyanga has a problem with malaria. For the CHWs what seemed paramount to them was ensuring that the people in the district lived an improved life through their input. A VHW commented:

"*Nyanga has the problem of malaria and we used to have a lot of people die of malaria because of late diagnosis but now we pick it quickly with RDT and if it's already late we refer to the hospital. People do not go to the hospital, it is far and when they have malaria they cannot walk long distances. We are at least 20 km from the hospital" (VHW 2).*

Thirdly, the workshop brought with it the excitement of being given dedicated attention and being taken away from their homes to a resort for the training, including being taken inside the hospital to complete the training. This gave them a sense of motivation to do the malaria Rapid Diagnostic Testing (RDTs). One CHW commented:

"*We went to some place in Nyanga for four days to do this training on malaria and after that we also had to be in the hospital for the training. We really enjoyed ourselves apart from the learning that we did" (VHW 5)*

In fact, they added that most of the training had been in the home area, in the village or clinic but for RDT malaria they were taken away from home and for some, this was their first experience to do so. Training for VHWs was normally done in the mornings at the clinic, returning to their homes at the end of the day. VHW 4 said about this experience:

"*I had never been to this resort and my work as VHW had never taken me away from home so it was an exciting experience for me to be in this place for three days on training." (VHW 4)*

Training was valued by all the CHW and they felt that it was a benefit as well, as one of the VHWs commented:

'I have been so much educated … and all for free.' (VHW 4)

While the training was seen very positively by the CHW, criticism was raised by the stakeholders. This was mainly about the consistency and completeness of the training, making most of them worry about the quality of the work that the CHW were actually doing. They raised the issue of the pre-qualifications of the CHWs, the training material which was mainly in English whereas most of the CHWs were not completely conversant in that language, and the time dedicated to the training.

The CHWs who volunteered to do this work had a minimum educational background which was a prerequisite for them to provide the service. Despite this the stakeholders thought this minimum requirement could be too low for the work CHWs are expected to do. However, those who had more skills did not want

to do CHW work and those less skilled were seen as those who would like to do the work as they had a higher level of commitment. This was explained by one of the stakeholders:

> "*Those who want to do more, have limited educational qualifications and skills limits. The tools for training them are mainly in English and some of them struggle with following these instructions and there are no job aides in the local language. We have been training the CHWs, but it is notable that we use English on most of the training guides but this has limitations especially when you go for such things as malaria RDT. For some of them you realize you are actually straining them. Visuals do help but there are some things which basically need you to understand English" (Stakeholder 2)*

There was no verification of the training received by the cadres. However one of the stakeholders explained that the curricula had been revised and it was now a standardised curricula which was meant to be conducted over eight weeks and was only approved in 2014. One Stakeholder reported as follows:

> "*We used to have a number of guides to train VHWs but now we have one guide which has everything that a VHW should be trained on but this has not yet been rolled out throughout the country". (Stakeholder 5)*

3.3.3.2 Feedback meetings

The CHWs held monthly meetings either at the NGO offices or the hospital. During this time, they submitted their reports and shared their plans for the coming month. The BCFs also met on a quarterly basis to conduct peer reviews with other BCFs in a two-day meeting. The CHWs highlighted that these meetings enabled them to share freely with the colleagues the challenges in the work place and also how others might have managed to deal with similar issues. It also gave the NGO and the hospital an opportunity to refresh the CHWs on some information at the same time and disseminate any new ideas or changed protocols. A VHW explained:

"*When we meet with Sister X at the hospital, we all meet at the same time and she teaches us on say, if we report too much of diarrhea, she shows us again the steps of managing diarrhea so we remember how to deal with it. We also can request Mrs. Y (another VHW) from another village to explain how she would have dealt with a specific challenge that she has encountered. We learn from each other and also from the hospital" (VHW 4)*

The reports that the CHWs submitted to the hospital were referred to but were not shared by the CHWs or at the hospital. There were no minutes or records of the meetings that were held with the VHWs. The researcher observed that the reports were more verbal accounts of what happened as neither the clinic nor the VHWs had copies of the reports filed away.

3.3.3.3 Supervision and Mentoring

Supervision for the BCF was described as a process which happens while they actually do the work and they expressed an appreciation for this exercise. One of the BCFs who had had an opportunity to work with the officers from the NGO that they are affiliated to commented as follows:

"*We like it when they come and we do the work together in the community. It kind of reaffirms our work and the trust the people have in us. When we are with the staff from the NGO I have observed that there is more opening up of the families in the discussions which we will be having" (BCF 1).*

The BCFs added that it helped to be mentored on the use of the tools for data gathering and also on how to engage with the community so they could open up more during such sessions. They felt that this capacitated them to do the work and made them more confident in using the checklist which was fairly new to them. A BCF explained:

"*The concepts of non-communicable diseases are still new and need more explaining to communities to understand the need for screening and seeking health assistance early. We see that when we do use the tool with staff from the NGO, the communities tend to open up more."(BCF 4)*

The supervision and mentoring of the VHWs was done during the monthly meetings when they submitted their reports and the plans for the coming month. The hospital staff would highlight the positive things coming from the reports and assist to correct the procedures that would have been used by the VHWs. One of the supervisors at the hospital said:

"*During the monthly meetings, that is the opportunity we have to supervise and mentor the staff. They narrate their activities and as they do that we are able to pick the challenges they are facing or where they might not be following a procedure properly. We then use this to determine the areas which need further training or where one of them needs to help the rest of the team" (Stakeholder 2)*

The same stakeholder however also felt that while this was positive more could be done in terms of the supervision of VHWs and this will be described in detail in the section on the barriers to CHW work.

3.3.3.4 Resources

The CHWs indicated that they received some inputs which they needed for them to carry out their work. The BCFs highlighted that they had a phone, a bicycle, two t-shirts, a hat and stationery that they used for capturing the data from the community.

The VHWs indicated that they all received bicycles but some received uniforms and phones. They all had kit bags which they used to carry medicines, an infant scale and Middle Upper Arm Circumference (MUAC) tape and thermometers. However, they indicated that there was variation in what they received amongst themselves. One of the VHWs gave the list of the items she had received as follows:

"*I have a phone, but others do not have, I have a uniform, kit bag and a bicycle. This does not make it easy for us as we all work together. It would be easy if we all got the same things at the same time" (VHW 1)*

The two cadres indicated that they were aware that they were volunteers and they were meant to receive an allowance of USD15.00 per month. They appreciated the allowance as they reported that it allowed them to travel to the NGO or to the hospital which cannot be done on a bicycle. It also came in handy to buy soap to wash the uniform and to look presentable in the community. As one VHW mentioned:

"*We use the allowance for transport to the clinic meetings and also to buy soap to clean the uniform as we have to be presentable in the village and we are sometimes asked to speak at community gatherings", (VHW 2)*

The stakeholders gave a similar outline of the support given to the CHWs. They explained that much of the guidance on this was from the original CHBC policy (2011) which outlined the following as the package for community home based care givers: "A standard minimum incentive package comprising: 10kgs mealie meal; 2kgs sugar; 2 bars of washing soap; 1 bath soap; 750 mls of cooking oil; 100mls Vaseline; 500gms salt; 1kg dry beans and 1 tube of toothpaste should be provided for all care-givers monthly. The value of this basic food pack was approximately USD 15.00. Organisations shall have the option of providing the package or cash." (MoHCC, 2011).

The two institutions working with the CHWs in this study were both making the pay outs as and when cash was available. The USD15.00 was being given to the CHWs, although delayed especially for the VHWs. Most of the CHWs indicated that the money was now being used to meet their transport needs rather than as an incentive as was the original intention of the policy which was to give a form of compensation for the

work. In some the instances, the VHWs had not received this money at all. This is further detailed in the section on barriers to CHW work.

In light of the sentiments presented in this section, the CHWs showed that they were fulfilled through the work they did and expressed motivation to do the work. They valued the education they had received which had transformed their lives, their families and their communities. Access to health services had improved for themselves and the rest of the communities through their efforts as community workers. They appreciated the support they received from the NGO and the hospital. However, there were limitations on the supervision and allowances for the CHWs. This will be given in the next section which reflects on the barriers to CHW work.

3.4 Barriers to Community work

The CHWs highlighted the issues constraining them from being as effective as they would aspire to be in their work. They mentioned challenges that relate to access to health services at the clinics and hospitals. The other issues they highlighted were related to supervision and mentoring, geographical coverage and resources.

3.4.1 Health Services

3.4.1.1 Availability of Health Services

The major outcry from the BCFs was that the hospitals and clinics were not providing the services the CHWs were encouraging the communities to seek. They were of the view that the demand that they were generating was not being matched at the health institutions. There were access bottlenecks caused by long distances to clinics, availability of trained personnel to conduct some of the cervical cancer screenings, long waiting times and limited availability of medicines. The BCFs were of the opinion that cervical cancer

screenings needed to be done in the clinics close to where the people lived, or better still if there could be outreach services in the villages. In addition, there were times when people travelled for the screening, only to find that there were no trained personnel at the clinic. In some instances, there were reportedly long waiting times before being attended to. A BCF lamented with regard to limited access to the health services:

> "*While we are creating demand for these services by giving knowledge on what the communities should ask for and get from the clinics, we have created long lists of people who would like to have cervical screening done, but this is has not been offered at the clinic nor at the hospital. The trust in people of our work has started to go down." (BCF 1)*

The stakeholders concurred with the BCFs expressing the opinion that there was a mismatch between demand and supply, especially on cervical cancer screenings and the readiness and the capacity of hospitals to offer these services. One stakeholder suggested the need to consider outreach services and to ensure that the health facilities were not only geared for the prevention of cervical cancer but also for the treatment. His comments were:

> "*The Ministry of Health should decentralize their services further and make sure they have the services which are required in those points. In addition, you will recall when we started the work on HIV and we wanted everyone to be tested, the response was weak, but when people got to know that they can get ARVs, testing became worth it for them. It is good to know your status but it is very good to know your status and there are options available for treatment". (Stakeholder 3).*

3.4.1.2 Logistics and Supply Chain Management

There was a challenge with the supply chain for medicines and reagents for the VHWs. The VHWs collected medicines from the clinic or hospital but these were reported to be always in short supply. This left the VHWs with no medication to use for minor ailments which they attended to. The VHWs found this very

inconvenient to themselves and to the community seeking their services. They were therefore travelling to collect the medicines and only to return with no supplies. This had resulted in the community getting partial service from VHWs and sometimes ending up travelling to the clinic to source the medication or not getting any treatment at all as they will not travel to the clinic. One VHW commented as follows on this issue:

> "*We are disappointed on the medication that we are supposed to have in our kits and is supposed to be provided by the hospital. We always get less than what we need. We then turn people away and they have to travel to the hospital to get the medication on their own. Sometimes they simply do not go to the hospital as they will not have bus fare to travel or they will be too sick to travel" (VHW 2)*

The community leader and the sister in charge at the hospital concurred with the VHWs and the sister in charge said:

> "*Pharmacy does not always give them what they need but there is a general shortage of medicines so this happens a number of times" (Stakeholder 2)*

During the time of the study some of the VHWs mentioned that they did not have the reagents necessary for them to conduct the malaria RDTs.

However in contrast to the issues of stock outs, one of the stakeholders indicated that his organization supported the Ministry of Health in ensuring that there were medicines at the lowest level of care. He gave the impression that there was no reason why the VHWs would have limited access to medicines as the quantification of medicines was population based. He thus noted that there should be enough medication for use by the VHWs and the clinics. He reported that the quarterly verification of medical supplies at clinic level showed availability of above 80% at clinic level for the primary level medicines. He explained:

"*We receive a report on availability of medicines with special focus on the primary level. In the latest drug monitoring report for the country Round 21, it is stated that less has less than .1% of the health facilities had ever had a stock out of medicines in all the rural health facilities in the country." (Stakeholder 4).*

On checking the referenced report it was noted that the report does not cover stock status of medicines with the VHWs. Verification on whether there was a policy that determined the flow of medicines between the clinics and the VHWs was not done during this study.

The accessibility of health services was deemed to be the worst barrier for the CHWs as they saw themselves failing to get the communities to access health services. This was pronounced mainly on access to the health institutions offering cervical cancer screening and the on the availability of medicines with the VHWs.

3.4.2 Supervision and Support

One of the ways CHWs are supported is through supervision and mentoring. The BCFs expressed appreciation for the mentoring that they received from NGO staff but this was reportedly also limited. One BCF commented on the support and said:

"Among us there is no one who is like a champion on any of the areas but we liaise among ourselves when we face challenges. But when we do our work with staff from the NGO, communities seem to respond better. I wish we would have more of the support coming from the NGO" (BCF 1)

This was mentioned to highlight the need for more support and also implied that there was limited skill on how to use the interpersonal communication tool.

As a suggestion on how to improve the work of the CHW, one stakeholder highlighted the issue of assisting the BCFs on the ground by giving more sessions with BCFs to demystify the interpersonal communication tool. He stated:

> *"I would have to give at least one session working directly with the BCF as they interface with the families." (Stakeholder 3).*

The Ministry of Health staff bemoaned the limited time they spend with the CHWs, indicating that they provided little support to the VHWs in their work because they were busy at the hospital. The response from one of the stakeholders gave the impression that they had limited time to support the VHW in their work to ensure that there is quality in the work that they do, and monitor that the standards are being adhered to. In addition, the staff felt that there were a lot of disturbances at the office such that they did not give the CHWs enough attention during the meetings. She said:

> *"Apart from the monthly meetings which we hold at the hospital, I don't get a chance to watch the VHWs actually doing their work. Which worries me especially now they are doing rapid testing for malaria. This is new to them and I would have been more comfortable with more practical supervision and support and at least observe each of them practically doing this in the communities. I am with the VHWs once a month and they come in their numbers but I listen to them with half an ear as I will be thinking of the long queue waiting for me in Family Health department. These meetings would be more productive I think, if we met maybe away from the hospital or in the village and we showed each other real issues on the ground". (Stakeholder 2).*

This sentiment however did not come out strongly from the VHWs who were very positive about the meetings they have at the hospital as they reportedly found them very informative. However, from the

discussions with VHWs it was evident that there is no on-the-job support being given to the VHWs. One VHW commented:

> "*The nurses do not come here in the villages, we report on the work we do at the hospital. We submit reports at the clinic and we are guided during those meetings to improve our work". (VHW 4).*

While there was notable supervision for both the BCF and the VHW, there were a number of gaps which needed to be addressed which are given in the section in the report on barriers.

3.4.3 Large geographical areas

The two cadres had different geographical areas to cover. The BCFs had to cover a ward[V] and a VHW had one village[VI] to cover. The BCF explained that their area was too large and this it was difficult to cover more so on a bicycle. One BCF bemoaned these issues as follows:

> "*We have a large area to cover and we are managing to reach our targets, using the bicycle. The problem is that we might not be covering all the needy areas because we can reach our targets by simply going to areas which we can access but not necessarily the neediest. I would suggest we get motor bikes if we have to have a fair coverage of the ward". (BCF1)*

The VHWs cited that each of them had a village, but there were some villages which did not have VHWs to provide services, therefore people from there tended to cross over into areas with VHWs and seek assistance

[V] A ward is a composite of a minimum of three villages (600 households and it is administratively created so that some activities can be done in a ward or the smaller unit which is a village

[VI] A village is an administrative unit in the rural areas of Zimbabwe which has at least 200 households and is headed by a village head

thus increasing their workload. The VHWs explained that some of the villages did not have VHWs allocated to them because there were few VHWs trained in the area:

> "*In theory we have one village to cover but in practice, you also have people from the neighboring villages which do not have a VHW crossing over. You cannot ignore them when they come for assistance and sometimes you know their problem and as volunteers you go across and visit the sick in those villages". (VHW 7).*

The situation had been worsened by the resignations of other VHWs who had to choose between continuing as VHWs or pursue formal employment. One VHW expanded on this issue, implying that those who were formally employed were finding it difficult to balance the work of VHW and their formal employment.

> "*Some of the VHWs have resigned. They were formally employed so their employers requested that they stop as it was taking up their productive time" (VHW 1)*

In addition to this challenge, the distance for the VHW to go and report on a monthly basis and collect provisions such as medicines and the testing kits was reported to be very long. One of the reasons why they were reporting far away was because they did not have a local clinic, as it was still under construction. While pointing out at the mountainous area in Nyanga district, the VHW commented:

> "*They should open the clinic near us so that we don't have to travel to the hospital for reporting and also when we refer patients to the hospital it's not easy for patients to go that far. They find it expensive to travel this distance to the hospital, look at the terrain which most people have to cover on foot while being sick" (VHW 2)*

The stakeholders agreed with the CHWs regarding the large areas which were meant to be covered by a volunteer. They were of the view that this was resulting in them not having sufficient time to attend to their families. This was cited as the reason why they are requesting a larger allowance than what they were currently receiving. A stakeholder said:

> *"The land reform has taken people where they never used to live and has left them more geographically spaced. This has meant larger villages for VHWs and this has to be done on a bicycle and usually on rough terrain. It is not easy for the CHWs who after this still have to earn a living doing something else" (Stakeholder 6)*

To support this view, The Vital medicines and Health Services Survey for the second quarter 2014, showed that the total number of VHWs in the country is 9067. However, the total number required for the country based on the 2012 census results is 20,570 VHWs therefore leaving a shortfall of 11,503 VHWs for the country. (UNICEF, 2014)

3.4.4 Resources

3.4.4.1 Communication barriers

The discussion on communication with the NGO, hospital and the community centered around cell phones with some of the CHWs indicating that they had received one, but some of the VHWs did not have them. Those who had them indicated that the phones were only rechargeable by electricity, thus recharging batteries was difficult as most of them did not have electricity in their homes. One VHW highlighted this and said:

"*The phones use electricity for charging the batteries, not all of us have electricity, I rely on neighbours to charge the phone, It would be better if they had solar chargers then we could charge from our homes and be reachable by the hospital and also by the community" (VHW 1)*

They added that the phones did not have WhatsApp which they felt was a better communication method because it is cheaper and can send the message as soon as you have next work coverage. One BCF who was more concerned about such facilities on the phone expressed his view regarding this:

"*The cell phone does not have WhatsApp, if it had this function it would be more convenient for us" (BCF 1)*

The researcher also observed the challenges of communication experienced by the VHWs and BCFs. The researcher could not reach any of them via the mobile phones as most of them did not have power. In some instances the phones were reported to have been at the neighbor's house being charged or there was no network. The researcher had to be taken physically to where the CHWs were working to be able to interview them, which meant that the meetings occurred with no prior appointments. This constraint consequently resulted in the CHWs experiencing difficulties communicating with the clinic and the community. This was an issue for both the staff at the clinic and also for the CHWs. One CHW explained this challenge using a meeting which was just concluding at the meeting point where the researcher was conducting the interviews:

"*We have missed a meeting, as you can see there was a meeting here and our colleagues managed to attend the meeting, but we didn't come because we could not be reached on the phones" (VHW 1)*

3.4.4.2 General resources and tools

VHWs indicated that they had received one set of uniforms while the BCF received a t-shirt per annum. The BCF indicated that one t-shirt was not enough. A BCF commented as follows:

"*We get one t-shirt and you wear it today and you want to wash it, what then do you wear tomorrow?" (BCF 1).*

The VHWs reported that they also received a bag with medicines, a timer, scale and thermometer and both cadres received bicycles. It was observed that there was variation in terms of what was received amongst the CHWs. Some had not received the bag with medicines and scales. The BCF bicycle came with spare parts while the one received by the VHWs did not. One VHW highlighted the need for the spare parts as the bicycles were breaking down. She said:

"*It would be good if the bicycles had spare parts for the bicycles so we can mend the bicycles when they break down." (VHW 1)*

Both cadres received stationery (books) to use although the one provided to the BCFs was preprinted thus they merely had to fill in the information they collected from the households. The researcher observed that the book provided to the BCF seemed to make recording and capturing of data much easier for the BCF as it guided them with the format given. This was confirmed by the stakeholder at the NGO who indicated that the interpersonal communication tool guided the BCF, and a tear off page from the book was sufficient to gather all the information on the work that the BCF will have done during the month. He added this in explaining the ease brought by using the tool for the NGO:

"*The tear off pages of the data gathering book gives us all the information necessary to help us to monitor the outputs of the BCFs and to see the trend in the work of each and every BCF in their area." (Stakeholder 3)*

The VHW were receiving plain exercise books which they were using to write their reports and to plan their work. Both cadres were happy with their tools for data gathering with the BCF indicating that theirs guided them and reduced their written work:

> *"Given a choice, I think the book that we use is good for us because I already have the questions and all I have to do is insert answers when I am talking to the households. I don't write a fresh report at the end of the month, I give the NGO the tear off page and I remain with the fast copy in the book" (BCF 1)*

Apart from what they had received, the CHWs indicated that there were some things which they could do with to conduct their work better. They mentioned shoes, torches and umbrellas which they needed to complement the materials they had already received. One BCF said:

> "*Apart from the dresses we have been given as uniforms we need shoes, our shoes are now worn out walking in the villages, we need torches as we sometimes have to walk at night, and umbrellas"(BCF 7)*

3.4.4.3 Delays in payment of allowances

All the CHWs interviewed indicated that they were aware that they were volunteers and they were serving the community. The study found out that the allowances were appreciated by the CHWs, however, they also perceived the modalities of payment and the amount as a barrier to their work. The VHW expressed their unhappiness with delays in the payment of the allowances and both the BCFs and the VHWs considered the allowance amount to be low. One VHW expressed her dismay at waiting for the allowances:

> *"I have not received the allowance for over a year and I only received it twice. I am meant to get my allowance every quarter as a cumulative figure of USD45.00 but this does not happen at all. It disrupts the way I do my work". (VHW 2)*

Because of this delay, they indicated that they struggled to travel to the hospital because they did not have any money for transport, sometime resulting in them not attending meetings or even managing to afford soap to clean their uniform. Interestingly, the VHW reported that some of the chiefs suggested that they should charge one dollar for the malaria tests to generate some funds for transport. The VHWs however expressed their reservations regarding this, indicating that they were aware that the community would not afford it. In addition they noted that the community was well aware that health services are for free in the country at the primary level. A VHW commented with much emotion:

> "*I can't charge the one dollar for RDT, and it's worse when you know that they are sick, they do not have the money. I know the community I work in, it's a poor community and I got into this work to help the people" (VHW 2)*

Depending on who the VHWs' funder was, some had never been given an allowance from the time they were trained. Indignation was expressed by one of the VHWs:

> *"We are able to do our work as we are volunteers but we should be given what we were promised. I sell one of my chickens so I get bus fare to reach the hospital and report when I should be getting an allowance which can an enable me to travel to the hospital," (VHW 3).*

Another VHW added:

> "*My husband is very free and allows me to go and do this work but it would also be good if I could bring something from this work which can support the family in one way or another," (VHW 7)*

A BCF said:

"*The allowance that I am getting does not cover my daily needs and I do not contribute to something that my children will be able to see and say, our mother did this when she was doing community work. If the allowance could be increased I could do something for my family and send my children to school." (BCF 3)*

On the other hand, the payment of the allowance was reportedly timely for the BCFs. The researcher noted on observation, that the two payment methods for the BCF and the CHW, were different in terms of duration. The BCF payment cycle seemed shorter and payment reached the BCFs on time. However payment for the VHWs was longer and had resulted in delays of over six months for some of them. The VHW payments were reported by the stakeholders to go through a number of levels before it was paid out. These levels: the national, provincial and district level, did not seem to add value to the process or the accountability of the resources apart from following a system designed for most government resources for paper trail and accountability purposes.

The CHWs and the stakeholders raised two critical issues on payments: the time it took them to get paid and the amount of the allowances. The stakeholders agreed with the CHWs that the allowance should be paid on time as stipulated in the policy as this could make a difference to the morale and how the CHW do their work. One stakeholder said the following, explaining the one thing she would do to enhance the work of the CHWs:

"I would give the VHWs their allowance on time! Getting the allowance on time would remove some of the dismay the CHWs have as it covers some of the areas such as transport costs. All the allowances come from partners, no CHW is paid by the government and as such we can only wait when the funds become available and we distribute" (Stakeholder 2)

The delay in the payment of allowances was very pronounced for the VHW working with the health institutions. The stakeholders pointed that there was no clean database of VHWs, citing limited coordination. He said:

> "*We have been asking for a database of the VHWs for the last year and none has been made available to us. It is very difficult to release funds for which you do not know how many you will be paying and for how long. To me it's a lack of coordination of this cadre which is causing these problems" (Stakeholder 3)*

Moreover, the stakeholders raised an interesting point with regards to allowances. Whilst they agreed with the CHWs on the payment of the allowance on time, they suggested that more support had to come from the community itself as a long-term strategy to address the challenges of the CHWs. They were of the view that the community's contribution would enhance what they receive and communities could also use their influence to generate funds which can be used to support the CHWs. One stakeholder said:

> "*The CHWs could benefit more if the communities on their own could support the CHWs. The support which is coming from the different partners needs to be managed closer to the community and there are facilities raising resources such as the mining community trusts, these could generate more resources to ensure that the CHWs are given their allowances or are even better remunerated" (Stakeholder 6).*

In summary, this chapter has highlighted the key issues raised by the CHWs and the relevant stakeholders as facilitators and barriers to CHW work. While CHWs were defined by the national health strategy as part of the health service system in Zimbabwe, it was noted that access to services was perceived to be a barrier to CHW work. Despite referrals to the health facilities, the patients either received the assistance late or would not get the service at all thus compromising the value of the referral. This was mainly as a result of shortage

of staff at the clinics and hospitals, user fees charged at the facilities and the transport costs. The CHWs considered this as a barriers because in their view they were providing limited services to the community as there was late or no follow through.

In addition, despite some positive views on the supervision and mentoring which came from the Ministry of Health and Child Care and the NGO, it seemed to be viewed as inadequate, was not timely especially that the mentoring after training and the quality thereof was questioned. The support items provided for use by the CHWs were also perceived as barriers in that they were distributed unevenly and came late to the CHWs. The limited numbers of the CHWs meant higher work load, bigger geographical coverage and raised issues of equity in access to health services for the communities.

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CHAPTER 4: DISCUSSION

The study explored the perceptions of CHWs on the enablers and barriers to providing services in Nyanga district, Manicaland Province in Zimbabwe. The aim of the study was to add more knowledge and better understanding of how CHWs work. It was also meant to identify the areas which can enhance their work and to provide a guide to those investing in the CHW programme in Nyanga district. In addition, it was to inform policy and decision makers on the CHW programme in Zimbabwe. The study findings showed that the CHWs defined their roles as that of bridging health services and the communities, treatment of minor ailments, health promotion, education, advocacy and health education. The main factors that enable and enhance the work of CHWs were the satisfaction drawn from the benefits which were accrued by the community, the benefits and/or indirect advantages received and the support services provided they received as CHWs. The main barriers to the CHW work were the difficulties of accessing health services, weak support services, high the workload and the large geographical areas they were expected to cover. The discussion will focus on these key themes, reflect on the literature that highlights similar or contradicting issues and give a policy perspective on these. Recommendations to stakeholders, limitations to the study and areas for further research will also be reflected on.

As indicated in the introduction of this report, Zimbabwe was coming from a near collapsed health system. However, it was noted that some CHWs were still providing a service demonstrating their resilience even in troubled times. They had withstood the test of the HIV scourge and continued to provide services to communities during the economic hardships of 2008. They ultimately became the backbone of a frail health sector and were the ones providing health services with little or no staff in the health institutions. The Health Systems Assessment of 2012 recommended that the CHWs be retrained and that their numbers be increased in order to contribute to health service provision (Ministry of Health and Care, 2012). According to Kruk et al (2010), post conflict countries and fragile states can face more mortality which is linked to disruption of livelihoods, inadequate food and water supplies, and the destruction of health systems, as well as continued

insecurity which are associated with the conflict unless specific efforts are made to rebuild the health systems. Zimbabwe is quoted as one fragile state which has had its maternal mortality rise from 283 to 1100 between 1994 and 2004 (Lancet, 2009). It is in light of this that as Zimbabwe government and its partners make efforts to rebuild the health system and found it necessary to ensure that investments are also made in the community health worker sector.

It is important to highlight that thus the major challenge facing the country was the limited fiscal space for the government in the face of a health system that needed rebuilding. The Health Sector Investment Case (2012) identified lack of resources as the single major challenge facing the health sector. It calculated that the additional budget required to revitalise the health sector and scale up high-impact interventions to assist Zimbabwe to make progress towards its MDG targets would be around US$200 million a year (Ministry of Health and Child Care, 2010). Efforts had been made by development partners to invest into the sector to address the crisis but these were limited against the many priorities of the country with no matching input from the government, (UNICEF, 2014).

In addition, there were other barriers which also restrained the work of the CHWs such as the difficulties of communities to access health services at the health facilities after referrals by CHWs. User-fees at the health facilities created a barrier to access health services for the communities. The user fees which were being charged were the result of poor investment into the health system and health facilities were using the funds from the fees to keep the institutions functional. Most of the CHWs were serving communities living in extreme poverty. One of the CHWs explained this by saying that she was not willing and was not able to ask of the community to pay anything for her services as she was well aware that most of the communities did not have money. The introduction of user fees further restricted access by the communities to the health services. The CHWs faced limited support services, heavy work load and the large geographical areas they were expected to cover.

4.1 Perceptions on roles and responsibilities

The research findings show that the CHWs perceived their work to be that of bridging the community and the health services and bringing the services closer to the people in the villages by treating minor ailments, referring to the hospital when necessary and also bringing in information from the hospital to the community through health promotion, education and advocacy. The views on what the CHWs are expected to do echoed those given in the VHW Handbook (Zimbabwe Ministry of Health and Child Welfare, 2012) which describes the work that is expected of the VHW and it covers more than what the CHWs described, but in broad terms the two agreed. This in some way should encourage the stakeholders especially funding partners in that CHWs were working in line with national guidelines. This is a critical area in the Paris Declaration (2005) which requires all the countries signatory to the declaration to use country systems and the priorities within the countries to which they are providing aid. The Paris Declaration has five principles, which are: ownership by the countries being supported, alignment of support to country priorities, harmonisation of procedures and guidelines, management for results and mutual accountability. The donors should work within one plan, one strategy and one monitoring and evaluation system as designed by the countries being supported. This has already been observed as giving better results and reducing duplication of effort on the part of the donors. Over 100 countries developing and developed countries signed up to this declaration in 2005 (OECD 2005).

The Alma Ata defined primary health care to involve and include: an adequate supply of safe water and basic sanitation, promotion of food supply and proper nutrition, maternal and child health care including family planning, immunization against the major infectious diseases, the prevention and control of locally endemic diseases, appropriate treatment of common diseases and injuries, health education and provision of essential medicines (Campbell & Scott, 2011). The Alma Ata formed the basis for the creation of the CHW cadre in Zimbabwe (Zimbabwe Ministry of Health and Child Welfare, 2012). According to Perry et al, (2014), low income countries CHWs are contributing to major improvements on health priority areas such as

children under nutrition, MNCH and control of malaria, HIV and TB. The results of the study show that these were also the areas which the CHWs focused on in the Nyanga district.

In a study in Iran on the perspectives of CHWs, Javanparast, et al (2011) showed that the CHWs in Iran were able to define clearly what they are meant to do and even knew the time they spent on each activity. In the same study, almost all the respondents placed a special emphasis on Health Education as their principal role and what they saw as the most important factor influencing rural health. Of interest was one of the comments the CHWs made in the study in which they stated that they performed additional tasks that their supervisors were not aware of. In their view, they conducted these additional tasks because they understood their communities better and would not want to miss an opportunity to get a health message across. This was also true for the CHWs in Nyanga. However, while these additional activities helped to create trust with the communities and also contribute in addressing the determinants of ill-health in the community, they were not documented and were not the major highlight of the work of the CHW. This could mean that there is a gap in understanding by stakeholders of the full work processes of the CHWs. This could result in incorrect value and timing of procedures in the CHW work.

The processes and how the CHWs actually do their work could be the major reason behind their success yet these are not documented and followed through. This results in lack of enrichment of the Programme as some of the key lessons which could enrich the programme go unrecorded. It would be of value to document activities such as the presentations made at functions, the cleaning of households, and looking for firewood for the beneficiaries. These could then be shared as they also seemed to have an impact on the households they served in addition to the other activities which they did.

This study did not go further to confirm whether the roles and responsibilities given during the discussions with the CHWs were what they practiced. This could have been confirmed by the direct beneficiaries of the services they provided.

4.2 Enablers for the work

This research found that the CHWs were able to do the work partly due to the level of motivation they had to do the work. They expressed personal satisfaction from observing the positive changes among the communities, more so as they lived with these communities. The CHWs reported that they were respected by the community. The community leaders who were interviewed showed respect for the CHWs and indicated this in the discussion. This respect though could easily wane due to failure to deliver on some of the critical components such as medicines. CHWs also appreciated the benefits that accrued to themselves. This included the information, the bicycles and the support they received from the community leaders, the hospital and NGO that they were working with and affiliated to.

4.2.1 Benefits derived by the Communities and Recognition of the CHWs

The CHWs identified with the communities they were working with as they were part of that community. In some instances they were related to the people they served. They liked the fact that they actually saw the positive change brought about by their work and were appreciated for this work. The area most referred to for CHW input was the HIV care work which they provided for the AIDS patients whom they had cared for in the villages, especially when there was no treatment offered for those living with HIV and AIDS. Zimbabwe took time before it could afford to put people living with HIV and AIDS on treatment, and during this time CHWs attended the patients. Moreover when they were discharged from hospitals, most ended in their rural homes and the CHWs cared for them. Rodlach (2014) detailed in his research in Zimbabwe how he witnessed the CHWs at work in Zimbabwe attending to people living with HIV and AIDS. In an evaluation of Global Funding Mechanism for Community Systems Strengthening, (PricewaterhouseCoopers, 2012), it was reported that the CHWs were known for the care work they provided to those with HIV and AIDS and were bed ridden. In light of this, the CHWs were gaining self-gratification for their work.

Lehmann and Sanders (2007), in a desk review, indicated that CHWs are motivated by the visible change that they witness during the community work, community empowerment and successful referrals to the hospital. In Iran in the study conducted by Javanparast et al (2011), the CHWs were convinced that they had brought positive change to their communities and they were proud of having contributed to this.

The CHWs could see that they were agents of change in the community they lived in. This was also reflected on by the Global Fund evaluation of Community Systems Support, (PricewaterhouseCoopers, 2012). However, the evaluation acknowledged that there was limited documentation and acknowledgement of the inputs from the CHWs. In Thailand, there are no financial incentives for the CHWs but the government provided for health cover for the CHWs and their families and they have an award for the best volunteers including a national ceremony attended by all the volunteers. This is done as a way to recognize the work of the CHWs (WHO, 2010).

According to Hermann et al, (2009) the need for CHWs to reside in the same communities they provide services to is higher than their educational qualification. They contend that the degree of trust between the CHW and the community is of paramount importance and should not be compromised. This agreed with the findings of this study and also confirmed the challenges described by van Ginneken, et al (2010), who raised concerns about the loss of attachment of the CHWs to the community when they are removed from it. In this study in Nyanga district, it was found that the CHWs would not even consider asking the people in the community to pay for the services they provided. This was because they understood the level of poverty in the area and sympathized with the community.

4.2.2 Benefits realized by the CHWs

The findings of this study show that the CHWs were encouraged to some extent by the benefits which they accrued by working as CHWs. They appreciated the additional knowledge they had gained which they were using to also inform their families. They also appreciated the bicycles and mobile telephones which they had received.

According to the evaluation of the Community Systems Strengthening funded by the Global Fund in Zimbabwe, (Pricewaterhouse 2013), there are enablers which overrode the financial incentives and had helped to retain the CHWs. For instance, they were the first people to have access to any new health related information before the community members. This encouraged them and they were also utilising the information with their immediate families. The second benefit was that their position was providing them with opportunities to learn and be recognized in the community which was seen as an invaluable social status. In addition, they also benefited from promotional material such as hats and t-shirts. This resonated with the findings in Kenya by Takasugi and Lee (2012) who identified a number of factors which were called non-financial drivers for CHW work. They identified social recognition and increased knowledge due to the training which they received. The Kenya study indicated that most of them would not have accessed the education provided during work as CHWs in any other way. Similar sentiments were observed in this study as the CHWs showed pride in the knowledge gained and in the recruitment process, highlighting that they were the ones the community trusted and they were held in high esteem within the community. This was a source of encouragement for the CHWs to do their work. In agreement with Mathauer and Imhoff (2006) and similar to Takasugi and Lee's (2012) sentiments, there are non-financial drivers which can keep health workers motivated to do their work. The prestige that is gained in the community has been observed in Bangladesh as a driver of the motivation of the CHWs in the Bangladesh CHW programme, (WHO, 2010)

4.2.3 Support services for the CHWs

The CHWs highlighted that they received support from the hospital and the NGOs. This was in the form of training, mentoring, and resources such as uniforms, bicycles, phones and allowances. The CHW in Brazil received a uniform, an ID badge, clip board, a bicycle, canoe or ship, scale for weighing children, chronometer, thermometer, and tape measure and educational material, (WHO, 2010). The packages were similar to what was observed in the Nyanga district in my research but on the transport model, Brazil seemed to have adjusted what they gave the CHW depending on the terrain they worked in. In Nyanga all CHWs had the same type of bicycle found in other districts despite the rough and mountainous terrain.

CHWs in this study appreciated the guidance by the hospital and NGO staff in conducting their work. This was not the case in the study conducted by van Ginneken (2010) in South Africa. It was reported that the support from the nurses to the CHWs was limited and constrained the CHWs in doing their work due to the differences between the nurses in the health facilities and the CHWs. In a study conducted by Hermann et al (2009) they gave the following as essential for the performance of CHW: selection and motivation, initial training, simple guidelines and standard protocols, supervision and relationship with the formal health services, adequate remuneration and career structure, political support and a regulatory framework, alignment with the broader health system, and flexibility and dynamism. In a separate study by Jaskiewicz and Tulenko (2012), they highlighted that there are four elements which can enhance the productivity of CHWs: work load proportional to the time allocated to do the work, supportive supervision, supplies and equipment and respect were necessary to create an enabling environment to conduct the work.

While in this study, selection, respect, motivation, initial training and a regulatory framework were observed as available and much appreciated by the CHWs, adequate remuneration, simple guidelines, standard protocols and clear alignment with the broader health system and a career structure were either not

mentioned or were not available. While the VHWs were recognized by the broad health care system, the BCFs were least discussed by the stakeholders in the health care system, raising the need to ensure that the two be linked the health care system and the behavior change facilitators. The BCFs were generating demand for a service provided in the health institutions, thus it was necessary that the two appreciated each other's roles. Limited connection between the BCF and the health institutions staff were highlighted as a major barrier to the work of the BCF especially on cervical cancer screening and gender based violence, as will be discussed in the section on the barriers to CHW work.

The BCFs had a good guideline which was also used as a record book. This was not in the local language, so while it was very comprehensive, the language made it difficult for the BCFs to use it. The record book made reporting much easier for the BCF and ensured continuity in the tracking of the home visits. This record keeping ensured that the NGO had clear records of the work they BCFs as they used the tear off pages from the record book. The manual was written in English which could have led to limited comprehension by the CHWs of the instructions therein as most of them had basic knowledge of English. The language could have been a barrier for the BCF as they worked through it with the communities. WHO (2010) recommended that trainings and the guides for CHWs be in a language which the CHWs would be comfortable with. Policy makers need to take cognisance of the complexity of the work of the CHWs especially when the guide is in a foreign language. It can form a barrier between the CHW and the community. The policy makers need to consider translating the manual into the home language of most of the CHWs.

The support which the NGOs and nursing staff in the Nyanga district provided should be applauded, although this had challenges which are reported in the barriers section. Other NGOs and health facilities could learn from the relationship that existed between the staff in the support organisations and the CHWs. However, the Nyanga district could learn from the training models in Brazil and Pakistan regarding the

different training models they use, such as the use of the monthly meetings as platforms and dedicated time for training on new concepts that the health centres wish to update the CHWs (WHO, 2010).

4.3 Barriers to CHW Services

The study identified that there were major barriers of CHW work in Nyanga. These were limited access to health services by the communities at the health facilities after being referred by the CHWs, and the poor support the CHWs received from the health system, the health facilities and the NGOs they worked with. Some of the major themes that were observed included: limited access to health services for the ommunities, limited support from the health system, and large geographical coverage which resulted in the high workload for the CHWs. Consequently, this threatened the equity and quality of the services accessed by the communities they served.

4.3.1 Access to Health Services

While the findings show that the CHWs were working within the health care facilities, there were barriers which deterred access of health services for the communities they were serving. There was a mismatch between the demand created by the BCFs and the supply of the services at health centre level. This was not a surprise though, as most CHW Programmes have been created to assist with the limited services at health facilities due to shortages of staff (Perry et al. 2014). As communities fail to access the services which the CHWs would have advocated, the trust of the communities of the CHW tended to wane.

The stakeholders seemed to suggest a weak distribution system of the medicines which were not being accessed by the CHWs in this study. One development partner highlighted that they were procuring medicines meant for primary health care and did not understand why CHWs were not getting the medicines.

This could be embedded in the near collapsed health system as was reported in the health facility assessment conducted in the country (MoHCC, 2010). WHO, (2010) systemic reviews of case studies indicated that Pakistan CHWs faced the same challenges of inconsistent medical supplies. In the same report it was also clear that Ethiopia and Bangladesh had challenges in ensuring that the CHWs had their supplies of malaria drugs and insecticide treated bed nets. In Bangladesh and in Kenya, the issue of medicines and medical supplies was managed through a revolving fund scheme decentralized to community based pharmacies. This was also used as a way to raise income for the CHWs. In this way the community and the CHWs were managing the medicines supply (WHO, 2010). This is a possibility in Zimbabwe but the weak fiscal space of the government makes it a difficult option.

In Senegal, the challenges of supply chain management and logistical support were observed (Blanas et al 2013). The clinics were hesitant to give the CHWs medicines for fear of running out themselves. In Malawi, in a community management of childhood illnesses programme study it was found out that there were no supplies of the necessary medicines in the first four months of the programme. This was mainly because the central medicine store did not have the medicines and the clinics were not able to supply the CHWs (Callaghan-Koru et al. 2013). In the evaluation of Community Systems Strengthening funded by the Global Fund in Zimbabwe, (PricewaterhouseCoopers, 2012), it was found that the health facility staff and community members reported that for a long time the VHWs had been operating without adequate supplies largely due to the broader supply chain constraints which had led to the local health facilities operating with inadequate and irregular supplies. In agreement with Global Fund sentiments, Perry et al (2014), indicated that the major reasons why the CHW programmes of the 1980s failed were due to inadequate training, insufficient remuneration, lack of supervision and limited logistical support and supplies.

The Zimbabwe health sector faced a near collapse in the 2007-8 period with medicines stock levels at less than 30% of the national medicines requirements, Ministry of Health and Child Welfare (2012). This left most health facilities with little or no confidence in the supply chain to the extent that there could still be

fear among the clinic staff to release medicines to another facility for fear that they would also run out. Reestablishing confidence in the system will require demonstration over a period of time that medical supplies are running normally without obvious disruptions and assurance from government that medicines will be supplied.

The situation in Zimbabwe is characteristic of a country in post conflict time. In 2014, the country was depending on transition funds from development partners and this had no guarantee that it would continue (Ministry of Health and Child Care, 2016). This created the hesitancy of the clinics to release medicines to the CHWs. While these efforts by development partners were working with the government, the building of trust all the way through to the implementers was still a long way away from being regained. According to Gilson (2006) trust is important in health care systems and more so as health systems are made up of a chain of relationships between the health system itself and the users of the system (Gilson, 2006). The government could invest in the procurement of medicines in a progressive approach which would demonstrate commitment to rebuilding the health system and in the long term gain trust in the health system by the health providers, the CHWs, the patients and the communities in general. This is difficult in a country where almost 80% of medical products are supplied by donors, (UNICEF, 2015). This could remain a challenge until there is enough fiscal space for the government to purchase medicines for the country.

The other option which could be considered is to capitalize on the results based financing which was initiated by the Ministry of Finance and the World Bank in 2012 (Ministry of Health and Child Care, 2013). The Zimbabwe health system operates within a decentralized approach where the district has autonomy on how they can manage resources (NHS, 2009). They are guided by the provincial directorate and follow the national policies and guidelines. The Results Based Funding mechanism operates at district level which allows the district to earn on average USD15,000.00 per quarter. Most of these funds are used to procure medicines for use by the clinics; however they do not include the requirements of the CHWs. Consideration should be made to pool these resources and a portion be used for the medicines which can be used by the

CHWs. In addition to this, the pooled funding mechanisms within the country do include community components but the community component tends to be over shadowed by the clinic and hospital needs. A separated pool dedicated to resources for community systems could ensure that CHWs get the necessary attention.

4.3.2 Support by Health Facilities and NGOs

4.3.2.1 Training and Support

In this study, skills limitations for both the VHWs and the BCFs were raised by the stakeholders as a barrier to conducting CHW work. It was indicated that this was despite the trainings which had been given. There were perceptions that this could be because of the language that is used in trainings, the training materials and in the field support.

In a study in Senegal, Blanas et al (2013), reported that there were gaps in the CHWs' knowledge, particularly in the understanding of the treatment of malaria. Some of the CHWs could not explain the algorithms from the RDTs. This specific challenge was not highlighted in this study but it could not be ruled out. In an evaluation by Global Fund in Zimbabwe (PricewaterhouseCoopers, 2012), it was reported that in certain wards visited during the evaluation some VHWs were trained for only 3 weeks, with the entire 8-week curriculum crammed into these 3 weeks leaving doubts about the extent of uptake and retention of the knowledge. In the same evaluation report it is stated that the ideal training should be 20 weeks broken down as follows: 8 weeks classroom training, 8 weeks field training and 4 weeks of additional theory training. Durations of trainings varied from one country to another in the systemic review conducted by WHO (2010). Uganda had a 10 day training program, while it was 3 months in Brazil and 15 months in Pakistan. The 15 months of training in Pakistan was divided into integrated training for the initial three months and 12 months for task based training The actual time taken for the trainings in Uganda depended on the resources

available and the capacity of the trainers, (WHO, 2010). WHO, (2010) recommended that each CHW be given a core set of skills and information related to the MDGs, then other areas would be added on depending on the needs of the specific area. From the literature, it would seem that there is no agreed duration and format of trainings which give the desired level of training.

In Nyanga there seemed to be no quality control in the training of the VHWs as there was no step wise approach to the training and there seemed to be no documentation of the trainings given to each CHW in one database. The VHWs had only been trained in malaria treatment in the year leading to the study and there was no report of them being followed up to see how they were performing in the field. This could imply that the VHWs across Nyanga might have different capacities depending on who trained them and how they were trained. This could have equity and quality implications on the service provided by the VHWs. The Nyanga CHWs reflected that they had limited follow ups from the health facilities and the NGO. This highlighted the missed opportunities for supervisors to note the challenges faced in the field to immediately correct any of them, especially when new tools are introduced. Ethiopia and Mozambique where reported as having the same challenge due to limited resources, (WHO, 2010).

Javanparasat et al (2012) in a study in Iran found that the CHWs were well trained and had specific knowledge on primary health care. They had a high school certificate approved by the rural council where the CHWs were interviewed and had to pass a theory test. This cadre called a ***beharz*** had brought much contribution to the health care system with recorded successes. Due to staffing shortages and budgetary limitations they were not able to do this as often as they would have wanted to. This meant that there was no immediate corrective action provided in the field and this could compromise on the quality of services that are provided by the CHWs. In Malawi the Environmental Health Technicians are the ones who supervise the CHWs and among the CHWs they have chosen senior CHWs to supervise the junior CHWs (Callaghan-Koru et al. 2013). The option of EHTs is not available as the vacancy rate for EHTs as at June 2015 was 37%, which was higher than the nurses vacancy rate which of 5% (Manicaland Provincial monthly report,

June 2015). The option remaining for Nyanga would be to consider a supervisor among the CHWs and build their capacity to take up the role. The WHO, 2010 reported that most countries were weak on this area as in most instances they used a nurse to conduct the supervision, who in most instances did not appreciate the work and often resented it. WHO recommended that this supervision role be done by someone from the community who is then capacitated to have supervisory skills. This was being successfully done in Bangladesh (WHO, 2010). The systemic review of WHO (2010) indicated that the duration of the training, support and supervision, and the robustness of the health system formed critical components to make CHWs effective.

Although the literacy rate in Zimbabwe is 96% (Zimstat, 2012), there were issues regarding the use of English only as the medium of training. Policy makers could consider translating the manual into some of the ethnic languages and make some of it into audio visuals as an alternative.

4.3.2.2 Resources

Allowances

The study highlighted that VHW allowances were irregular while the BCFs were paid on a regular basis. However, the BCFs indicated that the amount was not sufficient. The VHWs hoped that a consideration would be made to compensate them for the work they did. Both cadres were earning USD 15.00 per month as a CHW allowance.

Takasugi and Lee (2012), in their study in Kenya on CHWs, recommended that further research be done on volunteer work as they were of the view that it was not sustainable. Perry et al (2014) seemed to suggest that this could have been one of the contributing factors which led to the failure of the 1980s CHW Programmes. Lehmann and Sanders (2007), indicated that the debate between volunteerism and paid CHWs remained a controversial issue and it is difficult to see volunteerism sustaining CHWs who are known to be in poor settings and would require some form of income. In the same report they added that payment of CHWs also

comes with its challenges in that, the amount might not be enough, might be delayed and might stop being provided altogether. This description given by Lehmann and Sanders (2012) was similar to the situation in Nyanga district during the time of the research. The amount was perceived to be insufficient, delayed and some had not received it. In a desk review conducted by George et al (2012) they revealed that the countries which paid the CHWs had more than half of their districts with a functioning Community Case Management Programme for child survival in Sub Saharan Africa. These became less where the CHWs were volunteering. The same study indicated two payment mechanisms. One was in the form of a performance based payment and the other was one where the communities paid for medicines and the CHWs would pay themselves from the money generated.

The Lady Health Worker Programme in Pakistan had a formal salary which was paid to the lady health workers and contributed to the success of this programme, (WHO, 2010). From the literature, it would seem to suggest that payment of CHWs while it carries risks, also has its merits. The main merit of paying for the CHWs is the reduced attrition, which makes the programmes less productive when it happens ((WHO 2010). The systemic review though, done in 2010, showed that there were no outcomes that were related to giving allowances as compared to working with volunteers, (WHO, 2010)

It would seem that Nyanga district, while it was working with CHWs as volunteers, had realization that volunteer work without some form of compensation was not sustainable. The CHWs were of the opinion that the compensation was not enough. Brazil is reported to have done much better on its CHW programme because the CHWs are part of the civil service and are paid as government employees (WHO 2010). However, in the Public Expenditure Review for Zimbabwe conducted in 2013, the current fiscal space is already failing to meet the current civil service bill, (World Bank, 2015). The CHWs that were supported by NGOs were paid on time as compared to those working with the government health facilities. The study conducted in South Africa highlighted that, giving responsibilities to NGOs had its challenges especially if they are then not given enough resources and capacity to run CHW work (Nxumalo et al. 2013). Perry et al

(2013) highlight that NGOs are best for running small CHW programmes rather than large national programmes.

Telephones, Uniforms and Bicycles

This study found out that there were discrepancies in all of the different provisions which were given to the CHWs. The variation seemed to originate from limited adherence to the guidelines on how to support CHWs and the number of CHWs' supporters whose input were not coordinated. These supplies could have worked very well as non-financial incentives for the CHWs in Nyanga, as these were much appreciated by the CHWs. This would agree with Mathuer and Imhoff, (2006) on the role on non-financial incentives, but the uneven distribution of these was resulting in the demotivation of those that would have been missed out. This is a characteristic of a country in post conflict time and indeed holds true as given in the background. The country depended on transition funds from development partners and this had no guarantee that it would continue. This created the hesitancy of the clinics to release medicines to the CHWs. While these efforts by development partners were working with the government, the building of trust all the way through to the implementers was still a long way away from being regained. According to Gilson (2006) trust is important in health care systems and more so as health systems are made up of a chain of relationships between the health system itself and the users of the system (Gilson, 2006). The government could invest in the procurement of medicines in a progressive approach which would demonstrate commitment to rebuilding the health system and in the long term gain trust in the health system by the health providers, the CHWs, the patients and the communities in general.

The underlying challenge could be that while the broader health system in the country refers to the CHWs, support to them seemed to be the responsibility of development partners and NGOs, not the government who are poorly coordinated. This left the CHWs being supported by different partners who provided what they could afford at any given point in time. In Ethiopia, the CHWs are part of the health delivery system

and they are included in the full health package of health workers, (WHO 2010). In this way the country has eliminated the discrepancies and there is uniformity in the support of CHWs. Jaskiewicz and Tulenko (2012) highlight that each CHW strategy should address the enabling environment for the CHWs. This included a defined workload, supportive supervision, supplies, equipment and respect. It is argued that that a health practitioner without adequate tools is as ineffective as having the tools without the practitioner (Kabene et al. 2006). Nyanga district had supplied the telephones and bicycles, however not all of them had these. The CHWs were respected by the community and the community leaders, though there was the obvious threat that this could wane as they were not supplying medicines. In addition, there were other items in which there were still major gaps such as the medicines, a defined workload and the limited supportive supervision. A well maintained database giving all the CHWs details, where they worked and what they had received could help Nyanga district to better coordinate the inputs from NGOs and partners, so that the decision makers in the district could guide and provide leadership to the partners that come to Nyanga district to support them.

Use of Information Technology

Information technology is fast changing the terrain in health. In the Joint Review Mission in Zimbabwe (Ministry of Health and Child Care, 2014), it was reported that one of the teams found that cell phones were being used by the CHWs to contact ANC-booked mothers to remind them of their next date of booking as a way to promote focused antenatal care (UNICEF 2014). This however could only happen where the phones were available. In Rwanda, it is reported that an SMS platform created for the CHWs had increased the communication between CHWs and ambulances, clinics and hospitals for maternal and child health activities. It was also being used to monitor the work of the CHWs (Ngabo et al, 2012). Use of the mobile phones could change the way CHWs do their work, especially considering that CHWs in Nyanga had welcomed the technology and there was willingness to explore further how it can be used.

4.3.3 Workload and Geographical Coverage

The findings in my study show that the workload for CHWs was perceived to be high which could easily lead to burn out. This was made worse by the large areas they had to cover on a mountainous terrain and the reduced numbers of CHWs due to attrition. In addition to this, it was observed in the research that there was a possible duplication of effort and additional roles beyond what the VHWs and BCFs could actually do, whereas there were other cadres whose job descriptions covered the roles. This had the potential for role confusion and duplication of effort among the cadres.

Literature reviewed was non-conclusive on the recommended number of households which a CHW can cover. This was explained by Thabethe (2011), who indicated that this depends on the expected role or job description of the CHW. For the Barangay Health Workers in Philippines, (WHO, 2010) it was indicated that they had at least twelve different roles and the study indicated that their effectiveness on all these roles had been questioned. The *behazv* in Iran (Javanparast et al, 2012), indicated that heavy and increasing workload threatened the quality of their work. Lehmann and Sanders (2007) recommended that there is need to better understand the actual work in order to appreciate the workload of the CHWs. According to the Global Fund Zimbabwe (2013), the work of the VHW is meant to be done within 2-3 hours per day; however because of the nature of the work it had almost become a full time job. This could result in demands for increased allowances, poor quality of work arising from doing the work in a hurry or developing a negative attitude towards the work, and this could negatively influence the health outcomes in the district.

CHAPTER 5: CONCLUSION AND RECOMMENDATIONS

5.1 Conclusion

CHWs are critical in the health services in Zimbabwe particularly as it becomes clearer that the health system requires their contribution. The gaps in human resources in the health care system in the country has landed its reliance on the CHWs particularly in light of the increasing burden of disease driven by both communicable and non-communicable diseases. The CHWs described their work as key to bringing awareness of the determinants of health at community level in Nyanga and also the bridging of the actual health services between the community and health facilities.

This was a qualitative study which derived most of its themes from the interviews held with the CHWS and the stakeholders. The results showed that CHWs were motivated by the change for the better that they had witnessed in their community and the benefits they had accrued as CHWs. The CHWs assisted in the HIV and AIDS epidemic as they conducted most of the home based care work for people living with HIV and AIDS. They promoted primary health care. In the Nyanga area they were contributing in the treatment of malaria, one of the major leading causes of mortality in that district. They had also contributed to the improved health seeking behavior of the communities with early antenatal care bookings showing an improving trend for the province. Despite this, the study identified that there were major barriers of CHWs work in Nyanga which were: access to health services by the communities after seeing the CHWs, the support the CHWs received from the health system, the health facilities and the NGOs they worked with. The CHWs also highlighted the challenges they face with high work load and low compensation for the work they do. The CHWs' response to lack of training was not noted or explored, however there was some notable degree of confidence among them. It should be noted that from the descriptions on the trainings, one could observe the limitations which could easily affect the quality of service.

The district could get more benefits from the CHWs in the district if they could address these barriers. This could result in more benefits for the communities and the CHWs. The CHWs could improve their output if they were supported by a functional health system. Thus, while the CHWs are needed to ease the pressure on the health care system, particularly at the district levels, the extent of their contribution and effectiveness depends on the extent of support that they also receive.

While investments are being made at the community level there is need to also invest in all the six health systems blocks as these are required at all levels of care. This requires a stable macroeconomic environment and a willingness to invest in the social sector. The outcome of the work of the CHW depends on their willingness to provide the service but what was evident from the study is that they also require a functional health system. However, a functional health system also relies on the political and macroeconomics of the country (Perry et al, 2014). In Zimbabwe, at the time of the study the macroeconomic indicators were still showing a negative trend resulting in weak investment into the health sector. It is also notable that the CHW programmes in Brazil and Pakistan have succeeded and this is linked to strong health sectors (WHO, 2010).

5.2 Recommendations

5.2.1 Motivation of the CHW

The CHWs in Nyanga district could be motivated by ensuring that payment of their allowance is done on time and if possible to increase it. This can done through channeling the resources through the NGO which had already demonstrated that they can pay the allowance efficiently. The allowance is set at USD15.00 per month. The district should consider if this amount can still purchase the supplies stipulated as the benefit package for a CHW household. The second consideration would be to conduct a survey to consider if the basket of commodities still remains an incentive for the CHWs to continue to do their work effectively.

The CHWs noted that it would be help them to use their allowance to send their children to school, however the allowance was not sufficient. With better pay from government, the allowance could support the CHWs by meeting some other social basic needs: In addition to sending of children to school, the income could also assist in purchasing of food items, clothing and meeting health bills where necessary. What is notable in the successful CHW programs such as those in Pakistan, and Ethiopia is that the CHWs are paid salaries, they are actually employed as employees of the state in Ethiopia and an NGO in Pakistan employs them rather than to rely on them working as volunteers (WHO, 2010).

Instead of paying an allowance, it is recommended that the CHWs be employed and paid salaries and make them employees of the public health sector. Consideration of paying salaries instead of allowances could give some economic stability to the CHWs and they would then be able to pay for their specific needs as individuals. WHO, (2010), in their report entitled Global Experience of Community Health Workers for Delivery of Health Related Millennium Development Goals, indicates that CHWs are poor people coming from poor communities, they need an income (WHO, 2010). This would also agree with Perry, 2014 who argues that volunteerism has been one of the causes of the poor sustainability of most CHW programmes (Perry et al, 2014).

CHWs can be motivated through recognition at district or provincial or national level for their contribution to the health system through an award for the best CHW. It would also motivate them further if information about reviews showing the success stories of their work could be showcased to the community, indicating that their work is appreciated even at a national scale. Non-financial incentives are recognized as one way to incentivize CHWs and this is practiced successfully in Thailand, Ethiopia and Brazil (WHO, 2010). These non-financial incentives include the training, but in Thailand for instance, it also includes giving badges and free health care. Mathauer and Imhoff (2006) argue that non-financial drivers can motivate CHWs. They argue that providing the correct tools, a means of showing staff professionalism and the opportunity for further education can motivate and help in retaining staff (Mathauer and Imhoff, 2006)

5.2.2 Quality of Work

The quality of work for the CHW could be improved through ensuring that they receive sufficient training, they are supported in the field and are paid allowances through a performance based allowance system.

5.2.2.1 Trainings

The VHW hand book and the record book of the BCF are written in English. These should be adapted to a language which CHWs are familiar with. Simplified guides should be extracted from these for ease of reference when the CHWs are doing their work. In Nyanga, training was defined more by who supported the training rather than the certificate that a CHW had. This could mean training had gaps or was not completed due to resources and the trainers' capacity. There is need to have a cohort of CHW trainers in the district who are then used by each partner that wishes to train CHWs. This would guarantee the quality of training and influence the quality of work that the CHWs will eventually provide.

The district could explore a combination of classroom and on the job training. The latter would be in the form of mentoring and coaching and in the process would also be monitoring the work that the CHWs do. The monthly meetings held at the district hospital could be used for these processes. The method has registered successes in the Lady Health Worker Programme in Pakistan in which the workers are trained for 15 months, 3 months integrated training, 12 months of task based training and refresher courses once every month at the monthly meeting (WHO, 2010). This has the advantage that over a period of time the CHWs get different skills and continue to receive support from the trainers through mentoring and refresher trainings. According to a UNICEF report (2004) refresher training is necessary because acquired skills and knowledge are quickly lost without refresher trainings (UNICEF, 2004).

At the completion of a course, a dated certificate could be given. This could assist by knowing when a particular VHW will require a refresher course depending on the last modules they have been trained on.

This information would need to be kept in the database of the CHWs in the district such that they are better able to make informed decisions, and when funding partners approach the district, the managers in the district are better informed to guide on where and how resources are best used for the CHWs.

5.2.2.2 Supportive Supervision

It is difficult to get any of the staff at the health facility to conduct supportive supervision because of the staff shortages there. The option for policy makers is to consider the creation of a CHW monitor position for a group of CHWs. This will entail giving a higher allowance to the cadre and training the cadre to coordinate and manage the group. Apart from ensuring that supervision and support occurs, it will give the CHW another position to aspire for as a career path as was suggested by Osawa et al (2010).

5.2.2.3 Performance based payment

In the medium to long term, policy makers should consider introducing a pay for performance for the CHWs. According to Kruk 2010, when rebuilding a health system it is important to ensure that quality of health services is also considered (Kruk et al, 2010). One of the ways of making sure that quality is harnessed is through performance based financing (World Bank, 2013). For quality improvement for the work of the CHWs, Zimbabwe could build on the Results Based Financing (RBF) initiatives which have already been started in the country and work with the clinics in Nyanga district which are using the RBF mechanism by introducing a performance indicator that relates to the community system strengthening.

This system will incentivise the CHWs and also encourage the health system to establish a system to monitor the work of the CHWs and ensure that there are indicators for health at community level upon which performance can be measured. This could be linked to the use of technology for the monitoring of the performance indicators for the VHWs as is done in Rwanda (Ngabo et al, 2012).

5.2.3 Process Improvement

The CHWs were concerned about the varied distribution of resources and work amongst the cadres, which could result in inequity with regards to the quality of and the services rendered to communities.

5.2.3.1 Work Load Indicator for Staffing Needs

At policy level, there is need to ensure that CHWs give the best quality service to their communities equitably. Any additional roles given to CHWs need to take cognizance of earlier agreed roles to avoid overload and exhaustion. They can also have burn out which could result in poor health outcomes. It is also necessary for the policy makers in Nyanga district and Zimbabwe to revisit the number of activities which CHWs can do and be rational about the expectations they have on them. The same exercise for the CHWs will ensure that the roles that are defined for the CHWs are not being done by other health cadres, thus removing duplication of effort. The Workload Indicator Staffing Needs assessment could be conducted for the CHWs to determine what they actually spend their time doing how many of the CHWs are required in Nyanga district. From this study, Nyanga district can then determine how many CHWs they require and then seek for the resources to finance these.

5.2.3.2 Information Technology to improve health services access

There were a number of CHWs who had mobile phones in Nyanga. Nyanga district should take advantage of these phones for communication with the community and mobilise resources to ensure that they all have the phones. Mobile phones if effectively used for communication can reduce the time taken in travelling time and the cost thereof for both the CHW and the patient. Better reporting can improve the evidence that health managers have and they can then make informed decisions.

5.2.3.3 Improved coordination between the different levels of care

A policy needs to be developed which outlines the roles and responsibilities of the different levels of care and how these are linked to provide a service to the community. This could be done through in-service training of the health workers. This will bring respect and appreciation of each other's' different roles. The trainings of the CHWs should be done with the inclusion of the staff at the primary health care clinic for better coordination. Finally there is need to ensure that the different levels are well resourced to meet the demand created by the CHWs. Within the CHW sector, the government should consider conducting an audit and assessment of the CHWs cadres and an evaluation of the division of labor and expectations for each cadre.

5.2.3.4 Policy on medicines at the community level

Policy makers need to develop guidelines for the quantification and distribution of equipment, medicines and consumables for use by the CHWs. This would eliminate the confusion on what medicine the CHWs can access, when and how to replenish these. It would also include a guide on how to record on the usage of the kit they would have received and times to visit the health centre for replenishments. In addition there is need to make an effort to rebuild the trust and confidence in the health system. Consistent availability of medical supplies through government investment into purchasing of medical supplies would be one way to achieving this.

5.3 Study Limitations

In order to access the CHWs, the researcher used the hospital and the NGO. The databases of the CHWs were only available in these institutions and the researcher used them to purposively identify study participants. The two institutions then assisted in giving contact details and in some instances had to help with the directions to the homes of the CHWs. This could have limited the freedom with which the CHWs

gave their views and possibly limited their responses, because they knew that any information they were going to provide could be linked to them. The researcher was known to come from the national level and this could have created a power dynamic wherein the CHWs considered her as a policy maker and as such they could have been reluctant to be critical of some of the weak areas of the programme. Furthermore, the CHWs and the stakeholders could have made assumptions about the researcher, that as a Zimbabwean she was familiar with their context therefore they may not have been elaborate in their descriptions during the interviews.

The research focused on the CHWs and did not obtain the opinions of Health Centre Committees. Health Centre Committees are essentially the executive boards of rural health centres, they are comprised of members elected from the community and they work with clinic staff in making decisions on the developments at the clinic, (Community Working Group on Health, 2015). The research also did not get the perspectives of health service users which would have given additional voices to the research as it would have benefited from voices to the research. However the voices of the CHWs contributes to the information requirements on community work and should contribute to the body of information for policy makers on CHWs.

The issue of logistics and supplies needed to have the researcher interview the pharmacy managers to understand further the challenges they face in giving the supplies to the CHWs.

I hereby acknowledge that the research was based on only the personal experiences of the CHWs. In light of this, future research should seek to also focus on the health centre committees, communities, the patients and the staff from the facilities as this would contribute to policy recommendations with regards to improving CHW services. Despite these limitations the researcher believes that the research will provide useful information to the decision makers in Nyanga and Zimbabwe on the management of CHW programmes.

5.4 Areas for further research

Further research is needed to investigate what the Nyanga community can do to enable the CHWs to do their work as this study did not consider this important area. Another area of study would be to identify how best to train CHWs and the duration for the training as this tended to differ from one country to another and can impact on quality and equity of services. This would give policy direction on the training of CHWs. A comparative study in another district in Manicaland province which has newly trained CHWs that are functional in the district would give further perspectives on the CHW sector.

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APPENDICES

APPENDIX 1

Plagiarism Declaration Report

PLAGIARISM DECLARATION TO BE SIGNED BY ALL HIGHER DEGREE STUDENTS

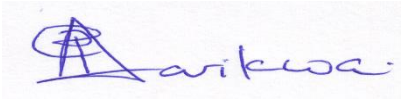
SENATE PLAGIARISM POLICY: APPENDIX ONE

I Patricia Darikwa (Student number: 676888 am a student

registered for the degree of Masters in Public Health in the academic year 2016.

I hereby declare the following:

- I am aware that plagiarism (the use of someone else's work without their permission and/or without acknowledging the original source) is wrong.
- I confirm that the work submitted for assessment for the above degree is my own unaided work except where I have explicitly indicated otherwise.
- I have followed the required conventions in referencing the thoughts and ideas of others.
- I understand that the University of the Witwatersrand may take disciplinary action against me if there is a belief that this is not my own unaided work or that I have failed to acknowledge the source of the ideas or words in my writing.

Signature:  Date: 8 June 2016

APPENDIX 2

An exploration of the perceptions of Community Health Workers on the enablers and barriers to providing services in Nyanga District Zimbabwe.

Interview Guide for the Community Health Worker

Introduction to interview

The interview is being conducted for my research which is a part of fulfillment of my Masters in Public Health Programme with the University of Witwatersrand in South Africa. My research is seeking a better understanding of the perceptions of enablers and barriers for Community Health Workers in carrying out their work. The opinions being sought are from the people who are currently offering some form of support to the community in areas related to health provision.

The information that will be collected will be used for research only and will treat with confidentiality and your name will not be disclosed at all. I would be happy if you can sign the consent form for the interview and also sign the form for audio recording of this interview.

Section A

Opening Questions

We would like to keep this interview confidential, I will not ask for your name and but will refer to you as CHW1, and I will conduct the interview in both English and Shona for better to enhance understanding.

001	Years in service	
002	Type of CHW	
003	Other work done apart from the main CHW work (dual community work roles)	
004	No of villages served	
005	No of households served	

Section B

006	What are you expected to do as a CHW?
007	Can you please describe to me how your work is organized on a day to day basis?

008	Ok then how many days do you work?
009	Whom do you report to and can you describe this as well, for instance, explain whether you have to report verbally, or is by completing a report, etc

010	In your view, What do you need to be able to do your work well

011	Of the work that you do what do you enjoy most and why. For instance, can you think about why you enjoy this part of your work?

(Enablers/ how to enhance them)

012	Of the work that you do what do you least enjoy, and why? Is there a way this can be done differently so that you enjoy it better or to improve the situation. ? For example, perhaps there are some things that can be done by different people, such as yourself, the community, government, maybe even your family? Please explain.

(Perceived barriers and how to improve on these, What could be done to improve these)

013	Have you received anything of late that you really thought could enable you to do your work? Probe: If they do not mention this in the response, you probe further: Who provided this and when?

014	Are there any interesting benefits you have received or gained because of your work which you would like to share
015	Is there Anything that has happened or not happened during the last few months that left you discouraged or encouraged to do your work?

016	What keeps you going as a Community Health worker

Section C

Closing Questions

017	How do you balance your time between your household work and the community work
018	How do you feel about the support you are giving to the community?

019	Do you have anything else you would like to tell me about your work as a Community Health Worker?

Thank you very much for your time and ideas.

APPENDIX 3

An exploration of the perceptions of Community Health Workers on the enablers and barriers to providing services in Nyanga District Zimbabwe.

INTERVIEW GUIDE

Key Informant Interview:

Introduction

Thank you for agreeing to meet with me. I will take at most an hour with you.

The interview is being conducted as part of my research in fulfillment of my Masters in Public Health Programme with the University of Witwatersrand in South Africa. My research is seeking to get a better understanding of the perceptions of facilitators and barriers for Community Health Workers in carrying out their work. The opinions being sought are from the people who are currently offering some form of support to the community in areas related to health provision.

The information that will be collected will be used for the purposes of this research only and will be treated with confidentiality and your name will not be disclosed at all. I would be happy if you can sign the consent form for the interview and also sign the form for audio recording of this interview. This you had a preview of when they were shared with you via email.

I have basically three areas I would like you to assist me on as a key informant on community health work in Zimbabwe:

The areas in which you are supporting community health workers

Your understanding of the barriers and facilitators in community health workers work

The gaps that you see in the areas which could facilitate the worker of Community health workers:

001	You are currently supporting CHWs, can you please inform me as to which cadres you are specifically supporting?

002	Would you kindly tell me how you are supporting these cadres
003	In the programme you are supporting, what are the CHWs expected to deliver?
004	In your opinion, how are the CHWs delivering on this mandate or expectation?"
005	What could be the reasons for this level of performance ? Enablers/barriers
006	If you were to change anything on the support you provide what would you change and why?
007	Do you have anything else which you would like to tell me?

Thank you very much for you time and suggestions

APPENDIX 4

Request to Conduct the Research to the Ministry of Health and Child Care, Zimbabwe

4 Gelcon Ave
AMBY
Greendale
Harare
Zimbabwe
Tel no: +263 772 262 991
Email: darikwa@gmail.com

1 September 2013

The Permanent Secretary
Ministry of Health and Child Care
4th Floor Kaguvi Building
Harare

Attention: Brigadier General Dr G. Gwinji

Subject: Request for Permission to conduct Research on Community Health Workers in Nyanga district, Manicaland Province

My name is Patricia Darikwa. I am a student studying for a Masters in Public Health at the University of Witwatersrand in Johannesburg. In partial fulfilment of my studies I am would like to conduct a qualitative research study on Community Health Workers (CHWs). I would like to conduct this research in Nyanga district, Manicaland Province.

Background

The research seeks to gain a better understanding of CHWs facilitators and/or barriers in doing their work. I am going to interview some CHWs that you have worked with and I will also interview other stakeholders who are playing a critical role in supporting CHWs.

I hereby seek your permission to carry out this research. Ethical approval for this study has been obtained from the University of the Witwatersrand Ethics Committee for Research on Human Subjects (medical).

Will there be any benefit from participating?

Those taking part in this research will not benefit directly from participating in this study.

Will there be any harm from participating?

No harm will come to those participating in the study, as all information will be kept confidential and no one will know what anyone said. Similarly there will be no negative consequences for individuals who do not want to be interviewed.

During the interview all the participants will have the right to decline to answer any of the questions, or stop the interview at any time. This will not be reported to anybody, will not be recorded in the research report and will not have any negative consequences for the individuals who take part in the interviews.

Permission to tape the interviews: To make the interview easier for me, I will also ask for audio recording the interview. If participants do not want the interview to be taped that will be their right, and it will not influence the interview or the research in any way. If the participants give permission to tape the interview, I will use the information for the research but will not record names of individuals in the report. I will keep the tapes under lock and key for six years, after which they will be destroyed.

Confidentiality

All the information that will be collected during this research will be treated in a confidential way. The names of facilities and individuals will not be used in the research report. All information that people provide will be kept confidential.

The Interview

The interview will take about an hour each. It will be carried out in your own language or in English. The interview will be carried out a time and place that is convenient to participants and will not interfere with routine duties in the organisation.

Contact Details of the Principal Investigator of the Research Project.

The Principal Investigator of the project contact details are given below and can be contacted should you need any further information on the project.

Patricia Darikwa
4 Gelcon Ave
AMBY
Greendale
Harare
Zimbabwe
Tel no: +263 772 262 991
Email: darikwa@gmail.com

Similarly you can also contact the Human Research Ethics Committee (Medical) which overseas the ethical aspects of this study. Members of this committee can be contacted through Ms Anisa Keshav on +2711 717 1234.

Thank you.

Yours Sincerely

Patricia Darikwa

APPENDIX 5

An exploration of the perceptions of Community Health Workers on the enablers and barriers to providing services in Nyanga District Zimbabwe.

Information sheet for Community Health workers

Good day. My name is Patricia Darikwa. I am a student studying for a Masters in Public Health at the University of Witwatersrand in Johannesburg. In partial fulfilment of my studies I am conducting research on Community Health Workers (CHWs). I would like to interview you to obtain from you an overview of the work that you do as a CHW, find out about the enablers and or barriers that you encounter in your work and any support that you have received that has enabled you to do your work. I hope that you will share with me your experiences as a CHW.

Background

To gain a better understanding of CHWs enablers and/or barriers in doing their work I am going to interview some CHWs and I will also interview other stakeholders who are playing a critical role in supporting CHWs. I believe that you will be able to provide me with valuable information about the CHWs as someone who has been doing the work for some time.

I would like to invite you to participate in this study and to ask your permission to conduct an interview with you.

Why I want to interview you?

I am interviewing a number of other key informants who are supporting CHWs and are familiar with their services. I would like to hear your story about your experience of working as a CHW what drives you to do your work and the constraints.

Consent

Permission to carry out this project has been obtained from the Ministry of Health and Child Welfare head office. Ethical approval for this study has been obtained from the University of the Witwatersrand Ethics Committee for Research on Human Subjects (medical).

Will there be any benefit from participating?

You will not benefit directly from participating in this study.

Will there be any harm from participating?

No harm will come to you from participating in the study, as all information will be kept confidential and no one will know what you have said. Similarly there will be no negative consequences for individuals who do not want to be interviewed.

During the interview you have the right to decline to answer any of the questions, or stop the interview at any time. The fact that you have done this will not be reported to anybody, will not be recorded in the research report and will not have any negative consequences for you.

Permission to tape the interviews

To make the interview easier for me, I will also ask if I can tape the interview. If you do not want the interview to be taped that is your right, and it will not influence the interview or the research in any way. If you give me permission to tape the interview I will listen to the tape and write down everything that you say but not use your name. I will keep the tapes under lock and key for six years, after which they will be destroyed.

Confidentiality

As a participant in the research you can expect that all the information you provide will be treated in a confidential way. The names of facilities and individuals will not be used in the research report. All information that people provide will be kept confidential.

The Interview

The interview will take about an hour each. It will be carried out in your own language or in English. The interview will be carried out a time and place that are convenient to you, and will not interfere with your duties in the organisation.

Contact Details of the Principal Investigator of the Research Project.

If you have any further questions, or any complaints about the way that the study is being implemented you can contact the Principal Investigator of the project.

Patricia Darikwa
4 Gelcon Ave
AMBY
Greendale
Harare
Zimbabwe
Tel no: +263 772 262 991
Email: darikwa@gmail.com

You can also contact the Permanent Secretary for Health and Child Care Brigadier General (Dr) G. Gwinji on:

Ministry of Health and Child Care
4th floor Kaguvi Building
Harare
Tel. No. +263-4-730011

Similarly you can also contact the Human Research Ethics Committee (Medical) which overseas the ethical aspects of this study. Members of this committee can be contacted through Ms Anisa Keshav on +2711 717 1234

APPENDIX 6

An exploration of the perceptions of Community Health Workers on the enablers and barriers to providing services in Nyanga District Zimbabwe.

Information sheet for Community Health Workers stakeholders

Good day. My name is Patricia Darikwa. I am a student studying for a Masters in Public Health at the University of Witwatersrand in Johannesburg. In partial fulfilment of my studies I am conducting research on Community Health Workers. I would like to interview you to obtain from you an overview of the work that you do through CHWs and to appreciate also the support that you have provided to enable them to do their work and your perceptions on where there are gaps in this. I hope that you will share with me your experiences supporting CHWs.

Background

To gain a better understanding of CHWs facilitators and/or barriers in doing their work I am going to interview some CHWs that you have worked with and I will also interview other stakeholders who are playing a critical role in supporting CHWs. I believe that you will be able to provide me with valuable information about the CHWs and the support you have provided to them.

I would like to invite you to participate in this study and to ask your permission to conduct an interview with you.

Why I want to interview you?

I am interviewing a number of other key informants who are supporting CHWs and are familiar with their services. I would like to hear your story about your experience of working with them, the enablers and constraints. I would also like to hear what you how you have acted on these to enable them to do their work.

Consent

Permission to carry out this project has been obtained from the Ministry of Health and Child Care head office. Ethical approval for this study has been obtained from the University of the Witwatersrand Ethics Committee for Research on Human Subjects (medical).

Will there be any benefit from participating?

You will not benefit directly from participating in this study.

Will there be any harm from participating?

No harm will come to you from participating in the study, as all information will be kept confidential and no one will know what you have said. Similarly there will be no negative consequences for individuals who do not want to be interviewed.

During the interview you have the right to decline to answer any of the questions, or stop the interview at any time. The fact that you have done this will not be reported to anybody, will not be recorded in the research report and will not have any negative consequences for you.

Permission to tape the interviews

To make the interview easier for me, I will also ask if I can tape the interview. If you do not want the interview to be taped that is your right, and it will not influence the interview or the research in any way. If you give me permission to tape the interview I will listen to the tape and write down everything that you say but not use your name. I will keep the tapes under lock and key for six years, after which they will be destroyed.

Confidentiality

As a participant in the research you can expect that all the information you provide will be treated in a confidential way. The names of facilities and individuals will not be used in the research report. All information that people provide will be kept confidential.

The Interview

The interview will take about an hour each. It will be carried out in your own language or in English. The interview will be carried out a time and place that are convenient to you, and will not interfere with your duties in the organisation.

Contact Details of the Principal Investigator of the Research Project.

If you have any further questions, or any complaints about the way that the study is being implemented you can contact the Principal Investigator of the project.

Patricia Darikwa
4 Gelcon Ave
AMBY
Greendale
Harare
Zimbabwe
Tel no: +263 772 262 991
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APPENDIX 7

An exploration of the perceptions of Community Health Workers on the enablers and barriers to providing services in Nyanga District Zimbabwe.

Consent to Tape Record In-Depth Interviews – Key Informants and Community Health Workers

I have read the project information sheet, and I understand that it is up to me whether or not the interview is tape-recorded. It will not affect in any way how the interviewer treats me if I do not want the interview to be tape-recorded.

I understand that if the interview is tape-recorded that the tape will be destroyed two years after the interview.

I understand that I can ask the person interviewing me to stop tape recording, and to stop the interview altogether, at anytime.

I understand that the information that I give will be treated in the strictest confidence and that my name will not be used when the interviews are typed up.

Yes, I give my permission for the interview to be tape recorded ☐
No, I do not give my permission for the interview to be tape recorded ☐

Interviewee's signature: _____ Date: _____

Interviewer's signature: _____ Date: _____

Interviewer's name
(please print): _____ Date: _____

APPENDIX 8

An exploration of the perceptions of Community Health Workers on the enablers and barriers to providing services in Nyanga District Zimbabwe.

Consent Form to be interviewed – Key Informants and Community Health Workers

I have been given the Information Sheet on the study on community health workers in Nyanga Zimbabwe. I have read and understood the Information Sheet and all my questions have been answered satisfactorily.

I understand that it is up to me whether or not I would like to participate in the interview and that there will be no negative consequences if I decide not to participate. I also understand that I do not have to answer any questions that I am uncomfortable with and that I can stop the interview at any time.

I understand that the researcher involved in this project will make every effort to ensure confidentiality and that my name will not be used in the study reports, and that comments that I make will not be reported back to anybody else.

I consent voluntarily to be interviewed for this study.

Interviewee's signature: _____ Date: _____

Interviewer's signature: _____ Date: _____

Interviewer's name
(please print): _____ Date: _____

APPENDIX 9

R14/49 Ms Patricia Darikwa

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

CLEARANCE CERTIFICATE NO. M131173

NAME: (Principal Investigator)	Ms Patricia Darikwa
DEPARTMENT:	School of Public Health Nyanga District, Manicaland Province, Zimbabwe
PROJECT TITLE:	An Exploration of the Perceptions of Community Health Workers on the Enablers and Barriers to Providing Services in Nyanga District Zimbabwe
DATE CONSIDERED:	29/11/2013
DECISION:	Approved unconditionally
CONDITIONS:	
SUPERVISOR:	Ms Nonhlanhla Nxumalo
APPROVED BY:	Professor PE Cleaton-Jones, Chairperson, HREC (Medical)
DATE OF APPROVAL:	24/01/2014

This clearance certificate is valid for 5 years from date of approval. Extension may be applied for.

DECLARATION OF INVESTIGATORS

To be completed in duplicate and **ONE COPY** returned to the Secretary in Room 10004, 10th floor, Senate House, University.
I/we fully understand the conditions under which I am/we are authorized to carry out the above-mentioned research and I/we undertake to ensure compliance with these conditions. Should any departure be contemplated, from the research protocol as approved, I/we undertake to resubmit the application to the Committee. **I agree to submit a yearly progress report**.

Principal Investigator Signature Date 11/02/2014

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

APPENDIX 10

Telephone 730011

Telegraphic Address
"MEDICUS", Harare
Fax: 791557
Telex: MEDICUS 22211ZW

ZIMBABWE

Reference:

MINISTRY OF HEALTH AND
CHILD WELFARE
P.O. Box CY1122
Causeway
Zimbabwe

12 September 2013

The Provincial Medical Director
Manicaland province

Attention: Dr Nyadundu

Subject: **Masters in Public Health Research on Community Health Workers in Nyanga District: Patricia Darikwa**

Mrs Patricia Darikwa is a Masters in Public Health (MPH) student with the University of Witwatersrand in South Africa. In partial fulfilment of her studies she has to conduct research in a chosen area. She has chosen to look into Community Health Workers in Nyanga district.

I hereby authorise her to visit two clinics in the district and liaise with two NGOs working in the area in order for her to access Village Health workers, Community Home Based Care workers, one community leader, the Nyanga district nursing officer and supervising nurses at the clinics she will work with. She would like to conduct interviews on these people.

I kindly request you to give her all the necessary support while conducting the research. Mrs Darikwa will come to your offices to work out on the logistics of the research at the end of October 2013.

A copy of the study protocol is attached for ease of reference.

Brigadier General (Dr) G. Gwinji

SECRETARY FOR HEALTH AND CHILD WELFARE

SECRETARY FOR HEALTH AND
CHILD WELFARE
(01) SECRETARY OFFICE (01)
2013 -09- 13
P.O. BOX CY 1122, CAUSEWAY
ZIMBABWE

Cc: Patricia Darikwa

APPENDIX 11

Telephone: 60624/60655
Fax: 60698/64401

ZIMBABWE

Reference:

PROVINCIAL MEDICAL DIRECTOR
MANICALAND
P.O. Box 323
Mutare

16 January 2014

Ref: Permission to carry out study in Nyanga, Manicaland by Darikwa : An exploration of the perceptions of Community Health Workers on the enablers and barriers to providing services in Nyanga District Zimbabwe.

The above named is an employee of Ministry of Health and Child Care currently studying for a Masters in Public Health Degree.

The directorate has granted her permission to conduct the study in Nyanga district.The student can liase with the DMO Nyanga during the study. She will be required to share her findings with the district and the Province.

Yours sincerely

Dr. S. M. Nyadundu

PMD MANICALAND

PROVINCIAL MEDICAL DIRECTOR
MANICALAND
2014 -01- 16
P.O BOX 323, MUTARE
ZIMBABWE TEL. 020-60624