



## **AN ANALYSIS OF VILLAGE HEALTH WORKERS AS COMMUNITY HEALTH DRIVERS OF CHANGE. THE CASE STUDY OF SHAMVA DISTRICT.**

---

Authors: \*Olivia Gumbo

\*Corresponding author Professor L.T. Nyaruwata

### **Abstract**

Zimbabweans continue to experience challenges in combating communicable diseases such as tuberculosis, diarrheal diseases, and HIV/AIDS. The country's health sector decentralisation implementation is moving at a snail's speed, triggering complaints of unsatisfactory service delivery at rural health centres. The study examined the impact of village health workers as community health drivers of change in Shamva District. The study was guided by interpretive and critical post-modernist paradigms. Qualitative methodology was utilised, key informant interviews, focus group discussion and desk reviews were data generation tools that were utilised. The data generated were analysed using grounded theory. The key findings are that village health workers improved community knowledge on health-related issues and encouraged communities to live in a clean environment. The study concluded that Village health workers were popular in communities and were the first port of call for health at community level. Village health workers doubled their mandate as community representatives and teachers of preventive health measures. The programme was institutionalised in the Ministry of Health and Child Care. However, the VHWs lacked clear grievance handling procedures that impacted negatively on their roles as health drivers of change. The major recommendation is that government should provide enough resources for village health workers to carry out their duties without budgetary constraints

### **Key Words**

Village Health Workers, Health services, community participation, empowerment and drivers of change.

## **1 Introduction**

The study was conducted in Shamva District to understand the role and impact of Village Health Workers in improving quality health services. The paper covers the back ground to the problem, statement of the problem, the purpose of the study, objectives of the study and research questions. The paper further covers the methodology, data analysis, discussion and presentation. The major findings, conclusions and recommendations are also given. The background to the problem is given below.

### **1.1 Background to the problem**

The health sector in Zimbabwe is not spared from the centralisation and decentralisation administrative challenges that are prevalent in the country (Conyers,2003). The communities are rarely involved in the development of their rural health centres' plans, there is lack of financial support to improve the health centres and the district staff lack full autonomy to make decisions that might help the rural health centres. Save the Children Report (2016) highlights barriers that communities are facing in accessing provisions of quality Maternal Neonatal and Child Health Services (MNCH). These barriers included, charging of user fees at referral hospitals under the management of Ministry of Health and Child Care (MoHCC). This excluded the poor people who cannot afford to pay the user fees. There are high levels of commercialisation and unregulated service provision that leads to high out of pocket payments by clients to enable access to health services (Health Finance Policy, 2017).

Furthermore, lack of infrastructure that comprise of inadequate water supplies at some Rural Health Centres, poor telephone network and bad roads are barriers that citizens are facing to access health service (Save the Children Report, 2016. Communities

also indicate bad staff attitudes as an element that led many patients to shun medical treatment (Training and Research Support Centre, 2016).

The above-mentioned challenges led to poor quality service delivery and this became a concern to the government and interested partners in health. The Ministry of Health and Child Care therefore signed a Memorandum of Understanding with donors and Civil Society Organisations (CSOs) to help address some of the challenges through implementing different programmes. This prompted the current researcher to examine the impact of village health workers in improving quality health services.

### **1.2 Statement of the problem**

HIV and Sexually Transmitted Infections (STIs) levels in Shamva District were high due to illegal mining activities in the district, resulting in high mobile population or internal immigrants. The Ministry of Health and Child Care (MoHCC) through the National Health Surveys acknowledges poor health services delivery in rural communities. However, there is lack of evidence on the impact of village workers in improving quality health services in Zimbabwe. It is not clear whether the work of village health workers led to the increase of communities' knowledge on their health rights and entitlements for them to demand quality health services. Therefore, this study sought to bridge the knowledge gap by examining the impact of village health workers on public health service delivery in Shamva District.

### **1.3 Purpose of the Study**

The purpose of this study was to examine the impact of village health workers as community health drivers of change in Shamva District.

#### **1.4 Objectives of the Study**

The objectives of the study were to:

1. Identify the role of Village health workers in Shamva District Health Sector.
2. Explore how the Village health worker model has been implemented in Shamva District Health Sector.
3. Analyse the impact of Village Health Workers in Shamva District Health Sector.

#### **1.5 Research Questions of the Study**

The study's research questions were:

1. What is the role of Village Health Workers in bringing change in Shamva District Health Sector?
2. How were Village Health Workers' strategies implemented in Shamva District?
3. What are the benefits of village health workers in Shamva District Health Sector?
4. What are the challenges faced by Village Health Workers in implementing health programmes in Shamva District Health Sector?
5. What are the recommendations that should be considered to embrace village health workers in improving quality health services in Shamva District?

## **2 Review of Related Studies**

Village health workers mandates are guided by Public Health Act (2018). The ministry of health and Child Care (MoHCC) trained the VHWs and award them a completion certificates but due to lack of budget since 2015, the Ministry of Health and Child Care was unable to train more VHWs despite their demand in the areas (CWGH,2018). Some NGOs also train VHWs under various programmes, but, these

were not given the certificates by the Ministry of Health and Child Care. The VHWs who were not trained by the ministry did not receive government monthly allowances (TARSC, 2016).

Social accountability strategies that utilised the community representatives such as village health workers were implemented in Benin, Guinea, Democratic Republic of Congo (DRC), Malawi, Zambia and Lesotho. In all the countries they were persistent service delivery failures. The expectations of social accountability to offer solutions were very high (Molynuex, Mulupi, Mbabu& Marsh, 2012). In all the case studies both the communities and service providers had interface meetings where they resolved some communities' challenges of poor service delivery (Arckerman, 2005). All the programmes yielded several results that include improvement in respect for patients where the health officials listen to patients' problems, the health staff are honest, transparent and non-discriminatory in providing supplementary nutrition, there are no favouritism and staff gives priority to serious cases (Shah, 2003) ;(Schaaf, Dumont, Arbesman & May-Benson, 2007).

### **3 Methodology**

In conducting this study, the researcher used qualitative methodology. The data generating tools used were desk review, focus group discussions, open-ended questionnaires and key informant interviews. The data were generated, interpreted, analysed and discussed using qualitative data analysis called grounded theory. Ethical considerations were observed during the data generation.

### **3.1 Research Methodology**

The study used interpretive and some elements of critical postmodernist paradigms because of its assumptions and beliefs that are based on qualitative research methodology. The study used purposive and convenience sampling to identify the key informants, focus group members and community members who participated in open-ended questionnaires.

### **3.2 Respondents Biograph data**

There were more women than men who participated in the data generating process. There were 473 people who generated data for the study. 117 were men who represent 33% and 239 were women who represent 67%. The respondents of the study were 204 community members who responded to open-ended questionnaires that were administered at five health centres. The pseudo names for these are QR-A, QR-B, QR-C, QR-D and QR-E. A-E refers to the five health centres under the study. 127 participated in thirteen focus group discussions, these were for VHWs and they will be referred to as VHW-A, VHW-B, VHW-C, VHW-D and VHW-E. Some Focus groups were for Parents with Children under five years who are referred as PC, Pregnant mothers referred as PM and women getting jaddelle contraceptives who are referred as WJ. There were 27 key informants who were interviewed these experts from community members, health centres, district health executive, Civil society Organisations and Ministry of Health and Child Care. Table 1.1 shows the pseudo for the key informants.

**Table 1.1: Key informants’ demography and pseudonyms**

<b>Facility</b>	<b>Profession</b>	<b>Pseudonyms</b>
Health Centre A	Nurse in Charge	NIC-A
	Community Monitor	CM -A1, CM-A2
	Community Literacy Facilitator	CLF-A
Health Centre B	Nurse in Charge	NIC-B
Health Centre C	Nurse in Charge	NIC-C
	Community Literacy Facilitators	CLF-C
Health Centre D	Nurse in Charge	NIC-D
	Community Literacy Facilitator	CLF-D
	Councillor	CL
Health Centre E	Nurse in Charge	NIC-E
	Community Monitor	CM-E
	Community Literacy Facilitator	CLF-E
District Hospital	District Medical Officer	DHE-1
	District Nursing Officer	DHE-2
	Community Sister	DHE-3, DHE-4
Organisation 1	Executive Director	IP-1
Organisation 2	Provincial Coordinators	IP-2, IP-3
	Country Director	1P-4
Organisation 3	Health Economist	NO-1
Organisation 4	Social Accountability Officer	IP-5
Organisation 5	Community researcher	NO-2
MoHCC	Director of policy and planning	HQ-1
MoHCC	Director of Community health	HQ-2
<b>Total</b>		<b>27</b>

### **3.3 Sampling Procedures**

Sampling is when a subset of people from a larger population is selected for the study to represent the population (Gill, Stewart, Treasure & Chadwick, 2008; Neuman, 2011). In this instance, these are community members who visited the five rural health centres and Shamva District hospital for service during the data generating process.

#### **3.3.1 Deliberate /purposive sampling**

Deliberative or purposive sampling is used for the selection of knowledgeable interviewees and experienced focus group participants under the case study (Cozby,

2009). In addition, Ellis (2014) indicates that purposive sampling, “is when you select your participants with a purpose in mind”. This links to the current study that used purposive sampling since the researcher selected the 27 experts from the national and district level in health institutions, to be the key informants and 127 participants for 13 focus group discussions.

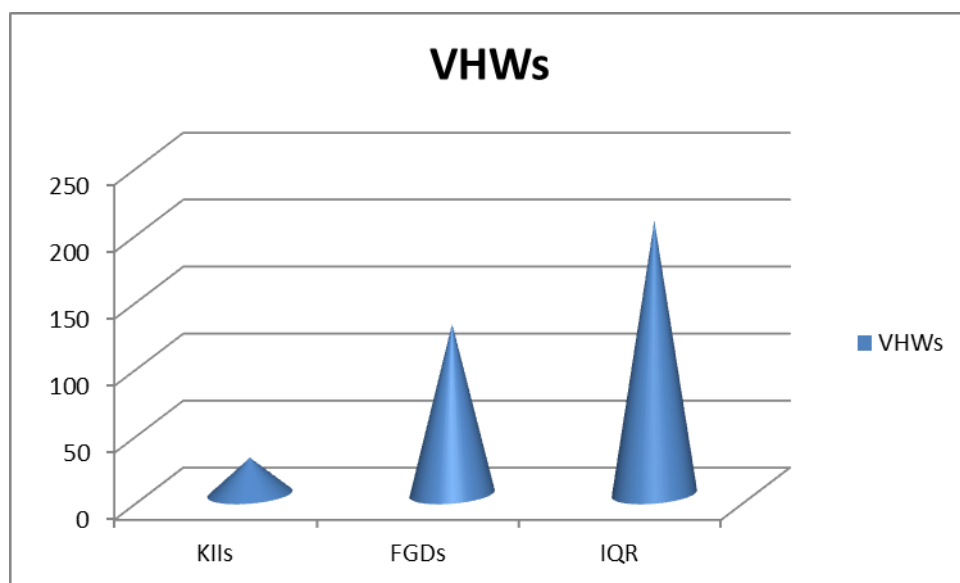
#### **4 Ethical Considerations**

This study considered ethical and legal issues when generating data. This study considered the ethical and legal considerations and developed consent forms that were signed by the respondents and participants before taking part in the research. The ethical and legal issues that were considered include: Voluntary participation of community members and experts, confidentiality and anonymity, disclosure of the research intentions to community members, asking consent for recording audio and taking, and getting approval letters from MoHCC and Shamva District Medical Officer to conduct the research.

#### **5 Findings**

Village health workers (VHWs) programme was led by the Ministry of Health and Child Care. IP-3 indicated that UNICEF, Global Fund and other donors were supporting the Ministry of Health and Child Care (MoHCC) with monthly allowances for VHWs. The programme was implemented throughout the country, hence, its presence at all the five health centres under study. The objective of the programme was for the trained VHWs to provide health information to communities taking a preventive approach. The community members who participated in the study indicated that they interacted with VHWs. Figure 5.1 shows that VHWs was a popular strategy across all the health centres.





**Figure 5.1: Engagements with VHWs**

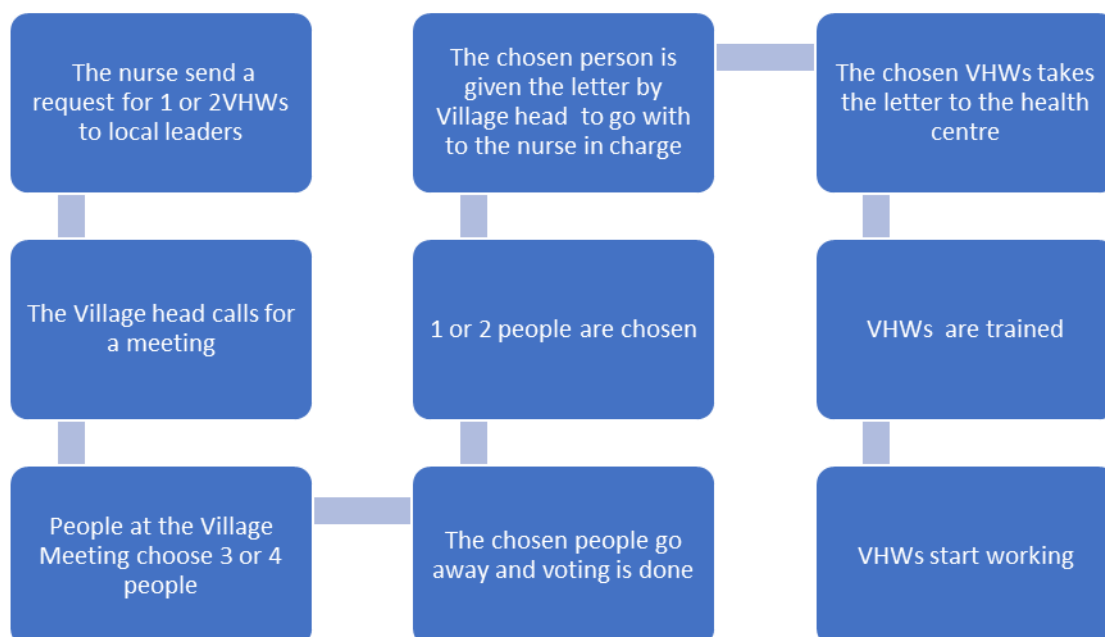
Figure 5.1 shows that all 204 individual respondents of open-ended questionnaires, 127 participants of FGDs and 27 KIIs referenced knowledge or interactions with the VHWs model as a social accountability strategy. IP-1 said, “VHWs were the health foot soldiers in the communities, the eyes and ears of the health officials”. His emphasis was that the VHWs were the first contacts of health concerns in the communities and they were very important in the health sector.

The Village health workers findings are discussed under three subheadings which are:

1. Selection process of VHWs
2. Roles of VHWs
3. Approaches used by VHWs to influence change in health sector

### **5.1 Village health workers’ selection process**

Figure 5.2 shows the selection process for VHWs. The VHWs were popular in communities because they were chosen at village meetings and they were given a chance to talk during the village meetings too.



**Figure 5.2: VHWs selection process**

The VHW-D highlighted that communities chose people who were sociable, who could write, who had good morals, smart and who were respected in the community. The NIC-A agreed that the chosen people were literate because they were supposed to produce written reports every month that were given to NICs. NO-2 anchored the same sentiments that the selection of the VHWs was very transparency and this made the programme known and acceptable by communities. NIC- D indicated that there were about two VHWs representatives per ward health. DHE-3 clarified that wards varied in size and they comprised between 15 villages and 30 villages. One VHW could cover about 3 or 4 villages.

## 5.2 Village health workers' roles

HQ-2 indicated that the VHWs were used as conduit to deliver health messages that came from the MoHCC to the communities. The VHWs during the FGDs highlighted that; they taught communities about health-related issues, weighed the under five years' babies, tested malaria and gave malaria tablets, taught about hygiene,

encouraged communities to dig the dump sites, constructed toilets, cared for the home-based patients just to mention a few. They also gave health updates to communities during the village meetings.

The QR-E pointed out that VHWs led discussions on how to prevent malaria, ways of stopping the spreading of HIV and AIDS and how to live in a clean environment. QR-C indicated that they felt that VHWs were more of their resource networks not just their representatives. The Nurses-In-Charge and District Health Executives also agreed with respondents that the VHWs were also resource centres for communities because they were constantly given new health information by the nurses.

The VHWs also picked community health concerns that they brought to the nurses' attention. HQ-2 revealed that the active role of the VHWs works as early warning system for the district in preventing disease outbreaks. DHE-2 supported this, he said that the VHWs model enabled the district to prevent recurrence of diseases such as diarrhoea and malaria. He went on to say, "*we as the DHE we are now aware of the community's disease concerns through the VHWs, the programme has brought us closer to the communities*".

The VHW-D said they conduct monthly meetings with nurses and they treat these as knowledge hub platforms where they learned about new health issues from the NICS and from their fellow VHWs from other villages. At the same time, the platforms gave the nurses an opportunity to understand the community demands on health-related issues. This shared the same beliefs with the empowerment theory and

participatory development theory that recognises that sharing and access to information by locals or poor people lead to sustainable development.

Furthermore, the VHWs did door to door visit to the sick in their villages. NO-1 pointed out that the VHWs were also the home-based care givers; they took care for the bedridden and chronically ill people. VHW-C revealed that they spent almost the whole day walking from one house to the other visiting their patients. About 98% of VHWs indicated that they walked more than 10 kilometres doing home visits per day and they did them at least three times a week. VHW-B supported this by indicating that they were treated as village nurses and people in the communities saw them as the first port of call when they were sick. DHE-4 applauded the VHWs' work, she said "*they are managing to convince patients from other beliefs such as apostolic faith to visit the health centres for treatment when they do their home visits which was a taboo in their religion*".

The VHWs also conduct their work using three strategies which are health clubs, cooking demonstrations and savings schemes.

### **5.3 Health club strategy**

The VHWs also used health clubs or support groups to conduct their duties. The VHWs enabled the communities to interact using the health clubs and nutrition garden model. The health clubs consisted of group members ranging from 10 to 30 members. The purpose of the group was for the members to encourage each other to live healthy through practising health standards. This aligns with participatory development theory that encourages participation of citizens in the development initiatives that change their life.

VHW-A said, “we conduct weekly health clubs during off farming season to discuss preventive medical care strategies”. The programme was working very well at health centres A, C, D and E off farming season. VHW-D indicated that during farming season people concentrated on farming and would not want to lose productive time. VHW-E postulated that constant interaction of club members normally developed a sense of trust among them leading the members to have open discussions.

However, VHW-B claimed that at health centre B, health clubs were not utilised because the catchment area had more immigrants who practised illegal gold panning. Health Centre B was also close to Shamva town and had farm workers. The NIC-B clarified that these populations did not have time to be active in health clubs. Some health clubs did food fare cooking demonstrations. Some did nutrition gardens, while others did saving schemes that led them to build toilets for each other.

#### **5.4 Food fare demonstration strategy**

VHWs conducted food fare demonstrations where they taught women how to cook indigenous food. The demonstrations helped young mothers to know the nutrition which babies needed. PC-A said “*ini semukadzi wechidiki ndakuziva kuti ndinobikira mwana chii zvinovaka muvirivake*” meaning “*I as a young woman I now know what to cook for my baby that builds his body*”. VHW-B explained that since the area had high numbers of child marriages, food demonstrations helped the young mothers to know that they could utilise the indigenous food for their children’s growth.

DHE-2 agreed that demonstrations were imparting knowledge to mothers and under nutrition records in the district were reducing. The researcher also witnessed the food fare demonstration at health centre B, where there were about 200 women who took part; they cooked more than 20 indigenous dishes that could be fed to babies. The demonstration gave opportunities to older mothers to impart knowledge to young mothers. The interaction was very good, and the nurses were given the time to share the importance of nutrition to young children.

### **5.5 Nutrition gardens strategy**

VHWs at health centre A, C and E also used nutrition gardens as a strategy to interact with community members. They met formally once every week where they discussed about health-related topics before conducting their garden chores. The gardens were allocated to women by village heads. VHW-C indicated that, "*women enjoyed coming to nutrition gardens because of the double benefits they brought*". The women gained health knowledge and there was also the nutrition aspect. They grew vegetables for household consumption and some were even getting some income from selling the vegetables. QR-A acknowledged that the interactions in the nutrition gardens were very informal, that led women to be truthful and genuine solutions to problems were also proffered.

### **5.6 Savings schemes strategy**

VHW-A pointed out that they used saving scheme as their health club. QR-A said, "*our saving scheme have 10 members who seeded \$10 per month and we borrow from the seeded money*". After three to four months they used the money to buy cement and other building materials needed to construct a toilet. They constructed toilets at

each other houses. NIC-D highlighted that the savings schemes enabled her catchment area to have more toilets as a response to the call made by MoHCC to VHWs. The VHWs used creative approaches that were acceptable by communities. The scheme transformed community's behaviours to cleanliness and made it possible for all to have hygiene toilets at their households. DHE-3 said that the approach was agreed after brainstorming meetings between the VHWs and health officials. This is in line with Kyed et al (2010) who indicate that, "the poor people normally support each other in solving their everyday problems and this is usually done in an informal way".

## **6 Results**

The Village health workers had positive impact on the quality of health services in Shamva District. The description of the first impact is increased health rights knowledge and it is given below.

### **6.1 Increased health rights knowledge**

The VHW model increased health rights knowledge to patients especially at health centres A, C, D and E. About 75% of communities who were interviewed under open-ended questionnaires highlighted that they were aware of their rights. QR-A pointed out that they acquired knowledge on right to privacy, confidentiality, choice of medication and consent. WJ-B indicated that, "*we now know that we have the right to*

*choose the family planning contraceptives of our choice and we also know our reproductive rights, we got the information from the VHWs”.*

## **6.2 Improved relations between health staff and communities**

The VHWs model led to improved relations between health staff and communities. NIC-D said, *“the good co-ordination between the VHWs led to improvements in ante natal bookings because, they mobilised pregnant mothers to register for the health centres to earn more results-based finance income and for pregnant mothers have safe birth deliveries”.*

## **6.3 Provision of free health services**

DHE-1 indicated that all the patients at rural health centres accessed free health services. IP-5 point out, *“that they believed the VHWs programmes led to the enforcement of user fee policy that enabled rural people to have access to free primary health care”.* WJ-B also indicated that women were getting family planning contraceptives for free. All the patients at the rural health centres got free services, although inaccessibility of drugs was still a challenge.

## **6.4 Improved health services**

The VHW model implemented in the district improved the health services. NIC-C indicated that, *“the programmes led to early bookings for pregnant mothers, increased number of people tested for HIV, especially males, which was a breakthrough because there were less men who were willing to be tested before”.* DHE-2 pointed out that prevention of malaria and diarrhoea was prevalent in the



district because, the VHWs were testing malaria in villages and giving the malaria tablets to patients. VHW-E acknowledged that by saying, *“our door to door visits broke a barrier for some apostolic sect people who are now going to the health centres with their children for immunisation and growth monitoring which was unheard of in our district”*. This was an indication that VHWs dialogues managed to contribute to the improvement of quality services offered at the health centres.

### **6.5 SAcc programmes and good hygiene**

Another good impact emerging from the study was practice of good hygiene. About 85% of communities that took part in answering open-ended questionnaires indicated that SAcc programmes in their areas especially the VHW model equipped them with knowledge on how to live in a clean environment. QR-C testified that, *“we are now practising good hygiene in our communities, we are now constructing toilets at household level, digging dump sites and having nutrition gardens”*. HQ-2 also acknowledged that this led to reduction in disease out breaks that were related to poor hygiene such as cholera and diarrhoea.

## **7 Challenges**

There were challenges that were identified during the implementation of village health worker model in Shamva District.

### **7.1 Lack of funding**

In addition, lack of funding was affecting the interaction of VHWs with the communities. VHW-C pointed out that, *“we do not have bicycles to use to go around*

the big catchment areas we serve”. Lack of funding also led to non-training of VHWs that was causing despondent between the certified and non-certified ones.

### **7.2 Deception of representatives**

Deception of representatives was another challenge that was identified by the study. The researcher got the sense that VHWs were sometimes treated by communities as extensions of health workers because of the allowances they got from MoHCC. CL indicated that, “some community members viewed the allowances given to the VHWs as salaries, thereby, associating them as civil servants who were employed by the government”. The VHW-E pointed out that they were excluded from food aid because of the allowances they got. VHW-D complained that they were treated as better off in communities while their allowances were very low. NO-2 noted that this confusion could influence other community members not to discuss the challenges they face at the health centres thinking that VHWs could expose their identities to nurses.

### **7.3 Poor uptake of VHW strategies in altered areas**

Another identified gap was of poor uptake of VHW strategies in altered areas. From discussions with VHWs focus groups the researcher noted that the VHW model worked better in rural areas which were not close to growth points and where there were less numbers of internal migrants. At health centres A, C and E, the model worked better because the areas were a bit far from the growth points. So, people there attended health clubs conducted by VHWs. The model did not work well in areas where there were many internal immigrants who did gold panning and informal trading. Attending health teachings disturbed their income flow targets.

#### **7.4 Lack of co-ordination**

There was lack of coordination between the Village health workers and MoHCC. During the discussion between researcher and VHW focus groups, the VHWs highlighted many challenges they were facing that were not addressed by the MoHCC because they did not have a representative who interacted with the Ministry of Health and Child Welfare on their behalf. VHW-C indicated that their allowances were very low, they were \$14 a month which demotivated them and made them to neglect their duties while looking for extra income for survival.

In addition, NO-1 pointed out that there was lack of co-ordination between the government and donors in that the CSOs were training VHWs, but they did not get certificates and they also did not get allowances from the Ministry of Health and Child Welfare, while they were performing the same duties as those trained by the Ministry.

#### **7.5 Lack of full decentralisation**

DHE-2 pointed out that lack of decentralisation made it impossible for district officials to resolve some VHWs grievances because there was unclear chain of command. Lack of implementation of decentralisation disempowered Shamva District officials to engage with communities as they wished.

### **8 Discussion**

The findings indicate that VHWs led to the improvement of quality health services offered in Shamva district. The rhetoric of full decentralisation, devolution mantra by the government officials did not translate to reality at district level. This hampered the

work of VHWs who were supposed to rely on adequate resources from the government to implement their work effectively. VHWs proved to be the real health agents of change in Shamva District.

## **8.1 Conclusions**

The findings of the study covered above informed the conclusions of this study. The researcher concluded that, the VHWs strategies were received by communities differently. The reception varied with geographical area and the type of livelihood one relied on.

In addition, the researcher concluded that voluntarism in Shamva District was at stake. Lack of extra resources for livelihoods affected voluntarism and involvement of men in becoming VHWs.

### **8.1.1 Recommendations**

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

#### **8.1.2 Inclusion of local leaders to lead on health-related issues**

It is recommended that health officials and implementing partners for VHWs strategies in Shamva District should train the local leaders (traditional leaders and councillors) on health issues, so that they can impart the knowledge whenever they call for community meetings.

### **8.1.3 Introduction of innovative VHWs strategies**

It is recommended that Civil Society Organisations and health officials in Shamva District to adopt innovative ways when implementing VHWs programmes in order for the programme to suit the needs of people in different geographical areas and who have different livelihoods.

### **8.1.4 Co-ordination of social accountability actors**

It is recommended that co-ordination of all the actors involved in the implementation of VHWs is necessary to reduce divisions of certified and non-certified VHWs in Shamva District. This will also address the grievances of the VHWs in the District.

### **8.1.5 Resourcing the VHWs Initiatives**

It is recommended that the government and donors should avail adequate resources such as financial and materials to enhance proper implementation of VHWs in Shamva District Health Sector.

### **8.1.6 Full implementation of Decentralisation**

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

## **8.2 Acknowledgements**

I want to acknowledge the Shamva District health personnel who were welcoming and enabled me to gather data from their community members. They gave me valuable information for this research.

## Referees

- Ackerman, J.M. (2005). *Human Rights and Social Accountability*. Social Development Papers No.86. Washington, D.C.: The WorldBank.
- Community Working Group on Health (CWGH). (2018). *Strengthening community participation in health programme report*. Harare: CWGH.
- Conyers, D. (2003). *Decentralisation in Zimbabwe: A local perspective*. [Adobe Digital Editions Version]. doi:10.1002/pad.265.
- Cozby, P.C. (2009) *Methods in behavioural research* (10th ed.). New York: McGraw Hill.
- Ellis, J. (2014). *Writing better questionnaires: getting better data*. UK: Charities Evaluation Services.
- Gill, K., Stewart, E., Treasure, B. & Chadwick, B. (2008). *Methods of data collection in qualitative research: interviews and focus groups*. *British Dental Journal*, (204), 291 - 295. doi:10.1038/bdj.2008.192.
- Ministry of Health and Child Care. (2017). *Zimbabwe Health Financing Policy*.
- Molynuex, S., Mulupi, S., Mbabu, L. & Marsh, V. (2012). *Benefits and payment for research participants: Experiences and views from a research centre on the Kenyan Coast*. Kenya: BMC Medical Ethics Bio Med Central Ltd.
- Neuman, W.L. (2011). *Social research methods - qualitative and quantitative*. White water: University of Wisconsin.
- Public Health Act (2018), Government of Zimbabwe, Government Printers. Harare.
- State of National Address by the President of Zimbabwe, Nov 2018. Harare.
- Save the Children. (2016). *Quarter 11 report on strengthening community participation in health*. UK: Save the Children International.
- Schaaf, R.C., Dumont, R.L., Arbesman, M. & May-Benson, T.A. (2018). *Efficacy of occupational therapy using Ayres Sensory Integration*. USA: US National Library of Medicine National Institutes of Health.
- Shah, M. (2003). "Using *Community Scorecards for Improving Transparency and Accountability in the Delivery of Public Health Services: Experience from Local Initiatives for Health (LIFH) Project*". CARE Malawi : CARE International in Malawi.
- Training and Research Support Centre (TARSC). (2016). *Supporting the role of the Village health workers*. Harare: TARSC.

Transitional Stabilisation Programme, 2018. Zimbabwe Government, Harare.  
Government Printers.

*Zimbabwe Constitution 2013*. Harare: Government Printers.

© GSJ