



Produced by  
Community  
Working Group  
on Health  
with Training  
and Research  
Support Centre  
in the Regional  
Network for  
Equity in Health  
in East and  
Southern Africa

## Strengthening the capacities of health centre committees as advocates for health in Zimbabwe

### Zimbabwe's health profile

Population	13 724 000
Percent population urban	39
Gross national income/capita PPP US\$	1570
Percent population living on <US\$1/day 2010	na
Adult literacy rate 2011	84
Life expectancy at birth	58
Under 5 year mortality rate	90
Maternal mortality /100 000 live births	470
Adult HIV prevalence	9.9
Percent unmet need for contraception 2006	16
Antenatal care coverage, one visit + 2011	90
Antenatal care coverage, four visits	65
Measles immunisation in 1 yr olds	90
Nurses and midwives / 10 000 people 2012	12.5
Per capita expenditure on health PPP\$	na

2012 data unless otherwise specified. NA=not available

Source: WHO Global Health Observatory 2015



Zimbabwe map, CIA world factbook 2005

Zimbabwe is a lower middle income country with a highly literate population and significant natural resources. The country experienced a fall in life expectancy in the 1990s due to AIDS, but the prevalence of HIV fell after 2002 and life expectancy improved. Economic decline in the 2000s was associated with falling incomes and health, but has also improved somewhat after 2008. The Ministry of Health and Child Care (MoHCC) reported in 2013 that the top ten causes of death in the country were HIV and AIDS, influenza and pneumonia, tuberculosis, stroke, coronary heart disease, malaria, diarrhoeal diseases, low birth weight, birth trauma and maternal conditions. The health services are organised at five levels, with village health workers and committees in the community, primary care level services called clinics or health centres, district, provincial and central referral hospitals. The MoHCC is responsible for health services. The majority of Zimbabweans use government services, faith based services and traditional health care, with about a tenth using the private for-profit sector. The country has adopted the

primary health care (PHC) approach and the National Health Strategy 2009–2015 makes a commitment to ensure that communities are empowered to participate actively in the management of their local health services. Village health workers, health literacy facilitators and home based carers in the community work with outreach workers and community nurses in health services to support community health. Ward health committees ensure community input is included in district health and health facility plans. Village health committees encourage wider participation by local communities and health centre committees (HCCs) are joint community – health service structures that provide a bridge of communication between the community and health care providers.

### Health centre committees in Zimbabwe

HCCs are a mechanism through which communities can participate at primary care level to support a people-centred health system, working with other community personnel and structures noted above.



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Zhombe HCC discussing work with communities  
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They primarily engage with activities of their local health centres. HCCs were originally proposed by the MoHCC in the 1980s to assist communities identify their priority health problems, plan how to raise their own resources, and to organize and manage community contributions to health services and PHC. While the Public Health Act (1924) and local government law broadly provide for public input to health services, there is no legal instrument that specifically establishes and sets out the role and functions of HCCs. They operate in terms of the policy support most recently set out in the National Health Strategy 2009-2015, and guidelines developed by national stakeholders with the MoHCC. The CWGH and other stakeholders have advocated for a regulation under the Public Health Act to provide a legal foundation for HCCs.

HCCs involve the councillor, clinic nurse, environmental health technician, community health workers and local civil society organisations representing women, youth and other social groups. They include the headmaster or schoolteacher responsible for health, church leader, traditional leader, traditional and faith healers and other health providers. Community representatives should be elected by the local community and be accountable to the community. The chairperson of the committee is a representative from the community .

HCCs have a number of roles. They:

- Use participatory approaches to facilitate people in the area to identify their priority health problems and what they think can be done about them.

- Use information from the health information system and from communities to plan, monitor and evaluate their work and to assess whether local health interventions are people's health.
- Are a channel for information flow from the community to the local council and health services and management and back to the community, including on the activities of different health providers in the area.
- Raise and discuss solutions for community and patient concerns on services.
- Promote activities that improve public health, such as for water and sanitation.
- Plan and raise their own resources for community health activities and organise and manage community contributions to health services, and
- Discuss and inform communities on the health budget allocations to wards and health centres for health, and provide community inputs to health planning.

HCCs have made a vital contribution to health services and community health. For example in Goromonzi and Chikwaka districts the HCCs working with local communities and with support from relevant ministries constructed maternity waiting homes. In Chikwaka, the mothers' waiting home included two-four bedded wards, a three bed-nursery, a rest room, kitchen, laundry and a room for the HCC. At Bindura Nyava clinic, the HCC installed a solar power system for the clinic, enabling it to improve maternal health and other services. HCCs have supported youth health awareness activities on sexual and reproductive health and established a youth friendly centre in Masvingo. They have monitored and reported on medicines availability at health centres using mobile phones and taken up issues of staff shortages, low staff morale, untimely medicine supplies and unaffordable fee charges in services. HCCs have played a role in discussing how funds in the Health Services Fund from fee collections are used in the clinics. In 2011 training materials were developed jointly by TARSC, CWGH and MoHCC for an approximately three to four day training for HCCs on these roles using participatory methods, with CWGH implementing this training. Since 2013, HCCs have played a role in overseeing the funding against service performance in maternal and child health activities at health centres, through results based financing

from an externally funded Health Transition Fund. The scale up of this fund and approach led to a requirement after 2013 that all health centres have HCCs. This led to a rapid scale up in their establishment and demand for their training. An initial assessment of this scale up by CWGH and Save the Children International in 2013 found that too rapid a scale up meant that HCCs were not always established with adequate community awareness on their roles and responsibilities, that some HCCs with councillors as chairpersons faced difficulties as councillors were often not available for meetings and that HCCs needed a more comprehensive induction and training.

## Strengthening the capacities of HCCs

The training of HCCs in 2011 drew participants from 13 districts, each sending three HCC members from the selected health centres. The three day initial training covered the roles, work, capacities and skills needed to support HCC functions, as a means to revitalising PHC in Zimbabwe, followed by further training and review of experience to make up a five day course. The training used the 2011 manual referred to above, applying participatory approaches and building new skills and knowledge on the evidence and experience within communities and amongst local health workers, local government personnel, civil society organisations and other sectors. In 2014 the training manual was updated and is now being used by CWGH to train HCCs in the large scale up exercise underway under the RBF programme.

Exchange visits were organised for HCCs within and between districts to allow for the exchange



Using participatory tools to map community needs  
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of good practice, experience and lessons learned across HCCs. Exchange visits allowed weaker HCCs to learn from doing by shadowing key processes and activities in better functioning HCCs. HCC members also participated in other training activities to deepen their knowledge, such as the annual Winter School in Public Health programme run for field personnel by TARSC and the University of Zimbabwe.

The training complemented existing health literacy training that had been taking place in communities since 2007, using materials developed by TARSC and CWGH. Facilitators from CWGH used participatory reflection and action methods to build knowledge and action on community priorities in health and health care, particularly in rural areas of Zimbabwe. In nearly two thirds of HCCs, the health literacy training has enabled HCCs to organize people in their area to identify their priority health problems and locally owned solutions to these problems. Communities have identified and implemented actions such as improving environmental health, establishing nutrition gardens and building shelters at clinics for mothers awaiting delivery. More recently HCCs and health literacy facilitators have raised and encouraged awareness and action on the delays in seeking and accessing maternal health services, given that new measures were introduced to offer these services without charge. The health literacy work has encouraged early booking at antenatal care and reduced home deliveries, while HCCs and communities have advocated for the construction of waiting mothers homes.

The training activities have not been without their challenges: Health workers have not always understood or appreciated the role of HCCs, especially if authorities did not communicate these roles well and in the absence of a legal instrument on these roles. The training activities are not funded from the national budget. They are funded from external funds and this affects the sustainability, timing and form of the training. For example, a shortfall in resources has often led to the five day training being compressed to two to three days, compromising the quality of HCC training, and leading to topics being left out or being hurriedly addressed. Funds may be made available at a time when people are busy with other community activities, such as farming, making them less willing to come for training.

Trained cadres move out of their districts and, as for other personnel, some have left for neighbouring countries due to the economic environment, so that skills need to be constantly replenished. Information flow to communities is slow, and cultural beliefs affect and need to be addressed in the training, with gender norms in some areas meaning that women and men cannot sit at the same place and discuss health issues, excluding women from effective participation. HCCs may be used as a political platform, with councillors taking chairmanship of HCCs instead of taking ex officio roles as set in the guidelines. HCCs funds may be abused if the structures are not accountable to communities.

## Lessons to share

Despite the challenges faced, the training of HCCs and their role in the health system has been key to strengthening PHC and health services in challenging times. Studies carried out in 2004 show that HCCs and strong primary care services support improved health outcomes. The lessons from our experience suggest that

- HCCs need to have a constitution and a legal status, including to receive and account for public and community funds.
- The district health executives and local councils as responsible authorities should ensure that HCCs are properly constituted, with community members properly elected by communities, with members aware of their roles and responsibilities and with adequate supervision and support.
- HCC training should be for 5 days to equip members with sound knowledge and skills to carry out their roles and responsibilities, and to effectively interact with communities and with local government, health workers and managers.
- Members of district health executives should be included in HCC trainings to raise their awareness on the operations of HCCs.
- The training should include public relations and communication and facilitation skills, to build relationships,

and to strengthen and implement strong community feedback mechanisms.

- Community health literacy is key to support effective community voice and feedback.
- HCC exchange visits between wards and districts should be implemented regularly, using participatory approaches and exchanging experience on both successes and challenges.
- HCCs could make increasing use of social media, such as 'Whatsapp' SMS lists to disseminate information on HCC actions to maximise impact.
- The MoHCC should, with input from key stakeholders, develop and implement a comprehensive guide and monitoring framework for the functioning and impact of HCCs.

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