Community views on the essential health benefit in Zimbabwe

REPORT

Training and Research Support Centre (TARSC)
working with

Ministry of Health and Child Welfare and Community based researchers

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Rene Loewenson contributed to the design, tools, analysis and reporting
Artwell Kadungure contributed to training, field work, analysis and reporting
Percy Mcijo, Audrey Titos, Melba Kasambira, Lewis Chitovoro, Douglas Shokoni, Patty Punungwe, Pfungwa Maringe, Tirivangani Paguti, Stephen Marima, Nyadzai Chinokwetu, Petra Adam, Shelly Kabanda, Mercy Muradzikwa, Zenzele Moyo, Sithabile Moyo, Lydia Maphosa, Tracy Ndlovu, Norma Zhou, Patrick Jengwa contributed to the field work
Senele Dhlomo and Zvikie Mlambo contributed to the training

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Executive Summary

The Zimbabwe government in its National Health Strategy 2009-2013 proposed to review the provision of the basic entitlements to health. In the February 2012 a national stakeholder meeting on the Zimbabwe Equity Watch, participants agreed that defining comprehensive health care entitlements calls for technical and policy dialogue (including with Parliament and civil society) to establish, cost and raise awareness on a clear set of comprehensive healthcare entitlements for the population at the various levels of the health services. As a starting point it was proposed that the District core services defined by MoHCW in 1995 need to be updated; initially at community, primary and district level- against the current epidemiological profile, be subject to review and input from communities and sectors that provide public health inputs, and be costed in various provinces, at various service levels (community, primary and secondary levels) and by various providers (central, local government, missions and other private).

An assessment was thus implemented in late 2012 by Training and Research Support Centre, working with review input from Ministry of Health and Child Welfare and with community based researchers from various civil society organisations. The assessment aimed to determine community, local leaders and frontline workers views on key areas relevant to the framing of the Essential Health Benefit (EHB). The assessment aimed more specifically to determine;

a. priority public health problems the EHB should address and any important features of their distribution by social and economic groups that services need to respond to.
b. the services for health promotion, prevention, PHC, treatment and care, rehabilitation and palliative care that communities expect to see in place at community, primary and district level that would (i) address these priority health needs (ii) fulfill the constitutional right to health services, and
c. the roles and contributions of ministry of health, other ministries, other agencies and of communities (households, communities and leaders) in providing these services.

A cross sectional design was used. Data collection was implemented through a one day Participatory Reflection and Action (PRA) meeting of between 30-50 people and an interviewer administered questionnaire with households, representatives of community based organisations, community leaders and community level workers. The assessment was implemented in three urban and seven rural districts from all the ten provinces of Zimbabwe. A total of 315 people participated in the PRA meetings and 601 in the questionnaire.

Respondents identified the major health needs and problems in Zimbabwe for which services should be provided for ALL people, no matter where they live or what social or income group they come from. Results indicate that there was

- Equal concern for services to address diseases and to address the social determinants of health (SDH), and in the latter particularly access to safe water, adequate food and safe transport
- Concern for both communicable and non communicable diseases (NCDs), including the health promotion activities for managing these
- A link between the diseases and SDH raised (eg cholera, typhoid and water, sanitation
- Continued prioritization of HIV and AIDS as a major concern
- Similarity between community and health workers views
- Greater focus amongst CBOs on AIDS than other needs and low public health focus, and
- Greater concern in urban communities on non communicable diseases (NCDs).

Particular issues were raised for specific groups, with serves prioritised for diarrhoeal diseases, nutrition and abuse in children, for sexual and reproductive health (SRH) in adolescents; for SRH and maternal health in women and for hypertension, diabetes, cancer, eyesight and hearing loss, kidney and liver problems and mental health in elderly people.

In relation to prioritised services, the findings showed that

- Certain services were expected to be delivered at all levels, including health education, SRH, nutrition services, environmental health, treatment for endemic communicable and NCDs, and psychosocial support.

- At *community level*, respondents gave a strong focus to environmental health, management of key social determinants such as road transport; solid waste; herbal gardens; social and spiritual support; dissemination of information on prevention and management of abuse; and home based care, disease control and nutrition activities and having accessible medicines in community level services
- At *clinic level*, in addition to areas prioritized at community level, respondents also noted that frontline services should screen for NCDs (eg blood pressure monitoring, diabetes and cancer screening) and for communicable diseases, (eg TB tracing); respond to major health issues, ie VCT,PMTCT, ART and DOTS; Pre-natal, post natal care, immunisation, delivery services; growth monitoring and nutrition; quarantine communicable diseases, ensure available medicines and personnel for prevention and treatment of endemic and other diseases; ensure water, sanitation and good hygiene at the clinic; train VHWs, provide counseling services and transport for referrals to district hospitals.
- In *district* hospitals while these issues are noted, so too was quarantine and management for infectious diseases; HIV/AIDS/TB testing and diagnostic services; family planning, VCT, condom distribution, support for health lifestyles/ exercise; medicines for communicable and NCDs; provision of specialist doctors, dental care, pharmacy; chemotherapy, physiotherapy, mental health, herbal medication and mortuary services, cancer screening and treatment; surgery, delivery of complicated pregnancies and training of district personnel such as health promoters.

(A combined list of the key services identified from both processes is shown in Table 7).

Communities generally agreed with the MoHCW proposed core health services at community and clinic level, except in relation to referring young people for SRH (although with some debate); kangaroo care of low birth weight infants (felt to be better managed at the clinics); breastfeeding in HIV positive mothers, and zinc for diarrhea management (with home made ORS preferred). They also noted concern about any message that promoted home treatment for children as they thought it was best for ill children to be taken to the clinic and in one area raised concern on drug resistance to malaria treatment.

Triangulating evidence from different sources there was agreement that
In the community:
- Households should be required by law to have a toilet (78 % agreement)
- All schools should screen children's health annually. (60% agreement)

In the services
- The set of guaranteed services should be posted at health facilities.(65% agreement)
- Both public and private services should provide the EHB. (75% agreement)
- All clinics - private and public should have trained midwives. (75% agreement)
- Medication for major chronic illnesses should be available in the clinics. (87% agreement)
- All clinics should provide VCT services (78% agreement)
- All women should access cervical cancer screening at their clinics. (74% agreement)
- Government should fund community health workers in all wards (80% agreement).

There was strong support for a defined benefit made known to the community and delivered, particularly at primary care level, and a view that information flow and preventive services were not currently adequate. The roles played by households, communities and other agencies were identified and support for these roles was perceived to be one of the essential functions of services and part of the EHB. This means that training, routine screening for conditions like breast cancer, eye check ups, preventive services like immunization; outbreak management; public health inspections, distribution of commodities such as condoms, mosquito nets, aqua tablets and information, assistance to home based care givers and VHWs, health campaigns, nutrition support; counseling and mobile treatment to cater for elderly or inaccessible communities should all be included in the EHB.

There was a strong view that fees should not be charged for primary care services or when people are referred to higher level services, but that fee charges should be applied when people bypass the referral chain, assuming that the primary care level is functioning.

1. Background

The Government of Zimbabwe through the National Health Strategy 2009-2013 identifies universality, equity and quality as central principles in the delivery of health services. The principle of universality calls for measures that ensure that the populations have access to health interventions and services, while the principle of equity calls for measures to close avoidable inequalities in health and in access to the resources for health, allocated in relation to health need. Closing inequalities in health calls for action on the social determinants of health, to address the causes of ill health that exist in people's living, working and community environments (MoHCW, TARSC, EQUINET, 2012). Figure 1 shows trends in Equity in Health in Zimbabwe as reported by the Zimbabwe Health Equity Watch report, 2008 and 2011.

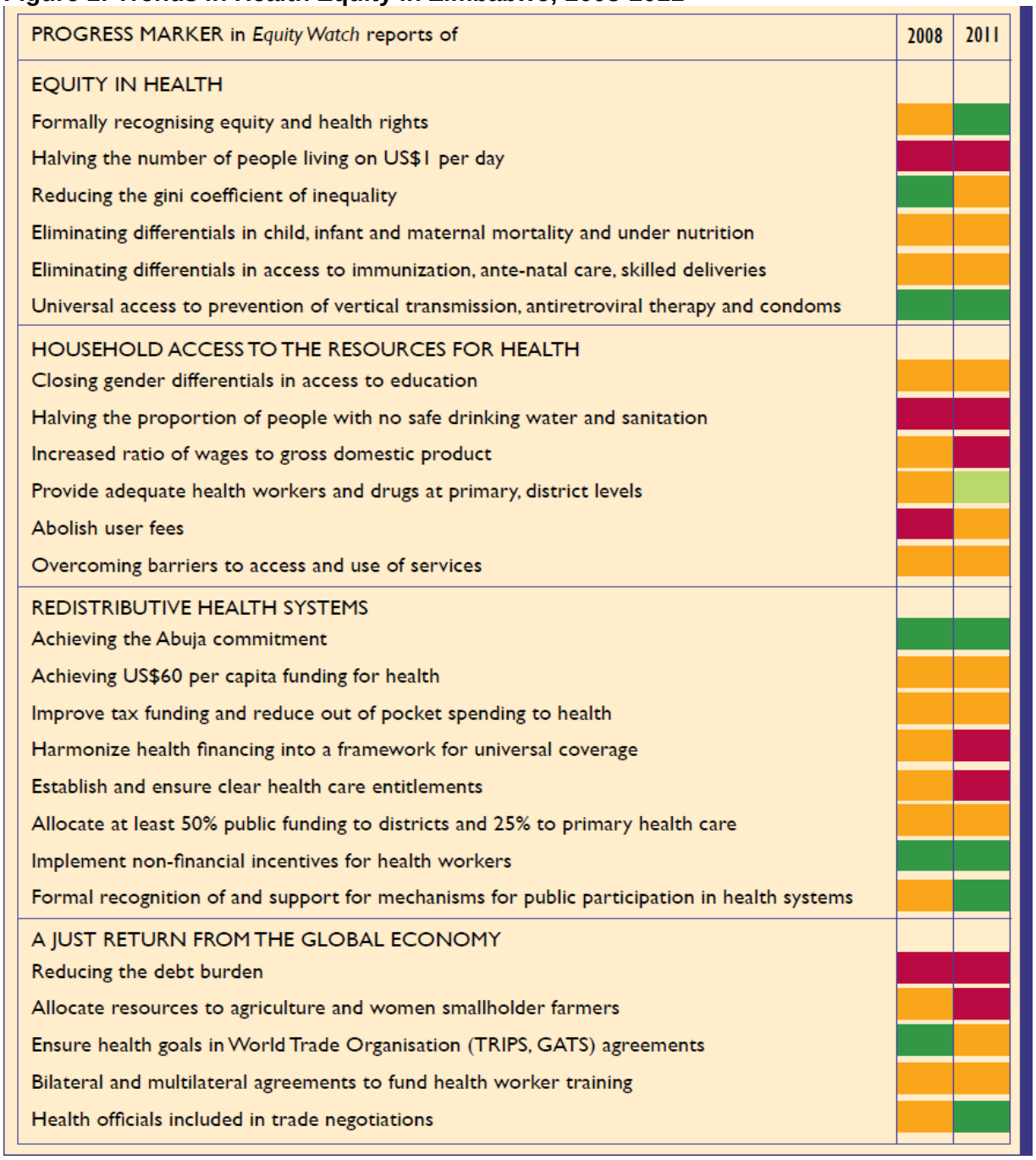
The 2011 Equity Watch report suggested that addressing inequalities in health in part calls for a more adequately resourced redistributive health sector to address the low levels of utilization, quality and inequities in access to services. The public sector currently provides what, to all intents and purposes, is an unlimited package of services, while the financing base has continued to shrink to levels where it is impossible to sustain this. In 1995 the MoHCW defined a core package of district health services, which was used as a guideline for services but was not costed. The National health strategy 1997-2007 stated a policy intention to set health care entitlements: 'To underpin future financing strategies the country will need to guarantee its citizens access to a strategic package of core health services' (MoHCW, 1999). There was no public document in the period that elaborated what these entitlements were.

In the early 2000s the Ministry of Health and Child Welfare conducted studies to identify and cost core health services at the various levels of care to assess the viability of financially guaranteeing these services (MoHCW, 2008b cited in TARSC, MoHCW 2012). The ministry identified core health services as: those interventions for conditions treatable at the primary care level; environmental health and disease control measures; TB treatment and follow-up; antenatal care and uncomplicated deliveries; and health education within communities (Chihanga, 2008 cited in TARSC, MoHCW 2012).The National Health Strategy (MoHCW 2009) proposed to review the provision of the basic entitlements to health. The 2009 assessment of primary health care in Zimbabwe (TARSC CWGH 2009) proposed that the comprehensive primary health care oriented services and resources be defined and costed at primary level (backed by district referral level services) and that priority be given that this basic level of provision be funded and universally delivered by all providers of primary care clinics (central, local government, mission and other private)

The new draft constitution of Zimbabwe includes the right to health services in its bill of rights, which makes identification of the entitlement even more important. The Advisory Board of Public Health identified as one element of Universal Health Coverage (UHC) the definition and delivery of services made universally available and accessible, ie

a. Access by the whole population to the same scope of acceptable quality services / benefits on the basis of their health need;
b. Essential health services – public health and personal care- made universally available to the whole population at a cost that society can afford;
c. Service entitlement to progressively improve as resources improve;
d. The reduction of inequity in access as a central goal –ie measures to avoid wide differences in availability or richer groups accessing or using health care more, or being offered considerably better quality care, than poorer groups;
e. Referral services accessed through primary care services;
f. Addressing barriers to access faced by socially disadvantaged and marginalized groups;

Figure 1: Trends in Health Equity in Zimbabwe; 2008-2011



Colour coding: Green - improving progress, Red -worsening trends, Yellow - uncertain or mixed trends. Source: TARSC, MoHCW (2011) Equity Watch

1.1 Defining comprehensive health care entitlements

In the February 2012 national stakeholder meeting on the Zimbabwe Equity Watch, participants agreed that defining comprehensive health care entitlements calls for technical and policy dialogue (including with Parliament and civil society) to establish, cost and raise awareness on a clear set of comprehensive healthcare entitlements for the population at the various levels of the health services, taking into account the social determinants of health and the economic situation of the country and it's people. In line with the National Health Strategy 2009-2013, tax funds raised for the health sector would be used to pay for such an equitable package of essential public health, prevention, and promotion and health care services. Co-payments should not be charged for these services. An integrated Intersectoral benefit including provisions that are

linked to the social determinants of health, particularly water, sanitation and environmental health was also recommended (MOHCW & TARSC/EQUINET, March 2012). As the economy grows, the delivery on the comprehensive entitlement can be progressively realized based on the resources of the state, population health needs and priorities, the epidemiological profile, and in a manner that ensures equity in access. It includes community and public health, comprehensive primary health care (including social determinants) and primary and district level care services, is linked to the right to health (an entitlement) and the financing to progressively realize this. It is thus not simply a minimum package, but an "Essential Health Benefit (EHB)". As a starting point it was proposed that the District core services defined by MoHCW in 1995 need to be updated; initially at community, primary and district level- against the current epidemiological profile, be subject to review and input from communities and sectors that provide public health inputs, and be costed in various provinces, at various service levels (community, primary and secondary levels) and by various providers (central, local government, missions and other private).

The national stakeholder meeting proposed that the Essential Health Benefit to be made universally available to the whole population be updated, and include also community roles and the inputs of other sectors in primary health care. An updated Essential Health Benefit (EHB) should take into account the population health profile, views of communities and other sectors, and should cost the agreed benefits.

It is thus vital that those who are affected by the benefit package be consulted before the framing of the package. Not only community views on their perceptions of priority public health problems and services to be provided at community, primary care and district level are important but their proposed roles and contributions including those for the health sector and other sectors are also important.

2. Objectives of the assessment

An assessment was thus implemented in late 2012 that aimed at determining community, local leaders and frontline workers views on key areas relevant to the framing of the Essential Health Benefit. The assessment aimed more specifically to determine;

d. priority public health problems the EHB should address and any important features of their distribution by social and economic groups that services need to respond to.
e. the services for health promotion, prevention, PHC, treatment and care, rehabilitation and palliative care that communities expect to see in place at community, primary and district level that would (i) address these priority health needs (ii) fulfill the constitutional right to health services.
f. the roles and contributions of ministry of health, other ministries, other agencies and of communities (households, communities and leaders) in providing these services

This work also aimed to build capacities in community level researchers in use of Participatory Reflection and Action (PRA) methods in gathering evidence on the EHB

3. Methods

3.1 Study design

A cross sectional design was used, with qualitative data being collected that allowed for analysis of variation of findings by category of respondents (households, community leaders, community level workers) and residents (rural and urban). Data collection was implemented through a one day Participatory Reflection and Action (PRA) meeting of between 30-50 people and an interviewer administered questionnaire with households[1], representatives of community based organisations, community leaders and community level workers. The assessment was

[1] A household refers to a person or group of related and unrelated persons who live together in the same dwelling unit(s), who acknowledge one adult male or female as head of household, who share the same housekeeping arrangements, and who are considered one unit.

implemented in three urban and seven rural districts from nine provinces of Zimbabwe. The districts were purposively selected to provide seven rural and three urban districts in all nine provinces and in areas where community based researchers with basic research and data collection skills who had worked with TARSC on previous assessments were present. The sample size was constrained by financial and time limitations. The districts included are shown in Table 1 below.

Table 1: Participating districts in the assessment work, 2012

Item	Province	District
1	Bulawayo	Bulawayo
2	Harare	Chitungwiza
3	Manicaland	Mutare
4	Mashonaland Central	Bindura rural
5	Mashonaland East	Goromonzi
6	Mashonaland West	Makonde
7	Masvingo	Bikita/Masvingo rural
8	Matabeleland North	Tsholotsho
9	Matabeleland South	Plumtree
10	Midlands	Kwekwe

Within each district, the wards and households for the questionnaires selected were obtained through a two stage randomized cluster sampling. Two community based researchers collected data from each district through a one day PRA meeting with households, community level workers and community leaders and through an interviewer administered to households, representatives of community organisations, community leaders and community level workers. Table 2 shows the targeted and actual sample. Appendix 1 provides detail on the participants who participated in the PRA meetings by district.

Table 2: Summary of targeted sample and actual respondents

Province	District	PRA Meeting	Questionnaire				
		Total Partici-pants	Commu-nity member	Commu -nity Leader	Health Worker	CBO represen-tative	TOTAL
Target per district		30-50	30	10	10	10	60
Bulawayo	Bulawayo	20*	30	10	10	10	60
Mash West	Makonde	31	28	12	10	10	60
Mat North	Tsholotsho	23	30	10	10	10	60
Mat South	Bulilima	35	30	10	10	10	60
Midlands	Kwekwe	33	30	10	10	10	61
Mashonaland central	Bindura South	30	19	10	10	22	60
Mashonaland East	Goromonzi	33	25	14	13	8	60
Harare	Chitungwiza	30	30	10	10	10	60
Manicaland	Makoni	40	31	9	10	10	60
Masvingo	Bikita	40	29	14	4	13	60
Total		**315**	**282**	**109**	**97**	**113**	**601**

*The lower number of participants to the PRA meeting in Bulawayo was attributed to people leaving during the meeting due to other commitments.

3.2 Data Collection

Participatory Reflection and Action

The participants to the PRA meeting consisted of representatives from three groups of purposively selected people from the community in each district, with 15-20 from community and between 10 and up to a maximum of 15 people for the other groups group (See Table 3 below).

The three sub groups convened on the same day and venue. Each PRA meeting consisted of five sessions which covered areas shown in Table 4 below. The PRA used a number of interactive activities to collect data from the participants and in the group activities, the participants were divided into their constituent groups so that the views obtained were first obtained separately and then brought together in the plenary. The community based researchers recorded data in a standard PRA Record Book and all entries in the record book were be verified by the second facilitator.

Table 3: Categories of members to the PRA meeting

Target group	Composition
15-20 Community members	Adult household members, community organisations, community based civil society, youths, womens organizations, producer organizations, community club members, residents associations, people living with HIV and AIDS; people with disabilities; members of faiths (including Apostolic) and traditional healers
10-15 Community leaders	Traditional leaders: chiefs, headman, kraal head, Government: councilors, Faith based: church leaders, traditional religious leaders; Health: Health centre committee members; Village / Ward assembly leaders, Residents association leaders;
10-15 Community level workers	Teachers, Agriculture extension workers, health workers (nurses, EHTs, VHW, Community Home based Care Givers) community based distributors that fall under ZNFPC, Police officers, Local council EHTs, Public health inspectors, EMA community based inspectors, District development fund workers), Veterinary inspectors

Table 4: The design of the PRA for data collection

Session Number and Name	Areas and issues covered
Session 1 Introduction	Opening, Introduction to the background and purpose, aims, a record of delegates to the meeting and their roles in the community
Session 2: Major Health Problems	The most important health needs that people have for which services must be provided for ALL people. Ranking of health problems.
Session 3: Expected Services	Given the health needs raised, identification of what health services people would expect to find (i) within community, (ii) within non health facilities in the community eg schools, social welfare, (iii) in the clinics, (iv) at the district hospital. For each level (community, non health facilities, clinics OR district hospital) identification of services that people expect to find within each one of the following categories (i) promoting health (ii) preventing diseases and ensuring health of specific groups (iii) treatment of ill-health and provision of rehabilitation and palliative care, (iv) any other roles. Identification of services expected for referral (to a higher or lower level) in part or in total, Completion (by agreeing or not agreeing) of the proposed core services from the MoHCW
Session 4: Roles and Contributions	Identification of roles and contributions for each of the four categories of services in Session 3 above, in terms of ministry of health, other ministries, other agencies and communities (households, communities and leaders). How the communities expect referrals to be managed and the fees applying for referrals from the district vs direct use bypassing primary care level.
Session 5: Closing	Recapping the purpose of the assessment and the discussions identification of issues raised that can be followed up / acted on locally and discussion of actions. Closing of the meeting by a community leader and health official.

Interviewer administered questionnaire

A questionnaire was administered to 30 households, 10 representatives of community based organisations, 10 community leaders and 10 community level workers in each district. The questionnaire gathered evidence on

- The major health needs and problems for which services should be provided for all people, no matter where they live or what social or income group they come from.

- Health needs for which services should be provided for all of the specific sub-groups (children, adolescents, women, men, elderly, poorest, others).
- Expected health services (to promote health, prevent diseases, to treat the ill and to provide rehabilitation and palliative care) within the community, within non health facilities in the community, at the clinic, at the district hospital.
- Roles and contributions for each of the categories of services above of ministry of health, other ministries, other agencies and of communities (households, communities and leaders) in providing identified/expected services
- A likert scale rating on key areas and debates for the compilation of the EHB.

3.3 Data quality and analysis

The district research teams were trained in a one day training programme before fieldwork commenced. The teams were supported during fieldwork through physical visits in some wards and by telephone in all others. The data was entered by two trained data entry clerks.
The data was cleaned and coded and analysis implemented using the Statistical Software for Social Sciences package (SPSS) within a tabulation framework developed for the assessment. The likert scale in the household questionnaire consisted of a response scale from one to 5, with 1 corresponding to “strongly agree” and 5 corresponding to “strongly disagree” During analysis, percentages within each response category were calculated showing disaggregation by type of area and category of respondents. Responses of open ended questions in the questionnaire and the PRA meetings were first entered in verbatim. Theme areas from the responses were identified and the data was coded to reflect these themes. The responses were then summarised using frequencies for each theme area captured by the respondents on each question.

3.4 Ethics and permissions

A letter of authority for the work was provided by the Ministry of Health and Child Welfare at central level. Each community based research team obtained further consent to proceed at two levels: (i) district level and (ii) individual participant level. Each team was assisted by a letter detailing the role of the assessment and guaranteeing confidentiality of individual views of participants (collective compiled information will be used). Further authority was obtained from (i) the Mayor in urban sites and (ii) the Chief in rural sites and the police. The research teams also obtained verbal permission to proceed from the participants to the PRA meetings on the day after explaining the exercise and before initiating the discussion. The team explained to the group the purpose of the discussion, guaranteed confidentiality and advised participants on permissions obtained. Participants voluntarily participated in the exercise with the right to withdraw and not to participate if they did not wish to. Participants who declined to participate in the meeting were replaced with others.

4. Findings

4.1 Major health need and problems

Respondents identified the major health needs and problems in Zimbabwe for which services should be provided for ALL people, no matter where they live or what social or income group they come from. Table 5 below shows health needs identified within different categories by more than 50% of the respondents in *any* category (community, leader, health worker or CBO, or rural or urban).

Results indicate that there was

- Equal concern for services to address diseases and to address the social determinants of health (SDH)
- Concern for both communicable and non communicable diseases (NCDs)
- A link between the diseases and SDH raised (eg cholera, typhoid and water, sanitation
- Continued prioritization of HIV and AIDS as a major concern

- Similarity between community and health workers views
- Greater focus amongst CBOs on AIDS than other needs and low public health focus, and
- Greater concern in urban communities on non communicable diseases (NCDs).

Table 5: Major health needs identified by respondents

Items/ Issues raised by respondents	Percent respondents raising issue by category of respondent by residence							
	Community members N=282	Community leader N=109	Health workers N=97	Representatives of CBOs N=113	TOTAL N=601		Rural N=420	Urban N=181
Diseases								
Diarrhoea	63	58	59	50	**59**		57	65
Cholera	50	44	53	41	**48**		45	54
Typhoid	53	36	66	42	**50**		48	55
HIV/AIDS	71	62	66	64	**67**		68	66
Hypertension	45	39	52	47	**45**		43	51
Tuberculosis	52	51	54	45	**51**		50	53
Cancer	62	51	63	35	**55**		53	61
Malaria	48	56	59	48	**51**		53	48
Sexually transmitted diseases	55	49	56	42	**52**		51	53
Social determinants of health								
Water Supply	54	52	54	54	**54**		50	61
Sanitation	60	46	52	38	**52**		51	54
Shelter and housing	59	55	51	38	**53**		51	56
Solid Waste management	45	39	35	45	**42**		36	56
Pollution	33	37	40	35	**35**		38	30
Food availability/ healthy diet	59	47	55	36	**52**		50	55
Health Services								
Health Promotion	48	45	51	38	**46**		46	45
Medicines, ARVs	50	48	40	50	**48**		46	54
Sexual and reproductive health	55	41	51	47	**50**		50	51

Also raised, but at lower frequencies were

Diseases: Influenza; Headaches; Meningitis; Diabetes; Asthma; Mental health problems; Bilharzia; Measles; Pneumonia; Scabies; Physical disability; Stress and Physical and sexual abuse

Social determinants: Transport; Food handling and hygiene; Poverty, lack of jobs, unemployment

Services: Health equipment; Community health services; Heath workers (nurses at PHC) and specialist services eg radiologists at hospitals; Health worker - community interactions; Ante natal and post natal care; Affordability of services; Ambulance services

These issues were raised for all groups. In addition to these, further issues were raised for particular subgroups, with those raised by more than 50% of the respondents in *any* category

For children: Diarrhoeal diseases including cholera and typhoid; Immunisation including for measles; physical abuse; diet and food security; Growth monitoring, nutrition surveillance

For adolescents: Sexually transmitted infections; Sexual and reproductive health services

For women: Delivery, antenatal and post natal services, sexual and reproductive health services (to include VCT, PMTCT, condoms)

For elderly people: hypertension, diabetes, cancer; mental health problems, and memory loss.

In the PRA meetings similar concerns were expressed. These results are therefore not repeated. The problems ranked in the top three in each district in the PRA meetings are shown in Table 6 and further detail is given on the full spectrum of rankings in Appendix 2.

As differences or key features in the PRA in relation to the questionnaire survey:

- Access to safe water was the main concern in *all* meetings in *all* districts
- Second highest rated concerns were food availability and diets, health promotion and transport.
- Transport and health promotion were both given higher priority in the PRA meetings than in the questionnaire, particularly in rural districts for transport.
- The PRA meetings gave greater priority than the questionnaire respondents to community level services, to health promotion and to the availability of health workers in local services, raising these are important health needs in a majority of meetings.

Table 6: Top three ranked health needs identified by respondents in the PRA

	Problem ranked number		
District	**1**	**2**	**3**
Bulawayo	Food	Diarrhoea	Cancer
Makonde	Accommodation and Food	Health promotion	HIV/AIDs
Tsholotsho	Diabetes and Cancer	Stress	Hypertension
Bulilima	HIV/AIDS services	Cancer treatment	Drugs in clinics
Kwekwe	Safe water	HIV/AIDS services	Affordable and accessible health services in clinics
Bindura South	HIV and AIDS services	Diabetes and Hypertension	Tuberculosis
Goromonzi	Cancer	HIV/AIDS	Hypertension
Chitungwiza	HIV/AIDS	Cancer	Hypertension
Makoni	HIV/AIDS	Food	Child health- immunisation
Bikita	Food and nutrition	Tuberculosis, HIV/AIDs	Diabetes, Cancer

In the PRA meetings these problems were seen to affect all in the community as well as specific groups such as children, the elderly or pregnant women. Beyond these issues, further problems were identified as affecting specific groups, for which services should be provided. These included:

For children: Measles, Ringworms, hookworm, roundworm, Bilharzia, Scabies. Pneumonia; chicken pox; sexual abuse; immunisation and ambulance services and social conditions such as loss or absence of parents and religious beliefs affecting children's health or response to illness

For elderly or poor people: greater focus was given to cancers (breast, cervical, prostate and lung), arthritis, eyesight and hearing loss, kidney and liver problems, typhoid, physical and sexual abuse, smoking, alcohol and drug abuse and to health promotion and to sexual and reproductive health than in the more general discussion.

The PRA meetings indicated that there are problems specific to particular areas, for example elephantiasis was raised in the Bikita PRA, and spinal problems that may relate to ergonomic conditions in mine and farm work was raised in Bindura.

Discussing the health problems in the PRA meeting in Tsholotsho, © TARSC 2012

4.2 Prioritised services

The detailed responses in the questionnaire survey on the services prioritized within communities are shown in Appendix 3, Table A3.1. The table shows the services identified as important Within the community, clinic and district hospital and provided by other agencies, such as schools.

From the findings it can be noted that

- Certain services are identified as necessary at all levels, although with a different type of functioning at the different levels. These include health education, reproductive health services including family planning, nutrition services, hygiene and environmental health (including ensuring safe environments at facilities, treatment for endemic communicable and NCDs, and psychosocial support.
- At *community level*, respondents gave a strong focus to environmental health, disease control and nutrition activities and having accessible medicines in community level services
- At *clinic level*, in addition to areas prioritized at community level, respondents also noted that frontline services should respond to major health issues, ie VCT,PMTCT, ART and DOTS; Pre-natal, post natal care, immunisation, delivery services; Child health- growth monitoring and nutrition checks; Isolation of communicable disease patients eg cholera, malaria, typhoid and TB tracing, available medicines and personnel for prevention and treatment of endemic and other diseases; water, sanitation and good hygiene at the clinic; blood pressure monitoring, diabetes and cancer screening; counseling services and transport to refer patients to district hospital
- In *district* hospitals while these issues are noted, so too was quarantine and management for infectious diseases; HIV/AIDS/TB testing and diagnostic services eg CD4 testing; family planning, VCT, condom distribution, medicines for communicable and NCDs; specialist doctors, dentist, physiotherapy, diagnostic equipment, cancer screening and treatment; mental health services and surgery, caesarians for women, and delivery of complicated pregnancies
- In *other agencies*, the services identified were similar to those identified in the community, but included also referrals to clinics; basic training of staff for managing minor diseases and counseling and psycho-social support.

Table A2.2 shows the expected services in the different levels as identified in the PRA meetings. As in the previous section, the PRA meetings raise a wider range of services at all levels. Hence in addition to those raised in the questionnaire noted above, the PRA meetings also include

- In the *community*, management of key social determinants such as road transport; solid waste; herbal gardens; social and spiritual support; dissemination of information on prevention and management of abuse; and home based care
- In *clinics*, equipment/Testing kits for BP, diabetes, cholera, typhoid, malaria; physiotherapy services; mental health care; training of VHWs and case tracing and follow up of communicable diseases
- In *district* hospitals, support for health lifestyles/ exercise, training of district personnel such as health promoters, dental care services, pharmacy services; chemotherapy, physiotherapy, herbal medication and mortuary services.
- In *other agencies*, the further services identified were monitoring disease outbreaks, and health research.

A summary of the key services identified from both processes is shown in Table 7 overleaf.

Table 7: Key services at different levels identified as essential by communities from the questionnaire and PRA processes

level	Services identified
In the community	• Health Education and awareness campaigns on hygiene, lifestyles, abuse • Nutrition/ Food for poor, nutrition gardens, herbal gardens • Building of toilets, wells and solid waste pits and shelter • Road maintenance • Reproductive Health services; condoms, contraception • Preventative activities eg Mosquito spraying, immunisation • Education on Sanitation, safe water and SWM • Home based care and support on medication provided to patients • Medicines for endemic diseases eg malaria with VHW • Medicines available in the private sector eg pharmacies • Spiritual counseling; Psycho-social support
In non health agencies	• Education on healthy lifestyles, hygiene; disease prevention including HIV/AIDS • Reproductive health education and condom distribution • Promote nutrition through sample gardens food hygiene and nutrition • Identify and support children for immunisation • Promotion of water, sanitation, solid waste management • Monitor disease outbreaks, • Distribute prevention items eg condoms, aqua tablets, • Medicines for endemic diseases eg malaria • Basic Training of staff in treatment of minor diseases • Transport arrangement for referrals • Counseling and Psycho-social support • Participate in health research
At the clinic	• Health Education through IEC on endemic diseases, NCDS, environments and food hygiene • Reproductive health education and condom distribution, VCT,PMTCT, ART • Promote nutrition through gardens, growth monitoring • Promote sanitation, solid waste management and safe water • Immunisation • Tracing, follow up, quarantine of communicable diseases, DOTS • Medicines and staff to prevent and treat endemic communicable and NCDs • Equipment/Testing kits for BP, diabetes, cholera, typhoid, malaria, X rays • Trained Health Staff, short course training for VHW, etc • Counseling services and mental health services • Physiotherapy services • Transport to refer patients to district hospital
At the district hospital	• Disseminating information, IEC to clinics on diseases control and prevention • Support healthy lifestyles eg sport, nutrition, condom distribution • Training Health Promotion staff • Support clinics to promote sanitation, water and waste management • Dental care services • Advanced reproductive health services eg pap smear; family planning, VCT • Surgery, caesarians for women, and delivery of complicated pregnancies • Expanded immunisation programmes • Infectious disease control- Quarantining infected persons • HIV/AIDS/TB testing and diagnostic services eg CD4 Counting • Mental health services; Counseling services • Pharmacy/Pharmacist; Medicines for communicable and NCDs, herbal medicine • Scanning and screening equipment, CD4 counting machines • Chemotherapy, Physiotherapy, dialysis • Other: Specialist doctors for cancer, kidney problems, DNA testing • Mortuary

Table A2.3 in Appendix 2 provides the findings on community views on the MoHCW proposed core health services at community and clinic level. There is generally agreement with those proposed with the following exceptions and the reasons for them shown in Table 8 below:

Table 8: Communities disagreeing with proposed core services and reasons given

A = agreement with the measure
DA - disagreement with the measure

Service area	% A	% DA	Reasons cited for Disagreeing
Refer young people for sexual and reproductive health as appropriate	70	30	Promotes bad sexual behaviour in young children (Makoni). In all groups that disagreed, there was no consensus on this issue with some participants agreeing with the statement. Facilitators noted that if a scale was provided in respect of the level of agreement or disagreement, this would have been rated as indifferent. In Goromonzi and Harare, facilitators said the participants were worried on the effect this would have on school children.
C.FAMILY MATERNAL, CHILD AND NEONATAL CARE			
Kangaroo Care of low birth weight infants	80	20	In Kwekwe it was felt that low birth weight infants would not be suitable for this type of care. The participants opted for clinic and hospital care for low birth infants.
D.INFANT AND CHILD FEEDING:			
Breast Feed exclusively for children 0-6 months	70	30	Reasons for not agreeing related to (a) For HIV positive mothers, they should have the option to either exclusively breast feed or use infant formula and not mix the two. (b) Some participants raised issues relating to constraints faced by working mothers who need to go to work and the paid maternity leave of 90 days.
Breast feed for children 6-24 mths	90	10	
E.CURATIVE CARE:			
Give sick children appropriate home treatment for infection.	90	10	The participants argued that emphasising on home treatment makes mothers seek health care when the ailment has already advanced (i.e delay health seeking behaviour from clinics and professionals). They disagreed and said that mothers should visit the clinic and then can be advised by the nurses to implement home treatment. They said that mothers would need to be educated to correctly administer the home treatments
Provide Zinc for diarrhoea management	80	20	Participants said they want to use ORS as the ingredients are readily available. Some participants said they were not aware of this type of remedy and thus would opt for ORS that they know. They require education for something new.
Use Artemisinin - based Combination Therapy for malaria in children, pregnant women and adults.	80	20	The group in Makoni raised concerns about drug resistance but did not elaborate what this was about.

These views were triangulated with the likert scale questionnaire administered to 601 respondents. Communities had strong agreement with the following statements, further conforming roles and services indicated in the community survey and PRA, and indicating the strength of agreement around these statements:

In the community:

- Households should be required by law to have a toilet (78 % agreement)
- All schools should have health screening and checks of children once a year. (60% agreement)

In the services

- A guaranteed set of services that all communities can expect to get at that level of facility should be posted at every health facility.(65% agreement)
- Both public and private services should provide the same guaranteed essential services. (75% agreement)
- All clinics - private and public should have trained midwives. (75% agreement)
- Medication for major chronic illnesses eg diabetes, hypertension, asthma should be available in the clinics. (87% agreement)
- All clinics should provide Voluntary counselling and testing services (78% agreement)
- All women should have access to cervical cancer screening at their clinics. (74% agreement)
- Government (central/local) should provide funds for all wards, urban and rural to have community health workers as part of health services. (80% agreement)

There was thus strong support in the community for a defined benefit made known to the community and delivered, particularly at primary care level.

In contrast, there was less agreement that health services are already providing enough information to support community and household roles for all the major health problems faced, and also that preventive services in the area are adequate to control all the major health problems we face.

There were some areas of service delivery where views were less clear. There was some disagreement that people should go to district hospitals to get antiretroviral treatment for prevention of parent to child transmission of HIV (largely as it was felt that this should be provided at clinic level). There was also weaker agreement on where resources should be prioritized if scarce, between spending on medicines and spending on delivering community and clinics services rather than hospital services, with relatively similar support for both.

Feedback session on the working groups in the PRA meeting in Makonde, © TARSC 2012

Through the questionnaire and the PRA sessions the roles of various actors in health services were identified. These are summarized for the different actors in Table 9 below, combining the input from both processes. They are shown for the actors in the community outside the health services below:

Table 9: Roles in health for different actors identified by communities

Level	Services identified
Households	• Grow food, vegetables/ herbs; Eat balanced diets and good hygiene • Build protected wells, protected wells, rubbish pits • Participate in healthy lifestyles eg sport, go for HIV testing • Use clean water, sanitation and rubbish pits • Fumigate, allow for mosquito spraying, water treatment chemicals etc • Families (husband and wives) visit the clinic for screening when wife pregnant, VCT, use condoms • Practice hygiene (food, the house) and good nutrition • Visit clinics when ill, report diseases outbreaks • Having children immunised, go with children for growth monitoring • Provide nutritious food to the ill • Supervise those on treatment for adherence eg DOTS • Form support groups eg for HIV treatment support • Counsel and providing moral and financial support to those on treatment
Community members	• Have community gardens/ good diet and hygiene • Have community safe drinking water sources, toilets and waste management • Have joint promotions of lifestyles eg community health clubs • Home based care activities • Monitor sanitation and waste management threats • Encouraging each other to immunise and vaccinate children • Share information and knowledge on disease prevention • Ensure early treatment of communicable diseases and reporting outbreaks • Counseling and psycho-social support to families and the sick • Support community care givers, provide material and moral help • Identify people who can be trained as VHW, campaign for more VHWs • Transport the sick to clinics
Community leaders	• Disseminate information on hygiene, nutrition • Mobilise community in infrastructure development- clinics, dams, • Monitor and report promotional activities in schools eg feeding programmes etc • Speak against negative cultural practices eg polygamy • Provide a platform for health workers to work • Monitor and ensure compliance with health laws, health ethics • Report outbreaks of diseases; distribute disease prevention chemicals eg aqua tablets, mosquito nets, condoms • Monitor Home based Care givers • Use herbs that have been tested, prepared hygienically, advise patients on potential effects and interactions of herbs • Encourage subjects to visit clinic early • Support to community care givers; home based care givers • Provide drugs for malaria, and other minor conditions • Provide spiritual counseling

The PRA meetings indicated the same roles as those shown in Table 9. These community roles are supported by actors in schools, agricultural extension services, local businesses, whose roles in health were also identified as shown in the continuation of Table 9 below.

Table 9, continued: Roles in health for different actors identified by communities

Level	Services identified
By other services (teachers, businesses, CBOs)	• Awareness campaigns on health, healthy lifestyles, diseases prevention • Screen children/ people for diseases/vaccination and refer them to clinics • Provide safe water, sanitation and waste management environment • Distribution of disease prevention items eg water purification tablets, • Conduct health checks on children and screen children for referral to clinics and support immunisation • Monitor children on treatment where necessary • Basic medical kits to treat minor conditions, burns and diseases like malaria • Monitor disease outbreaks, nutritional deficiencies and report to clinics • Support supplementary feeding, nutrition gardens, food safety • Support training of VHWs, home based carers • Contribute prevention materials eg mosquito nets, water treatment chemicals • Attending to infrastructure, drill boreholes, • Educate on use of chemicals used in controlling pests and diseases; on nutritional components of crops; on first aid

Support for these roles was perceived to be one of the essential functions of services and part of the core health services benefit. This was identified in the PRA meetings to include:

From the *clinic*, beyond the services identified in Table 7, communities thus identified that capacities and services should exist to:

- Train/collaborate with local health promoters for schools, provide information materials and other communication resources on health
- Carry out routine screening for conditions like breast cancer, eye check ups, preventive services like immunization
- Distribute commodities for prevention such as condoms, mosquito nets, aqua tablets together with information packs to patients
- Visit and offer assistance to home based care givers as well as support VHW
- Hold awareness campaigns in communities on hygiene eg celebrating hand washing days, AIDS days and disseminate information
- Hold demonstration events like nutritional feeding of children within the community
- Hold outreach immunisation campaigns
- Collaborate with VHW and community on adherence of people on treatment eg TB
- Have mobile treatment sessions to cater for the poor, elderly, orphans within the community
- Provide drugs and medicines to VHW, chronically ill patients
- React to emergencies, outbreaks by going into the community
- Follow up counseling sessions with patients

To support community roles the *district hospital* services were seen to need to include

- Train and support health promotion human resources
- Provide counseling services
- Community screening of diseases, old people, medical check ups, tests for BP, TB cancer
- Outreach treatments such as of eye specialists

4.3 Views on payments for services

This assessment did not intend to explore community views on costs or user fees for services. This would need to be done as a separate assessment given the complexity of the issue and the need to disaggregate by income group to obtain meaningful data relating to financial protection. In the PRA meetings communities did however discuss whether certain services should have fee

charges or be offered as part of the package of services that have no cost at point of care. The feedback in the meetings was that

If patient is refereed by the district

- They should not pay for transport to services (70% sessions)
- They should not pay for fees (90% of sessions)
- They should not pay for the bed if admitted (60% of sessions)
- They may be asked to pay for costs of some of the other services they receive e.g. x-rays (50% of sessions).

In the Likert scale questionnaire (601 responses), 71% of respondents strongly agreed that when people are referred to provincial and central hospitals from district services they should not have to pay for consultation fees or supplies .

In contrast, communities felt that if people bypass primary care services and go directly to district services

- They should pay for transport to services (80% sessions)
- They should pay for fees (70% of sessions)
- They should pay for the bed if admitted (60% of sessions)
- They should pay for costs of some of the other services they receive e.g. x-rays (70% of sessions.

There was thus a strong view that fee charges should be applied when people bypass the referral chain, and equally strong views that fees should not be charged for admission or transport for referral when people do not bypass services. This implies that communities would need to have available primary care services to make such referrals, and to have confidence in the capacities of these services.

Market place session in the PRA meeting in Tsholotsho, © TARSC 2012

5. Discussion and conclusions

This assessment provides information on community, local leader and frontline worker views on key areas relevant to the framing of the EHB, in terms of the priority public health problems to be addressed, the services for health promotion, prevention, PHC, treatment and care, rehabilitation and palliative care that communities expect to see in place at community, primary and district level and the roles and contributions of different actors in providing these services.

The results provide detail the findings in each of these areas, that would be important to take into account in framing the EHB. There was similarity between community and local health workers views. In particular the findings suggest that

1. The EHB should give attention at all levels to services to screen, treat and rehabilitate both communicable and non communicable diseases, as well as to provide for the health service roles in public health, promotion and prevention in relation to social determinants of health (SDH), particularly to safe water, adequate food and safe transport
2. While HIV and AIDS continue to be prioritized as a major concern, and priority conditions such as cholera, typhoid, TB, malaria, diarrhoeal diseases, STIs continue to be raised, there was also concern about NCDs such as hypertension, diabetes, cancer (especially cervical, breast and prostate cancer), eyesight and hearing loss, kidney and liver problems and mental health, particularly but not only from urban areas. There is an expectation that services from community, primary and district level will address these conditions. Further services were expected to provide mental health, counseling services and to provide services for psychosocial problems including physical and sexual abuse.
3. While maternal and child health continue to be identified as priorities, there were other groups identified as needing to be kept in mind in defining the EHB, particularly adolescents (eg for SRH services); and elderly people (for services for hypertension, diabetes, cancer, eyesight and hearing loss, kidney and liver problems and mental health).

In relation to prioritised services, communities expect the EHB to include the full spectrum of services, from population health services such as health education, health promotion, environmental health, disease control including quarantine facilities, through to prevention services at both individual and community level (immunisation, outbreak management, TB case tracing) and individual level (screening blood pressure, for cervical cancer, for diabetes, VCT) as well as the treatment and care services for SRH, nutrition, maternal health, for endemic communicable and NCDs, including for mental health and emergency care.

The views expressed indicated that the EHB should not only include the specific services, but the training, participation mechanisms, information, transport, and support for the health workers, home based and community care , outreach and community roles needed to support delivery and use of those services, appropriate referral to higher levels and back to communities. For example a requirement for households to have toilets, for annual health checks in schools, or for CHWs in every ward were seen to be a necessary part of the EHB.

A combined list of the key services identified from both processes is shown in Table 7.

Communities generally agreed with the MoHCW proposed core health services at community and clinic level. The few areas of concern raised suggest a need to better explain these services to communities, or to take community concerns (such as on young people and SRH, or expectations of home care) into account in framing these services.

The respondents felt that the set of services guaranteed at each level should be posted at every health facility, and should apply in both public and private services. There was a strong view that fees should not be charged for these services when provided at primary care level or when people are referred to higher level services, but that fee charges should be applied when people bypass the referral chain, assuming that the primary care level is functioning.

Appendix 1: PRA meeting participants

A. Number of participants by district and category of participant

Province	District	Date of meeting	Total # of delegates	Total number by Age category		Total Number by sex		Total Number by category of persons		
				Adults >18 yrs	Youths <18 yrs	Women	Men	Community members	Community leaders	Community level workers
Bulawayo	Bulawayo	3 Nov 2012	20	14	6	9	11	6	5	9
Mash West	Makonde	25 Oct 2012	31	29	2	22	9	11	10	10
Mat North	Tsholotsho	3 Nov 2012	23	21	2	15	8	12	6	5
Mat South	Bulilima	5 Nov 2012	35	29	6	19	16	14	10	11
Midlands	Kwekwe	26 Oct 2012	33	31	2	16	17	14	10	9
Mashonaland central	Bindura South	25 Oct 2012	30	24	6	11	19	12	5	13
Mashonaland East	Goromonzi	3 Nov 2012	33	30	3	23	10	16	7	10
Harare	Chitungwiza	3 Nov 2012	30	27	3	16	14	10	10	10
Manicaland	Makoni	27 Oct 2012	40	23	17	16	24	26	4	10
Masvingo	Bikita	7 Nov 2012	40	37	3	18	22	16	11	13
TOTAL			**315**	**265**	**50**	**165**	**150**	**137**	**78**	**100**

B. Percent distribution of participants by province and category of respondent

District	Total Number of Delegates	Percentage of participants by age category N=315		Percentage of participants by sex N=315		Percentage of Participants by category of participant N=365		
		Adults >18 yrs	Youths <18 yrs	Women	Men	Community members	Community leaders	Community level workers
Bulawayo	20	70	30	45	55	30	25	45
Makonde	31	94	6	71	29	35	32	32
Tsholotsho	23	91	9	65	35	52	26	22
Bulilima	35	83	17	54	46	40	29	31
Kwekwe	33	94	6	48	52	42	30	27
Bindura South	30	80	20	37	63	40	17	43
Goromonzi	33	91	9	70	30	48	21	30
Chitungwiza	30	90	10	53	47	33	33	33
Makoni	40	58	43	40	60	65	10	25
Bikita	40	93	8	45	55	40	28	33
Total	**315**	**84**	**16**	**52**	**48**	**43**	**25**	**32**

Appendix 2: Additional data from the PRA meetings

A2.1 Summary of average rankings of health needs by category and residence

Service	Average Rank (Rural and Urban Combined	Average Rank-Rural	Average Rank-Urban
HIV/Aids	1	1	1
Cancer	2	2	2
Water	3	5	1
Food	3	3	3
Affordable Health services	3	4	2
Diarrhoea	4	6	1
Stress	4	4	3
Hypertension	4	3	4
Health promotion	4	1	7
Bilharzia	4	4	4
Maternal health	4	5	3
Sanitation	5	3	6
Eye care	5	6	4
Accommodation	5	0	10
Diabetes	6	3	9
Drug abuse	6	9	3
Child diseases	7	3	10
Cholera	7	7	7
TB	7	4	10
Care for elderly	7	10	4
Malaria	7	4	10
Stroke	7	4	10
Sexual abuse	7	5	10
Ambulance	8	10	5
Child abuse	8	5	10
Flue	8	10	5
Headache	8	5	10
Health personnel	8	7	8
Hygiene	8	5	10
Social Support	8	5	10
Back aches	8	6	10
Drugs	8	6	10
Health and safety	8	6	10
Scabies	8	6	10
Sexual health	8	6	10
SWM	8	9	7
Asthma	9	7	10
Typhoid	9	7	10
Arthritis	9	10	8
Dental services	9	10	8
Physical abuse	10	9	10

An explanation on how the ranks were calculated

Services were listed by residence and a score assigned to the rank of the service. A service ranked 1 was assigned a score of 1 and ranked ten a score of 10. The average rank by residence was calculated by calculating the AVERAGE score for the service for URBAN and RURAL areas separately. The average combined ranking was calculated first by summing up the average scores for each service for RURAL and URBAN areas. A service with a rank in rural residence but without a rank (not ranked top ten) in either urban (or vice versa) was assigned a score of 11 to enable comparative analysis based on TOTAL rank scores. The total rank scores were arranged in descending order with the lowest score being assumed as rank one and the highest score as the last rank (rank 10)

A2.2 Services expected at different levels as raised in the PRA meetings

Service cited	Number of PRA meetings raising issue		Total
	Rural (7)	Urban (3)	
Within community			
Health Education and awareness campaigns on hygiene, lifestyles	5	3	8
Nutrition/ Food for poor, nutrition gardens	5	1	6
Building of toilets, wells and solid waste pits and shelter	6	3	9
Road maintenance	4	0	4
Disseminate information on abuse	0	1	1
Reproductive Health services; condoms, contraception	5	3	8
Medicines supply for the ill	2	1	3
Preventative activities eg Mosquito spraying, immunisation	3	1	4
Education on Sanitation, safe water and SWM	6	2	8
Home based care	4	1	5
HBC support on medication provided to patients	5	2	7
Treatment medicines for endemic diseases eg malaria with VHW	3	2	5
Medicines available in the private sector eg pharmacies	2	1	3
Herbs, nutrition gardens	2	1	3
Spiritual counseling	2	1	3
Psycho-social support	3	0	3
Within non health sector facilities.			
Education and awareness on health lifestyles, hygiene	5	3	8
Reproductive health education and condom distribution	3	1	4
Promote nutrition through sample gardens etc	4	0	4
Identify and support children for immunisation	2	1	3
Exemplary promotion of water, sanitation, solid waste management	5	2	7
Monitor disease outbreaks	4	3	7
Education on disease prevention including HIV/AIDS	5	1	6
Proper sanitation, water, SWM facilities, food hygiene and nutrition	5	3	8
Distribute prevention items eg condoms, aqua tablets	3	1	4
Medicines for endemic diseases eg malaria	6	2	8
Basic Training of staff in treatment of minor diseases	5	2	7
Transport arrangement for referrals	4	2	6
Counseling and Psycho-social support	6	2	8
Participate in health research	0	1	1
At the clinic			
Health Education through IEC materials	7	3	10
Reproductive health education and condom distribution	6	1	7
Promote nutrition through sample gardens etc	3	1	4
Be exemplary in promotion of sanitation, SWM and water	5	1	6
Awareness campaigns on endemic diseases, NCDS, safe environments and food hygiene	6	3	9
VCT,PMTCT, ART and DOTS	5	3	8
Immunisation	5	1	6
Isolation of Communicable diseases	3	1	4
Drugs that prevent endemic and other diseases	4	2	6
Adequate personnel for preventing diseases	4	1	5
Water, Sanitation and good hygiene at the clinic	5	2	7
Education on prevention of diseases	2	2	4
Essential medicines for common communicable and NCDs	7	2	9
Equipment/Testing kits for BP, diabetes, cholera, typhoid, malaria	5	2	7
ARVs	5	2	7

Service cited	**Number of PRA meetings raising issue**		
	Rural (7)	Urban (3)	**Total**
Trained Health Staff	3	3	6
Counseling services	5	2	7
Physiotherapy services	2	1	3
Transport to refer patients to district hospital	2	3	5
Other: Mental health care (x1), xray machines (x2)	1	2	3
Short Course training for VHW, etc	2	0	2
Tracing and follow up of people with communicable diseases	5	0	5
District Hospital			
Disseminating information to clinics	5	3	8
Supporting healthy lifestyles eg sporting events, nutrition	2	3	5
Training Health Promotion staff	4	3	7
Develop IEC materials for clinics on conditions specific to the district	7	1	8
Condom distribution support	2	1	3
Support clinics to promote sanitation, water and waste management	3	0	3
Dental care services	3	1	4
Advanced reproductive health services eg pap smear	3	2	5
Education on diseases control and prevention- supporting the clinics	6	3	9
Expanded immunisation programmes	4	0	4
Infectious disease control- Quarantining infected persons	2	0	2
HIV/AIDS/TB testing and diagnostic services eg CD4 Counting	6	2	8
Family planning, VCT, condom distribution	5	2	7
Mental health services	4	0	4
Pharmacy/Pharmacist	6	1	7
Counseling services	5	2	7
Scanning and screening equipment, CD4 counting machines	5	3	8
Drugs and medicines (communicable and non communicable)	7	3	10
Chemotherapy and Physiotherapy	3	3	6
Other: Specialist doctors for cancer, kidney problems, DNA testing	0	2	2
Provide herbal medication	1	0	1
Mortuary	3	1	4

A2.3 Community views on the MoHCW proposed core health services

A = agreement with the measure DA - disagreement with the measure

	DISTRICT										% districts (N=10)	
	Byo	Makonde	Tsholotsho	Bulilima	Kwekwe	Binduura South	Goromonzi	Chitungwiza	Makoni	Bikita	A	DA
A.HEALTH PROMOTION												
1. Provide information, counselling on family planning, pregnancy, breastfeeding	A	A	A	A	A	A	A	A	A	A	100	0
2.Educate adolescents about sexual and reproductive health and rights in a life skills context	A	A	A	A	A	A	A	A	A	A	100	0
3.Refer young people for sexual and reproductive health as appropriate	A	A	A	A	A	A	DA	DA	DA	A	70	30
4.Protect all including children from injury and accident and give first aid	A	A	A	A	A	A	A	A	A	A	100	0
5.Prevent child abuse and neglect, and take action when it does occur	A	A	A	A	A	A	A	A	A	A	100	0
6.Involve fathers in the care of their children and family reproductive health	A	DA	A	A	A	A	A	A	A	A	100	0
7.Ensure that children receive adequate amounts of micronutrients (vitamin A and iron, in particular, either in their diets or through supplementation	A	A	A	A	A	A	A	A	A	A	100	0
8.Respond to a child's needs for care through talking, playing and providing a stimulating environment	A	A	A	A	A	A	A	A	A	A	100	0
9.Take children to complete the full course of immunizations before first birthday	A	A	A	A	A	A	A	A	A	A	100	0
10. Dispose of faeces, including children's faeces, safely; wash hands after defecation, before preparing meals, and before feeding children.	A	A	A	A	A	A	A	A	A	A	100	0
11.Protect children in malaria endemic areas by ensuring that they sleep under insecticide -treated bed nets.	A	A	A	A	A	A	A	A	A	A	100	0
12.Adopt behaviours and action to prevention HIV	A	A	A	A	A	A	A	A	A	A	100	0
13.Provide appropriate care for people affected by HIV/AIDS, especially orphans	A	A	A	A	A	A	A	A	A	A	100	0
14.Use iodised salt	A	A	A	A	A	A	A	A	A	A	100	0
15.Lead healthy life styles (no smoking, drug abuse, have a balanced diet)	A	A	A	A	A	A	A	A	A	A	100	0
B.ENVIRONMENTAL HEALTH												
16.Prevent mosquito breeding; use insecticide treated nets, indoor spraying	A	A	A	A	A	A	A	A	A	A	100	0
17.Supply and use quality of drinking water (build/protect wells).	A	A	A	A	A	A	A	A	A	A	100	0
18.Build Blair toilets, refuse disposal pits	A	A	A	A	A	A	A	A	A	A	100	0
19.Hand-wash at 5 key times (after toilet, after dispositn child's faeces, before eating, before preparing food, before feeding a child)	A	A	A	A	A	A	A	A	A	A	100	0
C.FAMILY MATERNAL, CHILD AND NEONATAL CARE:												
20.Seek early family, ANC, PNC and post natal services including at least four	A	A	A	A	A	A	A	A	A	A	100	0

	DISTRICT										% districts (N=10)	
	Byo	Makonde	Tsholotsho	Bulilima	Kwekwe	Binduura South	Goromonzi	Chitungwiza	Makoni	Bikita	A	DA
antenatal visits with an appropriate health care provider and receiving the recommended tetanus toxoid vaccination												
21.Clean delivery and cord care if it accidentally happens at home.	A	A	A	A	A	A	A	A	A	A	100	0
22.Early breastfeeding and temperature management	A	A	A	A	A	A	A	A	A	A	100	0
23.Kangaroo Care of birth weight infants	A	A	A	A	DA	A	A	DA	A	A	80	20
24..Take Children for immunization, growth monitoring, well-baby clinics.	A	A	A	A	A	A	A	A	A	A	100	0
D.INFANT AND CHILD FEEDING:												
25. Breast Feed exclusively 0-6 months	A	A	A	DA	A	A	DA	A	DA	A	70	30
26. Breast feed for children 6-24mths	A	A	A	A	A	A	A	A	DA	A	90	10
27. At about 6mths feed children energy and nutrient rich complementary foods, while continuing to breastfeed	A	A	A	A	A	A	A	A	A	A	100	0
28. Provide therapeutic feeding for severely malnourished children	A	A	A	A	A	A	A	A	A	A	100	0
29 Implement community based growth monitoring.	A	A	A	A	A	A	A	A	A	A	100	0
30. Participate in Child Supplementary Feeding programs	A	A	A	A	A	A	A	A	A	A	100	0
31. Set up household or community gardens.	A	A	A	A	A	A	A	A	A	A	100	0
E.CURATIVE CARE:												
32. Recognize symptoms of local endemic condition e.g malaria and seeking treatment early: ORS.	A	A	A	A	A	A	A	A	A	A	100	0
33. Follow the health worker's advice about treatment, follow-up, and referral	A	A	A	A	A	A	A	A	A	A	100	0
34. Report early to a health facility when ill	A	A	A	A	A	A	A	A	A	A	100	0
35. Feed and offer fluids, including breast milk, to children when ill.	A	A	A	A	A	A	A	A	A	A	100	0
36. Give sick children appropriate home treatment for infection.	A	A	A	A	A	DA	A	A	A	A	90	10
37. Promote DOTS	A	A	A	A	A	A	A	A	A	A	100	0
38. Use Oral rehydration solution	A	A	A	A	A	A	A	A	A	A	100	0
39. Provide Home Based Care for the chronically ill	A	A	A	A	A	A	A	A	A	A	100	0
40. Provide Zinc for diarrhoea management	A	A	A	A	A	A	DA	A	DA	A	80	20
41. Use Artemisinin - based Combination Therapy for malaria in children, pregnant women and adults.	A	A	A	A	A	A	A	A	DA	DA	80	20
42. Practice Community management of childhood illness	A	A	A	A	A	A	A	A	A	A	100	0
F. REHABILITATION AND PALLIATIVE CARE:												
43. Take care of disabled people	A	A	A	A	A	A	A	A	A	A	100	0
44. Implement Community care projects such as community gardens	A	A	A	A	A	A	A	A	A	A	100	0

Appendix 3: Additional data from the questionnaire

A3.1 Responses on prioritized health services by respondent category and residence

Items/ Issues raised by respondents	Percent respondents raising issue by category of respondent by residence							
	Commu-nity members N=282	Commu-nity leader N=109	Health workers N=97	Represent atives of CBOs N=113	TOTAL N=601		Rural N=420	Urban N=181
WITHIN THE COMMUNITY								
Health Education on hygiene, lifestyles and nutrition and abuse	50	34	38	35	**42**		42	43
Nutrition/ Food for poor, orphans and vulnerable, HIV AIDS positive patients, nutrition gardens	38	30	35	31	**35**		32	40
Building of toilets, wells and solid waste pits and shelter	61	43	49	44	**53**		55	48
Reproductive Health services; condoms, contraception from VHW, Community distributors	42	39	38	35	**39**		41	36
Preventive activities eg Mosquito spraying, supply of mosquito nets	41	32	35	33	**37**		40	31
Education on Sanitation, safe water, solid waste	56	50	57	42	**52**		56	43
Treatment drugs for endemic diseases eg malaria with VHW	41	38	38	37	**39**		40	39
Drugs available in the private sector eg pharmacies	19	11	19	23	**18**		19	17
Herbs, nutrition gardens to provide nutritional support	28	31	26	20	**27**		26	28
WITHIN NON HEALTH FACILITIES IN THE COMMUNITY eg Schools								
Education on health lifestyles, hygiene in schools, creches through dramas, posters etc	54	49	48	41	**50**		48	52
Reproductive health education and condom distribution, refering children to clinics for testing	45	44	35	46	**43**		43	45
Promote nutrition, gardens	40	28	38	32	**36**		40	27
Identify children for immunisation	29	39	31	47	**34**		31	43
Promotion of sanitation, water , hygiene (hand washing)	41	34	39	21	**36**		37	31
Monitor disease outbreaks and report early to EHTs, clinics, etc	35	39	48	41	**39**		40	37
Education on disease prevention including HIV/AIDS	57	42	58	45	**52**		55	45
Proper sanitation, water, solid waste, food hygiene and nutrition	39	48	37	63	**45**		43	49
Distribute prevention items eg condoms, aqua tablets	38	34	21	35	**34**		33	36
Drugs for endemic diseases eg malaria, emergency kits, first aid	57	55	59	44	**55**		53	58
Basic Training of staff in treatment of minor diseases	38	31	29	37	**35**		37	31
Transport for referrals to clinics	34	28	35	31	**32**		30	38
Counselling, psycho-social support	20	15	22	29	**21**		22	19
AT THE CLINIC								
Health Education, IEC materials distributed to patients, on walls	61	51	61	44	**56**		59	50
Reproductive health education, condom distribution, teaching mothers on pre-/ post natal care	57	51	63	53	**56**		58	52

Items/ Issues raised by respondents	Percent respondents raising issue by category of respondent by residence							
	Commu-nity members N=282	Commu-nity leader N=109	Health workers N=97	Represent atives of CBOs N=113	TOTAL N=601		Rural N=420	Urban N=181
Promote nutrition, gardens	39	26	24	39	**34**		35	31
Provide safe water, sanitation and waiting rooms for patients	43	51	49	38	**45**		44	46
Awareness campaigns on endemic diseases, NCDS and safe environments, food hygiene	32	43	29	27	**32**		33	30
VCT,PMTCT, ART and DOTS	63	60	63	51	**60**		60	60
Pre-natal, post natal care, Immunisation, delivery services	54	51	59	55	**55**		56	52
Child health- growth monitoring and nutrition checks	44	31	43	36	**40**		42	35
Isolation of communicable diseases eg cholera, TB tracing,	19	14	19	25	**19**		19	19
Drugs for endemic diseases eg malaria prevention drugs	32	24	39	44	**34**		31	41
Adequate personnel for preventing diseases	38	35	43	42	**39**		40	38
Water, Sanitation and good hygiene at the clinic	35	39	37	56	**40**		41	38
Education on disease prevention	35	40	39	20	**34**		36	29
Essential Drugs for common local communicable and NCDs	61	52	74	50	**60**		60	58
Equipment/Testing kits for BP, diabetes, cholera, typhoid, malaria and cancer screening	60	55	64	49	**57**		59	55
ARVs	59	45	62	48	**55**		54	57
Trained Health Staff	52	55	55	51	**53**		53	54
Counselling services	21	16	16	23	**20**		21	17
Transport district hospital referral	35	29	32	19	**31**		31	31
AT THE DISTRICT HOSPITAL								
Health education on all diseases, through posters and information to clinics, education on lifestyles	66	50	67	53	**61**		63	56
Condom distribution, acqua tablets to vistors and patients	35	29	25	34	**32**		30	36
Clean Water, sanitation, wards	36	27	37	35	**34**		34	36
Expanded immunisation	46	39	41	45	**44**		44	44
Infectious disease control, treatment and houses for people with infectious diseases	41	42	42	28	**39**		38	41
HIV/AIDS/TB testing and diagnostic services eg CD4 count	61	48	57	42	**54**		55	54
Family planning, VCT, condom distribution,	36	35	30	27	**33**		34	31
Medicines for communicable and NCDs	55	51	54	56	**54**		54	54
Specialist doctors, dentist, physiotherapy,	62	46	67	57	**59**		60	57
Diagnostic equipment, cancer treatment and dialysis etc	56	51	55	48	**54**		55	51
Mental health services	30	30	40	22	**30**		31	29
Surgery, ceasarians for women, delivery of complicated pregnancies	29	38	33	33	**32**		31	34

Table A3.2: Likert scale responses to statements on services

Statement	Rating (%) N= 601				
	Strongly agree	Agree	Don't Know	Disagree	Strongly Disagree
Government (central/local) should provide funds for all wards, urban and rural to have community health workers as part of health services.	80	19	1	0	0
All schools should have health screening and checks of children once a year.	60	31	2	5	2
Households should be required by law to have a toilet.	78	15	4	2	0
Health services already provide enough information to support community and household roles for all the major health problems we face.	14	21	6	40	18
All clinics - private and public should have trained midwives.	75	23	1	1	0
Preventive services in my area not adequate to control all the major health problems we face.	48	38	3	7	4
Medication for major chronic illnesses eg diabetes, hypertension, asthma should be available in the clinics.	87	12	0	0	0
All clinics should provide Voluntary counselling and testing services.	78	19	1	1	2
People should go to district hospitals to get antiretroviral treatment for prevention of parent to child transmission of HIV	42	14	3	24	17
All women should have access to cervical cancer screening at their clinics.	74	21	3	1	0
If resources are scarce they should first be spent on medicines.	49	31	3	11	6
If resources are scarce then priority should be given to delivering community and clinics services rather than hospital services.	41	27	6	22	4
When people are referred to provincial and central hospitals from district services they should not have to pay for consultation fees or supplies.	71	19	4	3	4
A guaranteed set of services that all communities can expect to get at that level of facility should be posted at every health facility.	65	29	4	2	0
Both public and private services should provide the same guaranteed essential services.	75	20	1	3	1