FOURH SESSION – EIGHTH PARLIAMENT

FIRST REPORT

OF THE PORTFOLIO COMMITTEE ON HEALTH AND CHILD CARE ON THE DEPLOYMENT, ROLES AND RESPONSIBILITIES OF THE VILLAGE HEALTH WORKERS/CITY HEALTH PROMOTERS IN THE PROVISION OF PRIMARY HEALTH CARE IN ZIMBABWE.

Presented to Parliament February, 2017

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ORDERED IN TERMS OF STANDING ORDER No. 17:

- At the commencement of every session, there shall be as many committees to be designated according to government portfolios as the Committee on Standing Rules and Orders may deem fit.
- Each Select Committee must be known by the portfolio determined for it by the Committee on Standing Rules and Orders.

TERMS OF REFERENCE OF PORTFOLIO COMMITTEES S.O 20

Subject to these Standing Orders, a Portfolio Committees shall-

a) Examine expenditure administration and policy of government departments and other matters falling under their jurisdictions as Parliament may, by resolution determine;

b) consider and deal with all Bills and Statutory Instruments or other matters which are referred to it by or under a resolution of the House or by the Speaker;

c) consider or deal with an appropriation or money bill or any aspect of an appropriation or money bill referred to it by these Standing Orders or by or under resolution of this House;

d) monitor, investigate, enquire into and make recommendations relating to any aspect of the legislative programme, budget, policy or any other matter it may consider relevant to the government department falling within the category of affairs assigned to it, and may for that purpose consult and liaise with such a department; and

e) consider or deal with all international treaties, conventions and agreements relevant to it, which are from time to time negotiated, entered into or agreed upon.

On Thursday, 6th October, 2016, the Speaker announced that Committees of Parliament appointed in the Third Session of the Eighth Parliament would continue with their duties and functions pending appointment of Committees for the Fourth Session. The following Members serve on the Portfolio Committee on Health and Child Care:

Hon. Bhuda S.
Hon. Chibagu G.
Hon. Dr. Chimedza P.
Hon. Chivamba K.
Hon. Kachepa N.
Hon. Dr. Labode R.
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Hon. Tshuma D.
Hon. Vutete M.
Hon. Zhou P.
Hon. Zwizwai M.

Hon. Dr. Labode to be Chairperson

1.0 INTRODUCTION

1.1 Pursuant to its oversight role over the Ministry of Health and Child Care, the Portfolio Committee on Health and Child Care enquired into the roles and responsibilities of the Village Health Workers (VHWs)/City Health Promoters (CHPs) in the provision of primary health care in Zimbabwe. The Committee was compelled to enquire on the deployment, roles and responsibilities of the Village Health Workers/City Health Promoters following observations during the tours to Population Services Zimbabwe's Outreach Family Planning Services in Ntabazinduna and Chitindo areas in 2015.

1.2 From the tours conducted in Ntabazinduna and Chitindo areas, the Committee noted that the Village Health Workers have an essential role to play in the provision of the primary health care in Zimbabwe. The Committee learnt during these tours that the Village Health Workers face various challenges in the discharge of their duties among them were inadequate tools of the trade and some discrepancies in allowances given to them.

2.0 OBJECTIVES

The objectives of the enquiry were:

2.1 To appreciate the roles and responsibilities of the Village Health Workers in the provision of primary health care in Zimbabwe;

2.2 To appreciate recruitment and selection criteria of the Village Health Workers;

2.3 To assess the deployment of the Village Health Workers in the rural communities;

2.4 To understand the Village Health Workers' working conditions and remuneration; and

2.5 To recommend possible incentives for improved service delivery for increased Village Health Workers productivity and effectiveness in the health sector.

3.0 METHODOLOGY

The Committee used two methods of data collection namely; oral evidence and familiarization tours to selected Rural Health Centres and urban areas.

3.1 Oral Evidence Sessions

3.1.1 Brigadier General Dr. G. Gwinji, the Permanent Secretary for the Ministry of Health and Child Care briefed the Committee on the deployment, performance and remuneration of the VHWs/CHPs, on the 8th of March, 2016.

3.2 Familiarisation Visits

3.2.1 The Committee conducted familiarization visits to selected Rural Health Centres from 16 to 20 May 2016. The committee visited 8 Provinces, two Metropolitan provinces and one city. The purpose of the visits was to meet with sampled Village Health Workers (VHWs) and City Health Promoters (CHPs) from at least one district of each of the provinces. The Committee aimed at holding twenty-seven (27) meetings with the VHWs. However, due to unanticipated bad road networks in some districts, the Committee successfully held a total of twenty-three (23) meetings. The Committee interacted with a total of 567 Village Health Workers and City Health Promoters during the visits. The areas visited are presented in Table 1.

3.2.3 The Committee's first port of call was the District Nursing Officer/ Community Nursing Officer/ Health Promotion Coordinator or their representatives. These are the officers who mobilised the VHWs/CHPs and would lead the committee to each meeting point and took the privilege to brief the committee on statistics, recruitment and deployment and roles of VHWs/CHPs. The Committee employed focus group discussion tool to gather more information from the VHWs/CHPs. In light of this approach, the VHWs/CHPs were themselves given a chance to share with the committee their working conditions and challenges. Mostly the VHWs would gather at a health center were they report to. In rural communities, the number of VHW in a single meeting ranged from 4 to 19 while in urban areas it was above one hundred.

Table 1: Areas visited by the Committee

	Province	District	City	Rural Health Centre
1.	Mashonaland West	Karoi	-	-Kasimure Clinic -Tengwe Clinic -Zebra Downs
2.	Midlands	Gokwe-North	-	-Tsungayi clinic -Kuwirirana clinic
3.	Matebeland North	Nkayi	-	-Fanisoni clinic -Sesemba clinic -Zenka clinic
4.	Matebeland South	Plumtree	-	-Ndiweni clinic
5.	Mashonaland Central	Mt. Darwin	-	-Chitse Clinic -Dotito Clinic -Mutungagore
6.	Mashonaland	Murehwa	-	-Kambarami Clinic

	East			-Nyamutumbu -Kadzere Clinic
7.	Manicaland	Makoni	-	-Mayo1 Clinic -Weya Clinic -Headlands Clinic
8.	Masvingo	Gutu		-Matizha Clinic -Chesguro Clinic
9.	Harare Metropolitan	-	Harare	-Venue of the meeting was at Rowan Martin Building
10.	Bulawayo Metropolitan	-	Bulawayo	-Venue of the meeting was the Tower Block
11.	-	-	Chitungwiza	-Venue of the meeting was Young Africa Skills Centre

4.0 THE COMMITTEE FINDINGS

4.1 BACKGROUND TO THE VILLAGE HEALTH WORKERS PROGRAMME

The Village Health Workers (VHW) Programme was launched in April 1981. In 1984, the programme was moved to the Ministry of Women's Affairs, Gender and Cooperative Development. Following the recommendation of the Presidential Commission in 1999, the VHWs programme was moved back to the Ministry of Health and Child Care (MoHCC) and it was resuscitated under this Ministry in 2000. The broad objective of the VHWs programme is to reduce morbidity and mortality of all preventable and curable diseases. Specifically, the programme aims at the following:

- Strengthening of relationships between the communities and health service providers;
- Enhancing community ownership of the health programmes; and
- Strengthening early identification and referral of clients.

4.1.1 Administration of the Programme

The original funding was through the Zimbabwe AIDS Network (ZAN) and the agreement was an amount of US$15.00 for each Village Health Worker which was split into US$14.00 for VHWs and US$1.00 for administration fee. However, lack of capacity and cost of implementation became a challenge for ZAN and responsibility was transferred to the MoHCC under the same arrangement. The purpose of the administration fees is to covers the following:

- Quarterly meetings;
- Payment runs to each health facility to pay each VHW; and

- Fuel and transport related costs and communication costs.

4.2 Roles and Responsibilities of VHWs/ CHPs

4.2.1 Generally the Committee noticed that the roles and responsibilities of VHWs and CHPs were similar across the provinces and were mainly on primary health care, initial treatment and prevention, water and sanitation and hygiene promotion and health information dissemination.

4.2.2 They are a critical link between the clinics, other health care organizations/programs and the communities thus, improving access to health services. They are the first point of call to primary health care in a village or community as it were. It was however noted that the VHWs perform other functions that are not ordinarily their duties especially at the health centers.

4.2.3 In particular the roles and duties of the VHWs/CHPs were mentioned as follows:

- Diagnose and administer first dose treatments for malaria and minor ailments (e.g body aches, colds and baby eye challenges) and wound dressing;
- Refer patients that need further care to the nearest clinic;
- Advocate for sanitation and hygiene at households, encouraging each household to have a toilet, safe water source, rubbish pit and kitchen utensils drying shelf;
- Water sampling at new boreholes for onward transmission for bacterial and chemical analysis;
- Promote adherence to treatment and do follow ups on clients that are on treatment programs like for ART, TB, cancer and stroke;
- Social mobilization of communities during ministry of health and child care campaigns like the Expanded Program on Immunization (EPI);
- Record and monitor baby (under-fives) growth;
- Encourage and educate families on proper post-natal baby care;
- Transmit different health care information and messages to communities;
- Look out for disease outbreaks and make reports to the clinic;
- Observe the general wellness of villagers and encourage uptake of health care services were it is needed;
- Identify and register every pregnant woman and encourage them to go for ANC and then to the mothers waiting shelters on time;
- Educate on and distribute family planning products like condoms;
- Alert communities of sexual and reproductive health issues;
- Mobilize male villagers to take up VMMC;
- Patient counseling;

- Submit monthly reports at their clinic where there is a VHW Return Form which captures Malaria, PMTCT, OI/ART and TB, Condom Distribution, EPI, Disease surveillance, Health Promotion and Growth Monitoring;
- Assist several NGOs to proliferate their health community programs. The VHW has become the focal person for any health community program; and
- Sometimes are called in at clinics to assist staff with baby weighing, weeding and general cleaning.

4.4 Selection and Recruitment of VHWs and CHPs

4.4.1 In all the rural districts visited, the VHW is chosen by the community or village they are to serve, usually through the office of the headman. In Bulawayo City, all the City Health Promoters were selected by Councillors from 29 wards in 2010. In Chitungwiza, the City Health Promoters were selected by their Councillors in 2010 after having been trained as Red Cross cadres, while those for Harare City were selected at ZANUPF branches in 1986 with some having been recently selected through their Councillors' office. In some communities the selected candidates will be interviewed at the clinic to assess suitability. Communities look out for the following characteristics:

- Able to read and write
- Aged 25 years and above
- Interested/passion in health issues
- Exemplary in issues of health and hygiene
- Able to communicate
- Respectable
- Able to observe confidentiality
- Committed to work on voluntary basis
- Approachable person
- Organised person
- Married person (Dotito Community)

4.4.2 After the selection, they are called in batches for training (3 to 8 weeks), as and when funds are availed either form the Global Fund (GF) or the Health Transition Fund (HTF) which is now the Health Development Fund (HDF). Trainings are ongoing with the latest batches met being end of April 2016 trainees.

4.4.3 They are trained to have adequate understanding of health issues and to be able to teach communities and perform several primary health care procedures. Among other key issues, trainings were said to cover disease identification and testing (e.g using malaria test kit), administering of certain medicines to patients, wound dressing, home based care, PMTCT, T.B case management, baby growth monitoring, family planning and water

sanitation and hygiene (WASH). When available, they are given kits with medicines, bandages and malaria test kits. They are also given basic baby growth monitoring equipment like weighing scales.

4.4.4 After training the VHWs and CHPs are recruited to serve in the communities from which they were selected, reporting at their nearest clinic. The deployment standard is to have one VHW covering a hundred households which is roughly one village. Due to shortages of funding, majority of VHWs and CHPs interviewed are deployed to cover more than one village. As more VHWs get trained, those areas that are in much need and underrepresented are then relieved.

4.5 Conditions of Service

4.5.1 The current VHW and CHP cadre was recruited and trained under the GF, HTF, UNICEF, OPHID, World Vision and CWGH. Of these four organisations, only GF and HTF further support the VHW with, uniforms and regalia, kits, training costs (including allowances), a $14 per month allowance and sometimes bicycles. The VHWs and CHPs are treated as volunteers and not employees hence none of the said issuances are obligatory and come as and when availed. It was noted in Bulawayo city that a handful of CHPs were not happy with the volunteer tag and had believed that they were employed by the state.

4.5.2 The Village Health Workers/ City Health Promoters are supposed to work 2-3 half days in a week. However, in most cases, the VHWs are now working throughout the week and remain with their doors open for service even at night.

4.6 Remuneration

4.6.1 There is no VHW who is getting their $14 monthly allowance on time. There was a working gentleman's agreement to pay out the allowance once every quarter, however evidence gathered shows that the allowances payment is so erratic and uncertain with cadres sometimes paid once in a calendar year. When the allowances come, they will not be up to the payment date but have always remained behind, with the best performing districts having paid up VHWs up to February 2016.

4.6.2 It was noted that at most centers none of the VHWs appreciate how much they are owed in allowances. Some of the MoHCC staff also did not have the payments balance sheets at their fingertips and agreed that they employ a wait-and-see approach since they have no control or knowledge of what amount will come and when.

4.6.3 The HTF is giving cash payments through the MoHCC, while the GF has shifted to using Ecocash. There are recorded challenges with the Ecocash system were some cadres are not receiving their allowances (some from the onset while others received first and

second rounds only) and are sometimes skipped when disbursements come but are never back paid when the next disbursement reflects. In Bulilima district up to 49 GF VHWs have not received their Ecocash allowances in spite of resubmissions and verification of personal details since 2013 when that mobile payment option was adopted.

4.6.4 Some of the VHWs indicated that they have to travel to their district hospitals to collect their allowances. The worst scenario was reported at Mayo1 Clinic in Makoni district where the VHWs have to look up for accommodation after having missed their buses due to the delays in the payments of their allowances by the Accountant at Rusape District Hospital. However, the VHWs in Gutu District get their allowances at the clinic they report to.

4.6.7 The VHWs appreciate that they are volunteers but kindly requested for at least timeous payment of the little appreciation they were promised and an upward review of between US$20.00 and US$150.00 would be most welcome.

4.6.8 In the event that a VHW is deceased, his/her allowances are then given to another VHW who was not receiving this allowance before.

4.7 Deployment

4.7.1 Due to lack of government support and limited donor support to the VHWs programme, most of the communities are not adequately covered according to the one VHW per 100 household standards. The country has a coverage of 50% of the requirement—i.e 12 000/24 000.

4.7.2 The worst case scenario encountered was one VHW covering 17 villages in Cheshuro area, Gutu district. There are some scenarios in sparsely populated villages where there is more than one VHW in a village. But in most, if not all, cases interrogated, VHWs are enduring long distances to cover their areas of jurisdiction. In Matizha, one VHW serves communities that are as far as 40-50km from the health center and walks long distances of about 25km to provide health care services to other villages. Table 2 shows the deployment of the VHWs/CHPs by province. It is also important at this point to state that one thousand and forty VHW (1040) new VHWs were trained in 2015 but do not receive allowances.

Table 2: Coverage of Village Health Workers by Province

Province	**No. of VHWs in post that are paid by Health Transition Fund**	**No. of VHWs in post that are paid by Global Fund**
Manicaland	597	840
Mashonaland Central	530	920

Mashonaland East	1111	1080
Mashonaland West	413	840
Masvingo	392	840
Matebeleland North	562	840
Matebeleland South	447	800
Midlands	516	920
Bulawayo City	-	120
Harare City	-	120
Chitungwiza City	-	120
Total	**4568**	**7440** plus *(40 not being paid: GF not considering the split & funds were not provided for)*
Grand Total	12008 *(plus 40 not being paid).*	

Source: Submissions by the Permanent Secretary of MoHCC—March, 2016

4.7.3 From the table above, it is evident that Mashonaland East Province has the highest coverage of VHWs compared to other provinces. Mashonaland East province has one thousand, one hundred and eleven (1111) VHWs sponsored by HTF and one thousand and eighty (1080) VHWs sponsored by Global Fund, giving a total of two thousand, one hundred and ninety-one (2191). Consequently, the Committee expressed great concern over this disparity and sought justification for this kind of arrangement.

4.7.4 Justification of the high coverage of VHWs in Mashonaland East Province

The reasons given for the high coverage of VHWs in Mashonaland East Province were as follows:

i. Global Fund trained in all the nine (9) districts of the province;

ii. UNICEF trained 82 VHWs in Seke district;

iii. OPHID Trust trained 27 VHWs in Murehwa and 40 VHWs in Marondera districts;

iv. Community Working Group for Health trained 300 VHWs in Chikomba and 300 VHWs in Uzumba-Marammba-Pfungwe districts (U.M.P);

v. World Vision trained 117 VHWs in Mudzi district;

vi. Health Transition Fund trained 480 VHWs in 7 disricts, 40 each in the year 2015 (Seke, Wedza, Murehwa, Goromonzi, Marondera and Mutoko).

4.7.5 During the oral evidence, the Permanent Secretary for the MoHCC, Brigadier General Dr. G. Gwinji, attributed this high coverage to the potential of the province to attract

donors and further stated that donors preferred to train VHWs in Mashonaland East Province due to its proximity to the capital city, Harare. Such a great support for this province has resulted in some districts having more VHWs than what they require while other districts within the province and other provinces in the country faced acute shortage of this cadre as Table 3 would reveal.

Table 3: Demographic Data by District in Mashonaland East Province

District	Total Population 2015	Estimated Total Villages	Total VHWs in post	VHW Required
1. Chikomba	125 912	786	433	353
2. U.M.P	117 195	420	392	30
3. Seke	279 138	405	287	118
4. Mudzi	138 678	500	306	194
5. Murewa	209 362	450	221	229
6. Marondera	186 270	300	210	90
7. Goromonzi	293 133	500	199	301
8. Mutoko	152 077	400	199	201
9. Wedza	75 197	254	152	102
Totals	**1 576 962**	**4015**	**2399**	**1618**

Source: Submissions by the Permanent Secretary of Health and Child Care—April, 2016

4.7.6 The district numbers of VHWs that are highlighted in grey clearly show that five (5) districts (U.M.P, Seke, Mudzi, Marondera and Wedza) out of nine districts in Mashonaland East Province are over deployed with the VHWs.

4.8 Presentation

4.8.1 The committee noted that upon training, the VHWs and CHPs were promised uniforms. When the committee visited, some VHWs had their uniforms on while others did not have, either because the uniforms never came or are no longer usable or are oversized or small sizes. There was a unanimous outcry about the poor quality of materials and design used for uniforms. The cadre values the way they present themselves to the communities and pleaded for some uniforms as these will also make them easy to identify. A complete uniform would include a dress/trousers and shirt, hat, jersey and shoes (preferably leather shoes).

4.8.2 Depending with the partners handouts, items like umbrellas, T-shirts, bags and cellular phone handsets sometimes come but in limited numbers such that no one cadre can get all the regalia at once. Receiving these items proved very motivational to the VHWs.

4.8.3 Identification badges were also requested, to make sure the cadre gets the space they deserve, even when they visit a health center elsewhere to seek treatment, which would come for free. They also requested for raincoats and torches to use during the odd and adverse conditions under which they have to attend to work now and again.

4.8.4 The VHWs understood the need to be always smart and clean, but bemoaned their little allowance and erratic payments, a situation that makes it difficult for them to afford descend clothes and toiletries. They also even fail to afford money to build an exemplary homestead and would appreciate if funds could be availed to set up a model home at each VHW's homestead.

4.9 Tools of Trade

4.9.1 Some VHWs were given bicycles that are still functional while on the other hand, some are broken down. The bicycles are provided by World Bicycle Relief, and are designed in the USA. All the centers visited registered one similar challenge of lack of repair parts in local shops. They also informed the Committee that they use their own money for the bicycle repairs. The distances covered and the volumes of work to be done have exerted a heavy work load that most VHWs are failing to adequately carry. In the eight (8) provinces visited (the rural population), the VHWs who underwent training did not have bicycles to use and this also applied to their allowances and uniforms. In urban communities some CHPs end up using their own resources on public transport to access their places of work.

4.9.2 Village Health Workers Kits were inadequately equipped to enable them carry out their duties in the communities for example, shortage of drugs like painkillers, gloves, stationery, Mid-Upper Arm Circumference (MUAC) Tape, torches to use at night, and raincoats to use during rain season.

4.10 Community Work and Acceptance of the VHWs/CHPs

4.10.1 Generally the cadre is well respected, trusted and valued in most communities, both by the villagers and several other external health care stakeholders. The VHW has managed to uplift the countries primary health care system over the years with notable results. There is however a serious shortage of tools of the trade in every place visited. Majority of the VHWs never received kits after training, and those who did, no longer get stocks replenishments from the local clinics. They face difficulties when they fail to find even painkillers, or fail to dress a wound and always have to refer patients to the clinics which in many cases are too far away. This has limited their usefulness in the community as far as treatment is concerned. Kits would normally contain items like methylated spirit, Vaseline, gloves, small towels, painkillers, malaria test kit and pills, G.V, betadine, bandages and eye treatment creams.

4.10.2 Challenges were recorded with some religious groupings that refuse to take up any form of conventional medicine or utilize health care centers, as a way of their faith. In Headlands, the Committee received reports of maternal deaths that were due to home deliveries mainly from the Vapostori Religious Sect. This has presented a big problem especially during communicable diseases outbreaks. Such people are also known to collect prevention items like mosquito nets and use them for unintended purposes like fishing. However, some districts reported that they were successful in persuading these religious sects to access conventional health services although many of them would seek these services nicodemously. As a result, Matizha community reported zero maternal related deaths between January and May 2016. Of interests to note in Gutu district is the unequivocal support the VHWs and health system in general get from the traditional leaders, especially Chiefs.

4.10.3 As far as spreading health messages is concerned, the VHWs appreciated and preferred the use of posters and pamphlets. These media of communication are not as available as they would want, and sometimes they are available but written in a language that is foreign to the targeted community. An example was distribution of Shona Marvelon 28 (an oral contraceptive) pamphlets in a predominantly Ndebele speaking area of Fanisoni in Nkayi.

4.10.4 The VHWs registered demotivation when they have to preach a good message, say about WASH to a majority of citizenry who cannot afford the construction costs.

4.10.5 Lack of stationery was mentioned in several places as a big hindrance to the VHWs and CHP's referral and record keeping systems. This has also added up to the extra costs that the cadre has to face in order to execute their voluntary duties. Some clinics in Bulawayo town were giving their CHPs stationery.

4.11 Harare and Chitungwiza Health City Promoters

4.11.1 Harare City Council set a good example by paying the City Health Promoters allowances of US$122.00 per month over and above the US14.00 they get from the donors. This has motivated the CHPs in doing their work. It was quite visible how happy and organised the CHPs were and they attributed this to the good leadership of their Health Promotion Coordinators, Mr. Makwara and Ms. Makoni.

4.10.2 This situation was contrary to Chitungwiza City Health Promoters who indicated that there was no good work relation between the City Council and them. They accused the City Council of not being concerned with their welfare and working conditions as well as support on their allowances.

4.10.3 The CHPs bemoaned the failure by the city council to collect refuse regularly and supply clean and safe drinking water to the citizens, adding that the lack of these services in the city made their effort to prevent the outbreak of diseases, especially cholera and typhoid futile.

5.0 COMMITTEE OBSERVATIONS AND RECOMMENDATIONS

Observation

5.1 The Committee noted with concern that the VHW programme is donor driven and that raises sustainability issues. In light of this, the Committee recommends that:

Portfolio Committee on Health and Child Care Recommendation Number 1/2016

There is need for strong government support in terms of adequate budgetary allocation towards the VHW programme starting from the 2017 budget allocation.

The Committee further recommends that government should immediately start working on innovative domestic health financing such as sin tax in order to raise revenue to meet the demands in the health sector.

Observation

5.2 The Committee noted that there is variance in VHWs training periods. Some were trained for 3 weeks others for 6 weeks and yet still some official documents indicate they are supposed to be trained for a total of 8 weeks. The Committee therefore, recommends that:

Portfolio Committee on Health and Child Care Recommendation Number 2/2016

Ministry of Health and Child Care should ensure full training (8 weeks) of the VHWs/CHPs as a matter of urgency.

Observation

5.3 The Committee also noted that there is an imbalance on resources disbursed to VHWs from district to district. Some districts like Hurungwe have received at least two batches of bicycles from Goal and later on from HTF such that VHW received 2 bicycles between 2010 and 2013 and even afforded to give 23 more to untrained volunteers, while other districts have trained cadres who haven't received a bicycle. This poor coordination of state programs and donated resources was witnessed by the committee at Fanisoni clinic where two perimeter fences, from different sources, are erected adjacently. In light of this, the Committee recommends that:

Portfolio Committee on Health and Child Care Recommendation Number 3/2016

Ministry of Health and Child Care should come up with mechanisms to improve coordination of VHW programmes, particularly in the distribution of supplies and equipment by the second quarter of 2017.

Observation

5.4 The Committee noted that the Ministry of Health and Child Care is doing very little to keep the VHW motivated and active. The Committee therefore, recommends that:

Portfolio Committee on Health and Child Care Recommendation Number 4/2016

Ministry of Health and Child Care should provide visible examples of the VHW/CHP's status such as identification cards with photos and certificates and make it possible for them to get preferential access to healthcare services or provide healthcare services at reduced cost or free by the second quarter of 2017.

Observation

5.5 The Committee noted that there is less regard of this very pivotal cadre within the MOHCC administration systems as evidenced by the absence of proper channels for the VHW to present their concerns. It is apparent that the ministry and its partners dearly need, and in fact overuse, the VHW but do not demonstrate equal care and concern about their individual welfare, requests and challenges. In light of the foregoing, the Committee recommends that:

Portfolio Committee on Health and Child Care Recommendation Number 5/2016

Ministry of Health and Child Care should ensure that the VHWs/CHPs get the recognition and respect that they deserve from the health system with immediate effect. This should be done by provision of adequate tools of the trade and putting in place proper channels of communication through monthly meetings at the Rural Health Centres by the second quarter of 2017 to enable the VHWs air their views.

The Committee further recommends that Ministry of Health should review VHWs allowances upward and liaise with the GF and HDF on timeous disbursements of the VHWs' allowances starting from the first quarter of 2017.

Observation

5.6 The Committee noted some inconsistences in allowances given to VHWs trained during the same period and failure to address simple matters like ecocash payouts since 2013 demonstrated poor administration. In view of this, the Committee recommends that:

Portfolio Committee on Health and Child Care Recommendation Number 6/2016

Ministry of Health and Child Care should assist in addressing the inconsistence/discrepancies in the payment of allowances of the VHWs/CHPs through provision of funds by the first quarter of 2017.

Observation

5.7 The committee failed to get a single VHW who knew what they are owed in allowances. Some did not even know the actual figure they are supposed to get per month, and when it comes backdated, they do not know for which months it is supposed to cover. Such

practices create fatal grounds for corruption. In view of this, the Committee therefore, recommends that:

Portfolio Committee on Health and Child Care Recommendation Number 7/2016
Ministry of Health and Child Care should immediately avail to the VHWs how much they are owed and include in the pay sheets information on the month which the VHWs would be receiving their allowances.

Observation

5.8 The Committee also noted that despite all the listed recruitment characteristics, there is still a significant number of inactive VHWs due to resignation after failing to cope with the conditions of service. The Committee recommends that:

Portfolio Committee on Health and Child Care Recommendation Number 8/2016
Ministry of Health and Child Care should provide an enabling work environment in terms of reasonable workload, supportive supervision, adequate supplies and equipment, carrier growth opportunities and continuing education to motivate VHWs and keep them at work by the second quarter of 2017.

Observation

5.9 The Committee noted that there was untimely relaying of information on resignations, absconding and deaths of VHWs to paying agencies, such that there are high chances that an inactive VHW can still continue to receive allowance, especially on ecocash. For instance, in Bulilima, the Committee noted a case of 22 VHWs who had retired but were still on the payroll as a form of pension while there are more candidates waiting for funds to get trained and join the VHW workforce.

Furthermore, the Committee noted some disturbing arrangements in Matebeleland South, whereby payouts remaining after Health Transition Fund disbursement is not returned but given to VHWs under Global Fund whose payments were delayed. In some instances, some change is returned in cash to the provincial offices as it is not clear how the funds are to be handled. In light of this, the Committee recommends that:

Portfolio Committee on Health and Child Care Recommendation Number 9/2016
Ministry of Health and Child Care should come up with a clear policy on mechanisms for the payment of the VHW upon retirement, resignation or abscondment of duties or deceasing by the first quarter of 2017.

Ministry of Health and Child Care should come up with clear terms of reference or regulations regarding the acquittals of payments of the VHWs allowances.

The Committee further recommends that the Ministry of Health and Child Care put in place strong monitoring systems to ensure timeous reporting of such.

Observation

5.10 The Committee noted that Hurungwe, Weya and Cheshuro communities had many active yet untrained VHW while other districts only call for specific villages to appoint according to the disbursed training funds. The Committee recommends that:

Portfolio Committee on Health and Child Care Recommendation Number 10/2016

Ministry of Ministry of Health and Child Care should ensure that the untrained VHWs who are offering their services to the communities are trained through provision of funds by April, 2017.

Observation

5.11 The Committee noted that some deployment formulas used left a lot to be desired, whereby some villages have more than one (1) VHW yet other villages in the same district have none. The Committee recommends that:

Portfolio Committee on Health and Child Care Recommendation Number 11/2016

Ministry of Health and Child Care should ensure fair deployment of VHWs in all the provinces of the country by directing donors to the areas that are most underrepresented or underserved and stop the current practice of deploying VHWs to areas that are already represented, leaving the underrepresented areas unattended by the second quarter of 2017.

Observation

5.12 The Committee also noted that the working hours for the VHWs are not 2-3 half days due to the ever growing demand of their services by the communities. The Committee recommends that:

Portfolio Committee on Health and Child Care Recommendation Number 12/2016

Ministry of Health and Child Care should take cognizance that the VHWs/CHPs now work more than 2-3 half days as stipulated before and improve their working conditions and allowances accordingly from the first quarter of 2017.