ZIMBABWEANS AND AMERICANS
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EVALUATION REPORT: IMPLEMENTATION SCIENCE

Promoting participatory action dialogue to build shared responsibility in addressing gender dimensions in health service delivery through participatory evaluation in Makoni District, Zimbabwe

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Report compiled by the:

Women in Politics Support Unit (WiPSU) in the –
Zimbabwe Gender Challenge Initiative (GCI)

This project has been supported by the President's Emergency Plan for AIDS Relief (PEPFAR) through Cooperative between the Centers for Disease Control and Prevention (CDC) and the Research Triangle Institute (RTI) under the terms of Cooperative Agreement Number: 1U2GPS003118-01

GENDER CHALLENGE INITIATIVE

WOMEN in POLITICS SUPPORT UNIT

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The opinions expressed herein are those of the evaluator and do not necessarily reflect the views of the funding agency.

ACRONOMYS

ART:	Antiretroviral Therapy
CCZ:	Consumer Council of Zimbabwe
DA:	District Administrator
DNO:	District Nursing Officer
GPA:	Global Political Agreement
HIV/AIDS:	Human Immune-deficiency Virus/ Acquired Immune Deficiency Syndrome
HTF:	Health Transition Fund
MDG:	Millennium Development Goals
MIMS:	Multiple Indicator Monitoring Survey
MOHCW:	Ministry of Health and Child Welfare
MTP:	Medium Term Plan
MWAGCD:	Ministry of Women Affairs Gender and Community Development
NAC:	National Aids Council
NHIS:	National Health Information System
PMTCT:	Prevention of Mother To Child Transmission
RTI:	Research Triangle Institute
STERP:	Short Term Emergency Recovery Plan
TB:	Tuberculosis
UNICEF:	United Nations Children's Fund
VIDCO:	Village Development Committee
WADCO:	Ward Development Committee
WCF:	Ward Consultative Forum
WiPSU:	Women in Politics Support Unit
WOCBA:	Women on Child Bearing Age
ZDHS:	Zimbabwe Demographic Health Survey

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EXECUTIVE SUMMARY

The aim of the evaluation was to generate community based information about factors contributing to women's access to health in Makoni district through community dialogue process and to promote government and community partnerships in addressing women's access to health services. Not much research has been conducted in this field. The researcher wanted to provide a learning platform for local engagement around women's health in Makoni District as well as to inform the development of prototype initiatives to address priority local issues related to women's health in Makoni District particularly in Ward 20 and 22. In this evaluation, relevant literature and legislative frameworks were reviewed.

From the literature review, it was evident that regarding the priority health concerns of women, there are prerequisites for the service delivery having essentials like drugs, non-obsolete or unavailable equipment, good conduct of health personnel coupled with positive attitudes by patrons to seek medical help. Collective local action through collective learning, as well as government citizen, partnership should be and are the driving force for a quality health service delivery system. As such, all stakeholders have a role to play including traditional, local and political leaders together with the communities at large.In order to build a vibrant health service delivery system, there is urgent need to share responsibilities among the key stakeholders. Prioritizing local issues with a cross section of government officials, health officials, community leaders and community members proved to be of great importance.

The data collection instruments used, were questionnaires, interviews, case clinics, world café, dialogue walks, focus group discussions and observation. In order to achieve the objectives, questionnaires were distributed to the participants and interviews were conducted as well as the case clinics, world cafes, dialogue walks. The key results from the evaluation process included the effectiveness government-citizenship partnership, collective community action and awareness of rights, policies and frameworks in place within the health sector for the citizens at large. After analysing the data, the researcher formulated conclusions due to the positive community action and government-citizen engagement results in the Makoni wards 20 and 22. From those conclusions, some recommendations were made which promote the continued engagement and action between the governed and those who govern as well the proper implementation of already existing frameworks within the health sector under the Ministry of Health and Child Care and its partners.

1 INTRODUCTION AND BACKGROUND

1.1 Brief overview

In recent years, economic decline and political instability have led to a reduction in health-care budgets, affecting provision at all levels. Zimbabwe's health delivery system has been deteriorating over the past 14 years, resulting in most sections of society, especially the poor, being deprived of their right to decent, adequate and affordable health care. The current physical environment is characterized by poor and inadequate water supplies, breakdown in the sewer systems, inadequate sanitation in both urban and rural, poor waste management practices. There has been inadequately supervised food preparation processes and inadequate control of vector-borne diseases coupled with increased urban unplanned overcrowded settlements and poor enforcement of laws and regulations that protect health. This has increased the exposure of the citizens to hazardous factors in water, air, food and in some cases soil.

The commitments that countries have made to achieve gender equality and women's empowerment can only be implemented if the requisite services are delivered. In low-income countries, at least three-quarters of neonatal deaths and a similar proportion of maternal deaths occur outside the hospital (Hofmeyr, et al., 2009). With reference to (McPake, Bricki, Cometto, Schmidt, & Araujo, 2011), a vast amount of research in recent years has looked at the reasons why services fail poor people with particular attention and not limited to user fees. (Lee, et al., 2009), states that the most common obstacles to seeking obstetric care included financial barriers, challenges with transport and the distance one has to travel to seek medical attention.This evaluation sought to investigate how governance affects health service delivery and seek ways on how both national and local governance can improve people's access to health services in rural areas particularly the Makoni District. There is a lack of hard evidence on the impact of removal of user fees on women's health outcomes and reproductive health service utilization as other barriers constrain the extent to which the removal of a single barrier can make a significant difference (McPake, Bricki, Cometto, Schmidt, & Araujo, 2011). This in turn reminds us of the urgent need to examine how women cope with health care costs and other factors owing to the access to health services. However, a paradigm shift in global health policy regarding user fees has been evident in the last decade with a growing consensus that user fees are regressive and undermine equitable access to essential health services (Yates, 2009).

Makoni district is in the Manicaland province in Rusape which is about 170km and 200-250km to get to the two wards 20 and 22 from the capital city. The health centers in focus are Dumbawe and Nyahukwe clinics and Rugoyi (Makoni rural hospital). The areas were selected because WiPSU is already working in these areas with the female councilors and women in the communities. There was also a balance in terms of political parties represented with one ward being represented by a ZANU PF councilor and the other by MDC-T. It is important to note that both councilors are in their first terms of office after the July 2013 Harmonised Elections. Both wards in question are rural wards headed by female councilors both in their first terms after the just ended 2013 harmonised elections. The evaluation took place over a period of 4 months from May-August 2014 with continuous engagement and ownership by the community and its leadership. The paper sets on focusing on the literature review with particular attention to the key

themes in the research questions. The key themes emphasize on women's health priority issues in the Makoni District paying attention to supply and demand side barriers to their access to health services. Focus on government-citizen partnership and collective local action were the themes driving this paper and therefore empowering politicians with essential information on health access issues and priorities.

1.2 Rationale for the Evaluation

The purpose of the evaluation was two-thronged. Firstly, to generate community-based information about factors contributing to women's access to health in Makoni district through the community dialogue process and secondly to promote government and community partnerships in addressing women's access to health services. The evaluation aimed to assist Zimbabwean government to know the facts and impact of health service delivery and realising the strength in community engagement and government working together. The findings from the study outline ways in which better accountability including performance indicators and new mandates for health service delivery can improve service delivery for women and men and change the lives of the entire communities.The findings will be used to enhance WiPSU effectiveness in advancing capacity building and advocacy programmes.
The objectives of the evaluation were to:

- Identify priority issues to be addressed by the action learning process
- Facilitate a collective learning process about women's access to health involving a cross section of government officials and diverse community members
- Develop prototype initiatives for implementation by WiPSU in its future programs in Makoni district

Women in Politics Support Unit (WIPSU) is a feminist trust aiming to strengthen democracy and governance practices in Zimbabwe through active participation of women elected to political office and women as political constituents. The organisation works with female political leaders empowering them to advocate for women's human rights including access to health services. WIPSU has observed that local leaders have a tendency of discussing priority issues on behalf of people without being fully informed by community members themselves thus often misdirecting efforts and resources. This is evidenced by interactions with community women who note that leaders are failing to address issues related to access and quality of health service delivery that they are most concerned with. Reportedly there is no appropriate community-based information that routinely informs governance processes at the local level and this, in part, is related to the weak linkages between government and community.

U-theory is an interesting methodology that promotes participation by stakeholders. It is a research method that manages to appreciate and engagement of different stakeholder through participation and action by all stakeholders involved. Because of the continued dialogue between the government and its citizens, U-Theory gives a platform for effective engagement leading to positive action for the benefit of both citizens and the government.

Womenfolk in Zimbabwe are still a long way from comprehending their rights (RAU, 2008). Healthcare quality and maternal mortality are at a deplorable level. Most of these demises are avertable. User fees,

a known cause inhibiting access to maternal health care, continue to be charged. The deterioration in Zimbabwe's health-care services coincided with a fall in demand for services, following the introduction of user fees. Government policy is to provide free-of-charge health services for pregnant and lactating mothers, children under five and those aged 60 years and over, but the policy has proved to be difficult to implement. Currently, in the absence of substantial government financial support, user fees provide the primary income for many health care facilities, enabling them to provide at least the minimum service.
The new Constitution of Zimbabwe declares access to health care and the protection of all citizens from diseases as fundamental human rights that are enshrined in Chapters Two and Four (*Declaration of Rights*) of the Charter (Constitution of Zimbabwe, 2013).

The country's health delivery sector has arguably been affected by the exodus of skilled and passionate health workers to greener pastures in other countries during the economic decline the country faced. Poor working conditions and low remuneration are cited as the main push factors. There has also been a marked reduction in fiscal allocation to the health sector where Cabinet allocated US$330 millionfrom US$407 million. The government's inability to adequately fund public health force health centres to deny the poor access to health care (MMPZ, 2013).

The act of giving birth is a woman's way of performing national duty as they contribute to the populace of the nation. However, maternal mortality continues to be a major challenge in Zimbabwe. The major causes of maternal mortality are a bacterial infection, uterine rupture (scar from a previous caesarean section tearing during an attempt at birth), renal and cardiac failure. Statistics from the Ministry of Health and Child Care show that maternal deaths in the country increased from 555 in 2005 to 725 per every 100 000 births in 2009.According to the 2012 National Census Report, the maternal mortality ratio in 2012 was 525 per 100 000 live births (ZimStat, 2012). Health experts say Zimbabwe is losing eight women a day due to death caused by pregnancy complications.

Despite the free-of-charge policy on health services for pregnant and lactating mothers, children under five and those aged 60 years and above, the implementation side of the policy has failed. Giving birth in a government or municipal facility, costs between US$35 and US$50 in case of emergencies in the rural areas to cover for ambulance costs to the nearest General Hospital. These costs are often prohibitive, leaving some women to give birth outside the health system that is unsafe for both the mother and the child. According to UNDP, 50 percent of mothers in the rural areas in Zimbabwe are delivering at home and it is of great concern.

Only a decade ago Zimbabwe's public health system was ranked among the best in sub-Saharan Africa. However, like the rest of Zimbabwe's economic and social fabric during a decade-long socio-economic crisis, the health delivery system has alarmingly deteriorated. So many health conditions have affected Zimbabweans over the years. Based on data from the Zimbabwe Demographic and Health Survey 2005/6 (ZDHS), Multiple Indicator Monitoring Survey 2009 (MIMS), Maternal and Prenatal Mortality Study and other studies, Perennial cholera epidemics, increased in urban areas by breakdown of sewerage and water supply treatment systems, and compounded by declining water and sanitation

coverages in rural areas resulting in a loss of over 4,269 lives out of a total 98,000 cases by end of June 2009 (ZDHS, 2005) (MIMS, 2009).

Outbreaks of rabies and anthrax continue being reported in some parts of the country including mental illness, diabetes, hypertension and cancers of the reproductive system (29.4% of all cancers in women are cervical cancer and 11.1% are breast cancer, while prostate cancer accounts for 11.4% of all cancers in men) (National Cancer Registry 2009 Annual Report)

Life expectancy at birth has fallen from 63 in 1988 to 43 years in 2005/6. Most health indicators have deteriorated during the last decade. Consequently, the country is off-track in most of its health targets including the Millennium Development (MDGs) targets. Adequate resources and an appropriate enabling environment are critical prerequisites for the successful delivery of health services. The health sector has been affected by a myriad of problems which has affected its functionality. There has been inadequate medicines and equipment. Access to essential drugs and supplies has been greatly reduced. Hospitals have been failing to dispense essential drugs such as antibiotics and painkillers, forcing patients to turn to private pharmacies and clinics which are too expensive for the majority of the people (Mambo & Dumbreni, 2014).

1.3 Limitations to the evaluation

Limitations of the evaluation included the difficulty in securing appointment times for key informants as they were mostly overwhelmed by other responsibilities. There was a limitation in terms of budgetary constraints towards the process. Some of the key stakeholders were not able to be present in all the core group meetings due to other commitments.This evaluation also took the qualitative approach and not quantitative. Despite these limitations, the evaluation managed to value every participant's contribution as there is the cohesion of efforts by all stakeholders. A look at the emotions and feelings of the people rather than merely looking at numbers was imperative.Furthermore, the increased awareness and discussion of women's health issues and the increased capacity of communities to address the issues together with the government on the health system is of grave importance.

1.4 Ethical Consideration

The researcher respected both the confidentiality and human dignity of the respondents. A consent form that described the purpose and objectives of the research were undertaken.In the initial meetings during the Co-Initiation stage, the researcher shared the evaluation objectives and informed participants of the openness and freeness of the process whereby anyone was free to choose not to participate. The process was explained as voluntary and an open atmosphere was created through de-rolling(putting aside protocols that come with positions other stakeholder hold) by some of the stakeholders who were in the core team in order to be at the same level without anyone threatening the other with positions of authority. The sitting arrangement was also managed to create the free space as there were no special seats for community leaders with all participants sitting together. During the focus group discussions in

all the five stages, participants were mixed regardless of leadership positions and credentials. The whole environment was co-created with this methodology to be a very safe space.

2 LITERATURE REVIEW

2.1 Women's Health seeking behaviours

Literature on women s health-seeking behaviour suggests that women's ability to pay or access health services needs to be redefined from a gender perspective, taking into account their access to and control over resources and decision-making about health (Malaba, 2006). Further, women's willingness to pay and access health services is determined by the social costs of health care, including factors such as perceived morbidity and severity of illness and perceived quality of care. A qualitative study from Ghana reports that within poor households, women generally find it more difficult to pay for health care, but especially widows and unmarried women with children (Gyapong, 2009).
Furthermore, because illness necessitates reallocation of time and resources within a household, a person's position in the household will determine the reallocations made towards that person s healthcare. In a qualitative household study by (Gyapong, 2009) in Uganda on coping strategies to pay for health care, women were found to have the primary responsibility towards their own and their children's health, while it is frequently men who have cash available particularly that derived from the sale of cash crops. The burden of taking care of the sick falls on women, which not only increases their workload but also makes less time available for earning an income, creating a vicious cycle of gender inequalities (Gyapong, 2009).

2.2 User fees implications for women health access

According to a paper by (Nanda, 2006) on the implications of user fees and access for women's utilization of health care services in Southern Africa, lack of access to resources and inequitable decision-making power mean that when poor women face out-of-pocket costs such as user fees when seeking health care, the cost of care may become out of reach. It was noted that, as both men and women may be constrained by restrictive economic and health service conditions their access to health services differ. The paper by (Nanda, 2006) however did not collect gender-disaggregated data in relation to health service utilization and in relation to the range of reproductive health services, taking into account not only out-of-pocket fees charged by public health providers but also by private and traditional providers.According to (Nanda, 2006) the large body of empirical evidence on the impact of user fees on utilization of health care services, however, suggests that user fees are regressive and inequitable, in that poor people pay a greater proportion of their incomes on health care than the wealthy.

Neglected in much of the literature and the evolving debates, however, are the ways in which user fees and health care personnel attitudes are regressive as regards gender equity (Vera, 2010). Dzakpasu, et al., (2013),acknowledges the challenges presented by fee removal with reference to patrons acquiring

"free" health services if there are no qualified health worker available to provide care, or queuing up all day only to be afforded an ineffectual consultation that undermines respect, trust, privacy and confidentiality. The researchers further present these as the realities in many low-income countries, particularly in rural and remote areas, where health workers are drastically in short supply, and often over-burdened and or under-resourced (Dzakpasu, Powell, & Campbell, 2013). (Lee, et al., 2009)concur arguing "strategies to increase demand for services need to be accompanied by actions to ensure the supply side can cope with the increased demand" (p.114).

2.3 Priority Women's Health Issues

The estimate of the maternal mortality ratio for the seven-year period preceding the 2010-11 ZDHS is 960 deaths per 100,000 live births; that is, for every 1,000 births in Zimbabwe, there are about ten maternal deaths. The 2005-06 ZDHS was 612 maternal deaths per 100,000 live births. Although the 2010-11 ZDHS states that a determination of the statistical significance of the differences in maternal mortality ratio in the 1994, 1999, 2005-06, and 2010-11 ZDHS are said to require additional analysis, the skyward inclination clearly intensely advocates that maternal mortality in Zimbabwe has risen abruptly over the past two decades.

2.3.1 Pre-during and post-natal care

Moneti (2004) in a study reviewing priority health issues for women through the health micro-insurance schemes revealed that women mainly cover pregnancy and delivery services. It showed the major concern focusing on maternal health and the women also wanted coverage for transport costs in cases of complications with delivery. This proved to be one of the primary health care issues women covered through health schemes. The study also established that health needs related to pregnancy and deliveries seem to be instinctively and regularly raised by both women and men alike in the course of creating and operating micro-insurance schemes. Apprehensionsconsist of the incapacity to meet the expense of emergency obstetric care in circumstances of hitches with a delivery.

According to Moneti (2004) the term "reproductive health" is habitually assumed by communities to cover the trepidationsconcerning to pregnancy and delivery primarily. When these are raised, the subsequent discussion can lead to additional reproductive health issues like family planning, infertility, and sexually transmitted infections.Post Natal Care (PNC) is necessary for both the mother and the child to treat complications arising from the delivery. The 2010-11 ZDHS showed that 43% of mothers who gave birth in the last two years preceding the survey received PNC. This was a drop from the previous ZDHS rounds, 54% in 2005-06 and 44% in 1999.

2.3.2 Breast and Cervical Cancer

According to the UNFPA, cancer mortality in Zimbabwe is still high chiefly due to late presentation of disease, inter-current diseases including HIV and limited access to early detection and treatment services. Also, most of the developing governments focus mainly on illnesses like Cholera, HIV and AIDS

and Malaria while non-communicable ailments like cancer are left with limited funding. Conversely, Cervical Cancer screening is supported by the United Nations Population Fund (UNFPA, 2010). According to the Cancer Registry (2009) in Zimbabwe Cervical Cancer remains the leading cause of morbidity among all the cancers.In 2009 cervical cancers contributed to 19% (669 cases) of all new cancers and 13 % (134) of all cancer deaths.

According to Chokunonga et al (2010), it is challenging to get correct figures in developing countries such as Zimbabwe, because cancers are not captured by the routine National Health Information System because patients do not present for treatment or register deaths. Research has shown that the five commonest cancers in Black Zimbabwean women are cervical cancer (33.9%), breast cancer (9.7%), Kaposi sarcoma (9.6%), eye (8.7%) and non-Hodgkin lymphoma (4.1%). It is also estimated that 3,700 women die per year of cervical cancer in South Africa. In Zimbabwe, HIV and AIDS contributed 60% of cancers in 2005(Chokunonga et al, 2010).

2.3.3 High Blood Pressure

World Health Organization's Non-communicable Disease (2010) notes raised blood pressure as estimated to cause 7.5 million deaths, about 12.8% of all deaths. It is a major risk factor for cardiovascular disease. The prevalence of raised blood pressure is similar across all income groups though it is generally lowest in high-income populations. According to the World Health Organization's Non-communicable Disease report (2011), 39% of Zimbabweans suffer from raised blood pressure. World Health Organisation states that the prevalence rate for high blood pressure had reached 27% and as Africa continues to industrialize, rates of hypertension (high blood pressure) and other diseases associated with one's lifestyle are increasing.

2.3.4 HIV/AIDS

According to UNFPA (2011), Zimbabwe has become the second country in Africa to register a decline in the HIV and AIDS epidemic after Uganda. HIV prevalence in Zimbabwe dropped from 23.2% in 2003 to 14.3% in 2009. UNFPA attributes the decline as a result of combined effects of behavior change interventions including a decrease in sexual partners, improved condom usage plus the effect of mortality and out-migration. The National Survey of HIV and Syphilis Prevalence among Women Attending Antenatal Clinics (2009) also showed a decline in prevalence in young women 15 to 24 years from 25.7% in 2002 to 16.1%. However, despite this decline Zimbabwe's prevalence rate is still high. A total of 1.2million (adults and children) are currently estimated to be living with HIV. There are 66 000 new infections in the 15-49 age group and 15 000 new infections among children. Although HIV prevalence has declined in Zimbabwe, there is a need to continue accelerating prevention and treatment efforts in order to get a maximum reduction on the incidence that will significantly impact on HIV epidemic.

Zimbabwe has put in place guidelines and approaches for a government-driven HIV response. This includes the National HIV Policy and the Zimbabwe National HIV and AIDS Strategic Plan (ZNASP) and a National Health Strategy (2009 to 2013) which features HIV related responses within the health sector

prominently. The first ZNASP concluded in 2010, and the subsequent will run from 2011 to 2015. In Zimbabwe, although the estimated adult prevalence has dropped from 20.1% in 2005 (2005-06 ZDHS) to 15% in 2010 (2010-11 ZDHS), HIV continues to be a serious problem. The 2010-11 ZDHS showed that more females, 18%, were infected than males, 12%. The Ministry of Health and Child Care encourages every citizen of Zimbabwe to know their HIV status by getting tested. In its bid, therefore, HIV testing and counselling is offered for free in most of the health institutions. Figures from the 2005-06 ZDHS and the 2010-11 ZDHS indicate, in general, that a larger proportion of females than males aged 15-49 years were tested.

2.4 Supply and demand side barriers

According to the ZDHS 2010/11 the most significant element inhibiting women from accessing health care for themselves is getting money to pay for treatment; 50 percent of the women highlighted this worry. This problem was most habitually reported by women who resided in the rural areas (59 percent); had no education (75 percent); or were in the lowest wealth quintile which was70 percent (ZDHS, 2010).

Distance to health facilities was quoted by one-third of women in the ZDHS 2010-11 report, as an immense problem in accessing health care (34 percent). Not surprisingly, women residing in rural areas were more likely than those in urban areas to report distance as a big problem (49 percent compared with 11 percent). Eight percent of women reported getting permission to go, and 14 percent reported not wanting to go alone as big problems in accessing health care in the ZDHS 2010-11 report (ZDHS, 2010).

According to an article by the Zimbabwe Women Resource Centre and Network, it practically sums up most of the issues that women face with regards to their access to health services (ZWRCN, 2011). A mother of 4, married for 15 years speaks of her first pregnancy that she was not allowed to register at the antenatal clinic by her husband, a member of the Apostolic Faith.Her first two children she conceived at home under the care of church midwives as she had no access to the family income despite spending all her time watering, weeding and selling vegetables from their garden. Her third pregnancy with twins, she would sneak to the clinic to seek medical help. As required for all pregnant mothers, she was counseled and tested for HIV. She tested positive and told her husband who was furious as to how she knew of her status which then suggested that she used holy water from their church and refused to go for testing.

The article goes on to elaborate on issues of patriarchy where most patriarchal communities, boys and men are socialized to believe that they hold the key to all activities that women partake, accessing health services included.

> *'I would sneak out of the house and go to the clinic and was put on treatment. I hid my medication in a hole under a tree in our field. My husband denied me access to health services and he died early this year,"Mary.*

Some married women face challenges in seeking treatment such as enrolling on Prevention of Mother to Child Transmission (PMTCT) programmes because their husbands forbid them. With HIV and Aids being the leading cause of death among mothers and infants accounting for over 27 percent of all deaths as stated by the National Aids Council's planning and implementation coordinator at dialogue conference (The Standard, 2011).There is need to empower women so that they have access to health services. Coverage of PMTCT prophylaxis among HIV positive pregnant women at 59 percent remains sub-optimal. In general, there is lack of knowledge and literacy on HIV and health issues. Fear of disclosure and discrimination as result of shame associated with HIV is still huge (Baptist, 2008).

2.5 Government citizenship partnerships

Currently, the nation has commitments on paper in the form of polices and plans that have been outlined to push for better government and citizenship partnerships for the betterment of the lives of the people. At present in Zimbabwe, the Health Transition Fund (HTF) is a five-year plan formulated by the Zimbabwe Government, UNICEF and international donors aimed to reduce high maternal and child mortality rates. The abolishment of health-care user-fees is one of the plan's key goals by 2015. With only one year left until the deadline, it is very vital to make sure that the indicators thus far show an improvement.

Aim: Reducing maternal and child mortality through abolishing user fees and supporting high-impact interventions and health system strengthening
Goal: to contribute to reduced maternal mortality (by 3/4) and under-5 mortality (by 2/3) (MDGs 4 and 5) and eliminate user fees for children under-5 and pregnant and lactating women by 2015. The programme also aims to contribute to halving the prevalence of underweight in children under-5 (MDG 1c) and combat, halt and reverse trends in HIV and AIDS, Malaria and other diseases (MDG 6) by 2015.
Purpose:

- To improve maternal, newborn and child health by strengthening health systems and scaling up the implementation of high impact interventions through support to the health sector.
- Expected Results: National coverage of focused ANC (4 visits) increased to 90% by 2015
- National skilled birth attendance rate increased to 80% by 2015
- Access to comprehensive emergency obstetric and newborn care increased to 80% by 2015
- National coverage of postnatal care (at least three visits in the first week after delivery) increased to 80% by 2015
- MNCH program implementation is monitored quarterly in all districts by 2015
- 80% of health centers have a fully functional health committee by 2015
- Community based preventive and selected curative MNhtfCH services are provided for 80% of villages by 2015

Expertise for maternal health, continue to be short within the health personnel. With an estimated 50% of expectant women in rural areas delivering their babies at home and more than a third of them (40%) without a skilled birth attendant (UNICEF, Multiple Indicator Monitoring Survey (MIMS) Zimbabwe 2009), access to services and to skilled health workers remains a great challenge (MIMS, 2009). All Zimbabwean women must have access to reproductive and maternal health care.

An economic blueprint The Zimbabwe Medium Term Plan 2011-2015, outlines the platform for amalgamating the macroeconomicstability achieved under the Short-Term Emergency Recovery Programme (STERP, 2009). Furthermore itadvances the obligation to support the rebuildingof economic stability and growth in Zimbabwe which was adopted in Article III of the Global Political Agreement (GPA).The strategies to be employed by the Medium Term Plan (2011-2015) with regards to Health are in Chapter 16 of the document (MTP, 2011).There is commitment to implement the following strategies: Implement the National Health Strategy

- Review remuneration and other conditions of service to attract and retain skills in the health sector
- Intensify training of health personnel at all levels
- Set up referral medical institution to attend to high end medical problems and initiate medical tourism
- Enforce the implementation of a comprehensive Primary Heath Care approach
- Strengthen the PPP concept for the rehabilitation of health infrastructure and provision of medicine and equipment during the Plan period
- Promote health insurance schemes
- Encourage local production of pharmaceuticals through an appropriate incentive regime
- Promote health tourism
- Provide continuous supply of medicines and medical supplies
- Expand behaviour change communication, drugs availability, community support and counseling to mitigate the impact of HIV and AIDS
- Provide basic packages of preventive and curative maternal and child health HIV and AIDS, TB and Malaria
- Strengthen the Medicines Control Authority of Zimbabwe

Zimbabwe MTP (2011-2015)

According to Moneti (2004) in a study focusing on enabling women to address their priority concerns, the findings suggest that by increasing the interaction and the collaboration between communities and health service providers, health micro-insurance contributes to improvements in quality of health services and, more broadly, to a better functioning of the health system. Furthermore Moneti (2004) alludes to the fact that this indicates that these systems could enable communities to make progress in all Millennium Development Goals that are directly related to health; they can contribute to improvements in maternal health as well as to the reduction of child mortality and to combating HIV/AIDS, malaria and other diseases. Moreover, by making the health services more accessible, they can directly contribute to the eradication of poverty.

2.6 Gender issues and questions regarding access to health services

Gender differences in health in developing countries have, until recently, received little attention from researchers, health programmes and international development efforts, (Vlasoff, 2009). According to Vlasoff's study several issues related to gender and health in the Third World on which information, especially of an empirical nature, is inadequate. These include certain health conditions and diseases for

which gender differences remain largely uncharted, gender inequalities in the development of health and contraceptive technology, the lack of gender-sensitivity in the provision of health services, and gender inequalities in health policies, focusing mainly on structural adjustment (Vlasoff, 2009).Questions urgently requiring research are identified, and suggestions are made for improving the gender sensitivity of health policies and interventions.
Thus, gender is an essential concept for poverty analysis as well as the design and implementation of poverty reduction strategies. This is because both the causes and outcomes of poverty are heavily engendered and yet traditional policy formulation conceptualizations and practices fail to delineate and/or underplay poverty's gender dimensions.

2.7 Collective local action

The National Health Information Strategy which is a strategic direction to inform the Ministry of Health and Child Welfare from 2009 through to 2014 came at a time when the need for timely and accurate data for action is critical for bringing about efficiency and effectiveness in the delivery of health services in Zimbabwe (NHIS, 2009). According to the Zimbabwe Health Information System Strategy (2009), the goal number four Inclusive implementation and monitoring "*Community Participation Partnership for Health*" speaks specifically to the involvement of the communities in all actions to be taken (NHIS, 2009). A study commissioned in 2005 by MOHCW and UNICEF to assess factors affecting the functioning of Zimbabwe Health Information System Strategy revealed various challenges around the collection, processing, analysis, dissemination and utilization of health information. These comprise amongst other things insufficient human, financial and material resources. The MOHCW and UNICEF (2005)study then came up with several recommendations aimed at fortifying the NHIS but it is said that in the face of efforts by the Ministry to implement some of the recommendations, the majority of the identified NHIS challenges remain unaddressed.

There is currently the Patients' Charter (2006) which was developed by recommendations by the Consumer Council of Zimbabwe (CCZ) and the Ministry of Health and Child Welfare to offer security to patrons and improve health service delivery. The Charter consequently spells out broad end-user rights to access and treatment and was intended to offer official mechanisms for the voice of the people in communities to be heard. The charter set out clearly a person's rights to care within the health service, and the standards of service which the Government intended to see achieved (MOHCW & CCZ, 2006). Currently it appears no study has been carried out to ascertain the impact of the charter which is a very important step to take.

(Moneti, 2004) Speaks to the importance of empowering communities to take collective action in health in the form of information campaigns and other educational activities. In some cases, it takes the form of working with health service providers to assure availability of essential drugs at the health centre a measure that is beneficial to members and non-members alike.

3 METHODOLOGY

3.1 Study Population

As this evaluation is related to women's health issues in general the population of the evaluation included the following: health services providers and users; general population of community members who are mainly women; hospitals and clinics as objects of observation; elected and appointed district officials in Makoni were involved in the discussions about addressing women's health care issues, health leaders, traditional leaders.

Stage	Women	Men	Total
Co-initiation	19	4	23
Co-sensing	40	9	49
Presencing	74	12	86
Co-creating	21	6	27
Co-evolving	20	2	22
TOTALS	**174**	**33**	**207**

The sample was purposive and on a volunteer basis for selecting women in the areas as well as purposive sampling of relevant stakeholders. At each of the stages of the meetings, the objectives of the evaluation were shared by the researcher in order to guide the discussions for quality outcomes. The total number of participants reached was 207(174 women and 33 men) including stakeholders from both wards.

3.2 Methods of Inquiry

3.2.1 U-Theory

The evaluation methodology included five steps as follows:

1) *Initiation*, prioritizing local issues, planning component facilitated by WIPSU staff with participation from a small diverse team of senior officials including the District Administrator, health leaders from the District represented by the District Nursing Officer, community traditional and political leaders and community members;
2) *Collective Learning* process facilitated by the WIPSU staff and led by a diverse, committed team of approximately 20 – 30 participants (e.g., councilors, Village health workers, traditional leaders, women, men and youth);
3) *Reflection* whereby team members reflected individually and together on what they had learned;
4) *Collective Action Defined* where by the evaluation team identified cost-effective community initiatives to address one defined and measures to monitor effectiveness put into place;
5) *Action Evaluated and Refined* (The Presencing Institute, n.d.)

Relevance of the U-Theory in relation to the Evaluation Questions

1. What are the priority women's health issues in Makoni District of Zimbabwe in general and particularly in two target sub-regions which are Wards 12 and 22 (where WIPSU is currently working and has a signed MoU with the local authorities).
2. What are the supply and demand side barriers to addressing the identified priority women's health issues being addressed in the evaluation project and what are potential catalysts for advancing solutions through government-citizen partnerships? What are the barriers and catalysts to government-citizen engagement related to the identified women's health issues addressed by the evaluation process and what are the skill sets, logistics and other variables that could be put in place to empower politicians with capacity to successfully seek information and facilitate collective local action for change related to women's health issues

Guided by the Research questions, the Theory U methodology allowed for the priority health concerns to come from the women in the communities themselves. It further allowed for engagements that were not normally experienced by both the government and the citizens themselves thereof strengthening the relationship between the two. Theory U allowed for in-depth discussions and the opportunity for the key players to come up with their own solutions to the problems and act as catalysts to the advancement of their needs together with the local leaders in the Makoni District.

3.2.2 Analytical framework

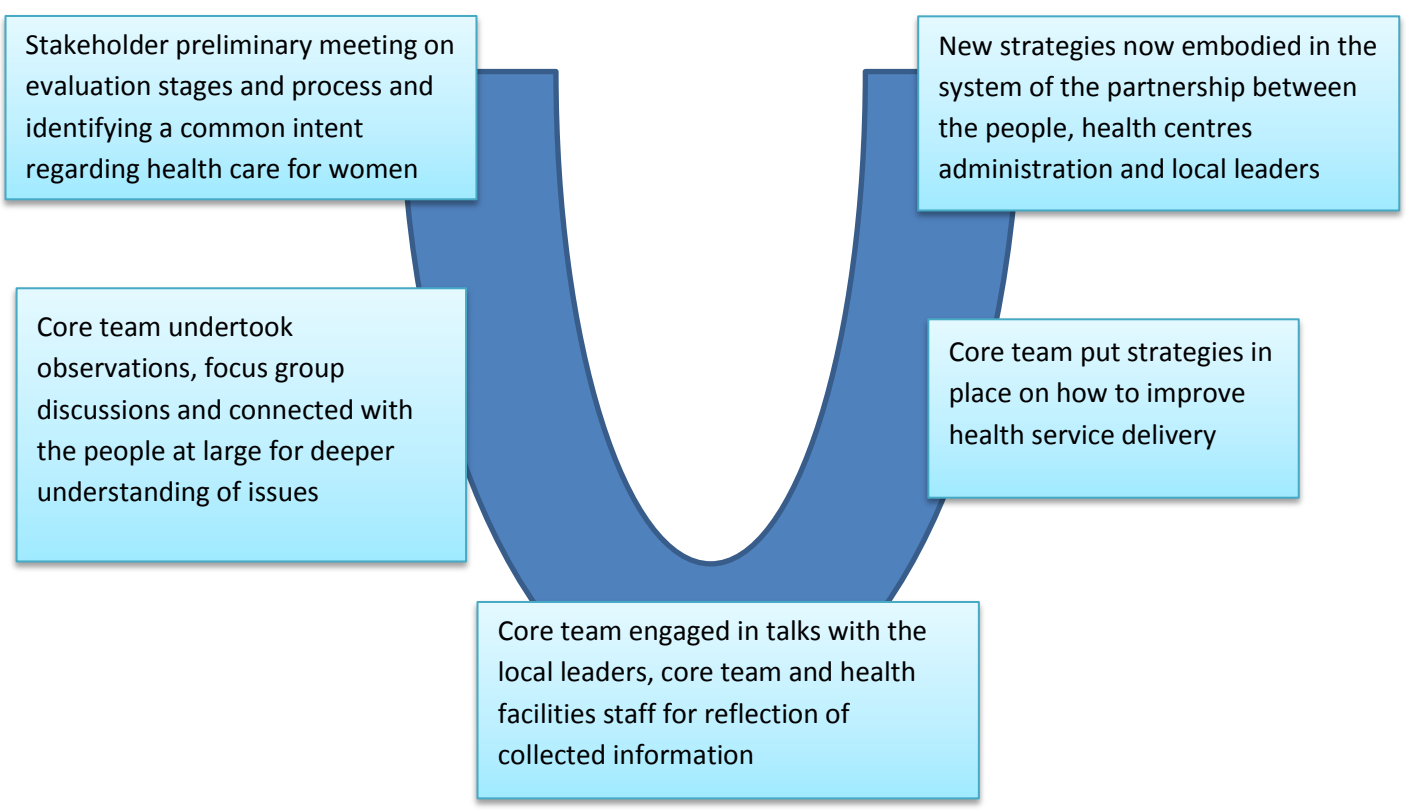


Figure 1: Theory U process in Makoni

3.2.3 Data Analysis

The outputs from the data collection processes were the core group collected information from the health centres official, this data was harvested in different ways where it was done through presentations by team members as well as taking relevant information for confirmation by the relevant authorities. Data collected was used for the evaluation team alone, to inform discussions and ideas about potential solutions. Data and reports are NOT formal and will not be public information at any time.Information sharing was limited to persons participating in the evaluation process as the focus was to develop a prototype initiative among the participants only.

However, summative information and reports will be provided as a part of the presentation of the change initiative, as a justification and will be shared as a part of larger stakeholder dialogue and further refinement of the change initiative.

3.2.3 Data Management

The findings outlined in the document stem from a variety of sources. A major source is the field experience, observation and analysis by WiPSU working directly with communities, local administrations, religious and traditional leaders as well as the government. Data collected was managed by WiPSU, as well as the storage of all information, was at WiPSU under the supervision of the principal investigator. Information was kept safe and locked up and was only be made available to relevant persons. No names were recorded when collecting data so as to stick to the ethical considerations of maintaining privacy and anonymity.The consent forms made it clear to the participants to avoid breaking the oath of privacy.

The information gathered through direct experience was complemented and validated by data collected in the course of this assessment aimed at drawing lessons and informing future programme development in the area. After reviewing the results, and the core team agreed on the go-ahead to publish the evaluation report, the data collected may be kept for an extra six months to a year in hard copy then destroyed. Soft copies will be backed up by the security system of WiPSU and safely coded.

4 Findings and Analysis

4.1 Priority women's health issues in wards 20 and 22 of Makoni District

The first two phases of the Theory U process, co-initiation and co-sensing processes, led to the priorities health concerns coming out.The beginning of the exploration process with the first meeting being set up and held in Rusape with the 2 wards combined was the Co-initiation stage whereby a small group of individuals who were involved in the action evaluation processes, gathered together to discuss the priority issues. There was need to concentrate on where the focus of learning and action was and some

of the key data points. This was the "core" group established and consisted of 20-22 members consisting of senior officials, health leaders, traditional and local leaders and community representatives.The core group managed to arrange four meetings with the communities, the councilors, local leaders and the VHWs for the period of 4 months that the evaluation was running. However the addition of more stakeholders at this point was considered as the exploration and evaluation continued.

The initial co-initiation meeting held in Rusape raised both supply and demand side barriers to women's access to health services in Makoni wards 20 and 22. However, this initial process seemed to not fit in well with the level of discussion at hand as the participants were quick to share their thoughts. It should be noted that the process of stillness is a method that is not a very effective one at the grassroots level. The researcher decided to redo the co-initiation in both wards before the co-sensing started with a minimum of 20 participants in each ward with the core group participants being part of the teams in order to introduce other methods of collecting more information from the participants. This time the groups involved members of the community both male and female. Interviews were held with key informants who were some of the village health workers, health personnel at the centres, councillors and a few selected members of the public. The village health workers raised concerns of being sidelined by the health personnel in the instance where they need to find out information and they are not assisted. They also raised concerns about the health issues being faced by the people in the communities whom they visit and see all the time.

Regarding the process of how problems and community concerns with regards to the health services were concerned, it was apparent the participants did not know how to raise their concerns and to who. One of the participants said

> *"When it comes to the problems we face in the villages, we do not know who to tell because we do not know at what platforms to raise these issues and what the repercussions will be of raising issues. What is I am then victimized*"

This clearly brings out the concern of participants not being aware of their rights and the process of policy making. Following interviews and focus group discussions during the presencing, co-sensing and co-creation phases, there emerged pressing women's health issues in the Makoni wards 20 and 22.

4.1.1 HIV/AIDS

Stigmatisation of people living with HIV/AIDS was noted as a concern by the village health workers as well as the core group as a whole. In as much as there have been educational community meetings and awareness raising activities in the wards by the Ministry of Women Affairs Gender and Community Development and an NGO called FACT Rusape, stigma around HIV/AIDS is still not yet dealt with completely. The participants attested that women do not want to go and get tested and in many cases men are getting tested on their own and not informing their wives. Some are said to be taking the retroviral drugs in secret and women continue to wallow in sickness without getting any medical attention.

A female participant said:

> *"Men discuss these issues at the bars and go to seek medical attention in secret. As a woman I will be scared that if I go and get tested and the results are positive, telling my husband will be a difficult thing. He may even blame me and ask me where I got the virus from. I don't want to be humiliated and made to look like I have been having extramarital affairs".*

In the cases of pregnant women, it is now required that every expectant mother get tested for the HIV and if she turns out positive is started on treatment immediately in order to protect the unborn child. Women in Makoni are required to bring their spouses but in most cases the partners/spouses decline. In some cases, because of fear and stigma, the women do not come out in the open to their partners for fear of being physically harmed or divorced.

4.1.2 Cervical and Breast Cancer

The participants stated that ahigh percentage of women were diagnosed with this ailment in the later stages or some cases when it is already too late.

> *"Most of the times we are not aware that we have any form of cancers in our bodies. We are too busy working in the madhumbe and tobacco fields to feel lumps in our bodies. It is only after it has incapacitated you or after you are too weak to work that some of the women find out they have cancer. But by then it is too late"*

The use of traditional medicines in order to increase the sexual appetite for their partners/spouses was said to have an impact by the participants during this evaluation.

> *"As women we are expected to keep our bodies warm in order to satisfy our husbands, so in order to do this, we stick some natural herbs to maintain and increase the warmth in our bodies and some of them maybe roots and some medicines we put on clothes and then we inset in our private parts. We do not know the impact these herbs have on our cervix but these are acts our great grandmothers used to perform before we were even born" said one woman.*

In some cases it is said women do not want to be attended specifically with issues that have to do with their private or sexual organs for fear of being labelled or stigmatised.

> *"I'm sorry but anything to do with my private parts apart from giving birth makes me feel ashamed and uncomfortable. I'm sure many women are like that in the villages so I would rather suffer discreetly".*

4.1.3 Maternal mortality

Women are dying while giving birth and during the first month of this evaluation there was a reported case of a young lady who had died.

> *"I know of a young woman who died just last week at the clinic and she was buried 3 days ago"*

.It is said by the participants that the pregnant women opt to wait until the last minute to seek medical attention when labour pains commence for the reasons of not wanting to stay at the clinics for a while due to the treatment, as well as the fear of being transferred to the District Hospital which needs the extra money. Giving birth at the local clinics in Makoni District is free but a payment is needed when one is to be transferred to Makoni Rural District Hospital.

Due to unavailability of the ambulances at the clinics, one has to be called from Rusape so in most cases people have to hire cars from neighbours who will charge as they please. Some women are said to be dying due to giving birth in their homes and not attaining adequate medical attention. Discussions with the clinic staff revealed that due to the inadequate number of staff at the health centres, it was difficult for one nurse to attend to 2 to 3 patients at the same time.

4.1.4 Prenatal care

Due to lack of knowledge and multiple roles of women, prenatal care is trivialised in Makoni. Respondents highlighted that some of the women ended up suffering miscarriages due to lack of knowledge that the medical visits are important.

> *"As women, we have many duties in the homes and going for pre-natal care visits will impact on the expected chores at the homestead," said one young woman.*

The village health workers further emphasised the relevance and importance of prenatal care with their major worry for the young women in the area. During the visits in homes by village health workers, they cited the challenge of too many chores by the women as well as the lack of knowledge as to what extent this can go in helping the unborn child and the mother.

One village health worker added

> *"there are now so many school going age girls falling pregnant and obviously they will try by all means to hide the pregnancy and they do not acquire the prenatal care they need. With some of them you can only tell they were pregnant when she gets into labour. It is really depressing, and we now need maybe outsiders to come and teach these young women the importance of prenatal care because they do not listen to us. Maybe different voices will help".*

4.1.5 Cultural practices post natal

There are cultural practices that are done after a woman gives birth, and one of these is called "*kuvhuranzeve"* meaning the new mother engages in sexual intercourse with her partner before the initial six weeks has elapsed. The participants in Makoni described the cultural practices as some of the problems women have to face as it is all said to be for the good of both mother and child. Because the district is a patriarchal one, women are subjects under their husbands. Makoni wards 20 and 22 are in the Rusape area in the Manicaland province, and the people found there were called VaManyika who believe in strong family relationships and respect for the husband who cannot be disagreed with. Normally according to the medical advice, it is advisable to wait for 6 weeks after giving birth to give the new mother time to recover from the act of labour that strains all muscles. In most cases, women get stitches from rapturing while in labour, and if intercourse takes place it means the stitches get undone.

However, due to the new constitution which the communities have become aware of through WiPSU's other empowerment programmes, the women in the core group have been working on educating and spreading the constitutional provisions which speaks to all customary practices and traditions that infringe on women's rights being void. The women are teaching others about their right to reproductive health rights also enshrined in the new Constitution. Interestingly, because the core group comprised of males, some of them have started championing this cause of raising awareness on the detriments of such cultural practices as "*kuvhuranzeve*". The communities are took action on this issue and have made it one of their advocacy issues in light of women's access to health.

4.1.6 Referrals to Rusape hospital

Any type of referral to Rusape hospital means payment. During this evaluation, it surfaced time and again that any financial cost to do with seeking medical services is very limited, and the charges are not available for the villagers. The participants further added that being referred to Rusape Hospital means paying an arm and a leg for the as the financial aspects will include transport, for not only one person but the accompanying two or three other family members, the medical charges for the patient herself and in some cases looking for accommodation. What the participants often do in such situations is commuting from the rural areas to the hospital should the patient need admittance for further medical examinations and care. Participants further reiterated that they would rather turn and go back to their homes and wait to get better or die there because there is also another cost associated with transporting a dead body should the worst happen to the patient after being taken to Rusape.

4.1.7 High blood pressure

This is one of the most recorded non-infectious diseases in Makoni affecting the women as the women stated how this was one of their biggest worries. The participants noted that their main problem was on the cause of high blood pressure as they do not have access to information on this particular problem. When one becomes privy to information on the causes, it will be easier. Participants added that the number people who are aware of their high blood pressure status is usually low since the condition is often without symptoms. Likewise, of those who are aware, a small proportion are on adequate treatment and control. In most cases, the participants attested to poor compliance with treatment due to forgetfulness as women have multiple roles that have been socially and biologically constructed

4.1.8 Un-availability of Pre-term baby machines

Participants noted that when a pregnant woman's labour is offset before the full term of the baby, there are no machines at the local clinics to cater for the newborn's necessities as there is need for incubation.The women stated that young mothers especially teenagers were more likely to suffer complications, furthermore, due to the distances to travel to the health centres; young mothers may get there with ruptured membranes. However, this was not only said to be limited to young mothers. In these cases if the baby is delivered before full term, there are no incubator machines to assist in the upkeep of the child to the time when they can breathe or live out of the confined and highly monitored environment. The participants showed their worry as this often leads to less favourable health outcome or even worse.

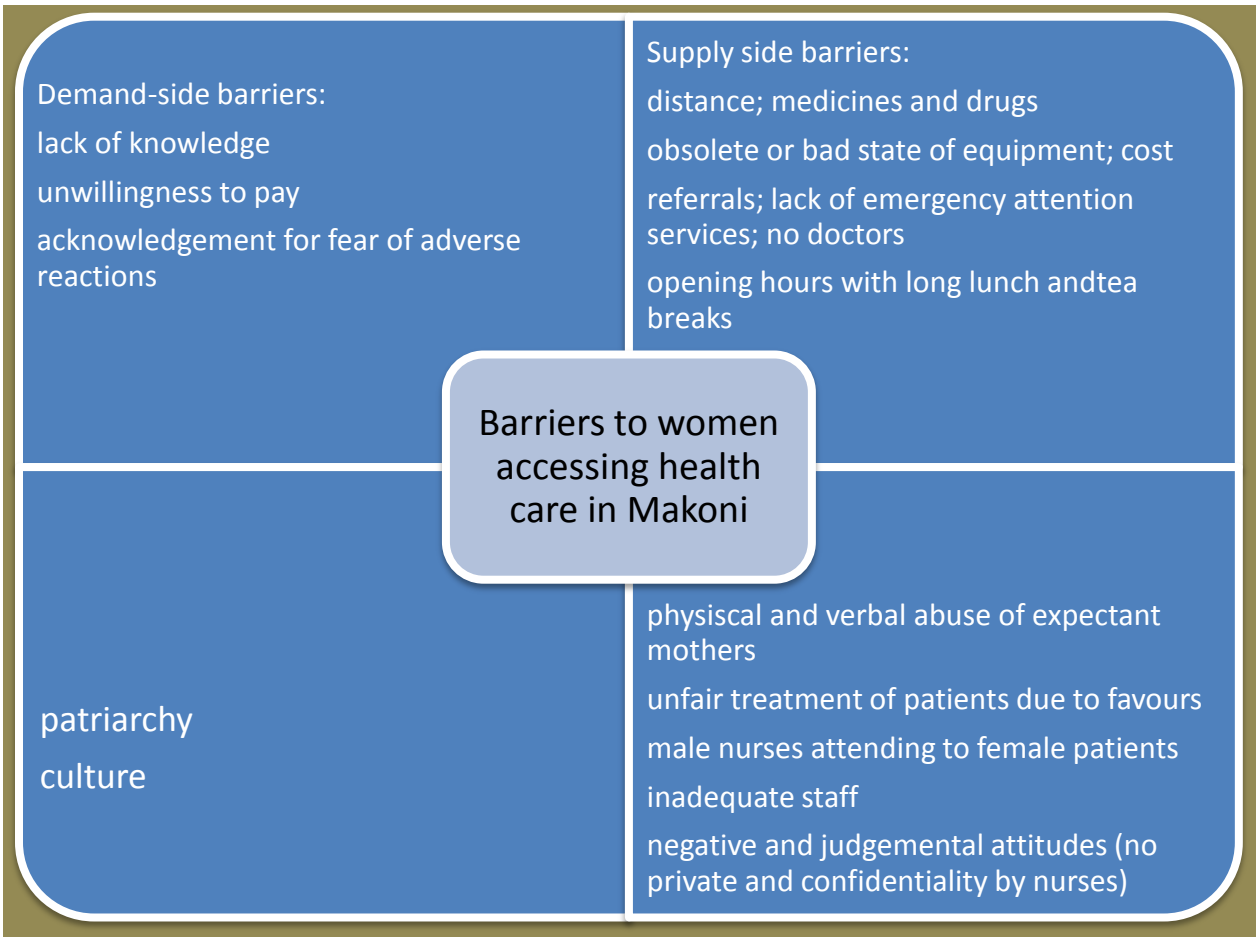
4.1.9 Un-availability of Tetanus and rabies vaccines and storage

At the moment, there is an outcry of the rabies virus due to stray dogs in the areas. Because there are no fridges to keep the vaccines, they are not easily available, and the issue of referrals plays in once again. Because the two wards have no electricity at their health centres, they cannot store any form of vaccine at the health centres which needs refrigeration. In times of emergency with challenges such as being bitten by a dog or being cut by a metal object, the participants stated that the process of getting the vaccine is difficult as they have to travel to Rusape at times. The fact that there are no fridges automatically means vaccines are never readily available for the community members.

4.1.10 No infant vaccines

For the same reason above, there are no vaccines for babies and infants due to the issues to do with storage. Vaccines for babies come on certain specific days and mothers have to be notified on the tie of the days that these vaccines will be received. Therefore, this means that, vaccination for babies is done on a particular day for all babies in the area and participants noted that these causes them to lose the whole day waiting in the queues for their babies to be vaccinated. This however, impacts on the multiple roles that women undertake in their homes.

4.2 Analysis of supply and demand side barriers



In order to find out from the participants what their main issues and concerns were, it was important for the researchers to ask questions during the focus group discussions and these questions were:

a. What are the barriers to accessing health for women in your area?
b. What are the state of the health service centre and the service offered?

Definition: Demand side barriers are factors influencing the ability to use health services at individual, household or community level.

4.3 Demand side barriers

4.3.1 Lack of knowledge

Information and awareness were said to be critical elements for the uptake of medical services available to the participants. The respondents cited the lack of knowledge on the importance of health seeking.One woman said, "*I only go to the clinic when I cannot perform chores, otherwise as long as I feel strong I will not visit the clinic*".The unfortunate outcome can be the continued toleration of illness and disease.Participants further cited the unwillingness to pay for health due to lack of knowledge of the women did not know what was important in their lives.Recognition of illnesses like breast cancer and cervical cancer and the potential benefits of treatment are prerequisites for health care demand.The respondents spoke to the importance of knowing what to check for when one is not well and when to seek medical attention. When a large proportion of the womendiscuss, in general, how they are feeling when fetching water or going to the fields, this becomes the norm and illness is not easily recognized. One quickly realizes because she is not the only one feeling that way then it should be a normal problem.

4.3.2 Culture

The female participants unanimously stated that cultural norms can prevent women from seeking health care outside the home for themselves and their children. The use of traditional medicines is still being favoured by the communities for giving birth as well as acts of *kuvhuranzeve* whereby the new mother has to engage in sexual intercourse just after giving birth, which is not encouraged by health practitioners. Such restrictions alsointeract with other barriers. The respondents articulated that it was culturally unacceptable for women to leave theirhomes for long periods, or it reflects less access tohousehold resources to pay for transport.Low demand for modern health interventions often derives from deep-rooted attitudes thatreflect culture and social norms in the Makoni district. One exampleddiscussed by the core group is that communities continued the preferences for traditional overmodern therapies. Since Makoni is a rural area and rural areas in Zimbabwe are where the traditional aspects are rooted, communities find it difficult to switch to new ways. However, the fact

that use of traditionaltherapies generally declines with issues like income andeducation submits that social norms are not sacrosanct.The participants highlighted that within the communities, those who have been exposed to education understand the importance of seeking health care at health centres and the opposite is true. Therefore, the observance of norms was said by the respondents to be influenced by the socioeconomic setting.

4.3.3 Patriarchy and gender issues

Gender attitudes and roles were particularly more prevalent during the discussions as important determinants of health-seeking behavior of the women in the community meetings. The women spoke to the challenges of raising access to maternal, reproductive health problems to their husbands within the society that may somewhat restrict the public lives of women. It was apparent that the utilization of prenatal care increases with the control a woman exercises over household finances although it remained a moot point. Again, the social is not completely divorced from the economic; it showed unequal control of resources within the homes. The man as the head of the house and the one who makes decisions mainly to do with the main use of finances in the come despite women spending most of their time in the fields planting tobacco and *madhumbe*.Consequently, gender inequality in the Makoni district and women's low social status and disempowerment relative to men significantly impact women's health, the health of mothers and overall demand for maternal healthcare services.

4.3.4 Male nurses attending to female patients

Eight women raised concerns of some of the nurses being of the opposite sex and they do not feel comfortable opening up to someone of the opposite sex on issues regarding their health with particular focus to sexual and reproductive health. This was further supported by a village headman in the core group who elaborated on the sacredness of the African tradition and the respect that comes for one's wife. If a woman is married, it will be unthinkable for another man to see her naked. The awkward feeling of a man attending to them especially regarding sexual and reproductive health for women was out of the question. Culturally, the women believed only your husband should see you naked and no other man.*"if I get sick and a male nurse attends to me, it may cause problems with my husband. He may start thinking I am having an affair with the nurse. So I think it is safe to not be attended to by male nurses at all to save my marriage".*The cultural barrier isoften raised still further when men provide services, and was offered by the respondents as one reason why the women living in the countryside often make little use of health services as they stated.

4.3.5 Fear of the unknownand stigma

HIV/AIDS has been seen to be a "disgraceful" ailment in Makoni with people shying away from necessary treatment, care and information precisely to those who need to be tested for HIV, acknowledgement of results by one as well as fear of the unknown in terms of what the results will be and how to move forward. Participants reported that fears of HIV testing; fears of involuntary disclosure of HIV status to others, including spouses; and HIV/AIDS stigma are among the reasons that women avoid delivering in health facilities or accessing any other health care service. For those who have been tested and have come out positive, the women fear and are uncomfortable in queuing up for the antiretroviral drugs which are given at the health centres on specific days. Some of the women end up

dying due to this. This was reported to not only affect women but men as well. "*No one wants to be seen in the queues. We all know that that in this ward, ARVs are given out to people twice a month with one group getting their medication mid-month and the other group end of the month. And the day they give out ARVs is on a Tuesday, so it is automatic when you see someone in the queue at the clinic they are infected with the virus",* said one respondent with the in agreement.

One participant mentioned that "In our Manyika culture, a daughter in law if seen sitting down and not doing anything is considered lazy". Another said "when our sons marry, it means they are bringing helpers at the homestead, so these young women should expect to work tirelessly should they choose to get married".

4.3.6 Multiple roles

Due to the socialisation of gender roles, women undoubtedly undertake a lot of tasks and duties around the home and away. More reasons were given which stated that some women do not seek health services due to pressing household chores which include child bearing and caring, cooking, cleaning, laundry and all other around the home chores. Women are also known in the Makoni area to be the ones who are found in the field planting tobacco and *madhumbe* which are the main agricultural products planted in that area. Therefore this means time to be able to attend to health issues may be limited. The young mothers were also said to not able to go for ante natal care because in the tradition, once a young man marries and a new wife comes to the homestead, she is expected of carrying out a lot of duties which may take up most of the day thereby limiting time to go for antenatal check-ups. One respondent went further to say that

"when a 'muroora' comes to the home, she becomes the mother of everyone so she needs to make sure everyone has eaten, bathed and has clean clothes to wear"

4.3.7 Cost and availability of resources

The issues of cost and availability of resources to be able to pay for the services were limited. There is much evidence through the discussions to suggest that distance to facilities imposes a considerable cost on individuals and that this may reduce demand.Cost is a key factor accounting for the low rates of utilization of maternal healthcare services among women especially in the rural areas like Makoni.

> "*From my garden I may be able to sell vegetables making $2 a day on average, but also have costs within the home with a loaf of bread costing $1 and a bundle of vegetables 50cents. Where am I supposed to get extra money to go to the clinic? I would rather feed my family that go and get checked and leave my children hungry*" said one respondent with the other women in the group attesting to the same predicament.

For women seeking maternal health care, costs include those for facilities and services, and involve both formal and informal fees, the cost of drugs and equipment, transport to a hospital or clinic, and the opportunity costs of getting to a health facility and receiving care. Formal fees ($35-$50 in case of

emergencies in the Makoni area) often take the form of user charges that accrue at the time of service and are typically financed out of pocket for the expectant mother. Informal fees ($1) are unofficial payments for airtime to call an ambulance if there is need to transfer the patient to Rusape Hospital andthat may have to be made even where services are nominally free.

4.4 Supply-side barriers

4.4.1 4.2.2.1 Inadequate staff

Definition: Supply-side barriers are aspects inherent to the health system that hinder service uptake by individuals, households or the community. Services at health centers are determined by the health facilities and ultimate responsibility for the performance of a health system, including ensuring access for the poor and vulnerable, lies with the respective government

The shortage of nursing staff at the health centres was reported as an important issue that needs addressing. One nurse at one of the health centres noted that even though there had been one addition to their team, they were still not enough nurses and they needed 2 to 3 more. There were also allegedly no doctors at the clinics that service the wards,therefore that problem elevates other problems of delays in being attended to by the staff and referrals for emergency complications.

> "*We have no doctor at the clinic, if only the Government could supply a doctor who comes even once a month it would help*" said one male respondent.

Shortages of skilled and professional health workers are also reported in the Makoni areas under evaluation. This was an issue from both the supplier of services who are the health centres and the patrons themselves. One respondent of the core said

> "*I am a nurse by professions and I live here in Makoni, but due to the freeze on posts I have to keep waiting. I wish I could get permission to go and lend a hand at the local clinic because I finished my studies but I am sitting at home doing nothing. I cannot be employed in my area to help the people in my area*".

4.4.2 4.2.2.2 Distance and Infrastructure

Location and distance costs are often seen to negatively impact service utilization in Makoni. A study in Zimbabwe, suggested that up to 50% of maternal deaths from hemorrhage could be attributed to the absence of emergency transport (Fawcus, 1996). The Access to Health Care Services Study found that most communities live within a 5km radius from their nearest health facilities, whilst 23% live between 5 to 10 km and 17% are over10km from their nearest health centre (Makuto & James, 2007).At the same time, distance was also cited as a reason why women choose to deliver at home which was said to be detrimental to the health of both mother and child by the participants rather than at a health facility with some women travelling between 9 and 14kms to the nearest Clinic. Due to the long distances

travelled, the community women from the Epiphany area in ward 20 requested that a clinic be built in their area.

> *"We have to walk long distances to the clinic and when you are not well it becomes difficult so you rather choose to stay and die at home than on your way to the clinic"* said one woman.

Complaints of of bad roads and bridges especially in bad weather conditions were noted as a hindrance especially during the rainy season on top of the distance matter. One woman retorted that

> *"We recently had an ECD child swept away by the rains due to the bad bridges and those same bridges are our only way to the clinic except f we go via Rusape town which will cost me up to $8 one way, which is money I don't have".*

Transport costs are high mainly because distances are great in the rural areas of low-income countries where the poor are concentrated, and road and transport infrastructure are in such a poor state.

4.4.3 Unfair treatment of pregnant women

Pregnant women at the health centres are made to bring and wash their own linen after giving birth which is a form of physical abuse as noted by the participants. When a woman gives birth, her body is not yet strong enough to perform any duties that require energy hence the giving of 6 weeks resting time in order to give the new mother time to heal. The female participants felt a relief and appreciation when a male participant added that:

The health personnel were also said to be verbally abusing pregnant women who then opt to use traditional methods for delivery or rather go to the health centre in the advanced stages of it. A village health worker added that "*there are a lot of women in the villages who are assisting in giving birth and the young women prefer to go there because they do not want to be constantly told harsh words although they know it is dangerous*".

> *"When a woman gives birth, how can they be expected to do their own laundry? I remember used to help my wife during her child bearing age days with laundry and cooking because she will be in pain and in recovery mode. That is plain abuse!!"*

4.4.4 Opening hours

The problems regarding the absence of nursing staff on public holidays was raised with one participant mentioning that *"sickness does not care if it is a public holiday or not, it attacks anytime of the year".*

Further to that the opening hours of the health centres are not adhered to by staff because sometimes the nurses choose to open late and religiously take their tea and lunch breaks no matter how an

emergency a situation has presented itself. The nurses were said to have a tendency to extend their stipulated tea and lunch break. Another participant added that
"Lunch hour is between 1 and 2pm but when the nurses go for lunch they go for more than an hour at times. So all we do is wait until they come back to open their doors." said one young lady who was sitting in the queue during a visit by the core team to the health centres.

Official opening times at the health centres are 8am, tea break from 10 to 10.30 am, lunch break from 1 to 2 pm and closing time is 4.30.

Due to lack of electricity the health centres cannot cater for emergencies at night as it will be too dark to attend to patients. Electricity is an essential part of a health centre due to certain medications in need of very low temperatures for preservation. The core group that comprised of community women and village health workers from both wards all requested for this to be a priority issue for the councillors to push for in Council for a speeded resolution. One mad narrated his concern when his grandchild was beaten by a dog, and Makoni being an area on high alert of rabies, he quickly rushed his grandchild to the clinic but could not be assisted as he did not have a letter from a Veterinarian and it was a prerequisite for the child to get treatment. He did make efforts to get a letter from the Vet, but the Vet had closed by 6pm and asked the man to return the following day. Meanwhile, the clinic also closed at 6pm. He resorted to rushing the child to Rusape General Hospital costing him more money. However, the councillor took the issue up with the Vet and suggested that there be 2 or 3 Vets in case of emergencies like these.

Apart from electricity, there is no clean water at the clinics. The women in the core group agreed to start up nutrition gardens at the clinics but due to lack of water, this project has not thrived. "*We have our manure and seedlings, but we don't have water. If only we could get boreholes sunk at the clinics to ensure that access to water is provided*" said one participant. One of the nurses at Nyahukwe clinic agreed with sentiments of the importance of water for the nutrition garden for the waiting mothers so that they are able to eat fresh vegetables. "*The women of this group are doing well, and they need the support they can get to boost this garden".*

4.4.5 4.2.2.5 Referrals

Patients are referred to Rusape General Hospital when the local health centre is not able to attend to the patient due to the state of the problem at hand. With regards to pregnant women in need of urgent emergency attention like the caesarean operation, the local health centres are not able to facilitate this hence the referrals. One expectant mother when asked said, "When coming to the clinic I have to come with $53 just in case of emergencies, and I have to be rushed to Rusape". The $53 was said to cover if need be, transport costs as well as delivery costs and with $1 used as airtime or phone credit to call for an ambulance. However, it should be noted that, this amount is only used when an emergency arises otherwise if all is well and delivery is normal, all services are free of charge. Referrals to Rusape hospital a problem the patrons would try by all means to avoid, and this hinders the access to health services by women due to the need for money to pay for transportation. The costs of emergency care in the event

of obstetric complications can be even higher. Thus, for many poor women, costs can be prohibitively high and prevent them from getting the maternal health care they need.

With continued discussions with participants it surfaced that pregnant women who now are required to register for pregnancy with their husbands present, end up not doing so due to the fact that the husbands do not seem to think it is important. *One pregnant woman retorted that "my husband said you can go and get tested, if you are negative or positive then I know my result, so there is no need for the two of us to go together".* The health care givers request for both husband and wife or both partners, but they end up not registering early and on time due to continuous delays.

4.4.6 4.2.2.6 Equipment and drugs issues

Further discussions regarding the equipment necessary for the rural health centers, the participants unanimously agreed that the medical equipment at the health centers critical for diagnosis and treatment is antediluvian, non-functional or none at all. There is no machinery for x-rays that the community women stated as a crucial tool as Makoni is a farming area, and a lot can go wrong in the fields. Because Makoni is a rural area, there is a high number of the elderly in the area and participants raised concerns of eyes scanning or teeth attention machinery as well as machinery for uterus checks not being found at their health centres. Beds were also noted to be in shortage with the need to add 2- to 3 more beds at each of the health centres visited.The majority of the physical health infrastructure is in a state of very serious disrepair. One participant added that *"Right now you can get checked for high blood pressure but there are no x-ray machines. This is a rural area and our children herd cattle. A lot of them come back hurt from playing during cattle herding but it is difficult if one gets hurt, and we cannot get their broken fractures checked"*.However, by the end of this evaluation there had been an addition of beds to the health centres with new mattresses comfortable for the expectant mothers.

The expecting mothers' waiting homes needed refurbishment and equipment to be suitable for waiting mothers and effort as stated above were made in that regard although not in totality. The health centers are unable to undertake the most basic operations because of shortages of anesthetics and other essential supplies. *"Because of the state of the mothers' shelters, the young mothers are opting to go to the clinic when labour has started already so that they do not spend much time there. This however is actually hazarded to the expecting mother and her unborn child as anything can happen on their way to the hospital."*

The problem of drugs shortages was reported throughout the evaluation from the beginning to the end. It is still a challenge as the problem of drugs shortage is a nationwide problem. The clinics receive medication, but it is reported to not be enough to serve the people in the communities. *"In this ward, to get treatment and medication is free, but we are also facing challenges of those people from the neighbouring ward 18 who are meant to use Nyagumbo clinic that charges to treat people. In that regard, once the medication is delivered at Rugoyi, the people quickly rush and get free medication therefore creating shortages for people who are intended to benefit from our clinic"* said one community member. Nevertheless, during one of the visits to Rugoyi, a woman from Ward 18 denied the issue of people from outside wards getting medication from the clinic as they are asked which village they come

from. However, the majority of the community members dismissed her claim. With more discussions with the health service providers, the outcry was the same that they do not get enough medication so at this point it is beyond their control.

4.4.7 Quality of health care service by staff

Poor quality of health services was cited as a major problem in the wards. There was reporting of the absenteeism of doctors completely with no single doctor in both wards. The participants went further to request for a doctor to be deployed at least once a month on a particular day if they cannot get a resident doctor and this was taken up by the councillors who will in turn take it to the relevant authorities. A challenge raised for having a resident doctor was an issue raised above of electricity whereby for a doctor to attend to people and get to the extent of being a resident doctor, he needs electricity at his place of residence.

There were further allegations by the communities that due to staff pilfering of free medication like the paracetamol although the nursing staff sticks to the inadequacy of medication provision by the government. Deficiencies in quality have direct implications for access to effective health care.Nurses were alleged to be practising favouritism offering services to those whom they are related or who perform favours for them e.g. bringing them food from homes.

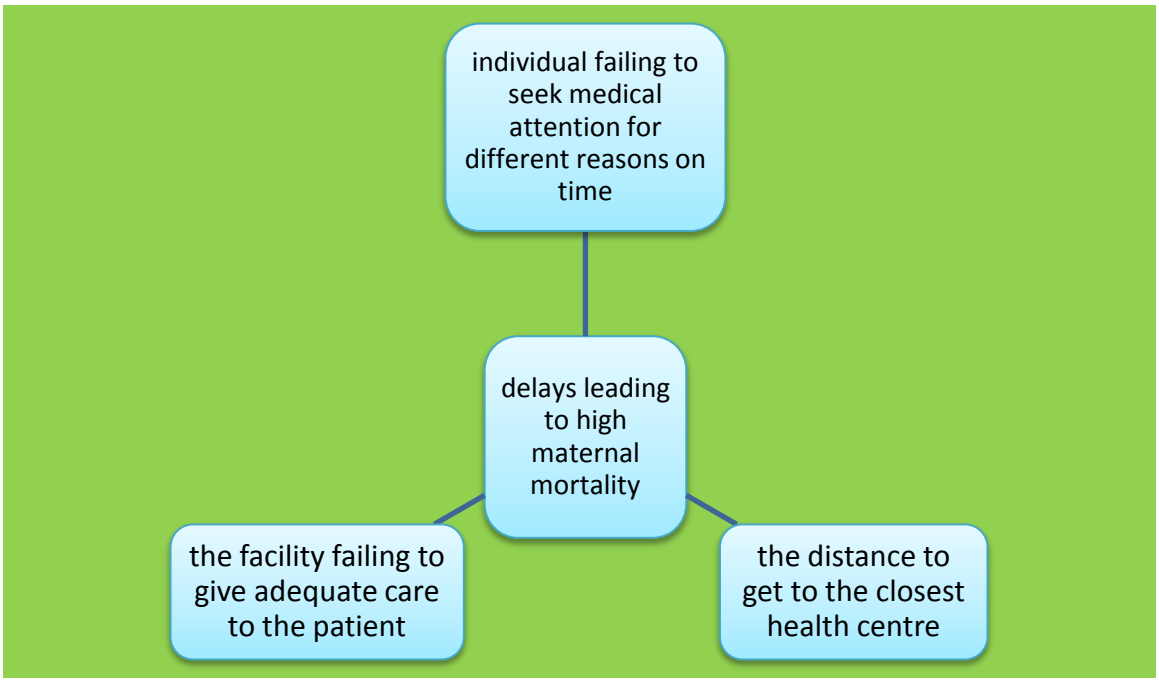
> *"I remember standing in the queue for almost the whole day with some people who came after e being served. When my chance came, I was told that they were out of paracetamol and had to purchase it elsewhere on my own. The man behind me who is known to the care giver was served and given paracetamol tablets. It was only after I had raised this alarm of favouritism that I was assisted and helped with the tablets"* said one participant.

Another participant added that when she went she had to pretend to be taking down notes for her to be noticed.

> "*I went there faking writing down notes as if I was assessing the work the nurses were doing, as soon as they noticed this I was given first preference to be treated as they were not sure where I was going to take the information to*".

Access is hindered due to the selective attention of patients and those who skip the line owing to favours by health centres personnel. Negative and judgemental attitudes by nurses towards patients treating them with no respect were a serious issue also noted during this evaluation. There were moreover issues of nurses not sticking to their code which speaks to handling patients' issues in the private and confidential manner. *"I am sacred to go and get tested for HIIV because if my result is positive, I know the whole village will know in no time. The nurse will tell their close friends that 'ndiripachoringwa'*

Furthermore, one expects that demand will diminish in response to the poor quality of the care offered. Low quality of public primary health care can result in patients forgoing ("bypassing") care at the nearest facility and seeking care at a higher level public facility or in the private sector.



These demand and supply-side elements cause the three serious deferments of maternal impermanence and these are the failure to seek suitable medical attention in time by the patron, followed by the delay in getting to an adequate healthcare facility; and finally the delay in receiving adequate health care at the facility.

4.4.8 Catalysts to government-citizen partnerships

For a partnership to be effective there needs to be facilitators, promoters or pushing agents for the effectiveness of the partnership. In this paper, the catalysts referred to will be the people who facilitate and promote for effective and viable government citizen partnership. The clinic staff in ward 22 urged community members to seek medical services at the clinic as often as they can so that when they compile reports to Ministry of Health there is evidence for need of medication and equipment at the clinic. This government-citizen engagement keeps the government abreast with what is happening on the ground. At the beginning of this evaluation, due to the poor services at the ward 22 clinic community members were opting to use another clinic in ward 21 where there were better services. The outcry was that if there are less numbers of patients attended to at the clinic the records will show that there is no need for more resources under the Health Transition Fund disbursed to the particular centre.

Institutional catalysts such as the Village Health Workers together with the female councillors in ward 20 and 22 engaged in some discussions with the District Nursing Officer during her visits to the clinic and highlighted the concerns by community members, the process of meeting the clinic staff and the impact

thereof. The DNO has put in place measures to ensure that the services at the clinics improve including by firstly transferring the current nursing staff and bringing in new crop of nurses. However this is not a move that is felt is solely directly linked to this evaluation although there has been a direct influence therefore resulting in impact. This according to the community members has helped reduce issues of favouritism. One of the community members in ward 20 noted that, *'The old nurses were transferred to other places and now we are being attended by new staff members, we hope they will be better than the ones who left'.*

PHASE	Changes enacted
Co-Initiation	Identification and Knowledge of rights and fostering of relations among community leadership
Co-sensing	Active citizen participation and community dialogue and transparency
Presencing	Government-citizen engagement aimed at fixing the problem of conduct by staff
Co-creation	Collective action leading to efforts by community leaders to improve infrastructure like roads therefore accountability and networking
Co-evolving	Enhanced engagements leading to positive change in community attitudes towards access to health and changes in conduct by nurse to the patrons and enacting of prototypes

The general consensus amongst both ward 20 and 22 community members is that there has been a significant change noted at the clinics since the first engagement between WIPSU and the stakeholders which was held in Rusape. It should be noted that the commitment that the district nursing officer offered was remarkable. In most cases it was apparent the community members, due to lack of information did not know what measures to take or how to handle certain situations. But due to the engagement with the DNO, it was all spelt out.

> *One village health worker added that "meeting the DNO during the initial meeting in Rusape opened doors for our communities because she is a woman who understands and cares for the people at large. She has already started making changes with some nurses having been transferred and service already changing".*

Makoni rural hospital (Rugoyi) which is in ward 22 reported a steady increase in the number of women visiting the health facility. However, it also shows that during the time when the statistics were collected, because the evaluation incorporated the communities as a whole and did not focus on women alone as it had a gendered perspective of involving all stakeholders, there is recorded minimal increaseof men between the months of May and June and a sharp 100% between the month of May to July.

Month	Male	Female	Children	Total
May	100	242	200	542
June	112	250	300	662

July	200	288	300	788
August (statistics are up to 15th)	30	70	200	300

Common cases: flu, diarrhoea

Current changes: 3 nurses added to staff personnel at the clinic

Rugoyi Makoni Rural Hospital

Dumbamwe clinic in ward 20 shows a steady increase in the number of patrons attended to at the centre. It shows an almost 100% increase in the number of women attended to from the month of May to the end of July.

Month	Male	Female	Total
May	59	93	152
June	89	121	210
July	88	201	289
August	Unavailable statistics for August and for children attended to during the time period		

Common cases: Flu, skin diseases, back aches

Thereafter, in ward 22 the Village Heath Workers engaged the clinic staff together with the female councillor to discuss issues of concern from the community. The meeting revolved on complaints about the service that community members especially pregnant women, delays in getting service due to long tea and lunch breaks by clinic staff, favouritism and unavailability of medicinal supplies. One woman had this to say,

> *'I went to the clinic and the nurses were so kind to me, they gave me my prescription drugs and attended to me as soon as I got in the clinic, i thought i was a dream'.*

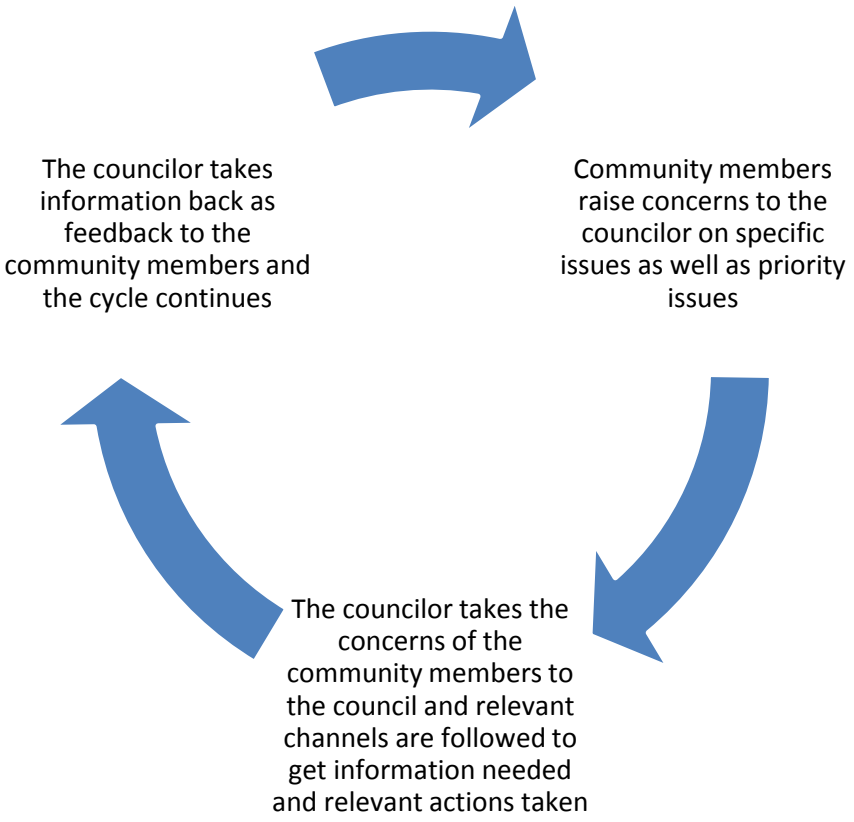
The clinic in ward 20 has also recognised significant changes as there has been acquisition of BP machines, diabetes and tuberculosis diagnostic machines as well as general clinic equipment.

4.5 Strategies in empowering politicians with essential information on health access issues and priorities

4.5.1 Increased accountability

Through the co-evolution stage there was more consensus bytheconstituents who were more and more demanding transparency and accountability from the councillors or rather political leadership. The communities became aware of the demands they could put forward to the councillors and the health staff in terms of their rights as citizens. This therefore is what led to the changes in attitudes, behaviours and working relationships. The leaders in turn became accountable to their deliverables especially for councillors who are the developmental leaders in the areas of social service delivery as they had to push forward and act on the concerns of the citizens. The government further cemented the relationship with the communities by listening and trying to attend to problems raised and made changes that were possible in a short space of time during this evaluation. It is a well-known fact that people in the

communities vote for an individual to lead them who is not only capable of leading but of delivering as well. One of the most important virtues a political leader should have is accountability and transparency. It is not possible for a leader to be effective in the eyes of the electorate if they are not transparent and accountable as they are answerable to the service delivery systems in the communities that's at ward level.



4.5.2 Participatory policymaking through community engagement

The major concern noted during the evaluation was the worry from communities and village health workers to the policy makers for policy making and mechanisms leading to the implementation to be accountable to them. In Makoni it was apparent that community members were not aware of how policies are made. Participants raised concerns that only specific people who are mainly those in leadership positions are the ones who are called and attend meetings at council. One participant said "*As an ordinary member of the community, I have never known how the process of coming up with policies s done and who should attend and why those specific people".* The same was said with the Health Committee at the clinic in ward 22, where some of the participants said the health meetings are open to everyone and others were vehemently denying this as true. One participant added *"I have never known that meeting at the clinic to be open to all members of the community because if it was so, how do they call for the meeting and how do they communicate with us so we attend?"*This demand goes beyond the usual perception of community participation, as a simple act of assembling stakeholders in a workshop in order to gather their views. Building participation in the development of health services by

the locals is a social, economic and political process, which will eventually mandate the accomplishment of visible outcomes.

Through building the relationship between the government and the communities, policy accountability at the national level most probably is determined by the extent to which structures such as the Parliamentary Portfolio Committee while exercising their oversight role on Health are able to enable wider civic involvement and consultation. This ensures that the populace's voice is heard and brought to stand on policy decisions taking place in and outside the health sector as a whole. The Parliamentary Portfolio Committee on Health has been very active in facilitating wide public participation and consultation. However, the wider participation has not been to the Makoni area and in essence the community members were not aware that their issues have to be taken to Parliament for the Portfolio Committee to practice the oversight role on the relevant Ministry. Due to budgetary constraints not all areas are covered and there is the element of sampling and selecting urban, peri urban, farming/resettlement areas and rural areas for data. It is imperative for politicians as well as the communities and other relevant and important leaders like the traditional leaders, to be aware of the channels to be taken when taking up issues for continued government-citizen engagements. The diagram below shows the essential communication pathways that communities should be looking into and following. Although in some areas the VIDCOS and WADCOS were no longer functional, it is important for the structures to be revitalized so as to have the proper flow of information to the relevant authorities.

An opportunity to get communities to contribute to the health sector exists through local level management structures. In Makoni there exists Village Development Committees (VIDCOs) and Ward Development Committees (WADCO-led by councilors who are the political leaders at the grassroots level in charge of social service delivery), are anticipated to take part in decision making and administration of health amenities at the community and district levels. Although it has been reported that these committees are not meeting regularly and in some certain instances disbanded, there are Health Committees that meet regularly which involve the traditional leaders of the area, the councilor, the village health workers and the health center personnel at the health centers in Makoni. In Makoni ward 22, there were confusions as to who sits in the Health Committees as the community members wondered what it is that is discussed during these meetings.

It was in these Health Committee meetings in Makoni that the structures began to engage the health personnel on the misconduct of the nurses at the health centres. During the shadowing and observation process, the village health workers accompanied the health personnel observing them during work to learn from observation. They managed to absorb practical and spontaneous knowledge from the personnel aiming for better working relations between themselves and the nursing staff. This also allowed them to find out from the personnel the challenges that they also face. It made the communication a two way positive process where the main aim was for both parties to work actively on making sure that teamwork yields action and progress.

4.5.3 Capacity building of politicians

Councilors are the political figures on the ground in charge of social service delivery and health falls in this category. Above all roles and responsibilities there is accountability which is of grave importance in terms of development which the participants attested to. When information was communicated during the time of the evaluation between the community leaders and the community at large through dialogue, there was need for feedback to make sure that the community stays informed of stages and actions taken to address their issues by their leaders. The relationship created a bottom up relationship among the researchers, local leaders and the communities at large. The researchers felt the need to not stop or direct any action or conversation that the participants wanted to take on as it clearly showed that cases are different. The participants were quite emotional as these were issues they face daily and the continued dialogue between the leadership and the community members managed to yield results that were acceptable by everyone. At the same time, this meant that the capacity of the politicians as leaders of not only those of their political parties, but every community member, was strengthened and made working relationship enhanced.

4.6 Priorities for collective local actions in relation to women's health issues in Makoni District

WiPSU conducted the reflection and discussion meetings in ward 20 and 22 of Makoni to follow up on the action that the community had taken following the previous meetings and discussions. Both communities had made efforts to meet with clinic staff and stakeholders to discuss areas of concern to community members with regard to service delivery at the clinics. Both communities had analogous complaints about treatment at the clinics by the clinic staff, availability of medication and status of mothers' waiting homes at the clinics.

The process by the VHWs was not smooth as initially the clinic staff were defensive on the allegations of misappropriate treatment of patients. They later on embraced constructive criticism and agreed to work together well with the VHWs and the community at large. The roles that each person should participate in were clearly defined during the meetings so as to ensure the smooth running and implementation of action plans by the communities and their leadership.

Notwithstanding the efforts by women and men in both wards to engage the clinics for improved service delivery there were still some challenges that are beyond the communities' control. In ward 22 there is still a challenge of short staffing of the clinic hence on days where there are many patients the clinic staff is overwhelmed by duties.

Community members reported improved care for pregnant women at ward 22 clinic where the waiting homes have few nurses. There has been noted government-citizen engagement whereby the clinic in ward 20 engaged Village Health Workers and trained them under an attachment programme on basic nursing care to curb the shortage of staff and delays in attending to patients timeously.

Community members highlighted that despite the positive changes in accessing health services there are some issues that are causing regression in the totality of health access. There are certain vaccines

which are still not available at the clinics for example the rabies vaccine which is only accessible in pharmacies in Rusape. The medication is also quite expensive for the majority of the community members as it costs about UD$20 in the pharmacies and it is not available at any of the local clinics. The veterinary services at community level do not have vaccines for dogs to prevent the rabies and they give the justification that the government does not have funds to vaccinate all dogs.

Community members were urged by the Veterinary Services to contribute a US$1 per house-hold in possession of a dog towards buying of the vaccines. Some community members were not for the idea whilst others thought it's a positive move to avoid costs incurred after one has been bitten by a dog. Other challenges associated with the veterinary service is the issue of getting a letter from the office before accessing medication, and sometimes the veterinary office will be closed hence endurance of pain between the process.

Through the continuous dialogue that the core group had with the health personnel during the co-creation and co-evolution phases at the health service centres, the issue of the HTF which had been raised during the co-sensing phase was discussed. It surfaced that the HTF is given to the service centres by the government according to the need of the health centres, this is determined by the number of patients that are treated at the centres thereby increasing or decreasing the amount of the HTF received. If there are few patients who are attended to the fewer funds the centre obtains.

Because of the barriers regarding lack of medication and the conduct of the personnel at the centres, the visits to the centres was very low. Due to the communication with the VHW the word has been spread thereby increasing the number of patients visiting the health centres and this is also owed to the change in conduct by the health centres staff. The visit by the DNO to the villages asking each patient who had recently visited the health centres according to the centres' records also contributed to the increase in the number of patients being attended to and merely visiting the centres to seek medical attention.

Another area of concern explicitly to women is the unavailability of 10days vaccine for new-born babies at the local clinics in both wards 20 and 22 due to lack of refrigerators to keep the vaccines at the correct temperatures. Although one health centre reported having electricity in the process of being installed, there is still no electricity at the local clinics to store and keep the vaccines at the required temperatures. This consequentially results in some mothers missing the visits for their babies' vaccinations owing to lack of money to travel to Rusape where the services are available.

Due to the involvement of the community, the core team managed to collect information from the health centres as well as engage in discussions with the personnel. This has developed a pleasant positive relationship between the workers and the villagers themselves. The VHWs together with the community members and leaders in the core group came up with a working plan of how they will need to continue with making sure the communities and the service providers are well linked.

- Regular Health awareness meetings targeting apostolic sect church members
- Monthly meetings with clinic staff, the councillor and local leaders to discuss concerns and areas of improving the quality of health services provided by the clinic
- Male involvement mobilisation ventures where the few men involved in the research will assist in mobilising other men in the wards to support women as well as increase health seeking behaviours
- Voluntary counselling and testing awareness raising campaigns per village and pre and post natal care
- Door to door education on health access and demystifying HIV/AIDS stigma
- Continuous engagement with District Nursing Officer for the continued support and collective action
- Monthly Statistics collection by the village health workers for evaluation of the health centres
- The traditional leaders will work hand in hand with the VHW, the councillors and the women and men in the core group so that they get a chance to speak on health issues at gatherings called for by the chiefs

The core group took it upon themselves to collect useful data so as to see the impact of their meetings with the relevant people in the areas. The main focus was on the numbers to assess the impact of their visits and meetings and if there was a direct positive correlation between the engagements with clinic personnel and the number of women who access health services.

5 Discussion of results in relation to research questions

5.1 Priority women's health issues

The theory U process has become a method for leading profound change in the wards visited during this evaluation. In the Rusape wards visited, women often carry the heaviest burden of transient poverty by virtue of their reproductive roles and/or household division of labour. Economic reforms have intensified their workloads by increasing their participation in formal and informal labour markets as well as shifting the burden of the care economy to them. The latter has in recent years been exacerbated by the HIV and AIDS pandemic which the participants during this evaluation attested to as one of their major health concerns. The community women often assume the responsibility of 'making ends meet' when real incomes fall and they do so by taking on several jobs, in both the formal and informal economic sectors, simultaneously. Succinctly, women have assumed the 'safety net/cushion' role under harsh socio-economic adjustments or in situations where the economy is contracting.

High unemployment, widespread poverty, and a deteriorating health system is a good breeding ground for the HIV/ AIDS pandemic. If Zimbabwe is to improve economically and the health system improves this will guarantee an even lower percentage of HIV in our country. A nation where everyone who is HIV positive is commenced on ARV's without having to wait until their CD4 count has gone down but as soon as they are tested and want to start treatment they should be able to do so. It is important for ARV's being a priority to all who need them so that there is never a time when they have to go without the

necessary drugs because of shortages surely the HIV prevalence rate will go down. It is also clear that there are still issues of stigma within communities and patriarchy also continues to play a role in the spread of HIV. This research continues to show the low handed nature of women's positions in the communities with regards to socialization. At the same time it shows the effects of some of the developmental work that has been done in the areas. It is therefore important not to generalize the findings of patriarchy but to also appreciate the work traditional leaders have contributed in making sure that both men and women understand the concept of gender equality.

Nonetheless, Zimbabwe, being a traditional country as it is with the rural areas being headed by the traditional leadership, there still remain quite visible cracks that have been made by the traditional and cultural practices experienced in the rural areas with regards to women's reproductive and health rights. Statistics according to the Zimbabwe Demographic Health Survey 2010/11 show that the economic decline has begun to affect key indicators such as maternal mortality which was noted at 960/1000 in 2010/11(ZDHS). As unearthed during this evaluation, maternal mortality is a cause for concern for women in the rural areas as they are the most hit due to lack of necessary equipment or emergency operations. The current economic degeneration in Zimbabwe has been a pronounced obstacle to women health accessing despite a fairly enabling policy frameworks in place. The limited resources for both patrons and the service providers, means that the ideals for women and health may not be met. The health service delivery system is cripplingly encumbered causing a compromised service delivery in areas such as maternal health and the prevention and management of HIV and AIDS. The problem of obsolete machines was reported throughout this evaluation, and this problem automatically negatively impacts of the service offered to patrons by the health service providers.

5.2 Supply and demand side barriers

A lack of utilization of primary health care services has generally been observed in the Makoni wards 20 and 22 and this is assumed partly to be related to supply side inadequacies, in terms of scarcities of drugs, equipment and adequate trained staff, and above all midwives. Subsequently, the society's capacity to make choices is influenced by their level of literacy. Education of the masses in society's remains important, more particularly women. It is an important factor in the exercise of community health rights. This is so as it was noted during the evaluation that some community women lacked knowledge due to little or no education. For communities to secure their own health they need to be part of the process as well as being part of the education agenda. Key players in health sector should and must have a common understanding of what needs to be done and that progressive involvement and partnership yields positivity.

Regarding patriarchy, though explicitly stated that the men may cause and stop their wives from accessing health services, a discussion ensued whereby some men in the communities refused this allegation and blamed the women for not taking care of themselves. The men spoke about their wish to have their wives well at all times. It came out that the total blame on patriarchy stopping women from accessing health services are not entirely factual although partly genuine.

Women are not only being charged for maternal health care services, but are charged more for complications and are at times threatened with being detained for non-payment of unaffordable fees. User fees were also noted to exclude mothers from services which provide those who are HIV positive with antiretroviral therapy to prevent them transmitting HIV to their infants.

Social and cultural practices and beliefs such as gender roles in the homes, power dynamics in sexual relations, poverty and dependence on men for money, biological make up and lack of knowledge of their own body as well as religious beliefs play an important role in women's vulnerability towards HIV and Aids. Cultural practices such as early marriages and polygamy play a bigger role in the denial of access to health services for women. Women are at the receiving end of these practices as they lack power to voice their concerns and their empowerment to sustain their choices and this confirms the findings in the literature review with reference to ZWRCN (2014) and the discussions with the core group.

5.3 Government-citizen partnerships

The establishments of local governance structures have enabled communities to at least have in principle appreciated political control over issues which affect their lives at the local level. This therefore had facilitated the health service placing community participation directly on the health development agenda. The communities in Makoni wards 20 and 22 successively felt that they are part of the development process in their areas.

Nevertheless, experience has revealed that knowledge gaps between communities and service providers remains eclectic to the extent that community contributions and influence have not always been taken on board. The fact that local development and administration is under the hands of the local officials, automatically controlled by the line ministries, suffocates collaboration between the planning, financing and ultimately execution of those plans. It is evident though that in as much as structures can be set up at community level of community members, it is important for the communities to work together with local leadership all the way to the line ministries who represent the government.

Due to lack of synergy in commitments, this situation has often resulted in community needs and interests being sidelined. A key finding was that the ability and capacity of communities to participate in health development activities depends on the decision making space they enjoy and the degree to which they control the resources for them to carry through those decisions. In practice, their ability to make these decisions will also depend on the quality and availability of the necessary information they require.

It is important that new ways to collect and analyze data for action at point of collection, efficiently forward information to the next levels for rapid decision making and deployment of support and response activities. The NHIS is a tool which needs to be fully implemented as it certainly needscommunities to be fully involved by using the community structures above in fig 5.The tool can be used to collect information from the sources who are the community members themselves. There is

need for a unified approach in order to provide a firm basis for forward planning of health interventions by the government. By bringing together key players in the health sector, not forgetting the patrons themselves a unified approach will be achieved routinely.

The NHIS needs to be implemented with the community involvement with the help of "core groups" whereby the communities take ownership of their health system working together with the government. TheZimbabwe Health Information System Strategy goal number four which speaks on Inclusive implementation and monitoring "*Community Participation Partnership for Health*" speaks specifically to the involvement of the communities, and this brings hope in the light of government-citizen engagement leading to meaningful participation and involvement of local communities connecting to one of the research questions of this current evaluation.
The government, through the Medium Term Plan and other policies reflects the collective wisdom which the theory u allows and shared goals pursued by outlining the economic policies, plans and programmes guiding the nation and setting state priorities for five years, 2011-2015. It is very urgent and important for there to be a link of policies, frameworks and activities being done by the government and other actors so as to come up with a solid way forward. Theory U allowed for actors to all take part and lend a hand in one way or another as well as allowing the relevant stakeholders to feel accountable to their actions. Policies such as the MTP plan allows for government-citizen engagements for the betterment of the lives of the governing and the governed. Therefore, there needs to be collective, systematic, tight, and effective collaborations between the government and the citizens.

With all the policies that are there and stated earlier in the report including the regional and international commitments the country has signed, it is clear the nation has a rich positive starting point. The challenge has been on the implementation because as noble as these ideas and plans and programmes are, they are not being implemented on the ground with the involvement of the masses. These policies are drafted in high places and prudent commitments and guidelines are outlined, but in the end there seems to be no action taking place on implementation. However, if drastic action is taken to revive the collapsing health sector by implementing the policies; the government can at least get closer to attaining Millennium Development Goal (MDG) Five (**Improve maternal health)**. Goal 5A targets the reduction of maternal mortality ratio by three quarters while 5B is about achieving universal access to reproductive health.

The government of Zimbabwe has prioritized women and health and is reflected in the various initiatives, policies and strategies some of them stated above and in the literature review section that the government of Zimbabwe has put in place to address health issues for women. These include the resuscitation of primary health care facilities in rural areas as well as the introduction of Antiretroviral Therapy (ART) to those living with HIV as well as the initiation by the health service provider of HIV testing and counseling in order to ensure that women are aware of their status and consequently are able to make informed health choices. According to the Millennium Development Goals Progress Report 2012 on Zimbabwe, the HIV infection rates have dropped from over 30% at the height of the HIV pandemic in Zimbabwe, to current levels of around 15%. The government of Zimbabwe's HIV and AIDS

response has been quite successful, as evidenced by the reduction in HIV infection rates in general and among women.

5.4 Collective local action

During the evaluation it was noted that village health workers seemed to have no restrictions to guide them in mobilizing communities to support health and health related activities. According to The Study on Access to Health Care Services it established that dialogue between health workers at the periphery and communities is minimal (Makuto & James, 2007). However due to the process of engagement using the theory U methodology, the village health workers were able to communicate together with the health services as well as the communities. Through the dialogue interviews where the village health workers dialogued with community members and local leadership, it created a reproductive chat that allowed for reflection, thinking collectively and triggered collective creativity.
According to the findings of this evaluation, the only challenge comes when not all community members accept due to cultural and for some religious reasons why they cannot participate in the promotion of access to good health services. This being the case, however, it was noted that some of the women from the apostolic sect churches have started accessing health services behind their churches' knowledge. It has also been noted through the statistics collected by the core group that there was a steady increase in the number of people accessing health services, and notably so, the highest being women. The fact that some members of the apostolic sect have started seeking health services shows a shift in mindsets by some. Through local collective action, challenges from the health centres of staff shortages were raised and this tends to weaken health facility managerial structures.

According to Fawcus, et al (1996) communities are willing to support their local health institutions in cash or in kind. This is also evidence and supported by the commitments that the local members have contributed through making bricks, starting nutrition gardens at the clinics, building the local mortuaries and contributing to the buying of bags of cement in the findings of this evaluation. Conversely, it is vital to note that they remain uncertain on how they should volunteer their aid and contribution therefore raising a need for guidance.

The community	**Councillors**
• Citizens must play a central role in the development of their ward • Stay well informed and able to initiate development activities • Organize local services to deal with local priorities, supported by local leaders both traditional and elected • Paying development levies and service charges, and must contribute to discussions on the district budget • Register as voters • Choose wisely a candidate to represent them as ward councillor, in local elections • In smaller groups ensure that their interests are	• Elected by the residents of the wards, (under the Rural District Councils Act) • Serve four years • Responsible for access to good service delivery which includes water, sewage, collection and disposal, refuse removal, electricity, health services, roads and drainage, parks and recreation • Chair ward development committees (WADCOs) • Without discrimination, improving the living standards of all residents in their areas

promoted within the ward's development processes	
Traditional leaders • Appointed in accordance with the traditions of people in a particular area (under the Traditional Leaders Act) • Appointed for life • Found only in communal areas • Responsible for the maintenance of customs and traditions, peace and stability and initiating development • Chair village assemblies and village development committees (VIDCOs) • Without discrimination, improving the living standards of all residents in their areas	**Rural District Councils** • Administratively headed by the CEO and politically by the Council Chairperson • Made up of councillors and administration staff • Makes policy, formulates plans and budgets (based on contributions from the wards) and provides resources for the councils' work • Sets up committees to focus on different aspects of district policy • Council staff implement the policy, carry out plans, and maintain council infrastructure and services

From the evaluations findings, the benefits of this type of collaboration are becoming apparent to national programmes including those aimed at improving reproductive health, reducing maternal mortality, improving infant and child health, and national programmes against HIV/AIDS – all of which are of particular importance to women. These programmes regularly have resources through government and non-governmental organisations but are antagonized with the toil of reaching poor communities. Community-based coordination of collective protection strengthens the organisational capacity of communities – especially women – around health concerns, enabling them to work with such developmental programmes.

The findings reflect the strengths and limitations of community-based co-ordinations are evident in their capacity to undertake educational activities. These same strengths and limitations reflect opportunities for linkages with government and non-government institutions whose goals include improvements in the health situation of communities and the fight against HIV/AIDS. Educational activities require technical expertise that is not found within the communities regularly as these usually come from non-governmental organisations, in some cases the village health workers. They also require financial resources for materials and supplies. On the positive side, the dialogue and co-ordinations play the important role of stimulating interest in health and reproductive health and community members and health workers demonstrate a willingness to devote significant time and energy in organizing activities to respond to this interest. In this context, governmental and non-governmental institutions can channel resources much more effectively to reach communities and households.

Hence from the findings, it is essential to provide support to community-based co-ordinations in ways that increase their linkages to national programmes and systems that channel resources to women, children and men with the most unmet needs especially in the rural areas.

The findings indicate that these studies provide an opportunity and a stimulus for communities to raise and discuss their health needs and to explore ways to address them. When women have the opportunity to voice their concerns, they consistently raise the problems linked to pregnancy and delivery as a priority concern. In varying degrees, they also raise other reproductive health concerns

including adolescent health, infertility, sexually transmitted infections and family planning. HIV/AIDS is also raised as a concern among many groups, especially where prevalence rates are significant.

The findings also indicate that this evaluation study go much further in raising awareness and in encouraging discussion of health priorities. As the studies produce evidence on the actual situation of a community, they are more real than general health statistics. The in-depth assessment and analysis deepens community understanding of its priority health needs, of the accessibility of health services to meet those needs and of its capacity to access the facilities.

6 CONCLUSIONS

The community-based structures and co-ordinations of community Safety appraised point to the conclusion that these systems strengthen the capacity of women to raise and address their priority health concerns. They further indicate that women's increased capacity to raise and address their health concerns initiates with the steps necessitated in setting up a coordinated team effort by leaders and the communities. These assumptions have programmatic effects for the way support is provided during the establishment of the core teams. It can be inferred that if the methodologies used are participatory and gender-sensitive, they can augment the raising of awareness on health issues. With respect to reproductive health, it can be concluded that participation of individuals with expertise in this field can be useful in encouraging in-depth discussion of reproductive health topics, particularly of the ones that are either not impulsively articulated as being of priority or which are considered complex.

Through this evaluation, it has been noted that communities are able to come up with solutions for their problems regarding the health sector with a commitment to assist in the best way possible. The communities have become aware of the relevant authorities to approach for specific issues regarding the access to health by women.

The principles articulated by the public health system suggest that health care is a human right, and consequently collaboration in significant ways amongst providers and the patrons is of utmost importance. All individuals and groups providing access to services have a continuing duty and responsibility to promote and improve the quality of services which people need. In this respect, community participation should be considered as a suitable means of dealing with health problems, which should be defined in collaboration with the people and the staff which serves them. Organizing communities for this purpose should be considered as a goal in its own right.

In as much as 5 stages in the U-Theory process have expected outcomes, it should be noted however that some of the outcomes that arose where already way ahead of the process. This has shown the importance of participatory action within communities as they take up their issues as there are rightfully

theirs and start acting upon them. It also shows the differences that are exuded from different societies focusing on different issues.

Community dialogue process towards improved health access

From the theory U process, it helps recognize the importance of getting communities on board although it takes time, effort and personal commitment. Considering the theory U process, it clearly brings out the stages of commitment and efforts by both the governing and the governed due to the involvement of all parties involved.

According to the Patients' Charter and why it is there, from the evaluation carried out in Makoni there have also been visible improvements in service standards as testified by the community members in both wards. The public has become more aware of their rights due to the core group cascading and engaging the rest of the community members. They are now more aware of what to expect from the health service. The communities have decided to play their part to improve their lives by working together with the government to ensure that they assist with material or labour for the advancement of their health services.

Through the use of the theory U methodology it has become evident that it promotes **active dialogue between authorities and the citizens** by making sure that everyone gets to own the process. It activates the drive in the citizens to demand their rights as well as their part to play in the development of their own lives by identifying problems and finding solutions to the difficulties. The stages assist the people to see from the causes and stages of the problem development thereby making it possible to come up with solutions. Improved engagement between service providers and community which helps them to understand what the challenges are.

Shared leadership was seen as a very important step to take as it is very important for the different leaders to recognize and respect each other's roles and work on uplifting the standard of living of the people they lead. Because this evaluation involved leadership at different levels, it is important to understand that leadership means building a group working towards its goals and leaders share power and responsibility, and help other people become leaders too by supporting each other in promoting the development of their areas. There was **enhanced engagement** between the local authorities, traditional leaders and the communities

Of pivotal importance is the **politicians' role as enablers to health access.** Swift responsiveness by the ministry responsible for health to the communities' plights was noted. At the moment after concerns of misconduct by some nurses, visits have been made by the district health officials and they have carried out their own survey. It turned out some of the nurses were moved from the said health centres. The complaint of staff shortages is however still prevalent. The district health officials have been working hand in hand with the village health workers. With regards to the provision level, accomplishment has been noted through the integration of the village health worker into the health system (health centre committees) thus restoring the vital linkage between a village community and the local health service centres.

The analysis further advocates that the underlying force of communities' coordination increases interaction, shared respect and partnership between health providers and communities. Consequently, they encourage people's participation, promoting the fulfillment of this human right. They contribute to the better operation of the health system. It calls attention to the importance of providing support to health care access by enabling a stronger community organisation around health, provide a "bridge" between community members and health service providers. By increasing dialogue and collaboration, such mechanisms such as the formulation of core groups can play an important role in bringing together initiatives stimulated at the national level with community-based initiatives and accelerating progress toward fulfilling the Millennium Development Goals and other policies at national level. Among the most important national level initiatives is the provision of health facilities of acceptable quality.

6.1.1 Future direction

This evaluation noted the need for adequate staff, medicines, shortages of ambulances, electricity, water supplies, telecommunication facilities and quality of food for the nursing mothers, as concerns most people in the final meeting wanted addressed. The society's needs should and must be the core business of this health all health strategies that districts come up with and this should translate to the national level strategies. With the core group having pushed for changes to take place, while the group is still carrying on pushing for a better health service, the group has decided to focus on other areas specifically areas of domestic violence and child abuse, as well as early child marriages while using the same approaches that were used during this evaluation. It is also important to highlight that the Ministry of Women Affairs Gender and Community Development will also be engaging with this group to ensure better services and information dissemination to the wards from the ministry.

Shifting social and cultural practices mandates a collective determination by all stakeholders including the government, civic society, the religious and traditional leaders and the communities at large. However, it is important to note that men also need to change their health seeking behavior as it has a direct impact on their female partners' health. Thus, it is important to note that just as health is a basic human right, it is every woman's human right too.

6.1.2 Recommendations

- It is anticipated that community participation will further be strengthened through the introduced Results Based Management system that requires that the needs and problems of clients be clearly identified and addressed with their involvement.
- There is need to inform and mobilize all stakeholders in the health sector and encourage wider social participation of all sectors, communities and individuals on health issues along with strengthened mechanisms for partnership, collaboration and funding of health sector activities.
- There is need to allocate funds so that women can receive the recommended amount of health care they need. Maternal health is not being given the attention it deserves, more maternal deaths are looming and if a road map for the resuscitation of the health delivery system is not crafted soon;

more mothers are likely to succumb to pregnancy complications. One way of averting this is through increasing access to skilled attendants during pregnancy and childbirth.

- Maternity fees should be removed immediately for at least those who indisputably cannot afford. These fees act as a barrier to accessing basic health services for many of the most vulnerable people in Zimbabwe especially in the rural areas.
- The charter is said to have had a very mixed reception, coming as it did at a time when the performance of the health system was declining. But it is imperative that the Patients' Charter be implemented as it is a very important tool as it offers an official mechanism of government-citizen engagement
- All policies including the Zimbabwe Medium Term Plan for 2011-2015 Chapter 16 strategies need to be implemented to ensure the effective delivery of services as well as a healthy nation
- Communities need to learn about local governance, their roles and responsibilities and bringing together abilities as well as choose representative leaders wisely on the basis of their track record, monitor and support and them It is important for age and gender balance at all meetings for community dialogues and use co-ordination and advocacy to bring about improvements they want, practice peace- building, and constructive communication.
- For positive progress communities need to be able to offer constructive suggestions to their leaders as well as co- operate with their leaders throughout the stages of development cycle on local priorities
- Access to information on effective engagement lacks in the communities, hence the need for capacity building initiatives or dialogues on relevant engagement channels.

6.1.3 Knowledge Dissemination Pathways

- A follow-on stakeholder forum will be held after the completion of the evaluation to disseminate findings.
- The structures (Ward Consultative Forum, WCF) that WiPSU helps set up for supporting the female councillors in the wards should act as a structure that helps raise health concerns to the councillor urgently so as to raise this in full council meetings
- WiPSU together with RTI need to find partners in order to educate the women on the importance of access to health services for women and help lobby the government for policy changes and implementation
- WiPSU together with RTI need to find ways of making sure that the ministry of health conducts refresher courses for nurses particularly focusing on the code of conduct

6.1.4 Lessons Learnt For WiPSU

- WiPSU has learnt that in as much as we are pushing for the women's agenda, we need to involve men as we are in a patriarchal society. If we get male alliances including male organisation to reach out to the men we can achieve more

- It is obvious that if we are to increase the number of women in Parliament and Local Government, we need to increase the capacity of the women in the communities to lobby for and advocate for key concerns by the communities and lead the process.
- Correct collection of data will assist with making informed decisions in terms of implementation of programmes, making corrections and amendments as required especially in terms of target groups and identification of key stakeholders that WiPSU can work with.
- Evidence based programming will avoid repetitive work and over subscribing of project areas or project objectives. New dimensions can be realised and adopted.
- Data analysis will improve tracking of changes for monitoring and evaluation purposes and documenting impact of interventions and thereby creating an elaborative tracking of the intended impact
- The networking with consortium members was also good for sharing experiences and even finding opportunities for future partnering on certain sectors that can be interlinked e.g women's reproductive health and how policies can be formulated around this by bringing this to light in front of the legislators
- Correct documentation of findings will assist to inform legislators on issues that are affecting the public in their areas of jurisdiction and find ways they can assist their constituents.
- Research findings will assist in feeding into programming which will not only improve interventions but also areas where gaps are, where improvements are required and where successes are achieved
- WiPSU has learnt the importance of making sure findings are brought out with a gender lens thereby means interventions will be sort according to the different needs of men and women.
- WiPSU has learnt that communication and cascading of information is not going down to the rest of the people from the leadership. There is lack of effective communication to make sure the women are on the same page as the rest of the communities
- We also need to better understand the power dynamics within the political parties as well the structures and processes and this will enable us to effectively assist when needed and map the power the power dynamics.
- It important that the organisation reflects on the point at which it schedules interventions to avoid being overtaken by events. We need to further develop our relationships with women in political parties so that we are aware or events as they unfold.

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