



Centre for Development Studies

**An exploration of the work of Behaviour Change Facilitators
in Matabeleland South Province, Zimbabwe: Knowledge,
barriers and enabling factors**

By

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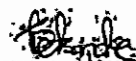
**A mini-dissertation presented to the University of the Free
State in fulfilment of the requirements for the degree of
Masters in Development Studies**

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Author's Declaration

I, Tendayi J Katsande, declare that the mini-dissertation hereby submitted for the Masters in Development Studies at the Centre for Development Support, University of the Free State, is my own independent work. I have not previously submitted this work for a qualification at any other university or faculty.



.....
Tendayi J Katsande

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I dedicate this work to my angels, Namatai and Nina Katsande. I hope one day this will inspire you to work hard and achieve your dreams. The world needs strong and empowered women and you my girls can do whatever you put your mind to!

Abstract

Evidence suggests that Zimbabwe has made substantial gains in addressing HIV and AIDS. Since exposure to Behaviour Change Programmes displays some correlation with this trend it has been suggested that that these programmes have contributed to the HIV prevalence decline in Zimbabwe. Policy development in line with this has been the deployment of community-based behaviour change facilitators (BCFs) in communities to assist in HIV prevention. BCFs mobilise their communities and conduct home visits using interpersonal communication to discuss HIV, sexual and reproductive health (SRH) and gender-based violence (GBV) prevention services. While BCFs are part of the group of community volunteers, there is no knowledge or previous research that has focused on BCFs and their realities.

This study explored the personal experiences and narratives of BCFs in Matabeleland South, Gwanda District. Along with this, the influence of BCFs in contributing to HIV prevention efforts was documented. The aim of the study was therefore to contribute knowledge on BCFs covering their work, their personal experiences and their narratives, especially given their motivation in continuing to volunteer in spite of possible burnout and the perception that volunteer work is unrewarding.

The study employed a qualitative research approach as the focus was on documentation, and exploration to discover deeper meanings and experiences including perceptions and challenges faced by BCFs. Data was collected through semi-structured interviews and focus group discussions (FGDs) with BCFs and district officers that coordinate their work.

The main findings of the study indicate that BCFs are active and engaging people on HIV, SRH and GBV prevention issues thereby creating demand for health services. BCFs are community-based people that work within their communities and are motivated by the desire to reduce the burden of health problems in their communities. Their knowledge levels on the programme and key thematic areas are good and this is in line with the secondary school level of education that most BCFs have. Positive perceptions and attitudes were exhibited through BCFs' experiences. These experiences exhibited a commitment in BCFs to serve their communities. BCFs face quite a number of challenges that can make their work difficult to carry out but have remained motivated regardless. A well designed programme that includes all the resources required by BCFs to carry out their work effectively is one of the main recommendations made.

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List of abbreviations and acronyms

ANC	-	Antenatal Care
AIDS	-	Acquired Immune Deficiency Syndrome
ART	-	Anti-Retroviral Therapy
BC	-	Behaviour Change
BCF	-	Behaviour Change Facilitator
CBD	-	Community Based Distributor
CHTC	-	Couple HIV Testing and Counselling
DFID	-	Department of International Development (UK Aid)
EMTCT	-	Elimination of Mother To Child Transmission
EQUINET	-	Equity in Health in East and Southern Africa
ESARO	-	Eastern and Southern Africa Regional office
EU	-	European Union
FGD	-	Focus Group Discussion
FP	-	Family Planning
HIV	-	Human Immunodeficiency Virus
HTC	-	HIV Testing and Counselling
IFRC	-	International Federation of Red Cross
MCP	-	Multiple Concurrent Partnership
M&E	-	Monitoring and Evaluation
MDG	-	Millennium Development Goals
MMR	-	Maternal Mortality Ratio
MNCH	-	Maternal, New-born and Child Health
MoHCC	-	Ministry of Health and Child Care
MoHCW	-	Ministry of Health and Child Welfare
NBCS	-	National Behaviour Change Strategy

NGO	-	Non-Government Organisation
PHC	-	Primary Health Care
PMTCT	-	Prevention of Mother to Child Transmission
SBCC	-	Social and Behaviour Change Communication
SRH	-	Sexual and Reproductive Health
SRHR	-	Sexual and Reproductive Health Rights
STI	-	Sexually Transmitted Infection
TARSC	-	Training and Research Support Centre
TB		Tuberculosis
UN	-	United Nations
UNAIDS	-	United Nations Joint Programme on HIV and AIDS
UNDP	-	United Nations Development Programme
UNFPA	-	United Nations Population Fund
UNICEF	-	United Nations Children's Fund
UNV	-	United Nations Volunteer
USAID	-	United States Agency for International Development
VCT	-	Voluntary Counselling and Testing
VIAC	-	Visual Inspection with Acetic Acid and Cervicography
VHW	-	Village Health Workers
VMMC	-	Voluntary Medical Male Circumcision
WHO	-	World Health Organisation
ZDHS	-	Zimbabwe Demographic Health Survey
ZIMSTAT	-	Zimbabwe National Statistics Agency

Chapter 1: Introduction and problem formulation

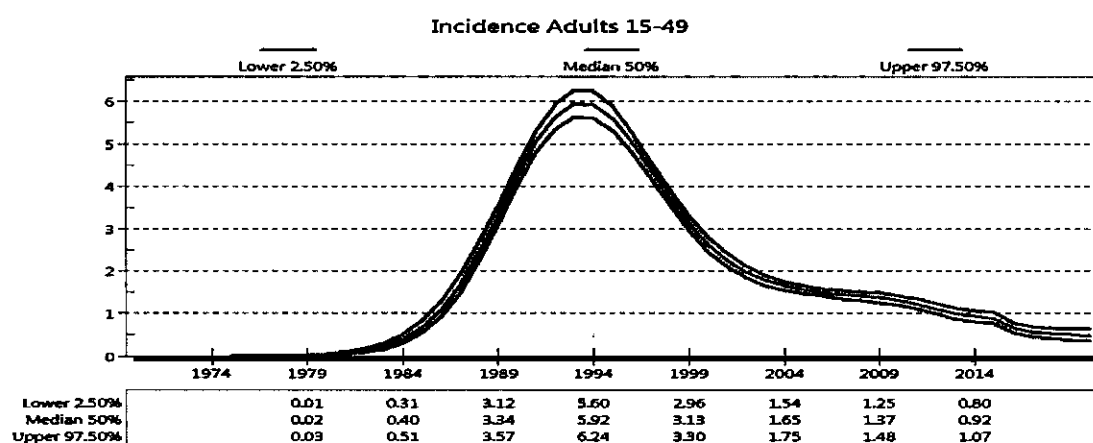
1.1 Introduction and background

This chapter provides an overview of the study. The problem statement, aim and objectives of the study are elaborated, along with a conceptual framework.

Zimbabwe has recorded a remarkable decline of the Human Immunodeficiency Virus (HIV) prevalence rate when compared to other countries in Southern Africa (Halperin *et al.*, 2011). The decline of HIV prevalence in pregnant women aged 15-49 visiting antenatal clinics fell from 25.7% in 2002 to 16.1% in 2011 (Gregson, 2012). The trend of decline continued and, according to the 2013 national HIV estimates, the prevalence is 14.4% (Ministry of Health and Child Welfare; National AIDS Council, 2014). The HIV incidence also declined from 5.8% in 2009 to 2.5% in 2011 (World Bank & UNFPA ESARO, 2013). HIV incidence recorded for 2013 according to Ministry of Health and Child Welfare and National AIDS Council (2014) is 1.05%.

The HIV incidence median is approximately 5.92 from 1994 to 0.92 in 2014 as shown in figure 1 below:

Figure 1: HIV Incidence Decline overtime



Source: HIV/AIDS Estimates, MOHCC (2015)

The decline is attributed to a range of factors related to a reduction in new HIV infections (Gregson, 2012; UNAIDS, 2005) of which behaviour change approaches have been attributed to significant changes in sexual behaviour (Halperin *et al.*, 2011). Behavioural studies in Zimbabwe showed a reduction in casual sex, number of extra-marital partners,

and in paid sex, along with high levels of condom use with non-regular sex partners since 1999 (Gregson, 2012; UNAIDS, 2005).

This evidence was important for the development of Zimbabwe's HIV prevention strategies, especially the National Behaviour Change Strategy (NBCS) in 2006. A specific goal was to reduce new HIV infections (National AIDS Council, 2006), while two outcomes specifically focus on behaviour related to safer sexual practices and the uptake of health services (National AIDS Council, 2006). These two outcomes were to be implemented through a decentralised approach at community level using social and behaviour change communication (National AIDS Council, 2011). Of significance is that the strategy recognises that communities are best placed to resolve their own problems. Hence, community based Behaviour Change Facilitators (BCFs) were introduced. BCFs started operating in 2007 interfacing between the community and the health system (National AIDS Council, 2006). Their primary role was to promote HIV prevention through behaviour change communication. As of 2013 their portfolio was extended to use interpersonal communication by conducting home visits within their catchment areas. Their focus was also adjusted towards an integrated response to include HIV, Sexual and Reproductive Health (SRH) and Gender Based Violence (GBV) (MOHCW & UNFPA, 2012).

BCFs are community based individuals of a minimum age of 25 and are able to read and write. They are recruited through community structures and should be influential, accepted and respected by the community. Through interpersonal communication techniques, when visiting families in their homes, BCFs are guided by a structured manual for generating demand for health services. The aim is for BCFs to build rapport with the families, educating and informing them on various topics, followed up with referrals to the most appropriate HIV, SRH and GBV services (MOHCW & UNFPA, 2012). While BCFs have a programme reporting routine that is used to track their work, their personal experiences, perceptions, attitudes toward their work and the influence they have had on their communities have not been explored. BCFs are community health workers who give their services on a voluntary basis.

1.2 Problem Statement

Current evidence suggests that Zimbabwe has made substantial gains in addressing HIV and Acquired Immune Deficiency Syndrome (AIDS). A key policy development in line with this has been the deployment of BCFs in their communities to promote HIV prevention. This has been done through the National Behaviour Change Programme implemented in sixty-five Districts of Zimbabwe and coordinated by the National AIDS Council along with eight non-government organisations (NGOs). BCFs mobilise their communities and conduct home visits through interpersonal communication on HIV, SRH and GBV services.

BCFs are part of the broader group of community health worker volunteers. There have been a number of reviews on community volunteers. In their study Kaseke and Dhemba (2007) found that community volunteering is viewed as unrewarding and that most volunteers are poor and cannot meet their basic needs. It has also been asserted that community volunteers are vulnerable and the duties they undertake at community level often result in burnout (SAFAIDS, 2004). While BCFs are part of the group of community volunteers, no previous research has focussed specifically on BCFs. The results of their work have been largely measured in terms of the target population reached by the behaviour change programme (National AIDS Council, 2009). However, it is important to explore the personal experiences, perceptions and attitudes of BCFs. Moreover, the more nuanced aspects of BCF influences at community level are yet to be unearthed.

The main function of BCFs is to promote behaviour change and promote the uptake of health services in their communities. This process is expected to result in a reduction of new HIV infections in the general population and contributes to Zimbabwe's goal of reducing HIV incidence by 50% by 2015 (National AIDS Council, 2011). The work of BCFs cannot be underestimated because without their successes reported in Zimbabwe's HIV response might have otherwise been different. As was noted in a review, behaviour change associated with HIV decline in Zimbabwe resulted primarily from increased interpersonal communication about HIV and risky sexual behaviour (Halperin *et al.*, 2011). BCFs are some of the community workers that use interpersonal communication with their communities to address attitudes that influence behaviour change and knowledge (UNFPA, 2010).

Routine programme reports capture numbers of people reached and three behaviour change surveys conducted have reported positive outcomes due to community work by BCFs. Some of the outcomes reported in the surveys included increased uptake of HIV testing and counselling and reported disclosure of HIV status by individuals (National AIDS Council, 2009). There has never been in-depth documentation of the work of BCFs, their perspectives, attitudes, and challenges faced in their role.

1.3 Aim and Objectives

This study aimed to document the personal experiences and narratives of BCFs and their influences in promoting behaviour change and in the creation of demand for health services.

The specific objectives of this research were as follows:

- 1) To explore perceptions of BCFs and their attitude towards daily tasks and responsibilities
- 2) To identify and describe factors that motivate and/or discourage BCFs in their daily activities
- 3) To assess BCF knowledge and understanding of the behaviour change programme elements, specifically HIV prevention and SRH
- 4) To identify the barriers and challenges faced by BCFs in achieving the goals of the National Behaviour Change strategy

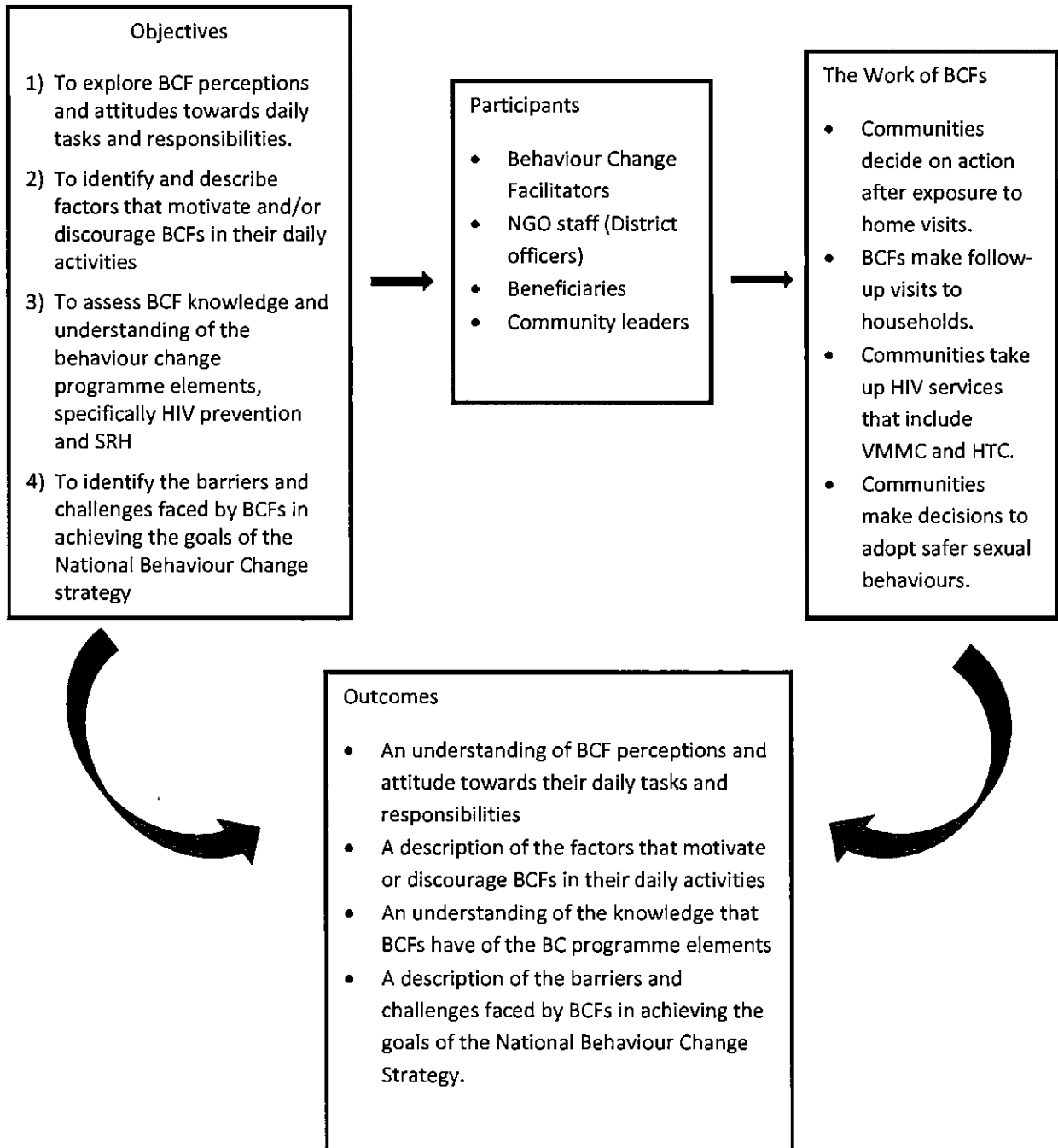
1.4 Research study conceptual framework

Concepts or theories are constructed in order to explain and predict social phenomena. Theories generalise about possible observations and consist of an interrelated, coherent set of ideas and models. The conceptual framework is a structure that can hold or support a research theory (Maxwell, 2013). It is designed to explain why the problem under investigation exists and serves as a basis for conducting research focusing on key factors, concepts or variables (Vaughan, 2008).

Specific to this study, the proposed conceptual framework is designed to explore and understand personal experiences, perceptions of BCFs and the influence they have in

promoting behaviour change and uptake of health services. Figure 2 below is the conceptual framework that will guide this study:

Figure 2: Study Conceptual Framework



1.5 Structure of this dissertation

This dissertation consists of five chapters.

Chapter 1 introduces the research topic and formulates the problem. The aim of the study is highlighted together with the four objectives of the study. The conceptual framework summarises the links between BCFs, their work and their contribution to national outcomes in the behaviour change programme.

Chapter 2 consist of an in-depth literature review on the background of the HIV situation. The national behaviour change programme, behaviour change facilitators, definition of volunteering, home visiting and access to health services are also reviewed.

Chapter 3 focuses on the methodology of the research followed to achieve its objectives. The research design is elaborated on and this is followed by the data collection and analysis instruments that were adopted in the research. The limitations and challenges encountered during the research are also highlighted.

Chapter 4 lays out the research findings. The responses from the research participants are used to formulate the findings, guided by the objectives of the study.

Chapter 5 presents the discussion, conclusion and recommendations.

1.6 Summary

This chapter introduced the study and the research objectives. This study aims to document the personal experiences and narratives of BCFs, their influences in promoting behaviour change and in the creation of demand for health services. To fulfil this aim, four objectives were formulated, to give direction and focus to the study. The next chapter focuses on the literature review, where scholarly work is reviewed to obtain and reflect on elements and information relevant to the objectives of the study.

Chapter 2: Literature Review

2.1 Introduction

BCFs are community-based volunteers that participate in a national behaviour change programme with a key function to create demand for health services and promote behaviour change in their communities. This literature review will first discuss the background to the Zimbabwe National Behaviour Change Programme and the involvement of BCFs. A description of volunteerism, specifically in the context of health promotion programmes will be given. A discussion on community volunteers, their characteristics, importance, and motivation will be given in the broader context as well as in the context of Zimbabwe. The home visit approach, in different contexts and as reported in previous studies, will be discussed in relation to BCFs. The review will be concluded with a discussion on the current situation of health services and how communities respond in taking up the health services in Zimbabwe.

2.2 Background of the Zimbabwe behaviour change strategy

Evidence suggests that Zimbabwe has made substantial gains in addressing HIV and AIDS. In 2004 HIV prevalence was estimated at 24.6% in the ages 15-49 (Ministry of Health and Social Welfare, 2004). Thirteen years later HIV prevalence is estimated at 15% in the ages 15-49 (Ministry of Health and Child Welfare & National AIDS Council, 2014). These gains have largely been due to HIV prevention programmes aimed at behaviour change and the prevention of mother to child transmission (Halperin *et al.*, 2011). A number of studies have reported increases in safer sexual behaviours and personal prevention of HIV by individuals that fear AIDS-related mortalities (Halperin *et al.*, 2011; Gregson, 2012).

Zimbabwe's HIV infection is spread mainly through sexual transmission and approximately 94% of adult infections are suggested to be due to heterosexual transmission (Fraser *et al.*, 2011). New HIV infections occur in multiple concurrent sexual partnerships that include casual sex and extra-marital sex (Fraser *et al.*, 2011). The changes in the epidemic were suggested to be a result of changes in behaviour with people reducing numbers of sexual partners and adopting personal prevention means such as condom use (Gregson, 2012). This evidence resulted in Zimbabwe identifying behaviour change promotion as the key element to HIV prevention. A National Behaviour Change Strategy

(NBCS) was therefore developed in 2006 with a goal to reduce new HIV infections (National AIDS Council, 2006).

The NBCS has specific outcomes that include increasing safer sexual behaviours through promotion of behaviour change at community level and increased access to behaviour change communication (National AIDS Council, 2006). Implementation of the strategy was funded through donors that include the European Union (EU) and Department for International Development (DFID) through the overall leadership and coordination of the National AIDS Council. Other stakeholders involved as funding mechanisms include United Nations agencies particularly United Nations Population Fund (UNFPA) that provides technical support for the overall implementation (National AIDS Council, 2009).

The current NBCS is implemented through the home visit approach which uses the diffusion of innovation theory and the health belief model (Ministry of Health and Child Welfare, 2005). The diffusion of innovation theory (Orr, 2003) has five qualities that guide the concept of the Behaviour Change Programme:

- 1) Knowledge that relates to the awareness of an innovation and how it functions
- 2) Persuasion that is based on compatibility of innovation with existing community values and practices
- 3) Decisions of individuals to change is influenced by the simplicity of the innovation. When people are engaged in activities that they find easy to understand they are likely to decide on taking up the innovation
- 4) Implementation of the innovation
- 5) Confirmation of innovation by individuals is based on observation of results. Visible results reduce uncertainty and can easily be tried by peers (Robinson, 2012)

These qualities contributed to the development of the programme framework and are central to encouraging people to attain certain behaviours.

The health belief model is a concept that links health behaviour to personal beliefs and perceptions about a disease and what can be done to decrease occurrence (Hayden, 2009). This model is widely used in health education and health promotion. It is believed that a new behaviour is adopted when a person believes the benefits of the new behaviour outweigh the consequences of continuing in the old behaviour (Hayden, 2009). Behaviour change is hence a key component because when people are exposed to the home visit approach, they are likely to take steps to change their behaviour. Some of the steps taken

to change behaviour include people adopting safer sexual behaviours and taking up health services. These are some of the expected outcomes of the behaviour change programme (MOHCW & UNFPA, 2012).

The programme aims to increase knowledge and utilisation of integrated HIV prevention, SRH and GBV services. Central to the implementation of the programme are trained BCFs, community-based volunteers that interact with their communities based on a structured manual, using interpersonal communication techniques. The aim is for the BCFs to build rapport with the families, educating and informing them on various health related topics and make referrals to the most appropriate HIV, SRH and GBV services (MOHCW & UNFPA, 2012).

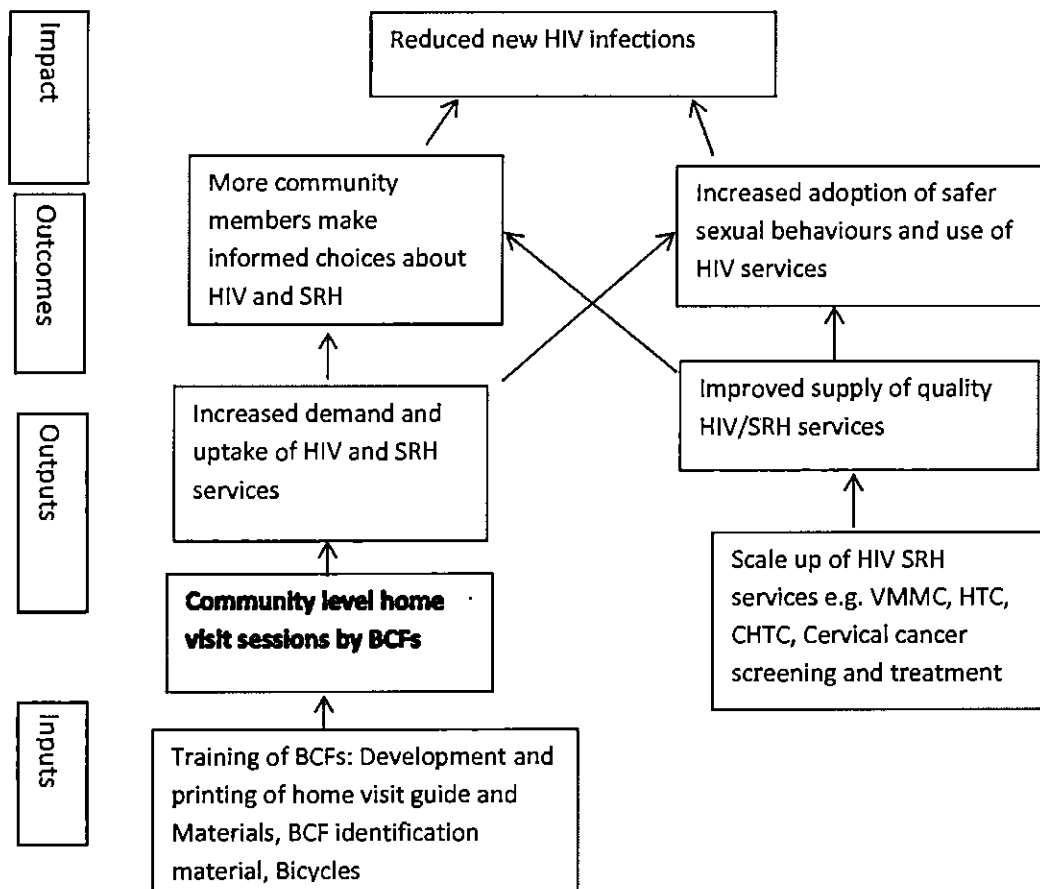
The demand generation manual used by BCFs includes the following themes:

- HIV testing and counselling, encouraging couple testing where relevant
- HIV sero-discordant relationships
- Sexually Transmitted Infections (STIs)
- Basic HIV knowledge and transmission
- Couple communication
- Multiple and Concurrent Partnership (MCP) and sexual networks
- Voluntary Medical Male Circumcision (VMMC)
- Antiretroviral Therapy (ART)
- Cervical cancer
- Family planning, including condom use
- Mother-to-child HIV transmission
- Gender and gender-based violence
- Stigma and discrimination
- Reproductive health for young people, including teenage pregnancy

The main function of the BCFs is to deliver these topics in the homes within their reach and make referrals to the appropriate health services (MOHCW & UNFPA, 2012).

The results chain and logic of the behaviour change programme through the home visit approach can be described as per Figure 3 below:

Figure 3: Behaviour Change Programme through Home Visits - Results Chain



Adapted from (MOHCW & UNFPA, 2012)

BCFs are community-based individuals of a minimum age of 25 and should be able to read and write at an adequate level. Based on the terms of reference for BCFs the following are the expected competencies (MOHCW & UNFPA, 2012):

- Popular and influential people who are considered opinion leaders in their communities
- People who are familiar with local customs and practices of their community
- Should be/have been resident in the same community for at least five years
- Gender-sensitive and have a good track record in gender-related issues
- Approachable, acceptable and respectable to community members
- Role models for peers in behaviour change

- Good interpersonal and communication skills
- Caring and compassionate
- Good leadership and organisation skills
- Experienced in community mobilisation

These competences are determined by the communities from which the BCFs come from. Recruitment is done through a participatory approach. Community leaders use their structures to solicit names of possible candidates. The people are assessed by the community leaders in collaboration with NGOs recruiting BCFs. Recommendations are made thereafter and the BCFs are recruited by the NGOs.

The main responsibility of BCFs is to conduct home visits. The home visits are to be concluded with specific recommendations for families which can include referrals for health services. Other responsibilities include mobilisation of communities through sensitisation of the home visits, distribution of behaviour change information, distribution of condoms, participation in health promotion activities and commemorations of important health and social days at community level. BCFs are given yearly contracts by the coordinating NGOs and receive a monthly allowance of \$15 (MOHCW & UNFPA, 2012).

It is important to note that BCFs are community workers providing their services within the context of volunteering. In a past review of community volunteering, Kaseke and Dhemba (2007) found that the practice is viewed as unrewarding and that most volunteers are poor and cannot meet their basic needs. It is also suggested that community volunteers are vulnerable and that their duties often result in burnout (SAFAIDS, 2004). While BCFs are part of the group of community volunteers in Zimbabwe, this study would like to explore and to understand their role, functions, attitudes, motivations and narratives.

2.3 Defining volunteerism

Volunteerism involves people helping other people, learning and actively participating in communities (UN Volunteers, IFRC & Inter-Parliamentary Union, 2004). It has been described as a necessity for good citizenship, and has been suggested to help build and strengthen cohesion in communities. Volunteerism also empowers individuals to take responsibility for development of their communities (UN Volunteers, IFRC & Inter-

Parliamentary Union, 2004). It is a human value that normalises altruistic tendencies, and feeds into processes that lead to self-empowerment (United Nations Volunteers, 2011).

Volunteerism has been defined in a number of ways:

- VOLSA (2004:6) describes the core characteristics of volunteering as an activity that is *“not undertaken primarily for financial gain or reward; the activity is undertaken at free will without coercion; the activity is undertaken to benefit someone or the society at large rather than the volunteer.”*
- Another definition by McBride *et al.* (2003:5) identifies volunteerism in terms of civic services as *“an organised period of substantial engagement and contribution to the local, Community, recognised and valued by society with minimal monetary compensation to the volunteer”*.
- According to Michael (2008:31) *“Volunteerism involves much more than working without pay; it involves people making choices to do things to help society in ways that go beyond their basic obligations”*.

There are, therefore, variations in the understanding but it is possible to identify key aspects that constitute voluntary activity. It is voluntary and not undertaken for financial reward, it is undertaken according to an individual's own free will and that the activity brings benefits to other people rather than the volunteer (UN Volunteers, IFRC & Inter-Parliamentary Union, 2004). In the guidance note on Volunteerism, UN Volunteers, IFRC and Inter-Parliamentary Union (2004:19) defines volunteerism as *“..group of activities carried out by individuals, associations or legal entities, for common good, by free choice and without the intention of financial gain, outside the framework of any employment ...”*. The generally accepted definition that encompasses all the other definitions is from the United Nations Volunteer organisation and is as follows (United Nations Volunteers, 2011):

“An activity that is:

- 1) Conducted out of free will;*
- 2) Done with little or no financial reward and*
- 3) Performed for the common good”*

There are different types of volunteering but specific to this study community-based volunteering is of interest. This involves volunteering that is structured, localised and

involves serving people of similar circumstances (Graham, Patel, Ulriksen, Moodley & Mavungu, 2013).

There are countries that have legislation for governing volunteerism but in some cases, general principles are observed. In Zimbabwe, for example, there is no specific legal regulation for volunteers and there is no statutory framework for the engagement of volunteers (Mutambara & Mutambara, 2012). There are however suggested general principles which are important to mention for this study as they can work as a benchmark for volunteer engagement.

Table 1: General Principles of Volunteerism

General Principles of Volunteerism	
1	Volunteers participate on the basis of freely-expressed consent.
2	Volunteering is not compulsorily undertaken in order to receive pensions or government allowances.
3	Volunteering is not carried out in expectation of any financial gain.
4	Volunteering complements, but must not result in, the downsizing or replacement of paid employment.
5	Volunteerism should be encouraged with a certain degree of autonomy from the public authorities, to safeguard its independence.
6	Volunteering is a legitimate way in which citizens can participate actively in the development of community and social life and address human needs.
7	Volunteers act for the common good and on the basis of a social commitment.
8	Volunteering promotes human rights and equality.
9	Volunteerism respects the rights, dignity, and culture of the communities involved.
10	Volunteering is inspired by democratic, pluralistic, participative, and caring social tenets.
Adopted from: (UN Volunteers, IFRC & Inter-Parliamentary Union, 2004)	

2.3.1 Volunteerism around the globe

A number of community volunteers can be identified in the world. In 2008, at least 26.4% of the adult population in the United States of America (USA) were involved in some

volunteer work within their respective states (Corporation for National & Community Service, 2009). Particularly young volunteers were driven by the belief of the importance of helping people in need. The second important motivator for volunteering was the satisfaction of fixing a community problem. The study suggested that people who volunteer often exhibit similar characteristics, such as having a stable income and a level of education. Further, whether the particular state housing the volunteer has a significant amount of community organisations and lower levels of poverty was also suggested to aid volunteerism (Corporation for National & Community Service, 2009).

The Corporation for National and Community Service (2011) suggested that between 2008 and 2010 volunteers in USA met crucial needs in their communities. At least 35% of adults devoted their time in the education sector through mentoring, tutoring and teaching. 26% participated in fundraising, while 23% participated in food distribution to the homeless and 20% through menial tasks required at community level (Corporation for National & Community Service, 2011).

A study on volunteers in the European Union by GHK International (2010) suggested that at least 22% of people aged 15 and above are engaged in some voluntary work in their respective countries. These volunteers are mostly in the sport, health, social and rescue services. It was further suggested that people that are educated and employed are more likely to volunteer and that volunteering is done by community members out of free will without expectation of payment and for the benefit of others.

In the United Kingdom, at least 55% of the citizens took part in some voluntary activity in 2011 (TimeBank, 2013). The volunteers are mostly women. British volunteers engage in volunteering because they want to improve the situation in their communities and help other people. Like most volunteers globally, the British volunteers are motivated by seeing the results of their involvement and the difference it makes in other people's lives (TimeBank, 2013).

While there is a similar trend of the people who are likely to volunteer in Europe, USA, and the United Kingdom, the situation may be different for the communities in developing countries. As early as 1980 after the Alma-Ata Conference of 1978 declared 'health for all by the year 2000' community health workers were recommended as a possible cadre to

bridge the gap between the health facilities and communities in the developing countries (Walker & Jan, 2005). Community health workers are community members who provide basic health-related services in their communities on a voluntary basis. They have a limited training provided by the health system (Perry & Zulliger, 2012). This is similar to the description given by Lehmann and Sanders (2007) that community health workers are people from within the community they live in and work and should be answerable to their communities. Community health workers have made significant contributions in providing antenatal and post-natal care, promotion of family planning through home visits, and promoting HIV and AIDS-related educational messages accompanied with the care of people living with HIV (Perry & Zulliger, 2012). In Zambia community health workers are seen as the main tool that can deliver health services to underserved populations in rural areas (Ashraf, Bandiera, Lee & Musonda, 2012)

2.3.2 Characteristics of Volunteers in Zimbabwe

In Zimbabwe, volunteering is part of the culture and norms of Zimbabwean communities (Kaseke & Dhemba, 2007). Traditionally a community, with the village head taking the lead, participates and contributes to a granary that targets the disadvantaged in that community such as orphans, widows and the elderly (Melville & Musevenzi, 2008). In a feasibility study by Melville and Musevenzi (2008) on national volunteer mechanisms in Zimbabwe it was shown that volunteers in Zimbabwe have been very active and made significant contributions to national development. Volunteers relevant to health services are the following:

- Home-based care volunteers that have contributed to the reduction of extreme poverty through nutritional gardens
- Volunteers working with orphans and vulnerable children by identifying the orphans and ensuring they are in school
- Peer educators, such as peer counselors in young people's programmes
- Peer educators at grassroots level who support the empowerment of women
- Volunteers, known as Village Health Workers and health promoters who promote family planning and work in the prevention of mother-to-child transmission of HIV
- Home-based care volunteers that work to increase the quality of care for people living with HIV

- Community volunteers in behaviour change promotion, condom distribution and promotion of safer sex behaviour who are the behaviour change facilitators

It has been found that community volunteers are mostly women within the ages of 14 to 60 in Zimbabwe (Kaseke & Dhemba, 2007). Melville and Musevenzi (2008) found the same though they also allude to the fact that decision making and coordination structures in the same communities have a male bias. This gender dynamic can be attributed to the fact that women are natural carers and the perception that women can perform the function better than men is inshrined in communities (Kaseke & Dhemba, 2007).

Selection of community-based volunteers is usually done through the community structures and dependent on the programmes available. There is a standard way of selecting volunteers for community based programmes (Kaseke & Dhemba, 2007; Melville & Musevenzi, 2008; Mutambara & Mutambara, 2012). The community plays a leading role in the selection and nomination of the people that can volunteer. The people interested take the initiative to be part of the programme. The community however bases their selection on maturity, literacy, trustworthy and the moral uprightness of the individuals (Mutambara & Mutambara, 2012).

2.3.3 Volunteer incentives

The global definition of volunteering above highlights that the service given by volunteers is free. This definition is however challenged in most developing countries because volunteering lies in the expectation of a payment that is given as an incentive (Graham, Patel, Ulriksen, Moodley & Mavungu, 2013). A qualitative study that explored incentives for volunteering in rural Africa found that community health workers are influenced into volunteering because they anticipate future rewards (Kasteng, Settumba, Kallander & Vassall, 2015). Volunteers are usually solicited by donor funded programmes and an incentive is given to encourage people to volunteer. The programmes are also implemented in the context of poverty and unemployment. It is therefore standard that most volunteers working on donor funded projects will receive a financial incentive on a monthly basis (Kaseke & Dhemba, 2007). A cautionary recommendation was, however, made to consider the opportunity costs of volunteering when designing and costing donor funded programmes to ensure sustainability (Kasteng, Settumba, Kallander & Vassall, 2015).

Programmes which are implemented with incentives but end because of lack of funding can be a disincentive for both the community and volunteers (Lehmann & Sanders, 2007).

Kaseke and Dhembra (2007) found the issue of incentives to be sensitive and received mixed reactions in their study. Some volunteers opposed the idea of incentives because it is contrary to the definition of volunteerism. It was, however, necessary to include some sort of incentive because of the poverty levels and vulnerability of the volunteers. The incentive is therefore not always money but can also be in the form of food packs to families. In their study, Mutambara and Mutambara (2012) found that incentives were provided in the form of a monthly allowance, provision of transport, clothing and workshops that include food and allowances. These were found to be motivators for the volunteers to continue with the work.

Incentives can be separated into financial and non-financial incentives. A qualitative study conducted by the JSI research and training institute reviewed the non-financial incentives for community health workers in Ethiopia. Rather than the financial incentive, the incentive for the community health workers was highlighted as the positive change in health behaviour of their communities (JSI Research & Training Institute, 2009). Other incentives identified in the study were to do with the work of community health workers and these are ongoing mentoring, training and follow-up, certification, performance reviews, uniforms, celebration for successful communities and provision of refreshments during meetings (JSI Research & Training Institute, 2009). These are also identified as motivators for community volunteering and a systematic comparison was made to separate the incentives and disincentives. Lehmann and Sanders (2007) found that monetary incentives motivate volunteers and can be satisfying for continuation of work. The reverse, however, is that financial incentives can be a disincentive when they are inconsistent, change or are inequitably distributed among different types of community workers (Lehmann & Sanders, 2007).

The non-financial factors that motivate and incentivise community health workers are community recognition and respect, acquisition of skills, personal growth and development, status within community and preferential treatment (Lehmann & Sanders, 2007). The non-financial motivations can also be disincentives when the specific volunteers

are not from the community they are serving, when training and supervision are inadequate with no respect for health facility staff (Lehmann & Sanders, 2007).

2.3.4 Importance of volunteers

There is no doubt that volunteerism is important and at the heart of community building. There are obvious benefits for communities when voluntary services are present. Such communities are characterised by responsible citizens who can engage within their communities to make a difference (IFRC, 2011). Volunteering is also of benefit to the volunteer. In a review of the value of volunteers, it was found that volunteers were happy and valued the opportunity to offer help to their communities. It is suggested that volunteers are satisfied when they receive acknowledgement for the difference they make in their communities and the new skills they gain in the process (IFRC, 2011).

Research has highlighted the importance of community volunteers and according to Singh and Sachs (2013) they are important if they are deployed at scale. Their work can have positive effects in the achievement of Millennium Development Goals (MDGs) specifically MDG4 (reduce child mortality), MDG5 (improve maternal health) and MDG6 (combat major diseases) (Women Deliver, 2013). This important observation is backed by evidence from the cost effectiveness study on the use of community workers (Walker & Jan, 2005). Having noted this Singh and Sachs (2013) have recommended an increase in the number of community health workers to reach at least a million by 2015 in Sub-Saharan Africa.

The importance of community health workers is reflected in the improvement of health outcomes specifically in their capacity to coordinate timely access to primary care, behavioural health, and preventive services as well as in the management of chronic conditions (Martinez & Knickman, 2010). Community health workers act as the first point of contact with people who do not normally access health services. In a review by Martinez and Knickman (2010) it is noted that several studies have shown that community health worker programmes produce improvements such as the increase in patients that use preventive services. Such an increase in the uptake of preventative services is the desired effect for the home visits conducted by BCFs in the districts they work in.

The contribution of community health workers to the achievement of the MDGs have been documented in Brazil, Bangladesh, and Nepal. These countries are on track to achieve MDG4 (reduce child mortality) and 5 (improve maternal health). Brazil scaled up its programme with community health workers who work as members of the health teams providing services for populations of about 1,000 families within a defined geographical area (Perry & Zulliger, 2012). In 2012, Brazil had 222,280 community health workers and each of them visited on average 150 families per month and the programme reached at least 110 million people. This programme has been highly effective in Brazil particularly for reduction in child mortality, its MDG target for child mortality was achieved in 2010 ahead of 2015 (Perry & Zulliger, 2012). Such success shows that it is possible for community health workers to make a real difference in health outcomes for countries.

Kaseke and Dhemba (2007) found that the attitude of volunteers is different from fully paid staff. Volunteers are people that bring personal passion and fresh perspectives into the projects that they work in (Mutambara & Mutambara, 2012). Volunteers reduce the burden on health facilities. Rather than having the professional staff going out to interface with the communities, this is done by volunteers. It frees up time for the health facility staff to concentrate on delivery of service and many other critical issues and tasks (Mutambara & Mutambara, 2012).

2.4 Motivation of volunteers

The motivation of people to volunteer has been widely researched. In a study to develop the volunteer motivation inventory, it is suggested that an understanding of the elements that motivate volunteers can be of great assistance to organisations in attracting and retaining volunteers (Esmond, 2004). A number of theories and models have been used to understand the motivations of those who volunteer. Models have been developed based on factors that distinguish between intangible rewards such as a good feeling after helping others and the tangible rewards such as an allowance (Esmond, 2004).

Further work on defining motivational models identified the multifactor model which was based on functional analysis and theorising, especially the theories on attitudes in social research. In their work to understand motivations of volunteers Clary *et al.* (1998) analysed empirical data on volunteering and identified six primary functions or motivations that are

served in volunteering. This has been identified as the functional approach and uses the set of six motivational functions served by volunteerism.

The six functions are (Clary *et al.*, 1998; Esmond, 2004):

1. **Values** which have to do with acting on deeply held beliefs about the importance of helping others. Concern for others is the main driver and separates the volunteers from non-volunteers. This function predicts whether volunteers complete their expected period of service.
2. **Understanding** serves to satisfy the desire to learn. Involvement in activities of volunteerism provides an opportunity to develop knowledge. A large number of earlier volunteers in health and mental institutions were motivated by this function as they expected to receive benefits related to self-development and learning.
3. **Social**, a function that shows conformity to the normative influence of people that are considered significant by the volunteer. This function provides the opportunity to be with one's friends or to participate in activities viewed favourably by the important others.
4. **Career** serves to create career related benefits that may become available from participation in volunteer work. Volunteers engage because they are seeking ways to explore job opportunities or development in the work environment.
5. **Protective** has to do with the concern to protect the ego from negative features of the self. People may serve to reduce guilt over being more fortunate than others or to address personal problems. It can be summarised as a way to escape from negative qualities or feelings.
6. **Enhancement** also identified as Esteem. This function has to do with the development of a person's sense of esteem. This involves a process that centres on the ego's growth and development. If focuses on positive qualities the develop ego.

The work of Clary *et al.*, (1998) hypothesised that these six functions are consistent with motivations for volunteerism. The efficacy of the functionality approach was tested through four field studies that replicated and confirmed the hypothesis. It is proposed that a person will continue to volunteer if their personal motivations match these functions and are likely to be more satisfied and enjoy serving (Clary *et al.*, 1998).

Another extensive study to understand the motivational drivers of volunteers in Western Australia was conducted based on the functions approach. In this study Esmond (2004)

used the six functions mentioned above and added four more based on his findings. His study ranked, 'values' as the most important function for volunteering. Volunteers hold dearly the belief of the importance to help others. This concurs with Clary *et al.* (1998) who also ranked the values function as most important motivator.

Kaseke and Dhembamba (2007) found that clear impact of a programme encourages volunteers to carry on as it is evident that their work is helping vulnerable people in their communities. Other factors that promote volunteering are to do with the way in which volunteers are selected for a programme. Training of volunteers and having regular meetings with them as well as amongst themselves is key in keeping volunteers motivated (Kaseke & Dhembamba, 2007).

In their study, Kaseke and Dhembamba (2007) also found that some people are discouraged from volunteering because of the high expectations of beneficiaries. In most cases volunteers are not able to perform or provide for the expectations of beneficiaries. This is particularly so in poorer communities as the would-be volunteers cannot do the work because they have to fend for their families instead (Mutambara & Mutambara, 2012). In addition, members of the community in some instances look down on volunteers making it difficult for them to carry out their work (Kaseke & Dhembamba, 2007).

2.5 Home visiting

The concept of home visiting was, and is still, used primarily for interventions involving children and parents (Daro & Dodge, 2010). A parent/early infancy project in New Jersey, America recruited 400 first-time mothers into a study in 1986. The purpose of the study was to measure the effectiveness of home visits to assist mothers raise their children from early infancy (Watson, White, Taplin & Huntsman, 2005). Half of the mothers in the intervention received visits by nurses trained in the programme while the other half did not receive visits. A follow up 15 years later showed that visited mothers of the adolescent children reported fewer health related adverse events compared to the mothers of adolescents who had not been visited. The study concluded that home visits had positive effects on child development. The review also showed that home visiting should be adopted as a strategy to deliver a multiplicity of services, and not only as a single uniform intervention (Watson, White, Taplin & Huntsman, 2005).

Sweet and Appelbaum (2004) performed a meta-analytic review of sixty home visiting programmes for families with young children in the USA. The findings reported positive effects due to the service being brought to the family and offering opportunity for family involvement, personalised service, individual attention, and rapport building.

In their review of the home visiting programmes in the USA, Daro and Dodge (2010) found that empirical evidence supports the efficacy of home visiting programmes. Home visiting has the capacity to achieve its stated objectives and can raise awareness of available local resources to families.

Another study on home visits was conducted in Canada in 2005. The data was collected through interviews with community-based volunteers who delivered information on healthy child development, provided emotional support, assessed family needs, and made referrals for community resources (Meyer, Estable, Maclean & Peterson, 2010). The intervention was reported to be effective in increasing healthy child development and decreased adverse effects on mothers such as postpartum depression.

In sub-Saharan Africa, home-based visits were used as a basis of care for terminally ill HIV patients and their families. In their research, Mazzeo and Makonese (2009) assessed the home-based care intervention between 2005 and 2008 in the rural and peri-urban locations of Zimbabwe using interviews, focus group discussions and participant observations. It was shown that home-based care addressed the material, physical, psychosocial, palliative and spiritual needs provided in part by health care providers and mostly by community-based volunteers (Mazzeo & Makonese, 2009).

For Zimbabwe the home-based care approach has been used since the 1990s to reduce the burden of care on health facilities with limited resources. The government developed policies, standards and training manuals for home-based care. A long term study observed the home-based care programme between 1991 and 1998 as well as during 2000, 2003 and 2009 in Bulawayo, Zimbabwe. Data for the study was collected through interviews and focus group discussions with home-based carers (Rodlach, 2009). It was revealed that success was subjective as the care was dependent on resources which were sometimes

limited and depended largely on churches, non-governmental organisations and the community (Rodlach, 2009).

For family planning Zimbabwe used the home visit approach to reach people through community-based distributors (CBDs) whose main mandate was to create demand through education, motivation, supply of condoms, oral contraceptives and spermicides to women and men in their catchment areas (Maggwa, Askew, Marangwanda, Nyakauru & Janowitz, 2001). This approach was very successful when it commenced in 1976, but the programme is no longer producing the desired outcomes. The reason may be that the existing CBDs spend much more time resupplying existing clients than recruiting new acceptors (Maggwa, Askew, Marangwanda, Nyakauru & Janowitz, 2001). This was documented in an assessment conducted in Zimbabwe in 2001. Data for the assessment was collected through in-depth interviews with stakeholders involved in the programme.

In Ethiopia the home visit approach through door-to-door visits conducted by health extension workers is reported to have increased numbers of mothers accessing health care services. Discussions in the home visit sessions cover a variety of health topics that include maternal health and HIV. Referrals are made after the visits and, over time, more women have attended antenatal care. Recorded numbers of the increase range from 169 in 2010 to 688 in 2012 at the Sululta Health Centre in Addis Ababa (The Interagency Task Team, 2013).

2.6 Health care services – access and barriers

The concept of universal coverage of health services was embraced by WHO member countries in 2005, but only a few low-income countries have achieved this objective (Jacobs, Ir, Bigdeli, Annear & Van Damme, 2011). There is no agreed definition of access to health services but it is suggested to be, the timely use of health services based on community members' needs (Peters *et al.*, 2008). O'Donnell (2007) proposed that access has four dimensions: acceptability, availability, affordability, and geographical accessibility. These four dimensions bring about the issue of demand and supply of health services. Acceptability and affordability agitate for the demand side of health services while availability has to do with the supply side of health services. In order to address barriers to

access, it is necessary to address the demand side and supply side of barriers concurrently (Jacobs, Ir, Bigdeli, Annear & Van Damme, 2011).

In a study that presented an analytical framework for appropriate interventions to address barriers to health service access, Jacobs *et al.* (2011) conducted a secondary analysis of published articles on barriers to access of health services and the interventions designed to overcome these. The analysis presented a number of barriers that hamper access to health services, which include low levels of knowledge, socio-cultural and religious beliefs, user fees, poor male involvement in programmes, lack of assertiveness and low self-esteem by users, stigma associated with a disease or condition, lack of health awareness and lack of information on health care services (Jacobs, Ir, Bigdeli, Annear & Van Damme, 2011).

In Zimbabwe an assessment of the maternal and neonatal health services identified three delays (in access to health care services) which are relevant in the reduction of maternal mortality. The first delay is '*Recognising the need for medical care and in deciding when to seek medical care*'. Some of the major contributors to this delay are the lack of knowledge about complications of pregnancy and childbirth, traditional beliefs and low socio-economic status. It is further added that family disputes, family practices and traditional attitudes prevent women from getting health care that is required (Ministry of Health and Child Welfare, 2007).

In the National Maternal and Neonatal Health road map the Ministry of Health and Child Welfare (2007) has one of its priorities as the scaling up of programmes and activities which are acceptable, accessible and affordable for all Zimbabweans especially the poor and vulnerable groups. The road map specifically brings out the need for demand generation at community level to address the first delay. It specifies, "*...efforts must be made to ensure that maternal and neonatal health issues are in the everyday language of the community.*" (Ministry of Health and Child Welfare, 2007: p 16). The access and barriers to health care issues mentioned above are addressed through interpersonal communication at community level. The mandate of BCFs is to mobilise their communities through interpersonal communication while raising the issues of culture, family practices and traditional attitudes that prevent people from taking up health services (Ministry of Health and Child Welfare, 2005).

2.7 Health Services – uptake and utilisation

Assessments conducted in Zimbabwe have pointed to the need for demand generation to increase uptake of health services. While there may be broad coverage of services such as HIV testing and counselling in Zimbabwe, there is generally low utilisation of most services targeted at communities.

Zimbabwe aims to reduce HIV incidence by 50% from 0.85% to 0.43% for adults by 2015 (National AIDS Council, 2011). To achieve such a result, high impact interventions which include social and behaviour change communication, condom promotion and distribution, voluntary medical male circumcision (VMMC), elimination of mother to child transmission of HIV (EMTCT), HIV testing and Counselling, prevention and control of sexually transmitted infections are required (National AIDS Council, 2011).

Uptake of these preventative services are hinged on people's behaviours and one of the key strategies is social and behaviour change communication (SBCC) intensified at community level. National AIDS Council (2011) identifies SBCC as a key intervention and this programme uses BCFs.

Literature suggests that low service uptake is not only because of the non-availability of services but mostly due to lack of knowledge, social and cultural reasons (National AIDS Council, 2011). This has been observed in programming for promotion of condoms as an example. In Zimbabwe condom promotion has been done since the onset of the HIV epidemic but the impact is mostly dependent on the willingness of men and women to use the condoms. The Zimbabwe Strategic Plan for HIV and AIDS still priorities promotion of the male and female condoms through community structures targeting key populations and young people (National AIDS Council, 2011).

Male circumcision can reduce the probability of HIV infection in HIV negative males by 60% (World Health Organisation, 2008). Regardless of Zimbabwe's adoption of this, as a key HIV prevention strategy, the uptake has not been as high as expected. National AIDS Council (2011) in the Zimbabwe Strategic Plan has suggested that the uptake is low because community mobilisation is low and there is lack of education on male circumcision. One of the priorities in the strategic plan is to intensify education, awareness and community

mobilisation to generate demand for male circumcision through BCFs (National AIDS Council, 2011).

Elimination of mother-to-child HIV transmission has been available in Zimbabwe but uptake of the service has been affected because of inadequate follow up of babies born to HIV-positive mothers. It is suggested that not all HIV-positive pregnant women utilise the service because of the stigma related to HIV (National AIDS Council, 2011). Intensified community education and awareness of EMTCT to encourage utilisation of the service is another priority for Zimbabwe (National AIDS Council, 2011).

Sexually transmitted infections (STIs) remain a serious public health concern in Zimbabwe. The presence of untreated STIs can increase chances for acquisition and transmission of HIV (World Health Organisation, 2007). National AIDS Council (2011) noted that uptake of STI services is low because of the double stigma associated with STIs and HIV. As a priority, Zimbabwe will use strategies to educate the general population with a particular focus on key populations and people that are engaged in multiple and concurrent sexual relationships (National AIDS Council, 2011).

2.8 Summary

Community Volunteers have made remarkable contributions to the improvement of health outcomes. Volunteering however should be viewed according to the context and geographical area. In Europe, America and Britain the person who is likely to volunteer is not the same as the person in Africa. Volunteering in Africa brings about the issues of incentives though the core value is to serve. The economic and social issues in Africa make it necessary to incentivise volunteers as a way to sustain and foster community volunteering. Zimbabwe has benefited from the work of community health workers with attributions being made for the reduction in the HIV prevalence rate.

Chapter 3: Research Methodology

3.1 Introduction

The methodology of research describes and explains the way research has been carried out (Bryman, 2012). The aim of this study is to explore the work of BCFs and understand their

experiences, knowledge, and barriers in promoting behaviour change and creating demand for health services. The approach to understand this will be described in this chapter focusing on the qualitative design, instruments used and the data collection and analysis process. Lastly, the research ethics clearance processes followed and limitations of the study will be discussed.

3.2 Research approach and design

A qualitative research approach emphasises a generally-constructed nature of reality (Guest, Namey & Mitchell, 2013). It often involves documenting, exploring, analysing and attempting to discover a rich, deeper understanding of human behaviour and experiences that includes perspectives, behaviours and emotions (Bryman, 2012; Guest *et al.* 2013). This approach was selected for this study because of its relevance to gaining an understanding of the experiences of BCFs as well as their perceptions and attitudes towards their work.

The study is descriptive, which is useful for describing, explaining, and interpreting conditions of the present (Brewer, 2000). The objectives of this study are to explore BCFs' perceptions and attitudes, to identify and describe motivations, to learn about the knowledge levels of BCFs and to identify barriers and challenges to their work. These can be answered using the descriptive approach. Mouton (2001) supports the assertion that such a design is used when the researcher wants to describe specific behaviours as they occur in the environment. This design allowed an in depth understanding of the real-life experiences, issues and challenges faced by BCFs in their day-to-day work.

3.3 Data collection strategy

The qualitative research approach allows for generation of data that is primarily in the form of words and not numbers (Bryman, 2012). The data collection strategy used interviews and focus group discussions. Interviews are a tool that extracts information to understand the meaning of responses from interviewees (Guest, Namey & Mitchell, 2013). Focus group discussions are a tool that gathers people of similar background or interest to discuss a specific topic (Guest, Namey & Mitchell, 2013). These were preferred because there are

based on a flexible structure made up of open-ended questions to explore the perspectives, attitudes and challenges that BCFs face in their day-to-day work (Bryman, 2012).

The use of these methods in data collection helped to make the study trustworthy (Bryman, 2012). Triangulation of data collection methods is one of the ways to add credibility in qualitative research. Shenton (2004) alludes that the use of different methods compensates for their individual limitations and enhances their respective benefits. It was therefore advantageous to use interviews and focus group discussions in this study.

3.4 Schedule development and fieldwork activities

The development of the schedules (Appendix 1) was guided by the objectives of the study. Using relevant literature on volunteerism, home visits, and behaviour change-related documents statements were developed for the semi-structured interviews and focus group discussion. As a way of refining the questions it was important to ensure that every question contributed to answering the objectives of the study (Bryman, 2012).

3.4.1 Semi-structured interviews

The semi-structured interviews were guided by semi-structured schedule. After development of the schedule a pilot was conducted by interviewing three BCFs from Harare. These BCFs were interviewed for the pilot only and did not participate in the study interviews. The pilot interviewees understood most of the questions though there was a tendency to give more information which resulted in somewhat unfocused interviews that lasted longer than the forty-five minutes planned for. To address this, prompts for each of the questions were added to the interview schedule to limit the duration to between forty-five minutes and one hour. As part of refining the instruments, the interview schedule was also reviewed by the study supervisor and some sensitive questions were removed.

The interviews were conducted with 12 selected BCFs. Written consent (Appendix 2) was sought before interviews commenced. The semi-structured interviews were administered by the researcher in one-on-one meetings. Four interviews were conducted per day in Gwanda and each interview lasted between forty-five and sixty minutes. All the interviews were scheduled and timing of the appointments was set in liaison with the interviewees.

Handwritten notes were taken as well as audio recordings made of the interviews. These were transcribed verbatim into Microsoft Word by the researcher.

3.4.2 Focus group discussions

Focus group discussions were held with two separate groups, one of BCFs and the other of district officers from the NGOs that coordinate the work of BCFs. A pilot of the focus group discussion schedules for both the BCFs and the District Officers was piloted in Harare. The focus group discussion schedules were piloted among the three BCFs and two district officers respectively, both groups in Harare. These groups did not participate in the final focus group discussions. The discussion schedules (Appendix 1) were found to be appropriate and required a minimum of changes.

Two focus group discussions were conducted, one with ten BCFs and one with nine NGO district officers. One focus group was held per day and the timing was agreed in liaison with the BCFs and the district officers. The discussions were done within the expected timeframe of sixty minutes. The researcher offered participants refreshments after the discussions. Participants who had to incur transportation costs were reimbursed.

The focus group discussions were recorded through note taking as well as through audio recording. These were transcribed verbatim after the discussions into Microsoft Word. The researcher found that the audio recording helped to provide more complete accounts and complemented the notes taken. It was rather challenging to ask the questions and record notes at the same time. The audio recording was therefore very useful in capturing the exact words of the participants.

3.4.3 Participant selection

BCFs were selected for interviews by means of purposive sampling (Bryman, 2012). Copies of the consent letters and information leaflets (Appendix 2) were provided to would-be interviewees through World Vision Zimbabwe, an NGO that coordinates BCFs in Matabeleland South province in Zimbabwe. Invitations to take part in the research based on the information leaflet were left in the reception area of the Gwanda offices of World

Vision Zimbabwe. When BCFs visited the offices, they were directed to the research invitation placed in the reception area.

BCFs indicated their choice to participate by completing a form with their contact details. The BCFs indicated which instrument they preferred between the interview and the focus group discussion. The researcher collected the completed forms and contacted the BCFs that chose to participate. Random selection was done for participants in both the interviews and focus group discussions. The total number of BCFs that consented to participate was high such that the participants in the interviews were different from the participants in the focus group discussion.

The list of NGOs that coordinate the BCFs is public knowledge, and all district officers were given an invitation to participate through email. Twenty-two NGO district officers were interested in participating in the focus group discussion. Nine district officers were randomly selected and participated in the focus group discussion. Participants were offered refreshments after the discussion and given mobile phone airtime vouchers as a token of appreciation for their time.

This study was conducted in Matabeleland South Province and the data collection was done in Gwanda district from 25 May 2015 to 5 June 2015. The map below shows the location of Matabeleland South Province in Zimbabwe.

Figure 4: Zimbabwe Map - Matabeleland South



3.5 Data analysis

Data analysis is the pathway to getting the findings for a study (Christensen, 2004). The process involves critically looking at data in order to judge its quality, cleaning it and converting it into an easily understandable format and drawing conclusions. This study is qualitative and used the thematic analysis approach. This provides a broad view across all data to identify the common issues that recur and identify the main themes that summarise all the views (Bryman, 2012). Green (2002) alludes to this method as suitable for descriptive, qualitative projects. The steps of thematic analysis were observed that included the development of a coding scheme from existing literature, as well as from the raw data, keeping the study objectives in mind. The final analyses are presented in the next chapter, according to the study themes and aided by direct quotations from participants.

3.6 Ethics

This research involved community-based people and applications for ethical clearance were made to University of the Free State (UFS), Faculty of Humanities Ethical Committee (University of the Free State, 2013) and to the Medical Research Council of Zimbabwe (MRCZ). Submission was made to UFS first. After the UFS clearance, a submission was made to MRCZ. Permission in the form of clearance letters (Appendix 3) were obtained

from both parties before the commencement of the field work. The process of clearance helped to refine the proposal and the tools used in the study.

This study emphasised full disclosure and efforts were made for respondents to understand their participation (Bryman, 2012). Participants were made aware that participation in the study was voluntary and that they had the right to refuse to participate. This extended to the right not to answer any question and they could withdraw from the study at any time (Mouton, 2001). Participants were asked permission for audio recording of sessions. Confidentiality was guaranteed by keeping data safely stored on a password-protected computer and no names were used in the study. It was not possible to guarantee confidentiality within the focus group discussion as the researcher did not have control over the participants. Confidentiality was however emphasised as a ground rule and participants were urged to maintain it. All Participants completed and signed consent forms. None of the participants terminated their participation in the process.

The researcher is employed by UNFPA the agency that coordinates the BC programme in 26 districts. This posed the risk of there being a conflict of interest in running the study. This was however countered by a declaration (Appendix 4) to the ethics boards, and by checking the quality of the research process against the study supervisor's critique.

3.7 Limitations

The most cited limitations in research are access to research participants, time management and limited resources and these can negatively affect research studies (Spring, 1997). Due to time and financial limitations, the study employed a sole qualitative perspective. Complementing this study with a quantitative component would have increased study validity, reliability and scientific robustness. Nevertheless, given the main purpose of this study is to add to the researcher's Masters Education, a sole qualitative component was deemed appropriate.

3.8 Summary

The process of conducting this study was described highlighting the qualitative approach which was suitable for answering to the objectives of the study. The data collection tools and the process of data collection were discussed. Data analysis that will lead to the findings of the research was laid out. Lastly, the ethical considerations and the limitations to this study were explained.

Chapter 4: Study findings

4.1 Introduction

This chapter presents the findings of the study based on the interviews and focus group discussion with BCFs as well as the focus group discussion with district officers. The findings are explained in relation to the four study objectives:

- 1) To explore perceptions of BCFs and their attitude towards daily tasks and responsibilities
- 2) To identify and describe factors that motivate and/or discourage BCFs in their daily activities
- 3) To assess the knowledge and understanding of BCFs by the behaviour change programme elements, specifically HIV prevention and SRH
- 4) To identify the barriers and challenges faced by BCFs in achieving the goals of the National Behaviour Change strategy

Various themes have been derived during analysis of the data and these will be presented as follows:

- Demographic description of study participants
- Knowledge of BCFs
- The work and processes followed by BCFs
- Acceptance of BCFs according to BCFs and District officers
- Perceptions and attitudes of BCFs towards daily tasks
- Motivation factors for BCFs
- Challenges faced by BCFs
- Recommendations by BCFs

4.2 Demographic description of participants

BCFs participated in interviews and an FGD. The interviews were conducted with twelve BCFs of whom five were male and seven were female. The FGD was conducted with ten BCFs of whom five were male and five were female. A few BCFs had primary level education and a few others had tertiary education level but most had secondary level education.

Most of the participating BCFs had no formal employment. One BCF was formally employed at a mining company and conducts home visits within the mining complex. Four of the BCFs were self-employed. The majority of BCFs are married with one who is single and one who is widowed. The BCFs followed a number of religious denominations with most being Christians. A considerable number followed the white garment apostolic faith. There were a few that follow a traditional religion.

Most BCFs, in both the interviews and the FGD, have other volunteer roles in their communities. The other roles that BCFs also undertake are Village Health Worker, Peer Educator, Community-Based Distributor, WAC focal person, Star Facilitator, Male Mobiliser, Caregiver, Paralegal and Child Protection Member.

All BCFs were trained as a first step and most were able to remember when they received the training. Most of the participants mentioned having received a refresher training course and other training, including basic counselling skills. It was noted that a few of the participants could not articulate the elements of the training received. A few remembered the detailed step-by-step process of behaviour change though most remembered the topics in the manual such as gender-based violence, teenage pregnancy, voluntary medical male circumcision and prevention of mother-to-child transmission of HIV.

District officers are coordinators that support and supervise the work of BCFs. Nine district officers participated in the FDG. Of these four were female and five were male. All the district officers are based in Matabeleland South, at their work duty stations. Three of the district officers have Masters-level qualifications while the other six have at least a degree. Most of the District officers have worked with the BCFs in Matabeleland South districts for more than two years. All the officers received training as part of orientation for the programme. The district officers conduct the training of BCFs as well as manage and maintain the complement of BCFs. District officers are also the link between the community and the BCFs. They liaise with the community leadership for recruitment or disengagement of BCFs.

4.3 Description of BCFs Knowledge

Participants showed an appreciation for the need for behaviour change and understood that it is a process. A few participants were able to articulate all the stages in behaviour change as explained in the home visit manual. Others however could name part of the processes but not in full or in the specific order. The FDG participants showed a clearer understanding of the process and could articulate the stages. BCFs related the behaviour change process to their communities and expressed how they expect their communities to progress. Some of the responses pointed out that behaviour change can be progressive or regressive. One interviewee defined behaviour change as follows:

"People in the community are unaware so basic information is provided, now they are aware but they are not concerned, they are now into it because of information given. Once they are concerned they acquire more knowledge and they are now ready to change and try living a new behaviour and maintain the new behaviour." BCF (female, 49)

Another interviewee simply defined behaviour change as follows;

"Provide basic information on situation, informing the participants, the benefits of changing behaviour. Tell participants what they can do to change behaviour such as going to the clinic for treatments". BCF (male, 47)

Voluntary Medical Male circumcision (VMMC) is one of the interventions discussed by BCFs. On this BCFs were asked the percentage of risk reduction of contracting HIV for a medically circumcised male. Except for a few that didn't know, most of the BCFs knew that the risk reduction is approximately 60%. The question was also asked in the focus group discussion but focused on the key messages when VMMC is discussed. The responses showed good knowledge on VMMC. BCFs were able to explain the need for dual protection as the risk reduction from male circumcision is not 100%.

One FGD participant said the following about dual protection from VMMC and condoms;

"There is need to continue using condoms because there is no 100% protection" BCF (female, 29)

BCFs showed a good understanding of HIV transmission modes. The most singled out transmission route was unprotected sex. Bodily fluids, open wounds and sharp objects were also mentioned as some of the ways of transmission. There was however some indication that BCFs had difficulties in explaining transmission through bodily fluids. This was mentioned a number of times but no clear explanations of how the bodily fluids transmit HIV.

One interviewee explained HIV transmission as follow:

“Unprotected sex, open wound, sharp object, during pregnancy and through bodily fluids”.
BCF (female, 50)

A follow-up question on HIV transmission was asked to establish BCFs’ understanding of factors that may increase chances of HIV infection. BCFs identified Multiple Concurrent Partnerships (MCP) as a major factor that increases chances of HIV infection. In addition, age mixing (also identified as intergeneration sex) inconsistent use of condoms and child birth were given. Cultural and customary practices were added as factors.

An additional question was asked to identify when an HIV infected person is more likely to transmit HIV. BCFs found it difficult to explain HIV infectivity stages and hence were not clear in their responses. Some of the responses included ‘*having sex when drunk and during ejaculation*’. One of the interviewee responses that showed an unclear understanding of HIV infectivity is as follows:

“Through blood and fluids entering an open cut during sexual intercourse”. *BCF (female, 52)*

A few of the BCFs, however, were able to identify the time stages after infection and pointed out immediately after HIV infection.

On the other hand BCFs in the focus group discussions were able to better explain infectivity stages. The collective participation made it possible for BCFs to discuss and remind each other of the infectivity graph. The discussions were, however, winding and

started off with some very simplistic answers such as *“having sex when drunk”*. Further discussion between the participants resulted in more accurate answers that pointed to high HIV viral load and during the first three months of HIV infection. One FGD participant described the most infectious stage as follows:

“During the first three months, when the viral load is rapidly increasing”. BCF (male, 46)

Cervical Cancer is a topic discussed by BCFs during home visits. A question on the signs of cervical cancer was asked. Participants in both the interviews and FDGs were able to list the signs of cervical cancer. Almost consistently the first point identified by BCFs was severe bleeding or continuous bleeding during the menstrual period. BCFs however suggested some additional signs that included stomach pain, backache and painful waist. It was noted that participants in the FDG were more accurate in detailing the signs of cervical cancer. One of the FDG participants explained the signs of cervical cancer as follows:

“The signs of cervical cancer include abnormal bleeding, menstrual periods last longer than usual, vaginal discharges”. BCF (male, 54)

The follow-up question on cervical cancer was to do with ways to prevent cervical cancer. BCFs showed good knowledge of the ways to prevent cervical cancer. BCFs were able to identify the delay of sexual debut, reduction in the number of sexual partners, regular screening and eating of fruits and vegetables. Other ways related to hygiene and avoiding the use of herbs and chemicals in the vagina were mentioned by BCFs. One interviewee explained the ways to prevent cervical cancer as follows:

“Delay sexual debut. Reduce the number of sexual partners you have. Go for regular VLAC Screening to check on the health of your cervix. Eat more fruit and vegetables”. BCF (female, 36)

In addition to the conventional knowledge they are taught, BCFs also bring the knowledge they gain in their work. The following are some of the lessons learned overtime:

Having visited a number of households, BCFs have learnt that each household has its own experience and cannot be compared or handled with a uniform approach. Each household is therefore different and requires a specific plan and recommendations.

"Each household has its own experience and cannot be compared or use a blanket approach". BCF (female, 45)

It's possible to find alternatives at community level. A BCF taught girls to make sanitary pads from old t-shirts. The pads are reusable and a cheaper option for girls that cannot afford to buy on a monthly basis. The interviewee said the following:

"I had to teach girls to improvise pads from T-shirt material. We had lessons to cut and sew the pads". BCF (female, 39)

The importance of early screening for cervical cancer and HIV testing and counselling was covered. It is important for people to know their status in order to start treatment early if required. BCFs learnt this as personal experiences and now use their experience when conducting home visits.

"I have learnt a lot about early screening for cervical cancer and have done so myself. I also learnt about HTC and applied it myself". BCF (female, 49)

BCFs have learnt that behaviour change is a process and people will not change immediately. BCFs observed that the process of behaviour change takes time and people require follow ups to take the steps towards adopting safer sexual behaviours and even seeking health services. The exposure to one home visit is not sufficient for people to change their behaviour. BCFs have found it takes more than one visit to follow up and see the difference with individuals. One interviewee expressed the lesson as follows:

"As a BCF I have learnt that behaviour change is a process. Achievements cannot be achieved in a short period". BCF (female, 36)

4.4 The work and processes followed by BCFs

The training of BCFs emphasises that their work is critical as it involves dealing with people at a personal level with specific objectives. BCFs revealed that they generally have a good understanding of their work and what is expected of them. A few however had more

limited comprehension of their exact function. Most BCFs gave comprehensive responses that included the creation of demand for health services as well as adoption of safer behaviours to prevent HIV:

"To communicate clearly and persuasively with households. Being strongly motivated to work towards STI/HIV/AIDS risk reduction. To encourage communities to seek health service providers on their own". BCF (male, 47)

"To create demand for HIV services at community level. To educate the community so that they demand services from service providers". BCF (female, 39)

On the other hand, a few of the BCFs were not so clear on their role. Two interviewees expressed their work as follows:

"I help people to live well and I see change". BCF (female, 49)

"To have good qualities as a BCF and to respect the community. To have good interpersonal skills". BCF (female, 55)

Linking the BCFs understanding of their work, district officers gave their views on what they expect of BCFs. District officers expect BCFs to conduct the door-to-door visits of households in their respective wards. They expect the BCFs to conduct the sessions using the home visit manual. BCFs are expected to interact with the families and to make referrals for appropriate health services. In addition, BCFs are expected to be role models in their communities and to be gatekeepers.

A district officer explained his expectation of BCFs as follows:

"That they conduct home visits of sixteen homes per month exposing a total of at least forty-eight household members per month per BCF, referring clients to receive services where ever they are provided, following up referred household members to check on progress and record changes that may be happening as a result of the services that were received, networking and collaborating with relevant stakeholders as they create demand for

services in the households, submit sixteen home visit report registers per BCF per month".
District Officer (male, 42)

BCFs were able to relate the process of conducting a home visit and the steps involved. Most BCFs make prior appointments with the households. The BCFs that do not make appointments alluded to the fact that people are always available and willing to participate. Other BCFs pointed to the fact that permission is sort from the kraal head before they can conduct home visits in specific areas. Most of the BCFs plan and ensure that they have the required resources for the visit. About a third of the BCFs mentioned that they actually read their material before the visit while others rehearse the topics that they might discuss in the preparation.

One interviewee explained how they prepare for a home visit:

"Read and understand their topic. I will be representing since I would have booked for an appointment and did the risk assessment. And carry all my tools, pen, marker, chart, register manual referral scoring sheet risk assessment tool". BCF (male, 47)

BCFs identified that a home visit session takes between two to four hours. Within this time a BCF is supposed to cover the selected topics and make recommendations for the participants. Thereafter the BCFs move to the next household. There are possibilities of conducting repeat visits though BCFs expressed that their target is to reach new households first. BCF expressed that they are people that need counselling even after the first visit and hence there is a lot of involvement with the families. They also mentioned that there are many cases of Gender-Based Violence (GBV) that requires follow up. Another example of follow up that takes the time of BCFs was when they encourage people to take up the referred health services. One Interviewee shared their experience showing the extent of involvement with families:

"I do stay in contact. For example, there was a girl who was being abused by an aunt looking after her. She was a minor but was not going to school and also being sexually abused by the Gardner. I stayed in contact with the family and she eventually spoke out and the man was arrested". BCF (female, 29)

Home visits are of a personal nature and confidential. BCFs were asked if they share any information on the sessions they conduct. All the BCFs alluded to the fact that they do not share any information beyond the home visits. The issue of trust was highlighted as important for them when conducting home visits. It was emphasised that people will not open their homes to people they do not trust. It was, however, noted that there are some cases where confidentiality is not possible, particularly where there is GBV or abuse. One FGD participant shared the following:

"Yes confidentiality is very important. I share information with my officers, that is, if the person is willing to share, or with the clinic, that is, when there is need to help. Otherwise I do not share information with anyone in the community". BCF (Male, 47)

In both the interviews and FDG with BCFs it was evident there is planning that goes into the process of conducting a home visit. Most of the BCFs showed commitment to the process and deliver the sessions using the materials provided.

4.5 Acceptance of BCFs according to BCFs and District Officers

BCFs gave their perception of the reception they receive from households during home visits. Most BCFs perceived households to be welcoming to their presence and mentioned that they are welcomed in most households. Some BCFs have actually been approached and requested for visits by families even before they have reached that area. One interviewee said the following:

"Yes, they are also welcoming. Now others even come to the point of calling me". BCF (female, 50)

There are, however, some households that refuse BCFs access for a number of reasons that include people not having time because of work commitments. Some people who follow the white garment apostolic faith do not believe in public health and hence are not willing to listen to community health workers. In such households the head, usually a man with a number of wives refuses to give access to the BCFs. The wives however are usually receptive as long as they are not seen by fellow church members. They sometimes approach

BCFs to have sessions on their own and request for family planning services. There are also people that generally look down on BCFs and do not want to have the sessions.

"Not always, sometimes at some homes they underrate BCFs. Some don't even open their gates and they do not give time to discuss such that you end up conducting some sessions at the gate. Some households are difficult, particularly the apostolic faith, because they do not believe in health care. Sometimes one of the people from the household can contact me the BCF after, particularly the wives". BCF (female, 36)

BCFs described how they continue to request appointments with people that would have refused. BCFs have noted that in most cases families end up giving time and accepting their participation in the home visit session. District officers gave their views on the response of the community to BCFs. District officers expressed that BCFs are generally accepted in their communities. It was pointed out that BCFs are selected through the community structures and people are more likely to be receptive. The district officers felt that BCFs have made a difference for their communities and the communities have noted their work. One district officer said the following:

"Communities have cooperated well with the BCFs in the communities as evidenced by being welcomed into households during home visit in the door-to-door visits, participating in discussions and accepting referrals for services and visiting health centres for services". District Officer (female, 30)

Another District Officer added the following:

"The community and its structures from traditional leaders have appreciated the work that BCFs have done in response to issues of HIV and AIDS. Also, the community leaders have pledged support and created a platform for them to execute effectively the home visit approach. They have also been applauded for their contribution to the decreases in the HIV prevalence and incidence rate". District Officer (female, 28)

District officers have an overview of the work of BCFs. They have noted that the response in urban areas is not as receptive. The low response was measured against the referral slips

that are collected at the clinics. People do not seem to take up health services in the urban areas as compared to the rural areas. A district officer noted the following:

“There is a difference in response because in urban areas the programme is taken lightly. There have not been referrals slips at the clinic. It’s either the BCFs are not presenting the programme well or people have not responded. There are still a lot of STIs reported at the clinic. This should have been going down if BCFs were working well”. District officer (Male, 30)

To show the process of acceptance by the families that BCFs work with, a story was shared highlighting the follow up that BCFs take until identified issues are resolved:

“There is a family that had a mental issue GBV. The husband was so strong headed. But when I got a chance to meet him he was receptive to the message and confessed that he thought BC was all about telling people there are HIV positive. He is now a changed man and his family appreciates him a lot. His habits have changed”. BCF (female, 39)

4.6 Perceptions and attitudes of BCFs towards their daily tasks

BCFs acknowledged that there are benefits of undertaking their role. Some of the benefits are to do with the impressions of the community on the BCFs. In most instances BCFs identified the benefits as personal gain as it improved their communication and leadership skills. In some cases their families were transformed because of their interaction. Some BCFs also changed their own behaviours in order to be effective role models. An interviewee expressed the following on how the role has benefited them:

“It has helped me in many ways. I am now confident to talk to my husband about HIV and we have regular HIV tests. It gave me confidence with people, I think I now have people skills and public speaking skills”. BCF (female, 36)

BCFs were asked if they are happy with their work and what they liked most. All BCFs expressed being happy with their work. Most find that the time spent doing home visit sessions is worthwhile. BCFs have found that their work earned them respect from the community and they are seen as role models. Most BCFs said they found it fulfilling when

communities show appreciation for their contribution. One FGD participant stated the following:

"Happy in the sense that I am now a role model, a person with respect because I am contributing much to the community". BCF (male, 47)

BCFs expressed that they are seen as leaders in their communities. Some BCFs think the experience may provide employment opportunities for them. One interviewee said the following:

"I might get a job one day through my experience and bring income to my family". BCF (male 46)

4.7 Factors that Motivate BCFs

The data revealed indications on BCFs' motivation in carrying out their tasks. A number of motivations were identified and these include:

- Personal exposure that results in BCFs gaining more knowledge. The exposure helps them to personally adopt safer sexual behaviours as well as a general positive outlook to life. A interviewee shared how the exposure changed their outlook to life:

"I was widowed in 2007 when my first wife passed away in an HIV related illness. In 2008 I was recruited to the World Vision family as a BCF. At the training venue I met two lady BCF trainees who I shared experiences with. After being empowered I buried the thought that HIV positive persons can't marry and lead a normal like. In 2009 I married my wife one of the two mentioned above. We are both HIV positive and happily married". BCF (Male, 47)

- The opportunity to learn from their work and live by example. BCFs revealed that the topics covered in the programme related to them personally and are motivated to take up health services. This works as an example for the people they are reaching through the programme

- Skills gained from interaction with families. These include communication and interpersonal relational skills
- Noticing changes that take place as a result of their work
- A reduction of the burden of health problems on their communities

One of the most mentioned motivational factors was the reduction of the burden of health problems in communities. It was evident that some of the BCFs have been on the programme for a long time to at least track movements on the burden of health problems on their communities. BCFs were able to relate that less people are bed ridden in their communities because of the knowledge and availability of antiretroviral treatment. More women are now attending antenatal care and delivering at the health facilities. One of the FGD participant summarised her motivation as follows:

“Personal exposure, skills gained and interaction with different characters in the home. Gain experience in dealing with families and communities. More people are seeking services after our interaction”. BCF (female, 49)

To highlight some of the notable changes that motivate BCFs, the following story was shared showing a process followed through with a BCF and good results achieved after:

“There is a lady who had three miscarriages so after sharing her experience with me I referred her first for HIV testing. She tested HIV positive. So later when she got pregnant I encouraged her to quickly register with ANC. She delivered safely. The child is HIV-negative”. BCF (female, 29)

Another interviewee shared his experience of working with a couple that was sero-discordant and achieved positive results after a number of sessions:

“I worked with a couple that is sero-discordant. Ever since their found out their status they have stopped having sex. They slept in separate bedrooms. I visited them as a family and had discussions with the couple. The risk assessment pointed to couple communication and we discussed. After discussing I encouraged them to go for couple HIV testing. They called me back after a few days and revealed to me that they knew their HIV status and having

not been sharing bedrooms. They wanted to know how safe it is for them to have sex now that they were talking openly. I encouraged to use condoms consistently but also referred them to the clinic to get for information as a couple. They have reported back to me that they are now living in the same bedroom and are a happy couple again". BCF (Male, 47)

Another example of when BCFs follow up on referrals made and make a difference when the services are taken up:

"I had discussions with a lady that thought the problem of being diagnosed with cancer was for others. She excluded herself saying nothing to me. When she finally decided to go for VIAC she was found with cancerous cells and treated immediately. She could not believe it at all. She came back with feedback about the screening and treatment. She was very grateful that at least she got early treatment. She was very happy with the programme saying it saved her to learn about cervical cancer". BCF (female, 39)

In addition BCFs mostly expressed satisfaction with the support received from World Vision district officers. They find the district officers to be very supportive and encouraging. Having the district officers on the ground supporting BCFs is used as a way to authenticate the programme. BCFs see it as a way to motivate the communities to participate in the programme. One interviewee said the following:

"They are very supportive and they keep encouraging and motivating. They sometimes visit us as we will be conducting our household sessions. The community will also be happy to see new faces". BCF (female, 54)

BCFs receive a monthly allowance of \$15. The issue of financial incentives was mentioned even in questions that were not directly related to incentives. Most of the BCFs mentioned that the incentive is something that they would change. There was a general feeling that the incentive is too little. In comparison with other community volunteers, BCFs felt that their incentive was low. No figures were given to compare with the other community volunteers but BCFs assumed that others are paid more. One FGD participant expressed the following about the incentive;

"As a volunteer I am happy that at least I am getting something but comparing with other volunteers BCFs are doing more to the community but getting less". BCF (female, 36)

Another interviewee added the following about the incentive;

"We joined as volunteers but the work we are facing and doing is very difficult so much so that the incentives are very low. They need to be raised to suit us for the hard work we are doing". BCF (male, 46)

BCFs also highlighted other issues that are discouraging for them, such as the long distances covered to reach some households as well as being looked down upon by some people in the communities. One of the FGD participants had the following to say:

"Being looked down at, being underrated. Some people look at us as if we are so poor and yet we are giving them good information, knowledge. Some of them stigmatise us because they assume that if you talk about HIV then you are HIV-positive". BCF (female, 49)

4.8 Challenges faced by BCFs

Challenges faced by BCFs were collected in both the interviews and FGD. District officers also gave their opinion on the challenges faced by BCFs. The challenges will be presented together with the solutions identified by BCFs as well as the relevant opinions of district officers.

Some BCFs felt stigmatised and discriminated against by members of the community. There are people that look down on BCFs and even give them derogatory names. This was also expressed by BCFs as one of the things they do not like about their work. One interviewee highlighted this challenge as follows:

"There are people that call us names and look down on us. They say 'vauya vemacondom' (the condom people have come)". BCF (female, 29)

To address these challenges BCFs continue their work and continue to encourage people regardless of some of the negative treatment. BCFs sometimes use this as an entry point to start discussion with the people. District officers added that some health service providers

look down on BCFs. There are health service providers that do not take BCFs seriously. District officers mentioned that lack of support from the health service providers is demoralising for BCFs as there are supposed to work hand in hand. The following was said by a district officer;

“Some service providers look down upon BCFs when conducting their work. This demoralises BCFs as they feel they are creating demand for health services with no acknowledgement”. District officer (female, 30)

The distances covered by BCFs are sometimes too long and in rough terrain even when they have bicycles. BCFs said they address challenge by dedicating a day to conduct home visits in places that are far to reach. There are cases where they have had to sleep over in rural to cover a number of households before returning home. They however also mentioned that this poses challenges because they have to provide for their own food and request for accommodation in those areas. One FGD participant expressed the challenge as follows:

“Some of the areas are now too far to go for home visits and return home. Even with a bicycle the areas are mountainous and difficult to travel in. There are time when I have to sleep over in the areas. I have to ask for a place to sleep and the families give me food out their own hearts. I then meet a number of households in that area before going back home”. BCF (male, 47)

District officers confirmed the long distances as a challenge for BCFs. Some of the wards that BCFs work in are vast and this makes it difficult to reach every household. A district officer said the following;

“Distances may be too expanse even with a bicycle”. District Officer (female, 30)

BCFs sometimes come across households that are not willing to participate in home visits. Some of the people are professionals such as health personnel that include doctors and in other cases teachers. These professionals are not always willing to give BCFs access because they say they have all the information already and are dealing with some of the issues at work. Other people are just not willing to participate because of religious reasons.

There are people from the white garment churches that do not believe in taking up health services. One interviewee said the following;

"The houses are far apart from each other. Ask for IDs as people need to identify us when we visit households. Some people in homes are doctors, nurses, teacher and they don't have time to listen, saying they are always dealing with the same issues". BCF (female, 39)

To resolve this challenge BCFs explain that the home visits are not just about health related issues but also cover social issues such as building relationships among families, communication and gender. Some of the professionals are receptive thereafter. One interviewee expressed the experience of working with school headmaster and his family;

"I got the headmaster's house and requested for appointment to meet them as a family. He asked what I can teach him and that he knows most of the issues. He said maybe I can visit his school to talk to the children but not him. I remained and said the topics are not just about health and that I wanted to meet him with this family. He asked for my materials and looked at them. He gave me an appointment. When I went back we had a good session with him and his family. The children were very happy to be discussing. He thanked me very much because he learnt to communicate with his family well". BCF (female, 36)

BCFs do not always have sufficient resources to carry out their work. BCFs mentioned that they do not always have stationery to carry out the sessions. The uniforms identified as T-shirt, hat and bag are not sufficient as only one set is given per year. BCFs do not receive protective clothing and this is a challenge particularly in the rainy season. BCFs mentioned that raincoats, umbrellas and plastic cases for materials would be useful. One FGD participant expressed this challenge as follows;

"Also tool kits need protection from rainfall. No umbrella, raincoats, plastic cases for books. Administration is poor because we have no time for review meeting". BCF (male, 54)

BCFs address this challenge by buying their own stationery and protective clothing. It was acknowledged that World Vision has at some point provided raincoats for them. The challenge was also identified by district officers. District officers find that BCFs have

difficulty in conducting home visits in the rainy season because they do not have rain coats. District officers highlighted that they find BCFs using a lot of their personal resources to carry out their work. They often have to buy stationery and use their airtime to communicate with the district officers as well as to make appointments for the home visits. One district officer said the following;

“Lack of accessories/ protective regalia such as canvas shoes and raincoats/umbrellas. Though highly appreciated, some of the BCFs only received their bags and hats in the 1st quarter of the final year of the Demand Generation Programme. BCFs use a lot of their own resources to buy stationery and for airtime. They are always phone me for clarification and they never get refunds of the airtime”. District officer (male, 37)

BCFs create demand for health services but some of the services such as cervical cancer screening and treatment are not available at the local health facilities. BCFs find this discouraging for the referred people because they cannot access the services. BCFs said that people end up not taking up any services because of that one service that is not available. Other challenges to do with health services are that BCFs do not have anywhere to refer young people as there are no services or youth friendly services for young people. It was also pointed out men are not always ready to take up male circumcision. They feel that it is not culturally right for them and hence BCFs have to make additional efforts to persuade men for circumcision. Similarly the female condoms is not readily accepted by women in the Gwanda community.

BCFs alluded to having difficulties to resolve this challenge because they do not have much control. They however have planned together with the district officer to take groups of women for cervical cancer screening at the district hospital. The district officers arranged transport to ferry the woman to the district hospital and back. The district officers confirmed this arrangement though they said it could not be done consistently because of a lack of resources. The organisational vehicle can only ferry women when there is a scheduled visit. The issue of a lack of services such as cervical cancer is a definite challenge that even the district officers find difficult to deal with. They have liaised with the Ministry of Health but were advised to wait for a time when the services are available at the local health facilities. One district officer said the following;

"They have created demand for cervical cancer screening but the services are not being provided and are now having pressure from clients. I have personally followed up with the MOH for these services but was told to wait until their time". District Officer (female, 30)

The monthly allowances for BCFs are low and there was a consistent call for an increase. BCFs have continued to work because of the understanding that they provide volunteer services. The calls for an increase were, however, quite strong because BCFs feel their work is a lot and important such that they deserve more. District officers found this to be a challenge for BCFs. This was aligned to burnout and district officers find it difficult to motivate BCFs because they also feel that the allowance is too low. A district officer said the following;

"Meagre allowances make it difficult to motivate BCFs or to chase them up for their targets. BCFs tend to use more of their personal resources than what they get from the programme". District Officer (female, 30)

The work and life balance for BCFs is sometimes a challenge. This is particularly in the agricultural season when both the BCFs and their clients are busy. Attaining targets at this time can be a challenge for BCFs. They resolve this challenge by balancing the time for conducting home visits and conduct them on days that people do not go to the fields. District officers have also found this to be a challenge for BCFs. A district officer said the following;

"Balancing their household obligations and the demands of the BC programme responsibilities, particularly in the agricultural season". District Officer (female, 29)

4.9 Recommendations made by BCFs and District officers

BCFs and district officers were asked for recommendations and these are follows:

- BCFs recommended for the programme not to be target-based because they are driven by passion and commitment. They would like to work at their own pace:

"We are mature and can plan our work to get to households. The targets put pressure and end just doing the work with not all the love. I would like to work at my own pace so that I can plan my things better". BCF (Male 45)

- The resources to carry out the work are important and should be made available. This should be complemented with additional information that is current on the programme and training workshops. The district officers had a similar recommendation. This was described as important because it will increase BCFs' knowledge.

"To make sure that material required or needed by BCFs is available. Programme information can be improved to give latest information of the epidemic. Some emerging issues such as Ebola should be including in programme information". BCF, (Male, 55)

- Increase of incentives was recommended. Some of the BCFs are breadwinners and would like the incentives to be more meaningful. The district officers made the same recommendation suggesting the allowance for BCFs should be increased. There was a suggestion to raise the amount from \$15 per month to \$50 and \$100. In addition, it was recommended for the profile of BCFs to be raised for communities to realise their value. A national network of BCFs was recommended. The sentiments on incentives as a recommendation were as follows:

"I recommend that BCFs are given enough resources that will see them being motivated. Increase their incentives. Improve their uniforms. Give them computers so that the households gain confidence in them. The incentive should be \$50 per month". BCF (male, 55)

"For the programme to be improved we need to have refresher courses and to have new and more information on demand generation. To study and research, we prefer to be given \$100 per month—it's because of the work we face". BCF (female, 44)

- The community leaderships should be more involved in the programme thereby creating an enabling environment to conduct home visits. BCFs felt the support of the community leadership makes people receptive to home visits.

“More stakeholders need to get into the programme. We can never reach all the people without the support of the Chiefs and kraal heads. These leaders need to be part of the programme because people follow what they say”. BCF (female, 29)

- The programme should be linked with other projects such as provision of food for households in need. BCFs found it difficult to conduct home visits when the families have other expectations such as food supplements.

“BCFs to be given drugs like pain stops. Transport for participants to cervical cancer screening. Have the ability to give assistance like food supply for those in need. People are hungry and sometimes cannot sit to listen to information only”. BCF (male, 47)

- More support visits from district officers to BCFs were recommended. The quarterly district review meetings were recommended by BCFs as a good platform for them to share experiences with other BCFs in their district.

“Through support and supervision to BCFs, we experienced that some of them need a lot of supervision and guidance on their work”. District Officer (male, 41)

- BCFs recommended for the demand generation manual to include other health related topics such as prostate and breast cancer. In addition, they expressed that mobilisation for the programme can also be done through community gatherings where young people play sport, drama and quiz shows as well as video screenings. Such gatherings are opportunities to sensitise communities on the programme.

“The programme can be represented in community social activities such as football and netball galas, school competitions and farmers field days. This can help to sell the programme to people in the community”. BCF (male, 55)

- District officers recommended for BCFs to follow up referrals issued out. This will encourage people to access health services and will also help with reporting the number of people that actually take up health services. In line with this recommendation, the strengthening of linkages between BCFs and health facilities will facilitate or make the work of BCFs easier.

“BCFs should follow up the referrals given to clients during home visits so that the people referred get the services since impact is measured on those who have accessed the services”. District Officer (female, 30)

4.10 Summary

This chapter presented the findings from the BCFs and district officers. The findings were presented with the objectives of the study in mind. BCFs are definitely conducting home visits in their communities. Their interaction with their communities has been highlighted in the findings presented. Their motivations, attitudes, challenges and personal experiences were shared. The district officers added useful inputs to understand the work of BCFs.

Chapter 5: Discussion of findings and conclusion

5.1 Introduction

The aim of this study was to document the personal experiences and narratives of BCFs, their influences in promoting behaviour change and in the creation of demand for health services. The final chapter is structured as follows: First, the study participants are described in terms of their demographic profile and work-related community interaction. Then, the study participants' work-related knowledge, perceptions and attitudes are discussed, followed by the factors that influence their work. Key recommendations are offered, after which some final conclusions from the study are drawn.

5.2 Characteristics of BCFs and their work

5.2.1 Demographic profile of BCFs

The BCFs that participated in both the interviews and FDG were based in the community they work. This was in line with the terms of reference for BCFs, which specify that the incumbent should be a person from the specific community they are to work in (MOHCW & UNFPA, 2012). There is a general understanding that community volunteers are people from within their communities (Lehmann & Sanders, 2007). It is important for community volunteers to be from within their communities as they understand the social and cultural factors that influence the health-related aspects (Ashraf, Bandiera, Lee & Musonda, 2012).

This study found that the BCFs that participated were fairly equally distributed in terms of sex. This could be because of the study's research design wherein participants opted to participate. Previous research has, however, shown that women volunteer more often than men. In Zimbabwe it was found that the gender distribution is tilted towards women because the tradition of caring is mostly the women's role (Kaseke & Dhemba, 2007).

The findings showed that the majority of BCFs have secondary education. A few had no education while a few others had tertiary education. According to previous literature there is no requirement or set education level for community volunteers. Community volunteers are selected through their community structures (Lehmann & Sanders, 2007). The terms of reference for BCFs specify that the person should be able to read and write (MOHCW &

UNFPA, 2012). A secondary level education can be an advantage for the demand generation programme as BCFs are expected to teach, explain and educate people on issues to do with HIV, SRH and GBV. BCFs are therefore likely to understand the concepts of the programme and also deliver it well.

5.2.2 Work-related community interaction

The findings suggested that BCFs generally have a good understanding of their work. BCFs have an appreciation of their main functions as they were able to identify this as engagement of families through home visits to create demand for health services. The home visit manual lists the key functions of BCFs and highlights the need to use interpersonal communication to deliver the home visit sessions. The main expectations for BCFs are to create demand for health services, promote behaviour change and encourage the adoption of safer sexual behaviours (MOHCW & UNFPA, 2012). It was noted that community health workers act as the first point of contact with people at community level (Kasteng, Settumba, Kallander & Vassall, 2015). Community health worker programmes have been noted to produce improvements such as the increase in patients that use preventative services (Martinez & Knickman, 2010). BCFs with a good understanding of the work expected of them are strategic as they are likely to influence people to take up health services as well as adopt preventative behaviours.

It was revealed that the BCFs follow a systematic process to prepare and conduct home visits. The home visit sessions take time and the process can be long as some households require more support from BCFs. BCFs end up spending more time than planned with households. The emphasis for BCFs to follow up on their work contributes to the changes that are expected in the communities such as the uptake of health services. Documentation of community volunteers' work in Brazil, Bangladesh and Nepal showed that the work of community health workers contributed to the achievement of some MDG indicators (Perry & Zulliger, 2012). Martinez and Knickman (2010) noted the same importance of community health workers as their study reflected improvements on health outcomes specifically in capacity to coordinate timely access to primary health care. This can suggest that work of BCFs with their communities may result in an improvement of health outcomes for Zimbabwe.

Most BCFs revealed that they are welcomed into the homes that they visit. It can therefore be assumed that there are households that readily accept meeting with BCFs. It was, however, also shown that there are some households that are resistant to BCFs. The lengths to which BCFs went to persuade community members to participate suggest commitment to serve others. One of the characteristics that characterises a volunteer is the need to serve others (Esmond, 2004). The principles of volunteering point to the fact that volunteers act for the common good and commitment to address community problems (UN Volunteers; IFRC & Inter-Parliamentary Union, 2004). The fact that BCFs are willing to go out of their way to visit homes several times to persuade households to participate suggest that they value their work and their need to help their community.

5.3 Knowledge, perception and attitudes of BCFs

5.3.1 Knowledge of key topics

The demand generation manual was used to review the knowledge levels of BCFs. This is the main resource for BCFs. All the key topics are covered in the manual which also contains guidance for BCFs on how discussions can be carried out with families.

The review of the behaviour change process showed that a number of BCFs had some difficulties in articulating the process as given in the demand generation manual. It was, however, noted that the idea of the behaviour change process was well understood. The explanations given by BCFs included aspects of the steps in the process and related it to their communities. It was evident that BCFs do not expect behaviour to change in an instant but over time. The behaviour change process is described as a step-by-step process in the manual, highlighting the following steps (MOHCW & UNFPA, 2012);

- Unaware
- Aware
- Concerned
- Knowledgeable and skilled
- Motivated and ready to change
- Trial change of behaviour
- Maintenance or adoption of new behaviour

Though these were not given in the specific order, most BCFs exhibited some knowledge of the process.

BCFs showed good knowledge on the HIV modes of transmission. Accurate answers that identified sexual intercourse, mother-to-child transmission, infected blood or sharing of needles were given. These are the same modes of transmission identified in the demand generation manual (MOHCW & UNFPA, 2012). BCFs were able to identify these as the main risks for HIV transmission. Another major risk is multiple concurrent sexual partnerships (MCP) and sexual networks (MOHCW & UNFPA, 2012). These were highlighted by the BCFs. Of note was the additional question for BCFs to explain HIV infectivity. BCFs had difficulties explaining the infectivity stages. The demand generation manual explains HIV infectivity stages. This is based on scientific evidence that suggests that a person is most infectious during the early stages of infection by HIV (MOHCW & UNFPA, 2012). The manual uses an infectivity graph showing viral load as being high between the first three months of infection. The viral load reduces significantly thereafter for months and even years. After some time the viral load starts to increase as the disease progresses (MOHCW & UNFPA, 2012). Though responses finally pointed to the correct stages of infectivity this topic needs to be revisited and explained for most BCFs.

Cervical cancer is a key topic in the manual and BCFs in both the interviews and FGDs suggested that it dominated home visit discussions. BCFs easily listed cervical cancer signs showing a good grasp of the topic. In most cases the signs were given as stated in the demand generation manual and included abnormal bleeding or spotting from your uterus, period that lasts longer and is heavier than usual and abnormal discharges. It was found that BCFs were also able to explain ways to prevent cervical cancer. Delaying of sexual debut, reduction of sexual partners, regular VIAC screening were mostly mentioned and these are also identified in the demand generation manual (MOHCW & UNFPA, 2012).

BCFs therefore exhibited good knowledge of the key topics in the programme. Male Circumcision, cervical cancer, HIV transmission are areas with sufficient knowledge levels and BCFs quoted accurate information. There were, however, areas that need refresher training of BCFs and these are particularly for the behaviour change process and the HIV infectivity stages for explaining HIV viral load. The issue of supervision and support by district officers was highlighted as a requirement and as a platform to reinforce where there

are knowledge gaps. The fact that the majority of BCFs have secondary education may be a contributing factor to the good knowledge levels on the topics that BCFs cover.

5.3.2 Perception and attitude of BCFs

The findings suggested that BCFs perceived their work to be beneficial. The most cited benefit was the positive impressions of the community about the BCF. BCFs found that their communities respected them more and they are seen as role models. In terms of personal benefits, BCFs perceived their communication and leadership skills to have improved. BCFs were generally happy with their work and found that the time they spent with households was worthwhile. These perceptions support a previous assertion that volunteering is also of benefit to the volunteer. (IFRC, 2011). It was suggested that volunteers are satisfied when they receive acknowledgement for the difference they make in their communities and the new skills they gain in the process (IFRC, 2011).

An important attribute of BCFs' attitude was shown in their respect for confidentiality when they deal with households. The findings showed that BCFs maintain confidentiality at all times. Confidentiality is one of the characteristics stated in the terms of reference for BCFs (MOHCW & UNFPA, 2012). The selection process of community volunteers values this attribute. Mutambara and Mutambara (2012) found that communities base their selection of community volunteers on maturity, literacy, trustworthy and moral uprightness. There are exceptional cases where BCFs find it important to share information with the appropriate stakeholders. This is true for cases such as GBV since there may be a need to protect the affected party.

5.3.3 Factors that motivate BCFs

The findings showed indications for BCFs' motivation in carrying out their tasks. A number of the factors can be linked to the functions of volunteerism. Previous research conceptualised six aspects of motivation in volunteerism:

- **Values** relate to deeply held beliefs about the importance of helping others (Esmond, 2004). Concern for others is the main driver and separates the volunteers from non-volunteers. BCFs highlighted the concern for the burden of health problems in their community. This drives them to participate and serve people in

the community. It was highlighted that BCFs are happy when they receive acknowledgement for the contribution they are making. Key to the selection of BCFs is the use of community structures and the major quality looked for is 'concern for others' (MOHCW & UNFPA, 2012). This is, therefore, a standard for a person to become a BCF and this can be suggested to be the number one reason for volunteering.

- **Understanding** serves to satisfy the desire to learn. Involvement in activities of volunteerism provides an opportunity to develop knowledge (Esmond, 2004). This function of understanding is key for BCFs as they clearly expressed that they gain skills from interacting with families and the exposure of conducting home visits are learning opportunities for them. BCFs also expressed the need for more training on new information which shows their desire to learn.
- **Social**, a function that shows conformity to the normative influence of people that are considered significant by the volunteer (Esmond, 2004). This function provides the opportunity to be with one's friends or to participate in activities viewed favourably by the important others (Clary *et al.*, 1998). For BCFs the social function was a critical element for them. One of the reasons given for enjoying the role was that they get respect from the community and people that they serve. The way communities value BCFs is important to them and this was expressed as a motivator for them. It is important to note that BCFs felt discouraged when households refuse to give them access to their homes or did not value their work. In addition, District officers felt that BCFs are discouraged when health facilities staff look down or do not appreciate the work of BCFs. This shows the affirmation by communities in which BCFs' work enhances their social function.
- **Career** serves to create career-related benefits that may become available from participation in volunteer work (Clary *et al.*, 1998). Volunteers engage because they are seeking ways to explore job opportunities or development in the work environment (Esmond, 2004). The findings do not show clear indications for the function of career. Some BCFs mentioned the leadership role that results from the work. BCFs in the workplace alluded to an enriched job description as they are

recognised by the company they work for. Most showed an appreciation for development in their role rather than future careers. It is also important to note that BCFs have multiple community volunteer portfolios. BCFs can also be a village health worker, peer educator, caregiver or community-based distributor. A BCF is likely to be selected for other community volunteer opportunities.

- **Protective** has to do with the concern to protect the ego from negative features of the self. People may serve to reduce guilt over being more fortunate than others or to address personal problems (Clary *et al.*, 1998). It can be summarised as a way to escape from negative qualities or feelings (Esmond, 2004). This function was evident in BCFs as some revealed how they personally benefited for the work. Some BCFs mentioned that the role helped them to change their personal behaviours and adopt safer sexual behaviours. Others mentioned that their communication skills improved such that even their communication with their partners and families improved. It was also noted that some BCFs saw this role as God given and felt the importance of continuing.
- **Enhancement** also identified as Esteem. This function relates to the development of a person's sense of esteem (Esmond, 2004). The findings show that BCFs enjoy being respected and being valued by the communities they serve. BCFs stated that they are highly regarded in their communities and people request them to visit their homes. The additional efforts made by BCFs when they meet with resistance is a way of developing their sense of esteem. In most cases people that would have resisted being visited become very appreciative when finally exposed to the sessions. It is suggested that volunteers are satisfied when they receive acknowledgement for the difference they make in their communities and the new skills they gain in the process (IFRC, 2011).

The comparison above shows that BCFs are community volunteers with motivations that match the identified key functions. It is however important to note that the six functions are mostly non-financial. This can be associated with the findings in other studies where community health workers were incentivised by the change in behaviour of communities who start seeking health services (JSI Research & Training Institute, 2009).

In contrast the financial incentive was mostly viewed as discouraging by BCFs as most complained that the monthly allowance of USD15.00 was too low. This is contrary to a common definition of volunteering as the service is supposed to be offered for free (UN Volunteers; IFRC & Inter-Parliamentary Union, 2004). It has however been noted that community volunteers recruited in the context of donor funded programmes receive an allowance (Graham, Patel, Ulriksen, Moodley & Mavungu, 2013). It has also been found that in developing countries community health workers volunteering are offered a financial incentive in the context of poverty and hence there is an expectation of some financial gain (Kasteng, Settumba, Kallander & Vassall, 2015). It should, however, be noted that the programme is donor-funded and an incentive for BCFs was part of the design because of the knowledge that a financial incentive would be expected.

Most BCFs felt that the work they were doing is important and intensive, requiring higher reward than the current \$15 per month. The low incentive mostly came as one of the things that BCFs dislike and as something that they would change. BCFs acknowledged that their function is volunteering and should otherwise not be paid. Nevertheless, the issue of financial incentives was frequently mentioned. The financial incentive was one of the things most cited as something that BCFs could change if they had the option to increase it. District officers alluded to the fact that the monthly financial incentive is not sufficient and they sometimes find it difficult to encourage BCFs.

It can be suggested that BCFs are motivated as they continue with their work regardless of the challenges faced. The findings show that motivational factors for BCFs fit well into the defined motivational functions for volunteers (Clary *et al.*, 1998; Esmond, 2004). Of note is the number one function of values that was highlighted by BCFs. BCFs are most concerned about the burden of health problems within their communities.

5.4 Challenges

The challenges identified by BCFs are not unique, and are similar to those faced by community volunteers. An important issue identified was being stigmatised by community members and feeling looked down on. This was also found in earlier studies that

community volunteers find it difficult to carry out their work in such circumstances (Kaseke & Dhemba, 2007).

Achieving a balance between volunteering and tending for families was highlighted, and supported by Mutambara and Mutambara (2012). This is common in poorer communities where people would prioritise providing for their families over working without compensation (Mutambara & Mutambara, 2012). The community of Gwanda is in a similar context and BCFs suggested challenges in achieving the balance. Their solution to this was setting aside specific times for home visits and allocating time to tend for their families.

Emerging challenges raised by BCFs relate to the creation of services that are not available at the nearest health facilities in their communities. BCFs create demand for services such as cervical cancer screening but the services are not yet available at rural health facilities except the district hospital. This has been a discouragement as BCFs are often asked by people for referrals. Access to health services has four dimensions, acceptability, availability, affordability and geographical accessibility (O'Donnell, 2007). In the case of this study BCFs are creating demand to satisfy the acceptability dimension. The availability and geographical accessibility have to do with the supply of health services. The four dimensions are supposed to work together if services are deemed accessible. To address barriers of access to health services, it was recommended that both the demand and supply side of the barriers have to be addressed concurrently (Jacobs *et al.*, 2011).

BCFs do not receive sufficient resources for them to carry out their work and have sometimes resorted to using their own resources. This is a challenge as BCFs are often poorly resourced themselves. Drawing from their personal resources could compromise the quality and output of the programme. This challenge emphasises the need for adequate planning and resources for the BCF programmes.

5.5 Recommendations

Several recommendations emerged from the findings. The recommendations should however be viewed against the limitations of this qualitative and small-scale study.

The behaviour change programme revolves around BCFs and is heavily dependent on their participation. The study showed their commitment to serving their communities despite the challenges faced. It is important for BCFs to uphold the values of volunteering that highlight the provision of services by free will. The financial incentive should therefore not be a demotivation as was suggested in the findings. The principles of volunteering point out that services is given out of a commitment to serve others and provided without expectation of compensation (UN Volunteers; IFRC & Inter-Parliamentary Union, 2004). It is noted that BCFs come from poorly resourced communities and hence the expectation of some payment is inherent. The behaviour change programme provides the financial incentive but the expressions from the study showed that BCFs feel it's not sufficient. Increased support, whether financial or resource-wise, should therefore be considered. There are challenges in determining a financial incentive that would be sufficient and still be in line with the framework of volunteering. The programme is recommended to consider a suitable package that remains within the framework of volunteering.

The behaviour change programme design was well thought out but the implementation at community level was shown by this study to harbour some gaps. This was particularly true for the resources that should be made available for BCFs to use in conducting home visits. The stationery and materials to use for conducting home visits were found to be in short supply and BCFs have to provide from their own resources. These are basic materials to enable the work and should be provided as part of the programme supplies. It is therefore recommended for the programme to ensure that the materials are available for BCFs to conduct their work. In addition, considerations can be made to provide protective clothing for BCFs as there are exposed to harsh weather conditions. This addition could work as an incentive for BCFs to continue with their work.

To prevent stress and burn out from the work, BCFs are encouraged to continue planning their work as this will enable them to carry out the home visits as well as conduct their home duties including fending for their families. Being volunteers, the financial incentives are a mere allowance and not a salary to sustain families. BCFs therefore require time to make up for the income to sustain their families. This recommendation is made to address the concerns raised in earlier studies that community volunteering is unrewarding and that most cannot meet their basic needs (Kaseke & Dhembba, 2007).

Following the above recommendation the programmers may find it useful to review the targets set for BCFs to achieve. This is with a view to help manage issues of burnout and stress for BCFs. It has been asserted that community volunteers are vulnerable to excessive work that often results in burnout (SAFAIDS, 2004). The findings showed that some BCFs feel the burden of work and may experience stress and burnout. As part of their routine supervision district officers are implored to assist BCFs to achieve a work and life balance. In addition support and supervision are key enhancing elements of community volunteering. Lehmann and Sanders (2007) found that a lack of supervision of community health workers can be demotivating. More support and supervision to BCFs is therefore recommended. This should be considered together with more platforms for BCF peer support where they share experiences and share ideas, as it can be an effective way to keep motivation levels high (Lehmann & Sanders, 2007).

The findings suggested that the knowledge levels of BCFs on the key concepts of the programme are good. A continued personal engagement with the materials used to conduct home visits is recommended. This will help BCFs deliver accurate information when conducting home visits. In the same vein, BCFs are also encouraged to seek updated information through the district officers. This will also enhance the quality of the programme and people may be more receptive if BCFs are able to deliver accurate and latest information.

By nature home visits cannot be a one-visit exposure because the stories shared by BCFs show that there is need for repeated follow-up visits once issues are identified. The commitment to follow up on issues is commended as this is one of the ways to track any changes taking place in the community. It is recommended for BCFs to continue to follow up with people visited, particularly where referrals are issued. Encouraging people to take up the recommended health services will help people to act and take up health services.

The behaviour change programme is being conducted in communities that are affected by many other problems that are not just health. Poverty is a major challenge and BCFs are faced with people that expect support in the form of food supplements. It is recommended for the programme to consider linkages with other programmes that can supply food or livelihood interventions. Such collaborations can increase people's receptiveness to the home visits.

The behaviour change programme cannot function in isolation from the support of the community leadership and health facilities staff. Their recognition of the work of BCFs and acknowledgement of their contribution can create an enabling environment. The contribution of community leaders has been acknowledged by some BCFs in the study. Community leaders can use their influence to mobilise their communities for participation in home visits.

5.6 Conclusion

The study aimed to contribute knowledge on BCFs, their perceptions, experiences, narratives and their influence in creating demand for health services and promotion of behaviour change. Their perceptions, experiences and narratives were documented in detail and related to the outcomes of demand generation for health services and promotion of behaviour change. The study found some clear indication that BCFs are touching lives and facilitating positive behaviour change in their communities. The task of volunteering has its challenges but BCFs revealed that there are benefits in serving their communities. The notable positive changes in their communities spur them to continue with their work. Triangulation of the qualitative data from this study with a quantitative study that measures the effectiveness and impact of BCFs on communities would be useful. This can be explored through further research.

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Appendices

Appendix 1: Study Schedules

Behaviour Change Facilitators – Semi-structured Interview Guide

An exploration of the work of Behaviour Change Facilitators in Matabeleland South Province, Zimbabwe: knowledge, perceptions, barriers and enabling factors.

Questionnaire Identification: Number - __

District:	
Ward:	
Villages/places covered:	
Consent:	
Date:	

Background characteristics:

When did you become a BCF?	
Which organisation recruited you as a BCF?	Guide: Zichire, ZAPSO, World Vision, Regai Dzive Shiri, MASO, MAC, FACT Manicaland/Mash West, Other.
Do you do any other Volunteer work?	Guide: Peer educator, Village Health Worker, Community Mobilisers, Community-Based Distributor, Other specify.
Briefly describe what being a volunteer means to you?	
Did you receive training before becoming a BCF?	Guide: When/where you trained, How many days was the training, query any refresher trainings received, Content of training.
Do you know the number of households you have visited so far?	Guide: Break down the numbers into periods

Perceptions and attitude:

Do you understand your role as a BCF?	Guide: What is your primary objective as a BCFs?
What processes do you follow to plan a home visit?	Guide: Process followed until a home visit is conducted.
Are you always welcome in the homes that you conduct visits	Guide: if not, what are the challenges
How do you handle refusal to conduct a visit to a household?	Guide: Do you continue to request, do you leave and proceed to other households
How involved are you with the households that you visit?	Guide: do you stay in contact; are there examples of when you have had to stay in touch, what are the reasons?
Beyond the household that you visit, do you share any information on the visit?	Guide: Confidentiality is important – examples of who information is shared with.
How does being a BCF relate with all the other aspects of your life?	Guide: Work/Life balance
In your opinion how have you benefited from being a BCF?	

Motivation and discouragement:

How happy are you in your role as a BCF as a whole	
How happy are you with the incentives that you receive	
Do you ever compare your incentives with those of other community-based volunteers	Guide: Does it seem there are better – What is different
What motivates you to carry on being a BCF	Guide: Categorise the motivators – Personal, for community or programme

How happy do you feel about the support that you receive from the organisation that you work for?	
What do you like most about being a BCF	Guide: specify the issues
What do you least like about being a BCF	
If you could change anything about being a BCF what would you change?	

Knowledge and understanding:

Do you think it is important for a person to change their behaviour?	Guide: Knowledge attitude skills
Can you name the stages in the behaviour change process?	Guide: Unaware, Aware, Concerned, Knowledgeable and skilled, Motivated and ready to change, Trial change of behaviour, Sustained behaviour change.
By how much does VMMC reduce the chances of a circumcised man from contracting HIV through unprotected sex?	
In what ways can a person get infected with HIV?	
Do you know of any factors that may increase the chances of a person to be infected with HIV?	
What are the ways in which an unborn child or infant become infected with HIV?	
When is a person infected with HIV most likely to pass on the infection through unprotected sex?	
Do you know the signs of cervical cancer?	
How would a woman guard against cervical cancer?	

Challenges / Barriers:

In your opinion what challenges have you faced as a BCF?	
How have you resolved the challenges in the past?	
Have you faced any challenges in attaining your targets?	
How have you resolved these in the past?	

Lesson, recommendation, stories:

How do you think the role of the BCF could be improved in the future?	
Are there any lessons that you have learnt as a BCF that you can share?	Guide: These are lessons learnt in trying to improve as a BCF.
What recommendations would you make for the programme to be improved?	
Are there any specific stories of where you made a difference as BCFs in anyone's life?	

BCFs – Focus Group Discussion Guide

An exploration of the work of Behaviour Change Facilitators in Matabeleland South Province, Zimbabwe: knowledge, perceptions, barriers and enabling factors.

- 1) What is your role as BCFs?
- 2) In general, what is the normal day of a BCF?
 - Check the views
 - Prompt understanding of the role of BCFs
- 3) In your view, how has the community responded to the work that you do?
 - Check for the reception when BCFs conduct home visits
 - How BCFs encourage people to participate in home visit
 - How do BCFs handle refusal of entry or participation in the home visit
- 4) How important do you think your role is?
 - Check for consensus on importance
 - Any expected changes because of their work
- 5) Compared with other community volunteers what is the value of BCFs
 - Check which other community volunteers are in the community
 - Do any have a dual role as another community volunteer
 - What are main the difference of the work of BCFs and other volunteers
 - What value do BCFs bring that is not found in the other community volunteers
- 6) Was everyone trained before commencing work as a BCF?
 - When; length of training; refresher training
 - How adequate was the training?
 - Additional support after training
 - Use of materials to conduct home visits (Home visit guide)
- 7) What key messages are there when you discuss male circumcision with participants?
- 8) How about in HIV testing and counselling?
- 9) When is a person infected with HIV most likely to pass on the infection through unprotected sex?
- 10) What are the signs of cervical cancer?
- 11) What is the process of behaviour change

- Is this how communities respond and do they go through these changes?
- 12) How do health facilities support your work as BCFs? How? Why?
- Where is negative ask for the reasons
 - Where there is support check what motivates the support.
- 13) Are the recommendations made by BCFs taken up e.g. changing of behaviour, taking up of health services
- 14) What are your expectations as BCFs
- 15) Have these expectations been met?
- 16) What motivated you to become a BCF?
- 17) What motivates you to continue?
- 18) What challenges have you faced as BCFs?
- 19) How have you resolved these?
- 20) If you were to change anything about your role, what would it be?
- 21) Are there any recommendations that you would like to make?
- 22) Do you have any experiences (personal or that you know of) that you would like to share of your interaction with the community?

District Officers (From organisations that coordinate BCFs) – Focus Group Discussion Guide

An exploration of the work of Behaviour Change Facilitators in Zimbabwe: knowledge, perceptions, barriers and enabling factors.

- 1) What do you think or understand about the home visit approach that is being conducted by BCFs?
- 2) In general, what do we know about BCFs?
 - Check the views
 - Prompt understanding of the role of BCFs.
- 3) In your view, how has the community responded to behaviour change facilitators?
- 4) How important is the role of BCFs
The BCFs are critical in the home visit approach in that:
 - Check for consensus on importance
- 5) Compared with other community volunteers what is the value of BCFs
 - Check which other community volunteers are in the community
- 6) Village Health Workers, Case Care Workers , churches, police constabulary, ARSH peer educators
 - What is the difference with BCFs
 - What value do BCFs bring that is not found in the other community volunteers
- 7) How do health facilities support the work of BCFs? How? Why?
 - Where is negative ask for the reasons
 - Where there is support check what motivates the support.
- 8) How do you support the work of BCFs?
- 9) What are your expectations of the BCFs
- 10) Have these expectations been met?
- 11) How would you rate the knowledge and understanding of the programme by BCFs?
- 12) Are the recommendations made by BCFs taken up e.g. changing of behaviour, taking up of health services?
- 13) What challenges do think BCFs face in doing their work?
- 14) Are there any recommendations that you would like to make for the work of BCFs?
- 15) Do you have any experiences (personal or that you know of) that you would like to share of your interaction with BCFs.

I am Tendayi Katsande, a student with the University of Free State, Bloemfontein, South Africa. As part of my Masters in Development studies, I am undertaking a study to understand the work of BCFs, their perceptions, attitude and motivations in their work and how this has been received by the communities they work with. You have been selected and requested to participate in the focus group discussion that will help to answer some of the research questions. I would like to talk to you about your general experiences and views on the work of BCFs. What you say here is confidential. You are free to discontinue/withdraw from the study at any time without penalty.

All participants willing to participate in the FDG are to complete a consent form and ask any questions or areas for clarification.

Personal information of the group

FGD Number:					
Date and time of FGD:					
Location of FGD:					
Name of note taker:					
Name of transcriber					
Participant Name	Organisation / Affiliation	Age	Gender	Level of Education	Any prior Interaction with BCF

Appendix 2: Invitations for Study and Consent forms

Invitation to participate in research

Project title: An exploration of the work of Behaviour Change Facilitators (BCFs) in Matabeleland South Province, Zimbabwe: knowledge, perceptions, barriers and enabling factors.

I am a Master in Development Studies student at the University of the Free State, South Africa, and am conducting research in order to complete my degree. I am in need of BCFs to interview about their work experiences, and the barriers and enabling factors that they face. Please read the section below for more information, and, if interested to take part, please contact me:

Principal investigator: Tendayi Katsande

Contact details: Phone Number +263772418930/Email tendayikatsande@gmail.com

Information Sheet

What you should know about this research study:

- I give you this consent form so that you may be properly informed about the research and what your participation will involve.
- The goal of the study is to gain knowledge and document the personal experiences of BCFs.
- This research will not have direct benefit for you as a participant.
- Your participation is voluntary. You have the right to refuse to take part or agree to take part now and change your mind later.
- Your name will not be revealed to anyone (for example in report or publications or presentations).
- Your decision to participate or not participate in this study will not affect you in any way.
- Please read this summary carefully, it will tell you about all the purpose, risks and benefits of this research study. You are welcome to ask any questions before you make a decision.
- Please read this consent form carefully and then sign to indicate that you are voluntarily willing to participate in the study. You will be given a copy of this consent to keep.

Purpose of study: The purpose of this study to gain an understanding of the work of BCFs. The research will document their personal experiences; explore understanding of their work, their perceptions, barriers and enabling factors. I am conducting the study for two reasons: to meet the requirements of a masters course in development studies and I am genuinely interested in understanding the work of BCFs and what motivates them to continue in the programme. You are selected as a possible participant in this study because you are a BCF and can give invaluable information for the study.

What you are expected to do as a participant: If you decide to participate, we will have a one-on-one discussion where you will be asked about your experiences, perceptions, knowledge and motivations as a BCF. The interview is expected to take about 45 minutes to an hour.

Risks and discomforts: Your participation in this study is voluntary. There are no anticipated risks in participating in this study. The study is not an assessment of you as a BCF. I expect that the study will make recommendations that may improve your role as a BCF.

Benefits and compensation: There are no direct benefits that you will receive for participating in the study. The study findings are expected to make recommendations which will try to address some of the challenges that come up or suggestions raised.

Confidentiality: I plan to share the study findings for the purpose of the master's in development studies course and with key stakeholders in the national behaviour change programme, NAC and UNFPA. Any information that is obtained in connection with this study that can be identified with you (for instance, what you say in your interview) will remain confidential.

Voluntary participation: Participation in this study is voluntary. If you decide not to participate, your decision will not affect your future your role as a BCF. If you decide to participate, you are free to withdraw your consent or discontinue participation at any time without penalty.

Offer to answer questions: Before you sign this form, please ask me any questions on any aspect of this study that is unclear to you or that you would like to know more about.

Should you choose to participate in the study, you will need to fill out the following before the interview:

Certificate of consent

I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study

Name of Research participant (please print) _____

Signature of Participant _____ Date _____

I have accurately read out the information sheet to the potential participant, and to the best of my ability made sure that the participant understands.

I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

A copy of the consent form has been given to the participant.

Name of Researcher (please print) _____

Signature of Researcher _____ Date _____

If you have any questions concerning this study or consent form beyond those answered by the research, including questions about the research, your rights as a research participant or

research related risks; or if you feel that you have been treated unfairly and would like to talk to someone other than the researcher, please feel free to contact the Medical Research Council of Zimbabwe on telephone +263 4 791 792 or +263 4791193 and fax number +263 4 253 979.

CONSENT FORM

Informed Consent form: Behaviour Change Facilitators (BCFs) (Semi-structured Interview)

Project title: An exploration of the work of Behaviour Change Facilitators (BCFs) in Matabeleland South Province, Zimbabwe: knowledge, perceptions, barriers and enabling factors.

Principal investigator: Tendayi Katsande

Contact details: Phone Number +263772418930/Email tendayikatsande@gmail.com

This Informed Consent Form has two parts:

- **Information Sheet (to share information about the study with you)**
- **Authorisation sheet (for signatures if you choose to participate)**

Part 1: Information Sheet

What you should know about this research study:

- I give you this consent form so that you may be properly informed about the research and what your participation will involve.
- The goal of the study is to gain knowledge and document the personal experiences of BCFs.
- This research will not have direct benefit for you as a participant.
- Your participation is voluntary. You have the right to refuse to take part or agree to take part now and change your mind later.
- Your name will not be revealed to anyone (for example in report or publications or presentations).
- Your decision to participate or not participate in this study will not affect you in any way.
- Please read this summary carefully, it will tell you about all the purpose, risks and benefits of this research study. You are welcome to ask any questions before you make a decision.
- Please read this consent form carefully and then sign to indicate that you voluntarily willing to participate in the study. You will be given a copy of this consent to keep.

Purpose of study: The purpose of this study to gain an understanding of the work of BCFs. The research will document their personal experiences; explore understanding of their work, their perceptions, barriers and enabling factors. I am conducting the study for two reasons: to meet the requirements of a master's course in development studies and I am genuinely interested in understanding the work of BCFs and what motivates them to continue in the programme. You are selected as a possible participant in this study because you are a BCF and can give invaluable information for the study.

What you are expected to do as a participant: If you decide to participate, we will have a one-on-one discussion where you will be asked about your experiences, perceptions, knowledge and motivations as a BCF. The interview is expected to take about 45 minutes to an hour.

Risks and discomforts: Your participation in this study is voluntary. There are no anticipated risks in participating in this study. The study is not an assessment of you as a BCF. I expect that the study will make recommendations that may improve your role as a BCF.

Benefits and compensation: There are no direct benefits that you will receive for participating in the study. The study findings are expected to make recommendations which will try to address some of the challenges that come up or suggestions raised.

Confidentiality: I plan to share the study findings for the purpose of the master's in development studies course and with key stakeholders in the national behaviour change programme, NAC and UNFPA. Any information that is obtained in connection with this study that can be identified with you (for instance, what you say in your interview) will remain confidential.

Voluntary participation: Participation in this study is voluntary. If you decide not to participate, your decision will not affect your future your role as a BCF. If you decide to participate, you are free to withdraw your consent or discontinue participation at any time without penalty.

Offer to answer questions: Before you sign this form, please ask me any questions on any aspect of this study that is unclear to you or that you would like to know more about.

Part 2: AUTHORISATION

You are making a decision whether or not to participate in this study. Your signature indicates that you have read and understood the information provided above, have had all your questions answered, and have decided to participate.

_____ Name of
Research participant (please print)

_____ Signature of Participant _____ Date and time

_____ Name of Witness (if required)

_____ Signature of Witness _____ Date and time

_____ Name of Researcher obtaining consent

_____ of researcher _____ Date and time _____ Signature

YOU WILL BE GIVEN A COPY OF THIS CONSENT FORM TO KEEP

If you have any questions concerning this study or consent form beyond those answered by the researcher, including questions about the research, your rights as a research participant or research related risks; or if you feel that you have been treated unfairly and would like to talk to someone other than the researcher, please feel free to contact the Medical Research Council of Zimbabwe on telephone +263 4 791 792 or +263 4791193 or +263772433166/5/7 or the following address:

CONSENT FORM

Informed Consent form: District Officers of the NGOs that Coordinate BCFs (Focus Group Discussion)

Project title: An exploration of the work of Behaviour Change Facilitators (BCFs) in Matabeleland South Province, Zimbabwe: knowledge, perceptions, barriers and enabling factors.

Principal investigator: Tendayi Katsande

Contact details: Phone Number +263772418930/Email tendayikatsande@gmail.com

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- The goal of the study is to gain knowledge and document the personal experiences of BCFs.
- This research will not have direct benefit for you as a participant.
- Your participation is voluntary. You have the right to refuse to take part or agree to take part now and change your mind later.
- Your name will not be revealed to anyone (for example in report or publications or presentations).
- Your decision to participate or not participate in this study will not affect you in any way.
- Please read this summary carefully, it will tell you about the purpose, risks and benefits of this research study. You are welcome to ask any questions before you make a decision.
- Please read this consent form carefully and then sign to indicate that you are voluntarily willing to participate in the study. You will be given a copy of this consent to keep.

Purpose of study: The purpose of this study to gain an understanding of the work of BCFs. The research will document their personal experiences; gain understanding of their work, their perceptions, and the barriers and enabling factors that they face. I am conducting the study for two reasons: to meet the requirements of a master's course in development studies and I am genuinely interested in understanding the work of BCFs and what motivates them to continue in the programme. You are selected as a possible participant in this study because of your role as district officer and coordinator of BCFs in your district. Since you work directly with BCFs and supervise their work, it is anticipated that you can give invaluable information for this study.

What you are expected to do as a participant: If you decide to participate, you will participate in a focus group discussion with six or seven other district officers from the districts that are participating in this study. The discussion will ask questions on the history of work of BCFs, your perceptions on their success in carrying out their duties as well as the challenges they may face. As the coordinators of BCFs, you will be asked make recommendations concerning BCFs and

their work and share any experiences and stories of your interactions. The discussion is expected to take about one hour.

Risks and discomforts: Your participation in this study is voluntary. There are no anticipated risks in participating in this study. The study is not an assessment of you as the coordinator of BCFs in your district. I expect that the study will make recommendations that may improve the role of BCFs to serve their communities more effectively.

Benefits and compensation: There are no direct benefits that you will receive for participating in the study. The study findings are expected to make recommendations which will try to address of the challenges that come up or suggestions raised.

Confidentiality: I plan to share the study findings for the purpose of a master's in development studies course and with key stakeholders in the national behaviour change programme, NAC and UNFPA. Any information that is obtained in connection with this study that can be identified with you (for instance, what you say in the discussion) will remain confidential. With your permission, I would like to audio record the session, in order to more accurately write down later what was said. No names will be used when the discussion is written up, and no identifying information will be used in the report (a mini-dissertation).

Since this is group discussion, I will ask you and others in the group not to talk to people outside the group about what was said in the group. I will, in other words, ask participants to keep what was said in the group confidential. You should know, however, that I cannot stop or prevent participants who were in the group from sharing things that should be confidential.

Voluntary participation: Participation in this study is voluntary. If you decide not to participate, your decision will not have any implications. If you decide to participate, you are free to withdraw your consent or discontinue participation at any time without penalty.

Offer to answer questions: Before you sign this form, please ask me any questions on any aspect of this study that is unclear to you or that you would like to know more about.

Part 2: AUTHORISATION

You are making a decision whether or not to participate in this study. Your signature indicates that you have read and understood the information provided above, have had all your questions answered, and have decided to participate.

Name of Research participant (please print)

Signature of Participant

Date and time

Name of Witness (if required)

Signature of Witness

Date and time

Name of Researcher obtaining consent

Appendix 3: Ethical clearances



25 March 2015

Mrs TJ Katsande
Centre for Development Support
UFS

Ethical Clearance Application: An exploration of the work of Behaviour Change Facilitators in Matabeleland South Province, Zimbabwe: Knowledge, perceptions, barriers and enabling factors.

Dear Mrs Katsande

With reference to your application for ethical clearance with the Faculty of the Humanities, I am pleased to inform you on behalf of the Ethics Board of the faculty that you have been granted ethical clearance for your research.

Your ethical clearance number, to be used in all correspondence, is:

UFS-HUM-2015-79

This ethical clearance number is valid for research conducted for one year from issuance. Should you require more time to complete this research, please apply for an extension in writing.

We request that any changes that may take place during the course of your research project be submitted in writing to the ethics office to ensure we are kept up to date with your progress and any ethical implications that may arise.

Thank you for submitting this proposal for ethical clearance and we wish you every success with your research.

Yours sincerely,

Katinka de Wet
Ethics Committee (Faculty of the Humanities)

Copy: Chamé Vercueil (Research Co-ordinator: Faculty of the Humanities)

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E-mail: mrcz@mrcz.org.zw
Website: www.mrcz.org.zw



Medical Research Council of Zimbabwe
Joshua Tsengigara / Mazoe Street
P.O. Box CV 573
Causeway
Harare

MRCZ APPROVAL LETTER

Ref: MRCZ/B/848

15 May, 2015

Tendayi Katsande
University of Free State
Centre For Development Studies
South Africa

**RE: Application For Ethical Review and Approval of Study Entitled: - An Exploration Of The Work Behaviour
Change Facilitators In Matabeland South Zimbabwe: Knowledge, Perceptions, Barriers and Enabling Factors**

Thank you for the above titled proposal that you submitted to the Medical Research Council of Zimbabwe (MRCZ) for review. Please be advised that the Medical Research Council of Zimbabwe has reviewed and approved your application to conduct the above titled study. This is based on the following:-

- Study Protocol
- Study Summary
- English and IsiNdebele Informed Consent Forms
- Data collection tool

• **APPROVAL NUMBER** : MRCZ/B/848

The above details should be used on all correspondences, consent forms and documents as appropriate.

• **TYPE OF MEETING** : Expedited review
• **APPROVAL DATE** : 15 May, 2015
• **EXPIRATION DATE** : 14 May, 2016

After this date, this project may only continue upon renewal. For purposes of renewal, a progress report on a standard form obtainable from the MRCZ Offices should be submitted one month before the expiration date for continuing review.

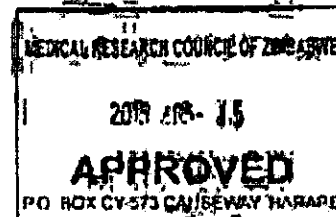
- **SERIOUS ADVERSE EVENT REPORTING:** All serious problems having to do with subject safety must be reported to the Institutional Ethical Review Committee (IERC) as well as the MRCZ within 3 working days using standard forms obtainable from the MRCZ Offices.
- **MODIFICATIONS:** Prior MRCZ and IERC approval using standard forms obtainable from the MRCZ Offices is required before implementing any changes in the Protocol (including changes in the consent documents).
- **TERMINATION OF STUDY:** On termination of a study, a report has to be submitted to the MRCZ using standard forms obtainable from the MRCZ Offices.
- **QUESTIONS:** Please contact the MRCZ by Telephone No. (04) 791792, 791193 or by e-mail on mrcz@mrcz.org.zw.

Other:

- Please be reminded to send in copies of your final research results for our records as well as for the Health Research Database
- You are also encouraged to submit electronic copies of your publications in peer-reviewed journals that may originate from this study.

Yours Faithfully

MRCZ SECRETARIAT
FOR CHAIRPERSON
MEDICAL RESEARCH COUNCIL OF ZIMBABWE



Appendix 4: Declaration of interest

9 Woodbridge Close
Glenlome
Harare

3 March 2015

To whom it may Concern

RE: Declaration of interest in research "An exploration of the work of Behaviour Change Facilitators in Matabeleland South, Zimbabwe: knowledge, perception, barriers and enabling factors"

This letter serves to inform you of my involvement with BCFs as follows:

- I work for the United Nations Population Fund (UNFPA), Zimbabwe Country Office as Programme Analyst for the Behaviour Change Programme.
- The Behaviour change programme is funded by UNFPA in 26 districts and is implemented through NGOs that coordinate BCFs to conduct home visits in their respective districts.
- My main function is to coordinate the implementation of the behaviour change programme through the NGOs. I have no direct contact with BCFs except during monitoring and support visits of the BC programme.

I admit that there is a possibility of conflict of interest because of this involvement and this could subsequently affect the data presented in this research. The credibility of the research study is very important to me. I therefore intend to lessen the possibility of compromising data quality by ensuring on-going consultation with my supervisor, especially during the fieldwork and data analysis.

Yours sincerely,



Tendayi Katsande
Student
University of Free State, Centre for development studies