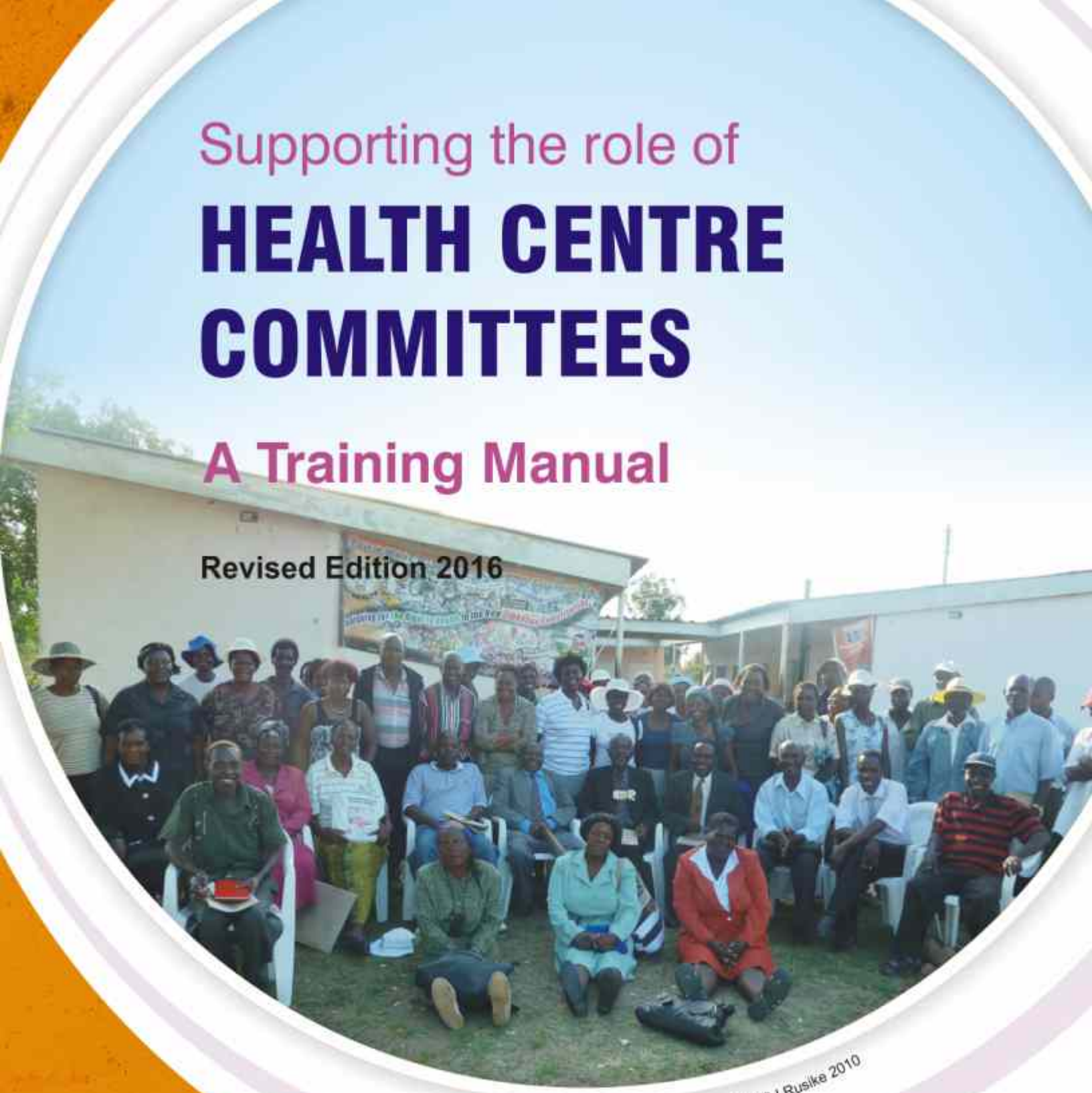
Supporting the role of
HEALTH CENTRE COMMITTEES
A Training Manual

Revised Edition 2016



Mwanza-Chiwundura HCCs 2010 © I Rusike 2010

Written by
Training and Research Support Centre (TARSC)

Produced in cooperation with
Community Working Group on Health (CWGH)
and the **Ministry of Health and Child Care**

Pilot edition - August 2011

SUPPORTING THE ROLE OF HEALTH CENTRE COMMITTEES

A TRAINING MANUAL

Written by **Training and Research Support Centre**
Produced in co-operation with the Community Working Group on Health and the Ministry of Health and Child Care Zimbabwe with input and resources from the Regional Network for Equity in Health in East and Southern Africa (EQUINET)

Acknowledgement of substantial use with author permission of participatory activities and materials from

1. **Loewenson R, Kaim B, Chikomo F, Mbuyita S, Makemba A (2005) Organising People's power for health:** Participatory Methods For People Centred Health Systems **TARSC, Ifakara in EQUINET: Harare Activity 21**

2. Loewenson R, Kaim B, Machingura F (TARSC) Rusike I, Chigariro T, Mashingaidze L, Makone A (CWGH) (2007) Health Literacy guide for people centred health systems: Zimbabwe, TARSC: Zimbabwe)

Any onward use of these materials should be with citation of the original source.

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CONTENTS

Table of contents

Why a manual for strengthening health centre committees?

This manual draws from work carried out since 2000 by Training and Research Support Centre and the Community Working Group on Health to establish and support the functioning of Health centre Committees, working with the Ministry of Health and Child Care. From 2008 the CWGH has given particular emphasis to re-invigorating HCCs in Zimbabwe, and TARSC, through its health literacy and participatory action research training programme has given capacity and technical support to dialogue mechanisms between health workers and communities in Zimbabwe and in the region. The Ministry of Health and Child Welfare National Health Strategy 20009 – 2013 emphasized its commitment to reinvigorate Primary Health Care and support community participation in health. A primary health care task force and then the Public Health Advisory Board recommended strengthening and formalizing the role of health centre committees for this. The Zimbabwe Association of Church Related Hospitals established work to strengthen accountability in health through HCCs.

This manual was thus produced as a tool to support capacity building of HCCs in these various initiatives.

The manual uses participatory methods as its approach to raise community voice and build skills and knowledge on the evidence and experience generated within communities. More information on participatory methods can be found in the EQUINET toolkit on "Participatory methods for people centred health systems" TARSC, Ifakara , EQUINET, Harare, 2006

The manual is not intended to be stand alone material. Health Centre Committees will need to use it together with other materials, including Ministry of Health Village Health Worker Manual guidance and training materials, Health Literacy materials, and other health resources. The manual should also be a lever to draw on the knowledge and experience of the people in districts working in health, the health workers, local government personnel, the civil society organisations in the CWGH and other institutions and sectors; and clarify their different roles and responsibilities in contributing to improved health of the communities

August 2011

MODULE 1
Health Systems in Zimbabwe

In this module Health Centre committee members will

- Be informed on what a health system is and how it is organised in Zimbabwe
- Be introduced to the major programmes of the Ministry of Health and Child Welfare
- Map the institutions of the health system in their area and discuss how they can work with these
- Discuss the roles communities play in health systems generally and in their area

1.1. What do we mean by a 'health system'

Imagine if the body did not get food, air and water… it collapses. Imagine if the body did not have arms – it would be difficult - perform many tasks!

A health system is the same- it has many parts, and these need to work together if the system is to work well.

A health system comprises all those actions, organizations and resources whose primary aim is to promote health.

For example

- Immunising children against measles is an action of the health system whose primary aim is to stop children getting measles.
- Building roads is an action that is very helpful for health systems, but is not part of the health system, as its primary aim is to enable people to travel or transport goods.

What other actions primarily promote health?
Your list of actions may include actions that prevent and treat disease, and actions that rehabilitate people with health complications in the community.

A health system has many parts.

- public and private health service providers
- health care workers
- the organizations that finance health (like government, medical aid societies, businesses, municipalities, mines),
- producers of medicines and health technologies
- non government organizations
- community support organizations that work in health, and
- training institutions.
- Regulatory authorities like Medicines Control Authority of Zimbabwe

It can also involve other institutions when they play a key role in health

- Parliament committees on health, when they debate the health budget or pass laws
- Schools when they provide school health services.

Not everything for health is done by the health sector.

Schools contribute to health by educating people, giving skills and information. An educated population readily appreciates and takes up health messages. Employment provides income to buy food and other supplies that keep us healthy. Phone companies provide a means to communicate – to call for emergency care or share information. Social networks provide support for caring. Therefore those working in the health system also need to involve and work with other sectors and services including the media.

Most people think that health is simply not being ill. But health is much more than this. It covers physical well being, mental well being, social well being, and spiritual well being. *A person suffering from stress may not show signs of physical illness, but this person is unhealthy!*

The World Health Organisation (WHO) states the definition opf health ast
'..health is thus not merely the absence of disease but a complete state of physical, mental and social wellbeing..'

Burst sewer pipes in a high density suburb in Harare

Discuss the picture above

- What do you see that is affecting health?
- What actions can be taken to improve health in this community?
- How does this compare with the WHO definition of health?
- What does it mean for the work of the HCC?

The activities that promote health happen at many levels\

- **At individual level:** individuals can use mosquito nets to prevent malaria
- **At community (village and ward) level,** people may take actions like digging waste pits to prevent fly borne disease, or organizing nutrition gardens to promote healthy diets
- **At local government level,** health service provision from the Rural and Urban local authorities e.g in infectious disease control
- **Non government organizations** may provide services to communities
- **At national level,** government may pass laws to prevent unhealthy practices, or collect and disburse money to support health programmes
- **At international level,** countries may co-operate to prevent diseases spreading through travel or trade.

So health systems operate at all these levels.

MODULE 1

In Zimbabwe, as in other countries, the ultimate responsibility for the country's health system lies with central government. Communities, municipalities, workers, business, agriculture, mining, individuals and others all play an important role. Everyone has an important role to play in health systems.

The social mapping activity below will help the HCC to identify social groups, organizations, health services, and other institutions in the health system in your area. After this activity HCC members will have identified the different institutions who contribute to health in their area and how operate or can be better involved in the actions for health.

Activity one- Social mapping

Materials: Flip charts, Markers, pencils, rubbers, stikkistuff
Approx Time: 75 minutes

The plan is a guide for facilitating HCC members to implement the activity. At the end of the activity the maps and groups identified should be recorded by the HCC for future planning of activities and health work.

Procedure:

a. Break into groups of not more than 10 people; ensuring equal representation of sex and age. Women, Men, young people: Each group will decide on own name.
b. Discuss as HCC members what you understand by the term 'social groups'. Give each other some examples. Discuss how these social groups influence ability to participate in quality of service provision, management and financing. Discuss how the health system interacts with these social groups (Probe so the HCC to come up with various social groups and how they contribute into the health systems)
c. Ask each group to draw a map of its community/district on a flip chart showing the following: Major land marks, such as schools, hospitals, clinics, , shops, residences, water points, vegetable gardens and to show how the social groups in their community are distributed on the map. For each social group ask participants to come up with a symbol. The map should be clearly labeled with a key describing the symbols used.
d. In each group discuss how the features observed in (c) above are relevant to the health system
e. Each group can now put their map on the wall. Take ten minutes for HCC members to move around from one map to the next. Have one person by each map from the group to answer questions and add features if needed.
f. After this in plenary, have a general discussion.
g. Which institutions on your maps currently work with the HCC or others on health? How?
h. Which institutions on the map not currently work with the HCC or others on health? How can they be involved in future?

1.2. How the Health System is organized in Zimbabwe

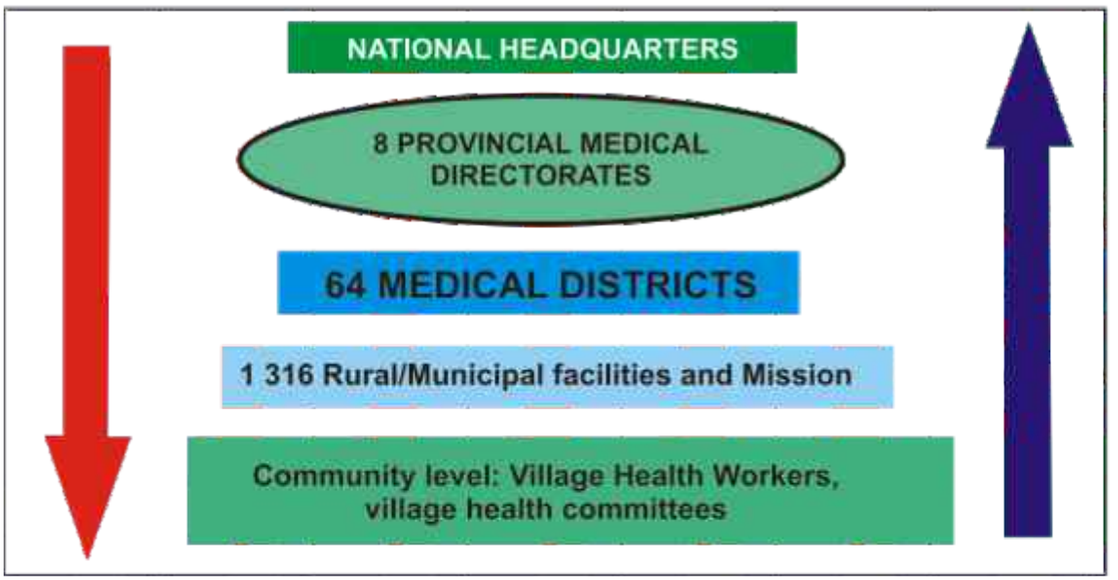
Let us discuss further how health systems are organised in Zimbabwe.

Both the public and the private sector play a role.

- The public sector consists of central government, local authorities (rural district councils and urban local authorities) while other providers include the defence forces, prison services, police etcetera.
- The private-for- profit sector consists of private hospitals, general practitioners, private maternity homes, and traditional health practitioners.
- The private not for profit sector includes medical missions under Zimbabwe Association of Churches Related Hospitals (ZACH) and Non Governmental Organisations (NGO) run services.

As you read the information below see if you can identify these roles and institutions in your own area

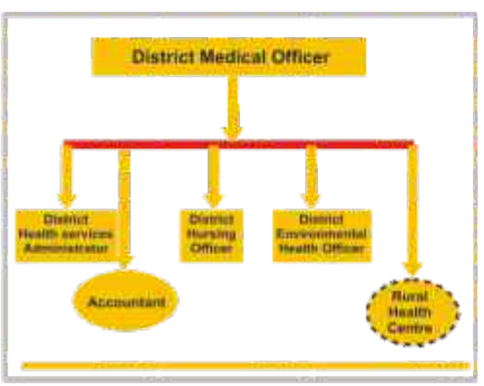
The flow diagram shows the organisation of the health system in Zimbabwe. Information flows from the community level upwards to the national headquarters and vice-versa.



The Primary Health care and community level provides the first point of contact between the community, village health workers and the formal health delivery system. It comprises of a network of clinics and rural health centers. These provide comprehensive promotive, preventive, curative and rehabilitative services

- Communities can plan and implement health plans and promote healthy lifestyles At this level we also find community **Health** workers and health outreach workers (field officers), like Environmental Health Technicians (**EHT**) and community nurses.
- Ward Health Committees provide leadership and support to communities to ensure that their needs are reflected in the overall District Health plan (DHP) and health facility plan.
- Village health Committees (VHC) provide a platform for wider participation by local communities.
- Health centre committees are joint community – health service structures that are, linked to the clinic and provide a bridge of communication between the people/community and health care providers.

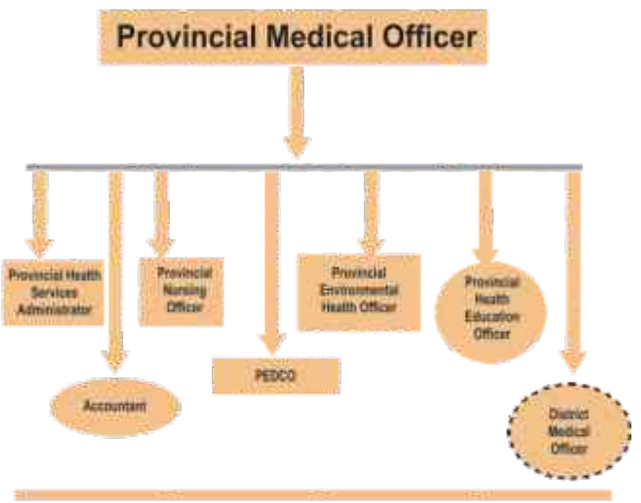
Further information on how these committees' co-ordinate and function is provided for in section 1.3 Mechanisms for coordination health providers in this manual.



The District Health System is the operational level of the health delivery system. Its goal is to provide a comprehensive range of promotive, preventive, curative, rehabilitative and palliative health services, to all the sectors of the community, in line with national and provincial policies and guidelines. Community and other sectors' health inputs are captured through the District Development Committees. At the district level we find the **District Health Executive (DHE)**, which organises health at the district

level co-ordinated by the district medical officer. The DHE monitors and regulates operations of the public and private providers such as the private medical doctors and traditional healers. The District Health Executive is composed of District Medical Officer: DHE chair person; District Health Services Administrator; District Nursing Officer; District Environmental Officer; Accountant; Co-opted members include the district Pharmacist, District Health Information Officer, District Lab Scientist.

The Provincial Medical Directorate (PMD) co-ordinates the planning and management of the health delivery system in the provinces. The PMD ensures that government policy is adhered to and that national policies and goals are being implemented. Community and other sectors' health inputs are captured through the Provincial Development Committees. The Provincial Medical Directorate monitors the performance of all health workers and health services at province level to ensure national policies and standards are met. The National level supports the PMD through professional and political support. This enables the Headquarters at National level to maintain its oversight role



At National (Central) Level, the Ministry of Health and Child Welfare's headquarters role is responsible for carrying out government's mandate of keeping the population in good health i.e regulatory, policy setting and provision of a legally enabling environment for the operations of the various health service providers and funders. A number of institutional updates are done in the form of Minister's policy making meetings, Permanent Secretary weekly meetings, the Planning Pool and the Top Management Meetings to guide the operations of the Ministry of Health and Child Welfare. The national level reports to the Health Service Board which is mandated to deal mainly with issues pertaining to the conditions of service for members of the public health sector.

As HCC members what do you know about the organization of health services in your area? How long do people take to get to the clinic? How long do you wait to be served? Which other services are available? In the next activity you will explore this further and identify in particular the barriers that people face in the system that the HCC need to help overcome.

Activity: The human sculpture
(Used with permission from Loewenson et al 2005)

The activity plan is a guide to a trained facilitator who should facilitate the activity.
Approximate Time: 90 minutes
Resources: a large space, pen, small pieces of paper to use as labels, sticky stuff or pins

Procedure:
You need at least 15 people for this activity. Participants will position themselves in ways expressing relations among the major actors in the health system. The result is a human sculpture that represents the groups understanding and knowledge of what is going on in their health system.

- To start with, the facilitator sets the scene or asks one of the participants to describe a common situation at a clinic, noting the person and the problem they come with. For example a 16-year old girl in her third trimester of pregnancy comes to the clinic in a poor rural area. She arrives on a day when the clinic is busy with its usual line of patients for treatment.
- Before beginning the human sculpture, participants name the major actors that would be found in this situation. One facilitator writes the names of the actors on the flip-chart; another facilitator writes the names on small slips of paper.
- Ask participants to place the actors as they are named. Start with the person who comes to the clinic and whoever comes with her or him. Then add the clinic personnel and others named (family members, people in the community and in the health services, the state and international players, and so on)
- If you use the pregnant teenager, for example, ask one of the participants to take her role and stick a label on her shirt. The group discusses how the teenager should be positioned in the middle of the room. Then invite the rest of her family to come forward and again, the group decides how they should be positioned in relation to the girl, keeping in mind that we are sculpting the communication between each actor (participants place people at different heights or distances from each other, using gestures, body movements, and so on to show how they are relating).
- The group continues to identify and place the other actors, leaving the national and international actors until last. Keep asking whether everyone agrees that the way people are placed reflects their status and links. This will ensure that the sculpture is an agreed outcome of the group.
- When all the actors are in place, discuss what this sculpture is saying about relations:
    - *Are the teenage girl's needs being met? Why or why not?
    - *What role is each level of the health system playing?
    - *What barriers does the girl/ client face in the way people are treating her?
    - *What barriers do the health workers face in communicating with clients?
    - *Is this how things are in your health systems generally?
    - *Is this how you think things should be?
- Now ask the participants to move the actors to position them to solve the problems they raised or to show things they want to change to make the system more people oriented.
- Discuss the difference between this sculpture and the one before.
    - *What has changed about the relations between the people and the health workers?
    - *What has changed in the way clients are communicating with/ relating to the service personnel?
    - *Have the changes reduced any of the barriers people face in using the services?
    - *Have the changes reduced any of the barriers health workers face in providing services?
- Discuss in plenary the barriers you identified and the changes you made.

Given your discussions, identify three actions you think you can take as a HCC to make the health systems in your area more people centred. Record the actions you have suggested in the HCC minutes/ record book for formal discussion at your next HCC meeting

1.3. Community roles in health systems

Let's explore further the roles communities play in the health system.

A mother at a health centre is in labour and bleeding. She has not been attended to though her case is clearly an emergency. She seems to have travelled a long distance. The other expecting mothers are in a long queue and there are too few health workers for emergency care.

What roles can communities play in
- Helping mothers access and use maternal health services
- Helping health services support mothers having problems with deliveries?

Are communities able to play these roles?

Do you have any of these problems in your area? What roles can communities play?

MODULE 1

As you saw and discussed in the picture activity above in section 1.1 *(what do we mean by health and health systems).*

See the ideas below, and identify those you have already discussed, and if any are new:

- People stay healthy by their understanding and awareness of health - parents are responsible for the health of their children, partners for each other's health, and communities should care for the elderly and poor in their communities.
- People share information with health service providers , on the conditions in their community and on preventing and treating disease.
- People have local health knowledge to contribute to their health systems, including on healthy foods and local health risks
- People play a role in implementing health actions, including outreach of health programmes, caring for ill people, supporting health services
- People contribute resources to the health system, including their time and even building clinics, waiting mother shelters and other services.
- People set priorities and make decisions on how health problems should be addressed, and on resources should be allocated
- Communities also monitor and make sure that their services are functioning in the way they expect, and give feedback to health authorities and discuss issues with health workers

Communities can mobilize their own resources to implement community based health initiatives through

- Village funds,
- Revenue collection,
- Selective exemptions from local levies,
- Private sector funds,
- Commodity sales and some cost-sharing.
- Provision of locally produced materials for building and maintance

These resources are complemented by the labor, time and other inputs people provide, particularly when villagers are directly involved in health activities.

As HCC members what can you do to strengthen PHC in your area?
In the next activity you will explore this further and identify in particular the actions you can take as a HCC to strengthen PHC.

Share in groups the actions taken by the HCC in your own area to strengthen PHC. For instance you may have done a cleanup campaign; supported and participated in an immunization campaign; malaria spraying or other disease prevention, nutrition gardening, health literacy etc. (the Table above may remind you of actions taken)

Now go through the discussion questions below and explore ways in which this can be done again or strengthened to support the health system

- What action was taken?
- Was the action successful? Why?
- If Not, Why was the action not successful?
- Who took the action?

How did the health providers interact from community level upwards?
How else can this be used to further strengthen the health system

If you do not yet have a fully functioning HCC in your area or have just set one up, read the case study below and discuss the roles played by different players that make up the health system and what ideas it gives you about the structure and functions of Health Centre Committees.

Kawoyo Health Centre Committee addresses prison overcrowding in Kawoyo area of Goromonzi District in Zimbabwe
Source: Ms Mudyiwa-Health Literacy Facilitator, Environmental Health Technician, and HCC member of Kawoyo, Zimbabwe

In 2007 in the Kawoyo Police cells housed too many prisoners.imprisonment is regarded as a fair sentence, not just for high-risk offenders, but for all offenders even though some serve a community service scheme depending on the intensity and severity of the crime. The Kawoyo Health Centre Committee conducted a needs assessment of the ward and realised that there was an urgent public health need at the local police cells in Kawoyo. The assessment revealed that inmates were overcrowded leading to unhygienic conditions, lack of adequate food, medical care, spread of diseases and deaths.

The Kawoyo Health centre Committee needs assessment revealed that in each cell (occupied by more than one prisoner) one bucket of water was provided for washing, drinking and for toilet purposes. This led to frequent diarrheal increased cases of TB, and Cholera outbreaks. Some of the health challenges pointed at inadequate blankets, lack of tissue paper (with most inmates reporting use of their clothes and pieces of the blankets to help remove faeces after defecation) The health hazards associated with this practice remain worrisometo the inmates who mostly do not have soap to wash their hands, bodies or clothes/uniforms. . Predisposing conditions like overcrowding, dirty linen, poor sanitation, poor food preparation and inadequate washing facilities render prisoners extremely vulnerable to diseases. Common diseases common among prisoners were noted as diarrhea, cholera, TB and HIV / AIDS.

The Kawoyo Health Centre Committee mobilized resources for the prisoners (the resources included new blankets, soap, bleach and food). The HCC succeeded in mobilizing the community, Health workers and local authorities to clean the premises wash the blankets and provide vegetables for the inmates. The police administration now maintains regular communication with the Kawoyo Health centre committee. This has enabled the clinic to keep records on any disease outbreak, statistics on ill health and consistently feeds to the district level. The Committee has continued to provide food on ad-hoc basis at the prison cells to alleviate hunger. In 2008 and 2009, the prison administration reported reduced cases of communicable diseases at the prison

Discussion questions

- What action was taken?
- Was the action successful?
- If Not, Why was the action not successful?
- If Yes, Why was the action successful?
- Who took the action?
    - How did the health care providers interact from community level upwards?
    - Is this possible in your district? How would you as an HCC implement similar actions?

We can see now how information flows across the community from one social group to another. Households can lose out when information is distorted, inadequate or suspicious; when this happens, a gap between health providers and the community is created. Therefore we can see the need to have a mechanism that ensures that relevant and correct information flows to and from communities.

So, what do you have in your community for this?

Many people can play this role

- Community health workers and civil society organisations can bring information from the health services to communities
- Community and social leaders can bring community views to health service providers

MODULE 1

- Communities can build health worker morale by contributing towards building and maintaining Health worker houses.
- Community based NGOs can distribute health resources such as condoms or bed nets
- Ministry of Health to obtain and distribute health information
- Community based organisations and communities can mobilise and organise for health
- Local Government can represent public and community interests in policy
- National NGOs can advocate for fair policies that support disadvantaged people
- Ministry of Health can waiver fees for specific groups that cannot pay for services
- Communities can monitor health services and build public accountability and transparency for health funds

Community project generating income for health, Chipinge © I Rusike, CWGH 2010

One way of bringing these different groups is through a committee to exchange information between health providers and the community. This is one of the roles of the Health Centre Committees.

In Zimbabwe Health Centre Committees (HCCs) identify priority health problems with communities, plan how to raise their own resources, organize and manage community contributions, and advocate for available resources for community health activities. The HCC is the mechanism by which people get involved in health service planning at local level. They can discuss their issues with health workers at the HCC, report on community grievances about quality of health services, and discuss community health issues with health workers.

As HCC members what can you do to get and share information for health?
In the next activity you will explore this further and identify in particular the actions you can take as a HCC to strengthen information exchange.

In buzz groups of four people identify the information that as an HCC member you

- Need to get for your work on health
- Need to share to promote health

As a plenary write these on a flip chart, ticking each time a need is raised so you can see which are most commonly raised.

Now with the list you have made as a plenary discuss

- Which of the information needs you have listed are met? What can you do about those that are not met?
- Which of the areas of information are being met at the moment? What can you do about those that are not met?

Record the actions you have suggested in the HCC minutes/ record book for formal discussion as your next HCC meeting.

1.4. Mechanisms for coordination of health services

We have explored community roles in the Health system and how the health system is organized. We will now investigate how health providers coordinate with each other in the whole structure from community level right up to the national headquarters. You will notice where you fit in, your responsibilities in the health system and who you are likely to interact with as HCCs.

Community Level

Health providers at community level include Clinics /rural health centers; Mission clinics; Private clinics; Traditional Healers and Community Health Services Providers (e.g. Environment health Community nursing). Health workers at clinic and rural health centre level include the nurse, nurse aid, EHT, general hand, nurse in charge, matron, patron, doctor, mortuary attendant, midwife, clerk, cook, accountant, and dispensary.

The nurse or sister in charge at the clinic is usually a member of the HCC and provides secretariat services in the committee. Thus, the HCC has a direct link with the nurse or the nurse in charge. In addition, the EHT interacts with the community on a regular basis; therefore the HCC also interacts with the EHT more regularly.

At community level, there are committees that help in communicating and coordinating work:

- **Ward Health Committees (WHC)** provide leadership and support to communities to ensure that their needs are reflected in the overall District Health plan. WHCs comprise the Headman, Councillor, Village health Worker, Headmaster/school health teacher, Church Leader, Non Governmental Organization representative, Nurse at local Clinic, Environmental Health Technician (EHT), Community nurse, Youth representative and Women's representative.

- **Village Health Committees (VHC)** provide a platform for wider participation by local communities. The VHC is made up of the Village Health Worker (VHW), Village Head (Sabhuku), Church Representative, Youth Representatives, Women Representatives, Traditional healer, Faith healer, Traditional birth attendant, and Representative of disabled people Specifically,

Members in both the VHC and the WHC may also be part of the HCC and feed directly or indirectly to the HCC. It is important to keep these linkages to coordinate work at the primary care level of the health system

- Health centre committees are joint community – health service structures that are, linked to the clinic and covering the catchment area of a clinic (covers a ward or more). They are made up by: the Nurse in charge, EHT, Kraal head, councillor headmaster/health teachers, 1 church representative, a VCW\VHW, a youth representative, representative of other health providers in the area (ZINATHA, private health services, NGOs), 1 civic group representative and any other community leader as appropriate for that area (about eleven people). Ministry of health/RDC health worker may be the secretary to the committee; however, it should be left to the communities to choose their own chairperson.

District level:

District Providers: Providers of Health Services at District Level are:
The District Hospitals; Rural Health Centers; Mission clinics and hospitals; Private hospitals and practitioners; Traditional Healers and Community Health Services Providers (e.g. Environment health Community nursing). The District Hospital Executive is responsible for the management of the day-today operations of the hospital, while the District Health Executive, is responsible for health service delivery in the whole district. The DHE consist of the Hospital Superintendent /Director; Hospital Administrator; Matron; Pharmacist and Accountant

The HCC can interact with the District Nursing Officer, the District Environmental Health Officer and the District Health Education Officer. These health workers interact with HCCs, NGOs, CBOs, VHW, Health literacy facilitators, communities directly and through the District Health team. The District Health Team liaises with the district Community health committee or the district Health Management board where selected members of the HCC should actively participate

Provincial level:

Provincial Hospitals: These hospitals are specialist referral hospitals for Providers in the Provincial level. They offer basic specialist care (obstetrics, pediatrics, general surgery and internal medicine). The Composition and role of the Hospital Management Board of a Provincial Hospital, is the same as that of a Central Hospital. However, as Central Hospitals and Provincial Hospitals differ in complexity and size, some of the positions may be combined, as the situation requires.

As at district level, the provincial level has a platform for HCCs to participate through the Provincial Nursing Officer (PNO), the Provincial Environmental Health Officer (PEHO) and the Provincial Health Education Officer (PHEO). These health workers are in the Provincial Health Team

Central level:

Central Hospitals: these are found at National level. The hospital management board provide for the efficient management of services in the hospital. The Composition of a Central Hospital Executive includes the Chief Executive Officer; Director of Clinical Services; Director of Administration, Planning and Human Resources; Director of Patient Care and Quality and Director of Finance.

At this level, the HCC can interact with Advisory Board of Public Health (PHAB) at national level. There is however, no direct link between the PHAB and the HCCs.

The civil society representatives in the PHAB may give feedback to the community through the HCC. The PHAB represents communities and Health workers as well as Primary health care and other health system related issues. The Health Services Board manages Health Worker related issues.

1.5. Major health programmes

The Ministry of Health at national level also organizes the different work on health into major health programmes, such as .

- Family and Child Health (Health and Child Welfare)
- Environmental health
- Epidemiology and Disease Control
- AIDS and Tuberculosis (TB)
- Policy and Planning
- Finance
- Technical Services
- Disease Prevention and Control
- National Health Information System (NHIS)
- Reproductive and Child Welfare

In buzz groups of four people identify one of the programmes or departments in the diagram that you know or have worked with and discuss

- What you know about what it does
- How you work with it as an HCC

In plenary exchange what you have discussed so you share information on the different departments and programmes between you,.

After this are there any programmes you have not covered? Can anyone in your group brief on these programmes? If not then write them down so you ask the health workers to brief you at the next HCC meeting on what these programmes do nationally, and in your district.

Finally as a group summarise

- What new information or skills you have from this module
- What questions you have to ask at your next HCC or DHE meeting
- What follow up actions you have identified to take up at your next HCC meeting.

MODULE 2
Health Centre Committees

In this module Health Centre Committee members will

- Be informed on and discuss the composition, roles, functions and duties of a health centre committee
- Review what the health systems structure and policies of Zimbabwe provide for on health centre committees

Before you start the module discuss feedback on the follow up from the last module

- What were the issues arising from the discussion at the HCC or DHE meeting?
- What follow up actions were discussed at the HCC meeting and what is being done?
- Are there any issues you still need to follow up on as an HCC? Who will do this?

2.1. What are Health Centre Committees

Source © M.Ndhlovu and TARSC, 2005

Look at the picture above, who do you see?

- What do you think is happening?
- What is the cause of the emotions displayed?

Often, health workers blame communities and communities blame health workers for problems present at the health facilities. Communication is poor and both the health worker and the community end up frustrated. In this module we discuss how HCCs can help communities and health workers to better relate and communicate with each other to better understand each others needs and roles and to plan and take effective action for health.

Joint structures such as health centre committees play an important role in improving co-ordination and communication. These committees involve both community and health service representatives. It is important for us to understand and strengthen community interactions with health services.

How can HCCs help to improve communication between communities and health workers? In the next activity you will explore this further and identify in particular the actions you can take as a HCC to strengthen the interaction between health workers and community members.

Activity: Discussion and role play
Understanding and strengthening community interactions with health services
(Adapted with permission from Loewenson et al 2005)

The plan is written as a guide to a trained facilitator who should facilitate HCC members to implement the activity.
Time: 15 minutes for the first group discussion, 15 minutes for role play, 15 minutes for plenary discussion.

Procedure

- Ask some participants to get into groups / a group
- Participants discuss their experiences of what HCCs are (what they know, what they have seen, and what they have heard)
- Participants volunteer to role play as village chief, members of village health committee (about 4), village health facility in charge and district health officer
- Let the health centre committee members convene a meeting. Their instructions are as folllows (you may want to write these instructions down on small pieces of paper to give to the health committee members):

"There's been a few suspected cases of cholera in your community. Discuss those cases that have been reported, possible causes for the outbreak and measures to be taken. Of the measures, show what you can do on your own (e.g. educating and sensitizing the community on hygiene issues, encourage households to have latrines and use them etc). Arrive at a point where you recognize you need assistance from your health facility in charge (e.g. drugs information on the disease, etc). At this stage, take the issue to a meeting of the health centre committee and invite the nurse in charge to come on stage."

Let the nurse in-charge attend the meeting and respond to some questions from the committee members and plan together what to do. The in-charge's instructions are:

"you've been invited to attend a Health Committee meeting. Let the members of this committee lead the discussion about what they want from you. Respond as best as you are able. Eventually, admit your incapability to tackle some of the issues without the help of the district officials. Go and report this to the District Medical Officer and invite him/her to the village.

- The DNO comes to the village and commits him/herself to what they are going to do to help the community (e.g. providing additional supporting staff, drugs, transport etc).

Once the play is over, the facilitator should lead a discussion with participants using some of the following questions:

- What conclusions came out of the play? Were the community representatives concerns met? How and by whom?
- What could the HCC members have done to make sure their concerns were met? How could the authorities have responded more effectively?
- What are your own experiences on community - health officials (of different levels) relationships in dealing with various community health matters?
- What have you identified in your discussion about what your own HCC could do to improve communication between health workers and communities?

Record the actions you have suggested in the HCC minutes / record book for formal discussion as your next HCC meeting

MODULE 2

Health Center Committees (HCCs) were originally proposed by the MoHCW in the 1980s to assist communities identify their priority health problems, plan how to raise their own resources, organize and manage community contributions, and tap available resources for community development.

Health Center Committees assist communities to identify their priority health problems, plan how to raise their own resources, organize and manage community contributions, and tap available resources for community health activities.

The Health Center Committee is the mechanism by which people get involved in health service planning at local level. Health Center Committees, report on community grievances about quality of health services, and discuss community health issues with health workers. It is a joint community-health service structure, linked to the clinic and covering the catchment area of a clinic (usually a ward or more).

Look at the list below that describes how HCCs are formed. Discuss the HCCs in your area – do they match the list below? In which aspects do they not match the statements in the list? Why? What actions will you take as an HCC to correct this?

1. The HCC is a joint community – health service structure, linked to the clinic and covering the catchment area of a clinic (covers a ward or more)
2. The HCC members are the Nurse in charge, EHT, Kraal head, councillor headmaster/ school health master, 1 church representative, a VCW\VHW, a youth representative, representative of other health providers in the area (Zinatha, private health services, NGOs), 1 civic group representative and any other community leader as appropriate for that area. About 11 people.
3. The Ministry of health/RDC health worker is the secretary to the committee
4. The communities choose their own chairperson.
5. HCCs meet at least once in every three months.

Source: Kaim B, Loewenson R, Rusike I (2001) Facilitator's guide for meetings to form Health Centre Committees: Guide to the phase 1 meeting TARSC/CWGH Monograph 4/2001 TARSC,CWGH: Harare

What are the functions and roles of HCCs?
In the next activity you will explore this further and identify in particular the roles you can play as an HCC

The Mwanza rural Health Centre Committee addresses Pilfering of drugs at the local health center
Source: Steven Marima -Health Literacy Facilitator, Environmental Health Technician, and HCC member of Mwanza, Zimbabwe

"In 1998, the Mwanza Rural Health Centre was often found without medicines, bandages and equipment. Burglary and pilfering of drugs by health staff and community members was one of the reasons why the Health centre almost always had no medicines. This reason prompted the formation of a Mwanza Health Centre Committee. In 1999 Mwanza Health Centre Committee in Chikwaka Goromonzi was formed through the assistance of the CWGH and TARSC. It composed of the Health care Worker, Councilor, Kraal Head, women's representative, youth representative and a village health workers. The committee put measures that prevented theft and pilferage of drugs. The HCC reported that conflict between self image of health workers and challenges surrounding their poor remuneration and work environment made it difficult to put up firm measures that prevent theft of drugs.

The Mwanza HCC committee acted quickly to address the problem of pilferage. Each household was asked to pay a small amount of money every month. The money was earmarked for security/guard at the clinic. This prevented drug theft, pilferage and shortages. Some of the funds mobilized by the HCC were used to construct a pit latrine at the health centre. Community monthly contributions still come at spaced intervals due to the current economic environment. Volunteers, often come to clean the health centre premises, wash blankets, clean equipment and cut grass. Since 1999 to date (2009), the health centre has always had a guard, the premises are always clean.

Discussion questions

- What did the Health Centre Committee do in this case?
- Who did they work with?
- What made their plan work?

Discuss what you have learned from this case about what you can do as a HCC? What are the roles of the HCC that you have seen from the example? Does your HCC implement these roles? Are there any actions you would want to take to clarify and strengthen your roles?
Record the actions you have suggested in the HCC minutes/ record book for formal discussion as your next HCC meeting

2.2. The Functions of Health Centre Committees

In 2005 the Ministry of Health set out guidance on HCCs and in 2010 in a meeting of the Primary Health Care Task -Force stakeholders further discussed and identified the functions of HCCs show in the table below:

HCC responsibilities are to:

- Bring community priorities into health plans
- Ensure that health resources, budgets, fees for service are used in a transparent way
- Organize community actions for health
- Promote dialogue with health services on quality of care issues
- Make claims on district level funds like the Health Services Fund
- Advocate for essential resources for their services from the RDC and MoHCW
- Organise community inputs to health services
- Monitor quality of care and take up community grievances.

HCC functions are to

- Organise people in the area to identify their priority health problems, identify what they think can be done about them, using participatory approaches and information from technical personnel.
- Plan how to raise their own resources, organise and manage community contributions, and tap available resources for community health activities.
- Use information from the health information system and from communities in planning and evaluating their work and should be trained to do this
- Assess whether the health interventions in the area are making a difference to peoples health using health information system and community information
- Be a a channel for information flow from the community to the RDC/DHT and back to the community
- Are informed about the activities of different health providers in the area (RDC, MoHCW, ZINATHA, private)
- aise and discuss aspects of patient care and represent communities on issues they raise on services offered, to see how these can be addressed.

MODULE 2

- Obtain information from the RDC and DHT on budget allocations for health, on ward level allocations, on the HSF, give input and feedback to the RDC and DHT on budget planning and keep communities informed on health budget issues, particularly where this relates to local resource mobilisation.
- Work with the RDC to motivate and implement public health standards, such as water supply, food safety and sanitation.

Divide into buzz groups of four people. Each buzz group takes two of the responsibilities listed in the table above. Discuss as HCC members:

- Is this a responsibility that you currently have as an HCC? Why? Why not?
- Is this a responsibility that you should have as an HCC? Why? Why not?
- What do you do or should you do to implement this responsibility?

In plenary present what you have discussed. Write on a flip chart.

- The responsibilities you have raised in the groups
- The actions or functions you have raised in the groups.

Now compare it with the list of responsibilities and functions on the table above. How does it compare?

Are there any responsibilities or functions you do not already cover as an HCC? Are there any responsibilities or functions you do not fully understand? If so then write them down so you can discuss these at the next HCC meeting and how they can be implemented.

Chiundura Health Centre Committee, Midlands © I Rusike CWGH 2010

HCCs have clear roles and functions. But these need policy and legal back-up. The HCCs do not have a yet have an Act of Parliament or statutory instrument specifically on their role and functions. However there are different laws and policies that acknowledge their work and contributions to the health system. The table below shows the policies and laws that acknowledges the HCC work

HCC functions and the laws that support them

FUNCTION	HEALTH CENTRE COMMITTEE	LAW/POLICY SUPPORTING THIS
Level of health system	Clinic, ward (clinic catchment area may be wider than a single ward)	1980 District Councils Act; 1984-85 Prime Minister's Directive on Decentralization; 1985 Provincial Councils and Administration Act; 1988 Rural District Councils Act
Composition	Councillor, clinic nurse, EHT and community local health workers, organisations representing civil society groups in the area including women and youth, Headmaster/school health master , church leader, traditional leaders, traditional healers, faith healers and other health providers	1980 District Councils Act; 1984-85 Prime Minister's Directive on Decentralization; 1985 Provincial Councils and Administration Act; 1988 Rural District Councils Act
Elects new members	Communities elect the committee after three years and health workers send representatives	MOHCW decentralization policy; MOHCW structures and functions
Relationship with local government	Not clear- links through the councilor	1984-85 Prime Minister's Directive on Decentralization; 1985 Provincial Councils and Administration Act; 1988 Rural District Councils Act
Relates to health system	Through the health staff to the District Health Executive	The Health Services Act
FUNCTIONS		
Identifying health needs and mobilizing community participation	Facilitate people in the area to identify their priority health problems, identify what they think can be done about them, using participatory approaches and information from technical personnel.	Public health Act; Health Services Act; 1980 District Councils Act; 1984-85 Prime Minister's Directive on decentralization; 1985 Provincial Councils and Administration Act; 1988 Rural District Councils Act; 2009-2013 National Health Strategy
Local resource mobilization	Plan and raise own resources, organise and manage community contributions, and use available resources for community health activities.	1984-85 Prime Minister's Directive on Decentralization; 2009-2013 National Health Strategy
Using health information for planning	Use information from the health information system and from communities to plan, monitor and evaluate work	Health Services Act; 2009-2013 National Health Strategy
Evaluate health programmes	Assess whether the health interventions in the area are making a difference to peoples health using health information system and community information	1984-85 Prime Minister's Directive on Decentralization;

MODULE 2

Information channel between communities and services	Are a channel for information flow from the community to the RDC/DHT and back to the community	Public Health Act; The Health Services Act; 1984-85 Prime Minister's Directive on Decentralization; 1997 – 2007 National Health Strategy 2009-2013 National Health Strategy
Information channel on other health providers	Are informed about the activities of different health providers in the area (RDC, MoHCW, Zinatha, CBOs, NGOs, FBOs, private)	Public Health Act; Health Services Act; 1980 District Councils Act; 1984-85 Prime Minister's Directive on decentralization; 1985 Provincial Councils and Administration Act; 1988 Rural District Councils Act
Represents communities in health service issues	Raise and discuss aspects of patient care and represent communities on issues they raise on services offered, to see how these can be addressed.	Public Health Act; Health Services Act; 1980 District Councils Act; 1984-85 Prime Minister's Directive on Decentralization; 1985 Provincial Councils and Administration Act; 1988 Rural District Councils Act
Health Centre budget planning	Obtain information from the RDC and DHT on budget allocations for health, on ward level allocations, on the HSF, give input and feedback to the RDC and DHT on budget planning and keep communities informed on health budget issues, particularly where this relates to local resource mobilization.	None
Co-ordinate health programmes and local government promotion of public health	Work with the RDC to motivate and implement public health standards, such as for water supply and sanitation.	1980 District Councils Act; 1984-85 Prime Minister's Directive on Decentralization; 1985 Provincial Councils and Administration Act; 1988 Rural District Councils Act, 2009-2013 National Health Strategy

The provisions in law and policy provided in the table above can help you to support the work you do formally with other structures in the Ministry of health, in local government and with other mechanisms for community participation. You can source the Acts, policy documents and laws from the nearest local government offices and some from the Ministry of Health if you need more information on them. The box below briefly provides some of the provisions of the laws listed in the table above:

The Health Services Act 2005 provides for the establishment and the operations of both public and private hospitals and Medical Aid Societies. The Act provides for the establishment of the Health Service Board, Community Health Councils and Hospital Management Boards at Central and Provincial Hospitals.

The District Councils Act 1980 (amended in 1981 and 1982) revived local government structures and how they interact with communities. The councils are the principal planning and development agencies within their authority zones. They ensure that central level policies are implemented at district level.

The Public Health Act: Ch15 provides for the duties, roles and organization of public health system in Zimbabwe, including mechanisms through local government to address public health issues.

The Prime Minister's Directive on Decentralization (1984 and 1985), provided the basis for the devolution of authority to subnational level (the district) . It also provided a hierarchy of representative bodies at the village, ward, district and provincial levels. It outlines the roles of the Village Development Committees (VIDCOs) at village level; Ward Development Committees (WADCOs), which cover about six villages and consist of VIDCO representatives. They oversee and prioritize local needs and forward these to the District Council; District Development Committees (DDC) responsible for planning and co-ordination committees at district level.

The Provincial Councils and Administration Act 1985 clarifies the roles of Provincial Councils. Provincial councils oversee District Councils in implementation and monitoring through the Provincial Development Committee (PDC). The PDC is responsible for formulating plans for provincial coordinated development. The committee produces long and shortplans that reflect District Development Plans, provincial plans of Ministries.

The health sector activities have been guided by policy documents, Planning for Equity in Health of the early 1980s, the National Health Strategy, "Working for Quality and Equity in Health" (1997-2007) and the National Health Strategy , "Equity and Quality in Health, a people's right" 2009-2013. The Strategy for 2009-2013 commits towards the establishment of health centre committees within the health system. The strategy identifies that, communities, through health centre committees or community health councils will be actively involved in the identification of health needs, setting priorities and managing and mobilizing local resources for health.

The law provides for different local government, Ministry of health and joint health service- community mechanisms at the different levels of the health system. These are shown in the Table overleaf. HCCs need to interact with these mechanisms in their work. For example

Structure for participation in health

Level of government; mechanism	Ministry of Health structure	Mechanism for community participation
Village development committee	Village health worker, other community health workers	Village health committee
Ward development committee	Health facility Health Centre- Rural Hospital	Ward health committee Heath centre committee
Rural district / Urban council	District health team District hospital	District community health council District hospital management board
Provincial council	Provincial health team, Provincial hospital	Provincial hospital management board
Central government	Ministry of Health and Child Welfare Zimbabwe Health Services Board	Advisory Board of Public Health National Taskforces; Interagency coordinating committees on Health

How should HCCs interact with these other structures?
In the next activity you will identify the actions you can take as a HCC to strengthen the interaction with structures at village, ward and district level

MODULE 2

Divide into three groups.

Each group take one of the three structures: i. Village development committee ii. Ward development committee iii. Rural district council/ Urban council, and discuss as HCC members

- How does the HCC relate to this structure?
- What does the HCC report to this structure? What information does it get from this structure?
- What does this structure do that affects the work of the HCC?

In plenary present what you have discussed.

After this are there any gaps you have in links with these structures as an HCC? Are there any links or structures you do not fully understand? If so then write them down so you can discuss these at the next HCC meeting.

Finally as a group summarise

- What new information or skills you have leaned so far from this module
- What questions you have to ask at your next HCC or DHE meeting
- What follow up actions you have identified to take up at your next HCC meeting.

MODULE 3
Working with Communities

In this module Health Centre committees will

- Discuss and practise how communities organise for health
- Learn and use basic skills in communication, holding meetings and report writing to advance health

3.1. Communities organizing for health

You have been tasked to organize a joint HCC and youth meeting in your own area to discuss young people's priority health problems. You are very excited about the meeting and on the day of the meeting you arrive at the venue a little late. However, there isn't anyone yet so you wait....after an hour, you are still alone, after three hours no one has turned up....

What would you do? What did you do wrong? ...or maybe everyone just got busy that day?
Do you know why? Discuss

Skill for community organizing is important for HCCs.
Community organizing is when communities and organizations work together to identify common problems and objectives, acquire and mobilize resources, and create and implement actions to achieve their goals.

In this module we will learn the basics of facilitating community organizing processes in health promotion, education and action processes. Health centre committee members work in teams, prepare and facilitate community sessions, write reports, and present their findings to both the health providers and the community.

When we organize for health in our communities we need to ensure the following:

- All members of communities have the opportunity to participate and have their voices heard
- People's views are heard and people participate in discussions and decisions
- Different social groups are involved including vulnerable and less powerful people

Discussion
Approx Time: 15minutes
If you have an HCC in your area:

- In your HCC meetings, what you have done to organize for health in your area?
- Who was invited?
- How did those who participated influence the decisions made?

If your HCC has just been formed:

- How is health planning and decision making done. Who is involved? Who has most influence?
- Who else needs to be involved?

Discuss what you have found. How much influence did community members have in the decisions?
What affects whether community member views are listened to or not?

Who are the different groups we need to work with in health?

When organizing for health we need to network with organisations and individuals around us.

MODULE 3

Many social groups are strategic in planning, implementation and in decision making, including for example:

- Civil society alliances;
- Parliaments and members of parliament;
- Community based Organisations,
- Church organisations;
- Schools, child and family service organisations,
- The business community;
- Agriculture extension workers;
- Women's groups; AIDS networks;
- Local, national and international NGOs.

Who have you worked with as an HCC? Who do you think you should work with?

Discussion: Mobilising social action for health
(Adapted with permission from Loewenson et al 2005)

The plan is a guide to a trained facilitator who should facilitate HCC members to implement the activity.
Approx Time: 20 minutes

Identify an action you have taken on health in your community. Describe the action you took.

- Who did you work with on it? How did you bring them in? What roles did they each play?
- What skills did each bring? What resources did each bring?
- What would have happened if each or any were not involved?
- What role did health workers/ local leadership / government agencies / civil society each play in the work?
- Were there any groups missing who would have improved the action?. Who? Why?

Discuss your findings. What do they indicate about who needs to be involved in health actions in your area.

Follow up Activity; Stakeholder mapping
Approx Time: half day
Time: 40 minutes
Resources: large piece of paper, small (if possible, coloured) pieces of paper, scissors

Procedure:

1. Working in groups, participants make a list of the main health-related institutions operating in their community.
2. Decide with participants what issue you want to explore, such as which institutions are important in supporting orphans or how one institution relates to the others in providing health education to the community. Make sure all members understand exactly what is being measured.
3. Participants cut out or draw circles to represent each institution, the larger the circle, the more important the institution.
4. Ask participants to place the circles on a bigger piece of paper showing their relationships and linkages – the overlaps indicate cooperation between or among institutions and separate circles show no links or that the roles or activities of the institutions are different.
   Participants can adjust the size or arrangement of the circles as they consider appropriate.

5. While participants are developing their diagram, explore with them why they are making certain choices. For example:
   - o Why is this institution so far away from the others?
   - o These two institutions are overlapping – what type of activities do they share?
   - o Document what they say.
6. At the end, ask the groups to exhibit their diagrams and do all or some of the following:
   - Identify the institutions in the area that need to be involved in health activities
   - Identify how the institutions relate to each other
   - Look at whether certain kinds of people, for example, women, the poor or orphans, are excluded from participation in certain institutions. Suggest how they can be reached.

Given your discussions, identify the organizations and individuals in the community that will be important to bring in to future activities and work. Record these in the HCC minutes/ record book for formal discussion at your next HCC meeting

If the HCC in your area has not done community organizing before use the following picture code from the TARSC/ IHI / EQUINET PRA toolkit to discuss elements that are important for community organizing and discuss the questions that follow

- What is happening in the picture?
- Who do you see in the picture?
- Why are they important for the actions in the picture?
- Are there any people missing?
- Why?
- How effective is this HCC in the picture in bringing the groups needed into their actions?
- How do you explain thiswhat are they doing to bring groups together?
- What else could they be doing?

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From your discussion what have you learned for how you operate as an HCC to bring in the organizations that should be involved?

We can see that HCCs need a number of skills to organize for health. For example we need skills to communicate, to hold meetings to organize, to discuss, to negotiate and to advocate amongst many. We need to be able to effectively relay our messages from the health providers to the community and vice versa. We will briefly look at some of these skills in the following sections and discuss how you can practice these skills.

3.2. Communication skills

In this section we will explore the basic elements of communication skills for Health Centre committee members when communicating with health authorities and communities. Steps for communicating with authorities are not rigid and exact. They often depend on the authority, the relationship, the issue and the situation. Some tips include

MODULE 3

- **Be Prepared:** Preparation is the single most important element in successful communications and negotiations. In negotiations, information is power. The more relevant information you have, the better your position is. Allow yourself adequate time to prepare prior entering any negotiation.
- **Listen:** Communication is a two way process of information . Tke time to listen and give others turns to talk and listening
- **Understand the needs of the other party in the negotiation.** Put yourself in their shoes. What would they like to gain from the negotiation? What can you discuss that they want to hear and what is nonnegotiable.
- **Know what you need out of the negotiations?** Make a list of the outcomes you want from the negotiations. Identify the items you are willing to negotiate and those items which are nonnegotiable. Most negotiations involve parties engagedin a long term relationship.
  Always be sensitive to the potential impact of your negotiations on these relationships.
- **Where your case is weak work to strengthen it** and plan how to handle areas that remain vulnerable, should they arise.
- **Be fair.** Negotiation is "to bring about by mutual agreement" . Not to win! The best negotiators create "win - win" situations Negotiation frequently involves compromise.
- Look for **creative solutions** and make tradeoffs in less important areas in order to gain
- your bottom lines. While it may be possible to bludgeon your adversary into agreeing to your terms, this does not create the "mutual agreement" that makes for a truly successful negotiation.
- **Quit while you are ahead.** The best negotiations are brief and to the point. Get agreement on your major points and stop. Additional items can be addressed in subsequent negotiations.

(Adapted with permission from Loewenson et al 2007)

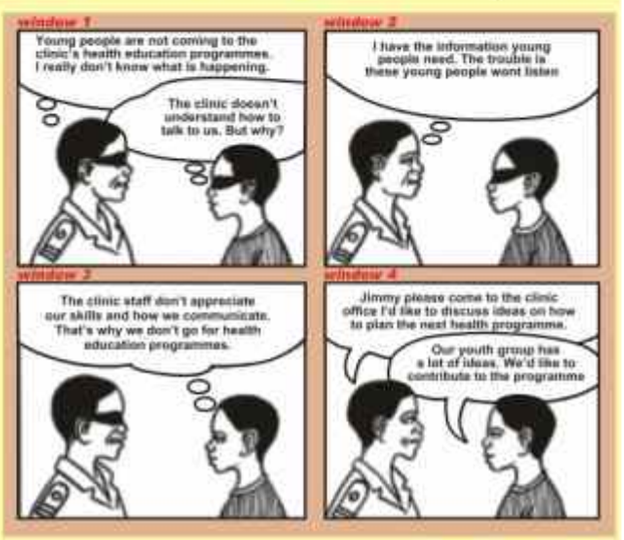
Now let's use the tips above to put into practice communication skills

Activity: Johari's Window
Adapted with permission from Loewenson et al 2005

The plan is written as a guide to a trained facilitator who should facilitate HCC members to implement the activity.
Time: 30 minutes
Materials: picture divided into four images or windows; two versions of Johari's window (you can draw these on flipchart paper)
Procedure: Show participants the picture called Johari's window,
which is shown below.

Ask them to discuss the picture,
using some or all
the questions below:

- What do you see happening in each picture?
- Why do you think the nurse or the young man are sometimes blindfolded and sometimes not?
- What do you think the blindfolds symbolise?



- Which of the four boxes represent most closely the type of communication that exists between the health system and community members in your area? Give some examples for each box.

During the discussion, encourage participants to look for examples which illustrate communication (or lack of it) between community representatives and health personnel in relation to community actions in planning and organising health systems.

Discuss as an HCC what you will do to improve the communication
- Between you and the health workers
- Between you and the community.
- Between you and other key stakeholders in your area

Record the actions you have suggested in the HCC minutes/ record book for formal discussion at your next HCC meeting

3.3. Holding meetings

In this section we will cover the basic elements of how to organize and hold meetings. Holding successful meetings requires adequate preparation and organization in order to meet the intended outcomes

Discussion: Share experiences on how you have held meetings in your area. Be sure to identify and list the skills that you used to organize that successful meeting, or the skills that you did not have that you think were key to have improved delivery of that meeting.

Village Health Worker Graduation, Chikomba district 2010

MODULE 3

Now discus the following basic principles of holding meetings

- Know what you want to achieve in the meeting and what needs to be discussed to achieve it
- Have an agenda preferably written that is shared in advance of the meeting so that people are clear on the purpose and expected outcomes.
- Be clear on whom to invite and why, send invitations in good time and follow up to confirm who is coming
- Make sure you have identified who will chair, who will take notes before the meeting and that they are properly briefed of expectations
- Check all items that you are supposed to bring to the meeting well before the meeting
- Circulate or prepare papers for the meeting well in advance
- Make sure the meeting room and supplies are organized
- Keep the meeting to time, and summarise the agreed outcomes, actions and responsibilities for each agenda item
- Make sure the minutes report on what was discussed, what was agreed, what actions were proposed, taken by whom and when
- Distribute minutes of meeting soon afterwards including action items and responsibilities
- Check in with those responsible for action items to keep process moving

Source: Loewenson et al 2007

Activity (Practice)-Developing an action plan
Materials: bean seeds/ corn seeds/stones; flip chart paper, Markers, pencils, rubbers, stikkistuff
Approx Time: Half Day

The activity is written as a guide to a trained facilitator who should facilitate HCC members to implement the activity.

Procedure

- Now, plan for a meeting with communities. You can use any agenda issue you already have. If you don't have an issue you can identify priority problems for health actions.

If you are identifying priority health problems then use ranking and scoring (See Loewenson R, Kaim B, Chikomo F, Mbuyita S, Makemba A (2005) Organising People's power for health TARSC, Ifakara in EQUINET: Harare Activity 12) to identify and prioritise health needs/problems. The HCC members should facilitate the process. When groups have finished, stick all the flip charts on the wall or lay them on the ground to identify cross cutting health needs and hence the cross cutting top three health problems.

- Use the tips in the box above to plan and organise the meeting
- At the meeting introduce the objectives of the meeting
- Facilitate the meeting using the tips in the box above
- Make sure you have achieved all your objectives and summarise what you have agreed on them before you close the meeting.
- After the meeting go back to the box of tips and see how you managed on each key tip for organising a meeting. Rate your performance: Good? Not so Good? Poor?
- Discuss how you can improve in the next meeting with communities.

Discuss as an HCC what you will do to better organise your meetings.Record the actions you have suggested in the HCC minutes/ record book for formal discussion at your next HCC meeting

It is important for people to participate during meetings. Therefore, Health Centre Committees are encouraged to use Participatory Reflection and Action approaches to make meetings more participatory and meaningful, exciting, involving and useful. Refer to the introduction section on what participatory approaches are.

3.4. Preparing and presenting a report

Now you have practiced skills for communication and skills for holding meetings. You sure need to document these activities including the community meeting report.

Discussion: In the last meeting you held, who wrote the report, who is intended to use that report? Is it clear? What is not clear? What should be changed?

This section will cover basic elements of how to write and present a report. HCC members are expected to write reports of the activities and share these reports with communities, health workers and other key stakeholders in the community. We will look at tips that will help us to write clear and interesting reports. These tips and the text in this section were adapted from Bartle (2007).

Keep your sentences short
Clear writing should have short plain sentences. Most long sentences can be broken up in some way, but, this does not mean making every sentence the same length. Differ your writing by mixing short sentences with longer ones and be punchy. stick to one main idea in a sentence.

Talk to your reader
Write with your reader in mind. If you want to encourage people to read your report, give them a piece of writing that is lively and readable. Imagine you are presenting your report to your reader yourself. Think carefully: What do they know already? What do you need to tell them? Talk directly to your readers in a language they understand. You will find that using shorter sentences and active verbs will already have made a difference. Think about who you are writing to, other HCCs? District Health Team? Rural District Council? Communities? Or parliamentarians? Add facts, agreed action points from the meetings

Understandable words
Say the simplest words that fit to say exactly what you want to say. Most importantly, don't use jargon that is part of your working life unless you are writing to someone who uses the same jargon. Again, imagine you are presenting your report in person. Write to communicate, not to impress.

Using active rather than passive wordings
Try to state things actively, that is by telling who did something, rather than passively, that is by saying something 'was done', without being clear who did it.

See the examples below – can you tell the difference?
Passive: A discussion was held about the matter
Active: The HCC members discussed the matter
Passive: Reference was made to staff shortages
Active: The medical director referred to staff shortages

Sounding positive
Always try to emphasize the positive side of things. For example:
Negative: *If you don't send your payment, we won't be able to renew your membership of the scheme.*

Positive: *Please send your payment so that we can renew your membership of the scheme.*

When writing reports, make your reader's job as easy as possible. Use active verbs, short sentences and keep to the point. Plan and organise the report carefully. Follow the suggestions below:

Define the purpose	Why you are writing? Who are you writing for? What do they want to know? What do you want to say? What can you leave out?
Investigate the topic	How you do this depends on the topic and purpose. You may need to read , research or get advice from someone more experienced if you need to.
Organise the report into sections	Make it easy for readers to find the information they want. Have a one page summary with the essential information In a longer report have o a one or two page summary o a table of contents with the headings and page number o page numbers on the bottom of the page o a maximum of 25 pages
Organise the report	Reports can be set out in parts e.g. Title page, Summary; Background, Aims. Findings Discussion; Conclusions; Recommendations
Executive summary	Give a one page summary of the report that provides the aims, what was done and the main findings and recommendations. This is often circulated as a separate brief as people can get the information they need without having to read the whole report. It may be better (and cheaper) to send everyone an executive summary, and only provide a copy of the full report if someone asks for it
The background or introduction	This should be brief and answer any of the following questions that seem relevant. What is the topic? Who asked for the report and why? What is the background? What was your method of working? If the method is long and detailed, put it in an appendix. What were the sources? If there are many, put them in an appendix.
The discussion or findings	This is the main body of the report. It is likely to be the longest section, containing all the details of the work organised under headings and sub-headings. In writing a section begin with the main points of the paragraph, then write further details or explanation.
The conclusions, recommendations	Keep this brief. Draw from the findings what the main issues are that are arising and what should be done in the future to improve the situation.
The appendix	Is for material which readers only need to know if they are studying the report in depth. It includes relevant charts and tables

Activity: Writing a report
Materials: Pen, paper
Approx Time: Half Day

The activity is written as a guide to a trained facilitator who should facilitate HCC members to implement the activity.

Procedure
Look at the report of the last meeting and discuss the following questions 9n the checklist below:

- Was the target audience clear?
- Were the sentences in the report short and clear?
- Were the words used simple? Did they communicate the intended information and message?
- What was the tone of the report?
- Was there a title page?
- Was there a one page summary?
- Were the sections clearly organized?
- Were the findings clearly presented?
- Did the recommendations link to the findings?
- How would you improve the report?

After you have had the discussion each HCC member will get a section to revise. Then compile the full report from the inputs and deal with any outstanding queries in the next HCC meeting.

3.5 Putting all our skills to practice:

You have now covered the skills to communicate, skills to hold meetings and skills to write a report. We now want to explore how these skills can be used collectively and learn how to present your report to the Rural District Council (RDC), the DHT or other Ministry of health/ local government Structure. Use the box below to discuss the skills relevant for the functions of an HCC.

Activity : Holding a community meeting and writing the report
Materials: flip chart paper, markers, pencils, rubbers, stikkistuff
Approx Time: 60 minutes

The activity is written as a guide to HCC members to implement.

Procedure

- Working as a team will require division of roles for this event to be successful. Each HCC member should be allocated each other a role on communication, holding the meeting and compiling a report.
- First: identify a representative from your committee who will go the RDC office and the District Hospital to pass the invitation to the meeting. The invitation letter should be written by one of you and signed by the chair
- Discuss what attributes and skills the person who is sending the invitation letter should have?
- Second: discuss next steps: for example how should the person who sent the invitation letters communicate to the group
- Third: set the agenda for the meeting: discuss how you should do this and what skills you need?
- Fourth: Holdthe meeting: discuss how this should be done and what skills each one of you would need
- Fifth: Write the report: discuss how the report should be written collectively and presented to the RDC and the DHT?
- Sixth: discuss the next steps

At the end of the activity discuss any general issues and lessons or any questions you still have on organising and holding meetings and report writing and raise these at the next HCC meeting.

Finally as a group summarise

- What new information or skills you have acquired from this module
- What questions you have to ask at your next HCC or DHE meeting
- What follow up actions you have identified to take up at your next HCC meeting.

MODULE 4
Working with Health Workers

In this module Health Centre Committees will

- Be informed on the roles of Health Care Workers and how they interact with them at different levels of the health system
- Discuss ways to improve their interaction with health workers
- Discuss skills for health advocacy and negotiation

4.1. Health workers at district level

You have probably been to a district hospital once or twice before.
Who did you see? Only nurses? What other health workers did you see?

The Health workers at the district hospital operate as a health care team, each with a special responsibility. Health workers at the district hospital level include the

- District Medical Officer (DMO),
- District Nursing Officer (DNO),
- District Health Promotion officer,
- District Environmental Health officer,
- District Environmental Health Technician (EHT),
- District Health Services Administrator,
- District Pharmacist; Nutritionist;, Lab scientist,
- Community sister, (Registered General Nurses)
- General hand, accountant and

Health Centre Committee meeting in Zhombe
Source © CWGH 2010

Others depending on circumstances e.g. a district eye specialist, health promoter, nutritionist etc.

Did you know that Health workers do more than just treating patients?

The role of Health Workers at district level is to provide comprehensive health services, including prevention, promotion and public health. The health workers at this level develop a plan of work, monitor and cost service provision, in line with national health policies, priorities and targets focusing on local needs. They also manage resources and services in collaboration with other providers to meet the health needs of communities.

What have been your experiences with Health workers at district level?
Discuss other roles that Health workers do.

The health workers are responsible for health service delivery in the whole district. A management team, The District Health Executive (DHE) is responsible for the management of the day-today operations of the district health activities and district hospital management.This team is composed of the Hospital Superintendent /Director, Hospital Administrator, Matron, Pharmacist and Accountant and manages the district Hospital Management functions of the DHE and the District Hospital are separate

Is this what we see when we go to the clinic? To the Hospital? Who is there? What do they do? Why do we not see all these Health workers? Why do not they do all we expect them to do? What do you think are the gaps?

4.2. Community Health Workers and their roles

Who are the community health workers in your area?
What are their roles? Are they in the HCC?
Do they interact with clinic health workers?

Community health workers provide health services within the communities and help in case management, referral and follow-up including home visiting. They support health promotion and education and mobilize communities for health action. They create a bridge between health, social and community services and the community,especially those who are hard to reach. Communities support CHWs through selecting them, through mobilizing resources to support their work, providing social support, attending meetings, giving information and advocating for their needs.

Community health workers provide a platform for wider participation in health matters by local communities. Village Health Committees are a community resource. They identify health problems in the village and report them to the ward, create awareness of health problems and give advice on health matters to the communities. The village health committee is composed of the Village Health Worker (VHW), Village Head (Sabhuku), Church Representative, Youth Representatives, Women Representatives, Traditional healer, Faith healer, Traditional birth attendant, Representative of the disabled.

Village Health Workers in Uzumba Maramba Pfungwe
© I Rusike 2010

Health Centre Committees are bridges used by Health care workers to report back to the community and vice versa. Communities also use this structure to communicate with Health workers on issues within the health delivery system that are of concern to them.

MODULE 4

Discuss

- How the community health workers in your area can be represented on the HCC.
- How the HCC can improve its communication with the CHWs in the area
- Which CHWs should be involved in the different health programmes in the area
- Any questions you still have on CHWs to raise with the Ministry of Health.

Record the actions and issues you have suggested in the HCC minutes/ record book for formal discussion at your next HCC meeting.

4.3. Health workers and their roles

Now we know the responsibilities of health workers, leadership and key stakeholders in our communities in advancing health. We now also know how these stakeholders can interact with HCC. We need to understand the issues that health workers deal with that we can tackle.

First, many clinics and hospitals have inadequate staff. The salaries and conditions of work remain unsatisfactory and this puts stress on the health workers and reduces quality of care on patients. However they also need to be able to carry out their work in a professional way and be valued by the system.

What are your experiences? In the HCC meeting let health care workers also share with us what other issues they face.

Use the activity below to share problems between health workers and community.

Activity: Understanding the problems Health workers face
(Used with permission from Loewenson et al 2005)
Method: Margolis Wheel
Approximate time: 45 minutes
Resources: Group of health workers and a group of community members; drum/mbira/ plate and spoon (something to make a noise) chairs (optional)

The activity is written as a guide to a trained facilitator who should facilitate HCC members to implement the activity.

Procedure:

1. Explain what people are going to do. Put people in two circles. Health care workers in the inner circle. Community members and others in the outer circle.
2. The health workers describe one or more of the problems they have in their job; and the people in the outer circle suggest possible solutions.
3. Tell them that when they start, they have 3 minutes to discuss the problems and potential solutions, When you give the signal - the health workers move one place to the left and talk to the next person. (You bang a drum or plate/ ping an mbira etc to show when its time to move)
4. Do this 5 or 6 times. The health workers will raise the same problem(s) with 5 or 6 people, so they get a range of different advice.
5. After this everyone sits down in one big circle this time. Give a couple of minutes for the health workers to write the best of the advice they heard, and the community / others to write down the problems they heard.
6. Take feedback from each group. First from the community on the problems they heard. List these on a flip chart. Then from health workers on the advice they received. List this.
7. Ask community members what they learnt about being a health worker.
8. Ask health workers what advice they got that will be useful.
9. Discuss how some of the health worker problems can be addressed in your area and also how to ensure that the HCC provides a means to raise and discuss the issues that health workers face.

Record the actions you have suggested in the HCC minutes/ record book for formal discussion at your next HCC meeting.

Health workers in Zimbabwe face a lot of problems. These problems cause them to leave their jobs and in some cases push them to leave the country to look for better opportunities in other countries. Some of their problems include:

- Poor salaries
- Absence of work benefits such as pension, hhousing allowances, access to medical acre including antiretroviral therapy
- Pension schemes, opportunities for Career paths and training opportunities
- Low credit worthiness
- Lack of access to credit facilities due to low remuneration
- No access to loans for education, housing, transport support
- Malfunction/defunct clinic/hospital equipment
- Shortage of drugs
- Inadequate and poorly maintained infrastructure to live in or work in

Discuss

- What do you think makes health workers stay in or leave your area?
- What should be done to keep health workers longer in your area?
- What role should communities play? What incentives can communities give them?
- What incentives should they get from the health services?

Record the actions and issues you have suggested in the HCC minutes/ record book for formal discussion as your next HCC meeting.

The table below summarizes options we have to keep health workers in our areas.

Financial incentives	Non-financial incentives
• Salaries • Top up allowances such as for rural service • Housing allowances • Pension schemes • Low interest loan schemes • Reasonable access to loans	• Adequately resourced health services • Safe work environments • Access to medical care including antiretroviral therapy • Career paths; training opportunities • Adequate day-care facilities • Education, housing, transport support • Good industrial relations and • management systems with adequate support from senior management

Source: EQUINET SC (2007)

4.4. Improving interactions between health workers and communities

Health workers should create and maintain a healthy relationship with communities. Communities should also do the same. In our communities there is often communication problems between communities and health workers. This results in suspicion and mistrust Community members complain that health workers are rude, do not communicate, spend little time with them and so on. Health workers complain that communities accuse them of stealing drugs, being lazy, threaten them and so on. This reduces the effectiveness of the health system and is bad for both health workers and communities. Health Centre Committees as representatives of both can address this. The case study below gives an example of how.

MODULE 4

Communication between health workers and communities in Masvingo urban district, Zimbabwe

The Health Literacy meeting held in 2007 in Masvingo revealed that there were communication barriers between health workers and communities. These barriers included dominance of technical knowledge and marginalization of common knowledge; absence of opportunities and resources to construct a body of shared understanding; cultural and linguistic distance; lack of staff training in intercultural communication; and lack of involvement of trained interpreters.

Communities spoke about the treatment they received from nurses, while nurses and other health workers also spoke about treatment and resentment from communities. There was a general agreement that a Health Centre Committee with representatives from both the community and the health workers would settle the disputes. Educational resources are needed to facilitate a shared understanding, not only of disease and treatment, but also of the cultural, social and economic dimensions of the community.

In the HL meetings, participating stakeholders included representatives from clinics, hospitals, the Councilor, Masvingo Urban Residents Association (MURA), District AIDS Action Committees (DAACS) etc. The meeting agreed to form an HCC in their area to act as a bridge between the community and the Health Worker in order to address challenges highlighted above.

The district agreed that the presence of a health worker in the team, who will work as the team's secretary will channel all issues raised by the committee to the formal hierarchy of the health system.

Discuss what you think helped to solve health worker – community interactions in this case. What problems do you have in your area? What actions do you think you can take as an HCC? Are any of the lessons from the case study relevant to your area?

Record the actions you have suggested in the HCC minutes/ record book for formal discussion at your next HCC meeting.

Source: Ms Entrance Takaidza -Health Literacy Facilitator, District Secretary CWGH, HCC member Rujeko Clinic –Masvingo City Zimbabwe 2010

4.5 Patient rights

We have seen that bad communication leads to resentment and stress. It is unfortunate that the patient usually suffers the most. However, there are rights that protect patients from mistreatment or abuse. The Zimbabwe Patients Charter provides for the basic rights that protect all patients.

Have you ever seen the Patients' Charter before?

The Patients' Charter describes the rights that patients have to health care and humane treatment and the responsibilities THAT COME WITH IT The role of the HCC is to educate communities and raise awareness on the provisions of the Patient charter as well as the meaning of the charter. The rights that patients have include:

Confidentiality: A patient has the right to have the details of their condition, treatment (including the use of new technology) diagnosis and all communication and other records relating to the patient's care to be treated as confidential, unless authorised in writing by the patient, or if it is undesirable on medical grounds to seek a patient's consent but it is in the patient's own interest that confidentiality should be broken or that the information is required by due legal process.

Privacy: Patients are interviewed, examined and treated in surroundings designed to ensure privacy and have the right to be accompanied during any physical examination or treatment if they wish.

Right to choice of care and Right to safety: if not incapacitated, shall have the right to a clear explanation of the proposed procedure and of available alternative procedures before any treatment or investigation. The information contains information on risks, side-effects, problems relating to recuperating, likelihood of success, risk of death, and whether the proposed procedure is to be administered by or in the presence of students. A patient may refuse any treatment or investigation and accept the consequences of doing so. However it is required that patients accept treatment where the condition may affect the wider public.

Right to Redress of Grievances- Patients have the right to appropriate grievance procedures bearing in mind that all health care delivery professionals are not super humans. They have the right to claim for damages for injury or illness incurred or aggravated as a result of the failure of the health professional to exercise the duty and standard of care required of him or her while treating the patient in addition to legal advice as regards any malpractice by a health care professional.

Right to participation and representation - Patients have the right to participate in decision-making affecting their health with the health professionals and other support staff involved in direct health care. Through consumer representation in planning and evaluating the system, types, qualities and conditions of service under which health services are delivered they are able to give an assessment of the quality of services offered to him/her

Right to health education - Every individual has the right to seek and obtain advice with regards to preventive and curative medicine, after care and good health.

Right to a healthy environment- Every individual has the right to an environment that is conducive to good health. This includes and extends to health professional's office, health centre, hospital room and any other facilities

The box below shows the contents list of the Zimbabwe patient's charter. A full copy of the patients charter is provided as a separate leaflet with this manual.

CONTENTS OF THE PATIENTS CHARTER

2.10 Keeping appointments
2.11 Health behaviour
2.12 Accepting preventive measures
2.13 Limitations of health care givers
2.14 Controlling medication
2.15 Taking medicine
2.16 Prescribed medicine
2.17 Non-interference

3. SERVICES
3.1 Admission and your stay in hospital
3.2 Outpatient Services
3.3 Inter-hospital transfer
3.4 Community services
3.5 Free services in Zimbabwe

Discussion:
How well communities know about the patient charter?.
Develop an action plan to facilitate a meeting with communities to educate them about the Patients Charter. You can also invite Ministry of Health Representatives such as Heath Promotion officers; local organizations and individuals in your area such as the CWGH and TARSC o talk more about the Patients charter and how it can be used by communities.

4.6 Advocating and negotiating health issues

Acting on the health needs raised by communities and health workers may require negotiation with other stakeholders who play a role in these actions. Negotiating for health involves liaising, discussing, debating, compromising and building consensus between groups on a way forward.

Advocating for health raises a targeted message, and works to get that message heard. Both demand preparation and planning.

HCCs will need to know and understand the position of participating stakeholders on the issue, to plan what information will be relevant and credible, who will be the right people to present it, where and how. In negotiations HCCs will need to know what evidence they will need to present, and what they are willing and not willing to compromise or how they might reach consensus.

Basic elements of negotiation

Developing the negotiation agenda: Health Centre committee members need to be well organised to know the issues to address. This will certainly enable to scope the issues to be added or removed in the discussion, to determine those who will be involved in the process. Knowing those who will be involved is as important as knowing their position and understanding with regard to the health need under negotiation.

Planning and preparation for negotiation: You are not encouraged to enter into a negotiation process without adequate planning. A check list will help you to know if you have achieved what you wanted from that meeting. The following are some of the questions to ask as a committee.

- What makes this such a high priority for us?
- What information would be helpfull to us?
- What are you worried or concerned about?
- Who else needs to know about what we are discussing?
- What would we like to see happen?
- What do we see as our next steps together?

Skills for negotiating: There are basic elements/skills for negotiating important for each level of negotiation. These include: being present in the moment, listening with an open mind, solving the problem together and making the other person feel good

Building trust: Building trust with other HCCs, health providers and communities is a process that requires you to acknowledge others' interests and views, to show understanding and good faith, and to listen as well as be heard.

Agreements: During negotiations it is important for participants to have freedom to express ideas without fear, editing or evaluation; this encourages full participation by all involved. Respecting one another is equally important as it guides and focuses the process on the future. Respect moulds trust, which is usually built by following through on small agreements. Big agreements depend on a great deal of trust. HCCs need to know who has the power to agree at each level of agreement well beforehand.

Basic elements of advocacy
HCCs may advocate for health in a number of ways, from writing letters to the Health Portfolio Committee in Parliament, to marching to raise concerns on Health services.

Clear issue within the HCC mandate: Health centre committees are advocates for community health and health services. So the advocacy issue needs to be clear, understood and within this mandate. The issue should be able to be stated in a single simple sentence.

Strength of action: Advocacy requires taking a lead, initiating, creating a sense of urgency and challenge to society and leadership. It can extend from passive measures like writing a letter to a responsible authority, to active measures like organizing community meetings and public dialogue with the authorities. It needs to be persistent: instead of complaining once about an unacceptable situation e.g burst sewer pipes, it may require you to complain weekly until you succeed to have the issue discussed.

Conflict of Interests: Like negotiation, it is important that HCCs minimize personal attacks, competition with other parties. Think about the persons or groups who oppose an issue and see how you will address their opposition or attempt to reduce conflict with their interests. At least be prepared to tackle opposition to our ideas.

Costs: Like negotiation, you need to budget for what you will do: Advocacy costs time, money, and can raise the need for meetings, materials, security and so on.

MODULE 4

Activity: Putting your skills to action
Approximate time: half day and longer for implementation

The activity is written as a guide to a trained facilitator who should facilitate HCC members to implement the activity.

Procedure:

- As an HCC identify an important issue that you want to negotiate or advocate, drawn from your discussion of community priorities. What is the key Message? What goal do you want to achieve?
- Plan a strategy for negotiating or advocating one of the issues. Respond to each of the issues in the text above in formulating your plan. Make clear the actions, actors, messages and forums for the strategy. What resources will you use?
- Role play your negotiation/ advocacy within your group. What worked? What was a problem? How does that affect your strategy?
- Implement one of the steps of the strategy. Then review as an HCC how you did. What worked? What did not? What did you achieve? How does that affect your strategy?

Finally as a group summarise

- What new information or skills you have acquired
- What questions you have to ask at your next HCC or DHE meeting
- What follow up actions you have identified to take up at your next HCC meeting.

MODULE 5
Health Planning

In this module Health Centre committees will learn and discuss

- How plans are developed at local, district and at national level in Zimbabwe
- How HCCs can participate in health planning with communities
- How HCCs can use the Health information system
- How HCCs can implement and monitor health plans

5.1. Development of plans at local, district and national level

Have you ever participated in health planning before? Can you describe what planning, with who and what role you played?
Were those plans implemented? If yes how were you involved?
How did you monitor the plans, the spending, and the change?

HCCs need to be involved in and participate fully in health planning. In this section we will look at the process of how health plans are developed from local to national level, and we will discuss the points at which community input is obtained.

1: On a day to day basis, community health workers support communities to secure their health needs, for instance, at clinics the sister in charge coordinates the collection of health information on Ministry of Health forms. These forms record the patients and disease cases reporting to the clinic as well as statistics on health delivery, like the number of births, children weighed and immunized, beds filled or schools visited for health checks. This is compiled on a monthly basis and reported to the district.

2: The information collected by Community Health Workers and Health Care Workers at the clinic is used to inform the clinic for planning and is consolidated at the district to inform district planning

3: Community health plans should be agreed at the Village assembly, and then forwarded to the Ward Health Assembly, which is chaired by the councilor.

4: The Ward Health Committee supports communities to ensure that their needs are reflected in the overall District Health plan. The Ward Health Committee is a subcommittee of local government. The HCC supports communities to ensure that their needs are reflected in the health facility plan. The Ward Health Committee and HCC thus act as channels of information flow from the community to the RDC/DHE and back to the community to raise funds for agreed health plans.

How do HCCs work on planning with

- Their CHWs and Village assembly?
- The ward health committee and local government?
- Their local clinic and the DHE and Ministry of Health?

Lets follow the steps:

1: At district level there is a District Health Executive Chaired by the District Medical Officer The DHE reviews plans for the delivery of health services in the District and seeks council approval of the health plans in the RDC.

2: Communities participate in planning for health at this level through the District Health Services Management board, District Hospital Management Board in the DHT. Members from the HCC, WADCOs, VIDCOS and from Health centres/Clinic participate at this level.

MODULE 5

3: Plans are reviewed by the RDC in consultation with the district development Committees (DDC). The District Development Committee (DDC) is composed predominantly of government Ministry officials and other stakeholders. It is the technical arm of the District council in which the district community health council represent the HCCs, WADCOs and VIDCOs

4: The District Health Executive (DHE) reviews plans for the delivery of health services in the District and seeks council approval of the health plans. It provides and manages the strategic framework within which services are provided in the District with the district development committee. It develops plans to meet the district health needs, taking into account available resources.

Have you been involved with any of these processes before?
How?
How can the HCC be more involved?

The main role of the national level is to mobilize resources for the health sector, set policy and provide for a legal enabling environment for the operations of stakeholders. The national level mobilizes resources for the health sector from central government as well as from other sources.

Second: Communities participate at this level through the Public Health Advisory Board (PHAB) and other stakeholder committees.

At Provincial Level, the Provincial Development Plans are formulated by the Provincial Development Committee (PDC), which is an organ of the central government. In the PDC, the chair is the Governor, attendance is by all government provincial heads. The disbursement of funds to Districts and other preferred providers and the monitoring of operations is the responsibility of the Provincial Medical Director (PMD). The PMD ensures that planning for Health in the Province is consistent with national guidelines and, disburses funds to support approved plans. In addition, the PMD may withdraw/withhold funding from any district that fails to comply with agreed conditions and plans. Funds are agreed to be disbursed on receipt of health plans and reports.

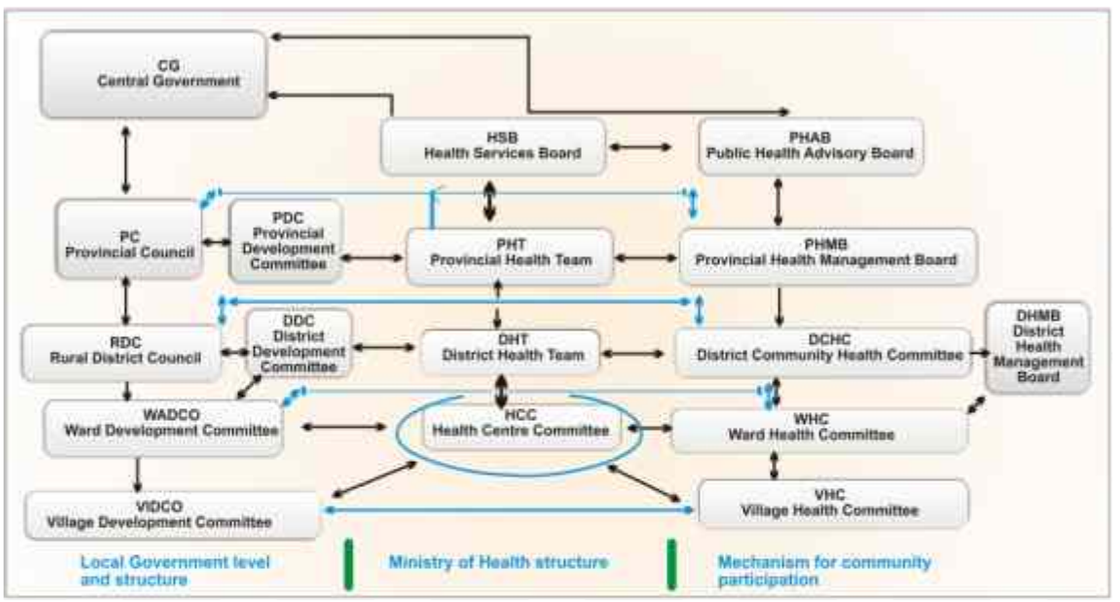
In summary:
HCC members can play a role in these process of planning for health

1: By developing a community plan that reflects community priority health needs.
2: By discussing this plan in the HCC meeting with the health workers to include it with the plan for the clinic.
3: Submitting this plan to the District Health Executive (DHE) and onward to the relevant District Health Management formations. DHT, DHMB and DDC Discussions are made regarding the community health plan that also reflects the health plan at health centre level. Some members from the HCC like the councilor also sit in the RDC and some such as the clinic nurse/matron also sit in the DHMB to represent the community health plan
4: The consolidated plan of the district and the community should be sent back to the HCC, WADCO and VIDCO where it should be consolidated in the HCC planning and review meeting. When there is consensus, this is sent back to the DHT who will also agree in consultation with the RDC/DDC and the DHMB.The HCC plan should draw from the DHT plan
5: The plan will be forwarded to the Provincial Health Team (PHT). To consolidate the plan, the PHT works with the Provincial Health Management Board (PHMB) in consultation with the Provincial Development Committee (PDC). Upon consensus on the provincial plan, that now reflects the community, district and provincial priorities should be sent back to the DHT, DHMB and the DDC/RDC who should also consult the health centre level and communities through HCCs.
6: Once agreed, the provincial plans are sent to central government through the Provincial council (PC). The plan may be shared by the Ministry with the Health services board (HSB). The Minister may ask the PHAB for advice on areas of the plan.
7: An annual Plan is made and shared with structures at all levels. Annual plans include background current health conditions, objectives, programmes, resources and roles. services,

Strategic plans are prepared every five years and implemented through operational or implementation plans e.g. bi annual plans. The operational plan should have clear indicators for tracking progress.

See if you can follow the planning steps in the flow diagram below, and if you know the roles of each of these structures shown. Do this jointly with someone from Local government and from Ministry of Health who can explain their roles.

Structures for health planning



If a plan is made for me, I should participate in the planning process!.

5.2. Identifying community priorities

How do you ensure that plans reflect community priorities?

When communities, health providers, local authorities and other stakeholders meet to identify health problems in the community, a long list of the problems is produced. This is because people have different interest and they prioritize problems differently. Collectively prioritizing health needs is therefore very important. Prioritizing health needs means that we establish the top problem in order of importance or urgency.

Nurses at the local health centre collect information on child births, growth monitoring, family planning, nutrition diseases, outbreaks and health in general. While this is alright we know that the community itself has as much to contribute on what the health needs and priorities are. We should note that when identifying our priority health needs all social groups are represented in the community. This is called community participation. Community participation should begin with planning i.e. identifying health problems. To identify the needs communities can gather information through:

MODULE 5

- Informal discussions among community members;
- Formal gathering like churches and schools;
- Local meetings organized by the chiefs, church or politicians;
- Visiting health centres to get information, and
- Talking to various community based health workers: village health workers, Community Home Based Care Givers (CHBCG) and traditional birth attendants.
- Public meetings
- Focus group discussions
- Interviews

Discussion:

- *What other mechanisms have you used to collect information from communities in your area? How effective were they?*
- *How can you strengthen these mechanisms?*

In Community health meetings, participatory tools can be used to help communities to identify priority health needs and obtain community inputs for planning. For example the ranking and scoring method below assists to include everyone's views.

Activity: Ranking and scoring
(Used with permission from Loewenson et al 2005)

Approximate time: 40 minutes
Resources: Pen and paper, counters (stones or seeds)

The plan is a guide to a facilitator who should facilitate HCC members to implement the activity.

Procedure:

1. Divide participants by gender, age or by other social groups. (One idea is to break people up into older men, younger men, older women and younger women, but make sure you are clear about how you define each of these groups. For example, is youth defined by age, or does it relate to some other criteria, like marriage.) This division is important since health needs can differ by group. In these groups, ask participants to list the health needs in their community. They can do this on a chart or on the ground.
2. When the lists have been developed, give each participant 3 stones, beans or any other counter available. Ask them to distribute or place their counters against the 3 health needs they think are the most important and, therefore, need greatest attention.
3. Count the total counters for each item listed and write the totals. Each group now has a list of 3 top health priority concerns.
4. Bring the four groups back together to share their findings. During report back, ask each group to justify why they thought these three health needs must be given most attention. (Someone shouldwrite down a summary of what each group said.) A table summarising the problems identified the scoring and ranking should reflect the number 1 problem.

Given your discussions, identify three priorities you should take as a HCC into health planning. Record the priorities you have suggested in the HCC minutes/ record book for formal discussion at your next HCC meeting. Make sure you take this forward through the steps shown on page 40.

5.4. Implementing and monitoring health plans

Health plans must be implemented, monitored and evaluated.

When you have prioritized the health needs in your community, and your plans have been incorporated into the annual plan at district level the next step will be to plan for action. Communities can also act on their plans even without approval of plans from higher level in order to advance health. Sometimes all our plans may not be budgeted for, but this does not mean we stop to act on them in order to address the identified problems

An example of an action plan is shown below, as well as an example of a work plan developed by HCC committee in Chipinge district:

Health need	Who is responsible	Who is involved	Timeline as per plan	Outcome/Evaluation
Your priority health need or problem	The HCC who will make sure that this is implemented	Those you are working with e.g. social group MP, Councillor/ Business community, Health Centre/ community	Due date: when this supposed to have been done	Desired outcome, What you want to see at the end of this particular implementation phase.

Chipinge Health Literacy district work plan for 2008

When	Community action plan	Training and action	Support and review
January	Engage local authorities, local leadership, health authorities and stakeholders in HL planning meeting	-	Financial support (meals, stationary and transport reimbursements
February	Malaria campaign in Chipinge town	Mobilizing skills	Financial support (meals, stationary and transport reimbursements)
March	Cutting long grass in residential places	-	Slashers and sickles from CWGH
April	Filling open pits, open water sources	-	-
May	Indoor residual spraying in collaboration with MOHCW Malaria spraying teams	Training on malaria spraying and prevention strategies	Technical support (Trainers to come from TARSC and CWGH secretariat and others)
June	Workshops and a campaign on male involvement in Prevention of Parent to Child Transmission (PPTCT) of HIV	Training on PMTCT and PPTCT	Leaflets in local language on PMTCT and PPTCT; Financial support (meals, stationary and transport reimbursements
July	Chipinge beer hall tour targeting men on PPTCT education	-	Financial support (for food, transport)
August	Household visit educating men and families on PPTCT and male involvement	Communication skills	Financial support (food and transport reimbursements)
September	Impact assessment workshop on male involvement in PPTCT	Monitoring & evaluation skills	Financial support (food and transport reimbursements)
October	HL workshops on healthy nutrition	-	Financial support (food and transport reimbursements)
November	Nutrition campaign and establish a community nutrition garden	Maintaining nutrition gardens	More information on foods for the special groups in Chipinge
December	Identify a team that manages the community garden (watering, weeding, planting and selling)	Training on entrepreneur ship	

Every time health literacy facilitators and community members meet, they reflect on the previous action to draw lessons and plan for next action.

MODULE 5

Activity: Developing an action plan
(Used with permission from Loewenson et al 2005)

Approximate time: 40 minutes
Resources: Flip chart paper, marker pens, note book, pen

The plan is written as a guide to a trained facilitator who should facilitate HCC members to implement the activity.

Procedure:

1. Explain to participants the health issue that they will develop an action plan on and agree jointly on the goal to be achieved and the time frame.
2. Divide participants into groups of about eight and give them 30 minutes to draw up the plan.
   - What are the specific objectives?
   - What are the actions to achieve them?
   - In what timing and where?
   - Who should play a leading role?
   - Who else should they partner with?
   - What resources do they need?
3. After 30 minutes, bring the groups together to discuss their plans and compare them
   - Where they complete?
   - Were they feasible and realistic?
   - Were all the necessary steps and groups included?
   - Were the resources adequate?
   - Do you think they would succeed to reach the goal?
   - What else needed to be included?
4. Discuss what you think are the characteristics of a successful action plan for the HCC? What does the HCC need to have, get, do and involve to produce a good action plan?

Given your discussions, identify any issues you have raised to support your planning. Record this in the HCC minutes/ record book for formal discussion at your next HCC meeting.

In implementing health plans we encourage HCC to use Participatory Reflection and Action (PRA) approach. This approach enables you to share experiences, identify, prioritize, act on your problems and monitor progress.It will help you to learn from your mistakes, share experiences and plan for the next step in implementation.

It is also important to monitor our health plans

There are some activities in your plans that definitely need some money and other resources to be implemented and some that do not need much resource.

Communities can monitor their own plans using a variety of methods and mechanisms. The following are examples of mechanisms and methods that communities can use

- Scorecard- you can use this tool to score service satisfaction, service uptake and availability against the expected/desired scores
- Suggestion Boxes- you can use these to suggest new ways of programme outreach or to raise concerns on what you do not like
- Community meetings

We can also use the information that the government collects at local and district level. In Module 2 we explained how the National Health Information System (NHIS) is operated. All health agencies routinely collect data on demographics

(characteristics of people), mortality (death), morbidity (illness) and health services. The clinic and other health facilities at community and at district level submit routine surveillance data to the designated HIS coordinating agency on a regular basis. The data is compiled by the district Health Information Officer at the district hospital and entered into a compuer for onward submission to provincial and national level. The NHIS coordinator will compile an epidemiological report, including analysis and interpretation of the data that will be shared with all relevant agencies, decision makers to sub national levels and the communities.

The Health Information system thus plays an important role in informing and monitoring planning priorities.

Have you ever used the HIS as an HCC to plan or monitor progress of your plans?
What issues did you face?
What other methods have you used in your community? Which ones were effective?
Why?

HCCs can come up with their own progress markers. These are called indicators and will help them (and you) to see if they have reached their goals and objectives. If there are gaps or shortfalls, mechanisms should be put in place to address them and notify authorities and other critical stakeholders including all social groups in the community.

A progress marker is an indicator of progress. It shows how far you have moved towards (or away from a set goal. For example

- The overall target in your area may be that all households should have their own toilet. You may have identified that this requires construction of a further 100 toilets in one ward.
- The progress marker may be that towards this, by the end of 2011 you will have built a further 60 toilets in the ward.
- If you review this monthly you would expect to find at least 5 new toilets every month.

HCC planning meeting in Chirumanzu© TARSC and CWGH 2010

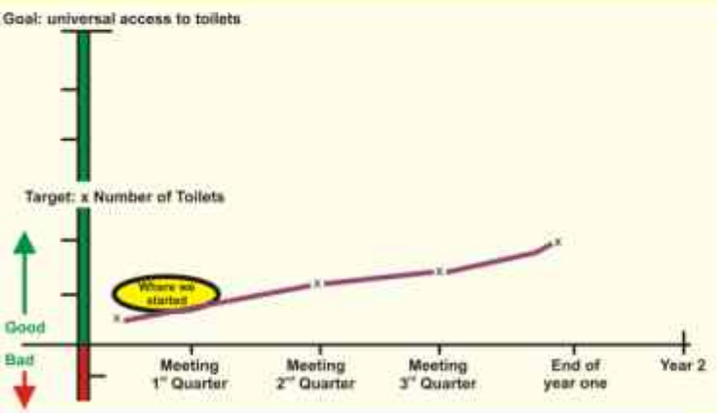
MODULE 5

Activity: Monitoring health plans
Approximate time: 40 minutes
Resources: Pen and paper

The plan is written as a guide for the HCC members to implement the activity.

Procedure:

i. From your last community action plan, identify the overall goal for one of your health interventions for your area.
ii. Identify how far you have gone towards reaching the goal and what the difference is.
iii. Taking this into account, and how urgent the issue is, and how feasible it is to act on it, set a progress marker for this goal for the year. It should say that by the end of .... we will have.....(done or achieved a specific number of something)... in our ward.
iv. Discuss the progress marker with the community. Is it feasible? Adequate? What needs to be done to achieve it?
v. Discuss and allocate roles to achieve the progress marker, what resources you need, who you need to involve, what obstacles you may face and how you may overcome them. The Health services, other government services, international and national non government organizations and business in the area may be able to support the intervention if they agree with the goal. Ensure that each one has a role to play in this intervention.
vi. Finalise what the progress marker is for the end of the year, and the steps towards it month by month. Set an outcome that you need to achieve in each month if you are going to reach the progress marker for the year.
vii. Chart your progress every month or every three months to see how you are doing, such as in the chart below. Discuss if progress is faltering- why? What can you do about it?
viii. Feed back the progress monitoring to the community and those involved so all can see how things are progressing and be involved in it.



ix. At the end of the year, check how far you have progressed. Record this on your graph. Compile your report and share your success or your challenges with the DHT and the RDC.
x. Make another target in the following year until you meet your goal.

Given your discussions, identify how you will monitor the plans that you have as an HC. Record any proposals in the HCC minutes/ record book for formal discussion at your next HCC meeting

Finally as a group summarize

- What new information or skills you have acquired from this module
- What questions you have to ask at your next HCC or DHE meeting
- What follow up actions you have identified to take up at your next HCC meeting?

MODULE 6
Health Budgets

In this module Health Centre committees will learn and discuss

- ways to mobilise and manage community resources for health
- the Zimbabwe budget cycle and how HCCs can input into it
- district allocations and budget lines in Zimbabwe
- HCC roles in monitoring and tracking of budgets at local level

6.1. Mobilizing resources for health

At the end of each month you probably need to pay rent, pay electricity bills, water bills, pay school fees, buy groceries, put aside money or transport to work, put aside money for seeds for the next planting season or any other bills that need to be paid. To do this you need resources at household level ···. you need to plan almost every month and set a budget to balance your income and your spending.

Similarly, we need a budget to plan the income and spending in health. It starts with the income which comes from the resources we are allocated and those we mobilize.

You can mobilize resources to implement community based health improvement initiatives through:

- village funds,
- revenue from activities and local levies,
- levies on households
- community insurance schemes
- private sector funds, and
- sales of goods produced.

These quantifiable resources are complemented by the contributions communities make of labour, time, and other inputs which are often not costed but are significant. Some clinics charge toffees to raise money and these can be retained locally, as the Health services Fund (HSF). The Rural District Council collects card fees at clinics. This is called out of pocket spending on health. This money may be used for security services at clinic level or locally defined needs.

However we also know that these fees for service can be a barrier to people who need care using services, especially the poorest. This is various forms of pre payment that are linked to what people can afford to pay are much better than requesting people to pay when they are sick. "Out of pocket spending" by households and individuals to pay these fees are the biggest source of money in the health sector today. ambulances, drugs, supplement Health workers salaries and other Primary Health Care services..

Have you mobilized resources in your own area before?
What method did you use?

The money that is raised locally supplements the money that is collected from taxes and allocated by central government. These are shown in the box overleaf.

Have a look at the box and discuss with health workers which of these funds are used at the clinic level or community in your area and what they are used for.

MODULE 6

Sources of funds allocated to the district health system:

At district level, funds for health services largely come through:

GOVERNMENT

- **Central government budget allocations from taxes:** These funds are used to buy drugs; build and maintain clinics; buy equipment; buy and clean linen and bedding; support events like commemorations; pay salaries and allowances for health workers. Pay for ambulance services; feed sick patients in hospitals; refer patients to Harare; settle bills for phones, water, electricity; buy stationary amongst other priorities
- **The Health Services Fund (HSF):** The HSF is made up of funds that are collected from district hospital fees and donor allocations made to district level. It was set up to supplement the Government of Zimbabwe Funds.
- **The AIDS levy fund** - earmarked for the purchase and procurement of antiretroviral drugs.

OTHER:

- **Firms/Employers:** These can pay health insurance and or other medical bills for their employees
- **Health Insurance** Private health insurance also called medical aid; Community-based insurance;
- **Pre-payment mechanisms:** These are recovering in Zimbabwe following high stress on personal incomes and the reduction in formal employment
- **Donor and non government organization funds:** These agencies can support the district level as well as the community level through various ways including supporting with vehicles, drugs and personnel

Young people in income generating projects for health in Chipiage
© I Rusike CWGH 2010

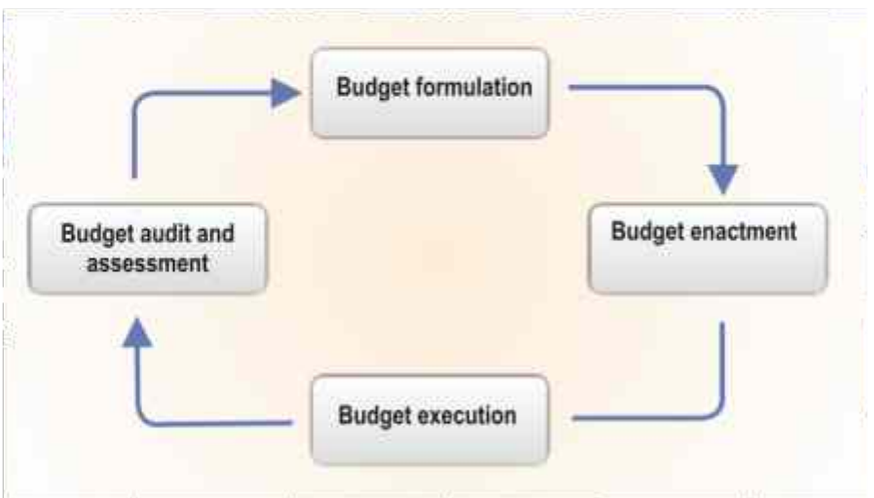
6.2. The budget cycle

Budgets are plans for raising and spending money. Budgets are made by all sectors of the economy, including the health sector. The steps are as shown below:

1: All levels of the health system produce their budgets, which are sent to the national/central level for approval.
2: Once approved by the Ministry of Health they are passed on to the Ministry of Finance where they are consolidated with other budgets from other ministries.
3: The Ministry of Finance revises the budgets according to the revenue available for spending in that year and the overall national goals.
4: Budgets are tabled and approved by Parliament.
5: Once approved, the money budgeted by the Ministry of Health is released by the Ministry of Finance and allocated to implement the Ministry of Health's planned expenditures, reflecting its policy priorities for the coming year.

From the steps above we see that a budget is more than just a single document – it is a year-long process whose steps offer communities access points to influence allocations.

The budget process in Zimbabwe follows the Re-Engineered Budget Concept introduced in 2001 by the Parliament of Zimbabwe. The re-engineered budget follows a simple schematic system of four major processes shown in figure.



The Budget Process
Source: Bennett, S., A. G. Kelley, et al. (2004). 21 Questions on CBHF: An overview of community-based health financing, PHR plus

In budget formulation we assign the resources needed to achieve a plan. This includes the plans HCCs make and send to higher levels discussed earlier. In budget enactment, budgets are reviewed at administrative levels of the Ministry of Health including by the DHE. HCCs can participate in this. For example TARSC and the CWGH provide position papers from civil society to the Parliament committee on health. TARSC reviews how the budget should reflect policy priorities and the CWGH how it reflects community priorities. This ensures that local priority plans are mirrored in the budget (the pre and post budget process. After budgets are approved then budget execution refers to the allocation and spending of resources. HCCs are also allocated and spend resources through the various clinic and community level allocations. In budget audit and assessment, objectives are evaluated in relation to expenditures and finances accounted for. This is used to plan for the next budget.

MODULE 6

The set of steps thus leads to a new budget and the whole process is called a budget cycle. The budget cycle in Zimbabwe is shown in the Table below:

Budget stages in Zimbabwe

Stage and period	What happens	Main actors
Policy direction setting. **(January – March)**	Cabinet develops and adopts development policies	Cabinet Ministers, Local authorities and development partners like the World Bank
Budget guidelines stage **(March - May)**	Framework to guide budget proposals developed and shared with Ministries	Ministry of Finance
Drafting stage **(June – September)**	Local authorities, Ministries submits bids to Ministry of Finance. Ministry of Finance drafts the budget	Ministry of Finance, Line Ministries and Local Authorities
Legislative/ Approval stage **(October – December)**	Pre and post budget consultations	Parliamentarians, Line Ministries, civil society, private sector
Implementation, Monitoring and review: **(April, July, October, January)**	Actual implementation of the budget	Line Ministries
Auditing stage: **(June- August)**	Audit of the previous years' budget.	Auditor General, Parliamentary Committee on Public Accounts.

Source: N Mulikita et al (2009).

Between August and September, stakeholders hold workshops to discuss consolidated bids. The, Parliamentary Committees discuss the ministries half-year budget performance with stakeholders (Civil society, trade unions, HCCs, business and government departments) in their respective sectors during this period. Ministries provide quarterly budget reports that should be discussed with the portfolio committees.

Between September and November final draft bids are presented to the Ministry of Finance for consideration by the Minister o Finance. The bids are consolidated and approved based on feasible given the available resources.
Between late November and early December, the Minister of Finance presents the budget to the House of Assembly within a period of 90 days before the end of a currently running financial year.

HCCs have various opportunities to make input to this budget cycle:

- At budget formulation (pre-budget) into the budget expenditure estimates
- At the budget review by lobbying with their MPs
- In budget implementation by ensuring resources reach their intended targets
- In budget audit, by reporting and evaluating how the funds were spent and whether the outcomes were achieved

Some examples of this are shown in the box overleaf.

HCC roles in the budget process

- **Budget formulation:** Prepare a budget that costs the activities identified for priority implementationwithin your ward(s). When this is done share it to stakeholders at community level such as the Village Development committee and WADCOs.
- **Budget review and adoption/ Budget enactment.** Once you have prepared share it with relevant administrative structures for approval. When approved by the administrative structures such as the RDC, you should get it back for approval.
- **Budget execution/implementation:** Once your budget has been approved and appropriated (given funds to implement your plans) it can be implemented. So use PRA approaches to implement your priority plans in line with budgetary allocations.
- **Budget audit and assessment/ Budget evaluation.** Develop progress markers that also match some of the progress markers that you developed in monitoring your action plans to ensure that resources are used efficiently.

Activity: HCC involvement in budget processes
Approximate time: 2 hours, then a further 2 hours for the community meeting
Resources: Pen and paper, flip chart, marker pens

The plan is written as a guide for HCC members to implement the activity.

Procedure

- Divide into 4 groups for each of the steps of the budget cycle below:
  - budget formulation
  - budget review
  - budget implementation
  - budget audit
- For each group discuss what that step involves at the district, clinic and community level; the role the HCC already plays in that step, and what the HCC could do to be involved.
- Convene all the groups and hear and discuss the report back from each.

Given your discussions, identify the actions you think you can take as a HCC to input to the budget cycle. Record the actions you have suggested in the HCC minutes/ record book for formal discussion at your next HCC meeting

In the next HCC meeting, invite an MP, local government official, or CBOs working in your area such as the CWGH to discuss and plan how you can be involved in the budget process.

The local level budget process is similar to the national budget process. However, unlike the national budget, the local authority budget is presented to the Ministry of Local Government for approval and gazetting, when it has been published in the print media for a period of one month, and then accepted by relevant local authority residents. So you can also contribute through this mechanism too!

6.3. Budget lines and resource allocation

A budget line item is specific in which the different financial items are grouped. For example the budget lines in the national budget in 2002 to 2008 are shown below.

Budget line: percent to	2002	2003	2005	2006	2008
Administration	4.8	6.7	6.8	8.3	9.1
Medical Care	78.0	81.3	80.5	81.7	80.6
Preventive Services	16.0	10.9	11.3	6.7	9.6
Research	1.2	1.1	1.4	3.3	0.8

Source: Shamu S, Loewenson R (2008)

MODULE 6

Community level actions and disease control also need adequate support, as do the HCC activities themselves. The Health Service Fund Constitution says for example that 40% of its revenue should go to clinic, disease control, and community level.

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6.4. Monitoring and tracking budgets/Expenditure Management

How do you know where the money has been spent?
What mechanisms exist for you and communities to monitor budgets?

HCCs can play a crucial role if they are able to monitor and track local health budgets. This is important as it shows the communities and the government how resources are being used at community level. This is called expenditure management.

People are employed to do expenditure management and performance management to see if the budget is spent according to allocations and if people who are supposed to action the plans are doing it in the right way. Communities can also augment this monitoring and tracking of budgets

HCC and community participation in budget monitoring can:

i. Monitor action plans and development targets,
ii. Increase the responsiveness of the government to the needs of the people.
iii. Provide scrutiny and inspection of expenditures against priorities,
iv. Check whether health services and communities are meeting their planned objectives.
v. Help to prevent corruption.
vi. Holding those who manage money accountable

Some examples of what HCCs can do are shown below:

i. Develop clear action plans and financial reports assist in monitoring and tracking of budgets. HCCs can review financial spending reports against plans and ensure that priorities are receiving resources

ii. HCCs can monitor and report on whether women and other priority groups are included in budgeting processes and whether the budget provides adequately for their needs

iii. HCCs with civil society organizations can develop score cards to gather community input on whether clinics and communities are obtaining funds, whether the resources for health are being made available and whether they are having an impact

iv. HCCs can use evidence from community monitoring to show who is accessing resources that are allocated.

v. HCCs can work with organizations such as the Training and Research Support Centre (TARSC) to do monitoring and research in their own area to see how resources available are changing health in their communities

vi. HCCs can oversee to make sure that resources allocated to the clinic and communities are not lost through theft or corruption.

For this HCCs need to know what resources are available at community level.

Activity: Monitoring budgets and community resources
Approximate time: over a year
Resources: Pen and paper, flip chart, marker pens, reports/minutes of previous meetings

The plan is written as a guide for HCC members to implement the activity.

Procedure

- As an HCC identify with the health workers and local authority the budgets that are identified as targeting the community and clinic level in health and what they are for. Make a table of these showing the budgets, the areas of activity they cover, and the population groups covered. If you can include the amounts allocated for the financial year for your area.

- Using the table make a list of how you would check whether these resources are reaching the social groups or programmes they are intended for. For example if the AIDS Levy Fund is intended to cover ARVs at the clinic for people living with HIV, then your checklist would include whether the ARVs at the clinic are adequate, always in stock or stock outs and for how long, covering pregnant women, children and adults adequately

- Fill your checklist every three months by interviewing health workers and asking the community. You can divide activities on different items between the HCC and combine the list as a team.

- Bring your checklist to an HCC meeting to discuss the findings with the health workers. When there are gaps discuss why and what can be done. If needed take problems to the DHE.

- Compare your reports every quarter and see whether things are getting better or worse. Discuss why and what can be done.

- At the end of the year use your reports to compile the annual report. Use this for the next years planning and also table them with the DHE and local authority to discuss how things are working in your area. If you can encourage other HCCs to do the same you can also compare performance across wards!

Finally as a group summarize

- What new information or skills you have learned from this module
- What questions you have to ask at your next HCC or DHE meeting
- What follow up actions you have identified to take up at your next HCC meeting?

MODULE 7

Building alliances for health

In this module Health Centre committees will learn and discuss

- How local government, members of Parliament and government ministries can support work on health
- The role of the Community Working Group On Health (CWGH)
- Other sources of support for their work on health

7.1. Working with members of parliament and local government

This manual has shown the various ways health centre committees can support community roles and rights in health and health services. In the different activities and modules, when we have discussed actions, the HCC is not acting alone.

- The Ministry of health is involved through local health services
- Other government services, like schools, agriculture or police, also play a role.
- Local government structures, committees and personnel are often involved.
- Non government organisations may support activities or play a direct role in health

Who else do we involve in health?
Who else have we raised in the course of the training?
Who else can we work with as a Health Centre Committee?

Two important institutions that play a role in health are parliament and local government.

For discussion
Have you engaged with members of Parliament or councillors in the past?
What was this engagement with Parliament about?
What interaction did you have? What did you each do?
What was the outcome of the interaction?
What roles do you think parliamentarians and councillors can play in health?

Parliaments promote health through their different roles: representation, legislative and oversight. Parliamentarians shape public opinion; and represent public voice in issues. Have a look at the roles in the box below and see if you can name examples of when parliamentarians play these different roles.

Oversight role: Parliament has an oversight role. It checks on the activities of the government ministries and parastatals to see whether they are implementing the laws and policies of the government in the most effective manner. It provides a forum for the public to raise concerns about the performance of government, such as through public hearings.
Legislative Role: Parliament's main function is to make laws. Parliament can propose or make new laws, amend old laws, or reject proposals made for new laws.
Representative role: Parliamentarians represent constituencies and electorates who voted for them, and more widely the public as a whole. They bring public input to national issues, but also take party positions on issues that come to debate and vote. In this role parliaments also work with civil society organizations, technical institutions and business and economic institutions.

Budget role: Parliament is responsible for considering the national budget presented by the executive (the ministries). Parliament has the powers to accept, amend or reject the budget. If parliament rejects the budget, however, it would be a crisis as government would not have any approved money to work with Hence this doesn't happen normally and parliament simply proposes amendments.

Local governments are the arm of government with the mandate to deal with matters at local level. They include the elected bodies (such as the councillors) and the executive bodies, such as the local government officials. They implement national policy at local level.

Councils oversee the functioning of local government, and set local by laws and budgets. Many public health issues are managed through by laws at local government level. Council budgets are made up of collections from local rates, fees and taxes, from central government allocations and from funds mobilised from other actors.

How do these institutions support the work of the HCC?
Look at the options below- can they play a role in any of these actions?

- Public outreach, information, consultation (e.g. on health reforms and budgets)
- Shaping public opinion (e.g. on HIV AIDS)
- Ensuring laws and policies protect public health (e.g. in agriculture and pharmaceuticals)
- Ensuring compliance with key areas of law and policy (e.g. food safety)
- Monitoring budgets and the performance of systems against targets (e.g.: budget allocation versus. national;)

In fact they can play all of these roles! What others can you think of? Working with these leaders from the onset is important for HCC processes.

Activity: Networking
Approximate time: half day
Resources: pens, note books, flip chart paper, marker pens

The plan is as a guide to a trained facilitator.

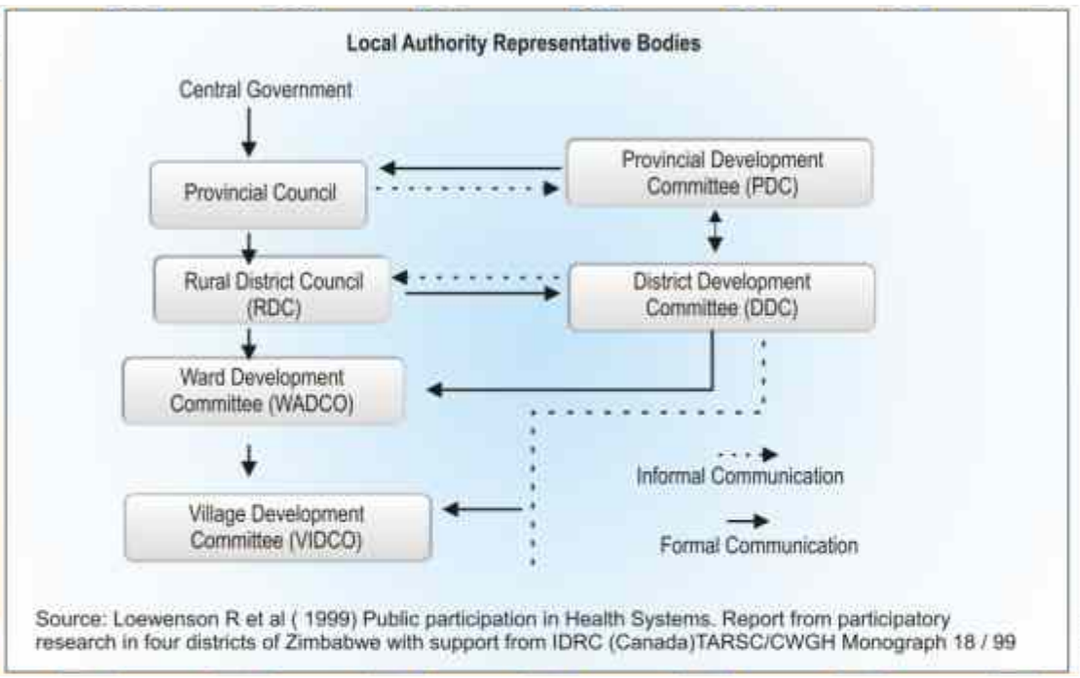
Procedure:

- In your HCC meeting discuss the role you think councilors and / or Members of Parliament can play in your health plan, or to address a particular problem you have identified as the HCC.
- Invite either the local councilor or your MP to your community so that they can meet the community and for the community to ask them questions on health and raise their health issues
- Have a meeting with them as the HCC to discuss the issue you have identified. Report on the issues, what you have done to date, and discuss and negotiate for the input you have identified from them to support your actions. (Remember this is for health in all the community. Do not mix partisan interests with health interests).
- Listen to their suggestions and dialogue on the way forward. This activity is a relationship building process that can take a long time, so be sure to mend relations and to invest in trust. Any strong relationship is based on mutual trust.

Remember to minute your discussions, and set progress markers for and monitor the plans that you make. Record any proposals in the HCC minutes/ record book.

It's not just the councillors who are important in local authority structures! We have already discussed this in previous Modules.

Take a look at the diagram below, it shows local authority representative bodies in Zimbabwe that you should work with. These have the capacity and mandate to support health plans from the community/clinic level.



Source: Loewenson R et al (1999) Public participation in Health Systems. Report from participatory research in four districts of Zimbabwe with support from IDRC (Canada)TARSC/CWGH Monograph 18 / 99

7.2. Support from the health sector

Health Centre committees will need support from the Ministry of Health, and in turn give support to health programmes and services.

One of the first areas of support is for the Ministry of Health to recognise Health Centre committees and provide for them in the law.

The Ministry of Health can also provide

- **Training:** Discuss with the local clinic staff and from the district hospitals to get officials from the Head quarters to support you in training particularly on your roles as HCCs and in basic public health protocols
- **Refresher courses:** The DNO or someone senior from the District office of the MOH can organize refresher courses for you. You can discuss with the DNO or the DEHO to support you with this
- **Materials:** Discuss with local clinic staff e.g. the EHT to link you up with District Health promotion officers to support you with Information education and communication materials of varying public health needs
- **Resources:** The budgets allocated to districts should support HCCs inorder for them tofunction well. So resources should reach you and communities if primary Health care is to be revitalized. Remember our Health system should be people centered, and so are the resources!. So when you do your planning and when you participate in the budget process make sure that you raise this issue in your discussion as an advocacy issue.
- **Networking:** Liaise with the local health centre or local and district leadership for onward networking with bodies such as the parliamentary portfolio committees

For discussion
What do you need as an HCC to implement your work plan?
Which of these needs can the Ministry of Health provide support for?
Who is your focal person in the Ministry of Health?
How will you organise this?

What support do you need from the Ministry of Health to improve your functioning as an HCC?
From whom can you get this?
How will you organise this?

From your discussions, what will you follow up on?

There are many other stakeholders that HCC can work with. These include non governmental organizations, Churches, the private sector and the business community.

The box below shows examples of the support these organizations and institutions can provide to the HCCs.

Research: Some organizations can help provide evidence and analysis, or technical support on health issues
Training: Organisations can provide skills through formal training, in-service training or mentoring or by working with the HCC on an issue
Income generating projects: Organisations can provide resources, skills, materials or facilities for these activities, or they can help to market the products.
Financial resources: Organisations can provide credit, markets or donate money or other resources to community activities
Information outreach: Organisations such as media can spread information through communities or raise issues at higher level
Legal advice: The HCC can obtain legal advice on health issues from legal aid clinics or non government organisations

…. And many others!

For discussion
Go back to your discussion of what you need as an HCC to implement your work plan?
Which organisations can support these needs?
Who in the organisations?
How will you organise this?
Which needs are not covered by these organisation ? Discuss this with the health workers and others you work with to see if they have a suggestion.

7.3. Sources of support

Health Centre Committees can network with a range of organizations in civil society and in the business community to advance their work on health and improve health services. Examples of these include

- The Business community: who can take actions to promote health, ensure that they do not harm health in production, and support with money, materials or skills
- The faith community: including churches and other religious organizations who can support information outreach, provide material resources, and directly engage on health activities; promote health rights and accountability;

- Non government organizations, like the Community Working Group on Health, residents associations; women's associations; agricultural or producer groups, People Living with HIV and AIDS (like ZNNP+); Zimbabwe Network of HIV positive Women; trade unions at national level, like Zimbabwe Congress of Trade Unions (ZCTU) or in specific industries
- Development institutions such as. [Informal Traders Association of Zimbabwe (ITAZ); Rural Unity for Development Organization (RUDO) etc]
- Youth Organisations such as . [Zimbabwe Young People Development Coalition (ZYPDC); Shiloh Zimbabwe; Students and Youths Working on Reproductive Health Action Team (SAYWHAT)
- Technical institutions, like universities, or in civil society, like Training and Research Support Centre, the institution that has written this manual.

And others! These organizations can provide the areas of support listed on page 59.

Community, health workers, civil; society, parliamentarians and ministry officials discuss PHC, Harare 2009 © TARSC 2009

For discussion

Go back to the discussion you had of the needs you have for your workplan, your advocacy or your functioning as an HCC. Which needs do you have that you cannot solve with the organisations you have already identified? What health advocacy issues do you need to build alliances for?
Do any of the other sources listed here provide this support?
How will you make links with these organisations?

Finally as a group summarize

- What new information or skills you have from this module
- What questions you have to ask at your next HCC or DHE meeting
- What follow up actions you have identified to take up at your next HCC meeting?

MODULE 7

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MODULE 7

LIST OF ACRONYMS

AIDS	Acquired Immuno-Deficiency Syndrome
AMWUZ	Associated Mine Workers Union of Zimbabwe
BURA	Bulawayo United Residents Association
CCJP	Catholic Commission for Justice and Peace in Zimbabwe
CG	Central Government
CRRA	Chinhoyi Residents and Ratepayers Association
CWGH	Community Working Group on Health
DCHC	District Community Health Committee
DDC	District Development Committee
DHE	District Health Executive
DHMB	District Health Management Board
DHO	District Health Officer
DHP	District Health plan
DHT	District Health Team
DMO	District Medical Officer
HSB	Health Services Board
HSF	Health Services Fund
EHT	Environmental Health Technicians
EQUINET	Regional Network for Equity in Health in East and Southern Africa
GAPWUZ	General Agricultural Plantation Workers Union of Zimbabwe
GRRA	Gweru Residents and Ratepayers Association
HCC	Health Centre Committees
HIV	Human Immune-deficiency Virus
HQ	Headquarters
ITAZ	Informal Traders Association of Zimbabwe
MaRRA	Marondera Residents Ratepayers association
MOHCW	Minister of Health and Child Welfare
MuRRA	Mutare Residents and Ratepayers Association
NGO	Non Governmental Organisations
NHIS	National Health Information System
ORAP	Organization of Rural Organizations for Progress
PC	Provincial Council
PDC	Provincial Development Committee
PEHO	Provincial Environmental Health Officer
PHAB	Public Health Advisory Board
PHEO	Provincial Health Education Officer
PHMB	Provincial Health Management Board
PHPO	Provincial Health Promotion Officer
PHSA	Provincial Health Services Administrator
PHT	Provincial Health Team
PMD	Provincial Medical Directorate
PNO	Provincial Nursing Officer

RDC	Rural District Council
RRRA	Rusape Residents and Ratepayers Association
RUDO	Rural Unity for Development Organization
SAYWHAT	Students and Youths Working on Reproductive Health Action Team
TARSC	Training and Research Support Centre
TB	Tuberculosis
VIDCO	Village Development Committee
VHC	Village Health Committees
WADCO	Ward Development Committee
WAG	Women's Action Group
WASN	Women and AIDS Support Network
VHC	Village Health Committee
VHW	Village Health Worker
VIDCO	Village Development Committee
WHC	Ward Health Committee
WHO	World Health Organization
WHP	Ward Health Plan
ZACH	Zimbabwe Association of Church Related Hospitals
ZCC	Zimbabwe Council of Churches
ZCTU	Zimbabwe Congress of Trade Unions
ZFU	Zimbabwe Farmers Union
ZHAAO	Zhombe AIDS AID Organization
ZINATHA	Zimbabwe National Traditional Healers Association
ZNNP+	Zimbabwe National Network of People Living with HIV and AIDS
ZNOHPW	Zimbabwe Network of HIV Positive Women
ZYPDC	Zimbabwe Young People Development Coalition
ZURA	Zimbabwe United Residents Association

Supporting the role of Health Centre Committees
A Training Manual

ADDITIONAL MODULES

Jointly developed by
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MODULE 8

Maternal, Newborn and Child Health (MNCH)

In this module Health Committee Members will learn about:

- A wide range of issues related to MNCH (Maternal, Newborn and Child Health).
- The three delays that contribute to high maternal and child mortality.
- Actions and practices which Health Centres, communities and individuals can implement to reduce maternal, newborn and child mortality.

8.1 The MNCH situation in Zimbabwe

In Zimbabwe, Maternal mortality rate has more than doubled from 283 deaths per 100 000 live births in 1994 to 960 deaths per 100 000 live births (2011); with Child mortality rate at 90 deaths per 1000 live births meaning about a 100 children dying every day. The situation has been worsened by under investment in health sector, severe shortages of skilled health workers and stock-outs of drugs and equipment. There is also inadequate coverage of basic services for rural and marginalised populations.

The Strengthening Community Participation in Health Project is being implemented jointly by Community Working Group on Health (CWGH) and Save the Children (SC) in partnership with the Ministry of Health and Child Care (MOHCC) in 14 districts in Zimbabwe, with support from the United Kingdom's Department of International Development (DFID). This project aims to strengthen citizen engagement in monitoring of and advocacy for improved quality and outcomes of MNCH.

8.2 MNCH Fact Sheets and link with MNCH Facilitators Guide

The module on Maternal, Newborn and Child Health can be used to increase knowledge of MNCH issues and services. It is best used in conjunction with the MNCH Facilitators Guide, which offers participatory activities for explaining the information in the fact sheets and engaging communities to address the issues.

Fact Sheets in this module

The Fact Sheets in this MNCH module contain vital information on a range of MNCH issues: Teenage Pregnancy, Child Health, HIV/AIDS and Maternal, Newborn and Child Health, Cultural Issues, Social Determinants of Health, Focused Antenatal Care, Abortion, and Malaria. The information in these fact sheets can increase the knowledge of Health Literacy Facilitators (HLFs), Village Health Workers (VHWs), Health Centre Committees (HCCs) and other community health workers, enabling them to raise community awareness and understanding on MNCH services.

Participatory Training Sessions in the "MNCH Facilitators Guide"

The Fact Sheets in this module can be used in combination with the MNCH Facilitators Guide. The MNCH Facilitators Guide offers a range of 30-60 minute sessions with participatory activities to engage and involve participants and enable them to understand and address the issues they have around MNCH.

8.3 FACT SHEETS

FACT SHEET 1 - MATERNAL HEALTH

The following MNCH Facilitators Guide participatory sessions can help to explain the information and address the issues in this fact sheet:

- Session 2: Responsibilities for our health and our child's health
- Session 3: Rights to MNCH services
- Session 4: Danger signs during pregnancy and the 3 delays
- Session 9: Forum Theatre Interactive Dramas

Maternal death is defined as the death of a woman while pregnant or within 6 weeks of termination of pregnancy. Almost half (about 45%) of maternal deaths occur within 1 day after delivery.

Most of the women die because they have no access to skilled routine and emergency care. Quality skilled care during pregnancy and childbirth are important for the health of the mother.

Most maternal deaths are preventable through increased access to skilled antenatal, delivery and post natal care.

1. The major causes of maternal deaths (80%) are due to direct causes namely:
   a. Severe bleeding
   b. HIV and AIDS
   c. Abortion complications
   d. High blood pressure
   e. Infections
   f. Malaria
   g. Obstructed labour.
2. Pregnant women die unnecessarily because of **'the three delays'**. These are:

.

1. **The first delay** - the delay in deciding to seek medical care by the individual, family or community.
2. **The second delay** – the delay in reaching a treatment facility. This delay may be due to lack of communication, lack of transport and financial constraints to pay for transport.
3. **The third delay** - the delay in getting adequate treatment at the health facility. Some women die due to delay in getting the appropriate treatment at the clinic or hospital. This is caused by failure by the health system to provide quality care due to shortage of staff, and lack of skills, medicines or other medical supplies.

Addressing causes of maternal deaths

Most maternal deaths are avoidable. Below are some ways of saving the lives of women:

MODULE 8

1. **Improve communication and knowledge**
   Empower women, families and communities with information on actions to take when a woman is pregnant and the importance of attending ANC and delivering at a clinic or hospital. This can be done through house to house visits and community forums targeting not just the women, but also household heads, husbands, mothers-in-law and other influential persons.

2. **Remove institutional barriers**
   a. Removal of user fees as a barrier improves access to maternal health services.
   b. Develop strategies to deal with emergency cases involving pregnant women.

3. **Antenatal care**

Pregnant women should:

a. Make their first ANC visit before 16 weeks of pregnancy and have a minimum of 4 ANC visits during pregnancy. Ideally one ANC visit per month till delivery is recommended, or as instructed by the health workers. (See Fact Sheet 2: Antenatal Care)
b. Be tested and treated for HIV and Syphilis early to protect the unborn baby and preserve the mother's health.
c. Receive malaria prevention treatment during pregnancy and use insecticide treated mosquito nets. Indoor spraying and closing of all mosquito breeding grounds can help prevent malaria. (This applies to those living in malaria zones)
d. Receive iron and folate supplements to promote good health and prevent anaemia during and after pregnancy.
e. Eat a balanced diet of nutritious food.
f. Make use of a Maternity Waiting Home (MWH) to ensure they stay near the health facility closer to their delivery time. All pregnant women should deliver at health institutions and be assisted by skilled health workers.

Men should be actively involved in MNCH programs and understand the issues so that they make good decisions which support the health of the pregnant woman and their child.

4. **Care during labour**
   With their baby kit ready, pregnant women should quickly visit the clinic as soon as they feel any pain or discomfort related to pregnancy.

5. **Post Delivery**
   a. After delivery women should be supported to attend postnatal care on day 1, day 3, day 7, day 10 and 6 weeks after delivery to monitor mother's health.
   b. Women must receive Vitamin A within 6 weeks after delivery.
   c. Encourage use of family planning methods to prevent unwanted pregnancies.
   d. Women must be tested for cervical and breast cancer and taught how to examine themselves for breast cancer.

6. **Community Support**
   a. Advocate for increased investment in maternal, newborn and child health.
   b. Build effective partnerships with local business people, communities, private health care providers and NGOs to improve MNCH services in communities.
   c. Address cultural, traditional and religious practices and beliefs that discourage use of MNCH services.

FACT SHEET 2 - ANTENATAL CARE

The following MNCH Facilitators Guide participatory sessions can help to explain the information and address the issues in this fact sheet:

- Session 2: Responsibilities for our health and our child's health.
- Session 5: Preventing HIV transmission during Pregnancy and Birth
- Session 8A :Breaking the wall of objections to using ANC services

Antenatal Care (ANC) is the health care given during pregnancy. The aim is to have a healthy mother and baby during pregnancy. Health problems identified in pregnancy and treated early can save both mother and baby. During the visits the woman receives information on danger warning signs of pregnancy, nutrition, personal hygiene and possible pregnancy complications. The health workers also discuss on the delivery plan of the woman. The woman is also examined and assessed for the various risks that could disturb the pregnancy.

Women with the following conditions need special attention during pregnancy:

- Diabetes Mellitus
- Anaemia
- Asthma
- High blood pressure
- Heart diseases
- Malaria
- Bleeding when pregnant
- Twins or more babies in womb.
- Sexually transmitted infections
- HIV/AIDS

A woman should have a minimum of **four ANC visits during pregnancy.** However some are required to attend more visits due to the different conditions they may have. This is determined by the health workers.

1. ANC visits are focused on goals for each visit (see table below):

ANC visit	When to go for ANC	What to expect from Health Workers
1.	From one to four months (before 16 weeks)	• The Health worker (HW) takes history of the last date of the client's menstrual period, sexually transmitted infections and conducts a general examination including Blood pressure checks. • The Health worker carries out tests for syphilis, HIV, urine tests, and check blood level (HB). They also provide counselling and education on nutrition in pregnancy, bleeding in pregnancy, signs and symptoms of miscarriage. • The Health worker assesses if one should be referred to hospital and discusses the delivery plan. • The HW gives the pregnant woman tetanus toxoid injection, iron tablets and anti-malaria tablets (only in malaria prevalent districts)

ANC visit	When to go for ANC	What to expect from Health Workers
2.	4 weeks after first visit (before 20 weeks / five months)	• The HW gives the tests results and counselling to the woman. • The woman is treated of any disease found during the first visit • The woman has BP and urine checks • Tetanus toxoid (TT2) is given
3.	After five months to 28 weeks)	• The HW assesses if woman has one or more than one baby in womb • The HW checks if baby is growing well and checks the heartbeat of baby • The HW assesses for signs of raised Blood pressure, checks urine for abnormalities • The HW asks if the woman is not bleeding, no discharge or any problem. • The woman is given another supply of Iron tablets, anti-malarial tablets in malaria prevalent districts.
4.	After seven months to 34 weeks	• The HW checks if baby is growing well, assesses mother for signs of raised Blood pressure, checks urine for abnormalities and eyes / hands for anaemia • The HW asks if the woman is not bleeding, no discharge or any problem. • The woman is given another supply of Iron tablets, anti-malarial tablets in malaria prevalent districts • The HW checks how the baby is lying, baby movements and any problems. • The HW discusses delivery plan with woman, signs of onset of labour including what to do if waters break (Early rupture of membranes).
5.	Eighth month to about 38 weeks	• The HW checks if baby is growing well • The HW assesses for signs of raised blood pressure, checks urine for abnormalities and Anaemia in eyes, hands • The HW asks if the woman is not bleeding, no discharge or any problem. • The woman is given another supply of Iron tablets, anti-malarial tablets in malaria prevalent districts • The HW checks how the baby is lying, baby movements and any problems. • The HW discusses delivery plan and possibility of woman moving into the maternity waiting home.
6.	Ninth month to about 42 weeks	• The HW checks if baby is growing well • The HW assesses for signs of raised Blood pressure, checks urine for abnormalities and Anaemia in eyes, hands • The HW asks if the woman is not bleeding, no discharge or any problem. • The woman is given another supply of Iron tablets, anti-malarial tablets in malarial districts • The HW checks how the baby is lying, baby movements and any problems • If the woman has not moved into Maternity Waiting Home, the HW discusses delivery plan and possibility of woman moving into Maternity waiting home and transport arrangements

ANC visit	When to go for ANC	What to expect from Health Workers
7.	Subsequent visits depend on delays in delivery and other problems as the HW sees it fit.	• The HW checks if baby is growing well • The HW assesses for signs of raised blood pressure, checks urine for abnormalities and Anaemia in eyes, hands • The HW asks if the woman is not bleeding, no discharge or any problem. • The woman is given another supply of iron tablets • The HW checks how the baby is lying, its movements and any problems • If the woman has not moved into Maternity Waiting Home, the HW discusses delivery plan and possibility of woman moving into Maternity Waiting Home and transport arrangements.

2. Birth Preparedness for the pregnant woman during ANC

a) Discuss with family where to give birth and book early.
b) Save the money needed to get to the place of birth and always have access to the money.
c) Have the means of transport to get to the place of birth.
d) Discuss who will take care of the family in your absence.
e) Have a bag with clothes for the baby ready near the due date (it does not need to be full of clothes). Soap, towel and pads are also some items needed.
f) Plan to stay in the Maternity Waiting Home towards delivery. Mothers receive frequent ANC checks in the Maternity Waiting Homes.

FACT SHEET 3: HIV AND AIDS AND MATERNAL, NEWBORN & CHILD HEALTH

The following MNCH Facilitators Guide participatory sessions can help to explain the information and address the issues in this fact sheet:

- Session 2: Responsibilities for our health and our child's health.
- Session 5: Preventing HIV transmission during Pregnancy and Birth
- Session 6: Infant Feeding and Immunization
- Session 8A Breaking the wall of objections to using ANC services

HIV and AIDS is the leading cause of death in women aged 15-44 years. Biological factors, lack of access to information and health services, economic vulnerability and unequal power in sexual relations expose women, particularly young women, to HIV infection. Adolescent girls and young women (15-24 years) are twice as likely to be HIV infected compared to boys and young men in the same age group. This higher risk of HIV is associated with unsafe and often unwanted and forced sexual activity. Discrimination on the basis of their sex leads to many health hazards for women, including physical and sexual violence, sexually-transmitted infections, HIV/AIDS.

MODULE 8

Effects that HIV may have in pregnancy if treatment is not provided

a. Can cause abortions
b. Associated urinary tract infections
c. Opportunistic infections (e.g. TB)
d. Preterm labour
e. Rupturing of membranes before time
f. Low birth weight babies that fail to grow
g. Still births

How to reduce the risk of HIV transmission to your baby

1. **Avoid HIV infection yourselves (primary prevention)**
   a. Educate men, women and girls on the prevention of HIV.
   b. Abstain from sex till marriage and keep sex within marriage.
   c. For those who do not abstain, practise safer sex. Use condoms correctly and consistently.
   d. Ensure availability and accessibility of contraceptives to sexually active persons.
   e. Observe universal precautions and as far as is practical avoid direct contact with the body fluid of others who are living with HIV, or whose HIV status you do not know.
   f. Getting tested together for HIV before getting married, before having a baby and after risky behaviour.
   g. Only receive blood transfusion from a hospital after proper screening is done.
   h. Medical Male Circumcision reduces the chance of a man becoming infected with HIV through sex by about 60%.

2. **During pregnancy**

a. Educate and involve men during pregnancy and in programs for mothers living with HIV/AIDS. The father can support and play a vital role in ensuring that HIV is not transmitted to their unborn or breastfeeding child.
b. Get tested for HIV early in pregnancy. Preferably do couples testing.
c. Avoid the risk of HIV infection or re-infection from a sexual partner.
d. Take ARVs every day as instructed. They supress the HIV in your body, and reduce the chance of HIV transmission to sexual partners and to unborn and breastfeeding children.

3. **During labour**

a. Deliver the baby in a clinic or hospital.
b. The mother must not be allowed to have prolonged labour, and blood contact with the baby should be kept to a minimum.

4. Infant feeding

a. Breastfeeding (exclusive for the first 6 months) is the best infant feeding option for the health of the baby, whether or not the mother is living with HIV.
b. Take ARVs every day as instructed – they are very effective at reducing the risk of HIV transmission through breastfeeding.

c. Babies who have lost their mothers should be fed with formula alone using a cup until six months old (no mixed feeding).

5. Antiretroviral (ARV) treatment

a. ARVs must be given as early as 14 weeks of pregnancy if not started already before the pregnancy. They must be continued either for life, or at least until a week after complete cessation of breastfeeding or as advised by health workers.

b. ARV's reduce the amount of HIV in the mother's body and help prevent HIV transmission to sexual partners and from mother to child during pregnancy, delivery and breastfeeding.

FACT SHEET 4 - MALARIA IN PREGNANT WOMEN

The following MNCH Facilitators Guide participatory session can help to explain the information and address the issues in this fact sheet:
• Session 2: Responsibilities for our health and our child's health.

Zimbabwe is a malaria prone country with approximately 60 per cent of the population of 12 million people at risk. 45 out of 62 districts are designated malaria prone areas.

Malaria is a common cause of death, and is a serious health threat to pregnant women, newborn and young children. Malaria infection during pregnancy carries substantial risks for the pregnant woman and her unborn baby. Malaria is associated with maternal illness and low birth weight.

1. Facts about malaria in pregnancy

a) Malaria parasites may be present in the placenta and contribute to anaemia. This can lead to low birth weight, which is a contributor to infant mortality.

b) Malaria may lead to spontaneous abortion, stillbirth, and prematurity.

c) Chronic anaemia and malaria infection in the placenta can lead to low birth weight and increases the risk of newborn death.

2. Signs and symptoms of malaria

2.1 Adults:

a. Headache
b. Feeling cold and hot (rigors)
c. Weak body
d. Diarrhea
e. Vomiting
f. Confusion, fits and convulsions

g. Hot body
h. Shivering

2.2 Children (infants)

a. Loss of appetite
b. Shivering, feeling cold and hot
c. Weak joints
d. Diarrhea & vomiting
e. Fits and convulsions
f. Sunken fontanel (the "soft spot" on top of a baby's head dips down)

3. Key ways to prevent malaria

a. All the people in a household sleeping under insecticide treated mosquito nets -) every night
b. Household spraying.
c. Three doses of intermittent preventive treatment in pregnancy (IPT) must be given to women living in malarias zones – this is 1 tablet given at 3 different times during a woman's pregnancy.
d. All pregnant women should receive iron and folic acid supplementation as a part of routine antenatal care to prevent anaemia.

4. Key ways to treat malaria

Rapid diagnosis and effective treatment of malaria both at health facility and community level within 24 hours of fever onset. This reduces maternal malaria episodes, maternal anaemia, low birth weight and newborn deaths.

FACT SHEET 5 - ABORTION AND MISCARRIAGE

The following MNCH Facilitators Guide participatory sessions can help to explain the information and address the issues in this fact sheet:

- Session 2: Responsibilities for our health and our child's health.
- Session 8A Breaking the wall of objections to using ANC services

Abortion is the termination of pregnancy. An abortion can be:

- Deliberately and purposely induced, e.g. a planned medical abortion.
- An unintentional spontaneous abortion or miscarriage

Unsafe abortions result in many maternal deaths. Abortion in Zimbabwe is acceptable in limited circumstances. Most planned abortions are cases of unintended pregnancies. Its legality can depend on specific conditions, such as incest, rape, foetal defects, a high risk of disability and the mother's health being at risk.

1. **The most common causes of spontaneous abortion / miscarriage**
   a. Gross abnormalities of the baby in the womb.
   b. Diseases like diabetes.
   c. High Risk pregnancy e.g. ectopic pregnancy - An ectopic or tubal pregnancy occurs when a fertilized egg implants outside the uterus, usually in a fallopian tube.
   d. Hormonal problems or infection.
   e. Trauma (intentional or accidental).
   f. Stress
   g. The embryo or foetus (baby in mother's womb) has body tissues that cause it to develop abnormally. It usually happens by chance when the fertilized egg divides and grows. This problem causes at least half of abortions.
   h. Severe chronic illness — such as heart diseases, TB.
   i. Serious infections.
   j. Abnormalities in the uterus, like scar tissue or uterine fibroids, can cause late abortions — after three months.
   k. Smoking, the use of alcohol or cocaine and heavy caffeine use.
   l. A woman's risk of abortion increases as she ages.
   m. Women who are underweight or overweight have a greater risk of abortion than other women.
   n. Women who have had two or more abortions in a row are at a greater risk of having more abortions.
2. **Signs and symptoms of spontaneous abortion / miscarriage**
   a. vaginal bleeding or spotting
   b. severe abdominal pain
   c. severe cramping
   d. dull, lower-back ache, pressure or pain
3. **Health risks of unsafe abortions**
   a. Tearing of the opening of the womb
   b. Negative psychological effects of abortion
   c. Incomplete abortion
   d. Infection / Sepsis
   e. Bleeding
   f. Damage to internal organs
4. **Why do women decide to have abortions?**
   Women have abortions for many different reasons. Some of these reasons are listed below:
   a. The need to postpone childbearing to a more suitable time.
   b. Limited resources for existing children, e.g. to provide schooling for existing children.
   c. Unable to afford a child (or additional child), either in terms of the direct costs of raising a child or the loss of income while she is caring for the child.
   d. Lack of support from the father, or other family members.

e. Disruption of one's own education.
f. Relationship problems with their partner.
g. A perception of being too young to have a child.
h. Unemployment.
i. Unwilling to raise a child.
j. Conceived as a result of rape or incest.
k. Failure of a contraception method and the pregnancy is not wanted.
l. Preference for children of a specific sex, and a scan has identified the baby as being the other sex.
m. Disapproval of single or early motherhood, stigmatization related to this.
n. Lack of access to or refusing to use contraceptive methods.

The decision to terminate any pregnancy is never an easy one. It is important to be supportive of any woman who has had an abortion. She should always be offered nonjudgemental support and advice and treated with respect at all times by health service providers, staff, and other community members.

5. Abortion and the Law in Zimbabwe (Termination of Pregnancies act)

Circumstances in which pregnancy may be terminated

Pregnancy may be terminated by doctors lawfully under the following conditions:

a. Where the pregnancy puts the life of the woman in danger.
b. Where there is a serious risk that the child to be born will have a physical or mental defect that he will permanently be seriously handicapped.
c. Where there is a reasonable possibility that the foetus is conceived as a result of unlawful intercourse rape or incest. (Incest - Blood relatives having sex like father and daughter).

Conditions under which pregnancy may be terminated

a. The process of getting a legal abortion / legal termination of pregnancy is long.
b. Pregnancy may only be terminated by a medical doctor in a hospital with the permission in writing of the Medical Superintendent.
c. Two doctors must first agree that it is necessary to have the legal abortion.
d. If the reason is that unlawful sex occurred there must be a police report of the case and written documents that the case is in a magistrate court.
e. In an emergency case when the doctor had to perform an abortion before all procedure has been followed; s/he shall prepare and submit a report in the prescribed form on the matter to the Secretary for Health within forty-eight hours.

FACT SHEET 6 - CHILD HEALTH

The following MNCH Facilitators Guide participatory sessions can help to explain the information and address the issues in this fact sheet:

- Session 2: Responsibilities for our health and our child's health.
- Session 3: Rights to MNCH services
- Session 6: Infant Feeding and Immunization

Quality skilled care during pregnancy and childbirth are important for the health of the baby and the mother. If the mother dies as a result of complications during and after pregnancy and childbirth, the child has much reduced chances of survival.

This care should continue from infancy through childhood and adolescence to adulthood. More than one third of all child deaths occur within the first month of life (newborn deaths), while the majority of child deaths are under the age of five years. Hence the first few years are the most critical in terms of providing care.

Causes of deaths of New-born babies

Most deaths of new-born babies are due to lack of safe childbirth and effective care during the first days of life. The first 48 hours following birth are the most crucial period for newborn survival.

A baby's chance of survival increases with delivery in a health facility in the presence of a skilled birth attendant. After birth, essential care of a newborn should include:

- Ensuring that the baby is breathing.
- Starting the newborn on exclusive breastfeeding right away and maintaining exclusive breastfeeding.
- Keeping the baby warm.
- Washing hands before touching the baby.
- Sick babies must be taken immediately to a trained health care provider as they can become very ill and die quickly.

Causes of under-five child deaths

- Failure to breathe at birth
- Preterm Birth (Prematurity)
- Acute Lower Respiratory tract Infections
- Malnutrition
- Pneumonia
- Poor or delayed health care-seeking behaviour
- Diarrhoea
- Malaria
- Measles
- HIV and AIDS and related illness

What can be done to save children's lives?

1. **Improve communication and information dissemination**
   a. Ensure that all mothers know about the MNCH services available and what action they and their families need to take to look after the health of the mother and child. These actions and responsibilities are summarised in the 2-page MNCH Flyer.
   b. Pregnant women should go for all the recommended antenatal and postnatal care visits. As well as checking the health of the mother and child and providing immunisation, these visits provide further information about ensuring the healthy development of a child.
   c. Delivering a baby at the clinic or hospital gives the baby a better chance of survival.

2. **Baby feeding**
   a. Breastfeeding within the first hour of birth fosters bonding and protects children from exposure to harsh external environments.
   b. Exclusive breastfeeding for the first six months of life gives life saving benefits to both baby and mother, reducing the risk of ovarian and breast cancer. Continuing breastfeeding for at least eighteen months is good for the baby.
   c. Introduce solid and semisolid foods at 6 months, and gradually increase the amount of food and frequency of feeding as the child gets older. This will help the child get all the nutrients they need to grow healthy and strong.
   d. Provision of safe drinking water and adequate sanitation helps to prevent diseases such as diarrhoea which is the most common killer of babies.

3. **Ten Steps to Successful Breastfeeding**
   a. Skin-to-skin contact between mother and baby immediately after birth. Skin-to-skin contact (kangaroo care) helps baby keep warm, prevents the baby from getting cold, stimulates the heart and improves breathing.
   b. Initiation of breastfeeding within the first hour of life.
   c. Breastfeeding on demand (as often as the child wants).
   d. Practise responsive feeding (e.g. feed infants directly; feed slowly and patiently, encourage but do not force them to eat; talk to the child and maintain eye contact).
   e. Rooming-in (allowing mothers and infants to remain together 24 hours a day).
   f. Not giving babies any additional food or drink, even water – breast milk is all the baby needs.
   g. Provision of supportive health services with infant and young child feeding.
   h. Community support, including mother support groups. These provide a valuable opportunity where mothers can help each other keep their babies and themselves healthy.
   i. Practise good hygiene and proper food handling by washing your hands before feeding your child.

4. **Danger Signs in a Baby**
   a. Take the child to the clinic immediately if child has the following danger signs. These are signs of serious illness which need treating urgently:

- Fever and hot body with or without fits or convulsions.
- Fast or noisy breathing, or difficulty breathing. Early detection of pneumonia can save your child's life.
- The child's feet and palms look yellow or blue.

b. **Diarrhoea** can also be very dangerous to a baby if it results in severe dehydration.
When a child has diarrhoea, give small sips of **oral rehydration solution or Salt and Sugar Solution (SSS)** after each loose stool to replace lost fluids. This SSS can be made by mixing one teaspoon of salt and six teaspoons sugar with one litre of clean water.

5. Other Baby Health Care Actions

a. Make sure that all your children are fully immunised. This helps to prevent specific infections and childhood diseases which can cause death.

b. Vitamin A should be given to all children from 6 months to 5 years to keep their immune system strong.

c. All children below 5 years must be presented regularly for growth monitoring to make sure that they have the right weight for their age and to detect malnourishment.

d. Prevent malaria in children under-five by ensuring that everyone in the household sleeps under insecticide-treated mosquito nets every night.

7. Community Support:

a. Communities should educate and encourage everyone to access health services (e.g. immunisations, family planning).

b. House to house visits with household heads, mothers, in laws, first wives & young wives encourage peer motivation on child care within communities.

c. Improve families' and communities' knowledge on how best to bring up healthy children and deal with sickness when it occurs, through VHWs visits and education.

d. Introduce and disseminate Community Integrated Management of Newborn and Childhood Illnesses. This is an integrated child care approach that aims at improving household practices that are likely to help the child's survival, growth and development.

Remember!

- Every infant and child has the right to good nutrition according to the Convention on the Rights of the Child.
- Food provision must be balanced to avoid under-nutrition, (Kwashiorkor, Marasmus, stunting) or over nutrition, (overweight, obesity) both of which impact children's health and development.
- The first two years of a child's life are particularly important. Good nutrition during this period reduces the risk of illness and death, and promotes better development overall.
- Exclusively breastfeed for the first 6 months.
- From 6 months to 2 years, introduce a variety of other foods while continuing to breastfeed.

MODULE 8

FACT SHEET 7 - ADOLESCENCE AND TEENAGE PREGNANCY

The following MNCH Facilitators Guide participatory session can help to explain the information and address the issues in this fact sheet:

- Session 7: Stigma, Support and Self Worth
- Session 8D Breaking the Wall of Objections by Adolescents to Sexual Abstinence
- Session 9: Forum Theatre Interactive Drama

Adolescence is the period when boys and girls make the transition from childhood to adulthood. During this period the body goes through physical and psychological changes. For girls it marks the onset of menstruation making them prone to teenage pregnancy.

The signs of pregnancy include:

- A missed menstrual period
- Nausea or vomiting ("morning sickness,") though it can happen throughout the day
- Craving for certain foods (like okra, dried vegetables)
- Sore nipples or breasts
- Unusual fatigue
- Frequent urination
- Unusual mood swings

About 25% of the national maternal mortality is contributed by teenage mothers (Zimbabwe Demographic and Health Survey, (ZDHS 2010/11). Children born to teenage mothers are more likely to suffer health, social, and emotional problems than children born to older more mature mothers.

Pregnant teenagers and their unborn babies have unique social and medical risks as stated below:

1. Teenage mothers book late at the antenatal clinics because either they are unaware that they are pregnant, or fear disclosure.
2. Most teenagers may lack support from their parents and boyfriends because the pregnancy is not planned and therefore not welcome.
3. Teenagers may not get adequate ante-natal care which is critical at or before 12 weeks of pregnancy which is vital for health of mother and child.
4. They may not access the balanced nutrition, vitamins and folic acid that are essential in preventing certain birth abnormalities and complications in the mother.
5. Pregnant teenagers have a higher risk of getting high blood pressure (Hypertension in pregnancy) than pregnant women in their 20s or 30s. This endangers their lives and that of their unborn baby.
6. Teenagers have a high risk of sexually transmitted infections because they are too young to negotiate for safe sex.
7. Teenage mothers are more at risk of developing stress-related physical and mental disorders during and after delivery as their bodies would not have fully developed for motherhood.

8. Teenage mothers and fathers are more likely to drop out of school, experience poverty, abuse drugs and alcohol (depending on family support.)
9. Teenagers that get pregnant are likely to get pregnant again before they reach 20 years and have more children leading to more health complications when compared to adult pregnant women
10. Children born to teen parents are more likely to have nutritional and developmental problems and endure a lower standard of living. They are also likely to have a higher risk of abuse and neglect from their parents and enter the vicious cycle of poverty, crimes and social ills than those born of older parents.
11. When teenage pregnancy ends in abortion, they are more likely to overlook the signs of complications and death due to lack of knowledge and access to health care services.

HOW TO REDUCE THE HEALTH RISKS OF TEENAGE PREGNANCY

1. AVOID TEENAGE PREGNANCY!
2. Keep girls in school, to improve their knowledge and awareness on matters of sexual and reproductive health, including family planning.
3. Encourage family and community support to teenagers to counsel on delaying sexual debut, delay the first pregnancy and building of healthy relationships.
4. In the event of teenage pregnancy, the teenage mother must go to the clinic for testing and booking on an ANC programme.
5. Avoid alcohol, and drug abuse, as this will harm the mother and child.
6. Family support to teenage mothers on family planning and contraceptive advice to prevent unplanned pregnancies and longer-term health consequences associated with teenage pregnancy.
7. Eat nutritious food for good health of both mother and child.
8. To help teenagers build and maintain their self-worth, facilitate with them *Session 7: Stigma, Support and Self Worth in the MNCH Facilitators Guide.*

FACT SHEET 8 - SOCIAL DETERMINANTS OF HEALTH

The following MNCH Facilitators Guide participatory session can help to explain the information and address the issues in this fact sheet:
• Session 9: Forum Theatre Interactive Drama

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (WHO 1987). Social determinants of health influence the health and wellbeing of people and must be adequately tackled if the goal of health in its fullness is to be achieved. Among those determinants of health in general and reproductive health in particular are:

1. Poverty
2. Social status
3. Housing
4. Environment
5. Early life experiences
6. Genetics
7. Access to nutritious food
8. Individual behaviours and lifestyle factors
9. Access to appropriate and effective primary health care

These factors are influenced by:

1. Healthy living conditions (including access to food, water and sanitation)
2. Education, literacy and health literacy
3. Stress
4. Early life (first five years of life)
5. Social cohesion
6. Employment
7. Age, sex and heredity factors
8. Culture, racism and discrimination
9. Access to information and appropriate health care
10. Social supports and access to transport

Poverty and poor health are linked. People from lower income groups are more likely to suffer ill health than wealthier citizens. One of the greatest determinants of our experience of health is income and socioeconomic status. (Zimstat Poverty Assessment, ZDHS 2010- 2011, MICS). Addressing the social determinants of health (as listed above) will help to improve maternal and child health.

Effects of Social Determinants on Health:

- People's **living conditions** can have a significant impact on their experience of and the enjoyment of health and wellbeing. The availability, ownership and quality of housing, particularly the cost of privately renting suitable housing, has a major impact on the disadvantaged. Where there is unregulated, unplanned housing particularly in urban areas, there tends to be overcrowding, more diseases linked to poor sanitation and unsafe water supply.

- Access to **nutritious food** is effected by knowledge about good diets, income levels and also by where someone lives. Within many disadvantaged communities, affordable and fresh nutritious food is often unavailable. Instead only limited types of cheap processed food may be available, resulting in unbalanced diets, often with high fat content. This shortage of food and a shortage of a variety of healthy foods contribute to poor nutrition and increased ill health, particularly for the vulnerable pregnant or breastfeeding women and their children.

- Access to **safe drinking water** is a problem in many urban and rural areas. Up to 50% of deaths due to diarrhea are children under the age of five years, (MOHCC Weekly Surveillance reports).

- Access to comprehensive **health services** with a good referral system impacts greatly on the quality of health services and community wellbeing, particularly on those disadvantaged from birth.

- Brain and biological development during the first years of life depends on the quality of **stimulation in the infant's environment**—at the level of family, community, and society. Early child development (ECD), in turn is a lifelong determinant of health, well-being, and learning skills. Taken together, these facts make early child development a social determinant of health.

What can be done to address the social determinants of Health?

Health Literacy

Health literacy is needed to raise awareness on social determinants of health. It should empower people with greater knowledge on health issues and the ability to apply this knowledge practically. It should empower them to make informed choices regarding their personal health and to contribute meaningfully to improved health in general.
Being health literate allows individuals to:

- Improve their knowledge regarding health related information.
- Make informed decisions regarding their personal health.
- Raise their own awareness of the social, environmental and economic determinants of health.
- Read medicine labels and follow instructions.
- Read, understand and act on health promotion information.
- Act upon necessary procedures and directions given by medical personnel as well as keep appointment schedules.

FACT SHEET 9 - CULTURAL ISSUES AND INFLUENCE ON HEALTH

The following MNCH Facilitators Guide participatory sessions can help to explain the information and address the issues in this fact sheet:
- Session 3: Rights to MNCH services
- Session 8A Breaking the wall of objections to using ANC services
- Session 9: Forum Theatre Interactive Drama

Cultural customs, practices, beliefs and values positively or negatively influence women's behaviours during pregnancy. In the Shona and Ndebele culture, pregnancy and child birth is not an individual or couple affair, but both families come together and advice the young family on pregnancy experience.

Some cultural practices have been noted to increase the likelihood of mothers dying in childbirth, as they are harmful.

Socio-cultural factors that prevent women from benefiting from quality health services

- Unequal power relationships between men and women.
- Low literacy level in women may limit their health literacy and contribute to the reinforcement of detrimental cultural beliefs and practises.
- Lack of employment opportunities for women.
- Potential or actual experience of physical, sexual and emotional abuse.
- Some religious sects discourage the use of health facilities for ANC, delivery, PNC or Immunisation.
- Poverty tends to yield a higher burden on women and girls' health. Poverty affects family feeding habits that affect both mother and child.

How to address socio-cultural factors

1. Using the rights and responsibilities action cycle to understand the socio-cultural and traditional factors that prevent people from accessing services and practising healthy behaviours.

2. Understanding the specifics of how the culture surrounding childbirth contributes to maternal mortality.

3. In Zimbabwe as in most societies, women have lower social status than men in families, communities and society. There is need to promote gender equality and integrate gender perspectives into health meaning that the different needs of women and men are considered at all stages, and the goal of social, cultural and biological factors that influence health outcomes in pregnant women can be achieved.

4. Educate communities on the danger of some cultural beliefs.

MODULE 9

Working with Vulnerable Populations

In this module Health Literacy Facilitators will:

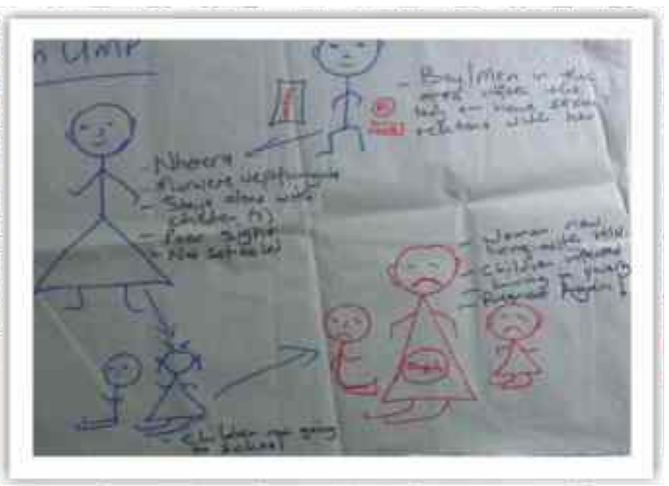
- Identify vulnerable and marginalized groups in their communities.
- Explore ways of addressing MNCH issues faced by vulnerable and marginalized groups.
- Explore how we can sometimes stigmatise those we think are different in some way (e.g. people with disabilities and those who are living with HIV).
- Identify how we can best support both adults and children who may by living with HIV, have a disability or who are vulnerable for some other reason.

9.1 Vulnerable Populations

There are many vulnerable people in the communities who face different problems. Vulnerable groups may include Orphans and Vulnerable Children (OVC), people living with HIV (PLWH), people living with disabilities, elderly, women, adolescent boys and girls. These groups often face a broader set of vulnerability factors, including poverty, the need to care for sick parents or other family members, food insecurity, political conflict, harmful child labour practices, gender related barriers and vulnerabilities, and inadequate access to basic health and education services.

Case study from Uzumba Maramba Pfungwe: People who are vulnerable

- In Zimbabwe, young people aged 15-24 years comprise 60% of new HIV infections, with girls six times more likely than boys to be infected.
- The alarming numbers of AIDS deaths has resulted in large numbers of children affected and orphaned by AIDS.
- Girls tend to drop out of school to care for family members. They are particularly susceptible to sex in order to survive and meet their own and their family's needs.



- In Uzumba Maramba Pfungwe there is a disabled woman who was orphaned years ago. Different men and young boys have sexual relations with her. She stays with two of her sisters. The sisters dropped out of school as they had to work for food. One of the sisters has two children and recently she tested HIV positive when she went to register her pregnancy. She is living in poverty and is malnourished.

Source: Participants from UMP at the material development workshop 2013

MODULE 9

HLFs can help to identify vulnerable groups in their local community in order to improve their well-being in relation to their:

(a) physical and mental health and emotional well-being
(b) protection from harm and neglect
(c) education, training and recreation
(d) contribution made by them to society
(e) social and economic well-being

Activity & Discussion: Vulnerable Groups

Why do this activity?

- To understand what the constitution of Zimbabwe says on children's rights.
- To explore the reality of children's rights in our communities and how these might be improved.

How to prepare

- Make slips of paper with a vulnerable person or powerful person written on each slip. e.g.: a person living with HIV; a child; a person who has to use a wheelchair, an orphan; a pregnant teenager, a community leader; an elder, a wealthy trader. Make enough slips to give one to each participant.
- Prepare a set of statements to use for the activity, such as 'I can go to the health centre by myself'; I can access quality health care; I am treated with respect; I can live without fear of discrimination; I can go to school; I can deliver in a health centre with the support of my family; etc.

Approx time: 30 minutes

Step 1: Exercise to explore who is vulnerable, who is powerful

- Ask all participants to stand side-by-side or at back the training area.
- Give each person a slip of paper with a vulnerable person or powerful person written on it (or tell them the role they should take if literacy levels are low.)
- Read out one of the statements you have prepared, for example "I can go to the health centre by myself." If the person (in their role) can answer 'yes' to the statement, they can step forward. If they cannot answer 'yes', they must stay where they are.
- Repeat with each of the statements in turn.
- Get each person to state the role they played, and why they ended up at the front or back of the training area.

Step 2: Share a case study example of people who are vulnerable

As an example of vulnerable groups in a particular community, share the information in the case study above on people who are vulnerable in Uzumba Maramba Pfungwe.

Step 3: Facilitate discussion around vulnerable groups in the local community

Facilitate discussion using the following questions:

- *Who is vulnerable in your community?*
- *What are the issues vulnerable groups face?*
- *How are people from each vulnerable group treated in your community?*
- *What activities are happening to support vulnerable groups?*
- *What else needs to be done to help?*

Step 4. Action planning

Identify and agree specific actions that participants can implement towards addressing the issues of vulnerable groups.

What to take note of when dealing with vulnerable populations

1. Communities must always take account of the level of social and emotional development of the vulnerable person they are dealing with. Ensure, wherever possible, that the individual's views, wishes and feelings are taken into account.
2. Assumptions must not be made about the inability of the individual to raise important issues and contribute valuable ideas.
3. Some individuals (particularly those who are hearing impaired) may develop or use their own means of communication (e.g. sign language). Communicating then requires specialist knowledge and skills, which must be provided in all interactions.
4. In dealing with vulnerable groups, communities need to think of ways they can help support and address the needs of the different groups.
5. Refer vulnerable groups when there is need to the relevant authorities or organisations that can help address their needs.

9.2 Children's Rights and Issues of Abuse and Neglect

Activity & Discussion:
Children's rights in the Constitution and in our Communities
Why do this activity?

- To understand what the constitution of Zimbabwe says on children's rights
- To explore the reality of children's rights in our communities and how these might be improved.
- To understand issues of child abuse and neglect and how to address these.

How to prepare
Read the information in Fact Sheet 10: Children's Rights and Dealing with Abuse (pages 88-92)

Resources
(optional) Copies of the MNCH Flyer for participants in the preferred language(s) of your participants (English, Shona or Ndebele). If you do not have the proper printed flyers, you can make 2-sided photocopies from Appendix 3 of the MNCH Facilitators Guide, and fold them yourself.

Step 1. Facilitate discussion on issues around children's rights and child abuse
Ask the following questions and facilitate discussion around them. If participants are not aware of the answers, summarise information from Fact Sheet 10:

- *Did anyone participate in the development of new constitution?*
- *What does the constitution say about rights of children?*
- *What rights should children have?*
- *Which rights are directly linked to health?*
- *What are the issues around children's' rights, child abuse and neglect in your community?*

- *What activities are happening to support children's rights and prevent abuse in your communities?*
- *What more needs to be done to help?*

Step 2. Refer to the MNCH Flyer section "To do for the physical and emotional health of your child"
If you have copies of the MNCH flyer, give them to those who do not already have one. Ask them to look at the section on page 2, column 2, headed "To do for the physical and emotional health of your child." Explain that this section reflects several of the rights of children that we have been discussing.

Read each of the 6 items in this section and ask participants with children to reflect on how many of these six they would be able to tick.

Step 3. Action planning
Identify and agree specific actions that both individuals and the community as a whole can do to improve children's rights and address issues of child abuse and neglect.

FACT SHEET 10 - CHILDREN'S RIGHTS AND DEALING WITH ABUSE

The following MNCH Facilitators Guide participatory sessions can help to explain the information and address the issues in this fact sheet:
- Session 2: Responsibilities for our health and our child's health.
- Session 3: Rights to MNCH Services

Every child and young person has rights, no matter who they are or where they live. Nearly every government in the world (including the Government of Zimbabwe) has promised to protect, respect and fulfil these rights, yet they are still violated worldwide.

Who is a child?
Section 81 of the Constitution of Zimbabwe, defines a child as every boy or girl below the age of 18. More than 40% of Zimbabwe's 12.9 million population are children.

What are rights?
1. Human rights are the basic freedoms and protections that people are entitled to simply because they are human beings.[1]
2. Rights are standards that govern how individual human beings live in society and with each other, as well as their relationship with governments and the obligation that governments have towards them.
3. Rights are basic standards without which people cannot survive and develop in dignity. Children's rights are essential for children to grow to their full potential.

[1] http://www.amnesty.org.au/about/comments/21681/

Children's Rights in the Zimbabwe Constitution:

The Constitution of Zimbabwe has sections on children's rights which can be summarized as follows:

76 Right to health care

1) Everyone has the right to basic health-care services, including MNCH services.
2) Every person living with a chronic illness has the right to basic health-care services for the illness.
3) No person may be refused emergency medical treatment in any health-care institution.

77 Right to food and water

Every person has the right to:

(a) Safe, clean and potable water;
(b) Sufficient food

81 Rights of children

1) Every child has the right to:
(a) equal treatment before the law, including the right to be heard;
(b) be given a name and family name;
(c) prompt provision of a birth certificate, if born in Zimbabwe or a Zimbabwean citizen by descent;
(d) family or parental care, or to appropriate alternative care when removed from the family environment;
(e) be protected from economic and sexual exploitation, from child labour, and from maltreatment, neglect or any form of abuse;
(f) education, health care services, nutrition and shelter;
(g) not to be recruited into a militia force or take part in armed conflict or hostilities;
(h) not to be compelled to take part in any political activity;
(i) not to be detained except as a measure of last resort and, if detained:
- to be detained for the shortest appropriate period
- to be kept separately from detained persons over the age of eighteen years
- to be treated in a manner, and kept in conditions, that take account of the child's age.

2) A child's best interests are paramount in every matter concerning the child.
3) Children are entitled to adequate protection by the courts, in particular by the High Court as their upper guardian.

Caring Adults: What A Child Needs Most

Children depend on many adults as they grow up. Parents, relatives, teachers, community leaders, and health workers all provide children with love, support, care and guidance. They can all contribute to the child's physical, mental and emotional development.

Why Do Adults Sometimes Abuse or Neglect Children?

It takes a lot to care for a child. A child needs food, clothing and shelter as well as love and attention. Parents and caregivers want to provide all those things, but they have other pressures, too. Sometimes adults just can't provide everything their children need.

Parents and caretakers don't always know that they are being abusive or neglectful. Few adults actually intend to hurt or neglect children.

Adults may hurt children because they:

- Lose their tempers when they think about their own problems. They are too frustrated with life and take it out on a child
- Expect behaviour that is unrealistic for a child's age or ability
- Have been abused by a parent or a partner
- Have financial problems
- Lose control when they use alcohol or other drugs
- Don't know how to discipline a child without using physical punishment

Types of child abuse

A) Physical Abuse

Examples of physical child abuse

- Shaking or shoving
- Slapping or hitting
- Beating with a belt, shoe or other object
- Burning a child with matches or cigarettes
- Scalding a child with water that is hot
- Pulling a child's hair out
- Breaking a child's arm, leg, or other bones
- Not letting a child eat, drink or use the bathroom

Case study: *Clement came home from work in a foul mood. Seven-year-old Peter ran out of the house just as his father walked in, and they ran into each other. Clement cursed and grabbed his son. He shook Peter hard while yelling at him, and then shoved him out of the way. The next day, Peter's arms and back had bruises.*

B) Sexual Abuse

Examples of sexual child abuse

- Fondling a child's genitals
- Having intercourse with a child
- Having oral sex with a child
- Having sex in front of a child
- Having a child touch an older person's genitals
- Using a child in pornography
- Showing pornographic books or movies to a child

Case study: *Nine-year-old Sarah's mother works at night at the local shabeen serving drinks. Her stepfather Jacob is around when she goes to bed, so many evenings Jacob lies down beside Sarah. As she goes to sleep, he rubs her breasts and genital area.*

C) Emotional Abuse

Examples of emotional child abuse

- Failure to provide a developmentally appropriate, supportive environment
- Restriction of movement, e.g locking the child in a room
- Treating in a degrading, threatening or humiliating way
- Ridiculing or other humiliating treatment, bad name calling

Case study: *Beauty is an intelligent 11 year old girl. Whenever her mother gets irritated, she tells Beauty that she is useless and stupid and that she was "an accident" (unintended pregnancy). Beauty has now started to think of herself as stupid, and has very poor self-esteem. She has become withdrawn and is no longer doing well at school.*

D) Neglect

Examples of child neglect

- Not meeting a child's needs for food, clothing, shelter or safety
- Leaving a child unwatched
- Leaving a child in an unsafe place
- Not seeking necessary medical attention for a child
- Not having a child attend school

Case study: *Martha's husband has recently passed away. Martha desperately needs more money to feed her 4 children. Martha has looked for other work, but the only job she could find required her to leave the children for the whole day and travel far. She can take the 6 month old with her, but the other children, two, four and six, were alone for a few hours until her sister could come to take care of them.*

What Happens to Abused and Neglected Children?

Abuse and neglect have harmful effects on children. At worst, a child could die. More often, abused or neglected children live with fear or pain.

The effects of child abuse can last a lifetime. An abused or neglected child needs help right away.

Abused or neglected children often experience:

- Frequent injuries
- Learning problems
- Fear or shyness
- Bad dreams
- Behaviour problems (e.g. not getting to the toilet in time and soiling themselves)
- Depression
- Fear of certain adults or places

The effects don't end when the abuse or neglect stops. When abused or neglected children grow up, they are more likely to:

- Abuse their own families
- Use violence to solve their problems

- Have trouble learning
- Have emotional difficulties
- Attempt suicide
- Use alcohol or other drugs

Abuse and neglect are hard on the whole family. Some families need help in dealing with practical problems — for example, getting help to buy groceries or learning how to discipline a child without resorting to violence. In other cases, a child may be moved away from their parents into a safe situation.

Child Protection: Our responsibility as community members

Child protection is the process of protecting individual children who are either suffering, or likely to suffer, significant harm as a result of abuse or neglect.

Protecting children from abuse, neglect and exploitation is everybody's responsibility. Families, communities, governments and non-governmental organisations (NGOs) together play a vital role in realising children's rights to protection.

The goals of child protection are to:

- Stop the abuse
- Give needed services to the family
- Help the family become safe and loving

Community involvement in child protection is vital. Adults and children in a community are best placed to identify local protection issues and to develop the most appropriate solutions in cooperation with service providers.

The role of communities

a. It is the responsibility of the community to make sure that any violation of children's rights is reported with prompt action taken. Reporting should be done to the police in collaboration with established child protection structures that are found in almost all the districts of the country.

b. The communities also should know about children's rights. There are many opportunities in the community to make sure that children are being protected. For example in health and education with the Health Centre Committees, parent and teacher committees, and communities can decide to set up child protection committees, which should document and report any violations happening.

c. Communities should teach children their rights and responsibilities.

d. Communities should uphold the once observed principle of communal ownership of children. They should take full responsibilities in making sure that the health facilities are child friendly, resourced and all the various categories of children are accessing these health facilities easily, including children living with disabilities.

e. For those community members who do not believe in getting treated at health institutions, the communities need to emphasize the benefits of doing so.

f. Programmes should support parents and teach positive parenting skills.

g. On-going care of children and families can reduce the risk of abuse and neglect reoccurring and can minimize its consequences.

Warning Signs of Abuse and Neglect

- Cuts and bruises
- Broken bones or internal injuries
- Burns
- Constant hunger or thirst
- Lack of interest in surroundings
- Dirty hair or skin, frequent diaper/nappy rash
- Lack of supervision
- Pain, bruising, or bleeding in the genitals
- More knowledge about sex than is normal for the child's age
- Hard-to-believe stories about how accidents occurred

Reporting Abuse and Neglect

Sometimes, people are afraid to report suspected abuse or neglect because they don't want to break up a family. Sometimes, people are afraid to get involved in someone else's problem. However, when you report suspected child abuse or neglect, you could be saving that child's life. The goal of stopping abuse and neglect is to keep children safe.

Report your suspicion to Police, a local or child protection agency (for example the local Child Protection Committee at the district level). Call a crisis hotline if one exists or report the abuse to the local police office.

You could also contact a member of Save the Children or CWGH staff who can give you advice on what to do about a case of abuse or neglect. See page 66 for contact details.

No child should have to live in fear of abuse or neglect. Help to stop it.

9.3 People living with Disabilities

The following MNCH Facilitators Guide participatory session can help to explain the information and address the issues in this section:
• Session 7: Stigma, Support and Self Value

Women living with disabilities

Adult women with disabilities are more likely to be victims of sexual violence than those without a disability. This leaves them with unwanted pregnancies and sexually transmitted infections. Some do not book their pregnancy at all resulting with complications during pregnancy and delivery. Other health problems experienced by older women that decrease physical and mental functioning include depression and dementia. These factors combine to increase vulnerabilities and reduce access to needed and effective health services.

MODULE 9

Children living with disabilities

Children living with disabilities are at greater risk of abuse and neglect than non-disabled children and are more prone to sexual, physical and emotional abuse. This includes abuse whilst being cared for in institutions like schools and health facilities. In general, the causes of abuse and neglect of children with disabilities are the same as those for all children.

Different types of disabilities have differing degrees of risk of exposure. Those with behaviour disorders face greater risk of physical abuse, whereas those with speech/language disorders are at risk of neglect.

Activity: Exploring issues of disability in the community

Why do this activity

- To develop an understanding of issues of disability in our community.
- To identify what support is being offered to children living with disabilities, and how this can be improved.

Approx Time: 30 minutes (or minimum 2 hours if you include the community mapping or transect walk)

Get participants into small groups to share and discuss the following questions:

- How many adults and children are there living with disabilities in your community? State the different types of disability that are in your community.
- What are the issues that face adults living with disability?
- What are the issues that face children living with disability? Are they different from those facing adults?
- How are children with a disability treated in your community?
- What activities are happening to support children living with disabilities?
- What else needs to be done to help?

Discuss these questions and the issues raised with the whole group in a plenary. Relate the discussion to the 'Rights of persons with disability' as defined in Section 83 of the Constitution of Zimbabwe (see box below).

If you have the time available to explore in more depth the issues around disability in the community, plan and carry out a community mapping or transect walk. These are described on page 19-21 of the Health Literacy Facilitators Guide.

Rights of persons with disabilities

Section 83 of the Constitution of Zimbabwe states that:
The State must take appropriate measures, within the limits of the resources available to it, to ensure that persons with disabilities realise their full mental and physical potential, including measures—

(a) to enable them to become self-reliant;
(b) to enable them to live with their families and participate in social, creative or recreational activities;
(c) to protect them from all forms of exploitation and abuse;
(d) to give them access to medical, psychological and functional treatment;
(e) to provide special facilities for their education;
(f) to State-funded education and training where they need it.

MODULE 9

ADDITIONAL REFERENCES

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5. Save the Children / Core Group / USAID (2010) Partnership Defined Quality – Monitoring & Evaluation Toolkit
6. World Health Organisation (2010) Guidelines on HIV and infant feeding. Principles and recommendations for infant feeding in the context of HIV and a summary of evidence.
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LIST OF ADDITIONAL ACRONYMS

CWGH	Community Working Group on Health
DFID	Department for International Development
ECD	Early Child Development
HCC	Health Centre Committee
HLF	Health Literacy Facilitator
HW	Health Worker
MNCH	Maternal, Newborn and Child Health
OVC	Orphans and Vulnerable Children
PLWH	People Living with HIV
SC	Save the Children International
SSS	Salt and Sugar Solution (Oral Rehydration Solution)
TB	Tuberculosis
VHW	Village Health Worker

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www.tarsc.org

The Community Working Group on Health is a national network of civil society and community – based organisations who aim to collectively enhance community participation in health in Zimbabwe. The CWGH was formed in 1998. www.cwgh.co.zw

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