Community Strengthening for a People Centred Primary Health Care System: The Case of Casa Banana Community in Zimbabwe

THIRD COMMUNITY MEETING REPORT

21st June 2014

Zimbabwe Association of Doctors for Human Rights (ZADHR)

Zimbabwe National Network of People Living with HIV (ZNNP+)
and the
Training and Research Support Centre (TARSC)

with the
Community of Practitioners in Accountability and Social Action in Health (COPASAH)

and the
Regional Network for Equity in Health in East and Southern Africa (EQUINET

With support from Open Society Foundations

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Cite as: TARSC, ZADHR and ZNNP+ (2014) Community Strengthening for a People Centred Primary Health Care System: The Case of Casa Banana Community in Zimbabwe; Third meeting report 21st June 2014. EQUINET, COPASAH, TARSC. Harare

Acknowledgements:
TARSC, ZADHR and ZNNP+ acknowledge with thanks Tatenda Chiware (ZADHR), Masimba Nyamucheta (ZNNP+), Barbara Kaim and Mevice Makandwa (TARSC) for facilitating this meeting, Barbara Kaim for her technical input in the design of this programme, and Edward Mutasa (CWGH)) for his presentation on the roles and responsibilities of HCCs. TARSC was responsible for photographs and compiling of this report. Special thanks to the Cassa Banana Community Health Committee for their energy and commitment in the implementation of this programme, and to COPASAH and Open Society Foundation for their financial support.

Cover photo: Participants in group discussion on the roles and responsibilities of members of the CHC

1. Background

This report documents a follow up meeting to the second community meeting held in Cassa Banana Community, Zvimba District, on 21st June 2014. The meeting is part of a programme facilitated by the Zimbabwe Association of Doctors for Human Rights (ZADHR) and the Zimbabwe National Network of People Living with HIV (ZNNP+), with support from the Training and Research Support Centre (TARSC) which aims to use participatory reflection and action (PRA) methodologies to strengthen community focused, primary health care oriented approaches to social accountability in health. The work in Cassa Banana follows training in PRA undertaken by TARSC in October 2013 in collaboration with the Community of Practitioners in Accountability and Social Action in Health (COPASAH) and the Regional Network for Equity in Health in east and southern Africa (EQUINET).

Cassa Banana community is a marginalised informal settlement, with a population of over 300 families, situated in Zvimba Rural District Council (ZRDC), approximately 30km west of Harare. While the community is part of the ZRDC, the residents live in wooden cabins which are the property of the Harare City Council who collect rents and rates from every household on a monthly basis. Both Councils deem the other to be the responsible duty bearer for the resettlement, resulting in neither council providing basic health and health – related services to the community. Consequently, residents of Cassa Banana remain underserviced in terms of their basic rights to health, clean water and sanitation, despite the fact that these rights are embedded in the new Zimbabwe constitution.

During the first community meeting, participants identified diarrhoea, gastro intestinal parasites and HIV as the major health challenges facing the Cassa Banana community. In order to address such health challenges, participants agreed that there was a need to form a Community Health Committee (CHC) to organise community actions for health. In addition they decided that it was necessary to form a support group for PLWHIV, and to identify youths who would volunteer to be trained as peer educators. Community members also resolved to conduct a de-worming exercise and to invite key duty bearers - namely the councillor, headman, local Member of Parliament, and officials from the Harare City Council and Zvimba Rural District Council - to the next community meeting.

During the second meeting, participants elected officials to the Community Health Committee and identified the need for skills training on the roles, functions and responsibilities of their CHC. This led to inviting a representative from the Community Working Group on Health (CWGH) to attend this third meeting to share their knowledge and experiences in the formation and establishment of Health Centre Committees (HCCs). 36 participants from the community participated in this third community meeting, facilitated by Tatenda Chiware from ZADHR, Masimba Nyamucheta from ZNPP+, Mevice Makandwa and Barbara Kaim from TARSC, and Edgar Mutasa from Community Working Group on Health. The objectives of this meeting were as follows:

- To conduct capacity building in the roles and functions of HCCs for the Community Health Committee, Peer Educators and members of the Support Group for PLWHA;
- To engage relevant duty bearers for improved dialogue and action in upgrading and resourcing service delivery in Casa Banana;
- To develop community-centred actions aimed at improving primary healthcare provision and accountability by duty bearers in Casa Banana.

2. Introductions and review of health problems

The Community Health Committee chair, Martin Musodza, started with a prayer, afterwhich participants introduced themselves for the benefit of those who were new to the meeting. Mr Musodza further reminded participants of the ground rules developed at an earlier meeting, including respect for each other's opinion, love, commitment to the activities of the meeting, time management, no politics, and to put all phones on silent.

The Community Health Committee Chairperson then went on to give a brief history of what had been achieved in the previous meetings, including a review of the three health problems identified by the community, and the root causes to these problems as summarised in the table below:

Table 1: Major health problems in Cassa Banana Community and their causes

Major problem	Root causes
Diarrhoea	Drinking of unsafe water, sewage flowing into burst water pipes, poorly maintained dumping sites leading to increased breeding of flies, non-maintenance of burst pipes and non-collection of rubbish bins
Worms/parasites	Poor sanitation
HIV/AIDS	Unprotected sex, lack of knowledge, unemployment and commercial sex

During this discussion, participants reiterated the need to work with the relevant duty bearers so that garbage could be collected regularly and to find a permanent solution to safe waste disposal and repairs of the burst water and sewer pipes. They noted that members of the community are doing their best to repair the burst pipes to ensure a clean water supply but, due to the state of the old pipes coupled with an increase in population and overcrowding, there is an urgent need for the relevant authorities to revamp the water and sewage system. Unfortunately, despite being invited to this meeting, the Councillor had excused himself at the last minute as he was attending to some family issues.

Burst sewer pipe close to the ablution block

Life in Cassa Banana

3. Capacity Building on the roles and functions of HCCs

Mr Mutasa gave a brief background to the Community Working Group on Health (CWGH), noting that the CWGH was formed in 1998 with the overall aim to promote and support active community participation in health in order to improve the health situation of people in Zimbabwe, especially at primary health care level. He explained that Health Centre Committees were first established in the 1980s as part of the Zimbabwe government's commitment to Primary Health Care. HCCs in the early years met with limited success due to economic and political developments that weakened the health system generally. In recent years, CWGH has been one of the lead civil society organisations working with the Ministry of Health and Child Care in supporting the re-establishment of Health Centre Committees (HCCs) at primary care level as a way to improve coordination and communication between health service and community representatives. This strategy has had some notable achievements. For example, HCCs in Nedziwe and Uzumba Maramba Pfungwe have each managed to build a clinic in their area.

Mr Mutasa expressed his commitment to sharing information at this meeting on the functioning of HCCs in the hope that it will clarify the roles and functions of the Cassa Banana Community Health Committee (CHC), called as such because there is no health centre in the area.

3.1 What are Health Centre Committees (HCCs)

A HCC is defined as a joint community- health service structure, linked to the clinic and covering the catchment area of a clinic (covering a ward or more). HCCs assist communities identify health problems, plan how to raise their own resources, organise and manage community contributions and tap available resources for community health activities. It is a mechanism for people to get involved in health service planning at local level. The Health Centre Committee and Village Health Worker (VHW) are mechanisms for participation as enshrined in laws enforced by the Ministry of Health and Child Care

Felder Chimanga, Cassa Banana Village Health Worker, taking notes

During discussion and in light of the above definition, participants to this meeting agreed that they cannot call their committee an HCC since they do not have a health facility in their area. The nearest health facility is in Dzivarasekwa Extension and falls under the Zvimba Rural District Council. They reiterated their unease about the confusion between the roles of the Zvimba Rural District Council, with their head office in Banket, and the Harare City Council to whom they pay their utility bills. Their current Councillor comes from Zvimba Rural District Council. Participants want representatives from both Councils to come to Cassa Banana to clarify the situation. They felt that the Dzivarasekwa Extension Health Centre should help deal with their health situation as they fall under them.

In the meantime, participants were in agreement that the existing Community Health Committee (CHC) in Cassa Banana is responsible for addressing health concerns in their area and in bringing these concerns to the relevant authorities. Mr Mutasa recommended that the CHC share their reports with the Dzivarasekwa Extension Health Centre so they know what is taking place in Cassa Banana.

3.2 Health Centre Committee Composition

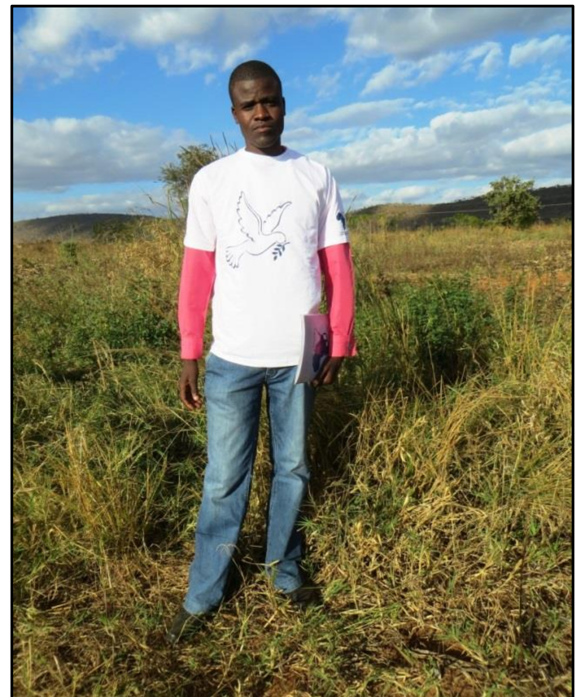
Mr Mutasa noted that the membership of an HCC can vary, but mainly consists of the following people:

- *Nurse in Charge of the health facility:* s/he will be the secretary of the committee. Due to her knowledge on health and her involvement in the planning of the health facility, she helps in clarifying certain issues which are relevant and unfamiliar to the committee.
- *Environmental Health Technician ('Tsanana'):* is the link between the community and the health facility and works on preventive health issues.
- *Kraal head ('Sabhuku'):* is the entry point into the community and is responsible for instilling community values and ensuring community support.
- *Councillor (Local Government):* who represents the community at local government level
- *Teacher/ head of school (Ministry of Education):* who ensures that the health needs of school-going children are met
- *Village Health Worker/ Health Literacy Facilitator/ Health Community Monitor*: These community-based health workers have an appreciation of the problems faced by the community; they are often involved in education campaigns and health literacy programmes and monitor the quality of service provision.
- *Youth Representative*: as tomorrow's leaders.
- *Representative from other service providers:* such as Zimbabwe Association of Traditional Healers Association (ZINATHA) and Apostolic sect
- *Other community leaders* as appropriate for the area

The above composition is what is expected by the MoHCC but each community has its own characteristics. So, an HCC may decide to include other community representatives – such as business people from the private sector - to help move the health agenda forward.

Mr. Mutasa also noted the following:

- ✓ The Chair of the HCC should come from one of the community representatives, and not from the health facility.
- ✓ The term of office of an HCC is two years,, but this can be extended by agreement
- ✓ The committee should meet once every month, more often if required.
- ✓ Minutes of the meetings held should be well documented and filed properly for future reference and record keeping.
- ✓ An attendance register should be kept, with apologies noted from those unable to attend.
- ✓ In event that there are disputes and misunderstandings between committee members, members have the right to say that they are failing to work with another.
- ✓ According to MoHCC guidelines, an HCC should be made up of no less than 11 people.



Martin Musodza, CHC Chairperson, standing by a burst water pipe

3.3 Roles and responsibilities of a Health Centre Committee

The participants were divided into three groups and were asked to come up with a list of the different roles and responsibilities of an HCC. They come up with the following roles and responsibilities:

Table 2: Group Presentation on the roles and responsibilities of HCCs

Group 1	Group 2	Group 3
• Coordinate the community to come up with actions plan • Teach the community about the basics of health, for example use of dumping pits for disposal of used pampers and condoms • Account for health issues affecting the community	• Teach people about health • Organise our community • Strengthen the relationship with health centre • See the challenges we are facing in our community • Improve living standards	• To see/observe matters arising about health issues • Find ways to solve health issues; do strategic planning • Network with all stakeholders • Identify orphans and vulnerable children • Ensure adequate access to health facilities • Organise health awareness campaign

Group work presentation on the role of HCCs

Following report back, Mr Mutasa outlined the responsibilities of health centre committees, as laid out by the MoHCC:

1. Bring community priorities into health plans
2. Ensure transparency on health resources, budgets and user fees
3. Organise community actions for health
4. Promote dialogue with health services on quality of care issues
5. Make claims on district level funds (health services fund and health transition fund)
6. Organise community inputs to health
7. Monitor quality of care

3.4 Functions of a Health Centre Committee

The functions of the health centre were spelt out as laid down by the MoHCC:

- Organise people to identify their priority health problems and to think what 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
- Use information from the health information system and communities in planning and evaluating their work
- Assess whether the health interventions in the area are making a difference to people's health
- Be a channel for information flow from the community to the Rural District Centre/ District Health Team and back to the community

It was noted that suggestion boxes could be used to pass relevant information to the CHC, to be opened and discussed on a monthly basis. The CHC and wider community also needs to understand the patient's charter, which outlines their rights and responsibilities. This includes: protecting the community and patients' right to privacy and confidentiality, tobe seen at a health facility for free, and the rights of patients to be transferred from one health facility to another when required. Participants were promised copies of the Patient's Charter at the next meeting.

Finally, Mr Mutasa advised the meeting that a health centre committee and community health committee are both legally binding. There is no legal provision for HCCs in Zimbabwe but HCC functions are enshrined in other legal documents, as outlined in the table below. Zimbabwe is currently negotiating a new legal instrument which CWGH hopes will make HCCs explicitly recognised.

Table 3: HCC functions and laws that support them

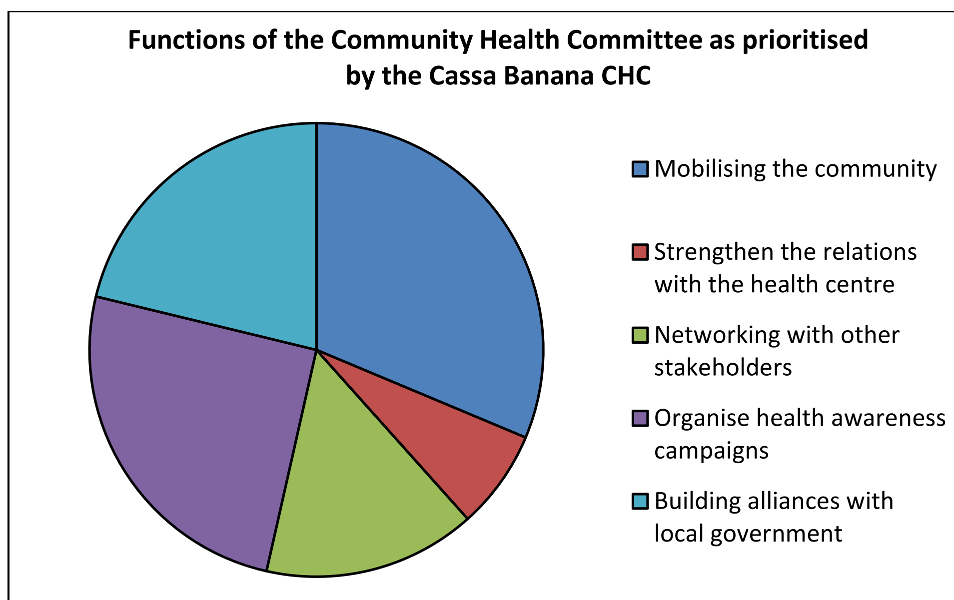
Function	Law/ policy support
Identify health needs and mobilising community participation	Public Health Act 1980 District Councils Act 1988 Rural District Councils Act 2009-2015 National Health Strategy
Local resources mobilisation	1984-1985 Prime Minister's Directive On Decentralisation 2009-2015 National Health Strategy
Information channel on other health providers	Public Health Act Health Services Act 1988 Rural District Councils Act
Information channel between communities and services	Public Health Act Health Services Act 2009-2015 National Health Strategy
Represents communities in health service issues	Public Health Act Chapter 15 (Duties and Roles) Health Services Act 2005
Coordinate health programmes and local government promotion of public health	Provincial and Administration Act 1985 National Health Strategy 2009-2015

3.5 Functions of the Community Health Committee in Cassa Banana

The participants went on further and come up with five major functions that they envisaged were critical to their situation. Through voting they came up with a list of what they consider to be the most important functions in order of importance.

Table 4: Functions of the CHC as prioritised by participants

Functions	Votes/score	Priority
Mobilising the community	31	1
Organise health awareness campaigns	25	2
Building alliances with local government	21	3
Networking with other stakeholders	15	4
Strengthen the relations with the health centre	7	5



From the above pie chart it shows that mobilising the community was the most important function of the CHC, followed by organising health awareness campaigns, building alliances with local government, and networking with other stakeholders. Strengthening relations with the health centre was voted as the least important function because the nearest health centre is too far away from the community.

4. Closing

In closing, it was noted that the CHC need to come together in the near future to finalise their action plan, since they did not manage to complete this task during this meeting. A decision was taken to do this in conjunction with a short training on participatory facilitation skills and methods in participatory reflection and action (PRA). The CHC Chairperson thanked the facilitating team for their time and effort. As participants they had gained a lot of knowledge and insight in dealing with their problems in the community.

Appendix 1: Meeting Programme

TIME	ACTIVITY	FACILITATOR
08:30 – 09:00	Registration of Participants	All
09:00 – 09:10	Welcome Remarks and Introductions	Masimba
09:10 – 09:20	Minutes of Previous Meeting / Matters arising & Action Points	Participant
09:20 – 09:30	Activity Background	Tatenda
09:30 – 10:00	Review of action/work undertaken since the last meeting • Support group formation • Health Committee formation • Peer Educators Committee	Volunteer Participants
10.00 – 10.15	**TEA BREAK**	
10:15 – 10:00	Capacity Building of: • The Health Centre Committee • The Peer Educators Committee • The Support Group of PLWHA	CWGH ZNNP+ ZADHR TARSC
01:00 – 02:00	**LUNCH BREAK**	
02:00 – 02:30	Refinement and review of programme progress markers	Participants and Facilitators
02:30 – 03:00	Plenary Session: To develop community centred actions aimed at improving primary healthcare provision and accountability by duty bearers in Casa Banana Community	Participants and Facilitators
03:00	Closing Remarks	

Appendix 2: Participants List

No.	Name	Surname	Committee Involvement	ID	Phone
1.	Martin	Musodza	Chairperson CHC	32-144814P47	0774415652
2.	Rambisai	Mbarire	Vice chairperson CHC	32-144119J32	0773710622
3.	Thomas	Chivese	Secretary CHC	63-1202958W43	0777557417
4.	Pamela A	Wachipa	Vice secretary CHC /Peer Ed	86-04136T86	0772819726
5.	Milton	Ncube	Treasurer CHC	32-146611S73	0775409336
6.	Charles	Masvosva	Committee member	63-1130169C07	0773032591
7.	Auxilia	Muzondidya	Committee member	83-058697R83	
8.	Felder	Chimanga	Village Health Worker	32-079532F24	0775612552
9.	Milliam	Ncube		32-146510H73	
10	Patience	Mupandu	HIV Support Group	24-113155A26	0736337636
11	Jennifer	Gara		63-764044S42	0773136255
12	Sithokozile	Moyo		03-048542G03	0714616586
13	Sifikile	Banda		63-1169689J63	0737782925
14	Misheck	Mharadze	Peer Educator	86-077935X26	0739569501
15	Leeroy	Dhumukwa	Peer Educator	63-1489798D07	0778231036
16	Stella	Mutasa	Peer Educator	86-063661G50	0771519394
17	Shupikai	Sinhali	Peer Educator	85-063416Q85	0736850610
18	Brenda	Tauro	Peer Educator	63-1558284V63	0775409336
19	Nomatter	Nyabani	Peer Educator	86-062502X86	0733361325
20	Elisa	Rembani	Peer Educator	32-14671W32	
21	Mitchett	Ncube		63-1558598L73	0779257123
22	Tracy	Matibiri	HIV Support Group	38-074441L71	0775343853
23	Fumisai	Hlanga	HIV Support Group	12-046135Z12	0737209088
24	Muchanyara	Denhere		63-973997C48CH	0734875529
25	Austine	Watch	HIV Support Group	63-444071W63	0712036861
26	Edmore	Chikaka		63-487925W70	0773704482
27	Percy	Nyama		63-165388E24	0733603701
28	Mark	Chipungo		32-154578D71	0715825912
29	Betty	Chipangura		27-146676F27	0775568957
30	Naome	Madho		83-050809S83	0779257123
31	Chipo	Mahodobi	HIV Support Group		0712693028
32	Talkmore C	Rwanyanya	Member	63-2035682F27	0776754270
33	Beauty	Rwanyanya		63-379062J27	0773027818
34	Tinashe	Motsi			0774124046
35	Regina	Deda		47-057774D47	
36	Edgar	Mutasa	CWGH HCC Facilitator		0775502750
37	Really	Makainganwa	ZNNP+ Focal Person	70-113247A70	0773185245
38	Maimba	Nymucheta	ZNNP+		0716041240
39	Mevice	Makandwa	TARSC		0772234646
40	Barbara	Kaim	TARSC		0772395523
41	Tatenda	Chiware	ZADHR		0773063256

Appendix 3: Abbreviations

CHC	Community Health Committee
CWGH	Community Working Group on Health
HCC	Health Centre Committee
MoHCC	Ministry of Health and Child Care
TARSC	Training and Research Support Centre
VHW	Village Health Worker
ZADHR	Zimbabwe Association of Doctors for Human Rights
ZINATHA	Zimbabwe Association of Traditional Healers Association
ZNNP+	Zimbabwe National Network of People Living with HIV