Reflections on actions and learning from participatory work on health in Cassa Banana, Zimbabwe

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In cooperation with the
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and the
Cassa Banana Community Health Committee

in the

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Photos by: Cassa Banana Community Photographers, and as acknowledged.
Cover photo: © Dephine Hondongwa, Cassa Banana community photographer, 2015

A short forward: what this report is… and what it isn't. This report sets out to list the activities, successes and challenges faced in Cassa Banana over the last two years. It also seeks to document some of the 'sticky' issues faced by those who work in or with marginalised and disenfranchised communities such as Cassa Banana. It attempts to reflect honestly on problems faced, and raises a number of complex issues without trying to find all – or even some – of the answers to those issues. The hope is that at least a few of the points mentioned in this report will stimulate further discussion and action – in Cassa Banana and other communities in Zimbabwe and in the region, in TARSC, ZADHR and other civil society organisations and public personnel engaged in participatory work at community level, and finally in the pra4equity network in EQUINET which has been a guiding force in this work for over 10 years.

In 2014, the Zimbabwe National Association of People Living with HIV (ZNNP+) was also involved in this programme, specifically to strengthen HIV prevention and support services in Cassa Banana. This report focuses on the work on water and sanitation, and the work on HIV is separately documented.

1. Background

Over the last two years (2014-2015), the Training and Research Support Centre (TARSC), in cooperation with the Zimbabwe Association of Doctors for Human Rights (ZADHR), has been building a programme that aims to foster local and national dialogue to build active citizenship and public and private accountability on water and sanitation, as a key element of primary health care. The work draws on experiences and learning arising from the Health Literacy programme and pra4equity network within the Regional Network on Equity in Health in east and southern Africa (EQUINET). It draws on work of TARSC and the Zimbabwe Association of Doctors for Human Rights (ZADHR), a local organization with a commitment to ensuring the right to health as based in the Zimbabwe constitution. Working in Cassa Banana informal settlement on the outskirts of Harare, the programme has used participatory approaches to work with and through a representation of community members – an elected Community Health Committee (CHC) - to explore and document the health challenges faced by the Cassa Banana community and to formulate actions to solve these challenges. The project also sought to support community action in demanding accountability from the relevant duty bearers in the formulation and delivery of health services, and to strengthen community/stakeholder engagement for the provision of people-centered Primary Health Care (PHC) services to the Cassa Banana community.

Cassa Banana is a marginalised informal settlement, with a population of approximately 850 people. It is situated in Zvimba Rural District, approximately 30km west of Harare close to the town of Norton. While the community is part of the Zvimba Rural District Council (ZRDC), the residents live in wooden cabins which are the property of the Harare City Council (HaCC). The council aims to collect rents and rates from every household on a monthly basis. After some initial dispute as to whether the ZRDC or HaCC were the responsible duty bearer, it is now clear that the latter is accountable to the people living in Cassa Banana for ensuring their right to health and in providing clean water and sanitation. These rights are embedded in the 2013 Zimbabwe Constitution.

Despite these rights, Cassa Banana, remains sorely underserviced. The 850 men, women and children live in badly ventilated, leaking one-or-two-bedroomed wooden cabins. There are two ablution blocks in the community which include 48 toilet holes, 4 showers and 5 working taps for drinking and laundry. The sewage system overflows because it is not connected to the main city lines and sewage sometimes seeps into the water supply through the broken water pipes. Council trucks have not come to Cassa Banana in a number of years to collect rubbish.

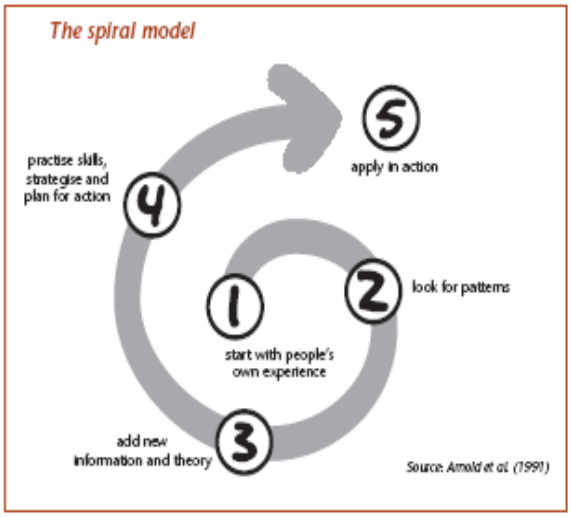
Not surprisingly, during community meetings residents identified intestinal parasites and diarrhoea as two of their major health problems. The nearest public sector clinic is in Kuwadzana, 20 kms away.

Aerial view of Cassa Banana

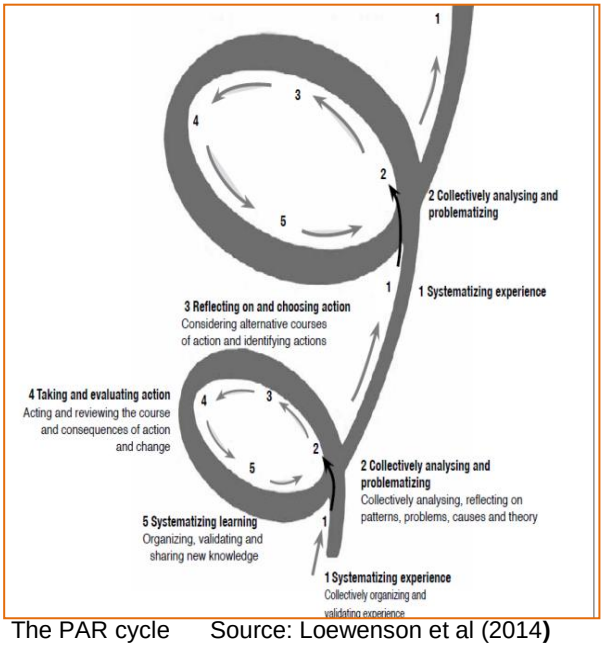
This paper explores the Cassa Banana residents' response to this situation over the last two years, with a particular focus on the role of the Community Health Committee (CHC) in meeting community health needs and in trying to strengthen relations with the HaCC and other key stakeholders. In doing so, the paper reflects on the successes and challenges faced by the CHC, and looks at issues of leadership, social cohesion and power within the community as key components to the successful mobilisation of a diverse and fractured community in trying to get its needs met. It ends by recommending possible actions to deal with the problems identified and comments on the extent to which the challenges faced in Cassa Banana can be generalised to other communities in Zimbabwe.

2. PRA and PAR – our approach

In the early part of this programme, the facilitation team (TARSC and ZADHR) were closely following the methods and tools described in a Participatory Reflection and Action (PRA) manual 'Organising People's Power for Health: Participatory Methods for a People-Centred Health System' (Loewenson et al., 2006). This was the manual TARSC used during a 5-day regional training on PRA (TARSC 2013) attended by ZADHR and which kick started the programme in Cassa Banana. In line with the PRA spiral model introduced to partners during the training, the work in Cassa Banana centred on a continuing cycle of action and reflection, with each new action generating new learning that was expected to deepen the type of actions that followed.



The programme thus began with a series of community meetings that identified key priority health problems (using such tools as the social map, ranking and scoring, problem tree and market place), saw the formation of the Community Health Committee (CHC) in June 2014, and their development of an Action Plan and set of progress markers which the CHC used to measure progress over time. The objectives and progress markers developed by the Cassa Banana CHC in June 2014 and subsequent actions are well documented in previous PRA reports (see References)



The PAR cycle Source: Loewenson et al (2014)

In the latter part of 2015, TARSC began exploring ways in which the Cassa Banana CHC could start becoming more systematic in learning and documenting from their actions, under an approach called Participatory Action Research (PAR). PAR embraces many of the same concepts of participation, reflection and action in PRA. But, as shown in the diagram opposite, in PAR the work is deepened by systematising the learning and knowledge built from actions, and by consciously attempting to build new knowledge that can be documented, disseminated and shared in various forms - visual, written and/or verbal. In PAR, control of knowledge creation shifts toward those affected by the problem so that the traditional split between those who research and those who are researched falls away: instead the 'researcher' is either part of the affected community or, if an outsider, plays more of a facilitation role. As in PRA, PAR continues to challenge social and institutional structures and processes that oppress, disempower and undermine health, with a view to transforming them (Loewenson et al 2014).

The PAR work initially centred on a participatory tool called Photovoice. In Photovoice, control of knowledge creation is handed over to community photographers who are given the freedom to take photographs that reflect the realities, experiences and concerns of their community. Photovoice follows elements of the PAR cycle in that it aims to support community efforts to analyse problems and their causes through the visual image which, in turn, leads to specific actions embedded in the local context. Ideally, both the experience of taking the photos and the use of the photos themselves lead to further analysis, learning and action. This paper will discuss later how Photovoice was used in Cassa Banana and reflect on its use as a PAR tool.

The component of work that focuses on moving from action to learning in PAR is still in its early stages in Cassa Banana and, as will be reviewed further on in this report, deserves greater attention in the coming year/s.

3. Activities and initial reflections

As outlined in the previous section, the first few months of work in Cassa Banana focused on supporting community efforts to identify their priority health problems and to strengthen community structures and leadership in order to successfully implement community-identified actions. This led to the formation of the Cassa Banana Community Health Committee (CHC) and the development of an Action Plan with related progress markers. Implementation of the Action Plan saw the CHC involved in a number of activities over the next 18 months (June 2014 – December 2015), broadly defined under 3 main objectives, that is:

1. To improve the water and sanitation situation in Cassa Banana.
2. To build alliances with local government.
3. To build alliances with other stakeholders in supporting the activities of Cassa Banana.

Activities included the following:

- An intensive CHC training in mid-2014, organised by ZADHR and with the assistance of the Community Working Group on Health (CWGH), on the functions, roles and responsibilities of a Health Committee; the CHC underwent a refresher course in October 2015.
- A number of community meetings led by the CHC and with support from the Cassa Banana Residents Committee which, through the use of theatre, dance and other participatory tools, aimed to increase the health literacy of the resident population.
- Bimonthly (approximately) clean-up campaigns in which the CHC encouraged community members to get involved in collecting refuse, digging new dumping pits and cleaning the communal toilets. The CHC also organised daily clean-ups of the ablution block, working with and through a City of Harare employee based in Cassa Banana.
- Community members, under the leadership of the CHC, periodically taking responsibility for repairing burst water pipes and emptying overflowing sewage tanks using their own labour and resources.
- Four HIV and AIDS awareness campaigns in 2015 (reported separately by ZADHR).

Polluted water outside the ablution block © Community photographer

Keeping our community clean

© Community Photographers (clockwise): L Dhumukwa, P Dimingo, T Rwanyanya 2015

- Strengthening relations with a private clinic - BevKing Clinic - close to the community who is offering outpatient health care services with consultation fees comparable to the public sector clinic which is 20kms away.
- Two deworming exercises, facilitated by ZADHR and the Ministry of Health.
- A series of meetings with the District Officer (DO) for Kuwadzana District which helped to strengthen relations with the District Office and led to the DO clarifying the support the Council could give Cassa Banana in meeting their health and environmental needs (see below).
- Under TARSC's guidance, 9 community members were trained as community photographers using a PAR tool called Photovoice. The photographers took 100s of photographs reflecting the lives and struggles in their community which they then self-edited to be included in a 12-page advocacy booklet that described their community, their main challenges and what they are already doing about it, ending with a request for assistance to purchase the needed materials to undertake basic repairs to the water and sewage system in Cassa Banana.
- The CHC, with ZADHR assistance, developed a plan and budget as an addendum to the advocacy booklet and used both to engage with a range of stakeholders from both the public and private sector, including the Director of City Health Services in Harare, non-governmental organisations such as UNICEF, as well as a number of local companies to garner material support.
- At the end of 2015, the Cassa Banana CHC, ZADHR and TARSC met for one day to review the successes and challenges faced in the previous year and to set priorities for 2016.

While this list of activities looks impressive and indicates a degree of community leadership and organising, it does not reflect the major challenges the CHC faced during this period of implementation. Cassa Banana residents mostly live a precarious existence with high unemployment and very few safety nets in times of stress. While they have managed to pull together small amounts of resources for collective benefit – for example, in pooling together small amounts of money to purchase needed appliances to maintain their electricity supply – this cannot happen on a routine basis. During regular

reflection sessions (both formal and informal), the CHC noted that with no reliable financial resource pool to draw on, clean-up campaigns are usually done without the necessary equipment (such as cleaning detergents or safety gloves) or tools. Advocacy work is dependent on outside assistance to provide transport and communication costs.

The reality is that most of the activities undertaken by the CHC involve doing the work which is ultimately the responsibility of the City Council. The District Officer in Kuwadzana admitted this, acknowledging to the CHC that the Council has no resources to repair burst water pipes or fix the sewage or bring trucks in to collect the community's rubbish. She did, however, offer to assist with the labour if the community could purchase the materials needed (budgeted by the CHC to the amount of USD 3 500) to do the necessary repairs. This explains why the CHC started in earnest an advocacy and fund raising drive. And this drive was undertaken despite CHC calculations that the City Council receives an estimated USD 3 000 per month from the approximately 50% of residents who manage to pay their rates at USD17 per month per room.

This has a direct impact on community members' (lack of) motivation to get involved in CHC activities. The CHC is caught between, on the one hand, a disgruntled community who expect more outside support - if not from the District Council then from other outsiders such as ZADHR or TARSC - and, on the other hand, a local authority who is unable and/or unwilling to meet their constitutional obligations. This is further exacerbated by political divisions along party lines with certain members of the community abstaining from CHC activities because they believe the CHC is affiliated to 'the wrong' political party.

Consequently, overall community participation in meetings and activities such as clean-up campaigns is often quite low (although it has been improving over time) with CHC members and community photographers (in some cases, the same people) taking a major role.

The CHC is aware of these difficulties but is often not sure how to respond. They acknowledge that, despite the training they received, they still lack the necessary skills and experience to successfully mobilise such a fractured community; just as they also acknowledge that they have made mistakes in not setting up clear reporting mechanisms to ensure that everyone involved knows what they are doing, who they are working with and what finances are involved. As a result, there have been times when the primary role of the CHC - to represent community voice on needs, actions and priorities to improve health in their interaction with health services and other actors – has been lost. Instead, sections of the community have had expectations that ZADHR and TARSC were in Cassa Banana to solve their problems, rather than to assist in helping them become more informed and organised.

CHC meeting © T Chiware 2015

Despite these challenges, the CHC have had some noticeable victories. The foremost was in clarifying the confusion in roles and responsibilities between the rural and urban councils (ZRDC and HaCC) so that the CHC was then able to engage with the correct duty bearer (the HaCC) to try to get their needs met. They have a distinct voice and role as the health 'monitors' in the community, have the support of the Residents Committee, and have strengthened links with other stakeholders in the surrounding area and in Harare. The photographs taken through the Photovoice programme have given them an alternative voice to articulate their views and demands, and tapped into a new level of creativity in the community. Women members of the CHC have become more vocal, especially in demanding greater accountability within the CHC. The CHC has a matured understanding of what is in their power to change (increase community involvement – with challenges) and what is not (limited role of local authorities in providing services and improving their environment). As a result of these successes, members of the CHC are clearly more confident and articulate than at the start of the programme.

4. Deepening reflections and building new knowledge

In October 2015, the full Cassa Banana Community Health Committee and community photographers met with TARSC and ZADHR to discuss and reflect on progress to date, and to make some decisions on priority areas of action in the coming year. Their initial reflections are, in large part, documented in the previous section of this report. After listing their main successes and constraints, they went on to dig deeper into the underlying reasons behind the challenges they have faced, and continue to face, in realising their objectives. This resulted in some important new learning which, in turn, influenced their thinking on priority areas of work in 2016.

The first learning focused on recognising that both the Committee and community as a whole have been over emphasising the measurement of success in terms of concrete results ('outputs' such as improved access to clean water and a solution to the overflowing sewage system) to the detriment of a more community-oriented approach that focuses on building community health literacy, community ownership and cohesion. This is certainly a challenge, especially in an environment where members of the community have come to expect outsiders to fix the problem on their behalf, based on previous experience with funders; where they are a heterogeneous group, coming from different parts of the country; where there are continual social and economic pressures that divide the community; and where certain members of the community are overtly not cooperating with the CHC for political reasons. Despite the fact that residents of Cassa Banana have a shared set of needs (wanting improved health and well-being) and grievances (in this case, limited access to clean water and improved sanitation, as well as little action on the part of the local authorities), they have yet to develop a consciousness where collective organising and action – a sense of community solidarity - is recognised as the most enduring path to reaching their shared goals.

This points to some important learning in the way PRA and later PAR was implemented in Cassa Banana. In retrospect, it can be seen that the facilitators did not spend enough time both with the CHC and the wider community in analysing the problems and their causes beyond the more material issues that came to dominate the work of the CHC over the last year. The Action Plan that the CHC developed in 2014 was well grounded in the reality of Cassa Banana residents' lives, and the progress markers included a number of strategic issues that aimed to build stronger collective organising and action, such as regular community meetings and discussion and improved relations with relevant local authorities. The move toward a more 'project' mode, however, reflects a weakness in the analysis of the actions, and in the phase in the PAR cycle that focuses on "reviewing the course and consequences of action and change" leading to the "organising, validating and sharing of new knowledge".

Reflection leading to action - the PAR process © B Kaim 2014

The Photovoice component of the PAR work is an interesting example of how important it is to move from action back into deeper reflection and learning. Throughout the Photovoice process, photographers were reminded that it is not the photographs themselves that create the change, but how they are used as evidence for the change they want. Ultimately, the strength of the Photovoice approach lies in the social action plan in which it is embedded, in the degree of dialogue taking place between key players in relation to the messages conveyed through the visuals, and in the advocacy skills of those using the photographs.

Photographer in action ©Community photographer P.Wachipa 2015

This has only been partially realised. At the October 2015 final review meeting, the nine community photographers were unanimous in saying that this component of work was life changing in that it gave them a valuable skill and an alternative voice for describing community issues. There was also general agreement that the advocacy booklet, the main output of the Photovoice work to date, was an important document that represented community interests and concerns. It was especially important for CHC attempts to solicit funds for their project work and as an advocacy tool when engaging with Local Authorities. The component that is still missing is deeper discussions on the learning coming out of this work, asking questions such as: *has the process of taking and using the photos deepened understanding on underlying conditions related to the social determinants? has the process changed relations and/or levels of organising between community members (photographers and non-photographers alike) and if so in what way? and what impact has use of the booklet had in facilitating changes in interactions with policy makers?*

Reflections on these issues will deepen our collective understanding of the potential of Photovoice as a tool for change. It may help to facilitate Cassa Banana residents into a new way of thinking about their next round of actions.

Intrinsic to the above discussion is the question of how the distribution of power between social groups and institutions either enable or constrain change. The October 2015 meeting explored this issue through discussion on the different forms of power, as being:

- *Power over* – referring to the power of the strong over the weak, including the power to exclude others;
- *Power to* – where individuals or groups of people exercise agency and begin to realise their rights and their capacity to act;
- *Power with* – which is a more collective form of power through organisation, solidarity and joint action to counter injustices; and finally
- *Power within* – where people have gained a sense of self-identity, confidence and awareness often linked to culture, religion or other aspects of identity and which influences their thoughts and actions. (Gaventa 2006; Kaim 2013).

Residents in Cassa Banana are only too aware that in many situations in their lives they are left feeling powerless. This takes a number of forms and at multiple levels – psychological, household, cultural, institutional, economic/access to resources, governance. The CHC felt keenly that when people are denied access to services like health care, or are told for the last 20 years that they would eventually be given land in a more developed area in Harare with no tangible outcome, then this is an abuse of institutional power. So it came as an important insight at this meeting to see that there were other forms of power that are more liberating. The last three definitions of power – 'power to, with or within' – are all forms of power that have the potential to resist the domination of 'power over'. Identifying these forms of power reinforced the notion that the CHC needs to further strengthen the collective process – to build greater understanding at community level of the social and institutional structures and processes that disempower and undermine health, and to find new strategies for overcoming these barriers.

In part, this also involves consciously linking up with other groups outside of Cassa Banana – community organisations, resident associations, rights groups, legal institutions – to overcome the sense of isolation the Cassa Banana leadership feel in their struggle to get their community's health and other rights met. The CHC recognises that it is important to continue trying to get the funds needed to repair the burst water pipes and to link the septic tanks to the main sewage system. They understand that this will probably have to be done through private donations. But, as shown in the section below, building collective power in Cassa Banana must also go hand in hand with building a stronger network of people and organisations that work with the Cassa Banana community in demanding services and greater accountability from the City Council.

5. Looking ahead into 2016

As a starting point, the CHC has defined a set of principles for how they want to work in the coming year. These are outlined in the box below.

Cassa Banana CHC Basic Principles for Implementation of Activities – 2016
(developed both at the 2015 review meeting and in further discussions in early 2016)

- Try to improve community participation, ownership and collective learning. Explore ways of mobilising a larger number of residents to get involved in meeting our collective needs. We recognise that this is a long process which needs to be integrated into all activities, using PAR approaches.
- Don't wait for outsiders to come in to solve our problems – for example, we can organise clean-up campaigns without outside support.
- At the same time, we need to continue engaging with the Harare City Council to demand they provide the services we expect as rate payers.
- Commit ourselves as leaders in the CHC to greater transparency in what we are doing, and what resources we have at hand; continue with our non-partisan approach to leading the community.
- Improve community involvement in decision-making.
- Develop our 'power with' and 'power within' in order to overcome the 'power over' us. We will explore ways of doing this effectively in our relationships at community level, and with existing and new partners.
- Continue to document – with our cameras, in the stories we need to tell, with support from our partners.
- Develop new partnerships with institutions that are strategically placed to help us network with other communities and/or organisations in getting our health and other basic rights met; to share our experiences and learning with others, and to learn from them.

In terms of implementing these principles, there has already been some movement in the early months of 2016. Three developments stand out for the CHC:

- In mid-January there was a period of five days when municipal water ran dry in the community. Individual householders were going to a near-by well to collect water for their own household needs. In the first few days, only the CHC members took responsibility for cleaning the communal ablution blocks. After a couple of days, the CHC organised for every household to contribute one bucket of water per day for cleaning the toilets. Women collected the water and the men did the cleaning, thus involving the whole community in a shared action with collective benefit. Participation in clean-up campaigns are also on the increase probably because of a growing, but as yet unarticulated, understanding of the 'power with'.

- A female member of the CHC was selected to participate in a one month leadership immersion with other young women at Kufunda Village outside Harare. Kufunda Village is a learning centre that is exploring what it takes to build healthy, vibrant communities through working with the diversity and wealth of every person that makes up that community. The one month immersion programme aimed to create a safe space for participants to build personal and community leadership skills. The CHC endorsed the member's participation in this programme, seeing it as an important step toward

building their collective skills, and in making links with others seeking answers to some of the questions they are asking.

- Members of the CHC have continued to meet with local authorities and possible external funders in trying to get resources to improve the water and sanitation situation at Cassa Banana. One external funder in particular has expressed an interest in supporting the community, still to be confirmed. The CHC wants to make sure that the support is in line with their action plans.

As we move into 2016, TARSC plans to continue working in Cassa Banana in supporting the community and the CHC leadership in building relationships and alliances with other organisations that can work with them to advance their right to health. We will especially focus on the use of PAR to further synthesize community level evidence on the implementation of public health rights and entitlements, and to enhance participatory community level actions on holding duty bearers accountable. Based on the learning to date from the use of PAR, we will strive to be more strategic in terms of what needs to be done to unblock the barriers to change in Cassa Banana - at community level. We will do this in terms of the processes we use, and how we move from taking action to reflecting on lessons learnt.

ZADHR will also continue to work with the Cassa Banana community in conducting various programmes aimed at improving access to HIV/AIDS information and services. Activities include CHC meetings, community dialogues/ speak out sessions on HIV and related health issues, Join in Circuits (JIC) runs, community meetings and refresher training with the CHC. Collectively, these activities aim to raise the health literacy of the community, to bridge the gap between the community, the health facility and other stakeholders (including councillors, village heads, religious leaders, youth and PLWHIV), and to progress the community action plan through the leadership of the CHC. The Join-In Circuit (originally developed by the German Federal Centre for Health Education) will focus on behaviour change communication to improve interpersonal communication on HIV and sexual and reproductive health.

Join-In Circuit community meeting ©Community Photographer P. Domingo

It is hoped that this next year will be a time of growth for the Cassa Banana CHC and the community as a whole, and that the actions they take will enable them to contest the institutional power imbalances that undermine their wellbeing. Considering the political and economic uncertainty in the country, it will not be an easy time. But this may bring opportunities for connecting with other communities also in need. The issues that the Cassa Banana community are exploring are not particular to them. This may thus be just the time, with the right partners, to find a path in which actions can make a difference and become potentially transformative.

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Acronyms

CHC	Community Health Committee
CWGH	Community Working Group on Health
DO	District Office/ District Officer
EQUINET	Regional Network for Equity in Health in East and Southern Africa
HaCC	Harare City Council
PAR	Participatory Action Research
PLWHIV	People living with HIV and AIDS
PRA	Participatory Reflection and Action
RC	Residents' Committee
TARSC	Training and Research Support Centre
ZADHR	Zimbabwe Association of Doctors for Human Rights
ZESA	Zimbabwe Electricity Supply Authority
ZNNP+	Zimbabwe National Network of People living with HIV and AIDS
ZRDC	Zvimba Rural District Council

Appendix 1: List of CHC members and community photographers

Name	Position
Martin Musodza	Chairperson CHC; community photographer
Paradzai Dimingo	Chairperson RC; community photographer
Rumbisai Mbarire	Vice Chair CHC
Thomas Chivese	Secretary CHC
Pamella Wachipa	Vice Secretary CHC; community photographer
Talkmore Rwanyanya	Treasurer CHC; community photographer
Auxillia Muzondidya	Member CHC
Charles Msvosva	Member CHC
Dephine Hondongwa	Community photographer
Mitchel Ncube	Community photographer
Ruth Waeni	Community photographer
Leeroy Dhumukwa	Community photographer
Misheck Mharadze	Community photographer

Cassa Banana Community Photographers

Equity in health implies addressing differences in health status that are unnecessary, avoidable and unfair. In southern Africa, these typically relate to disparities across racial groups, rural/urban status, socio-economic status, gender, age and geographical region. EQUINET is primarily concerned with equity motivated interventions that seek to allocate resources preferentially to those with the worst health status (vertical equity). EQUINET seeks to understand and influence the redistribution of social and economic resources for equity oriented interventions, EQUINET also seeks to understand and inform the power and ability people (and social groups) have to make choices over health inputs and their capacity to use these choices towards health.

EQUINET implements work in a number of areas identified as central to health equity in east and southern Africa

- Protecting health in economic and trade policy
- Building universal, primary health care oriented health systems
- Equitable, health systems strengthening responses to HIV and AIDS
- Fair Financing of health systems
- Valuing and retaining health workers
- Organising participatory, people centred health systems
- Social empowerment and action for health
- Monitoring progress through country and regional equity watches

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