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

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)

in 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)

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Through institutions in the region, EQUINET has been involved since 2000 in a range of capacity building activities. This report has been produced within the capacity building programme on participatory action research for people centred health systems. It is part of a growing mentored network of PRA / PAR work and experience in east and southern Africa, aimed at strengthening people centred health systems and people's empowerment in health.

Acknowledgements: This report is a summary of field reports written by Tatenda Chiware and Calvin Fambirai (ZADHR), Masimba Nyamucheta (ZNNP+) and Mevice Makandwa (TARSC) with technical input from Barbara Kaim (TARSC). We thank Really Makainganwa (ZNNP+) and Edgar Mutasa (CWGH) for sharing their skills and experience with members of Cassa Banana, to COPASAH and EQUINET for training and technical input, and to Open Society Foundations for providing the funding needed to work with the community of Cassa Banana. Most of all, we express our appreciation to the Cassa Banana Community Health Committee and other community members for their energy and commitment to the work they are doing to improve their living environment.

Cover photo: Members of the Cassa Banana Community Health Committee in discussion on their roles and responsibilities, TARSC 2014

1. Background

This report documents work undertaken in Cassa Banana Community 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), from February – July 2014. The programme aimed to use Participatory Reflection and Action (PRA) methodologies in working with members of Cassa Banana to strengthen community focused, primary health care oriented approaches to social accountability. The work follows a PRA training facilitated by TARSC in October 2013 and undertaken 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) (TARSC 2013)

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 (HCC) who collect rents and rates from every household on a monthly basis. Both Councils consider the other to be the responsible duty bearer for the resettlement, resulting in neither council providing basic health nor health–related services to the community. There is no primary health care facility within Cassa Banana. Consequently, residents of Cassa Banana remain underserviced in terms of their right to health, clean water and sanitation, despite the fact that these rights are embedded in the new Zimbabwe constitution.

The project began in February 2014. It aimed to use Participation Reflection and Action (PRA) techniques to work with a representation of community members and health providers/authorities to explore and document the health challenges faced by the Casa Banana community and to formulate actions to solve these health 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 Casa Banana community.

The programme included 3 rounds of community meetings involving representatives from the community, the health facility and other stakeholders. Early on in the process, the community elected a Community Health Committee (CHC) which became the focal point for organizing activities between each of the meetings, further supported by ZADHR, ZNNP+ and TARSC in providing training and technical support in participatory facilitation, community organizing and community monitoring skills, in defining the role of a CHC, and the development of an action plan.

A view of Cassa Banana, TARSC 2014

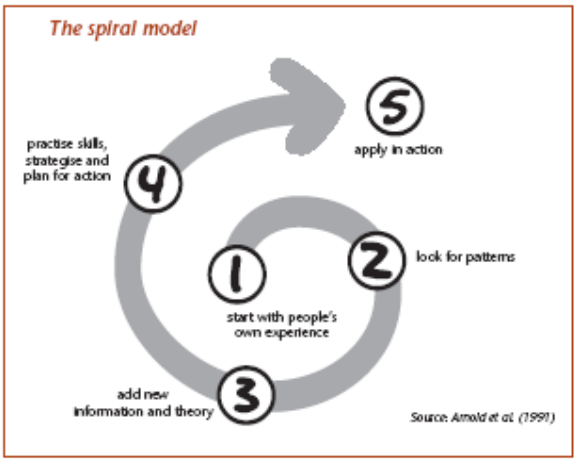
This first phase (February – July 2014) ended with the CHC developing an Action Plan and progress markers to be used as a guide for implementation of the next phase of work in the community.

This report documents the process used during the 6-month implementation period, highlighting actions undertaken and an assessment of the successes and challenges faced. It ends with a description of the Action Plan and outlines plans for the next phase of the programme.

2. Methodology

The facilitation team included Calvin Fambirai and Tatenda Chiware from ZADHR, Masimba Nyamucheta from ZNNP+ and Mevice Makandwa from TARSC. Barbara Kaim (TARSC) gave input to the design, analysis and documentation of the work and mentored the programme. Three of the facilitators had attended the PRA training in October 2013 and were responsible for conceptualisation of the programme and initial consultations with community members and stakeholders involved in Cassa Banana. The programme used the spiral model concept of participating, reflecting and acting by the participating groups in such a way that each round of the spiral deepened the process of learning and action. As the facilitators had learnt in the October 2013 training, the spiral is a central concept in the PRA process in which:

1. learning begins with the experience or knowledge of the community
2. after community participants have shared their experiences,, they look for patterns – what is the same? what is different?
3. participants then collectively add or create new information or theory. This information can come from within the group, or can be brought in from outside.
4. participants then practice their new skills, make strategies and plan for action
5. after the community meeting, participants apply in action what they've learnt and agreed to during the meeting.



The three community meetings used a series of PRA tools including:

- community mapping: to identify key geographic and social issues in Cassa Banana, including areas of health risk;
- ranking and scoring: to identify key priority health problems in Cassa Banana
- problem tree: to identify the immediate, social and environmental causes of the health problems they face
- picture codes and three pile sorting
- focus group discussions
- market place
- progress markers
- and more.

The target group for this programme were community members, representatives from the nearest health facility in Dzivarasekwa and duty bearers from both the ZRDC and HCC. In reality, community members, the village health worker and a volunteer from ZNNP+ based in Norton (15kms away from Cassa Banana) were the primary participants, with approximately 30 – 40 people attending each meeting. Facilitators shared facilitation and note taking roles and in a number of activities the community representatives were divided by age and gender to illicit differences and similarities for wider discussion. Each meeting spent some time in assessing actions taken between meetings and in defining further plans for realising their objectives.

Meetings also included specialist training on the role of Health Centre Committees, provided by the Community Working Group on Health (CWGH), and a dedicated two day workshop for the Cassa Banana CHC in training on participatory facilitation skills and the development of an Action Plan. This meeting also concluded with the creation of a set of Progress Markers (PMs), adapted from the Outcome Mapping approach (Earl et al., 2001) as a qualitative monitoring tool. Specific PMs were identified by participants from the prioritised problems and actions identified in terms of what participants would

'Expect to see' (usual situation)
'*Like to see*' (higher level or improved situation)
'Love to see' (more ideal situation)

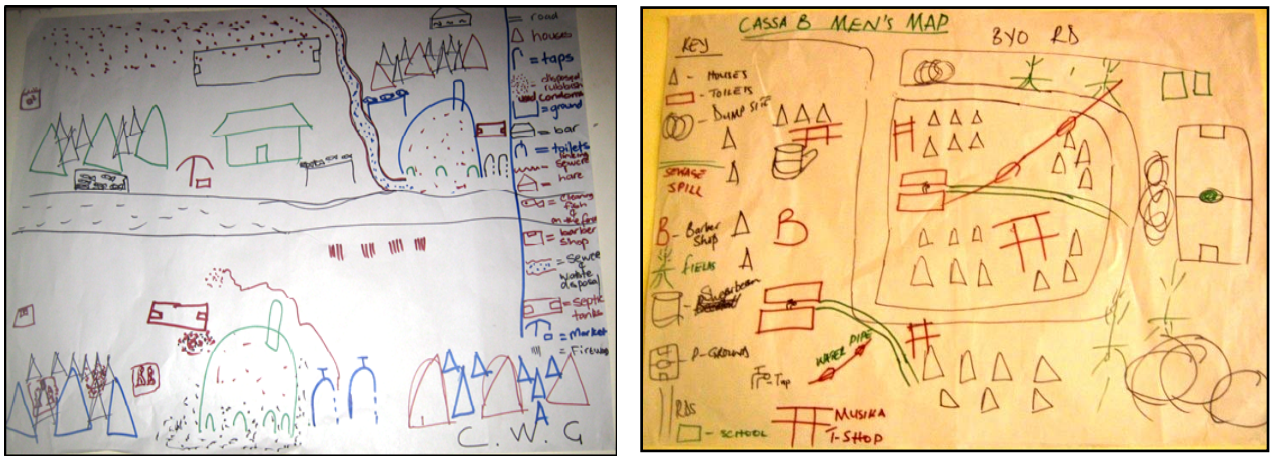
3. Findings and Actions Taken

3.1 Identifying and prioritizing health problems

Community mapping showed that youth, men and women were all concerned with problems of poor sanitation in their community. During discussions following the drawing of the maps, both the men and women expressed concern that sewage effluence often overflows from the septic tanks onto the ground close to people's homes and where the fishmongers and vegetable vendors are displaying their wares. Food is often contaminated by flies which breed in the sewage effluent.

A burst water pipe also appeared on both maps. The burst water pipe is close to the sewage effluent, indicating that the water coming out of the pipe is contaminated by the sewage. Dumpsites are also haphazardly dug and they breed maggots and flies which also tend to contaminate food in people's homes. Children play in the sewage effluent flowing from the septic tanks.

The maps also depicted that there are tuck shops and Shebeens[1] where people drink alcohol and urinate wherever they want. Sometimes used condoms are strewn around the Shebeens, exposing children to infections in the event that they pick up the condoms and use them as balloons.



Men and Womens' Social Maps in Cassa Banana, TARSC 2014

Both the men and women noted that there was a small private health facility called Bev King Clinic about 1km away from the compound. The private facility is rarely used by the community members as they cannot afford the services provided there. It also emerged that Bev King Clinic was established by the previous owner of the farm who used to grow flowers before the land reform programme. Bev King clinic was established for farm workers as a free service. However, since the eviction of the previous farm owner, the clinic now requires payment for its services.

The ranking and scoring activity reinforced the notion that water borne diseases were the main health problem faced in the community, followed by HIV, as shown in the table below:

Table 1: Presentations of the three groups on their priority health problems

Men		Women		Youths	
Disease	**# counters**	**Disease**	**# counters**	**Disease**	**# counters**
Diarrhoea	3	Diarrhoea	4	Diarrhoea	6
Intestinal worms	2	Intestinal worms	3	Intestinal worms	4
HIV	2	HIV	2	HIV	2
STI	1	TB	1	Sewage	1
Cholera	0	STI	1	TB	0
Dysentery	0	Malaria	1	STI	0
Malaria	0	Dysentery	0	Dump site	0

[1] A Shebeen is an informal and unlicensed bar, often in a private home, where alcohol is sold.

When the 3 groups came together to prioritise their health problems as a community, they were unanimous that their priority problems are, in order of importance:

1. diarrhoea,
2. intestinal worms, and
3. HIV and AIDS

During the discussion on the causes underlying these 3 priority health problems, participants drew up the following table:

Table 2: 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, drinking infected water, ingestion of undercooked meat
HIV/AIDS	Unprotected sex, lack of knowledge, unemployment and poverty leading to commercial sex

Burst sewer pipe close to the ablution block, TARSC 2014

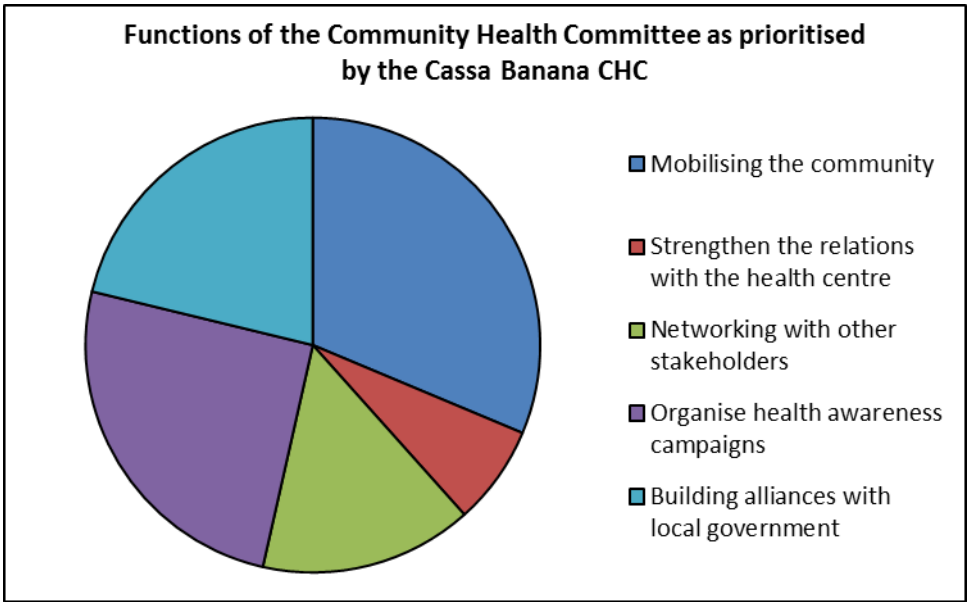
Participants noted the need to work with the relevant duty bearers to ensure regular rubbish collection and to find a permanent solution to safe waste disposal and the repair of burst water and sewer pipes. They commented that members of the community are doing their best to repair the burst pipes but there is an urgent need for the relevant authorities to replace the water and sewage system. Unfortunately, despite being invited to the community meetings, neither the Councillor nor any other representative from the local authority was in attendance.

3.2 Formation and Role of the Community Health Committee

During the Second Community Meeting held in March 2014, participants indicated that there was a need to establish a Community Health Committee (CHC) to deal with the health challenges they face in Cassa Banana. Realising that they were not connected to any primary health care facility, they opted to call themselves a Community Health Committee, and not a Health Centre Committee (HC Committee) i.e. a joint community –health service structure, linked to a clinic and covering the catchment area of the clinic. Nevertheless, they got training from the Community Working Group on Health (CWGH) on the roles and functions of an HC Committee to be adapted to their situation. They elected 7 members to the committee, including a Chairperson, Vice Chair, Secretary and Treasurer. They also nominated others to represent people living with HIV and AIDS (PLWHIV) and youth. The Village Health Worker also joined the committee.

With guidance from the PRA Facilitators and CWGH, the committee identified that their primary role was to contribute to the improvement of health conditions of people in the Cassa Banana Community. Within this larger objective, they recognised that they needed to mobilise members of the community to

take responsibility for improving their health, organise health awareness campaigns, build alliances with local government, network with other stakeholders, and strengthen relations with the neighbouring health clinic.



As can be seen from the above pie chart, mobilising the community was seen as the most important function of the CHC, while strengthening relations with the health centre was voted as the least important because the nearest health centre is too far away.

3.3 Moving into action

Collective discussions on the health situation in Cassa Banana, and the subsequent formation of the Cassa Banana CHC, initiated a range of activities in the community to try to resolve some of their health problems.

Water and sanitation: In dealing with the water and sanitation problems, the CHC initiated a clean-up campaign, dug a new rubbish pit, and began discussions with ZADHR in organising for a voluntary group of doctors to visit Cassa Banana to undertake an assessment of the health situation in the community and to provide deworming treatment. The CHC also discussed the possibility of getting technical advice on the construction of Blair toilets in Cassa Banana. They especially wanted to find out whether it was legal to build Blair Toilets in their area and, if possible, how they could go about doing this. The Environmental Health Technician (EHT) could be approached for technical advice. The EHT could also be approached to assist with providing brooms, gloves and detergents for the clean-up campaigns.

HIV and AIDS: With support from a ZNNP+ volunteer from Norton, the CHC established a support group for PLWHIV. A total of 12 HIV positive people joined the support group which aimed to provide them with a platform in which they could receive psycho-social support, skills training and a place where they could work together to fight stigma and discrimination. The ZNNP+ volunteer also helped to set up a group of youth peer educators. In the longer term, the support group planned to undertake community campaigns, especially on providing information on Parent and Mother to Child Transmission of HIV (PMTCT) and the importance of Voluntary Medical Male Circumcision (VMMC). They also agreed that they need to target private businesses for sponsorship.

Members of the newly established support group indicated that PLWHIV face several challenges. In addition to facing high levels of stigma in Cassa Banana because of their HIV status, they often do not have enough money to buy healthy food or to pay for transport to go to the clinic for health care or to collect their ARVs. Many of their children are not going to school due to poverty and a number of the

women have resorted to commercial sex to earn a living. Multiple concurrent partnerships are common in Cassa Banana and this facilitates the continued spread of the virus.

Engagement of duty bearers: At the first meeting held in February, participants agreed to engage duty bearers responsible for service delivery in Cassa Banana Community. Harare City Council was identified as the primary duty bearer as the community members pay their rates to Harare City Council. Efforts were made prior to each of the community meetings to invite the local councillor responsible for Cassa Banana and the Director of the City Health Department. Both initially indicated that they would attend but gave excuses at the last minute. The CHC resolved that they needed to continue their efforts to engage with the duty bearers.

3.4 Development of an Action Plan and Progress Markers

5 months after the start of this programme, the CHC came together for 2 days to work on a more focused Action Plan to guide them over the next 6 month period (July – November 2014). They also developed a set of Progress Markers which they plan to return to every few months to measure progress. A complete outline of the Action Plan is available from the participating organisations. Below is a summary of the main strategies and progress markers as defined by the CHC:

OBJECTIVE 1: IMPROVING THE WATER AND SANITATION SITUATION IN CASSA BANANA

Strategy
1. To ensure safe and clean drinking water in our community • Repair and eventually replace old water pipes. • Sink a borehole. • Awareness campaigns. • Treatment tablets. **2. To improve sanitation and hygiene** • Construct Blair toilets. • Dig dumping pits. • Clean toilets / showers • Conduct clean up campaigns. • De-worming exercise. • Empty septic tanks regularly
Progress Markers
EXPECT TO SEE
New dumping pits dug every two months. Clean Up campaigns (1 per month). Community doing short term repairs on water pipes. Public toilets cleaned every day. Detergents supplied every month De-worming exercise done twice before December (ZADHR)
LIKE TO SEE
Septic tanks drained at least twice before December Refuse collection done every week HCC fixes or replaces water pipes A borehole sunk Received technical advice on building a Blair Toilet
LOVE TO SEE
Blair Toilets constructed Clean, safe and sufficient amounts of water readily available

OBJECTIVE 2: STRENGTHENING HIV PREVENTION AND SUPPORT

Strategy
1. To educate the community on key drivers of HIV **2. To improve ARV adherence for PLWHIV:** • To improve access to VCT • To ensure ARVs are easily available • To educate people on the importance of adherence. • To engage key stakeholders such as churches, traditional leaders etc in supporting VCT and ARV adherence. **3. To increase access to MTCT and VMMC**
Progress Markers
a. Lack of knowledge on HIV and AIDS
EXPECT TO SEE
12 x CHC facilitators trained on HIV and key drivers Group discussions held once a month 500 IEC Materials distributed every month. (PMTCT, VCT, VMMC, Adherence to ART) 50 households reached per month through door to door campaigns.
LIKE TO SEE
Group discussions held twice a month. Youth facilitators trained in use of Auntie Stella with youth 1000 copies of IEC material distributed every month.
LOVE TO SEE
Information Centre established in Cassa Banana. One Youth Friendly Corner established in Cassa Banana.
b. Lack of adherence to ARVs
EXPECT TO SEE
100 PLWHIV on ART able to access their medication. CHC have their first strategic meeting for a mobile clinic One training of Treatment Buddies / primary care givers
LIKE TO SEE
Mobile clinic visits Cassa Banana at least once a month 120 people on ART able to access their medication Formation of 5 support groups Sensitisation meeting with church and traditional leaders
LOVE TO SEE
Clinic in Cassa Banana servicing all health needs, including HIV-related health concerns Every person on ART with easy access to ARVs
c. Lack of information on PMTCT and VMMC
EXPECT TO SEE
200 people reached in both PMTCT and VMMC. 50 pregnant mothers enrolled on PMTCT programme. Formation of support groups for lactating pregnant mothers One community group discussion on PMTCT and VMMC.
LIKE TO SEE
100 pregnant mothers enrolled on PMTCT. 30 males circumcised.
LOVE TO SEE
Children born free from HIV PMTCT services at Cassa Banana Clinic.

OBJECTIVE 3: BUILDING ALLIANCES WITH LOCAL GOVERNMENT AND OTHERS TO IMPROVE HEALTH AND HEALTH RELATED SERVICES IN CASSA BANANA

Strategy
1. To engage with local authorities to clarify roles and responsibilities • inform authorities about actions in Cassa Banana including formation of the new CHC • seek clarification about which duty bearer is responsible for health and the underlying determinants (water, sanitation) in Cassa Banana • develop joint actions with local authorities to resolve problems **2. To engage other stakeholders in supporting the activities at Cassa Banana** eg headman, local farmers, private sector.
Progress Markers
EXPECT TO SEE
Meetings with HCC and ZRDC successfully held Stakeholder meeting successfully held Community meetings (or sub group meetings) held once every month to report and get input on activities. CHC meets at least once every month, and more often if necessary, to report and plan.
LIKE TO SEE
Clarity on which local authority is responsible for health and health-related issues in Cassa Banana (HCC and/or ZRDC) Clear understanding of roles and responsibilities of local authorities/duty bearers Increased interaction between ZRDC, HCC and the community Local authority provides support to community activities Stakeholders provide financial and other resources in support of community activities
LOVE TO SEE
Action plan developed with responsible local authority on ways forward in addressing health-related issues Clinic in Cassa Banana servicing all health needs

4. Discussion – Critical reflections

One of the questions this programme tried to address was whether the implementation of a PRA process and increased community engagement could lead to greater social accountability (especially on the part of the local authorities), increased access to resources for PHC and improved uptake of services. To date, the programme in Cassa Banana has failed to identify the roles and responsibilities of the duty bearers and engage with them in terms of meeting their obligations. Members of the community continue to try to resolve their health problems with minimal support from the outside. Nevertheless, despite this harsh environment, the last 6 months have seen an increased level of community awareness, organisation and planning, and a renewed energy to find solutions within their own community. It may be early days in assessing whether this impetus will lead to a positive engagement with local authorities, but considering the lack of overall accountability in the Zimbabwean socio-economic and political arena, this is likely to be a long process. This points to the importance of ensuring a long-term commitment on behalf of the institutional partners in supporting the efforts of the Cassa Banana community.

Phase Two of the programme (July – December 2014) will see the continued support of the outside institutions in supporting the Cassa Banana CHC in implementation and monitoring of their Action Plan.

5. References

1. TARSC (2013) *Strengthening community focused, primary health care oriented approaches to social accountability and action* Report of the training workshop held October 7-10 2013, Chengeta, Zimbabwe, COPASAH, EQUINET, Harare accessed at http://www.copasah.net/training-workshop-on-participatory-methods-for-a-people-centred-health-system-in-zimbabwe.html).

Acronyms

ART	Anti-retroviral Therapy
COPASAH	Community of Practitioners in Accountability and Social Action in Health
CWGH	Community Working Group on Health
EHT	Environmental Heath Technician
EQUINET	Regional Network for Equity in Health in east and southern Africa
HC	Health Centre
HCC	Harare City Council
PHC	Primary Health Care
PLWHIV	People Living with HIV
PMTCT	Parent and Mother to Child Transmission
PRA	Participatory Reflection and Action
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Disease
TARSC	Training and Research Support Centre
VHW	Village Health Worker
VMMC	Voluntary Medical Male Circumcision
ZADHR	Zimbabwe Association of Doctors for Human Rights
ZNNP+	Zimbabwe National Network of People Living with HIV
ZRDC	Zvimba Rural District Council

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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This report has been produced together with the Community of Practitioners in Accountability and Social Action in Health (COPASAH), a community of practitioners who share an interest and passion for the field of community monitoring for accountability in health to interact regularly and engage in exchanging experiences and lessons; share resources, capacities and methods; in the production and dissemination of conceptual, methodological and practical outputs towards strengthening the field; and in networking and capacity building among member organizations. http://www.copasah.net/

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