Building Capacities for Health Centre Committees in Zimbabwe:

Report of Health Centre Committee Training Workshops:

Training and Research Support Centre (TARSC)
Community Working Group on Health (CWGH)
Ministry of Health and Child Welfare (MoHCW)

12-14 September 2011 and 12-14 November 2011
Health Centre Committees training Workshops Report

Training workshops held with support from MEDICO International and the German Federal Ministry of Economic Cooperation and Development (BMZ)

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Group photo- September Workshop Group

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Report produced by TARSC with input from CWGH

1. Background

The training for Health Centre Committees (HCCs) to strengthen their capacities in executing their roles and functions was held on the 12th -14th of September 2011 and on the 12th-14th of November 2011. The two batches of training drew participants from 13 districts each, represented by three HCC members (66 delegates total) from each selected clinic/health centre. The three day training was building a foundation for a shared understanding of the nature of HCCs work, the approach, functions, capacities and skills to support their roles in supporting the revitalisation of Primary Health Care (PHC) in Zimbabwe.

The HCC is the mechanism by which people get involved in health service planning at local level. 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. They 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.

Supporting the functioning of HCCs corresponds with the MoHCW National Health Strategy 2009 – 2013 which emphasises commitment to reinvigorate PHC and support community participation in health. To support HCCs to understand these roles an HCC manual developed by the Training and Research Support Centre (TARSC) with input from the Community Working Group on Health (CWGH) and peer review support from the Ministry of Health and Child Welfare (MoHCW) was used. The manual draws from work carried out since 2000 by TARSC and the CWGH to establish and support the functioning of HCCs, working with the MoHCW. The work is levered by TARSC work on health literacy and Participatory Action Research training programme that has been giving capacity and technical support to dialogue mechanisms between health workers and communities in Zimbabwe and in the East and Southern African (ESA) region.

The manual used in the training was thus produced as a tool to support capacity building of HCCs in their various initiatives. It uses participatory approaches to raise community voice and build skills and knowledge on the evidence and experience generated within communities. We used the manual as a lever to draw on the knowledge and experience of the people in districts working in health, the health workers, and 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.

This report gives a summary of the two training batches conducted in September and November 2011. The HCC manual is separately available and provides the detail on the sessions and how they were conducted so this report doesn't record this detail. The training involved dialogue and exchange of experiences, activities to encourage reflection and discussions on follow up *(see programme in appendix 2)*. This report will reflect some of the diverse issues that were noted during the training, and some major agreed areas of action.

2. Introduction and Objectives

Health Centre 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. Despite these clear roles and functions, HCCs currently do not yet have an Act of Parliament or statutory instrument to specifically govern their roles and functions. However, there are different laws and policies that acknowledge their work and contributions to the health system in Zimbabwe. These *'legal'* provisions can help formally support the HCC work with other structures in the MoHCW, in local government and with

other mechanisms for community participation. It is these policies that provided a backup for HCC training, recognising their key roles in revitalising PHC central to the orientation of people centred Health systems. For instance, 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. Also, the *"District Councils Act 1980 (amended in 1981 and 1982)"* revived local government structures and how they interact with communities. While among others the *"Public Health Act: Ch15 amended 1980"* provides for the duties, roles and organization of public health system in Zimbabwe, including mechanisms through local government to address public health issues.

Thus the 3 day training workshop specifically aimed to

1) provide core skills and information to Health centre committee members to implement activities and responses that revitalizes primary health care at community level
2) Work with the health centre committee manual to enable use of the manual in the HCC work
3) Build the capacity of health committees to execute their functions
4) Strengthen mechanisms for community participation in health

Each district was represented by a health worker *(working as the committee's secretariat)*; a community representative *(working as the committee's chairperson);* a civil society/community group representative *(mainly representing the CWGH community structure- this was aimed at strengthening CWGH capacities in HCC work at community level).*

The training oriented HCC members to deepen their understanding on who they are; their legal status; how they work with other structures in the MoHCW, within Local government and other community structures. It gave information on how HCCs engage with communities and with Health workers, how they can effectively participate in budget planning processes and effect their roles in oversight management of health resources *(see programme in appendix **2**)*

3. Health Systems in Zimbabwe

This session introduced the background of the Zimbabwe Health system. It explained and described how the health system is organised and how it functions. It further elaborated the scope and mechanisms for coordination of health workers and the roles of communities in the health systems. It also briefly highlighted the major health programmes in the Ministry of Health and Child Welfare.

Public facilities, nonprofits groups, church organizations, and for-profit clinics provide health care in Zimbabwe. The health delivery services are decentralized, with health care provided at primary, secondary, tertiary, and quaternary levels. However, the public health system is centralized for policy and administrative guidance, providing system decision-making, completing and determining funding allocation, coordinating responses to national health issues all administered from the MOHCW.

"The decentralisation of the health system is now a thing of the past, the economic crisis reorganised the system back to centralisation, all decisions including planning, preventive services, curative services are done in Harare, in the capital at central hospitals, even with a minor cold, you go to Parirenyatwa because that is where the nurse and the paracetamol is found" Participant Goromonzi

At the provincial and district political levels, the health system is administered by provincial and district health offices, as representatives of the MOHCW.

At community level, there are committees that help in communicating and coordinating service delivery including the 1) Ward Health Committees (WHC) 2) Village Health Committees (VHC) which provide a platform for wider participation by local communities and 3) Health centre committees. The HCCs can interact with the MOHCW district representatives such as the District Nursing Officer, the District Environmental Health Officer and the District Health Education Officer.


Plenary session

"The challenge with community level structures is the method through which they can be sustained, often, they are set and left untrained and with no resources to implement work. This makes them incompetent"
Participant Chipinge

"For me the problem i see is political manipulation of these committees. When they are established they work well, once politicians become a part of them, they lose focus, abuse resources and abandoned"
Participant Bindura

4. Health centre committees

In this session we identified who HCCs are - their functions and responsibilities. We accentuated the composition of HCCs as much as their functions and responsibilities in the way these are elaborated in the HCC manual.

Using prior knowledge, experience on the work we do and information from the HCC manual we collectively defined and agreed that HCCs 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, Environmental Health Technician (EHT), Kraal head, councillor headmaster/health teachers, 1 church representative, a Community Health Worker (CWH)/ Village Health Worker (VHW), a youth representative, representative of other health providers in the area (traditional healers, private health services, Non Governmental Organisations (NGOs)), 1 civic group representative and any

other community leader as appropriate for that area (about eleven people). Ministry of health/Rural District Council (RDC) health worker may be the secretary to the committee; however, it should be left to the communities to choose their own chairperson.

We used several case studies from the manual and case examples from the participants to discuss and learn the functions of HCCs.

"I think the one area that we have to push is that of health worker and patient relationships. You see the shortages in drugs, equipment and low pay frustrates health workers and they transfer the pressure and pain to us. We need to support them to get a pay rise at the same time they need to support us by taking good care of us when we visit the health centre. We can even plan work that we can do together to improve health outcomes in our communities" Participant Masvingo

5. Working with Communities

Working with communities is central to HCC work. Knowing how to communicate, how to involve and to participate requires specific practical skills and knowledge. It embeds community participation, providing HCCs with the concepts and the practical tools for increasing community participation in health. Activities and discussions in this session were drawn from HCC experiences, this was used to illustrate the principles, approaches, and issues related to working with communities. The activities, used in conjunction with the *'reflective practice approach'* illustrated in the manual; demonstrated the importance of using people's experiences to pave way for an environment rich for learning, and working effectively with communities. Using group discussion, various PRA tools including song, drama the session further teased out the basics of facilitating community meetings; writing reports, holding meetings, advocacy and ways to present findings to both the health providers and the community.

"Ya, these skills are important and useful, i think though the Ministry of Health should equip us more especially to some us health workers, especially the writing skills and writing basic reports. This is lacking significantly. I think that if we could have a repeat PRA and HCC training we would be adequate to try out for the first time. We need refreshers next year just to appraise us and give us comments on how we faired" Participant Kwekwe

We noted in our discussion that one of the prominent challenges in working with communities lies in institutionalizing and mainstreaming community participation. The legal instrument to govern the functioning and existence of HCCs can sustain social participation. This means that community participation does not become an alternative, but an integral part of the country's responsibility for health care delivery.

"But what is worrying me is whether we actually have a legal instrument, an act of parliament of some sort, that supports what we will do, how we are going to work and that even justifies what we are doing here?" Participant Chikwaka

The question of whether HCCs should be volunteers or remunerated in some form remained controversial. On one hand it was clear from the discussions that volunteerism could not be sustained for long periods given that some (most) members of HCCs are poor and expect and require an income. Although, often, they are expected to spend only a small amount of time on their health-related duties, leaving time for other breadwinning activities, community demand often requires full-time performance.

"You should know that there is nothing called absolute volunteerism, there should be allowances to accompany this work—it's an issue of opportunity costs..." Participant Victoria Falls

Group activity

6. Working with health workers

Health worker - community interactions are important to strengthen opportunities for communities to become more responsive to health needs and increase uptake of health services. Health workers at the training expressed a myriad of concerns on difficulties they experience in working with communities. We realised that, these concerns related to their their relationship with communities, conditions and arrangements of interaction practices emanating from conditions of work or from community dissatisfaction with services. Expectations from health workers by communities are often compounded by illness and uncertainty provoking emotional distress in communities and health workers. Unfortunately, both communities and health workers seldom approach these and other issues in a focused or systematic manner, and frequently lack communication skills, to interact well. This undermines potential in improved service uptake and health outcomes. More often, this leads to suspicion, vindication and distrust between providers and recipients of care. The session challenged traditional norms of interaction between communities and health workers and provided means and ways on How HCCs can be central in strengthening the communication between these subjects.

"Health workers are too few and not well trained...so what then happens is that they fail to treat a patient well and a patient dies or gets worse. They begin to be accused by communities for negligence or culpable homicide in some cases...so to avoid that they always start from a very negative attitude, defending every move and blaming every mistake on the ignorance of the patient or the government or whatever is fit at that particular moment... these people need more training especially the new student nurses of today ...HCCs need to educate them if the government is failing dismally like this..ey!" Participant Chitungwiza

To illustrate how Health worker-community interactions could be initiated and sustained, a PRA tool termed the *'Margolis wheel'* was used. This method stimulated discussion and some issues that were noted among others included the need to invest in trust between these two social groups and support their joint actions at community level.

"This method is the best, you will not run away from saying what troubles you, it enables people to speak it also allows those who are afraid to speak to finally speak..." Participant Chiwundura

7. Health Planning

In the session on *'Health Planning'* we learned how plans are developed at local, district and national level in Zimbabwe. We further discussed how HCCs can be effective in identifying community health priorities and how those priorities can be made a part of the planning process, how they can be integrated in the Health Information system and subsequently how the plans could be monitored. Several PRA activities were employed in this session including *'ranking and scoring'* for identifying community priorities, picture codes; drama and case studies.

The challenges that emerged from these group activities showed that many health personnel lack the background and orientation to provide a supportive environment for HCC programmes. They are socialized into the hierarchical framework of disease oriented medical care systems and have a poorly developed concept of primary health care. We noted such paradigms to be ill-suited in creating an environment supportive of partnerships and teamwork between different health workers, communities, local authorities and local leadership particularly if some categories are thought of as less important.

We agreed that it was a responsibility of each HCC member to individually support the revitalization of HCCs to provide community input at all levels of the health system. In the same vein, training health workers and community members on the roles and responsibilities of the HCCs should be a part of the long term revitalization process.

Working with local structures to access funding was also noted and carefully dialogued. District officials retain control of resources for development activities in their jurisdiction. They are supposed to use resources with input from District Development Committees; however, because funding is at the discretion of district officials, with direction from the line ministries, they are able to disregard input from the District Development Committees in which HCCs somewhat have some level of oversight, participation and involvement in planning and other activities.

One of the most important conditions for sustainability of HCC work is the capacity of the community members and HCCs to organize themselves. We noted that if local people had been mobilized in such a way that they were able to carry on solving their own problems and securing the health services that they wanted they create a mass of rights holders that is able to protect their *'right to health'* and claim their resources for health.

"We can always learn from the way people were organised during the liberation struggle, you needed to be committed, to have a spirit of hope and need to win. This is the same principle that we should apply in health struggles, we are in a state of ward because the health system is not working. Literally we fighting against an army of disease and causes of disease and we therefore need to fight not only for ourselves but also for the future generations. This training is very practical I wish we could have more of such..." Participant Hwange

8. Health Budgets

The session on *Health budgets* presented skills on how HCCs and communities can mobilise resources. It outlined the background of the budget cycle, budget lines and allocation in Zimbabwe and how to monitor and track local budgets.

The discussion on health budgets was done at a slow pace noting the financial jargon involved in the discussions and the difficulties associated with it. The budget process in

Zimbabwe follows that the MOHCW submits its annual budget to the Ministry of Finance (MOF), listing budget costs as curative and preventive line items. It then distributes its budget allocation to each province, in proportion to the "priorities" of the province as described in their work plans. At the provincial level, we learned that the Provincial Medical Director (PMD) meets with district health officials and determines budget allocations for each district and its facilities.

However, the process used for determining how funds are allocated at this level is unclear: it seems to vary greatly, but factors such as compliance with work plans, demographics, and health campaigns are considered. A similar process is completed at the district level. Overall, expenditures at all facilities are expected to comply with provincial and district work plans. While the process is clear there is very little participation if meaningful from Communities in these processes. Further crippling the participation is little understanding of the use of the government "Resource Allocation Formulae" to health offices for equitable distribution of the health budget. We observed in this session that training, follow-up and support systems need considerable strengthening including on how communities can be involved meaningfully at each stage of the budget cycle.

Group activity

"We definitely need to be involved in the budget process, we therefore ask our trainers to try to involve us in any budget processes that you already have access to (participation) as part of the practical training. The pre budget and post budget meetings would be a good starting point" Participant Chimanimani

9. Building alliances and sources of support for HCCs.

Building alliances is central to sustaining the work of HCCs. Alliances can lever HCCs to reach their full potential through a number of ways among them are resource mobilisation, adocasy, legislative support, legal support, financial and technical support. The session provided Health centre Committees with information and skill on how to work with members of parliament and local government and the support needed from the Health setor.

In our learning we placed focus on the on the work on health social movements and networks such as Health litercay and CWGH respectively. We did this to deepen understanding on the issues involved in mobilizing diverse participants and framing the discourse on the issues. We shared ideas on tactics that have advanced social movement

activism. Central to this discussion was the role of trust HCCs and other institutions that are important in supporting the work of HCCs. We used the HCC manual to explore how HCCs can work more effectively with members of parliament, with line ministries, with civil society organisations, churches and other bodies. We further explored mechanisms for sustaining the relationships and how HCCs could be supported to do their work.

10. Next steps and Conclusions

Given present pressures on the Zimbabwean health systems and its proven inability to respond adequately, proper establishment, training and supporting HCCs was agreed to be difficult but nonetheless a good investment. While there is a lot to learn, there is a lot we do know about the value of HCCs in a PHC oriented health sytem: appropriate selection, continuing education, involvement and reorientation of HCCs in their work, training and support are non-negotiable requirements.

" Now that we know who we really are and how we work, i want to encourage you to go and set up HCCs using the guidelines in the HCC manual. Try as much as possible to involve the community so that people are elected democratically by communities. This is an essential part in enabling long term support and ownership of interventuosn from communities" Facilitator Fortunate Machingura

We observed that political leadership and substantial and consistent financial, technical and material support was a key requirement. We further jointly agreed that 2011-2012 period would be the first leraning year following a first formal HCC training. Each HCC was provided a platform to learn how an action plan would be developed at community level and how the wider community would be include.

" let us share the workplans once you have finalised so that we can assist you in implementation, CWGH, TARSC, MoHCW and MEDICO will continue supporting the work of HCCs" Closing remarks Delegate Itai Rusike

" I am very much impressed with the content and approach of training, the level of engagement has been very high and intercative. The participatory approaches in the manual are very useful in that they made it very easy for me to understand the issues. I want to encourage you all to use the learning to improve service delivery in Zimbabwe" MEDICO representative Sabine Eckart

We need to learn from successful examples of work that has been and that would be implemented by each HCC trained, particularly providing long term evidence of what works and what does not work. This presently constitutes the biggest knowledge gap. TARSC working with CWGH and MEDICO international would continue to support HCCs with technical support, refresher training, reviewing of the HCC manual and repeat training. Continuing the process of learning by doing with technical, training, supervisory and overall general support at HCC level could help to make the difference.

11. Appendices

11.1. Appendix 1: Delegates List

	Name	Sex(M/F)	District	Organisation & Contact Details
	12-14 September 2011			
1.	Mafion Nyamhandu	M	Bindura	(MoHCW) Mupandira Clinic P.Bag 922 Manhenga, Bindura 0773690944
2.	Moses Gongera	M	Bindura	(DDF) Nyava Clinic P/A Manhenga Bindura 0772442453
3.	Munhamo Ncube	M	Zhombe	(Community rep) Sidhakeni Clinic/ Zhombe District HCC. VHW 0774466905
4.	Khumbulani Moyo	M	Chiwundura	(Commuinty rep) Gunde Clinic Chiwundura Box 124, Gweru 0775562860
5.	Shuvai Gavi	F	Chiredzi	(FACT) Chiredzi Hse no. 2627 Pius Dube Rd Chiredzi. 0772400603
6.	Mary Sumbani	F	Chiredzi	(Zimbabwe Women in Agriculture) 1718 Sengwe Rd Chiredzi
7.	Kingstone Maselesa	M	Chiredzi	(YPWNHA) Chiredzi 556B Pote Rd Tshovani
8.	Enetty Wadhau	F	Chirumhanzu	(VHW) Chirumhanzu 41 Chengwena Sec Charandura
9.	Charity Marutawana	F	Chikwaka	(VHW) Mwanza St John's Primary Box 50 Juru
10.	Martha Masumba	F	Chikwaka	(ZWW)St John's Primary Sch Box 50 Juru
11.	Queen Machanisi	F	Kwekwe	(VHW) Malisa Clinic/ Zhombe St Judes P. Bag 32 Kwekwe
12.	Cleopatra Mutya	F	Chirumhanzu	(VHW) Denhere Clinic P.O Box 18 Charandura, Chirumhanzu
13.	Godfrey Chiribani	M	Chirumhanzu	(Community rep) Hama Clinic P.O Box 44 Charandura, Chirumhanzu
14.	Bekezela Mangena	M	Kwekwe	(Community rep) Ntabeni HCC Zhombe P.Bag 8141 Kwekwe 0774771396
15.	Elias Mapfumo	M	Chitungwiza	(Community rep) 8825 Unit K Seke, Chitungwiza; Seke south Clinic
16.	Tinashe Namphungu	M	Kariba	(Pastors' Fraternity) 849 Nyamhunga 2, Kariba 0772358688
17.	Joseph K. Utumbe	M	Kariba	(Catholic Health Care Commission) 824 Nyamhunga Kariba 0773773817
18.	Kesani Chihlangu	F	Masvingo	Runyararo Clinic Hse no. 2650 4th St 0773734162
19.	Constance Tamayi	F	Masvingo	Mucheke Clinic 866 Mambo St Mucheke 0775004296
20.	Dendere Prosper G	M	Masvingo	Rujeko HCC Masvingo Hse no. 3663 Zororo St Rujeko A Masvingo 0773552172
21.	Rosa Mufunde	F	Chitungwiza	(Life Empowerment Support) Organisation 2253 Unit F Seke, Chitungwiza 0772916902
22.	Dzapasi Jessie	F	Kariba	(OLLR) 0773010723 1760 Nyamhunga 1 Kariba
23.	Abraham Makungawya	M	Chiwundura	Chinamasa Clinic Gambiza Sch, Box 1152, Gweru. 0773641321
24.	Ephania Chidziva	F	Bindura	(DAAP+) Nyava High 582 Highlands, Nyava Bindura
25.	Penningna Annoda	F	Chitungwiza	1962 Kasipiti Rd St Mary's, Chitungwiza
26.	Manganzo Moses	M	Chikwaka	(MoHCW) Mwanza Clinic Box 86 Juru 0772700634
27.	Dadirai C. Mapfumo	F	Kwekwe	(Inform Sector)Amaveni Kwekwe 0774410423
28.	Tabeth Karonga	F	Kwekwe	(HBC) R12 Amaveni Kwekwe Behaviour Change
29.	Evangelist Bhuza	F	Kwekwe	(Church rep) HCC 378/7 Mbizo Kwekwe
30.	Mashiri Nanzile	F	Chiwundura	Box 1058 Gweru, Chiwundura Clinic 0733769463
31.	Faith Kowo	F	Secretariat	114 McChlery Ave, Eastlea, Harare
32.	Nonjabulo Mahlangu	F	Secretariat	114 McChlery Ave, Eastlea, Harare
33.	Kundai Chebundo	F	Secretariat	114 McChlery Ave, Eastlea, Harare
	12-14 November 2011			
34.	Rose Simango	F	UMP	(MoHCW) Chikuhwa RHC Box 663 Phone 0779117143
35.	Tendai Nyama	F	Chikomba	(MoHCW) Zvamatobwe Clinic Box 50 Sadza
36.	Temba Masenda	M	Chikomba	(Community rep) Zvamatobwe RHC Box 50 Sadza 0773464396
37.	Johanne Sithole	M	Chipinge	(Church rep) Nyaututu Primary P. Bag 2017 Chipinge
38.	Joe Ngawaoange	M	Chinhoyi	(MoHCW) Chikonohono Clinic
39.	Mlilo Sithandinkosi	F	Zvishavane	(MoHCW) Vugwi RHC Box 191 Zvishavane0712348637
40.	Mafundi Katiyo	M	UMP	(VHW) Chikuhwa Primary School P.O Box 667 Murehwa
41.	John Pfidze	M	Chinhoyi	(MoHCW) Chinhoyi Clinic Municipality of Chinhoyi
42.	Ronnie Sibanda	M	Tsholotsho	(MoHCW) Tsholotsho Urban Clinic MoHCW 0772321939

43.	Ferinos Mukwazhe	M	Gweru	(Councilor) Gweru City Council Mtapa Clinic Box 278
44.	Patricia Chirove	F	Gweru	(MoHCW) Gweru City Council Mkoba Poly Clinic 0773098527
45.	Barbra Nyakupinda	F	Arcturus	(Community rep) Arcturus Mine Box 14 Arcturus
46.	Elizabeth Muriro	F	Mutare	(MoEdn) Chakohwa Primary School PBC 7314 Mutare
47.	John Rudo Mutonhere	M	Mutare	(MoEdn): Chakohwa Primary PBC 7314 Mutare
48.	Jacob Dhliwayo	M	Arcturus	ZYPDC Box 14 Arcturus youth rep
49.	Denna Moyo	M		Secretary Resident Association
50.	Tinashe G Mcatshelwa	M		MYDW Secretary for health
51.	Elisha Nyamukunda	M	Rusape	Vengere HCC/ ZINATHA
52.	Dickson Mamwara	M	Acturus	(ZFCT) HCC Vice Chairperson Arcturus
53.	Micah Musiwa Nondo	M	Zvishavane	HCC Committee member
54.	Theresa Chiweya	F	Marondera	(Health in churches) 10A1 Chitumbwana Marondera 0773595011
55.	Dorothy Masora	F	Marondera	(ZICHIRE) BC 22 Hunyani Marondera 0733835758
56.	Charity Mutumwa	F	Chipinge	(Jekesa Pfungwa) 3590 Gaza E, Chipinge 0772521915
57.	Miriam Maparura	F	Rusape	(Community rep) HCC Chairperson Rusape 0774366937
58.	Gladys Muzimba	F	Mutare	CWGH Chairperson Dangamvura 4926 Area 3 Dangamvura, Mutare 0773872451
59.	Deslinah Moyo	F	Insiza Filabusi	WAAC Chairperson, Zhulube RC Insiza 0712282357
60.	Lizwelihle Ncube	F	Insiza Filabusi	HCC Secretary and VHW Nkankezi Clinic Insiza 0776421667
61.	Z. Khembo	F	Plumtree	Trature Marula Clinic, Plumtree
62.	Tatenda Kujeke	F	Secretariat	114 McChlery Ave, Eastlea, Harare
63.	Carol Mubaira	F	Secretariat	Community Working Group on Health carol@cwgh.co.zw
64.	Sabine Eckart	F	Secretariat	BMZ- Medico international
	Facilitators			
65.	Fortunate Machingura	F	Secretariat	Training and Research Support Centre (TARSC) fortunate@tarsc.org /fmachingura@gmail.com / www.tarsc.org
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67.	Rachel Gondo	F	Secretariat	Community Working Group on Health rachel@cwgh.co.zw
70	Itai Rusike	M	Secretariat	Community Working Group on Health, itai@cwgh.co.zw

11.2. Appendix 2: Programme for delegates (September and November 2011)

Health Centre Committees Delegates Training programme: 12-14 September 2011 and 12-14 November 2011

EVENING

TIME	SESSION CONTENT	ROLE
Evening	Distribution of the Health literacy manual	Faith Kowo Mevice Makandwa Edgar Mutasa

DAY ONE

TIME	SESSION CONTENT	ROLE
Welcome, objectives, introductions		
0800-0830hrs	Registration, logistics	CWGH/ TARSC
0830-0900hrs	Welcome Introductions: facilitators; Participants Workshop objectives,	Edgar Mutasa Fortunate Machingura
0900-1030hrs	Overview of the health centre committee work : governance and participation work in the wider Health Literacy programme	Fortunate Machingura
1030-1100hrs	**tea**	
Health Systems in Zimbabwe		
1100-1130hrs	What do we mean by a health system?	Esther Sharara Fortunate Machingura
1130-1300hrs	How the Health System is organized in Zimbabwe	Rachel Gondo Fortunate Machingura
1300-1400hrs	**lunch**	
1400-1450hrs	Community roles in health systems	Edgar Mutasa Fortunate Machingura
1450-1505hrs	Mechanisms for coordination of health services And Major health programmes	Edgar Mutasa
Health Centre Committees		
1505-1615hrs	What are Health Centre Committees	Esther Sharara
1615-1700hrs	The Functions of Health Centre Committees	Fortunate Machingura
1700hrs-1715hrs	**Tea and end of day evaluation**	

DAY TWO

TIME	SESSION CONTENT	ROLE
0830-0900hrs	Review and logistics	EM
Working with communities		
0900-0945hrs	Communities organizing for health	Mevice Makandwa Esther Sharara Fortunate Machingura
0945-1015hrs	Communication skills	Esther Sharara
	Holding meetings	Fortunate Machingura
	Preparing and presenting a report	Rachel Gondo
1015-1030hrs	**tea**	
1030-1115hrs	Group presentations	Mevic eMakandwa
1115-1200hrs	Putting all our skills to practice:	Fortunate Machingura
Working with health workers		
1200-1215hrs	Health workers at district level Community Health Workers and their roles	Edgar Mutasa
1215hrs-1300hrs	Health workers and their roles Improving interactions between health workers and communities	Esther Sharara Mevice Makandwa
1300hrs-1400hrs	**lunch**	

1400hrs-1450hrs	Patient charter	Fortunate Machingura Rachel Gondo; Esther Sharara Edgar Mutasa
1450hrs-1540hrs	Advocating and negotiating health issues	Rachel Gondo Fortunate Machingura
Health planning		
1540hrs-1620hrs	Development of plans at local, district and national level Identifying community priorities	Mavis Makandwa Fortunate Machingura
1620hrs 1640hrs	Implementing and monitoring health plans	Edgar mutasa Mavis Makandwa
1640hrs-1700hrs	Tea and end of day evaluation	

DAY THREE

TIME	**SESSION CONTENT**	**ROLE**
0830hrs- 0900hrs	Review and logistics	
Health budgets		
0900hrs-0925hrs	Mobilizing resources for health The budget cycle	Rachel Gondo Fortunate Machingura
0925hrs-1015hrs	Monitoring and tracking budgets/Expenditure Management	Esther Sharara Fortunate Machingura
1015-1030hrs	tea	
Building alliances for health		
1030hrs -1130hrs	Working with members of parliament and local government Support from the health sector Other Sources of support	Esther Sharara Fortunate Machingura Edgar Mutasa
1130hrs-1150hrs	Setting up the community HCC work	Edgar Mutasa Fortunate Machingura
1150hrs -1155hrs (5 min)	Next steps and closing	Fortunate Machingura Itai Rusike