

PARTICIPATORY METHODS FOR COMMUNITY INVOLVEMENT IN HEALTH: SOUTHERN REGION HEALTH LITERACY FACILITATOR TRAINING

WORKSHOP REPORT



**Training and Research Support Center (TARSC)
With the
Community Working Group on Health (CWGH)**



Health Literacy Programme



**Selborne Hotel, Bulawayo
November 20th-24th 2007**

**With support from Kellogg Foundation
Report produced by TARSC and CWGH**

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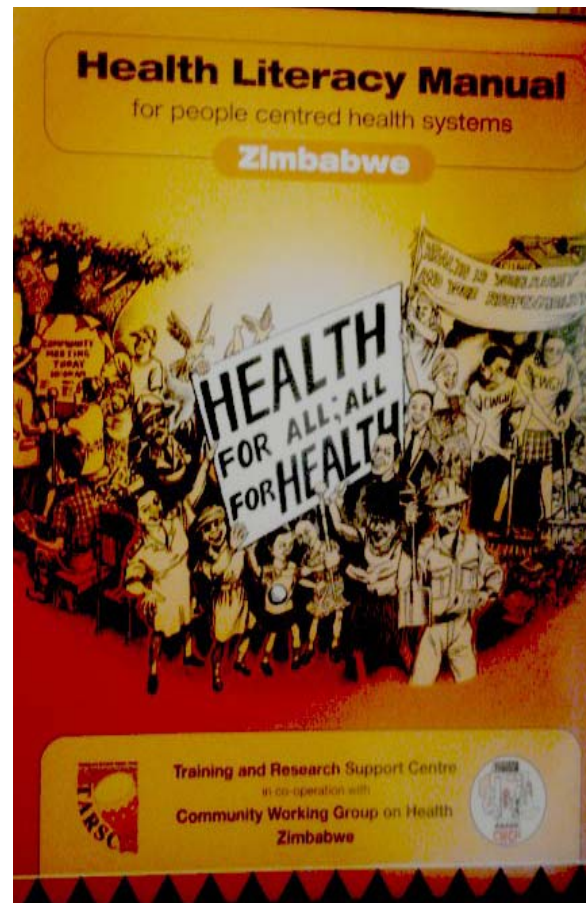
1. Background

In November 2007, Training and Research Support Centre (TARSC) and Community Working Group on Health (CWGH) under the Regional Health Literacy programme held a five-day Health literacy facilitator-training workshop. It aimed at introducing the health literacy programme and provide core skills and information to CWGH health literacy facilitators to implement the programme.

The regional health literacy programme in east and southern Africa is being implemented through TARSC Zimbabwe in co-operation with CWGH Zimbabwe, with MHEN Malawi and the Regional network for Equity in health in east and southern Africa (EQUINET). The programme aims to support the development and use of participatory health education materials for health civil society. It is being implemented in Zimbabwe, Malawi and in third country being identified in 2008 with support from Kellogg Foundation.

This report presents a summary of the proceedings of the 5-day workshop. It involved facilitators drawn from the academia, private industry, associations, health institutes, health workers, and various governments' institutions of Zimbabwe under the CWGH umbrella as listed in Appendix 2.

TARSC and CWGH have a history of work on Participatory Reflection and Action (PRA) approaches in health since 1997 through the Civic Education Programme on Health. This programme in the CWGH arose because of well-articulated demands for information and participation arising from a survey of health needs and the priority strategies in 1998. The programme and materials for it were developed by TARSC/CWGH members and covered public health, health systems and organizational issues prioritized by the CWGH. The programme used participatory approaches, facilitators were trained from within CWGH members and a facilitator' guide was provided with the training materials to support these roles. The CWGH used the programme between 2000 and 2006 to support district activities, dialogue with health care providers and to strengthen informed participation and joint planning on health activities. An evaluation of the programme was carried in 2005 by TARSC with CWGH, separately reported ([see: *TARSC (2005) Evaluation of the CWGH Civic education programme on Health TARSC: with CWGH, Harare Zimbabwe*] Discussion of this evaluation revealed information, capacity and skills gaps that would be addressed in the next stage of health literacy training and in the development of a Health Literacy manual



[see: TARSC, CWGH (2006) *The CWGH facilitators' review meeting report; 1-2 November; Silveira house- Harare TARSC: Zimbabwe*]

The Health Literacy manual was developed by TARSC with input from CWGH, piloted, peer reviewed, revised, edited and finalized (Loewenson R, Kaim B, Machingura F (TARSC) Rusike I, Chigariro T, Mashingaidze L, Makone A (CWGH) (2007) *Health Literacy guide for people centred health systems: Zimbabwe, TARSC: Zimbabwe*)

The criterion for selection of a Health Literacy Facilitator (HLF) was determined at the CWGH board meeting, with characteristics including that the person would:

- Be a member of a CWGH member institution with a district level function- e.g. committee member, educator, organizer, youth member etc
- Have had experience of working with CWGH for 2 years or more
- Have experience and skills in health and in education and training, preferably but not essentially, using PRA approaches
- Have good communication skills, is literate in English and local languages, has good facilitation skills, and works well with communities
- Not hold other conflicting posts or roles – e.g. formal office in political parties, formal role managing in health services
- Have flexibility in time and work to hold community meetings

The facilitator is expected to facilitate health literacy training for CWGH, facilitate community dialogue on experiences, and encourage reflection on health problems, their causes, and actions. Importantly to obtain, communicate and ensure provision of relevant information on health to communities and encourage all relevant stakeholders in health to communicate and take joint and informed action on health issues

For this first round of training a total of eleven districts from the Southern districts of Zimbabwe were covered in the workshop. The workshop covered an introduction to the CWGH (and Module 8), and the training in Modules 1,2,3,4,6,7 and 8. Module 5 will be covered in April during the review workshop. Facilitators for different sessions of the workshop were Fortunate Machingura and Senele Dhlomo from TARSC and Albert Makone and Tafadwa Chigariro from CWGH.

This report does not go into detail on how the sessions were conducted. The manual that goes into detail on sessions is separately available. The meeting involved exchanging experiences, activity, dialogue, reflections, and discussions on next steps and follow up. The programme is shown in Appendix 1.

The objectives of the 5-day facilitators training meeting were to

- Introduce the health literacy programme
- Provide core skills and information to CWGH health literacy facilitators to implement the programme
- Work with the health literacy facilitators manual to enable use of the manual in the programme

2. Overview of the health literacy programme

We introduced the Health Literacy Programme and the approach that we were going to use during training. We explained that Training and Research Support Centre (TARSC) is currently implementing a regional health literacy programme in East and Southern Africa in co-operation with the Community Working Group on Health CWGH in Zimbabwe with support from Kellogg Foundation. The programme is developing and supporting work with participatory health education materials for health civil society working at community level and aims to build core public health skills in people working at community level on health.

We highlighted that we would use participatory reflection and action methods during the training workshop tested at regional and national level in health. The programme is now advancing in Malawi and Zimbabwe and we are hoping to include a third country working with a partner at community level in Mozambique, Botswana or Lesotho

We began by asking participants about their prior experiences with health education-strengths and weaknesses. We then highlighted that the strengths will be taken forward in the Health Literacy programme and weaknesses addressed. We went through the manual together with the participants explaining the flow of modules, links between information and participatory activities, and use different sections.

We stressed the importance of merging technical content in the manual and the participatory tools in order to make understanding of the technical information much easier as well as taking note of the vital participatory tools that facilitate the process

3. The Community Working Group on Health

We outlined the formation of CWGH, its vision and mission. We noted that it was important for participants to understand the history of CWGH and its work, its core values and objectives.

We highlighted that the Community Working Group on Health is a network of civic/community-based organizations that aim to collectively enhance community participation in health in Zimbabwe. The CWGH was formed in early 1998 by six civil society organizations and co-ordinated through Training and Research Support Centre Zimbabwe to take up health issues of common concern. Today, the approximately 30 organizations in the CWGH include national membership organizations that have branches across the country, while others have areas-specific membership (such as the residents associations). The CWGH was registered as a trust in 2002 and aims to collectively promote and support active community participation in health issues through advocacy in order to improve the quality of human life in Zimbabwe and in the region. It aims to lead in health advocacy to promote and support full community participation in health issues in Zimbabwe and the region.

The Health Literacy programme strengthens some of CWGH's core values and principles, *“the Health literacy programme will raise community concerns, issues, and positions with health care providers at local and central level and promote dialogue with health worker organizations to resolve issues of common concern. This will help to develop collective positions on policy and other issues on health. With such*

communication, there is assurance of grassroots participation at all levels of development.” Albert Makone; Monitoring and Evaluation officer CWGH.

Participants in their various groups used an illustration/drama as an entry point to show how the CWGH is organized, strengths and weaknesses and what actions make the CWGH stronger at all levels. The illustrations drew out common features of their experiences...



“Building alliances is very important today; and I appreciate the effort put in by the CWGH secretariat to make new partners and in strengthening membership, I would love to know how new members are selected, what criteria is used,” Alima Milazi; Hwange Aids Project-Hwange

“Resources given to districts should support some unbudgeted costs faced by the district committee members especially in this hyperinflationary environment I want to suggest that the CWGH Monitoring and evaluation officer based in Harare submit reports of activities done, so that we are kept abreast on current achievements and commitments, also-for best practice learning approaches” G. Bepete; Ministry. of Gender-Chiwundura

“from my experience as a community voice activist, and also having been part of the CWGH, I really feel that the secretariat should approve financial requests early. If communications on the phone or fax are difficult and if situations become more unbecoming like now, we suggest that the secretariat provide a personnel who travels

around the districts disbursing cash and communicating with the CWGH district representatives.” Owen Sibanda; SPW-Plumtree

“We have a national office that is too busy and hardly has time to attend to all districts needs at urgent times. I think one weakness we have as CWGH is that in our structure we do not have provincial offices. So, in order to address this weakness, I feel we need a provincial office that helps to improve communication and lessen the amount of work the secretariat has.” Dumisani Masuku; Min. of Education-Victoria Falls

Some chairpersons at district level have taken so long at the same position; I feel we need to reshuffle this through a policy, perhaps a policy that says a chairperson should not serve for consecutive years” Herbert Mhonde; Kwekwe Polytechnic-Kwekwe

From the illustrations, it was clear that the participants understood and showed that the CWGH aims to collectively promote and support active community participation in health issues through advocacy in order to improve the quality of human life in Zimbabwe and in the region. It stimulates the formation of local structures for civic participation in health and support informed community participation in local health structures. As such important to strengthen, the CWGH structures so that these deliverables are met

While describing the CWGH programmes, we briefly outlined the major programmes (civic education, adolescent and reproductive health, HIV and AIDS from a gender and sexuality perspective) as explained Module 8.2 of the Health Literacy Manual



We displayed all the materials that CWGH has documented, based on this material and the participants experiences, participants commented on action taken and support needed at different levels in the CWGH structure

We would appreciate if we could have a capacity building workshop in every district once a new committee is elected” Moses. M. Ncube; CIVNET-Tsholotsho

“National members should brief the district committee on issues that would have been discussed at national level that affect the community” T Mpofu; NCDPZ-Gweru

“We would love the CWGH to come and support projects that we do we initiate as community members and not necessarily under the CWGH. We are trying to set up a VCT centre in rural communities, maternal mortality is on the increase yet we often hear that statistics from the Ministry of health report otherwise. Maternity clinics are often very far and most women do not go for their antenatal visits, they opt to go when they are seven-months pregnant and stay there until they deliver. Often, they are told of their HIV

status and at this stage little can be done. Furthermore, there is little male involvement in PMTCT, making it difficult for the mother to reduce her chances of infecting her baby and re-infecting herself. Often, women are found breastfeeding their babies and they do not tell their husbands about the HIV for fear of being hit, divorced or victimised. We would love it if the CWGH could support the recent domestic violence act, and help women as a vulnerable group. The CWGH could do this by encouraging everyone's participation , and this will include men who are at this point lost!" G. Bepete; Ministry. of Gender-Gweru

Participants concluded that it was important that all activities become community based, participatory, independent, and sustainable if action oriented interventions were to succeed.

4. How TARSC works on health

We looked at the different work areas and resources of TARSC. This was through a mini exhibition whilst participants circulated around the room looking at the literature and engaging in discussion with a person from TARSC at each 'station'/exhibition site. At the end, participants discussed in plenary on how TARSC's work supports and deepens the activities of organizations such as CWGH. Hence, complimentary work in areas of reproductive health through the auntie Stella toolkit used by the CWGH Youth Programme, the PRA toolkit used in several participatory projects within the CWGH, the Health Literacy Manual that will be used in many Health literacy projects in the country , the Community Based Research and Training Programme provides research support to the health basket monitoring and so on. Examples of how TARSC supports CWGH in research, training, and other work were highlighted.

5. Introduction to health literacy and PRA

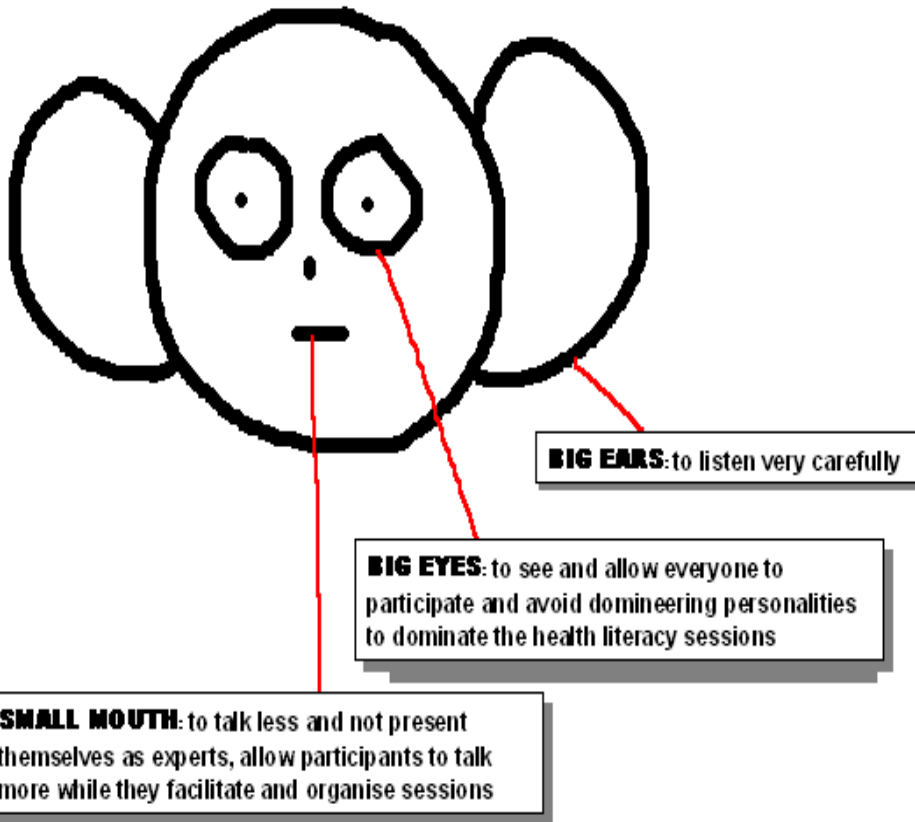
5.1 Using PRA approaches in health

Participants were given a short introduction to PRA, the facilitator asked participants to break into groups to share their experiences in participatory approaches and to list the key features of a participatory process/ experience

During plenary, the following common themes emerged:

- Collective and active involvement of everyone in the community
- Collective action- ownership of the program and empowerment
- Need for monitoring and evaluation
- Problem identification and empowerment
- The community needs to address their needs in order of priority

All of the groups identified the need to come up with *solutions*. The facilitator stressed the need rather to come up with *action plans* and noted that in order to collectively move towards action plans *participatory tools are needed*.



A health literacy facilitator is expected to facilitate processes in the community and ascertain that the spiral model is understood as communities reflect, meet to discuss and share experiences and act on priority health needs while weaving this with the health literacy information. Participants highlighted that there is need for health literacy facilitators to be attentive, to listen, to talk less, prepared to learn new things from communities and not to present themselves as experts.

5.2. Approaches to health literacy- using PRA in health

We looked at two case studies in the manual and analyzed the actions taken by communities for each case study. We identified what made the actions successful and what made them fail. We gathered that successful participatory action by all stakeholders (social groups) is important in all interventions at community level.

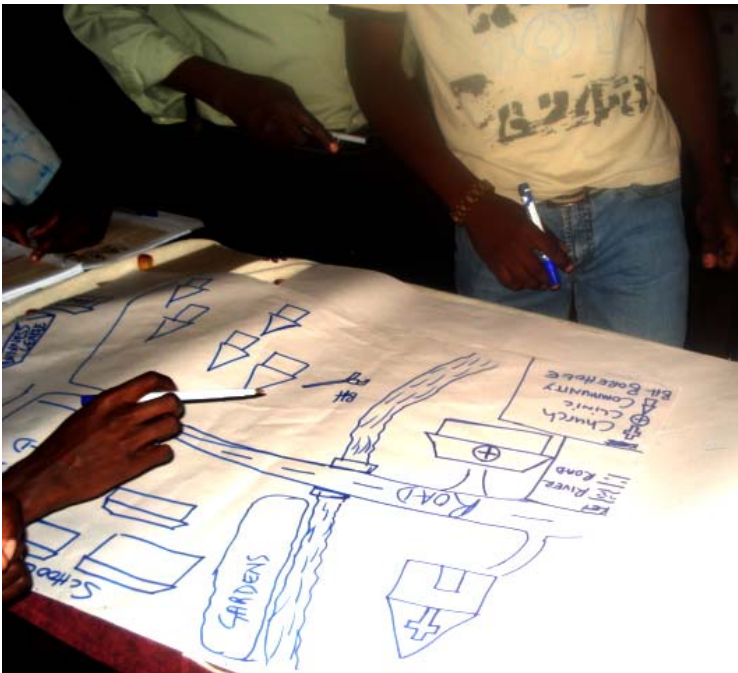
In plenary, we agreed that health literacy requires the ability to improve health that often depends on understanding the causes of health problems then encouraging dialogue between the public and health services on these problems and how to deal with them. Often, this is be accompanied by feedback from health services on how they are addressing health issues. We concluded that improving health goes beyond simply knowing about health. It is about being able to take effective action. As such, we are choosing health literacy over health education because it goes beyond giving information, to supporting action. We highlighted that supporting action was depended on community participation and effective resource mobilisation and that these two complimented each other

Participants had mixed feelings when they were asked how they felt when they facilitated and when someone else was facilitating. Some felt that it was challenging to facilitate whilst some enjoyed the process. Some participants felt neglected when there was someone dominating the group, other interesting views pointed at ways to make passive participant who lacked self-confidence participate. Rappoteuring was viewed as a boring and difficult role, it needs someone who concentrates and who is a good listener and able to follow the discussion and write at the same time. We highlighted that

a Health Literacy facilitator should be conversant with all these roles as they compliment each other.

6. Health of communities

Four pictures were put on the wall and participants were asked to comment if the people on the pictures were healthy, why they were healthy or not healthy. This session enabled us to understand that health is not only the absence of disease but also a combination of many other factors. This session was found to be quite relevant in empowering communities as it is the backbone for promoting health and motivating action within communities. We resolved that Health is a multi-faceted and cannot be described by one aspect of well being; we used the WHO definition of Health as in the manual to illustrate the meaning of Health.

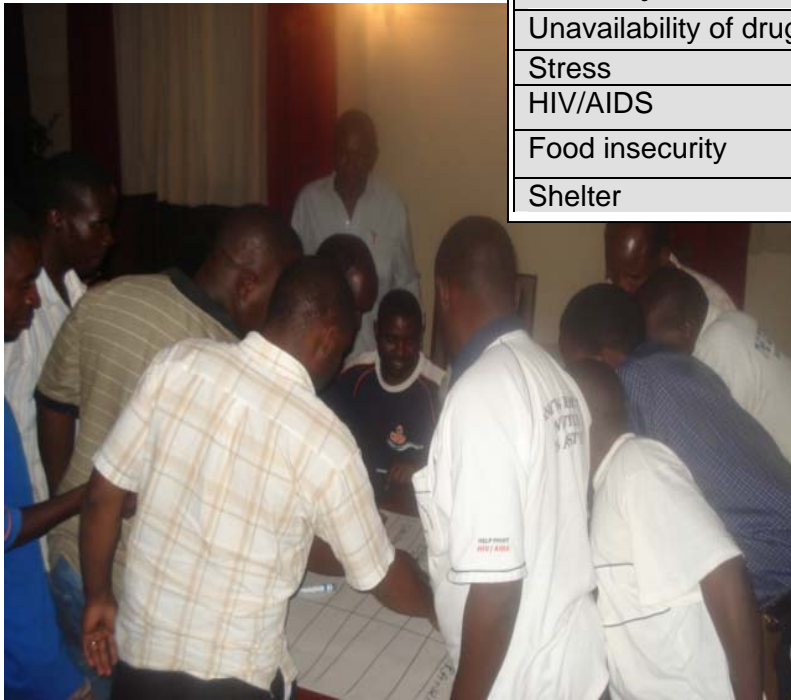


When we had all agreed that health is multi-dimensional, we explored how different communities and social groups react and understand health differently. We discussed the components that define communities and how we understand 'community' consequently, we explored how we understand 'social groups'. Fictitious social maps were drawn representing fictitious communities with features that directly or indirectly influence health of different social groups.

We explored the transect walk. *"I think the transect walk is more practical in clustered settlements and urban communities, not in sparsely settled areas in some rural areas, it would otherwise be very impossible unless we can do it in a moving vehicle to observe a range of features, resources and conditions in the area, in that case I would then call it a transect drive!"* Jotham Mutemeri; GAPWUZ-Gweru

We agreed that mapping is usually an entry point of a health literacy facilitator into a community; it enables the facilitator to understand problems associated with social groups in that community.

It is important in Health Literacy programmes to identify and prioritize health needs. We explored ways in which these needs could be prioritized through the 'ranking and scoring method'. Three different groups, men, women and youth, identified their priority health problems. An example from the men's group is given below:



<i>What is your health problem</i>	<i>Score</i>	<i>Rank</i>
Unavailability of drugs	3	5
Stress	7	2
HIV/AIDS	6	3
Food insecurity	8	1
Shelter	5	4

We compared the above list with the top ten out patient conditions in Zimbabwe in 2002. We saw that there were huge differences. For example the number one problem according to the Ministry of Health was '*acute Respiratory infections*' with a

total of 25.8% of total new cases in 2002 alone. The health worker priorities are clearly different from community priorities. We explored reasons why there were such huge disparities and the following is what the participants concluded

- *The methods used in determining the most priority condition or problems are not people centred*
- *Data collection does not represent the whole population as such not all demographic variables are considered.*
- *Some social groups are left out e.g. children and infants*
- *The economic environment has made many social groups poorer, most do not visit hospitals and clinics were most of this data is captured from. The community voice is silent in those statistics*
- *The question is who prioritizes those health conditions the health provider of the communities? Clearly, it is the health provider; the information resembles the provider's perceptions on what the priority health conditions are.*
- *Data is not captured regularly; the data in the manual is 2002 data, which makes it difficult to compare with today's problems.*

7. Healthy Environments

We briefly talked about the constitution of Zimbabwe, participants were advised to learn more about the constitution so that they converse well with it and are able to apply or quote from the constitution and when addressing issues that are related to it.

The constitution reveals that people have a right to life, the Public Health Act supports the constitution and the right to health, and participants were encouraged to get the public health act and be acquainted with it so that they are able to give reference to it.

Participants also suggested some issues that should be considered in the Zimbabwean 'constitution, examples include the following

"Ministry has a policy on essential drugs there is need for a clause in the constitution that defines the issue of essential drugs"

"There should be a clause in the constitution that specifies the amount of coli forms that can be accepted in water for it to be rendered safe for drinking "

We explored characteristics of an environment that promotes well being and examples included toilets/waste disposal, water, cleanliness, social facilities e.g. playing ground, decent accommodation. We discussed consequences of water privatization drawing in from participants experiences, the following are some remarks on the effects of water privatization...

"i am from a rural district, sometimes we sacrifice to go for years without enough saving for boreholes, then once you have the borehole you are required to pay some money to ZINWA every month, I don't understand why I have to pay for water at a rural homestead" D Rumona; VHW-Chiwundura

"in Kwekwe, we are in the process of finding alternative ways to curb cholera outbreaks. These outbreaks have been caused by a permanently burst sewer pipe, which has caused many diseases other than cholera. What's surprising is that we pay monthly to ZINWA to correct such and they never come, we often wonder where our money is put" M C Mukamuri; Min Of Education-Kwekwe

"Commercialization of water is leaving families broke, food insecure and poorer than before. This is because we are paying twice for the same service. We pay for water when we pay tax, then we pay again through ZINWA, it is just unfair. Nothando Moyo; Plum tree AIDS Project-Plum tree

We discussed several ways in which the CWGH could get involved, and reiterated that when facilitators have gone back to their districts they should hammer on drawing out issues from community experiences then add new information where necessary and beginning planning for action before the actual implementation.

In relation to this, we laid seven pictures on the floor and asked three volunteers to sort the pictures into three piles, BAD, GOOD, or NEUTRAL. Other members agreed whilst others disagreed on the decisions the volunteers had made on the pictures depiction of effects on environmental diseases in the community. After several discussions around what and how diseases spread from unsafe water and sanitation in our community, the

pictures were resorted. Diseases discussed included diarrhea, cholera, malaria followed by diseases spread through overcrowded or unsafe housing such as Tuberculosis. These discussions informed development of action plans that communities can develop when dealing with Healthy environments in their communities.

We discussed approaches to dealing with diseases arising from unsafe environments. We highlighted the five-stage approach as given in the example below

1. *Look for and identify the source of the problem*
2. *Control the problem at the source - for example if it is unsafe water due to an uncovered well, cover the well and introduce a handpump*
3. *Control the problem along the path way – for example using bed nets to stop mosquitoes reaching and biting people*
4. *Screen people who might be exposed to the problem- for example screening urine for blood to detect bilharzias, treat it and avoid further spread*
5. *Treatment*

For example, in the case of an outbreak of bilharzias:

Look for the source: *The disease is introduced by urinating in the river*

Control the source; *People need toilets, build toilets; People need to get education on how bilharzias is spread, effects of bilharzias, prevention and control*

Break the path way and control on the pathway:
Eliminating the infected snail population by using molluscicides

Screen people: *Look for signs and symptoms such as blood in urine*

Treatment: *treat those with positive signs and symptoms of bilharzias*



8. Healthy Nutrition

We reviewed what we mean by food security and food sovereignty in buzz groups. Participants knew there was a difference but could not draw the line between the two. As we discussed and shared experiences we all began to understand the relationship between the two but also noting the differences. These concepts are described in the HL manual.

The issue of 'quality *and* quantity' was common for both concepts, as participants kept referring to 'enough, balanced, nutritious' food. This led us into an engrossing debate on the healthiness of the foods we eat through a three pile sorting approach. In this discussion, we emphasized more on major nutrients, how best we can extract them in their natural form and without losing them through overcooking and/or processing. Consequently, we discussed what happens to people when they do not get adequate

healthy food using an illustration in the manual of a well-being map and how to monitor nutrition in the community using examples such as the Shakier strip. In addition, we talked about selecting foods that are locally available and highly nutritious such as beans for children as a special vulnerable social group. Other social groups that we discussed include People Living with HIV and AIDS, Expecting mothers, old aged people, manual workers, infants. An example of nutritional needs for one of the groups is as follows....

What do you think Pregnant mothers should eat and why?

“When I was pregnant with my first baby my mother in law often said I should eat for two, have a diverse diet that is rich in energy and micronutrients, I would eat a lot of energy giving foods like potatoes, sadza, rice and cassava with vegetables such as rape and pumpkin leaves. The vegetables are good sources of micro nutrients such as iron” Arleta Dube, NAC, Tsholotsho

‘I often see many women nowadays being encouraged to eat Carrots for vitamin B, liver and spinach for iron, beef and chicken for protein. Physician always encourage expecting mothers to eat a lot of protein to build new cells for the growing baby:’ Agnes Mamvura; CHBC-Kwekwe

“I ate a lot of butternut, pumpkins and carrots, a nurse at the antenatal classes told me that yellow vegetables were good for good eye sight for my baby” Mary Jokoza Sundami, Zimbabwe Women Farmers Federation Association-Chiredzi

“I have always hated fish, but whenever im pregnant I eat fish, my gynaecologist told me that fish has oils that are important for my bay’s brain development, and all my children are very intelligent.” M C Mukamuri; Min Of Education-Kwekwe

The contributions were rich and informative. We closed the day with a reflection of the day on lessons learnt, outstanding questions, and whether modules in the manual provided enough tools to be able to strengthen the link between knowledge and action at community level. We also reflected on what additional support and information participants would need to facilitate sessions on these modules. Feedback on what was learnt was generally good and positive.

9. Understanding health systems.

We began by discussing Primary Health care in relation to the health delivery system. What is the health delivery system made up of and how should the different components relate in order to have an equitable strengthened health delivery system? Is this what is happening?

We took the example of a young man who had been hit by a car and rushed to the clinic. *Would he be given enough attention? Would he be supported? How would the family support him?* We made a human sculpture of how we think our health systems currently respond.

For example,

- the health workers ignored the young man who was bleeding to death...
- *he was with his mother in pain (lack of support)...*
- *The nurse was busy on the phone ...*
- *The clerk was busy telling stories with the general hand...*
- *The Doctor was far away from the scene...*
- *There were no drugs*
- *Other patients in the queue looked tired and hopeless...*
- *There was no transport to ferry the patient to the hospital...*

- *The resources were far away in the Ministry of health (too much beaurocracy)...*
- *The ministry of health was not aware of what happens at clinic level...*
- *The parliament was high up on the chair and communication was impossible from clinic level....*
- *The IMF and other donors only cared about money, and how much loaned given to which country at what interest rate, or at what benefit*



After this, we moved the human sculpture around until it looked more like what we thought people centered health systems should look like. There were many differences after turning around the Human sculpture

- *The young man was at the centre of the health system (continuum of care)*
- *The family was being supported by other structures in the community, such as the police the CWGH,*
- *The health workers were more involved, prepared to listen, supportive and ready to give aid (more dialogue and communication)*
- *There were drugs and other resources at the clinic and better links and communication with other levels in the health delivery system*
- *The ministry of health had a clear picture of what happens at clinic level and work centered on supporting the structures and people at the clinic*

- *The IMF and other donors though far away from the clinic were putting people first before profits*
- *The health system was more people centred*

From this sculpture, we discussed attributes that make health systems people centered, and that turning this around meant empowered communities that are able to take action of their own health problems, we re-emphasized the concept of health literacy once more! Furthermore, we strengthened the lessons from the Human sculpture with lessons learnt from a talk show around ways in which health systems respond to social differences in traditional services and youth friendly services. We were also able to discuss factors facilitating or hindering the utilization of the health systems by communities. One of the factors looked at the relationship between communities and the health workers.

As a result, we brainstormed on health workers, push, and pull factors and how Health Workers relate to the community and vice versa. We used the Margolis wheel to explore and strengthen communication between health workers and communities and to find ways to involve health workers in the HL meetings

Communities and health workers blame each other for the collapsing health system some of the comments raised include the following...

Communities

- *Health workers take communities as uneducated people who know nothing and view themselves as highly educated, they forget that some of the community members they treat are actually professors who teach medicine!:*
- *'Nurses are busy pursuing other interests at work instead of attending to patients..'*
- *'Doctors and nurses are rude to patients...'*

Health workers

- *'Most community members forget that from another angle we are also community members and we have rights just like them take us for granted and do not respect us...'*
- *some patients make it difficult for us, they think we are supposed to stay even if conditions of stay are not supportive.*

We realized that it is important that both communities and health workers work together from planning level. It is therefore essential that during Health literacy activities communities involve health workers and local leadership to strengthen communication in health systems.

10. Community roles in health systems

Through dialogue and effective communication, we realized that health workers and communities have important roles to play in health systems. We used "*where's Wadzai*" concept to show the important roles the community can play to strengthen health systems. The activity is illustrated in the Health Literacy manual page 125-127.

We explored the role of Health Center committees and current health planning mechanisms such as district development committees and rural district councils, and how well they be used to strengthen Health systems.

We used a wheel chart as a way of exploring how health systems listen to people's views. The manual provides further information on this. The wheel chart helped to explore views on reasons why the health systems do not listen to people by looking at the current situation and what should be. We discovered that there is an urgent need for wider engagement in health if strong health systems are to stand firm. Engaging with key institutions is key in ensuring community health needs are met. We identified groups, institutions, and individuals involved with health issues who should be engaged in health systems. Furthermore, we explored the role of civil society in ensuring local action addresses community priority needs. We did this by looking at the priorities adopted by health civil society groups at the Southern African Social Forum in Zimbabwe 2006. We explored the important priorities in relation to what was happening in communities to address these priorities in reclaiming resources for health and building people centered health systems, what still needs to be done and how. We wrapped the day by another reflection exercise.

11. Next steps and closing

We began by discussing how we would set up a community Health Literacy programme. We discussed the importance of drawing both a facilitator plan and a community plan and what each should include. Detail on facilitator and community plans are at the end of each module in the manual. Participants were reminded that training on Module 5 'Health life cycles' would be done in April 2008 during the review meeting. We emphasized that when participants develop their work plans, they should consider including core modules. Participants went into groups where they discussed and developed Community Health Literacy Programs for their districts. These work plans were to specify 'Who will come to the Health Literacy session in terms of both participants + facilitations; when these sessions would be held? For how long and how long before the next session? How many sessions between now and feedback session set for January 17 2008?

The following is an example of a community plan –Chiwundura District

Where	Who	When	Support	Module
<i>From this Health Literacy workshop, we will go and make contact with other CWGH committee members and set a date for a meeting. In this meeting, we will discuss the Health literacy facilitator training workshop and what we intend to do in the community as Health literacy Facilitators.</i>				
<i>Muchakata</i>	<i>CWGH Committee members</i>	<i>11/12/07 10-1200hrs</i>	<i>Transport reimbursements, refreshments and snacks</i>	<i>Feedback</i>
<i>We will begin to notify the chief, the councilor and other important stakeholders, including some community representatives about the Health literacy workshop that we will hold, at specified date, time and venue</i>				
<i>Muchakata</i>	<i>Mobilization</i>	<i>17 /12/07</i>	<i>Transport</i>	<i>Organize workshop</i>

	<i>and sensitization meeting</i>	<i>1000-1200hrs</i>	<i>reimbursements, refreshments and snacks</i>	
<i>We will put fliers around schools, shops, beer halls, shopping centers, and schools about the health literacy workshop.</i>				
<i>Muchakata</i>	<i>All key stakeholders Local authorizes Community (all social groups)</i>	<i>10 /01/08 0900-1300hrs</i>	<i>Lunch Refreshments CWGH pamphlets (not too important), notebooks and pens</i>	<i>Information 8a, 8b and 8c Module 1.1 and 1.3 (we will briefly discuss CWGH and TARSC and introduce Health literacy)</i>
<i>At this point participants have a full understanding of what Health literacy is. That it involves using health information and services to promote own health through action. We ask participants to think and discuss issues, conditions and/or problems they think are crucial in Chiwundura district. They can do it as friends, social clubs, at bars, at women's clubs, youth centers etc to prepare for the next session. Meanwhile we (the trained HL facilitators) will be planning for the next session i.e. programme, resources, food and invitation for other official authorities</i>				
<i>Muchakata</i>	<i>As above</i>	<i>After every fortnight</i>	<i>As above</i>	<i>Module 2.1; 2.5; 2.3; 2.2</i>
<i>After this session, participants would have identified, their priority health problems. We will refer to module 2 community and facilitator plans to plan for next session, some of the issues to consider will be who to invite as a resource person for the next session etc</i>				
<i>Muchakata</i>	<i>As above</i>	<i>After every fortnight</i>	<i>As above</i>	<i>Either module 3; 4 or 6. The module to be done shall depend on the priority problem raised by the community from the previous workshop</i>
<i>Community and facilitator plans at the end of optional modules will guide us to the next level. We are assuming that at this point we would have gone through the first steps in the spiral chain and we would be ready for action.</i>				
<i>Muchakata</i>	<i>Review CWGH Committee</i>	<i>Two weeks after</i>	<i>Local Authority CWGH</i>	<i>Informed by the previous sessions and planned activities between sessions</i>

More than half of the districts in this workshop developed an almost similar work plan, the work plans were designed up to April 2008. We agreed that the health literacy review meeting would be held in April. This would give facilitators just enough time to begin implementation. We explained that the manual is not similar to a book as such the approach should not be that of a book, facilitators would have to pick a module that matches with the community priority needs e.g. if a community is having problems with water, then module four 'healthy environments' would be ideal. The design of the manual is to facilitate dialogue with community. It may not be necessary to do everything in the manual, as some sections/modules may not be relevant. We discussed core essential modules that should be dealt with to give communities an understanding of Health literacy, CWGH, community roles in people centered health systems and health of communities. The other modules are optional and provide information on health and health systems. These would be used depending on the community priority health needs.. this was well understood as shown by their work plans preferred/selected modules.

After developing the draft work plans we discussed and planned a follow up strategy. We agreed that the CWGH health literacy facilitators would have to report to the CWGH secretariat on their work. To facilitate this TARSC and CWGH developed a feedback format that would be used by every district when giving feedback on the community Health literacy programme as shown...

Each facilitator keeps a small A5 diary to record

- The preparations etc they made for training
- The sessions they personally took. How they went and what their experiences were of doing them
- Any difficulties they had.
- Anything that worked really well?
- What they would like to bring to our attention in the review meeting.



You will be asked to bring this during the review meeting in April 2008

Each team of 3 facilitators trained on 20-24 November 2007 to send in a report on the 20th of January-first week of February 2008 and by the 24th of March 2008 of

- District. Names of facilitators
- Dates, times and venues of sessions held
- Participants (how many, who)
- Facilitators, and resource persons if any - who
- What was covered in the sessions – can refer to Modules covered
- What actions were carried out between sessions and with what result?
- What problems or difficulties were encountered? (in Information, skills resources etc.?)
- What support is needed from CWGH? What support is needed from TARSC?

We urged participants to submit their work plans with budgets for the community health literacy programs the following week. We thanked the participants for their commitment and participation and urged them to begin implementation as soon as they got back to their districts. We closed the workshop with a prayer.

Appendix 1: The programme



PARTICIPATORY METHODS FOR COMMUNITY INVOLVEMENT IN HEALTH: SOUTHERN REGION HEALTH LITERACY FACILITATOR TRAINING-PROGRAMME



TIME	SESSION CONTENT	SESSION PROCESS	ROLE
Evening	Distribution of the Health literacy manual	Delegates will each be given a health literacy manual to go through before the workshop in pairs, groups or individually	FM, AM,
DAY ONE – TUESDAY, 20th NOVEMBER 2007			
800am	Registration, logistics	Participant registration	FM, AM
830am	Welcome Introductions: facilitators Participants Workshop objectives,	CWGH opening TARSC welcome remarks Introductions session Clear outline of the aims and objectives of the workshop.	CWGH national member, FM, TC,
915-1030am	Overview of the health literacy programme	Brief introduction to the health literacy programme and approach to training : Module 1.5	FM
1030am tea			
1100am	Background on the CWGH	Information on the CWGH, its formation, vision and mission	AM
1130am	How is CWGH organised?	How CWGH is organised and functions See Module 8.1	TC
1230pm	CWGH programmes	Outline of the major CWGH programmes See Module 8.2	AM
1300hrs lunch			
2pm	Taking local action: CWGH experiences	Group work on CWGH actions at local, district, national and international level and review of experiences	TC, AM
245pm	Taking local action: CWGH experiences	Report back of group work and discussions	AM, TC
345pm: tea			
400-430	How does TARSC work on health?	See Module 8.2.	FM, SD,
430-500pm	End-of-day evaluation	Exercise and discussion .Materials to read for the next day	SD
DAY TWO – WEDNESDAY, 21ST NOVEMBER 2007			
0815am	Review and logistics	Logistics, Recap of day one and Warm-	TC

		up exercise	
830am	Using PRA approaches in health	Module 1.3 and 1.4 Intro to PRA; role of facilitators in PRA	SD
1030hrs tea			
1100hrs	Approaches to health literacy- using PRA in health	Module 1.1 and 1.2 Understanding Health literacy	FM,TC
12.30hrs lunch			
1400 pm	Understanding health	Module 2.1 and 2.2	AM, TC, FM
1545pm tea			
1600pm	Causes of our health problems and acting on priorities	Module 2.3 and 2.4	SD, AM
1745 pm	Closing reflection and next steps	Discussion on Modules 1 and 2	FM
DAY THREE – THURSDAY, 22ND NOVEMBER 2007			
0810am	Review and logistics	Logistics, Discussion of health rights areas	AM
830	Healthy environments	Module 4.1	TC, FM
1010hrs tea			
10.40hrs	Diseases from unsafe environments	Module 4.2 and 4.3	TC, AM SD
12.40hrs lunch			
1400 pm	Health diets and consequences of poor diets	Module 3.2 and 3.3	FM, AM
1545pm tea			
1600pm	Nutrition needs of special groups	Module 3.4	TC, AM
1715 pm	Closing reflection and individual evening assignment	Discussion on Modules 3 and 4	FM, SD
DAY FOUR – FRIDAY, 23RD NOVEMBER 2007			
0810am	Review and logistics	Logistics, Review of feedback from individual assignments	SD
830am	People centred health systems and PHC	Module 6.1 and 6.2, 6.3, 6.4	FM, SD, TC, AM
1030hrs: tea			
1100hrs	Relationships with health workers	Module 6.5	FM,TC
12.30hrs: lunch			
1400 pm	Community roles and alliances in health systems	Module 7.1 and 7.2	SD, AM
1600pm : tea			

1615pm	Wider engagement on health	Module 7.3 and 7.4	FM, SD,
1745 pm	Closing reflection and next steps	Discussion on Modules 6 and 7 Evening work: Develop a plan for how you would go back and organize the training: When; Where, With who, What flow of sessions	FM,
DAY FIVE – SATURDAY 24th NOVEMBER 2007			
0815am	Review and logistics	Logistics Assessment using flip charts with faces	SD
830am	Setting up the community HL programme	Module 1.5 , facilitator and community plans, training schedules Introduction and discussion on plans	FM, TC
1000hrs (30 min) tea			
1030hrs	Planning the literacy programme	Development and discussion of district plans	FM, AM
1215 pm	Next steps and closing	Modules not covered and next steps on training- FM, TC Next steps on implementing the programme- AM Reporting back and getting feedback and support – FM Participant remarks and comments – assigned participants	All
13.00hrs lunch			

Appendix 2: The delegates list

NAME	DISTRICT	ORGANISATION/ CONTACT DETAILS
L. Jele	BULAWAYO	BHCWTF-P. O. Box 24 Mpopoma, Bulawayo 011 591284
Amos. Kazembe	BULAWAYO	ZYPDC-706 Old Mutual Centre (09) 403408 011 914874
Isao Zvarevashe	CHIREDDI	F.A.C.T-Box 381 Chiredzi Tel: 031-3375 /3002/ 091 752 908
Henry Madakadze	CHIREDDI	TUNZA Trust-Chiredzi 0912756747
Mary Jokoza Sundami	CHIREDDI	Zimbabwe Women Farmers Federation Association-Chiredzi; 0912840390
D Rumona	CHIWUNDURA	VHW- Chikutubwe School Box 1299 Gweru
G. Bepete	CHIWUNDURA	Min. of Gender-St. Barnabas School, P. Bag 1030 Gweru
D. Tonhodzai	CHIWUNDURA	YOUTH-St. Barnabas School, P. Bag 1030 Gweru
Nsindane Nhlanhla	FILABUSI	MoHCW- F. D. H Box 31 Filabusi Tel. 050 234
Rabson Dube	FILABUSI	Min. of Education-PB 5816 Filabusi
Sifelumusa Moyo	FILABUSI	Min. of Youth-Box 16 Filabusi Tel. 017 232
T Mpofo	GWERU	NCDPZ-3535 Mkoba 16 Gweru 054 21906/58, 023 836 180
W. Muringani	GWERU	GRRRA-475 Tembo Road Ascot T/ship Gweru 054 229177 023 689 147

Jotham Mutemeri	GWERU	GAPWUZ-Hse No. 10852 Mkoba 20 Gweru 011 619 685
Itai Owen Sakabuya	HWANGE	ZYPDC-Hwange
Alima Milazi	HWANGE	Hwange Aids Project-02 Lwendule Village, Hwange 081 20778 011 593893
Frank Chirwa	HWANGE	Churches-U12 No 5 Village Lusumbami Hwange 081 24099
M C Mukamuri	KWEKWE	Min Of Education-2 Plambago Crescent, Masasa Park KweKwe Min of Education, Box 90, Mbizo T/Ship 055- 22770 011 778 970
Agnes Mamvura	KWEKWE	CHBC-59/2 Mbizo KweKwe
Herbert Mhonde	KWEKWE	KWEKWE POLYTECHNIC-828 -3 Mbizo KweKwe
Bazibi Ndebele	PLUMTREE	MoHCW-Plumtree District Hospital P. O. Box 27 019 2291/2 011 792728
Owen Sibanda	PLUMTREE	SPW-Shop 3 Vuku Ntengene Complex Dgumuzi Plumtree 023 415839
Nothando Moyo	PLUMTREE	Plumtree AIDS Project-Box 314 Plumtree 0912 655325
Moses. M. Ncube	TSHOLOTSHO	CIVNET-Regina Mundi Mission P B L5182 Bulawayo 0898-447, 0898-576
Arleta Dube	TSHOLOTSHO	NCA-Sipepa Rural Hospital, P.B.L 5181 Bulawayo 0898 – 326/576
G. Mutunzi	VICTORIA FALLS	FBO-Box CT 458 Victoria Falls 0912 899 378 / 013 41886
Dumisani Masuku	VICTORIA FALLS	Min. of Education
Gloria Ndlovu	VICTORIA FALLS	Min. of Education-2673 Chinotimba Township Victoria Falls 0912 475237
Moffat Zulu	ZHOMBE	ORAP-PO BOX 1510 Kwekwe
Bekezela Mangena	ZHOMBE	ZFU-P O Box 1510 Kwekwe
John Zunze	ZHOMBE	ZEPPDRA-P O Box 1510 Kwekwe

