PARTICIPATORY APPROACHES FOR SUPPORT OF ORPHANS AND VULNERABLE CHILDREN AND FOR YOUTH REPRODUCTIVE HEALTH

Training workshop report
11 July 2006-13 July 2006

National AIDS Council of Zimbabwe (NAC)

with Training and Research Support center (TARSC)

ZESA Training Center
HARARE

With the support from
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1. Background

In July 2006, the Zimbabwe National AIDS Council (NAC), in cooperation with the Training and Research Support Centre (TARSC), undertook a 3-day training of trainers in participatory approaches for Orphans and Vulnerable Children (OVC) and for youth reproductive health. The training included representatives from 10 districts in Zimbabwe and aimed to train District level NAC officers, NGO co-operating partners in districts and district youth co-ordinators. The training aimed to build skills in using participatory methodologies for HIV and AIDS programming, particularly in relation to mobilizing and strengthening community support for care of orphans and vulnerable children and promoting adolescent reproductive health.

National AIDS Council is mandated to coordinate the multisectoral response to HIV and AIDS in Zimbabwe. It operates through decentralized structures at provincial, district and ward level and village level. The decentralized structures develop plans, which are based on community needs and cover action from various sectors. The priorities for National AIDS programme are prevention, care and mitigation. Recently Zimbabwe registered a decline in the prevalence and incidence of HIV and this was as a result of positive change in behaviour. The challenge now is to sustain the positive behaviour and further lower the incidence levels, which are still too high.

According to the Zimbabwe National Plan of Action for orphans and other vulnerable children June 2004, a child is defined as a person below the age of 18; orphans as those whose parents have died, vulnerable children as those with unfulfilled rights. In the Zimbabwe National Orphan Care Policy, orphans are children aged between 0-18 years whose parents have died. What are the estimates of percent OVCs in communities in Zimbabwe? Vulnerable children include children with one parent deceased (in particular the mother), children with disabilities, abandoned children, destitute children, abused children, children infected and affected with HIV/AIDS, children living on the streets etc. As in other countries, Zimbabwe aims to implement strategies to support orphans and vulnerable children.

TARSC has worked in participatory (PRA) methodologies for over a decade, and recently held a regional workshop on participatory approaches to a people-centred health system in cooperation with Ifakara (Tanzania) under the auspices of the Regional Network for equity in health in east and southern Africa (EQUINET). A NAC representative attended this workshop and recommended a similar training for NAC facilitators at district level. TARSC was asked to provide technical input to this workshop to support and strengthen the work of the National AIDS Council (NAC).

The programme aimed to train District level NAC officers, NGO co-operating partners in districts and district youth peer educators to build skills in using participatory methodologies for HIV and AIDS programming, particularly in relation to mobilizing and strengthening community support for care of orphans and vulnerable children and promoting adolescent reproductive health.
Specifically it aimed to

- equip NAC youth peer educators with skills on use of Auntie Stella package for reproductive health education.
- equip district level NAC officers and NGO co-operating partners in districts with skills in use of participatory methodologies to plan, implement and assess support of orphans and vulnerable children (OVCs).
- review district plans for use of PRA methods and skills and develop action plans for how each selected district will implement use of participatory tools for mobilizing and strengthening community support for care of orphans and vulnerable children and promoting adolescent reproductive health.

The selected ten (10) districts countrywide (see Appendix 1) would function as pilot training districts and mobilize community support for orphan care and youth involvement in reproductive health systems. The pilot programme would be set to function as a learning log for the rest of the districts.

The training used (with modification) two participatory toolkits developed by TARSC
- The TARSC/Ifakara training toolkit on participatory methods for people centred health systems, and
- The updated Auntie Stella kit for adolescent reproductive health (already being used by NAC in several districts).

The workshop programme (see Appendix 2) included training on PRA approaches to

1. social mapping and needs assessments of youth and OVC,
2. current means of community support, NGO and government support for OVC,
3. identifying ways in which communities can enhance support of OVC,
4. identifying support from NGOs and government to facilitate community roles,
5. work with youth to strengthen their ability to enhance their reproductive health and effectively use reproductive health services, including those for HIV and AIDS prevention, treatment and care.

The programme included an instruction on the NAC work with OVC and provided time for participants to prepare plans for follow up work. It also included a general introduction on PRA methods and on the facilitation skills to use these methods at district and community level. It was noted that this was an introductory course, and that follow up and mentoring would be needed to implement the programme in the selected districts and to support those who had participated in the PRA training. It was also noted that some of the district delegates had prior training and that there were other people with PRA skills in the districts to support such work.

The facilitation of the workshop was done by both TARSC (R Loewenson, B Kaim, F Machingura) and NAC (T Masiye, B Nymanza, S Marunda). The NAC and TARSC agreed to use the exercise as a pilot to review the training and programme design for future such PRA training in other districts.
2. Proceedings

2.1. Introduction to program and delegates

Mr. Amon Mpofu, the National Monitoring and Evaluation manager, National AIDS Council, opened the workshop; He welcomed the participants and emphasized the importance of the presence of youth peer educators. He also acknowledged the facilitators from TARSC and the sponsorship by TARSC of the workshop.

Mr. Mpofu from NAC stressed that behavior change is slow in Zimbabwe despite the fact that the HIV infection rate seems to have decreased. He stated that the focus now needed to be on the individuals within the community and that it is important to orient this work with a belief in self-efficacy that each person could change. He expressed the hope from this workshop was that PRA processes would be used in OVC programmes, with the focus also on youth reproductive health.

Mr. Mpofu expressed an appreciation for the synergy in the composition of participants from civil society and government represented by NAC and the need for a coordinated approach to HIV and AIDS. He then went through the workshop objectives (outlined earlier). He noted that the ultimate aim was to bring the prevalence level down to single figures in Zimbabwe.

The facilitators asked participants to write about themselves, to state whether they had experience in participatory methodologies, likes and dislikes. The norms of the workshop were then outlined on flipchart and agreed by everyone.

2.2. Participatory methods

The participants were each given a copy of the toolkit, “Participatory methods for a people centered health system”. After 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:

a) Collective and active involvement of everyone in the community
b) Collective action- ownership of the program and empowerment
c) Need for monitoring and evaluation
d) Problem identification and empowerment
e) 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.

Participants were then asked to return to their groups. Each group was given six statements and asked to decide by consensus ‘true’ or ‘false’ statement or ‘no consensus’ and ‘don’t know’.

The participants decided on the following statements as being false—
• **PRA is just a set of fancy methods** - the example was given of the World Bank using PRA tools but not being committed to the spirit of PRA

• **PRA has no theoretical basis.** Participants were asked to define PRA and the facilitator explained that it is a process in evolution over the past four decades originating with participatory rural appraisal and the work of Paulo Freire in education at community level. It has also evolved from action research- working with communities in partnership. The linking factor in all of these approaches is a commitment to giving “voice to the voiceless” – the empowerment of diverse groups in the community.

• **Findings from use of participatory methods do not reflect reality** – using different tools in a crosschecking process called triangulation we can check the facts on the ground

• **People involved in use of PRA are neutral** - the participants agreed that everyone works with their own prejudices and ideas

There was ‘No consensus’ on the following statements:

• **PRA approaches are quick and easy to use** - the participants discussed effectiveness, the need for communities to introspect and examine themselves and that some communities are more problematic than others

• **Anyone can use participatory approaches successfully in their work** - some participants felt that this depended on the individual and the circumstances

At the end of this session the participants were referred to **Module 1** in the PRA Toolkit

### 2.3 Definitions of OVC and children in difficult circumstances

The participants were asked to break into groups to define OVC. This was agreed as including orphans who are children under 18 with one parent who has died. By definition all orphans are vulnerable. The concept of vulnerability was examined at length

**NAC definitions of OVC**
The definition of a child is a human being below the age of 18 years. This comes from the African Charter on the rights and welfare of the Child and the UN Convention on the rights of the Child. An adolescent is anyone aged 10-19, a teenager anyone aged 13-19, a youth anyone aged 10-24 years. The definition of orphan comes from the Zimbabwe Orphan Care Policy- anyone under 18 who has lost one or both parents. An orphan is automatically vulnerable. A handout from NAC on the minimum package for OVC was given to participants.

**Profile of OVC**
In an effort to get closer to an agreed definition of OVC participants were asked if OVC were a social group on their own in the wider community? Some participants agreed with this view. However, within communities, OVC do not recognize themselves as a separate group. There are different types of OVC- single orphans, paternal orphans, maternal orphans, double orphans, children living with grandparents, children heading households etc. It was stressed that it is not easy to be exhaustive or have a definitive list of OVC but that it is important to *allow communities to define the vulnerable children in their midst.*
2.4 Social mapping

The participants were introduced to social mapping as one PRA tool to use at community level with the following instructions-

- Identify the health and other facilities in the community that affect and are points of contact for OVC
- Identify where the different types of OVC are located

The participants were then split into three groups to prepare their social maps. They were instructed to draw the major points of contact for OVC, using symbols to indicate which OVC grouping related to each point of contact. The groups then presented their social maps and discussed the process and information outcomes.

Figure 1: An example of a social map from the group work
The participants agreed that social mapping as a tool:
- Reveals new information about the community
- Can be used as a referral system
- Can help to identify types of OVC and service provision,
- Can help to identify the needs of particular vulnerable groups.

The groups identified were: Double orphans, maternal orphans, paternal orphans, child headed households, and grandparent headed households. (other categories identified were- child sex workers, children with absent parents, children living with hiv, married orphans, displaced children, and child parents

Participants realized that this tool could not only help to identify the underlying links between these categories of OVC but also identify the different types of OVC in their communities and their key contact areas. Social mapping is also useful as an icebreaker to the PRA process.

The participants were referred to Module 2 in the PRA toolkit.

2.5 Economic, social and health needs of OVC

The facilitator explained that the workshop now needed to get a deeper sense of what is going on at community level. Out of the previous long list of OVC the following four categories were selected- Paternal orphans, Grandparent- headed households, Children with absent parents, Children living with HIV and AIDS.

The participants were then divided into four groups, each with one of the four groups of OVC identified. Each group was tasked to think of specific social, economic and health needs of children in their group using the spider diagram. They then represented the four selected categories of OVC in four spider diagrams.

Figure 2: An example of one of the spider diagrams drawn
Using seeds, the groups were asked to prioritize the needs of these four groups in a **ranking and scoring exercise**. While participants first allocated their seeds individually to their own priorities, they then debated the allocations until they agreed collectively. The priority needs of each group identified were the following:

**Table 1: Priority needs of each group of OVC**

<table>
<thead>
<tr>
<th>Category of OVC</th>
<th>NEEDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children living with HIV</td>
<td>Health services, Psychosocial needs, Shelter</td>
</tr>
<tr>
<td>Child headed households</td>
<td>Food, Love, Protection/information</td>
</tr>
<tr>
<td>Children with absent parents</td>
<td>Sex education, Guidance</td>
</tr>
<tr>
<td>Paternal orphans</td>
<td>Food, Shelter, Education</td>
</tr>
</tbody>
</table>

The exercise enabled:
- Identification of needs for specific groups
- A collective assessment of needs
- The prioritizing of needs

It was noted that there are different ways of handling the exercise and stressed that there is a need to keep this exercise simple. The exercise demonstrated the need for active facilitation, to help move the process without taking over. Participants reviewed the process and identified that
- At community level- it is important to remember that the opinions of the facilitator on the priorities may be different to the community
- The value of ranking and scoring – giving each individual the same number of beans gives everyone the same voting power.
- This PRA tool may be used in separate sex / age groups. One can put all the beans together and get the whole group to vote on priorities, but recognizing that this can give power to those “with the big voices”.
- The session concluded that PRA is a process to help to decide on reasons for diversity of opinion and then act upon those.

The participants were advised to refer to Modules 2 and 3 in the PRA Toolkit

**2.6 Types of support for OVC**

Reflecting on the above prioritized needs for the four categories of OVC, it was pointed out that there are different needs for different subgroups and a need to strategize differently for them. Four issues identified as priority needs across the different groups were taken forward, that is
- Health services
- Food
- Shelter, and
- Guidance

The participants were then introduced to the **Stepping-Stones** approach to explore:
This approach uses an analogy of crossing a river using stepping stones. In this case the stones are the resources each group of OVC need to address their priority needs (using each of the four above). First the ‘stones’ available within the community are laid, and the participants test whether these are enough to get across the river. Those added are those from outside the community that enable the crossing. The interdependence of these two sets of resources emerges. Table 2 shows the resources identified in the training activity for the four areas of priority needs.

Table 2: Stepping Stones exercise: Sources of support for OVC needs

<table>
<thead>
<tr>
<th>Need</th>
<th>Goal</th>
<th>Resources in the community</th>
<th>Resources outside the community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health services</td>
<td>Accessible affordable, friendly health services and empowered OVC</td>
<td>Community involvement; OVC friendly staff; Support in ARV adherence; Counseling by elders, Life skills education; Youth clinic, Sharing information on OVC health related issues</td>
<td>More clinics close by; Subsidized fees, OVC trained as peer educators; Trained staff in clinics; Available drugs</td>
</tr>
<tr>
<td>Food</td>
<td>Food and nutrition secure nation</td>
<td>Agricultural inputs, manure, seed, draught power, labor, water, farming skills, land, zunde ramambo</td>
<td>Water; Fertilizer; Seed; Food packs, Information; Education; Counseling</td>
</tr>
<tr>
<td>Guidance</td>
<td>Children to make informed responsible choices</td>
<td>Youth Friendly corners set up by local churches, schools and elders including locally based community organizations.</td>
<td>Education assistance funds such as beam also including AIDS levy and funs from NGOs</td>
</tr>
<tr>
<td>Shelter</td>
<td>Affordable secure and decent accommodation</td>
<td>Land labor, local building materials, water, financial support, coordination meetings</td>
<td>Cement, roofing sheets, door/window frames, technical advice, financial support, coordination meetings</td>
</tr>
</tbody>
</table>

In the presentations it was observed that the plans presented useful information but did not indicate the specific connection or dialogue with the OVC themselves, which was important.

Participants observed that it was interesting how much was put into the community column, noting that communities are over-stretched. This makes it important to find ways of reinforcing these community roles.

The participants were referred to module 4 of the PRA Toolkit. The facilitators and participants also noted the need to be very familiar with the methods to build confidence in PRA techniques.
2.7 OVC, their needs and support

The NAC provided an introductory lecture on OVC and their needs and support. There are 5.6 million children in Zimbabwe out of which 1.3 million are classified as OVC. Some of the main challenges facing OVC were identified as poverty, pressure to drop out of school, lack of rights, stigma and discrimination. The participants were referred to the National Plan of Action (NPA) for OVC that gives the national minimum standards of support to OVC.

The NPA for OVC aims towards increased school enrollment of OVC and retention of OVC in schools; increased access to food and shelter; access to education, health and nutrition; protection from abuse; involvement in nation; increased birth certification; increased resource mobilization to OVC. A NAC document was circulated to participants on the NPA for OVC.

This raises a need for coordination and channeling of resources so that there are no gaps. Participants reflected on the sources of these resources, and from the lists compiled on the previous day classified these the major resource into groups needs as:

<table>
<thead>
<tr>
<th>Health service support</th>
<th>Eg: ARV adherence; OVC friendly staff Drugs; subsidized fees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counseling</td>
<td>Eg: Life skills education; Spiritual nurturing</td>
</tr>
<tr>
<td>Education and information</td>
<td>Eg: Health education and information; Peer education</td>
</tr>
<tr>
<td>Farming inputs</td>
<td>Eg: Farming inputs and skills</td>
</tr>
<tr>
<td>Food security</td>
<td>Eg: Food inputs</td>
</tr>
</tbody>
</table>

A large circle with OVC was put in the centre of the room. Using a rural community as a case example the various sources of support for these inputs and resources for OVC were mapped using cut out circles, the size reflecting the importance of the institution in providing this support and the proximity to the OVC circle representing the access of this institution to OVC. Those institutions that work together were placed more closely together.

This produced a large ‘Venn diagram’ on the floor as a ‘stakeholder mapping’

The role of the facilitator in this exercise at district/community level was emphasized-interviewing the map, exploring the relationships, and understanding more deeply what is happening in that community. Participants were asked to focus on whether anyone had been left out – those with direct or indirect contact with children.

The stakeholder map was then reviewed through the following questions:

- Are there areas of support that do not have relevant actors/institutions- which are they? Can any other actors in district address these areas of support- which?
- Do actors outside the district need to do this – which ones?
- How can institutions close to children access be strengthened? What does this mean for how resources are channeled into the district?
Some of the main issues raised for the case study district were that

- While many organizations are involved in providing services, there are problems of adequate coverage for all groups of OVC
- Not all needs are adequately covered, for example there is a lot of attention on education and counseling, but less on food and agricultural inputs
- Where needs are covered, as in counseling, it is not always clear that the services are of adequate quality
- The co-ordination between diverse organisations working in the same area is not always string, despite the presence of co-ordinating mechanisms

For example while there are many health service agencies, the gap in access to clinics leaves some communities and OVC poorly covered. Food distribution is specified for specific groups (emergency, displaced people) leaving some OVC not covered. The quality of counseling services is not always clear.

It was also noted that where resources outside the district are introduced or channeled it would be best to do this through those institutions that have closest contact with OVC and to strengthen these institutions. These were identified on the Venn diagram.

The participants agreed that using the Venn diagram as a tool gives a visual format that enables the community to see the extent of coverage and coordination at community level between the community members and institutions within those communities and to use this for planning services, interventions and improving co-ordination.

The participants were referred to Module 4 Activity 20 of the PRA Toolkit
Figure 3: Venn Diagram of stakeholder mapping for case study district

- World Vision (E; F)
- Zinatha (H)
- Guardians/foster parents (C; H; A)
- Community leaders (C)
- Support groups
- Health/grassroots workers (C; H; E)
- Business
- Deseret (NGO): (E)
- Zinatha (H)
- Faith based organizations (C; H)
- Junior council (C)
- Isiphele senkosi (NGO) (E; F; A)
- ZRP: (C)
- Teachers: (C)
- UNICEF
- MSF (C; E; H)
- MoHCW (E; C)
- SIBAMB ENE AIDS Network (A; H; C)
- Plan International (A; F; F)
- Save the Children Norway
- Zimbabwe AIDS Prevention (F)
- Relaides of OVC (A; C; E)
- Camp fire council
- AREX: A
2.8 Strengthening the systems of support for OVC

The stakeholder mapping raised a number of questions on how to strengthen support to OVC.

a) How do we fill the gap in access to health inputs?
b) How do we improve coverage of educational support to OVC?
c) How do we support those who are doing the counseling?
d) How do we ensure coordination between different actors providing the same support to OVC?
e) How do we collectively support those (organizations /individuals) in closest contact with OVC?
f) What support do we expect from NAC?

These were discussed using a ‘market place’ where questions were put on flip charts on the wall and people wandered around the room adding their views and debating the issues at the flip charts. The charts were then brought together for plenary review and discussion.

Two examples of the areas of discussion are shown below:

**How do we improve coverage of educational support to OVC?**

- Include child protection committees in BEAM selection committees, BEAM should be decentralized to province level, BEAM funds should be accountable, funds should be channeled through NAC, strengthen WAACs and VAACs
- Need to create shared database by the DAC for all agencies on the OVC in the district, need to train more peer educators, establish child protection committees, more education in RH, strengthen role of VAACS in protection of children
- Block grants to schools, advocate for more resources from the government, in-school child protection committees

**How do we improve coordination between different actors providing the same support to OVC?**

- Build networks
- Sharing beneficiaries registers and create database for OVC needs
- Standardize criteria for OVC at community level
- Coordinate organizations and ensure transparency of effort

The market place approach was reviewed as a means of drawing out information and options where there is need for debate. It was noted that

- There is lots of feedback- a great quantity of information is generated.
- There is also a quality of information generated including new information from community level.
- This format allows for free expression there are no right or wrong opinions
- It allows opportunity for discussion and opens the mind
• It allows for exchange of views through reading and writing and also discussion between people at different ‘kiosks’ in the market place
• Everyone has an equal say and contribution have equal value
• The role of the facilitator is crucial to guide and support the process.

2.9 Summary of steps

The session recapped the building blocks of the PRA process up to that point and the purpose of each tool

• **Social mapping** to find out the key contact areas for OVC, and the health facilities surrounding them and discuss their access to these facilities. This identifies the points where different types of OVC are found at community level.
• **A spider diagram** to examine the economic social and health needs of OVC. Prioritizing these needs through **ranking and scoring**
• Identifying available resources within and outside the community to meet needs through the **stepping stones**
• **Stakeholder mapping using a Venn diagram** to identify support structures for OVC, the gaps and to plan resource allocation
• **The market place** to discuss how to fill gaps and address issues on co-ordination

It was emphasized that PRA uses a building block approach. At community level this process can take two full days, with the facilitator using **triangulation** – ie linking with other sources of information- to crosscheck the information gathered.

The process reflects steps in the PRA spiral shown in Module 1 in the PRA Toolkit.
• Problem identification,
• Reflection on this information, plus new information
• Discussion on action
• Define actions needed

Participants were reminded that the goal of this workshop is to develop familiarity and confidence in the PRA process, methodology and tools and not to replace their local planning processes. These methods would need to be used at district and local level to support such planning.

2.10 Youth Reproductive Health (RH) and Auntie Stella

This session defined reproductive health as the ability to have a safe and satisfying sex life and the capability and control over reproduction and areas surrounding reproductive health (Participants were referred to the NAC Documents on coordination of youth RH programmes)

The TARSC Auntie Stella toolkit was distributed as one PRA tool for use with youth on reproductive health. Participants were asked to break into groups, with the peer educators constituting a separate group and to start using one of the Auntie Stella cards. To help the participants get into the mood they were asked by one of the facilitators to share how they felt when they were first attracted to someone of the opposite sex. This was then linked up with an introduction to the Auntie Stella youth reproductive health toolkit. Participants were asked to refer to the facilitators guide in the auntie Stella toolkit
to help them in understanding the use of AS as a PRA tool. The facilitator explained that Auntie Stella was not developed in isolation. It is a product of a PRA process which began in 1997 with production of the first version of AS. Many organizations and individuals have been involved, with each card reflecting the stories and experiences of young people. The cards were produced and then pretested with youth from Zimbabwe and other countries in the region. The second version came out in October 2005.

The facilitator explained the different ways of using the AS including the basic session, including:
- Own letter writing
- Pair reply session- into pairs or threes
- Single sex groups – for sensitive issues
- Using the cards thematically – the facilitator’s guide has 10 suggested themes

It was pointed out that there is a need to experiment in AS sessions– different approaches are valuable for different reasons. It is also important that facilitators lead without dominating, and that it’s good to leave young people working on their own in small discussion groups.

Participants then worked in pairs to do pair reply and wrote their own reply letter. The participants discussed the differences in approach- the AS reply was seen as more factual and more empowering that the letter produced by the group but there were many similarities.

The participants agreed that the use of Auntie Stella would help greatly in youth reproductive health education.

The peer educators group indicated they felt using AS helped to give a ‘factual basis’ to their reproductive health dialogue with youth. They noted that the teenage period is an age of experimentation and using AS provides opportunities for open debate. It helps youth decide what is good or bad behavior.

The participants were then asked to focus on the following questions for use of Auntie Stella as a tool that would be dealt on the third day:
- Who are our target groups?
- Where will we be meeting them? -How often? -Over what length of time
- What do we hope will be the outcome of using AS with this target group?
- What change do we hope for?
- What additional support or assistance do we need?
- How will we know what impact this program is having on youth?

2.11 Facilitation skills in using participatory methods

A buzz group on facilitation skills explored the qualities of a PRA facilitator, including issues such as being good at giving instructions, a good listener, being neutral, knowledgeable friendly, innovative, able to give good advice, observant, etc. The participants were given a handout on PRA facilitation skills including the following:
Facilitators should
Show respect
   Establish rapport
   Abandon preconceptions
   Hand over the stick
   Watch, listen, and learn
   Learn from mistakes
   Be self-critical and self-aware
   Be flexible
   Support and share
   Be honest

Don’t rush, lecture, criticize, interrupt, dominate, sabotage, and take yourself too seriously

Participants re-looked again at the PRA true and false statements that they debated on day one and dealt with those where there had been no consensus.

- The six statements used at beginning of the workshop were all false.
- The PRA process needs a facilitator, a rapporteur and an observer- if a rapporteur is not available then the role of rapporteur and observer become one
- It is important not to create ‘uppers’ and ‘lowers’ by having everyone on the same level.
- The rotation of roles is important

A demonstration of facilitation of a session was done using a small group with the rest of the participants acting as observers

- The participants then understood that it is important to plan carefully what goes in the center of the spider diagram or the exercise does not work. It is important to get down to the level of the participants so you become part of them.
- The observers noted that the group dynamics changed- the members of the group were initially seated far from the spider diagram and then moved closer as they started to get involved in the process.
- Importance of use of silence in the facilitation process- silence is an indicator that people are thinking. It is important to give people time to think out the process. The facilitator needs to be able to understand whether it is constructive silence or not.

In a recap on the components explored in the PRA process, participants demonstrated that they had understood the process and made the links between the different components of the workshop.
3. Follow up district work

The NAC explained that participants in this workshop would be expected to pilot PRA in their 10 districts from July until September on two levels:

- Sensitizing stakeholders on AS and PRA in stakeholder meetings – need to extend stakeholder meetings to two days
- Expecting participants to go to the ground and give ‘voice to the voiceless’ at community level.

Support for the PRA process was pledged from NAC and it was stated that all PRA itineraries/plans to be sent to Amon Mpofu. NAC then expected that districts would send progress reports on AS and PRA. The importance of documenting the process was stressed, and of giving feedback on the use of the PRA tools and Auntie Stella cards. It was also suggested that there be exchange of information within the group, such as through email. A regional email list by EQUINET on using PRA for health was introduced (pra4equity@equinetafrica.org) and participants who wanted to join this list were invited to subscribe. It was recommended that participants network at district level with other organizations using PRA and AS. Finally it was suggested that a review workshop for participants be organised after the first cycle of their work was complete.

3.1 District plans

Participants then went into groups to address the following questions to prepare district follow up action plans:

**On the work with OVCs**
1. What changes are we aiming to achieve in communities on support of OVC
2. How will we use PRA with communities for this?
   - What activities/doing what/which PRA approaches? With whom? When?
   - With what resources?
   -

**On the youth reproductive health activities**
1. What changes are we aiming to achieve in youth using AS
2. How will we use our target group?
   - Where will we meet them? How often? Over what length of time?
   - What adult support or assistance do we need?

**Generally**, how will we use the district stakeholders meeting to introduce and support OVC/youth work (Who? What? How?)

Participants worked on detailed work plans in their district teams. The work plans were presented and reviewed in plenary. Proposed improvements to plans were discussed:

- to make very clear the link in the work plans between objectives and activities
- to make clear the links between the community level and the DAC level
- to make clear the link between the issue being addressed (eg mapping stakeholders, improving co-ordination- and the appropriate PRA tool to address this issue.
To make clear how Auntie Stella will be integrated into programming, either into existing programs on an ongoing basis or through a focus on AS for specific period to introduce it.

The role of the DAC was discussed, with the district stakeholder meeting necessary to introduce and get support for the OVC and Auntie Stella work before going to community level.

It was suggested that the following five steps could help to take the PRA work forward in their districts:

1. Finalise the draft district plans taking the comments from the final session into account
2. At DAAC level through the district stakeholder meetings carry out a PRA meeting using PRA tools (two days) to show how the methodology can be used to involve communities in OVC and adolescent reproductive health interventions. Discuss the district plans.
3. Review and finalise the district objectives and plans based on feedback from the DAAC and involve other PRA skills within the district
4. Facilitate PRA meeting(s) at community level and identify issues, areas for action etc at community level. Support the local actions based on outcomes
5. Report back to DAAC level on the activities at community level and review against the objectives set

It was noted that the PRA process needs a lot of reflection, it needs to be taken a step at a time and phased into the work cycle. The focus needs to be on involving and enabling action by communities. PRA becomes a way of working- it is not a one-stop visit but an ongoing process. PRA facilitators are thus supporters of community processes and not leaders. It was also noted that the process is a learning process, should be enjoyable (!) and therefore that the objectives should not be too broad and unachievable.

3.2 Monitoring and evaluation

The meeting discussed options for monitoring impact. It was noted that the core output indicators already collected cover the OVC and youth areas that the programme covers. What was needed was communication and feedback on the process to better support and learn from the work in the districts. The issues for such feedback include:

- Progress on implementation of the workplan
- Responses of the DAAC and the community to the work and the PRA methods
- Experience of use of the methods- issues, positive outcomes, challenges and comments
- Review of process by the community in terms of their involvement and outcomes
- Review of the process by the DAAC in terms of the effects of the process
- Review of the process by the facilitators in terms of whether they are feeling more confident and skilled

Participants identified that they needed support from NAC for the process in
- Financial resources for meetings
• Technical support and
• Follow up from national level.
It was agreed the focal person for this was Mr. Mpofu, the M&E manager.

Similarly the participants and PRA teams needed to give support to communities in terms of
• Financial resources for meetings.
• A plan and strategy for the roll out of AS at district level
• Organising of meetings – giving organizations working with OVC, communities and OVC a structure to have a voice

It was agreed that a national review meeting of the work with the 10 districts would be held after the DAAC meeting to introduce the work, the community meetings and the second DAAC meeting to review the work had all been held in all 10 districts. This was likely to be late 2006/ early 2007. In the meantime NAC would provide monitoring and mentoring support to the districts. Any TARSC support on PRA skills would be through NAC.

4. Closing

The NAC Human Resources Manager, Mrs. Siduduzile Ntombi thanked the facilitators, the participants and the support from TARSC. She indicated that the skills gained should be used to uplift the OVC and youth and hoped that this would be apparent from the follow up. The workshop was closed with a prayer.
## APPENDIX 1: Participants list

<table>
<thead>
<tr>
<th>Name</th>
<th>Institution, province, town</th>
<th>Physical address</th>
<th>Phone/email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lovemore Moyo</td>
<td>DAC-NAC, Midlands Mberengwa, Midlands</td>
<td>Box 89 Mataga</td>
<td>0517-545</td>
</tr>
<tr>
<td>Emmerson Zungura</td>
<td>World Vision, Mberengwa, Midlands</td>
<td>1015 Eastlea Ext, Zhishavane</td>
<td>051-4118/9/011439785 <a href="mailto:emmerson_zungura@wvi.org">emmerson_zungura@wvi.org</a></td>
</tr>
<tr>
<td>Macdonald Matengwa</td>
<td>Youth coordinator/ PE World Vision Mberengwa</td>
<td>Box 89, Mataga</td>
<td>0517 545/427 <a href="mailto:ceraz@coolhead.com">ceraz@coolhead.com</a></td>
</tr>
<tr>
<td>Mrs. Makanyire</td>
<td>DAC-NAC Masvingo, Gutu</td>
<td>Box 37, Mupandawana</td>
<td>030 3041/039 262907/091 954 553</td>
</tr>
<tr>
<td>Lovemore Gwenzi</td>
<td>Care International, Masvingo, Gutu</td>
<td>Box 210, Gutu</td>
<td>030 3095 091 669 859</td>
</tr>
<tr>
<td>Christopher Ruhode</td>
<td>Youth Coordinator/ PE MPandawana/ Gutu AIDS Council, Masvingo, Gutu</td>
<td>Marondera Municipality Head Office, Box 261</td>
<td>011 513 327 <a href="mailto:mosesnyamaz@yahoo.co.uk">mosesnyamaz@yahoo.co.uk</a></td>
</tr>
<tr>
<td>Mrs. K Kundiona</td>
<td>Save the Children Norway, Mash East, Marondera</td>
<td>Marondera Municipality Head Office, Box 261</td>
<td><a href="mailto:childpro@mweb.co.zw">childpro@mweb.co.zw</a></td>
</tr>
<tr>
<td>Ignatious Marupi</td>
<td>Youth coordinator/ PE Save the Children Norway, Mash East, Marondera</td>
<td>42 Horwe St, Rujero T/ship, Marondera</td>
<td>079-23337</td>
</tr>
<tr>
<td>Michael Alibi</td>
<td>DAC-NAC Mash Central Rushinga</td>
<td>Rushinga DAC Offices, Box 104 Rushinga</td>
<td>011 713315</td>
</tr>
<tr>
<td>Enock Mandlopera</td>
<td>Hope Humana Mash Central, Rushinga</td>
<td>P.Bag 74 Rushinga</td>
<td>011 787 465</td>
</tr>
<tr>
<td>Spencer Chiwarange</td>
<td>Youth coordinator/PE Hope Humana, Mash Central Rushinga</td>
<td>DAAC Rushinga, Box 104, Rushinga</td>
<td>011 713 315</td>
</tr>
<tr>
<td>Mkululeko Sibanda</td>
<td>DAC Mat North Tsholotsho</td>
<td>Tsholotsho Rural District Council, Box 40</td>
<td>0878 357</td>
</tr>
<tr>
<td>Mr Mutupa</td>
<td>SAPOAB Mat North Tsholotsho</td>
<td>Magama Mission</td>
<td>089?883199</td>
</tr>
<tr>
<td>Sibusisiwe Sibanda</td>
<td>Youth Coor/PE MSF, Mat North Tsholotsho</td>
<td>Tsholotsho Rural District Council, Box 40</td>
<td>0878 351 595</td>
</tr>
<tr>
<td>Mr. S Mutinabanyoka</td>
<td>DAC- Batsiranai Mash West, Hurungwe</td>
<td>NAC Mash West, Chinoyi</td>
<td>067 22741-3</td>
</tr>
<tr>
<td>Charity Mereki</td>
<td>Youth/PE Batsirai Group Mash West Hunungwe</td>
<td>Po Box Magunje</td>
<td>023 298 220</td>
</tr>
<tr>
<td>Lindile Ndebele</td>
<td>DAC- HOCIC Bulawayo, Nkulumane</td>
<td>NAC Bulawayo Province</td>
<td>881339/881826</td>
</tr>
<tr>
<td>Trevor Chirimambowa</td>
<td>HOCIC Bulawayo, Nkulumane</td>
<td>43A George Silundika Ave, Bulawayo</td>
<td>885870 <a href="mailto:chirimambowa@yahoo.com">chirimambowa@yahoo.com</a></td>
</tr>
<tr>
<td>Tumisang Moyo</td>
<td>Youth coord/PE HOCIC, Bulawayo, Nkulumane</td>
<td>Po Box 5960 Nkulumane</td>
<td>486169 <a href="mailto:tumisasngmoyo@yahoo.com">tumisasngmoyo@yahoo.com</a></td>
</tr>
<tr>
<td>Name</td>
<td>Organization</td>
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</tr>
<tr>
<td>James Gabaza</td>
<td>DAC-NAC Manicaland, Chipinge</td>
<td>NAC, 92 3rd St. Chipinge</td>
<td>027 2316</td>
</tr>
<tr>
<td>G.A. Muchinako</td>
<td>FACT-MDM Manicaland, Chipinge</td>
<td>FACT-MDM, 208 Phillips Ave, Chipinge</td>
<td>027 7353</td>
</tr>
<tr>
<td>Rusia Mupanda</td>
<td>Youth coord/PE DAAC, Manicaland, Chipinge</td>
<td>3662 Gazae, Chipinge, DAAC Chipinge Rural</td>
<td>027 2316</td>
</tr>
<tr>
<td>Lyncolin Ncube</td>
<td>DAC-NAC Mat South Mangwe</td>
<td>Mangwe RDC(DAAC) P Bag 5912 Plumtree</td>
<td>019 3139</td>
</tr>
<tr>
<td>L Tshuma</td>
<td>CADEC Mat South Mangwe</td>
<td>Stand 303 Industrial Site Plumtree</td>
<td>019 2495</td>
</tr>
<tr>
<td>Blessing Ncube</td>
<td>Youth /PE Mat South Mangwe</td>
<td>Imvimila High School</td>
<td>019 3242</td>
</tr>
<tr>
<td>Edith Chigondo</td>
<td>DAC- Shingirirai Youth Centre(Harare Southern)</td>
<td>7 Meredith Rd, Eastlea, Harare</td>
<td>011 526 803</td>
</tr>
<tr>
<td>Knowledge Tapera Bazion</td>
<td>Youth Coord/PE Shingirirai Youth Centre, Harare Southern</td>
<td>36 Ardbennie Rd Mbare, Harare</td>
<td>023 405295</td>
</tr>
<tr>
<td>Mrs. B. Nyamwanza</td>
<td>NAC HQ</td>
<td>100 Central Ave, Harare</td>
<td>091 381 201</td>
</tr>
<tr>
<td>S. Chafuka</td>
<td>Shingirirai Youth Centre, Harare Southern</td>
<td>46 A Waterfalls Ave, Ardbennie, Harare</td>
<td>023 243320</td>
</tr>
<tr>
<td>Ms. B. Nyamwanza</td>
<td>NAC HQ</td>
<td>100 Central Ave, Harare</td>
<td>091 381 201</td>
</tr>
<tr>
<td>Ms. S Marunda</td>
<td>NAC HQ</td>
<td>9th St/Central Ave</td>
<td>091947633</td>
</tr>
<tr>
<td>Mr. A. Mpofu</td>
<td>NAC HQ</td>
<td>100 Central Ave, Harare</td>
<td>04 791170-3/8</td>
</tr>
<tr>
<td>Dr R Loewenson</td>
<td>TARSC</td>
<td>Box CY2720, Causeway, Harare</td>
<td>04 708835</td>
</tr>
<tr>
<td>Ms. B. Kaim</td>
<td>TARSC</td>
<td>Box CY2720, Causeway, Harare</td>
<td>04 708835</td>
</tr>
<tr>
<td>Ms F Machingura</td>
<td>TARSC</td>
<td>Box CY2720, Causeway, Harare</td>
<td>04 708835</td>
</tr>
<tr>
<td>Ms. M Davies</td>
<td>Consultant c/o TARSC</td>
<td>Box CY2720, Causeway, Harare</td>
<td>04 708835</td>
</tr>
<tr>
<td>Ms. S. Masiye</td>
<td>NAC Matebeleland North Province</td>
<td>Box 1127 Bulawayo</td>
<td>09 882943</td>
</tr>
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**COURSE FACILITATORS / CO-ORDINATORS**

<table>
<thead>
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<td>100 Central Ave, Harare</td>
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<td>04 791170-3/8</td>
</tr>
<tr>
<td>Ms. S Marunda</td>
<td>NAC HQ</td>
<td>9th St/Central Ave</td>
<td>091947633</td>
<td><a href="mailto:smarunda@nac.org.zw">smarunda@nac.org.zw</a></td>
</tr>
<tr>
<td>Mr. A. Mpofu</td>
<td>NAC HQ</td>
<td>100 Central Ave, Harare</td>
<td>04 791170-3/8</td>
<td></td>
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<td>Dr R Loewenson</td>
<td>TARSC</td>
<td>Box CY2720, Causeway, Harare</td>
<td>04 708835</td>
<td><a href="mailto:admin@tarsc.org">admin@tarsc.org</a></td>
</tr>
<tr>
<td>Ms. B. Kaim</td>
<td>TARSC</td>
<td>Box CY2720, Causeway, Harare</td>
<td>04 708835</td>
<td><a href="mailto:admin@tarsc.org">admin@tarsc.org</a></td>
</tr>
<tr>
<td>Ms F Machingura</td>
<td>TARSC</td>
<td>Box CY2720, Causeway, Harare</td>
<td>04 708835</td>
<td><a href="mailto:fortunate@tarsc.org">fortunate@tarsc.org</a></td>
</tr>
<tr>
<td>Ms. M Davies</td>
<td>Consultant c/o TARSC</td>
<td>Box CY2720, Causeway, Harare</td>
<td>04 708835</td>
<td></td>
</tr>
<tr>
<td>Ms. S. Masiye</td>
<td>NAC Matebeleland North Province</td>
<td>Box 1127 Bulawayo</td>
<td>09 882943</td>
<td><a href="mailto:Sithenjiisiwe@yahoo.com">Sithenjiisiwe@yahoo.com</a></td>
</tr>
</tbody>
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APPENDIX 2: PROGRAMME

TRAINING OF TRAINERS IN PARTICIPATORY APPROACHES FOR SUPPORT OF OVC AND FOR YOUTH REPRODUCTIVE HEALTH

National AIDS Council
Training and Research Support Centre
ZESA Training Centre July 11-13 2006

<table>
<thead>
<tr>
<th>JULY 11</th>
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| 830am -915am     | Opening
|                  | Introductions
|                  | Background to the course and course objectives 
| Chair: A Mpolu   | Welcome: A Mpolu for Director NAC Dr. T Magure                   |
| 915am-1045am     | Participatory methods, what they are and why we use them 
| Facilitator: B. Kaim TARSC | Rapporteur: T. Masiye                           |
| 1045-1115am      | Tea/ coffee 
| 1115-1145am     | Definitions of OVC and children in difficult circumstances 
| Facilitator: S Marunda, NAC | Rapporteur: F Machingura TARSC  
| 1145am-100pm     | Profile of OVC 
| Facilitator: F.Machingura, B Kaim TARSC | Rapporteur: T Masiye               |
| 1-2pm            | Lunch 
| 2 – 3.15 pm      | Economic, social and health needs of OVC 
| Facilitator: R Loewenson TARSC | Rapporteur: B Nyamwanze       |
| 315-340 pm       | Tea/ coffee 
| 340-5pm          | Types of support for OVC 
<p>| Facilitators: F. Machingura, B.Kaim TARSC T. Masiye, S. Marunda NAC | Rapporteur M. Davies          |</p>
<table>
<thead>
<tr>
<th>Date and time</th>
<th>Session objectives</th>
<th>Session facilitator/ speaker</th>
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<tbody>
<tr>
<td><strong>JULY 12</strong></td>
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| 830-915 am    | OVC, who are they, what do we know about their needs and support | Facilitator: S. Marunda  
Rapporteur: F. Machingura |
| 915-1030am    | Institutions that support OVC | Facilitator : R Loewenson TARSC,  
T Masiye NAC  
Rapporteur F  Machingura TARSC |
| 1030-1100am   | Tea/ coffee         |                             |
| 1100-1.00 Pm  | Strengthening the systems for support of OVC | Facilitators:  
R Loewenson,  
B. Kaim TARSC  
Rapporteur B Nyamwanza, NAC |
| 1-2pm         | Lunch               |                             |
| 2 -5 Pm       | Youth reproductive health and AS | Facilitators:  
B Kaim, F Machingura TARSC;  
B Nyamwanza: NAC  
**Rapporteur:** T. Masiye, NAC |
| **JULY 13**   |                    |                             |
| 8.00-9.00     | Facilitation skills in using participatory methods | Facilitators:  
Fortunate Machingura, B Kaim TARSC T Masiye NAC  
Rapporteur B Nyamwanza NAC |
| 9.00 – 9.45   | Follow up steps and introduction to group work | T Masiye B Nymanzwa, S Marunda NAC  
Rapporteur Fortunate Machingura TARSC |
| 09.45- 10.15  | Tea/ coffee         |                             |
| 10.15– 1200pm | GROUP WORK: Next steps for the follow up workplans for the districts | All facilitators  
Rapporteur: Mel Davies TARSC |
| 1200-100pm    | Review and discussion of workplans | All facilitators  
Rapporteur: Mel Davies TARSC |
| 1.00-120Pm    | Evaluation of the workshop and training | Facilitator : B Nyamanza NAC  
Fortunate Machingura TARSC |
| 120-130pm     | Closing             | NAC                         |
| 130-230pm     | Lunch and departure |                             |