# REPORT OF THE PUBLIC HEALTH WINTER SCHOOL TRAINING


**TRAINING AND RESEARCH SUPPORT CENTRE**
**and**
**UNIVERSITY OF ZIMBABWE DEPARTMENT OF COMMUNITY MEDICINE (DCM)**

**UZ Health Sciences Building,**
**Harare, Zimbabwe**
**July 5-10 2010**

**With support from Oxfam Canada, TARSC**

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Cover photograph: Winter School 2010 participants, TARSC and UZ DCM representatives © TARSC 2010

# Executive Summary

The Training and Research Support Centre (TARSC) and the University of Zimbabwe, Department of Community Medicine (UZ-DCM) held the sixth Public Health Winter School short course-training programme at UZ Health Sciences Building from the 5th-10th July 2010.

The structure and content of the course was based on the findings from a needs and capacity assessment carried out by the two institutions in 2005 and the feedback from the July 2009 Winter School course. The course has been run annually since 2010.

The programme was aimed at building capacities for people working particularly at district level in health-related work, but who may not have had the benefit of formal training in health. The course included people from government, social security sector, workers representatives, health related civil society and researchers working at community level. The course aimed to build an understanding of public health and of health systems, particularly at district level. The course covered

- Principles of public health , epidemiology and gender and reproductive health issues.
- Major public health issues, including HIV and AIDS, TB, Malaria, nutrition, major non communicable diseases; hypertension, diabetes and mental health.
- Elements of health systems, health financing, and human resources for health.
- Zimbabwe's health services at national, district and primary healthy care level
- Community and non health sector roles in health.

An open invitation was made for applicants on the TARSC website, in media and on institutional notice boards and of the pool of 85 applicants a total of 33 participants were selected attended the course, with the selection process aiming for relevance to work, gender and geographical equity and a spread of organizations and disciplines. Participants included district level officers from various government ministries, non governmental organisations, civil society and research organisations working on HIV and AIDS and nutrition programmes and workers' representatives. Participants came from or worked in various districts across the country.

The resource persons and facilitators for the course came from the University of Zimbabwe, Training and Research Support Centre, Ministry of Health and Child Welfare, Zimbabwe Health Services Board (ZHSB), Non governmental organisations and United Nations agencies (Community Working Group on Health (CWGH), Elizabeth Glazier Foundation, UNFPA, UNICEF), Local government, Parliament of Zimbabwe and City of Zimbabwe and Harare City Health Department. Sessions were accompanied by handouts and course materials. Two assignments were done by the students in groups to test their public health and health systems knowledge. An end of course test was completed and all students passed.

Students completed a course evaluation form at the end of the training to give feedback on the strengths and weaknesses of the training. The evaluation indicated that students found the course relevant to their work and the course useful. Students rated trainers and materials as good. The majority of students understood the lectures, and found the handouts and assignments clear and appreciated the Zimbabwe relevant content. For future courses students proposed the inclusion of various other topics not covered.

The Dean of the School of Medicine Prof MM Chidzonga gave closing remarks and awarded certificates of completion to students, marking the end of the course.

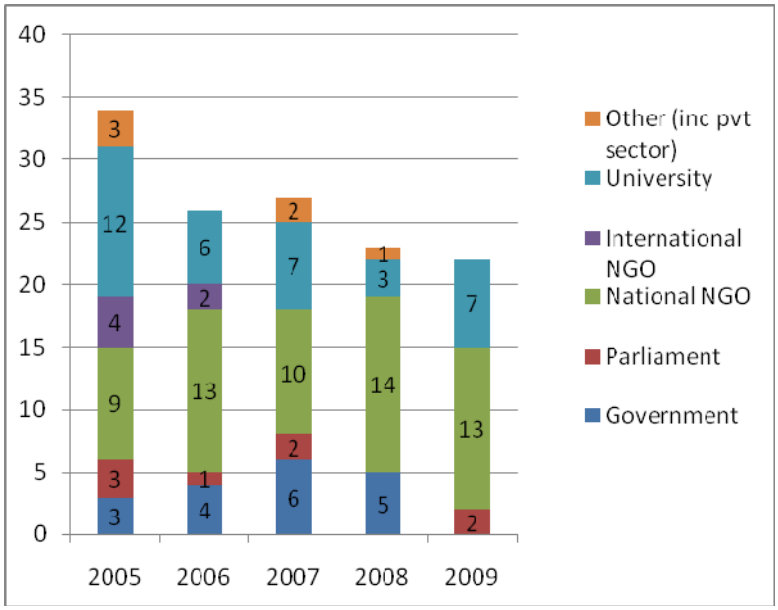
# 1. Introduction

The University of Zimbabwe, Department of Community Medicine (UZ-DCM) together with the Training and Research Support Centre (TARSC), held the sixth Public Health Winter School short course-training programme at UZ Health Sciences Building from the 5th-10th of July 2010. The programme has been running since 2005 and by 2009, a total of 132 participants from different organisation types have been trained (Table 1 and Figure 1)

**Table 1: Number of participants trained in the winter school by year and sex:2005 to 2009.**

| Year | Number of people trained | | |
|---|---|---|---|
| | Male | Female | Total |
| 2005 | 21 | 13 | 34 |
| 2006 | 10 | 16 | 26 |
| 2007 | 8 | 19 | 27 |
| 2008 | 10 | 13 | 23 |
| 2009 | 12 | 10 | 22 |
| **Total** | **61** | **71** | **132** |

**Figure 1: Number of participants trained in the Winter school by year by organisation type - 2005 to 2009**




The Winter School programme is aimed at building capacities for people working particularly at district level in health-related work, but who may not have had the benefit of formal training in health. The course thus aims to include people from local government, from health related services and sectors working in areas related to health at district level, from civil society and from community leaders with roles in health.

The course aims to build an understanding of public health and of health systems, particularly at district level.

The course covered

- Principles of public health , epidemiology and gender and reproductive health issues.
- Major public health issues, including HIV and AIDS, TB, Malaria, nutrition, major non communicable diseases; hypertension, diabetes and mental health.
- Elements of health systems, health financing, and human resources for health.
- Zimbabwe's health services at national, district and primary healthy care level
- Community and non health sector roles in health.

Participants were selected from applicants to an open call, and a total of 33 participants attended the course. Participants included district level officers from various government ministries, non governmental organisations, civil society and research organisations working on HIV and AIDS and nutrition programmes and workers' representatives. Participants came from or worked in various districts across the country. The full list of participants is shown in Appendix 3.

The course involved teaching, presentations and mentored assignments. The course programme is shown in Appendix 1. Students carried out two mentored assignments during the course to consolidate their knowledge in areas of Public health, and Health systems.

Handouts were provided for each session in the programme, and a list of reference materials and useful websites made available for follow up reading on subject areas. An end of course test was completed and certificates of completion were given at the end of the course.

The resource persons and facilitators for the course came from the University of Zimbabwe, Training and Research Support Centre, Ministry of Health and Child Welfare, Zimbabwe Health Services Board (ZHSB), Non governmental organisations and United Nations agencies (Community Working Group on Health (CWGH), Elizabeth Glazier Foundation, UNFPA, UNICEF), Local government, Parliament of Zimbabwe and City of Harare Health Department. Sessions were accompanied by handouts and course materials. Two assignments were done by the students in groups to test their public health and health systems knowledge. An end of course test was completed and all students passed.

Students completed a course evaluation form at the end of the training to give feedback on the strengths and weaknesses of the training. The evaluation indicated that students found the course relevant to their work was useful. The full results of the evaluation are shown in Appendix 2.

The course was jointly administered by UZ DCM and TARSC. Proceedings of the one week training course are briefly outlined below. A full set of handouts and reading materials is provided with the course. The sessions provided time for questions and discussion- these elaborate discussions are not reported here but were an essential element of each session. Mentors inputs to participants' group assignments are however reported in brief as are the discussions in the panel discussion on non health sector roles in health.

# 2. The course

## 2.1 Introduction to the course

Dr Rene Loewenson (TARSC Director) and Professor S Rusakaniko (UZ DCM Chair) welcomed the participants to the course. Participants introduced themselves, noting their areas of work and expectations from the training. Dr Rene outlined the background to the course, course overview, target audience and objectives (as highlighted in the introduction above). She stressed that follow ups on the use of the course would be done to evaluate the effectiveness of the training and identification of any further gaps in skills. Professor Rusakaniko went through the programme (as shown in Appendix 1) highlighting the issues to be covered and their relevance.

## *An Introduction to public health*

### 2.2 Introduction to epidemiology and public health

Dr Rene Loewenson TARSC, gave a general introduction to the principles of public health and key concepts in epidemiology and how they are used in public health. She defined public health, and outlined using examples the basic elements of public health, the measures and concepts in epidemiology, how the data is collected and used and how it is applied to address public health.

### 2.3 Epidemiology of HIV and AIDS: Current situation.

Dr A Mahomva (Elizabeth Glazier Pediatric HIV and AIDS Foundation) gave an outline of the epidemic pattern of HIV and AIDS: the transmission and natural history of AIDS and the trends globally and in Zimbabwe of the epidemic. She went on to inform delegates of the distribution and determinants of HIV, and the current levels and trends in the HIV and AIDS epidemic through prevalence, incidence and mortality statistics. She used the evidence to describe patterns of vulnerability and susceptibility in HIV and AIDS and the major public health challenges and the opportunities for responses.

### 2.4 Gender and reproductive health issues and services

Mrs T Chinhengo (UNFPA) gave a lecture on gender and reproductive health issues covering Introduction to reproductive health, Elements of reproductive health including reproductive health indicators, Gender concepts, analysis tools and linking gender and finally linked gender to reproductive health.

### 2.5 Epidemiology, prevention and management of TB, Typhoid Malaria and Cholera

Dr C Duri (City of Harare Health Department) covered the epidemiology of Tuberculosis (TB). History of TB, sources of infection, Risk, TB control and treatment. He outlined the current TB trends including the new MDR strains. He then covered the conceptual framework of the Stop TB Strategy, covering the six elements in detail. On typhoid, he covered, the epidemiology, sources of infection, signs and symptoms and diagnosis, complications and treatment.

On Malaria Dr G Gonese (Harare City Health Department) presented on the epidemiology of malaria, the burden of malaria, malaria transmission in Africa, Zimbabwe and its burden on Health Systems, economies and in society in general. She also provided information on cholera in which she covered causes, signs and symptoms, policies and strategies for effective cholera prevention and control at district and community level.

### 2.6 Nutrition patterns and promoting health dietary practices

Mrs R Madzima (Nutrition Consultant) gave a lecture on nutrition, defining terms and outlining the major elements of individual, household, and national food needs, how these are met and the elements of malnutrition. She outlined the impact of HIV and AIDS on nutrition and the nutritional requirements for people living with HIV and AIDs. She presented the national policies for food security and nutrition and how the interventions on nutrition interact with wider health issues.

### 2.7 Traditional Concepts and management of health and disease

Mrs T G Monera (Lecturer- UZ School of Pharmacy) presented on the definitions of key terms in traditional medicine and practice and then highlighted the global, regional (Africa) and local (Zimbabwe) prevalence and reasons for use of traditional medicine.

She then covered the effects of traditional medicine on the management of health and disease and its integration with conventional health systems. Mrs Monera also covered Zimbabwe Law on traditional medicine, traditional doctors training and distribution, research and the value of traditional medicine to health and disease control. Finally, she noted the current trends, issues and obstacles in traditional medicine and practice and suggestions on how these could be addressed.

## 2.8 Mentored assignment one : On Public health

This exercise aimed to use the teaching on public health to test how participants, as public health practitioners would apply the knowledge gained in the course to develop an action plan for the most important health problem in their district and use available resources to address this problem through approaches **outside** the curative health services. Participants were asked to prepare an intervention plan in groups of six and presented their plans in plenary. Groups outlined their problems, proposed interventions, programme content, target groups and stakeholder involvement with guidance from Prof S Rusakaniko as summarised in table 2 below

**Table 2: Assignment 1: Consolidated Group Reports**

| Group Number | Title of Proposal | Content of Proposal |
|---|---|---|
| Group One | Diarrhea in Mwenezi District | ***Introduction***: Following the heavy morbidity and mortality rates is on the increase in the district. Evidence suggests the rates are high due to lack of clean water.<br>***Proposed Intervention***: Provide clean drinking water through rehabilitation of boreholes, constructing toilets, capacity building in hygiene.<br>***Target group***: The whole community<br>***Partnerships***: Ministry of Health, Local Government, District Development Fund, and local NGOs based in the district and the private sector.<br>***Community Involvement***: Pprovision of bricks for the rehabilitation of communal water drinking points, provide labour, dig their toilets and organize bricks, river and pit sand and other local materials.<br>***Indicators***: public meeting attendance and participation, diarrhoea related morbidity and mortality, number of toilets constructed and water points rehabilitated |
| Group Two | Response to malnutrition in Goromonzi District | ***Introduction***. Malnutrition has been a major cause of morbidity and mortality within Goromonzi and mainly affected the under 5's<br>***Proposed Intervention***: Nutrition education to increase the number of people with good feeding practices through awareness campaigns health clubs, capacity building, drama, focus group discussions ,road shows and food wares.<br>***Target group***: under 5's, caregivers of under 5s, regnant and lactating women.<br>***Partnerships***: MoAgriculture, Local Government and District Aids Committee.<br>***Community Involvement***: Mobilisation, M&E of health clubs, participation of men in health clubs.<br>***Indicators***: Number of under 5's recorded who are underweight, reduction in incidence rat, number of functional clubs formed -reduction in death rate, number of care givers knowledgeable on good feeding practices, KAP survey |
| Group Three | Adolescent and Reproductive Health Program in Beitbridge | ***Introduction***: Beitbridge, being a border town, is a hype of socio-economic activities. The issue of STI's in the district has been on the increase based on statistics from the District Hospital.<br>***Proposed Intervention***: Education & Income generating projects will be the key method. The team has identified risk factors that lie in the district which are contributing to the increase of STI's i.e. unemployment, migration, truck drivers, high school drop outs, poverty and brothels. Due to these risk factors, there has been an increase in risky sexual activities like CSW and the small house saga etc. Proposed actions to decrease STI's amongst the youth is Peer education(TOT),IEC material production & distribution, Condom promotion & distribution, Advocacy, Awareness Campaigns(include Behaviour change), Health Education & Promotion, YES, engaging other stakeholders, Flea Markets<br>***Target group***: Both male and female adolescents (15-23)<br>***Partnerships***: MoHCW, DAC, MoEnterprise Development, MoYouth, Town Council, ZRP (VFU)<br>***Community Involvement***: The community needs to be sensitized on the program, |

| | | |
|---|---|---|
| | | the community should identify their peer educators, influential leaders in the community can be approached (role models)<br>***Indicators:*** No. of STI cases being reported(incidence and prevalence rate), number of condoms being distributed, number of trainings held, increase in the IEC being distributed, created social activities, number of out of school youth employed |
| Group 4 | Malaria Prevention in Chiredzi | ***Introduction***: Chiredzi has high temperatures and incidence and mortality rates from malaria have been on the increase.<br>***Proposed Intervention***: Training health workers, Health Education on causes ,prevention and control of Malaria, distribution of IEC material, Distribution of Long lasting Insecticide treated Nets( LLITN), indoor residual spraying (IRS), Larvidicing<br>***Target group***: Children under 5 years, pregnant woman, lactating mothers, people living with HIV/AIDS.<br>***Partnerships***: Local government e.g. Chiefs, headmen, Ministry of Education and culture, women action groups, NGOs, family based organisations, the community at large.<br>***Community Involvement***: MoEducation, community volunteers and health workers – distribution of IEC material; Distribution of nets-trained community volunteers; Monitoring use of nets-trained village health workers; IRS –trained youths in the community.<br>***Indicators***: Reduction in malaria incidence reported at health institutions in the district, rreduction in the number of deaths due to malaria, increase in the number of people with access to treated nets, IRS percentage coverage, number of health workers trained, number of health education sessions conducted. |
| Group Five | Cholera outbreak in Zvishavane Urban | ***Introduction*:** The urban area is characterised by poor living conditions, with burst sewer pipes and erratic water supplies, with mostly crowded houses.<br>***Proposed Intervention***: The District Health Executive came up with the following measures to prevent further spread of cholera in the urban area: Health education sessions, Public awareness campaigns, Provision of clean water , Sewer rehabilitation, Distribution of hygiene kits, Advocacy<br>***Target groups*:** School children, Religious groups, mothers/caregivers, men at public drinking and recreation places, general community<br>*Partnerships*: Urban council-water and sewer system, residents' association, Min of Education, Civil protection unit, local government<br>***Community involvement*:** The urban community will mainly be involved through their representatives, who include councillors and residents' association, Councillors and the residents' will help in community mobilisation, to ensure that awareness is raised.IEC material including pamphlets and posters will be designed in appropriate local language.<br>***Impact Indicators***: Number of new confirmed cholera cases, Number of deaths due to cholera, % of households within 500m of safe water source, % increase in households practicing safe hygiene practices. |
| Group Six | Malaria in Mwenezi | ***Introduction***: Each year around 200 people die of clinical malaria, 80% of which are children and pregnant mothers.<br>***Proposed Intervention***: Ccommunity outreach, supply insecticides treated nets ITNs, indoor residual spraying, malaria prevention during pregnancy (and other target groups), prompt, effective anti-malaria treatment (prophylaxis).<br>***Target group***: Pregnant women, under fives, children up to 12 years, households.<br>***Partnerships***: MOHCW,MoEducation, local Government, NGOs<br>DAAC<br>***Community Involvement***: Sensitisation meetings with local leadership, Situational analysis, monitoring and evaluation, hhousehold surveys / Heath facility survey, net-making, school and community campaigns and competitions<br>***Indicators***: % of under 5yr children (and other target groups) with uncomplicated malaria correctly managed at health facilities, % of U5 children (and other target group) with severe malaria and correctly managed at health facilities, % of children U5s sleeping under and insecticide treated nets (ITN), % of pregnant women (and other target groups) sleeping under ITN, % of households with at least 3 ITNs or Indoor residual spraying, incidence of confirmed malaria case. |

The mentor- Prof S Rusakaniko raised several points and gave feedback to the group presentations as summarized in the box below;

1. Teams were not identifying themselves (no names) on the presentations
2. Problem statements were not clear. It was difficult to see the problem. Proposals should put the intended recipient into the shoes of the person making the proposal. In some cases, the problem statement was not fitting well with the interventions. A clear justification of the intervention should be made.
3. The interventions were not well presented. Groups needed to go into the core of the problem and justify why the interventions are being done. Some of the interventions were not appropriate to the background information.
4. Sustainability of interventions should also be considered.
5. Identification of stakeholders and level of participation was not well articulated.
6. The target groups were sometimes vague, and inappropriate.
7. Local stakeholders needed to be specifically stated e.g. chiefs, councillors
8. There is need to make indicators clear and measurable against some baselines. Some indicators related to rural areas yet interventions were being done in an urban area.
9. Community participation need to be clearly spelt out, i.e specify who does what.
10. There is need to follow the prescribed format when doing proposals.
11. Most groups did not include budgets yet these are very critical in proposals.

Prof S Rusakaniko mentor groups during presentations of Assignment 1 in plenary © TARSC 2010

Prof S Rusakaniko said that he would prepare and circulate to participants a document on writing proposals.

### 2.9 Zimbabwe's health services and district health systems

Dr P Manangazira (Ministry of Health & Child Welfare), presented a lecture on Zimbabwe's health systems. She outlined the MOH&CW vision and mission, the organogram for the ministry and the health care providers in Zimbabwe. Her presentation covered the relationships and operational context of the different providers, and the roles and responsibilities of different levels of the health system. She also explained the composition of district health executives and Hospital Advisory Boards. She also noted the importance of community participation at all levels of the health system.

### 2.10 Primary health care policies and practice

Mrs J Maradzika (UZ-DCM) introduced the concepts of Primary Health Care (PHC). She gave a background to PHC, its attributes and components and the PHC policies and practices in Zimbabwe within the context of the overall National Healthy policy framework and the mission and core values of the MOHCW. She gave examples of different aspects of PHC as practiced in Zimbabwe, and the value of these approaches in addressing the major health burdens.

### 2.11 Ensuring and supporting health workers for Primary health care

Dr L Mbengeranwa ( Chair- Zimbabwe Health Services Board) outlined the structure of health service delivery in Zimbabwe. He then briefly outlined primary health care approaches in health delivery and district health services; - composition, current staffing levels and challenges. He noted and explained the findings of the Commission of review into the health sector and the birth of the Health Services Board. Dr Mbengeranwa outlined the functions of the ZHSB. Lastly, he gave a lecture on current conditions of service in the health sector and retention initiatives, noting the need for multi-sectoral approaches in policy formulation and implementation to retain human resources for health using both financial and non financial incentives.

### 2.12 Managing chronic and non communicable diseases: Diabetes, hypertension and mental health

A new session was included on non communicable diseases in 2010. Mrs D Sithole (MoHCW) gave a lecture on common mental health disorders, their causes, signs and symptoms. She highlighted the various policies and actions that can be taken at national, district and community level to deal with mental health problems. She also outlined the various Ministry of Health activities at different levels of care aimed at improving mental health delivery systems in Zimbabwe.

Dr C Duri (Harare City Health Department) outlined the causes, presentations and complications of diabetes as a major chronic disease. He then noted its diagnosis, management and investigation. On treatment, assessment and control, Dr Duri noted the need for proper education of patients on appropriate diets and management of blood pressure.

### 2.13 Health care financing: Budgeting and resource allocation at district level

Mr Shepherd Shamu (TARSC), gave a presentation on health care financing in Zimbabwe. He described the health financing flows between purchasers, providers and consumers in Zimbabwe and how these are reflected in national health accounts in Zimbabwe. He discussed the major resource mobilization, resource allocation approaches for health and their equity, adequacy, effectiveness and efficiency, the

national policy goals for health financing and their reflection in budget and resource allocation policies and strategies.

## 2.14 Mechanisms for community participation in health

Mr I Rusike (Community Working Group on Health Director), presented the concepts and levels of organization of community and of participation in health, the mechanisms for community participation in PHC and district health systems, He talked about the role of civil society, of individuals and of households and the mechanisms for co-operation with health service providers and within wider intersectoral action for health. He also explained the composition and functions of a Health Centre Committees, giving practical examples of how these have been useful in improving health delivery in selected districts in Zimbabwe, for instance in Bindura Nyava.

## 2.15 Assignment two: Fair financing of primary care level health systems

This exercise was aimed at evaluating ho participants would apply the knowledge gained on district health systems (structure, financing, human resources, community participation).this knowledge. The assignment was on fairly financing comprehensive primary health care services within districts. Participants were asked, in groups, to report on choices and measures for strengthening fair financing for primary health care and clinic services

Noting the thrust of the MoHCW to revitalise the Primary Care Approach to address health needs of the nation (as outlined in the 2010 Zimbabwe Health Sector Investment Strategy) as well as the fundamentals of fair financing, the assignment tested the participants' capacity and skills to;

- Indentify the criteria that they would propose to inform choices about how available financial resources (national or district) are used, given the scarcity of resources
- Identify new or additional sources of funding that they would propose to improve the level of resources for community and clinic services as well as issues to be considered in planning collection and management of the funds.
- Give and justify their position on what should happen with user fees at clinic level, i,e if applicable, explain who they should be collected from, for what and how they should be managed and used. If non applicable, explain what they would need to do to ensure the policy is effective.

The three groups reported back in plenary, and the summary of reports is shown in table 3 below.

**Table 3: Assignment 2: Consolidated Group Reports**

| Group Number | Criteria for allocation of resources |
|---|---|
| Group 1 | • Major contributors to mortality and morbidity, i.e history.<br>• Essential medical supplies<br>• Staff retention and motivation considerations<br>• Allocation by department eg maternal department<br>• Community involvement- prioritization<br>• Data analysis of major contributors to morbidity and mortality<br>• District plans and guidelines.<br>• Emergency cases eg cholera |
| Group 2 | • Needs, eg drugs<br>• Mortality and morbidity<br>• Cost effectiveness of interventions |
| Group 3 | • Morbidity and mortality<br>• History- previous deficits and surpluses |

| | |
|---|---|
| | • Population and population groups<br>• Infrastructure and equipment<br>• Promotive and preventive programmes rather than curative |

**The feedback on user fees was moderated in the form of a TV panel debate, with each group represented by a panelist**, and participants giving feedback and asking questions on the topic "should user fees be abolished?".

In the group work all three groups felt some fees should be applied in some levels of services, with exemptions for chronic patients, children below five years, orphans and vulnerable children, destitute and pregnant women. One group noted that the social welfare department should provide assistance to destitutes.

In the panel debate, it was noted that the social welfare department is not functional hence the need for more robust frameworks to assist the low income and vulnerable groups. It was also noted that identifying groups that fall into the exemption category may be difficult at clinic level. Some groups proposed that the level of user fees and definitions for those in the exemption category be defined by the community. Some participants suggested that Health Centre Committees determine the levels of user fees. Participants felt that the health delivery system is in a transition period; and user fees should stay as we move towards more sustainable equitable health financing mechanisms like a National Health Insurance Scheme. The user fees could be administered at the HCC level for such costs as administration and maintenance of equipment and infrastructure.

However, other participants noted that the user fees may be too insignificant to the revenue of the health facility, exemptions may be difficult to implement, encourage stigmatization, are regressive, can be abused and discourage links with health facilities.

Dr Rene shared with participants' evidence from the region and Zimbabwe on user fees. She noted that user fees have been shown to affect access to health services. Evidence shows that user fees may cause people to delay visiting health services, only doing so when the condition has worsened further raising costs of curative care. They should also be viewed in the context of other costs that households are paying to access health care, for instance transport costs. Participants identified employers, donors, health insurance, companies, levies from local authorities and taxes as other possible sources of funding.

Dr Rene gave facilitated a discussion and gave feedback on the criteria for resource allocation, noting that the groups had shared and different criteria. The box below summarises the discussion on this area

- **Need based**: Disease burden is a reflection of health needs, and resources are always allocated to health needs. Assessing needs through health facility statistics is measuring health demand and not health needs. Health needs are assessed in the community through surveillance and surveys. Participants concurred that the current allocation of resources to districts is based on health demand.
- **Capacity to absorb**: This is also considered when allocating resources. Such issues like health staff, facilities needed to run programmes are also vital. Thus, resources need to be allocated where there is capacity for them to be spent and utilized.
- **Fundamental rights**: Resources may be allocated based on whether the programmes that are regarded as fundamental rights eg water and immunization of children. There is need for these rights based needs to be costed. Dr Rene noted that the current constitution of Zimbabwe does not protect these rights. These rights should be progressively realized and should be in the constitution and in public health law.
- **Cost benefit consideration**, i.e what health benefit is being realized from the programme.

- **Community/ District preferences**: Resource allocation should not be totally guided by this as the community may not be seeing the need, for instance chronic diseases. There is need to dialogue more with the community and get evidence of needs since those with power normally decide what to do.

Dr Rene noted that that people can make a difference at district level even with the few resources that are allocated from central government provided these are allocated to areas of need.

## 2.15 Panel discussion: Non health sector roles in health:

The panel discussion session was chaired by Dr G Gonese and papers were presented and discussed by the following;

- Dr D Parirenyatwa (Chair of the Parliamentary Committee on Health, Parliament of Zimbabwe) - Key roles played by the Parliament in Health.
- Mrs S Chitsungo (Health Specialist- UNICEF) – Role of International Agencies in Health.
- Mr R Mozhentiy (Interim Secretary General, Zimbabwe Local Government Association) – Role of Local Government in Health

Their presentations outlined the roles in intersectoral action for health, how they are linked to the health sector and health services and to district level health interventions.

All the sessions were followed by discussions of issues raised by students and the facilitators. The panel and participants noted that;

- Members of Parliament should correctly carry out their representative function and should articulate such issues like transport and user fees on behalf of their constituencies.
- The issue of scrapping traditional birth attendants need to be revisited, especially when no mechanisms to fill the gaps they will leave are not yet in place.
- Parliament should adequately debate the National Health Insurance Scheme, this should be implemented across a wider base of employees and not burden the already burdened few workers.
- The training and incentives for Village Health Workers need to be standardized.
- Actors in health need to come up with a minimum package for interventions, as some districts reported some organisations giving school pencils as interventions.
- Monitoring and standadisation of organisations' overheads is important as very little sometimes goes directly to benefit communities.
- Local authorities should not divert resources that are being paid for specific purposes, eg refuse collection.

## 2.16 Presentation Skills

Ms B Kaim TARSC, facilitated on presentation skills and key points for preparing and delivering presentations and for using visual aids. Students showed much interest this session and used the skills they had learnt in preparing and presenting their assignments.

## 2.17 Test of knowledge

Participants completed a test designed to assess the levels of knowledge. The test assessed knowledge on content raised in the lecture sessions and was aimed to assess the extent to which materials were understood by students. All students passed the test. The answers were discussed with the students by Dr Loewenson on the last day.

# 3. Course evaluation and closing

## 3.1 Course evaluation

Participants completed a course evaluation form at the end of training. Twenty nine of the thirty three participants to the course completed the evaluation forms. This was aimed to collect feedback on the strengths and weaknesses of the training programme for future planning.

All (100%) of those completing the evaluation found the Winter school course relevant to their work. All participants (100%) noted that the course is very useful. Nearly all (97%) reported that the trainers were good, 38% rated the course materials as good and a further 62% noted that the materials were very good. The detailed results are shown in Appendix 2. Generally students understood the lectures, with some partially understanding some areas .Some sessions were less well understood than others; at least one participant noted that they had not understood the following teaching sessions;

- Epidemiology, prevention and management of major communicable diseases: TB, Cholera, Malaria and typhoid.
- Nutrition patterns and promoting healthy dietary practices
- Traditional concepts and management of health and disease
- Primary health care policies and practice
- Health care financing: resource mobilization, budgeting and resource allocation at district level
- Mechanisms for community participation in health
- Co-coordinating and involving different roles in health at district level

Participants also noted that more time was needed for the course. They felt that through the course they had gained a broader understating of public health issues and said that they would share this knowledge with their organisations and workplaces. They also noted that the course would help them implement public health programmes in their areas of work to advance public health at community level. Sessions were highly rated as relevant and useful .Handouts and assignments were also rated as clear and useful. Nearly four fifths (79%) of the participants found assignment 1 on district health services to be clear and useful while 93% felt Assignment 2 on health financing to be clear and useful. The full results are shown in Appendix 2.

## 3.2 Follow up discussion and priorities

Professor S Rusakaniko observed that it was very easy to get training but difficult to practice. The participants were now equipped with skills and were urged to apply them to ensure evidence based programming in their areas of work. He noted that the course was just the beginning of opportunities into public health. On opportunities for further study and training, Prof Rusakaniko outlined the structure and requirements into the programmes offered by the UZ DCM, namely;

- Masters in Public Health (Both on part time and fulltime)
- Diploma in Environmental Health
- Bachelor of Science in Health and Environment
- Short courses offered in conjunction with BRTI. Currently there are 16 courses being offered, including epidemiology, research methods, data management, ethics in research, laboratory practice and quality control

The need for a well defined career path structure in the future was noted. Participants noted that there is a lot of uncoordinated training going on in Zimbabwe and these needed to be coordinated. The need to differentiate academic training from employment development training was also highlighted.

Dr Rene Loewenson advised the participants that a follow up on what the participants will be doing after the training would be done three months after the training. She also invited participants to subscribe to the EQUINET newsletter, which includes information on health from the region.

Participants made suggestions on areas to improve in the future:

- Include project monitoring and evaluation, or, noting that this is a course in its own right, build this into one of the assignments to strengthen this capacity
- Instead of the panel discussion on non health sector roles in health, perhaps have a session on intersectoral action for health and have presentations from different sectors.
- Review the nutrition session content.
- Include in sessions examples of promising practices that people can draw on;

Participants also noted the need for training in managing data and evidence. Participants concurred that all the content in the syllabus was relevant. Dr Rene indicated that a follow up evaluation would be carried out after three months to find out how participants had used the training and they could further advise on areas for improvement at that stage.

## 3.3 Closing

To orient Professor M Chiodzonga, Dr Rene Loewenson gave a background on the course and the different disciplines and organizational backgrounds of the participants. She was encouraged the team had a vision for public health for the future. She acknowledged the good gender and geographic representation of the participants. Dr Loewenson thanked the team at TARSC, especially Artwell Kadungure, for their work on the course, thanked the staff at UZ DCM for their support and input, particularly Prof Rusakaniko, and expressed appreciation for the long collaboration between TARSC and UZ DCM on the course and other areas. She also noted the support of TARSC, UZDCM, CIDA/Oxfam Canada, and the delegates and their organizations for the costs of the course.

Professor M Chidzonga (Dean UZ DCM) gave the closing remarks. He appreciated the diversity of backgrounds of the participants, and expressed satisfaction that the participants had covered a lot of work during the six days. He encouraged the participants to make public health popular and participate in informing the public health curriculum. He expressed his gratitude for his association with the winter school program since 2005 and thanked Dr Rene Loewenson and Professor S Rusakaniko for their commitment. Participants were awarded certificates of completion, to the applause of their colleagues.

This is the product of my six days here! One of the participants seems to be saying after receiving a certificate from Prof M Chidzonga (middle) and Prof Rusakaniko (right). © TARSC 2010

# Appendix 1: Training Programme

## TRAINING AND RESEARCH SUPPORT CENTRE and UNIVERSITY OF ZIMBABWE DEPARTMENT OF COMMUNITY MEDICINE (DCM)

## PUBLIC HEALTH WINTER SCHOOL SHORT COURSE TRAINING
## July 5-10 2010, UZ Harare

| COURSE BLOCK | COURSE TITLE | FACILITATOR |
|---|---|---|
| | **Monday July 5** | |
| **Session number, time** | **INTRODUCTION** | |
| 1.1<br>0800-0900 hrs | Registration and administration | Artwell Kadungure |
| 1.2<br>0900-1015 hrs | Course overview, objectives, delegate introduction and background<br>Outline of course programme, assignments, practical arrangements | Dr R Loewenson, TARSC<br>Prof Rusakaniko, UZ DCM |
| **1015-1045 hrs** | **Tea Break** | |
| **INTRODUCTION TO PUBLIC HEALTH** | | |
| 1.3<br>1045-1230 hrs | Introduction to epidemiology and public health | Dr R Loewenson<br>TARSC/EQUINET |
| **1230-1330 hrs** | **Lunch** | |
| 1.4<br>1330-1500 hrs | Epidemiology of and responses to HIV and AIDS: situation and services | Dr A Mahomva<br>Elizabeth Glazier Pediatric HIV and AIDS |
| **1500-1515 hrs** | **Tea break** | |
| 1.5<br>1515-1700 hrs | Gender and reproductive health issues and services | Mrs T Chinhengo - UNFPA |
| | **Tuesday July 6** | |
| 1.6<br>0830-0945 hrs | Epidemiology, prevention and management of major communicable diseases: TB, Cholera, Malaria and typhoid | Dr G Gonese – Malaria, Cholera<br>City Health Dept<br>Dr C Duri – TB, Typhoid<br>City Health Dept |
| 1.7<br>9.45 to 11.00 hrs | Nutrition patterns and promoting healthy dietary practices | Mrs R Madzima<br>Nutrition Consultant |
| **1100-1115 hrs** | **Tea Break** | |
| 1.8<br>1115-1245 hrs | Traditional concepts and management of health and disease | Tsitsi G. Monera- UZ School of Pharmacy |
| 1.9<br>1400-1445 hrs | Assignment 1: District health project<br>Introduction, sources of information | Prof Rusakaniko UZ DCM, |
| **1445-1500 hrs** | **Tea break** | |
| 1500-1700 hrs | Project work<br>Student group work time | Prof Rusakaniko UZ DCM, |
| | **Wednesday July 7** | |
| 0830-1000 hrs | Report back and discussion Case study work/mentored assignment | Prof S Rusakaniko UZ DCM |
| **1000-1015 hrs** | **Tea break** | |
| **DISTRICT HEALTH SYSTEMS** | | |
| 1.10<br>10.15 - 1145 hrs | Organization of Zimbabwe's health services and district health systems | Dr P Manangazira- MOHCW |
| 1.11<br>1145-1300 hrs | Primary health care policies and practice | Mrs J Maradzika- UZ DCM |
| **1300-1400 hrs** | **Lunch** | |

| | | |
|---|---|---|
| 1.12 1400-1445 hrs | Case study work /mentored assignment 2 Introductory session | Dr R Loewenson, TARSC |
| **1445-1500 hrs** | **Tea break** | |
| 1500 - 1630 hrs | Case study work/mentored assignment student work | |
| | **Thursday July 8** | |
| 1.13 0830-1000 hrs | Managing, retaining and improving the conditions of health workers at district and primary care level | Dr Mbengeranwa ZHSB |
| **1000-1015 hrs** | **Tea Break** | |
| 1.14 1015-1115 hrs | Managing chronic and non communicable diseases: Diabetes, Hypertension, cancers and mental health | Mrs D Sithole MoHCW<br>Dr C Duri- City Health Department |
| 1.15 1115-1230 hrs | Health care financing: resource mobilization, budgeting and resource allocation at district level | Shepherd Shamu TARSC |
| **1230-1330 hrs** | **Lunch** | |
| 1.16 1330-1430 hrs | Mechanisms for community participation in health | Mr I Rusike CWGH: |
| 1430-1500 hrs | Presentations and feedback on mentored assignment | Dr R Loewenson, TARSC |
| **1500-1515 hrs** | **Tea break** | |
| 1515- 1630 hrs | Presentations and feedback on mentored assignment | Dr Rene Loewenson, TARSC |
| | **Friday July 9** | |
| 0830-930hrs | Students Revision Time | |
| **0930-1000 hrs** | **Tea break and admin/ resource files** | |
| 1.17 10.00-12.00 hrs | Presentation skills:<br>Presentation and use of assignments to mentor students | B Kaim, TARSC |
| **1200-1330 hrs** | **Lunch** | |
| 1.18 1330-1530 hrs | Panel discussion: Co-ordinating and involving different roles in health **at district level:**<br>Parliament of Zimbabwe<br>Faith based organisations<br>Ministry of local government<br><br>International agencies | Chair: Dr Gloria Gonese<br><br><br>A. Mukono/ Dr D. Parirenyatwa.<br>Methodist Church - Rev Sithole<br>Speaker from the RDCAss -<br>Mr Mozhentiy<br>Shelly Chitsungo UNICEF |
| **1530-1545 hrs** | **Tea break** | |
| 1.19 1545-1630hrs | Test of knowledge | Artwell Kadungure, TARSC |
| | **Saturday July 10** | |
| **CONCLUDING SESSIONS** | | |
| 1.20 0830-0915 hrs | Course evaluation<br>Review of resource materials | Artwell Kadungure, TARSC |
| 1.21 0915-1000 hrs | Test results<br>Discussion of follow up | Dr R Loewenson, TARSC |
| **1000-1015 hrs** | **Tea Break** | |
| 1.22 1015-1130 hrs | Priorities not covered in the course: further training needs and information sources | Prof Rusakaniko UZ DCM |
| 1.23 1130-1200hrs | Course certificates and closing remarks | Dean Faculty of Medicine |
| **1200 hrs** | **Closing** | |

# Appendix 2: Evaluation Results

**Participants' responses on the overall relevance of the course to roles, course usefulness and quality of trainers**

| | **% Student response** | | **N=29** | |
|---|---|---|---|---|
| | Relevant to my work or role | | Not Relevant to my work or role | |
| Research Skills Training is | 100 | | - | |
| | Very Useful | Useful | Not Useful | |
| Overall, the course was | 79 | 21 | - | |
| The trainers were | Very good | Good | Poor | Very poor |
| | 31 | 66 | 3 | - |
| The materials were | Very good | Good | Poor | Very poor |
| | 31 | 66 | 3 | - |

| **SESSION** | **% Student response on understanding of sessions** | | **N=29** |
|---|---|---|---|
| | Understood all | Understood most of it | Did not understand |
| 1.2 Introduction: Course overview and objectives | 59 | 38 | 3 |
| 1.3 Introduction to epidemiology and public health | 45 | 55 | - |
| 1.4 Epidemiology of and responses to HIV and AIDS: situation and services | 24 | 76 | - |
| 1.5 Epidemiology, prevention and management of major communicable diseases: TB, Cholera, Malaria and typhoid | 28 | 69 | 3 |
| 1.6 Nutrition patterns and promoting healthy dietary practices | 35 | 55 | 10 |
| 1.7 Traditional concepts and management of health and disease | 41 | 55 | 3 |
| 1.8 Gender and reproductive health issues and services | 24 | 76 | - |
| 1.9 Assignment 1: District health project Introduction, sources of information | 31 | 59 | 10 |
| 1.10 Organization of Zimbabwe's health services and district health systems | 38 | 62 | - |
| 1.11 Primary health care policies and practice | 24 | 66 | 10 |
| 1.12 Case study work /mentored assignment 2 | 41 | 59 | - |
| 1.13 Managing, retaining and improving the conditions of health workers at district and primary care level | 45 | 55 | - |
| 1.14 Managing chronic and non communicable diseases: Diabetes, Hypertension, cancers and mental health | 45 | 55 | - |
| 1.15 Health care financing: resource mobilization, budgeting and resource allocation at district level | 41 | 55 | 3 |
| 1.16 Mechanisms for community participation in health | 41 | 49 | 10 |
| 1.17 Presentation skills: Presentation and use of assignments to mentor students | 69 | 31 | - |
| 1.18 Panel discussion: Co-coordinating and involving different roles in health at district level | 21 | 76 | 3 |

| | % Student response on relevance and usefulness of sessions N= 29 | | |
|---|---|---|---|
| | Relevant and Useful | Somewhat relevant and useful | Not relevant and useful |
| 1.2 Introduction: Course overview and objectives | 97 | 3 | - |
| 1.3 Introduction to epidemiology and public health | 100 | - | - |
| 1.4 Epidemiology of and responses to HIV and AIDS: situation and services | 90 | 10 | - |
| 1.5 Epidemiology, prevention and management of major communicable diseases: TB, Cholera, Malaria and typhoid | 86 | 14 | - |
| 1.6 Nutrition patterns and promoting healthy dietary practices | 79 | 21 | - |
| 1.7 Traditional concepts and management of health and disease | 72 | 28 | - |
| 1.8 Gender and reproductive health issues and services | 72 | 28 | - |
| 1.9 Assignment 1: District health project Introduction, sources of information | 90 | 10 | - |
| 1.10 Organization of Zimbabwe's health services and district health systems | 83 | 17 | - |
| 1.11 Primary health care policies and practice | 93 | 7 | - |
| 1.12 Case study work /mentored assignment 2 | 90 | 10 | - |
| 1.13 Managing, retaining and improving the conditions of health workers at district and primary care level | 83 | 17 | - |
| 1.14 Managing chronic and non communicable diseases: Diabetes, Hypertension, cancers and mental health | 76 | 24 | - |
| 1.15 Health care financing: resource mobilization, budgeting and resource allocation at district level | 83 | 17 | - |
| 1.16 Mechanisms for community participation in health | 86 | 14 | - |
| 1.17 Presentation skills:<br>Presentation and use of assignments to mentor students | 97 | 3 | - |
| 1.18 Panel discussion: Co-ordinating and involving different roles in health at district level | 66 | 31 | 3 |
| | % Student response on clarity and usefulness of handouts N = 29 | | |
| | Clear and useful | Partly clear and useful | Not clear and useful |
| 1.2 Introduction: Course overview and objectives | 93 | 7 | - |
| 1.3 Introduction to epidemiology and public health | 100 | - | - |
| 1.4 Epidemiology of and responses to HIV and AIDS: situation and services | 69 | 28 | 3 |
| 1.5 Epidemiology, prevention and management of major communicable diseases: TB, Cholera, Malaria and typhoid | 79 | 17 | - |
| 1.6 Nutrition patterns and promoting healthy dietary practices | 52 | 38 | 10 |
| 1.7 Traditional concepts and management of health and disease | 66 | 34 | - |
| 1.8 Gender and reproductive health issues and services | 62 | 38 | - |
| 1.9 Assignment 1: District health project Introduction, sources of information | 79 | 21 | - |
| 1.10 Organization of Zimbabwe's health services and district health systems | 83 | 17 | - |
| 1.11 Primary health care policies and practice | 79 | 21 | - |
| 1.12 Case study work /mentored assignment 2 | 93 | 7 | - |
| 1.13 Managing, retaining and improving the conditions of health workers at district and primary care level | 86 | 14 | - |
| 1.14 Managing chronic and non communicable diseases: Diabetes, Hypertension, cancers and mental health | 69 | 31 | - |

| | | | |
|---|---|---|---|
| 1.15 Health care financing: resource mobilization, budgeting and resource allocation at district level | 83 | 14 | 3 |
| 1.16 Mechanisms for community participation in health | 73 | 24 | 3 |
| 1.17 Presentation skills: Presentation and use of assignments to mentor students | 97 | 3 | - |
| 1.18 Panel discussion: Co-coordinating and involving different roles in health a**t** district level | 55 | 41 | - |

Note: Non responses make up the differences.

**Changes that should be made to improve course content and delivery**

- The course needs more time **(15 responses)**
- The syllabus was great and the course was very useful **(10 responses)**
- Need more practical assignments/more time for practical assignments (3)
- Nutrition should be linked to public health and current programmes should be covered
- The HIV/IDS session needs more coverage on PMTCT
- Include diseases such as measles and ARV issues.
- The Primary Health Care sessions need to be revisited and properly presented.
- Improve time management, and more time needed for revision, questions.(2)
- Reduce the number of groups for group work assignments to allow for more time for discussions.
- Some presenters need to improve presentation skills, link powerPoints to handouts (2).
- All handouts should be available on the first day.

**Any other comments including how the training will be used in participant's areas of work.**

- The syllabus was great and the course was good x 8
- The course will help in the writing of district proposals x 2
- Consider sending a draft programme before the training date to participants.
- We need refresher courses for those trained already.
- We would appreciate if the Minister of Health can also find time to come and share public health issues with us.
- The training was useful on environmental health, it was an eye opener.
- The course clarified a lot of issues on public health and am now able to assess and analyse public health issues in my areas of work
- The course will help me integrate my work with other public health programmes, will contribute to public health in my district.
- I will share the knowledge with my organisation and workers at my workplace
- The course will improve my advocacy and facilitation skills.
- The course ensures a broader understanding of public health issues and will assist me in implementation of nutrition programmes.
- Certificates should be of competency and indicate subjects covered.

# Appendix 3: List of participants

| # | Applicant name, institution, position in institution and contact address | Email Address |
|---|---|---|
| 1. | Tapiwa Chipangura, Concern Worldwide, Field Officer 322-28th St, Hatcliffe Harare Tel: 0912 806 488, 011 766 551, 0733 058446 | chipangurat@yahoo.com |
| 2. | Patience Panganai, Medicines Sans Frontie, Health Promotions Officer , 46 Mt Pleasent Drive Harare Tel: 0912 935232/ 011806118 /0912935287 | patiencep@yahoo.co.uk |
| 3. | Faith Kamusono, Action Contre La Faim Deputy Programme Manager No.11 Wistaria Street Masvingo Tel: 0913002323 | fkamusono@gmail.com |
| 4. | Tonderai Mutsago, Min of Labour and Social Services, Labour Officer No 4179 Dendera Close Coldstream Chinhoyi Tel: 0913 612404/ 067 22075 | tondmutsago@gmail.cim |
| 5. | Tariro Kutadza , GTZ, Project Officer , 1 Orange Groove Drive Highlands HarareTel: 0912626870/ 04 496723 Fax: 04- 495628 | tariro.kutadza@gtz.de |
| 6. | Nyasha Gwamanda, Action Contre La Faim ,Assistant Nutritionist ,4th Floor ZIMRE Building Masvingo Tel: 0912 527 891 | nyagwa@gmail.com |
| 7. | Mpho Chiringa, Action Contre La Faim, Assiatant Nutritionist Box 1363 Masvingo Tel: 0913 588975 | mphochiringa@yahoo.com |
| 8. | Blessing Murerwi, Action Contre La Faim , Programme Manager , 4 Lyndhurst Lane Avondale Harare Tel: 0912 117754 | nutmanager@zw.mossions-acf.org |
| 9. | Meshack Chisango, Plan Zimbabwe, 7 Lezard Avenue Milton Park Harare Tel: 0913 276815/ 0913245309 | meshmild2002@yahoo.co.uk |
| 10. | Patience Dube, Population Services International Zimbabwe, HIV Services Operations Officer (Testing and Counselling) 30 The Chase West Emerald Park Harare Tel: 0912287946/ 04-334631 | pdube@psi-zim.co.zw |
| 11. | Taurai Takaruza, MERCYCORPS, Steven Mudhuviwa Programs Manager –Urban Wash 4 Aerodrome Rd Mutare Tel: 0912426510 | smudhuviwa@zw.mercycorps.org |
| 12. | Blessing Madondo Plan International , Health Programme Coordinator Kwekwe Programme Unit Bag 8020 Kwekwe Tel: 055-23511/23584/24203 Fax: 055-24213 | blessing.madondo@plan-international.org |
| 13. | Rachel Tinashe Goba, Childline Zimbabwe Social Worker Intern 93 Pendennis Rd Mt Pleasent Hre Tel: 0912120369/ 793715/301453 | rachietg@gmail.com |
| 14. | Clara Zadzagomo, International Organisation for Migration, Nurse AID Tel: 0912637841 | czadzagomo@iom.int |
| 15. | Marizeni Zhoya, CWGH, Voluntary Health Worker, St Johns Primary School Box 50 Juru Tel: 0913489722/ 011309570 | Na |
| 16. | John Mwenda, National Institute of Health Research, Medical Research Officer – Water and Sanitation Box 573 Causeway Harare Tel: 0912907325 | jmwenda54@yahoo.co.uk, jmwenda@nihr.co.zw |
| 17. | Timothy Kuramba, MoHCW, Community Health Nurse (Save the Children UK) Box 180 Nyika Tel: 0912905124 | Na |
| 18. | Margareth Mutsambwa, Seke Teachers College, Lecturer Health and Life Skills Coordinator 20488B Unit B Seke Tel: 070-26444/ 0912292253 | Na |
| 19. | Willard Chindalo Field Monitor Plan International 10 Cleveland Ave Milton Park Harare Tel: 0912422070 | wchindalo@gmail.com |

| | | |
|---|---|---|
| 20. | Ngoni Progress Ngwenya, AGRITEX, Agricultural Extension Officer 8088 Cold Comfort Tel: 0913775199/ 0733889572 | Na |
| 21. | Skangele Mary Mandhlokuwa, Zvishavane Water Project, WASH Programme Officer 14 Agate Mimosa Cottages Zvishavane Tel: 0913252463/011779224 | mandhlokuwa@yahoo.com |
| 22. | Israel Sango, CMAM Goal Zimbabwe, Nutrition Sepervisor – 22 Vito Street Mbare Harare Tel: 0912936787 | issangy@yahoo.com , isango@goalzimbabwe.org |
| 23. | Beatrice Savadye, SAYWHAT, Information and Advocacy Officer Box HG 152 Highlands Harare Tel: 0913560811 | beatrice@saywhat.org.zw |
| 24. | Violet Moyo, Zimbabwe Project Trust. Project Officer 52 Fort Street and 3rd Avenue Bulawayo Tel: 09-68804/71019 | vilet-moyo@hotmail.com, vmoyo@zimprotbyo.co.zw |
| 25. | Thokozile Ngwenya, Ingutsheni Central Hospital Health Promotion Office, P O Box 8363, Belmont, Bulawayo. Tel: 09-466463-5, | Na |
| 26. | Sammy Garikai Chaikosa Civic Forum on Housing Development Practitioner Civic Forum on Housing Box 1744 Harare Tel: 0912354473 | cvcfh@hotmail.com |
| 27. | Chenjerai Mushawatu, CWGH, Teacher, Ministry of Education, Sports and Culture Nyava High Box HG 582 Highlands Harare Tel: 0912599976 | Na |
| 28. | Joseph Kunashe, ZCTU-FFAWUZ, Health and Safety Officer Box 4211 Harare Tel: 04-748482 Fax: 04-748482 | ffawudick@mweb.co.zw |
| 29. | Upenyu Patience Muteyo, Citizen Participation Trust (CWGH), Coordinator No 8 Third Street Marondera Tel: 0912967985/ 0912304324 | cptrustpartners@gmail.com ,umuteyo@yahoo.com |
| 30. | Tendai V Nhidza, Action Contre La Faim, Nutrition Assistant 1812 Section 5 Kambuzuma Harare Tel: 0912 960 980./ 0912 114 053 | nhidzatv@yahoo.com |
| 31. | Toindepi Dhure, Zimbabwe Domestic and Allied Workers Union ,Trade Unionist Box 6850 Harare Tel 0914 075 592, 04 775817 | tdhure@yahoo.co.uk |
| 32. | Chipo Chipisa, MoHCW, Registered Nurse NRZ Box 74 Gweru 0912548508/ 0733022687 | chiporon@gmail.com |
| 33. | Tandiwe Tendai Maruta, National Social Security, Senior Occupational Health Nursing Officer Box 1294 Bulawayo Tel: 09-74094/60689 | marutat@nssa.org.zw |