Using photovoice to strengthen Health Centre Committee roles in east and southern Africa

Report of the Training of Trainers Workshop

29th September – 1st October

Harare, Zimbabwe

Training and Research Support Centre
with CWGH, LDHO and UCT

in the
Regional Network for Equity in Health in east and southern Africa (EQUINET)

With support from OSIEA

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Cover photo: Participants with community photographers in Cassa Banana, Zimbabwe. Photo: Jon Pilch, 2015

1. Background

In 2015-16, the Training and Research Support Centre (TARSC) is coordinating a programme on the use of Photovoice as a tool for strengthening and supporting the role of Health Centre Committees (HCCs) in 3 countries in east and southern Africa. This programme is part of a larger regional focus on HCCs undertaken within the Regional Network on Equity in Health in east and southern Africa (EQUINET) and coordinated by the Community Working Group on Health (CWGH) which aims to explore various aspects of social participation and power in relation to the functioning of HCCs.

The TARSC component of this regional programme is engaging with 3 institutions in the region – the Community Working Group on Health (CWGH) in Zimbabwe, the Lusaka District Health Office (LDHO) in the Ministry of Health, Zambia and the School of Public Health and Family Medicine at the University of Cape Town (UCT) – to explore the use of Photovoice to support the negotiating power of HCCs, especially in terms of influencing the planning and budgeting processes at facility and district levels in meeting community priority health needs. Photovoice is a Participatory Action Research (PAR) tool that combines photography with community action by putting the camera into the hands of community participants so they can represent their community point of view through the visual image.

TARSC and partners are implementing this programme through training members from 2-3 HCCs in each participating country (approximately 15 HCC members per country) in basic photographic skills and then to provide them with cameras to capture images that give voice to how people's lives are impacted by poor access to the social determinants of health (SDH – water, sanitation, food). The decision to focus on the SDH was taken by all 3 participating institutions in recognition that this was a common and poorly addressed problem in all 3 countries. HCC members, with support from their implementing partners, will then use these photographs as evidence in existing processes such as local level clinic meetings, district health meetings, and in dialogue with other sectors. The programme is divided into 3 stages:

1. A training-of-trainers' workshop for coordinators from each country to be facilitated by TARSC in Harare, followed by an in-country training of HCC members from 2-3 HCCs undertaken by the 3 participating institutions (October – November 2015)
2. Implementation of the programme (Nov 2015 – July 2016) at HCC/community level to include 2-3 cycles of taking photographs, the development of a communication tool and sustained interactions with decision-makers at health facility and/or district planning meetings
3. Joint reflection and production of a report that documents the process, outputs and outcomes of the photovoice experience with recommendations on future use of this approach in strengthening the role of HCCs in the region (August – November 2016)

Within this context, the training-of-trainers' workshop aimed to provide participants with the needed skills to be able to train the participating HCCs in the Photovoice process and to strengthen their capacity to coordinate, monitor and document the programme at country level. It was attended by 1 to 2 representatives from each implementing partner (CWGH, LDHO and UCT) and one HCC member from each country, with facilitation support from TARSC and MacPherson Photographers.

This report documents the proceedings of this training-of-trainers' workshop held in Harare, Zimbabwe from 29th September to 1st October 2015. It does not include information from the 20-page training guide produced for this training, nor does it provide all the exchanges and skills inputs that took place in the meeting. However, it does capture through words and pictures the major skills areas covered and agreed areas of follow up action arising from the training.

2. Objectives of the photovoice programme

The overall objective of the Photovoice programme is to explore the use of Photovoice as a tool for strengthening the role of HCCs as a vehicle for social participation in 3 countries in east and southern Africa.

The programme seeks to reflect on the following key questions to be used as a guide for monitoring purposes:

1. Does Photovoice help bring the SDH, an issue that is important to communities in ESA, into the HCC for discussion and action? Does it help strengthen HCC members' understanding of key community health needs?
2. Does it help empower the HCCs to take these issues to existing budgeting and planning processes, both within the health system and in interaction with other sectors?

The expected outcomes will be measured at two levels. The first will look at impact within the health system:

- Did the HCCs manage to bring about change in their own areas in relation to improving the SDH?
- Are ways to improve the SDH now reflected in the budgeting and planning process?
- Did the HCCs manage to get other sectors to respond?

Secondary learning will relate to critically reviewing the Photovoice approach:

- Was the Photovoice approach effective in levering the power of HCCs? In what ways? What worked? What didn't and why?
- Is this an approach that we should consider using more widely with other HCCs, and possibly including as an additional tool in our HCC training?

Section 9.3 outlines the indicators to be used to measure successes and challenges arising from this process.

3. Welcome and Introductions

Tafadzwa Nkrumah from the Community Working Group on Health welcomed all participants to the training of trainers' workshop and facilitated a process where each member introduced themselves (see Appendix One for list of participants), the work they do with Health Centre Committees and their expectations for this training. He then handed over to Barbara Kaim, TARSC, to explain the background and objectives of this work.

Barbara introduced the aims and process of the programme (as outlined above), pointing out that this work is drawing on a number of previous experiences within EQUINET. She noted that TARSC, CWGH, UCT and LDHO are all active members of the pra4equity network and have been involved in implementation of PRA processes, health literacy and, more recently, in discussion on the use of PAR as a research tool for strengthening health systems. Two of the four institutions (TARSC and LDHO) also participated in the EQUINET "Eye on equity: Community visions of equity in health" programme in 2009 which involved pra4equity network members from seven countries in using photography to display images of health equity from a community lens. In addition, all four institutions have already developed synergies around our work with Health Centre Committees (HCCs) and have identified common issues that need to be addressed in strengthening the functioning of HCCs within a primary health care (PHC) approach to building more just and equitable health systems in our region.

Participants reviewed and agreed that the objectives of the training were:

- To discuss and strengthen our collective understanding of Photovoice and how we plan to use this approach in our work with HCCs at country level
- To provide participants with the needed skills to be able to train select HCCs in basic photographic skills and implementation of the Photovoice process
- To build the capacity of participants to be able to coordinate, monitor and document the programme at country level, and to share these experiences at regional level.

Barbara then went on to review the programme (see Appendix 2) and distributed the manual of handouts for the training which included information on:

- What is photography – where do we start?
- Elements of a good photograph – lighting, framing, angle of view, etc
- What is photovoice?
- Communicating our message – selecting photos, captioning, developing a communication tool
- Interacting with people – ethics and permission

She noted that this manual was in draft form - participants were encouraged to give feedback/ input to the handouts before they are finalized for use in their own training sessions with HCC members later on this year.

Barbs introducing the programme, Harare 2015

Therese, Manzunzo and Mavhuto, Harare, 2015

4. Understanding HCCs

4.1 HCCs - successes and challenges

Participants broke up into two groups to discuss and then report on the following questions:
What are the successes and challenges HCCs face in:

- *identifying community needs and priorities?*
- *representing these interests at local and district level (through what structures)?*
- *getting these interests included in planning and budgeting processes at local and district level?*

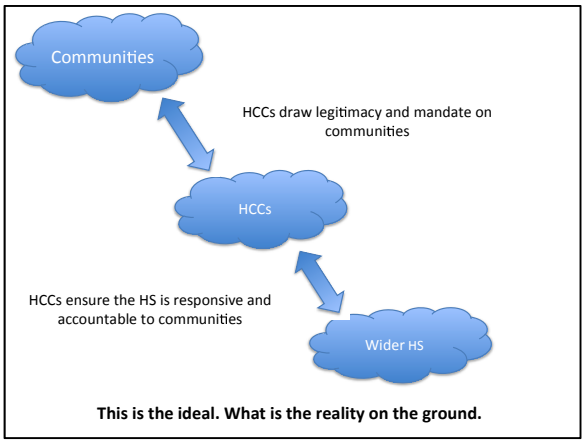
A number of important and insightful points arose during discussion around these three questions:

Both groups acknowledged that HCCs, and especially those who have gone through the health literacy programme or are familiar with participatory approaches to working with communities, are successfully working with communities in identifying priority health needs. They are using a range of participatory tools such as community mapping, and ranking and scoring. The problem arises in representing these interests at local and district level. The reasons for this are varied but mostly boil down to the ***lack of power*** HCCs have in voicing the needs of communities: in all 3 countries, HCCs do not have the legal mandate to hold those in higher positions accountable and this is exacerbated by the fact that there is often a lack of political will from 'those on top of us' to respond to community needs. Instead, HCCs are often dominated by those with greater authority (chiefs and councilors in Zimbabwe, ward councilors in S Africa) who act as gatekeepers in the interaction between community reps and higher levels within the health system.

The ***skills of the HCCs*** were also brought into question. HCC members often lack negotiating skills and do not know how to be proactive. They tend to implement programmes designed from 'above' rather than arguing for the needs of the communities they represent. In some cases, HCC members simply bring their own personal views into the HCC meetings, instead of representing community interests. HCC members also remain weak in keeping their constituents informed on developments within the HCC.

Even in situations where HCCs are developing action plans with communities and bringing these plans into facility meetings, the problem arises in the ***allocation of resources***. There is little or no transparency on how resources reach the facility level and little is given to the HCCs to be able to function effectively. Implementation of the Results Based Financing (RBF) programme in Zimbabwe has resulted in greater allocation of resources to facility level, but these funds have stringent guidelines for how they can be used and may not meet the priority needs of the people in that catchment area. In Zambia, HCCs are only receiving funds from the *imprest* account, which is a petty cash fund for the day-to-day running of the health facility and is not enough to implement any programmes.

So there are certainly some key challenges. But there are some successes. Participants talked about the role HCCs have played in strengthening relations with health personnel at PHC level. In all 3 countries, HCCs are using a variety of mechanisms to raise community voice in HCC/facility meetings and in monitoring the quality of health services, including the strategic use of strong and articulate HCC members around the negotiating table (South Africa), the use of suggestion boxes and score cards (Zimbabwe), and the involvement of HCCs and community members in local government health planning and budgeting (Zambia).



During the feedback session after group work, participants reiterated the need to empower HCCs to make and execute decisions on behalf of the communities they represent. The meeting developed a simple diagram (see above) to show that HCCs draw their legitimacy and mandate from the communities they represent, and in turn have an important role in ensuring that the health system is responsive and accountable to those same communities. The central challenge is how to strengthen the negotiating power of HCCs so they can bring community evidence into existing structures in a more bottom-up approach to planning and budgeting at local and district level.

This last point moved discussions into the next session of the meeting.

4.2 Can HCCs use photos as a tool for change?

Prior to this training, participants were asked to bring a few of their own photos to the meeting: photos that said something important about the role of HCCs, and their relationship with community and the work they are doing, especially in relation to specific health needs and resulting actions. Participants now presented these photos and a discussion ensued on what message/s the pictures were conveying, what made the pictures interesting, how the pictures have been used, and whether the pictures provoked a reaction (positive or negative).

The photos covered a wide range of themes – a number showed HCC members deep in discussion with health facility personnel; there were a few which showed community action, such as during a cleanup campaign in Lusaka organized by an HCC; and others that revealed the infrastructure of the health facility. The photos are not included in this report but are available from the individual institutions.

By the end of the session, participants agreed that their pictures had shown that images can be a powerful tool for change because:

- they stimulate discussion and storytelling, they draw out people's own experiences, have the ability to provoke an emotional reaction (both painful and celebratory) – all of which can be used as a jumping off point to talk about action ('why is this happening?' 'what needs to change?' 'what can we do about it?' etc)
- photos can show the role of, and make explicit the power dynamics between, different players in the health system. Just one snapshot can show what words cannot as easily express who is involved in, for example, a group process and who is not, which can then lead into a useful discussion on improving community participation and dynamics.

Participants also talked about the way they have used their photos to date. The most common ways they have used their photographs are: to document an event or activity (before and after), to use as part of a report, or as a photo essay (for example, using a series of photographs to tell a story, like what happened during an exchange visit). Participants recognized that there is potential to use visual images in other more proactive ways. This session also elicited some useful tips on how to take a good photograph and the importance of knowing why we are taking a particular photo, for what audience and to what end.

5. Introduction to the camera and elements of a good photograph

Jon Pilch and Laurie MacPherson, consultant photographers from MacPherson Photography, introduced participants to their cameras (3 per country) , showing them the different parts of the camera, how to hold a camera, how to take flash cards in and out and how to take care of their cameras. They then introduced some basic skills on taking photographs in terms of composition, lighting, subject placement, framing and angle of view.

In the photos below (from Google Images), Jon showed participants how important it is to make sure that the horizon is not tilted (a common mistake).

STRAIGHT HORIZON – CORRECT

TILTING HORIZON - INCORRECT

The angle of view is also important. In order to make the photo more interesting you can take a picture from a high position looking down, or bend down low to get a completely different perspective. The photos below were taken by community photographer Leeroy Dhumukwa from Cassa Banana Informal Settlement in Zimbabwe:

HIGH ANGLE OF VIEW

LOW ANGLE OF VIEW

Additional content and advice is captured in the meeting handouts, so is not repeated here. Participants then practiced using their cameras and taking photographs both inside and outside of the venue, with Jon giving assistance.

In the latter part of the day, participants returned to the meeting room and downloaded the photos they had taken to show the rest of the group. With guidance from Jon, the group commented on the photos in relation to composition and noted common mistakes and ways to overcome them.

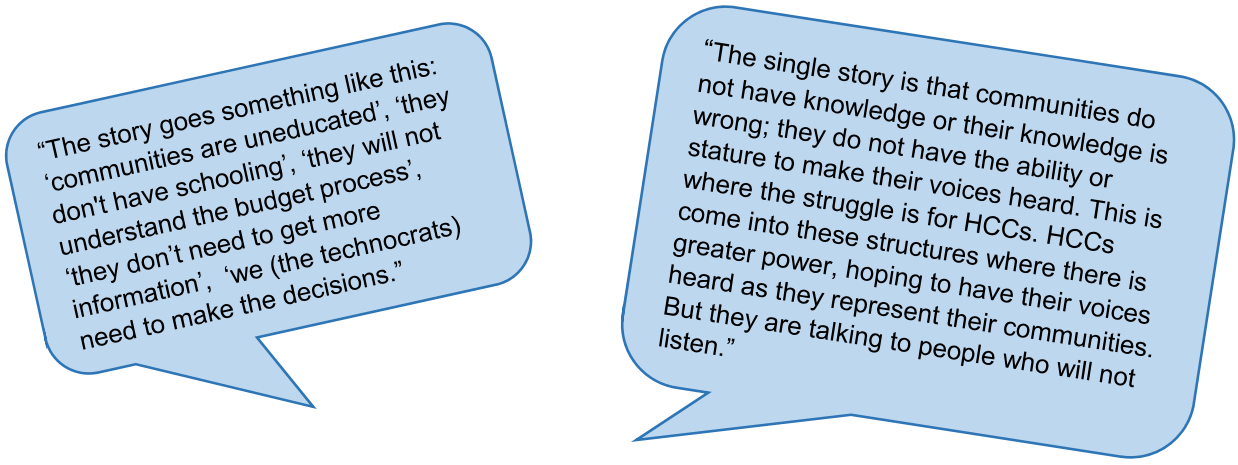
Nceba and Edgar, Harare, 2015

6. Introduction to photovoice

6.1 Countering the 'single story'

As a way of introducing the Photovoice concept, Barbara showed a 20 minute video of the Nigerian novelist, Chimamanda Adichie, talking on TED Talks about 'The Dangers of the Single Story' (www.ted.com/talks/chimamanda_adichie_the_danger_of_a_single_story?language=en). In this talk, Adiche argues that inherent in the power of stories, is the danger of only knowing one story about a group. "The single story creates stereotypes, and the problem with stereotypes is not that they are untrue, but that they are incomplete. They make one story become the only story." Adiche introduces an Igbo word, 'nkali', which means 'to be greater than another' and argues that "Like our economic and political worlds, stories too are defined by the principle of nkali: How they are told, who tells them, when they're told, how many stories are told, are really dependent on power."

Following the viewing of the video, participants reflected on whether our work in HCCs and in communities carry the danger of 'the single story', how it is perpetuated, by whom and what it says about the role of health activists (and photographers!) in countering these stories or stereotypes. Participants felt strongly that there are many 'single stories' about communities with a common theme that communities are uneducated or unskilled and consequently do not have the ability to determine their own future. This single story is disempowering, patronizing and wrong!



These 'stories' counter the underlying premise of Participatory Action Research (PAR) – that people's knowledge can and should be respected as a valid source of information when developing programmes or policies that affect their health.

6.2 Introducing Photovoice

The question, then, is can Photovoice – as a Participatory Action Research (PAR) tool - play a role in countering this single story?

To answer this question, Barbara gave a short summary on the history and basic concepts underlying Photovoice. She explained that Photovoice is about putting cameras into the hands of ordinary people so they can generate visual images of their experiences and actions as they relate to their everyday lives. It has been successfully used over the last 20 years in the public health sector to facilitate dialogue on health and environmental issues and as a mechanism for personal and community change. It draws on three theoretical frameworks: Paulo Freire's philosophy of education for critical consciousness, feminist theory, and non-traditional approaches to documentary photography which aims to use photography to represent the voice of the marginalized.

There are certain basic beliefs underlying Photovoice:

1. Communities have a wealth of knowledge and experience to draw on – their capacity to change their environment starts with their ability to produce, analyse, share and act on that knowledge;
2. The Photovoice process is a creative, catalytic way of generating community knowledge;
3. The process of taking photographs and the way they are used can change the way people (including community members, policy makers, others) perceive a situation and can motivate them to take action; and
4. This process can shift the power dynamics between researcher and researched, and between policy makers and an articulate, active citizenry.

In follow up discussions, participants discussed how they will be using Photovoice in a very specific way – as evidence to try and influence the budgeting and planning process to resource people's expressed need to improve access to clean water and sanitation at local level. However, one of the key criticisms of Photovoice is that it's exciting and fun to take photos, but often it does not generate action, either at community or institutional level. What is key to understand here is that **it is not the photographs themselves that will create the change, but the way they are used as evidence for the change that is needed.** Our challenge as HCC members and/or community advocates, is to make sure we are clear about the change/s we are trying to create and to ensure that the people who are using the photographs to motivate for that change have the necessary skills to engage with key decision makers in a way that is proactive and community focused.

6.3 Experiences from the 'Eye on Equity' programme

At this stage, Idah Zulu Lishandu from the Lusaka District Health Office (LDHO) in the Ministry of Health, Zambia came forward to share her experiences as a member of the 'Eye on Equity' team under an EQUINET programme called "Keeping an eye on equity: Community visions on equity in health". This programme was undertaken in 2009. It involved pra4equity network members from 7 countries (DRC, Kenya, Uganda, Zambia, Zimbabwe, South Africa and Tanzania) in using photography to display images of health equity through a community lens.

Idah began by giving a brief overview of the PAR work the LDHO has undertaken within EQUINET since 2006, noting that they used PAR methods to understand and promote equity in health, and to strengthen health worker/community interaction through dialogue. In 2008, the Zambian PAR team sent two members to Bagamoyo, Tanzania to be trained by TARSC in photography as part of the 'Eye on Equity' team. Upon returning to Zambia, the 2 photographers took a range of photographs that looked at community participation in health. Other country photographers focused on different themes. For example, the Congo looked at issues around accessibility and testing, Kenya talked about maternal health as well as community responses to HIV, and Uganda looked at community empowerment.

These photos were incorporated into a large photo exhibition at EQUINET's Regional Conference on Equity in Health in Uganda in September 2009. They were also published in a book called "Keeping an Eye on Equity: Community visions of equity in health" (see www.equinetafrica.org/bibl/docs/Eye%20on%20Equity%20book2010.pdf). Community photographers from this programme also participated in an exhibition at a global health conference in Cuba and held a panel discussion at the Global Symposium on Health Systems Research in Cape Town in 2014.

The Eye on Equity exhibit at the EQUINET Conference,2009

The 'Eye on Equity' teams learnt a lot about taking photos. It was easy to take photos and Idah noted that they found the photos were a useful tool for eliciting discussions with and between community members and health workers. They also brought out some difficult issues – such as the long queues at the clinic – which were easier to describe visually than to address in words. It was also useful to take photos before the start of a programme, and then again at the end, to show the change.
The main challenges related to getting permission to take and use the photographs. People were initially suspicious about why the teams were taking photos and were worried about how they planned to use them.

7. Communicating our Message

7.1 Defining the change, defining the message

In their country teams, participants were asked to discuss the following questions, taking into account the theme of this programme, ie to influence decision makers to integrate the SDH in their planning and budgets:

1. What type of change/s do we want to see?
2. What messages do you want to communicate? Who are our main audiences / target groups?
3. What types of images / content do we want to photograph to get this message across?

The table overleaf summarises the feedback from each country team, recognizing that this was only a first attempt at clarifying their messages, to be discussed further when they meet with other HCC members at their in-country training.

Below are selected comments that participants made during the discussions:

Edgar (Zimbabwe): We want the HCC to be given a legal mandate. That is another struggle. Once we are given a legal mandate then decision-making will be easier, as well as recognition of our efforts as HCCs.

Therese (SA): What was interesting was realizing how important it is for the authorities to recognize the voice that communities have and that HCCs are legitimate representatives of that voice. We can do that through our photos. If more of our authorities can see the work that we do and what value we add, they may start to listen to us better.

Tafadzwa (Zimbabwe): Photovoice will go a long way in trying to show what is happening in that mine. Ever since the Government introduced the 49% - 51% sharing ratio, mining companies have withdrawn from investing in the mines. Workers have gone for months without salaries, school children used to be given a bus to take them to school – now they walk long distances to school. Hopefully the Ministry of Health and the RDC can intervene in helping the mining community

Idah (Zambia): The community should be continuously engaged. The leaders will know and see the knowledge that the community is sharing.

Table 1: Changes aimed at in the work

Country	What change/s?	What message/s?	Targeted at?	What images?
SOUTH AFRICA	Working in an urban area: Decision makers know their communities and the SDH problems they face Improved relations at facility level Budget for HCCs Municipality officials actively engaged in improving sanitation and water issues	Communities are resourceful and knowledgeable; they are an asset to local authorities and health services HCCs represent community voice and deserve greater recognition and support We want resources to support effective functioning of our HCCs We want improved living conditions in our communities, especially with sanitation, water and waste management	District management Provincial MEC, chief of staff (DoH) Municipality: water, sanitation, waste, integrated development plans Informal trading areas that are without toilets or water, yet food is sold in those areas	Children on dumping sites – often adding to waste Women and children collecting water Bucket system / with waste trucks Informal housing – some of which is inadequate and cramped
ZAMBIA	Change of approach to how local authorities deal with the SDH; improved level of engagement of HCC in all structures	Disease free communities, especially in relation to safe water and sanitation, and food engagement of HCCs in planning, budgeting and implementation of programs	Community members, civic leaders, leadership at all levels, PMOs, DMOs, local authorities, media	Toilets and sewers type of water systems and the way food is being sold and cooked in the streets pictures of the people who should be involved at all levels
ZIMBABWE	Working in a mining area: Improved water and sanitation: (short term) increased number of water points and renovation of existing toilets (long term) each household to have water and sanitation system – to move from bucket system to Blair toilets; more toilets constructed.	Improved / accessible water and sanitation unity of purpose in improving the health welfare of the community	Mine management and the community, the media, MP for the constituency, Ministry of Health, Rural District Council	People queuing at water points, blockages of toilets, people practicing the bucket system

7.2 Developing a communication tool

At this stage of the training, Barbara reminded all participants that one of the objectives of this programme is for each country team to work with the participating HCCs in developing a communication tool. This could be a poster, a slide show, a travelling exhibition, a small display to make a particular point at a meeting, a booklet, a series of photos - whatever they decide which will help engage with the decision makers and others around the hoped-for changes. The communication tool can be used to elicit a feeling or mood, to inform, to stimulate discussion and debate. How you use the photos is strongly dependent on the message you are trying to get across, the particular characteristic of the audience, and the type of change you are hoping to achieve. She pointed out that they will be talking more about this in subsequent sessions.

7.3 Ethics and permission

The meeting acknowledged that getting permission to take photos is an ethical imperative. When taking photos, it's possible that you will be met with suspicion with people wanting to know who you are and how the image will be used. As part of this regional HCC photovoice programme, every HCC photographer will be asked to sign a release form which gives EQUINET and the participating organisations permission to use the photos they take. The photographers will also be responsible for making sure that the individuals photographed are willing to let their photographs be used. Participants reviewed the EQUINET Release Form and agreed that the photographers will sign this release form before the end of the in-country training.

8. Field visit to Cassa Banana informal settlement

After a session to further deepen participants' photography skills, Tatenda Chiware from the Zimbabwe Association of Doctors for Human Rights (ZADHR) joined the meeting to give a brief overview of Cassa Banana where participants planned to go to practice their photographic skills. TARSC and ZADHR have been working in Cassa Banana for over 18 months and, in recent months, have trained 9 community photographers. Participants were introduced to the nursing staff at the private clinic close to the community and the chairperson of the Cassa Banana Residents Association before going out to take photos, paired up with a local community photographer.

Below are a sample of some of the wonderful photos the team took while at Cassa Banana.

Cassa Banana,2015 **Photo: Nceba Magoxo**

Therese talking to the children, 2015 Photo: Mavhuto Katimbe

Nceba with the Cassa community photographers Photo: Idah Zulu

Watering the garden Photo: Edgar Mutasa

Idah with nurse at nearby clinic Photo: Manzunzo Daka

Aerial view of Cassa Banana, 2015 Photo: Tafadzwa Nkrumah

Upon returning to the training venue, participants uploaded their photos onto the computer and showed them to the full group for feedback on content, technique and overall messages. Participants enthusiastically acknowledged that the field trip was a highlight of the training. They were particularly struck by the resilience of the people living in Cassa Banana and their openness in welcoming the team into their homes and lives.

9. Looking Ahead

9.1 Overview of the programme

The next steps and related outputs of the programme, post this training of trainers, were discussed and agreed on as follows:

Time Frame	Activity	Outputs (for each CSO, unless otherwise stated
October / November 2015	Trainers who participated in the September meeting will organize and facilitate a 2-3 day training in-country with HCC members from 2- 3 Health Centre Committees, approx. 15 people in total.	• Country training report, including findings from the pre-test monitoring tool (wheel chart)
Post training – July 2016, ongoing	Implementation of the Photovoice programme at HCC/community level, with support from relevant authorities and ongoing technical input from TARSC. During this period, • Photographers will go through 2-3 cycles of taking photographs followed by a meeting with the institutional reps in identifying and discussing the underlying stories of a select number of photos to be used as evidence in decision-making processes within the health system and in interactions with other sectors • Selected photographs and relevant background text will be incorporated into a communication tool (brief, display, story book, etc) to be presented at health facility/district planning meetings with the intent of influencing planning and budgeting of health priorities at community level specifically in relation to the SDH. • Institutional reps will monitor progress through the use of an agreed set of monitoring tools.	• Bi-monthly reports (at least 3 in total – February, May and July 2016) giving an update on progress to date, successes and challenges; and sending select photos on Dropbox • Developed communication tool/s • Completed monitoring tool (pre and post -test wheelchart)
July – November 2016	TARSC will take a lead in producing a publishable report that documents the process, outputs and outcomes, and shares images and stories from the participating institutions and HCCs.	• Synthesis report (TARSC with input from CWGH, LDHO and UCT) - draft: August 2016; - final report: Nov 2016
August / September 2016	Regional meeting to review the draft report, reflect on changes realized through the programme, lessons learnt and the way forward in the use of Photovoice (meeting dependent on the availability of funds).	• Outcome of regional meeting reflected in final copy of synthesis report

Participants also discussed the steps involved in implementation of the programme, post the HCC member training and agreed to the following:

Table 2: Steps in implementation of the Photovoice programme, post HCC member training

	Activity
1.	Introduce the programme to policy makers, community leaders and others; obtain ethical clearance
2.	Photographers go out and do a first round of taking photos
3.	Photos uploaded from cameras and downloaded onto a storage device
4.	Team discussions on: o Selecting photos (choosing the best both visually and in terms of its message) o What's missing? o What are our plans on how to use them?
5.	Go back and take more photos!
6.	Repeat cycle re selecting photos (and may need a third round)
7.	Share photos with others in this programme, using Dropbox
8.	Solicit support/technical input as needed from TARSC, others
9.	Prepare communication tool
10.	Prepare and present at agreed meeting (local level clinic meeting, district council meeting, in dialogue with other sectors, community meeting, other…);
11.	Repeat cycle as necessary
12.	Monitor progress
13.	Document experiences, lessons learnt and recommendations for the way forward

Note: This list is deceptive in that the work we are doing here is not a linear progression, with one step neatly following the next. It is useful, at this stage, to outline these 'steps', but participants were reminded that the process is more likely to – and should! – flow within an action-reflection-action cycle – something we all already know about as PAR practitioners!

9.2 In-country training and criteria for selection of HCCs

The meeting then went on to discuss the in-country training.
As a starting point, participants used small A5 cards to develop a list of criteria for selection of the HCCs. The group eventually came up with the following criteria.

Criteria for selection of HCCs:

- HCCs come from both urban and rural communities
- HCC members have been trained and/or have experience in Health Literacy and PAR/PRA
- They have a commitment to working with communities and have already gone through a PRA process to identify and prioritise community health needs
- The composition of the HCC includes a wide range of social groups
- The workload of the HCC allows time for involvement in the photovoice programme
- They have a good working relationship with the health facility and local leadership
- They are eager to take up issues of concern with higher authorities
- The HCC has already identified one or more of the social determinants of health as an issue that needs to be addressed

Prioritising criteria for selection of HCCs, Harare, 2015

Each HCC will have to choose about 5 members to be trained as photographers at the in-country training.

Criteria for selection of HCC members:
- active member of the HCC
- have a commitment and interest in improving their community's health
- have an artistic flair and an interest in photography
- are motivated
- mix of age and gender
- are available to participate in the programme

Participants then broke up into country teams to discuss which HCCs they want to include in this programme, based on the above criteria.

1. South Africa
Identified 2 HCCs in relatively close proximity to each other, both in an urban setting:
- Max Mandlingozi Clinic: the clinic is operational and has a strong HCC. It has challenges with regard to the size of the clinic.
- Soweto on Sea Clinic: This clinic is based in a settlement area, but now has new houses. The clinic is very small compared to the number of people it services.

Proposed dates for the training: end of November

2. Zambia
Identified 2 or 3 HCCs:
- Kanyama - peri-urban area in Lusaka. It is a densely populated area, with serious sanitation problems. The mindset of the people is also bad to the point where they have destroyed sections of the facility and beaten up the nurses.
- Matero – urban area in Lusaka. It has a well-functioning and well-organised HCC who usually speak for the facility and community. They are good mediators and their relationship with the local authorities is good
- George – still debating whether to include them. Peri-urban area; has political interference within the HCCs.

Proposed dates for the training: 2nd week of November

3. Zimbabwe
Identified 3 HCCs:
- Arcturus Health Committee – in a mining community
- Rujeko Health Committee – in Masvingo (urban area)
- Nyamhunga Kariba – in a tourist area

Proposed dates for the training: 17-19 November. The plan is to bring the HCC members from Masvingo and Arcturus to Kariba for the training.

TARSC and MacPherson Photographers offered to support each team through email and skype in designing and setting up their training programme. The programmes will be loosely based on the agenda of this workshop.

9.3 Monitoring progress

The Wheelchart will be used to measure progress against an agreed set of 10 output indicators. Every country team will begin their training programme by facilitating a session where participants, divided into their specific HCC teams, will use the wheelchart to measure where they think they are at on a

scale of 1-5. Each group will also 'interview the wheelchart' with a rapporteur documenting the discussion, to be included in the training report.

Participants reminded each other that it will be important to have a facilitator and documenter at each wheel chart station to explore questions, such as 'why have you made this decision? do you all agree? If not, what are the reasons for the differences in opinion? Why is the marker so high/low? What else do you want to say about this point? etc.

Output indicators:

1. The community in our area wants to take action on the SDH in order to improve their living environment
2. Our HCC has discussed the need for action on the SDH in our meetings
3. Our HCC has represented community views on the SDH in existing local and district decision-making structures within the health system
4. Our HCC has addressed the issue of the SDH in interactions with other sectors
5. Actions on improving the SDH are reflected in budgeting and planning processes within the health system
6. Other sectors have responded to the need to take action on the SDH
7. In the last 3 months, our HCC has been responsible for improvements in relation to the SDH in our area
8. In the last 3 months, our HCC has worked closely together, and with the larger community, in meeting community health needs
9. Our HCC is respected and valued by authorities for the contribution it makes in improving people's health
10. Our HCC is respected and valued by communities for the contribution it makes in improving people's health

These indicators need to be more specific, especially the underlined words. So, for example, the indicator:

Our HCC has addressed the issue of the SDH in interactions with other sectors

may read once participants have become more clear about their programme:

Our HCC has addressed the issue of waste disposal in interactions with the local city council

10. Evaluation and Closing

The meeting ended with each participant reflecting on what the training and the programme meant to them and their hopes for the future of the programme. The full text of what people said is shown in Appendix Three. Generally, participants expressed enthusiasm for the photovoice programme, feeling that it had great potential in meeting the overall goals of the HCC regional work. They found the training itself valuable and especially appreciated the regional focus of the participants – there was much learning that took place across countries. The Cassa Banana field trip elicited some strong reactions in participants who were shocked by the conditions in which the people of Cassa Banana live. But it also generated some useful discussions on the importance of community organizing and the role of the state in supporting community needs. As Therese said: we are now ready for action.

In the next 8 months, participants plan to share their newly acquired knowledge about Photovoice with their HCC colleagues who will then use photography to document community experiences and actions in relation to unsafe water, bad sanitation and dumping of waste. The programme will also move toward strengthening relations with local and district decision makers, and in using photographs as evidence to justify the need for more focused planning and budgeting around environmental health.

In closing, participants reminded themselves that what we are fundamentally talking about is the transformation of our health systems – so they become more equitable and people centered, with communities and HCCs more empowered and working in close collaboration with health facility personnel in meeting people's priority health needs. This is what is underlying our work – to challenge and question the basic assumptions, the 'single story', that determines how our health systems function. The question we need to look at in the coming year is whether Photovoice - as one specific tool - can play a role in this transformation.

Finally, the Zimbabwe participants wished everyone a safe journey home and good health to all.

The HCC Photovoice team, Harare, 2015

Appendix 1. List of participants

Name	Organisation
Mavhuto Katimbe	CWGH
Tafadzwa Nkrumah	CWGH
Edgar Mutasa	CWGH
Nceba Magoxo	UCT
Therese Boulle	UCT
Idah Zulu	LDHO
Manzunzo Daka	LDHO
Jon Pilch and Laurie Macpherson	MacPherson Photography
Barbara Kaim (facilitator)	TARSC
Barbara Mutedzi (rapporteur)	Consultant

Appendix 2. Photovoice Training of Trainers Workshop programme

DAY ONE – Tuesday 29th September

TIME	SESSION CONTENT	SESSION PROCESS	ROLE
8.30	Introductions and welcome Objectives of the meeting	Welcome, delegate and facilitator introductions Introduction to the process and workshop	Tafadzwa Barbs
Understanding HCCs			
9.30	HCCs – successes and challenges	Group work to discuss and then report on the successes and challenges HCCs face in • Identifying community needs and priorities? • Representing these interests at local and district level (through what structures)? • Getting these interests included in planning and budgeting processes at local and district level? Report back and discussion	Barbs - overall 2 volunteers to facilitate each of the groups
11.00	**TEA**		
11.30	Can HCCS use photos as a tool for change?	Participants show photos they brought to the meeting. Discuss.	Barbs and Jon
13.00	**LUNCH**		
Introduction to photography			
14.00	Cameras and how they work	Explanation of the parts of a camera, functions of different parts, taking flash cards in and out; how to hold the camera Handout 1: What is photography? Where do we start?	Jon and Laurie
14.45	Key elements of a good photograph – part 1	Composition (foreground, background, subject placement) Handout 2: Elements of a good photograph	Jon and Laurie
15.30	**WORKING TEA**		
15.30	Photography exercise: images of people	People take photos of each other - posed, unposed; expressions; self-portraits; peer portraits	All
16.30	Discussion of photos	Download photos, and show as slides and discuss Queries and questions	Jon and Laurie, All
17.30	**END OF DAY ONE**		

DAY TWO – Wednesday 30th September

TIME	SESSION CONTENT	SESSION PROCESS	ROLE
8.00	Recap	Feedback, questions and comments from Day 1	
Introduction to Photovoice			
8.15	Countering the 'single story'	TED Talk by Chimamanda Adichie TED Followed by discussion	Barbs
8.45	What is Photovoice?	Intro to Photovoice Reflections on the Eye on Equity programme Handout 3: What is Photovoice?	Barbs Idah
Communicating our message			
9.15	What images? For whom and to what end?	Group work to discuss: *What type of change do we want to see?* *What messages do we want to communicate?* *Who are our main audiences/target groups?* Report back and discussion.	volunteers
10.15	Communicating our message	Summary discussion on: Selecting photos; Use of captions; Developing a communication tool Handout 4 – Communicating our message	Barbs and Jon
11.00	**TEA**		

Deepening skills in photography			
11.30	Key elements of a good photograph - part 2	Key elements of a good photograph part 2 - lighting, framing, angle of view, etc Handout 2: Elements of a good photograph	Jon and Laurie
12.30	Interacting with people when taking photos	Summary discussion on issues in taking photos: Taking pictures of strangers Concerns (eg own and camera security) Ethical issues and asking permission Handout 5 – Interacting with people when taking photos	Barbs and Jon
Going into the field – visit to Cassa Banana Community			
13.00	Preparations for our field visit	Overview from Tatenda Chiware, Zimbabwe Association of Doctors for Human Rights (ZADHR)	Tatenda
13.15	**LUNCH**		
14.00	Visit to Cassa Banana	Field exercise – to apply practical learning and communicate issues on SDH and other health issues.	All
17.00	**DINNER and RELAX**		

DAY THREE – Thursday 1st October

TIME	SESSION CONTENT	SESSION PROCESS	ROLE
Review of photographs			
8.00	Review of photos from field visit	Feedback from field exercise Review of photos taken during the fieldtrip	Jon and Laurie/all
Looking ahead – An overview			
9.30	Overview of the programme	Overview of the programme from now onwards Identifying what still needs to be covered in this TOT Handout – Next steps	Barbs
10.00	We've taken the photos. Now what?	A more detailed step-by-step review of the implementation process Discussion on how to share photos across countries	Barbs Jon
11.00	**TEA**		
Developing the training programme			
11.30	Developing the training programme	Group work on: • Criteria for selection of HCCs • What to include in the training Report back and agreements on criteria and outline of the training programme Agreements on next steps on the training protocol	2 groups, each with a chosen facilitator
13.00	**LUNCH**		
Monitoring progress			
14.00	Developing indicators of change	Review and discussion of output and outcome/process indicators Handout: Indicators of change	Barbs and 2nd facilitator
Looking ahead – Tying up the loose ends			
14.30	Next steps and questions	Discussion of next steps and questions: timelines, issues in implementing the work; budgets, other	Barbs
15.30	**CLOSE AND TEA**		

Appendix 3. Feedback on the training

Edgar: *Ladies and gentlemen it was a wonderful time being together. What a brilliant idea and initiative to come up with such a project which in its initial stages has already promised great results in terms of focusing on SDH. I am happy that this dream which started in 2010, with several regional meetings and other meetings, is still forging ahead. I am happy with the commitment that you have shown.*

Therese: *I can't actually explain how valuable a session like this is. I work a lot on my own in SA and so the community of practice often has become the TARSC / EQUINET group which has given me so much motivation and courage in terms of persevering and going forward – I am ready for action. I'm so excited that I have Nceba with me so thank you. The evenings with Mavhuto taking us around Harare – it is not only what you learn in the trainings, it is the friendships that you develop. Mavhuto has taught us a lot in the last couple of days. Thank you Mavhuto.*

Mavhuto: *It is an honour to be involved in a regional meeting. This has been an eye opener to me. I have learnt a lot, especially to hear what other people are doing with their HCCs. From here, I am going back to my community and I will try and let them see that they have the power to change their lives.*
Ida: *I am so excited. Thank you Barbs and thank you CWGH. We have learnt a lot. We are happy that we are still going to work on Photovoice. To all the members it was wonderful being together again and going to Cassa Banana. This program has great potential to identify and change issues.*

Nceba: *Thanks for the opportunity to speak, especially as a new person in the group. This training was a great experience for me. We have terrible places in SA. What I saw at Cassa Banana yesterday - I was about to cry. I was so touched. And I was thinking the whole night how these people managed to survive in this place. What made them wake up every morning and living in that environment for more than 30 years. I would like to thank you Barbs and Therese for taking me into the group. We enjoyed the walk with Mavhuto. You are all wonderful people.*

Tafadzwa: *This was quite enriching, insightful, I learnt a lot, especially the cross-country experience, when you exchange information. Personally I am going to work harder to improve my photographic skills because when you look at those pictures you want to say that I am the one who captured that moment in history. Photovoice will go a long way in advocacy, especially in our work. Our regional partners – thank you for coming. It has been like a family experience. Thank you Barbs for facilitating and organizing this project. I am certain that this will strengthen the overall project goals.*

Manzunzo*: Many good things will come out of this programme. The knowledge is so good. I think it was like adding sugar to Fanta to make it more sweet. It opened my eyes. In Zambia there is a saying that the child who doesn't visit other families will always say that the mother is the best cook. But if you visit the neighbour you may change your mind. It is the same with us visiting Zimbabwe. The photos will speak for us. Thank you everyone, no one was a stranger in this house. To everyone let's be in touch.*

Barbs: *Thank you to everyone for the collective work we've done here in the last few days. There were times when I was designing this programme when I wondered whether it would work. But being with all of you this week and sharing our experiences and wisdom has confirmed for me, once again, that the whole is so much greater than its parts. We have planted many seeds in the last few days and it is now our collective responsibility to water the ground for that seed to grow. I feel very inspired to be in a community of practitioners where we share such solid values. I am extremely thankful for this family. So thank you everyone for such commitment and enthusiasm. Aluta continua.*