Report of The Regional Review Meeting of the Health Literacy Programme

Harare, Zimbabwe
12th – 13th April 2013

Training and Research Support Centre (TARSC)
Zimbabwe
in association with
Coalition for Health Promotion and Social Development (HEPS) Uganda and Lusaka District Health Team, Zambia

Ministry of Health

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

With support from CORDAID

Cordaid

Contents

Cite as: Training and Research Support Centre, HEPS Uganda and LDHMT Zambia (2013) Report of the regional review meeting of the health literacy programme, Harare, Zimbabwe, 12th – 13th April 2013, TARSC, EQUINET , Harare

Acknowledgements to TARSC admin personnel for support for the meeting organization and to Cordaid for financial support



Photos of the meeting Source A Zulu LDHMT.

1. Background

Participatory Reflection and Action work coordinated by Training and Research Support Centre (TARSC) in the Regional Network for Equity in Health in East and Southern Africa (EQUINET) has shown that building increased awareness within communities supports early detection of and response to problems and uptake of services. Activating joint mechanisms increases co-operation and trust between communities and health systems. This led in the PRA studies to strengthened detection of health problems, more effective uptake of local resources for health, and improved uptake of and adherence to services. The pra4equity network in east and southern Africa in EQUINET, a network of institutions in the region, has explored in contrast the role of participatory processes for strengthening health worker-community interactions on planning and implementing health systems and supporting PHC oriented approaches to health care.

In 2011, building on work done on health literacy in Zimbabwe, Malawi and Botswana, and in the EQUINET pra4equity network to strengthen communication between health workers and communities, TARSC implemented a one year programme with HEPS Uganda and Lusaka District Health Team, Zambia with Cordaid support, to extend health literacy in Uganda and Zambia and used the skills built to promote dialogue and accountability between health workers and communities. In 2012-2013 the Health Literacy (HL) Programme in Uganda and Zambia, coordinated by TARSC in EQUINET builds on work done in 2011 to extend health literacy (HL) in Uganda and Zambia. Working in cooperation with HEPS Uganda and the Lusaka District Health Management Team (LDHMT), the work aimed to support the institutionalizing of the HL programme in Zambia and the handover and scale up of the programme in the Ministry of Health, to widen and deepen CSO capacities for HL and PRA in Uganda by working with 5 CSOs in identifying and implementing options for deepening the integration of HL and PRA methods within the existing programmes of the CSOs and to strengthen PRA/HL work on SRH and women's health to better understand the barriers and facilitators to provision, access and uptake of services for women's health.

This report documents discussions at a regional review meeting held in April 2013, eight months after the start of the 2012 programme. The objectives of the meeting were to:

- Report on and review the programme to date and identify progress against the planned outputs, progress markers and outcomes, and identify issues to address
- Review and go through the new SRH module; review arrangements for the pilot and discuss use of the module in the HL programmes
- Discuss and plan the DVD/ photojournalism aspect of the project
- Develop the plan for Cordaid for July 2013 to June 2014 and other HL support

The programme is shown in Appendix 1. The meeting was attended by representatives from LDHMT, Ministry of Health Zambia, HEPS Uganda, NAFOPHANU and TARSC (See delegate list Appendix 2).

2. Introductions and welcome

The meeting began with each participant introducing themselves. Rene Loewenson, TARSC Director, gave a short welcome. She noted that HL is not just about tools but about the values, perspectives and information that we share when using these tools, and the conscious and capacity and power to act that emerges from their use. The HL work is part of

a larger programme of work and alliances in EQUINET that aims to advance equity and social justice in health. She distributed the 2012 Equity Watch as a summary of the analysis on health in the region. Our work at community level informs that perspective, which is why it is so important to document the learning from it. Our experiences in using participatory approaches is building a body of practice and knowledge that will not only be important within the HL programme itself, but will also be of wider relevance within EQUINET.

3. Participatory work on sexual and reproductive health

Barbara Kaim facilitated a session that aimed to share the understanding of the aims of the planned participatory work on sexual and reproductive health (SRH). Two background papers were written in 2012/3, one each in Uganda and Zambia, to inform the work. Drawing on this a module for the health literacy work was developed on SRH in early 2013 that would be a protocol for the participatory work on SRH. The session thus aimed to reflect on the changes we are trying to achieve, and to review the draft module in the light of the experience brought by HEPS from their pilot of the first draft version of the protocol in one clinic catchment area in Uganda. The reason for producing this additional module to the HL manual was identified as to support organizations and health personnel to design and implement plans to improve their SRH, and to overcome the three delays in accessing and using SRH services.

The SRH protocol introduces two frameworks for analyzing the range of factors that prevent people, and especially women and young people, from accessing appropriate SRH services.

The first is the **Tanahashi Module of Health Care Coverage** that was developed in 1978 as a way to identify the most important barriers to receiving health coverage. This module has mainly been used for health services generally but can also be used to think about at what step specific groups fall out of specific services in order to make sure that we address the problem at the right point. The steps in this module are:

- Availability – related to infrastructure, medicines, etc
- Accessibility – physical or financial barriers
- Acceptability – cultural and other social barriers
- Contact coverage –who does or does not make contact with the service
- Effective coverage – people receive the intervention they come for and comply with it.

The second module is called **The Three Delays Approach** and it is the module that will be used at community level in this protocol. The Three Delays Approach identifies barriers to effective SRH services (whether promoting, preventive, curative or care) in terms of three barriers:

- In deciding to seek an appropriate SRH service
- In reaching an appropriate provider or facility
- In receiving adequate service when a facility is reached.

All three delays need to be addressed for effective coverage to take place and for SRH to improve. The protocol is used to identify the barriers identified as the most important in that community and to look at ways in which these barriers can be overcome to strengthen use and effective coverage of SRH services.

In reviewing the module, participants noted that it was important to get the community's perspective of the barriers identified, and to include different social groups so as to ensure that marginalized groups are not excluded from the discussion. At the same time, actions are

not only taken by communities. They also need to be taken at higher levels, including at national policy level.

Barbara led participants through **an overview of the content of the SRH protocol** summarized as:

Sexual and reproductive health as a part of healthy life cycles (listening)
Definition of SRH and SRH rights; international treaties and national policies
Identifying stages in life cycle when greatest SRH risks/needs

↓

How far are we achieving our SRH rights? (listening)
SRH situation in our area

↓

How are different social groups in our community affected by SRH? (reflection)
Identifying priority SRH needs for men, women, youth, children
Underlying causes

↓

What services, programmes and actions do we have for SRH? (reflection)
Translating laws and policies into services, programmes and actions
Tanahashi Model of Health Care Coverage

↓

Exploring the barriers people face in using SRH services (reflection)

↓

Overcoming the Three Delays in SRH (action)
Come to collective agreement on actions to include in final action plan and time lines
The Three Delays – identifying barriers

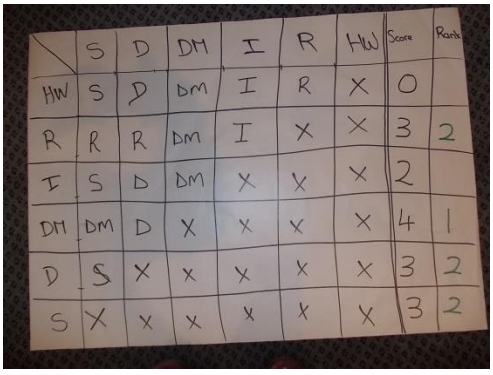
↓

How will we know if we are making progress? (action)
Progress Markers

↓

What else do we want to discuss and know more about? (action)

Before concluding this part of the session, participants undertook a short exercise in learning how to do a pairwise ranking, one of the new activities in this module. Pairwise ranking allows people to rank order a large number of preferences, choices or problems by comparing each choice with all others, one by one. The preferred options are cross tabulated and laid out in a table as shown in the picture. It is important that participants using this ranking do not compare two problems more than once by crossing out the bottom half of the table. It is also important that all issues are either expressed in the positive or negative.



Pairwise ranking table implemented

Implementing the pairwise ranking

The discussion then moved on to **experiences in using the SRH Module**. Given their experience in piloting the SRH module, HEPS explained that they had used the module in one rural catchment area with plans to pilot it in another two areas within the next month.

They are specifically looking at the questions:

- Does the module do a good job in documenting evidence and generating action? and
- What needs to change in both the module and the recording book?

The first pilot found that the protocol captures a lot of information and generates a lot of discussion, even though there is sometimes a reluctance to talk about sexual issues since this is considered taboo. Women's views were often overshadowed by the men, suggesting that they need time separately. The pilot test also highlighted a need to simplify the language and to consider carefully what words to use in the local language for SRH terminology. Technical aspects of the document still need to be included since these are an important part of the learning process.

HEPS reiterated that a bottom-up approach to facilitation is essential and that facilitators need to be literate, able to read and write in English, and to be able to communicate effectively in the local language. In the discussion it was agreed that teachers or community health workers from the local area could be good to include. It would also be a good idea to blend different types of facilitators, combining district facilitators with core support from the national level.

The module has many activities and that it takes a long time to do them all. Both facilitators and participants got tired during the pilot and this led to them cutting short some of the discussions. After some discussion, the meeting recommended that the SRH protocol may need 3 half days to complete. HEPS will need to test this out in the follow up pilots.

Implementation of the programme needs two people – one to facilitate and the other to document. HEPS reported that **the record book** captures all the issues but, because it is quite a complex document, it is important that the recorders are familiar with the programme and the content of the record book prior to implementation. HEPS noted that discussions were often quite complex and that it was difficult to capture the richness of the discussions within the recording book framework

4. Review of the HL programme to date

Rene, TARSC facilitated the session on the programme to date. She gave an overview of the programmes aims and objectives and distributed a summary document on the log frame and what had been done to date.

The delegates from Zambia (LDHMT and Ministry of Health) and HEPS presented the progress to date in their respective country programmes. These presentations were supported by photographs as one form of documentation of their processes. A selection of these photos is included in this report.

The work of the **Uganda team** was presented by Rosette Mutambi, Pelagia Tumisiime and Margaret Happy. The Uganda HL team has:

Health Literacy programme in action (and 2 pictures below). Credit: HEPS Uganda

- Planned and co-facilitated with TARSC a four day training workshop for 5 CSOs facilitators in HL/PRA focusing on health, SRH and women's health and health systems.
- Co-designed with TARSC the Ugandan HL training materials and written Uganda input for input to TARSC to develop the Uganda HL manual.
- Co-developed a country monitoring and reporting framework to review program results.
- Piloted the Uganda specific HL training materials in the 3 catchment areas of Kiboga, Gayaza and Kawembe.
- Commissioned and finalised with TARSC a review paper on SRH and women's health in Uganda.
- Made input to the draft SRH module and tested it in one catchment area;
- Convened a Uganda HL coalition of the five participating HL civil society organisations to support communication and strengthen networking and skills sharing on HL.


Social mapping during pilot testing of the SRH module. Credit: HEPS Uganda

For the remainder of year one (to June 2013), HEPS plans to:

- Supervise, monitor and report on follow up health literacy meetings undertaken by the 4 participating CSOs in clinic catchment areas in four districts
- Pilot test and report on the SRH protocol in two more districts, including review of the monitoring and reporting tool
- Report on the programme to date.

The **Zambia National Health Literacy Programme** was presented by Adah Zulu Lishandu, Rosemary Masilani and Clara Mbwili-Muleya. To date the programme has:

- Held a stakeholder meeting within the MoH and in July 2012 facilitated a national health literacy launch, with the Hon Minister of Health, Dr Joseph Kasonde, attending and with TARSC/EQUINET.
- During the National Stakeholder meeting, a National Health Literacy Steering Committee/Task Force was set up with following institutions as lead representatives; MOH, LDHMT, MCDMCH, Local government, and three Civil Society representatives (TALC, MAZ and ZAMFOHR).
- The Steering Committee/Task Force met in October 2012 to agree on a road map for the sca Literacy Technical Working Group / Secretariat led by the Ministry of Health and LDHMT for the purposes of reviewing the Health Literacy materials, discuss a Monitoring and Evaluation frame work for health literacy, and agree on provinces for initial trainings
- Co-produced with TARSC the Zambia-specific HL training manual and drafted a a monitoring and evaluation framework. The Zambia Health Literacy Manual was peer reviewed and piloted in November 2012, finalised and printed in February 2013. They are now ready for use in upcoming trainings.
- Commissioned with TARSC a review paper

Minister of Health, Dr Joseph Kasonde at the Launch of the National HL programme. Credit: LDHMT Zambia

Zambian Health Literacy Facilitator. Credit: LHMDT Zambia

on SRH and women's health in Zambia.

In the remainder of year one, LDHMT plans to:

- Hold a provincial training covering four districts of two provinces (Northern – Mpulungu and Kasama; and Muchinga – Nakonde and Chinsali) to train twenty-two participants as HL facilitators.
- Monitor trained pilot districts for 6 months.
- Publish a paper on Zambian HL scale up work by May 2013.
- Produce with TARSC a DVD on Zambian PRA and HL work since 2005

Rene, TARSC summarised the regional level work implemented to date. TARSC has at regional level

- Co-ordinated, administered, mentored and monitored the programme and the learning;
- Designed and facilitated the training and skills building and review workshops in Uganda and Zambia
- Written, and published the local health literacy training materials in Uganda and Zambia, with input from the local writers on country specific materials
- Co-designed the monitoring systems with the leads in Uganda and Zambia;
- Using the HL approach, drafted the SRH module with input from Uganda
- Organised the regional review meeting.

In the remaining months of the first year TARSC will.

- Mentor and support the ingoing country work
- Revise the module/ tool on action at community level on the barriers and facilitators to provision, access and uptake of services for women's health
- Document the work and learning in the two countries, including in a paper, and in the EQUINET newsletter and in a DVD of photojournalism.

5. Identifying progress markers for year one work

Dr Clara Mbwili, LDHMT introduced the concept of progress markers. She explained that the use of progress markers as a monitoring tool deriving from a method called Outcome Mapping. The idea is to focus on the desired change to solve an identified problem, seen at three levels:

- *'Expect to see'* (most possible change in the situation)
- '*Like to see*' (higher level or improved situation)
- *'Love to see'* (more ideal situation)

For progress markers to work successfully, a programme needs to be clear about the outcome challenge.

Rene, TARSC and Clara facilitated a discussion with participants on the progress markers for year one. The outcome challenges identified for year one were:

Group	Outcome Challenge
For Zambia	HL institutionalised in Zambia
For Uganda	5 CSOs to have improved capacities for the HL and PRA in Uganda
For the Regional level	Country processes are supported and learning captured through documentation

The 3 teams came up with the following progress markers for their programmes from now until the 30th June 2013:

Expect to see	Like to see	Love to see
Zambia: HL institutionalised in Zambia		
• Ministry of Health adopts Health Literacy as important for community partnership • Zambian Health Literacy manual produced • National stakeholders informed, aware and support health literacy scale up programme	• Four districts trained in Health literacy • Trained facilitators organizing Health Literacy activities in their districts	• Communities taking informed health actions based on identified needs
Uganda: 5 CSOs to have improved capacities for the HL and PRA in Uganda		
• HL/ PRA materials produced ie Ugandan version of HL manual, monitoring and reporting tools • Operational HL working group in Uganda • SRH paper completed • SRH module piloted in 3 health catchment areas • Work plan and budget from HL partners approved and programme implemented in 4 clinic catchment areas • Commitment to HL by leadership of CSO partners	• Key people from partner organizations skilled in HL and PRA • At least 3 of the partner organizations integrated HL and PRA • Community action plans from 4 health catchment areas in place • At least 3 MOUs signed by May • Documentation of HL/PRA and SRH intervention in Uganda	• Duty bearers from 5 health catchment areas engage with communities based on the issues identified • Enhanced visibility of HL/PRA and SRH work in Uganda
Regional: Country processes supported and learning captured through documentation		
• Health materials written and in the hands of the organisations • Sufficient number of people capacitated to run the Health Literacy programme in both countries • Clear and accessible documentation (reports) of what has happened in the programme • Feasible and credible SRH protocol for identifying barriers to SRH outcomes	• HL materials are being used and experience on use has been shared, opening dialogue in country and across countries • Clarity on how to sustain and widen this programme and how to move it forward • Shared analysis and learning in country and across countries documented (DVD, Oped, mailing lists, etc)	• Trigger a much wider discussion and excitement around this programme, within region and internationally

Participants agreed to use these progress markers to review the programme in end June 2013.

6. Looking ahead to year two (2013/14)

This session aimed to build a log-frame for Year Two for country activities and regional or inter-country activities. Country teams first discussed their plans separately. Rene, TARSC provided a set of flip charts for countries to identify key dimensions of their log frames and each country and the regional level inputted to the flip charts. A plenary discussion was then help on the flip charts. Ideas were shared and integrated across countries and comments and feedback given, so that each strengthened their own area of work and the overall work formed a combined whole.

The final version of the log-frame drawn from the flip charts is presented below:

Log-frame for Year Two Activities: 2013/ 14

	Aims	Changes and outcomes for Year Two	Main activities for Year Two	What challenges or risks
Zambia	• To have a national costed plan for scale up of the HL programme including SRH • To roll out the HL programme to 8 more districts • To strengthen M+E at district level • To enhance awareness and documentation of the HL programme • To identify and overcome barriers to SRH and health generally at district level	• Programme planning, implementation, monitoring and evaluation institutionalized • SRH module included and used in HL Zambia manual • Pool of 40 Zambia HL Trainers • Scheduled Bi-annual review meetings with HL facilitators • Active participation and support in HL programme of stakeholders (government and CSOs) • Scheduled quarterly monitoring and review of the HL activities with set aims achieved • Barriers to SRH and health in districts identified and acted upon	• TOT for 40 participants from all provinces • Conduct 3 trainings of 80 HL facilitators in 10 districts plus 5 community meetings • Conduct monitoring and documenting of HL activities in 14 districts twice a year • Hold task force meetings quarterly; include in TORs at district level • Adapt SRH paper into a module • Pilot SRH module in 4 districts and document barriers and actions • Mapping of other HL/PRA organisations and/or individuals trained	• Inadequate resources for monitoring activities • Low appreciation of health literacy • Inadequate resources at national level for conducting review meetings • Inadequate resources to conduct trainer of trainers • Lack of technical expertise to modify paper into module • Re-assessment of directorate of public health
Uganda	• To strengthen 5 CSOs' capacities to implement the HL/SRH programme and to strengthen links with line ministries • To implement HL/SRH in 6 districts to identify and overcome barriers to SRH and health generally	• 5 CSOs in Uganda skilled in HL/SRH and M&E • HL / SRH skills transferred to 10 national facilitators, 50 district level facilitators, 240 country level HL activists • CSOs and line	• Carry out 1 training in SRH and refresher in HL for 10 CSO facilitators • Hold 6 districts level meetings, quarterly CSO coalition meetings, and 2 national meetings with the technocrats and policy makers • Hold 8 community	• Staff turnover in partner organizations • Resistance to integration of SRH/ HL work in the local government budgets and plans • Resources for meetings, monitoring and evaluation

	• To strengthen M+E of HL at district level • To enhance awareness and documentation of the HL programme	ministries incorporate HL/ SRH into their programmes • Barriers to SRH and health in 6 districts (12 catchment areas) identified and acted upon • Documentation • Active participation and support in HL programme of stakeholders (government and CSOs) • Scheduled quarterly monitoring and review of the HL activities with set aims achieved • Visible CSO Coalition on Health Literacy	meetings (5 for HL and 3 for SRH) per district to identify the barriers and actions • Implement 12 community actions plans for the 6 districts (12 catchment areas) • Document HL/SRH processes in the 6 district and 12 catchment areas	
Region	• To support, communicate and document learning from country programmes • To produce a guidance document on HL programming • To produce an interactive electronic version of the HL materials	• Wider understanding and energized HL programmes in region • Wider use of HL in and beyond region • Stronger links to EQUINET work • Exchange visits across countries to create more opportunities for country programmes to support each other	• Organise exchange visits • Continue role in coordination, mentoring, M&E, documentation and reporting • Write structure and facilitate a regional workshop with 5 countries to finalise the guidance document • Produce, peer test and go live on web version • SRH analysis and documentation • Monitoring and evaluation	• Resources • Communication • Inactive programme

In the discussions on the future programme it was noted that:

- We need to ensure in Year 2 that we consolidate the country programmes so that they are sustainable
- It is important to have a long-term plan for scale up. There are a number of different models that can be used. Zambia, for example, at the moment has a centralized form of training but, in Year 2, would like to decentralise training so that provinces will start taking a role in training new districts. Both Uganda and Zambia will need to explore possible strategies in the coming year.
- In Uganda one of the ways of strengthening task force/ CSO coalition commitments is to include the leadership in some of the district visits and training. At the same time, HL facilitators must ensure the visibility of community actions at the top level of organisations.
- The report back from the meeting will need to be discussed within the full group of CSOs in Uganda to keep the collective process in planning year two.

- We need to keep the regional co-ordination strong. The work is being done as part of EQUINET and will feed into the pra4equity learning network. It will be important to share this report with the wider pra4equity network through the mailing list and to share learning from the work within EQUINET. It was noted that CWGH leads the cluster on social empowerment and work done in Zimbabwe, Malawi, Botswana should also continue to link with this process.
- There are other opportunities to be tapped for regional interaction in the pra4equity network, including exchange visits. It was also noted that the COPASAH network is planning throigh TARSC and in association with the pra4equity network in EQUINET to organize a PRA training in the ESA region later in 2013.

As a final activity, participants got into mixed groups to review the challenges and risks outlined by each country group and to give recommendations on how to overcome these challenges. The challenges and actions are outlined below:

Challenge or risk	Proposed actions or solutions
High staff turnover	• Build a team at national and local levels. • Encourage visible management support to the programme • Facilitate in-house skills sharing • Invite the top management to the CSO coalition meetings
Inadequate resources	• Advocate for HL to be considered in the national budget • Mobilize resources from other donors • Use the DVD as a fund-raising tool
Low appreciation of health literacy	• Use DVDs to raise appreciation • Involve strategic people in community meetings • Through documentation, meetings, etc develop strong evidence-based arguments to explain the approach, vision and outcomes of this programme
Communication problems	• Budget for communication • Schedule email interaction and skype conference calls • Use the mailing list pra4equity@equinetafrica.org

7. Next steps and final remarks

The follow up steps were discussed. LDHMT and MoH Zambia informed that they will be holding their provincial training and will convene the task force after to review and discuss strategies for widening the programme. TARSC (RL) will be in Zambia in early July and will exchange further on this at that time. HEPS will convene the 5 CSOs to give feedback on the meeting and ensure that the four CSOs send in their plans for their HL training by end April. It was also agreed that the feedback from the final two pilot districts on the SRH module be sent by HEPs May 3 for TARSC to finalise the module. TARSC (RL) will send a template for the year two proposal and LDHMT and HEPS will send TARSC their finalized log-frames and budgets by May 12, with suggestions on possibly options for funding to complement Cordaid funding. The year one report will need to be sent by all organisations by mid June.

In the closing TARSC thanked the delegates for travelling to Zimbabwe and wished all a safe journey back. Thanks were given to Cordaid for their support of the process and for the opportunity to exchange and share in this programme. Such opportunities were seen to be important to exchange learning and experience.

Appendix 1: PROGRAMME

DAY ONE – Friday 12 April 2013

Time	Session Content	Session Process	Role
Welcome, objectives and overview			
9.00 - 9.30	Welcome, objectives, overview	Welcome remarks Overview of HL programme to date Individual intros; Objectives of this meeting	TARSC HEPS, LDHMT
Overview of the SRH Module			
9.30 – 10.30	Overview of SRH Module	Summary overview of SRH, the Tanahashi and the three delays– background, knowledge and action aims Priorities for strengthening coverage of SRH services in Zambia and Uganda Walkthrough of the whole module • Knowledge and information shared, questions • being explored on SRH • Other resources, information on SRH • Activities- quick walkthrough of familiar activities,	Barbara, TARSC Peggy HEPS on feedback from the pilot
10.30 –11.00			
11.00 – 13.00	Using the SRH Module	• Target groups and settings for discussing the barriers to SRH. • Options for overcoming the three delays and for community action plans • Using progress markers Documenting the findings of the SRH module- the recording book; Discussion on applying the SRH module in year 2 in Uganda and Zambia	Barbara, TARSC
13.00 – 1.30 LUNCH			
Review of the HL programme to date			
1.30 – 3.15	Review of HL programme	Introduction on intended goals/ change areas/ outcomes, and activities to achieve them Setting and reviewing like and love to see progress markers in key areas for review and reporting on the programme Update from Zambia team on activities, outputs and plan to end June 2013- and using photos Update from Uganda team on activities, outputs and plan to end June 2013- and using photos Regional activities, outputs, plan to end June 2013 Review of experience and issues for future work (team buzz groups) and plenary discussion	Rene, TARSC Clara, LDHMT Clara/ Adah , LDHMT Rosette, HEPS Rene, TARSC
TEA			
Completing the year 1 work			
3.30 – 5.00	Key areas remaining for year 1 work	Review of remaining processes and activities/ outputs to end June 2013 • HL and SRH in Uganda and Zambia • Proposals for the DVD/ media product: Target, scope, messages and form • Publications, year end reporting • Monitoring and Evaluation	Rene, TARSC HEPS LDHMT
4.30 End of Day One			

DAY TWO – Saturday 13th April 2013

Time	Session Content	Session Process	Role
Looking Ahead – July 2013 – June 2014 YEAR TWO			
8.45 – 9.45	Country planning	Country teams brainstorm on the areas for year 2 plans.	Uganda Zambia
09.45 - 10.15 TEA			
10.15 -12.30	Year two planning	Market place to build a log frame for year two for country activities, regional or inter-country activities Discussion and finalizing the broad log frame Steps and time frames and roles to complete the proposal for Cordaid	Teams and Rene
12.30 – 1.30 LUNCH			
13.30 – 14.30	Taking forward the proposal	Regional interactions and others to bring in • Regional exchange visits • The PRA4equity network in EQUINET • Copasah in Africa • Others	Barbs Teams
14.30 – 14.45	Closing	Next steps and final remarks	Rene, TARSC and all



Various discussions in the meeting, Source A Zulu LDHMT

Appendix 2: Delegate List

Organisation	Name	Address	Email
HEPS	Ms Rosette Mutambi	P.O BOX 2426, Kamapala (U) Plot 351 A , Balituma Road Tel: +256 (0) 414 270970	rosettem@heps.or.ug; rosemutambi@gmail.com
HEPS	Ms PelagiaTumisiime	P.O BOX 2426, Kamapala (U) Plot 351 A , Balituma Road Tel: +256 (0) 414 270970	ptusiime@heps.or.ug
NAFOPHANU	Ms Margaret Happy	P.O BOX 70233,Kamapala (U) Plot 213, Sentamu Road, Mengo Tel: +256 414 270 976	margarethappy@nafophanu.org
LDHMT	Dr Clara Mbwili	Lusaka District Health Team PO Box 50827, Lusaka, Zambia	cmbwili@hotmail.com; cmbwili@gmail.com
LDHMT	Ms Adah Zulu	Lusaka District Health Team PO Box 50827, Lusaka, Zambia +260-977803567	adahzulu@yahoo.com
MoH Zambia	Ms Rosemary Masilani	Ndeke House, Box 30205, Lusaka	rosmas2007@yahoo.com
TARSC	Dr Rene Loewenson	47 Van Praagh Ave Milton Harare +263-4-708835	rene@tarsc.org
TARSC	Ms Barbara Kaim	47 Van Praagh Ave Milton Harare +263-4-708835	barbs@tarsc.org;
TARSC	Ms M Makandwa	47 Van Praagh Ave Milton Harare +263-4-708835	tarsc@ai.co.zw