Provincial Health Literacy Training Report
Northern and Muchinga Provinces

AT MANGO GROVE LODGE, MPIKA, ZAMBIA
23-26TH APRIL 2013

Ministry of Health and Lusaka District Health Team, Zambia

Ministry of Health

in association with
Training and Research Support Centre (TARSC) Zimbabwe
In the
Regional Network for Equity in Health in east and southern Africa (EQUINET)

With support from CORDAID

Cordaid

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National facilitating team in Mpika, Zambia

1. Background

Holistic primary health care oriented,people-centred and publicly led health systems appear to have the greatest benefit to disadvantaged communities,especially when they build in additional measures to support effective up take in these groups.Many ways have been developed to empower people in health,with some evidence of health gain.A growing network of institutions in the region in Regional Network for Equity in Health in East and Southern Africa (EQUINET),led by Training and Research Support Centre (TARSC) and with involvement of Lusaka District Health management Team (LDHMT),have explored the role of participatory processes for strengthening health worker –community interactions in identifying and implementing prioritised health issues and in supporting Primary Health Care (PHC) oriented approaches to health care.

Health Literacy,a process of information and skills building on health for action,has been found to provide the space for communities to express and shape their health programmes and services atprimary health care level,especially when using participatory methods.Health Literacy refers to a process of reflecting on experience,informing and empowering people to understand and act on health information, to advance their health and improve their health systems.It builds knowledge and capacity to act within a framework of participatory reflection and action (PRA) that strengthens community level diagnosis, action and engagement with health systems.This is achieved by investing in community capacities to articulatetheir health,monitor the delivery on the health service commitments and participate in shaping their services.

In 2010,as part of the learning network,and building on positive changes found in using participatory action research(PAR) in 2006-2009,LDHMT with TARSC and with Cordaid support piloted a programme to train health literacy facilitators and hold community health literacy sessions in 3 areas of Lusaka, Zambia.The positive feedback from that programe led to its recognition by Ministry of Health (MoH) and the launch through a stakeholder's workshop of a national level health literacy programme in July 2012. With the launch came the formation of a National HL task Force / Steering Committee and a HL Working group with MoH and LDHMT as the secretariat to propel the implementation of the scale up to other districts in the country(MoH Zambia, LDHMT, TARSC. 2012). The Northern and MuchingaProvinces were identified as the first provinces in which selected districts were to be trained and the first to be trained using the Zambian Health Literacy training Manual.The provincial trainings were expected to thereafter translate into grassroots implementation of the HL programme in the respective districts.

Aims

The main objective of the trainings was to train facilitators, and lead personnel from 4 health districts of 2 provinces in Zambia to be able to scale up, implement and monitor health literacy (HL) and participatory reflection and action (PRA)work /programmes at district level;
Specifically the training aimed to:

- Build health literacy capacities and use of PRA approaches in health literacy facilitators;
- Plan,implement and facilitate training at community level using the Zambia Health LiteracyTraining Manual.

The participants for the training were government health sector workersand community members drawn from five districts namelyMpulungu andKasama from Northern Province; andNakonde, Chinsali and Mpika from MuchingaProvince.
They included officers from Ministry of Health, Ministry of Community Development Mother and Child Health (MCDMCH),civil society, churches, media and community health volunteers.Mpika district which was the host district for thetraining was initially not amongst the 4 selected

districts, however it was included after an appeal by the District Medical Officer who cited a lost opportunity for his community if his district was left out thus bringing the total number of districts that received training to five (5) with 23 participants.
The national resources persons and facilitators were Rose Masilani MOH/MCDMCH, Adah Zulu Lishandu, Christine Shawa and Clara Mbwili-Muleya LDHMT (see Participants list Appendix 3; andProgramme Appendix 4).

2. Opening

The training workshop started with the registration of participants at 08.30hrs on day one. This was followed by participants introducing each other in pairs and specifically highlighting any experience with participatory methods (See introductions Appendix 2).

Welcome remarks
Dr Masina the District Medical officer(DMO) for Mpika officially welcomed the participants and the initiative and also thanked everyone for coming to Mpika for the activity. He indicated that the program should be implemented because the health sector was facing a lot of challenges which could be resolved by the involvement of communities themselves. The DMO stated that he had visited the District Commissioner's Office to inform him of the presence of HL participants in the district. Dr C. Mbwili-Muleyathe session facilitator and a national resource person, thanked the DMO for the encouraging words and for finding time to come and greet the participants.

Opening remarks
The four days training workshop was officially opened by Ms Rose Masilani the Senior Health Promotion Officer representing both MoH and MCDMCH.She stressed the importance of and expressed appreciation to those present for coming to the provincial health literacy programme. She described health literacy as a participatory way of discovering and addressing various issues affecting communities.She also said that the workshop was not the *usual type* of workshop that participants may have been exposed to before, where information was imparted to participants by the trainers.

She emphasized that this was rather a process that would ensure that information was generated by the participants who are themselves masters of knowledge in their local settings. She also reminded participants that the vision of the health sector currently is *to encompass all players in the community in order to solve health issues that may arise*.

Ms Masilani said *"This workshop, should act as a catalyst for all participants. Who should not to go back to their districts and conduct business as usual, but should facilitate change where ever there is need for it.Furthermore, I expect participants to leave the venue, at the end of the week as changed people who should make things happen"*.

Finally she wished all a very enjoyable and interactive experience that will motivate participants to motivate others.She thanked the people present, acknowledged the national organizing team/ facilitators, the DMO for Mpika and CORDAID for the support through TARSC/EQUINET.After the official opening the training progressed as per programme and as outlined in this report (seeopening speech Appendix 1).

Ms Masilani, MoH/MCDMCH, opening the training

Participants introducing each other at the opening

3. Ministry of Health and LDHMT

3.1 Background information on MOH

Ms Rose Masilani,Senior Health Promotion Officer at MCDMCH, presented an outline on the Ministry of Health and informed participants that the MoH is charged constitutionally with the health of all Zambians through "**provision of equity of access to cost effective affordable and quality health services that are close to the family in a Clean, Caring and Competent manner".**

This she said is achieved at various levels of health service implementation namely central, provincial, district and facility/community levels.
The MoHalso achieves service delivery by partnering with statutory boards such as Zambia flying Doctor Services; Radiation protection; General Nursing Council of Zambia and National AIDS Council.

She further explained that the Government in September 2011 began the process of re aligning the MoHwith the MCDMCH. This process began with the transfer of the Mother and Child Health Section of the Directorate of Public Health and Research.
This process has continued and in the last two months, almost all Primary Health Care Services have now been taken over by the MCDMCH.This entails that all the district hospitals, district health offices, and all facilities under this level would move to MCDMCH.

The MCDMCH thereby seeks to provide an enabling environment for active participation of communities, individuals and the private sector in community development, including working towards the health of citizens.The MCDMCH has taken on board primary health care services together with those of development and social welfare. In this way communities would work in a more integrated manner other than the segmentation of members by various sectors that have been working towards the health of the people.

Ms Masilani explained that the determinants of health should be talked through a coordinated approach of the health sector. The health aspects to be handled by this sector include:

- Policies on community development and skills training
- Disability issues
- Activities of Non Governmental Organizations

- Social welfare
- Non-formal education
- Supporting self-help initiatives
- Juvenile correction and probation services
- Rehabilitation of persons with disabilities
- Social safety nets
- Child welfare
- Social welfare, food programs,
- Adoption and social welfare etc

The MOH therefore, will focus on policy direction and research. It will also manage general and tertiary hospitals and training institutions in the country.The presenter also reminded the meeting that the Health Literacy program was launched in July 2012 by the Minister of Health, Dr. Joseph Kasonde who had welcomed the initiative and had noted that it was important that it be spread across the country.The Hon Minister had also appreciated the adoption of health literacy as a national program that was based on work that had been implemented within Zambia, making it a home-grown program

Ms Masilanifurther stated that the Government considered community involvement as key in the development of the country and essential in addressing the health inequalities in the health service delivery system. The improvement of the status of women through empowering them with reproductive health knowledge was identified as a great concern. Health literacy programs such as the provincial workshop could also help women learn how to overcome the barriers of seeking sexual and reproductive health care services. The health sector therefore is committed to ensuring that the HL program succeeds through ensuring its scale up to more districts.

The presenter reiterated the honorable Minister's call forHL to be a major movement, to transform our society into a community of health literate men, women and children who would be the fertile soil upon which seeds of healthcare would thrive.
She concluded by encouraging participants that as HL facilitators, they had a big challenge to nurture this movement to great heights.

3.2 Background on LDHMT

Dr Mbwili –Muleya, Lusaka District Health Office presented the background to the LDHMT PRA work in EQUINET.She explained how the health reforms of the early 1990s were based on the principle of leadership, accountability, partnerships and sustainability and aimed to provide *equity of access to cost effective quality health care as close to the family as possible*. However there have been misunderstandings between health workers and community members especially on resourcesas community members were not engaged in planning, budgeting and implementation. As a result of this mismatch between policy and practice, LDHMT hypothesized that participation action and research could be used to improve relations between health workers and community members.

Therefore through the interaction and support from EQUINET regional programme of work LDHMT and Chama DHMT a rural district, participated in the implementation of a PRA project in 2006/7. The project aimed to strengthen planning, budgeting, resource allocation and activity implementation (PIB) between health workers (HW) and community members (CM). The project produced positive changes in PIB and in 2008/9 LDHMT went further to assess further the possibility of scale up to new health centres from the initial three. Once again as in 2006, the follow up work showed that the participatory methodology improved communication and

interaction between HWs and CMs and that the changes achieved did not require significant resources however capacity building through mentorship and dedicated leadership were necessary for sustainability of the process.

She indicated that as a result of the PRA work the LDHMT went on to participate in the health literacy work as part of another EQUINET regional programme. It is that work that had given rise to the current Zambian HL programme piloted in 2011 in Lusaka, Zambia.

4. Using participatory approaches in health

Idah Zulu Lishandu, Health Literacy Coordinator under Lusaka District HealthOfficeintroduced country experiences with PRA and HL.She involvedparticipants to brainstorm on what PRA was and responses included: *participation rapid appraisal, participation research, action and Participation Reflection and action.* Vernacular responses *were 'kuitumpamo' or 'kuibumbamo' [Bemba: to get involved].*

Participants were told of projects that were brought to communities without involving them and therefore were unable to appreciate what was expected of them. PRA involves a bottom up approach that involves participation, reflection and action. PRA uses visual and verbal methods where participants should be actively involved. These methods are used to provoke mutual discussions.

Why PRA?
To strengthen the power people have in order to change their lives. People need to be part of the action in order to bring about change. People should be able to bring out issues on their own through. An expert deciding on behalf of the work is not participatory. PRA provides communities with opportunities to share information, experiences and views and contribute to decision or plans being developed. It is a two way method since people in the community have a lot of information. It strengthens the power that people have to change their own lives, their communities and solutions that affect them. When communities identify a problem or see an opportunity to improve their lives, a PRA process can be used.
A facilitator can help communities to:

- Share information and think critically together about their situation and are doing experiences and knowledge
- Look for patterns
- Feed back on what is common difference about solutions
- Identify and obtain new information or skills they need
- Plan for action
- Implement the action

The *Spiral Model*was discussed thenparticipants were later asked to give examples of the Spiral according to their understanding.
The roles of a PRA facilitator were discussed in a participatory method with participants identifying some of the roles. The facilitator later took participants through the listed roles of a facilitator.

- The facilitator should be one who does not know all the answers but willing to learn from others.
- Facilitator should also be willing to follow up questions and respond later when they have answers.

- Facilitators should be agents of change who will work with the people in the community. Participants were later put into two groups for group activities.

The success of PRA depends on the role and skills of the facilitators in what you do and how you have facilitated the process of PRA.

Being an Health Literacy facilitator
Participants were further asked to brain storm on *what being a health literacy facilitator* is all about. Responses included:

- Coming from domination going to empowering community skills and knowledge
- Going from Closed to open
- Individual to group
- From I toWe
- Verbal to Visual and Verbal
- Providing awareness by use of PRA methodologies
- Non judgmental
- Respectful
- Able to listen and ask the right questions
- Recognize that we donot always have all answers

The role of Health Literacy facilitator

- Organizing sessions
- Encouraging participation

A facilitation group activity was done using statements that could be –*true, false, not sure, or consensus*.

Reports from groups indicated that the groups had some understanding on the statements given as their responses were that:*no one knows anything*, *everyone knows something*, or *we all know something*. In this way PRA encourages different opinions from participants.
Communities should be involved in action planning and implantation to encourage sustainability and ownership of the program. The session was concluded by applying techniques such as *probing, proper dressing, have big ears, big eyes and a small mouth*.

Some facilitation tools used at training

5. The health literacy programme

5.1 Overview of the Health literacy program

Mrs Christine Shawa began the session by defininghealth literacy as *the ability to obtain, interpret, and understand basic health information and health services and use such information and services in ways that promote health.*

She explained that Literacy is not only the ability to read and write, but the ability to understand, communicate and use information to support action. Health literacy goes beyond simply giving information and support, reflection, dialogue, decision making and action.
The Group activity was a case study of George compound *to look at what changed; what produced the change; and what was the role of the facilitator, communities and others.*
The responses from the groups were:

Change that happened	Facilitator's Role	Discussion
People stopped drinking dirty water from shallow wells and began drinking water from taps. This led to reduction of diarrheal diseases. Political will by government was supportive	• Facilitators provided community awareness and mobilization • Feasibility studies • Communities were also involved in awareness, participation in community programs e.g. garbage collection, monitoring, site mapping • Others supporting were; ZESCO; MTN; MUVI; through funds and equipment.	• The health problem was identified as cholera outbreaks, shallow latrines, flooding and uncollected garbage. • What was done about the problem; mobilization of communities and government involvement. • These actions were said to have been successful. • What made them successful was identified as; involvement of both the affected and infected; intensified sensitization and change of behavior.

Ms Masilani then led a plenary discussion on the participants' understanding of health.

After the discussion with the group, the facilitator summarized the key points below:

- Health is not just about taking medicines or treating disease.
- It includes physical, mental, and social health and well being.
- It involves living and working in healthy conditions and having healthy practices and lifestyles.
- Improving health depends on:
    - Actions to ensure that people get the health in puts they need. Both within the health facilities and community
    - To do this communities also need skills to act, skills to use services effectively to organize social action and to influence decisions about how resources are allocated and used.
    - Making sure that people obtain these inputs is a matter of fairness and social justice. This looks at those who are less healthy and least able to afford health inputs get a greater share of resources from health services

- Those with greater wealth contributes more to health services
- This is what is meant by equity in health. Equity in health addresses differences in health status that are unnecessary , avoidable and unfair

The facilitator gave the W.H.O definition of health as **"…***not merely the absence of diseases but a complete absence of diseases but a complete state of physical mental and social well being"*

Later in the discussion, health was also defined as '*complete well being of a person physical, social, emotional, life styles for well being'.*

Participants Keep healthy using outbreakers

5.2 Using the Zambia HL Manual

Mrs Lishandu the HL Coordinator, ended the session by taking the participants through the whole HL manual in order to help them understand its importance and how to use it. She explained that the manual has eight modules and three sections that are meant act as a guide and reference document. Participants were encouraged to read the manual in advance before sessions.

5.3 Social mapping

Participants were taken through plenary description of social mapping before going into groups according to districts to draw maps that depict the resources available in the district.

Mapping the community was said to be possible through *transect walks, drawing maps and focused group discussions*. During presentations similarities and differences were noted.Some similarities were bars, markets; roads, grave yards, houses, schools, clinics, water and police. Differences included railway system, dump sites, sex workers, churches, water sources, bus stops, mosques, football pitch,*loafers' corner*, brothels, harbour,oil pipeline and international borders. During plenary, participants presented their maps according to their districts.

Mapping Mpulungu&Nakonde Districts

The term ***community*** was understood as:*human beings in one environment, group of people with a view of improving their life, place that is habitable, and where people share common norms & values in a geographical area*.
The social groups were understood as groups with common interests such as football team; musicians; women's' group; sex workers etc.

5.4 Rights to health

This topic was presented as a lecture discussion where all the participants were involved through reading text and responding to questions. The participants further discussed the various laws of Zambia and cited the ones that affect the health of community and the environment as a whole.

5.5 Healthy living and work environments

The facilitator introduced the session by discussing three key areas:

- From where the water is obtained
- How much water is available for use by households
- How water is collected and stored

A group discussion was then initiated by using Picture Codes depicting different lifestyles. Three volunteers were asked to stick the pictures according to their assessment on whether the picture portrayed*good, bad or neutral lifestyle*. The participants thereafter explained why they thought the pictures were graded as such.

Those picture placed in the*bad* column were said to promote unhealthy environment which could be a vehicle for diseases. Those placed in *good* were said to depict healthy environment. No pictures were placed under *neutral* as participants agreed that there was nothing neutral where health is concerned. Participants later identified different diseases which came up as a result of unhealthy living environment such as poor sanitation, lack of safe water and poor hygiene practices.

The feacal oral route was a major contributor to unhealthy living and the theory of **5Fs** was discussed and summarized as;

F –flies; **F** –food;**F**–fingers;**F** –fluids; and **F** –feacal matter.

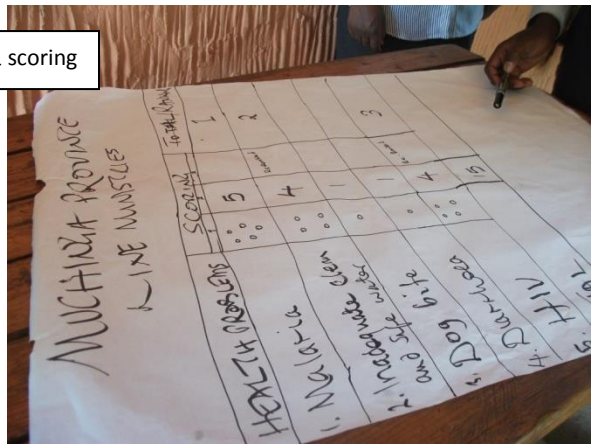
5.6 The Life cycle

Participants were also introduced to the *Life Cycle Mapping*that showed how health is understood at different stages of a person's life. It also understands the changing health needs and priorities at different stages of a person's life. Finally the group used the Life Cycle to identify community action in meeting those health needs. This exercise was also another eye opener for most participants to realise how some stages especially the very early formative years (1 to 2 years) of a person's life are overlooked and yet have serious repercussions on a child's development.

5.7 Prioritising health needs, identifying and addressing determinants

Participants reviewed the social maps they had drawn in order to pick out priority issues in their various districts. Identifying the priority issues was done by putting the participants by province and then astwo groups of government health sector workers and those coming from the community in each province.

Prioritising health problems by ranking & scoring



Ranking and scoring

The groups presented their priority issues according to their ranking and these were issues were later compared betweenthe different groups. The identified priority problems from the groups were**malaria, HIV/AIDS, lack of proper communication, alcohol and drugsand poverty;** however**malaria** was identified as the common major problem in both provinces.

BUT WHY exercise

The ranked issues were later analyzed in order to identify the real causes of the issues. Below is an example of a problem that was identified and analysed using the **But Why** process:

POOR COMMUNICATION WITH HEALTH WORKERS
But why
Staff do not explain operations at the facility
But why
No time
But why
Shortage of manpower
But why
Government not employing
But why
Few training institutions

But why
Government has no funds
But why
Lack of political will
But why
Lack of clear policies.

The session was very well taken and thereafter *BUT WHY* became a workshop phrase.

6. Deepening knowledge using health literacy

The session on Nutrition was used to deepen knowledge on some health issues.

6.1 Healthy diets and consequences of poor diets

The activitywas doneas a large plenary group where participants were requested to write down on small piece of paper types of foods they felt were *healthy, unhealthy* or *they were not sure of where to categorize the foods*. Thereafter each participant dropped their selection in the box with the corresponding label.

Participants throwing food types in baskets

A facilitator reviewing types of foods in plenary

Participants presented the foods according to how they categorized them as:

1. **Healthy foods**: meat; chicken; pumpkin leaves; okra-not cooked with soda; kacesha; lumanada; chilli; rice; nshima; mushroom; chikanda; beans; fish; kapenta; beef; maize meal; pork; chibwabwa; ifisashi; kalembula; and groundnuts.
2. **Not healthy foods:**fanta; cocacola; tinned foods- fish; fried chips; fizzy drinks; soil; vegetables grown in sewerage; cassava not well processed; potatoes- chips; beer; okra cooked with soda.
3. **Not sure:** cassava meal; chikanda; boiler chicken; soil; and okra

Later a discussion was held to enable all understand why specific foods were categorized as either *healthy* or *not healthy* foods. Those foods that were put into *not sure* category were extensively discussed and were then either put into healthy or unhealthy. This session was also quite a revelation for some participants as new information was shared from experiences by other participants. For example the group learnt of how methods of processing foods could render them healthy or unhealthy.

Spider diagram on special groups of people

The participants went on to identify some Groups with special nutritional needs as being:

Groups with Special Nutritional Needs	
➢ People living with HIV ➢ TB patients ➢ Malnourished patients- marusmas and kwashiorkor ➢ People with high blood pressure ➢ Chronically ill people	➢ The aged ➢ People with poor sight- night blindness ➢ Infants ➢ Expectant mothers ➢ Body builders ➢ Diabetics

Group work on vulnerable groups

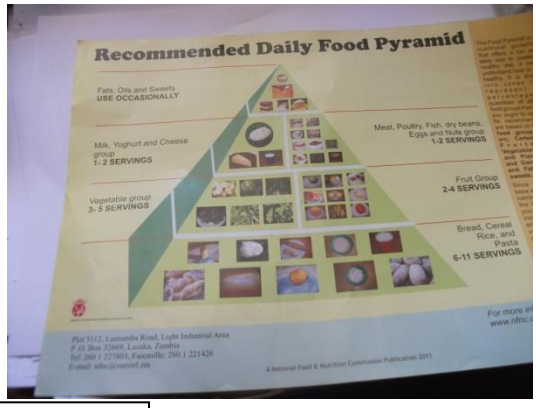
Participants were put in three groups where they selected one vulnerable group from the Spider diagram and then responded to the following questions:

1. *What do you know and don't know about nutritional needs of this group and how can they be met?*
2. *What other information do you think you need on this issue?*
3. *What can you do as a community to promote good nutrition in this group?*

Responses from the groups.

Question	Infants	Chronically Ill	People with HIV/AIDs
1. What do you know and don't know about nutritional needs of this group and how can they be met?	• Exclusively breastfed for six months; • Introduce quality balanced foods after six months and continue to breast feed up to two years. e.g. porridge with groundnuts, beans, eggs, fruits, vegetables, pounded fish.	• They need balanced diets, • Need adequate proteins, • Need more carbohydrates	• They need a balanced diet • Nil unknown
2. What other information do you think you need on this issue?	• What foods to be given to infants living with HIV	• Quantities needed and duration; • How often to be checked by the doctor; • The diseases we are dealing with	• For them to avoid alcohol, • their diet should be in conformity with drugs e.g. some ARVs don't work well with fatty foods
3. What can you do as a community to promote good nutrition in this group?	• Growth monitoring and promotion, • Through sensitization on infant feeding, promoting maternal health, • Male involvement and family planning.	• Through forming nutrition groups; • Food demonstrations and processing Encourage farming.	• Through promotion of backyard gardens for people living with HIV, livestock rearing such as chickens and goats, • Sensitization on the importance of good nutrition

The group was privileged to have a senior Nutritionist (the Provincial officer from Northern Province) amongst the participants who contributed richly to the debate and gave a summary of a *healthy diet* by presenting the Daily Food Pyramid diagram.



Mr Chiluba, Northern Provincial Office explains the Food Pyramid

6.2 People centered health systems and relationship with health workers

The key focus in this session was on explaining what a health system is; discussing primary health care services including youth friendly services and the roles of health workers; and exploring the way that different approaches to financing health affect health. Participants also discussed "gaps in primary health care".

Understanding health systems

Health systems were understood as:

- protecting the population's health and
- preventing disease e.g. by making clean water available
- Providing health services to care for major diseases
- Looking after people who have long term illnesses or who have disabilities.

Health systems lead us to think about curative health services such as hospitals and clinics; district hospitals; and provincial hospitals. Primary health care however focus on a health post; health center and district hospitals for referral.

Financing health services For purposes of analyzing financing of health systems the *Double Spider Diagram*was used to explore the *impact of user fees* on the community and the health services. Various issues came out of group discussionsdivided into civil servants and community members as outlined below.

Civil servants group

1. *Positive impact*: health facilities were properly maintained (clean); enhanced adherence to treatment; acted as supplementary funding to the government; created employment; community participation enhanced (authority and planning); volunteers were supported with incentives.
2. *Negative impact*: led to emergencies; proliferation of drug stores/dealers; increased mortality; increased self treatment; abuse of funds; the poor were disadvantaged; reduced attendance at clinics;

Civil servants vs Community members using double spider diagram to respond to Impact of User Fees

Community group

1. *Positive impact*: hospitals were decongested; quality services were delivered; un necessary demand for drugs were reduced; procuring of logistics (supplementing on government funding); job creation; staff motivation (bonuses); good working environment; enough drugs.
2. *Negative impact*: Poor/bad working attitudes; poor communication; promoted corruption; poor accountability; high deaths; promoted segregation between the rich and the poor; community was not recognized.

Community roles and alliances in health systems

The*Margoli's Wheel*a PRA tool,was used to help the participants appreciate the interaction challenges between community members and health sector workers.

During the Margoli's exercise the health sector workers asked the community members how to resolve some issues that they faced in their line of duty. The responses and solutions to the problems identified were as outlined below:

Health Sector Problems/Issues	**Community Responses/Solutions**
1. Lack of transport e.g. motorbike/cycles 2. Communication with patients 3. Non commitment of Neighbourhood Health Committees (NHC) 4. Poor turn up to meetings called 5. Community not appreciating work services 6. Inadequate health workers 7. Why are NHCs not doing their work	1. Monthly meetings 2. Involve the local CBOs 3. Involve the media to mobilize the community 4. Motivation of community volunteers (trainings and incentives) 5. Replace volunteers who are not active 6. Monitoring and supervision of volunteers by staff 7. Encouraging inter sectoralcoorperation 8. Utilization of CDF 9. Request for transport from M.o.H 10. Opening of more health learning institutions 11. Building more houses 12. Involving local leaders such as chiefs

Health workers & community members interact through Margoli's Wheel

The groups used **the Where is *Mapalo*** drawing to further explore ways of strengthening people-centred health systems through involving community members. Mapalo a cartoon character, is found in different parts and situations in the community drawing and the participants are tasked to look for Mapalo and to explain how the community is involving Mapalo in the particular situation.

Stakeholder Mapping

The participants engaged in a discussion on the key stakeholders affecting or influencing the health system in their districts in order to identify the structures and possible partnerships. The community stakeholders identified included those listed in the table below.

District	Stakeholder/Partner	Involvement
Muchinga Province		
Chinsali	Zambia Police, ALM (missionaries), local council, Community Development & Social Welfare, ChambeshiWater and Sewerage Company, DAPP, Dept of Agriculture, NHC, Ward Development Committee, ZPCT 11 and traditional healers	- Law enforcement of health issues; care and support of OVCs, treatment of PLWHA; adherence support for HIV/AIDS - Provision of skills e.gcounseling and craft; Environmental and health inspection; - Funding health referral cases; - Health literacy facilitation; awareness and sensitization; collection and consolidation of health information - Nutrition, food processing and utilization training; - Supplying clean and safe water; - Technical support in public institution e.g. schools; - Supplying subsidized farming inputs; Mobilization of community members; - Care and spiritual support; traditional medicine healing; refurbishing of care and treatment centers,
Nakonde	Corridors of Hope; Marie Stopes; SPAZ; ActionAid; St Mary's, HBC; DWA; NZP+; Selantambe; Hope OVC; THAPAZ; Clearing Association; Council; MCDMCH; ZCPT 11, MOE; MACO.	- Community sensitization through drama; sensitization on HIV/AIDS;adherence support - Educational support to OVCs; HIV/AIDS sensitization; support to PLWHA; HIV testing - Treatment of minor ailments; primary health care; treatment of STIs; family planning; abortion services; male circumcision; community mobilization; coordinating support groups;

		- Resource mobilization; D-WASHE; health inspection and service provision; - Community empowerment (clubs); - Food security; nutritional support; behavior change counseling; skills training; - Infrastructure development, poverty reduction; human rights; home based care; capacity building and women's clubs; women empowerment.
Mpika	Ministry of Health DOPE; Corridors of Hope; MCDMCH; D-WASHE; DAPP.	- Family planning and HIV/AIDS services; MCH services; environmental health and sanitation; school health services; health education; - Provision of water and sanitation; promotion of good nutrition.
Northern Province		
Kasama	Society for Family Health; World Vision; DAPP; ZCPT 11; SNV; CHAZ; YWCA; MCDMCH	- Safe water by providing chlorine; promotion of good sanitation; promotion of hygiene in boarding schools; distribution of medicines; nutrition promotion - Condom distribution; family planning; male circumcision; HIV/AIDS services; helping victims of rape,
Mpulungu	Radio Walamo, YASAM, and Ministry of Education, Women's groups, HBC/NHC, Great Lakes products, MpulunguHarbor, Good News II, Zambia police and local council	- Information dissemination; sensitization and community mobilization; promotion of school health education; - MCH promotion; caring for the sick; resource mobilization; health service provision; - Health law enforcement and environmental health provision

7. Acting on,monitoring and reporting on health literacy activities

Using the Zambia HL Manual

A plenary discussion was used to get feedback from the participants on their experience from using the Zambian Manual after the training. The following comments were recorded.

1. First page to be laminated as it easily rips;
2. Include sectionson children and youths e.g. Role of youths in case study;
3. Manual is full of messages on participation and sends signals to us to involve the community;
4. Manual is good as it is focusing on the community and how to come up with issues.
5. It is a simplified manual for behaviour change;
6. Language used in the manual is easy to understand.
7. Need modules to be in local language, for ease of converting into fliers, magazines newsletters etc.
8. Some of the information should also be available in power pointegHistory of PRA in Zambia;

Activity monitoring and reporting

Sessions were done on how to plan and develop activity plans with communities and the importance of documenting their work through Feedback Forms as well as other channels e.g. photography, newsletters etc; the concept of Progress Markers and other participatory monitoring tools was explained and some group work using Wheel Charts done as an exercise.

Participants went on to develop action plans based on their earlier identified priority health issues. However this was a training exercise to prepare facilitators develop similar plans with communities once back in their districts to guide their health literacy activities. The facilitators reemphasised how the progress markers and the Health Literacy Monthly Feedback Form would be used in the process as well as the reporting channels. The concept of progress markers and other PRA monitoring tools such as the Wheel Chart as well as the Feedback formwere well taken and appreciated.

The Provincial Facilitators were appointed to coordinate the activities within their provinces by supporting and monitoring the district levels.Health literacy focal persons for the 5 districts were also identified. Communication with the national team would be mostly through emails and phone with a physical follow up to all the districts after three months. This was to allow facilitators to work on their action plans and review their work, reflect on their experience and evaluate their progress with their communities.

8. Closing

In closing the training workshop Ms Masilani speaking on behalf of MOH and MCDMCH, emphasized the importance of taking the work forward and ensuring that the health literacy programme succeeded. She thanked the national facilitating team and acknowledged the support from CORDAID through TARSC which had made this first provincial scale up and training possible. She also thanked the participants as pioneers of the process for their active participationand contributions during the training and wished everyone a safe trip back to their destinations.

One of the participants from Chinsali, Mr Chinunka gave an emotional vote of thanks in which he applauded the initiative by the MOH. Speaking in Bemba, the local language, he pledged to work hard and implored his colleagues not to throw away this novel opportunity to *make real change* in the communities they work in. He further thanked the national team which he described as *an all powerful women's team* for traveling and sharing so openly and humbly their experience with PRA and health literacy.

Finally the participants were encouraged to continue reading their manuals and to seek advice whenever necessary. The proceedings of the training were also captured through photos, video and audio clips for purposes of documention by producing DVDs and other media materials. The participants dispersed after the closing prayer from a participant, Mr Chinunka in the afternoon on 26th April 2013.

Participants evaluating the day's activities

Participants & facilitators say their farewells

9. References

1. MoH Zambia, LDHMT, TARSC (2012), National launch meeting of the Zambia Health Literacy programme, Workshop report, Lusaka, 26 July 2012 LDHMT, TARSC EQUINET, Zambia
2. TARSC, LDHMT (2011), Strengthening Health Worker-Community Interactions through Health Literacy and Participatory approaches, Zambia Training workshop report, TARSC, Harare.
3. Mbwili-Muleya C, Lungu M, Kabuba I, Zulu Lishandu I, Loewenson R (2008) Consolidating processes for community – health centre partnership and accountability in Zambia, Lusaka District Health Team and Equity Gauge Zambia, EQUINET Participatory Research Report An EQUINET PRA project report. EQUINET: Harare

Appendix 1: Opening remarks

FOR THE HEALTH LITERACY FACILITATOR'S WORKSHOP- 22-25TH APRIL 2013 AT MANGO GROVE LODGE- MPIKA

Good morning ladies and gentlemen!

On behalf of the Ministries of Health and Community Development, Mother & Child Health, I wish to welcome you all to this important and first provincial workshop for health literacy facilitators;

The Health literacy program was launched in July 2012 by the Minister of Health Dr. Joseph Kasonde. The minister welcomed the initiative and noted that it was important to for it to spread across the continent.

He appreciated the adoption of health literacy as a national program that was based on work that has been implemented within Zambia. Making it a home-grown program
The minister further stated that the Government considers community involvement as key in the development of our country which is also essential in addressing the health inequalities in the health service delivery system. The improvement of the status of women through empowering them with reproductive health knowledge was identified as of great concern. Health literacy programs such as the workshop this week will help women learn how to overcome the barriers of seeking sexual and reproductive health care services.

Health literacy is a participatory way of discovering and addressing various issues affecting our communities. It is not a general type of a workshop that you may have been exposed to before, where information has been imparted to you as participants by the trainers

This is therefore a process that will ensure that information is generated by the participants who are the masters of knowledge in their local settings;

Colleagues, let me remind you that the vision of the health sector currently is to encompass all players in the community in order to solve health issues that may arise;

This workshop should act as a catalyst for all participants. You should not go back to your districts and conduct business as usual, but to facilitate change where ever there is need;

I expect that we will all leave this venue, by the end of the week as changed people who should make things "happen".

I therefore wish you all a very enjoyable and interactive experience that will motivate you to motivate others.
Thank you and may we all be blessed.
Ms Rose Masilani (Senior Health Promotion Officer, MoH/MCDMCH)

Appendix 2: Introduction of Participants:

1. Davies Shula a community mobilization officer with Corridors of Hope in Nakonde district. Davies is married to one wife and has one child. He understands health literacy as about health education, sensitizing community to be able to take action about their health matters. He has also been involved in PRA through Reflect methodology approach.
2. Gordon MwansaChinunka a community literacy instructor from Chinsali district. He works for a community development organization. He is married with two girls and four boys. He understands health literacy as a methodology aspect that enlightens community individuals on health aspects fit for all. He has sometimes participated in the participatory Reflections and action methodologies through NHCs
3. Daniel SampaChiluba is coming from Kasama where he works as Principal Nutritionist who is also working as acting Senior Health Education officer coordinating health promotion activities in the province. He is a father of two boys and one girl with one wife. He understands health literacy is about educating and involving communities, and other players in health to take part in health.
4. MwangalaMulundano (Mwangi) is an Environmental Health officer/Health promotion officer working at Kasama district health office. She is the second born in a family of three. She understands health literacy as the ability to obtain and understand basic health information.
5. BarzilarMunkombwe comes from Mpulungu district and works as a Nutritionist/Health promotion officer. He understands health literacy as an aspect which helps people to understand health matters very well.
6. Allan Mulenga comes from nakonde district where he is working as an environmental health officer. He understands health literacy as implementation of all public health concerns in the district. He is from a family of two
7. Sidney MwindeNakubaya comes from mpulungu where he is working as a community development officer in the ministry of CDMCH, department of community development. He is married with one son, and he understands HL as to do with the understanding of health issues such as how to prevent malaria or cholera or what types of food is necessary to maintain good health. He has been involved in PRA through sensitization in various programs like food security pack and monitoring to find out if the inputs were put to good use.
8. Merriam Muyabala (Mrs Mauluka) comes from Mpulungu district and works as community development agent by providing literacy programs to adult learners. She is married with two sons and one daughter. She understands health literacy as the provision of awareness on health matters. She has participated in PRA as a coordinator of a youth drama group also as a facilitator in health related issues.
9. Felix Chola comes from Chinsali provincial medical office where he works as health promoter. His work involves community sensitization. He is married, and understands HL as information on health issues and practice. He has used PRA under combor and ZAMSIF projects.
10. Emmanuel Simutengu (Ba Emma) comes from mpulungu where he works as a community base care giver. He understands HL as knowing the causes of diseases and how to prevent them. He is married and has four daughters and four sons.
11. Morris Kabanda comes from Nakonde and works as a community development officer under community development department. He is married with 3 children- on boy and two girls. He understands HL as having knowledge about health and hygiene, having basic knowledge about health related issues. He has been involved in a lot of PRA methodologies as a facilitator as well as a participant.

12. Morgan Timba (Tima Bricks) comes from Chinsali where he works as a lay counselor/HC coordinator. He works for association of Lay Missionaries. He is married and has two girls and two boys; he indicated that he has participated in PRA.
13. Ernest Chitu comes from Chinsali community development office where he works as an assistant community development officer. He is married and has one child. He understands HL as primary health care at community level by finding solution to health problems at household level.he has been involved through mainstreaming of PRA tools as departmental programs.
14. Charles Musonda (Shimwamba) comes from Kasamanewtown, he is a drama artist and is involved in phone promotion with ZAMTEL. He is a community health worker who is married with three children. He has participated in PRA with society for Family Health in health matters like family planning, water sanitation and malaria prevention.
15. Greene Sikaona comes from Chinsali district community medical office where he works as a Public Health Officer/Health Promotion Officer. He is married with five children. He understands that HL is a process of empowering community for better health.
16. Howard Sinkamba comes from Nakonde as a community development literacy instructor. He is also a community health worker and a lay counselor. He understands HL as a preventable method of disease. He is married with four girls and three boys.
17. ChimwemweSimpito comes from Mpulungu district where he is involved in community sensitization on health matters on Walamo community radio station (CBO). He is single and willing to mingle. This is the program that government has introduced to equip its citizens about their health rights. The introduced health programs have led to the eradication of some diseases in the district.
18. Beatrice Chalwe comes from Chinsali where she works as a lay counselor for PMTCT and she is also a member of the Neighbourhood health committee. She is married and is a mother of three girls and two boys. She understands HL as educating people on health matters for caring and support. She said that she has not been involved in PRA before
19. Godfrey Mwansa comes from Kasama and works as a Community Development Officer. He is married and has two kids also keeping three dependants. He understands HL as a way of enlightening the communities and empowering them on health issues. He has been involved in PRA on more than two occasions.
20. PetronelaKalyoti comes from Mpikaurban, she is a Lay counselor at Mpika urban clinic. She is representative of a community based organization. She is a single mother of three children and three dependants. She has enjoyed exposure to health literacy and has participated in PRA.
21. Virginia MaposaMwenya comes from Mpika and is working at urban clinic as a health technologist (health inspector). She is married with three children. Her understanding of HL is sensitization of the community members on health issues. She has not participated in PRA before.
22. Precious ChishaLungu comes from Mpika where she works as a community development groups. She is married with two kids, and she understands HL as involving understanding health issues in ways that can help in line in an environment that is clean, this include access to clean water and health services. She has participated in PRA before.

Participants' expectations were:

- To learn and understand fully health literacy programme x 5 participants
- To be a good facilitator x 2 participants
- To be equipped on how to organize health literacy activities x 2 participants
- To learn ways to disseminate information in the community
- To know how to sustain HL programmes in the community
- To know about PRA and how to use it in the community
- To know the benefits of health literacy
- To learn about the working structures
- Need for certificates x 4 participants
- To know the incentives of the programme x 3 participants

Appendix 3: Participant list

NAME	ORGANISATION	POSITION/TITLE	CONTACT PHONES (mobile, landline etc)	CONTACT & EMAIL ADDRESS
MerrianMuyabala	Community Development	Literacy Instructor	0978 506484	Box 420062, MPULUNGU merrian1999@yahoo.com
Godfrey Mwansa	Community Development	Community Development Officer	0966 538339	Community Development Office, Box 410092, KASAMA stramwansa668@gmail.com
Morgan C Timba	NGO - Association of Lay Missionaries - Chinsali	HBC Coordinator	0979 838583	Catholic Church, Box 480048, CHINSALI
Ernest Chitu	Community Development Mother & Child Health	Assistant Community Development Officer	0972 680618	Community Development Office, Box 480030, CHINSALI ernestchitu@ymail.com
Gordon M. Chinunka	Community Development Mother & Child Health	Literacy Instructor	0976 165513	C/o Mundu RHC, DHMT Box 480035, CHINSALI
Charles Musonda	Kasama DHMT	Community Health Worker / Drama Performer	0968 694523	C/o Box 410648, KASAMA
BarzlarMunkombwe	DHMT Mpulungu	Health Promotion Officer	0973 307250	DHMT, Box 113, MPULUNGU smartbm83@yahoo.com
ChimwemweSimpito	Walamo Community Radio Station – CBOrganisation	Radio Station Coordinator	0978 365341	WALAMO Community Radio, PO Box120, MPULUNGU simpitoh@yahoo.com
Sidney MwindeNakubaya	Community Development Mother & Child Health	Community Development Officer	0977 422435	Community Development Office, Box 86, MPULUNGU nakubayasidney@gmail.com
Morris Kabanda	Community Development Mother & Child Health	District Community Development Officer	0977 377923	Community Development Office, PO Box 430227, NAKONDE morriskabanda@yahoo.com
Allan Mulenga	Nakonde DHMT	Ag Public Health Officer	0977 107196	DHMT, Box 430019, NAKONDE mulengaa2011@gmail.com
Daniel S. Chiluba	MoH – PMO Northern Province	Ag Senior Health Education Officer	0977 350335	PMO, Box 410026, KASAMA dschiluba@yahoo.co.uk
Felix Chola	MoH – PMO Muchinga Province	Senior Health Education Officer	0977 413966	PMO, Box 480035, CHINSALI cholafelix@yahoo.com
Emmanuel Simutengu	Mpulungu DHMT	Community HBC Site Coordinator	0977 351005	C/o DHMT, Box 113, MPULUNGU
Sinkamba Howard	Community Development Mother & Child	Literacy Instructor	0969 305905	Community Development Office, Box 430227, NAKONDE

	Health			
Margret Katongo	Nakonde DHMT	TB Treatment Supporter	0972 550690	C/O Nakonde Clinic, DHMT, NAKONDE
Davies Shula	Corridors of Hope	Community Mobilisation Officer	0979 512901	Box 430106, NAKONDE shuladavies@gmail.com
Beatrice Chalwe	Chinsali Urban Clinic, DHMT	NHC, Lay Counsellor	0978 364500	C/o Chinsali Urban Clinic, DHMT, Box 480035, CHINSALI
MwangalaMulundano	Kasama DHMT	Environmental Health Officer / Health Promotion Officer	0977 325347	Kasama DHMT, Box 410156, KASAMA ladymwangi@gmail.com
Greene Sikaona	Chinsali District Community Medical Office	Public Health Officer/ Health Promotion Officer	0978 065032	Box 480035, CHINSALI gsikaona57@yahoo.com
Precious ChishaLungu	Community Development Mother & Child Health	Community Development Assistant	0977 999343	Dept of Community Development, Box 450062, MPIKA
Virginia MaposaMwenya	Mpika Urban Clinic	Environmental Health Technologist	0977 242039	Mpika Urban Clinic, DHMT, Box 450046, MPIKA virginiamaposa@gmail.com
KalyotiPetronela	Mpika DHMT	Lay Counsellor / Community Volunteer	0973 411021	C/o Mpika Urban Clinic, DHMT, Box 450046, MPIKA
IdahLishandu	Lusaka DHMT	Nursing Sister / Health Literacy Coordinator	0977 803567	Lusaka DHMT Box 50827, Lusaka adahzulu@yahoo.com
Christine Shawa	Lusaka DHMT	Environmental Health Officer / Health Literacy Facilitator	0977 512380	Lusaka DHMT Box 50827, Lusaka adahzulu@yahoo.com
Rose M Masilani	MCDMCH, Lusaka	Senior Health Promotion Officer	0977 355385	MCDMCH Head Office, LUSAKA mubotu@live.com
Clara Mbwili-Muleya	Lusaka DHMT	MPD/PCCO / Participatory Reflection Action Facilitator	0977 827276	Lusaka DHMT Box 50827, Lusaka cmbwili@hotmail.com

Appendix 4: Programme

EVENING - MONDAY22 APRIL 2013

TIME	SESSION CONTENT	SESSION PROCESS	ROLE
Evening	Distribution of the Health literacy manual	• Delegates will each be given a Health Literacy manual to go through before the workshop in pairs, groups or individually	AZL

DAY ONE – TUESDAY23 APRIL 2013

TIME	SESSION CONTENT	SESSION PROCESS	ROLE
Welcome, Objectives, Introductions			
0800-0830hrs	Registration, logistics	Participant registration	LDHMT
0830-0900hrs	Welcome	Welcome remarks-LDHMT Welcome remarks-MOH MPIKA DHO officiating	CMM RM
0900-0930hrs	Introductions	▪ Activity – identifying range of orgs present, roles in orgs, districts work in, gender breakdown, etc. ▪ Individual intros	CS
0930hrs-1000hrs	Overview of the health Worker Community Interactions Workshop objectives	Brief introduction to the work on Health Worker community Interaction and approach to training Workshop objectives (Note using the Zambia toolkit with info on how it is structured and used later on in the programme)	AZL MOH and Districts present
LDHMT Zambia and MOH work on health			
1000hrs	**TEA**		
1030hrs-1100hrs	Background on MOH	Information on MOH Zambia-Its objectives, vision and mission**8.2**	RM
1100hrs-1115hrs	Background on LDHMT	LDHMT work on PRA in EQUINET**8.1**	CMM
Introduction to health literacy and PRA - MODULE 1			
1115hrs-1300hrs	Using PRA Approaches in health	**Module 1.3 and 1.4 intro** to PRA role of facilitators in PRA ▪ Based on group work discussions, identify key features of a participatory approach ▪ Introduce the Spiral Model (10 mins) ▪ Follow up with Roles of a PRA facilitator *(true or false statements)*	AZL
1300hrs	**Lunch**		
Linking Health Worker community interaction to health literacy and PRA			
1400hrs-1530hrs	Being an HL facilitator	**Module 1.1 and 1.2** Role of HL facilitator, Understanding health literacy **(page 1 and 4 HL manual) case study George compound** Group work questions 1.what change happened 2.what produced the change 3.what was the role of facilitators, communities, others	CS
1530hrs-	**TEA**		**10.**

TIME	SESSION CONTENT	SESSION PROCESS	ROLE
1545-1645	**11. Intro to the HL toolkit** Overview of the health literacy programme	**Module 1.5** Go through the toolkit-explain flow of modules, merging of text and participatory activities use of discussion and Reflection section, etc. Conclude that we will be discussing more on how to use the manual in following days .Note that we will talk about Facilitator and community plans and how to use the manual in programmes on the last day	AZL
1645-17.00	**12. End of day evaluation**	Tick on chart at back of room. Discuss how the day went and request to read materials for the next day *(Module 1, 2 and 5)*	CS

DAY TWO – WEDNSDAY, 24 APRIL 2013

TIME	SESSION CONTENT	SESSION PROCESS	ROLE
0800hrs-0815hrs	Review and logistics	Logistics, Recap of day one and Warm-up exercise	RM
The Health of Communities - Module 2			
0815-1000hrs	Understanding Health: Identifying community health problems and their causes (Definition of health, Social mapping, Transect walk, Health information system)	**Module 2.1 and 2.2** ▪ Show 4 health pictures in plenary and generate a quick discussion on the definition of 'health' Conclude by emphasizing the important contribution of communities in defining their health needs and priorities AND of making people aware of wider needs, new information and approaches in health. How to ensure widest community experience obtained … (10 mins) *(pg 17 and pg 36)* ▪ Social mapping: *'How can I describe my community with a map?'* – (page 20) – (40 mins) ▪ Debrief and briefly talk about the Transect Walk (10 mins) *page 21* ▪ Discussion: Other sources of information on health issues – health information system; health workers; community monitoring, discuss importance of knowing and comparing w local problems for the area, HW views. (20 minutes)	CS, RM
1000hrs	**TEA**		
1030hrs-1230hrs	Causes of our health problems and acting on priorities	**Module 2.2-2.5** ▪ What are the priority health issues or needs?' – ranking and scoring (30 mins) - *(page 22)* ▪ In buzz groups, do the '*but why'* exercise each with a priority problem. Discuss type of causes identified – 20 min ▪ Discuss different views of health workers and communities, holding separate and then shared discussion. How to deal with debate and difference – 20min ▪ Actions, stakeholders and their roles on causes – Venn / stakeholder maps ▪ Review rest of module, community and action plans, how to use priorities in planning HL programme	AZL, CMM

TIME	SESSION CONTENT	SESSION PROCESS	ROLE
1230-1330	**LUNCH**		
1330hrs-1500hrs	Health environments and diseases from unsafe enviroments	Module 4.1-4.3	CS, AZL
1500hrs-1600hrs	Health diets and consequences of poor diets	**Module 3.2-3.3**	RM, CMM
1600	**TEA**		
1615hrs-1715hrs	Nutrition needs of special group Reflection	**Module 3.4** **Module 2 and 3**	RM, CMM
	Safe Water and Poor Sanitation	**Module 4.3**	AZL
17:15-1720	**13. Day evaluation**		

DAY THREE – WEDNESDAY24 APRIL 2013

TIME	SESSION CONTENT	SESSION PROCESS	ROLE
0800-0830hrs	Review and logistics	Logistics, Discussion of the right to health	RM
0830hrs-1015hrs	Health life cycles	**Module 5.3** *Sipiwes story* - Run through the module **Module 5.4** *Health of Our Children*	AZL
1015hrs-1030hrs	***TEA*** **Module 6**		
1030hrs-1230hrs	*People centred health systems* and relationship with health workers	**Module 6,1 and 6.2, 6.3, 6.4,6.5** *(Spider diagram to be used here)*	AZL,CS
1230-1400hrs	***LUNCH*** **Module 7**		
1400hrs-1600hrs	Community roles and alliances in health systems	**Module 7** ▪ *'Where's Mapalo'***7.1** and follow up discussion *(page 127*) Do in Plenary as a walk through – 20 mins ▪ *'How well do health systems listen to people's views?'-* Discuss and review how to use the wheel chart **7.2** - briefly show use of one or two segments - 20 min (*page131)* ▪ Discuss role of HCCs **7.2** and use of picture code for discussion on HCC and roles (10 min).	AZL,CS
1600hrs-1715hrs	Wider engagement on health	**Module 7.3 and 7.4**	CMM, RM
1715-1730	***Day Evaluation and TEA***		

DAY FOUR – FRIDAY, 24 APRIL 2013

TIME	SESSION CONTENT	SESSION PROCESS	ROLE
0800hrs-0815hrs	Review and logistics	Logistics, Recap	RM
0815hrs-1000hrs	Setting up the community HL programme	**Module 1.5**, facilitator and community plans, training schedules Introduction and discussion on plans, schedules, monitoring and reporting–30 min Group work on plans and schedules – 60 min *All facilitators assisting as needed.* *Flip charts with plans put around the walls and discussion*	AZL,CS
1000hrs-1030hrs	***TEA***		
10;30-1315hrs	Planning the Literacy programme	Development and discussion of district plans	CS AZL
1315hrs-1400hrs	***Lunch***		
Final Reflections and Closing			
1400hrs-1530hrs	Reflections and Evaluation	Discussion on Content and Activities of **Modules 1-7** • Questions, etc on content and/or activities (30 min) • Comments on the manual content areas (15 min) • Additional support, info needed to facilitate HL (15 min) • Final overall evaluation of training (30 min)	AZL CMM
1530hrs-1630hrs	Next Steps Closing and goodbyes	✓ Next steps on implementing the programme ✓ Reporting back and getting feedback/support ✓ Participant remarks and comments ✓ Closing remarks	CMM AZL Participant RM
16.30	***Day evaluation and TEA***		***CS***