Health Literacy Capacities in East and Southern Africa
Regional meeting

Training and Research Support Centre (TARSC),

With the

The Community Working Group on Health (CWGH), The Botswana Network of Ethics, Law and HIV/AIDS (BONELA), Malawi Health Equity Network (MHEN), Botswana Federation of Trade Unions (BFTU)

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The regional health literacy programme in East and Southern Africa is implemented through Training and Research Support Centre (TARSC) Zimbabwe in co-operation with the Community Working Group on Health (CWGH) Zimbabwe, with the Malawi Health Equity Network (MHEN) Malawi, the Botswana Network of Ethics, Law and HIV/AIDS (BONELA) with the Botswana Federation of Trade Unions (BFTU) Botswana, and the Regional network for Equity in health in East and Southern Africa (EQUINET). The programme aims to support the development and use of participatory health education materials for health civil society. This programme is implemented with support from the Kellogg Foundation.

Health Literacy refers to people's ability to obtain, interpret, and understand basic health information and health services, and to use such information and services in ways that promote their health.

This is a report of the Regional Health Literacy planning and review meeting held in Kampala, Uganda

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Executive Summary

The importance of grassroots social movements, or “change from below,” in the history of the health Literacy programme is a critical one. Revitalization of Primary Health care invests in the central role of the people as both the primary beneficiaries and active participants in the national Health systems. Health Literacy processes in the East and Southern African Region are initiated, run and led by common man, vulnerable social groups and communities more concerned about defending and protecting their right to health. The programme focuses on both immediate, incremental changes and transforming the health care system into primary health care oriented people centered health systems.

Training and Research Support Centre (TARSC) has implemented the regional health literacy programme in 2006-2009, in co-operation with Community Working Group on Health (CWGH) Zimbabwe, Malawi Health Equity Network (MHEN), Botswana Network of Ethics, Law and HIV and AIDS (BONELA) and Botswana Federation of Trade Unions (BFTU) with support from Kellogg Foundation. Health Literacy refers to people’s ability to obtain, interpret, and understand basic health information and health services, and to use such information and services in ways that promote their health. The Health Literacy Programme aims to support the development and use of participatory health education materials for health
civil society working at community level. The Health Literacy programme is building core public health skills in civil society facilitators, in actions on health issues at community level, at national level and at regional level. In 2006-9 it was initiated in Zimbabwe, Malawi and Botswana and is extending to a wider network through TARSC in the Regional Network for Equity on Health in East and Southern Africa (EQUINET).

The Regional Health Literacy meeting was held on the 26th-27th of September 2009 in Kampala at the Munyonyo Speke conference Center soon after the third EQUINET regional Conference. The Third EQUINET Regional Conference was held at the same venue from the 23rd -25th of September 2009. The conference theme was *'reclaiming the Resources for Health: Building Universal People Centred Health Systems in East and Southern Africa'*. The regional Health Literacy Participants were able to attend both the EQUINET conference and the Health Literacy meeting. This allowed them to mix with people from other processes in the regional health community to facililate learning and exchange of information and ideas building up to the regional Health Literacy meeting. The meeting convened by TARSC joined participants from the Health literacy implementing country networks and new country partners in the region. It was aimed at reviewing past work and experiences of the health literacy programme; sharing ideas for and planning for future work in the region.

The following give s a summary of the lessons learned in the regional Health Literacy programme:

i. Health Literacy is building a health social movement that is able to demand health, recognizing that health is a fundamental human right and this will work as an effective tool to foster commitment for equity when community action oriented interventions claim social and economic entitlements
ii. Health Literacy can support local initiatives for participation, transparency and good governance (for example collaborating with Health center committees, elect leadership, traditional leadership and other important stakeholders)
iii. Communities are concerned and capable (as witnessed by the successful development of Community plans; the commitment to processes and meetings). Health Literacy is people driven and invests in the central role of the people as both beneficiaries and participants of Primary Health care
iv. The Health Literacy process and communities contribute to health sector and local government reforms through the strengthening of comprehensive PHC oriented health systems across all providers
v. Health Literacy empowers communities with knowledge, a resource that is timeless and powerful! Communities are able to build control over new and old knowledge, build reflection and analysis on past experiences, link this to community voice and action making the programme an effective mechanism in social empowerment and in reclaiming people’s resources for health to redefine an understanding of people centred Health systems.
vi. Health literacy offers a platform for marginalized groups to actively participate in health. The essence of Health Literacy is to empower people to take charge of their own health and to foster a spirit of self-reliance

vii. Health Literacy invest in people's power enabling people to reclaim, own and translate knowledge into action and use this knowledge and information to advance primary health care.

Best practices identified in the Regional Health Literacy programme and how they should be institutionalized

- Health Literacy is integrated in already existing programmes - making implementation holistic and easy to implement through collective planning, community monitoring programmes and primary health care assessments: these mechanisms institutionalize processes
- Health Literacy uses community health structures that are supported by civil society and government; this promotes accountability and sustainability of the programme: public meetings, community health forums, community radio dialogues, self and community collective monitoring and reflection institutionalize these processes
- Health Literacy uses participatory approaches that promote local engagement, involvement and participation: participatory planning, health facility committees, public hearings, community voice newsletters, patient charters, health worker charters, health right in national constitutions institutionalize this.
- Health Literacy organizes communities to demand their entitlements, this organizes people's power in health and addresses equity issues that impedes people driven and people centered health systems: Health laws that promotes Primary Health care, legally supported Health facility committees, Health campaigns, demonstrations and nationally supported marches help to institutionalize this.
- Health literacy involves all-important stakeholders at community level. Relationships between communities, health workers, traditional leadership, elect leadership, legislators, relevant line ministries, the business community and local governments have been improved and this has heightened implementation of activities, increased trust and cooperation between actors and ultimately improved policy frameworks.
- Health literacy allows communities to identify and prioritize own health needs for action while also learning and reflecting from own experiences. It is people led, people driven, people centered and builds towards people centered health systems: exchange visits, peer group support, social group networks, edutainment campaigns help to institutionalize this
- Health Literacy uses locally available resources through bottom up planning to address barriers that impedes access and uptake of health information and services. It offers opportunities for collective health planning and decision making processes in health

The weaknesses and gaps identified in the regional Health Literacy programme and how they should be addressed

- Financial resources to support community activities have been inadequate in relation to the demand of activities across implementing countries. Health Literacy communities and facilitators should fund raise at community level, Implementing country partners should mobilize resources for Health literacy at national level and TARSC should mobilize resources for the Health Literacy programme at Regional level.
- The Health Literacy manuals are only available in English; increased access to health information requires popular materials to be in local languages. The Health Literacy materials should be translated into local languages.
- There are no incentives to motivate Health Literacy Facilitators. Resource mobilization for health literacy should have a budget to cater for Health Literacy incentives. Incentives can be either or both financial and non financial.

Lessons learned about the way the programme is established

- The Health Literacy programme relies on the active participation of communities in building networks and harnessing support for communal activities. Established on the principles of convergence of common agenda, it is about people, and the key to success is based on mature social investments and a close bond between stakeholders – communities – and governments.
- Established on Community appreciation of their own resources and capabilities and that communities have indigenous knowledge- a timeless, valuable and priceless resource at community level that enables them the understanding of own resource problems and the socio-economic opportunities for sustainable humane development.

- Founded on collective, shared and common vision for primary health care oriented, people centered health systems that promote socially permissible systems for information exchange, vertically and horizontally
- Health Literacy is established on values of all stakeholder participatory planning to encourage more sustainable resource use. Involvement of all key stakeholders including communities supports social cohesiveness, cooperation thus pooling ideas, resources, labor and talent to achieve communal projects that are important to health.
- Health Literacy is designed in such a way that it replicates, it is people led, people driven and 'responds to issues that affect them and are more likely committed to find and implement solutions on their own ways, than those imposed by external agencies'. Health Literacy is bridging gaps between knowledge and practice, addressing social justice and enabling people to gain control over determinants of their health

Lessons learned about the way the programme is sustained

- It is encouraging that Health Literacy embraces the vision of 'integration' of physical, societal and political perspectives about moving towards a comprehensive, people centered system approach The essence of the integrative vision is characterized by learning, interdisciplinary enabling processes that embrace uncertainty, complexities and dynamics of change in order to balance social, economic and physical sustainability
- Health Literacy reflects a clear and coherent common agenda (or set of priorities) among stakeholders. For this reason it contributes to partnership building, trust building and this builds towards programme sustainability including local understanding of this.
- Health Literacy embraces the 'triangulation principle' (multiple sources of information and methods), and links together various resource people and knowledge sources. This builds trust, increases confidence in results by adding new information, assessing and crosschecking, reflecting and acting from multiple 'points', including various sources, various methods or in various conditions. The explicit cooperation at every level in Health Literacy with local stakeholders on an on-going basis creates the opportunity for distortions or misunderstandings to be corrected relatively rapidly and easily. Relatedly, activities and results are more widely accepted as they build on and link the 'best of diverse resource angles'
- Health Literacy is based on iterative learning and feedback loops and there is a two-way sharing of information (local people take a lead role in sharing of experience and knowledge, facilitation, investigation, analysis and learning, action and reflection), sharing of information and ideas, triangulation, the quality of behavior and interaction, rigorous observation and reflective judgment and action. For this reason it allows for the proper identification of stakeholders, community structures, and provides space for the adequate representation of stakeholders that provide stability and sustainability, recognition and acknowledge to community roles in Primary Health care.

Lessons learned about people centered health systems

- They invest in people as the primary beneficiaries and participants of the Health system. This promotes use of locally available resources to advance health through increased knowledge on prevention, effective and practical prevention strategies.
- People centered health systems can be achieved through huge investments at primary care level thus the need to revitalize Primary health care through Health Literacy. Investment in Primary health care ultimately reduces the total cost for health (reduced disease burden, lees people needing curative services)
- People Centered Health systems are founded on a turf layer of trust. Health Literacy builds trust, and promotes two-way communication between communities and other actors in the Health system. Accordingly access to and uptake of health services is significantly increased.

Lessons learned about social empowerment in health

- Health Literacy is an efficient social empowerment process. It is encouraging to note that the values and ideas of social empowerment are synonymous with the Health Literacy process. Social empowerment processes should be people initiated, people driven, people led, dynamic, sustainable, robust, flexible and adaptive, so is Health Literacy.
- Constitutional entitlements, health laws, community structures, health freedoms and health rights that enable people to organize power to control their own resources should support social empowerment processes.

- Social empowerment processes are sustained by fundamentals of social justice, equity, accountability, and participation and good governance

Taking the health Literacy Programme forward

Next steps in the implementation of Health Literacy in implementing country partners (Zimbabwe, Malawi, Botswana) and new country partners (Mozambique, Zambia, Uganda, Kenya and Tanzania) highlighted that **new country partners** will consider following all the implementation steps taken by Zimbabwe, Malawi and Botswana to define the steps for implementation. Further to this new country lead organisations agreed to carry out national advocacy, national coordination, country specific Health Literacy, material development and support community level Health Literacy. The regional support from TARSC would include regional level fundraising for the Health Literacy movement, advocacy at that level, providing the link for regional and global connect and linkages for information sharing, exchange, networking, planning and reviews. TARSC provides some financial support to partners, however implementing country partners are also expected to take responsibility for meeting the financial needs of the programme at country level

The **implementing country partners** agreed that the transition towards translation of materials into local languages was as important as supporting and strengthening community health literacy. The focus for implementing countries would be championing Health Literacy to revitalise primary health towards people centred Health Systems. The community activities should push the Primary Health care agenda. To further strengthen the link between Health Literacy and Primary Health care, the following elements were agreed:

- Build a regional base of evidence on mechanisms that enhance PHC and use that platform to engage relevant national, regional and global bodies on the 'Health for all' goal. ***(TARSC)***
- Integrate Health Literacy in Health systems e.g. Health Literacy facilitators could be drawn from village health workers and civil society to support government efforts at primary care level, promote sustainability and accountability. (TARSC with implementing country partners)
- Create sustainable regional linkages with regional platforms that support the same cause such as SEAPACOH, SADC, WHO, UN etc ***(TARSC)***
- Support regional exchange visits and promote regional learning workshops, review meetings, conferences etc ***(country partners with TARSC)***
- Promote the participation of all relevant stakeholders, alliances and actors builds trust and is key in Primary Health care***. (Country partners)***
- Launch the Health Literacy social Movement process: coincide the launch with Alma Ata days ***(TARSC with country partners)***

1. Background and Objectives

Training and Research Support Centre (TARSC) has implemented the regional health literacy programme in 2006-2009, in co-operation with Community Working Group on Health (CWGH) Zimbabwe, Malawi Health Equity Network (MHEN), Botswana Network of Ethics, Law and HIV and AIDS (BONELA) and Botswana Federation of Trade Unions (BFTU) with support from Kellogg Foundation. Health Literacy refers to people's ability to obtain, interpret, and understand basic health information and health services, and to use such information and services in ways that promote their health. The Health Literacy Programme aims to support the development and use of participatory health education materials for health civil society working at community level. The Health Literacy programme is building core public health skills in civil society facilitators, in actions on health issues at community level, at national level and at regional level. In 2007-9 it was initiated in Zimbabwe, Malawi and Botswana and is extending to a wider network through TARSC in the Regional Network for Equity on Health in East and Southern Africa (EQUINET).

The Health Literacy work has in the past three years provided a platform of dialogue and engagement between communities and the health services to collectively revitalize primary health care from the bottom to the top. In 1978 the Alma Ata declaration called for universal access, for equity and community participation. In East and Southern Africa we lag far behind where we could be in terms of equity, or even building towards equity, universal access and community participation. We have barely touched the whole question of appropriate use of resources. A strong comprehensive primary health care system can provide the solution to serious public health needs, but it is all too deeply mired in entrenched systems, turf battles and structural barriers to change. Yet, we have seen that Health Literacy is the vehicle to address these challenges. A central feature of the Health Literacy programme is its ability to build a health literacy social movement in East and Southern Africa and beyond, drawing on simple approaches to change, accountability, flexibly working within, beside, or complimenting the existing health systems. The values and fundamentals of Health Literacy as a social empowerment process have fostered a commitment to health for all, and a distinctive approach to knowledge. This approach seeks to combine the rationality of the socio-economic, socio-political and cultural framework, within which Health Literacy is implemented and contextualized,

The programme supported national activities[1] through regional planning, regional material development for common core materials, regional support for monitoring and evaluation, mentoring and skills building, regional review meetings and exchange programmes in Malawi, Botswana and Zimbabwe. In each Country the programme has formalized partnerships (TARSC with CWGH, MHEN, BONELA and BFTU)[2]; carried out needs and capacity assessments to inform material development; developed and piloted health literacy training materials, built facilitator skills, supported the implementation of the health literacy programme within pilot districts and in all three countries evaluated the programme[3]

The Regional Health Literacy meeting was held on the 26th-27th of September 2009 in Kampala at the Munyonyo Speke conference Center soon after the third EQUINET regional Conference. The Third EQUINET Regional Conference was held at the same venue from the 23rd -25th of September 2009. The conference theme was *'reclaiming the Resources for Health: Building Universal People Centred Health Systems in East and Southern Africa'*. The regional Health Literacy Participants were able to attend both the EQUINET conference and the Health Literacy meeting. This allowed them to mix with people from other processes in the regional health community to facililate learning and exchange of information and ideas building up to the regional Health Literacy meeting. The meeting convened by TARSC joined participants from the Health literacy implementing country networks and new country partners in the region. It was aimed at reviewing past work and

[1] TARSC (2007) Health Literacy Regional Planning meeting report; 5 January; Harare; TARSC: Zimbabwe

[2] A memorandum of understanding between TARSC and the implementing country partner has formalized partnerships in Health Literacy programme of work since 2007. Implementation plans agreed between the implementing country partner and TARSC have been used to define roles, activities, financial implications and expected deliverables and outcomes of each phase of implementation. (MOUs formalize partnership between TARSC and MHEN in Malawi, TARSC and CWGH in Zimbabwe, TARSC and BONELA and BFTU in Botswana)

[3] TARSC (2008) Health Literacy Regional Planning meeting report; 17-18 January; Harare; TARSC: Zimbabwe

experiences of the health literacy programme; sharing ideas for and planning for future work in the region.

The meeting specifically aimed to

- review country experiences, progress, performance, challenges and opportunities in implementing Health literacy work,
- identify strengths and best practices taken forward in key areas of social empowerment and action on health through health literacy.
- consolidate lessons learned at regional level to inform future work in existing and new country partners at community level in ESA

This report compiled by TARSC presents the major points of discussion and agreed follow up from the meeting.

2. Introductions and welcome Remarks

Dr. Rene Loewenson, the Director of TARSC gave the opening and welcome remarks. She outlined the objectives of the two-day meeting as highlighted above. Participants introduced themselves, the organizations they represented and talked briefly about Health literacy as a social empowerment process.

Mr. Jacob Ongala from Kenya briefly gave an outline of Rachuonyo Health Equity is a Community Based Organization (CBO) working with people living with HIV/AIDS. He added that Rachuonyo Health Equity **(**RHE) works closely with the Kasipul Division Home Based Care Stakeholders Group (KDHSG), one of the local non-profit making organizations that has conducted HIV awareness in the area, working closely with HIV positive clients, HIV clinic personnel and other stakeholders in the community. The CBO is now scaling up to have a more national framework and influence at policy level. Its current programme seeks to increase access to primary health care on HIV and AIDS prevention and treatment in the community based on findings from the PRA work with EQUINET.

"PRA as a social empowerment process allows the voice of marginalized social groups to be heard, I feel that health literacy will not only empower marginalized girls in Kenya with information and knowledge but to also act responsibly to improve their own health. We think the Health Literacy program will benefit the institution and communities in Kenya in many ways. We know increasing health literacy among these marginalized groups will make them more likely to create a sustainable healthy living, they will make more informed decisions about their health and more actively support their children to attend school and hopefully overcome similar barriers in future" **Jacob Ongala Owiti**

Ms. Rosette Mutambi the Director of the Coalition for health Promotion and Social Development (HEPS-Uganda) introduced HEPS-Uganda as a health consumer's organization advocating for health rights and responsibilities in Uganda. It broadly aims to become a strong health advocacy organization in promoting access to health care for all Ugandans, with specific focus on the poor and vulnerable. HEPS brings a strong network of organizations already involved in advocacy for health rights, and is the focal point for Uganda Health Equity Network. HEPS-Uganda has three strategic programmes: Community outreach, Health Policy advocacy and, health counseling and complaints desk.

" I feel like we have been implementing health literacy all the while, however we have not been implementing it well, our community outreach programme shows that if we are to change it to health literacy we will advance health more in Uganda and communities will ultimately be empowered!" Rosette Mutambi-Director HEPS Uganda

Mr. Francisco Sitoe from the Rural Development Initiative (IDR) in Mozambique described IDR in the Inhambane Province as a non-profit organization with autonomous administrative and financial assets, governed by its statutes; funded by the will of friends united by a common cause, through the intellectual and professional qualities of its members in order to facilitate overall development. IDR Facilitates communities' empowerment in accessing health information and services and in decision-making to embrace sustainable use of resources and social justice. IDR supports rural communities to mitigate the causes and effects of absolute poverty by adopting participatory approach to development while promoting mainstreamed development in rural communities.

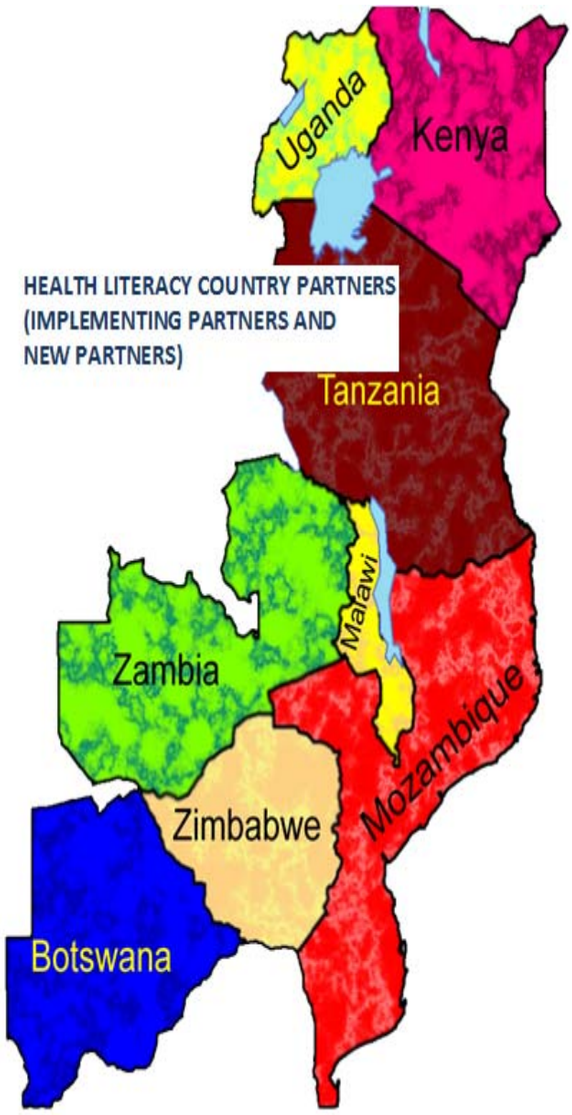
"We are excited about the opportunity for Health Literacy in Mozambique, especially that it will come and benefit vulnerable social groups that we interact with on a daily basis, in the Inhambane Province, this is were there is greatest need, I see health literacy as a mechanism that organizes poor people's power to reclaim resources for health…" Francisco Sitoe-Mozambique

Mr. Itai Rusike from the Community Working Group on Health (CWGH) in Zimbabwe briefly outlined the role of CWGH. The CWGH is a network of membership based civic organizations focusing on advocacy, action and networking around health issues in Zimbabwe. It aims to collectively enhance community participation by sharing civil society experiences, issues and views on health in Zimbabwe. The CWGH stimulates the formation of local structures for civic participation in health and supports informed community participation in local health structures and makes input of community perspectives, position and experiences to statutory health structures at national level, including commissions of inquiry and health boards.

"We have been implementing Health Literacy In Zimbabwe for the past three years, Health Literacy, has given a platform for communities to build the health system from the bottom, organized networks that put the health providers and legislators to account. People have shown that they can improve their own health and we are currently pushing the agenda of the inclusion of the right to health in the new Zimbabwe Constitution" Itai Rusike-Zimbabwe

"People in some districts have been in a position to demand provision of certain social amenities including provision of potable water from the city fathers, this shows the level of power and empowerment communities have reached through health Literacy in Zimbabwe.." Tafadzwa Chigariro-Health Literacy Facilitator CWGH Secretariat-Zimbabwe

"Health Literacy puts people of different political affiliations together to plan and implement interventions that improve their own health regardless of their political differences; this is the beauty of participation and involvement organized through Health Literacy. Health Literacy is so dynamic so much that districts in Zimbabwe that are so different have been able to implement it very well, because it takes into consideration the cultural, socio-political and socio-economic contexts of each geographical area and its populace…" Dumisani Masuku-Health Literacy Facilitator-Victoria Falls Zimbabwe



Ms Nana Gleeson from the Botswana Network of Ethics, Law and HIV/AIDS (BONELA) noted that BONELA is a non-profit making Network of individuals from the legal community, community based organizations, public and private sectors, academics, concerned individuals and people living with HIV and AIDS. BONELA integrates a legal, ethical and human rights dimension into the response of the HIV pandemic; strengthening NGOs to participate fully and effectively in policy planning and implementation; addressing human rights of people affected by HIV and AIDS; supporting public health interests, to educate and research in human rights and public health areas.

"Health literacy is giving the people of Botswana an opportunity to look at health issues holistically, previously all our programming including the Ministry of Health was centred around HIV/AIDS and we were running the risk of forgetting other key public health needs. Within BONELA health Literacy gives us an opportunity to strengthen our role from the bottom, Health Literacy made us see that we have been implementing our programmes top-down and this had implications on ownership and implementation of other programmes…" Nana Gleeson- Botswana

The Botswana Federation of Trade Unions (BFTU) was formally registered in 1986 under the Trade Unions and Employer' organization Act of 1968 as a Federation of Trade Unions. All the major trade unions in the country are affiliated to this federation. Membership of the BFTU is open to all

registered trade unions irrespective of their political or ideological orientation. Botswana Teachers Union is one of BFTU members. Mr Ronald Ketshabe from the BTU further explained that the major areas of interest for BFTU include; preventing the transmission of HIV through effective information dissemination, education, and communication; support of PLWA and reduce the social and economic impact of HIV/AIDS on their families.

"We have been implementing Health Literacy for the past year and I'm sure with more experience and exposure we will see how we can rope in more shop floor workers around the country to use Health Literacy at work, at home and in their everyday lives to improve health. The workers are the people! The people are the major players in the Health System! So we see health literacy playing a big role in strengthening our primary health care in Botswana…" Ronald Ketshabe -Botswana

African Medical Research Foundation (AMREF) Tanzania focuses on families with emphasis on adolescents and youth; women and children; and the poor in urban and rural settings AMREF Tanzania supports and contributes to the accomplishment of the mission of AMREF Africa. The Tanzania country programme aims at reducing diseases associated with high mortality and morbidity, improving access to quality health services, and enhancing efficiency in health and development initiatives. AMREF works in all regions in Tanzania. Mr. Martin Mkuye observed that AMREF Tanzania partners with communities and empowers them to improve their own health and uses evidence-based research to advocate for change.

"AMREF Tanzania is excited about Health Literacy, and I am here to learn about Health Literacy...I'm sure after the two days meeting I would be able to tell how this can easily be integrated in already existing work and further strengthen what we do as AMREF and what we do with Ministry of Health Tanzania..." Martin Mkuye- Tanzania

Mr. Saiti Chikwapulo a programme officer at the Malawi Health Equity Network (MHEN) described MHEN as an independent alliance of organizations and individuals promoting equity and quality in health for all people in Malawi. It is a non –profit-making alliance of civil society organizations and other interested parties promoting equity and quality in health for all people in Malawi. He added that MHEN is a recognized key partner in health development in Malawi. It promotes equal and equitable access to health care services for all Malawians by influencing public and private policies and practices through Research, Monitoring, Evaluation, Advocacy and Civic Education. These five aspects form the core business of the organization.

" the Health Literacy programme is exceptionally unique! It has added value in basic primary health care issues in Malawi, for instance, in Blantyre, we have taken Health Literacy in schools and we are now working with the Ministry of education to promote health issues in schools and beyond in communities where school going pupils and young children come from, improvements are small but visible and we reckon that in the next few years of implementation other schools would have taken it up…" Maziko Matemba-Health Literacy Facilitator Blantyre-Malawi

"*We have worked with Ministry of Health and we are resuscitating a Health Post that has been defunct for years in one of the districts in Lilongwe…People have taken the responsibility amongst themselves to get health services to where they are…and this is one of the fundamentals of Primary Health care, accessing health services will promote uptake and improve health…*" Caleb Thole-Health Literacy Facilitator Lilongwe Malawi

Dr Rene noted that the common elements that came form the introductions of delegates across the participating countries were:

1. **Participation and involvement:** Active involvement and high level participation of different social groups through use of participatory processes enhances building exchange of experiences, reflection, and action between health workers and varying social groups in different communities. Active participation and involvement promotes bottom up approaches, supports Primary health care interventions and leads to publicly led health systems.
2. **Power and control:** Health Literacy organizes people's power for health within vulnerable social groups and within poor communities to claim a greater share of national resources to improve their own health thus strengthening ability to demand equitable health systems, overcoming social imbalances and building social power to advance social justice in health. The power that we refer to is the collective ability of people to own, and control resources
3. **Empowerment:** The empowerment that we refer to is the collective capability of people to assert their own needs and interests, challenge the distribution of power, resources and the actions that block their interests, and influence the allocation of societal resources towards their needs

She added that it was clear from the introductions that Health Literacy provides the space for communities to express and shape the health policies and programmes, which are delivered to them. It also utilizes the expertise on-the-ground knowledge of the people working in health care, which is key in any planning and further strengthening of health systems in the region. People centered health systems are organized to involve and empower people, and create powerful constituencies to protect public interests in health. Furthermore, she observed that building health literacy in communities across the region will increasingly build informed, concerted public leadership for people centered, Primary Health Care oriented health systems. Health Literacy is investing in the public, parliamentary and civil society institutions and is creating mechanisms that empower people through participatory processes that engage and build power within communities

Dr Loewenson introduced Ms. Fortunate Machingura to give an overview of the Health Literacy programme in the Region. She noted that Ms Machingura has been coordinating the Programme since its inception from the Training and Research Support center (TARSC) in Zimbabwe providing mentoring, support, and coordination in all the implementing country partners in the region. TARSC has provided institutional co-ordination to the programme over the past two years through technical input and oversight of Dr Rene Loewenson, programmes and technical teams and an administration unit. The skills and capacity input has been used to guide, manage, document and administer the

Vulnerable social groups take part in community Health literacy- Malawi

programme and to report on it to country partners and key stakeholders.

3. Overview of the regional HL Programme

Ms Machingura began by linking her presentation to Dr Rene's summary from the Introductions. Ms Machingura argued that the pillars **(*Participation and involvement; power and control; and empowerment)*** from the introductions were the main anchors of Health Literacy and defines the identity and forte of Health Literacy in the region. Health Literacy is the social empowerment process that is revitalizing primary health care and redefining people centered health systems. Health Literacy provides useful opportunities for civil society and communities to lever government action to enhance health equity based on fundamental principles of health as a human right.

People centered health systems are organized to involve and empower people, and create powerful constituencies to protect public interests in health. Health Literacy is organizing people 's power to control resources for health. Ms Machingura added that the Health Literacy Work in the Region has involved members of parliament who have a role in the region in advancing health equity through laws, budgets and social empowerment.

Ms Machingura highlighted that the regional health literacy programme in east and Southern Africa is being implemented through TARSC Zimbabwe in co-operation with the Community Working Group on health (CWGH) Zimbabwe, with Malawi Health Equity Network (MHEN) Malawi, BONELA and BFTU Botswana and the Regional network for Equity in health in east and southern Africa (EQUINET). The programme aims to support the development and use of participatory health education materials for health civil society. It is being implemented in Zimbabwe, Malawi and in Botswana with support from Kellogg Foundation.

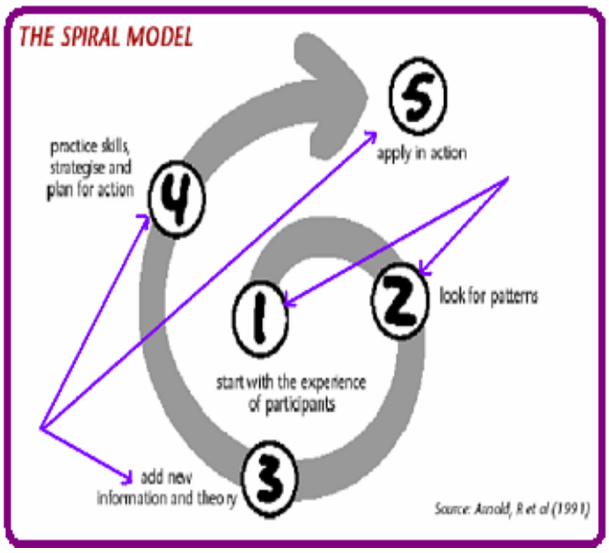
Training and Research Support Centre (TARSC) Zimbabwe is a non profit organization that provides training, research and support services to develop social and organizational capacities within organizations to interact with the state and private sector on areas of social policy and social-economic development. TARSC provides technical support, mentoring, cadreship building and

organizational development to a range of membership based civil society organizations, to organizations in the state, in local government and in parliament at local, national and international level. It is a learning and knowledge organization, with a particular focus on skills building and methods to support community-based work, and with a commitment to long-term national capacity building in the public sector and in civil society. This skills and capacity building and input has been used to guide, manage, document and administer the Health Literacy programme and to report on it to country partners and key stakeholders. The Regional Health Literacy coordination at TARSC supports national activities through regional planning, regional material development for common core materials, regional support for monitoring and evaluation, mentoring and skills building, regional review meetings and exchange programmes. TARSC provides some financial support to partners, however implementing country partners are also expected to take responsibility for meeting the financial needs of the programme at country level. The programme links with wider regional networking on health through EQUINET.

This body of work in EQUINET in which the Health Literacy programme links to is the EQUINET work on building national, people centered health systems. This work aims to bring together the knowledge, capacities, social networking and practice that brings people centered, primary health care oriented health systems into practice in the ESA region. In addition, the TARSC/ Ifakara PRA training and the Pra4equity network that uses participatory processes to engage and build power within communities. Other work included the Health civil society network and the national health awareness and education activities that seek to bring the PHC principles at Alma Ata onto the health agenda, to consolidate and claim health as a right, to strengthen knowledge, understanding capacities and engagement about how communities and social actors engage to build people centered health systems.

She added that the programme aims to:

- Build health literacy at community level – knowledge, reflection/ strategic thinking; action while also,
- Building capacities of national health civil society in EQUINET in existing country partners (Zimbabwe, Malawi, and Botswana) and extend further to new country partners (Kenya, Uganda, Tanzania, Mozambique and Zambia) and,
- Provide materials, skills, mentoring, networking, co-ordination and resources for the work
- Monitor and evaluate the programme and,
- Create a sustainable base for work in the countries and wider regional coverage



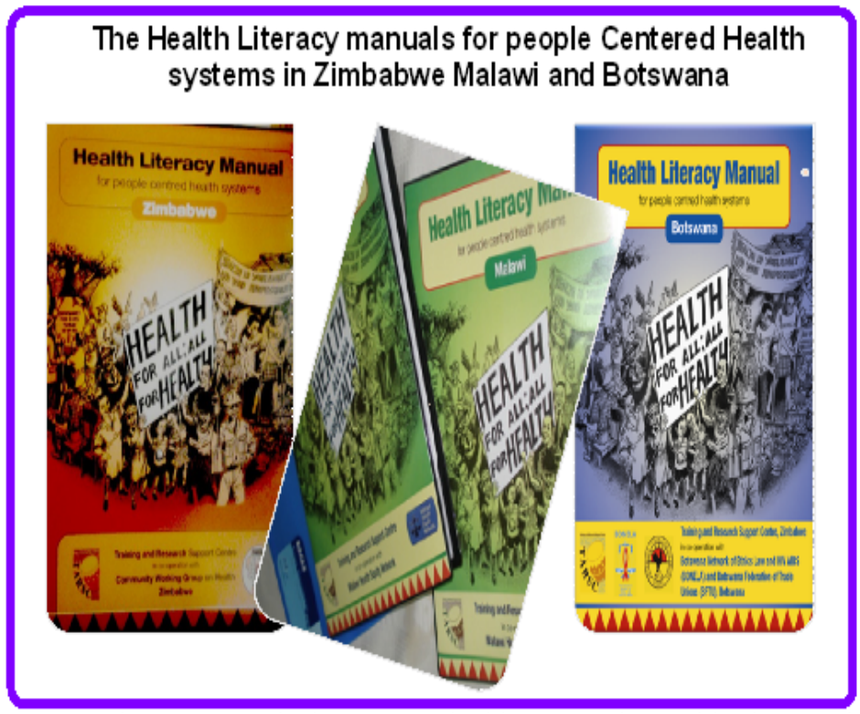
Participatory tools have been embedded in the Health Literacy core materials to help Health Literacy facilitators link with key stakeholders and varying social groups at community level. Participatory tools have shown the ability to enable people to engage actively and fully in understanding health information and services to self empower and to demand health services that are due to them. This creates a sustainable base in building people's power in health. Health Literacy implementation allows community cadres to reflect on their own experiences, look, plan and act in series of cycles that allow learning and growth at own pace.

Our understanding of Health Literacy is unique. We understand Health Literacy as people's ability to obtain, interpret, and understand basic health information and health services, and to use such information and services in ways that promote their health. It is an initiative of the South, built by people at grassroots level and is being led by people at grassroots level. It is a bottom up intervention that is PHC oriented and is building people centered health systems in the East and Southern African Region. The programme is dynamic, robust and replicates in different settings to suit the culture of the people in any setup.

The Health Literacy programme has been implemented in phases as shown below

1. **Organizational assessment**: Starting from the EQUINET network identifying organizations that are national, operate at community level and take issues from the bottom for advocacy to influence policy and practice
2. **Needs and capacity assessment**: to determine the content of the Health Literacy materials based on the needs of the people in each country
3. **Development of Regional core materials:** core regional material that is standard (done at TARSC) that define the overall spine and core of the HL work
4. **Development of National materials:** development of country specific materials based on the needs and capacity assessment done by implementing country partner and TARSC
5. **Pilot in two districts (one rural and one urban):** testing the draft materials with the target audience and getting their input, comments and additions to strengthen materials
6. **Peer review:** by a technical country group identified collectively by implementing country partner and TARSC to peer review the materials from a technical side
7. **Revision of materials:** consolidating the inputs and comments from the district pretest and the peer reviewers into final materials
8. **Facilitator training:** facilitators are chosen on the basis on their ability to read and write in English since the materials are still in English, understand community health and have been involved in community health, use of PRA tools is an added advantage, good communication and organizing skills, already working on other community health work is also an added advantage
9. **Evaluation and follow up:** to consolidate learning and practice to plan for future work and to reflect on own way to facilitate exchange of practice and ideas on best practices

Ms. Machingura noted that the organizational assessment of MHEN was done in 2007, while that of BONELA and BFTU was done in 2008. The Zimbabwe, Malawi and Botswana materials for Health literacy were published in 2007, 2008 and 2009 respectively. A total of 63 Health Literacy facilitators were trained in 21 districts of Zimbabwe while 30 Health Literacy facilitators were trained in four districts of Malawi and 30 Health Literacy facilitators were trained in four districts of Botswana. She added that the evaluation of the Health Literacy programme had been ongoing from July 2009 in Zimbabwe, Malawi and in Botswana.



The health literacy progress and process monitoring process had been ongoing and implemented from district level/community level to national level processes[4]. This has been done through health literacy facilitator own evaluation, national review meetings and the online '*HLAfrica'* email list where the Health Literacy network exchange ideas and share best practices. The regional Health Literacy planning and review meeting discussions would also feed into the regional evaluation. She observed that the regional evaluation began in July 2009. An external evaluator identified and collectively interviewed by the implementing country partners and TARSC was conducting the regional evaluation.

In terms of the expected outcomes and lessons learned, Ms Machingura argued that the Health Literacy Learning Network was convinced that Health Literacy was the social empowerment process

[4] TARSC (2008) The Regional Health Literacy Annual Report-2008; December 2008, TARSC, Harare: Zimbabwe

that has been able to translate knowledge into action. It is the process that is championing people's power for health. The process that was organizing communities to revitalize primary health care and shape effective strategies in redefining people centered health systems. She further noted that the network is building a social movement in health that is capable; that demands health and that understands that health is a fundamental human right.

She summarized some of the lessons learned in the region as shown below:

- Health Literacy is building a health social movement that is able to demand health, recognizing that health is a fundamental human right and this will work as an effective tool to foster commitment for equity when community action oriented interventions claim social and economic entitlements
- Health Literacy can support local initiatives for participation, transparency and good governance (for example collaborating with Health center committees, elect leadership, traditional leadership and other important stakeholders)
- Communities are concerned and capable (as witnessed by the successful development of Community plans; the commitment to processes and meetings. Health Literacy is people driven and invests in the central role of the people as both beneficiaries and participants of Primary Health care
- The Health Literacy process and communities contribute to health sector and local government reforms through the strengthening of comprehensive PHC oriented health systems across all providers
- Health Literacy empowers communities with knowledge, a resource that is timeless and powerful! Communities are able to build control over new and old knowledge, build reflection and analysis on past experiences, link this to community voice and action making the programme an effective mechanism in social empowerment and in reclaiming people's resources for health to redefine an understanding of people centred Health systems.
- Health literacy offers a platform for marginalized groups to actively participate in health. The essence of Health Literacy is to empower people to take charge of their own health and to foster a spirit of self-reliance
- Health Literacy invest in people's power enabling people to reclaim, own and translate knowledge into action and use this knowledge and information to advance primary health care.

She added that while strengths and lessons learned would be used to strengthen future work it was imperative that we learn from our weakness and turn them into strengths. She further acknowledged that the overwhelming interest for the Health literacy programme in the region was astounding and confirmatory that this programme is people led and people driven.

In plenary discussions participants highlighted that when working at grass roots level, it is important that communities actively appraise and express their understanding of their health care situation. It is vital that local ownership of the process is given. Equally, local cultures and indigenous systems of knowledge must be considered within the scope of any health literacy action reflection cycle. There are challenges when applying participatory approaches. Capacity and time can restrict their effectiveness. The most vulnerable and poorest can often be excluded from the process due to social structures, timing or lack of awareness of the processes themselves. Extending existing social networks such as churches, women's organizations or residents' associations can help alleviate this exclusion.

" We have been able to tap from all our network members and some of the most vulnerable social groups have been able to participate freely, consistently and fully in most of the health literacy community meetings, members come from church groups, from residents associations, from sex workers, and even children also take part in the health literacy meetings…it does offer a platform for participation for the marginalized social groups" Dumisani Masuku-Health Literacy Facilitator - Zimbabwe

At a national and more fundamental level a key challenge is that, although governments have developed policies for dealing with community participation in local health care, there is often little implementation of these policies. Both national and international efforts to implement public health strategies can disregard local input, and the delivery of 'decentralized' health care is often at odds with the local communities they are serving. When community input is acknowledged, there can be a strong sense that it was only a 'token'. In order to maximize the effectiveness of participatory approaches, it is not sufficient for governmental ministries to write policy documents that promote participation by the citizenry; they must also construct mechanisms and citizen-friendly paths for participation.

"*Through health literacy we have been able to make local government account and old people have gone to clinics and demanded free services because that is what the policy say. In Zimbabwe there is a policy that says children under five, pregnant women and the elderly above the age of 65 should not pay for health services, this policy is sparsely implemented and where it is implemented is where people have the knowledge about it, this is where we have seen that through health literacy a critical knowledgeable mass can make governments accountable and in turn this promotes primary health care…"* Itai Rusike CWGH- Zimbabwe

'I am getting to have a clear understanding of Health Literacy and I see it working well in Tanzania, however I feel that perhaps the approach would be slightly different taking into cognizant the context of Tanzania and how we work as AMREF Tanzania. I see a situation whereby we invest in the ministry of health and Health Literacy facilitators could be invested in already existing government volunteer cadreship so that skill and capacity investment is measurable, sustainable though a pool of resources coming from different ends and angles to strengthen our primary health care efforts. Working within can also give pressure for governments and ministries alike to take community participation and inputs seriously from the onset…" Martin Mkuye AMREF-Tanzania

We agreed that Health Literacy ensures that the community is an equal and active partner with the other stakeholders and links knowledge to action in a continuous two-way learning process. As such, it is an impetus for change. We will form a Health Literacy Social Movement in Africa and beyond that addresses Primary Health care and strengthens Health systems through bottom up approaches.

4. Country experiences

This session was aimed at reviewing country experiences, progress, performance, challenges and opportunities in implementing Health literacy work. It also identified strengths and best practices taken forward in key areas of social empowerment and action on health through health literacy. Implementing country partners explored the key features of the programme and their link to the changes effected at community level; in facilitator skills; in organizational capacities and skills; and health systems and health while this was a learning platform for new country partners in the region.

4.1. Zimbabwe

Mr. Itai Rusike the Director of the Community Working group on Health briefly gave the background of the CWGH and the Health Literacy programme in Zimbabwe. He highlighted that after the training of Health Literacy facilitators in 2007, implementation began to unfold at community level in 21 districts across nine of the ten provinces of Zimbabwe. Facilitators were trained in two batches one covering the northern region of Zimbabwe and another covering the southern districts of Zimbabwe. 2008 saw the spiraling of the Health Literacy programme, into a vibrant, relevant and self sustaining process, at community level, at organizational and at national level.

Mr Rusike added that the Health Literacy programme in Zimbabwe successfully provided mentorship and support to district Health Literacy facilitators during community meetings and other local health activities in the 21 CWGH chapters. Health literacy has successfully empowered and strengthened the voices of vulnerable social groups in Zimbabwe. The national health literacy review meetings Consolidated experiences and enabled Health Literacy facilitators to exchange and share experiences and best practices in the implementation of the health literacy programme at community level. He aknowdged the technical support and mentoring from TARSC throughout the period and in

When	Community Action Plan	*Training Action Plan*	HL Session	*Support and Review*
January	Engage local authorities, local leadership, health authorities and stakeholders in HL planning meeting	–	Covered sections in modules 1,6 and 7	Financial support (Meals, stationary and transport reimbursements
January	Attend HL review meeting in Harare		Training in module 5	
February	Malaria campaign in Chipinge town	Mobilizing skills	Module 4	Financial support (Meals, stationary and transport reimbursements
March	Cutting long grass in residential places	–	Module 4	Slashers and sickles from CWGH secretariat

all stages of implementation as vital and essential in all steps of implementation even in the succeeding stages of health literacy in future. Mr Rusike noted that communities are capable and they are an important resource in the implementation of public health responses that shape primary health care oriented health systems. Most Health Literacy activities in Zimbabwe were focused on improving health of the poor and the marginalized through simple community led initiatives and campaigns. Some of them included the campaigns against cholera through civic education platforms and health literacy led actions, Malaria and TB activities, water and sanitation focused interventions. The activities varied across districts as they depend upon the priority health needs of each district. The table below shows a work plan from one the Health Literacy districts in Zimbabwe

Mr. Rusike explored the challenges faced implementing health Literacy in Zimbabwe. The demand for the Health Literacy programme at community level and the call by the ministry has increased beyond expected levels vis a vis available resources. The programme has been implemented in a context of *major* political and economic instability, with challenges in social mobilization at community level, hyperinflationary environment, in the demands on communities and civil society, the competing pressures for those working in the health sector and the tensions in some communities. Activities have had to be planned to avoid timings that would exacerbate these constraints. District activities in Zimbabwe were banned for some time in 2008 while support funds were at one point locked up in the Reserve bank of Zimbabwe. The deteriorating socio-economic environment also made it difficult for communities to fundraise towards community health action plans. However, there are some strengths that have been synonymous with the progress of the programme over the years. These include that health literacy is building on past experiences through participatory approaches. This is vital in that people build on from what they know already and from what they are familiar with. Further, the programme is dynamic, ongoing and transformational ensuring long-term sustainability.

Mr. Rusike went on to share with the participants the lessons learned in the programme. He observed that involving community leaders at every stage of the programme ensures their support and better flow of processes and activities at local level. In addition, the Health Literacy programme in Zimbabwe stimulated reflection and debate on key health needs. This helped communities to deal with the real problems rather than symptoms of problems. Based on this lesson, the Zimbabwean Health Literacy team has seen that communities are better placed to organize and carry out activities at district level, as they are in touch with proceedings on the ground, these are the values and essentials ‘bottom up processes’. Consequently, bottom up approaches improve community engagement and dialogue with health workers at local and national level. This has been able to protect the poor and offer alternatives especially now that the Zimbabwe health system is buckled. There has been an increased demand for health promotion programmes such as the Health Literacy programme at national level to give support to the mainstream health delivery system that is drastically going down. This has been evidenced by the call from the people to nationalize the Health Literacy programme and include the Village health workers in the programme to be trained as Health literacy facilitators to ensure sustainability of the programme.

4.2. Malawi

The Health Literacy Programme in Malawi began in the year 2007 with the Malawi Health Equity Network Organizational assessment. Mr. Saiti Chikwapulo from MHEN explained that the organizational assessment of MHEN was carried out in order to enable a clear understanding of the organization. The assessment encapsulated the health programme, the internal organization, and external relations. The assessment was done through both secondary and primary data. Secondary data was collected from various documents of the organization. A document review was done by way of analyzing documents such as annual plans, annual reports, and periodic review reports, minutes from activities and meetings and evaluations. Primary data was collected mainly through face-to-face interviews. He observed that the assessment aimed to solicit information about the organization from internal and external individuals on the operation of the organization. The Malawi Health Equity Network (MHEN) with support from TARSC carried out a needs and capacity assessment for the health literacy programme in April 2007. The assessment was a build up to the country review meeting held in May 2007. Both exercises informed the content of the Malawi Health Literacy manual. The Health Literacy Materials were pre-tested in two districts and peer reviewed by a technical team in Malawi.

He highlighted that the facilitators' training was carried out in four districts in Malawi, with 30 facilitators trained in 2008. MHEN facilitators were drawn from member organizations in the academia, health institutes, health workers, and various governments' institutions of Malawi. Community Health Literacy work began in 2008. Support and mentorship was collectively done by

Participants sharing experiences Source: TARSC 2009

MHEN and TARSC from then to date. The facilitator's review meeting was part of the on going support, mentorship, monitoring and evaluation of the Programme. The national review meeting was done in July 2009. Mr. Chikwapulo argued that the Malawi team faced some challenges in the process. Some of the clear challenges have been associated with inadequate financial resources to support local activities *Vis a Vis* the demand for health Literacy at community level. He recommended the need to raise more resources to support some of the local health literacy activities while also encouraging Health Literacy facilitators to fund raise at local level. Mr. Saiti Chikwapulo further added that in order to enrich exchange of ideas and sharing of best practice it was important to support the exchange visit programme between and amongst implementing country partners in the region. Furthermore, The Health Literacy programme should also be viewed as a fundamental equity watchdog as it exposes unfair and unnecessary disparities at community level.

4.3. Botswana

Ms Nana Gleeson from BONELA gave an overview of the Health Literacy programme in Botswana. The Health Literacy programme was first introduced in Botswana in the year 2007 through TARSC and EQUINET. BONELA and BFTU had time to reflect and think through how health literacy could be implemented in Botswana and if they would be able to implement it at community level. The regional planning meeting of 2007 brought together Zimbabwe and Malawi (implementing country partners then) and Botswana and Mozambique (interested country partners then) to learn from the Zimbabwe and Malawi processes and see how implementation was being done and to use the learning from the processes to inform Health Literacy work in Botswana.
Ms Nana argued that the Health Literacy programme is unique to Botswana in a number of ways. It:

- Is a holistic approach that significantly supports the agenda of health systems strengthening
- Supports communities with ability to understand, communicate and use information to support action.
- Gives BONELA a platform to fully advocate for pertinent grassroots issues at district level and at national level. Health literacy creates an opportunity to strengthen advocacy at district level.

- Uses participatory approaches that enable full engagement of communities with leadership (the Kogtla), elect leadership, health workers, and other important stakeholders at local level.
- Promotes the '*bottom up'* approach where communities identify their priority health needs and acts on them
- Compliments government efforts to revitalize primary health care in Botswana.

A total of 30 facilitators in four districts of Botswana were trained after the Health Literacy material development process. Facilitators were drawn from BONELA and BFTU members. These facilitators have an opportunity for further training through refresher courses. The treatment literacy programme of BONELA will be embedded in the Health Literacy programme complimented by a treatment literacy module that will be included in the Health Literacy manual. The Health Literacy programme offers opportunities to strengthen the BONELA and BFTU district structures while also increasing BONELA and BFTU's visibility at community level. Health Literacy will improve health at primary care level and create a knowledgeable health movement that will demand the inclusion of right to health in the constitution of Botswana. Further, Health Literacy offers a platform for collective community, stakeholder and leadership participation in health related issues.

Mrs. Gleeson recommended that the Health Literacy programme in Botswana needs more resource support to cushion implementation. There is a huge demand for the health literacy manuals in Setswana, the future Health Literacy work should look into translation of the manuals into local languages to increase understanding and interest across the country in Botswana. She further noted the importance of creating a regional connect of the Health Literacy work through TARSC for collective regional advocacy on pertinent issues that affect health in the ESA region. To share experiences and exchange of ideas the '*HLAfrica-e-list'* should be used more regularly by new and old partners to facilitate information sharing and exchange. A regional stakeholder meeting through EQUINET should be held to solicit buy in from other important regional stakeholders such as SADC, ARASA, WHO AFRO and UN towards the strengthening and launch of the Health Literacy social movement in the ESA region. In addition, Mrs. Gleeson recommended the need to consider production of a quarterly regional Health Literacy newsletter to strengthen opportunity for sharing best practices and lessons learnt. TARSC should actively resource mobilize for long-term support for Health Literacy project for at least 3 – 5 years in order to adequately monitor and measure the impact of the project both at national and regional level in all implementing country partners and new country partners. There is a powerful voice in masses than in a single country mobilizing resources. She added that TARSC should coordinate the establishment of a pool of HL experts in the region by developing a cadre of HL facilitators in the region to propagate HL at national level, as a constant regional resource pool.

4.4. Summary of Country Experiences

Positive changes achieved at community level	**Features of HL programmes associated with positive changes**
• **Facilitator skills** keep improving with experience and practice and they keep adding new skills (Communication skills, knowledge skills, organizing skills, planning skills, report writing skills, facilitation skills, PRA skills and they are all in the HL manual) *(Zimbabwe, Malawi, Botswana)*	• Health Literacy is an evolving process and new skills are gained with time, experience, exposure and practice
• **Organizational capacities and skills** to run with the Health Literacy programme have improved significantly in planning, training, support mentoring, review meetings, progress monitoring and evaluation, and documentation of each process. However we still need technical support from TARSC. *(Zimbabwe, Malawi, Botswana)* • Organizational capacities have enabled contact with the grassroots and strengthened evidenced based advocacy *(Malawi, Botswana)* • There has been an increased level of understanding on how social empowerment process should work in the ESA region	• The Health Literacy programme is tapping skills from a huge skill and capacity resource pool of EQUINET. EQUINET has varying skills and evidence resource in the ESA region. • TARSC is coordinating the Regional HL programme and provides a wide range of skills in material development, participatory approaches, research, planning, training mentoring, monitoring and evaluation and makes the implementation of the programme easier.

(Botswana, Malawi) • There has been need to reorganize and amend organizational structures to reflect the voice of the people *(Botswana)*	
• **Change achieved in health systems and health** is huge. These include a deeper and wider understanding of public health issues, diseases and other community health needs, prioritizing health needs, engagement with resource people, local government and other stakeholders to act on own health; prevention strategies, primary health care fundamentals this has all culminated to improvements in access of health services and uptake of health services, increase in community participation in health literacy community meetings, interest form different vulnerable social groups such as children, orphans, women, the disabled, peasant farmers*. (Malawi, Zimbabwe, Botswana)* • Interest from the Ministry of Health, local government and other stakeholders to nationalize the programme *(Zimbabwe)* • Health Literacy is organizing people's power for health evidenced by the demand by communities to include the right to health in the national constitution *(Zimbabwe)*	• Health Literacy organizes reflection and analysis of own experiences and builds towards local action thus building people's power to claim own entitlements to define equity oriented, people centered health systems. • The Health Literacy materials not only provide the public health knowledge but also provide participatory approaches that enable engagement and dialogue at community level. • Health literacy invests in the role of the people as the primary actors and beneficiaries of primary Health care • Health Literacy organizes power imbalances and unnecessary bureaucracies that impedes empowerment and development • The materials can be changed, adapted in any setting and new materials can be added. Materials are easy to understand, easy to use, practical and manageable. Health Literacy programme strengthens primary health care and joins different actors in the health system together

5. Lessons from the Regional Health Literacy programme

5.1. Lessons learnt in the Regional Health Literacy Evaluation

Ms. Fortunate Machingura gave an outline of the findings of the Regional Health Literacy evaluation. The Regional health Literacy evaluation has been conducted in Zimbabwe, Malawi and Botswana since July 2009 to build on the Health Literacy regional internal monitoring and review activities. TARSC with implementing country partners commissioned an independent external evaluator to identify the progress of the programme in three respects, i.e.:

i. How far has the HL programme achieved its intended purpose, outputs, and outcomes at community, national and regional level as set in its terms of reference? What obstacles were faced and strengths built internally and externally in this regard?
ii. What opportunities, threats, (in the context) and strengths and weaknesses (in the programme) existed in relation to sustaining and expanding the programme at community, national and regional level?
iii. How the programme could strengthen its internal monitoring and evaluation processes and parameters at community, national and regional level to support planning and implementation?

The evaluation was also aimed at providing strategic, evidence based proposals to strengthen the functioning of the programme at community, country and regional level. Specifically, the evaluation was hoped to give guidance to the Health Literacy program on

- Strengths to be consolidated and shortfalls to be addressed
- Factors influencing the relationship between outputs and purpose in the terms of
    - Internal strengths and weaknesses of the Health Literacy Programme (implementing partners, secretariat, communities, districts, members)
    - Processes and activities of the Health Literacy Programme - activities, communication, organizing etc
    - External opportunities and threats - policy, health system, wider political, legal, economic and social conditions, etc

The Health Literacy country programmes are at different phases, the evaluation was set therefore assess a mature programme in Zimbabwe, a programme underway in Malawi and a programme at very early stages in Botswana. It was intended that the evaluation, while independent, would engage with TARSC and co-operating partners to support their strategic reflection and planning for future work.

The Evaluation confirmed that the regional Health Literacy programme is a highly effective programme with unprecedented potential to empower health civil society and enable communities to become more pro-active in taking responsibility and demanding for rights in health related issues. The programme's content is evidently relevant to community health needs and efforts were successfully put into making it context-specific for the respective country programmes. This made implementation of Health Literacy country activities more useful as they addressed the health needs of the population. Further more, the training of HL facilitators creates a pool of resources at the community level that are crucial drivers of the programme at that level. This resource pool can in future drive the same processes in other districts in the same country and facilitate exchange of information in other implementing countries in the region. The use of PRA methodologies in Health Literacy is markedly the trademark of the programme, owing to their enhancement of community engagement in taking responsibility of their own health. The box below gives a summary of this:

- Health Literacy empowers health civil society and enables communities to become more pro-active in taking responsibility and demanding for rights in health related issues
- The programme's content is relevant to community health needs and is specific for country needs
- The use of PRA methodologies enhances community engagement
- The training of HL facilitators creates a pool of resources at the community level,

While there were areas of difference, there were also areas of commonality. One such area of harmony showed that successful implementation of the Health Literacy programme should be founded on sound, reliable and operation grassroots structures for participation. This was argued because the Health Literacy programme is grassroots based, driven and led, hence the importance of these 'vehicles' (the structures) to drive the processes at that level. Ms Machingura highlighted that the evaluation further stressed that Health Literacy is a social empowerment process that has huge potential to transform health systems through bottom up processes, it was therefore essential that mechanisms for community participation are strengthened and supported. To support this, implementing country partners could learn from each other on how to build and strengthen community mechanisms for participation and engagement while new country partners and other regional partners in this programme can draw and learn from the existing partners' experiences.

The evaluation findings also suggested that TARSC and its incumbent partners should collectively develop a regional resource mobilisation strategy that will see them establishing a multi-donor basket fund from which respective country programmes could tap into for programme implementation support purposes. Key in the strategy would be marketing of the programme through documentation and publications of most significant change, as well as impact at country and regional level from the HL programme. A larger funding pool would unlock the full potential of the programme, with country programmes more flexible in terms of needs-based budgeting and programme implementation. Furthermore, the Health Literacy programme in the new countries could begin in one or two districts at a time, then learn from their experiences to extend further to other areas in the same country.

Some of the major challenges picked in the evaluation across the implementing countries were the volunteers' difficulties. Health Literacy facilitators at community level drive the Health Literacy programme. These cadres work as volunteers at that level. While this has its advantages vis time, availability, flexibility and commitment, it also had its challenges that if left undressed could negatively affect the implementation of the Health Literacy programme. In order to ensure that these volunteers do not get demotivated, there is need for TARSC and its implementing partners to collectively agree on a framework of providing incentives to support the volunteers' work, financially or otherwise. Some of the suggested incentives included participating in national, regional and international conferences on health; short courses such as the TARSC/University of Zimbabwe public Health Short course winter school; provision of administrative and community meeting logistical support.

There was a realization that in the next phase of the regional health literacy work the internal monitoring and evaluation framework should embrace growth and benefits received by implementing country partners at organizational level such as in programming, administrative functions or other Organisation Development aspects enhanced as a result of being part of the Health Literacy programme. This would also include collectively agreeing on programme benchmarks *(i.e. defining*

what success would look like after how long) and consequently agree on the means of verification and collection methods for that information. To support such, the evaluation reflected on the importance of strengthening Health Literacy facilitator skills in basic monitoring and evaluation techniques, documentation and reporting so as to improve internal monitoring of the programme.

Ms Machingura added that the evaluation, thus far, has recommended strengthening the already existing regional exchange programme to facilitate learning. To support this there is need to heighten the Health Literacy documentary film project while also investing in community films, photography, music, blogs and moderated web-based discussion forums for HL social empowerment movement. Such platforms would also facilitate the harmonisation of implementation of the programme as well as foster other health programming collaborations beyond just Health Literacy. Accordingly, this creates a 'connect' between the operational social movement level and the policy level networks. The evaluation further recommended the establishment of a regional technical group drawn from the respective country programmes, whose role would be to provide technical guidance to new Health Literacy country programmes. This technical group would have members with different comparative advantages, so that a wholesome pool is available as and when required

In plenary Mr Tafadzwa Chigariro, the Health Education officer at the CWGH in Zimbabwe confirmed that the Health Literacy programme in Zimbabwe was effective in terms of building the capacity of individuals and organisations. It stirred communities into taking various actions related to their own health. He noted that Health Literacy facilitators at district level consistently confirmed that the Health Literacy manual was comprehensive and provided a lot of health knowledge important for community public health

"*The most interesting element of the manual is that it is a living manual, you can add new information, with support from TARSC we developed a Cholera pamphlet to support already existing information in manual during the Cholera epidemic in Zimbabwe and we are currently in the process of developing a pamphlet that provides information on HINI"*

He added that communities need to continuously receive refresher training courses so that they are kept abreast on health issues in the region, this is so because ccommunities have capacity to understand their own Health Problems and act on them, they only need empowerment and enablement through imparting them with skills to make the best use of the available resources. He added that implementation in Zimbabwe has been successful due to the existing community structures. These structures are structures that are already recognised by government. The inclusion of civil society in supporting their existence increases accountability and their efficiency. Despite the unstable socio-economic and political environment over the past three years that has caused migration of some of the trained Health Literacy facilitators in some urban areas Health Literacy has been implemented successfully. He argued that it was important for TARSC and CWGH to lobby the government towards taking up of the programme as part of the national health promotion strategy.

Mr Saiti Chikwapulo from MHEN also added that The Health Literacy programme had enhanced technical competency among MHEN secretariat members with regards to more in-depth understanding of participatory health promotion and social empowerment issues. Further the programme was benefitting the MHEN partner organisations from which the facilitators came from, in the application of PRA approaches to other development interventions beyond just health. Subsequently the Health Literacy programme led to a significant improvement in health service delivery and more responsive implementation of health policies by relevant authorities.

Mr. Chikwapulo added that while the evaluation could have regarded the differing approaches in implementation in the districts as a weakness, MHEN felt that it was a strength in that Health Literacy facilitators showed competency in their flexibility skills to implement health literacy in the best way they saw fit depending considering the context in which the Health Literacy programme was being implemented. Behaviour and cultural contexts have to be taken into consideration when implementing health literacy in any locale. Like in Zimbabwe, the experience in Malawi also confirmed that the involvement of local authorities was fundamentally significant in the realisation of Health Literacy implementation community participation. He noted that periodic field visits to communities where the programme was being implemented was key in mentoring and supporting local health Literacy issues.

Mr Ronald Ketshabe representing the BFTU observed that the Health Literacy programme was significantly complimenting government's efforts in revitalising primary Health care in Botswana. He added that the Health Literacy programme offered an opportunity to define community structures that enhance community engagement at participation at that level and beyond.

"*We are currently at the stage of developing our five year strategic plan, and I see health literacy in that plan because we already have functional community health structures already recognized by government that we take advantage of in Uganda. I think Health Literacy was the missing link between the people-the health providers and primary health care in Uganda. Now we will be able to used evidenced backed arguments for advocacy at national level specifically on access to medicines and on the right to health…" Ms, Rossette Mutambi-Director HEPS Uganda*

The following gives a summary of the consolidated issues and questions raised by the Regional Health Literacy evaluation. It was encouraging to observe that there were clear synergies and linkages of processes in Health literacy in terms of how the process has been established, implemented, the visible changes at community level and lessons learnt about people centered health systems and the social empowerment process.

Participants sharing experiences Source: TARSC 2009

5.2. Best practices identified and how they should be institutionalized

- Health Literacy is integrated in already existing programmes - making implementation holistic and easy to implement through collective planning, community monitoring programmes and primary health care assessments: these mechanisms institutionalize processes
- Health Literacy uses community health structures that are supported by civil society and government; this promotes accountability and sustainability of the programme: public meetings, community health forums, community radio dialogues, self and community collective monitoring and reflection institutionalize these processes
- Health Literacy uses participatory approaches that promote local engagement, involvement and participation: participatory planning, health facility committees, public hearings, community voice newsletters, patient charters, health worker charters, health right in national constitutions institutionalize this.
- Health Literacy organizes communities to demand their entitlements, this organizes people's power in health and addresses equity issues that impedes people driven and people centered health systems: Health laws that promotes Primary Health care, legally supported Health facility committees, Health campaigns, demonstrations and nationally supported marches help to institutionalize this.

- Health literacy involves all-important stakeholders at community level. Relationships between communities, health workers, traditional leadership, elect leadership, legislators, relevant line ministries, the business community and local governments have been improved and this has heightened implementation of activities, increase trust and cooperation between actors and ultimately improves policy frameworks.
- Health literacy allows communities to identify and prioritize own health needs for action while also learning and reflecting from own experiences. It is people led, people driven, people centered and builds towards people centered health systems: exchange visits, peer group support, social group networks, edutainment campaigns help to institutionalize this
- Health Literacy uses locally available resources through bottom up planning to address barriers that impedes access and uptake of health information and services. It offers opportunities for collective health planning and decision making processes in health

5.3. Weaknesses and gaps identified and how they should be addressed

- Financial resources to support community activities have been inadequate in relation to the demand of activities across implementing countries. Health Literacy communities and facilitators should fund raise at community level, Implementing country partners should mobilize resources for Health literacy at national level and TARSC should mobilize resources for the Health Literacy programme at Regional level.
- The Health Literacy manuals are only available in English; increase access to health information requires popular materials to be in local languages. The Health Literacy materials should be translated into local languages.
- There are no incentives to motivate Health Literacy Facilitators. Fund raising for health literacy should have a budget to cater for Health Literacy incentives. Incentives can be either or both financial and non financial incentives

5.4. Lessons learned about the way the programme is established

Demanding own entitlements

- The Health Literacy programme relies on the active participation of communities in building networks and harnessing support for communal activities. Established on the principles of convergence of common agenda, It is about people, and the key to success is based on a mature social investments and a close bond between stakeholders – communities – and governments.
- Established on Community appreciation of their own resources and capabilities and that communities have indigenous knowledge- a timeless, valuable and priceless resource at community level that enables them the understanding of own

resource problems and the socio-economic opportunities for sustainable humane development.

- Founded on collective, shared and common vision for primary health care oriented, people centered health systems that promote socially permissible systems for information exchange, vertically and horizontally
- Health Literacy is established on values of all stakeholder participatory planning to encourage more sustainable resource use. Involvement of all key stakeholders including communities supports social cohesiveness, cooperation thus pooling ideas, resources, labor and talent to achieve communal projects that are important to health.
- Health Literacy is designed in such a way that it replicates, it is people led, people driven and 'responds to issues that affect them and are more likely committed to find and implement solutions on their own ways, than those imposed by external agencies'. Health Literacy is bridging gaps between knowledge and practice, addressing social justice and enabling people to gain control over determinants of their health

Participants reviewing lessons learnt in the health Literacy programme

5.5. Lessons learned about the way the programme is sustained

- It is encouraging that Health Literacy embraces the vision of 'integration' of physical, societal and political perspectives about moving towards a comprehensive, people centered system approach The essence of the integrative vision is characterized by learning, interdisciplinary and enabling processes to embrace uncertainty, complexities and dynamics of change in order to balance social, economic and physical sustainability
- Health Literacy reflects a clear and coherent common agenda (or set of priorities) among stakeholders. For this reason it contributes to partnership building, trust building and this builds towards programme sustainability including local understanding of this.
- Health Literacy embraces the 'triangulation principle' (multiple sources of information and methods), and links together various resource people and knowledge sources. This builds trust, increases confidence in results by adding new information, assessing and crosschecking, reflecting and acting from multiple 'points', including various sources, various methods or in various conditions. The explicit cooperation at every level in Health Literacy

with local stakeholders on an on-going basis creates the opportunity for distortions or misunderstandings to be corrected relatively rapidly and easily. Relatedly, activities and results are more widely accepted if they build on and link the 'best of diverse resource angles'

- Health Literacy is based on iterative learning and feedback loops and there is a two-way sharing of information (local people take a lead role in sharing of experience and knowledge, facilitation, investigation, analysis and learning, action and reflection), sharing of information and ideas, triangulation, the quality of behavior and interaction, rigorous observation and reflective judgment and action. For this reason it allows for the proper identification of stakeholders, community structures, and provides space for the adequate representation of stakeholders that provide stability and sustainability, recognition and acknowledge to community roles in Primary Health care.

5.6. Lessons learned about people centered health systems

- They invest in people as the primary beneficiaries and participants of the Health system. This promotes use of locally available resources to advance health through increased knowledge on prevention, effective and practical prevention strategies.
- People centered health systems can be achieved through huge investments at primary care level thus the need to revitalize Primary health care through Health Literacy. Investment in Primary health care ultimately reduces the total cost for health (reduced disease burden, lees people needing curative services)
- People Centered Health systems are founded on a turf layer of trust. Health Literacy builds trust, and promotes two-way communication between communities and other actors in the Health system. Accordingly access to and uptake of health services is significantly increased.

5.7. Lessons learned about social empowerment in health

- Health Literacy is an efficient social empowerment process. It is encouraging to note that the values and ideas of social empowerment are synonymous with the Health Literacy process. Social empowerment processes should be people initiated, people driven, people led, dynamic, sustainable, robust, flexible and adaptive, so is Health Literacy.
- Constitutional entitlements, health laws, community structures, health freedoms and health rights that enable people to organize power to control their own resources should support social empowerment processes.
- Social empowerment processes are sustained by fundamentals of social justice, equity, accountability, and participation and good governance

6. Taking the Health Literacy programme forward

This session was aimed at assessing capacities and skills for health literacy in new country partners. The session observed opportunities for Health Literacy in Kenya, Zambia, Mozambique, Tanzania and Uganda. The session further explored the roles, capacities and actions for the country lead organizations as well as the regional support / actions that should be included in the next phase of Health Literacy work in East and Southern Africa linking to the wider health work.

Overall, the new country partners had varying suggestions on the way the Health Literacy programme would be implemented. While there were areas of commonality, there were also areas of difference. Mr. Martin Mkuye from AMREF Tanzania noted that Health Literacy would easily be integrated in programming areas of AMREF in all the 21 mainland regions of Tanzania. The programme would also engage with already existing alliances in local government authorities at regional and district levels, over70 as sub-grantees in Civil Society organisations, development partners and the private sector where Health Literacy facilitators will be drawn from. He added that the programme would enhance the organisational capacity building while also benefiting and up-scaling the skills and capacities of health care workers such as Community Health Care workers, enrolled nurses, clinical officers that AMREF is already working with. He added that Health Literacy facilitators would also come from this resource pool in government to compliment and support government efforts in Primary Health care. Mr. Mkuye noted that Health Literacy would create community movements and organisations that will ensure that communities are an integral part of a responsive health system, and harness community resources in Tanzania. Consequently, the programme would strengthen health systems research for policy and practice, and influence programming into people led participatory social empowerment processes

Mr. Francisco Sitoe from IDR Mozambique also argued that the Health Literacy programme integrates flawlessly in current plans and programmes both within IDR and in the Ministry of Health Mozambique. He said that IDR plans to work out an expanded, extensive community health literacy programme targeting different social groups starting in Inhambane province and extending further to other provinces in Mozambique. He added that the Health Literacy programme would strengthen effective involvement of key stakeholders including communities, local health workers and other relevant social groups. Working with local government and the Ministry of Health Mozambique will enable community efforts to be integrated in national planning and decision-making processes. Mr. Sitoe argued TARSC should consider inter-ministerial lobbying in SADC countries and establish agreements thereof in health related issues at regional level. As an umbrella body of the Health Literacy movement, TARSC should monitor and foster member countries' potential and support this by identifying and building capacities of focal point cadres in implementing country partners. Accordingly, TARSC with EQUINET should push the agenda of revitalizing primary health care through Health Literacy towards the realization of people centered Health systems in East and Southern Africa and beyond.

"A luta continua with HEALTH literacy in East and Southern Africa countries! "knowledge-is-power-is-freedom"; Francisco Sitoe -IDR Mozambique

Ms. Adah Zulu a health worker in the Ministry of Health in Zambia noted that Health literacy process is dynamic and evolves with time, thus the importance of learning from own experiences. She argued that the Health Literacy would be implemented in one district and extends to other districts with learning and experience. She noted that the team that will implement Health Literacy in Zambia had already benefited from PRA skills in EQUINET and would use these skills to facilitate the implementation of the programme with guidance and support from TARSC while key advocacy and policy issues would be channeled directly to the relevant offices within the Ministry of Health in Zambia. Similarly, Mar Jacob Ongala from Rachuonyo Health Equity in Kenya would begin implementation in one district and extend further with experience and learning. Mr. Ongala observed that need for Health literacy in the Rachuonyo district was realized from the participatory research carried out with EQUINET. Issues for advocacy and policy will be taken up to Kenya Health Equity Network. Further, he added that increasing health literacy among vulnerable social groups in Kenya would strengthen primary health care. Likewise Ms. Rosette Mutambi the Director of HEPS-Uganda felt that the Health Literacy programme would easily be integrated in the institution's activities. She

added that HEPS-Uganda was in the process of developing their 2010-2015 strategic plan and the Health Literacy programme would be an integral part of the plan. The Health Literacy facilitators would come from the district facilitators working on the community outreach and empowerment work at community level and the Ministry of Health Village Health teams volunteers.. She added that HEPS organisational structure supports the implementations of Health Literacy while the Health Literacy materials would add value and capacities to the facilitators at community level

"HEPS-Uganda is so excited about the Health Literacy programme, especially the materials, they are well packaged, they last long, they are attractive to look at, they have information that we need, the graphics, picture codes and other PRA tools enhance activity and fun! We can't wait!" Prima Kazoora- HEPS-Uganda

In groups the new country partners agreed that all the implementation steps taken by Zimbabwe, Malawi and Botswana should also define the steps for implementation. New country lead organisations agreed to carry out national advocacy, national coordination, country specific Health Literacy, material development and support community level Health Literacy. The regional support from TARSC would include regional level fundraising for the Health Literacy movement, advocacy at that level, providing the link for regional and global connect and linkages for information sharing, exchange, networking, planning and reviews.

The existing country partners agreed that the transition towards translation of materials into local languages was as important as supporting and strengthening community health literacy. The focus for implementing countries would be championing Health Literacy to revitalise primary health towards people centred Health Systems. The community activities should push the Primary Health care agenda. To further strengthen the link between Health Literacy and Primary Health care, the following elements were agreed"

- Create a regional base of evidence on mechanisms that enhance PHC and use that platform to engage relevant national, regional and global bodies on the 'Health for all' goal.(TARSC)
- Integrate Health Literacy in Health systems e.g. Health Literacy facilitators could be drawn from village health workers and civil society to support government efforts at primary care level, promote sustainability and accountability.(Country partners)
- Create sustainable regional linkages with regional platforms that support the same cause such as SEAPACOH, SADC, WHO, UN etc (TARSC)
- Support regional exchange visits and promote regional learning workshops, review meetings, conferences etc (Country partners with TARSC)
- Participation of all relevant stakeholders, alliances and actors builds trust and is key in Primary Health care. (Country partners with TATRSC)
- Launch the Health Literacy social Movement process: coincide the launch with Alma Ata days (TARSC with country partners)

7. Closing

MS Nana Gleeson from BONELA, Botswana chaired the closing session. Ms Machingura, TARSC provided a consolidated summary of the key issues raised for future planning in implementing country partners and in new country partners. Ms Machingura thanked all delegates for the committed participation during the intensive and successful two day meeting. She pointed that TARSC would continue to give technical support and mentorship to existing country partners and to new country partners. She encouraged Health Literacy country partners to keep focused on the agenda of primary health care and noted that it was possible to have comprehensive primary health care oriented health systems. Ms Machingura added that some of the reflections and discussions in the two-day meeting would be consolidated in the regional health literacy evaluation while some inputs would be used to inform the regional proposal of work and future work in East and Southern Africa.

Ms Nana Gleeson reaffirmed that the visionary goal of 'Health for all' is what Health Literacy seeks to support. While efforts to revitalize primary health care can be addressed by other interventions, Health Literacy has given evidence to show that it is the most effective social empowerment process that will organize people's power to build national health systems that are people centered. People centered Health systems address equity issues, answers questions on reduction of poverty and stimulate creativity, well-being and development. After a vote of thanks to TARSC by Ms. Prima Kazoora, HEPS Uganda, Ms Nana Gleeson, chairing the session closed the meeting.

8. Appendices:
8.1. Appendix one: Programme

Time	Session	Role
Day one - 26 September 2009		
800hrs-830	Registration	M Makandwa, TARSC
Session 1: Opening, introductions and overview. Session Chair R Loewenson		
830hrs-900	Welcome, Introduction, aims of the meeting	R Loewenson, TARSC
900hrs-945	Overview of the regional HL Programme	F Machingura, TARSC
945hrs-1000	Tea Break	
Session 2: Country experiences Session Chair T Chigariro		
1000hrs-1200	Three working groups on country experiences of the Health Literacy Programme Each group to explore the key features of the programme and their link to the changes effected at community level; in facilitator skills; in organisational capacities and skills; and health systems and health. Each group starts with a 15 min presentation from the country followed by a facilitated discussion. Group 1: Zimbabwe Group 2: Malawi Group 3: Botswana	Itai Rusike,CWGH Saiti Chikwapulo, MHEN Nana Gleeson, BONELA
1200hrs-1300	Plenary report back from working groups (30 min) Discussion (30 min) on Positive changes achieved at community level; in facilitator skills; in organizational capacities and skills; and health systems and health Features of HL programmes associated with positive changes	Facilitators F Machingura, TARSC T Chagariro, CWGH
1300hrs-1400	Lunch Break	
Session 3: Lessons from the HL programme Session Chair S Chikwapulo		
1400hrs-1445	Report on the findings of the evaluation (20min) Discussants: CWGH, MHEN, BFTU (5 min each)	F Machingura, TARSC T Chagariro, CWGH; M Maziko MHEN; R Ketshabe, BFTU
1445hrs-1545	Market place on issues and questions raised by the evaluation: • What were the best practices identified? How should they be institutionalized? • What were the weakness, gaps and how can they be addressed? • What lessons have been learned about the way the programme is established? • What lessons have been learned about the way the programme is sustained?	B Kaim, TARSC
1545hrs-1600	Tea break	
1600hrs-1645	Discussion on market place, continued Plenary discussion on overall learning: • What lessons have been learned about people centred health systems? • What lessons have been learned about social empowerment in health?	B Kaim, TARSC
1645-1730	HL programme video	
Day 2- 27 September 2009		
Session 4: Taking the HL programme forward Session Chair N.Gleeson		
830-915	Summary of issues raised on day one	F Machingura TARSC
915-1030	Presentation from other countries on opportunities for Health Literacy (10 minutes each) Uganda Tanzania Zambia Kenya Mozambique Discussion	R Mutambi, HEPS M Mkuye, AMREF I Zulu, LDHMT J Owiti, RHE F Sitoe
1030-1100	Tea	
1100-1200	Two working groups on taking the Health Literacy Programme Group 1: Existing Countries Group 2: New Countries Taking the discussions of day 1 into account: • What steps should be implemented?	I Rusike, B Kaim F Machingura, S Dhlomo

	• What role, capacities and actions for the country lead organisation? • What regional support / actions should be included?	
1200-1300	Plenary feedback on group 1 (10 min) and Discussion (10 min) Plenary feedback on group 2 (10 min) and Discussion (10 min) Overall discussion (20 min)	Gp 1 rapporteur Gp 2 rapporteur I Rusike CWGH
1300-1400	Lunch Break	
Session 5: Next steps		
1400-1530	Market place discussion on next steps and links to wider health work: see *guiding questions* • For existing country partners (National Level) • For new partners in HL (National Level) • For all national level partners • At regional Level Discussion and consolidation	F Machingura TARSC
1530-1545	Tea	
Session 6: Closing Session Chair R Mutambi		
1545-1630	Closing remarks –TARSC, CWGH, MHEN, BONELA Closing remarks from delegates	F Machingura, I Rusike, S Chikwapulo, N. Gleeson Delegates

8.2. Appendix two: Delegates List

	LAST NAME	FIRST NAME	COUNTRY	CONTACT DETAILS
1.	Asibu	Wilson Damien	Malawi	Country Minders for Peoples Development (CMPD)
2.	Machingura	Fortunate	Zimbabwe	Training and Research Support Centre (TARSC) Zimbabwe
3.	Masaigana	Mwajuma Marwa	Tanzania	Training and Research Support Centre (TARSC) Tanzania
4.	Mayanja	Andrew	Uganda	School of Education, Makerere University
5.	Mpeirwe	Arthur	Uganda	HEPS-Uganda
6.	Owiti	Jacob Ongala	Kenya	Rachuonyo Health Equity
7.	Chigariro	Tafadzwa	Zimbabwe	Community working Group on Health (CWGH)
8.	Chikwapulo	Saiti	Malawi	Malawi Health Equity Network (MHEN)
9.	Mkuye	Martin	Tanzania	AMREF Tanzania
10.	Kazoora	Prima	Uganda	HEPS-Uganda
11.	Ketshabe	Ronald Ontefetse	Botswana	BFTU
12.	Gleeson	Nana	Botswana	BONELA
13.	Kulabako	Phiona	Uganda	HEPS-Uganda
14.	Makandwa	Mevice	Zimbabwe	Training and Research Support Centre (TARSC) Zimbabwe
15.	Matemba	Maziko	Malawi	Malawi Health Equity Network (MHEN)
16.	Mugisha	Richard	Uganda	HEPS-Uganda
17.	Mutambi	Rosette Christine	Uganda	HEPS-Uganda
18.	Obua	Thomas Ocwa	Uganda	HEPS-Uganda
19.	Rusike	Itai	Zimbabwe	Community working Group on Health (CWGH)
20.	Sitoe	Fancisco Antonio	Mozambique	IDR-Mocambique
21.	Thole	Caleb	Malawi	Malawi Health Equity Network (MHEN)
22.	Kaim	Barbara	Zimbabwe	Training and Research Support Centre (TARSC) Zimbabwe
23.	Loewenson	Rene	Zimbabwe	Training and Research Support Centre (TARSC) Zimbabwe
24.	Tumusiime	Kenneth	Uganda	Enviro-Plan Consult Limited
25.	Gooding	Kate	UK	Sight Savers International
26.	Singogo	Ireen	Zambia	Plan International-Zambia
27.	Zulu	Idah	Zambia	Ministry of Health Zambia
28.	Masuku	Dumisani	Zimbabwe	Together for Children Project (HOCSI)
29.	Wamani	Samson	Uganda	Ministry f Health Uganda
30.	Imasiku	Monde	Zambia	
31.	Mutambi	Atuhaire	Uganda	HEPS Ugnada