# UGANDA HEALTH LITERACY TRAINING PROGRAMME REPORT

**Entebbe, Uganda**
**24th – 26th September 2012**

**Training and Research Support Centre and**
**Coalition for Health Promotion and Social Development (HEPS)**
**With**
**AGHA, CEHURD, NAFOPHANU and UNHCO**

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

**With support from CORDAID**

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Regional health literacy logo, M Ndhlovu TARSC 2006


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# 1. BACKGROUND

Participatory Reflection and Action work coordinated by the Training and Research Support Centre (TARSC) in the Regional Network for Equity in Health in East and Southern Africa (EQUINET) has shown that health workers suffer problems of poor work environments, poor remuneration, lack of growth opportunities and motivational incentives. This may pose a barrier to their interaction with communities, despite the role that communication plays in patient-centred care. Communities on their side may not possess the skills and capacities to negotiate or communicate with service providers, leading to misunderstanding, lack of knowledge and even anger.

In 2011**,** building on work done on health literacy[1] in Zimbabwe, Malawi and Botswana, and in the EQUINET pra4equity network[2]to strengthen communication between health workers and communities, TARSC implemented a one year programme with HEPS Ugandaand,with Cordaid support, to extend health literacy in Uganda and use the skills built to promote dialogue and accountability between health workers and communities. We used existing health literacy materials to train 30 facilitators and community members in three clinic catchment areas in Kyankwanzi rural district in Uganda who then used the HL capacities and participatory methods to improve communication between and joint action by health workers and communities, particularly in relation to strengthening Primary Health Care (PHC). Reports on this work are separately documented - TARSC, HEPS Uganda (2011) - available at www.tarsc.org.

In 2012-2014 TARSC and HEPS-Uganda aim to build on this work, specifically to widen and deepen CSO capacities for Health Literacy (HL) and Participatory Reflection and Action (PRA) work in Uganda. This meeting was a first step in this two year programme which brought together five CSOs working within districts on health to train their facilitators, education and lead personnel in HL and PRA.

The 3-day workshop aimed to:

- Train facilitators, education and lead personnel from 5 CSOs in Uganda to plan, implement and monitor health literacy (HL) and Participatory Reflection and Action (PRA) work/programmes at district level.
- Within the Health Literacy training, include a specific focus on SRH and women's health.

The training was facilitated by Rene Loewenson and Barbara Kaim from TARSC, and Rosette Mutambiand PelagiaTusiimeWambi from HEPS with 30 people attending from HEPS-Uganda, AGHA-Uganda, CEHURD, UNHCO and NAFOPHANU (see Appendix Three for a description of each organization).

1 Health literacy refers to a process of reflecting on experience, informing and empowering people to understand and act on health information to advance their health and improve their health systems. It builds knowledge and capacity to act within a framework of Participatory Reflection and Action (PRA) that strengthens community level diagnosis, action and engagement with health systems

2 The pra4equity network is a consortium of frontline health workers, district level cadres, national level members, state, non state actors, NGOs, academic and professionals working on health using PRA approaches to advance health and health worker-community interactions in the framework of Primary Health Care (PHC)

## 2. WELCOME AND OVERVIEW OF THE REGIONAL PROGRAMME

The Executive Director of HEPs, Ms. Rosette Mutambi, officially opened the training workshop. She welcomed participants to Entebbe and expressed gratitude for the opportunity to work with TARSC andthe 5 Ugandan CSO partners in strengthening a more people-centred focus on health in Uganda. She noted that HEPS and TARSC already have a history of working together on the Health Literacy programme in Uganda and that she looks forward to sharing these experiences and working more deeply with a wider group of partners on this programme.

Dr. Rene Loewenson, Director of TARSC Zimbabwe, reiterated Rosette's welcome. She briefly explained that the regional programme on health literacy (HL) began 4 years ago and has now been used successfully in Zimbabwe, Botswana and Malawi, with a present focus of deepening the work in Uganda and Zambia. She noted that HL refers to a process of reflecting on experience, informing and empowering people to understand and act on health information to advance their health and improve their health systems. It builds knowledge and capacity to act within a framework of participatory reflection and action that strengthens community level diagnosis, action and engagement with health systems. To this end, the HL programme facilitated by TARSC has produced an 8 module manual that will be used as a basis for training in this workshop (see Section 5 of this report for more details on this manual.)

Both Rosette and Rene then thanked participants for taking time off to attend the training.
This was followed by a short session led by Barbara Kaim, TARSC, in which all participants were given an opportunity to introduce themselves. Using a Buses Game to provide a quick social x-ray of the group, participants noted that there were more female than male participants at this training,that the majority work at community level, and the rest move between national and community work.

## 3. PUTTING HEALTH LITERACY IN CONTEXT

Participants decided to work on the situation of a 20 year old female university student who was pregnant and coming to the clinic for the first time because she was bleeding. The father of the child was a married man who had no intentions of staying with the girl.

Working with this scenario, participants identified all the major actors involved with trying to support the health needs of this 20 year old woman. These included actors at community, clinic, district, national and international levels. They then developed a human sculpture to express the power relationships between all the different actors. The resulting sculpture highlighted the following:

- The young girl was accompanied by a friend to seek medical services.She first approached the Traditional Birth Attendant who did not help her. She then proceeded to the medical facility.Participants acknowledged that in a real situation like this, the technical involvement of professionals would be minimal, with inadequatetools to saveher life.
- Even though the clinic administrator, other health professionals, the Member of Parliament andMinisterof Health are mandated to ensure services are delivered at local level, they often lacked the commitment, and in some cases the resources and power, to ensure adequate services are made available at local level.
- The donor fraternity has economic influence and power, but they often follow their own agendas.The challenge is to strengthen the way the decision makers, implementers and community worktogether to solve the health challenges faced by this young woman at community level.

Creating a human sculpture. Photo: B.Kaim

After reviewing the human sculpture depicting the state of the health system in Uganda to date, participants remade their sculpture to present a more people-centred, responsive health system. In this scenario, all actors were put at more or less the same level. People became involved in the activities and decision-making of their health centre, policy makers worked more closely with the people they serve and the Ministers and international community also interacted with, and listened to the views of, people at community level.

The question then posed was: how can we move from the current situation to the more equitable, people-centred system we all strive to have in Uganda?

Participants identified the following blocks to achieving this ideal:

- Community members are often not well informed about existing policies and ways to participate in the health system to make it more people-friendly.
- Policies and legislation are not translated into action.
- Resistance to change from actors at all levels
- Health workers lack professionalism
- Understaffing of health workers
- Corruption
- The role of the international community

At the end of this session, participants commented that they now had a better understanding of the wider context in which the Health Literacy programme is situated.

## 4. USING PARTICIPATORY APPROACHES IN HEALTH

This session focused on exploring the features of a participatory approach to health. Participants identified the following important features:

- Using participatory approaches in health is not a one-off process but is made up of a regular cycle of reflection and action leading to a deepening understanding of the causes of and solutions to problems. This is why we use the term 'participatory reflection and action' or PRA to describe the approach used in our health literacy work.
- People in communities have a great deal of knowledge and experience, and, if given the opportunity and skills, can creatively identify and find solutions to their own problems.
- PRA provides communities with opportunities to share information, experiences and views, and to participate in decisions and plans on how to improve their health. It strengthening relations between the community and health workers through a process of mutual sharing, understanding and joint planning.Ultimately, PRA approaches are used to strengthen the power that people have to change their own lives, their communities and the institutions that affect them.
- PRA approaches take into account the different, sometimes conflicting, interests in communities and don't try to force full consensus.

- To facilitate all of the above, PRA uses a variety of visual and verbal methods – including mapping, ranking and scoring, role play and drama, songs, case studies and many more – to provoke discussion, analysis and planning for action.

The meeting went further to acknowledge that the above features of a participatory approach to health involve very specific skills and attitudes on the part of the health literacy facilitator. In particular, a health literacy/PRA facilitator has toencourage health service providers and communities to communicate and take joint action. Facilitators need to be able to show respect for the diverse opinions of the community, provide relevant technical information, ensure diverse voices within the community are heard, provide links with outside resources, to support the community's action planning, implementation and reflection processes and also to link the knowledge and evidence generated at local level to wider national processes to ensure greater opportunities for change.

More information on this is available in Module 1 of the HL manual.

# 5. THE HEALTH LITERACY MANUAL – OVERVIEW

At this stage, participants were given the opportunity to review the entire HL manual. Rene described that the manual is divided into 8 modules, implemented through participatory activities over time periods agreed as appropriate with communities. Each module takes about a half day so it could take 4 weekends, 8 afternoon sessions,or whatever is appropriate, to complete. Each module includes a component of identifying actions and follow up work that can be implemented by communities and health workers. Rene explained that the previous sessions had covered the content of Module 1: Introduction to Health Literacy. For the next 1 ½ days, the training would review the remaining modules before going into a final session on use of the manual by facilitators from the 5 CSOs involved in this programme and a reflection on what needs to be included in the soon-to-be produced Uganda version of the manual..

A summary of the training and subsequent discussions arising out of each module is given below (see Appendix One for the complete programme).

## 5.1 Module 2: The Health of Communities

Through the use of **4 pictures**, participants reflected on the meaning of what it means to be healthy. They noted that health is not simply about the absence of disease, but also includes wider social, economic and environmental issues (called the social determinants of health). They concluded by reflecting on the WHO definition of health that states that: "health is not merely the absence of disease, but a complete state of physical, mental and social well- being".

Participants then went on to review their definition of community. They concluded that 'community' is often used to define a certain geographic area but can also be used to define a group of people with the same experiences and/or interests (eg community of people living with HIV). Some time then was then spent on **drawing a community map**, and then reflecting on the use of such a tool at community level.

The participants noted that

- Social maps may demonstrate different priorities between different social groups at community level eg between women and men.
- It is an exciting activity that defines group ideas. It is important not to ignored member's different opinions.
- Social mapping creates innovation and creativity, as well as empowering group members. The role of the facilitator during this process is to help group members to generate ideas and to understand implications of what they are describing.
- The outcome is a collectively owned visual description of their community that can be used again for future work in the HL programme.

Following this mapping exercise, participants reviewed the role of **a transect walk** in triangulating evidence arising from the map and reflected on **other sources of information** on health issues, such as getting information from local leaders and other key resource people, as well as through a literature review.

Doing a community map. Photo: B.Kaim

The next session (Module 2.2- 2.5) looked at how to prioritize health issues or needs at community level (**ranking and scoring**), ways to explore the causes of problems (**but why?**) and which organizations and people are already involved in trying to deal with the problems raised (**venn or stakeholder analysis and spider diagrams**)

Participants highlighted the following community health needs:

- Safe and clean environment – water and sanitation
- Better nutrition and availability of good quality, affordable foods
- Medicine
- Infrastructure
- Reproductive health
- Sufficient number of skilled health workers
- Access to financial resources through IGPs
- Family planning services
- Enabling legal framework
- Quality health care
- Personal safety and security
- Social welfare services

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Lessons learnt as facilitators:

- Gaining consensus is not easily attained in the group
- As a facilitator do not worry if there are moments of silence during the group discussions.
- Facilitators can also find out if the issues identified are rights or entitlements, and then use the rights dialogue to address the issues raised.

## 5.2 Module 5: Healthy Life Cycles

Participants went through this module in a fair amount of detail, starting with a review of the **Life Cycle Mapping** exercise which looks at how we understand health at different stages in a person's life Through the use of this mapping exercise, participant's discussed what is needed to promote good health and to prevent and manage ill health. The table below outlines some of the findings arising from this exercise.

| Age group | Maintaining good health | Danger signs |
|---|---|---|
| Birth<br>(0 years) | • Well trained health personnel<br>• HIV clients access to facilities.<br>• Breast / other feeding option<br>• Immunization. | • Lack of knowledge<br>• Environment of delivery of baby<br>• Cultural /social status |
| Infancy<br>(0-1years) | • Breast feeding<br>• Immunization<br>• Parental care<br>• Proper nutrition<br>• Basic needs | • Poor maternal health<br>• Malnutrition<br>• Poor hygiene<br>• Domestic violence |
| Early childhood<br>((1-5years) | • Malaria control using mosquito nets.<br>• Immunization against polio and others.<br>• Proper feeding to prevent malnutrition<br>• Hygiene to control diarrhea. | • Malaria<br>• Diarrhea<br>• Malnutrition<br>• Polio/disability. |
| School age<br>(5-16years) | • good nutrition<br>• education<br>• good hygiene<br>• room to play<br>• spiritual guidance<br>• parental guidance | • domestic violence<br>• poor hygiene<br>• illiteracy<br>• low income<br>• death of parents<br>• political environment. |
| Adults<br>(12-18years) | • Practice safe sex or abstain.<br>• Routine medical checkups.<br>• Balanced diet / physical exercise.<br>• Access to information<br>• Adequate rest.<br>• Parents guidance | • Unsafe abortion<br>• Unprotected sex<br>• Alcohol/drug abuse<br>• Being secretive about health problems<br>• Poor nutrition |
| Early adult adulthood | • Sex education<br>• Sex reproduction<br>• Balanced diet<br>• Employment<br>• Sexuality at this stage willinfluence the next stage. | • Over ambitiousness<br>• Negative peer influence<br>• Lack of focus |

| Age group | Maintaining good health | Danger signs |
|---|---|---|
| Adulthood | • Good employment<br>• Good social life<br>• Stable family and friends | • Being faithful<br>• Marriage<br>• Good health practices<br>• Balanced diet. |
| Old Age | • Eat a balanced diet<br>• Regular medical checkups<br>• Plenty of rest<br>• Keep a social balance. | • Avoid isolation<br>• Good hygiene<br>• Avoid alcohol<br>• Avoid smoking |

As can be seen from the above, a person's life cycle is not only influenced by health factors but also by issues of education, employment, etc. During the early stages of a person's life, interaction with responsible adults is key. It is also essential for children to be immunized.

Training in Module 5 also included a special session on understanding the **barriers to womens' and sexual and reproductive health (SRH).** Participants discussed the concept of the **Three Delays** which include:

1. Delay in decision to seek care
2. Barriers in access to care (or to reach SRH services) and
3. Barriers in supply of SRH services

As an alternative model, we also introduced the **Tinahashi Model** which looks at the availability, acceptability, accessibility, andeffective coverage of health services for women. Participants found this module most useful and easier to use than the 3 delays concept.

## 5.3 Module 4: Healthy Environments

As participants became more familiar with the format of the HL module, so it became easier to move through the remaining modules more quickly. As a result, less time was spent on the next few modules. In Module 4, on Healthy Environments, participants began by reflecting on the different features of a healthy environment. They saw waste management, safe water (including problems of stagnant water and floods), access and storage of food and climate change of greatest priority in Uganda.
**Social mapping, transect walks and three-pile sorting,** were some of the tools mentioned as useful to use in identifying priority environmental needs and exploring possible solutions.

## 5.4 Module 3: Healthy Nutrition

This module looks at the meaning of food sovereignty and its implications for community nutrition. Participants briefly reviewed the use of the **story with many gaps and well-being map** in this module.

### 5.5 Module 6 and 7: People centred health systems, community roles and alliances in health systems

Module 6 has a particular focus on the relationship between health workers and the wider community. To facilitate this discussion, Rene used the **Margolis Wheel** which divides participants into the two groups (community and health workers) to discuss and share problems faced by both groups. Participants liked this method as a way of breaking down barriers between the community and the health system.

In terms of Understanding Health Systems, we acknowledged that the **Human Sculpture**, done earlier in the training, is an ideal tool for exploring the unequal power dynamics between the different actors in a health system. It is also possible to use **a panel discussion**.

In the section on Community Roles in Health Systems, Barbara introduced the activity **'Where's Mpatso?'** from the Malawi version of the HL manual to explore what functions communities can play in a health system and then to compare this with the reality in Uganda.

These functions include:

- Providing health services
- Promoting health
- Making policies
- Mobilizing and allocating resources for health, and
- Monitoring quality of care and responsiveness

Deep in discussion on health worker - community relations. Photo: B Kaim

There was also a good discussion on the importance of assessing changes in the role of communities in health system through the use of the **Wheel Chart.**

## 6. IMPLEMENTING THE HL PROGRAMME IN UGANDA

Rene began this session by reviewing how the HL manual can be used, referring back to the description in Module 1 of the manual. The meeting then went on to explore the following questions to be answered by each of the five participating CSOs:

- What activities are each of the five CSOs presently involved in?
- Who are we planning to invite to the HL meetings?
- Where would each of the CSOs want to go to (area of operation) to introduce the HL work?
- What issues/modules in the manual would we most likely use first?
- What support and input do we need?

Responses to these five questions are noted below.

**What activities are each of the five CSOs presently involved in?**

| Organization | Activities |
|---|---|
| NAFOPHANU | • Access to ART/PMTCT<br>• Stigma and discrimination<br>• HCT, information sharing<br>• Member networks<br>• School outreach by young positive. |
| CEHURD | • Maternal mortality campaign<br>• Community participation in health systems.<br>• SRH to prevent unsafe abortions among the youth. |
| AGHA | • Maternal Health activities<br>• Adolescent health capacity building<br>• Improving health outcomes for vulnerable groups. |
| UNHCO | • PMTCT<br>• Immunization<br>• Family planning<br>• ANC<br>• Nutrition<br>• Condom use<br>• Health education |
| HEPs | • The HEAR project<br>• ACT Health project<br>• Sexual reproductive Health<br>• Health Equity<br>• Maternal Health<br>• SMC in Pallisa and Budaka<br>• School outreach |

**Who are we going to bring to HL meeting?**

| | |
|---|---|
| HEPs | • CBOs, FBOs, VHTs, HUMCs<br>• Elderly, workers disabled, local council members. |
| UNHCO | • DHTs, CBOs<br>• Community<br>• VHTs and HUMCs |
| AGHA | • VHTs, HUMCs, CBOs<br>• Community members, HWs<br>• Youth groups and civic leaders. |
| CEHURD | • Local leaders, VHTs, religious leaders, women, VHTs, Youth<br>• HUMIC, Nurses, Midwives, DHOs, school Management committee. |
| NAFOPHANU | • PLHIV in all cohorts, H/Ws, religious leaders,<br>• VHTs. |

**Areas of operation :Where would we use HL- what districts?**

| | |
|---|---|
| HEPs | • Mbarara, Kawepe, Bugiri, Lira, Namayango, Kyankwanzi, Budaka, Pallisa, Kiboga, Ntungamo |
| UNHCO | • Kamauli, Oyam,Lyantode,Bushenyi,Nwoya<br>• Sheema, Luwero, Mityana, Kyankwanzi |
| AGHA | • Mityana, Pallisa, Nwoya, Lyantonde and Soroti. |
| CEHURD | • Kiboga, Kyakwanzi, Arua, Mityana, Buikwe, Mubende, Dokolo, Butambala, Masaka and Soroti. |
| NAFOPHANU | • National Networks and District Forums. |

**What issues/modules in the manual would we most likely use first?**

| **Organization** | **Module** |
|---|---|
| HEPs | 1,2,4,5,6,7,8 |
| UNHCO | 1,2,4,5,,6,7 |
| AGHA | 1,2,4,6,7,8 |
| CEHURD | 1,2,5,4,6,7 |
| NAFOPHANU | 1,2,3,4,5,7 |

**What support and input do we need?**

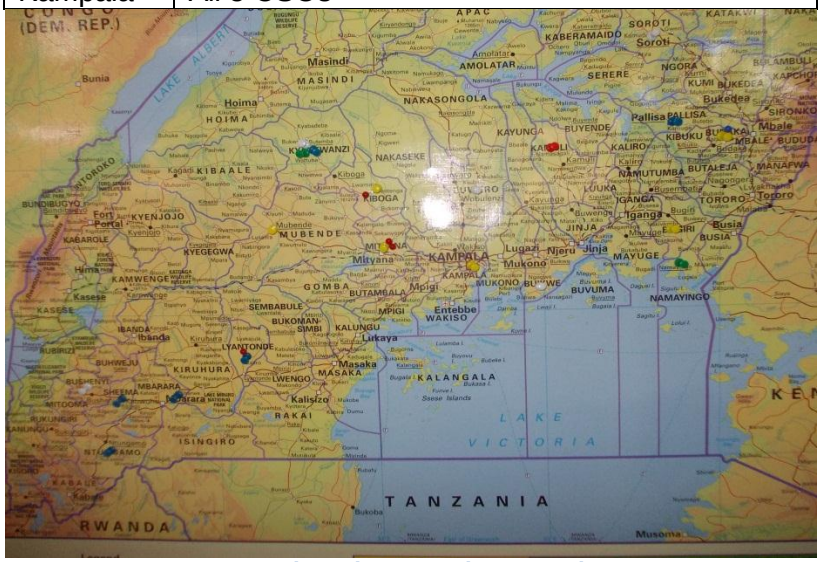
| **Organization** | **Support** |
|---|---|
| NAFOPHANU | • Study tours to Malawi, Botswana<br>• User friendly IEC materials<br>• Logistical support<br>• Technical support |
| CEHURD | • IEC materials ( field tools)<br>• Technical support<br>• Financial support<br>• Professional support |
| AGHA | • IEC support<br>• Logistical support<br>• Technical support<br>• Financial support<br>• |
| UNHCO | • ICT materials<br>• Capacity building/refresher training<br>• Manuals<br>• Logistical support |
| HEPs | • IEC Materials<br>• Training materials<br>• Technical support through mentorship<br>• Exchange programs<br>• M&E<br>• Facilitators sharing forum/meetings<br>• E-forum, video and other documentation |

In discussing these inputs from each of the five CSOs, it was agreed that:

1. Each organization would work in two districts, partnering with a second CSO to strengthen links and draw on each others experiences
2. All 5 CSOs would work together in one district
3. Since the issue of youth reproductive health was a common denominator in the work of all five CSOs, this would be the main focus of the HL work in the next 6 – 9 months.

Finally, the CSOs agreed to work in the following districts:

| DISTRICT | ORGANISATIONS |
|---|---|
| Kankwanzi | CEHURD and HEPS |
| Mityana | AGHA and NAPOPHANU |
| Lyantonde | AGHA and UNHCO |
| Kampala | All 5 CSOs |




**Mapping where we plan to work**

# 7 CLOSING REMARKS

In the closing remarks, HEPS Executive Director Ms. Rosette Mutambi, thanked all the participating organizations and facilitators. The HL programme will help health workers and community members to work together in solving their health needs. This also strengthens HEPs and its partners to deliver better programmes. She pointed out that, following this training, there would be a planning meeting with two representatives from each of the 5 CSOs to further discuss implementation of the programme. Once the Ugandan manual is completed (expected in the first quarter of 2013) all the trained facilitators will obtain a copy to guide them in the process of facilitating others.

She thanked Cordaid, Netherlands for enabling this training to take place through TARSC and EQUINET.

## APPENDIX ONE: TRAINING PROGRAMME

### DAY ONE – Monday 24th September 2012

| TIME | SESSION CONTENT | SESSION PROCESS | ROLE | |
|---|---|---|---|---|
| **Welcome, objectives, introductions** | | | | |
| 8.30 – 9.00 | Registration, logistics | Participant registration | HEPS | |
| 9.00 – 9.30 | Welcome | Welcome remarks – HEPS<br>Welcome remarks - TARSC | RM<br>RL | |
| 9.30 – 10.10 | Introductions | ▪ Buses Game<br>▪ Individual intros | BK | |
| 10.10-10.30 | Overview of the HL programmeand Workshop objectives | Overview of regional programme on HL<br>Work on HL/PRA in Uganda<br>Workshop objectives | RL<br>HEPS | |
| **10.30-11.00** | **TEA** | | | |
| **Introduction to health literacy and PRA- MODULE 1** | | | | |
| 11.00 – 12.45 | People centred health systems | Health systems: The Human sculpture (Module 6.1)<br>Approaches for change including PR and HL<br>Discussion | RL | |
| **12.45 – 1.45** | **LUNCH** | | | |
| 1.45 – 2.45 | Using Participatory Reflection and Action (PRA)approaches in health | **Module 1.3 and 1.4** Intro to PRA; role of facilitators in PRA<br>▪ key features of a participatory approach<br>▪ The Spiral Model<br>▪ Roles of a PRA facilitator | BK | |
| 2.45 – 3.45 | Being an HL facilitator | **Module 1.2** Role of HL facilitators in change | BK | |
| **3.45 – 4.00** | **TEA (or held during gp work)** | | | |
| 4.00 – 5.00 | Intro to the HL toolkit | **Module 1.5**<br>- The toolkit and flow of modules<br>- Use of activities, information, Discussion and Reflection sections<br>- Facilitator and community plans | RL | |
| 5.00-5.30pm | End-of-day evaluation | Review of the day went<br>Reading for the next day *(Module 1, 2 and 5)* | PT | |

## DAY TWO – Tuesday, 25th September 2012

| TIME | SESSION CONTENT | SESSION PROCESS | ROLE | |
|---|---|---|---|---|
| 8.00 – 8.15 (15min) | Review and logistics | Logistics<br>Recap of day one and Warm-up exercise (Ball game) | PT | |
| **The Health of Communities Module 2** | | | | |
| 8.15 – 10.00 | Understanding Health: Identifying community health problems and their causes | **Module 2.1 and 2.2**<br>▪ Definitions of 'health'<br>▪ Social mapping: '<br>▪ Transect Walk<br>▪ Other sources of information on health issues – health information system; health workers; community monitoring, | BK (with MM) | |
| **10.00 - 10.30** | ***TEA*** | | | |
| 10.30-12.30 | Prioritising and taking action on health problems and their determinants | **Module 2.2-2.5**<br>▪ What are the priority health issues or needs?' – ranking and scoring<br>▪ Causes of health problems –but why?<br>▪ Views of health workers and communities<br>▪ Actions, stakeholders and their roles on causes – Venn / stakeholder maps (Module 2); spider diagrams (Module 3);<br>▪ Community and action plans | RL (with PT) | |
| **12.30 – 13.30** | ***LUNCH*** | | | |
| **Healthy Life Cycles – Module 5** | | | | |
| 13.30 – 14.50 | What do we mean by healthy life cycles? Information and actions on life cycles | **Module 5.1**<br>• What affects our health at different times of our lives?- life cycle mapping | BK (with RM) | |
| 14.50 – 16.10 | Understanding the barriers to Womens and Sexual and Reproductive Health (SRH) | **Module 5.4+ rest of module**<br>• The three delays<br>• Barriers for the three delays - list, rank and score, comparative ranking<br>• Closing the gap<br>• Walk through of the rest of the module | RL | |
| **16.10-16.30** | ***TEA*** | | | |
| 1630-17.15pm | Panel on SRH – (talk show format) | **(See Module 6.3 for example of talk show)**<br>5 CSO panelists on the priority SRH barriers they are tackling, with whom and how.<br>Discussion; Using 'expert' panels in HL | All CSOs | |
| 1715-17.30pm | End-of-day evaluation | Review of how the day went.<br>Reading for the next day (*Modules 3 and 4)* | Delegate | |

## DAY THREE – Wednesday 26th September 2012

| TIME | SESSION CONTENT | SESSION PROCESS | ROLE | |
|---|---|---|---|---|
| 8.00 – 8.15 (15min) | Review and logistics | Logistics, Recap of day two and Warm-up exercise<br>Outline agenda for Day Three | RM | |
| **Healthy Environments Module 4** | | | | |
| 8.15- 9.30 | Healthy Environments | **Module 4.1- 4.4**<br>▪ Intro to 'healthy environments'- safe water, sanitation, and housing - social maps and transect walks<br>▪ Implications of privatisation of water<br>**Module 4.2 and 4.3**<br>▪ Diseases from unsafe water and sanitation (3 pile sorting);<br>▪ Walk though of the rest of the module, action plans, new issues- solid waste management etc to be included | RL | |
| 9.30-10.30 | Healthy nutrition | **Module 3**<br>▪ Food sovereignty - story with a gap<br>▪ Healthy foods –3-pile sorting<br>▪ Malnutrition? – Well being map; spider diagram Module 3.4<br>▪ Brief walk through of rest of module (nutrition monitoring; special groups), Discussion | BK | |
| 10.30 – 11.00 | ***TEA*** | | | |
| **Understanding health systems Module 6** | | | | |
| 11.00-12.00 | People-centred health systems and relationship with health workers | **Module 6**<br>▪ Health systems and their functioning Module 6.1, 6.2 and 6.3<br>▪ Impact of user fees -a spider diagram (6.4)<br>▪ Relationship with and role of health workers - Margolis wheel.<br>▪ Wrap up discussion on the module | RL | |
| **Community Roles in Health Systems Module 7** | | | | |
| 12.00 – 13.00 | Community roles and alliances in health systems | **Module 7**<br>▪ 'Where's Mpho?' 7.1<br>▪ Listening to people's views? wheel chart 7.2<br>▪ Role of HCCs (7.2) - picture code<br>▪ Discussion of wider alliances across CSOs | BK | |
| **13.00 – 14.00** | **LUNCH** | | | |
| **Using the manual for a HL programme** | | | | |
| 14.00 – 15.30 | Setting up the community HL programme | **Module 1.5**, facilitator and community plans, training schedules<br>Introduction and discussion on plans, schedules, monitorijng and reporting - Group work and report back<br>Issues to carry forward to planning discussion on the 27th | RL | |

| TIME | SESSION CONTENT | SESSION PROCESS | ROLE | |
|---|---|---|---|---|
| 15.30-15.45 | ***TEA*** | | | |
| **Final reflections and closing** | | | | |
| 1545 – 16.45 | Reflections | Discussion on Content and Activities of Modules 1-7 | BK | |
| 16.45-17.15 | Next steps and closing | Next steps on implementing the programme<br>Participant remarks and comments<br>Closing | RM<br>CSOs | |

## APPENDIX TWO: PARTICIPANTS LIST

| No. | Name | Designation | Organisation | Contact |
|---|---|---|---|---|
| 1. | Ms. Barbara Kaim | Programme Manager | TARSC Zimbabwe | barbs@tarsc.org |
| 2. | Dr Rene Loewenson | Director | TARSC Zimbabwe | rene@tarsc.org |
| 3. | Mr. Francis Ssentongo | Lab Technician | AGHA-Uganda | 0706925935 |
| 4. | Ms. AnnetBinomugisha | Program Assistant, CEP | HEPS-Uganda | 0700535670 |
| 5. | Mr. Mark Mugisha | Admin. Assistant | AGHA-Uganda | 0782180472 |
| 6. | Ms. Margret Happy | ADV. Manager | NAFOPHANU | 0772695133 |
| 7. | Ms. Prima Kazoora | M & E Officer | HEPS-Uganda | 0772611179 |
| 8. | Mr. EriyaKamya | Program Administrator | AGHA-Uganda | 0717700901 |
| 9. | Ms. Connie Tinka | Rapporteur | Self employed-Kampala | 0753429427 |
| 10. | Ms. Juliana Nantaba | Program Assistant | CEHURD | 0774698490 |
| 11. | Ms. Noor NakibukaMusisi | Program Officer | CEHURD | 0782496681 |
| 12. | Ms. Olive Kalekwa M | Program Assistant | HEPS-Uganda | 0773010363 |
| 13. | Ms. Clara Atuhaire | Logistics Assistant | HEPS-Uganda | 07770507779 |
| 14. | Mr. Gabriel Amori | National Programs Coordinator | NAFAPHANU (UNERELAY) | 0772414868 |
| 15. | Mr. Brian Kaamuzi | Focal Person | UNHCO | 0774280715 |
| 16. | Mr. PettersonMuhanguzi | Assistant Programs Officer | UNHCO | 0772060880 |
| 17. | Mr. ChriscstormAhizada | Focal Person | UNHCO | 0707128623 |
| 18. | Mr. John BoscoApeku | Assistant Program Officer | UNHCO | 0779188835 |
| 19. | Ms. Mariam Akiror | Program Officer, Research & Documentation | HEPS-Uganda | 0700386501 |
| 20. | Ms. MackleanTwinomuhangi | Assistant Program Officer | HEPS-Uganda | 0777347806 |
| 21. | Ms. Rosette Mutambi | Executive Director | HEPS-Uganda | 0782371401 |
| 22. | Ms. Peace Baguma | Project Manager | NAFOPHANU | 0704533346 |
| 23. | Mr. James Lule | Supervisor | NAFAPHANU | 0712380676 |
| 24. | Mr. James Kibirige K | Community Officer | CEHURD | 0782194841 |
| 25. | Ms. PhionaKulabako | Program Officer | HEPS-Uganda | 0702214478 |
| 26. | Ms. LoiceEpetiru | Communication & Documentation Officer | HEPS-Uganda | 0777108797 |
| 27. | Ms. Diana Oromu | Program Assistant | HEPS-Uganda | 0774805058 |
| 28. | Mr. Kenneth MugumyaNyehoora | Compliments & Compliments Officer | HEPS-Uganda | 0779226321 |
| 29. | Mr. Moses Birikwija | Program Assistant | HEPS-Uganda | 0772573423 |
| 30. | Mr. David Kabanda | Programmer | CEHURD | 0772480179 |
| 31. | PelagiaTusiime | Program Manager, CEP | HEPS-Uganda | 0772445521 |
| 32. | Mr. Ronald KaggwaMande | Coordinator SEHC | AGHA-Uganda | 0773093928 |
| 33. | Mr. Moses Mulumba | Executive Director | CEHURD | 0712657974 |
| 34. | Mr. Amos Zikusooka | Consultant | HEPS-Uganda | 0712425004 |
| 35. | Mr. Richard Turyamwesimira | Administration & HR Officer | HEPS-Uganda | 0782434975/ 0706941448 |

## APPENDIX THREE: DESCRIPTION OF PARTICIPATING UGANDA CIVIL SOCIETY ORGANISATIONS

The **Coalition for Health Promotion and Social Development or HEPS Uganda** is a health rights organization that advocates for increased access to affordable essential medicines for the poor and vulnerable people in Uganda. It aims for a just and fair society in which all Ugandans – irrespective of gender, age, ethnicity, religion, physical well-being or socio-economic status – can exercise their health rights and health responsibilities. HEPS educates people, especially in poor and vulnerable areas, and provides information on health rights and responsibilities including rational use of medicine. The CSO provides a channel to allow people to voice their health complaints on access to health care services, receive professional support in their efforts to get redress, as well as a feedback mechanism to government and health care providers. It is building up a core of health advocates who constantly watch, participate and influence policies that safe guard public health interests in order to ensure that quality health care is available, accessible and affordable for all. At national level, HEPS advocates for consumer friendly health care laws and policies. These activities are implemented through a community outreach programme, a health policy advocacy programme, and a health complaints and counseling desk. HEPS is one of the lead organisations in the Uganda health literacy programme.

The **Center for Health, Human Rights and Development (CEHURD)** is a national, non-profit, research and advocacy organization which is pioneering the enforcement of human rights and the right to health in Eastern Africa. CEHURD seeks to realize social justice and human rights in the health systems in East Africa. It takes action to ensure that laws and policies are used as tools for the promotion and protection of health and human rights of populations in Uganda and in the East African region. CEHURD does this through human rights advocacy and documentation; community empowerment; and strategic litigation programmes. The last refers to court action.
CEHURD focuses its efforts on human rights and health systems issues that are important in East Africa, such as sexual and reproductive health rights, trade and health, and medical ethics. It chooses issues that affect less-advantaged populations such as women, children, orphans, sexual minorities, people living with HIV, persons with disabilities, internally-displaced persons, refugee populations and victims of violence, torture, disasters and conflict. It also advocates for access to medicines through enabling national and regional laws and community mobilization; and to ensure that laws and policies on intellectual property do not infringe human rights at national, regional and international levels.

The **Action Group for Health, Human Rights and HIV/AIDS (AGHA)** is a health rights advocacy organization in Uganda dedicated to raising awareness of the human rights aspects of health, and improving the quality of health and healthcare for all Ugandans. It aims for a world of equity and social justice where health rights are respected and enjoyed by all. Grounded in a rights-based approach, AGHA mobilizes health professionals, in collaboration with communities, to be health rights advocates, promoting equity and social justice for all Ugandans. AGHA places particular focus on marginalized and vulnerable populations. AGHA has a proven track record of addressing health rights violations in Uganda through advocacy-oriented research, education and training. AGHA implements its work through various programmes, including a health rights leadership campaign that carries out networking, outreach, and education with health workers, CSOs, the public, students and the media; a health workforce campaign that advocates for improved health worker training, financing, conditions, management and retention. AGHA also has a campaign to combat stigma and discrimination in healthcare settings, which is implemented through locally-based Task Force Committees in Rakai, Tororo, Mbarara and Kampala, reaching over 200 health workers and community members.AGHA's health financing campaign aims to increase health funding in Uganda to at least 15% of the government budget through advocacy and research. AGHA participates in policy forums, media outreach, meetings with key national leadership and civil society engagement.

The **National Forum of PLHA Networks in Uganda (NAFOPHANU)** is an umbrella organization that coordinates all forums, associations and groups of PLHAs in Uganda. NAFOPHANU envisions a community of People Living with HIV realizing their full potential through mutual support, respect of human rights and positively influencing the HIV/AIDS response at all levels. Since it was created in 2003, NAFOPHANU has undertaken numerous activities in five key areas. It strengthens advocacy capacities of PLWHIV and their groups and associations to ensure their wellbeing, and to mobilise resources, including through strengthening the financial systems of the networks. It carries out research, documentation and disseminates information on HIV/AIDS related issues at all levels. It also builds and strengthens partnerships within and across networks of PLWHIV and with other stakeholders in the national response to AIDS.

**Uganda National Health Users'/Consumers' Organisation (UNHCO)** was conceived by a group of Ugandans drawn from various professional disciplines who shared common concerns and a vision of a health sector that provides quality health care for the mutual benefit of both providers and communities (consumers). Since its inception in 1999, UNHCO has advocated for a strong, institutionalized platform that can represent the voices of consumers of health goods and services. Its vision is a society where consumers' rights and obligations are realized for quality health care and their mission is to advocate for health consumer rights and responsibilities. UNHCO has championed the rights based approach to healthcare delivery and contributed to efforts to improve community participation and accountability. UNHCO focuses on vulnerable people including women, PWDs, children, and PLWHIV. The organisation raises awareness among health service users, providers and policy makers about health rights and responsibilities. It carries out policy research, advocacy and review processes to address access, equity, quality and accountability. UNHCO creates synergies with other CSOs, relevant Government departments, development partners and strategic allies and has a credible working relationship with the media. It improves communication between users and providers by strengthening referral and redress mechanisms and building a partnership for conflict resolution. In 2012 UNHCO spearheaded an advocacy campaign on maternal mortality