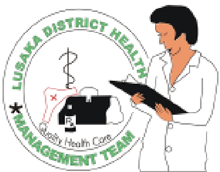
Strengthening Health Worker-Community Interactions through Health Literacy and Participatory approaches

Health Literacy Training Workshop Report
Lusaka District-Zambia
29 March-1 April 2011



Training and Research Support Centre (TARSC)
and the Lusaka District Health Management Team (LDHM) with
the
Regional Network for Equity in Health in east and Southern
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Strengthening Health Worker-Community Interactions through Health Literacy and Participatory approaches

1. Background

People centered health systems are organized to involve and empower people, and create powerful constituencies to protect public interests in health, if they effectively engage health workers and communities. A growing network of institutions in the region, led regionally by Training and Research Support Centre (TARSC) and Ifakara Health Institute in EQUINET explored the role of participatory processes for strengthening health worker- community interactions in planning and implementing health systems and in supporting Primary Health Care (PHC) oriented approaches to health care, and has built a learning network of community based institutions to share learning and experience in this area. The reports of this work are found at www.equinetafrica.org.

The learning showed that communication between health workers and communities is important in building

- Shared understanding of the patterns of ill health and its determinants
- Recognition of health problems in the communities
- Shared understanding of patterns of use of and barriers to use of health services;
- Shared understanding of how health services respond to health needs and what needs to be done to improve this;
- Shared understanding of whether and how services disempower or empower communities and health workers, and what that means for health (TARSC 2009, Loewenson et al 2011).

The studies show that shortfalls on these issues are also amendable to change through participatory approaches that strengthen communication and that engage others that have power in the community (TARSC 2009). PRA processes made communities more confident and open in their communication, health workers more open to listening to community members, and to communicating information, and enhanced team working, and shared decision-making and local problem solving.

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 that strengthens community level diagnosis, action and engagement with health systems.

Health Literacy, a process of information and skills building on health for action, has also been found to provide the space for communities to express and shape their health programmes and services at Primary Health Care level, especially when it uses participatory methods. It does this by investing in community capacities to articulate their needs, present their conditions, negotiate for the resources that improve their health, monitor the delivery on the health service commitments and participate in shaping their services.

The Health Literacy (HL) training held in Lusaka district was aimed at building capacities of Health workers and communities jointly to work together to strengthen their interactions through HL and PRA approaches. It is anticipated that the training will go a long way in strengthening communication between health workers (employed in the health system in the community or the primary care level services) and community members at primary care

level towards specific, measurable improvements of the health system for both with local coordination by Health Literacy facilitators.

Aims: Specifically the training aimed to:

- Introduce the health literacy programme and Participatory Reflection and Action (PRA) approaches to community members and Health Workers in Lusaka District
- Provide core skills and information to LDHMT health literacy facilitators to implement joint action to improve and strengthen Community-Health worker interactions
- Reflect on the current facilitators and blocks to communication between health workers and communities, and how to improve this.
- Provide training materials and orient LDHMT facilitators to jointly identify and prioritize health needs and ill health problems, identify actions on shared priorities, identify gaps or barriers to uptake of primary health care (PHC) responses to prioritized problems, and set a shared (HW-Community) action plan.
- Orient LDHMT Facilitators in Lusaka District on administering the baseline and the programme post survey instruments

The participants for the training were drawn from three pilot areas (sub-districts each with its own health centre i.e. a) Chilenje b) Chipata and c) Matero reference health centre within Lusaka District. These trained facilitators are expected to use the skills and capacities from the training in their sub districts through jointly prioritized actions to strengthen communication between health workers and communities at primary care level towards specific, measurable improvements in the functioning of health systems for both.

A combined Health Literacy and PRA protocol was developed by TARSC (Loewenson et al 2011) with input from Lusaka District Health Management Team (LDHMT) and HEPS Uganda to guide trained HL facilitators to work with communities, primary care level health workers and other stakeholders. The protocol orients the HL facilitators from each sub county to use PRA and HL tools, to jointly identify and prioritize health needs and ill health problems, identify actions on shared priorities, identify gaps or barriers to uptake of primary health care (PHC) responses to prioritized problems, and set a shared action plan taking this into account. The protocol also gives a framework through which the HL facilitators can reflect on the current nature and blocks to communication between health workers and communities, and how to improve this using PRA and HL tools

The evidence from practice (documented through a monthly reporting framework developed by TARSC and HEPS Uganda) and from the baseline and post surveys in Lusaka District will be analyzed and reported on, including for scientific publication on health worker – community interactions.

This report captures through quotes, pictures and examples of some of the discussions that were held during the training workshop (see programme in appendix 3). Details on the activities and how they were conducted are separately available in the EQUINET PRA toolkit (Loewenson et al 2006), the Health Literacy manual (Loewenson et al 2009) and the Combined Health Literacy and PRA protocol for Health worker community interactions.

The mix of health workers and communities from three different sub districts from the same district (see appendix 1-participant list) brought together rich discussion, open dialogue and a desire to address the blocks that hinder progressive communication between communities and health workers. The facilitators were Fortunate Machingura from TARSC, Adah Zulu, Dr Clara Mbwili-Muleya and Moses Lungu from LDHMT.

2. Opening

Dr Roy Chavuma, the Director and District Medical Officer of LDHMT officially opened the workshop. His opening speech is in Appendix 2. He welcomed the delegates and expressed appreciation of the initiative addressing Health worker-community interactions through collective efforts. He noted that Zambia, Lusaka District in particular was facing challenges, including fights between health workers and communities. He highlighted that this initiative will be supported by the Ministry of Health Zambia as it is line with policies of the Ministry of Health. He added that such initiatives will also be included in the national Health care strategic plan so that Health worker community issues are addressed more holistically and more widely across the country.

".. it is our conviction that this training is in line with the ministry of health vision of taking health care services as close to the people as possible. we therefore need your concerted effort and we hope that you will use this training as a stepping stone to addressing the challenging health issues we face as Lusaka district health workers and community members" **Dr Roy Chavuma –District Medical Officer-Lusaka District Health Management Team**

Group photo with the director of LDHMT © M Lishandu LDHTM

3. LDHMT and TARSC work on health

The **Lusaka District Health Management Team (LDHMT)** Zambia is within the Ministry of Health Zambia. LDHMT has a history of using PRA approaches to strengthen health service delivery. Its previous work using PRA approaches was done with collaboration from EQUINET and TARSC since 2006 in the Zambia Equity Guage. The work was implemented in Lusaka city and rural Chama district. It targeted health providers from each health centre and community health volunteers from each district. It was aimed at strengthening community-health centre partnership and accountability. In 2007/8 the team consolidated the participatory approaches initiated in 2006 to further enhance the community voice in planning, budgeting and implementation activities at Health Centre and at community level. A pre and post intervention questionnaire was administered to assess change in the new HCs involved in Lusaka District.

Training and Research Support Centre (TARSC) provides training, research and support services for social and economic development in east and southern Africa (ESA). It does this by developing social and organizational capacities within organizations to interact with communities, the state and private sector on areas of social policy and social development. TARSC provides technical support, mentoring, cadreship building and organizational development to a range of membership based civil society organizations, and community based organizations to organizations in the state, in local government and in parliament at local, national, regional 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. TARSC has built understanding of a range of participatory approaches and their use in strengthening people centred health systems through material development, training, photography (keeping an eye on equity). TARSC has provided mentoring and support to research and training proposals on equitable, community driven responses in health. TARSC work in Health literacy in east and southern Africa derives from the work implemented in Zimbabwe with Zimbabwe Congress of Trade Unions on workers health since 1990 and with Zimbabwe Community working group on public health since 1998. The Regional Health Literacy programme coordinated by TARSC since 2006 has been implemented in Malawi and Botswana working with civil society in these countries. In 2011, the Health Literacy work has been extended to Zambia and in Uganda.

4. Using participatory approaches in health

In the discussion of key features of participatory approaches we noted that learning HL and PRA approaches and tools is not achieved in short periods of time such as training workshops, but the learning is a reflection and action continuous cycle, in a learn, know, do-act cycle. There was consensus that this programme of work should be sustained in the longer term enabling change in practice, attitude and behavior both in health workers and communities and not to assess impact too early. There was a general recognition that this training workshop was aiming at skills building - to listen, to be patient, to facilitate, to unlearn, and to learn in ways that are consistent to a learning cycle. Reflecting on their own experiences, participants discussed the basic principles of PRA methods, why they are central and fundamental in facilitating the interaction between health workers and communities. We also discussed how engaging health workers and communities particularly in the way they communicate are central to the building people centered health systems.

Group activity, Lusaka workshop 2011 © F Machingura TARSC

We discussed the basis for strong effective interactions between health and communities, including that

- Local people are creative, they know their own problems and how to act on them
- Local people are more knowledgeable and know the problems that affect them
- Local people know the solutions to their problems
- The community can act on their problems
- PRA enables ownership of interventions at community level

Central to this is the role of facilitators who have to unlearn and learn, be able to listen and respect participants, show no prejudice, be knowledgeable, speak loudly, to mobilize communities and understand patterns of experiences. We encouraged participants to read further in Module 1 of the Health Literacy Manual that introduces the Health Literacy facilitator to using PRA methods. Importantly, we put emphasis on the PRA spiral with regular cycles of reflection and action, from which, communities draw lessons from their experiences and continue to find better solutions to their difficulties, this continues to move them closer to their positive change in their lives. The approach gives communities and health workers opportunities to share their opinions and jointly contribute to decisions or plans being developed. This encourages strong health worker community interactions.

5. Understanding health worker -community Interactions

In the discussion of health worker community interactions we noted that HL and PRA approaches used in strengthening interaction between communities and health workers but also between health workers. Participants observed that health workers were just as likely to be misinformed as community members. Communities and health workers should learn to jointly act on their priority health problems to improve interactions between them. To explore health worker-community interaction issues, we used the 'Margolis Wheel tool'- a PRA tool that exposes interaction challenges between two social groups- particularly health workers and communities. The tool further suggests solutions to the identified problems. Everyone had a chance to report in plenary what they received as a problem and what solution they provided so we could see how communities and health workers experience communication challenges and how they are interacting. The responses are shown in the table below:

Problem	Reasons	Solution
Community Problems		
"Health workers do not care; they wait until there is Cholera outbreak for them to start thinking of action. Health workers with the MOH should do something before disease outbreak! So as communities we are bitter and angry at them!"	Communities reject volunteers from the health facility who are trained to train communities on outbreaks. Communities demand Health workers to do the work on the fact that health workers are paid to do so	It is not a health worker role to clean the city, but a city council role. Health workers educate communities on waste management, disease outbreaks and their prevention and treatment. There should be joint action between health workers, communities, MOH, Lusaka City Council (LCC), CSOs and other stakeholders to clean the city to prevent cholera, malaria and other diseases of unsafe environments.
"Health workers are too slow; they take their time with each patient knowing that the queues are long and we would have paid some bus fare to get to the clinic, this makes it difficult o respect them when we talk to them"	Inadequate staff; increased disease burden; long queues leading to long waiting times at the health facility	Ministry of health should allocate adequate health workers at each facility. However this should be facilitated by informed communities and health workers who are able to demand for effective interventions for their problems.
"*Health workers do not understand communities, especially when we bring in our dead relatives to the mortuary, we are returned back home with a corpse. Frankly the next time I see the health workers even the community I will curse!*	- The mortuary can only accommodate nine (9) bodies at a time. Thus the mortuary space for the dead is reserved for the ones who decease from the Clinic.	Health workers should explain to communities why Bought in Dead cases are not accepted in the facility mortuary before sending them back home. Further, communities should bring their critically sick relatives early to avoid relatives and friends from dying at home.
Health Worker Problems		
Unnecessary personal Confrontation between health staff and patient due to the arrogance of communities	Friends and or relatives who escort the patient to health facility often want to represent the patient rights by standing in front, being rude to the health worker or enticing patients to demand services may not be provided by the health facility.	- Need for volunteers to conduct Health education to fellow community to appreciate staff have workload - Enforcement of regulations to protect both the patient and the health workers
Communities are not honest. They often dump critically ill patients at the health facilities with no trace of	Communities are poor and cannot afford funerals of these patients	Ministry of Health should work hand in hand with the social welfare department. Communities and health workers must be

contacts. . There is a huge problem when the patient die in the hands of the facility		educated on how these cases or incidences must be handled.

These experiences showed that there was suspicion, distrust, anger and resentment from one group to the other. Health workers accused communities of certain actions, attitudes, prejudice and behaviour and communities also showed the same. We discussed most of these problems and how they affect service delivery. One participant observed that poor interaction with health workers is a barrier to people accessing health services.

"If you are not getting along with one health worker at the health centre it's likely that the whole team will know about you and they will be rude to you whenever you visit the facility. Now, when health workers that we entrust with our lives are not good to us, we certainly cannot trust their services, treatment or the medication given. So you end up going to the next health facility in the next sub-district or in some cases another district. This means that you are using more money and other associated resources to access health care using more than what you might have incurred. If one does not have the money they will die at home!"
Participant

"In some cases, we feel that we have to beat them up, some of these health workers think they own the facilities, they refuse with drugs. Like what happened in Lusaka her, communities beat up health workers recently" **Participant**

Health workers on their part feel unappreciated and over burdened by ungrateful communities who resent them and do not understand what they go through. Community members feel they need to be more aggressive and stubborn to get the services from the health centres. Communication between communities and health workers is poor. Participatory approaches would need to address the problem of and the underlying causes of poor communication.

From these stories we observed that

- Interaction skills are built and supported. Thus stakeholder involvement in supporting health worker-community joint actions is priority.
- Improving awareness on the part of health workers and communities on interaction problems, as strategies to reduce health care disparities is effective in building people centered Health systems.
- Knowledge, capacity and communication skill of the workers is key to both their own confidence and building trust within communities.

The case experiences shared showed that when communities and health workers jointly identify their problems and collectively act on them they are both motivated and organise for services to address their real needs. They recognize, appreciate and communicate about each other's strengths and weaknesses and have some leeway to turn each other's weaknesses into strengths.

We examined how drawing out current experience is generally more comfortable in a community setting and how important it was to begin the learning form a common platform. We also explored how using PRA tools such as the Margolis wheel can be fun but also very strategic in enabling health workers and community members to speak, dialogue, debate and discuss.

6. Mapping factors affecting health worker community interactions

Using social mapping, participants in their sub district groups drew maps resembling their communities. We discussed the features of communities that affect interactions between health workers and communities. Social maps are used to identify existing social groups and

their distribution in the community and use these groups to discuss how they interact with services in their catchment area. On the maps that participants drew they included health services and health related services. In the discussion we discussed the barriers to using the primary care service that people raised. They included geographical, financial and social. Most of these affected communities while others affected health workers. Either way they contributed to ill communication between health workers and communities.

Each sub district identified barriers that interfere with health worker community interactions as shown in the table below:

Sub district	Barrier	How barrier interferes with community-health worker interaction
Matero	flooded roads particularly in the rainy season	Patients skip injections and miss important treatment. When a patient fails to adhere to treatment health workers are often furious and rude to the patient/community
	patients from other catchment areas visit Matero health centre increasing the workloads of Health workers	Long waiting times agitate communities; huge workloads frustrate health workers sparking tension and tempers.
	houses built along the sewage pipelines have populations prone to diarrheal diseases increasing health worker workloads	Huge workloads frustrate health workers; low staffing means low coverage/attendance to the sick. Some patients die waiting for services. Communities end up thinking that the health worker(s) do not care. This leads to shouting at each other exchanging offending words
	absence of economic sources mean that employment is low, and for those employed, income is low making it impossible for communities to pay for health	Communities shout at health workers for asking for payments for health care Health workers are caught in between complying with the national user fee policy ad saving a life. A decision difficult to make because the consequences of both are significant.
Chipata	Few schools in Chipata means that literacy levels are very low	Reasoning and cordial communication is often absent in societies with low literacy. Often the communication is associated with blame and violence
	The health centre is surrounded by many taverns and beer halls	People who are drunk loiter at the health centre and abuse health workers verbally, emotionally or even threaten to beat them up.
	Low economic activities means low income making it difficult for communities to pay user fees	Communities shout at health workers for asking for payments for health care
Chilenje	There are very few, if any toilets at public places in Chilenje. This leads to communities abusing the health centre toilet facilities.	Those who visit the health facility toilet often quarrel with health staff. Health workers are forced to work in violent environments.

Defaulting treatment, long waiting times, long queues, staff shortage, increasing disease burden, user fees, drunk people from nearby taverns often agitates either the community or the health worker, or in most cases both. While these problems may seem distant to service efficiency, they act as barriers to health-worker community interaction. These interactions do not thus just relate to personality issues, lack of understanding, low pay or shortage of health workers, but also from how resources and services are distributed and accessible in the community. Overcoming barriers between communities and services needs to be integrated with other areas of resource provision and budget allocations .Participants proposed that this needs to be reviewed and organized into how they affect interactions between communities and the health system.

7. Prioritizing health needs, identifying and addressing the causes

Prioritizing health needs is important in that it allows communities and health workers to systematically act on their problems. In order to practice how this is jointly done at community level with health workers we used the ranking and scoring tool. The tool allowed the participants to identify the priority social and economic determinants at individual household, community and system level that facilitate and block interaction between communities and health workers. Below is a summary table of the health needs and health problems prioritized by health workers and communities.

Social group	First priority (number 1)	Second priority (number 2)	Third Priority (number 3)
Health Worker	Sanitation (uncollected garbage)	Malaria	Security (dangerous working environments-HW are often threatened or beaten by communities)
Community	Uncollected garbage	Cholera	Malnutrition

We discussed the importance of joint community – health worker negotiations on the commonest health needs/ health problems for joint action. For example, uncollected garbage automatically became the commonest health need as it appeared in both social groups. With

Garbage next to a vegetable vendor, Lusaka 2011 © F Machingura TARSC

higher numbers of community members compared to that of health workers, the priority needs of the latter could be overshadowed. We agreed that when Health Literacy facilitators are implementing work at community level, strategies for combined action should include needs of both health workers and communities.

On the issue of uncollected garbage, communities and health workers can jointly organize a day for a cleanup campaign on the streets while also marching with placards and t-shirts at Matero Ref centre for example. While this action addresses the problem on uncollected

garbage, it also addresses low staffing levels, or security issues depending on what health workers prioritize to be addressed.

Ranking and scoring activity, Lusaka 2011 © A Zulu, LDHMT

In groups, participants identified the causes of the most common prioritized health need using the "But why" method. Participants then collectively conceptualized the causes into background/structural, intermediate and immediate causes. We discussed the causes that were important to address and reduce or stop blocks in communication between health workers and communities.

An example of the "but why" activity from one of the groups at the workshop is shown below:
"Uncollected garbage is a priority health problem in Lusaka district "- But why
"The Lusaka City council is not collecting"- But Why
"It does not have money for bins, shovels, rakes and other tools needed "- But why
"Employment of untrained people who cannot mobilize funds for the city"- But why
"Corruption"-But why
"No public accountability systems"- But why
"Poor planning"-But why
"no government allocation for resources to support public accountability and role of the city council "-But why
"Political interference"

When we consolidated all the groups analysis of 'causes of causes of causes' we synthesized the cases and grouped them into immediate, intermediate and underlying causes of uncollected garbage in Lusaka district as shown below:

- Immediate: – lack refuse bins, lack of knowledge; shortage of resources to purchase bins
- Intermediate: - poor planning, employment of untrained staff, brain drain
- Underlying causes: - poverty, lack of public accountability, political interference

We explored how stakeholder mapping in the community is done. We did this to practice how communities and health workers work with stakeholders in their areas to address communication challenges as well as other interaction issues around their priorities. Participants identified the actions that mainly involve the health workers, the primary care services and those that mainly involve the community. Both communities and health workers discussed the actions that they want to individually follow up and those they would prefer to do jointly to strengthen their interactions.

8. Deepening knowledge of priorities using health literacy

The Health Literacy Manual strengthens the capacity of Health Literacy facilitators by discussing, sharing information and giving tools for dialogue on what causes diseases (social determinants of health). This is so that communities can share the information they

hold and add new information on how to plan for and act to prevent disease. For example, in the training workshop we highlighted that knowing that malaria is caused by mosquitoes that often breed in open potholes and in long grass around homesteads means that people can plan information campaigns to promote clean homestead surroundings with short grass, covered potholes, and can take extra measures to reduce malaria. Better still, knowing the causes of diseases means that people can promote health in their community, by changing the conditions that make them unhealthy. We observed that, it is not only individual actions that people take, or only community actions that should be implemented but, joint health service and community actions need to be taken by people collectively, organized by both of them to improve the interaction between them

Using the manual often depends on the issues jointly identified by communities and health workers and what information they want to discuss. Hence for example participants prioritised malaria, thus information on deepening the knowledge on what the health services do about it and how to advocate for improvements, can be taken from the Health Literacy Training Manual Section1 Module 4 on Health Environments ; Section 2-Module 6 on understanding health systems and Section 3- Module 8 on Organising for health. At the end of each module participants discuss the plans that health workers and communities can make and what health literacy facilitators also need to do and think about between the times they meet to plan and when they meet to reflect. This period in between sessions is the action time that will take about three months. This is to give enough time for joint health worker community action and improved interaction.

9. Addressing barriers to health worker- community interaction

After identifying the actions that could be done by communities; those that could be done by health workers and those that could be done jointly, we realized that there were some actions that were not within our control to change, which needed action or advocacy by people at other levels. In order to learn how communities and health workers could jointly act on their priorities at the level of the primary care services while also involving others, we used a stepping stones tool. Participants identified the measures / stepping stones needs to address uncollected Garbage. On each measure/stepping stone they marked whether the community of the health worker was responsible for the action. On crossing the river, health workers failed to cross alone, similarly communities also failed to cross just by themselves. We realized that in order to address major health problems, health workers and communities need each other. See the river with stepping stones identified by participants below:

Stepping stones	What action are you going to take *(action points have been summarized and grouped)*	Who is responsible for action?
1.	Start with self and community on waste disposal knowledge	Community
2.	Sensitization of people on proper waste disposal	HW
3.	Holding meetings with key stakeholders	HW
4.	Mobilisation of communities for action	Community
5.	Orientation training on proper garbage disposal	HW
6.	Fundraising for Bins	Community
	Lobby Partners for purchase of refuse bins	HW
7.	Lusaka City Council to introduce solid waste collections and communal points for waste disposal	HW
8.	Advocacy for policy regulation on waste management	Community
8.	Re- enforce law on waste management	HW

Acting on, monitoring and reporting on priorities

Participants developed a sketchy action plans to practice how they would work with communities and other health workers in their sub districts to develop a collective action plan that would guide action on priority health needs. This would also help to strengthen the interactions between them.
"We have a little resource to support Health worker community interaction work. Thus, we can support financially your two day health literacy facilitator workshop; your resources targeted for the meeting can then be used for implementing that action…"

Vending in Lusaka, 2011 © F Machingura TARSC

We noted that the process during training was a training exercise to prepare facilitators to develop similar plans with communities. However, the plans would only depend on what communities with health workers jointly plan to do. We also discussed how progress markers would be used in the process and how the LDHMT monthly feedback form for Health Literacy facilitators would be used. We highlighted how facilitators would at each month provide a report using a simple guide developed by TARSC with input from LDHMT. We explained the requirements of the form.
"This form is very flexible it will allow me to write stories that can be shared in the wider health literacy network in the region" **Participant**
"This reporting back style is unique yet very uniform so that you get organized and meaningful feedback. I also think that the issues requested are not too much, so its not an overburdening process you know…" **Participant**

We agreed that facilitators with communities would spend about three months working on their action plans before they meet to review their work, reflect on their experience and evaluate on their progress.

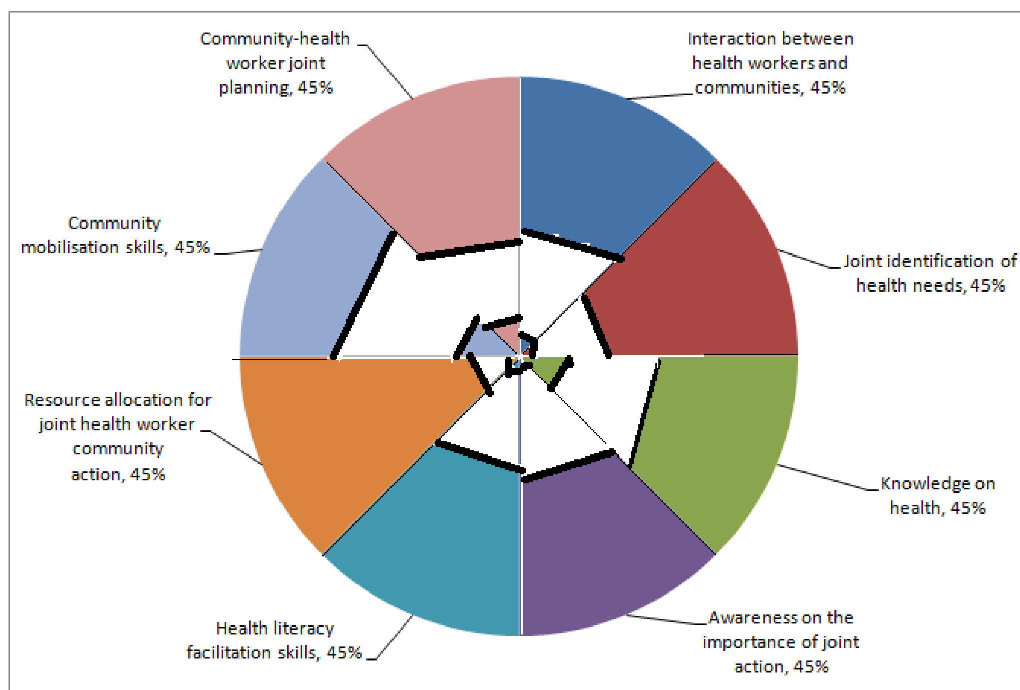
We discussed several methods that Health Literacy facilitators could use to reflect on experience and evaluate their progress using PRA tools. The wheel chart is one PRA mechanism of evaluating how far progress has been made and how far health workers and communities interact after the implementation of the intervention. We made fictitious progress markers and practiced how the evaluation using the wheel chart is including a participatory discussion on obstacles hindering progress.

As we got deeper into the discussion on obstacles we realized that communication styles also need to be re-evaluated during the review workshop. We used a participatory tool known as the Johari's window to explain different styles of communication. The Johari's window discussion showed that interaction between health workers and communities needs a process of reciprocity and horizontal relationships by which the community's rich

experience, knowledge of customs and beliefs, and intimate understanding of the local situation, can be integrated with the health worker's technical know-how.

We observed that this can be effective when engaging with structures that exist at community level that facilitate health worker/community dialogue and actions. Some of the structures identified included the opinion Leaders and Elders; Village Health Teams; Traditional Birth attendants; Health Unit Management Committees; Local Councilors, Schools, Sub County and parish Chiefs.

Joharis Window tool, from Loewenson et al 2006



Wheel Chart: The solid line at the base of each segment represents the level at which we were before the joint hw-community interaction action. The solid line at the top of each segment represents where we are now after the intervention. Each segment of the wheel chart represents the progress marker. The white shaded area is the change effected as a result of the intervention.

10. Assessing change

Discussions on assessing change effected on health worker-community interactions through HL and PRA approaches was agreed to be done through several mechanisms. Some of the approaches that were discussed included the monthly feedback reports and the wheel chart as already elaborated in preceding sections above.

We agreed that a baseline survey was going to be conducted before the Health Literacy intervention. It would assess the perceived level of and satisfaction with shared understanding, communication and joint action between health workers and communities on health needs, recognition of ill health problems, uptake of and barriers faced in using health services and responsiveness and effectiveness of services in relation to prioritized health needs. A similar process would be done at the end of the intervention to assess the change effected. The comments and input to the baseline and post survey tool included the following:
Add these two questions after question 17:

- ✓ Do communities understand the challenges Health Workers go through?
- ✓ Do Health Workers understand the challenges communities go through?

11. Existing structures for health worker-community interactions

A discussion on interaction and engagement with key stakeholders was opened up to identify the structures and discuss possible ways linkages and synergies.
The community structures identified included:

1. **Churches:** for community mobilisation, information dissemination and health education,
2. **Ward Development Committees**-for engagement with local authorities
3. **Advisory Committees:** to support in address of health worker-community challenges and disputes
4. **Police-** support in the enforcement of city by laws and public health policies
5. **Markets: -** support with space for income generation projects and organizing Community support groups
6. **Schools –** social mobilisation, information dissemination, education, health literacy
7. **CATF (Community AIDS Task Force)** – support with programme coordination, advocacy and mobilisation of action HIV social determinants

Cholera treatment center- Matero Ref Health Facility 2011. © F Machingura TARSC
Other stakeholders including community structures support with equipment and drugs needed for cholera

12. Closing

On closing, Ms Mwelwa Chilufya from Chilenje Health centre, one of the participants gave a vote of thanks. She thanked Fortunate Machingura from TARSC and the LDHMT and Adah Zulu for the support in building capacities of health workers and communities at a time when interaction issues were priority in Zambia. She observed that it was fact that health workers were being beaten and abused by communities based on accusations of ignorance, lack of care amongst other things. She added that while health workers continue to blame communities for not understanding health workers, the workshop had shown that this situation would persist unless communities and health workers work together and address their differences.

"Facilitators, the stepping stones, the Margolis wheel, ranking and scoring and the HL manual will sure go a long way in changing attitudes in Zambia. PRA is uniquely placed in the HL approach. Its amazing how HL is so simple yet so empowering, we are looking forward to this and thanks for your support. " **Mwelwa**

Fortunate Machingura from TARSC thanked all participants on behalf of TARSC, EQUINET and CORDAID for participating fully. She encouraged each one of the participants by name to support effective interaction between health workers and communities. Adah Zulu the Health Literacy Focal person for Zambia, also a facilitator of the workshop acknowledged support from the Ministry of Health and encouraged participants to keep the momentum. Dr Clara Mbwili - Muleya the District Health Officer for Lusaka Zambia was very grateful that all participants had enjoyed the training workshop.

Participants were encouraged to read their manuals more and seek advice on areas they need more information on from Health workers and other experts working in areas of health. We agreed that the baseline survey would be conducted in April 2011 and the phase one HL training workshop would be held immediately after the baseline with 4 health workers and 30 community members.

13. References

1. Loewenson R, Kaim B, Machingura F (2011)Strengthening Health Worker-Community interactions through participatory interactions and health literacy-combined protocols for the work- TARSC Zimbabwe; HEPS Uganda, Lusaka District Health Management Team (LDHMT); EQUINET, TARSC, Harare
2. Loewenson R, Kaim B, Mbuyita S, Chikomo F, Makemba A, Ngulube TJ (2006) Participatory methods for people centred health systems A toolkit for PRA methods, TARSC, Ifakara , Ideas Studio, Harare
3. Loewenson R, Kaim B, Machingura F (TARSC) Kelemi C (BONELA), Mhotsha G (BFTU) (2009) Health Literacy guide for people centred health systems: Botswana, TARSC: Harare

14. Appendices

14.1. The Director's opening speech

Welcome Speech By The Lusaka District Medical Officer Dr Roy Chavuma
At The Workshop On Health Literacy Training Programme Supported By Training And Research Support Centre (TARSC), Held 29th March-1st April 2011 At ZAMCOM Lodge, Lusaka.

- the representative ministry of health
- the representative provincial health office
- The facilitators from TARSC and Lusaka DHMT
- the participants
- distinguished guests

Firstly I would like to thank you for giving me this opportunity to officiate at this important workshop.

I am reliably informed that this is yet another breakthrough in terms of he community and health worker interaction under the participatory reflection and action (PRA) initiative which started in 2006 in two Zambian districts namely Chama and Lusaka.

The PRA approach was initiated with a view to improving and strengthening effective involvement of community members in health programmes. The programme resulted in tremendous improvement in interactions between health workers and the community members at the selected health centers that participated; and in Lusaka these were Chipata and Matero reference health centers in phase 1; and extended to Mandevu and George HCs in phase 2. It is due to these recorded achievements that we have been given yet another task to add another component to strengthening health worker and community interactions in the name of health literacy. The focus of this training is aimed at building health literacy capacities using participatory approaches resulting in a pool of local facilitators that will in turn contribute to scaling up health literacy and participatory approaches to other health facilities with the aim of strengthening the health system through improved communication and interaction between the key players.

Participants, ladies and gentlemen, it is our conviction that this training is in line with the ministry of health vision of taking health care services as close to the people as possible. we therefore need your concerted effort and we hope that you will use this training as a stepping stone to addressing the challenging health issues we face as Lusaka district health workers and community members. Ladies and gentlemen, Lusaka DHMT is open to any suggestions that will help move this initiative forward, therefore feel free to make them.

I therefore wish you all a very successful training and take this opportunity to thank the funding organization and TARSC Zimbabwe for their support and commitment to ensuring Lusaka district continues to strive to provide people-centered health services. Please keep up the good work.
I now declare the Health Literacy training workshop officially open.
I thank you and God bless you all.

14.2. Participant list

No.	NAME	POSITION	HEALTH CENTRE	CONTACT DETAILS. Email
1.	Mwelwa Chilufya	Health worker	CHILENJE HC	0974389250 chilufydenise@yahoo.com
2.	Kakoma Samudata	Health worker	CHILENJE HC	0979663114 kakomasamudata@gmail.com
3.	Margaret S Mulabe	Health worker	CHILENJE HC	0966577032 msmulabe@yahoo.com.uk
4.	Irene K Nyirenda	Health worker	MRHC	0979221028
5.	Davison Chibilika	Community member	MRHC	0979775343
6.	Grace Kashoka	Community member	CHIPATA	0979491914
7.	Regina Temani	Community member	CHIPATA	0979755618
8.	Roy Chavuma	DMO	DHO	0966763698
9.	Bertha Kaluba	SNO	DHO	0977767570
10.	Christine Shawa	Health worker	MATERO REF	0977512380
11.	Ireen Zulu	Health worker	MATERO REF	0969483403 ireenzulu@yahoo.com
12.	Whiteson Chibelya	Community member	CHILENJE	0978290221
13.	Raymond Chirwa	Community member	CHILENJE	0977624642 pastorray05@yahoo.com
14.	Christopher Moondwa	Community member	CHIPATA	0979543170
15.	Mutemwa Kawana	Health worker	MATERO REF	0976918563
16.	Janet Banda	Community member	MATERO REF	0979189270
17.	Robert Banda	Community member	MATERO REF	0977489751
18.	Joel Kunkuta	Community member	CHILENJE	0977448443 kunkutajoel@yahoo.com
19.	Boniface Muzantani	Health worker	CHIPATA	0977676436
20.	Harriet M Zuze	Health worker	CHIPATA	0977746136
21.	Rhodah Lungu	Health worker	CHIPATA	0977465771
22.	Lunguwe L Mwitumwa	Health worker	CHIPATA	0977428103
23.	Moses Lungu	Workshop PRA Facilitator	CHAWAMA	0977782198 moseslungu@yahoo.com
24.	Mercy Lishandu	Community member	MATERO REF	0975409067
25.	Fortunate Machungura	Health Literacy Program Coordinator East &southern Africa	TARSC	+263772971481 fmachingura@gmail.com fortuate@tarsc.org
26.	Adah Zulu Lishandu	Health Literacy Program Focal person-Zambia	MATERO	0977803567 adahzulu@yahoo.com
27.	Clara Mbwili Muleya	MPD / PRA - Facilitator	DHO	0977827276
28.	Leah B Kanene	Health worker	DHO	0979156137 lkanene@yahoo.com
29.	Monde M C Imasiku	Health Worker	DHO	0977378438 cimasiku@yahoo.com
30.	Paul Kasonkomona	Community member/civil society	CSHF	0977421548 paulsitive@yahoo.com
31.	Beatrice Mwape	MOH Chief Health Promotion Officer	MOH	0977762132
32.	Patrick Kamangala	MOH Senior Technician		

14.3. Programme

DAY ONE – TUESDAY 29 MARCH 2011

TIME	SESSION CONTENT	SESSION PROCESS	ROLE
Welcome, objectives, introductions			
0800-0830hrs	Registration, logistics	Participant registration	**Adah Zulu** **Moses Lungu**
0830-0900hrs	Welcome	Welcome remarks	Dr Roy Chavuma DMO Lusaka distrci/Director LDHMT
0900-0930hrs	Opening Introductions: Workshop objectives,	LDHMT opening facilitators and Participants Clear outline of the aims and objectives of the workshop.	Dr Roy Chavuma Adah Zulu Fortunate Machingura
0930hrs-1000hrs	Overview of the health Worker Community Interactions	Brief introduction to the work on Health Worker community Interaction and approach to training	Fortunate Machingura
LDHMT and TARSC work on health			
1000hrs-1030hrs	**TEA**		
1030hrs-1100hrs	Background on LDHMT	Information on LDHMT, its objectives, vision and mission LDHMT work on PRA in EQUINET	Adah Zulu
1100hrs-1115hrs	Background on TARSC	TARSC, its role and work in ESA particularly on HL and PRA	Fortunate Machingura
Linking Health Worker-community interactions to health literacy and PRA			
1115hrs-1300hrs	Using PRA approaches in health	**Module 1.3 and 1.4** Intro to PRA; role of facilitators in PRA (page 5 and 7 HL manual)	Moses Lungu Adah Zulu
1300hrs-1400hrs	**Lunch**		
Linking Health Worker community interaction to health literacy and PRA			
1400hrs-1530hrs	Approaches to Health Worker community Interactions using health literacy and PRA in health	**Module 1.1 and 1.2** Understanding Health literacy (page 1 and 4 HL manual)	Fortunate Machingura
1530hrs-1600hrs	**Day evaluation and TEA**		**Fortunate Machingura,**

DAY TWO – WEDNESDAY, 30 MARCH 2011

TIME	SESSION CONTENT	SESSION PROCESS	ROLE
0900hrs-0930hrs	Review and logistics	Logistics, Recap of day one and Warm-up exercise	Adah Zulu
Health Worker-Community Interactions and the Health Literacy work			
0930-1030hrs	Understanding health worker community interactions	**Module 6.5 page 131 HL manual**	Fortunate Machingura
1030hrs-1100hrs	***TEA***		
1100hrs-1130hrs	Organisation of the Health Literacy Manual	• The contents, organisation of sections and modules • Facilitator and community plans • How it has been used in other countries	Fortunate Machingura
The Health Worker-Community Interaction Protocol			
PHASE ONE of the Health Worker-Community interaction Protocol			
1130hrs-1200hrs	Overview of the PRA/HL protocol and the HL/PRA process	• How the protocol will be used, when, by whom with whom? • Organisation of work over 3-6 months in 3 sites and the role of the Facilitators and communities in the process	Adah Zulu
1200hrs-1300hrs	Mapping the catchment area of the primary care service	Community mapping Module 2.2 page 22 HL manual	Adah Zulu
1300-1400hrs	***LUNCH***		
1400hrs-1445hrs	Identifying priority health problems in the community	Ranking and scoring Module 2 .2 p 24 HL manual	**Moses Lungu**
1445hrs-1530hrs	Identifying the causes of our problems	But why? Module 2.3 p 29 HL manual	Adah Zulu
1530hrs-1600hrs	Day evaluation and TEA		*Moses Lungu*

DAY THREE – THURSDAY 31 MARCH 2011

TIME	SESSION CONTENT	SESSION PROCESS	ROLE
0800-0900hrs	Review and logistics	Logistics,	**Moses Lungu**
0900hrs-0915hrs	What can we do about these causes?	Group work Module 2.4 p30 HL manual	Moses Lungu Adah Zulu
0915hrs-1015hrs	Using Health Literacy to act on our priority health needs (deepening our knowledge of Health Literacy using PRA approaches)t	HL Manual section depends on the priority	Fortunate Machingura
1015hrs-	**TEA**		

1030hrs			
1030hrs- 1230hrs	How can we work together to address our health problem, (what are the barriers to this, and how can we address these barriers)	Stepping stones PRA toolkit Activity 18(activity separately provided for this training- see protocol)	Fortunate Machingura Clara Mbwili-Muletya Adah Zulu Moses Lungu
1230hrs- 1300hrs	Developing a HW-Community action plan for joint implementation	Planning and Progress Markers Using the HL facilitator monthly feedback form	**Moses Lungu** **Fortunate Machingura**
1300-1400hrs	**LUNCH**		
1400hrs- 1430hrs	Consolidation, next steps and agreement on feedback for next meeting.	Discussion on the importance of consolidation and planning for action, action and feedback expectations in the following meetings	Adah Zulu
Baseline and Follow up Assessment Protocols			
1430hrs- 1530hrs	Orientation on the use of the baseline protocol and follow up	• Understanding the objective of the baseline survey and follow up assessment • Understanding the content and meaning of questions that make up the survey tool	Fortunate Machingura,
1530hrs- 1600hrs	**Day evaluation and TEA**		**Adah Zulu**

DAY FOUR – FRIDAY, 01 APRIL 2011

TIME	SESSION CONTENT	SESSION PROCESS	ROLE
0900hrs-0915hrs	Review and logistics	Logistics, Recap	**Adah Zulu**
PHASE TWO of the Health Worker-Community interaction Protocol			
0915hrs-0930hrs	Linking Phase one with Phase two: review actions taken by health workers and community groups since the last meeting	discussion	Fortunate Machingura
0930hrs-1000hrs	Review: Progress Markers and discussion on progress and obstacles	Group work, wheel chart Mod 7.2 p142 HL Manual	Fortunate Machingura,
1000hrs-1030hrs	**TEA**		
1030hrs-1130hrs	Exploring communication styles and assumptions between health workers and communities	Johari's Window: Activity 27 PRA toolkit (activity separately provided for this training- See protocol)	Adah Zulu
1130hrs-1230hrs	Strengthening communication with health workers	Margolis Wheel Mod 6.5 p 134 HL Manual	Fortunate Machingura
1230hrs-1300hrs	Identifying structures THAT exist at community level that facilitate health worker/community dialogue and actions	Group work and discussions	Adah Zulu
1315hrs-1400hrs	**Lunch**		
1400hrs-1430hrs	Reviewing and revising Action Plans, Use the HL manual to facilitate planning and acting on priority health needs (deepening the knowledge)	Group work, discussions	Fortunate Machingura, Adah Zulu
1430hrs-1530hrs	Next Steps Closing and goodbyes	Follow up, communication, feedback, monitoring and Closing	Fortunate Machingura Adah Zulu; Moses Lungu Dr Clara Mbwili-Muleya
1530hrs-1600hrs	**Day evaluation and TEA**		Adah Zulu

Uncollected garbage Lusaka 2011
© F Machingura TARSC - Health workers and communities planned joint action to address uncollected garbage in residential areas, in public places in the central Business District