

National launch meeting of the Zambia Health Literacy Programme

REPORT



Lusaka, Zambia
26 July 2012



Ministry of Health Zambia and Lusaka District Health Management Team with

Training and Research Support Centre
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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Cover photo: workshop delegates, A Zulu LDHMT, July 2012

National launch meeting of the Zambia Health Literacy Programme

1. Background

Comprehensive, Primary Health Care oriented, people-centred and publicly led health systems appear to have the greatest benefit to disadvantaged communities, especially when they build in additional measures to support effective uptake in these groups. Many ways have been developed to empower people in health, with some evidence of health gain.

A growing network of institutions in the region in EQUINET, led by TARSC and with involvement of LDHMT, have 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.

Health Literacy, a process of information and skills building on health for action, has been found to provide the space for communities to express and shape their health programmes and services at Primary Health Care level, especially when using participatory methods. Health literacy refers to a process of reflecting on experience, informing and empowering people to understand and act on health information to advance their health and improve their health systems. It builds knowledge and capacity to act within a framework of participatory reflection and action that strengthens community level diagnosis, action and engagement with health systems. 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.

In 2006-2009, as part of the regional learning network, LDHMT used participatory action research (PAR) to strengthen joint planning and communication, co-operation and trust between communities and health workers. In 2010, building on positive changes found, LDHMT with TARSC and with Cordaid support piloted a programme to train health literacy facilitators and hold community health literacy sessions in 3 areas of Lusaka. The positive feedback from that programme led to dialogue with the Ministry of Health and the proposal for national level implementation of the healthy literacy (HL) programme. This national stakeholder workshop was thus held with lead stakeholders to review the work done to date and discuss the content, approach and steps towards implementing the programme at national level.

Aims: Specifically the workshop aimed to:

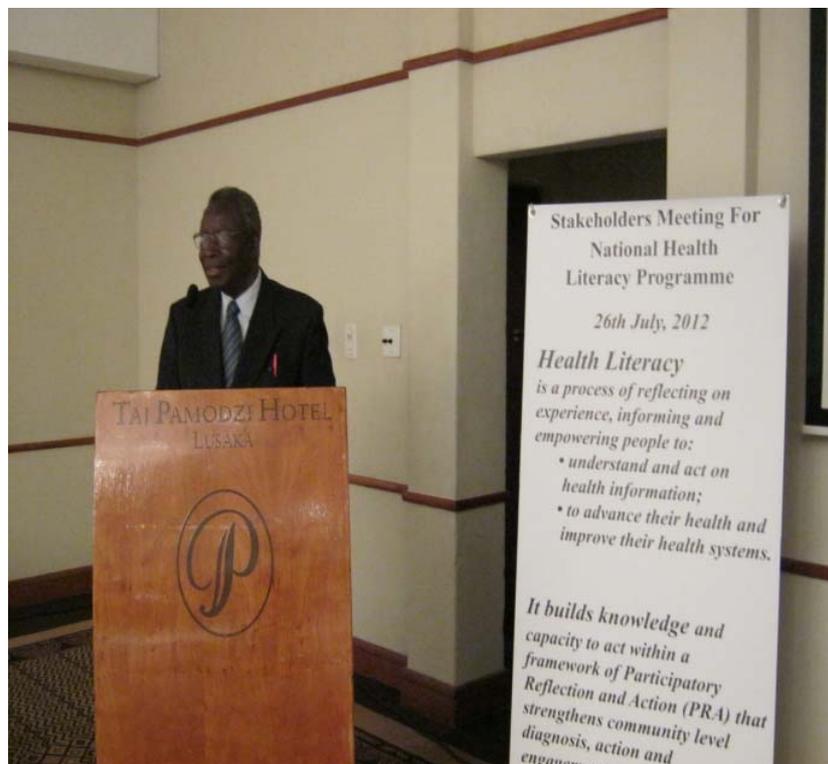
- Present and discuss the experiences of and learning from the HL and PAR work to date
- Identify options for scale up of the programme, including the core curriculum, the institutional leads, processes and monitoring and evaluation framework .
- Form a National health literacy committee to take the work forward and follow up on and monitor the programme

The participants for the meeting included Ministry of Health Zambia, LDHMT, Ministry of Community Development, Mother and Child Health; Ministry of Education; Lusaka city council; ZAMFOHR, Communication Support for Health; Midwifery association of Zambia; non state partners; HL facilitators from the three pilot areas a) Chilenje b) Chipata and c) Matero reference health centres and TARSC (See delegate list Appendix 1). The facilitators were Dr Elizabeth Chizema, MOH, Adah Zulu Lishandu, Dr.Clara Mbwili-Muleya, LDHMT and Dr Rene Loewenson, TARSC. This report presents a summary of the presentations and discussions at the meeting (see programme Appendix 2).

2. Opening

The meeting commenced at 09:00hrs with introduction and welcoming remarks from Dr Elizabeth Chizema, Director of Public health, Ministry of Health, who was standing in for the Permanent Secretary Dr Peter Mwaba. She expressed appreciation to those present for coming to this important stakeholders meeting for the national health literacy programme. She described Health Literacy as an initiative aimed at empowering communities to identify and tackle their own health issues in their communities, giving examples of actions on water and sanitation; sexual and reproductive health; alcohol and drug abuse and HIV and AIDS. The process of communities tackling their own health issues is in line with the MoH's vision of taking health services as close to the family as possible. Health literacy fosters collaboration and dialogue between health workers and communities which goes a long way in solving and finding solutions in our diverse communities. She urged those present to participate fully in order to achieve the objective of effectively scaling up this valuable Health literacy initiative. She thanked people present acknowledged the organizing team, the HL Facilitators present and Cordaid support. She invited the Minister of Health Hon Dr Joseph Kasonde to officially open the meeting.

Dr Joseph Kasonde, the Minister of Health officially opened the meeting. After salutations to those present, in his opening speech he welcomed the initiative, and noted that it was important for it to spread across the whole continent. He appreciated that the adoption of this as a national programme was based on work that was implemented within Zambia, making it a home-grown programme, and appreciated the support of TARSC/EQUINET and Cordaid in the process. His full speech is included below:



Hon Dr J Kasonde, Minister of Health, Zambia at the opening

“The just ended conference on cervical cancer revealed, among other things, a strong desire by the community to know more about health, the causes of ill-health and what can be done about these factors. This concern is inevitable. For many years now health workers the world over have acknowledged and welcomed the growth of a generation who know more and more about their own health and can be done to promote it. This state of being knowledgeable about health matters in general and one’s own health in particular is called “health literacy”. It is an attribute on which healthcare services must build, and without which health services cannot be effective.

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.

The Ministry of Health, through Lusaka District Health Office has been involved in a regional programme of work in co-operation with the Training and Research Support Centre (TARSC) in Harare, Zimbabwe, the Coalition for Health Promotion in Uganda and the Regional Network for Equity in Health in East and Southern Africa (EQUINET) aimed at:-

- Building community and organizational level capacities in health literacy; and
- Setting up health literacy programmes to strengthen community–health worker relations and improve women’s health.

These efforts build on participatory, reflection and action (PRA) work done since 2006 to strengthen communication between health workers and communities in the *pro4equity network* in East & Southern Africa (ESA), and particularly that done in Zambia by Lusaka District Health Management Team. In light of the positive outcomes from the work done in the pilot areas of Lusaka District, the MoH in Zambia is looking to scale up to other health districts in the country and to institutionalize the Health Literacy (HL) programme.

It is for this reason that the Ministry of Health has organized this initial stakeholder meeting with the following objectives:

- To present the experiences of the HL and PRA work within the Ministry of Health, the wider civil society and partners;
- To form a national health literacy committee to take the work forward.
- To identify options for scale up of the programme, the core curriculum as well as the institutional leads;
- To identify the processes and monitoring and evaluation framework for this scale up.

As Government we consider community involvement key in the development of our country and essential in addressing the health inequities in the health service delivery system. We are particularly concerned with improving the status of our women through empowering them with reproductive health knowledge. It is through health literacy programmes such as this one that women can learn on how to overcome barriers to seeking sexual and reproductive health care services which in turn will contribute to reducing maternal and child morbidity and mortality. MoH is committed to ensuring that the HL programme succeeds and in this vain wish to acknowledge CORDAID, TARSC and EQUINET for supporting this initial process for the national scale up in Zambia.

As MoH we will ensure that the scale up programme is included in the annual health plan; however the MoH is also cognizant of the fact that improving community health outcomes requires support from many sectors and hence the appeal to all of you present to contribute to this pioneering initiative.

In conclusion, I see this exercise as the beginning of a major movement: a movement to transform our society into a community of health literate men, women and children who will be the fertile soil upon which the seeds of healthcare will thrive. You have a big challenge to nurture this movement to great heights: you also have the capacity to do it. Do it I have a personal interest in health literacy and I hope to be kept updated on the progress of the programme.

I wish you all a productive and successful deliberation and declare this stakeholders meeting for the National Health Literacy Programme officially open.

Thank you and God bless”.

3. Health Education, Community Participation Progress and Challenges

Elizabeth Chizema, Director of Public health, Ministry of Health presented an outline on the Ministry of Health approach to health education. She noted that health education refers to those processes of empowering communities with information so that they are enabled to take correct actions towards the attainment of healthier lives. It comprises, consciously constructed opportunities for learning involving some form of communication designed to improve health literacy, improving knowledge, and developing life skills which are conducive to individual and community health.

Health in turn is defined as the state of “Complete physical, mental, spiritual and social well-being and not merely the absence of disease.” It follows therefore that Health Education should go beyond

considerations of disease but also take in its wake economic and social factors that influence health. On the other hand Community participation is when community members and other stake holders come together to work on communal health programs that improve the health and welfare of the community.

Community participation generates dialogue, negotiations and consensus among a range of players that include decision makers, media, NGOs, opinion

leaders, policy makers and private sector in the community.

During the process Individuals, groups or organizations identify needs, plan, carry out and evaluate activities on a participatory and sustained basis, so as to improve health and other needs, either on their own initiative or stimulated by others.

She then explored the challenges and successes in implementing health education in Zambia. In dealing with the issues of Health Education and Community Participation, the Ministry conforms to the realm of logic arrived at during the Ottawa Conference on Health Promotion held in Canada in 1986. Here five action areas were arrived at. For the purposes of this meeting she raised only the relevant two, ie .

- Increasing individual knowledge- :We have a considerable robust Health Promotion Program that supports personal and social development through providing information and education for health and enhancing life skills. The major aims are to increase the options available to people to exercise more control over their health and environment, and to make choices conducive to health. The Education and communication effort uses a combination of several channels such as meetings, drama, radio, television and print materials. The messaging is packaged to achieve different goals such as, creating demand for interventions e.g. family planning, immunisation, cancer screening etc. Increasing access to services e.g. announcing



Dr E Chizema, Ministry of Health, Zambia

availability of sites for services or addressing the underlying causes of diseases such as HIV/AIDS.

- **Strengthening Community Action:** The Ministry endeavours to empower communities to implement and own community projects by utilizing existing human and material resources existing at community level to enhance self-help and social support and to strengthen public participation in health matters.

However she noted that the program has its challenges. These include limited resources, the process of mounting effecting Education and Community mobilization requires huge investment in terms of funds and facilities. Health Education and Community mobilization are not a one off process, but a process that need repeating thereby ending up being more costly. The other challenge is staffing especially at district and community levels.

With the foregoing challenges she noted that it is important to encourage communities to supplement the efforts of the Health Sector via such programs like the Health Literacy Initiative. Thank and God bless.

4. Regional experiences with participatory approaches and health literacy

Dr Rene Loewenson,. TARSC/EQUINET presented an outline of the regional experiences with participation and health literacy. She noted that participation makes a difference in health systems, that PHC policies that have been adopted in all ESA countries make public participation central to health systems and that active, informed participation improves action on social determinants, can improve autonomy, especially in women, can improve health care use, experience and outcomes. Meaningful participation occurs when people are informed, able to plan and act, are capable of organizing, participate in decisions and can overcome power imbalances that stop them from improving their health. For example, women have less influence over health care related decisions and less control over the finances to meet health care costs. Poor households lack the information and power to demand effective services from the health system, have fewer resources to pursue alternatives and may delay seeking treatment or become indebted to meet health needs.

She explained the principles of PAR that are central to Health Literacy, including that local people are creative, they know their own problems and if they identify them collectively build knowledge and social organisation to act on them. Participation enables ownership of interventions at community level

She explained the spiral model of building participatory knowledge for action, that

- Systematises local experience
- Organises reflection, analysis on relationships, causes
- Uses collective validation to generate knowledge
- Links analysis to community voice and action
- Builds local control over new knowledge



THE SPIRAL MODEL

Dr Loewenson then presented how these approaches were used in participatory action research in the region, and specifically in

Namibia, Zimbabwe, Uganda, Zambia, Malawi, South Africa, Tanzania, Kenya, DRC. She described how the work benefited frontline health systems, supported effective uptake of services, increased co-ordination, and co-operation and trust between communities and health systems and raised local resources for PHC, while noting that it was not able to tackle deeper determinants outside the control of local health workers or communities.

Some of these deeper factors called for wider national actions and for institutionalizing participation in planning, budgeting, in the policy guidelines on services and in mechanisms for decision making. One of the approaches towards widening and institutionalizing participation is health literacy.



Dr Rene Loewenson, TARSC, EQUINET

She confirmed earlier definitions that health literacy refers to people's ability to obtain, interpret and understand basic health information and health services, and to use such information and services in ways that promote their health.

"Literacy is not simply the ability to read and write. It is also the ability to understand, communicate and use information to support action"

Finally, she outlined the HL programme in the region and presented the materials developed in Zimbabwe, Malawi, Botswana and the widening of the programme in Uganda and Zambia. After three years of HL work in the region an external evaluation had found in 2009 a number of benefits, including 'effective in strengthening capacities in participatory public health promotion'; 'that it was extremely beneficial at the community level', with communities increasingly taking responsibility to organise and act on health, changing health behaviour, and improving health service uptake in vulnerable groups, and that the content was relevant, comprehensive and easy to use. There were also challenges, including the need for stronger systematic monitoring of impacts; for formal recognition to institutionalise and sustain resources and for material development capacities in countries to add new modules. She noted that these issues would be taken into account in the Zambia programme, which was already building on a strong base. After the presentation there was some discussion with delegates on different aspects of the regional programme and the learning for Zambia.

Building on a strong base for HL in Zambia

Go with the people:
Live with them.
Learn from them.
Love them.
Start with what they know.
Build with what they have.

But, of the best leaders,
When the job is done,
the task accomplished,
The people will all say:
"We have done this ourselves."

Lao Tsu



Ministry of Health



Cordaid

5. Experiences of Health Literacy in Zambia

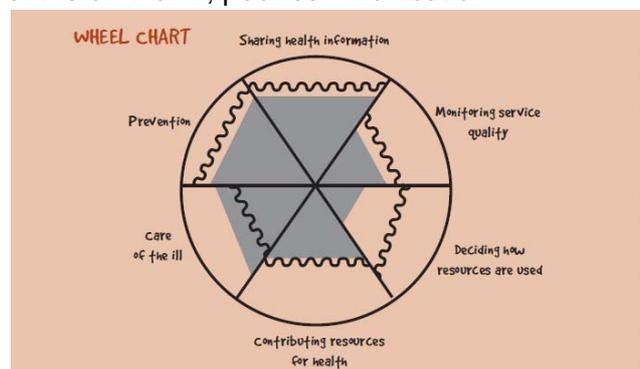
Dr Clara Mbwili-Muleya, of the Lusaka District Health Team, described how in the early 1990s Zambian government health reforms aimed at enhancing the health system at all levels. This included providing equity of access to cost effective quality health care as close to the family as possible', based on leadership, accountability, partnerships, sustainability. However misunderstandings between health workers and community members on resources have arisen. These arise as the conventional training of health workers assumes that clients are not knowledgeable on health issues and as community members are not engaged in planning, budgeting and implementation. One result is a mismatch between policy and practice in health services delivery and outcomes. The team in Zambia hypothesized that PAR could be used to improve relations between health workers and community members within a public health system, complementary to the quantitative methods that provide evidence for health system strengthening.

In 2006/7, PAR was implemented in two Zambian urban Lusaka and rural Chama districts at health centre level, to strengthen information sharing for planning, budgeting, resource allocation and activity implementation (PIB); involve health worker (HW) and community members (CM) at health centre level and tools to identify needs, proposed actions, systems barriers and changes needed for PIB. In 2008/9 in Lusaka we again used these methods to assess feasibility of scale up to new health centers, while consolidating and building capacities for institutionalizing the approaches in existing centers. Both intervention studies used an iterative spiral model of participation, reflection and action carried out by health workers and community members involved in health activities at the selected health centres. Experiences, issues and areas for change were obtained using participatory tools during combined workshops of health workers and communities, followed by an implementation phase of the activities planned. Regular review meetings were held to reflect on activities and outputs achieved, followed by identified further necessary action. A pre and post intervention questionnaire was administered to participants to assess change.

Dr Clara Mbwili Muleya presenting the PAR work in Zambia



In 2006, following the PAR process outlined in the regional programme earlier, the research identified blocks in joint planning, including fear of the unknown; poor communication between and among health workers and community members, poor understanding of roles; health workers perception that community members have low knowledge on health issues; and community members feeling powerless and unappreciated by health workers. There were also system level barriers, with few fora or resources for health workers and community members to exchange as equal partners. The PAR itself, the shared identification of factors and the dialogue it build across health workers and



community members on actions to remedy problems had a direct impact on the system. Information sharing between health workers and community members increased, community members were able to approach health workers for information more confidently, and health workers provided information to community members on planning and resource allocation. The process led to a change in perceptions, understanding of constraints and behaviours around the planning process and increased the mutual respect between health workers and community members.

The 2006 project showed that the participatory methodology improved communication and interaction between community members and health providers, and strengthened the inclusion of community and primary care workers priorities in health plans. The follow up work found that sustaining participatory approaches progressively de-mystify and increase community involvement in planning and budget processes, strengthen dialogue and resolve issues in the interface between communities and health workers. When the PAR was scaled up to new areas of Lusaka in 2008/9, it was found to build communication, trust, transparency and accountability. It did not require significant resources, but did need to be encouraged by feedback and strategic review. It can be scaled up and sustained in district health systems through horizontal capacity building, mentorship as part of routine duties. This takes time and leadership support. Institutionalizing the process calls for mentoring and resource support in early stages, and for integration within routine work, support by authorities, and orientation of new health workers.

Mrs Adah Zulu Lishandu highlighted the main features of the health literacy work in 2011, including its successes impact and changes observed. She noted that the work used the process of reflecting on experience, informing and empowering people to understand and act on health information to advance their health and improve their 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. This process was used in 3 catchment areas of Lusaka positive out comes were observed it

Ms Adah Zulu Lishandu presenting the HL work in Zambia



helped community own their health problems and involved various stake holders to improve their health. Media, civic leaders, banks, churches were part of the change process. In Lusaka the participants for the HL 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. Similar problems of distrust, anger and resentment were reported. The team explored the interactions between health workers and communities by sharing people's current experience in their interactions. While participants presented their experiences, the team realised that everyone wanted to share an experience and the tension between health workers and communities immediately emerged. They gave more time to share and discuss these experiences using a PRA tool- the Margolis Wheel. The tool identifies challenges faced by health workers in communicating with communities and communities suggest solutions to address the health worker problems in a dialogue fashion (and vice versa). Following the dialogue in the HL programme people identified actions that they organised and implemented. In Matero, 56 participants participated in the removal of waste in the Chingwele market. Health workers, community volunteers the market vendors, members of the public outside Matero catchment area MTN , media including MUVITV and

TV2 ZNBC were involved. In Chilenje, a hundred people participated in the clean up campaign done at Chifundo market. The participants were drawn from community members in Zone 1 to Zone 10, vendors, Health Literacy facilitators, Police, Ward Development committee members, health workers and community health workers. About 40 people participated in the Chipata garbage removal activity. The participants were drawn from local government, Health centre management, Community based organisations/ groups such as Chicobaf run by community members, Lions Club Of Emmasdale, Chipata police post ,Danny Enterprise, community HL facilitators and health workers. The activities highlighted the ability of communities to organise and mobilise resources to address the health problems they prioritised.

6. Planning for the national health literacy programme in Zambia

The participants present were divided in three groups to discuss and propose plans for the next steps in terms of

- The contents of the Health literacy manual
- The organization of the Health Literacy training
- The coordination mechanism and links with other actors.

The feed back of the work was chaired by Beatrice Mwape from Ministry of community Development, Mother and Child Health. The groups presentations were then discussed in plenary and the final outcomes are summarised below:

GROUP 1.Content of the Health Literacy materials:

Given that the manual is designed to support facilitators and should be relevant to comprehensive health and health system issues, the group reviewed the content areas in the current regional manual to make additions/ subtractions and note specific issues for inclusion.

The group proposed that

- In Module 1: Introduction to Health Literacy, some information on myths and misconceptions be included, as well as information on what is already being done on HL and the case study of the work in Zambia by Lusaka.
- In Module 2 – The health of Communities, the role of all actors in health be included (such as through a panel discussion with civil society, churches, civic and traditional leaders) and a case study be added for discussion on alcohol, smoking and drugs, in youth to raise the issue of non communicable diseases and social determinants.
- In Module 3 – Healthy Nutrition- the campaign for traditional foods be included, as well as Zambia's position on GMO foods, updated food safety guidelines and information on food preservation and storage. It was suggested that information also be raised to encourage nutrition gardens.
- Module 4 – Health Environment, it was proposed that the module also include information on solid waste management and recycling; typhoid and the environments faced by health workers. A definition of safe water needs to be given.
- In Module 5 – Health Life Cycle, it would be important to include couple

HL materials and reports on display



counseling and testing (CCT) in VCT, and to update with paediatric HIV treatment regimes and the scope of family planning services

- In Module 6 & 7 – Understanding Health Systems, the group noted the need to raise the range of institutions in Zambia, and the measures to strengthen communication among stakeholders and line ministries. The module should present the focal point persons at all levels- MOH, Min of Local Government & Housing, Min Community Development, Mother & Child Health and encourage the stakeholders in health to co-ordinate within a shared forum, especially in civil society.

Group discussions on the HL content at the meeting



The material will be developed by TARSC and a local health writer working with MoH and LDHMT in 2012. It will be piloted and peer reviewed before it is finalised and printed. It was noted that as it is printed as a resource file, new modules can be added over time.

GROUP 2.Organisation of the Health Literacy training programme gave advice on the organisation of the programme in terms of the target facilitators, their training, the community literacy activities and the review of the work.

The group noted that facilitators are needed at provincial, district and health centre level and particularly in the community. It was proposed that a pool be built of potential trainers within provinces from amongst the health literacy facilitators trained at district level. Various cadres who have health promotion functions can be drawn on for the training, ie

- Provincial health promoters (Nutritionists, Environmental Health Technologists included)
- District Health promoters (officers working with community workers eg EHT, Nutritionist, Education, MCH etc)
- Health centres (EHT, Nutrition, MCH, CO, Peers) to incorporate other ministries & stakeholders

While one model was proposed of top down training- centre → province → district → health centre → community it was raised in the plenary that this will take too long to get to community level and to produce change and that it will also need build the community experience needed to be a HL trainer. Hence an alternative model was adopted whereby each province will train within districts facilitators at health centre level as in Lusaka (drawing initially on the training skills in Lusaka), and then after these have applied the HL at community level, will chose the best of these to provide further training to so that they can now train in other districts, in each case building a wider pool of potential trainers. While the district and provincial level need to be involved in and support follow up to the training it was noted that the HL programme needs to grow from the bottom up.

It was proposed that the provincial and district cadres support the sampled districts where facilitators are trained, with mentorship from the national team.

The group proposed that there needs to be a mapping of existing trained cadres in districts for literacy of any kind to integrate into the programme.

It was proposed that the first round of training cover three provinces (three districts in each) and one further district in Lusaka. There was no final agreement on which and this is to be resolved with MoH after mapping of the existing capacities.

Review of the programme progress should be done quarterly using:

- Action plans developed by teams
- Activity reports (showing achievements, events etc)
- A check-list to be developed as standard monitoring tool
- An annual review meeting for provincial and selected District facilitators.

It was agreed that LDHMT as secretariat and Ministry of Health will finalise the training plan for the provincial training to be implemented as soon as the manual is complete. This will give time for the mapping exercise to be done in 2012 and used for review of provinces and districts to be included.

GROUP 3.Coordination mechanism and links with other actors –The group discussed how the HL programme will be co-ordinated in the Ministry of Health and with other key institutions. It also discussed the terms of reference of the national HL committee/ task force that will co-ordinate and review the work in the programme. The group presentation was debated in plenary.

The group identified core institutions for the programme and thus members of the national HL task force as MoH (in the lead), MCDMCH, LDHMT (secretariat), Local government; 1-2 civil society members, ZAMFOHR¹

It was noted that a range of other stakeholders may be co-opted when needed to this group and may be informed and linked with on the programme, including other Ministries (education, information, chiefs; agriculture; Civil Society Organisations; Faith Based Organisations; Media; Community based organizations and associations; and others such as Zambia Environmental Management Agency; Parliament.

It was proposed that the national HL task force have a limited time frame and fulfil the objective of ensuring the national HL scale up. The meeting identified that the national HL task force be responsible for

- Guiding, overseeing and reviewing programme implementation , including review of districts selected

Group discussions on partner links at the meeting



¹ The representation was agreed as institutional but the names for the current committee were noted as MOH Dr Chizema, R Masilani, G Sikazwe; Mr Mate Mulonda; Lusaka DHO, Dr Masaninga, Dr Mbwili-Muleya, Mrs. Adah Zulu Lishandu ; MCDMCH – B Mwape; Local Govt-M Kalumba Civil Society-Treatment Campaign and Midwifery Association of Zambia; ZAMFOHR - Dr Maimbolwa.

- Reporting to policy levels
- Sensitising other institutions, district and provincial structures and guiding links with other HL programmes
- Peer review of the manual and materials of the programme
- Review of the Monitoring and evaluation framework and reports
- Planning the longer term work for the scale up after the initial phase
- Mobilization of policy support and resources for the scale up of the programme

It should meet quarterly. The Secretariat will be MOH and Lusaka DHMT who will implement the work and report back to the quarterly meetings.

7. Next steps and Closing

On behalf of Dr Mwaba, Permanent Secretary MOH, Dr Chizema summarized the way forward based on the outcome of the group discussions as captured in the previous section. She noted that a report would be produced from the workshop that would record the conclusions.

She thanked Dr Loewenson for being part of the facilitating team, the support from Cordaid and urged everyone present to be committed and see health literacy reach further parts of our country. She declared the meeting officially closed at 15:45hours

Appendices

7.1. Participants List

National Health Literacy Stakeholders Meeting

| No | Name | Institution | Designation |
|----|------------------------|---|--------------------------------|
| 1 | Dr Joseph Kasonde | MINISTRY OF HEALTH | Minister of Health |
| 2 | Dr Elizabeth Chizema | MOH | Director Public Health R |
| 3 | Dr Masumba Masaninga | LUSAKA DISTRICT HEALTH OFFICE | Ag District Medical Officer |
| 4 | Dr Matimba .M.Chiko | LUSAKA DHO | Ag PCCO |
| 5 | Dr Dorothy o.v.Mumba | LUSAKA DHO | MO Ic |
| 6 | Dr Clara Mbwili-Muleya | LUSAKA DHO | MPD/PCCO |
| 7 | Dr M.C.Maimbolwa | ZAMFHOR | Director |
| 8 | Dr Rene Loewenson | TARSC/EQUINET | Director |
| 9 | Grace Kashoka | CHIPATA HEALTH CENTRE | HI Facilitator |
| 10 | Davison chibilika | MATERO REF | HI Facilitator |
| 11 | Phidelina .M.Kunda | MIDWIFERY ASSOCIATION OF ZAMBIA | Nursing Sister |
| 12 | Mwelwa . c. kayinda | CHILENJE | HI Facilitator/Rn |
| 13 | Moses Lungu | LUSAKA DHO | PRA Facilitator |
| 14 | Kenny Simamuna | CONSULTANT | Consultant |
| 15 | Mulonda Mate | MOH | DDPHR-MOH |
| 16 | Robert Banda | MATERO REF | HI Facilitator |
| 17 | Mavis Kalumba | LUSAKA CITY COUNCIL | SHEO |
| 18 | Anna Fiedler | CSH | COP |
| 19 | Dorothy Kavindele | UNIVERSITY TEACHING HOSPITAL PEADS | Consultant |
| 20 | Monde M.C.Imasiku | LSK PHO | PNO-MCH |
| 21 | Beatrice Mwape | MINISTRY of COMMUNITY DEVELOPMENT MOTHER&CHILD HEALTH | Health Promotion Officer |
| 22 | Carol Phiri | MCDMCH | Director |
| 23 | Evelyn Chilufya | LUSAKA DHO | Community Coord |
| 24 | Christine .C Shawa | LUSAKA DHO | HI Facilitator/Eho |
| 25 | Moses.C,Phiri | MINISTRY OF EDUCATION | Desk Officer |
| 26 | Idah Zulu Lishandu | LUSAKA DHO | HI Focal Person/Nursing Sister |
| 27 | George Sikazwe | MOH | Chief Health Promotion Officer |
| 28 | Potifar Njobvu | LUSAKA DHO | Transport Officer |
| 29 | Nkhoma Tony | ZANIS | Reporter |
| 30 | Xavier Manchichi | TIMES OF ZAMBIA | Journalist |
| 31 | Mubanga Chimambo | JOYFM RADIO | Journalist |
| 32 | Yande Musonda | MOBI TV | Reporter |
| 33 | Lungowe Simbotwe | MOBI TV | Camera Person |
| 34 | Kalobwe Bwalya | TBZ | Reporter |
| 35 | Monde Phiri | QFM RADIO | Reporter |
| 36 | Gloria Mwape | TBN | Journalist |
| 37 | Grace Mukowane | TBN | Journalist |
| 38 | Teddy Kuyela | DAILY MAIL | Reporter |
| 39 | Angela Mwenda | DAILY MAIL | Photojournalist |
| 40 | Nanatana Kilunda | CHRISTIAN VOICE | Journalist |

7.2. Programme



NATIONAL MEETING ON HEALTH LITERACY

Taj Pamodzi, Lusaka, 26 July 2012



| TIME | TOPIC OF DISCUSSION | FACILITATOR/ SPEAKER |
|-------|--|---|
| 09:00 | Introductions and Welcome Remarks | Dr. Peter Mwaba, Perm Sec Ministry of Health |
| 09:15 | Ministers Opening Remarks/Official Opening | Hon Dr Joseph Kasonde, Honorable Minister, Ministry of Health |
| 09:30 | Health Education, Community Participation Progress and Challenges | Dr Elizabeth Chizema, Director Public Health, Ministry of Health |
| 10:00 | TEA BREAK | |
| 10:15 | Health literacy and participatory approaches at Regional Level | Dr. Rene Loewenson, Director, Training and Research Support Centre, EQUINET |
| 10:35 | Presentation on the Zambian Experience -Participatory Reflection and Action -Health Literacy | Dr. Clara Mbwili-Muleya, Lusaka District Health office Mrs. Adah Z Lishandu, Lusaka District Health office |
| 11:30 | Working Groups 1.Content of the Health Literacy materials 2.Organisation of the Health Literacy training programme 3.Coordination mechanism and links with other actors | Dr. Rene Loewenson Dr. C Mbwili-Muleya Mrs. Adah .Z,Lishandu |
| 13:00 | LUNCH | |
| 14:00 | Feedback From working groups | Chaired by Ministry of Community Development, MCH |
| 14:30 | Formation of National HL Working Group members and Roles | Dr Chizema |
| 15:30 | TEA BREAK | |
| 15:45 | Way forward and Closing remarks | Dr. Mwaba, Permanent Secretary |