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

Health Literacy Training Workshop Report
Kyankwanzi District-Uganda
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Training and Research Support Centre (TARSC) and the Coalition for Health Promotion and Social Development (HEPS Uganda) in the Regional Network for Equity in Health in east and Southern Africa (EQUINET)

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Kiboga area, 2011 © HEPS, TARSC

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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 training held in Kiboga district Uganda was aimed at building capacities of Health workers and communities jointly to work together to strengthen their interactions through health literacy and participatory 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 Kybwanzi District (Former Kiboga District)
- Provide core skills and information to HEPS Uganda 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 HEPS Uganda 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 HEPS Facilitators in Kybwanzi District on administering the baseline and the programme post survey instruments

The participants for the training were drawn from three pilot areas (sub-counties each with its own clinic i.e. a) Gayaza b) Butemba and c) Ntwetwe within Kyankwanzii District. These trained facilitators are expected to use the skills and capacities from the training in their parishes and sub counties 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 Kyankwanzi 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, Mulwanyi Lydia Mukombe; Aaron Muhinda and Phiona Kulabako from HEPS Uganda

2. Opening

Ms Rosette Mutambi the Director of HEPS welcomed delegates to the training workshop. She highlighted that health literacy work would strengthen the social empowerment component of HEPS Uganda.

"The concept being brought about through TARSC, our partners is quite unique…its about ACTION! Know and Act. Knowing is not adequate, it is the action component that is important…for example, the ministry of Health tells us to visit the ANC four times and if you go once you are not health literate because you are not acting. It's the same thing about vaccination, including other services, its knowing and acting! "

Opening with Rosette Mutambi, Kyankwanzi District HEPS 2011

3. HEPS Uganda and TARSC work on health

The Coalition for Health Promotion and Social Development (HEPS Uganda) is a health rights organization that advocates for increased access to quality, affordable essential medicines for the poor and vulnerable people in Uganda. It is a coalition of health consumers, health advocates, health practitioners, CSOs and community-based organisations. HEPS Uganda is concerned about the bottlenecks that hinder access to affordable, quality essential medicines and healthcare. It does this in the districts of Kampala, Mbarara, Ntungamo, Kamwenge, Pallisa, Budaka, Lira, Kyankwanzi and Kiboga. The work of HEPS is achieved through its three main strategic programmes i.e.: 1) Community Empowerment formerly Communty Outreach 2) Health Policy Advocacy and 3) Health counseling and complaints desk **Community Empowerment**; empowering health consumers (men, women, expectant mothers, families, youth and community), to know and demand their health rights and responsibilities including maternal and reproductive rights and responsibilities.

- **Health Policy Advocacy:** advocating for consumer-friendly health laws and policies at all levels through policy analysis & research, policy formulation and monitoring its implementation. HEPS works through coaltion building.
- **Health Counseling & Complaints Desk**;

HEPS Uganda is instituting a redress mechanism and provision of counseling services for health consumers whose health rights have been violated and monitoring of consumer access to health services at different health service delivery levels.

HEPS Uganda has worked with TARSC in EQUINET on community participation and social empowerment in previous years. The work of HEPS in EQUINET was implemented in Kiboga and Kamwenge Districts. The work aimed to contribute to the improvement of the health of expectant mothers using PRA approaches by increasing demand for, access to and utilisation of maternal health services by expectant mothers. This work was implemented as part of a multicounty programme exploring different dimensions of participatory approaches to people centred health systems in east and southern Africa, through TARSC and Ifakara Tanzania in (EQUINET).

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
.

Further, we discussed at length the principles of PRA central to Health Literacy facilitators in building strong effective interactions between health and communities. Some of the principles that were identified are listed in bullets below:

- Local people are creative, they know their own problems and know 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

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

We began exploring the interactions between health workers and communities by sharing people's current experience in their interactions. While participants presented their experiences, we realised that everyone wanted to share an experience and the tension between health workers and communities immediately emerged. We realised that we needed 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).

The experiences were many!

Butemba Sub County: *'Work Load is high versus current staffing levels at the health center. This does not match with the demand of health service from the community. In addition to this each client needs at least 15-30 minutes time with a health care provider. This amount of time is too much compared to the number of patients that we receive per day in relation to the number of health workers at the facility. So when I know that I have huge workloads and a patients need too much time, I am afraid I won't be able to this, in fact this is the source of many our problems in communication with communities"* **Health worker**

Ntwetwe Sub County: *"I had a sick daughter, so I took her to the health centre. The distance is long, so travelling with a sick child you either carry her on your back and you walk slowly, taking every opportunity to rest along the way. You arrive at the health centre very tired. All you want at this stage is to get your daughter treated. Instead I was asked for money first. I had the money in my pocket and I asked the Nurse to treat my daughter first. I knew about the money…I was going to pay after my daughter had been received and receiving medication. The Nurse said, I'm sorry my brother if you do not pay we are not touching your daughter. I was not only filled with anger and desperation, but with spite and resentment. I quickly left the health centre and went to the private clinic where I got very good service. Of course I paid more money; I tell you if I had opened my mouth during the conversation with the Nurse I would have beaten her up!* - **Community Member**

Gayaza Sub County: *"I m not talking about my personal experience but an experience of someone very close to me. I know that people continue to have communication glitches with Health workers on privacy and confidential information. Health workers have failed to keep patient confidential information to themselves. They spread information like gospel to community members living in the same area. I understand that in some health centers in Kyankwanzi and Kiboga districts, the Health centre is just a single big room and privacy issues are just but a dream. This is because your STI problem for example is spoken about in public as if people were discussing relish for last night dinner. The next time I see the health worker who exposed my dirty linen in public, I will surely try to find something to expose him/ her too- 'an eye for an eye'. This is one serious problem that perpetuates ill interaction between us and these health workers"* **Community member Gayaza**

Using the Margolis wheel we explored communication issues between communities and Health workers and the problems were many! But the solutions were even more! 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 are experiencing the current communication, and what we learn about how they are interacting. Some of the responses from the Margolis wheel are shown in the table below:

Issue	Reasons	Solution
Community issues		
Health workers are rude to patients	• Huge workloads and low salaries make health workers impatient and rude	• Supervision from more experienced health workers is needed to mentor junior health workers on communication skills. Ministry of Health (MoH) can partner with local and International NGOs to provide this training. • MoH should adequately staff health workers at health centres.
There is gross lack of Privacy at Health Centers	• There is poor Infrastructural design of the Health Centers (Some only have one room) • Some health workers prefer to group patients according to disease patient is suffering from to cut short the long queues.	• The MoH should create mechanisms within the health system that ensure and enforce implementation of statutory instruments and regulatory provisions on the rights to privacy
Health workers judge nature of interaction with community based on their dress and hygiene.		• Communities should be more hygienic. Health Literacy can facilitate improvement of personal hygiene through action oriented interventions • Health workers should be trained on interpersonal communication skills to improve health outcomes.
Language Barriers	Due to the many local languages spoken in Uganda, some health workers fail to understand patients and patients fails to communicate their problem	• Health workers should be trained to communicate in more than one local language
Health Worker issues		
Communities always blame Health workers for any shortages at the health	Communities do not understand Health System procedures and health worker problems	• Health Workers and communities should jointly plan for their needs, • Health workers should make as transparent as possible the procedures required in drug

centre such as drugs and gloves		procurement (ordering) to communities.
Patients refuse/ fail to follow instructions	• Some patients think that they know everything • Some patients think that because they are more educated than Health Workers, they can challenge prescribed medicine amongst other recommendations from the Health worker	• Patients should follow instructions and adhere to treatment. • This should be facilitated by community based health education programmes supported by MoH and other stakeholders working in the health sector • Community based interventions (including through media) should support investment of trust between communities and health workers
communities refuse to pay user fees	The health centers lack adequate materials and government support. User fees are meant to generate revenue for the day to day running of the Health Centre	• Government should provide health centers with adequate materials and abolish user fees. Government can get revenue from other sources such as road taxes.
Communities demand quality service in areas of huge scarcity.	Government, in political rhetoric gives empty promises to the health sector. This raises patient's expectations and patients come to clinics demanding services and resources that are not there.	• Political mudslinging should not be mixed with promises in health service provision. • Government should allocate more resources to Health care. Communities can demand for government to meet the Abuja obligation of 15% government spending on health. • HEPS Uganda and other civil society organizations should, through advocacy and capacity building strengthens the role of Health Unit Management Committees as mechanism for community participation.

These experiences signalled problems in the interactions between health services and the community, although each is vital to the other! Health workers feel demotivated, unappreciated and 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; the relationship is unbalanced in an environment of resource scarcity and unshared dialogue and communication.

From these stories Participants noted that

- Knowledge, capacity and communication skills of the workers are key to both their own confidence and building trust within communities.
- Substantial disparities in health and health care persist. Although many actors—including the health systems, contribute to these disparities, discrimination, and stereotyping during contact with the health service (between health worker and community member) at the health centre can also explain health care disparities.
- Participants noted that reducing fragmentation in health system, 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.

Health Literacy Facilitators, Kyankwanzi District 2011 **-Margolis Wheel Activity, HEPS**

Together the case stories from the Margolis wheel activity provided 'evidence' that improved Health worker community interactions increase appropriate health care utilization (e.g. more use of VCT, ANC services). The stories shared also reflected that when communities and health workers jointly identify their problems and collectively act on these problems they both are motivated and organised around these services so they 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 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 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.

Social map, Kyankwanzi District 2011

Some of the barriers that we observed to interfere with health worker community interactions included that hlls/ mountains and poor roads create long distances and long travel times. Fatigue and exhaustion creep in by the time the patient arrives at the health centre. Often, the patient arrives late. This combined with exhaustion of the health worker flares tempers. In addition to this, patients often miss injections and default on treatment dreading to walk the long hilly or swampy road to the health centre. When they finally travel to the health centre the communication between them and health workers is not pleasant.

"Often, when I walk long distances to the health centre I arrive there dirty especially because of the swampy points along the way. When the nurse looks at you even if you haven't said anything bad to her she frowns and gives you attitude, so when she asks you what the problem is you just do not want to talk to her. It's so belittling, infarct she starts talking about hygiene forgetting to address your problem. Often this leads to non constructive community –health worker interaction": Participant

Travelling long distances to access health services in Kiboga swampy, wet and mountainous terrain. Kankwanzi District 2011. TARSC, HEPS

We learnt that health worker-community interactions are not only an issue of personality, lack of understanding, low remuneration of shortage of health workers, but also a result of how resources and services are distributed and accessible in the community. Overcoming any barriers between communities and services needs to be integrated with other areas of resource provision and budget allocations .We agreed 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. Overleaf 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	Low staffing levels	Malaria	HIV AIDS
Community- Men's Group	Malaria	HIV/AIDS	Poverty (Lack of Money)
Community – Women's Group	Malaria	long distances to Health Centers	Shortage of potable Water and Sanitation facilities

Group discussions, Workshop, Kyankwanzi District 2011, TARSC, HEPS

We discussed the importance of joint community – health worker discussions on the commonest health needs/ health problems for joint action. For example, Malaria automatically became the commonest health need as it appeared in all social groups.

With 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. Communities and health workers can jointly organize a day to cut grass, fill empty ponds while mobilizing huge community campaign on adequate health worker staffing levels at Ntwetwe Health Centre IV, Kiyuuni Health Centre III in Gayaza and Butemba health centre III to combat Malaria in Kyankwanzi District

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 the workshop is shown below:

"Malaria is our Priority Health Problem in Kyankwanzi"- But why
"We get bitten by Mosquitoes"- But Why
"We live in swampy areas and we have long grass and open potholes around the homesteads"- But why
"People do not clear the bushes, cover the pot holes and fill the Swamps"- But why
"People are simply ignorant"-But why

“There is lack of awareness“- But why
*“Shortage of Health Workers“-*But why
*“Government fails to fairly distribute health workers“-*But why
“There are few trained Health Workers and too few willing to work in rural areas like Kyankwanzi“- But why
“Too few Health worker training institutions”- But why
*“Government has very little resources to expand training facilities and numbers“-*But why
“Very little funds are allocated Health”- But why
*“There are other sectors that always get more resources than Health“-*But why
“Communities are not involved in planning, budget processes and resource allocation“
But why
“Macro Political reasons“

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. This is so that communities can share the information they hold and add new information to better understand how to prevent diseases before they occur, and plan actions for this. 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 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 and 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 people at different levels to

advocate for change. 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 PRA tool.

Identifying actions, Workshop, Kyankwanzi District 2011, TARSC, HEPS

Participants identified the measures / stepping stones needs to address Malaria. 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.

Stepping stones activity, Workshop, Kyankwanzi District 2011, TARSC, HEPS

10. 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 parishes and sub counties to develop a collective action plan that would guide auctioning on priority health needs. This would also help to strengthen the interactions between them. We discussed how progress markers would be used in the process and how the HEPS Uganda 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 HEPS. Thus we explained the requirements of the form.

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 health system is organized in a way that health workers have the knowledge, they are in control and communities are ignorant and have no control at all. There is an imbalance of power and often, it is the cause of communication imbalances"

"..changing perception requires a great deal of joint collaborations with health workers. Again, this might only work if they feel a part of the community, most are disgruntled to work in rural areas and never feel like they were a part of us. So involving them to be a part of the joint work is the biggest challenge…"

"a situation where we all accept that we both do not know enough of each other and are willing to learn is the best approach. One nurse in the whole district and one community member in whole of Kybwanzi appreciating this fact is not adequate. We need to work in groups and parishes to address this challenge. Health centre staff should all appreiacie this and we meet halfway including us from the community"

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

11. 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 were discussed 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.
We went through the questions in the baseline survey tool to solicit for more ideas, input, changes and comments on this. There were no changes or additions to the questions that make up the questionnaire.

Documenting the community meetings and actions: We flagged various concerns relating to follow up, including report backs on monthly basis, supporting capacities and learning after the workshop. We also revisited the requirements of the HL facilitator monthly feedback to assess whether or not it was understood. There were no additions or changes; however facilitators agreed to have a follow up discussion with HEPS office on means and ways of submitting the forms to the HEPS office.

12. Closing

On closing, Ms Lydia M. Mukombe thanked all delegates for participating and wished them well on their Health Literacy interventions at community level. She encouraged participants to report back on their actions and to watch over time how interactions between them (health workers and communities) will be changing with more joint action. 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.

13. References

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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. Participants List

no	Name	Role in the Community	Contact	Leadership position among the facilitators
		Gayaza Subcounty		
1	Sebitalo Samuel	Community member	0772335377	Chairperson
2	Kabonge Andrew	Community member	0784670467	Vice Chairperson
3	Nassuna Rosemary	Village health team member	0787599846	Secretary
4	Kintu Mesearch	Community member	0783033356	
5	Okoth Julio	Village Health Team member	0779901825	
6	Nassuuna Prossy	Community member	0783535178	
7	Birungi Hadijah	Village Health Team member	0778005494	
8	Twaib Lukabwe	Health Worker (health centre in charge, gayaza hc iii)	0782937082	
		Ntwetwe Subcounty		
1.	Nassimbwa Goretti	Village Health Team member	0789497189	Chairperson
2.	Kato Hussein	Community member	0774335804	Vice Chairperson
3.	Misanvu Dan	Community member	0775704949	Secretary
4.	Namugerwa Scovia	Community member	0788363827	
5.	Musoke Frank	Community development officer at Ntwetwe sub county	0777424766	
6.	Nangonzi Ruth	Health worker, senior nursing officer-Kyankwanzi district	0772676924	
7.	Okello Paul	health worker- health assistant at Ntwetwe HC iv	0781418921	
		Butemba		
1.	Kintu Moses	health worker- dispenser at Butemba HC iii	0781435723	Chairperson
2.	Kalule Fecusious	Community member	0777590429	Vice Chairperson
3.	Namuganza Lillian	Health worker- Nurse	0392825905	Secretary
4.	Kaye Dan	Community member	0787969132	
5.	Kyakuwa Juliet	Village Health Team member	0754231896	
6.	Semujju Moses	Community member	0777895390	
7.	Nakasaka Jesca	Health Worker- Nurse	0785985543	
		Facilitators at the meeting		
1	Fortunate Machingura	Training and Research Support Centre (TARSC)	fortunate@tarsc.org fmachingura@gmail.com	
2	Mulwanyi Lydia Mukombe	HEPS Uganda	lmukombe@heps.or.ug lydiaem2006@yahoo.com	
3	Phiona Kulabako	HEPS Uganda	kulabakophiona@yahoo.co.uk	
4	Aaron Muhinda	HEPS Uganda	muhindaaaron@yahoo.com	
5	Prima Kazoora	HEPS Uganda	pmkazoora@yahoo.com	
6	Diana Oroma	HEPS Uganda		
7	Oliver Kalekwa	HEPS Uganda		
8	Kenneth Mwehonge	HEPS Uganda		
9	Rosette Mutambi	HEPS Uganda-Director	rosemutambi@gmail.com	

14.2. Programme

EVENING - MONDAY 7 MARCH 2011

TIME	SESSION CONTENT	SESSION PROCESS	ROLE
Evening	Distribution of the Health literacy manual	• Delegates will each be given a health literacy manual to go through before the workshop in pairs, groups or individually	Lydia Mukombe; Phiona Kulabako

DAY ONE – TUESDAY 8 MARCH 2011

TIME	SESSION CONTENT	SESSION PROCESS	ROLE
Welcome, objectives, introductions			
0800-0830hrs	Registration, logistics	Participant registration	**Phiona Kulabako**
0830-0900hrs	Welcome	Welcome remarks	Prima Kazoora
0900-0930hrs	Opening Introductions: Workshop objectives,	HEPS opening facilitators and Participants Clear outline of the aims and objectives of the workshop.	Rosette Mutambi 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
HEPS Uganda and TARSC work on health			
1000hrs-1030hrs	TEA		
1030hrs-1100hrs	Background on LDHMT	Information on HEPS Uganda, its objectives, vision and mission HEPS work on PRA in EQUINET	Lydia Mukombe Aaron Muhinda
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)	Aaron Muhinda
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, 9 MARCH 2011

TIME	SESSION CONTENT	SESSION PROCESS	ROLE
0900hrs-0930hrs	Review and logistics	Logistics, Recap of day one and Warm-up exercise	Lydia Mukombe
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	Lydia Mukombe, Fortunate Machingura
1200hrs-1300hrs	Mapping the catchment area of the primary care service	Community mapping Module 2.2 page 22 HL manual	Aaron Muhinda
1300-1400hrs	*LUNCH*		
1400hrs-1445hrs	Identifying priority health problems in the community	Ranking and scoring Module 2 .2 p 24 HL manual	**Aaron Muhinda, Lydia Mukombe**
1445hrs-1530hrs	Identifying the causes of our problems	But why? Module 2.3 p 29 HL manual	Lydia Mukombe
1530hrs-1600hrs	Day evaluation and TEA		**Phiona Kulabako**

DAY THREE – THURSDAY 10 MARCH 2011

TIME	SESSION CONTENT	SESSION PROCESS	ROLE
0800-0900hrs	Review and logistics	Logistics, Discussion of the right to health	**Phiona Kulabako**
0900hrs-0915hrs	What can we do about these causes?	Group work Module 2.4 p30 HL manual	Aaron Muhinda
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-1030hrs	**TEA**		
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
1230hrs-1300hrs	Developing a HW-Community action plan for joint implementation	Planning and Progress Markers Using the HL facilitator monthly feedback form	**Aaron Muhinda** 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	Lydia Mukombe
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, Lydia Mukombe
1530hrs-1600hrs	**Day evaluation and TEA**		**Lydia Mukombe**

DAY FOUR – FRIDAY, 11 MARCH 2011

TIME	SESSION CONTENT	SESSION PROCESS	ROLE
0900hrs-0915hrs	Review and logistics	Logistics, Recap	**Phiona Kulabako**
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, Lydia Mukombe
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)	Lydia Mukombe, Fortunate Machingura
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	Lydia Mukombe
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, Lydia Mukombe
1430hrs-1530hrs	Next Steps Closing and goodbyes	Follow up, communication, feedback, monitoring and Closing	Lydia Mukombe
1530hrs-1600hrs	**Day evaluation and TEA**		Phiona Kulabako