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SCHOOL OF GRADUATE STUDIES AND RESEARCH

**ASSESSMENT OF HEALTH LITERACY PRACTICES FROM ADULT
LEARNING PERSPECTIVES: THE CASE OF HEALTH CARE CENTERS
IN ADDIS ABABA**

BY

DAGMAWI MELESSE



JUNE 2011

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COLLEGE OF EDUCATION AND BEHAVIORAL STUDIES

**ASSESSMENT OF HEALTH LITERACY PRACTICES FROM ADULT LEARNING
PERSPECTIVES: THE CASE OF HEALTH CARE CENTERS IN ADDIS ABABA**

**A Thesis Submitted to the School of Graduate Studies of Addis Ababa
University in Partial Fulfilment of the Requirement for the Degree of Master
of Education in Adult and Lifelong Learning**

BY

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ADDIS ABABA

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LIST OF ABBREVIATIONS AND ACRONYMS

CDC-	Center for Disease Control and Prevention
EHSP-	Essential Health Services Package
FDRE-	Federal Democratic Republic of Ethiopia
HIV-	Human Immuno Deficiency Syndrome
HLP-	Health Literacy Program
HSDP-	Health Sector Development Program
MDGs-	Millennium Development Goals
MoE-	The Ethiopian Ministry of Health
MoH-	The Ethiopian Ministry of Education
PHC-	Primary Health Care
SDPRP-	Sustainable Development and Poverty Reduction Program
TB-	Tuberculosis
UNESCO-	United Nations Educational, Scientific and Cultural Organization
USA-	United States of America
WHO-	World Health Organization

Abstract

The main purpose of the study was to investigate into the health literacy practices of health centres of Addis Ababa from adult learning perspectives. The study aimed at answering basic research questions with regards to the types of health literacy practices provided, its' considerations of adult learning perspectives and the major challenges encountered. The study participants were randomly selected adult attendees of health literacy lessons and health professionals who provided the health literacy lessons. The study settings were 5 out of the 25 health centres found in Addis Ababa city administration selected through a two stage simple random sampling of lottery technique. Overall, a total of 181(150 adult learners and 31 health professionals) participants took part in the study. As to the selection of adult learners, 75 male and 75 female participants were randomly selected from the 5 health centres, 30 (15 male and 15 female) from each of the health centres. Here, participants were randomly selected based upon the entry criteria: having attended a health literacy lesson at least once the previous year and opting to participate in the study voluntarily. As to selection of health professionals, a total of 31 health professionals representing the selected five health centres were randomly selected taking 5 to 7 health professionals from each of the health centres. For the triangulation of the study, a mixed approach was employed comprising both quantitative and qualitative methods. A descriptive survey method was the major approach employed for the study. Hence, questionnaires, interview guides, focus- group discussion guide and an observation checklist were developed and employed in the data collection process preceded by a pilot testing. The analysis of the data was performed using quantitative percentage analysis and qualitative thematic analysis. The findings of the study have shown that predominantly oral lecture- based, prevention- oriented and group-based health literacy lessons were provided in the health centres. However, according to the study findings, core adult learning principles were not given due and satisfactory considerations in the implementation of the health literacy lessons in the health centres. Thus, the study results across the main dimensions had shown that the content selection, teaching methodologies, and physical and psychological environment were not in line with core adult learning principles. With regard to the major challenges encountered in the implementation of health literacy lessons, the majority of adult learner participants rated in descending order that there are problems in facilities, teaching methods, competence and commitment of health literacy educators. On the other hand, majority of health professionals pointed out that lack of responsible body to give attention for the follow up, lack of motivation from adult learners' side, lack of readiness and efficiency in health literacy educators' side as major challenges encountered in descending order as among the major challenges observed in the health centres. Clear organizational structure, accountable leadership, facilitation of appealing physical and psychological environment, participatory approach in content selection and lesson presentations, the use of flexible programs and alternative options of mediums in presenting the lessons, facilitating resource centers and the provision of in-service trainings on the teaching of adults for health professionals, widening the horizon of the program and the study sphere were the major recommendations provided.

CHAPTER ONE

1. INTRODUCTION

1.1. Background of the Study

Health Literacy research dates back to the 1960's with a significant focus on written materials. The field continues to grow with new areas of interest. Today, leaders in the field of public health and adult education are shifting the focus from the hospital to the community to improve how people understand and use health information in their daily lives. New evidence-based strategies to address health literacy and public health literacy are emerging from the fields of communication, healthcare, public health and adult education (CDC, 2009).

Health education has become wide in scope and sophisticated in its application during the last hundred years. It is evidently clear that the development of health education is mostly depending on the health promoting activities. Hence in this virtue, at the beginning of the 20th century, official formulation of education policies had been started in Europe and USA. The growth and development of health education have been accelerated with the inception of primary health care concepts. At global level many countries endorsed and showed their commitment at the time of declaration of Primary Health Care(PHC) at Alma Ata, Russia in 1978(Getnet,2003).

In Ethiopia, it is very difficult to know as to when and where health literacy has started. Indeed, during the Emperor Menilik II and Haile Selasse I eras modern medicine had already been started but the primary focus was to increase the awareness of people in modern medicine and encourage them to benefit from the services. After the Italio-Ethiopian war, the medical services as well as trainings expanded. Mobile Child Health Centers also started to give health education on child nutrition, personal hygiene and others. This was the time that the health centers were opened, in fact their primary objective was to be involved in preventive, curative and promotive activities (Ibid).

During the Derg regime building health centers and health stations were given emphasis and the number of hospitals remained relatively the same. However, during the same period, Ethiopia has signed and accepted the Alma Ata declaration. Moreover, as member state of the WHO, Ethiopia has signed and accepted the strategy (Ibid).

Since the downfall of the Derg regime, the Transitional Government of Ethiopia Ministry of Health has adopted health policies in support of Primary Health Care and has been enforcing health education as a primary means of prevention of diseases and promotion of health. Taking into account this, at present, the national health policy and Health Sector Development Program of Ethiopia identified health education as a major component of program services (Meseret & Yihenew, 2004:4). Furthermore, from 2004 onwards, The Federal Democratic Republic of Ethiopia, Ministry of Health has been implementing a number of health literacy extension packages: Family Planning, Food hygiene and Safety, Maternal and Child Health, Nutrition, Malaria Prevention and Control, Construction and usage and Maintenance of Sanitary Latrine extension packages, etc. These urgent and salient health literacy issues have been funnelled in different channels to reach out the public. Primary health care centers have been among the major executors of the programs at grass root level.

When it comes to the implementation of the health literacy programs, the learning perspectives of adults, who are the significant program beneficiary targets, should be given credible recognition in the health literacy process. In line with this, Fasokun, Katahoire & Oduaran (2005:10) explained the notion of adult education with a belief that adult learners are different from children, hence, there should be separate theory which underpins the teaching and learning of adults. The same authors further discussed that much of adult learning based research have been conducted in the western world. Hence, the need for research and documentation on adult learning in Africa is an imperative endeavor to undertake. There is, therefore, a need for systematic research and documentation on adult learning and on adult learners' perceptions, cognitive functioning, learning styles and challenges in Africa. Evidently, in this context, nothing significant has been done so far in Ethiopia especially concerning health literacy practices from the view of adults' learning perspectives. Definitely, from this justification, one could establish the significance of undertaking this particular research.

1.2. Statement of the Problem

Health status and a country's development are closely linked to each other (MOH, 2004). It is obvious that the health status of people has a significant determinant impact on the growth and prosperity of a country. Lack of health creates unproductive citizen which could significantly debilitate the strive for development and might be a potent challenge in the fight against poverty of a nation by affecting the wellbeing of productive citizens.

Ethiopia is committed to address the abject poverty it faces in a comprehensive and rapid manner through the adoption of the Sustainable Development and Poverty Reduction Program (SDPRP) and achieving the Millennium Development Goals (MDGs). Health interventions plays crucial role in these endeavours (MoH, 2005a).

The Millennium Development Goals (MDGs), towards which the Ethiopian government has been working, aims to improve significantly the health of a nation by 2015 and to create healthy citizens. Moreover, the country has also signed the ALMATA declaration of “Health for All” through universal primary health care. In order to implement these commitments, an efficient and effective health system is required (Wondwosen, 2009).

The Health policy of Ethiopia emphasizes the strong commitment in the general directions towards prevention and promotion of health care components. Subsequently, addressing the development of equitable and acceptable standards of health services in order to reach all segments of the population (Ibid).

According to MoH (2005a,4), Ethiopia has adopted a sector wide approach to a 20-year sector program and strategy, broken in to 5-year rolling programs, beginning in 1997/98. The health sector policy framework of Ethiopia emphasizes on prevention, thus several health literacy programs have been implemented primarily by the Ministry of Health, and its local and international partners. Taking this into account, health care facilities are functioning as principal channels of health literacy activities, which primarily target the adult population.

However, review reports on HSDP programs showed that the achievement so far was far from the desired , indicting that the emphasis given to preventive and promotive approach to the implementation level was not adequate and effective. Therefore, there was a need to refocus, show more commitment and gather a stronger momentum for the effective implementation of preventive and promotive health services (MoH,2005b:84).

The practice of health literacy is a rarely studied area in Ethiopia. It is particularly an area hardly examined from an adult learning perspective. This specific research is planned to contribute to basic baseline knowledge regarding the current health literacy practice from an adult learning perspective and taking health care centers of Addis Ababa as its study setting.

Research Questions

The study aimed at examining the following research questions:

- What health literacy activities are in place at health care centers of Addis Ababa?
- Do the health literacy practices of the health care centers of Addis Ababa embody adult learning considerations?
- What are the major challenges of health literacy practices of health care centers of Addis Ababa?

1.3. Objectives of the Study

General Objective

The general objective of the study was to explore and highlight the health literacy practice of health care centers of Addis Ababa from an adult learning perspective. Moreover, the study also planned to identify challenges of health literacy practices at health care centers of Addis Ababa.

Specific Objectives

The specific objectives of the study were:

- To identify the major health literacy practices of the health care centers of Addis Ababa.
- To assess whether the health literacy practices of the health care centers of Addis Ababa are implemented in line with adult learning principles.
- To explore the major challenges of health literacy practices in the health care centers of Addis Ababa.

1.4. Significance of the Study

This study was conducted on the “health literacy practice of health care centers of Addis Ababa from adult learning perspective”. Even though it is very difficult to generalize the situation from a single descriptive survey study in selected health care centers of Addis Ababa, the study can provide basic baseline knowledge regarding current health literacy practices. It would also give an insight as to how the health care centers are implementing the health literacy activities and perhaps inform programs as well as policy frameworks.

The study hopefully provides significant information about adults who constitute a notable proportion of the population. It also could prove to be a useful resource material for policy makers and executers. Moreover, it may inspire further research undertakings in the area.

1.5. Delimitation of the Study

The study was delimited to five health centers which are run by the City Administration of Addis Ababa Health Bureau. The scope of the study was also delimited in assessing the methodological features in the provision of health literacy lessons from the dimension of adult learning principles.

The main reason for the selection of health centers was that they are ideal places whereby health literacy lessons are provided regularly and significant members of the public with attend the services.

1.6. Limitations of the Study

This study is not free from limitations which affect the generalization of the findings.

- The data was collected from certain selected health care centers of Addis Ababa which makes it difficult to generalize the findings for the overall health care centers across the country.
- The data collection period represent a certain limited period of time. Hence generalizations made upon the completion of the study might limit the scope in terms of time.
- Some participant adults were reluctance to frankly disclose their feelings and experiences and were not assertive enough to respond openly.
- Literature works in terms of the specific study topic were hardly available for the purpose of review and substantiate the study with well established body of knowledge.

1.7. Definition of Terms

Adult: a person who is age of 18 years and above.

Adult Learning: is a process of acquiring knowledge and skills and developing behavioral change.

Adult Learning perspective: A learning perspective which takes into account the nature, needs, abilities, priorities, roles and responsibilities of adults which is based on the current body of knowledge and research about adults.

Alma Ata Declaration: refers to “Health for All” through universal primary health care. At global level many countries endorsed and showed their commitment at the time of declaration of primary Health Care(PHC) at Alma Ata, Russia in 1978.

Health literacy: the cognitive and social skills and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health.

Health literacy practices: refer to any health education attempt made with an aim to assist adult service recipients acquire desired health outcomes. It has interchangeably used with health education in education in this thesis work.

Health care centers: refer to the health centers providing health services in Sub cities of Addis Ababa.

CHAPTER TWO

2. REVIEW OF RELATED LITERATURE

In this section, attempt has been made to illustrate the health literacy practices and the perspectives of adult learning in overview manner to provide background information with the available literature works in the fields.

2.1. Basic Concepts and Definition of Health Literacy

The World Health Organization (WHO) in Kickbusch (2004), define the health literacy, as the cognitive, social skills and ability of individuals to gain access to, in understanding and use of information which promote as well as maintaining good Health. Nutbeam (2008) described the above definition, the health literacy that reflects a health promotion orientation that health literacy represents the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in order to promote and maintain good health. Therefore, health literacy implies the achievement of a level of knowledge, personal skills and confidence to take action to improve personal and community health by changing personal lifestyles and living conditions.

The focus of this study however is on the practice of health literacy programs targeting the health care centers. It is also important to define the health literacy practice in accordance with their parameter. In this particular scenario to look in to the health literacy practices, it is important to examine the definition stated by Tolsman (1991) cited in English(2005), which is as follows:

...Health education is conceptualized as a systematic, planned social action and learning experiences designed to empower people by enabling them to exercise control over those factors that influence health and health educator , as well as the social and environmental conditions that affect their own health status of others, in order to achieve a state of complete physical, mental and social wellbeing. Its goal is encouraging informed personal and communal choices, actions and activities that promote the quality and quantity of life... (p.274).

In the context of adult education health education seals to equip adults with the necessary skills, knowledge and attitudes to precipitate positive change in the quality of their physical, mental, emotional and social lives by inducing desirable health behaviors and health choices(English,2005:275).

2.2. The Significance of Health Literacy Practices,

Kickbusch (2001) commented in many aspects the significance of health literacy practices. The following analysis were approached in accordance with his paper on health literacy practices. Health literacy has enormous contributions towards the health care services. Literacy is an important determinant of health, it is not sufficient to address the major health challenges in developing countries. As the contribution of the health literacy, health promotion is vital. Most importantly, conceptual measurement and strategic challenge must be set. Health challenges need more attention by the population due to its epidemics and extreme social and economic impacts.

Society need to set a certain preconditions for health, people must also actively participate in their health as part of their contribution to the society. Health literacy can also explore further research avenue such as empowerment, that is to say health literacy includes physical, mental and social well-being. A broader understanding of literacy includes a range of skills to navigate and apply knowledge. It is important to clarify the issue of empowerment in the health literacy so as to promote health literacy and compliance issues. It has been suggested that a lack of concern with empowerment has been one of the reasons why large scale literacy efforts around the world have failed. In addition, health literacy is an essential skill as an individual and as a public health issue. Therefore, it is an essential part of a social capital (Ibid).

Similarly, Hohn (1997) cited by Kerka (2000) explained the significance of health literacy practices in the following terms:

...Adult educators, health educators, health care providers and literacy learners should collaborate in order to increase health and literacy issues, develop appropriate materials and programs, and insure that adult learning principles underlie health education and communication. Embedding health education in adult literacy in an approach where active learning is connected to the realities and concerns of people's everyday lives, supported through the naturally occurring social webs of literacy classrooms and processes that create and sustain power-sharing, provides a rich and meaningful learning forum for health... (p.2).

Therefore, it can be seen from the aforementioned explanations that there are areas of collaboration, inter-dependence and common working ground between the health and education sectors.

2.3. Health Literacy Policy and Implementation Contexts

Health policy is an explicit concern for health and equity in all area of policy and by accountability for health impact. The main aim of public policy, according WHO citing to the recommendations of the Adelaide Conference which took place in 1988, is to create a supportive environment to enable people to lead healthy life. Such a policy makes healthy choice possible or easier for citizens. It makes social and physical environments health-enhancing. In the pursuit of public health policy, government sectors, concerned with agriculture, trade, education, industry, and communication need to take into account health as an essential factor when formulating policy. These sectors should be accountable for the health consequence of their policy decision. They should pay as much attention to health as an economic consideration. A basic principle of social justice is to ensure that people have access to the health literacy in order to have healthy and satisfying life.

Inequalities in health are rooted inequities in societies. Disadvantaged people required a health policy that will improve access to health- enhancing goods and services, and creating supportive environment. In line with this, the constitution of the World Health Organization states that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being. Health is not just the outcome of genetic or biological process. It is influenced by the social and economic conditions in which people are born, grow, live work and age, and the systems put in place to deal with illness (WHO, 2010).

The reason why health literacy is so important in health literacy policy also discussed by Pavelovick (2000) that health literacy is not only a personal characteristic; it is also a key determinant of population health. Gastien Health Declaration in 2005 urged policy-makers, researchers and public health professionals to lead the way in making health literacy a central pillar of its policies and actions at European, national and local level.

The present health policy of Ethiopia is not far from the framework stated above, and mostly reflects the commitment and general directions towards preventive and promotive components of health care and development of equitable and acceptable standard of health services to reach all segments of the population (MoH, 2005a:3).

Ethiopia adopted a sector wide approach to implement a 20-year sector program and strategy, broken into 5-year rolling programs in 1997/1998. At the present, it has reached the fourth HSDP IV (Health Sector Development Programs IV). The goal of delivering an Essential Health Services Package (EHSP) is to contribute to poverty reduction and sustainable development by promoting efficient, effective and equitable access to essential health services of the population, particularly the poor. This will also contribute to enhancing the country's advance towards meeting the MDGs targets (MoH: 2005a, 8).

Likewise, the Federal Democratic Republic of Ethiopia (FDRE) also put forward National Adult Education Strategy published in 2008 establishes a common working ground under its strategic programs such as establishing and capacitating institutions for continuous adult education. The document states that adult education is founded on the needs of beneficiaries and requires multi-sectoral activities. However, adult education programs carried out in the past were inconsistent, uncoordinated and hence could not bring the required results. Prevalence of strengthen and coordinated management and organization will enable these limited efforts to be expanded and sustained.

Therefore as a strategy, it is necessary to provide the sector with a coordinated management of relevant ministries for Agricultural and Rural development, Health, Women's Affairs, and Youth and Sports, Labour and Social Affairs and there by organizing adult education in a strengthened a coordinated manner based on the decentralized administration system of the country (MoE, 2008:20).

Based on the aforementioned cross linkage of the ministries in working -together atmosphere towards the common goal of meeting , the MDGs goals and 'A renewed vision of Literacy for All' as launched by United Nation and coordinate by UNESCO in which literacy understood to be as functional and lifelong process associated to all segments of society. Hence, the issue of health literacy has policy points across the sectors in Ethiopian context.

2.4. Dimensions of Health Literacy Practices

According to Glanz, Lewis & Rimer (1997) cited in English (2005:275) health education adopts a multi-sectoral approach in packaging and delivery, involving professionals in the

areas of health , education , agriculture, information, industry and so on. Its scope covers the continuum from diseases prevention and promotion of optimal health, detection of illness and treatment, to rehabilitation and long term care.

Similarly, Meteka (2003:13-15) discussed several dimensions of health literacy which is the practical values imbedded in health education programs that health education touches upon many fields ranging from medical sciences, behavioral sciences, politics, demography and management. It has also another dimension that it is lifelong process which begins from birth. Concern with people at all points of health and illness are also the stated dimensions. Health education involves both formal and informal teaching using a variety of methods and materials. Education on health could be given anywhere depending on the purposes and circumstances are the dimension worth mentioning. Another dimension is that health education is concerned with a range of educational objectives (cognitive, attitude and skills or practice). Thus, educational objectives are planned and they target specific areas. The other dimension in relation to health literacy is that health problems are result of complex interactions with the environment and the cause of many problems are multiple. Health is an asset of the individual and community is another dimension in order to support oneself and lead normal life one needs to be healthy. Creation of a healthy society is a goal for nation.

2.5. Basic Principles of Health Literacy Practices

The principal objective of health education is to help people achieve health by their own actions and efforts. Health education is not onetime affair that it is a continuous process based on planned and organized activities. It is planned to address different community members and not limited to a specific audience. Health education uses different communication methods as appropriate and limited to a specific method only. Starting from planning health education, implementation, monitoring and evaluation stages involves active and full participation of the concerned audience; and not limited to program heads and administrative officials (MoH, 2004:11).

The activities of health education are planned and organized based on specific findings and correct knowledge. Thus it is unthinkable to provide health education without scientific knowledge. The other basic principles with regard to health literacy practices, is that it is given based on the objective reality of area culture, tradition, language and local resources. Also for

the success of health education program, it is necessary to create conducive atmosphere by all possible means. It should also be prepared and delivered in such a way to be informative, recreational and attractive. For the program to be successful, according to the basic health literacy principles it requires coordinated approaches, full participation of different professionals and resources; and the community at large (MoH, 2004: 11).

The advantages acquired by adult learning in health literacy practices were also elaborated differently. MoH (2004:21-23) stated that the advantage acquired adult learning in health literacy practice enables adults to develop self-reliance, self-confidence, strong will power and initiative to participate in development undertaking of the community mentioned as an advantage. Building capability to generate new ideas that it builds talent for creativity, self-preparedness for change and enabling to generate ideas for solving one's own problems was also mentioned as another advantage.

Furthermore, the practice enables to scrutinize in depth society's beliefs, value systems, traditional practices; and determine their negative or positive impact on health and deciding at steps to be taken on them was stated as advantageous feature of health literacy practices in relation to adults learning. The practice also stated as an advantageous event that it enables to investigate one's own health problems and their causes, and once known to take alternatives for solution. Enabling to study problems in depth and to reach at solutions and then plan and implement these solutions and in the process to develop capability of solving these problems was stated as another important advantage of the practice (Ibid).

2.6. The Prevalent Challenges of Health Literacy Practices

The Alma-Ata conference 1978 was an important milestone in the struggle for health. The conference was organized in response to understand dissatisfaction with existing health services. Despite great efforts by countries and WHO in the late 1960s and early 1970s improve and extend services, large numbers of people, particularly in the rural areas of developing countries, remained with no access to health care. Primary health care seen as the route to health for all (Tarimo & Cresse, 1990:1).

Primary health care as outlined at Alma Ata calls for three developments; universal availability of essential health care to individuals, families and population groups according to need; involvement of communities in planning, delivery and evaluation of such care ; and an

active role for other sectors in health activities. Each of these developments has far-reaching implications for health resources. The conference provided a green light for implementing them quite different. There can be a difference between what is planned nationally and what is done locally (Ibid).

The prevalent challenges faced in the health literacy discussed by Agha et.al cited in English (2005) as follows:

...The contention in that although it seeks the level of participation of the people from passive recipients to active participation to active participants, it still retains the responsibility of the decisions on content and context, as well as on the production of educational materials in the hands of the experts. Also it often uses pre developed and pre packaged frameworks and modules that may be incompatible with the socio-economic and cultural realities of adults with in the target community, and that may even sometimes offend their socio-cultural sensitivity. Critics also say that the strategy sometime uses communication modes that may be inaccessible to people in the target community... (p. 276).

MoH (2004: 64-67) listed out barriers in health literacy practices during learning process in terms of different factors. Previous practices, contrary to the area culture and tradition have been mentioned as barriers. If the health education delivered create fear, exaggerated condition and create stress on the audience, if it is delivered in a way which is not clear to the audience and if it is conducted in a poor and limited way could be cited as barriers. If there is unwillingness of the audience to learn and try new things and if they consider the health education delivered or advices given may not bring much difference in their health status that is also another side of barriers. Not conducting health education at appropriate time and at convenient place, not obtaining encouraging support before hand from close friend, household family member or from colleagues of the audience were also listed as barriers and not creating conducive conditions for conducting health education.

The same document illustrated health literacy barriers which may encountered from using communication method. Accordingly, the barriers listed which may be encountered from using communicative method are related to case of addressing message to a limited segment of audience alone and through using inappropriate communication method for example using printed material for addressing who cannot read or write. Other scenarios were explained that if the message is communicated to the enlightened group for those who can understand whereas the remaining majority will not understand for whom the message was prepared and delivered in language which they cannot understand(Ibid).

Moving further, the document states that the message is clearly understood, and people know what are expected for proper application, they may not apply in practice if it contradicts with habits and experience. Furthermore, even if the message is clear and acceptable they may not apply and bring about behavior change as the result of economic problem and lack of resource stated in the documented. According to the document, for those problems encountered due to poor use of communication methods, and can be overcome by using properly planned and communicated health education messages (Ibid).

2.7. Adult Learning Principles and Perspectives

Adults as significant members of a society playing vital role in any development endeavors. Considering that, Gboku & Lekoko(2007: xii) explained that it became clear during the 1990s that adult learning must be an important of all strategies for development. In a series of world conferences between 1990 and 1996, various agencies of the United Nations addressed the issues of education for all, the environment, human rights, population, social development, the status of women, human settlements and food security. Each of these conferences recognized that progress would be dependent on adult members of society transforming their life circumstances and gaining greater control over their lives.

The same authors stressed on the relevance of developing effective programs for adults' learning process. Hence, they further forwarded their explanation that the successful implementation of adult learning policies and programs depends in large measure on the availability of knowledgeable, skilful, and socially committed educators of adults. Because they are key agents in the realization of adult learning, the quality of their initial and continuing training is crucial (Gboku & Lekoko, 2007: xiii).

In this section attempt have been made to discuss some of the major adult learning principles, facilitations required, factors influencing the learning process and such pertinent issues which have direct implications in assessing adults' learning programs which in our case the practice of health literacy.

2.8. The Andragogical Model of Adult Learning

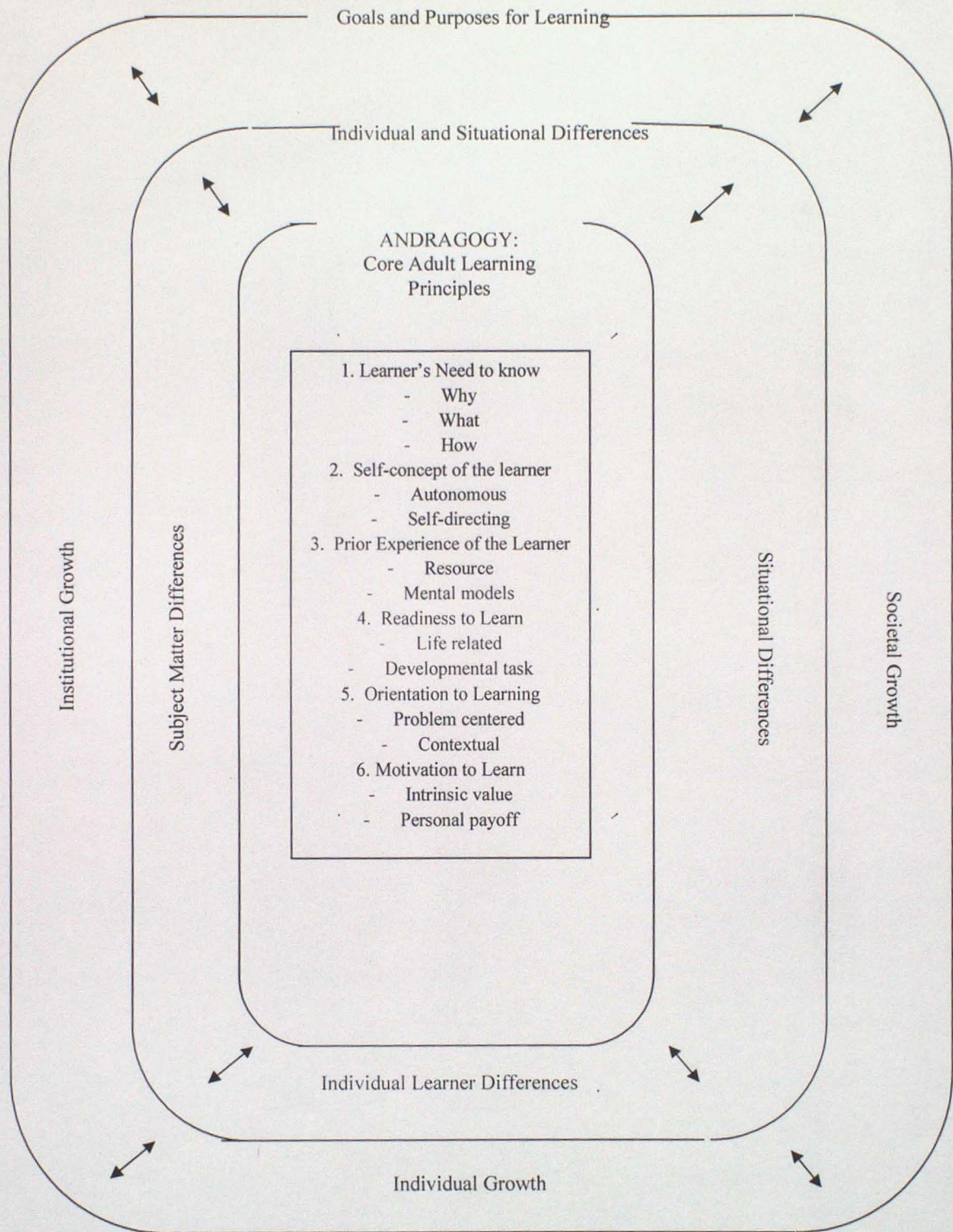
The andragogical model is an ideal framework for the assessment of the health literacy practices from adult learning perspectives. Accordingly, Thomson in Smith & Densch (2009:479) described that Malkom Knowles in his famous adult education publications

identified andragogy as including five basic assumptions about the characteristics of adult learners. These are:

1. Adults move from a dependent personality to an increasingly self-directed human being.
2. As adults mature, they accumulate a growing body of experience that serves as an increasingly important resource and foundation on which to base new learning.
3. As adults, motivation for learning is increasingly focused on life tasks, issues, and challenges.
4. As a person age, focus changes from postponed application of knowledge to current application.
5. Adult learning is problem centered rather than content centered.

The following model presented in figure: 1 shows andragogy in practice.

Figure 1. Andragogy in Practice



Source: Knowles, Holton, and Swanson(1998).*The Adult Learner. The Definitive Classic in Adult education and Human Resource Development.*(5th ed).Houston Texas. Gulf Publishing Company.

Knowles, Holton and Swanson (1998:64-68) discussed the andragogical model as it is based on several assumptions that are different from those of the pedagogical model:

- ***The need to know:*** Adults need to know why they need to learn something before understanding to learn it. Tough (1979) cited in Knowles, Holton & Swanson (1998) found that when adults undertake to learn something on their own, they will invest considerable energy in probing into the benefits they will gain from learning it and the negative consequences of not learning it. Consequently, one of the new aphorisms in adult education is that the first task of the facilitator of learning is to help the learners become aware of the "need to know". At the very least, facilitators can make an intellectual case for the value of the learning in improving the effectiveness of the learners' performance or the quality of their lives.
- ***The learners' self concept:*** Adults have a self concept of being responsible for their own decisions, for their own lives. Once they have arrived at that self-concept they develop a deep psychological need to be seen by others and treated by others as being capable of self direction. They resent and resist situations in which they feel others are imposing their wills on them.

As adult educators become aware of this problem, they make efforts to create learning experiences in which adults are helped to make the transition from dependent to self-directing learners.

- ***The role of the learners' experiences:*** Adults come into educational activity with both a greater volume and different quality of experience from youths. By virtue of simply having lived longer, they have accumulated more experiences than they had as youths. But they also had a different kind of experience. This difference in quantity and quality of experience. This difference in quantity and quality of experience has several consequences for adult education.
- ***Readiness to Learn:*** Adult becomes ready to learn those things they need to know and be able to do in order to cope effectively with their real life situation. There are ways to induce readiness through exposure to models of superior performance, career consulting, simulation exercises, and other techniques.

- **Orientation to learning:** In contrast to children's and youths' subject- centered orientation to learning (at least in school), adults are life centered (or task centered or problem- centered) in their orientation to learning. Adults motivated to learn to the content that they perceive that learning will help perform tasks or deal with problems that they confront in their life situations. Furthermore, they learn new knowledge, understandings, skills, values, and attitudes most effectively when they are presented in the context of application to real life situations.
- **Motivation:** While adults are responsive to some external motivators (better jobs, promotions, higher salaries, and the like), the most potent motivation are internal pressures (the desire for increased job satisfaction, self- esteem, quality of life and the like).

Tough (1979) in Knowles, Holton & Swanson (1998:68) found in his research that all normal adults are motivated to keep growing and developing, but this motivation is frequently blocked by such barriers as negative self -concept as a student, inaccessibility of opportunities or resources, time constraints and programs that violate principles of adult learning.

Wlodkowski (1993:6) similarly assert the findings of research in adults' motivation as a essential factor that research consistently shows that vocational and practical education that leads to knowledge about how to do something is chosen by more adults than any other form of learning.

2.9. Characteristic Behaviors of Adults as Learners

Adult learning researchers and theorists agree that adults differ from one another in needs, styles, and preferences. However, there is agreement among most adult educators that adults require self-directed, self-paced learning that is relevant to their personal or vocational interests. This is particularly so for the most mature learners. Adults expect to rely on their experiences and abilities as they engage in learning activities and seem to prefer process approaches rather than content approaches. Adults like to have the educator provide the structure while they as a learner engage in the study for themselves. Effective use of time, accuracy and mastery of content are also important to adults (Andrews, Houston & Bryant, 1981:5).

According to Tesfaye, Hailu & Shenkut (2004:10) adults have some unique characteristics that distinguish them from children and adolescents, although this does not mean that are common among the adult groups. They depend upon themselves for maternal support and life management. Although they meet most of their psychological needs through others, they are largely self directed. They also learn best when they perceive the outcome of learning process as valuable, contributing to their own development, work and success in life (Ibid).

The same authors further discussed that adults often have their preferences regarding what is important for them to learn. They also have common characteristics; nevertheless, they have differences also in terms of educational level, age, sex, background, occupation, etc. Effective use of time than other group is the characteristics of adults as learners. Realizing that they have something to offer to their own development programs encourages adults as beneficiary communities. In addition, broad and rich experience that they can relate to new learning characterizes adult learners (Ibid).

Adults' speed of learning may be slower, especially when they begin as compared to children but they learn just as compared to children but they learn just as well. They reject or adapt new information that contradicts with their believes. Readiness to learn is another characteristics which is more directly linked to their needs to fulfilling their roles as workers, spouses, parents, etc and coping with life changes. Adult have the characteristic that they are more concerned about the immediate applicability of what they learn and motivated internally when they see their potentials, their ability to contribute, their achievements and etc. They have well-formed expectation, which sometime are negative because of unpleasant past learning experiences (Ibid).

With respect to adults' expectations in learning, Mackeracher & Tuijnman (1996, 10-11) discussed as to how adults move on their learning that adults usually posses a number of clearly defined expectations as to why they first enter into learning centers. Their expectations include in such a way that adults want to share their own experiences and knowledge and take responsibilities for their own learning and performance. They also expect that facilities know well the subject areas, be competent teachers, models of good practice. Adults also learn in the atmosphere of self-direction active involvement and participation. Thus adults expected the facilitators to recognize adult learners' readiness to learn and value adults experience and build on it.

2.10. Basic Principles and Techniques in Facilitating Adult Learning

There have been several scholars who have dealt about the principles of adult learning. But most of them share the basic assumptions of Malkom Knowles who had been the pioneer scholar in the field of adults' learning. Here ,we would be selective and illustrate the salient feature for our purpose.

Robinson (1981:2-3) discussed the major adult learning principles as follows:

- Learning is an active process and adults prefer to participate actively. Therefore, those techniques that make provision for active participation will achieve more learning faster than those that do not.
- Learning is goal directed and adults are trying to achieve a goal or satisfy a need. Therefore, the clearer, the more realistic and relevant the statement of desired outcomes, the more learning that will take place.
- Group learning insofar as it creates a "learning atmosphere" of mutual support, may be more effective than individual learning. Therefore, those techniques based on group participation are often more effective than which handle individuals as isolated units.
- Learning that is applied immediately is retained longer and is more subject to immediate use than that which is not. Therefore, techniques must be employed that encourage the immediate application of any material in a practical way.
- Learning must be reinforced. Therefore, techniques must be used that insure prompt, reinforcing feedback.
- Learning new materials facilitated when it is related to what is already known. Therefore, the techniques used should help the adult establish this relationship and integration of material.
- The existence of periodic plateaus in the rate of learning necessitates frequent changes in the nature of the learning task to insure continuous progress. Therefore, techniques should be changed frequently in any given session.
- Learning is facilitated when the learner is aware of his progress. Therefore, techniques should be used that provide the opportunities for self- appraisal.
- Learning is facilitated when there is a logic to the subject matter and the logic makes sense in relation to the learner's repertoire of experience. Therefore, learning must be organized for sequence and cumulative effects.

Tesfaye, Hailu & Shenkut (2004: 24) explained that good learning environment for adults can be considered from two aspects: physical environment and psychological environment. The physical environment includes the learning centers, its surrounding, and facilities in the classrooms itself. The point is, there should be a place for learning with some necessary facilities. Thus, several inquires listed. Whether the facilities have proper places to sit on, whether there is enough light (not necessary electric light), whether it is warm enough, interesting to look at whether it is free from noise from outside forwarded as creating conducive learning environment. Whether the place can accommodates with facilities for people with different disabilities mentioned as important inquiry to address the problem of creating conducive learning environment.

The same authors explained that we need to consider seriously the psychological environment, in the other words, adults learners need to feel comfortable and psychologically accepted and free to engage in learning. Adults want to be relaxed in class, not threatened by anybody. They want facilitators, and other learners to listen to them. They want to express their opinions freely or without any fear. Learners with various disabilities often may not have enough confidence for learning. They may need encouragement and special attention and assistance in doing things that they cannot do during the learning process (Ibid).

Similarly, Fasokun, Katahoire & Oduaran (2005:118-122) also suggested as to how to proceed with the process of facilitation for adults learning. Thus, facilitating the process of adult learning requires intensive and comprehensive assessments and preparation for effectively implement the planned programs:

The use of a learner's mother tongue as the medium of education is a highly complex issue. But the use of mother tongue enables learners to explore their own natural environment and communicate in a familiar way. Thus, they will acquire self –confidence, initiative, resourcefulness, creative reasoning and adaptability, all of which are necessary for further growth in learning. Empirical findings carried out in modern educational practice support the use of mother tongue .The use of mother tongue ensures a wider participation in adult education programs while it prepares the way for the linguistic and social goals of an empowering literacy process. As far as possible, the mother tongue, or the language of the immediate environment of the learners, should be the medium of education in adult learning. It is useful in literacy and non formal programs at lower levels (ibid).

Specifically in relation to health education English (2005) described the facilitation for effective communication:

...Language and communication are important components of health education, and the goal of communication in health education is to facilitate changes in health related practices and consequently in the health status of people. Effective communication and language ensures credibility, relevance and clarity of the message- in context. The language used in health education is usually the language of the target community, and the modes of communication include the mass media (electronic and print) in the form of jingles, press releases, advertisements; visual materials like posters, t-shirts, leaflets; workshops, symposia, seminars, campaigns, rallies; as well as the traditional means of communication-play, song, poems and at times the talking drum (with an African context) ... (p.276)

Fasokun, Katahoire & Oduaran (2005) stated that facilitators need to understand the characteristics of the learners, their learning styles and their interpersonal communication strategies. They also have to know how to recognize and exercise verbal and non-verbal communication strategies and learn how to improve oral communication skills among different adult learners. Similarly in the context of health education, Cornet (2009) states that effective communication strategies will both serve patients with low health literacy and also benefit more literate patients.

Adult learners can be motivated more effectively if they are involved in planning their courses in cooperation with the facilitator. The facilitator should work in a spirit of community mobilization. Adult learners should identify the needs that may promote community interests and all of them should be engaged in some form of participation in planning that will increase their motivation for learning. The facilitator should understand the adult learner from a holistic perspective (ibid).

Tuijnman (1996:449) summarized the facilitation of adult learning that the readiness and capacity to learn is influenced, both positively and negatively, by previous experiences of learning; that adults in general want to learn, and that they learn most effectively when they have strong intrinsic motivation; that adults generally wish to assume considerable responsibility for their own learning-conversely. They may resist learning; that adults tend to learn effectively if they consider material relevant to their personal needs and interests; that adults seek to learn what can be applied-they are generally problem-oriented learners; that adults value information related to their expectations and previous experience, and that adults

want to know the outcomes of their learning efforts- they require positive reinforcement and performance feedback.

In general the relevance of assessment in the learning process of adults will have various implications. With this regard, Tesfaye, Hailu & Shenkut (2004) explained that an assessment is identifying how much learning has taken place. If there are some indications that show that our adult learners did not gain much, then we should be able to improve our approach and to do something to help them learn better. Assessment is mainly a tool to help learning not only to evaluate it. Assessment results can help us improve our program, information gathered through regular assessment can be used to evaluate the effectiveness, efficiency and impact of our teaching-learning activities.

The need for assessment of adults' learning process is essential instrumental measure to find out more about the strengths, challenges and opportunities to work on the area adult education further; health literacy is one of priorities in our country context. In developing countries like Ethiopia whereby adults take the wider actual productive force in development endeavors should be given credible priorities in relation to their welfare and health. Addressing the health promotional activities thus should be oriented in adults' learning needs and capabilities. Assessing and the adults' learning perspectives whether they have been properly addressed or not is imperative rather than channeling tremendous resources without approaching the actual targets.

CHAPTER THREE

3. RESEARCH METHODOLOGY

3.1. Research Setting

The research setting for this study was government run health care centers found in Addis Ababa City Administration. The research setting was purposefully selected for it represents an ideal setting to assess health literacy practice in depth. As health literacy programs are primarily government run and mostly operate in government facilities, health care centers provide ideal locations to conduct a close and an in-depth study. Moreover, health care facilities are known to be accessed by significant number of the city's adult inhabitants.

Therefore, health care centers representing the health care centers of Addis Ababa which are under the City Administration of Addis Ababa Health Bureau were selected. Hence, the following health centers were the study settings in which the study was conducted. The health care centers were namely:

- Shiromeda Health Center which is found in Gulele Sub city.
- Kazanchis Health Center which is found in Kirkos Sub city.
- Lideta Health Center which is found in Lideta Sub city.
- Kolfe Health Center which is found in Kolfe Keranio Sub city.
- Nifas Silk Lafto No.2 Health Center which is found in Nifas Silk Lafto Sub city.

3.2. Research Design

A mixed method research design was employed comprising both quantitative and qualitative research design methods. According to Cresswell (2003:19) data collection in mixed methods involves for gathering both numeric information as well as text information so that the final database represents both quantitative and qualitative information. A descriptive survey method which intends to describe the distribution of characteristics was employed for this research work where by stakeholders directly involved in health literacy practices participate. This study involves quantitative method in describing and analyzing the data from the health literacy stakeholder's perspectives and qualitative method to supplement findings of the quantitative study and triangulate the result.

3.3. Sample Selection Procedures

The study participants were both male and female adults who did attend health care centers of Addis Ababa for medical or follow-up reasons during the study's data collecting period, that is from 20th January to 10th February 2011. In addition, health care center staffs responsible for health literacy practices were also substantial parts of the research.

A two stage simple random sampling procedure was employed in the selection of sample health centers. First, 5 sub cities out of the 10 Sub cities were selected using a lottery technique. Then out of the selected 5 Sub cities, one health center from each of the selected five Sub cities were selected through simple random sampling method of lottery technique making the total 5 (20%) out of the overall 25 health care centers found in all of the 10 Sub cities, which are under the city administration of Addis Ababa.

Participants representing medical service recipient adults were randomly selected based on entry criteria: given that they at least had attended health literacy sessions once during the previous year, and opt to respond voluntarily. Hence, in the quantitative part of the study, data was gathered from a total of 150 (75 male and 75 female) adult participants of the program in which 30 (15 male and 15 female) participants from each of the selected five health centers took part in the study.

A total of thirty one (12 male and 19 female) health professionals providing health literacy lessons in the selected five health care centers also took part in the research as representative samples. In addition, in an effort to triangulate the study results, qualitative study was also employed. Thus, a total of 15 participant adult learners and 15 health professionals who filled the questionnaire took part in a guided interview representing the randomly selected 5 health care centers which the study dealt with. In addition, a focus group discussion comprising 4 adult learners and 2 health literacy providers were also conducted.

3.4. Data Gathering Instrument

Questionnaires, interview guides, an observation checklist and focus group discussion guides were used as instruments to collect data from health care center service recipients. In addition, interview and focus group discussion guides were used as instruments to collect data from adult service recipients and health care providers.

Questionnaires with both open and closed ended items was prepared by the researcher based on a thorough examination of the related literature. In addition, semi-structured interview guides were developed to conduct the interview with health care center service recipients and health care providers. The semi-structured pattern was employed in the case of focus group discussion guide as well. An observation checklist was also developed in order to assess the health literacy practices of the health care centers. All items passed on serious scrutiny of ethics and language for verification purpose.

3.5. Pilot Test

Before employing the questionnaire and interview guidelines to gather information from respondents, a pilot test was conducted before the actual data collection. Accordingly, the data collection instruments were translated into Amharic and the Amharic version of the questionnaire and interview questions were administered in one of the randomly selected health care center namely the Shiromeda health center. The criteria for the selection of a setting for the pilot test was conducted on the basis of considerations that across the 25 care health centers which run under City Administration of Addis Ababa Health Bureau, the provision of health literacy lessons were similar in their basic features. Hence, the pilot test was conducted for a day on 6 adult learners (3 males and 3 females) and 2 health literacy educators who did not took part in the actual research.

Based on the feedback obtained from the test try out, the researcher revised the questionnaire whereby words and phrases that created hindrances in understanding were modified, questions with ambiguous alternatives, redundant questions and questions which need to be open rather than restrictive closed ended options were taken out according to the results obtained from the pilot test.

3.6. Data Collection Procedures

Having secured permission from the city administration of Addis Ababa health bureau, the questionnaire, interview, focus group discussion and direct observation were conducted in a period of three weeks across the sele5 health care centers of Addis Ababa directly by the researcher himself.

The data for the questionnaires was collected from adults who came to the health center for medication and follow-up purposes. The researcher have attended the early hours health

literacy lessons altogether with incoming adults. Then afterwards, questionnaires were distributed to be filled by adults themselves based on the entry criteria set that they had attended once health literacy lessons and up to their willingness confirmation. For those who couldn't fill by themselves the questionnaire, the questions were read to them and their responses were recorded. On the other hand the questionnaires distributed to the health professionals randomly working in different departments and collected afterwards. The data collections taken place until the sample proportions (both in gender and number) needed could be fulfilled from each health centers. Each of the health centers were visited three times for data collection purposes making a total of three weeks spent in the data collection process.

Interviews were also simultaneously conducted for the randomly selected adult learners who were also willing to provide their opinion in addition to their response to the questionnaires. Similarly, the randomly selected health professionals who partake in filling the questionnaire provided their descriptive explanations in the interview part. The reason for inclusion of the both types of respondents in both cases of questionnaires and interviews was for the purpose of triangulation of the results obtained. Furthermore, the focus group discussion was conducted in one of the health centers to find both health professionals and adult beneficiaries of the program in one table. Direct observations through the pre-planned checklist were conducted within the period of the working days of three weeks assigned for data collection purpose.

3.7. Data Organization and Analysis

The data collected from participants of the study were organized in line with the objectives of the research. Quantitative data were coded and analyzed. To see proportions and sometimes averages of characteristics of variables, descriptive statistics of percentage was computed. The qualitative data, on the other hand, were organized and summarized thematically and are presented in descriptive manner in the analysis part of the study.

3.8. Ethical Considerations

The research work was initially secured by a written permission from the Health Bureau of the Addis Ababa city Administration to conduct the study. The consent of study participants' to partake in the study was confirmed. Moreover, confidentiality and privacy were maintained throughout the study.

CHAPTER FOUR

4. PRESENTATION OF DATA AND ANALYSIS

This chapter describes the study results obtained from the study participants and attempts have been made to analyze the results in terms of the reviewed literature works. Hence, the procedures followed from data collection to organization and interpretation are presented as follows.

The data were collected from adult health literacy program beneficiaries of five selected health centers of Addis Ababa who attended the centers during the period of 20th January -10th February 2011. Moreover, health professionals providing health literacy lessons at the health centers participated in the study. Data were gathered by way of questionnaires, semi-structured interview guides, focus group discussion guide and an observation checklist.

A total of 150 adults (75 male and 75 female) who attended the health literacy practices and 31 health service professionals (12 male and 19 female) took part in the quantitative part of the study. To triangulate the study results, qualitative data was also conducted with 15 adult learners and 15 health professionals through interview and a focus group discussion (4 adult learners and 2 health professionals). Furthermore, observation check list was employed in the collection of data. Hence, the data presentation, analysis and discussion are dealt in consecutive sections of this chapter.

4.1. Presentation of the Data

4.1.1. Socio-Demographic Profile of Participants of the Study

Socio-demographic information obtained from adults who had attended the health literacy program of the health care centers and the health professionals who provide health literacy lessons are presented hereunder. Therefore, both the quantitative and qualitative parts of the study participants are presented successively.

Table 1 below presents the socio-demographic information of adult learners of the study participants who took part in the quantitative part of the study.

Table 1: Socio-demographic characteristics of adult learner participants of the quantitative study

No.	Socio-demographic Information		Frequency	Percentage
1.	Gender	Male	75	50%
		Female	75	50%
		Total	150	100%
2.	Age	20-29	85	56.7%
		30-39	35	23.3%
		40-49	14	9.3%
		≥ 50	15	10%
		Total	150	100%
3.	Educational Level	No formal	6	4%
		Grade1-8	43	28.7%
		Grade9-12	66	44%
		College and above	35	23.3%
		Total	150	100%
4.	Marital Status	Single	65	43%
		Married	77	51.3%
		Separate	5	3.3%
		Widowed	3	2%
		Total	150	100%
5.	Occupation	Employed	92	61.3%
		Unemployed	58	38.7%
		Total	150	100%
6.	Disability	Yes	8	5.3%
		No	142	94.7%
		Total	150	100%
7.	Average attendance per year	one time/year	59	39.3%
		2-4 times/year	70	46.7%
		5-8 times/year	11	7.3%
		9-12times/year	6	4%
		≥ 12 times	4	2.7%
		Total	150	100%

Table 1 above presents the socio-demographic characteristics of the adult learner respondents. Gender proportion was maintained equal in the study where both male and female participants constituted 50 % each. The participants' age ranged from 20 to 54 years where the majority (56.7%) belonged to the age group 20-29 years, 23.3% in age group of 30-39 years, 9.3% in 40-49 years and the rest 10% 50 years and above respectively.

Most of the participants (44%) attended secondary school (grades 9-12), while 28% attended primary education (grades 1-8), 23% college or above higher education, and 4% of the study participants reported not to have attended any formal education.

As to marital status, most of the participants (51.3%) were married. Those who reported to be single accounted 43% of the respondents. The rest were separated or widowed, 3.3% and 2% respectively. With regards to employment the majority (61.3%) responded that they have a job or employed and 38.3% had not a job or with no regular income. The majority (94.7%) of them were not disabled while the minority (5.3%) of them stated that they had disability.

The study participants responded about their average attendance to health centers where the majority 46.7% responded that they visit health centers from 2 up to 4 times during the previous year. The other 39.3% responded that they did visit health centers once within last year. Attendance to the health center from 5 to 8 and 9 to 12 times per year was responded by 7.3% and 4% of the respondents respectively. The minority (2.7%) of the respondents responded that they did visit health centers more than 12 times in the year. In the qualitative part of the study the socio-demographic information of adult participants of the study is presented as consequently. Table 2 below presents the socio-demographic information of adult participants for the qualitative study.

Table 2: Socio- demographic information of adult learner participants for the qualitative study

No.	Socio-demographic information of participant		Frequency	Percentage
1.	Gender	Male	8	53.3%
		Female	7	46.7%
		Total	15	100%
2.	Age	20-29	12	80%
		30-39	1	6.7%
		≥40	2	13.3%
		Total	15	100%
3.	Marital status	Single	11	73.3%
		Married	4	26.7%
		Total	15	100%
4.	Educational Level	No formal education	1	6.7%
		Primary Education(1-8 grade)	1	6.7%
		Secondary Education(9-12)	8	53.3%
		Tertiary	5	33.3%
		Total	15	100%

As can be referred from table 2, the participants of this qualitative study who also took part in the quantitative study were 15 in number. The majority respondents (80%) were with in the age range of 20-29 while the remaining participants between the age range of 30-39 and above 40 were 6.7% and 13.3% respectively. With respect to marital status, majority (73.3%) of respondents were single and the rest (26.7%) were married. Most of them (53.3%) claimed that they completed secondary education (Grade 9-12).Tertiary level education was claimed

by 33.3% of the respondents. The minority were with primary level education and with no formal education 6.7% each.

Corresponding to the adults participants' responses, responses of the health professionals who took part in the quantitative and qualitative parts of the study are presented below consequently. Table 3 below presents the socio-demographic characteristics of the study participant adult educators: their gender, age, marital status, educational level, total years of experience in the profession, their particular years of experience in the health literacy practices and whether they took a course or training in adult teaching are presented hereunder.

As can be referred from table 3 below, majority (61.3%) of the respondents were female and 38.7% were male. The age range of participants extending from 21 to 29 years, most of the respondents (58%) belonged in the age range 21-30 years. The other 25.8% of respondents in the of the age group of 31-40 years. The remaining 12.9% and 3.2% were between the age range of 41-50 years and above/equal to 51 years respectively. Of the respondents, 51.6% were single while 48.4% were married. With regard to their educational qualification, most respondents (54.8%) had diploma and 34.4% had degree. The rest have completed a certificate program or secondary education 3.2% each.

Table 3: General information about health educator participants of the quantitative study

No.	General Information about the health		Frequency	Percentage
1.	Gender	Male	12	38.7%
		Female	19	61.3%
		Total	31	100%
2.	Age	21-30 years	18	58.1%
		31-40 years	8	25.8%
		41-50 years	4	12.9%
		> 51 years	1	3.2%
		Total	31	100%
3.	Marital status	Single	16	51.6%
		Married	15	48.4%
		Total	31	100%
4.	Educational qualification	Secondary educ.	1	3.2%
		Certificate	1	3.2%
		Diploma	17	54.8%
		Degree	11	35.5%
		Total	31	100%
5.	Total experience	Less than a year	7	22.6%
		1-5 years	7	22.6%
		6-10 years	7	22.6%
		11-15 years	2	6.4%
		16-20 years	2	6.4%
		Above 20 years	6	19.3%
		Total	31	100%
6.	Experience in HLP	Less than a year	8	25.8%
		1-5 years	8	25.8%
		6-10 years	9	29%
		11-15 years	2	6.4%
		16-20 years	2	6.4%
		Above 20 years	2	6.4%
		Total	31	100%
7.	Training in adult teaching	Yes	0	0
		No	31	100%
		Total	31	100%

With regard to professional experience of the study participants, respondents with total experience of less than one year, were 22.6%. Similarly, those who claimed to have the experience of 1-5 years and 6-10 years constituted 22.6% each. The other respondents who claimed to have 11-15 years and 16-20 years of experience were 6.4% each. The rest others who claimed to have a total service of above 20 years constituted 19.3% of the respondents.

With particular reference to experience in health literacy practice, about a third (29%) of the respondents had 6-10 years of experience while 25.8% of them had less than a year experience and a similar proportion had 1-5 years of health literacy related experience. The rest had 11-15 years, 16-20 years and, above 20 years of experience constituting 6.4% of the respondents each. All of the participants however stated that they have not taken any sort of training in teaching adults.

Similar to the quantitative part of the study, the general information of health literacy educators who took part in the qualitative study is also presented hereunder. Thus, table 4 below shows the general information of health educator participants for the qualitative study.

Table 4: General information of health educator participants for the qualitative study

No.	General information of Health literacy		Frequency	Percentage
1.	Gender	Male	7	46.7%
		Female	8	53.3%
		Total	15	100%
2.	Occupation title	General Nurse	12	80%
		Psychiatric nurse	3	20%
		Total	15	100%
3.	Educational Level	Diploma	8	53.3%
		Degree	7	46.7%
		Total	15	100%
4.	Total experience in provision of health literacy	Less than 1 year	3	20%
		1-5 years	1	6.7%
		6-10	2	13.3%
		11-15	1	6.7%
		16-20	3	20%
		Above 20 years	5	33.3%
		Total	15	100%

As can be referred from table 4, the participants of this qualitative study were 7 male (46.7%) and 8 female (53.3%) comprising a total of 15 participants. Of the respondents, 53.3% were Degree graduates and 46.7% were diploma graduates. As to their occupation title, they were all general nurses from junior to senior ranks. The respondents claimed to have a range of experiences in the provision of health literacy lessons. Those who claimed to have less than a year experience were 20% and on the other extreme, those who claimed to serve more than 20 years were 33.3%. The others claimed to have 16-20 years experience were 20%. The rest of those who claimed to have the experience of 6-10 and 11-15 were 13.3% and 6.7% respectively.

4.1.2. Results Obtained From the Study Participants Adult Learners about Health Literacy Practice in the Health Centers

The responses given by the study participant adult learners and the health professionals who provide the health literacy lessons about the overall current practices implemented in the health centers are presented hereunder.

Table 5 below presents reasons for visiting health centers and the types of health literacy lessons attended by rank of adult learners respondents in the quantitative study.

Table 5: Reasons for visiting health centers and the types of health literacy lessons attended by rank of adult learners respondents in the quantitative study

Reasons for visiting the health center	Frequency	Rank	Type of health literacy lesson attended to	Frequency	Rank
Tonsillitis and common cold	41	1	HIV/AIDS	61	1
Internal problem (gastric,	32	2	Communicable diseases	50	2
Pregnancy follow up	21	3	Family planning	41	3
Head ache	19	4	Mother and child health	38	4
Family planning	16	5	TB(tuberculosis)	37	5
HIV follow up	15	6	Reproductive health	35	6
Tuberculosis(TB) follow up	12	7	Immunization	30	7
Visual problem	11	8	Environmental	28	8
Child health	8	9	Food hygiene	20	9
Blood pressure	7	10	Epidemics	17	10
Skin problem	5	11			
Asthmatic case	3	12			
Ear ache	2	13			

As can be referred from the table 5 above, most of the respondents' reasons to visit the health centers were tonsillitis and common cold cases. Internal problems such as gastric, diarrhea and pancreatic problems were also cited as reasons to visit the health centers. Follow up programs of pregnancy, family planning, HIV/AIDS and Tuberculosis (TB) were also mentioned as reasons. Head ache, visual problems, children's health were the other reasons mentioned by the respondents. In addition, a range of reasons from blood pressure up to problems of skin, asthmatic cases and ear aches were the various reasons for attending the health centers.

According to the respondents, the most frequently attended health literacy lesson dealt with HIV/AIDS. The other literacy topics were lessons with regards to communicable diseases, family planning, mother and child health, TB, reproductive health, immunization, environmental sanitation, food hygiene, epidemics and as such types of health issues.

Table 6 below contains information particularly associated with participants' experience of health centers' health literacy practice.

Table 6: Experience of the health literacy practices of health centers by adult learners who participated in quantitative part of the study

No.	Information related to health literacy		Frequency	Percentage
1.	Time of HLP provided?	In the morning	133	88.7%
		In the afternoon	5	3.3%
		Mornings and	12	8%
		Total	150	100%
2.	Duration of HLP	Less than 10 minutes	41	27.3%
		10-15 minutes	53	35.3%
		15-30 minutes	43	28.7%
		≥30 minutes	13	8.7%
		Total	150	100
3.	Venue for HLP	Patients' waiting area	118	78.7%
		It has its own venue	13	8.7%
		It has no venue	6	4%
		In any open space	9	6%
		Combination of places	3	2%
		Total	150	100%
4.	Medium for HLP	Amharic	150	100%
		Total	150	100%

As to the majority of respondents (88.7%) in table 6 above, health literacy lessons of health centers are mainly provided early in the morning. The other 8% of the respondents stated health literacy lessons both in mornings and afternoons and the minority 3.3% stated the literacy provided in the afternoons.

With regard to duration of health literacy lessons, the majority (35%) stated that it would take 10-15 minutes, 8.67% stated it would take more than 30 minutes, 28.67% said 15-30 minutes and 27.33% stated it would take less than 10 minutes. As to the venue often used for health literacy lessons, patients' waiting area was reported by the majority (78.67%) of the respondents. Those who said it has its own venue were only 8.67%. Others said it has no venue (4%) or it is conducted in an open space (6%). With respect to medium of communication, all the respondents reported that Amharic was used as medium for the health literacy sessions in the health centers.

Similarly, the general information of health literacy practices implemented in the health centers as provided by the qualitative study participant adults are presented as well. Thus, regarding the average frequency of attendance through the year, most (N=9) were able to visit to the health center two to four times. The other (N=4) respondents who did visit once the remaining (N=2) claimed to visit the health center more than four times. As to what type of health literacy lesson they attended, the majority (N=11) claimed to attend about chronic and

communicable diseases HIV/AIDS and tuberculosis (TB). Those claimed to have attended family planning(N=2) and follow-ups of pregnancy(N=1) followed by a respondent who claimed to follow child health lesson. All respondents stated that the health literacy lessons were provided in the mornings at the patients waiting area near the health report card documentation room. As to how long the programs took, seven(N=7) claimed that it would take 15-20 minutes while six(N=6) stated the time to be 10-15 minutes. The rest (N=2) stated it would take less than 10 minutes. All of the respondents confirmed that the lessons were presented through oral lecture. Most (N=10) of the respondents stated that the lessons were supported with visual teaching aids such as posters. The rest claimed to have come across with audiovisual teaching aid such as television.

Correspondingly, the experiences of the overall implementation of the program as stated by the health professionals who participated in both quantitative and qualitative parts of the study are presented successively hereunder. Table 7 below presents adult educators' response about the health literacy practices of health centers.

Table 7: Response of adult educators in quantitative study about the health literacy practices of health centers

No.	Health literacy practices of health centers		Frequency	Percentage
1.	Average adult learner attendance per lesson	< 25	1	3.2%
		25-50	15	48.4%
		51-100	6	19.3%
		>100	9	29%
		Total	31	100%
2.	When is the HLP provided?	In mornings	28	90.3%
		In mornings and afternoons	1	3.2%
		Whenever they come	2	6.4%
		Total	31	100%
4.	Gender most frequently attending HLP	Females	29	93.5%
		Males	2	6.4%
		Total	31	100%
5.	Venue for HLP	In Patient waiting area	24	77.4%
		No regular place	1	3.2%
		On its own venue	2	6.4%
		On health treatment	4	12.9%
		Total	31	100%
6.	Taking turn to provide HLP	Monthly	13	41.9%
		Every two weeks	9	29%
		Weekly	4	12.90%
		On the regular duty	1	3.2%
		No response	4	12.9%
		Total	31	100%
7.	How are HLP topics selected?	By the health center	16	51.6%
		By the Sub city Health	5	16.1%
		Personal selection by the	6	19.3%
		No response	4	12.9%
		Total	31	100%
8.	Health topics posted on notice board?	Yes	27	87.1%
		No	3	9.7%
		I don't know	1	3.2%
		Total	31	100%

According to the responses provided by the participant adult educators, most of them (48.4%) stated on average 25-50 adults attend per lesson. Of the respondents 19.3% responded 51-100 adults attend per lesson. The other 29% stated that above 100 adults attend per lesson. The remaining 3.2% of respondents stated less than 25 adults per lesson.

As to timing of the lessons, the majority (90%) of respondents stated that health literacy programs of the health centers are provided in mornings. The other 6.4% of respondents said that adults would be provided the service whenever they come for treatment. The remaining 3.2% stated in the mornings and afternoons.

Concerning the venue of health literacy, the majority (77.4%) said that the lessons are provided in the patients' waiting area. Those who said that there is a department based health literacy provision were 12.9%. Others responded it has its own venue were 6.4%. The rest 3.2% stated that there is no regular venue for the provision.

With regard to taking turn to provide health literacy lessons, most of them (41.6%) stated they would take turn on monthly bases. Those who responded as taking turns every two weeks and on weekly bases were 29% and 12.9% respectively.

Concerning the selection of health literacy topics, most of the respondents (51.6%) responded that it would be decided by the health center itself, while others (16.1%) claim that the sub city takes the responsibility. Selection of topics based on personal choice and preference was also responded by 19.3% of the respondents.

As to posting health literacy topics, the majority (87.1%) of respondents assured that the selected topics would be posted on notice board. Some 3.2% however claim to have no awareness with this regard. Others (9.7%), on the other hand, said that topics were not posted. Similarly, the general information of health literacy practices implemented in the health centers as provided by the qualitative study participant health educators are discussed in highlighted manner. According to the responses of health educators, the majority of respondents pointed mother and child health as the major health literacy provided in the health center. Food hygiene, family planning, HIV/AIDS, communicable diseases and TB were also referred as major types of the health literacy programs provided.

With respect to frequently provided health literacy, most of the respondents referred mother and child health as frequently provided. The second frequently provided health literacy provided stated by the respondents was family planning. Immunization, epidemics, nutrition and reproductive health were also mentioned as frequently provided health literacy practices. All respondents agreed that the health literacy lessons are provided in the mornings. The venue for health literacy according to the majority (N=11) of the respondents was in the patients' waiting area. While the remaining respondents stated that it was given in the patients' waiting area and in departments whenever clients or patients come for examination and checkups. The average time of 10-15 minutes for health literacy sessions was referred by the majority (N=11) of respondents. Other respondents (N=4) claimed that it takes 15-30 minutes. All respondents agreed on oral lecture as the teaching methodology used in the health centers for health literacy sessions. Visuals as teaching aid materials were implemented

according to the response of the majority (N=11) of respondents. Others (N=4) claimed audiovisuals were also commonly used during the health literacy lessons.

Results from focus group discussants also show the current implementation of the program with respect to the awareness of the public about the presence of the program.

A woman participant of the discussion who put forward her experience demonstrates the situation:

... As far back as I remember that we were well aware of the presence of the provision of health literacy lessons in the health center. I am a woman and came here to different treatment in family planning, pregnancy follow-ups and for my children's medication cases. In most of the times I encountered health literacy lessons given by health educators whenever I come here in early mornings. There used to be in the form of drama presentations in which most of patients were enjoying while waiting their queue for treatment. But now a days I haven't come across with such kinds of presentation except brief lectures. It has been weakened nowadays...

In the case of focus group discussion, health literacy educators also tried to explain the presence of the program with respect to the general public awareness. A case in point for this explanation demonstrated through discussant health professionals.

A discussant medical professional affirmed the public awareness about the presence of health literacy lessons in the health center and the trend of implementation:

...The program has been well aware by the majority of the public living in the vicinity. In the past the trend was that health professionals would be given their topics and assignment date and posted in the notice board. But due to transportation problem the professional living far away from the center couldn't reach at the time and the schedules were not properly executed. So as an option we made discussions and agreed upon with the decision that a medical professional who attend an emergency night shift should teach before going back home in the morning. So, we have been giving all week days according the monthly program except weekend days of Saturday and Sundays...

The other medical professional discussant elaborated the new trend of departmentalized lessons as follows, "We are providing the lessons and consultations for both patients who came for occasional treatment in group and departmentalized lessons for regular clients visiting for family planning, pregnancy follow-up, Immunization follow-up for the babies, ART treatment, TB follow-ups".

From the discussion participant health educators and adults who attended the health literacy have been reflected their opinions about the presence of the health literacy program in the health center. According to the results of the focus group discussion conducted in one health center most of the discussant adults and medical professionals agreed with public awareness of the provision of the service.

4.1.3. The Study Participants' Perception about the Contents of Health Literacy Lessons Provided at the Health Centers

Table 8 below presents the perception of adults who took part in the quantitative part of the study about the contents of the health literacy lessons.

Table 8: Perception about contents of health literacy lessons by adult learner respondents of the quantitative study.

No.	Perception about the health literacy contents		Frequency	Percentage
1.	Are the contents related to your life?	Yes	132	88%
		No	15	10%
		I don't know	3	2%
		Total	150	100%
2.	How often are the contents clear and easily understandable?	Always	36	24%
		Usually	61	40.7%
		Sometimes	49	32.7%
		Never	4	2.7%
		Total	150	100%
3.	Are the topics prevalent in your living place/region?	Yes	119	79.3%
		No	22	14.7%
		I don't know	9	6%
		Total	150	100%
4.	How urgent are the topics of HLP?	Very urgent	102	68%
		Urgent	44	29.3%
		Not urgent	4	2.7%
		Total	150	100%
5.	Do you have prior Knowledge about the topics?	Yes	126	84%
		No	24	16%
		Total	150	100%
6.	Topics sensitivity to diversity in educational level	Satisfactory	51	34%
		Unsatisfactory	74	49.3%
		I don' know	25	16.7%
		Total	150	100%
7.	Topics sensitivity to cultural sensitivity	Satisfactory	85	56.7%
		Unsatisfactory	45	30%
		I don't Know	20	13.3%
		Total	150	100%
8.	Topics sensitivity to address diverse disabilities	Satisfactory	43	28.7%
		Unsatisfactory	72	48%
		I don' know	35	23.3%
		Total	150	100%

The table above presents the perception of adults about the contents of lessons raised during health literacy sessions. According to their responses, the majority (88%) of the respondents depicted that the health topics are related to their life while 10% of them said that it is not

related to their life. With regard to clarity of the lessons, most of them (40%) stated that it is usually clear and understandable and few (2.7%) stated it had never been clear and understandable.

As to the presence (in adults' living place/region) of health issues discussed in health literacy lessons, the majority (79.3%) revealed their agreement while others who disagreed and couldn't tell were 14.7% and 6% respectively.

As to urgency of health literacy topics, the majority of the respondents (68%) stated that the health literacy topics provided in health centers were of very urgent nature whereas 2.7% responded that they were not important. In another dimension, the majority (84%) of the respondents stated that they had prior knowledge about the health topics thought at health centers while 16% reported none.

Sensitivity to diversity of health literacy information recipients' was also among the content related issues rated by the adult learners. Thus, sensitivity to diversity in educational level was primarily rated as unsatisfactory by (49%) of adults. Some (34%) of the respondents however expressed their satisfaction and the rest (16%) were not certain. With respect to cultural sensitivity, the majority (56.7%) expressed their satisfaction while some (30.7%) of them reported dissatisfaction and the rest (13.3%) were not sure of their satisfaction level. Similarly the majority (48%) of respondents revealed their dissatisfaction with the programs' sensitivity to address diverse needs of adult learners with disabilities. The other who expressed their satisfaction and indecision were 28.7% and 23.3% respectively.

Similarly, the perception of the qualitative study participant adults about the relevance and sensitivity to diversities of the contents of the health literacy programs for adult learners are presented as follows. Thus, all respondents did agree with the relevance of the contents of health literacy programs for adult daily life in practice. Whereas, the majority (N=11) had a doubt whether the lessons were sensitive enough to the diverse types of learners' need and abilities and disabilities. While the rest of minority (N=4) agreed with the sensitivity of the lessons.

A respondent's response for the lack of sensitivity is exemplary for this:

...There are people coming with different abilities and interest. The people coming here are ranging from illiterate to elites. From sensitivity point of view, there are people coming who can't read and write, people without sight or hearing problem. For those kinds of people, even though the lesson is provided orally, I have a doubt whether they would understand

the lesson effectively. Another thing is the language used here is Amharic only. For those people in which Amharic is their second language it is not as such easy to follow lesson....

4.1.4. Results obtained from the Study Participants about the Teaching Methodologies Employed in the Health Literacy Practices

The results obtained from both study participants about the methodologies employed in the health centers are presented in descriptive manner this section. Table 9 below presents the quantitative part study participant adult respondents' perception of teaching methodologies used in health centers.

Table 9: Adult learner respondents' perception about teaching methodologies used in health centers

No.	Respondents' perception of teaching methodologies used in health	Frequency	Percentage
1.	Active conversation involvement with health professionals	Yes	76 50.7%
		No	63 42%
		I don't know	11 7.3%
		Total	150 100%
2.	The use of medical jargons by health professionals	Yes	52 34.7%
		No	82 54.7%
		I don't know	16 10.7%
		Total	150 100%
3.	How often Medical jargons used by health professionals?	Always	3 5.7%
		Usually	4 7.7%
		Sometimes	27 51.9%
		Never	18 34.6%
		Total	52 100%
4.	Chances for adults to share ideas in groups about the raised topic	Yes	70 46.7%
		No	63 42%
		I don't know	17 11.3%
		Total	150 100%
5.	Personal testimony by adults	Yes	64 42.7%
		No	51 34%
		I don't know	35 23.3%
		Total	150 100%
6.	Predominant medium used in the lesson	Oral lectures	125 68.7%
		Audios	26 14.3%
		Visuals	16 8.8%
		Audio visuals	15 8.2%
		Total	182 100
7.	Verbal and nonverbal encouragements from the health professionals	Always	34 22.7%
		Usually	52 34.7%
		Sometimes	45 30%
		Never	19 12.7%
		Total	150 100%
8.	How frequently get feedback from adult educator	Always	48 32%
		Usually	49 32.7%
		Sometimes	42 28%
		Never	11 7.3%
		Total	150 100%
9.	Willingness of health educator to listen adults problem	Yes	116 77.3%
		No	21 14%
		I don't know	13 8.7%
		Total	150 100%
10.	Are the HLP lessons presented in sequence or order?	Yes	95 63.3%
		No	38 25.3%
		I don't know	17 11.3%
		Total	150 100%
11.	Health educators willingness to manage the needs with different learning abilities	Yes	86 57.3%
		No	35 23.3%
		I don't know	29 19.3%
		Total	150 100%
12.	Can adults with lower literacy skills follow the HLP?	Yes	107 71.3%
		No	29 19.3%
		I don't know	14 9.3%
		Total	150 100%

Table 9 above presents adult learners' perception about the methodologies employed by health educators in the delivery of the health literacy lessons. The opportunity of holding an active conversation with health literacy professionals is stated by the most (50.7%) of the respondents while 42% of the respondents stated that active conversational involvement with health literacy educators were not there. The rest 7.3% were undecided.

Use of medical jargons by health professionals during health literacy sessions was reported by 34.7% of respondents while the majority (54.7%) stated that there were no use of medical jargons and the rest 10.7% remained undecided. With regard to how frequent medical jargons used by health professionals during health literacy lessons, most of them (51.9%) responded that sometimes health literacy educators use medical jargons. The chances for adults to share ideas in group about the raised health topics was reported by 46% of respondents while 42% of the respondents stated its absence and the remaining 11.3% were undecided. The presence of a chance for adults presenting personal testimonies during the health literacy sessions was also assured by 42.7% of respondents while 34% of the respondents responded its absence and the rest 23.3% of them stated that they don't know.

Oral lectures were ranked the most predominantly used medium in the health centers followed by the use of audios, visuals and audiovisuals ranked consecutively in descending order. With respect to verbal and non verbal encouragement from health literacy educators, most respondents who stated that always encouragement was given were 22.7% of the respondents, while those who claimed the usual encouragement were 34.7% while some (30%) of the respondents described they sometimes got encouragement. The minority respondents however said that they were never given encouragement from health literacy educators' side.

The majority of the respondents (77.3%) expressed the willingness of health educators to listen adults' problem. Willingness to manage the needs of adults with different needs was also assured by most respondents (57%). It was also indicated from the responses that the majority of respondents agreed that the health literacy lessons were given in sequential order. In addition, the notion of adults with lower literacy skills could follow health literacy lessons was assured by the majority 71.3% of respondents. Conversely, to the aforementioned responses 14% of respondents expressed their disagreement with the willingness of health educators to listen adults' problems.

Conversely, with regard to the management of adults' need, nearly a quarter (23.3%) of the respondents stated that adult educators were not willing to manage adults' with different abilities and needs. Concerning the health literacy presentation, a fourth (25.3%) of respondents stated that the lessons were not presented in sequence and order. Adult with lower literacy skills could not also follow the lesson was responded by 19.3% of the respondents. On the other hand, the adult educators' responses about teaching methodologies utilized in the health literacy sessions in the health centers are also presented hereunder. Concerning the methodologies used for the health literacy programs, most of the respondents responded that they use audio mediums/channels in the health literacy programs. The other 35% of them cited they used audiovisuals as mediums. The rest of respondents stated that they use visual mediums (12.9%) and oral presentation (12.9%) as medium for health literacy programs. With regard to the common language used in the lesson, all respondents stated Amharic language is used in the provision of the lessons. Similarly, 67.7% of the respondents stated that they don't use other language other than Amharic while 29% affirmed that they use other language also during health literacy sessions.

For inquiry whether health literacy educators have clear manuals at hand as to how to teach adults the majority (74.2%) responded that they hadn't while the minority stated that they had. In relation to methodology, the majority (74.2%) responded that they usually repeat main points for reassurance in the health literacy sessions. The other 16.1% stated that they had always done that while the remaining (9.7%) responded that they did that sometimes during the lesson. As to how frequently did they respond for the questions raised by adults, 48.4% of them responded that they always had done so. The other 45.2% of them stated that they usually do while the rest 6.4% of them cited that they sometimes respond for questions raised by the adults. Majority (87.1%) of the respondents stated that they check adult's acquisition of the lesson by asking questions. The other respondents (6.4%) stated that they had prior experience. Asking to demonstrate was also cited as checking mechanism while having no mechanism to check was mentioned by a respondent.

All of the respondents believe that medical knowledge by itself does not guaranty the provision of effective health literacy lessons for adults. Thus, all respondents of the qualitative part of the study participants acknowledge the need to take for additional training on the methodologies of adult teaching.

4.1.5. The Study Participants Perception about the Physical Environment of the Health Centers

The study participant adults in the quantitative part of the study responded about the physical environment as to how it looks like for the implementation of the health literacy services. Thus, table 10 below presents respondents' perception about the physical environment of health centers for health literacy.

Table 10: Adult learner respondents' perception about the physical environment of health centers for health literacy

No.	Perception about physical environment of the		Frequency	Percent
1.	Adult's perception about the venue of the HLP	Satisfactory	58	38.7%
		Unsatisfactory	87	58%
		I don't know	5	3.3%
		Total	150	100%
2.	Is the venue for HLP looks interesting?	Yes	92	61.3%
		No	58	38.7%
		Total	150	100%
3.	Is there enough furniture for HLP attendant adults?	Yes	63	42%
		No	87	58%
		I don't know	0	0
		Total	150	100%
4.	Is the venue suitable for elderly people	Yes	73	48.7%
		No	77	51.3%
		Total	150	100%
5.	Is the venue suitable for people with disability	Yes	59	39.3%
		No	91	60.7%
		Don't know	0	0
		Total	150	100%
6.	Is the venue suitable for pregnant women	Yes	72	48%
		No	77	51.3%
		Don't know	0	0
		Total	150	100%
7.	Is the venue suitable for women carrying a child	Yes	68	45.3%
		No	82	54.7%
		Don't know	0	0
		Total	150	100%

Table 10 above shows that most participants (58%) were not satisfied with the venue for the health literacy programs. Some of them (38.7%) were however satisfied in the venue and the remaining (3.3%) of respondents were undecided. When it comes to particulars, the suitability of the venue was expressed so. Thus, greater proportions (60.7%) of respondents were unsatisfied with the suitability of the venue for people with disability, for women carrying a child (54.7%), for pregnant women and elderly people 51.3% each. On the other hand there

were some respondents who agreed with suitability of the venue for health literacy. With regard to furniture, most of the respondents (58%) expressed their dissatisfaction about the furniture in the health centers that are used for health literacy programs, while the rest 42% expressed their satisfaction.

4.1.6. The Study Participants' Perception about the Psychological Environment of the Health Centers

The study participants' perception about the psychological environment of the health centers are presented here under. Therefore, how the psychological environment looks like as perceived by adult learners and the responses of health literacy educators' perception about adults attending the health literacy sessions in the health centers are dealt successively in this section.

Table 11: Perception about the psychological environment of health centers for health literacy by adult learners of the quantitative study

No.	Perception about psychological		Frequenc	Percentage
1.	Perception of getting reliable information	Yes	127	84.7%
		No	23	15.3%
		I don' know	0	0
		Total	150	100%
2.	Expressing opinion without fear and/or embarrassment	Yes	98	65.3%
		No	52	34.6%
		Total	150	100%
3.	Adult educators treatment with respect	Always	62	41.3%
		Usually	47	31.3%
		Sometimes	34	22.7%
		Never	7	4.7%
		Total	150	100
4.	How frequently get feedback from adult educator	Always	48	32%
		Usually	49	32.7%
		Sometimes	42	28%
		Never	11	7.3%
		Total	150	100%

As to table 11 above, the respondents' perception whether they get reliable information from health educators or not, the majority (84.7%) assured that they did get reliable information from the health literacy program and the rest 15.3% expressed their disagreement. Of the respondents, 65.3% of them stated that they were able to express their opinion without fear and embarrassment while the remaining 34.7% of them stated that they were not able to express their opinion without fear and embarrassment. With regard to treatment of adult

educators, most of them agreed that they were treated with respect and frequently given feedback for their inquiries from health literacy educators.

4.1.7. Perception of Health Literacy educators about Adults Attending the Health Literacy Sessions in the Health Centers

The health literacy educators' perception about adults attending the health literacy sessions in the health centers shows other dimensions which worth due considerations for depicting the actual implementation of the programs. Thus, table 12 below presents responses of health literacy educators' perception about adults attending the health literacy sessions in the health centers.

Table 12: Responses of health literacy educators' perception about adults attending the health literacy sessions in the health centers

No.	Health literacy educators perceptions		Frequency	Percentage
1.	Do you think the health literacy provided in the health center meaningful to adults life?	Yes	31	100%
		No	0	0
		I don't	0	0
		Total	31	100%
2.	Do you think adults visiting the health center know the presence of health literacy lessons	Yes	23	74.2%
		No	4	12.9%
		I don't know	4	12.9%
		Total	31	100%
3.	Who are the most frequent beneficiaries of the health literacy lessons?	Male	2	6.4%
		Females	29	93.5%
		Total	31	100%
4.	Do you think adults have the motivation to follow the health literacy lesson?	Yes	16	51.6%
		No	6	19.3%
		I don't know	8	25.81%
		Total	31	100%
5	Do adult show reluctance to follow the health literacy lessons?	Yes	14	45.2%
		No	10	32.3%
		I can say	7	22.6%
		Total	31	100%

All of the respondents did believe that the health literacy lessons were meaningful to the adult's life. The majority (74%) of respondents thought adults visiting the health center knew the presence of health literacy lessons. The other 12.9% of respondents stated that adults were not aware of the presence of health literacy lessons. The rest 12.9% of them were undecided. In terms of frequency of beneficiaries, the majority (93.4%) of respondents assured that females were the most frequently attending beneficiaries of the program. The minority of them pointed males as frequent beneficiaries. Most respondents stated that dramatic method of

presentation of the health literacy preferred by adults. Consecutively in descending order; group discussion, lecture method, audiovisuals and demonstration based presentation were also cited as adults' preference. Almost half (51.6%) of the respondents stated their agreement with the presence of motivation to follow the health literacy lesson. The rest 19.3% of them disagreed and a quarter (25.8%) of respondents were undecided. With respect to adults' overt behavior, most respondents (45.2%) referred that adults did show reluctance to follow the health literacy lessons. The remaining respondents who stated their disagreement and indecision were 32.3% and 22.6% respectively.

4.1.8. Results Obtained from the study Participants about Major Challenges Observed in the Health Care Centers in Implementing Health Literacy Program

The major challenges impending the current implementation of the health literacy programs as viewed from the study participant adult learners and health professionals is presented in this section. Therefore, successive presentations of adult learners and health professionals who took part in the quantitative and qualitative part of the study are dealt hereunder consequently.

Table 13 presents adult learners' ratings from the quantitative part of the study about the major challenges facing the health literacy program. Therefore, ratings of those adults who were part of the quantitative part of the study are listed below. (Respondents were advised that it is possible to suggest more than one answer).

Table 13: Adult Learners' ratings of the major challenges facing the health literacy program as viewed by qualitative study participants

No.	Major Challenges encountered in the HLP	Frequency	Rank
1.	Problems of facilities	67	1
2.	Problem in the teaching methodology	59	2
3.	Problems observed on health literacy educators	43	3
4.	Administration and supervision problems	18	4
5.	Adult learners lack of interest to follow the	13	5
	Total responses	200	

The majority of respondents stated problems in facilities among the major challenge facing the implementation of the health literacy program. Inconvenience of the venue, shortage of time for the program, shortage of furniture and teaching aids were also cited as part of the facility related problems. On the other hand, the methodology adopted by health educators was referred as another major problem observed in the program. Accordingly, not interesting and

weak method of lesson presentation, presentation of similar topics, mixing up of all types of patients and clients together provide untargeted topic, provision of the lesson in one language only and lack of translation for people who can't fluently understand the medium Amharic language and lack of communication options for people with disability mentioned as frequently observed challenges with respect to the methodology of the lesson presentation.

On the part of health literacy educators' situation, lack of motivation, preparation, punctuality and respect for adults were mentioned as problems. In addition, lack of experience in teaching, presentation of a topic with random selection without preparation, and inefficiency in teaching the lesson were also stated as problems respondents encountered during visit to the health centers.

The other dimension of challenges observed by the respondents was regarding administration and follow up of the literacy program. Inadequate attention for the program, lack of supervision and follow up, and attention when only epidemic outbreak happens were among the challenges reported by respondents. Furthermore, budget and man power constraints and less attention for planning were mentioned as problems on administration dimension. Adult learners' lack of interest and reluctance to follow the health literacy program was also mentioned as the other major challenge facing the program.

Similarly, adult participants of the qualitative part of the study described the major challenges they did observe in the current health literacy programs of the health centers. Therefore, results obtained from interview sessions with the adult learners are presented. According to the respondents, the challenges of the health literacy program were of various dimensions. But, the majority of respondents pointed out the problem of poor methodology at the heart of the problems. Lack of proper facilitation and venue, lack of competent literacy educators, problems in administrating and follow up and supervision were also mentioned in descending order as the major health literacy challenges encountering the health centers currently.

The major challenge pointed out by the majority of respondents reflected on the response of an interviewee was, "In my opinion, the teaching method is not attractive. Whenever presented, they are very brief and on similar topics. If they were on TV, they might be interesting and people can give attention to them".

Lack of proper facilitation and furniture which was mentioned as another major challenge explained by an interviewee said, "As you can see the chairs are wooden benches without

shoulder. Elder people can't sit comfortably and follow the lesson. There are not enough chairs as compared to the flow of patients' number. People are compelled to stand up to follow the programs".

With regards to lack of competent health literacy educators an interviewee said, "I don't think some of the educators are adequately experienced in teaching. They are not giving adequate information for people with different learning abilities. Treating the needs of different types of adult learners requires competence in the profession. In addition to their medical proficiency they need additional qualities in teaching".

About problems related to administering and follow up supervisions a response by an interviewee about the situation was, "There is no follow up in the programs. Sometimes there may not be a lesson in the health center. Since it is provided before the opening hours by the night shift emergency attendant, I don't think there is a cross checking mechanism whether the person gave the lesson or not".

Corresponding to the responses provided by the adult learners participants of the study, health professionals who participated in the study were also provided their response about the major challenges encountered in the implementation of the program. Hence, their responses are also incorporated and presented in descriptive manner.

Health professionals who partake in the quantitative part of the study identified the most frequently observed challenges facing the health literacy practice in the health centers. Accordingly, most respondents considered the lack of proper attention and follow ups for the health literacy programs as the major challenge facing the health literacy programs. The other consecutively rated challenges in descending order were lack of motivation from adult learners' side, lack of readiness and efficiency health literacy educators, poor methodologies of teaching, lack of proper teaching methodologies, lack of teaching aids, lack of proper venue and time allotment were all mentioned.

Similarly, on the health professionals' side participants in the qualitative part of the study described about the major challenges observed in the implementation of the health literacy programs.

According to most of the respondents', adult learners' reluctance and lack of attention to follow the program was the most frequently observed challenge in the implementation of the health literacy programs. As to adults' reluctance an interviewee said:

...Adults come to the program with their cultural beliefs. So, when we teach them for instance about long term family planning, they reflect what they heard at their surrounding without any scientific base that 'Lup' will go up to head and causes infection. Even after the lesson, they may still be skeptic to use the family planning. Some women would say that they are daily laborers and so that they can't take it...

Another respondent explained her experience in relation to lack of attention of adult learners as:

...I came across with different people especially youths disturbing others through making noises. You can see from their faces that they are not willing to listen. Some even put earphones and others watching other directions. In the mean time those who needed the lesson would be distracted especially the older ones. It is very unlikely for us to give each individual sufficient consultation inside the examination room since plenty patients lined up for treatment. Instead of using such limited opportunity, some are just ignorantly done that while some others rush to get away with what they want to their business. Since this area is hugely business area that they don't want to spend more time here...

Lack of responsible body to give credible attention and follow up on the programs was also cited as major challenge. The experience reflected by an interviewee shows the extent:

...There is no budget and no responsible body to follow up the program. In the past, the Sub city health office will send us a form and direction as to how to implement the program and report. I used to send monthly report to the Sub city. But since some times in the past they haven't showed up and their supervision becomes weakened. Thus, I quitted sending the report being confused for whom exactly to report...

Another respondent affirmed the current program coordination like this:

... There is only one person who is assigned for coordination of the program. But as far as I know once the schedules are posted in the notice board there is no as such serious scrutiny as to how the lessons are going on. The only thing expected from the health professionals is to state their topic and registering number of males and females attended in the form. For this reason, educators would teach any topic of their choice randomly in contrast to what they have been assigned...

Other challenge cited by the respondents was the problem of inconvenience of the health literacy venue. This was what an interviewee explained:

...The venue is not comfortable for the programs. Since it is in front of record and triage offices. Adults who came to the center as early as 6:00 am in the morning would be anxious to get the treatment which would start at around 8:30 am. While people are given queue card and in return they give their registration card to the clerks, being called from the clerks through the window during the lesson, most of them are alert to listen attentively to their names. So, there are too much noises going on while the health literacy educator tries to provide the lesson...

Lack of insufficient and out -of- dated teaching aid materials among the challenges encountered in the implementation of the program was also stated by the respondents.

Looking at an interviewee response shows a case in point:

...Our teaching aids especially the audiovisuals were out-dated. For instance, we have a lesson about HIV which used to be said it was very dangerous diseases with relatively negative connotative implications. However, nowadays, the trend has been improved that people assumed to live together and can still lead productive lives besides the diseases. Thus, to present such old videos for them which they have already known and passed the course of such time is not commendable. Thus, we tried to focus on lecturing method...

Reluctance and lack of motivation from adult educators' side was another challenge mentioned by the respondents. An interviewee said, "Most of my colleagues have been fade up with the provision of the lesson. So, all what they want to do is just come up with their interest a topic and do their routine assignment and go to the report statistics".

Poor methodology which was not up-to-date and unattractive to adult learners was also cited as the dimensions of challenges encountering the programs. A response from an interviewee is an example for such situation, "Almost all of our methodologies rely on lecturing. Thus, I think adults would not be as such interested to follow with only information which they think they already knew".

Furthermore, in the focus group discussion undertaken with adult learners and health professionals, the major challenges observed in the health care centers which hamper the effective implementation of the health literacy programs were pointed out amongst the participants. Hence, problems related to methodologies, teaching aids, facilitations, lack of motivation from educators and learners, mediums problem and budget constraints were pointed out among the major challenges observed in the implementation of the program.

A discussant adult learner emphasized the problem from budget constraints side said, "The things we have been discussing are all related to financial constraints and management

problems. Therefore, attention should be given to these problems. The venue problem, teaching aids and materials like posters, leaflets etc. All could have been fulfilled had the situation was given attention in the budget and finance”.

Another discussant woman pointed out the major challenges from adult learners’ perspective and the schedule of the program status was that, “There is lack of interest from adults’ side to attend the program as the result of poor and unattractive method. The drama type of presentation could have involved actively all types of people. The health literacy is also provided only once in the morning. Patients who came late in the morning and in the afternoon couldn’t get the chance for the lesson”.

From the health professionals’ side, the major challenges encountered in implementing the health literacy program were listed out by a discussant health literacy professional like this:

...The health literacy lessons provided not oriented in patient’s interest rather directed to them according to the health center schedule. There is lack budget for the program. There is mismatch between patients flow and health professionals. Educators haven’t been motivated to engage in the work actively rather they work just to fulfill their duty. Health professionals do not have resource center to access up-to-date information to equip themselves with recent knowledge. The films that we have are old and what people already know. The pamphlets are not as such up-to-date. Adults’ lack of interest is also a problem. The venue is too narrow. Patients who came for diarrhea treatment may not be willing listen attentively our lesson of the day about TB. There are language barriers especially the medical terminologies cannot be easily translated to Amharic language...

The major challenges encountered in the implementation of the health literacy programs which have been described above were the reflections of the participants about the situation from their experiences.

4.1.9. Results Obtained from the Study Participants about Practical Measures that Should be Undertaken to Improve Health Literacy Program

Practical measures that should be undertaken in improving the current implementation of the health literacy programs as viewed from the study participant adult learners and health professionals is presented in this section. Therefore, successive response presentations of adult learners and health professionals who took part in the quantitative and qualitative part of the study are dealt hereunder consequently.

Table 14 below presents the responses of adult learner respondents' practical solution measures to improve the health literacy programs. (Respondents were advised that it is possible to suggest more than one answer).

Table 14: Practical solution measures to improve the health literacy programs as viewed from adult learners of the quantitative study

No.	Measures that should be taken in HLP	Frequency	Rank
1.	Improving the facilities	110	1
2.	Improving the follow up of the programs	37	2
3.	Improve the teaching methodology in the programs	13	3
4.	Upgrading health literacy educators' skills,	10	4
5.	Reaching out to the community	3	5
	Total responses	171	

The majority of the respondents, as indicated in table 10 above, commended the improvement of facilities of health centers for the effective implementation of health literacy programs. Specifically, teaching aids, a wider and separate venue (from the waiting space), adequate furniture, and noise and interruption free space were cited as proper solution measures in relation to improving facilities.

Strengthening the follow up of literacy programs at the health centers was the other commendation raised by many respondents next to improving facilities. According to the responses cited by participants, establishing continuous and regular supervision, assessment of the program implementation regularly, assigning responsible body to follow thoroughly were among the solution measures cited by the majority of the respondents.

The other major solution cited by the respondents regards to improving the methodology of lesson presentations. With this regard, presenting lessons based on recipients' interest in clear

and attractive manner, provision of translation to jargons, presenting lessons supported with demonstration, provision of discussion questions at the end, and engaging all participant adults were cited as solution in fulfilling the methodological constraints observed.

Upgrading health literacy educators' skills, efficiency, and work ethic were cited by the respondents as another potential solution in solving the challenges observed from health literacy educators' side. Thus, becoming punctual, respectful to adult learners, and working up to the professional standard were cited in this respect. Furthermore, reaching out to the community in different social and communal settings was also cited by the respondents as possible solutions to raise the level of awareness among the general public and decreasing the rate of preventable diseases.

Similarly, adult participants who partake in the qualitative study provided their opinion as to how practical measures should be undertaken to improve the health literacy programs. According to the majority of respondents, for effective health literacy program, implementing effective follow up mechanism for the health literacy should be undertaken. Improving the teaching methodology, facilitation of the learning venue were also cited as the possible solutions. Furthermore, reach out the community outside the health center was cited as a mechanism for improvement of the program.

In implementing effective follow up mechanism for the health literacy that should be undertaken described by a respondent as such, "I don't think there is proper follow up going here as to how the program is provided. If it was done, the teaching aids could have been fulfilled, the lenient behavior of educators could have been improved. All they are doing is treating people without giving attention to health education".

With regards to improving the teaching methodology adult learner respondent's response was: "It is better to use attractive methodology for the program. Otherwise people will not be attracted to the lesson and provide enough attention to the program".

In relation to facilitation of the learning venue, a respondent's opinion was, "The venue should be a hall, free from distractive noises. The benches should have at least shoulder to lean on. Recent and educative posters and pictures should be posted on the wall".

With regards to reaching out the wider community and the general public, an opinion cited by an interview was, "In my opinion, the health literacy provided in the health center is for very minimum number of people. It cannot be said that it covers the vast majority of people. So, enormous amount of job is required".

On the other hand, health literacy educators provided their opinion as to how practical measures should be addressed in improving the health literacy practices in the health centers. Thus, responses of the health professionals who partake in the qualitative and quantitative part of the study subsequently presented hereunder.

Table 15 below presents responses of health literacy educators' about the possible measures should be taken to improve the health literacy practices in the health centers.(Respondents were advised that it is possible to suggest more than one answer).

Table 15: The possible measures should be undertaken to improve the health literacy practices in the health centers as viewed by health literacy educators in quantitative study

No.	Possible Measures that should be taken to improve HLPs	Frequency	Rank
1.	Improve and apply attractive teaching methodologies for adults	14	1
2.	Have responsible body to lead and follow-up the programs	9	2
3.	Providing in-service trainings for adult educators	9	3
4.	Improve the venue of the health literacy center	7	4
5.	Establish resource center for health literacy educators	5	5
6.	Allocation of proper time	3	6
7.	Fulfill proper teaching aids	2	7
8.	Widen the awareness raisings beyond the health centers	1	8
	Total Responses	50	

With regards to the measures that should be taken, most respondents agreed with the need for improvement in methodologies of the lessons provided. Responsible body to lead, run and follow up the program was also rated as an important measure that should be undertaken. The other measures cited as solution for effective implementation of that the program were the provision of in-service training for adult educators, improving the venue, establishing resource center for educators, allotment of sufficient time, fulfilling teaching aids, reaching out the general public of through wider scoped awareness raising works in other social settings were stated as essential measures that should be undertaken.

Similarly, from health professionals' side, measures that should be undertaken to solve problems and enhance the health literacy programs as viewed by qualitative part of the study results are described below.

According to the majority of respondents, raising the motivation of health literacy educators and upgrading their skills cited as the solution for the implementation of health literacy programs effectively.

A respondent stated about raising the motivation of the educators and upgrade their skills in such a way that:

...Adults have different behaviors in the learning process that their need and interest should be fulfilled. So, for such effect the need for the training is unquestionable...what we know is more of academic knowledge filled with medical jargons, even a lack of proper Amharic translation for a medical term might confuse the participants especially with no formal education or at lower literacy level from attending the lesson attentively...

Providing the health literacy lesson in a more appealing methodology was also cited as an imperative task to be undertaken. A respondent interviewee cited the current trend like this:

...The methods that we are currently applying in addressing the lessons are of very much of traditional way and restricted to lecturing only. It doesn't attract most of them. Some youths used to come here and present live dramas in relation to topical health problems such as HIV/AIDS, but currently that trend had stopped for the sponsoring NGO's project phase out from the kebeles whereby the youths no longer come to the health center...

Facilitating the venue for the program, were also cited among the major measures that should be undertaken. Hence the task of facilitating venue that should be undertaken cited by a respondent was, "The venue where the health literacy provided is narrow and inconvenient for the patients. For the reason that it is open space, people get freezing cold in the morning. Therefore, a proper venue for the health literacy should be facilitated in such a way that it should be a separated hall with sufficient furniture".

Furthermore, reaching out the general public outside the health center in raising awareness was cited by the respondents as measures that should be addressed. A case in point for such measure let us consider a response by a health literacy educator in reaching out the general public:

... Provision of health literacy lessons for those patients who came for medication is very difficult. It could workout for clients following some programs. But for out patients who rarely visit the center, it will fail to

fulfill its desired objective of raising awareness of prevention from diseases and develop behavioral change. Therefore health professionals should work together with the health extension workers who have started working at grass root levels in different social settings. Health professionals can attend in different places and provide lessons in topical health issues...

Strengthening the follow up and having a well established responsible body and structure mentioned as major measures that should be addressed for the effective program implementation was also cited.

An interviewee explained the essentiality:

... This job has to have its own accountable administrative body. Proper continuous follow-up, both internal and external supervision, are essential. Allocation of budget, up-to-date teaching aids such as CDs and DVDs of recent production in health issues should also be distributed to the health centers rather than working whenever epidemic come or on special campaign days...

Facilitating resource center in the health center for health professionals which plays a major role in providing resourceful input for educators stated as the measurer that should be addressed. A response of an interviewee shows the point:

...There were some books which we have being donated. We are currently serving five kebele people. Since there is mismatch between numbers of patients flow and health professionals. We have been short of rooms. Hence, the room which we have been using as resource center became a store room that we don't have a room left for us to sit and read and we are just busy all day long. Fortunately, I did put the books for the staff in a box so that anyone who want to refer them can take from that box. The need for health professionals to have a resource center is very important...

Furthermore, the focus group discussion conducted amongst participant adult learners and health professionals illustrates the measures that should be undertaken to alleviate the problems encountered the health literacy program and the roles of stakeholders should play towards achieving this.

The discussants come up with their opinion about the roles stakeholders should play in implementing the health literacy programs. According to a discussant adult learner, the stakeholders role was explained in the following manner:

...All things that we have discussed relies on finding solution for alleviating resource problems and managing the program effectively. Stakeholders should then allocate sufficient budget and manage the program. Budget allocation for teaching aids like posters, picture and films is

essential. Timely materials preparation, attention should be given to adults' interest, provision of health literacy education outside the health center and as such...

From health literacy educators' perspectives a participant discussant pointed out her views:

...There should be a role in our part to employ our professional commitments efficiently. Assessments like this as to how we have been practicing our teaching methodologies should be assessed and based on the findings proper measures of training professionals or facilitating the program could be decided based on the evidences obtained at the ground. It is our professional obligation to provide both the preventive and curative aspects of our services in the health center. It is used to be said from the health policy implementation strategy that 15% is curative and the majority 85% should be on preventive aspect in which health literacy took the lion's share. From the government side proper attention should be given to the health literacy programs implemented in the health center since there are significant number of people use the service...

The other participant health professional added up on his views that should be done by stakeholders:

...Professionals should be motivated to up-to-date their knowledge and skills. Resource center should be facilitated. How we teach adults should also be assessed. Even using a single word may distort the entire message which might wanted to be transferred. Health extension programs should be supported by us the professionals. As a visiting professional we can contribute to widen the awareness raising programs in collaboration with the health extension workers who had been very instrumental in the recently started program...

The stakeholders' role that is reflected among participants illustrates the various dimensions that should be considered in the implementation of health literacy programs. The analysis of the data presented with respect to adult learning perspectives as frameworks are discussed in the next section.

4.2. Analysis on the Health Literacy Practices with respect to Adult Learning Assessment Dimensions

4.2.1 Reflections on the Socio- Demographic Characteristics of the Study Participants and their Perceptions about the Health Literacy Provisions

According to the study findings, the overall socio-demographic characteristics of the study participants showed that most of them were between the age of range of 20s and 30s, have a

job, attended secondary education and with household responsibilities at their near grasp. Conversely, there were even adults with no formal education, without a job and with marital responsibilities. Thus, these diversities in their characteristics have got their implications on how to meet the diversified population problems, needs, priorities and how the health literacy provisions should be addressed.

From the findings of the study, there were health care professionals with even more than 20 years of experience while there were also with less than a year experience. Their educational qualification ranged from Diplomas to Degrees and they were assigned from junior to senior professional posts. The general overview of the socio-demographic information of the health care providers reflected their professional experience and expertise in the service rendering and the roles and responsibilities they had within the health center. By implication, addressing the health literacy issue has a linkage with the aforementioned variables and the statement that they had given that all had not taken any sort of training in the teaching of adults.

The findings of the study also indicated that there were regular clients who follow regular medication services in the health centers for follow-up programs and occasional patients coming for medication. Most people visiting the health care center were victims of diseases which could have been easily preventable. But, there were also chronic diseases follow-ups such as HIV/AIDS and TB. In addition, follow-ups of pregnancy, family planning and maternal health issues were attended by women. This shows chronic and communicable diseases and maternal follow-up literacy topics were given emphases in the health centers.

The study results obtained and the direct observation conducted in all the study settings showed that health literacy lessons were provided in the morning before the working hour begins at the patients waiting area in front of health report card office of the health centers. Moreover, the duration of the health literacy programs, in most of the cases, on average take 10 to 15 minutes. The results on both the qualitative and quantitative parts of the study singled out that oral lecture was the predominantly major medium of teaching. That was also confirmed through direct observation conducted during the study period. By implication, the duration and method of teachings had their contributing factors to the perception, interest and motivation of adults who attended the program. The average time which took the health literacy was stated to be 10-15 minutes had implications that it could not have been reasonably sufficient for application of other types of presentation methods involving the group attendee,

which left oral presentation to be the dominant methodology employed. That was what reflected by the majority of the health literacy educators respondents as well that oral lecture method was predominantly employed for the health literacy sessions. The inflexibility of the schedules had also their implications in reaching out the diverse-natured adults coming to visit for medication and follow-ups later in the morning.

Similarly, the responses provided by health literacy educators showed that the average number of attendees per lesson as it has been stated by the majority of respondents was a group of adults with the range of 25-50. As the direct observation conducted in the health centers also confirmed the situation. Whether the day is working day or not might fluctuate the average attendees. Hence, a day after the weekend days, that is, on Mondays, the number might exceed the average since there are no services in weekend days of Saturdays and Sundays except for cases of emergency services.

As the results obtained and the direct observation conducted confirmed, it was in the mornings that the health literacy lessons provided in the health care centers. Departmentalized education in different sections of the health centers were also referred by the adults as services they got whenever they attend. Patients' waiting area has been used as the primary setting for health literacy programs. Most of the health literacy educator participants of the study also stated that on average, they teach a health literacy lesson at least once and at most 4 times which give way ample space of time for preparation for a lesson.

According to the results obtained from the health literacy professionals, the health literacy topics were forwarded by the committee of the health center or else, guidelines were channelled from the Sub-city health office to the health centers. The prevalent ten top diseases were given emphases in selection and outlining of the topics selection. On the other hand, self determination by the health professionals in the selection of topics was also mentioned. This indicates elements of loose management and coordination to implement in the program on ground effectively. Hence, clear leadership body and accountable organizational structure needed to be given priorities for the overall implementation of the program.

Announcement of the monthly program for the public on noticeable place is essential preparation for the implementation of the program. However, in the visited health centers the posted announcement were not visible for visitors to notice as to what topics to be discussed

by whom and on which date and for how long and at what specific time. Transparency and accountability issues can be raised here.

4.2.2. The Health Literacy Practices in terms of Content with respect to Adult Learning Perspectives

4.2.2.1. Relation to Adults' Life

According to the majority (88%) of the respondent adults who took part in the quantitative part of the study stated that the health topics are related to their life while 10% of them said that it was not related to their life. Similarly, in the case of the qualitative part of the study all adult learner respondents agreed with the relevance of the contents of health literacy programs for adult daily life in practice. Likewise, all health literacy educators who took part in the quantitative part of the study believed that the health literacy lessons were meaningful to the adults' life. As the results indicated the topics raised in the health literacy sessions were closer to the daily life of the adult attendees. This might have has an implication for a lesson to be attentively followed by adults. The literatures also confirm this situation that an adult will be encouraged to learn, only if they found the programs related to their life, problem-solving and brings about a change in their in their lifestyle(FDRE:2008). Similarly Knowles, Holton and Swanson (1998:64-68) assures such situation that adults are motivated to learn to the content that they perceive that learning will help them perform tasks or deal with problems that they confront in their life situations.

4.2.2.2. Clarity of the Content

With regard to clarity of the lessons, most of participant adult learners(40%) in the quantitative part of the study them stated that it is usually clear and understandable and only a few (2.7%) stated it had never been clear and understandable. With respect to the use of medical jargons by health professionals during health literacy sessions, it was stated by 34.7% of adult learner respondents who took part in the quantitative part of the study while the majority (54.7%) stated that there were no use of medical jargons and the rest 10.7% remained undecided. With regard to how frequent medical jargons used by health professionals during health literacy lessons, the majority (51.9%) responded that health literacy educators sometimes use medical jargons. Although the majority of the responses explained the clarity of the lessons there were also study participants who referred the use of medical jargons by

health educators more frequently. The implication of using medical jargons for diverse nature participants could have significant impact in their level of understandings and engagement to the lessons.

4.2.2.3. Practicality to Real Life Situation

As to the real local presence of health issues discussed in health literacy sessions in the living places of adults, the participants of the quantitative part of the study among which the majority (79.3%) revealed their agreement while others who disagreed or couldn't tell were 14.67% and 6% respectively. Similarly, as to urgency of health literacy topics, the majority of the respondents (68%) who took part in the quantitative part of the study stated that the health literacy topics provided in health centers were of very urgent nature whereas 2.7% responded that they were not important. In another dimension, the majority (84%) of the respondents stated that they had prior knowledge about the health topics thought at health centers while 16% reported none. The practicality and the need of urgency of the topics addressed in the health centers were observed from the results obtained from the responses of participants. It can be referred back from the frequently provided health literacy topics that those preventive and follow up programs which had closer link in the adults life and locality had been implemented. Literature also confirms that adults tend to learn effectively if they consider the material relevant to their personal needs and interests; that adults seek to learn what can be applied-they are generally problem-oriented learners (Tuijnman.1996:449). Similarly, Fasokun, Katahoire & Oduaran(2005: 55) affirms programs that will attract adult learners are really those that involve reflective discourse and provide knowledge that is culturally, economically and socially relevant and capable of helping learners to deal with challenges.

4.2.2.4. Sensitivity to Diversity

Sensitivity to diversity of health literacy information recipients' was also among the content related issues rated by the adult learners who took part in the quantitative part of the study. Thus, sensitivity to diversity in educational level was primarily rated as unsatisfactory by the majority (49%) of adults. Some (34%) of the respondents however, expressed their satisfaction and the rest (16%) were not certain. With respect to cultural sensitivity, the majority (56.7%) expressed their satisfaction while some (30.7%) of them reported dissatisfaction and the rest (13.3%) were not sure of their satisfaction level. Similarly, most respondents (48%) revealed their dissatisfaction with the programs' sensitivity to address diverse needs of adult learners with disabilities. The other who expressed their satisfaction and

indecision were 28.7% and 23.3% respectively. Similarly, in the case of the qualitative part of the study, among the participants, the majority (N=11) had a doubt whether the lessons were sensitive enough to the diverse types of learners' need and abilities and disabilities. While the rest of minority (N=4) agreed with the sensitivity of the lessons. Oral oriented lectures and the use of only Amharic language were among the cited problems to the sensitivity of the programs. As can be referred from the results obtained from the study participants' responses, the issue of sensitivity in diversity of the attendees educational, cultural, disability and related issues had not also been satisfactorily met. Although Amharic language is common in the study areas, there were people who still need support in translating the language for they couldn't understand fully the messages especially in the two health centers namely Shiromeda and Kolfe health centers where by Gamo and Silte languages are frequently spoken in the respective addresses. Thus, all the aforementioned factors could have implications in the overall implementation and transfer of the messages to the targeted public. The question of preparation, readiness and competence of the educators could also be linked to this situation.

4.2.3. The Health Literacy Practices in terms of Teaching Methodology with respect to Adult Learning Perspectives

4.2.3.1. Mediums of the Lessons

Oral lecture was ranked the most predominantly used medium in the health centers according to the results obtained from adult learners who took part in the quantitative part of the study. The use of mediums of audios, visuals and audiovisuals ranked consecutively in descending order. Similarly, health literacy educators who took part in the quantitative part of the study responded concerning the methodologies used for the health literacy programs. Most of them responded that they use audio mediums/channels in the health literacy programs. The others (35%) cited audiovisuals as the mediums they used. The rest of respondents stated that they use visual mediums and oral presentation were 12.9% each. Likewise, with regard to the common language used in the lessons, all respondents stated Amharic language was used in the provision of the lessons. Similarly, 67.7% of the respondents stated that they didn't use other language other than Amharic while 29% of the respondents affirmed that they did also use other language during health literacy sessions. With respect to common medium of language used in the health literacy sessions, the results obtained from the participants reflect that Amharic, even though it is not mothers tongue for all city dweller adults, it is commonly spoken by the majority of the city dwellers reflects this. Fasokun, Katahoire and Oduaran

(2005:118-122) stated with regard to the use of mother tongue that as far as possible, the mother tongue, or the language of the immediate environment of the learners, should be the medium of education in adult learning. It is useful in literacy and non formal programs at lower levels. In the health center settings the use of Amharic language for the programs could made the message to be transferred satisfactorily. English (2005) also affirms that effective communication and language ensures credibility, relevance and clarity of the message- in context.

In relation to the mediums used the health literacy sessions, audio, visual and audiovisual materials were ranked consecutively in descending order. As study results obtained from the participants and the direct observation conducted in the selected health centers reassures, oral lecture was the predominantly used method to address the health topics in the sessions. However, as observed, supporting materials were which neither employed nor functional during the study period. The mediums applied could have motivating effect if they were considering the preferences and the learning styles of the diverse nature attending adults. For instance, studies have shown that the use of pictures in health information improves learner comprehension, especially when information about spatial relationships is presented (Cornet: 2009).

4.2.3.2. Organization and Presentation of the Lessons

It was also indicated from responses that the majority of respondents agreed that the health literacy lessons were given in sequential order. Concerning the health literacy presentation, a fourth (25.3%) of respondents stated that the lessons were not presented in sequence and order. Adults with lower literacy skills could not follow the lessons was also responded by 19.3% of the respondents.

The results obtained from the study participants reflect that adults with lower level of literacy could catch-up with the program since it is predominantly provided orally. The sequence of the lessons presented was rated to be satisfactory by the majority of the respondents. But, concerns were pointed out by a fourth number of participants doubt the sequence.

In relation to methodology, the majority (74.2%) responded that they usually repeat main points for reassurance in the health literacy sessions. The other 16.1% of the respondents stated that they had always do that while the remaining 9.7% responded that they do that

sometimes during the lesson. Reassuring the points of discussion by repetition stabilize the lessons provided to diverse nature of participants with respect to their follow-ups.

Majority (87.1%) of the respondents stated that they check adult's acquisition of the lesson by asking question. The other respondents (6.4%) stated that adults expressed that they had prior experience. Asking to demonstrate was also cited as checking mechanism while having no mechanism to check was mentioned by a respondent. Checking mechanism are useful instrument to find out whether the lesson provided resulted in fruitful end. Asking questions was mentioned as the predominant checking mechanism employed in the centers. Proper follow up by the learners could be assessed from their overt behavior as well. Fasokun, Katahoire & Oduaran (2005:118-122) stated that facilitators should keep an eye on the learners' body language. They should look out for signs that indicate interest or difficulty. Facilitators should also look out for signs of boredom such as slumping, fidgeting or looking at watches. However, a response stated by respondent whereby no mechanism employed for checking might have diverse implications on abilities, efficiency, motivation and interest in either side of the learners or the educators.

4.2.3.3. Active Learning Methodologies Implementation in the Lessons

About the methodologies employed by health educators in the delivery of the health literacy lessons, the opportunity of holding an active conversation with health literacy professionals is stated by most (50.7%) of the respondents who took part in the quantitative part of the study while 42% of the respondents stated that the chances for active involvement in conversation with health literacy educators were not there and the rest 7.3% of the respondents were undecided. Active engagement in conversation among participant educators and learners can has implications in the learning process. Above a third of the participants claimed to have no active conversation with the health educators which might leave them as passive listeners of the lesson all the time. Moreover, even if there was interest in the involvement of active conversation, the time constraints and the number of participants might not be conducive and allow for such active involvement. Thus, it has could have implications in the learning processes as well.

The chances for adults to share ideas in group about the raised health topics was responded by 46% of the respondents while 42% of the respondents who took part in the quantitative part of

the study stated its' absence while the remaining 11.3% of them were undecided. Likewise, the presence of chances for adults to present their personal testimonies during the health literacy sessions was assured by 42.7% of respondents who took part in the quantitative part of the study while 34% of them responded its absence and the rest (23.3%) of the respondents stated they didn't know. Similarly, in the case of adult health literacy educators who took part in the quantitative part of the study, most of the respondents stated that dramatic method of presentation of the health literacy programs were preferred by most adults. As the results obtained also show group discussions, lecture methods and audio visuals were mentioned consecutively in descending order as the preferable options to follow the health literacy program by the majority of the respondents. The chances to have sharing of ideas in a group and experiencing evidences of personal testimonies could substantiate the knowledge of adults with respect to the health issues. However, as the results indicate more than a third of the participants claimed that they had no experiences of such kind in the health centers. This might have an implication that communication was usually not two way but unidirectional, i.e. from the health educator to the passive listeners of adult learners. It seems that the chances for discussion left to the examination rooms only. Evidences from literature, however, shows the benefits of customized group learning. According to Robinson (1981:2-3) group learning creates a learning atmosphere of mutual support, it may be more effective than individual learning. Therefore, those techniques based on group participation are often more effective than which handle individuals as isolated units.

4.2.3.4. The Need for Training in Adult Teaching Methodology with respect to Health Literacy Practices

The results obtained from the participant health literacy educators who took part in the qualitative part of the study have shown that all of the respondents believed that medical knowledge by itself did not guaranty to the provision of effective health literacy lessons for adults. Thus, all respondents acknowledged the need to take additional training on the methodologies of adult teaching. As the results obtained from the study participant health professionals suggests, the majority of them were well aware of the fact that special training in the area of methodological aspects for health literacy lessons are highly essential to effectively and efficiently implement the medical knowledge to participant adults. Thus, the need and relevance of adult education methodologies were pointed out as the essential cross-sectoral links for the two professions working together in a platform for ultimate objective of

the wellbeing of a society. Fasokun , Katahoire & Oduaran(2005:118-122) cited an exemplary situation of methodological proficiency in the case of communication that communication is the essence of teaching and learning process, but the facilitator has to be aware that there are many other ways of communicating than simply delivering messages to the learner. There are many channels of communication based on the culture, customs and traditions of adult learners. Therefore, Indeed, there is a working common ground for both professions in the matter of health literacy in trainings and upgrading the skills of the professionals.

4.2.4. The Health Literacy Practices in terms of the Psychological Environment with respect to Adult Learning Perspectives

According to the results obtained from adults in the quantitative part of the study, the respondents' perception whether they did get reliable information from health educators, the majority (84.7%) of them assured they did get reliable information from the health literacy program and the rest 15.3% expressed their disagreement. As the results suggest, health professionals considered or believed to be credible source of knowledge about health issues. Thus, getting reliable information might encourages participants and can have positive implications in the learning process and the psychological readiness of the learners.

Of the respondents, 65.3% stated that they were able to express their opinion without fear and embarrassment while the remaining 34.7% expressed they were not able to express their opinion without fear and embarrassment. Adults, unlike younger youths have the courage to express their views and opinions as the result of experience. Thus, it has been reflected on the responses of the majority of the respondents. However, almost a third of the participants stated that they were not able to express their opinion during the sessions. The situation shows that there were also some grey areas untouched in having opinions expressed openly. Literatures suggest that conducive psychological environment are helpful in learning situation of adults. Accordingly, Bello (1998) cited in Fasokun, Katahoire & Oduaran(2005 :53-54) suggested that adults must be allowed to express themselves freely in open and loving learning environments. In other words, adult learners function best in emotionally supportive instead of threatening environment. With regard to consideration of the psychologically accepted, adults want to be relaxed in class, not threatened by anybody. They want facilitators and other learners to listen to them. They want to express their opinions freely or without any fear.

On the other hand, as to how frequently did they respond for the questions raised by adults, 48.4% responded that they always had done so. The other 45.2% that stated they usually do while the rest 6.4% cited that they sometimes respond for questions raised by the adults. As the results suggested by the majority of respondents, there might be suitable situations in the provision of answers for inquiries raised by adult learners. Thus, these situations have their contributions and can have positive implications in the learning process. Thus, there is still gap to fulfill in terms of addressing people with diverse needs and abilities.

The majority of the respondents (77.3%) expressed the willingness of health educators to listen adults' problem. Willingness to manage the needs of adults with different needs was also assured by most respondents (57%). In contrast to the aforementioned responses, 14% of respondents expressed their disagreement with the willingness of health educators to listen adults' problems. Willingness of health professionals to listen attentively to the problems of the adults facilitates the psychological welfare of the participants and prompt them to address their problems openly. Tesfaye, Hailu & Shenkut (2004: 24) also reassures that adults learners need to feel contented and psychologically accepted and engage in learning freely.

Similarly, with regards to the treatment of adult educators, most of adult learners agreed that they were treated with respect and frequently given feedback for their inquiries from health literacy educators. Treatment with respect creates positive mental set up so that it can encourage adults to move forward in the learning process. The way we perceive our self worth either trigger or hinder our motive to learn. Literatures also assure this point. Hence, Bello (1998) cited in Fasokun, Katahoire & Oduaran (2005 :53-54) stated that the ways in which we see ourselves affect our perception of situation and the world as a whole. If this view is positive, it will help us to strive to do well or even better. If it is negative, it will reduce the level of interest in what we are doing.

With respect to verbal and non verbal encouragement from health literacy educators, most (34.7) respondents stated that they were usually given encouragement while others (30%) responded that they sometimes got encouragement from the educator's side. The remaining 22.7% of the respondents described that they always had got encouragement. The minority of the respondents (12.7%) however, stated that they were never given encouragement from health literacy educators' side. As the results obtained from the respondents suggest verbal and non verbal encouragements which were addressed by the health professionals could

facilitate the psychological readiness of the adult learners with respect to following the program.

In contrast with the overall aforementioned trend however, with regard to the management of adults' need, there were nearly a quarter (23.3%) of the respondents still stated that adult educators were not willing to manage adults' with different abilities needs. As the result of the respondents responses suggest the needs of adults with diverse nature has not been met fully. There were also a quarter of respondents who did cite that educators were not willing to manage adults with different abilities. Bello (1998) cited in Fasokun , Katahoire & Oduaran(2005 :53-54) stated that adult learners come to learning programs with diverse and rich experiences. If their learning is to be enhanced, the kind of activities of the program should enable learners to tap their experience as they attempt to investigate new information and ideas. Therefore, failure to fulfil adults with diverse needs has implication in the learning process. Similarly, with respect to people with disabilities, the need to address was explained by Tesfaye, Hailu & Shenkut (2004:24) that learners with various disabilities often may not have enough confidence for learning. They may need encouragement and special attention and assistance in doing things that they cannot do during the learning process.

4.2.5. The Health Literacy Practices in terms of the Physical Environment with respect to Adult Learning Perspectives

Among participants who took part in the quantitative part of the study, most (58%) of them were not satisfied with the venue for the health literacy programs. Some of them however satisfied (38.7%) in the venue and the remaining 3.3% of the respondents were undecided. When it comes to particularities, the suitability of the venue was expressed so. Thus, greater proportions of respondents were unsatisfied with the suitability of the venue for people with disability (60.7%), for women carrying a child (54.7%) and for pregnant women and elderly people 51.3% each. With regard to furniture, most respondents (58%) expressed their dissatisfaction about the furniture in the health centers that are used during health literacy programs, while the rest 42% of them expressed their satisfaction.

According to the results obtained from the respondents, the issue of physical facilitation, which plays a an essential decisive role in the process of learning haven't been addressed to the level of satisfaction for most of the participants of the study. The suitability of the venue for adults with diverse types of needs were also found to be unsatisfactory for most of them.

Thus, can have it has direct implication in the proper implementation of the program having adults with diverse needs and priorities dissatisfied by the nature of the venue. The literatures also suggested the need for proper physical setting in creating conducive learning environment. Tesfaye, Hailu & Shenkut (2004: 24) listed out several inquiries as to how the venue looks: that it should have proper places to sit on, enough light, warm enough, interesting to look at, free from noise and accommodates people with different disabilities mentioned as important inquiries to address the problem of creating conducive learning environment. Yet, these aspects of facilitations have not yet been satisfied according to the responses suggested by the participants. Thus, it needs to be addressed for the implementation of the program effectively.

4.2.6. Major Challenges in the Health Literacy Programs with respect to Adult Learning Context and their Implications

The adult learners study participants who took part in the quantitative part the study pointed out the major challenges observed in the health literacy lessons. Accordingly, problems of facilities, the teaching methodology, problems observed on health literacy educators, administration and supervision problems and adult learners lack of interest to follow the program were the major challenges identified in descending order by adult learners. Similarly, in the case of qualitative part of the study, adult learners who attended the programs identified the challenges observed in the health literacy program. The majority of respondents pointed out the problem of poor methodology as the core of the problems. Lack proper facilitation and venue, lack of competent literacy educators, problems in administrating and follow up and supervision were also mentioned in descending order as the major health literacy challenges observed in the health centers currently.

Correspondingly, from health literacy provider health professionals perspectives, the major challenges in the implementation of the health literacy programs were listed out. Accordingly, most respondents who took part in the quantitative part of the study, considered the lack of proper attention and follow ups for the health literacy programs was cited as the major challenge facing the health literacy programs. The other consecutively rated challenges in descending order were lack of motivation from adult learners side, lack of readiness and efficiency health literacy educators, poor methodologies of teaching, lack of proper teaching methodologies, teaching aids, proper venue and time allotment were mentioned. Similarly, the

participant health literacy educators who took part in the qualitative part of the study pointed out the major challenges which they observed in the health centers. Accordingly, in descending order, challenges related to adults' lack of attention and reluctance to follow the program, lack of responsible body to give attention and follow up of the program from administrative perspective, the problem of inconvenience of the health literacy venue, lack of sufficient teaching aid materials, reluctance and lack of motivation from adult health literacy educators perspective and poor, out-dated and unattractive methodology were pointed out by the participants as major challenges observed in the health centers. The major challenges with their respective theme of category are discussed here under.

4.2.6.1. Administration, Supervision and Follow-up Challenges

Amongst the major challenges observed by adult participant respondents who took part in the quantitative part of the study was with regards to administration and follow up of the health literacy program. Inadequate attention for the program, lack of supervision and follow up, and attention when only epidemic situation happen were the challenges reported by the respondents. Furthermore, budget and man power constraints and plans were mentioned as problems on administration dimension. Similarly, in the qualitative part of the study, the study participants stated problems related to administering and follow up supervisions among the major challenges observed. There was no follow up and cross check mechanisms whether the lesson were given or not. Adult learners, lack of interest to follow the program was also stated by the participant adult learners in the quantitative part of the study as a major challenge observed in the health literacy lessons.

On the other hand, from health literacy educators side, the seriousness of the challenge also stated by most respondents who took part in the quantitative part of the study. They considered the lack of proper attention and follow ups for the health literacy programs was prominent major challenge facing the health literacy programs. Similarly, those who took part in the qualitative part of the study stated that lack of responsible body to give credible attention and follow up on the programs was among major challenges. Lack of budget, absence of responsible body to follow up the programs, lack of coordination and supervision and report mechanisms were also stated among the major challenges observed in the health center.

Administration and supervision have irreplaceable role in implementation of any program. As the results obtained with respect to health literacy attending adults suggest the lack of attention and follow up mechanisms have direct weakening effect in the current as well as the future fate of the program. Without evaluating the achievements and challenges encountered, it is difficult to look ahead further and plan to achieve the goal of securing the well being of productive citizens. Thus, the multifaceted problems listed out need to be addressed with credible attention and seriousness.

The lack of proper attention and follow up was referred by the majority of the respondent health literacy providers. It is obvious the fact that proper attention and follow up is the central basic issue in which the continuation of the program relies upon. The multi-dimensional assessment makes it possible whether the program is effective enough in addressing the country's prevention-oriented strategy of the health policy.

4.2.6.2. Challenges in terms of the Facilitations for Health Literacy Program

The majority of respondents who took part in the quantitative part of the study stated problems in facilities among the major challenge facing the implementation of the health literacy program. Inconvenience of the venue, shortage of time for the program, shortage of furniture and teaching aids were also cited as part of the facility related problems. Similarly, in the case of qualitative part of the study, lack of proper facilitation and furniture was mentioned as major challenge. Challenges for elder people to attend the lesson comfortably, lack of adequate chairs in comparison with compared to the inflow of patients' number which did compel people to stand up and to follow the programs were among the challenges stated. As the results obtained shows facilitation problems were observed which obstruct the effective implementation of the programs. The literatures also point out facilitation problems as challenges in health education. Accordingly, MOH (2004: 64-67) listed out the barriers of not conducting health education at appropriate time and at convenient place, not obtaining encouraging support before hand from close friend, household family member or from colleagues of the audience were also listed as barriers and not creating conducive conditions for conducting health education.

Correspondingly, from health literacy providers side, participants in the quantitative part of the study pointed out lack of proper setting and time allotment for health literacy program was another major challenge pointed out by health literacy provider participants of the quantitative

part of the study. Similarly, in the case of qualitative part of the study, the respondents identified the problem of inconvenience of the health literacy venue as a major challenge. Lack of comfortable venue & destructive noises were among the major challenges cited by the respondents. As the results obtained from the participants suggest, the lack of proper venue and time were distracting the proper implementation of the program. A venue in which the lessons would be implemented without distractive noises and a proper time allotment could have encouraging effect on practice.

Furthermore, in terms of teaching aid materials facilitations, health literacy provider participants who took part in the quantitative part of the study identified lack of proper teaching aids as major challenges observed in the health literacy sessions. Similarly, in the qualitative part of the study, the participants also pointed out insufficient and out-of-date teaching aid materials among the major challenges encountered in the implementation of the program was also stated by the respondents. As the results obtained from the participants suggest the health literacy programs were short of teaching aids. Hence, if proper attention is given for the program, the shortage of supplementary teaching aid materials should have been solved. Otherwise the program will only be unidirectional, lecture-oriented lessons.

4.2.6.3. Challenges of Teaching Methodology

On the other hand, the methodology adopted by health educators was referred by participant adult learners who took part in the quantitative part of the study as another major problem observed in the program. Accordingly, not interesting and weak method of lesson presentation, presentations on similar topics, mixing up of all types of patients and clients together to provide untargeted topic, provision of the lesson in one language only and lack of translation for people who can't comprehend the medium Amharic of language and lack of communication options for people with disability mentioned as frequently observed challenges with respect to the methodology of the lesson presentation. Similarly, participants in the qualitative part of the study, problems in teaching methodology were pointed by the majority of the participants. Very brief lesson focused on similar topics through unattractive teaching method of oral lecture was stated as challenges observed. As the results obtained from the participants reflect, the methodologies implemented in the health centers were cited as another challenge. Conversely, the literature suggest as to how the methodologies have to be that it should be prepared and delivered in such a way that it should be informative,

recreating and attractive. For the program to be successful, according to the basic health literacy principles it requires coordinated approaches, full participation of different professionals and resources; and the community at large (MoH, 2004: 11).

Correspondingly, from health literacy providers perspectives, poor teaching methodologies were also identified by the participants who took part in the quantitative part of the study. Similarly, in the case of qualitative part of the study, participants pointed out poor methodology which was not up-to-date, unattractive and lecture-oriented lessons were cited as another dimensions of challenges encountering the programs. The problem of methodologies which were listed out by the respondents suggests that failure in the methodology could be a barrier in reaching out the targeted audiences properly. Thus, implementing appealing methodology is an important task to be addressed in the health centers.

4.2.6.4. Challenges observed from Health Professionals' Side

On the part of health literacy educators' situation, lack of motivation, preparation, punctuality and respect for adults were mentioned as problems by participant adult learners who took part in the quantitative part of the study. In addition, lack of experience in teaching, presentation of a topic with random selection without preparation and inefficiency in teaching the lesson were also stated as problems respondents encountered during visit to the health centers. Similarly, in the qualitative part of the study, participant adult health educators pointed out the lack of competence in health literacy educators among major challenges observed. Lack of experience in teaching, inability to provide enough information for people with different learning abilities, lack of competence for treatment of adult learners with different types of needs and reluctance of the health literacy educator reflected upon presenting very brief notices were challenges listed out as to the qualitative part of the study results. The results obtained from the participants suggest that the majority of respondents believe that the health educators were committed and competent enough with respect to the health literacy programs. Hence, the presence of low perception leads to low interest and expectation to follow the program attentively by the adults.

Correspondingly, from health professionals perspectives, the major challenges in terms of readiness and efficiency of health literacy educators were pointed out by health professionals participated in the study that lack of readiness and efficiency of health literacy educators were among the major challenges observed according to the response of those who took part in the

quantitative part of the study. Similarly, participants who took part in the qualitative part of the study stated reluctance and lack of motivation from adult educators' side as another major challenge. Considering the sessions as part of routine duties and lack of interest and preparation for the sessions were stated as major challenges observed. As the results obtained indicate, the pulling force towards implementation of professional work has essential role. However, the overt behaviors reflected on the health educators as referred by the respondent adult learners shows there is problem of motivation which might have been related to the reasons mentioned in the previous inquires. Nevertheless, the readiness of educators has decisive implications as to how effectively the programs would be executed. This was indicated in the literature. Hence, Gboku & Lekoko(2007: xiii) pointed out that the successful implementation of adult learning policies and programs depends in large measure on the availability of knowledgeable, skilful, and socially committed educators of adults. Because they are key agents in the realization of adult learning, the quality of their initial and continuing training is crucial.

4.2.6.5. Challenges observed from Adult Learners' Side

Most health literacy provider respondents who took part in the quantitative part of the study pointed out lack of motivation from adult learners' perspectives among major challenges observed in the health centers. Similarly, most of the health literacy provider respondents who took part in the qualitative part of the study stated that adult learners' reluctance and lack of attention to follow the program was among the most frequently observed challenges observed in the implementation of the health literacy programs. Being over shadowed with culturally held erroneous beliefs, doing other things instead of listening and making distracting noises were among the major challenges observed during the lessons.

Lack of interest and attention from adult learners side has to do with different factors. The reasons for adult's reluctance to follow attentively the health literacy were stated by the respondents. Most of the respondents agreed that adults were carried away with the thought of their illness. The other frequently observed reasons were the thought that they had already knew the topic, lack of attractive presentation, not related topic for their reason of visiting the health centers, lack of well prepared educators, mixing up of all type of people compelled to attend a single lesson were cited by the respondents as the causes for the reluctance of attentively following the program. As the results obtained from the study participants responses indicate, there were various reasons for reluctances of participant adults which

might have direct implications in the learning process. The literatures also confirm that lack of willingness of the audience to learn and try new things and if they consider the health education delivered or advices given may not bring much difference in their health status is also another side of barriers(MoH ,2004: 64-67).

Therefore, the overall results obtained from the participants suggest that the issue of addressing the needs and priorities of adults should be of prime interest in reaching to the targeted audience effectively and efficiently.

CHAPTER FIVE

5. SUMMARY, CONCLUSION AND RECOMMENDATION

This study tried to explore the current health literacy practices from an adult learning perspectives in selected five health centers found in Addis Ababa. Data collection was conducted from adults who were attending in the health literacy program during the study period. Data were collected from 150 adults (75 male and 75 female) and 31 health professionals (12 male and 19 female) in the quantitative part of the study, and 15 health educators and 15 adult learners took part in the qualitative part of a study. There was also a focused group discussion (4 Adult learners and 2 health educators). Moreover, direct observation was conducted during the period of the study. In this section, summary, conclusions, and recommendations are presented.

5.1. Summary

The summary of the major findings of the study are presented as follows:

- The health literacy practices implemented in the health centers were predominantly in terms of group-based lessons for occasional outpatients. Similarly, department-based lessons which include lessons for regular clients visiting for follow ups in family planning, pregnancy, immunization, HIV and TB were also provided. In addition, individual -based face to face consultations were conducted during medical examination period.
- Disease prevention-based lessons were predominantly provided in the health centers with respect to mother and child health and family planning health issues. Similarly, lessons on chronic and communicable diseases especially HIV/AIDS and TB were also provided largely.
- There was no apparent criteria and uniformity in the selection of the topics for discussion across the health centers. Health literacy lessons announcements were also placed not visible for visitors to notice as to what topics to be discussed by whom and on which date and for how long and at what specific time. In addition, the health literacy lessons had inflexible schedules and the alternative teaching mediums or materials were scarce and out-dated. Furthermore, transparency and accountability of leadership are not clearly put in place with respect to running the health literacy programs. The emphases seems taken on monthly report documentation.

- The majority of the adult population had the awareness about the presence of health literacy practices in the respective health center addresses and claimed to have prior knowledge about the topics. Females were claimed by majority of study participants to be the most frequent beneficiaries of the health literacy programs provided in the health centers. The majority of the lessons provided in the health center were claimed to be practical, urgent and closer to daily life of adults' health issues by both of the study participants. However, sensitivity to diversity of the attendees' educational, disability and interest were not satisfactorily met in health literacy lessons.
- The majority of health educators stated that they didn't have clear manuals at hand as to how to provide the lessons for adults. Consequently, all the study participant health professionals agreed with the need and relevance and feasibility of adult teaching methodologies in the implementation of health literacy lessons.
- Dramatic approach was referred by most participant adults as preferable method. However, oral lecture presentation method was the predominantly implemented method to address the health topics in the sessions. Dramas, group discussions, lecture methods and audio visuals were mentioned consecutively in descending order as the preferable options to follow the health literacy program by the majority of respondents. In addition, the common medium of language used in the health literacy sessions was Amharic. However, second language speakers' translation problems and the use of the medical terminologies were cited as challenges needed to be addressed.
- The majority adult learners respondents pointed out the problem of facilities, the teaching methodology, lack of competence and commitment in health literacy educators side, problems in administrating, supervision and follow up and lack of interest among adult learners as the major health literacy challenges rated in descending order which are observed in the health centers currently.
- The majority of health professionals pointed out that lack of responsible body to give attention for the follow up was the major challenge in the implementation of the health literacy program. Lack of motivation from adult learners' side, lack of readiness and efficiency in health literacy educators' side, poor teaching methodologies, lack of teaching aids, lack of proper venue, and time allotment were rated in descending order as among the major challenges observed in the health centers currently.

5.2. Conclusion

In this section the conclusions drawn based on the findings of the study are presented as follows:

- Group-based health literacy lessons were predominantly implemented in the health centers. Departmentalized and individual- face-to-face lessons were also provided which were integrated with the medical treatment and follow- up programs. It was evidenced that the majority of adults have the awareness about the presence of health literacy lessons in the health centers. However, the lessons were not free from limitations in its duration, venue facilitations and composition of attendees to follow the program effectively which calls for substantial attention from stakeholders.
- The majority of health literacy lessons were salient health problems which address the urgent, practical and daily life need of adults. The majority of adult learners study participants also claimed that they had prior knowledge about the topics. However, sensitivity to diverse nature of attendees were not given due attention. Thus, the lessons were not customized in fit- for- purpose for adults' problems, needs, priorities visiting the health centers. Rather, mixing up all patients with different cases for visiting health centers compelled to attend a single topic which may have debilitating implications. The gender-parity and the needs of persons with disability also implicates there is still gap and need to be fulfilled to address health literacy lessons to all sections of the public.
- Leadership for the overall program planning, implementation, monitoring and follow-up were not clearly put in place and loose chain of accountability and transparency with respect to health literacy programs within the health center. This can contribute in the overall implementation of the program.
- In most of the health centers, there was absence of resource centers, limited reference materials and clear guiding manuals which contribute for absence of preparation for the lessons by health professionals. The experience of health literacy lessons educators were not also supported with in-service trainings and limited to their medical knowledge from their respective academic studies. The need for further training in the methodology of adults teaching was claimed by most study participants. Thus, it was obviously pointed out that common working ground across the sectors and interdisciplinary cooperation are apparently feasible in the health and education sectors.

- Oral lecture method was employed predominantly in the health literacy programs. Approaches in drama, group discussions, lecture methods and audio visuals were mentioned as preferable options to follow the health literacy programs by the majority of the study participants. Alternative health literacy mediums were not satisfactorily implemented in the health centers. The need to implement diversified lessons with appealing, educative, informative and recreational methodology require the commitment and due attention from the concerned bodies.
- The predominantly used Amharic language facilitated the smooth flow of the lessons. However, the use of medical terminologies and second language speakers' translation problems were evidently not addressed. Initiative in plain language utilization and translation mechanisms should be adopted to serve the diverse types of adults attending the program.
- The physical and psychological environment and facilitations which have decisive role and implications in the teaching –learning process haven't been successfully addressed to the level of satisfaction for most of the participants of the study which requires substantial attention and practical solution.
- The lack of attention in the planning, implementation, monitoring and follow-up of the programs has been critically weakening the current implementation of the program. The financial, physical, psychological and methodological facilitations were also not to the level of satisfaction. Establishment of responsible organizational body, accountable leadership and sense of ownership calls immediate attention from the stakeholders in order to run the currently fragmented efforts.

5.3. Recommendation

In this section, recommendations are forwarded based on the study findings and the subsequent conclusions drawn.

Health literacy is a major prevention strategy to combat preventable diseases in the health policy Ethiopia. The current practices employed in the primary health care centers which are referred as the settings in which the prevention activities sought to be emphasized. However, in addressing the beneficiaries need and priorities of adults, who represent significant productive force of the general public, haven't yet satisfactorily met the diverse learning abilities and needs of adults. Indeed, currently considerable amount of finance have been

invested in the health sector through government, non-governmental organizations and international partnerships. Yet, there seems still a missing gap in addressing targeted learning needs and priorities of adults. Therefore, in order to achieve productive and healthy citizens who contribute much more in the socio- economic and development endeavors, the learning arenas should reflect the considerations of adult learning perspective. Therefore, in view of this, based on the findings of the assessment the current health literacy practices in the health care centers of Addis Ababa the following recommendations are put forwarded.

- The organizational structure should clearly identify an accountable body for the overall implementation of the health literacy programs. Assigning sufficient budget for the implementation of the program is also imperative. Thus, in order to plan, implement, monitor and follow up the overall programs, the financial inquiry should be given priority. Follow up of the program in terms of fulfilling the required proficient manpower and supply of educative resourceful materials should also be given proper attention and commitment.
- The discrepancy between scarcity of resources and the inflow of patients could be significantly mediated through addressing the root causes by implementation of health literacy lessons. Health literacy has significant role meeting the desired behavioral change through the felt needs of adults. Without the implementation of comprehensive strategy, it is futile to expect fruitful end. Thus, in the preparation and implementation of the program, learners' diverse needs and priorities should be considered cautiously. The needs of persons with disability should also be given the appropriate considerations.
- It is commendable to have clearly set criteria for the lessons to be addressed and comprehensive plan with consultation of the target groups as stakeholders rather than expert- based, top-down directives without evaluating the current developments.
- Health literacy programs should strengthen the provision of topical health issues of which are more practical in a household context to reach out all members of a family than the prevalent orientation to female beneficiaries' maternal services.
- The group-based and department-based lessons should also follow the practical alternatives implemented for everyone attending the health center could at least know the causes of their health problems through using different mediums of communications.
- Appealing psychological environment should be given credible emphases. The psychological aspect of treatment has strong implication as part of the medication or

treatment process. Willingness to listen, showing respect, verbal and nonverbal encouragement are crucial elements in facilitating the psychological environment. Trainings in how to treat adults should be facilitated for health professionals by the health bureau.

- The distracting and noisy venue, lack of sufficient and comfortable furniture which have negative impacts for adults to follow the programs attentively needs to be addressed and given priorities for effective implementation of the program. For instance, administering the registration of incoming patients could take place separately rather than simultaneously during group based lesson provision sessions to preserve the short comings of simultaneous activities at the same time which largely caused distractive effect .
- Active learning through participatory lecture method should be considered to fulfill the needs of incoming adults with different learning styles and chances of group learning situation should also be strongly implemented. Communication should have to be two way rather than unidirectional. It is practically essential to facilitate and secure up-to-date productions of audiovisual materials from the concerned government body. Furthermore, the use of multilingual approach and devising alternative communication for persons with disabilities , preferable mediums and methodologies should be implemented in the program.
- The methodologies employed have to be prepared and delivered in such a way that it should be informative, recreating and attractive. Alternative means of reaching targeted beneficiaries of the health literacy programs should also be employed to reach the unreached without time limitation. Thus, audio and visual materials could be implemented for those adults who did not had the chance to attend the morning literacy session whenever they arrive.
- Learning is a never ending lifelong process in all walks of life. Both health literacy providers and recipients belong on this continuum. Thus, creating a participatory rather than provider-recipient type of relationship in terms of knowledge sharing for the common goal of voluntary behavioral change should be facilitated within the health centers. The claims made by the study participants about their prior knowledge in health issues also demonstrated the need for widening the horizon.
- Upgrading the skills, efficiency and work ethics of the health professionals are imperative tasks. The relevance of methodologies from adult education play pivotal role

in addressing the problems of the learners is unquestionable. Thus, providing in-service trainings adult teaching methodology training for health professionals in addressing the problem should be considered seriously and given priorities by the health bureau. There should be practical working space for professions in health and education in the matter of health literacy in trainings and upgrading the skills of the professionals.

- Facilitating a resource center for health educators can help to motivate the health professionals and update their knowledge. Thus, resource centers in the health centers should either be established or strengthened. Health professionals should at least have access to up-to-date reference materials, clear guiding manuals as to how to address effectively health literacy lessons since the world of science is continuously changing.
- In the implementation of the current medical study programs in the tertiary level, the inclusion of adult education methodologies should be given credit and reasonable number of courses should be included in the curriculum of medical studies in higher institutions. Similarly, inclusion of basic health education issues through appealing and appropriate methodology should be vertically and horizontally integrated in the formal curriculum starting from the very grass root level.
- Stakeholders should play the role of widening the program, giving attention to the program and pointing out the problems, coordinating in implementing the program, establishing timely and essential guidelines, organizing discussion forum with patients about the program weakness and in establishing professional development system.
- Widening the horizon and go beyond the health centers is essential strategy of reaching out the community at grass root level and raising the awareness. Therefore, facilitations should be made that health professionals should serve as a visitor educator in various social and communal settings like schools, worksites and social gatherings to share their professional expertise and experiences.
- It is commendable to have further countrywide baseline survey to assess the methodological problems and consequent impacts about the implementation of health literacy programs in the health centers. National and international partners working in the health sector should also assess the methodologies implemented in their programs to evaluate the impact it brought in effective execution of their respective programs or else consider the need for revision.

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APPENDICES

Appendix A

Addis Ababa University

School of Graduate Studies & Research

Faculty of Education and Behavioural Studies

Department of Teachers Professional Development Studies

Adult and Life Long Learning Unit

Questionnaire to be filled by adult learners

The following questioner is part of a thesis work undertaken by graduate student of adult education and lifelong learning. Its primary aim is exploring into the health literacy practices from adult learning perspectives. Its major parts deals with general demographic information, the health literacy practices, assessment dimensions of the practice from the adults' learning perspectives, the challenges faced on the practices and recommendations for improvement. I would like to ask your kind collaboration to take part in the study and also like to assure you the confidentiality of your responses. Thank you in advance for your genuine responses.

PART ONE: GENERAL INFORMATION

DIRECTION: For the following questions please respond either by a word/phrase of your opinion or by putting a check mark(✓) on the option of your choice.

1. Gender: Male ☐ Female ☐
2. Age: _____
3. Level of Education : Illiterate ☐ Elementary ☐ Secondary ☐ Tertiary ☐
4. Marital status: Single ☐ Married ☐ Divorced ☐ Widowed ☐
5. Employment Status: Employed ☐ Unemployed ☐
6. Have you got a disability? Yes ☐ No ☐
7. How often do you visit the health care center in a year? _____
8. For what type of health problem are you visiting? _____

PART TWO: THE HEALTH LITERACY PRACTICES FROM ADULT LEARNING PERSPECTIVES

Direction I : For the following questions please respond either by a word/phrase of your opinion or by putting a check mark(✓) on the option of your choice.

1. What kind of health literacy topics have you attended at the health center? (You can choose more than option)

Chronic & communicable diseases ☐	Family Planning ☐	Epidemics ☐
Environmental sanitation ☐	Immunization ☐	Malaria ☐
Mother and child health ☐	HIV and AIDS ☐	Disabilities ☐
Reproductive Health ☐	Food hygiene ☐	TB ☐
First aid ☐		
Other _____		

2. What health literacy topics have you attended most often at the health center?

3. From your experience, at what time does the health care center provide the health literacy lessons?

In the morning ☐ In the afternoon ☐ Both mornings and afternoons ☐
Other _____

4. On average, how long does a health literacy service take at the center you often attend?
_____ minutes.

5. Where in the health center is the venue for the provision of health literacy located?

In the patient's waiting area ☐ It has no venue ☐
It has its own place ☐ In an open space ☐
Other _____

6. How important are the health literacy services provided in the health care centers you often attend? If yes, how?

They are important ☐ They are not important ☐

7. How do rate the urgency of the contents (topics) provided in your health center? Very urgent ☐ Urgent ☐ Not urgent ☐

8. Which type of mediums used dominates in the health literacy services provision?

Audio materials ☐ Visual materials ☐ Audio visual materials ☐
Oral presentation ☐ Other _____

9. What medium/channels do you prefer to learn the health literacy lessons?

10. In the health center what language is used during the health literacy sessions?

Direction II: Please read each questions carefully and put a check mark(✓) on the option of your choice.

N o	Items	Options		
		yes	No	I don't know
1	Are you aware of the presence of health literacy services in the health center?			
2	Have you noticed time schedules of health literacy posted at the health center?			
3	Are there facilitations for elderly people in need assistance in the health care centers?			
4	Can people with disability attend health literacy services with the available facilitation of the health care center?			
5	Do you think the contents of health literacy services are related to your life in the practice?			
6	Are the contents (topics) of the lesson a prevalent health problem in your specific living place or region?			
7	Do you personally think that you will use what you have learned in the center for your life?			
8	Do you have previous experience or knowledge with the content of the lesson you have learned in the health care center?			
9	Does the health literacy of the center use different channels of information transmission?			
10	Are there other supportive channels of communication for people with disabilities?			
11	Are different mediums of communication integrated as a whole in the health literacy sessions?			
12	Did you ever get a chance to express your views during health literacy provision sessions?			
13	Are you actively involved in the conversations with the health professionals of the center?			
14	Do the health professionals use medical terminologies which you do not understand?			
15	Are there chances for adults to share ideas in group in relation to the raised topics?			
16	Are other adults given chances to provide their personal testimonies regarding health literacy sessions?			
17	Do you think you can broaden your knowledge outside the health care center in your own way after attending the health literacy lesson?			
18	Is the health literacy educator willing to listen attentively your problems?			

19	Is the health literacy facilitator willing to listen attentively your inquires during the lesson?			
20	When the health literacy lessons presented, are they presented orderly and in sequential order?			
21	Is the health literacy willing to manage the needs of adults with different learning abilities?			
22	Do you think people with lower literacy skills can follow up the health literacy services provided in the health care center?			
23	Do you personally think the learning venue for health literacy session looks interesting and educative?			
24	Do you think the venue for health literacy suitable for elderly people?			
25	Do you think the venue for health literacy suitable for people with disability?			
26	Do you think the venue for health literacy suitable for pregnant women?			
27	Do you think the venue for health literacy suitable for women carrying a child?			
28	Did you observe enough furniture for adults to follow the health literacy lessons in the health care center?			
29	Do you think you found out reliable information about health related issues from the health care center?			
30	Could you express your opinion without any fear and embarrassment during the health literacy sessions?			

Direction III: Please read each questions carefully and put a check mark(✓) on the option of your choice.

No	Question Items	Options			
		Always	Usually	Sometimes	Never
1	How often do you get health related advice and consultation from the health care professionals during and after medical examinations and checkups while you visit the health center?				
2	How often do you get the contents (messages) of the health literacy services clear and easily understandable to you?				
3	How often does the health professional use difficult medical terminologies in the health literacy programme?				
4	How often you get appreciations (whether verbal or non-verbal) from the health professionals for your views in relation to health problems?				
5	How often are you treated with respect by health literacy services providers in the health care center?				
6	How often have you been given feedback from the health literacy service provider professionals?				

Direction IV: Please read each questions carefully and put a check mark(✓) on the option of your choice.

No	Items	Options		
		Satisfactory	Unsatisfactory	Undecided
1	How do you rate the health literacy practitioners' preparation for the service?			
2	How do you rate the health literacy practitioners' knowledge of the content they teach?			
3	How do you rate the health literacy practitioners' willingness to help and being at service?			
4	How do you rate the health literacy services in terms of sensitivity to the diversity in levels of education?			
5	How do you rate the health literacy services in terms of sensitivity to diversity in relation to disability?			
6	How satisfied are you about the health literacy services sensitivity to cultural diversity?			
7	What is your overall impression about the venue for the provision of health literacy services looks like?			

PART THREE: CHALLENGES OF THE HEALTH LITERACY PRACTICES FROM ADULT LEARNING PERSPECTIVES

Direction: Please read the questions carefully and describe your honest opinion briefly.

1. What do you think the health literacy provided in the health center lacks? What are the major challenges you face while attending health literacy services at the center?

2. Do you think challenges have been given attention by the concerned stallholders of the health center? (explain your answer briefly)

3. What do you think would be the solution for effective implementation of the health literacy services in the health care center?

4. What do you think pertinent stakeholders should play in realizing the solution on the ground?

Appendix B

Addis Ababa University
School of Graduate Studies & Research
Faculty of Education and Behavioral Studies
Department of Teachers' Professional Development Studies
Adult and Life long Learning Unit

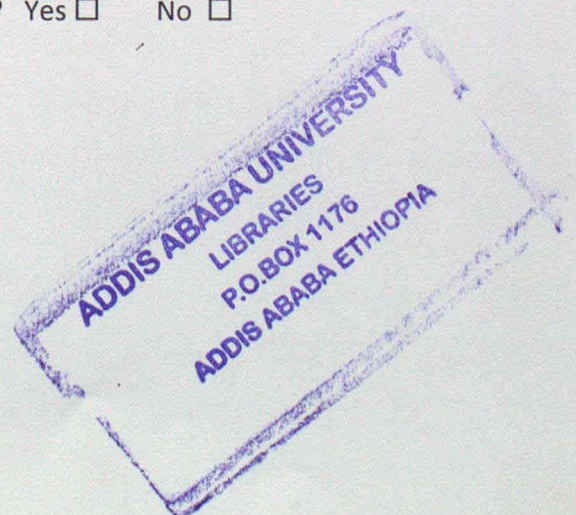
Questioner to be filled by health literacy educators

This questionnaire is part of a thesis work undertaken in partial fulfilment of Masters Degree in Adult Education and Lifelong Learning. Its primary aim is exploring into the health literacy practices from adult learning perspectives. Its major parts deals with general demographic information, the health literacy practices, the challenges faced on the practices and measures Should be taken for improvement. I would like to ask your kind cooperation to take part in the study and also like to assure you the confidentiality of your responses. Thank you in advance for your genuine responses.

PART ONE: GENERAL INFORMATION

Direction: For the following questions please respond either by a word/phrase of your opinion or by putting a check mark(✓) on the option of your choice.

1. Sex Male ☐ Female ☐
2. Age _____
3. Marital Status _____
4. Level of Education Secondary education ☐ Certificate ☐
 Diploma ☐ Degree ☐
5. Total years of experience _____
6. How long have you served in health literacy lessons? _____
7. Have you taken any course in adults' teaching? Yes ☐ No ☐



PART TWO: THE HEALTH LITERACY PRACTICE FROM ADULT LEARNING PERSPECTIVES

Direction I: The following questions are inquires with regard to your experience in providing the health literacy services. Please read each questions carefully and respond either by a word/phrase of your opinion or by putting a check mark(✓) on the option of your choice.

1. What type of health literacy services are provided in the health care center?
Family Planning ☐ Food Hygiene ☐ Environmental Sanitation ☐
Reproductive health ☐ Nutrition ☐ Immunization ☐ Epidemics ☐
First Aid ☐ Meningitis ☐ HIV/AIDS ☐ TB ☐
Chronic & communicable diseases ☐ Mother and child health ☐ Malaria ☐
Disabilities ☐
Other _____
2. What health literacy topics you most often provided in the health care center? (Rank the health literacy services from the most often provided to the least often)
Family Planning ☐ Food Hygiene ☐ Environmental Sanitation ☐
Reproductive health ☐ Nutrition ☐ Immunization ☐ Epidemics ☐
First Aid ☐ Meningitis ☐ HIV/AIDS ☐ TB ☐
Chronic & communicable diseases ☐ Mother and child health ☐ Malaria ☐
Disabilities ☐
Other _____
3. How many adults attend health literacy programmes in one (single) session?

4. When is the time for provision of health literacy?
Early morning ☐ Noon ☐ Afternoon ☐ Other _____
5. Which sex does benefit the most frequent attendance of health literacy in your center?
Male ☐ Female ☐
6. What venue do you use for the provision of health literacy services?
At waiting area for patients ☐ At a special hall reserved for health literacy ☐
No regular venue ☐ Other _____
7. How frequently do you get a turn to teach adults in the health literacy programme of the health center?
Weekly ☐ Every two weeks ☐ Monthly ☐ Other _____

8. How are topics for discussions in the health literacy sessions selected by the health care center?

9. How do you prepare yourself for the content of your session in the health literacy program?

10. What do you refer in order to substantiate your presentation?

Manuals ☐ Audiovisual materials ☐ Reference books ☐
Other _____

11. What sort of medium do you use in the health literacy programmes?

Audio materials ☐ Visual materials ☐ Audiovisual materials ☐
Other _____

12. What is the common language used to transmit the health literacy lesson in the health care center? _____

13. How do you think adults prefer to learn about health issues in the health care center?

Lecturing ☐ Group Discussion ☐ Demonstration ☐
Drama and art ☐ Audiovisual records ☐ Other _____

14. Do adults feel reluctant to attend the health literacy programme?

Yes ☐ No ☐ I can't say ☐

15. If your response for item "14" is yes, why do you think that is?

16. Do you supplement instruction with appropriate instruction materials?

17. Is the teaching floor open for adults' to express their views without reservation?

Yes ☐ No ☐ I am not sure ☐

18. If your response for item "17" is No, why do you think is it?

19. How do you check whether the adult learners understood the lesson they have learnt?

20. How do you rate the presence of educative materials (posters, pictures etc) in the health center?

Excellent ☐ Fair ☐ Poor ☐

21. Is the venue of the health literacy programmes free from destructive noise?

Totally free ☐ Somehow free ☐ Somehow noisy ☐ Totally noisy ☐

Direction II: For each of the following questions please respond your opinion by putting a check mark(✓) on the option box provided.

No	Items	Options		
		Yes	No	I don't Know
1.	Do you think incoming adults for medical treatment aware of the presence of health literacy service provisions in the health center?			
2.	Is there a resource (reference) room for the preparation of health literacy materials?			
3.	Does the health center have planned (scheduled) programmes for the provision of health literacy?			
4.	Is the health literacy programme to be implemented posted in the notice board?			
5.	Do you have area of expertise in the topic of health literacy issues you teach in the programme?			
6.	Do you think the health literacy programs have direct implication in the life of adults attending the programme?			
7.	Do you think that the adults are eager to follow the content of the health literacy programme?			
8.	Do you speak other languages other than Amharic in translating difficult medical terms?			
9.	Do you have clear guidelines at hand as to how to teach adults?			
10.	Can all the venues for the health literacy programmes of the center accommodate the learners comfortably?			

Direction III: For each of the following questions please respond your opinion by putting a check mark(✓) on the option box provided.

No	Items	Options		
		Always	Some times	Never
1	How often do you prepare lesson outlines for the topic discussion in the health literacy programmes?			
2	How often do you refer to the literacy manuals for health literacy programmes?			
3	How often do you repeat important points for assertion of teaching process?			
4	How often do you provide immediate feedback for health inquires raised by adult learners?			

PART THREE: CHALLENGES OF HEALTH LITERACY PRACTICES FROM ADULT LEARNING PERSPECTIVES

Direction: Please read the questions carefully and describe your honest opinion briefly.

1. What sorts of problems did you observe in the health literacy programmes of your health center?

2. What should be done in order to improve the quality of the health literacy practices in the health center?

Appendix C

Interview Guide for Adult Learners

1. What type of health literacy service do you receive from the health center?
2. How is health literacy the center conducted? (When, where, for how long)
3. What types of teaching methodologies are used in the health center?
4. What types of teaching aid materials are commonly used?
5. Are the contents of health literacy lessons relevant to adults?
6. Is the health literacy education of the center sensitive to learners' diversity?
7. How do you evaluate the competence and commitments of health professionals towards teaching in the health literacy programmes?
8. What should be done in order to solve the problems and enhance the health literacy programmes?

Appendix D

Interview Guide for Health Literacy Providers

1. What type of health literacy services do you provide for clients in the health care center?
2. When and where are the adult literacy programmes provided?
3. How long does it usually take?
4. What types of teaching methodologies and teaching aid materials are predominantly used in the health literacy programmes?
5. What do you think of teaching adults? Does it require special training or the medical knowledge by itself suffice for the provision of the health literacy programmes?
6. What sorts of problems do you encounter from adults coming to the health center in relation to the health literacy programmes?
7. What do you think are the major challenges you as a professional faced in relation to health literacy programmes?
8. What should be done in order to solve the health literacy practice problems provided in order to enhance and improve it?

Appendix E

Focus Group Discussion Guide for Adult Learners and Health Literacy Providers

1. Do you think there is awareness on the community on the presence of health literacy practices implemented in the health centers?
2. Do you think the needs and priorities of adults treated in the health literacy programmes? Why?
3. What are the major challenges observed in the health care centers in implementing health literacy programmes?
4. What measures should be taken in order to alleviate the problems of adult learners in the health centers?

Appendix F

Observation Checklist of the Health Literacy Programmes

Ser. No_	List of Observation	Implementation Status		Remark
		Yes	No	
1.	Learning Schedule			
	Regular Assignment of educator			
	Regular selection of health topics			
	Regular time schedule			
2.	Organization system			
	Organizational structure			
	Regular supervision			
	Reporting procedure			
	In-service training for educators			
3.	Learning Resources			
	Availability of learning resources			
3.1	Audio materials			
	Visual materials			
	Audio visual materials			
	Models			
3.2	Availability of references			
	Guides/ manuals			
	Journals/ research outlets			
	Health related magazines,			
	On-line based services			
4.	Learning Venue			
	Convenience for adults			
	Free from destructive noises			
	Convenient for people with disabilities			

አዲስ አበባ ዩኒቨርሲቲ
የድህረ ምረቃ ትምህርትና ምርምር
የስነ ትምህርት ኮሌጅና የስነ-ባህሪ ጥናት
የሥርዓተ ትምህርትና የመምህራን ሙያ ማሻሻያ ጥናት ክፍል
የጉልማሶች ትምህርትና ህይወት ሙሉ መማር ንዑስ ክፍል

በጎልማሳ ተማሪዎች የሚሞላ

የሚከተለው መጠይቅ በአዲስ አበባ ዩኒቨርሲቲ በጉልማሶችና ህይወት ሙሉ ትምህርት ዘርፍ የማስተራት ዲግሪ ማሟያ ጥናት አካል ሲሆን ዋና ዓላማው ከጉልማሶች የመማር ሁኔታ አንፃር የጤና ትምህርት ሂደትን መዳሰስ ነው። የመጠይቁ ዋነኛ ክፍሎች አጠቃላይ መረጃዎችን፣ ከጉልማሶች የመማር ሂደቶች አንፃር የጤና ትምህርት ሂደትን መዳሰስና አብይ ችግሮችን የመለየት ነው። በመሆኑም በጥናቱ ላይ በመሳተፍ አስፈላጊውን ትብብር እንዲያደርጉልኝ በትህትና እየጠየቅሁ የሚሰጡኝ መረጃ ሚስጢራዊነቱ የተጠበቀ መሆኑን አረጋግጥልዎታለሁ። ስለሚሰጡኝ መረጃ በቅድሚያ ምስጋናዬን አቀርባለሁ።

ክፍል አንድ፡ አጠቃላይ መረጃ

መመሪያ፡- የሚከተሉትን ጥያቄዎች በሚገባ በማንበብ እንደየአስፈላጊነቱ የ “✓” ምልክት በማድረግ ወይም በባዶ ቦታዎች ላይ መልስዎን በመሙላት ምላሽዎን ይስጡ።

1. የታ:- ወንድ ☐ ሴት ☐
2. ዕድሜ _____
3. የትምህርት ደረጃ:- በመደበኛ ት/ትያልተማሪ/ች ☐ የመጀመሪያ ደረጃ ትምህርት (1-8) ☐
የሁለተኛ ደረጃ ትምህርት (9-12) ☐ የከፍተኛ ትምህርት (ዩኒቨርሲቲ /ኮሌጅ) ☐
ሌላ _____
4. የጋብቻ ሁኔታ:- ያላገባ/ች ☐ ያገባ/ች ☐ በፍቺ የፈፀመ/ች ☐
የትዳር አጋር በህይወት የሌለ/ች ☐
5. የስራ ሁኔታ:- ሥራ ያለው/ላት ☐ ሥራ የሌለው/ላት ☐
6. አካል ጉዳተኛ ነዎት? አዎ ☐ አይደለሁም ☐
7. ባለፈው አንድ አመት ውስጥ በአማካኝ ለምን ያህል ጊዜ ወደ ጤና ጣቢያው መጥተዋል?
8. ወደ ጤና ጣቢያው አዘውትረው የሚመጡበት የጤና ችግሮች ምንድን ናቸው?

ክፍል ሁለት፡ የጤና ትምህርቱ ሂደት ከጉልማሶች የመማር ሁኔታ አንፃር

መመሪያ አንድ፡ የሚከተሉትን ጥያቄዎች በሚገባ በማንበብ እንደየአስፈላጊነቱ የ “✓” ምልክት በማድረግ ወይም በባዶ ቦታዎች ላይ መልስዎን በመሙላት ምላሽዎን ይስጡ፡፡

1. በጤና ጣቢያው በምን ዓይነት ርዕሰ ጉዳዮች ዙሪያ ትምህርት ተከታትለዋል? (ከአንድ በላይ አማራጮችን መምረጥ ይችላሉ)

ተላላፊ በሽታዎች ☐

የቤተሰብ ምጣኔ ☐

ወረርሽኝ ☐

የአካባቢ ፅዳት ☐

ክትባት ☐

የወባ በሽታ ☐

የእናቶችና ህፃናት ጤና ☐

ኤች አይቪ ኤድስ ☐

የአካል ጉዳት ☐

የስነ ተዋልዶ ጤና ☐

የምግብ ንፅህና ☐

የሃንፃ ነቀርሳ ☐

የመጀመሪያ ደረጃ ዕርዳታ ☐

ሌላ _____

2. በጤና ጣቢያው ከሚሰጡት የጤና ትምህርት ርዕሰ ጉዳዮች መካከል እርስዎን በብዛት የሚያጋጥሙት ምን ዓይነት የጤና ትምህርት ነው?

3. ከልምድዎ በመነሳት በጤና ጣቢያው የሚሰጡት የጤና ትምህርቶች በየትኛው ጊዜ ነው?

በጠዋት ☐

ከሰዓት በኋላ ☐

ጠዋትና ከሰዓት ☐

ሌላ _____

4. እርስዎ በሚጠቀሙበት የጤና ጣቢያ በአማካይ ለምን ያህል ጊዜ የጤና ትምህርቱ ይሰጣል? ደቂቃዎች፡፡

5. በጤና ጣቢያው የጤና ትምህርት የሚሰጥበት ቦታ የት ነው?

በታካሚዎች የመጠባበቂያ ቦታ ☐

የራሱ ቦታ የለውም ☐

የራሱ የሆነ ቦታ አለው ☐

በማንኛውም ክፍት ቦታዎች ☐

ሌላ _____

6. በጤና ጣቢያው የተከታተሏቸውን የጤና ትምህርቶች በተመለከተ ምን ዓይነት አስተያየት አልዎት? መልስዎ አዎን ከሆነ አስፈላጊነታቸውን በአጭሩ ያብራሩ፡፡

በጣም አስፈላጊ ናቸው ☐

አስፈላጊ አይደለም ☐

7. በጤና ጣቢያው የሚሰጡት የጤና ትምህርቶች ከሚኖሩበት አካባቢ አንፃር ያላቸውን አስፈላጊነት እንዴት ይገልጽታል?

በጣም አንገብጋቢ ናቸው ☐

አንገብጋቢ ናቸው ☐

አንገብጋቢ አይደለም ☐

8. በጤና ጣቢያው የሚሰጡት የጤና ትምህርቶችን ለማስተላለፍ የሚጠቀሙባቸው ዘዴዎች የትኞቹ ናቸው? (ከአንድ በላይ አማራጮች መምረጥ ይችላሉ)

የድምፅ መሣሪያዎች ☐

የእይታ መሣሪያዎች ☐

የድምፅና ☐

ዕይታ ☐

መሣሪያዎች ☐

የቃል ትምህርት ☐

ሌላ _____

9. እርስዎ በምን ዓይነት የመልዕክት ማስተላለፊያ ዘዴ /መንገድ የጤና ትምህርቱን መከታተል ይመርጣሉ?

10. በጤና ጣቢያው የጤና ትምህርት የሚሰጠው በየትኛው ቋንቋ ነው?

መመሪያ 2፡ የሚከተሉትን ጥያቄዎች በሚገባ በማንበብ ምርጫዎን የ “✓” ምልክት በማድረግ ምላሽዎን ይስጡ።

ተ.ቁ	ዝርዝር	አማራጮች		
		አዎ	አይ	አላውቅም
1	በጤና ጣቢያው የጤና ትምህርት ይሰጣል?			
2	የጤና ትምህርት የጊዜ ሰሌዳ (ኘሮግራም) በጤና ጣቢያው ተለጥፎ አይተው ያውቃል?			
3	በጤና ጣቢያው ዕድሜያቸው ገፋ ያለ አዛውንቶች ለመደገፍ የተመቻቹ ነገሮች ይገኛሉ?			
4	አካል ጉዳት ያለባቸው ሰዎች በጤና ጣቢያ ተገኝተው የጤና ትምህርት በምችት መከታተል ይችላሉ?			
5	የጤና ትምህርቶቹ ይዘት በእርስዎ ህይወት በተግባር የሚታዩና ግንኙነት ያላቸው ናቸው ብለው ያስባሉ?			
6	በጤና ጣቢያው የሚሰጡ ትምህርቶች በሚኖሩበት አካባቢ ጎልተው በሚታዩ የጤና ችግሮች ዙሪያ የተዘጋጁ ናቸው?			
7	ከጤና ጣቢያው ያገኙትን ትምህርት በግል ህይወትዎ በተግባር ለመጠቀም ያስባሉ?			
8	በጤና ጣቢያው ስለተከታተሉት ትምህርት ቀደም ያለ ግንዛቤ ነበርዎት?			
9	የጤና ጣቢያው የጤና ትምህርት ኘሮግራም ልዩ፣ ልዩ የመረጃ ማስተላለፊያ መንገዶች ይጠቀማል?			
10	አካል ጉዳት ላላቸው ጎልማሶች አጋዥ የመግባቢያ መንገድ መሣሪያዎች ይገኛሉ?			
11	በጤና ትምህርቱ የተለያዩ የመግባቢያ መንገዶች ተቀናጀተውና ተዋህደው ይገኛሉ?			
12	የጤና ትምህርቱ በሚሰጥበት ወቅት የግልዎን አመለካከት ለማንፀባረቅ ዕድሉን አግኝተው ያውቃል?			
13	ከጤና ጣቢያው የጤና ባለሙያዎች ጋር በንቃት ውይይት ያደርጋሉ?			
14	እርስዎ ትርጉሙን የሚቸገሩበትን የህክምና ቃላት የጤና ባለሙያዎቹ ይጠቀማሉ?			
15	በጤና ትምህርቱ ወቅት ከተሣታፊዎች ጋር በጋራ ሃሳቦችን ለመወያየት ዕድሉን ያገኛሉ?			
16	ጎልማሶች ስለጤና ትምህርቱ የግላቸውን ምስክርነት ለመስጠት ዕድል ይሰጣቸዋል?			
17	በጤና ጣቢያው ከሚሰጠው የጤና ትምህርት ውጪ በራስዎ መንገድ ዕውቀትዎን ለማስፋት እንደሚችሉ ያስባሉ?			
18	የጤና ትምህርት መምህሩ/ሯ የእርስዎን ችግር በንቃት ለማድመጥ ፍላጎት አለው/ላት?			
19	በጤና ትምህርቱ ወቅት የትምህርቱ አመቻች እርስዎ ለሚያቀርቡት ጥያቄዎች በንቃት ለማድመጥ ፍላጎቱ አለው/ላት?			
20	የጤና ትምህርቱ በሚሰጥበት ወቅት አቀራረቡ ቅደም ተከተል የጠበቀና የተደራጀ መልክ አለው?			
21	በጤና ትምህርት ወቅት የጤና ባለሙያው የተለየ የመማር ደረጃ ያላቸውን ጎልማሶች ፍላጎት ለማስተናገድ ፈቃደኛ ነው/ናት?			
22	በጤና ጣቢያው የሚሰጠውን የጤና ትምህርት በዝቅተኛ የትምህርት ደረጃ ላይ የሚገኙ ሰዎች ሊከታተሉት ይችላሉ			

	ብለው ያስባሉ?			
23	በግልጽ የጤና ትምህርት መማሪያው ስፍራ አስደሳችና ትምህርት ሰጪ ነው ብለው ያስባሉ?			
24	የጤና ትምህርት መስጫው ስፍራ ለአረጋውያን አመቺ ነው ብለው ያስባሉ?			
25	የጤና ትምህርት መስጫው ስፍራ ለአካል ጉዳተኞች አመቺ ነው ብለው ያስባሉ?			
26	የጤና ትምህርት መስጫው ስፍራ ለነብሰጡር ሴቶች አመቺ ነው ብለው ያስባሉ?			
27	የጤና ትምህርት መስጫው ስፍራ ልጅ ይዘው (አዝለው) ለሚመጡ ሴቶች አመቺ ነው?			
28	ጎልማሶች ትምህርቱን ለመከታተል እንዲችሉ የጤና ትምህርት መስጫው ስፍራ ላይ በቂ መቀመጫዎች ተሟልተው ተዘጋጅተው አስተውለዋል?			
29	በጤና ጣቢያው ከጤናጋር ተዛማጅ የሆኑ ጉዳዮች ላይ ተገቢና የሚታመን መረጃ እግኝቹያለሁ ብለው ያስባሉ?			
30	በጤና ትምህርቱ ወቅት ሃሳብዎን ያለአንዳች ፍራቻና ማፈር መግለፅ ችለዋል?			

መመሪያ 3: የሚከተሉትን ጥያቄዎች በሚገባ በማንበብ ምርጫዎን የ “√” ምልክት በማድረግ ምላሽዎን ይስጡ።

ተ.ቁ	ዝርዝር	አማራጮች			
		ሁል ጊዜ	አብዛኛውን ጊዜ	ጥቂት ጊዜ	ምንም ጊዜ
1	ለምርመራና ህክምና ወደ ጤና ጣቢያው ሲመጡ ምን ያህል ጊዜ ከጤና ባለሙያዎች ምክር ያገኛሉ?				
2	የጤና ትምህርቱ መልዕክት ምን ያህል ጊዜ ግልጽና በቀላሉ ለመረዳት በሚያስችል መልኩ ይሰጣል?				
3	ለፍቺ አስቸጋሪ የሆኑ የህክምና ቃላት ምን ያህል ጊዜ በጤና ትምህርቱ ወቅት ያጋጥሞታል?				
4	ስለጤና ችግርዎ አስተያየትዎን በሚሰጡበት ወቅት ምን ያህል ጊዜ ከጤና ባለሙያው/ዋ ማበረታቻ አግኝተዋል?				
5	ወደ ጤና ጣቢያው በሚመጡበት ወቅት የጤና ባለሙያዎች ምን ያህል ጊዜ በአክብሮት ያስተናግድዎታል?				
6	ስለጤና ትምህርቱ አስመልክቶ አስተያየትዎ ሲገልፁ ምን ያህል ጊዜ ከጤና ባለሙያው/ዋ ግብረ መልስ (ምላሽ) ያገኛሉ?				

መመሪያ 4: የሚከተሉትን ጥያቄዎች በሚገባ በማንበብ ምርጫዎን የ “✓” ምልክት በማድረግ ምላሽዎን ይስጡ፡፡

ተ.ቁ	ዝርዝር	አማራጮች		
		አጥጋቢ ነው	አጥጋቢ አይደለም	አላወኩም
1	የጤና ትምህርት ባለሙያዎቹ ለጤና ትምህርቱ የሚያደርጉትን ቅድመ ዝግጅት እርስዎ እንዴት ይገመግሙታል?			
2	የጤና ትምህርት ባለሙያው/ዋ ስለሚያስተምሩት የጤና ትምህርት ያላቸውን ዕውቀት እርስዎ እንዴት ይገመግሙታል?			
3	የጤና ትምህርት ባለሙያዎቹ ታካሚዎችን ለመርዳትና ለማገልገል ያላቸውን ዝግጁነት እርስዎ እንዴት ይገመግሙታል?			
4	የጤና ትምህርቱ በተሳታፊዎች መካከል ያለን የትምህርት ደረጃ ልዩነት በጥንቃቄ ለማስተናገድ ያለውን ዝግጁነት እርስዎ እንዴት ይገመግሙታል?			
5	የጤና ትምህርቱ የአካል ጉዳት ያለባቸውን ተሳታፊዎች በጥንቃቄ ለማስተናገድ ያለውን ዝግጁነት እርስዎ እንዴት ይገመግሙታል?			
6	የጤና ትምህርቱ ለአካባቢው የባህል ሁኔታ ያለውን አግባብነት እርስዎ እንዴት ይገመግሙታል?			
7	በአጠቃላይ የጤና ትምህርት መስጫ ስፍራውን እንዴት ይገመግሙታል?			

ክፍል ሦስት፡- በጤና ትምህርት ሂደት ከጉልማሶች የመማር ሁኔታ አንፃር የታዩ ችግሮች

መመሪያ፡- የሚከተሉትን ጥያቄዎች በጥንቃቄ ካነበቡ በኋላ ምላሽዎን በአጭሩ ይግለጹ፡፡

1. በጤና ጣቢያው በሚሰጠው የጤና ትምህርት ዙሪያ ምን ዓይነት ችግሮችን አስተውለዋል?

2. የጤና ትምህርቱን በሚከታተሉበት የጤና ጣቢያ ውስጥ እርስዎ ዋነኛ ናቸው የሚሏቸው ችግሮች ምንድናቸው?

3. በጤና ትምህርቱ ዙሪያ ላሉት ችግሮች በባለድርሻ አካላት (የሚመለከታቸው ክፍሎች) በቂ አፅኦት ተሰጥቶታል ብለው ያስባሉ? (መልስዎን በአጭሩ ያብራራሉ)

4. ለውጤታማ የጤና ትምህርት አተገባበር በጤና ጣቢያው ሊወሰዱ የሚገባቸው መፍትሔዎች ምንድናቸው ብለው ያስባሉ?

5. የመፍትሔ ሃሳቦችን ዕውን ለማድረግ ባለድርሻ አካላት (የሚመለከታቸው ክፍሎች) መጫወት ይገባቸዋል የሚሉት ሚና ምንድን ነው?

Appendix H

አዲስ አበባ ዩኒቨርሲቲ

የድህረ ምረቃ ትምህርትና ምርምር

የስነ ትምህርት ኮሌጅና የስነ-ባህሪ ጥናት

የሥርዓተ ትምህርትና የመምህራን ሙያ ማሻሻያ ጥናት ክፍል

የጉልማሶች ትምህርትና ህይወት ሙሉ መማር ንዑስ ክፍል

በጤና ትምህርት ባለሙያዎች የሚሞላ

የሚከተለው መጠይቅ በአዲስ አበባ ዩኒቨርሲቲ በጉልማሶችና ህይወት ሙሉ ትምህርት ዘርፍ የማስተራት ዲግሪ ማሟያ ጥናት አካል ሲሆን ዋና ዓላማው ከጉልማሶች የመማር ሁኔታ አንፃር የጤና ትምህርት ሂደትን መዳሰስ ነው። የመጠይቁ ዋነኛ ክፍሎች አጠቃላይ መረጃዎች፣ ከጉልማሶች የመማር ሂደቶች አንፃር የጤና ትምህርት ሂደትን መዳሰስና አብይ ችግሮችን የመለየት ነው። በመሆኑም በጥናቱ ላይ በመሳተፍ አስፈላጊውን ትብብር እንዲያደርጉልኝ በትህትና እየጠየቅሁ የሚሰጡኝ መረጃ ሚስጢራዊነቱ የተጠበቀ መሆኑን አረጋግጥልዎታለሁ። ስለሚሰጡኝ መረጃ በቅድሚያ ምስጋናዬን አቀርባለሁ።

ክፍል አንድ፡- አጠቃላይ መረጃ

መመሪያ አንድ፡- የሚከተሉትን ጥያቄዎች በሚገባ በማንበብ እንደየአስፈላጊነቱ የ “✓” ምልክት በማድረግ ወይም በባዶ ቦታዎች ላይ መልስዎን በመሙላት ምላሽዎን ይስጡ።

1. ፆታ ወንድ ☐ ሴት ☐
2. ዕድሜ _____
3. የጋብቻ ሁኔታ _____
4. የትምህርት ደረጃ፡ የሁለተኛ ደረጃ ትምህርት ☐ ስርተፍኬት ☐ ዲግሪ ☐
ዲግሪ ☐ ሴላ _____
5. አጠቃላይ የስራ ልምድ በአመት _____
6. የጤና ትምህርት በመስጠት ላይ ለምን ያህል ጊዜ አገልግለዋል? _____
7. ጉልማሶችን የማስተማር ኮርስ ወስደው ያውቃሉ? _____

ክፍል ሁለት፡ የጤና ትምህርቱ ሂደት ከጉልማሶች የመማር ሁኔታ አንፃር

መመሪያ አንድ፡- የሚከተሉትን ጥያቄዎች በሚገባ በማንበብ እንደየአስፈላጊነቱ “✓” ምልክት በማድረግ ወይም በባዶ ቦታዎች ላይ መልስዎን በመሙላት ምላሽዎን ይስጡ።

1. ምን ዓይነት የጤና ትምህርት አገልግሎት በጤና ጣቢያው ይሰጣሉ? (ከአንድ በላይ ምርጫ መምረጥ ይችላሉ)
የቤተሰብ ምጣኔ ☐ የምግብ ንፅህና ☐ የአካባቢ ፅዳት ☐
የስነ ተዋልዶ ጤና ☐ ስርዓተ ምግብ ☐ ክትባት ☐
የመጀመሪያ ደረጃ ዕርዳታ ☐ የእናቶችና ህፃናት ☐ ጤና ወረርሽኝ ☐
ከባድና ተላላፊ በሽታዎች ☐ ኤች አይ ቪ ኤድስ ☐ የሃንባ ነቀርሳ ☐
የአካል ጉዳት ☐ የወባ በሽታ ☐
ሌላ _____

2. በጤና ጣቢያው በአብዛኛው የሚሰጡት የጤና ትምህርቶች የትኞቹ ናቸው? (ተዘውትረው የሚሰጡትን ደረጃ በቁጥር በመስጠት ያስቀምጡ)

የቤተሰብ ምጣኔ ☐	የምግብ ንፅህና ☐	የአካባቢ ፅዳት ☐
የስነ ተዋልዶ ጤና ☐	ስርዓተ ምግብ ☐	ክትባት ☐
የመጀመሪያ ደረጃ ዕርዳታ ☐	የእናቶችና ህፃናት ☐	ጤና ወረርሽኝ ☐
ከባድና ተላላፊ በሽታዎች ☐	ኤች አይ ቪ ኤድስ ☐	የሣንባ ነቀርሳ ☐
ከባድና ተላላፊ በሽታዎች ☐	የአካል ጉዳት ☐	የወባ በሽታ ☐

ሌላ _____

3. በአንድ ጊዜ በአማካይ በቁጥር ምን ያህል ጉልማሶች በጤና ትምህርቱ ላይ ይሣተፋሉ?

4. የጤና ትምህርቱ የሚሰጥበት ጊዜ መቼ ነው?

በጠዋት ☐ ቀትር ላይ ☐ ከሰዓት በኋላ ☐ ሌላ _____

5. እርስዎ በሚሰሩበት የጤና ጣቢያ ውስጥ የትኞቹ ይበልጥ አዘውትረው የአገልግሎት ተጠቃሚ ናቸው? ወንዶች ☐ ሴቶች ☐

6. የጤና ትምህርቱን ለመስጠት ምን ዓይነት ቦታ ትጠቀማላችሁ?

በታካሚዎች መጠባበቂያ ስፍራ ☐ ለትምህርቱ ሲባል በተዘጋጀ አዳራሽ ☐

መደበኛ ስፍራ የለውም ☐ ሌላ _____

7. በየስንት ጊዜው የጤና ትምህርት ለማስተማር ተረኛ ሆነው ይመደባሉ?

በሣምንት ☐ በየሁለት ሣምንቱ ☐ በወር ☐ ሌላ _____

8. በጤና ጣቢያው የሚቀርቡት የጤና ትምህርት ርዕሶች እንዴት ይመረጣሉ?

9. ራስዎን ለጤና ትምህርቱ ይዘት አስቀድመው የሚያዘጋጁት እንዴት ነው?

10. ያዘጋጁትን የጤና ትምህርት ለማዳበር የሚያጣቅሱት ምንድን ነው?

ማኑዋል መመሪያ ☐ የኦዲዮቪዢዊል መሣሪያዎች ☐ መጽሐፍት ☐

ሌላ _____

11. በጤና ትምህርት ኸርግራም ላይ ምን ዓይነት የመረጃ ማስተላለፊያ መንገዶች ይጠቀማሉ?

የድምፅ መረጃ መሣሪያዎች ☐ የምስል መረጃ መሣሪያዎች ☐

የድምፅና ምስል መሣሪያዎች ☐ ሌላ _____

12. በጤና ጣቢያው የጤና ትምህርቱን ለማስተላለፍ የተለመደው ቋንቋ ምንድን ነው?

13. ጉልማሶች በጤና ጣቢያው የሚሰጠውን የጤና ትምህርትን እንዴት ቢማሩት ይመርጣሉ ብለው ያስባሉ?

በገለፃ ☐ በቡድን ውይይት ☐ በሰርቶ ማሳየት ☐

በድራማና አርት ☐ በምስልና ድምፅ ☐

ሌላ _____

14. ጉልማሶች የጤና ትምህርቱን ለመከታተል ቸልታ ይታይባቸዋል?

አዎን ☐ የለም ☐ ምንም ማለት አልቻልኩም ☐

15. ለጥያቄ ቁጥር “14” መልስዎ አዎን ከሆነ ምክንያቱ ምን ይመስልዎታል?

16. የጤና ትምህርቱን ለማዳበር ተጨማሪ አጋዥ መሣሪያዎችን ይጠቀማሉ?

17. የጤና ትምህርት የማስተማሪያ ስፍራው ጉልማሶች ያለመቆጠብ አመለካከታቸውን መግለፅ የሚችሉበት ነው?

አዎን ☐ አይደለም ☐ እርግጠኛ አይደለሁም ☐

18. ለጥያቄ “17” መልስዎ አይደለም ከሆነ ምክንያቱ ምን ይመስልዎታል?

19. የተሰጠውን የጤና ትምህርት ጉልማሶች ስለመረዳታቸው እርስዎ እንዴት ያረጋግጣሉ?

20. የጤና ትምህርት መረጃ መሣሪያዎች (እንደ ስዕል፣ ፖስተር ወዘተ) በጤና ጣቢያው በምን ያህል ሁኔታ ይገኛል?

እጅግ በጣም ጥሩ ☐ መጠነኛ ☐ ዝቅተኛ ☐

21. የጤና ትምህርት መሣሪያው ስፍራ ከሚረብሹ ነገሮችና ድምፆች የተጠበቀ ነው?

ፍፁም ነፃ ነው ☐ በመጠኑ ነፃ ነው ☐

በመጠኑ የሚረብሹ ድምፆች አሉ ☐ በጣም የሚረብሹ ድምፆች አሉ ☐

ሌላ _____

መመሪያ 2: የሚከተሉትን ጥያቄዎች በሚገባ በማንበብ ምርጫዎን የ “✓” ምልክት በማድረግ ምላሽዎን ይስጡ።

ተ.ቁ	ዝርዝር	አማራጮች		
		አዎን	አይ	አላውቅም
1	ወደ ጤና ጣቢያው የሚመጡ ጉልማሶች በጤና ጣቢያው የጤና ትምህርት አገልግሎት እንደሚሰጥ ያውቃሉ ብለው ያስባሉ?			
2	ለጤና ትምህርቱ ዝግጅት ለማድረግ የሚያስችል የመረጃ ማዕከል በጤና ጣቢያው ይገኛል?			
3	የጤና ጣቢያው በዕቅድ ላይ የተመሠረተ የጤና ትምህርት የጊዜ ሰሌዳ አለው?			
4	የጤና ጣቢያው የጤና ትምህርት መርሐ ግብር በማስታወቂያ ሰሌዳ ላይ ተለጥፎ ይገኛል?			
5	ስለሚያስተምሩት የጤና ትምህርት ይዘቶች ላይ ጥልቅ መያወጃ ክህሎት አልዎት?			
6	የጤና ትምህርት ፕሮግራም በትምህርቱ ለሚሳተፉ ጉልማሶች ህይወት ላይ ትርጉም ይኖረዋል ብለው ያስባሉ?			
7	በእርስዎ ግምት የጤና ትምህርቱን ለመከታተል ጉልማሶች ተነሳሽነት አላቸው ብለው ያስባሉ?			
8	የጤና ት/ት በሚሠጡበት ወቅት ከአማርኛ ቋንቋ ሌላ የሆኑ የህክምና ቃላትን ይጠቀማሉ?			
9	ጉልማሶችን እንዴት ማስተማር እንደሚቻል የሚገልጽ ግልፅ የሆነ መመሪያ በእጅዎ ይገኛል?			
10	በጤና ጣቢያው ለጤና ትምህርት የተዘጋጁት ስፍራዎች ጉልማሶችን በተመቻቸ ሁኔታ ለማስተናገድ ይችላሉ?			

መመሪያ 3: የሚከተሉትን ጥያቄዎች በሚገባ በማንበብ ምርጫውን “✓” ምልክት በማድረግ ምላሽዎን ይስጡ

ተ.ቁ	ዝርዝር ነጥቦች	ሁል ጊዜ	አብዛኛውን ጊዜ	ጥቂት ጊዜ	ምንም ጊዜ
1	ለውይይት ስለሚቀርቡት የጤና ትምህርት ጉዳይ ምን ያህል ጊዜ የፍሬ ሀሳቦቼን ዝርዝር ያዘጋጃሉ?				
2	ስለጤና ትምህርቱ አስመልክቶ ምን ያህል ጊዜ የጤና ትምህርት መመሪያዎችን ያጣቅሳሉ?				
3	በማስተማሩ ሂደት ወቅት አስፈላጊ ነጥቦችን እርግጠኛ ለመሆን ምን ያህል አዘውትረው ይደግሙታል?				
4	በጉልማሶች ለሚነሱት የጤና ጉዳይ ጥያቄዎች ምን ያህል አዘውትረው ፈጣን ምላሽ ይሰጣሉ?				

ክፍል ሦስት: በጤና ትምህርት ሂደት ከጉልማሶች የመማር ሁኔታ አንፃር የታዩ ችግሮች

መመሪያ: የሚከተሉትን ጥያቄዎች በጥንቃቄ ካነበቡ በኋላ ምላሽዎን በአጭሩ ይግለፁ::

1. በጤና ጣቢያው የጤና ትምህርት ኘርግራም ላይ ያስተዋሉዋቸው ዓብይ ችግሮች ምንድን ናቸው?

2. በጤና ጣቢያው ውስጥ የሚሰጠውን የጤና ትምህርት ጥራት ለማሻሻል ምን መደረግ ይኖርበታል?

Appendix I

የቃለ መጠይቅ መመሪያ ለጉልማሳ የጤና ትምህርት ተማሪዎች የተዘጋጀ

መመሪያ፡- መልስዎን በአጭሩ ያብራሩ

1. ከጤና ጣቢያው ምን ዓይነት የጤና ትምህርት አገልግሎት ያገኛሉ?
2. በጤና ጣቢያው የጤና ትምህርት እንዴት ይከናወናል? (መቼ፣ የት፣ ለምን ያህል ጊዜ)
3. ምን ዓይነት የማስተማሪያ ዘዴዎች በጤና ጣቢያው ይሰራባቸዋል?
4. ምን ዓይነት የማስተማሪያ መርሃ መሣሪያዎች ይዘወተራሉ?
5. የጤና ትምህርቱ ይዘት ለጉልማሶች ተገቢነት አላቸው?
6. በጤና ጣቢያ የሚሰጠው የጤና ትምህርት የተማሪዎቹን ልዩነት ያገናዘበ ነው?
7. በጤና ትምህርት ኘርግራም ላይ የሚሰሩትን የጤና ባለሙያዎች ብቃትና ቁርጠኝነት እንዴት ይገመግሙታል?
8. የጤና ትምህርቱ ኘርግራምን ችግሮችን ለመፍታትና ኘርግራሙን ለማሳደግ ምን መደረግ አለበት?

Appendix J

የቃለ መጠይቅ ለጤና ትምህርት ባለሙያዎች የተዘጋጀ

1. እርስዎ በጤና ጣቢያ ውስጥ ምን ዓይነት የጤና ትምህርት አገልግሎቶችን ይሰጣሉ?
2. የጤና ትምህርት ኘርግራሞቹ መቼና የት ነው የሚሰጡት?
3. የጤና ትምህርቱ በአብዛኛው ምን ያህል ጊዜ ይወስዳል?
4. በጤና ትምህርት ኘርግራም ላይ ምን ዓይነት የማስተማሪያ ዘዴዎችና የማስተማሪያ መሣሪያዎች ይዘወተራሉ?
5. ጉልማሶችን ስለማስተማር ምን ያስባሉ? የጤና ዕውቀቱ ብቻ የጤና ትምህርቱን ለማስተማር በቂ ነው ብለው ያስባሉ ወይንስ ልዩ ስልጠና መውሰድ ያስፈልጋል ብለው ያምናሉ?
6. ወደ ጤና ጣቢያው ከሚመጡ ጉልማሶች የጤና ትምህርቱን አስመልክቶ ምን ዓይነት ችግሮች ያጋጥሞታል?
7. እርስዎ እንደባለሙያ የጤና ትምህርቱን አስመልክቶ ያጋጠምዎት አብይ ችግር ምንድን ነው?
8. የጤና ትምህርቱን ችግር መፍትሔ ለማግኘትና ለማሳደግና ለማሻሻል ምን መደረግ አለበት?

Appendix K

ለቡድን ውይይት የተዘጋጀ

1. በማህበረሰቡ ዘንድ በጤና ጣቢያ ውስጥ የጤና ትምህርትን ተግባራዊ እየሆነ እንደሆነ ዕውቀቱ አለ ብለው ያስባሉ?
2. በጤና ትምህርቱ ላይ የጉልማሶች ፍላጎቶችን ቅድሚያ የሚያሰጡ ጉዳዮች ትኩረት ተሰጥቷቸዋል ብለው ያስባሉ? ለምን?
3. በጤና ጣቢያ ውስጥ የጤና ትምህርቱን በመተግበር ሂደት ላይ የሚያጋጥሙ አብይ ችግሮች ምንድን ናቸው?
4. የጤና ትምህርቱን ችግሮች ለማቃለል ምን አይነት እርምጃዎች በጤና ጣቢያው ሊወሰዱ ይገባቸዋል?

Appendix L

በጤና ጣቢያዎች የሚሰጡትን የጤና ትምህርት አስመልክቶ የተዘጋጀ የእይታ መረጃ መሰብሰቢያ ቅጽ

የጤና ጣቢያው አድራሻ: _____

ተ.ቁ	የእይታ ዝርዝሮች	የተግባራዊነት ሁኔታ	
		አለ	የለም
1	የጤና ትምህርት ኘርግራም - መደበኛ የመምህራን ምደባ - መደበኛ የጤና ትምህርት ርዕሰ ምርጫ - መደበኛ የማስተማሪያ የጊዜ ሰሌዳ		
2	የጤና ጣቢያው አደረጃጀት ስርዓት - ድርጅታዊ መዋቅር - መደበኛ ሉፐርቪዥን - የሪፖርት ስርዓት - የስራ ላይ ስልጠናዎች		
3	የመማሪያ መሣሪያዎች		
3.1	የትምህርት መሣሪያዎች መኖር - የድምፅ መሣሪያዎች - የእይታ/ምስል መሣሪያዎች - የምስልና ድምፅ መሣሪያዎች - ሞዴሎች		
3.2	የዋቢ መጽሐፍት መኖር - መመሪያዎች (ማትዋሎች) - ጆርናሎች (የምርምር ፅሁፎች) - ከጤና ጋር ተዛማጅነት ያላቸው መጽሔፍት - የድረ-ገፅ አገልግሎት		
4	የመማሪያ ስፍራ - ለጉልማሶቹ ምቹ መሆን - ከሚረብሹ ድምፆች ነፃ የሆነ - ለአካል ጉዳተኞች ምቹ የሆነ		

Appendix - M

Reference

2/2/m/5134/227

Date

9/5/2023

To

Lideta Health Center
Shiromeda Health Center
Kolfe Health Center

Kazanches Health Center
N/S/Lafo No. 2 Health Center

Addis Ababa

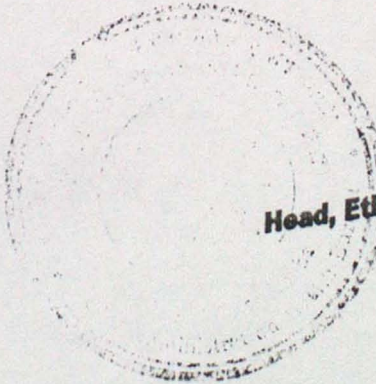
Subject; A request to allow research work at the health center

This letter is to support Dagmawi Melesse to conduct his research, which is titled as "An Assessment of Health Literacy Practices from Adult Learning Perspective; the Case of selected Health care Centers in Addis Ababa."

The study proposal was duly reviewed and approved by Addis Ababa Health Bureau IRB, the Principal investigator is informed with a copy of this letter to report any changes in the study procedures and submit an activity progress report to the Ethical committee as required.

Therefore we request the Health facilities to provide support to the principal investigator.

With Regard



Alemu H/Mariam
Head, Ethical Clearance Committee

Cc

To:-

✓ Dagmawi Melesse

Addis Ababa

Ethical clearance committee

Health Bureau

ETHICAL REVIEW COMMITTEE

ETHICAL REVIEW FORM

Tel: +251 115 513911

P.O. Box 30738

Fax No. +251 115 515689

Directed study Project:. "An Assessment of Health Literacy Practices from Adult Learning Perspective; The Case of selected Health care Centers in Addis Ababa."

Principal Investigator Dagmawi Melesse

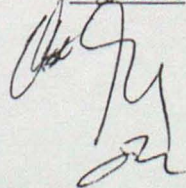
CRITERIA/ITEM	RATING
consent form	☒ Yes
1. Does the consent contain all the necessary information that the subject should be aware of?	☐ Requires revision ☐ No ☐ Not applicable ☐ Not attached
2. Are the objectives of the study clearly stated?	☒ Yes ☐ No
3. Are provisions to overcome risks well described and accepted? a. Justice b. Beneficence c. Respect for a person	☐ Yes ☐ Not well described ☐ No ☒ Not applicable
4. Are the safety procedures in the use of vaccines, drugs and other biological products acceptable?	☐ Yes ☐ No ☒ Not applicable
5. Are the procedures to keep confidentiality well described?	☒ Yes ☐ No ☐ Not applicable
6. Are the proposed researchers competent to carry out the study in a scientifically sound way?	☒ Yes ☐ No ☐ Not applicable ☐ Unable to assess
7. Does it have material transfer agreement?	☐ Yes ☐ No ☒ Not applicable
8. Recommendation	☒ Approved on condition
9. Remarks	

Ethical Clearance Committee Members:

Name

1. Ato Alemu Haile mariam
2. Dr. Addis Akalu
3. Ato Ezra Muluneh

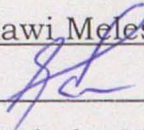
Signature




DECLARATION

This thesis is my original work and has not been presented for a degree in any other university and all sources of materials used are for this thesis has been duly acknowledged.

Name Dagmawi Melesse Hailu

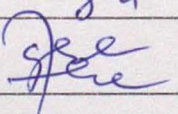
Signature 

Place: Addis Ababa University

Date April 6, 2011

This thesis has been submitted for examination with my approval as university advisor

Name Teresgen Frgs

Signature 

Date Apr. 7, 2011

