TW
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015

PHC MANAGEMENT ADVANCEMENT

TRAINING OF TRAINERS

HELD IN HOSANA

CCIDA

SUPPLEMENTARY DOCUMENT TO THE PHC MANUAL

MAY 31st - JUNE 10, 1994

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NOTE TO THE READER

The material presented in the Supplementary Document to the PHC Manual is mostly the work of the participants. It is with the request of the participants of the PHC MAP training who requested the preparation of this document. Minor editorial corrections are made and we feel the document can provide additional information and reference to the participants.

May I take this opportunity to thank all participants for their active participation and enormous input to the making of this supplementary document.

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THE COORDINATOR OF THE TRAINING

GROUP WORK QUESTIONS

1. You are facilitating a workshop. How will you ensure effective communication with in the group?

* BEFORE

- Select appropriate participants and facilitators.
- Prepare teaching aids in advance.
- Look for comfortable area/bright room.
- Set-up a good time table.

* DURING

- Create pleasant atmosphere.
- Attractive approach-Greeting, introducing each other.
- Stimulate the group
  - . introduce the objectives of the workshop
  - . ask for expectations and ideas on the subject matter
  - . relaxing act, stories, dramas
  - . a short lecture - elaborative
  - . give time for group discussions and share their experiences
- Observe the physical expressions of the participants.
- Ask group members how they feel about the way of presentation.

* DURING BREAKS

- Informal discussions.

2. What can prevent effective communication in the group?

- One-way communication.
- Unfriendly approach.
- Lack of interest on the side of facilitator.
- Imposing one's idea, blaming.
- Discouraging suggestions.
- Physical discomfort.

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CHARACTERISTICS OF MOTHER

Mother's Name :- _____

Mother's Address :- _____

Mother's Age :- _____

Mother's Marital Status :- Married _____

Single _____

Widowed _____

Mother's Educational Status:- Literate _____

Illiterate _____

Formal Educ. _____

Total No. of children in the Family _____

No. of Children < 2 yrs _____

How much do you & your husband earn?

Per month < 100 Birr - /100-300 _____

300 - 600 - />600 _____

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RAPID SURVEY QUESTIONNAIRE

For Mothers with Children 12-23 months. (IF TWO, FILL FOR BOTH)

2.1 CHILD IMMUNIZATION

Mother's Name :- _____

Mother's Address :- _____

Mother's Age :- _____

Mother's Marital Status :- Married _____
Single _____
Widowed _____

Mother's Educational Status:- Literate _____
Illiterate _____
Formal Educ. _____

Total No. of children in the Family _____

No. of Children < 2 yrs _____

How much do you & your husband earn?
Per month < 100 Birr - /100-300 _____
300 - 600 - />600 _____

ASK A MOTHER WITH CHILDREN 12-23 MONTHS OR

1. Was your child vaccinated?
   a) Yes b) No c) Do not know

2. If Yes do you have EPI card?
   a) Yes b) No c) Do not know

3. If Yes copy the dates for
   a) From card b) History

   BCG _____ DPT_1 _____ DPT_2 _____ DPT_3 _____

   $POLIO_0$ _____ $POLIO_1$ _____ $POLIO_2$ _____ $POLIO_3$ _____

   Measles _____

   State the vacc. status.
   a) Fully _____ b) Part. _____ c) No _____

   d) On appoint. _____

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4. If the child is not vaccinated. WHY?

- No Need _____
- Child sick _____
- Mother sick _____
- Other specify _____

5. Do you know the use of vaccination?
a) Yes b) No

6. If Yes give the use: (Prevention for)
a) She knows all b) Partial c) No

Of the disease to be prevented _____

7. Where from did you hear about EPI.
FIRST a) H.C.U. b) Neighbors c) Other _____

8. Do you think vaccination is useful for a child?
a) Yes b) No c) Other

9. At what age should a child be vaccinated? _____

Date _____ Name of Interview _____

If partially Why? Ill _____ Fever _____

Abscess _____ Busy _____ Health Prof. not friendly.

Others specify _____.

- Were Health Prof. Present Yes _____ No _____
- Were Vaccine available Yes _____ No _____

Are your neighbor's children Vaccinated Yes _____
No _____ Don't know _____

If No why do you think this is so?

Do you have difficulty reaching vaccination site?

Yes _____ No _____

Distance to walk < 1 HR _____
1-2 Hrs 2-3 Hrs > 3 Hrs

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DUMMY TABLES

ALL IN RELATION TO VACCINE COVERAGE

AGE OF MOTHER

VACCINE STATUS	15-20 YRS	21-30	31-40
FULLY			
PART			
NONE			

DUMMY TABLES CONT.

MARITAL STATUS OF MOTHERS

STATUS OF VACC.IM	SINGLE	MARRIED	DIVORCED	WIDOWED
FULLY				
PART				
NONE				

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EDUCATIONAL STATUS

STATUS	ILLITERATE	LITERATE	F.EDUC.
FULLY			
PART			
NONE			

MOTHERS KNOWLEDGE OF EPI

	YES	NO
FULLY		
PART		
NONE		

ATTITUDE TO E.P.I.

	POS.	NEG.
FULLY		
PART		
NONE		

MONTHLY INCOME OF PARENTS (BIRR)

	< 100	100-300	300-600	> 600
FULLY				
PART				
NONE				

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DUMMY TABLES CONT

DISTANCE FROM VACC. SITE BY FOOT

VACC. STATUS	0-1 HRS	1-2	2-3 HRS
FULLY			
PART			
NONE			

REASONS FOR INTERRUPTION OF VACC.

	ABSES	ILL	H.PROF. ATTITUDE	VACC. AVAIL.
FULLY				
PART				
NONE				

FAMILY SIZE

	SMALL	MED	LARGE
FULLY			
PART			
NONE			

ENVIRONMENTAL FACTORS

	SITE ACCESSIBILITY			NEIGH. INFLUENCES	
	ALL YEAR	ART YEAR	NOT	POS.	NEG.
FULLY					
PART					
NONE					

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2.2. FAMILY PLANNING

1. Name _____ Address _____
   Age _____ Religion _____

2. Marital Status _____ Married _____ Divorced _____

3. Educational Status _____ Literate _____ Illiterate _____

4. Occupation _____ House Wife _____ Trader _____
   Others _____

5. Do you have children? Yes _____ No _____
   If Yes How many _____
   < 5 yrs _____ > 5 yrs _____

6. Do you have any children who died < 5 yrs of age?
   Yes _____ No _____
   If Yes How many _____
   At what age? _____

7. Do you attend MCH clinic?
   Yes _____ No _____

   Do you know the health personal? Yes _____ No _____
   Do you like them? Yes _____ No. _____
   If No why? _____
   How many hours do you walk to the clinic? _____

8. Do you bear children with 1 or 2 yrs difference?
   Yes _____ No _____
   If Yes have you faced any problem? _____

9. Have you ever heard of child spacing?
   Yes _____ No _____

   If Yes from where? _____

   Have you used it? Yes _____ No _____

   If Yes are you using it now? _____

   If No why? _____

10. Do you breast feed? Yes _____ No _____
    If Yes for how long? _____

11. How many pregnancies did you have? _____

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12. Are you using contraceptives?

a) Yes b) No

13. If Yes what?

a. Natural _____) _____

b. Pills _____ c. Condom _____ d. Other spec. _____

14. If No why?

a) No need _____ b) Bad for health _____

c) Only prostitutes use it _____ c) Other _____

15. Do you think contraceptives is useful?

a) Yes b) No c) Not known _____

16. If not useful why?

a) b) Mother told _____

17. Do you know where you could get contraceptives?

a) Health Institutions _____ b) Shops _____

c) Other specify _____

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RAPID SURVEY QUESTIONNAIRE

Ask 15-49 years Married/Divorced Mothers

Identification:- House No. _____

Village No._____

Woman's characteristics:-

Age _____ in Years.

Marital status:- a) Married _____ b) Divorce
c) Separated _____ d) Widowed _____

1. Are you now living with partner?
   a) Yes b) No c) Other specify _____

2. How many children do you have? _____

3. What is the age (in yrs./in months) of your last child?
   Years _____ (for > 1 yr. Months for children less than 1 yr.) _____

4. Are you using contraceptives?
   a) Yes b) No

5. If Yes what?
   a) Natural _____) _____
   b) Pills _____ c) Condom _____ d) Other spec. _____

6. If No why?
   a) No need _____ b) Bad for health _____
   c) Only prostitutes use it _____ c) Other _____

7. Do you think contraceptives is useful?
   a) Yes b) No c) Not known _____

8. If not useful why?
   a) b) Mother told _____

9. Do you know where you could get contraceptives?
   a) Health Institutions _____ b) Shops _____
   c) Other specify _____

Name and Sig. of Interviewer:- _____

Date _____ Signature _____

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SAMPLE DUMMY TABLE

VARIABLES	USERS	NON-USERS	TOTAL
AGE 15-20 21-35 36-49			
MARITAL STATUS MARRIED DIVORCED			
OCCUPATION HOUSE WIFE TRADER OTHER			
RELIGION CHRISTIAN MUSLEM OTHER			
EDUCATIONAL STATUS LITERATE ILLITERATE 1-5 GRADE >6 GRADE			
CHILDREN YES NO			

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2.3. ANTENATAL SERVICE

ASK WOMEN WITH A CHILD < 1 YEAR

IDENTIFICATION:- House No. _____ Village _____

1. Age _____

2. Marital Status _____
   a) Married _____ b) Divorced _____

3. Education
   a) Illit. _____ b) 1-6 _____ c) 7-12 _____
   d) Above 12 _____

4. Occupation
   a) H. Wife b) Other (Specify) _____

5. Income per month _____Birr

6. How many children do you have? _____

7. Did you get Antenatal service for your last child?
   a) Yes _____ b) No _____

8. If Yes how many times? _____

9. If Yes when during your Pregnancy _____

10. If Yes where did you get?
    a) Hospital _____ b) H.C. _____ c) H.S. _____ d) HP ____

11. Who advised you to get antenatal service?
    a) Med. Per. _____ b) Parents _____c) Neighbor ____
    d) Other specify _____

12. Did you get treatment?
    a) Yes _____ b) No _____ T.T. Yes No

13. If she say no to Q No. 7 ask
    - Do you know Antenatal service?
      a) Yes _____ b) No _____
    - Do you think Antenatal service is useful for pregnancy
      a) Yes _____ b) No _____
    - Why did you not get Antenatal service?
      a) No need _____ b) Distance _____
      c) Health Worker not friendly _____
      d) No service _____
      e) Other _____

Date _____ Interviewer_____

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DUMMY TABLE FOR ANTENATAL CARE

INFORMATION

SER. NO.	VARIABLE		USERS	NON USERS
1	AGE OF THE MOTHER	13-20 21-30 30-40 40 & Above		
2	MARITAL STATUS	Married Single Divorce		
3	RELIGIOUS	Christian Muslem		
4	EDUCATION LEVEL	Illiteracy Elementary School High School Diploma & Above		

Date _____

Interviewer _____

Sign _____

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2.4. SANITATION

IDENTIFICATION:- House No. _____

1. Is there a latrine in the household?
   a) Yes _____ b) No _____

   If Yes answer Q. No. 2 If No go to Q. No. 5.

2. If Yes what type?
   a) Private _____ b) Communal _____ c) Other _____

3. If Yes is it properly used?
   a) Yes _____ b) No _____

4. If not properly used? What?
   a) Dirty _____ b) Closed _____ c) Full _____

5. If there is no latrine ask why?
   a) No space _____ b) No money _____ c) No useful _____
   d) Soil not appropriate _____ e) Other specify _____

6. If there is no latrine do you intend to built one?
   a) Yes _____ b) No _____ c) Don't know

7. Do you know the use of latrine?
   a) Yes _____ b) No _____ If Yes specify _____
   c) To protect disease _____ d) Other specify _____

8. Do you think it is useful?
   a) Yes _____ b) No _____ If No Ans. Why? _____

9. What is your source of water?

	Protected	Unprotected
a. River	_____	_____
b. Well	_____	_____
c. Spring	_____	_____
d. Pipe	_____	_____

10. Do you think your water source is safe for human consumpti
    Yes _____ No _____

11. How often do you wash your body?
    Daily _____ Weekly _____ Monthly _____ Occasiona
    _____

12. Are insects and rodents a problem in your community?

    Yes _____ No _____

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I. CONSTRUCTION OF A DUMMY TABLE

	YES	NO	TOTAL
Presence of latrine			
Knowledge about latrine			
Usage of latrine			
Usage of latrine by the household			
Availability of materials			
Safe water supply			
Attitude towards the usefulness of latrine	Positive	Negative	

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3. ANTENATAL CARE QUALITY ASSESSMENT

3.1. CHECK LIST

GROUP 4 (EECMY)

Health Personnel

- Professional
- Training
- Experience
- Attitude

The Client

- Attendance (Statistics, Records, when & how they att & Recorded)
- TT coverage
- Interview (level of satisfaction)
- Distance to health institution

Service

- Registration & follow up of risky mothers up to delivery
- How often is the service provided? daily, weekly, monthly
- Integration of services
- Examination carried out
- Obstetrical & Medical history (As MOH Antenatal card
- Hgb, urine, wt, ht
- Blood Group & cross match
- Physical examination
- Odema
- Eyes for anemia & jaundice
- Tongue for digestive problem, dehydration & anemia
- Teeth for caries
- Glands for goiter (Neck)
- Breast exam, for appearance of nipple, lumps
- Palpation for fetal movement
- Fundal ht
- Position
- Engagement
- Abdominal scars
- Size of abdomen to assess twins, hydraminosis
- Pelvic assessment
  - Vaginal discharge
  - Hemorrhoids
- Inching
- Vitamin & Iron supplements
- Varicose veins
- Oedema any where
- Ankle oedema specially
- Health education
- Nutritional status

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Postnatal Check

Baby - Delivery time & place
- Problems they had
- Baby size
- Alive/still born
- Number
- General appearance
- Neonatal tetanus

Mother
- Health
- Breast
- B/P
- Wt
- Physical condition
- Urine
- Hg
- Genital tears
- Uterus size
- Lochia
- Hemorrhoids

Supportive services
- Transportation
- Funds
- Equipments & supplies (medicine)
- Lab-services

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3.2. CASE STUDY ON QUALITY ASSESSMENT

You have been assigned to head the supervisory team responsible f
MCH. You have the primary responsibility of preparing a check li
to assess the quality of Antenatal Case given by health station

TASK:- Prepare a check list for monitoring the quality
Antenatal Case.

Points for Discussion
on
Monitoring and Evaluation

You are given a task of monitoring and evaluation of the followi
services and activities:-

a) Growth Monitoring - Group 1
b) Antenatal Services - Group 2
c) CDD - Group 3
d) Family Planning Services - Group 4

Write down the indicators you would use to monitor and evalua
these programs and/or activities after 10 minutes of gro
discussion.

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QUALITY ASSESSMENT CHECKLIST FOR ANTENATAL CARE IN HEALTH STATION

I. IDENTIFICATION:

1. Health facility _____
2. Date _____
3. No. of Health Professionals in the Institution _____
4. Profession:- Nurse _____ Health Assistant _____
5. Name of PA's under the catchment area _____, _____, _____, _____
6. Total catchment area population:- _____
   (Male _____, Female _____)

II. BENEFICIARIES:- (Antenatal Care Attendants)

1. Routine examinations done for ANC attendants

   B/P _____, Wt _____, Ht _____

2. What are the commonly identified high risk factors?
   - Hypertension _____, - Anaemia _____
   - Height <150cm _____, - Antepartum Haemoohage _____
   - Repeated Abortion _____, - Mal-position _____

3. Do most pregnant women in your catchment area attend the ANC service? Yes _____, No _____

   If not why?

   Distance _____, Culture _____, Other _____

4. How many of the ANC attendants have got TT immunization?
   - TT_1 _____
   - TT_2 and$^+$ _____

5. What is the work relationship between the clinic and community health workers (TBA's/CHA's)

   by - Health Education _____
   - On Examining AN Women _____
   - Doing Home-visits _____
   - Report _____

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III. RESOURCES

1. Do you have ANC cards? Yes _____ N _____

2. Do some essential drugs are available for AN service? Fe 504, Antacids.....

Yes _____, No _____

3. Do you have materials for the service? " " Yes, "X" N

- Examination Bed _____

- Foetuscope _____

IV. HEALTH PERSONAL (PROVIDER)

1. Do you have any training on ANC?/Yes _____, N _____

2. Do you have any training on EPI?/Yes _____, N _____

3. How many sessions of ANC do the clinic has in a week _____

4. What are the common Health education topics on ANC?

a. _____ c. _____

b. _____ d. _____

V. REFERRAL SYSTEM

1. What is your nearest referral Health institution?

HC _____, Hospital _____, Othe _____

2. How many women were referred to a higher healt institution due to high-risk factors in a month _____

VI. SUPERVISIONS COMMENT, SUGGESTIONS ETC.

_____

_____

_____

Name of the Supervisor _____

Signature _____

Date _____

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Assessment Guide for PAC in Attot

This is a guide to organize your observation for the discussion of next thursday's Report. You may raise additional question.

Community Participation

1. Names of community organizations or structures established and the purpose, role for their establishment.

2. Who is responsible for establishing these community organizations or structures.

3. To the best of your observation are the community organizations functional?

4. What is the involvement of communities in the recruitment and maintenance of CHA and TBAs?

5. Is there community based mechanism for supporting CHAs and TBAs?

6. What is the mechanism for paying CHAs and TBAs?

7. What is the role of women's group in supporting TBAs?

8. What is the role of women's group in health activities?

9. Is there a mechanism for improving the economic life of women?

10. Who coordinates the activities of community organizations at the community level?

11. What is the role of community organization in PHC?

12. From the brief observation of Attat PHC, Is the experience of Attat replicable, sustainable in other areas? If No, Why not?

13. What mechanisms are in place for participatory planning with the community?

14. What role do the community members have in deciding on priorities for health actions?

15. How are community members involved in monitoring and evaluating their health programmes?

16. How were VDC's se up?
What information was given to them/
How did they elect their members?

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What benefits or problems have occurred because of thi approach?

17. At what stages of the planning process are communit members involved?

18. At what stages of the planning process are the VI involved?

19. What approach/methods does the team use to rais awareness concerning the need for communit participation?

20. What approach/methods do the team use to motivate peopl to act and sustain the action.

21. How do they assess/evaluate the empowerment of th community?(Indicators)

4.2. Organization and Management of PHC in Attat Analysis of PHC Components

1. Water Supply and Sanitation

- Safe water supply coverage - %
- Families who use latrine - %
- Who covers the cost and operation of the water syste
- How were communities motivated to build and use latrine.

2. MCH Services including EPI

- Pregnant women receiving *22^I^\ tal care - %
- Infant mortality rate /1000
- Maternal mortality rate /1000
- Children under 2 years immunized - %
- Women practicing natural family planning services -
- Women delivered by trained TBAs - %
- % of TTBA involved in health activities other than birth attendance
- What is the role of women's group in MCH?

3. Nutrition

- % of children <5 years below 80% W/A
- % of children with malnutrition who attend nutritiona rehabilitation services
- Type of staple food.
* Who is the main promotion of tac NR H/E

4. Health Education

- Who is responsible for health education?

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- What is the main forum for giving health education?

- Is there any indication to show that families in Attat observe better personal hygiene practices?

- What health education topics are usually covered?

5. Treatment of Disease

- Do families in the village have access to health services?

- Are there community health posts in the villages?

- What are the services provided by health posts and/or CHAs?

- Are the health posts regularly visited?
  If Yes by whom?

- Is there a referral mechanism?

- Who pays for the medical services patients get?

- What are the major diseases and services provided by health posts?

- What is the population coverage of a health post?

- Who pays the maintenance allowance of CHAs?

- Are there traditional healer? What is their relationship with the health system?

6. Drugs

- Who supplies drugs to health posts?

- Who pays for the cost of drugs?

- Is there a revolving drug fund?

7. What is the cost per person for PHC services?

These are, but few of the questions you may be interested to get answers for. You may think of other questions.

*At the end, how do you grade the level of PHC in Attat?

Good _____ Fair _____ Poor _____

If Good, mention at least five reasons for the success.

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If Poor, mention the problems associated with t implementation.

5. REPORT OF PARTICIPANTS ON ATTAT PHC PROGRAM

5.1. PHC ORGANIZATION AND MANAGEMENT IN ATTAT

S:A I village is one of the four village located in the distance 1 km from Attat hospital. The weather condition is semi-lowlan It consists about 83 household total population 504 of 212 a Males and 292 are Females. It is a village in line no body liv scattered.

People grow Inset, Chat, Coffee tree, Orange, Papaya, Cabbag Maize and Potato. There are livestokes at each house.

PHC Service

VDC (Village Development Committee) was established 7 yrs ago, the community. The formed committee has 5 member one women a four men.

Women groups were established 7 yrs ago. Now there are 72 wor organized in 12 sub groups.

AIM of VDC

- Build and maintain village health post
- Leadership for all village activities
- Water maintenance
- Collect funds for TBA & CHA
- Pit latrine construction, use village health post.
- Encourage the use of a health post and administer the health post.

The village has one health post run by CHA & TBA also used meeting place for VDC & Womens group. The health post is open fr 8:00 - 10:00 a.m. daily five days/week.

Water Supply and Sanitation

The community contributed about 2,000 Birr the rest of the expens were covered by Attat Hospital. The running cost is covered the community they have water attendant who is paid 20. Birr/month through VDC. They are depending on Attat hospital f maintenance and technical support.

. All families own and use pit latrine.

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MCH

Full EPI coverage and low Infant Mortality rate is reported. The TBA is new. She attended only one delivery. Natural Family Planning is reportedly high, but cannot be easily confirmed because women keep such practice secret. The TBA working at the Hp. daily 9-10 a.m. five days/week. Every home is visited once in two weeks.

Home visiting every two weeks

Women's Group

- Have influence on EPI, they are the main promoter for health activities, health education.

Nutrition

- No growth monitoring done currently for the last 3 months.

Health Education

- Mainly the womens group responsible of HE. They have full participation through sub-groups.

Indicators of Success

- Improved environmental sanitation
- Good personal hygiene
- Full EPI coverage
- Low morbidity and mortality rate

Common Topics for H.E.

- TB, Trachoma, Malaria, Natural family planning Environmental Sanitation, EPI.

They have access to the health post and hospital including referral system from the health post to hospital. Simple RX at the health post commonly disease treated at HPs Intestinal parasite, Malaria eye disease and minor wound - payment 25 cents/person.

In general Attat Hospital doing a very good work in that area for the following reasons:-

- Most of the PHC components are implemented
- Community involvement is very good
- There is good communication & relationship between Attat and the community
- It is accessible, affordable and acceptable health services
- The community is empowered

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All activities have relatively some community material a financial input.

Recommendation

- Improve supervision on sanitation especially on latrine usage
- Consider drug revolving fund
- Emphasize on sustainability of all activities by encouraging more community input

5.2 Problems identified by health workers, Government officia and NGOs

- Very low motivation
- Discouraged
- No hope
- Budgetary constraints
- No practical examples
- Supervision to-down, no education
- Low salary
- Fear and insecurity
- Maldistribution of health institution
- Poor inter sectoral collaboration
- Interference of administration - vehicles
- Superficial knowledge in PHC
- Shortage of trained manpower
- Lack of awareness in PHC
- Lack of self confidence
- Un skilled approach to the community
- Lack of skill in community assessment
- Poor participation
- Lack of skill in participatory planning
- Poor management

5.3 LESSONS/ISSUES

How to work with the Community?

1. Mobilization of the community (LEPSA)
2. Creative ways to overcome budgeting constraints
3. Supervision
4. Concepts and principles of PC
5. H/A role in communication for action
6. Community health diagnosis
7. Mobilization of resources
8. Communication skills for rural community
9. How to upgrade/strengthen routine PC activities, eg. EPI
10. Experience sharing
11. Participatory planning and management
12. Co-operation and delegation
13. Work ethics
14. Duties and responsibilities

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5.4 PROBLEMS IDENTIFIED BY CHAS' TBAS AND RELIGIOUS LEADERS

- Poor support and follow-up - GOVT.
  - NGO
  - COMM.
- CHA's not recognized by Comm.
- Lack of resources for CHA's
- Poor CHA selection
- No acceptance
- No training in community based development
- Poor motivation (No Salary)
- Poor participation from community
  - Vaccination programme
  - House cont. for CHA/TBA'S
- Expect incentives - compare with others eg. f/w
- Payment according to ability
- Community hasn't organized pay
- Poor motivation by community
- Bad experiences
- False promises

Lessons Learned from Attat PHC Programme

1. Community Participation

1. Structures

- PA (Government Organization)
- VDC Cooperation
- Womens group (Attat Hospital)
- Religious organization

2. PURPOSE

. PA For permission to work with the villages in new places, now they also select VDC.

. VDC To mobilize the community
Supervise TBA's and CHA's
To ensure implementation of the programme
To collect funds for CHA's, TBA's and Water Supply Structure for participatory planning

. Womens Group - Improved health of women
- To empower women
- To promote womens activity in Dev.
- To promote self support
- To give health education

. Religious Group - Co-operation for development activities
Eg. Nursery, Well-digging

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b. ROLES

. PA Practically, No integration in PC programme
. VDC As stated above and registering people
. WOMENs Group - Health education Eg. Nutrition, Hygiene e
- Loan scheme for economic development
- To give moral support to each other
- To develop sense of dignity and responsibil for their own environment
- Control over their own fertility

. Religious Group - Technical support

c. Benefits of the Community Participation Structures

- Promotes changes
- Enables health personals to reach the people
- Promotes empowerment and sustainability at village leve

d. Constraints

- Government structures is not utilized this may affect longterm sustainability

2. Participatory Planning

a) Mechanisms

. Approach community through PA
. Start EPI programme or survey
. Discuss with village leaders - Inform about VDC
. Comm. meeting - Discuss selection of VDC members
. Monthly planning meeting (Attat, VDC and Community

b) Election

. Information and criteria comes from Attat
. Comm. elects VDC (new places PA may do it) CHA's a TBA's
. Comm. has the right to change them if they don't d their work properly

c) Educational Training for Practice. Training

. No training for VDC's
. Attat staffs trained in Delta in the last 2 years

d) Functions of VDC in participatory planning

. At all stages

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e) At community level

- In some at all levels, and in others participation is limited to implementation and evaluation

f) Benefits

- Promotes sustainable change
- Promotes sense of ownership
- Promotes empowerment
- Motivation to implement discussions

g) Constraints

- Attat suggests the criteria, the people not understand the reasons for the criteria and they don't select the right people (causes many changes)
- No training for VDC
- Having only 1 women and 4 men in VDC
- Authrterian leadership style at VDC level

Motivation and sustainability

a) Motivation stables and factors

- Reward and punishment style from Attat
- Great encouragement and support from Attat
- Benefits - The community draw from Attat Hospital
  - Reffered patients from HP pay very little
  - Safe water
  - Health service
  - Loan money

b) Sustainability

- Build own health post
- CHAs and TBAs paid by the community
- CHAs and TBAs training paid by comm.
- Supervision done by VDC and comm.
- Buying medicine by themselves
- Contribution towards all activities - Eg. water maintenance
- Loan money is revolving fund and women pays 25 cents in every meeting to raise the loan fund
- knowledge of health (How to improve)

c) Benefits

- People are very motivated because of benefits and success
- People are developing habits in practicing health behaviors
- Good health education promotes sustainability

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d) Constraints

- Reward and punishment method (style). The participar were unsure of the factors which led to the obser changes:-

  1. Is it fear of punishment? (fear of losing serice)
  2. Conscious attempt to change.

- Ques. Are people changing behavior because they wa benefit or fear punishment or because they understand t need for the change?

  3. Has Attat created a psychological dependency on t community?

4. Women's Participation

a) On Decision Making Bodies

- There are very few females in the VDC (1/5)

b) Health Education and Activities

- To the women's groups
- Some CHA's are women and TBAs

c) Support for TBAs

- Providing payment through the VDC
- Providing gifts to TBA's on delivery
- Moral support

d) Economic Development

- Loan schemes

e) Fertility Control

This is an area declared successful but hard to confirm ot than the low reported birth rate which is an indirect measu

5. The Role of Attat Hospitals PC Team

- Facilitate community participation
- Training CHA's, TBA's
- Formulating women's groups
- Village level health education
- Advising and educating VDC's
- Supporting village level activities
- Providing loan schemes

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- Facilitated assistance from other organization
- Reporting to Donor's
- Preparing projects
- Coordination with MOH
- Conduct surveys
- Doing EPI programme
- ANC?
- They give rewards with hold benefits

Replicable Activities

- Community participation/planning
- Our commitment and vision to help our people progress
- We need committed staff (attitude training)
- Lapse approach
- Women's groups

5.6 CONSTRAINTS

- No extra resources
- Wide target area
- Rapid staff turn over
- Staff motivation and commitment
- Poor incentive system to motivate CHA's and TBA's
- Un helpful organizational polices (the need for clinics to be totally self supporting)
- Staff work load in some places
- Extra staffs or separate staff needed for PHC work
- Extra separate budget for PHC

ACTION PLAN PREPARED BY PARTICIPANTS

6.1 CATHOLIC CHURCH

OF ACTION:-_____ DATE:- _____

Refreshment Training Programme for TBA's

- To achieve the expected service form the TTBA's.
- To improve the existing problems of delivering.
- To improve the adjustment weakness of the TTBA's with that their great responsibility.
- To motivate and strength TTBA's towards to PC service.

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NEED ACCESSEMENT

Lack of health facilities in the community
Lack of community participation
Lack of interests
Mobilization of resources
No acceptance
Community has not organized PC

TOPICS

Health education
Immobilizing the community
Management of normal delivery
Communication skills

TEACHING METHODS

Demonstration two way communication, and
Rolling play by common language
Experience sharing

TEACHING AIDS

Black board
Story telling
Group discussion
Audio visual
Drawing picture
supplying posters for group discussion

Participants:- 10 TTBA's from different medabors

Duration :- For 5 working days

Place :- At wereda clinic

Facilitators are:- C.R.S. training facilitators

Fund allocated from C.R.S for training.

The required fund management or accounting table is:-

Budget Line	Perdiem Daily	No.		Total
1. Trainer	30	2	5	300
2. Participants	10	10	5	500
Total				800

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Stationary

Item	Quantity	Each Price	Total
1. Writing Pad	5	5.00	25
2. Pen	5	1.00	5
3.	10	3.00	30
4. Markers	5	7.00	35
			95 Birr

Time Schedule for Lesson:-

Health Education	10 Hours
Immobilizing Community	7 "
Management Normal Delivery	16 "
Communication Skills	7 "

PLAN OF ACTION FOR PC MANAGEMENT TRAINING

FREEDOM FROM HUNGER CAMPAIGN - ACTION FOR DEVELOPMENTS (FFHC/AD)

I. PARTICIPANTS:

- CHA's, TBA's and community elders
- 20 in Number (10CHA's, 5 TBA's, 5 Elders)

II. AIM OF THE TRAINING:

a) To enable and empower the community health workers and other participants implement PC effectively and make decisions in health related issues respectively.

b) Raise the awareness of participants on PC Management.

III. METHODS FOR SELECTING PARTICIPANTS:

a) Actively functioning CHW's from sites of project.

b) Respected and trusty community elders.

c) Priority is given for a sites, where PC management can be implemented at low-cost, near areas .... etc.

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4. TRAINING NEEDS ASSESSMENT:

Because there is:-

a) Low or very limited concept on PC.

b) Irregular or No follow-ups and supports to CHW's Government community itself and NGO's.

c) Lack of resources.

d) Low community participation in planning implementing evaluating PC activities.

e) Poor communicational ways.

f) Lack of community organizations.
EG:- Health Committee's

g) Negative attitude on CHA's and TBA's.

5. CONTENTS OF THE TRAINING:

- Introduction and overview on PC - (2 HRS)
- Aim /Objective/ of this training - (1 HR)
- Briefings on the 8 PC components - (8 HRS)
- Participatory planning, implementing and evaluating HRS)
- Empowerment and community awareness - (2 HRS)
- How to set-up village health committees - (2 HRS)
- Mobilizing community to support CHW's & Approach HRS)
- Sustainability - (3 HRS)

6. METHODOLOGY:

- Pre-test
- Questions and Answer
- Lepse (Comm. Awar. M.)
- Experience sharing (Practice)
- Role-play
- Group Discussion
- Post-test

7. COURSE DURATION AND PLACE

. 4 Days at _____

8. RESOURCES:

A) Financial - Available _____
- Needed _____

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. Perdiems for participants & 2 trainers
. Transportation of participants & 2 trainers

B) Stationeries - Available _____
- Needed
. Ex-books
. Ball-points
. Handouts

C) Teaching AIDS - Available
- Needed
- Markers
- Flip charts

D) Training Hall - Available:- Room, Seats, Tables
Needed _____

E) Man-power - Available _____1_____
Needed _____2_____

NOTE:-

1. The payment rate will be according to the usual projects standard.

2. The implementation of this action plan will be practical only when funds are obtained, and probably for the coming year.

3. The time table could be prepared according to the hours of each lesson.

DATE:- June 9th, 1994

ZONE:- Kambata, Alaba & Tembaro ZHD.

- Workshop on primary health care management.
Duration of training - 7 days
Place - Alaba town

- Participants:- 24 health workers from governmental and NGOs health institutions.

- Objective:
- to equip health workers and knowledge, skills and attitudes to strengthen community based health service

- Specific Objective:
- to enable participants' competence in PH activities operation
- to help them acquire knowledge and skills in PC management
- to develop attitudinal and behavioral changes toward PC development

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- Trainees' need assessment:
  - Unskilled approach to community
  - Absence of awareness of community
  - Lack of interest motives and devotions
  - Lack of proper supervision style
  - Inadequate methodological concepts and principles of
  - Difficulties in reaching access pop.

- Subject matter (topics) to be covered during the Workshop:
  - Concepts and principles of PC
  - Participatory planning and management
  - Experience sharing
  - How to mobilize local resources and work ethics
  - Community health diagnosis
  - How to strengthen the routine MCH/F.P. activities
  - Intersectoral collaboration
  - Health workers' role of communication in primary heal care
  - Mechanisms to overcome budgetary constraints

- Resources:

The ZHD has: - human resource (facilitators)
- one vehicle
- black board
- chalk
- place to train

The ZHD needs - financial support
- handouts, posters,

- Participants:

Govt. - 11 H/As from 11 H/S
3 Nurses from 3 H/CS
3 from Z.H.D.

Different NGOs 9 H/As from 9 h/S

Total No. of participants - 26

Facilitator 3

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Per diem for 7 days

- Participants 26 x 7 x 24	=	4,368.00 Birr
- Facilitators 3 x 7 x 30	=	630.00
Stationery		
- Writing pad 29 x 6	=	174.00
- Pen 29 x 1	=	29.00
- Pencil 29 x 0.50	=	14.50
Transportation for participants		
- 26 x 15	=	390.00
Fuel 100 liters x 1.46	=	146.00
Refreshment		
Before noon 29 x 1 x 7	=	203.00
After noon 29 x 1 x 7	=	203.00
Sub total		6,157.50
Contingency 10%	=	615.00
Grand total		6,772.50

(Six Thousand Seven Hundred Seventy Two Birr & 50/100)

SLA. SOUTH CENTRAL SYNOD
SOUTH WEST SYNOD
SOUTH ETHIOPIA SYNOD - EECMY CENTRAL OFFICE

PREPARATION PLAN OF ACTION FOR PC MANAGEMENT TRAINING FOR THE RESPECTIVE INSTITUTIONS

1. Participants - Health assistants from the clinics and woreda leaders.

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2. Aim - To have the necessary knowledgs, attitude and ski
PHC.

- To facilitate implementation of communities based

3. Training need assessment
What are the reasons that prevent implementation of comm
based PC?

4. Objectives -

- To be able to list and describe the complements of

- To be able to demonstrate the approach to particip
planning with the community.

- To describe the structures and process involve
participatory planning working together with
organization.

  - Need assessment
  - Prioritizing
  - Planning (programming activities)
  - Implementation (supporting & motivating TB
CHAs)
  - Monitoring

- To be able to describe the process for integ
services provision by the synod

5. Target Groups -

1. Health workers and woreda health leaders

2. Woreda via head of council

Contents:-

Day 1. Team building

- Introduction
- Pretest (personal experience of PHC)
- Problem needs identification

Day 2. Community based PHC

- What is PHC
- The needs for community based PHC
- The components of PHC

Day 3. Approaches for community based PHC

- Empowerment
- Communication skills
- Integrated approach

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Day 4. LEPSA method for participatory planning in the community

Day 5. Structures and processes for participatory planning

- How to work together with the community organizations?
- How to do a community assess

Day 6. REPORT BACK

Day 7. How to make a good decision when setting priorities
- Analysis of data from practical

Day 8. Programming & organizing solutions with the communities

- Working together with CHA's and TBa's
  - Selection, motivation, sustainability

Day 9. Participatory monitoring & evaluation

Day 10. Conclusion

6.5 HADIA ZONE HEALTH DEPT.

Hadia Zone/MOH Training Programme on Primary Health Management advancement workshop which will be held at Hossana Town for 7 days in Hossana Hospital auditorium.

1. General Objective

a) To select and train 25 health workers from government and NGO's health stations, health centre and hospital.

b) To strengthen community based PHC health services.

Specific Objects:-

1. To help and acquire participants knowledge and skill in PHC activities.

2. To maintain and develop attitudinal change as well motivation.

2. Trainers need assessment

Problems of priority

1. To equip them with methodological concepts principles of PHC.

2. Unskilled approach to the community.

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3. Difficulty to reach access pop.

4. Inadequate community awareness about PHC activities.

5. To train and use supervises CHAs and trained traditic birth attendants.

6. Lack of interest and motivation.

7. Lack of proper supervision of health units and commu health services.

8. Lack of resources.

3. Lessons to be covered in workshop

1. Duties and responsibilities of health workers in activities.

2. Concepts of PHC components.

3. Participatory planning and management of PHC.

4. Cooperation and delegation of staff, and other sect

5. How to mobilize the resources and work ethics of st

6. Discussion of experience sharing.

7. Community health diagnosis.

8. How to strengthen the routine PHC programs.

4. Resources need (Participants)

1. Human	-	From Gov. H.Stion	=	13
	-	From NGOs H.Stion	=	7
	-	From Hospital	=	1
	-	From Health Centre	=	1
	-	Zonal Office	=	3
		TOTAL		25

2. Perdiem for participants - 25 x 7 x 24 = 4,200.00
Perdiem for facilitators - 3 x 7 x 32 = 672.00

TOTAL 4,872.00

3. Stationary

1.	Writing pad	30 x 6	=	180.00
2.	Pen	1 x 30	=	30.00
3.	Paper	30 x 1	=	30.00
4.	Pencil	0.50 x 30	=	15.00
	TOTAL			255.00

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4.	Transportation fee 30 x 10 =	300.00
	Fuel for Cars 200L x 1.40 =	314.00
	TOTAL	614.00
5.	Recreation - AM 30 x 1 x 7 =	210.00
	PM 30 x 1 x 7 =	210.00
	TOTAL	420.00

5. Total Input

1.	Perdiem	4,872.00
2.	Stationary	255.00
3.	Fuel & transportation	614.00
4.	Recreation	420.00
5.	Contingency	616.00
	TOTAL AMOUNT NEEDED	6,777.00

Teaching Aids Available:- 1. Overhead Projector
2. Black Board
3. PHC Poster

Resources Needed:-
1. Films
2. Slides
3. PHC Hand outs
4. Markers (Different Size)

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MSF (HOLLAND)

6.6 PRIMARY HEALTH CARE TRAINING PROGRAM

BACKGROUND

Medicine San Frontiers (MSF, Holland) is an organization working on an emergency situation in Ogaden region (5) since 1992 - January 1994. Then after the organization started new project in the same region mainly on rehabilitation of health infrastructures. MSF covers large area of the region by supporting all the activities in the existing eight MOC clinic, namely Bare, After, Hargelle, Cheretti, Elkere, Dollo bay, Dollo odo, Suffu.

It also involved on training of TBAs, CHAs and on job training of health assistance, to have skilled man power to start integrated health service. After maintenance and equipping the clinics with necessary materials.

At the moment there is no supervisions by MOH regional or Z level many of health assistance are demotivated due to var reasons and majority of them are focus on curative aspects, lost work interest, because of working for many years at the place and position.

Based on the above mentioned situations it is good to train who are working in the area to start PHC services.

GOAL AND OBJECTIVES

GOAL

The goal of the training H.A. on PHC is

- To equip the H.A. with knowledge skill and attitud PHC and enable them to implement it.

OBJECTIVES

a. To train 10 HA selected from each clinic in the area.

b. To help the HA to get knowledge and skills on PHC implement on their respective areas.

c. To enable the HA on need assessment of the commun planning, organizing and implementing PHC by involving communities at all level.

REASONS FOR TRAINING

- They are completely forgotten by MOH or neglected.
- No supervision _____, Zonal health team which is supp to do it. Not yet established because of various reaso
- They worked in that remote area for many years and no them called for refreshment courses by MOH.
- They are the Health personal who are at the operational l where the PHC can be started to be implemented.

PROBLEMS WHICH MIGHT PREVENT IMPLEMENTATION OF PHC

- Salaries of H.A are not paid in time.
- They don't have material support from RHD regularly.
- Assignment of untrained person by RHD as a clinic manag
- Frequent changes of governmental policies.

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TOPIC

- Introduction of PHC
- Objective of PHC
- Components of PHC
- Implementation of PHC
- Importance of community involvement at all level for PHC to be implemented
- Assessment of needs of the community, planing organizing - implementing

METHODS OF TRAINING

- Lecture, and Lapse method
- Group discussion
- Demonstrations
- Roll plays
- Problem solving assignment

TEACHING AIDS

- Video show, pictures
- Posters, Fillip chart + Black board
- Handout for reference

FACTORS TAKEN IN TO CONSIDERATION

- H.A.
  a) Not too aged
  b) Willing to stay in the area
  c) Extra person has to be in the clinic not affect the service
  d) Has interest on the subject
  e) Level of education - Trained or
     - By experience of long year

RESOURCE

Available - Room
- Black board - Chart
- Transport
- Video

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Needed

- Man power — 2 Facilitators
- Finance for materials
  - Stationery + paper for handouts
  - Posters - Flip charts
  - Video casetts, concerning the subj
  - Folder for handouts
  - For participants/perdiem
  - For facilitators/perdiem

TRAINING WILL BE CONDUCTED FOR FIVE DAYS

Day One

8:00	-	8:15	Attendance
8:15	-	9:00	Well Come Address
9:00	-	10:00	Aim of the workshop
10:00	-	10:30	Coffee Break
10:30	-	12:00	Introduction to group interaction and pre on PHC
12:00	-	14:00	Lunch Break
14:00	-	15:00	Assessment of the need of participants
15:00	-	15:30	Coffee Break
15:30	-	17:00	Introduction PHC

Day Two

8:00	-	8:15	Attendance
8:15	-	9:30	Objective PHC
9:30	-	10:00	Why PHC is not implemented (group discus
10:00	-	10:30	Coffee Break
10:30	-	12:00	Components of PHC
12:00	-	14:00	Lunch Break

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14:00	-	15:15	Component of PHC
15:15	-	15:30	Coffee Break
15:30	-	17:00	Problem solving on PHC (team work)

Day Three

8:00	-	8:15	Attendance
8:15	-	10:00	Con. Component of PHC and team presentation
10:00	-	10:30	Coffee Break
10:30	-	12:00	PHC planning and implementation
12:00	-	14:00	Lunch Break
14:00	-	15:00	PHC implementation
15:00	-	15:30	Coffee Break
15:30	-	17:00	Assessment need of the community

Day Four

8:00	-	8:15	Attendance
8:15	-	9:00	Group discussion
9:00	-	10:00	Importance of community involvement
10:00	-	10:30	Coffee Break
10:30	-	12:00	Continue on community involvement
12:00	-	14:00	Lunch Break
14:00	-	15:00	Group discussion
15:00	-	15:30	Coffee Break
15:30	-	17:00	Individual assignment (to work on PHC implementation on their respective area)

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Day Five

8:00	-	8:30	Attendance
8:30	-	9:00	Submission of the assignment
9:00	-	10:00	Group discussion
10:00	-	10:30	Coffee Break
10:30	-	12:00	Post test and provision of prepared materia
12:00	-	14:00	Lunch Break
14:00	-	15:00	Closing Address
15:00	-	15:30	Good buy Coffee Break

6.7. FHI

PHC Management Advancement Programme

Training - To train 3 health educators 3 CHA & 2 TBA 4 Communi Members from VHC.

Goal and Objective of Training

- To help participants acquire knowledge and skill in Prima Health Care.
- To enable and empower participants to implement PHC servic effectively in their respective village.

Method of Selecting Participants

- CHA & TBa - from our catchment area where PHC is going on.
- health Educators - staffs who are working in FH/E H/Educati activity.
- Community members - those who are selected by the communi for VHC activity.

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Issue - 1. Introduction and overview on PHC principle 1/2 day

- 2. Objective and Goal of the training 1/2 day
- 3. PHC components - 2 days
- 4. Participatory planning, implementation and evaluation
- 5. Sustainablity, empowerment, comm. approach

Training time - 10 days 1/2 + 1/2 + 2 + 3 + 3 + 1 for closing ceremony

Time frame - 9 a.m. - 12:30 p.m. 2p.m. - 4:30 p.m.

20 minutes for tea break in the mornings and afternoons.

Method of Training

- Pretest
- Lecture
- Lapse
- Question and Answer
- Experience Sharing
- Group Discussion
- Roll Play
- Post Test

Resource - Available - Training Venue

- Perdiem for 3 H/Educators
- Transport
- Stationeries

24 Ex. Books, 12 pens, 12 pencils, 3 pkt typing paper for hand out

12 flat file

12 fasteners

Available - Teaching Aid - Poster, Leaflet, Black board and Chock

Resources Needed - 2 Trainers (MOH)

- Perdiems for 9 participants and 2 trainers

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Participant perdiem - 12 Birr per person per day

Trainers - 24 Birr per person per day

12 x 9 x 10 = 1,080 Birr for participants

24 x 2 x 10 = 480 Birr for trainers

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