

PDAAT-828

12n-46043

9365927

DEVELOPMENT OF
CHILD HEALTH STRATEGY
FOR OMAN
INTERIM REPORT

A Report Prepared by PRITECH Consultants:
DON CHAULS
NED WALLACE

During The Period:
JULY 10 - 28, 1985

TECHNOLOGIES FOR PRIMARY HEALTH CARE (PRITECH) PROJECT
Supported By The:
U.S. Agency For International Development
AID/DPE-5927-C-00-3003-00

AUTHORIZATION
AID/S&T/HEA: 12/17/85
ASSGN. NO: DC 117

TABLE OF CONTENTS

	<u>PAGE</u>
I. EXECUTIVE SUMMARY	1
II. BACKGROUND	1
A. Narrative	1
B. Important Considerations	3
III. DOCUMENTS	4
A. Draft Outline of Five Year Child Health Plan	4
B. Planning Process for the Five Year Health Plan	7
C. Plan for Training of Trainers of Low Level Health Workers	10
D. Working Draft Outline for National ORT Program	13
E. Proposal for Future PRITECH Technical Contribution to the Oman Program	17
F. Draft Terms of Reference for Child Health Program Planning Team	18
IV. CONTACTS AND VISITS	22
V. REFERENCES	23

I. EXECUTIVE SUMMARY

The following assignments were completed during this consultancy to Oman, for the development of a Child Health Strategy.

1. Assist Omani Ministry of Health develop a planning process by December, 1985; a strategy and a work plan for a 5 Year Child Health Program to relate to Oman's third 5 year development plan (1985-1990).
2. Identify technical assistance requirements to support this planning process. Write terms of reference for technical assistance personnel.
3. Contact and coordinate planning of this technical assistance with WHO, UNICEF, and other relevant participants.
4. Produce four documents:
 - a. A description of the planning process;
 - b. A first draft of the outline of the 5 Year Child Health Plan, including a more detailed outline of the CDD/ORT section of the Plan;
 - c. A proposal, including a budget, for future PRITECH contributions to the Oman program; and
 - d. A plan for training low level health workers, primarily for CDD efforts, to begin prior to the 5 Year Child Health Program.

II. BACKGROUND

A. Narrative

Efforts to expand the acceptance and use of ORT began in Oman in 1981. Dr. M. Boually, an Omani Senior Pediatric Consultant in the Ministry of Health, initiated change in the traditional treatment of acute diarrhea in response to a major health problem in children. He has remained the primary force behind expansion of efforts to increase the use of ORT in health establishments and in homes.

Recent reports by UNICEF (1), WHO (2), and Dr. Jon Rohde (3) convey historical and statistical information related to diarrheal diseases in particular and child health in general. The triad of malnutrition, respiratory and diarrheal diseases has been the major cause of infant deaths which were reported to be 128/1000 in 1984.

-
- (1) Plan of Operations - Child Health and Development Program in the Sultanate of Oman, 1985 - 1987.
 - (2) Assignment Report Control of Diarrhoeal Diseases in the Sultanate of Oman, 1984.
 - (3) Oral Rehydration Therapy Program, A Self Reliant Study of Child Health Services in Oman, 1983.

The Ministry of Health adopted a general plan of action in 1984, along guidelines recommended by WHO for a National Control of Diarrheal Diseases Program (CDD). That action plan has provided a useful framework for the development and presentation of training programs for senior health workers, and subsequent training of lower level health workers. A number of activities within the ORT program have already been completed or are now underway. However, these fall far short of providing universal coverage.

UNICEF made a significant 3 year program commitment in Oman, in 1984, with CDD/ORT as one of the major components. The major UNICEF contribution already begun is the development of mass media information and education materials. Expanded efforts by UNICEF are anticipated later in 1985.

In February, 1985, a Task Force was established in the Ministry of Health to develop a long term Child Health Plan to coincide with the new government Five Year Development Plan (1986 - 1990). The Task Force will present the draft Five Year Child Health Plan for the Planning Committee of the Ministry of Health. No definitive deadline has been set for the completion of the Plan. It is expected that early in 1986 the Sultan of Oman will announce the Five Year Child Health program as a major health initiative in the country.

In 1984, the MOH requested technical assistance from the Omani-American Joint Commission for Economic and Technical Development, the organization in Oman responsible for development and administration of USAID programs.

Dr. Ron O'Connor, President of Management Sciences for Health, visited Oman briefly in May 1985, to assess the feasibility and appropriate type of technical assistance required by the MOH.

One of his recommendations suggested a 2 - 3 person team to work for a total of 10 - 12 person weeks: to assist the MOH complete its National CDD/ORT Plan; to devise a practical, collaborative planning process for the Five Year Child Health Program; and to determine future technical assistance requirements.

Dr. Wallace and Dr. Chauls were selected as consultants. However, other commitments and visa delays resulted in a significant decrease in the amount of time available to complete the above tasks. It was felt, however, that a shorter visit could be productive and if necessary some of the tasks could be completed in September.

The documents enclosed and the recommendations therein have been prepared in a priority order which will permit completion of the original tasks as well as provide valuable support to the MOH in the preparation of the master Five Year Child Health Program.

With the explosive increase of health facilities and services in Oman during the past 15 years, the MOH has not been involved in any long term, extensive health planning exercise. The MOH commitment to this 5 Year Child Health Plan provides a unique opportunity to facilitate the development of planning skills and experience by Omani health professionals, while at the same time providing a framework and guide for expanded and improved child health services.

The initial focus on Oral Rehydration Therapy permits the establishment of a needed technology as well as a useful introduction to the planning process. It is anticipated that there will be a need for ongoing, periodic technical assistance in the implementation, monitoring and evaluation of the Plan. Details for appropriate future involvement by the Joint Commission will become apparent during the planning phases of the program.

The successful completion of planning for child health can provide the stimulus and confidence within the government to consider a comprehensive national health plan which would significantly increase the effectiveness, efficiency, coverage and impact of government health services.

B. Important Considerations

Several factors should be considered in selecting dates for the planning exercise:

1. Increasing security concerns in Gulf countries has resulted in a longer approval process for visitors entering the country.
2. The Gulf Cooperation Council Meeting scheduled for mid-November will probably result in a refusal of visa applications throughout October and November and possibly late September.
3. The Ministry of Health is genuinely concerned about the qualifications of consultants, and apparently carefully reviews the resumes of consultant candidates to ensure adequate training and experience.
4. The present visa approval time is estimated to be 4 weeks with a possibility of extension in the near future to 6 weeks. This means that for PRITECH consultants to arrive by mid-September, visa requests should be submitted by early or mid-August. Therefore the time available is quite limited to identify and recruit high quality consultants for 4-6 weeks of work.
5. To avoid unforeseen and perhaps unavoidable delays, postponing the planning exercise to December or January would be a possible alternative.

III. DOCUMENTS

Draft Outline

A. Child Health Plan 1986 - 1990

Ministry of Health
Sultanate of Oman
July 1985

PART ONE

- I. History and Current Status
 - A. The Health of Children in Oman
 - B. Child Health Problems and their Determinants
 - C. Public Sector Policies and Programs to Improve Child Health
 1. Control of Diarrheal Diseases
 2. Expanded Program of Immunization
 3. Tuberculosis Control
 4. Malaria Control
 5. Trachoma
 6. Health Education
 7. Maternal Health Services
 8. Curative Services: Ambulatory and Hospital
 9. Ministry of Defense: Preventive and Curative Services
 10. Ministry of _____: Water and Sanitation
 11. Ministry of Education: Female Literacy
 12. Ministry of Social Affairs: Community Development
 13. Other
 - D. Resources Available for Implementation of Child Health Activities
 1. Personnel
 2. Facilities and Equipment
 3. Financial

E. Management Systems Used to Employ These Resources

1. Planning
2. Finance/Accounting
3. Training
4. Supervision
5. Public Information and Education
6. Supply and Logistics
7. Health and Management Information/Evaluation
8. Operational Research

F. Management Structure to Direct and Coordinate These Management Systems

G. Private Sector

1. Resources
2. Activities

H. Priority Problems and Major Constraints

II. Analysis of Current Situation

- A. Major Constraints
- B. Priority Problems

PART TWO

III. Goals, Objectives and Targets of the Child Health Program

IV. Strategies to Achieve These Objectives (See Annex 1)

V. Activities to Achieve These Strategies

VI. Management System Requirements to Achieve Each Objective

- A. Planning
- B. Finance/Accounting
- C. Training
- D. Supervision

- E. Public Information and Education
- F. Supply and Logistics
- G. Health and Management Information/Evaluation
- H. Operational Research
- VII. Resource Requirements to Achieve Each Objective
 - A. Personnel
 - B. Facilities and Equipment
 - C. Financial
- VIII. Structural Organization
- IX. Intragovernmental and Private Collaboration
- X. External Agency Participation
- XI. Implementation Plan and Budget
- XII. Program Review, Evaluation and Revision

Annexes

B. Planning Process for the Development of a National Five-Year Child Health Plan

1. Basic Principles

The basic principles behind this suggested planning process include the following:

- ° Decisions are to be made by Omanis only.
- ° As far as feasible, ideas for the content of the plan should come from Omanis. The second most important source for ideas should be the expatriate health professionals who have been working long-term within the Omani health system.
- ° Effective planning requires an active interaction over time among a number of people; it cannot be done by one person alone.
- ° To ensure that it is realistic, reactions to draft versions of the plan should be elicited from some of the people who will be expected to implement it.
- ° Every aspect of the plan should undergo at least one revision before it is accepted.

2. Planning Team

The first task in the planning process is to establish a Child Health Planning Committee; this has already been accomplished. The committee consists of key personnel from the MOH, as well as representatives from WHO and UNICEF. Among other responsibilities, its assignment is to prepare and present to the Minister of Health a Five-Year Child Health Plan.

The planning committee has assigned a small sub-committee of its members (the Working Group) the major responsibility of drafting this plan. It is desirable for this Working Group to have access to ideas from both central MOH personnel and field personnel, as well as from representatives of relevant multinational and bilateral organizations. If it is not possible to formally add field personnel to the Working Group, it might be possible for the Working Group to conduct many of its meetings away from the capital where it can draw upon expertise of personnel from the local hospital and PHC (to ensure continuity, it would be helpful to select one community which is reasonably near the capital and contains experienced, articulate individuals in both the hospital and PHC).

Additional individuals should be brought temporarily into the Working Group for meetings which concern their areas of responsibility/expertise. This is especially desirable for some of the administrative aspects of the planning, on topics such as personnel, finance, and logistics.

A team of short-term consultants is expected to be added to the Working Group to assist it in the planning process. Terms of reference, types of expertise required, and timing of these consultants are presented in Annex 1.

3. Initial Activities

At its first meetings, this Working Group should:

- ° develop the goals and objectives of the Child Health Program;
- ° review, revise, and approve the draft outline of the plan;
- ° develop the major strategies to achieve the objectives of the Program;
and
- ° review, revise, and approve the schedule for development of the plan,
including any external technical assistance to assist this process.

It is suggested that this planning process begin in September 1985.

4. Planning the Components of the Program

Following these preliminary activities, the basic steps in the planning process are:

- a. Designate one individual as Secretary/Facilitator, to serve for the entire planning period (estimated to be 5-6 weeks). It is expected that one of the short-term consultants, with health planning experience, will assume this role.
- b. For each component of the plan, the Secretary/Facilitator (assisted by the technical consultants) should:
 - ° study all relevant documents;
 - ° obtain suggestions from knowledgeable individuals in the central MOH and in field units; and
 - ° prepare a first draft of the portion of the plan.
- c. The first draft is given to members of the Working Group to read and prepare comments.
- d. A day or two later, a meeting of the Working Group is convened to review and revise this component of the plan. The Secretary/Facilitator records all conclusions and decisions during this meeting.
- e. If the Working Group has decided that additional information or opinions are not needed at this stage, proceed to step f. However, in some instances, it is expected that the Working Group will decide that insufficient evidence exists to draw conclusions on which to base some aspect of the program. In these instances, the Secretary/Facilitator, accompanied by one or more members of the Working Group, can obtain the required information from field or central health personnel or other relevant individuals.

- f. The Secretary/Facilitator prepares a revised version of this component of the plan, based on the comments made by the Working Group and any additional information obtained. This revised version is distributed to the Working Group members.
- g. If the revised version is significantly different from the original draft, or if any of the Working Group members believes that another meeting to discuss this component of the plan would be useful, additional meetings can be convened to repeat this process.
- h. Repeat steps b-g for each component of the plan.

After this process is completed for each of the components of the plan, one person will edit all of it for consistency of style and terminology, and combine the pieces into a complete draft plan. The entire draft can then be presented to the Working Group for review and, if necessary, revision.

Following approval by the Working Group, the draft plan is presented to the appropriate MOH authorities for review and final approval.

It is estimated that this entire process would require 4-6 weeks of concentrated work, including an average of two Working Group meetings per week during this period.

5. Portions of the Plan

A separate document suggests a possible outline for the Child Health Plan. According to this outline, a series of "strategies" are to be developed, each representing a cluster of activities aimed at achieving one or more of the program's objectives. These strategies will not be finalized until the planning process begins. Nevertheless, for working purposes, an initial division of the proposed child health components is helpful. The following "portions" are suggested, with each representing the basic topic for a meeting or set of meetings:

- ° Description of current status; development of goals, objectives, and strategies
- ° CDD and EPI
- ° Child health surveillance (other than CDD and EPI); this would focus on growth monitoring
- ° Maternal health services
- ° Other.

This is only a tentative list. When the Working Group has outlined the major strategies, this list should be revised.

C. Suggestions for the Training of Medical Orderlies and Other
Para-professional and non-professional Health Staff Objectives

Content and Curriculum

1. Medical orderlies and other health staff have recently received a very brief training in oral rehydration. There has not been an evaluation of the impact of this training. Our impression is that most health workers have been convinced that they should use it, but that they do not perceive ORS as being very different from most other drugs. The simplicity of such a key life-saving procedure and the fact that it requires no medical expertise to implement have not been truly internalized.

Recommendation: A major objective of another training course for medical orderlies and other para-professional and non-professional health staff is to change attitudes on ORT, as a complement to the knowledge training they have already received.

2. If considered desirable, a second topic for this training might be immunization. Presumably, the objective would be for these people to motivate mothers to immunize their children.
3. Training programs tend to be more valuable if it is very clear what people are being trained to do and if the training program is then planned to enable them to experience these behaviors.

Recommendation: A curriculum development process for the training course should consist of: a) identifying current skills and attitudes on ORT (and immunization?), b) identifying desired skills and attitudes on the same topics (i.e., learning objectives), c) developing a series of activities to help these people to go from 'a' to 'b', and d) developing an evaluation procedure to determine whether this has been achieved.

Trainers

4. Training of these people must be in Arabic, preferably by Omanis, preferably by women. There is only a very small quantity of people with the potential to conduct such training. It would be highly desirable not only for them to conduct this training, but also to further develop their capabilities as trainers so that they may conduct other training programs in the future.

Recommendation: Identify 3-6 appropriate people to serve as trainers. They should be Omani, female, interested in training, and willing to go to a 2-3 week preparatory course.

Recommendation: A major objective of the training of medical orderlies and others should be the in-service training of the trainers, helping them to be better prepared to conduct other types of training in the future.

Training Methodology

5. The single most important flaw in the previous training of health personnel is that it was not experiential. Listening to lectures is a poor learning methodology which only rarely is effective at either developing a skill or motivating the listener. Experiencing the task is far more effective. This is especially true in the case of ORT.

Recommendation: Technical assistance to this training effort should emphasize the training of trainers to use more effective, participatory, experiential learning/teaching methodologies.

Recommendation: As a specific and extremely important example of an experiential methodology, each trainee should be provided the opportunity to spend three or four hours with a single dehydrated patient, mixing the ORS and feeding it to the child. Such an experience, especially when the trainee actually saves the child's life (as with a severely dehydrated patient), is unforgettable. This approach should be required as a methodology for use with all health workers, including doctors and nurses.

Coordination

6. The current functional division of MOH personnel into curative and preventive branches results in a confusing dichotomy with respect to both ORT and immunization, since some personnel of both branches are expected to promote ORT, distribute ORS, and immunize children. It is desirable to ensure that the procedures they use are standardized and that their activities complement each other.

Recommendation: Wherever hospitals and PHCs exist in the same community, a single joint training program should be conducted, rather than separate programs for preventive and curative personnel. Primary responsibility can alternate between the heads of the two branches.

Follow-up Training

7. Follow-up training provides opportunities for health workers to learn from the experiences of others.

Recommendation: Some follow-up training sessions should be planned during the initial training and conducted in each institution -- at first frequently, then at less frequent intervals -- to review the objectives and topics of the training program and discuss any problems encountered in implementation. Some of these sessions should be conducted jointly with both the preventive and curative personnel.

Implementation Plan for the Development of this Training

The following (incomplete) workplan is suggested:

Activity	Person Responsible	Sep	Oct	Nov	Dec	Jan
1. Omani female training team is identified.	M El-B	x				
2. Training consultant arrives.	G T	x				
3. Training team and consultant work together to:						
° refine the learning objectives						
° assess trainee existing competencies						
° develop teaching/learning activities	crng team/ consultant	xxx				
° develop training aids						
° develop evaluation procedures						
° plan administrative aspects of the training (location, time, facilities, funds, etc.)						
4. Each member of the training team conducts one training program, with the consultant and the other trainers as observers. At the conclusion of each day, they jointly discuss and plan changes.	trng team/ consultant		xx			
5. Finalize the curriculum and training aids. Plan the expansion of this training to others throughout the country.	ditto		xx			
6. Consultant departs.	consultant		x			
7. Conduct remaining training in other places in the country.	trng team			xxxxxxxxxxxxxxxxxxxxxxxxxxxx		

D. Five Year Child Health Program 1986-1990

Oral Rehydration Therapy (ORT) Section

Working Draft

Ministry of Health
Sultanate of Oman
July, 1985

TABLE OF CONTENTS

Preface

- I. History and Current Status
- II. Goals, Objectives, and Targets
- III. Strategies
- IV. Analysis of Current Situation
- V. Activities
- VI. Management Systems
- VII. Structural Organization
- VIII. Budget
- IX. Role of External Agencies

Annexes

I. HISTORY AND CURRENT STATUS

Diarrheal diseases have long been recognized to be a major health problem of young children in Oman. The acceptance of ORT as a safe, effective and simple method of prevention and treatment of dehydration from diarrhea provided the stimulus for a major decision by the Ministry of Health.

In 1982 the Minister of Health appointed a Task Force to develop a country wide program designed to reduce deaths and serious illness and malnutrition which result from improperly treated diarrhea. At the same time the Ministry emphasized efforts to reduce the impact of diarrheal diseases through the implementation of a Control of Diarrheal Disease Program with the technical support of the World Health Organization. UNICEF has also worked in close collaboration with the Ministry in its efforts to diminish the impact of diarrhea.

In 1983 and 1984, ORT efforts with the country were reviewed by international consultants. The results of these studies and the experience of Ministry health professionals were combined in a Draft Plan of Operation developed in collaboration with WHO, with the support and approval of UNICEF. This plan has been used as the framework and guideline for MOH activities during the past 2 years. A number of activities have been undertaken to expand and strengthen the CDD/ORT program. Based on the experience from ORT activities it is now possible to develop a detailed National ORT project which can serve as an operational guide for the period of time until ORT is included as an integral part of the health services of the country.

This project, therefore, builds upon the valuable experience of several years, includes the components of the original plan and specifies in more detail the activities required over the next 3 years when it is planned that no further special emphasis on ORT will be required.

The draft document will be presented to individuals and organizations interested and involved with diarrheal disease and with ORT. Based on responses, reactions and recommendations which will be received, the draft will be revised and eventually presented for approval to the Ministry. The official project document will then serve as a valuable frame of reference for project operation, evaluation and for efficient collaboration with external agencies.

II. GOALS, OBJECTIVES AND TARGETS

To reduce the morbidity and mortality and malnutrition associated with diarrheal diseases in children, primarily under age 5 years.

By June 1987:

- ° To reduce the rate of mortality associated with diarrheal diseases of children 0-5 years of age by 50%.
- ° To reduce the rate of morbidity associated with diarrheal disease in children 0-5 years of age by 25%.
- ° To reduce the hospital admissions for the treatment of uncomplicated diarrhea by ____%.

III. STRATEGIES

1. WHO strategies for the Control of Diarrheal Diseases will be used: "improved diarrheal disease case management; promotion of appropriate mother and child care practices; disease surveillance and epidemic control; water supply and sanitation development."
2. The project will consist of _____ phases. Phase I, Planning; and the early part of Phase II Implementation, have been completed. Phase III will be the Institutionalization of ORT within child health services.
3. For the next 2-3 years, the CDD/ORT project will receive special priority and attention within the Ministry of Health. By that time ORT will have been accepted and considered an integral part of proper health services for children.
4. ORT will be considered one of the major components of the 5 Year Child Health Plan. As such, it will be emphasized and integrated with other key child health activities included in the 5 Year Development Plan.
5. All health workers who provide services for children will receive special training in ORT. The training will be related specifically to the role and responsibility of the health worker.
6. Training at all levels will be experiential, learner-oriented, and competency-based. Experiential includes actual preparation of the ORS and feeding of ORS to a dehydrated child. Learner-oriented includes focusing most attention on the learner (rather than the teacher) and designing material for the learner. Competency-based includes ensuring skills and competency as the final criteria for successful teaching.
7. Oral Rehydration Salts (ORS) using the WHO formula (citrate) in one liter quantities will be used by the Ministry.
8. ORS will be available from all Ministry health services free of charge.
9. No "home mix" will be recommended.
10. Training courses will be presented in English for high level health workers, and in Arabic for lower level health workers.
11. All employees of the Ministry health establishments are recognized as potential teachers for mothers and will receive appropriate training.
12. To the extent possible trainers will also serve as supervisors for those they have trained in ORT.
13. A key group of senior health workers will receive special training and will meet periodically to review field experience and to provide technical input for project assessment.

14. Small scale, uncomplicated operations research will be encouraged at those health establishments which care for large numbers of children with diarrhea.

15. A small number of Treatment and Training Centers will be established to serve as the focal point for clinical, patient-oriented training.

16. The CDD/ORT project will not be organized as a vertical project. The organization will consist of a Coordinator with overall supervision responsibility and authority. The Coordinator will be assisted by a full time Manager.

17. Close, ongoing collaboration will be established with WHO and UNICEF since both of these organizations have made major program commitments to work with the MOH in CDD/ORT during the next 3 years.

E. Future PRITECH Contributions

<u>Expertise</u>	<u>Duration</u>	<u>Cost</u>
Trainer/Educator	5 weeks	
Health Planner	6 weeks	
Nutrition/Growth Monitoring	4 weeks	_____
	Total	

These requirements are for the planning exercise only. As a consequence of this planning it is anticipated that other types of technical assistance from PRITECH would be considered.

F. Terms of Reference for Child

Health Program Planning Teams

Draft

Ministry of Health
Sultanate of Oman
July 1985

1. HEALTH PLANNING CONSULTANT

Location: Muscat, Oman

Dates: Beginning on or about 10 September for 6 weeks

Background: The Ministry of Health of the Sultanate of Oman has established a planning committee to prepare a national five-year child health program. The major components of this program are expected to be:

- ° control of diarrheal diseases;
- ° immunization;
- ° growth monitoring and promotion of improved nutrition; and
- ° maternal health services.

Currently, some activities do exist for each of these components. There is a reasonably complete EPI program, with objectives, targets, operational personnel, and monitoring and evaluation procedures. This program has been so successful that some of its personnel are expected to be underutilized in the near future.

To a lesser extent, the CDD activities also can be considered to be an existing program. It is, however, a program which does not have its own personnel, clear targets, accessible resources, etc. Most of its activities are ad hoc in nature.

Both the EPI and CDD programs require that activities be implemented by personnel of both the curative and preventive branches of the MOH. Thus far, mechanisms for coordination of the activities of the two branches are inadequate.

For growth monitoring and maternal health services, there are no organized programs. Some activities in these areas are performed by field personnel, but it is not known how extensive or effective they are.

A large-scale survey of child morbidity and mortality, diarrheal disease practices, breastfeeding and weaning practices, and immunization was conducted in late 1984. Data from this survey has not as yet been analyzed.

To coordinate these efforts and to develop elements of a child health program which currently are lacking, the MOH will prepare a national plan for a child health program for the period 1986-1990. A three-person team -- comprising a health planner, a trainer, and a nutrition program specialist -- has been requested to assist the MOH Child Health Program planning committee to develop this plan.

Task Description: The health planner will:

- serve as a facilitator to the child health program planning team, developing and implementing approaches for eliciting ideas from as many sources as feasible, including field personnel;
- serve as a secretary to the planning team, editing all sections of the successive versions of the plan and incorporating conclusions, decisions, and other comments made during team meetings;
- prepare the first draft of selected sections of the plan, including but not limited to: history and current status, analysis of the current situation, goals/objectives/targets, strategies, structural organization, intragovernmental and private collaboration, and external agency participation;
- coordinate the contributions of other short-term consultants.

Qualifications:

- at least five years experience in a health planning or related role in developing countries, preferably in the Middle East;
- demonstrated ability to manage inputs from numerous sources, both oral and written;
- demonstrated ability to write clearly and concisely;
- MD or PhD.

2. TRAINING CONSULTANT

Location: Muscat and other locations, Oman

Dates: Beginning mid-September for five weeks

Background: A. (Same as for Health Planning Consultant. See above.)

B. Because the educational system of Oman only began functioning on a reasonable scale fifteen years ago, the majority of the personnel working in the health system are expatriates. Most of the Omanis who do work within the system are in para-professional and non-professional positions. Less than 15% of the health staff are Omani women.

For oral rehydration therapy to be learned correctly by mothers, it is essential to communicate with them in culturally-appropriate Arabic. It is not essential, but it is preferable if this is done by a woman.

The MOH has decided, therefore, to prepare its female Omani para-professional staff to better convey to village women the advantages, methods, and limitations of ORT. (This program may also include male Omani para-professional and non-professional staff, as these people are the next most culturally appropriate individuals for this task.)

A small number of female Arabic-speaking staff (maximum ten) are available to teach a course to the female para-professionals. Most of these people are bilingual in English and Arabic. Most of them know ORT, but have little or no experience in developing a training course, developing training aids, or teaching using participatory methodologies.

Task Description: The training consultant will:

(approximately 1/4 time)

- prepare the first draft of the training sections of the child health plan;
- prepare other sections of the child health plan, as requested by the health planning consultant or the planning committee members;

(approximately 3/4 time)

- conduct a training-of-trainers course for up to ten nurses and other female health staff;
- together with these trainers, develop a curriculum and training aids for a 1-3 day training of para-professional and non-professional health staff; the major focus of this training will be ORT, although some immunization may also be included;
- assist these trainers to conduct one or two of these courses each in their own communities.

Qualifications:

- at least five years experience conducting or advising health para-professional training activities in developing countries, preferably in the Middle East;
- at least Masters level degree in education or training;

- ° demonstrated ability to write clearly and concisely;
- ° Arabic language capability preferred.

3. NUTRITION PROGRAM CONSULTANT

Location: Muscat, Oman

Dates: beginning on or about 15 September for 4 weeks

Background: (Same as for Health Planning Consultant. See above.)

Task Description: The nutrition program consultant will:

- ° prepare the first draft of the nutrition sections of the child health plan; the major aspects of this role will consist of the development of a growth monitoring system appropriate for Oman;
- ° prepare the first draft of the maternal health services sections of the child health plan;
- ° prepare other sections of the child health plan, as requested by the health planning consultant or the planning committee members.

Qualifications:

- ° at least five years experience conducting or advising nutrition activities in developing countries, preferably in the Middle East;
- ° at least Masters level degree or specialization in nutrition;
- ° demonstrated ability to write clearly and concisely.

IV. CONTACTS AND VISITS

A. Dates of Consultancy

D. Chauls July 15 - 26

N. Wallace July 15 - 27 Extra day visit to UNICEF Area
Office, Abu Dhabi

B. Discussions Conducted With:

1. Mr. Gary Towery, Co-Director, Omani-American Joint Commission for Economic and Technical Development
2. Dr. M. Ghassani, Director, Preventive Medicine, Ministry of Health
3. Dr. Mousallem Boually, Senior Pediatrician Consultant, Ministry of Health; Coordinator of the Control of Diarrheal Diseases Program.
4. Dr. M. Fergamy, Advisor to the Minister of Health
5. Dr. P. Portineri, Advisor to the Ministry of Health
6. Dr. P. Giocometti, Country Representative, World Health Organization
7. Dr. H. Traverso, Resident Epidemiology Consultant, World Health Organization
8. Mr. Abdulmir Ali, National Officer, UNICEF
9. Dr. H. Hunter, Consultant for Health Manpower Training

Information was obtained from numerous other officials and health workers.

Field visits were made to 2 hospitals, 3 health centers, 1 public health compound, 1 public health unit and 1 dispensary.

V. REFERENCES

The following major documents were reviewed. Copies will be placed in the Health section of the Joint Commission library:

<u>Source</u>	<u>Title</u>
WHO	Assignment Report - Control of Diarrheal Diseases in the Sultanate of Oman, Feb. 1984. By D.J. Tulloch
MOH	Annual Statistical Report - 1983 By Directorate of Statistics, Planning and Follow-Up
MOH	A Manual for the Prevention and Treatment of Acute Diarrhoea: For Use by Senior Health Workers in Hospitals and Health Centers, 1984.
MOH	A Manual for the Prevention and Treatment of Acute Diarrhoea: For use by Health Workers in Dispensary and Community, 1984.
PRITECH	Oman ORT Status Report, May, 1985. By R. O'Connor
UNICEF/MSH	Oral rehydration Therapy Programme: A Self Reliant Study of Child Services in Oman, 1983. By Jon Rohde
UNICEF	Working Draft: Plan of Operations - Child Health and Development Programme in the Sultanate of Oman 1985 - 1987, 1984.
MOH	Evolution of a National CDD Project in Oman, 1984. By M. Boually