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## Trip Report

# 0-388

**Travelers:** Dr. Alain Fontaine, INTRAH Consultant  
Mrs. Jedida Wachira, INTRAH/ESA  
Regional Projects Officer

**Country Visited:** UGANDA

**Date of Trip:** July 9 - August 2, 1989

**Purpose:** To conduct the End-of-Project Evaluation

Program for International Training in Health  
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The University of North Carolina  
Chapel Hill, North Carolina 27514 USA

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## LIST OF ABBREVIATIONS

<b>ADMS</b>	Assistant Director of Medical Services
<b>AHV</b>	Assistant Health Visitor
<b>CDD</b>	Control of Diarrhoeal Diseases
<b>CHW</b>	Community Health Worker
<b>CNO</b>	Chief Nursing Officer, MOH
<b>CTT</b>	MOH/INTRAH Core Training Team
<b>DHI</b>	District Health Inspector
<b>DHMT</b>	District Health Management Team
<b>DHV</b>	District Health Visitor
<b>DMO</b>	District Medical Officer
<b>DMS</b>	Director of Medical Services
<b>EM</b>	Enrolled Midwife
<b>EN</b>	Enrolled Nurse
<b>FHI</b>	Family Health Initiatives, USAID Project
<b>FPAU</b>	Family Planning Association of Uganda
<b>HE</b>	Health Education
<b>IST</b>	In-Service Training
<b>MA</b>	Medical Assistant
<b>NFP</b>	Natural Family Planning
<b>PST</b>	Pre-Service Training
<b>SNO</b>	Senior Nursing Officer
<b>TBA</b>	Traditional Birth Attendant
<b>UNEPI</b>	Expanded Program of Immunization, Uganda

## EXECUTIVE SUMMARY

The End-of-Project evaluation of the MOH/INTRAH Training Project for Extension and Improvement of Family Planning Services II was conducted in Uganda, July 9 - August 2, 1989. INTRAH Consultant Dr. Alain Fontaine and INTRAH/ESA Regional Projects Officer Mrs. Jedida Wachira were joined by an MOH team of 4 CTT members.

Evaluation questions were specified on the basis of the project activities and operational objectives; inputs were solicited from INTRAH/ESA, USAID/Uganda, MOH Acting Director of Medical Services and senior MOH officials. Qualitative and quantitative data were collected from a randomly selected sample of 10 clinical FP skills trainees working in 7 districts of 3 regions, their co-workers, clients, immediate supervisors, and hospital and district supervisors. Participants to other types of training residing in the same districts as the clinical FP trainees were also interviewed. In addition, CTT members were interviewed, pertinent records and documents reviewed, and additional information secured from the CTT files. Data from these sources were analyzed and interpreted. Preliminary findings were presented to Acting DMS, senior MOH officials, USAID/Uganda and INTRAH/ESA at debriefing sessions.

The evaluation concluded that the project accomplished its operational objectives in part. Some activities scheduled had to be cancelled and the total number of trainees in each activity carried out was less than the number planned (see summary of findings and Appendix C-5).

Major achievements include the development of an effective core training team and subsequent training of 69 MOH and 19 NGO personnel in clinical FP skills.

Recommendations include: improving accessibility and availability of quality integrated PHC services including FP; developing integrated planning activities at the district level as a basis for training needs assessment and training plans formulation and implementation; improving coordination of training for PHC at the central level; developing links between pre-service training, in-service training and service delivery; and identifying alternative procedures for channeling project funds until MOH procedures can be improved.

The INTRAH evaluation team expresses appreciation to the health personnel who gave their time freely during interviews and meetings, to MOH, MCH/FP Division, and to USAID/Uganda for the assistance and guidance provided to the team.

**SCHEDULE OF ACTIVITIES**

- July 9** Departed from Nairobi at 2:00 p.m. and arrived in Kampala at 5:00 p.m.
- Met with 3 CTT members to review tentative plans for Day 1.
- July 10** Briefed with Mr. Paul Cohn, Population and Health Officer, USAID/Uganda.
- Met with CTT for briefing and to prepare planning schedule and commence planning activities.
- July 11** Briefed with Mr. Gaifuba, ADMS Health Education Division, and Mr. J.W. Kyebambe, Planning.
- July 12** Briefed with Dr. F. Katumba, Acting ADMS MCH/FP.
- July 13** Planning.
- Briefed with Dr. Kyabaggu, Acting DMS, MOH, and Mrs. L. Walusimbi, CNO.
- July 14** Met and held discussions with WHO Advisor to the MOH UNFPA Project on Strengthening MCH/FP, Dr. S.N. Darfoor.
- Pre-tested instruments and finalized plans for data collection.
- July 15** Prepared final data collection tools.
- July 16** Data collection team for S.W. Region departed Kampala for Fort Portal.
- July 17** Data collection team for Eastern Region departed Kampala.
- July 17-21** Collected data in Kabarole, Mbarara and Mpigi districts.
- Collected data in Mukono, Kamuli, Mbale and Kampala districts.
- July 24** Collected data in Kampala district.
- Analysis of data.

- July 25** Analysis of data.  
Met and held discussions with Mr. A. Nzabanita, Head of Planning Division, MOH.
- July 26** Met and briefed with Mr. David Puckett, Child Survival Technical Officer, USAID/Uganda.  
Met and held discussions with Mrs. Lydia Muranga, FPAU Acting Executive Director, and Mr. C.H.M. Barlow, FPAU Consultant Administrator.  
Debriefed Dr. Kyabaggu and Mrs. R. Elangot, Deputy CNO, on preliminary highlights of the evaluation.  
Data analysis.
- July 27** Data analysis.  
Met and held discussions with MOH officials from Training Division Mrs. R.O. Lematia, SNO Training, and Mrs. M. Okochu, CNO Administration.
- July 28** Data analysis.
- July 29** Data analysis and interpretation.
- August 1** Debriefed the CTT and MOH senior officials:  
- Dr. E.M. Kaijuka, ADMS, MCH/FP  
- Dr. F. Katumba, Senior Medical Officer, MCH/FP  
- Dr. S.N. Darfoor, WHO Advisor  
- Dr. Otim-Odoi, ADMS Training  
- Mrs. M. Okochu, SNO Administration, Training Division  
Debriefed Mr. Puckett.  
Held process review meeting with 4 CTT.
- August 2** Departed Entebbe at 1:00 p.m. and arrived Nairobi 2:00 p.m.
- August 3** Prepared for report writing and completion of data analysis.
- August 4** Debriefed Miss Pauline Muhuhu, INTRAH/ESA Director, and Mrs. Grace Mtawali, INTRAH/ESA Regional Training Officer.

**August 5-6** Report writing.

**August 7** Debriefed Mrs. Rosalind Waithaka, REDSO/ESA.  
Reviewed findings, conclusions, and  
recommendations.  
Dr. Fontaine departed Nairobi for Paris at  
11:15.

**I. PURPOSE OF TRIP**

The purpose of the trip was to conduct the End-of-Project Evaluation July 9 - August 1, 1989.

**II. ACCOMPLISHMENTS**

- A. REDSO/ESA, INTRAH/ESA, USAID/Uganda MOH Acting Director of Medical Services, senior MOH officials and WHO Advisor to the MCH/FP UNFPA Project were briefed separately concerning proposed evaluation activity plans; their input in the identification of relevant evaluation objectives was solicited.
- B. Evaluation questions were specified and information sources were identified. Data collection instruments previously developed, used and revised by the CTT were modified when appropriate; additional instruments and procedures were developed when necessary.
- C. A representative sample of ten clinical FP skills trainees was selected. For each clinical FP service provider (8), a knowledge test was administered; clinical performance was assessed; information on program achievements, constraints and recommendations for future activities were collected from the service providers themselves, their supervisors, colleagues, and clients as well as from hospital and district management team members; and clients and commodity records were reviewed. Knowledge and performance were assessed for two tutors. Evidence of FP integration in pre-service training curricula was reviewed.
- D. Participants to doctor-nurse team FP clinical skills courses (1), study tours (3), evaluation workshops (2), orientation of hospital management teams (4), management skills workshops for DMT (7), and visual communication workshops (5) were interviewed to assess

each activity's consequences and to obtain recommendations for future activities.

- E. Senior MOH and NGO officials were interviewed to assess program achievements and limitations, and to obtain recommendations for future programs.
- F. Program curricula, trainee follow-up and annual reports were reviewed. Additional information was collected from CTT files.
- G. Collected data were compiled and interpreted. Conclusions and recommendations were drawn.
- H. MOH/INTRAH CTT members participated actively and very productively in the whole evaluation exercise.
- I. A preliminary report was submitted to senior MOH officials in a debriefing. USAID/Uganda, REDSO/ESA and INTRAH/ESA were debriefed.

### **III. BACKGROUND**

The Training Project for Expansion and Improvement of FP Services II was a follow-on of PAC-I MOH/INTRAH training collaboration in Uganda. The goal of the project was to extend and improve family planning services within the existing MOH and non-governmental maternal and child health service system. The project effective October 1, 1986 is due to terminate on September 30, 1989. The FHI Project and INTRAH provide financial support.

Prior to October 1986, INTRAH funded a number of third country and US-based activities for senior officials in preparation for an MOH and FPAU support system for the FP program in respect to policy issues, clinical practice/ referral and evaluation aspects. Activities included 2 study tours to CBHC and CBD programs in Thailand (see Trip Report #0-157); 6-week FP clinical skills training for 5

physicians and 5 nurse-midwives in Manila, Philippines and 2 evaluation and monitoring trainings for a total of 8 trainees in the U.S. and Kenya.

Under the current project and in accordance with the contract workplan, activities conducted include training in FP clinical skills for service providers (both with and without IUD insertion); FP clinical skills refresher for service providers and PST tutors; orientation of hospital management teams to MCH/FP management skills for district health management teams; and visual communication skills for service providers, tutors and health educators. In addition, annual reviews and trainee follow-ups have been conducted.

#### IV. DESCRIPTION OF ACTIVITIES

- A. Preparation and Planning: A preliminary list of questions to be addressed during the evaluation was developed by Dr. Fontaine and Mrs. Wachira at INTRAH's regional office in Nairobi and discussed with INTRAH/ESA Director Miss Pauline Muhuhu from July 6 to July 8, 1989. This list was revised and developed with MOH/INTRAH CTT members Mrs. Rachel Rushota, Mrs. Mary Luyombya, Miss Lucy Asaba and Dr. Anthony Aboda. Additional information needs were identified during briefings and meetings held with Mr. Paul Cohen, Population and Health Officer, USAID/Uganda, Dr. Katumba, Senior Medical Officer, MCH, Dr. Kyabaggu, Acting DMS, Mrs. Walusimbi, CNO, Dr. Darfoor, UNFPA/WHO Advisor to the MCH Division, and Mr. Gaifuba, ADMS/HE.

Evaluation questions were specified with respect to potential beneficiaries and practical use of the information. Information sources were identified. A representative sample of clinical FP trainees was selected and stratified by district and type of clinical training. Northern regions were excluded for

security and accessibility reasons. To minimize travel time, it was decided to interview participants to other types of workshops residing in the same districts as the clinical FP trainees selected. Information required to answer evaluation questions was listed according to each identified source. Data collection instruments were adapted from those previously used by the CTT or developed when appropriate. In-country planning took place during the first week of the visit.

- B. Data collection: Two teams, each made up of one CTT member and one INTRAH staff/consultant, collected evaluation data from the sample selected. The other CTT members collected information from project files and documents. Data collection took place between July 17 and July 24, 1989.
- C. Analysis: Grading rules were established for the knowledge test. Average knowledge scores were computed for each respondent and for each question across all respondents. Critical tasks were identified for each dimension of performance and a grading rule was established. Average scores were computed for each respondent. Specific indices -- based on the proportion of at least acceptable activities -- were computed for each main area of performance: applied knowledge, skills and decision-making. Answers to individual questionnaires and interviews were grouped by geographical area to assess similarities and differences in the various (respondents') answers. Indices were computed for participants' assessment of learning content, clinical activities and equipment availability. All information collected was summarized. Preliminary conclusions and recommendations were formulated. Analysis took place between July 24 and July 31, 1989.

- D. Debriefing: Preliminary results were presented to Dr. Kyabaggu on July 26, 1989. The preliminary report was presented to Dr. Kaijuka, ADMS MCH/FP, Dr. O. Odoi, ADMS Training, Dr. Katumba, Mrs. Okochu, SNO Training (Administration), and Dr. Darfoor on August 1, 1989. Mr. David Fickett, Technical Advisor for Child Survival, USAID/Uganda, was debriefed on August 1, 1989. Debriefings were held in Nairobi with Miss Muhuhu on August 4, 1989, and with Mrs. R. Waithaka, REDSO/ESA, on August 7, 1989.

V. FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

A. Findings

1. Operational objectives were only partially achieved. Some of the activities scheduled had to be cancelled. The number of participants attending each activity was generally less than the number planned.
2. Activities carried out after November 1987 relied on USAID FHI funding. Although the project coordinator consistently issued requests for funds at least six weeks before the beginning of the scheduled activity, funds were not once released in time. Two activities had to be cancelled. All other activities could only be carried out on credit, sometimes with the effect of restricting the scope of the planned activity. The procedure for channelling funds established by USAID/Uganda and the MOH involve major delays at two levels: approval by the Permanent Secretary and release of government checks by the Treasury.
3. The core training team was originally composed of six members designated by the MOH. Due to drop-outs and replacements, ten persons have been at one time or another included in this team. The present CTT consists of three full-time and one half-time members. CTT members' skills developed through the project include FP clinical skills, TOT, evaluation methods, training needs assessment, management skills and visual communication skills. The CTT has demonstrated exceptional abilities and accomplishments in the face of difficult circumstances in conducting training needs assessment, curriculum development

and review, in planning and conducting training activities, trainee follow-up and evaluation. The current CTT works effectively as a team combining different individuals' skills and specific abilities. The team is recognized as a valuable resource by most interviewed in the MOH and in NGOs.

4. Sixty-nine MOH and nineteen NGO personnel received clinical FP training. Information on current positions is available for 53 MOH and eighteen NGO personnel. About 12% of the trainees never provided FP services. While all NGO personnel who started to strengthen FP services are still providing them, 18% of the MOH trainees have stopped providing FP services. Clinical FP trainees are found as tutors in nursing schools, and as providers in government hospitals and health centers, in FPAU clinics and in non-governmental rural aid posts. MOH trainees have been selected by district or hospital management teams on the basis of their qualifications and potential for involvement in MCH/FP.
5. Clinical FP trainees are generally satisfied with the quality of the preparation provided by the training except in the areas of natural family planning and infertility. History taking and physical assessment figure prominently among the training contents cited as most useful.
6. Retained knowledge explored by the revised test is generally very good. The only trainee with less than 50% correct answers had actually been posted in maternity shortly after FP training and had not practiced FP since.
7. FP providers have generally not been able to implement more than half of their workplan to establish or strengthen FP services. All providers report, however, a marked increase in the scope of FP activities performed, in their practice of counseling and of physical examination, and in the management of STDs.
8. The provision of FP services remains most often limited to one session per week in MOH facilities, while all NGO clinics, including rural aid posts, offer FP services daily. The average number of FP clients served seems directly related to the availability of the services.

9. The quality of more than half of the activities explored by the performance assessment is below the level determined as acceptable by the CTT for a majority of the service providers, particularly in the dimensions involving actual skills and decision making. Most critical errors involve the omission of history taking or physical examination procedures. IUD removal procedures also appear problematic. The quality of performance, however, seems better for those providers who see the greatest number of clients. It should also be noted that the only provider with an overall acceptable level of performance serves as a field supervisor in a NGO rural development program.
10. Among the consequences of training, most providers and providers' colleagues report that clinical FP trainees shared their new knowledge and skills with their colleagues.
11. The number of FP clients seen has, according to providers' self reports, increased after training (a number of the trainees did not actually provide FP services before their training). This increase is more marked for NGO than for MOH facilities.
12. The increase in the number of returning visits seems higher than the number of new acceptors, which can indicate good client satisfaction and retention. While the overall unavailability or inadequate quality of the records available does not permit validation of the figures reported, a similar trend can be observed from the analysis of one clinic's records over 5 years. Clients interviewed report that the information received from the service provider is usually quite complete and satisfactory although more discussion of alleged or actual side-effects might be desirable.
13. While MOH policy is oriented toward the integration of PHC/MCH/FP services, progress in that direction seems as yet limited, with a few notable exceptions. The understanding of the concept itself and of the means of achieving integration was not always consistent among the different respondents. Obstacles identified include the limitation of resources, the curative orientation of the health system, the support of specific programs by external donor agencies and the lack of joint planning activities.

14. The development of FP services is hampered by several shortages in the public health system. MOH hospital and health centers' FP clinics lack some of the basic equipment necessary for MCH/FP services. Basic supplies like soap and stationery are lacking. Contraceptive supplies are irregular. Health personnel salaries are at a purely nominal level -- the monthly salary for a senior nurse is equivalent to the price of 6 meals of the basic staple food -- and have reportedly not been paid for the past 7 months in some of the areas visited.
15. FP providers generally lack appropriate supervision. Hospital and district management team members often lack appropriate clinical experience. There is a lack of clinical standards and guidelines. The recording and reporting system is inadequate, in part because of the lack of stationery. Prototype standard client records developed in 1987 have not yet been released.
16. Hospital and district management teams' participants to orientation and management skills workshops generally express their satisfaction with the insights and skills gained. They have, nevertheless, generally not been able to carry out the plans developed during these activities although most have provided additional support to the development of FP services. A review of the workplans developed during management skills workshops reveals that, although the terminology and general methodology seem to have been mastered by the participants, activities were often unrealistic, required resources were usually not adequately identified, and process and outcomes monitoring indicators were not clearly specified. Several respondents also regretted the lack of concrete follow-up activities after completion of the workshop.
17. Participants to the study tours organized at the onset of the program seem to have gained appreciable insights and motivation from these experiences. Participants to Doctor-Nurse team FP courses have sometimes been unable to put their skills into practice and have usually not remained as a team. The group sent to evaluation workshops in the USA and Kenya seem to have disintegrated without any evidence of support to the program.

However, CTT participants to the workshop on Evaluation Strategies and Tools have demonstrated knowledge and skills gained by conducting training performance evaluation and use of evaluation results.

18. Hospital and district management teams usually appreciate the work done by the program. Most identify the need to increase the coverage of FP services, particularly at the primary level. Most respondents also identify the need to decentralize training activities, involve district management personnel in the training, and develop supervisory capacities at the district level. The need for coordinating training activities is also recognized by most respondents at all levels of the health system.
19. FP has been integrated in the curricula of the nursing school and the public health nursing school visited; however, a lack of trained tutors and practical training facilities exists.
20. The Comprehensive Nursing curriculum recently developed with the contribution of one of the CTT members is about to enter a pilot testing phase. Appropriate sites for these tests have not yet been fully identified.
21. Respondents at all levels of the health system expressed strong appreciation for Visual Communication Skills workshops. Participants to these workshops were generally able to use and revise the visual aids developed, and to start developing new ones.

## B. CONCLUSIONS

1. While some constraints affecting project implementation can be related to difficult circumstances experienced as a result of recent Ugandan history, unnecessary burdens have been added by the fund release procedure developed by the MOH.
2. The development of a very effective CTT is a major achievement, establishing a valuable resource for national and regional training efforts.
3. Positive effects of the training program can be seen in the increase quantity of FP services delivery points and the scope of services delivered.

4. These effects, however, are limited by the shortages affecting the government health system and by an insufficient commitment of national and local resources to the development of MCH/FP services.
5. Inadequate quality of performance can be seen as the result of both limited practice, due in part to insufficient resources, and lack of an appropriate support and supervision system. It is worth noting that the areas where performance is defective are identified by the providers themselves as important areas of the training received, and as new components of their clinical practice. This suggests that work conditions and environment play a major role in producing sub-standard performance.
6. Efforts to develop support for the development of MCH/FP services have met some success both at the national and local level. Practical consequences seem to have been limited by insufficient consideration given to concrete implementation realities at the operational level. Insufficient attention has been given to planning the development of services to use effectively the FP service providers trained.
7. The current availability of FP services remains very limited, while recent survey results indicate high levels of unmet demand for family planning. The development of adequate FP services requires, however, that attention be given to all the levels of the health system.
8. Non-governmental organizations still play a major role in the provision of FP services, either specifically, as is the case with FPAU, or as a component of comprehensive PHC programs.
9. Efforts to integrate FP into pre-service training programs may help to improve the availability of properly trained health personnel. These efforts still seem insufficient to deliver in a timely fashion enough adequately trained personnel.
10. The strategy initially adopted for the development of program evaluation capability in the MOH was not appropriate.

**C. RECOMMENDATIONS**

1. The MOH should pursue its efforts to improve the availability, quality and accessibility of integrated PHC services, including family planning.
2. The MOH should develop integrated planning activities as a preliminary to any training activity. Planning should be done at the district level within policy guidelines specified by the MOH. Particular attention should be paid to the specification of concrete and realistic operational objectives for each level of the health system, the identification of all necessary resources, and the specification of an appropriate supervision, monitoring and evaluation system. Training needs should be defined on the basis of these plans.
3. Specific training curricula should be developed in concert by members of the Training Task Force. These curricula should address specific training needs for each level of the health system. The curricula should individualize, at each level, fundamental PHC organization and delivery issues, and specific content areas required for the implementation of the particular tasks to be accomplished by each category of health personnel.
4. Workshop participants should be selected by district management teams on the basis of established district plans, with a clear commitment to use acquired skills and knowledge for the implementation of planned activities, and to provide necessary support and supervision.
5. District-level training capabilities should be developed to address primary level training needs. Continued technical assistance and support should be provided to district training units by central MOH trainers such as the FHI current Core Training Team.
6. Links between pre-service training, in-service training and field supervision should be developed.
7. USAID/Uganda should pursue its assistance to MOH and NGO efforts. Procedures for channelling alternative funds should, however, be identified until the efficiency of MOH procedures can be improved.

**APPENDIX A**

**Persons Contacted/Met**

## APPENDIX A

### **Persons Contacted/Met**

#### USAID/Uganda

Mr. Paul COHN, Population and Health Officer  
Mr. David PUCKETT, Technical Advisor for Child Survival

#### Ministry of Health Headquarters

Dr. J. H. KYABAGGU, Acting Director of Medical Services  
Mrs. L. WALUSIMBI, Chief Nursing Officer  
Mrs. F. ELANGOT, Deputy Chief Nursing Officer

#### Maternal and Child Health/Family Planning Division

Dr. E. M. KAIJUKA ADMS, MCH/FP  
Dr. F. KATUMBA, Senior Medical Officer  
Dr. S. N. DARFOOR, WHO Advisor to UNFPA Project  
Mrs. Rachael RUSHOTA, FHI Project Coordinator  
Mrs. Mary LUYOMBYA, CTT Member, MOH/INTRAH Project  
Miss Lucy ASABA, CTT Member, MOH/INTRAH Project  
Dr. Anthony ABODA, CTT Member, MOH/INTRAH Project

#### Health Education Division

Mr. J. GAIFUBA, ADMS  
Mr. J. KYEBAMBE, Deputy Chief Health Educator

#### Planning Division

Mr. A. NZABANITA, Head of Planning Division

#### Training Division

Dr. Otim ODOI, ADMS  
Mrs. R. O. LEMATIA, SNO, Training  
Mrs. Mabel OKOCHU, SNO, Administration

#### FPAU Kampala

Mrs. Lydia MURANGA, Acting Executive Director  
Mr. C.H.N. BARLOW, Consultant Administrator

**KABAROLE DISTRICT**

**Buhinga Hospital**

Mrs. Rachael KAIJA, Acting Senior Nursing Officer

**District Medical Office**

Dr. NYAKOOJO, District Medical Officer

Mrs. SSEMEBWA, District Health Visitor

Mr. MPUUGA, District Health Educator

**FPAU, Kabarole**

Mr. H. M. KABOYO, Area Officer

Mrs. H. RUBONGOYA, Junior Nursing Officer, FP Service  
Provider

1 Colleague

3 Clients

**MBARARA DISTRICT**

**Mbarara Hospital**

Dr. J. ASIIMWE, Medical Superintendent

Mrs. G. WAMALA, Senior Nursing Officer

**District Medical Office**

Dr. Phillip MBYEMEIRE, District Medical Officer

Dr. J. AKATWIJUKA, Medical Officer

**Buzibwera Health Centre**

Mr. George RWABUNUNCA, Medical Assistant

Mrs. Mabel M. NDIKORA EM, FP Service Provider

Miss Margaret TUMWEBAZE, Nursing Aide, (Colleague)

2 Clients

**FPAU**

Mr. Elly MUGUMYA, Area Officer, Mbarara and Busyenyi

**MPIGI DISTRICT**

**Gombe Hospital**

Dr. Edward KATEREGGA, Medical Superintendent

Mr. Victor KANYIKE, Nursing Officer In-Charge

Miss Rosemary NANTEZA, Registered Midwife, FP Service  
Provider

2 Clients

**District Medical Office**

Dr. J. M. KAFUKO, District Medical Officer

Miss T. NAMISANGO, District Health Visitor

Miss J. Z. NAMUSOKE, Acting District Health Visitor

**KAMPALA DISTRICT**

**Mulago School of Nursing**

Mrs. S. MRABALI, Acting Principal

Mrs. V. NALUBEGA, Nurse Tutor

**Public Health Nursing College**

Miss E. MBONYE, Tutor

**Murchison Bay Hospital**

Dr. MAGUMBA, Acting Medical Superintendent

Mrs. Anne JACKSON, Nursing Officer in-Charge

Mrs. Dephine MASABA, Health Visitor, In-charge MCH/FP

Mrs. Teddy OKELLO, EM/Assistant Health Visitor

Miss Sarah IGALI, RM/Service Provider

Miss Catherine WAIBALE, EM/Service Provider

Miss Ted Kettie RWEHIRA, RM/Service Provider

Miss Jennifer MUGOYA, EN

2 Clients

**Mengo Hospital**

Dr. KYOHERE, Acting Medical Superintendent

Mr. S. MUKASA, Nurse Tutor

**FPAU Clinic**

Mrs. Angela OKOT, Nursing Officer in-charge

Ms. D. M. NAMUYOBO, Junior Nursing Officer, Service Provider

Mrs. J. SEMAZEHERA, Service Provider

3 Clients

**MBALE DISTRICT**

**Mbale Hospital**

Dr. ZAKE, Obstetrician/Gynaecologist

Mrs. F. M. GIDUDU, Acting Senior Nursing Officer

Mrs. Samalie E. MUYAMA, Nursing Officer, In-charge of Mbale  
FP Clinic

Miss OPECHO, Service Provider

Ms. L. M. NAMONO, EM/FP Service Provider

3 Clients

**District Medical Office**

Dr. D. LWAMAFU, District Medical Officer

Miss E. NAMBAFU, District Health Visitor

Mrs. WASAGALI, District Health Educator

**FPAU**

Mr. MANDU, Area Officer

**Mukono District**

Mrs. H. MWANJA, District Health Visitor

Mr. P. KIYUBA, District Health Educator

**Busoga Diocese/Kamuli District**

Mrs. Joyce KINTU, Deputy Manager, Family Life Education  
Project

Mr. Sebastian BALINAIME, Bugenywa Aid Post, Service  
Provider/Supervisor

Miss Regina BAMUTIRE, RN Service Provider

Mr. John A. BWANGO, Chairman Health Committee, Kisozi  
Village

Mr. Patric DHIKUSOOKA, RC1, Chairman, Kisozi Village

APPENDIX B.1

Evaluation Team Members

*Uc*

APPENDIX B.1

Evaluation Team Members:

Dr. Alain Fontain	INTRAH Consultant
Mrs. Jedida Wachira	INTRAH/ESA Regional Projects Officer
Mrs. Rachael Rushota	MOH/FHI/Project Coordinator (CTT)
Mrs. Mary Luyombya	MOH/INTRAH CTT Member
Miss Lucy Asaba	MOH/INTRAH CTT Member
Dr. Anthony Aboda	MOH/INTRAH CTT Member (Part-time)

**APPENDIX B.2**

**Activities in Which Core Training Team (CTT) Were Involved**

ACTIVITIES IN WHICH CORE TRAINING TEAM (CTT) WERE INVOLVED

<u>ACTIVITY</u>	<u>PARTICIPANTS</u>	<u>DATES</u>	<u>NO OF CTT</u>
1. Orientation of Hospital Management team workshop I	10-Physicians 12- S.N.O	Oct 13 - Oct 17 '86	3 CTT
2. " II	3 - Physicians 3 - S.N.O 1 - Reg. Nurse 1 - Laboratory Technician	Oct 20 - Oct 24 1986	3 CTT
3. " III	9 - Physicians 13- S.N.C 1 - Nurse Admn 1 - Nurse Tutor	Oct 27 - Oct 31 1986	3 CTT
4. Follow up of Trainees trained in April/May 1984	8- Nurse-Midwives trained June 1984  11-Tutors trained April/May 1984	Nov 10 - Dec 5 1986	3 CTT
5. FP Clinical Skills (Comprehensive)	10-Nurse/Midwives 3-PHN 1-Social worker	Jan 5 - Feb 12 1987	5 CTT
6. FP Clinical Skills (Comprehensive)	18-Nurse/Midwives	July 20 - Aug. 28 1987	6 CTT
7* FP Clinical Skills (Basic)	11-Nurse/Midwives (Busoga Diocese)	Feb 14 - March 7 1987	3 CTT
8. Refresher Clinical Course for Service Providers	16 Nurse/Midwives	Oct 5 - Pct 7 1987	5 CTT
9. Refresher Clinical Course for Tutors	12 Tutors	Oct 12 - Oct 14 1987	5 CTT

10.	Follow up of PHN, Nurse Midwives Trained	7 Nurse/Midwives	Nov 16 - Dec 5 1987	3 CTT
11.	Management Skills Course I	4 - DMO 4 - DHV 1 - H/V 3 - CTT 1 - DHI, 1 DNO 1 - M/O	Jan 11 - Jan 29 1988	2 CTT
12.	Management Skills Course II	6 - DMO's 9 - DHV's	Feb 8 - Feb 24 1988	2 CTT
13*	FP Clinical Skills (Basic)	13 -Enrolled Nurse/ Midwives	Feb 8 - March 4 1988	3 CTT
14.	FP Clinical Skills (Basic)	15 Enrolled Nurse/ Midwives	April 17 - May 13 1988	5 CTT
15.	Follow up of Nurse/Midwives trained in July/Aug 1987	13 Nurse/Midwives	Aug - Dec 1988 (3 phases)	4 CTT
16.	Visual Communica- tion II	2 H/Educators 3 Comm. Artists 6 N/M Tutors 1 PHN 4 N/M	Jan 30 - Feb 17 1989	1 CTT
17.	FP Clinical Skills (Basic)	10 Enrolled Nurse/ Midwives 1 Medical Assist.	Mar 13 - April 7 1989	3 CTT
18.	Follow up of trainees trained April - May 1988	7 N/Midwives in Health Centres	June 20 - June 28 1989	3 CTT
19.	Follow up of Busoga Diocese EN/M trained Feb/March 1987	8 EN/M in AID POSTS	March 14 - March 18 1988	2 CTT

20*	Supplies and Logistics Management Course I	33:	Area Officer - FP Service Providers - Store Keepers	Nov 22 - Nov 26 1987	2 CTT
*	" II	31:	Area Officers - FP Service Providers - Store Keepers	Nov 29 - Dec 5 1987	2 CTT
*	" III	38:	Area Officers - FP Service Providers - Store Keepers	Dec 6 - Dec 12 1987	2 CTT
20*	Development of Policy Guidelines for TBA training	18:	SMO MCH/FP - FHI Project Coordinator - UCMB - CNO - SNO (T) 3 CTT, Midwifery Supervisor, Registrar N/M, UNICEF Project Manager SWIP, MOLG, MO-Planning MOH. Principal Tutor	May 2 - May 5, 1989	3 CTT
21*	Curriculum Development for TBA training	9:	Training Officer UCBHCA  - SNO (T) - Nurse tutor (PHS) - N/O I/C Kampala Clinic FPAU - Midwifery Tutor - Project Officer SWIP - 3 CTT	May 8 - May 19 1989	3 CTT
22*	TOT Curriculum for TBA's	-	3 CTT ACNM	May 22 - May 25 1989	3 CTT
23*	Participated in Development of OPL Curriculum (Operational level PHC)	-	Trainers of all Programs	Oct 5 - Oct 9 1988	2 CTT

24*	Editing of OPL Training materials	Trainers of all MOH programs	May 17 - May 18 1989	2 CTT
25*	Editing of OPL Training materials		June 27 1989	1 CTT
26*	Involved in the Needs Assessment on Management of FP Logistics and Supplies		April 1987	3 CTT
27*	Involved in Collection and destruction of expired contraceptives		March 1988	4 CTT
28*	FPAU Clinic Review		November 1988	1 CTT
29*	Training of Interviews involved in the MOH Demographic Health Survey	Nurses, Teachers University students and School leavers	Sept 1988	1 CTT
30*	Training of CHW (U of Makerere)	27 Community workers	June 1989	1 CTT
31*	Participated in UNEPI/ CDD Bio-Annual Project coverage evaluation		July 1989	1 CTT

\* Activities outside MOH/INTRAH Programme

**APPENDIX B.3**

**Courses Attended by CTT Members**

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## APPENDIX B.3

COURSES ATTENDED BY CTT MEMBERS

<u>NAME</u>	<u>COURSES ATTENDES</u>	<u>DATES</u>	<u>PLACE</u>	<u>SPONSOR</u>
1. Mrs. Laheri Rushota	o Team Building and TOT	April/May 85	Nairobi	INTRAH
	o Evaluation Follow up	Feb/1986	Nairobi	INTRAH
	o CBD Prog. Observation Tour	July 1985	Thailand	INTRAH
	o Management of PHC Programs	July 1986	Arusha	ESAMI
	o PST, IST, S Linkages	Feb 1987	Nairobi	INTRAH
	o Management Skills for FP Programs	Oct 1987	Mombasa	CAFS
	o Evaluation Tools and Strategies	Aug/Sept 1987	Nairobi	INTRAH
2. Mrs. Mary Luyombya	o Team Building and TOT	April/May 85	nairobi	INTRAH
	o Management of FP Programs	Sept/Oct 85	California	USAID
	o Evaluation of FP Programs	Oct 1986	Harare	WHO
	o FP Clinical Skills	Feb/Mar 87	Harare	INTRAH
	o Evaluation Strategies and Tools for Trainers	Aug/Sept 87	Nairobi	INTRAH
	o Visual Communication Skills	Cct/Nov 88	Kampala	INTRAH
3. Miss Joyce Zirabamuzaale	o Management of PHC Programs	July 1986	Arusha	ESAMI
	o TOT		Nairobi	CAFS
	o Supplies and Logistic Management TOT	April 1987	Arusha	ESAMI
	o Evaluation Strategies and Tools for Trainers	Aug/Sept 87	Nairobi	INTRAH
	o Management Skills for FP Programs	Jan 1988	Kampala	INTRAH

4.	Lucy A. Asaba	o FP Clinical Skills	Feb/Mar 1987	Harare	INTRAH
		o Evaluation Tools and Strategies for Trainers	Aug/Sept 1987	Nairobi	INTRAH
		o Observation Tour for VSC Program	Nov 1987	Nairobi	AVSC
		o Management Skills for FP Program	Jan 1988	Kampala	INTRAH
		o TOT	Sept/Oct 1988	Nairobi	CAFS
		o Visual Communication Skills	Oct 1988	Kampala	INTRAH
5.	Dr. Anthony Aboda	o FP Clinical Skills (Dr/Nurse Team)	April 1986	Phillipines	INTRAH
		o Management of PHC Program	July 1986	Arusha	ESAMI
		o TOT	Oct 1986	Nairobi	CAFS
		o PST, IST, S Linkages	Feb 1987	Nairobi	INTRAH
		o Management Skills for FP Program	Oct 1987	Mombasa	CAFS
		o Consultation Skills	Feb 1988	Nairobi	INTRAH
6*	Mrs Judith N Kaija	o Team Building and TOT	April/May 85	Nairobi	INTRAH
		o Supervision and Evaluation	July/Aug 87	CEDPA USA	INTRAH
		o Evaluation Strategies and Tools for Trainers	Aug/Sept 87	Nairobi	INTRAH
		o Clinical Skills Course	Jan/Feb 87	Kampala	INTRAH
		o Management Skills for FP Programs	Jan 1988	Kampala	INTRAH
		o CBD Prog. Observation Tour	Sept 1985	Thailand	INTRAH
7*	Dany B. Parma	o Team Building and TOT	April/May 85	Nairobi	INTRAH
		o Evaluation Short Course	May/July 85	Chapel Hill	INTRAH
		o Evaluation Follow-Up	Feb 1986	Nairobi	INTRAH
		o Evaluation Strategies and Tools for Trainers	Aug/Sept 1987	Nairobi	INTRAH

8*	Dr. Margaret Kaisa	o Team Building and TOT	April/May 85	Nairobi	INTRAH
		o CBD Prog. Observation Tour	July 1985	Thailand	INTRAH
		o Evaluation Follow Up	Feb 1986	Nairobi	INTRAH
9*	Mrs. Marcella Ochwo	o CBD Prog. Observation Tour	July 1985	Thailand	INTRAH
		o Project Management Prog.	Oct 1985	Connecticut	INTRAH
10.	Miss S. Katesigwa (Deceased)	o Team Building and TOT	April/May 85	Nairobi	INTRAH
		o CBD Prog. Observation Tour	July 1985	Thailand	INTRAH
		o Natural FP TOT	Mpve,ner 1095	Phillipines	INTRAH
*	Trainers left the team				

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APPENDIX C.1

Summary of Meeting with ADMS (Planning)

SUMMARY OF MEETING WITH ADMS (PLANNING)  
(July 24, 1989)

Policy on FP Data

- No written policy in the past/was only implicit.
- Health information in total has not been streamlined.
- No feedback system was built in from planning - no feedback sent to field at present.

In future

The New Health Policy document has streamlined this.

- Some basic health information including MCH/FP will be sent from health units to DMO in each district who will compile and send to Planning Division.
- Planning Division will send feedback to DMO which will be used for further planning.
- Hospital records from MOH and NGOs will also go to the respective DMOs for onward transmission to Planning.
- The data planned to be collected will not be comprehensive - Division managers are empowered to collect comprehensive data as they need.
- Planned Health Information system is in phases and is expected to be effected in all districts by 1992.
- Different donors are funding HIS in different areas (AMREF-CIDA, Italian Govert, etc).
- There are also plans to set up sentinel sites for indepth information in future.
- Printing and production of records will be coordinated by UNICEF in Uganda.

views on CTT

- CTT to be given more time to train more service providers to establish more service sites.
- CTT has not done much due to financial constraints - release of funds.
- Integrated training to be explored to establish areas where one can integrate.

VISUAL COMMUNICATION WORKSHOPS

Current Jobs

Current Activities

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N = 5	o Providing FP Service clients - 4
FP Service Providers -3	o FP service supervisor/provider - 1
Nurse Tutor - 1	o Training - PST Students -1
Deputy Project Manater - 1	- CBNC workers -1
	- On Job -1
	o Providing MCH/FP services-1
	o FP Clinic Management -1

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WHAT THEY LEARNED/MISSED IN WORKSHOP

Most useful

- o Development methodology - 11
- o Development using local materials - 3
- o Adult leaning methods - 1

Missing

- o Actual practice using designed visual 1
- 

Methodology for developing visual was liked most (11) especially pre-testing and workplans followed by use of local materials (3). Shortage of time alloted the workshop was sited frequently (4) and 1 respondent wanted real practice using the new visuals.

HOW MATERIALS DEVELOPED WAS USED

<u>Setting</u>	<u>Target Audience</u>	<u>Frequency</u>
o ANC Clinic	Expectant mothers	Many times
o Young Christian Fellowship Camp	Youth	3 times
o Youth workshop	Youth	Once

- o Sensitization Workshop            Community Members    4 times
- o Mothers Club                        Rural mothers/women 2 times
- o FP Clinic                            Clients  
(individual and groups)            20 times
- o FP and Immunization Clinic    FP Clients and mothers    3 times a week
- Medical Staff            Once
- o TOT Workshop                      FP Trainers            Once
- o Classroom                          PST Students            Once
- o        ?                                Service Providers    ?

4 Respondents used the visual materials for educating mothers and clients in MCH/FP Clinics several times. 4 respondents used visual materials for educating community groups between and 4 times while 3 respondents used visual aid training others.

#### USEFULNESS OF VISUAL MATERIALS

- 
- o Stimulated and created interest in learners - 4
  - o Helped to generate discussion - 3
  - o Enhanced understanding of message - 2
  - o Helped in summarizing the lesson - 1
- 

Responses included that students laughed, provider knows clearly message she/he intends to pass and stimulated many questions from clients.

#### CHANGES MADE IN THE MATERIALS

- o Wrote message in local language            )    1
- o Revised the children picture in order    )
- to make them of different ages            )    1
- o Unspecified change                        )    1
- o No change                                    )    1

1 respondent translated message into the local language and revised the family picture to make children look different ages while one reported an unspecified change. 3 respondents did not make any changes.

## NEW MATERIALS DEVELOPED

<u>Subject</u>	<u>Audience</u>	<u>Progress</u>
"How to use the Condom correctly"	Men/women	Currently undergoing pretesting
"Barrier Methods"	Not specified	Not specified
"Teenage Pregnancy"	Teenagers	Sketches made still to be pre-tested
"Fears and Misconceptions on IUCD"	Women	Incomplete

4 respondents have developed or in the process of developing new materials. The target audiences range from teenagers to women and men. Subjects include barrier methods, teenage pregnancy and IUCD misconceptions.

## RECOMMENDATIONS

Train more people	:	3
Refreshers	:	2
Access to materials	:	2
Focus on Rural Community	:	1

ORIENTATION WORKSHOP FOR HOSPITAL MANAGEMENT TEAMS

-----  
CURRENT POSITIONS

	<u>SNO</u>	<u>TUTOR</u>	<u>AG/MED SUPERINTENDENT</u>
MOH	2	-	-
NGO	-	1	1
CHANGE OF STATION AFTER TRAINING	2	-	-

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Total	-	4	
	2		MOH SNO changed station after training but retained position.
	1		NGO Acting Med. Suprintendent promoted from Acting deputy.
	1		NGO tutor retained both station and position.

WHAT THEY LEARNED/MISSED IN WORKSHOP

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<u>Most Useful</u>	<u>No of respondents</u>
Update knowledge of MCH/FP	2
Integration of MCH/FP	2
Developing work Plan	1
<u>Missing</u>	
FP Clinical Skills	2

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Most useful knowledge included Integration of MCH/FP services (2), Update knowledge of MCH/FP (2) and Developing work plan (1). 20 MOH SNOs stated that FP clinical skills was missing.

## HOW THEY UPDATE FP KNOWLEDGE/SKILLS

<u>Response</u>	<u>No. of Respondents</u>
Reading books about FP	3
Discussion with Providers	2
Too busy with administration	1

## RECOMMENDATIONS

o Increase number of workshops	3
o District level training	1
o Combine knowledge with skills	1
o Involve more management team members	1
o Organise orientation within hospital	1
o Hospital participants to include enough people at responsibility level to ensure inclusion of plans in budget	1
o Enter into agreements with trainees to undertake specific activities after training	1
o Establish quarterly follow-ups	1
o Provide incentives	1

## DHMT WORKSHOPS

<u>Most useful</u>	<u>Frequency</u>
o Human Resources Management	8
- Job descriptions	
- Team Building	
- Supervision	
o Planning	8
o Integration of Services	1
o Evaluation	1
o Supplies management	1

Least useful

- o AIDS 1
- o Management content too theoretical 1
- o No answer 3
- o Do not remember 2

Missing

- o Clinical skills 4
- o Field visit to FP Clinic 1
- o Cultural practices influencing contraceptive practice 1
- o Nothing 2

3 out of 4 DHVs and 1 DMO out of 3 wanted FP clinical skills for themselves.

DHMT SELECTION CRITERIA TO WORKSHOP

Participants to the Management skills workshop for DHMT all selected to central level.

Criteria used was the responsibilities they have over all district health services including FP.

WORKPLAN IMPLEMENTATION

None of the DHMT had completed workplan implementation. Also, only a few could produce evidence of progress. Members of same team differed as to how much of workplan had been implemented. They also differed in number of SDPS providing FP in the district.

HELPING FACTORS IN WORKPLAN IMPLEMENTATION

Availability of resources:

- Transport 1
- Supplies 2
- Trained Personnel 3

Sharing of Resources

- Team work 1
- EPI Transport 1
- Sharing of what was learned 1

## HINDERING FACTORS

- o Funds
  - To buy fuel - 4
  - To motivate community 1
  - To buy posters 1
- o Personnel
  - Not trained 2
  - Not motivated - salaries late 1
  - Too many programs 1
- o Equipment
  - Stationery 1
  - BP Machines 1
  - Logistics 1
- o Resources
  - Funds not allocated by DA 1

### Supervisory Tool      Usefulness

Only one tea, found tool useful because it includes all PHC areas.

One team did not use tool because it "has not been approved".

### Revision

No revisions	2 teams
No revisions	1 DHV

### Revisions

- o Used selected information to formulate District Tool 1
- o Added logistics, Personnel appraisal records 1 DMO
- o Cross out records 1 team

OTHER MANAGEMENT TRAINING BEFORE OR AFTER

Supplies and Logistic Management

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o	PHC/PHC Programs	:	2
o	Supplies and Logistics	:	2
o	UNEPI/Essential Drugs/Continuing Educ.	:	1
o	Personnel/Mid level managers	:	2
o	Project management	:	1
o	None	:	1

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All the 3 DMOs had training in management of PHC or UNEPI or essential drugs before or after INTRAH workshop. 3 DHVs also had training in FP supplies and logistics (2) and midlevel managers course (1). Only 1 DHV who had no training at all. Most of the training was done between 1987 - 1988.

EVALUATION WORKSHOPS SUMMARY

ADMS  
Planning

One participant

Title/Position

Before	-	Biostatistician	Tutor
After	-	Head of Planning Division	Ag. Principal

What did you Learn?

Most useful

Most Useful

- Everything
  - o Monitoring & Evaluation
  - o Reasons for Evaluation
  - o How to evaluate training
- o Evaluation of Training Program

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Time was too short

- o Application of computer (does not have access to computer).

Evaluation Activities involved since

Program Evaluation

Nov. 1986 (First MOH/INTRAH Trainee Follow Up)

- o 1987/89 UNEPI
- o 1987 Essential drugs
- o 1988 AIDS Control Program

Effects on Your Participation on others

- o Helped set up monitoring and evaluation unit in late 1986 in planning (D)
- o Uses it when preparing and using Training designs

## ADMS PLANNING

## PARTICIPANT

Recommendations to MOH on  
evaluation capabilities

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Managers are not using Health  
information to make decisions so:

1. They should be helped to consolidate capacity to evaluate and monitor their programs.
2. Bring those trained in evaluation together to share their experiences in evaluation. (Follow-up on trainees be done early)
3. Develop evaluation capability at all levels particularly at program level.
4. In doing so, utilize the local resources in the MCH/programs and Planning division
5. Consider training in country using MCH/FP Division as the locus but fully involving planning as trainee and also as facilitators.

1. Maintain evaluation Training for CTT
2. INTRAH/MOH keep in touch with trainees constantly.
3. Adequate Resources for evaluation to be assured.
4. People in other programs should be trained.

### Hindering Factors

- a. Lacked coordination to keep group together.
- b. Lacked follow up (should have come from Planning Division and INTRAH)

APPENDIX C.2

Summary of Discussions/Interviews with Senior  
Ministry of Health Officials in the Ministry Headquarters

**SUMMARY OF DISCUSSIONS/INTERVIEWS WITH SENIOR MINISTRY OF  
HEALTH OFFICIALS IN THE MINISTRY HEADQUARTERS**

1. Dr. J.H. KYABAGGU, Acting Director of Medical  
Services, MOH Uganda

(Discussion/Interview Summary: July 13, 1989)

**MOH/INTRAH Training Program**

In general, the program has not had any serious administrative problems and in itself has been "something good" and has made "some impact". Main weaknesses - as with all other programs - is its verticality and lack of "integration" with other training programs.

Constraints: These include the counter funding system - which is beyond MOH scope of influence - and the FP supplies distribution system which has been linked to the general drug distribution system. Sometimes the latter has interfered with FP service provision.

Integration: MOH's goal is to conduct "integrated" training to avoid personnel being called several times in a year for training. Management training is an area where integration could begin and there is need to find other areas where linkages in training could be established. In addition, decentralized training is an MOH objective and requires proper preparation and assistance from the central level.

Integration of services is important if training is to respond in an integrated way.

The Centre for Continuing Education at Mbale is the key resource for training.

**The MCH/FP Core Training Team (CTT)**

As "integration" takes place, there is need to find ways of re-absorbing the CTT into the "integrated" system. The CTT could provide training in special skills. MOH plans to phase out the CTT and have its role performed within the "integrated" system in future.

There is concern that while the CTT as initially carefully selected and now has capabilities to carry out its work, the members left a vacuum still not yet filled. In future, it would be important to guard against depleting areas of such personnel who are difficult to replace.

## Study Tours for Senior MOH and FPAU Officials at beginning of the Project

There was a tremendous change in attitude and the program received much support from the individuals all of whom were in positions to do so. A good example was the distribution of FP supplies from the Central Medical Stores.

2. Mrs. L. WALUSIMBI, Chief Nursing Officer  
Date: July 13, 1989

Personnel should be selected centrally by MOH so that DMOs and DHVs may attend most of the workshops. DMOs and DHVs are not consulted on trainee selected and personnel trained do not go back to their original stations.

SNOs should be educated - those who are in-charge of hospitals should have been the ones oriented.

### Integration

Integration is when one person has all the skills. Integration will be achieved by the comprehensive curriculum. However, there is need for in-service training in order to fill gaps.

3. TRAINING DIVISION

Mrs. R.O.M. LEMATIA, SNO (Training) and Mrs. Mabel OKUCHU, SNO (Administration)

(Summary of Interview : July 27, 1989)

### Pre-service and In-service Training and Mbale Centre

INTRAH Training started within training division. Training division is responsible for both PST and IST. The Manpower development and Training Centre situated in Mbale conducts and coordinates training activities on behalf of Training Division. It is financed by CIDA and executed by AMREF. Policies are jointly developed by the Mbale Centre and Training Division and implemented by AMREF. Coordination by Mbale Centre is through the AMREF Office (Entebbe) to ADMS (T). Ag. Director of Mbale Centre (Dr. Ojome - Paediatric Consultant) is counterpart to AMREF Medical Training Officer.

### Training Focus/Progress

Training focus is both district and community based, so training should be conducted at district level.

District level training has already started with district administrators being the recipients of two types of workshops:

- a) Managerial level (DMO, DHV, DHI) and
- b) Operational level for those lower than DMO (health educators, health inspectors)

So far 3 workshops have already been run by the Mbale Centre.

The idea of preparing district administrators is for them to go back and "radiate that to the periphery".

There is need for assistance in both strengthening and developing curricula being used in current workshops.

### Integration

Integration of training programs makes better use of resources. The target to be trained in all the programs is the same - DMOs, DHVs.

In-service training should be integrated. FP is vertical because of its clinical aspects. UNEPI Cold-Chain is also vertical and CDD?

By training district administrators and operational staff using "integrated" curriculum, integration will be achieved through the district workshops.

### Consequences of FP Training

During phase 1, Nurse tutors and Medical assistant tutors were trained in FP Clinical Skills. Some of these nurse tutors are providing FP services. There has been knowledge loss among the paramedicals because of lack of time to provide FP services due to overload from administrative duties.

Before the FP training program, enrolled nurse schools were not teaching FP but now it is included. FP has also been included in the comprehensive curriculum.

During Phase II, tutors have been trained in Visual Communication Skills and although for them it was a revision, in-depth skills were developed. Some visuals prepared during the workshops are now used by other tutors at Mulago School of Nursing and Midwifery.

### Training Task Force

The Training Task Force was established by MOH in 1984 for the purpose of coordinating all the training activities and

streamlining policy matters affecting training e.g. trainee and facilitator allowance rates during training. It meets quarterly in a year. There are two levels; policy and operational. Policy level includes ADMS(T), and ADMS (MCH/FP) among others.

Members of the Task Force include:

ADMS (T)

SNO (T)

Essential Drugs Program Manager

FHI Project Coordinator

Director and Medical Training Officer, Centre for Continuing Education

UNEPI Training Manager

CDD Manager

Planning Unit

MCH/FP (MOH/INTRAH Project) Division

At present it is the feelings of SNO (T) that the FP section of MCH/FP Division is not very involved in these meetings and it should get more involved (See note at end of this summary).

There are no problems in coordinating training of other MCH Programs except FP. (Others include UNEPI, CDD, Essential Drugs). All these others share training reports on completion of a training activity during the meetings.

SNO (T) has not yet witnessed any FP training activity report sharing.

Coordination problems should be avoided by careful planning.

CTT Capability

CTT conducts training in FP Clinical skills. SNO (T) is not aware of what other training skills CTT has.

District level training

FP training has been carried out at the main centres. UNEPI has prepared trainers at district level.

CTT's first experience in district level training is the forthcoming TOT for TBA trainers.

Note: Review of minutes of the Task Force meetings revealed that FHI Project Coordinator or 1 - 2 CTT members attended 1 meeting in 1985, 3 in 1986, 2 in 1987 and 2 in 1988.

Dr. S.N. DARFOOR, WHO Advisor to the MCH/UNFPA Project on Strengthening of MCH/FP

July 14:

### The Project

Target is on 8 districts (Arua, Moyo, Mukono, Iganga, Bushenyi, Tororo, Mubende and Hoima). Integrated Family Health services is the focus to improve MCH and FP service. The training program in the project is for middle level managers (District level personnel MPH scholarships) and primary level providers (TBAs and CH workers).

The project is not involved in training FP service providers and no plans have been made on CBD at this point. Training program for CHW is supposed to start January 1, 1990.

### Observed constraints

- o Number of trained FP providers is negligible and not able to support CHW/TBAs in service provision.

### Conclusions

- o There is urgent need to train FP providers in the project districts.
- o Training should be decentralized to the regions to assure a larger number of providers being trained (Dr. Katumba cautioned that the trainee source is also thin nationwide so that it may be impossible to train large numbers of midwives, nurses or assistant health visitors at present)

### Possibilities

- a) MOH/USAID arrangements on filling the gap created by lack of FP providers need to be hastened so that project implementation is not delayed.

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- b) Though the project has no provision for training FP providers, temporary measure may be for UNFPA project to rearrange the activities/funds and train some FP service providers using the MCH/FP CTT - until (a) above is finalised. This would need to be negotiated.

The CTT:

As trainers of TBA trainers, they will establish a good link with service providers.

He referred to the ongoing TBA training plans. Dr. Darfoor sees this group (CTT) as a potential source of national training managers in MCH/FP.

Functions they could perform include the following:

- o He would like to use CTT to train trainers of Trainers for the Project.
- o CTT can assist MCH/FP to standardize MCH/FP training and training curricula.
- o Monitor regional training and help MCH/FP division make training projections.
- o Resource persons for mid-level management training.
- o As the training arm of MCH/FP, can advise the division about strengthening of FP services.

What needs to happen

- o CTT number need to be increased.
- o CTT may need re-orientation in order to conduct training for MCH/FP/PHC integration and training of TBAs.

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Mrs. Lydia Muranga, Acting Executive Director,  
Family Planning Association of Uganda

(Interview Summary : July 26, 1989)

Discussions centred on Training linkages and coordination with the CTT, FP Commodities records and reporting.

Training, Linkages and Coordination with CTT:

FPAU's clinics are used as practice sites for FP clinical Trainees. FPAU is dissatisfied with its non-participation in CTT activities for planning training and conducting it. This has occurred during this 2nd phase of the MOH/INTRAH Project.

FPAU would benefit from more active involvement in training besides precepting for MOH trainees. This would offer opportunity for FPAU clinic staff to know what experiences trainees should get and help collerate what is taught in classroom with practice. For instance, the FPAU follow up schedule for the pill differs from what MOH/INTRAH CTT teaches. One person from FPAU should be fully involved in the CTT.

FPAU also feels that it is often blamed for any problems related to FP e.g. they were blamed for some expired OCs found in the market which had missed destruction along with others (Office of President did not know that MOH has an FP Unit)

CTT and FPAU have identified their differences related to FP training and practice but the group never went past identification of the differences. There is need to officially communicate in writing and keep an official report of agreements reached in resolving the differences. Dialogue is necessary if problems are to be solved. There are no agreed on procedures of FP practice. MOH/INTRAH training is very comprehensive but trainees may not always be able to utilize all the knowledge gained.

Commodities, Reporting and other Supplies

In 1980, MOH issued a population statement stating it was going to deliver FP services while FPAU would provide IEC. Since then, FPAU cannot attract funding for clinic services and so MOH should take its duties seriously.

Following the FP Supplies and Logistics Management Workshop in 1987, it was decided that MOH should coordinate FP supplies and information system. DMOs are supposed to supply all units including NGO and FPAU at the district

6/2

level. However, MOH has not been able to replenish its supplies and FPAU - which obtains supplies from IPPF, has been supplying most of the units in the country.

In April 1989, a circular (see Appendix) detailing the changed FP supplies system was issued by FPAU to FPAU area officers and DMOs. FPAU area officers are now supplying commodities and records to FPAU clinics and private practitioners while DMOs are expected to order direct from FPAU Kampala or MOH and supply all MOH and NGO units in their respective districts. About 20 DMOs have so far acted according to circular.

FP Reporting system for IPPF now requires that FPAU submit number of new acceptors and re-visits. Continuing acceptor items is now dropped from current format.

FPAU Kampala Clinic has on its own initiative began keeping a record of drop-outs on first return visit and is attempting to follow up such clients.

FPAU plans to recruit new Executive Director within the next 6 months.

\* Mr. C.H.M. Barlow

Consultant Administrator started work on July 24 and is on a 6 months consultancy to FPAU.

In discussions with him, he explored what INTRAH is and does and how it relates to USAID country Missions in respect to its training projects.

## SUMMARY OF FOLLOW UP REPORTS

5 FP service provider follow-up evaluation reports were revealed covering 1986, 1987, 1988 and 1989. A total of 52 trainees were followed up. 44 were service providers and 8 were tutors.

Of the service providers 29 were working in clinics within hospitals, 8 in aid posts (Busoga Diocese) and 7 in Health centres.

### Performance/Knowledge

Weak areas of knowledge/performance were reported in the follow-up results as IUD skills (5), diaphragm fitting/removal (4), Natural Family Planning (4), Management of side effects of Depo-Provera (3) Client follow up schedule for various methods (2), record keeping (1) and physical assessment (1).

Recommendations were made in each case for special emphasis in training on IUD, diaphragm, NFP, and management of side effects of injectable FP method. Although clinical refresher course of Oct. 5 - 7 1987 addressed above areas of weakness and developed draft protocols, a number still kept recurring and later follow ups (see above). Areas addressed in the refresher include NFP, IUD, Pills, Depo-provera. Protocols were developed and distributed to service providers.

### Hindering Factors

A number of recurring hindering factors to service provision were identified at each follow-up. These included lack of vital clinic equipment/commodities/facilities (5), lack of FP protocols or guidelines on procedures and practice (4), unavailability of a record keeping system and stationery (3), and unsatisfactory supervision due to poor relationship between supervisor and supervisee, or lack of trained supervisor or complete lack of supervision (3).

Recommendations for provision of basic FP instruments, commodities and supplies at the clinic was made in each case. There were also recommendations to: develop and make available FP protocols to service providers, to establish a record system and provide record/and reporting forms and in June 1989 report it was recommended that support and the supervisory system for H/Centre service providers should be strengthened.

It was noted that of the FP service providers followed up each year in general, the group in Busoga Diocese seemed to have less problems with the basic equipment/commodities/supplies than the others. However, none of this group (8) had antiseptic lotions for IUD and only 4 had uterine sounds and 2 had various sizes of IUD.

It was also noted that whereas the total number of vital clinic equipment available at each MOH clinic was less than the number essential, each of the providers followed in June 1989 and who were all at Health Centre level, seemed to have even less number of total essential equipment than those stationed at hospital clinics followed up earlier. For example, out of the 15 vital equipment/supplies list, 5 of the 7 providers had 1 - 5 items each while the other 2 had 6 - 10 items each.

#### Major Recommendations from Follow-up

The following are recommended in the five reports in the following order of recurring frequency:

- a. Provide each service provider with essential equipment/commodities/supplies (5)
- b. Develop and provide protocols/guidelines for FP practice (4)
- c. Outline a clear information flow and provide record forms and stationery for FP data gathering and reporting (3).
- d. Conduct refresher training on identified weak areas of knowledge and skills (4).
- e. Train more service providers in IUD skills (Busoga Diocese).
- f. Develop checklist for service providers and village health workers on awareness creation (Busoga Diocese).

**APPENDIX D**

**CTT Member Questionnaire**

MOH/INTRAH FP Training Project  
Final Evaluation

CTT.QST

CTT Member  
Questionnaire

1. When did you become a member of the CTT?

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2. How were you selected and by whom?

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3. What were your previous training and experience?

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4. What training did you receive in preparation for, or as a member of, the CTT?

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5. How do you update your knowledge and skills?

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6. What do you think has been missing from your preparation as a CTT member?

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7. What have been, in your opinion, the most important activities of the CTT?

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8. What have been your own responsibilities?

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9. What do you see are/have been the specific skills and contributions of other members of the team (please also include those who have left the CTT).

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10. What other skills do you think should have been developed or included to improve the effectiveness of the team?

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11. What do you see as the main achievements of the FP training program (if any)?

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12. What do you see as the main weaknesses of the FP training program (if any)

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13. What have been the main facilitating factors?

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14. What have been the hindering factors?

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15. What do you see as the main functions of participants' follow-up?

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16. How well do you think these have been achieved?

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17. What have been the main facilitating factors?

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18. What have been the main hindering factors?

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19. How does CTT coordinate its activities with other divisions of the MOH? (give specific examples and comment on the quality of the coordination)

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20. How does the CTT coordinate its activities with District Health Teams? (give specific examples and comment on the quality of the coordination).

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21. How does the CTT coordinate its activities with Hospital Management Teams? (give specific examples and comment on the quality of the coordination)

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22. What do you think should be done to provide adequate supervision to FP service providers?

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23. How do you think FP training should be carried out to contribute to the integration of MOH/PHC services?

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24. Has the program, in your opinion, contributed to or adversely affected the integration of MOH/PHC services? Please support your answer?

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25. If the program was only beginning, what do you think should be done differently?

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26. Please comment on the quality and timeliness (or weaknesses) of technical assistance and support received from INTRAH regional office and consultants:

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27. What do you think should be done now to develop FP services? (Please specify training activities for specific personnel categories)

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28. What do you think could be the future role of the CTT?

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29. What have you gained as a result of your participation in the CTT?

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30. What have been negative consequences of your participation in the CTT?

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31. What would you say are your skills now? Please describe how you developed these skills:

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32. What do you see as your own role in the future?

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33. Any additional comments?

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**APPENDIX E**

**Methodology**

**APPENDIX E.1**

**ie of Data Collection Strategy**

Evaluation questions and information sources:

A preliminary list of questions to be addressed by the evaluation was developed by Dr. Fontaine and Mrs. Wachira at INTRAH/ESA headquarters and discussed with INTRAH/ESA Director Miss Pauline Muhuhu.

This list was revised and developed with MOH/FHI CTT members. Additional information needs were identified during briefings and meetings held with Mr. Cohn, USAID/Kampala, Dr. Katumba, SNC/MCH, Dr. Kyabaggu, ag. DMS, Mrs. Walusimbi, CNO, Dr. Dafoor, UNFPA/WHO technical Advisor I to the MCH division, and Mr. Gaifuba, ADMS/HE.

Evaluation questions were specified with respect to potential beneficiaries and practical utilization of the information. Information sources were identified, including: project files, in particular follow-up and annual review reports; MOH headquarters officials; Medical Superintendents and Senior Nursing Officers in hospitals; District Medical Officers, District Health Visitors and District Health Educators in district headquarters; FPAU area officers; workshops participants; their immediate supervisors, colleagues and clients; client and commodity records.

Instruments development:Knowledge Test

Ten questions were selected from the Basic FP skills pre/post test by Miss Asaba. The knowledge areas identified include:

- 1 Population issues
- 2 FP Benefits for mothers
- 3 Gynecological physiology
- 4 Contraceptives action
- 5 O.C. contraindications
- 6 O.C. decision making
- 7 Injectables contraindications
- 8 IUD decision making
- 9 Physical examination purpose
- 10 AIDS transmission

Performance Assessment:

The performance assessment form had been previously developed, used for field follow-ups and revised by the Core Training Team.

A list of elementary tasks to be observed for each dimension of performance was completed. Execution criteria were specified when necessary.

Questions used to prompt for the execution of the tasks were simplified after a pre-test performed in the Entebbe hospital FP clinic.

Areas and dimensions of performance were identified as:

1 Applied knowledge

1.1 Oral contraceptives:

1.1.1 Absolute contraindications

1.1.2 Follow-up schedule

1.2 IUD

1.2.1 Signs and symptoms of complications

1.2.2 Indications for removal

1.2.3 Follow-up schedule

1.3 Injectables:

1.3.1 Follow-up schedule

1.4 Natural Family Planning

2 Skills

2.1 IUD

2.1.1 Establishing rapport

2.1.2 Preparation

2.1.3 Insertion

2.1.4 Instructions to clients after insertion

2.1.5 How to feel for strings

2.1.6 IUD Removal

2.2 Injectables

2.2.1 Depo Provera injection

2.3 Barrier Methods:

2.3.1 Condom instruction

2.3.2 Foaming tablets instruction

3 Decision Making:

3.1 IUD:

3.1.1 Management of client asking for removal

3.1.2 Management of abdominal pain

3.2 Injectables

3.2.1 Management of bleeding complaint

Questionnaires and Interview guidelines:

Information required to answer evaluation questions was listed according to each identified source. Questionnaires and interview guidelines were developed when appropriate. The questionnaire developed by the CTT for participants follow-ups was adapted to accommodate additional needs for information.

Questionnaires were developed for MSs, SNOs, DMOs, DHVs, and for participants to specific project workshops, and CTT for the Interview guidelines were developed for each provider's immediate supervisor, colleagues, clients, and for DHEs. Questionnaires and guidelines covered the following areas:

- 1 Trainees characteristics, selection procedures and criteria;

- 2 Training effectiveness, with respect to trainees knowledge, perceived usefulness of training content, and FP activity;
- 3 Training consequences, with respect to service integration, sharing with colleagues, client recruitment and satisfaction;
- 4 Helping and hindering factors, including resources availability, support and supervision, and program awareness by the supervisors;
- 5 Criticisms and Recommendations.

Checklists were designed for clients and commodities records review, to assess information availability and quality, contraceptives availability, and to attempt to estimate clients recruitment and retention.

Specific questionnaires were also developed for participants to Orientation, Management Skills and Visual Communication workshops.

#### Data collection:

Two field data collection teams were formed. Each comprised one CTT member and one INTRAH staff/consultant. A field schedule for data collection was developed (attached)

The performance assessment questions were submitted to each clinical FP provider or tutor included in the evaluation sample. Pre-specified non-leading prompts were used when required. As it seemed likely that clients would generally not be available, performance was assessed on role-play or simulation.

A single rater (in some cases 2 independent raters were used) recorded on the performance assessment instrument whether each elementary task had been executed as specified. An informal feedback was provided to each respondent.

The abbreviated knowledge test was administered to each clinical FP provider or tutor included in the sample.

Questionnaires were administered to each identified respondent: colleagues, immediate supervisor, clients, Hospital and/or District Management Team members. Written answers were reviewed and eventually clarified or completed with the respondent.

Clinic records were reviewed.

Project files and documents were reviewed. Information that had been identified during the planning week was collected and summarized by the two CTT members remaining in Kampala/Entebbe.

FIELD SCHEDULE FOR DATA COLLECTION

DISTRICT HEADQUARTERS

- I. SEE DMO:
  - A. INTRODUCE EVALUATION TEAM AND EXPLAIN EVALUATION PROCEDURE
  - B. ADMINISTER DMO QUESTIONNAIRE
  - C. ADMINISTER SPECIFIC PARTICIPANT QUESTIONNAIRE IF DMO HAS BEEN INVOLVED IN MOH/INTRAH WORKSHOP
  - D. [IF POSSIBLE, LEAVE QUESTIONNAIRES WITH DMO AND MAKE AN APPOINTMENT FOR INTERVIEW]
  - E. REVIEW AND CLARIFY ANSWERS
  
- II. SEE DHV:
  - A. INTRODUCE EVALUATION TEAM AND EXPLAIN EVALUATION PROCEDURE
  - B. ADMINISTER DHV QUESTIONNAIRE
  - C. ADMINISTER SPECIFIC PARTICIPANT QUESTIONNAIRE IF DHV HAS BEEN INVOLVED IN MOH/INTRAH WORKSHOP
  - D. [IF POSSIBLE, LEAVE QUESTIONNAIRES WITH DHV AND MAKE AN APPOINTMENT FOR INTERVIEW]
  - E. REVIEW AND CLARIFY ANSWERS
  
- III. SEE DHE:
  - A. INTRODUCE EVALUATION TEAM AND EXPLAIN EVALUATION PROCEDURE
  - B. INTERVIEW FOLLOWING INTERVIEW GUIDE
  
- IV. SEE FPAU AREA OFFICER:
  - A. INTRODUCE EVALUATION TEAM AND EXPLAIN EVALUATION PROCEDURE
  - B. INTERVIEW FOLLOWING INTERVIEW GUIDE

IN HOSPITAL

- I. SEE MS/SNO:
  - A. INTRODUCE EVALUATION TEAM AND EXPLAIN EVALUATION PROCEDURE
  - B. ADMINISTER MS QUESTIONNAIRE
  - C. ADMINISTER SPECIFIC PARTICIPANT QUESTIONNAIRE IF MS HAS BEEN INVOLVED IN MOH/INTRAH WORKSHOP
  - D. [IF POSSIBLE, LEAVE QUESTIONNAIRES WITH MS AND MAKE AN APPOINTMENT FOR INTERVIEW]
  
- II. SEE FP PROVIDER:
  - A. ADMINISTER PROVIDER QUESTIONNAIRE
  - B. ADMINISTER KNOWLEDGE TEST
  - C. WHILE PROVIDER IS ANSWERING QUESTIONNAIRE AND KNOWLEDGE TEST:
    - 1. REVIEW CLINIC/CLIENTS RECORDS
    - 2. INTERVIEW 3 CLIENTS IF POSSIBLE
    - 3. INTERVIEW 1 COLLEAGUE IF POSSIBLE
  - D. ADMINISTER PERFORMANCE EVALUATION INSTRUMENT
  - E. REVIEW AND CLARIFY ANSWERS TO QUESTIONNAIRE
  - F. GIVE FEEDBACK AS APPROPRIATE

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**APPENDIX E.2**

**Sampling Plan**

As the main purpose of the program was the establishment of FP services, the sampling frame was based on clinical FP trainees. Stratification was used to ensure that all geographic areas and types of clinical FP trainees would be represented.

The size of the sample was determined with respect to time and transportation constraints. It was estimated that each data collection team could see, on the average, one provider and related respondents per data collection day. The sample size was thus determined to be 10 clinical FP trainees.

The sampling frame was designed by listing Ugandan regions, and districts within regions, from West to East (selected at random). Northern regions were excluded for security and accessibility reasons. Kampala and Entebbe were considered as a specific entity distinct from the rest of the Mpigi district. Within each district, the number of providers were listed for each type of clinical FP workshop and numbered sequentially (sampling frame attached).

The sampling interval was calculated by dividing the total number of clinical FP trainees by the desired sample size. The first sample member was selected randomly within the first interval. Additional trainees were then selected systematically following the sampling interval. This procedure achieves direct representation by selecting stratified sample elements with a probability proportional to the size of the stratum.

To minimize travel time, it was decided to interview participants to other types of workshops residing in the same districts as the clinical FP trainees selected.

## FIELD SCHEDULE FOR DATA COLLECTION

DISTRICT	Comp. C. F/P	Basic F/P	Orient.	D.H.M.T.	Vis.Comm.	Refr.Clinical	Refr.Tutor
<u>Southwest Region</u>							
1. Rukungiri	-	1	-	1	-	-	-
2. Kabale	1	-	1	1	3	2	2
3. Kasese	-	-	-	1	1	-	-
4. Kabarole	-	1	1	1	2	2	-
5. Bushenyi	1	1	-	-	-	-	-
6. Mbarara	4	2	1	1	-	-	-
7. Hoima	-	-	-	-	-	-	-
8. Masindi	-	1	1	1	-	1	-
9.							
<u>Central Region.</u>							
9. Rakai	-	-	-	-	1	-	-
10. Masaka	1	-	-	1	-	-	-
11. Mubende	1	2	2	-	-	-	-
12. Mpigi	1	2	-	1	-	-	-
13. Luwero	-	1	-	1	1	-	-
14. Kampala/Entebbe.	16	2	7	-	20	8	3
15. Mukono	1	2	-	1	-	-	-
<u>Eastern Region</u>							
16. Jinja	1 + 2	2	2	1	4	-	-
17. Kamukhi	4	6	-	1	-	-	-
18. Iganga	4	6 + 2*	-	1	-	-	-
19. Tororo	1	2	-	1	-	-	-
20. Kumi	-	-	-	-	-	-	-
21. Mbale	-	7	2	1	2	1	-
22. Kapchorwa	-	-	-	-	-	-	-
* Busoga Diocese.							

**APPENDIX E.3**

**Collection Instruments**

**E. METHODOLOGY:**

**3. DATA COLLECTION INSTRUMENTS**

- a. Knowledge Test
- b. Performance Assessment
- c. Self Assessment for Clinicians
- d. Colleague
- e. Clients
- f. Client Record
- g. Commodity Record
- h. Immediate in-charge
- i. MS/SNO )  
DHV )  
DMO ) Questionnaires for MS/SNO,  
DHE ) DHV, DMO, DHE  
FPAU Area Officer )
- j. Orientation workshop )  
Management workshop )  
Refresher for Tutors ) Questionnaires for  
Visual Communication ) workshop participants  
Evaluation workshop )  
CTT Questionnaire )

**APPENDIX E.3a**

**Knowledge Test**

3a. Knowledge Test:FAMILY PLANNING CLINICAL SKILLS COURSEPRE/POST QUESTIONNAIRE

The following are some of the reasons why Uganda Government is advocating for integrating Family Planning into MCH services

(Tick correct answer)

- a) It increases the number of nurses in the clinic ( )
- b) Several services can reach the community under similar resources ( )
- c) Patients will get more drugs ( )
- d) Gives the mother a chance to visit the clinic several times ( )

Health benefits of family planning to a Mother includes:-

(Tick the correct answer)

- a) Prevents maternal mortality and morbidity ( )
- b) Reduces complications of pregnancy and child birth ( )
- c) Decreases the incidences of hypertension ( )
- d) Prevents dangerous illegal abortions ( )

Match the number of the term in section 7 B beside the statement it describes in section 8 A by writing the number of the correct statement in the suitable space of 7 A.

Section 7 A

- \_\_\_ (a) Hormone produced by ovarian follicle
- \_\_\_ (b) Release of a mature ovum from ovary
- \_\_\_ (c) Pain in lower abdomen during ovulation
- \_\_\_ (d) Joining of sperm and ovum
- \_\_\_ (e) Hormone produced by corpus luteum
- \_\_\_ (f) Fertilized ovum being embedded at the endometrium
- \_\_\_ (g) Yellow body or empty sac left at the ovary after ovulation
- \_\_\_ (h) Hormone secreted by Anterior pituitary gland which stimulates development of the corpus luteum
- \_\_\_ (i) First menstruation at puberty
- \_\_\_ (j) Hormone secreted by the Anterior Pituitary gland which stimulates the follicle.

Section 7 B

1. Oestrogen
2. Prolactin
3. Menarche
4. Luteinizing hormone
5. Fertilization
6. Progesterone
7. Implantation
8. Ovulation
9. Androgen
10. Progesterone
11. Mittelschmerz
12. Follicle stimulating hormone
13. Corpus Luteum

The purpose of physical assessment in Family Planning is to:-  
(Tick 'T' if it is True and 'F' if it is false)

- |                                                                      |   |   |
|----------------------------------------------------------------------|---|---|
| a). Rule out abnormalities before prescribing contraceptives         | T | F |
| b). To detect if client is fit for future pregnancy                  | T | F |
| c). To detect diseases not related to F.P.                           | T | F |
| d). To demonstrate the nurses skills in family planning              | T | F |
| e). To rule out nulliparity                                          | T | F |
| f). To provide baseline information about the client health status.  | T | F |
| g). To help physician/Nurse choose a suitable method for the client. | T | F |

The absolute contra-indications to the use of contraceptive pills include :-  
(Tick the correct answer)

- a) Irregular menstrual flow
- b) Impaired liver function
- c) Breastfeeding
- d) Tendency to uterine infection.
- e) Depression

The statements in section 11 B describe contraceptive methods in section 11 A match the number with the method it describes by writing it in appropriate blank space of 11 A.

- | <u>Section 11 A</u>                                                                                 | <u>Section 11 B</u>        |
|-----------------------------------------------------------------------------------------------------|----------------------------|
| ..... (a) helps to kill the sperm                                                                   | 1. Coitus interruptus      |
| ..... (b) Contains synthetic hormones                                                               | 2. Intra - uterine device  |
| ..... (c) Requires careful withdrawal of the penis from the female genital area before ejaculation. | 3. Obstinancy              |
| ..... (d) Surgical contraceptive method for men                                                     | 4. Oral contraceptive      |
| ..... (e) Placed in uterus by trained family planning Nurse/Midwife                                 | 5. Natural Family Planning |
| ..... (f) Dome shaped rubber placed over cervix.                                                    | 6. Spermicide              |
| ..... (g) A thin rubber sheath                                                                      | 7. Vasectomy               |
| ..... (h) Requires co-operation of husband and wife and knowledge of menstrual cycle                | 8. Condom                  |
| ..... (i) Surgical contraceptive method for women                                                   | 9. Traditional method      |
|                                                                                                     | 10 Tubal ligation          |
|                                                                                                     | 11. Diaphragm.             |

Mrs. Kasule had an IUCD inserted three months ago, she comes to your clinic complaining of severe abdominal pain. What will you do for her? (Tick correct answer).

1. Examine client, reassure and send her back home.
2. Examine client, remove IUCD and refer her back home.
3. Examine and refer her to doctor for treatment.
4. Examine client, remove IUCD give an alternative F.P method and refer her to doctor.

Depo - Provera injection can be given to the following clients  
EXCEPT (Tick the correct answer)

1. Those with sickle cell disease.
2. Lactating mothers.
3. Nulliparous.
4. Those above 35 years of age.
5. Grand multipara.

The common ways in which AIDS is transmitted are as follows  
EXCEPT (Tick the correct answer)

- a) Contaminated needles and instruments.
- b) Sharing eating utensils and towels.
- c) Sexual intercourse with infected persons.
- d) Contaminated or unscreened blood transfusion.
- e) From AIDS infected mother to newborn.

A client has been taking oral pills regularly for 3 months, she complains of missing one period. After physical assessment, and not suspecting pregnancy how will you deal with her?

(Tick one correct answer).

- a) Refer her to Doctor for treatment.
- b) Encourage her to continue taking the pills.
- c) Stop her from taking the pills.
- d) Advise her to have a pregnancy test done.
- e) Ask her to return to the clinic if she misses the next period.

**APPENDIX E.3b**

**Performance Assessment**

3b. PERFORMANCE ASSESSMENT

Date:

District:

Name:

DIMENSION OF PERFORMANCE

(Rate according to key)

++, +, +/-, -, 0

SKILL/FUNCTION (To be evaluated)	Accuracy and sufficiency of information found and knowledge	Execution of Clinical Skills Procedure and exams.	Appropriateness of Decision making. Protocal whenever possible
<u>Family Planning Methods</u>			
1.a. <u>ORAL CONTRACEPTIVES</u>  States absolute contraidications . Liver disease . Coronary Heart disease . Pregnancy . Breast Tumours . Genital malignancy . Thrombo embolic disorders . Undiagnosed abnormal vaginal bleeding. . CVA			
b. Distinguishes between high and low dose O.C. * Microgynon, * Lo-feminal . Mini-pill. * -States that these do not <sup>significantly</sup> reduce breast milk.			
2. a. <u>INTRA-UTERINE DEVICE</u>  . Explain what you are going to do. . Show equipment to use to client. . Ask rapport building questions (relax client) . Tell her - little discomfort that soon ceases when inserting. . Encourage questions from clients.			
b. Sterile equipment . Clean site (trolley) . Wash your hands . Lay all required equip- ment on trolley . Explain next step to client. . Ensure bladder is empty.			

SKILL	KNOWLEDGE	SKILLS	DECISION MAKING
<p>c. <u>INSERTING IUD</u></p> <ul style="list-style-type: none"> <li>• Position the Client.</li> <li>• Inspects vulva</li> <li>• Clean vulva</li> <li>• Bimanual exams -</li> <li>• Change gloves</li> <li>• Speculum exam</li> <li>• Clean vagina &amp; Cx with antiseptic (hibitane)</li> <li>• Apply tenaculum</li> <li>• Sound the uterus</li> <li>• Determines the depth of uterus</li> <li>• Load the IUD</li> <li>• Insert IUD</li> <li>• Remove tenaculum</li> <li>• Stop bleeding from site of tenaculum if any by applying pressure.</li> <li>• Tream or cut IUD string if too long.</li> <li>• Remove speculum</li> </ul>			
<p>d. <u>INSTRUCTIONS TO CLIENT AFTER IUCD INSERTION</u></p> <ul style="list-style-type: none"> <li>• When IUD become effective (immediate)</li> <li>• How to fill for string</li> <li>• How often to check for string.</li> <li>• Changes on menstrual periods.</li> <li>• When to start normal sexual relation (coitus)</li> <li>• When to come back to clinic               <ul style="list-style-type: none"> <li>- routine</li> <li>- for problems</li> </ul> </li> <li>• Risk of exposure to STD.</li> </ul>			
<p>e. <u>HOW TO FEEL FOR STRING</u></p> <ul style="list-style-type: none"> <li>• Wash hands</li> <li>• Position of client for feeling (back or standing with one leg on a step)</li> <li>• Insert clean 2 fingers in vagina to feel for string -<del>reach</del> up to ext OS cervix.</li> <li>• Remove fingers (<u>Prompt</u>) how often?</li> <li>• Frequently in first one month after insertion <del>then</del></li> <li>• Then every time after her menstrual period thereafter.</li> </ul>			

SKILL	KNOWLEDGE	SKILL	DECISION MAKING
<p><b>3. REMOVAL IUD</b></p> <ul style="list-style-type: none"> <li>- Insert speculum</li> <li>- Clean vagina &amp; Cervix with cutiseptic (hibitane)</li> <li>- Apply tenaculum</li> <li>- Remove IUD and hold string close to ext OS slowly and gently.</li> <li>- Show removed IUD to Client.</li> <li>- Remove the tenaculum</li> <li>- Insert another one if necessary.</li> </ul>			
<p><b>4. SIGNS AND SYMPTOMS OF COMPLICATION OF IUCD</b></p> <ul style="list-style-type: none"> <li>- Fever, plus chills</li> <li>- Cramps/Abd.pain and/or without tenderness &amp; guarding</li> <li>- Vaginal foul smelling discharge</li> <li>- May be Nausea and vomiting</li> <li>- Heavy bleeding or irregular bleeding, Anaemia</li> <li>- Missing strings</li> <li>- Amenorrhoea</li> <li>- Part IUD in vagina ext. OS.</li> <li>- Inflamed cervix</li> <li>- Tender fornices plus palpable tender adnexial mass</li> </ul>			
<p><b>5.a. INTRA-UTERINE DEVICE</b></p> <p>States:</p> <ul style="list-style-type: none"> <li>. Desired pregnancy.</li> <li>. P.I.D.</li> <li>. Excessive bleeding,</li> <li>. Wants to change to another method.</li> </ul>			
<p>b. Finds out from client why she wants IUCD removed,</p> <ul style="list-style-type: none"> <li>. Counsells client to keep IUCD since has no. problem,</li> <li>. Shows respect for clients personal reasons,</li> <li>. Agreea to remove IUCD</li> </ul>			
<p>c. Obtains information on how</p> <ul style="list-style-type: none"> <li>. long she has had the IUCD</li> <li>. last menstrual period,</li> <li>. how long and any vaginal discharge,</li> <li>. if she feels the threads.</li> </ul> <p>Does - speculum exam</p> <ul style="list-style-type: none"> <li>- to locate threads</li> <li>- state of cervix</li> <li>- nature of discharge</li> </ul> <p>- Bimanual - tenderness</p> <ul style="list-style-type: none"> <li>- smelling</li> <li>- size of uterus.</li> </ul> <p>- Removes or refers client</p>			

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SKILL/FUNCTION	KNOWLEDGE	SKILL	DECISION MAKING
<p><b>6. INJECTABLES</b></p> <p>a. Follows procedure correctly.</p> <ul style="list-style-type: none"> <li>• maintains sterility</li> <li>• checks expiry date</li> <li>• shakes bottle</li> <li>• expells air,</li> <li>• cleans site,</li> <li>• stretches skin, gives inj. IM. deeply,</li> <li>• withdraws needle and does not rub site,</li> <li>• instructs client to come back for next dose.</li> </ul>			
<p>b. Find out from client how long she has had the bleeding</p> <ul style="list-style-type: none"> <li>• how heavy the bleeding is. (can ask how many pads she uses in a day).</li> <li>• Examines clients to exclude anaemia.</li> <li>• Does speculum exam to exclude other courses of vaginal bleeding, and determine amount of bleeding.</li> <li>• Gives appropriate treatment - co.c, Inj. Depo-oestradiol 5 mg. Ferrous sulphate.</li> </ul>			
<p><b>7. CONDOM</b></p> <p>Instruct client on correct usage</p> <ul style="list-style-type: none"> <li>• Inspects unopened condom,</li> <li>• Puts condom on rect penis before contact with vagina</li> <li>• withdraws penis before it softens,</li> <li>• Removes condom from penis</li> <li>• Disposes it properly, i.e burn it or bury</li> </ul>			
<p><b>8. FOAMING TABLETS</b></p> <p>Instruct client in correct usage including demonstration.</p> <ul style="list-style-type: none"> <li>• Inserts tablet high up in vagina, waits for 5-10 minutes before sexual intercourse,</li> <li>• Adds more tablet for next act,</li> <li>• Advises not to wash out foam.</li> </ul>			

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SKILLS/FUNCTION	KNOWLEDGE	SKILL	DECISION MAKING
<p>9. <u>NATURAL FAMILY PLANNING</u></p> <p>Instructs client on how to observe different cervical mucus changes (white thick, mucus, clear stretchy and increased, white thick mucus again. Observe dry and wet days).</p> <ul style="list-style-type: none"> <li>. Instruct client to abstain when mucus appear (wet days).</li> <li>. Advises client where to go for further instructions if not sure.</li> </ul>			
<p>10. <u>FOLLOW UP SYSTEM</u></p> <p>Provides information regarding follow up system -</p> <p><u>PILLS</u> - 2-3 months, to check whether minor side effects have subsided.</p> <p><u>IUCD</u> - 6 weeks, 3 months, 6 months then yearly.</p> <p><u>Injectable</u> - every 3 months to keep hormones at constant level.</p> <p>Note: Anytime Client has a problem. She can return to clinic.</p>			
<p>11. <u>RECORD KEEPING</u></p> <p>a. Records kept for clients, New acceptors.</p> <ul style="list-style-type: none"> <li>. Follow ups,</li> <li>. Continuing acceptors</li> <li>. Commodities, used and needed.</li> </ul>			
<p>b. <u>Purpose Monitoring:</u></p> <ul style="list-style-type: none"> <li>. Attendance</li> <li>. Usage of commodities</li> <li>. Evaluation of program/ service</li> </ul>			
<p>c. To whom: Clinic i/c</p> <ul style="list-style-type: none"> <li>- DMU/DHV at district</li> <li>- MS/SNO at hospital</li> <li>- MOH</li> </ul>			
<p>d. <u>How often</u></p> <ul style="list-style-type: none"> <li>- Monthly</li> <li>- Quarterly</li> <li>- Annually</li> </ul>			
<p>e. Feedback</p> <ul style="list-style-type: none"> <li>- Yes</li> <li>- No.</li> </ul>			

Rating Competency of Service Provider : Performance Test  
Family Planning Methods Questions.

1. ORAL CONTRACEPTIVES

- a). What are the absolute contra-indications for combined oral contraceptives.
- b). Which oral contraceptive would you give to a breast feeding mother? Why?

2. INTRA-UTERINE CONTRACEPTIVE DEVICE

- a). A client comes to you for IUCD insertion, please demonstrate all that you would say and do including IUCD insertion.  
(PROMPT)

- . Is there anything else you would need to explain to the client before she goes home.

3. Demonstrate how you would remove an IUCD

4. What signs and symptoms would indicate complications in an IUCD user.

5. a). What are the indications for IUCD removal?

- b). What would you do for a client with an IUCD, who has no problem but requests its removal?

- c). What would you do for a client with IUCD, who complains of severe abdominal pain?

6. INJECTABLES

- a). Demonstrate how you would give a client a Depo-Provera Injection.
- b). How do you manage a client with heavy menstrual bleeding on Depo Provera?

7. CONDOM

What would you tell the client about the correct usage of a Condom and why?

8. FOAMING TABLETS

What would you tell the client about the correct usage of foaming tablets and why?

9. NATURAL FAMILY PLANNING

What advice would you give to a client who wants to use Natural family planning method.

10. FOLLOW UP SYSTEM.

What is the appropriate follow up schedule for Pills, IUCD and injectables and why?

11. RECORD KEEPING

- a. What kind of records do you keep?
- b. What is the purpose of keeping correct records?
- c. To whom do you send your returns.
- d. How often do you send your returns.
- e. Do you receive feedback about your returns?

**APPENDIX E.3c**

**Self-Assessment for Clinicians**





<u>SERVICE/ACTIVITY</u>	<u>PROVIDED BEFORE TRAINING</u>	<u>CURRENTLY PROVIDING</u>	How well did your F.P training prepare you for this activity		
			<u>Not Enough</u>	<u>Enough</u>	<u>Very Well</u>
3. Use of visual aids in client education	( )	( )	( )	( )	( )
4. Counselling and referral for surgical sterilization	( )	( )	( )	( )	( )
5. Dispensing and counselling for foaming tablets and condoms	( )	( )	( )	( )	( )
6. Dispensing oral contraceptives (OCs)	( )	( )	( )	( )	( )
7. Decision of who should receive oral hormonal contraceptives	( )	( )	( )	( )	( )
8. Making decision as to which type and what dosage of oral contraceptive a client should receive	( )	( )	( )	( )	( )
9. Managing side effects of OCs	( )	( )	( )	( )	( )
10. Providing follow up for OCs clients	( )	( )	( )	( )	( )
11. Decision of who should receive injectable hormonal contraceptives	( )	( )	( )	( )	( )
12. Providing the hormonal injection	( )	( )	( )	( )	( )
13. Managing side effects of injectable hormonal contraceptives	( )	( )	( )	( )	( )
14. Providing follow-up for injectable hormonal contraceptive clients	( )	( )	( )	( )	( )
15. Physical assessment - basic (weight, breasts, abdomen, extremities)	( )	( )	( )	( )	( )
16. Pelvic examination: bimanual	( )	( )	( )	( )	( )
17. Pelvic examination: speculum	( )	( )	( )	( )	( )
18. IUD counselling and referral only	( )	( )	( )	( )	( )
19. IUCD Insertion	( )	( )	( )	( )	( )
20. Managing side effects of IUCD and counselling	( )	( )	( )	( )	( )
21. IUCD, removal	( )	( )	( )	( )	( )
22. STD screening and referral based on clinical examination.	( )	( )	( )	( )	( )
23. STD diagnosis and treatment: based on clinical examination	( )	( )	( )	( )	( )

	PROVIDED BEFORE TRAINING	CURRENTLY PROVIDING	How well did your F.P training prepare you for this activity		
			<u>Not Enough</u>	<u>Enough</u>	<u>Very Well</u>
24. Infertility counselling and referral.	( )	( )	( )	( )	( )
25. ORT (including education of mothers	( )	( )	NA		
26. Natural family planning mentioned. Client referred for instruction	( )	( )	( )	( )	( )
27. Natural family planning counselling and instruction	( )	( )	( )	( )	( )
28. Antenatal care	( )	( )	NA		
29. Intrapartum care (labour and delivery)	( )	( )	NA		
30. Postnatal care	( )	( )	NA		
31. General MCH counselling (breastfeeding, referral for immunization)	( )	( )	( )	( )	( )

17. If you are not providing family planning services for which you were trained please explain the reason for this:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

18. Are there particular constraints which impede your work that you would like to see corrected? Please explain what specific problems or obstacles you see, if any, in each of these areas:

a). Your clinic's equipment/supplies/tools: \_\_\_\_\_

b). Your clinic's commodities  
(the supply of contraceptives: \_\_\_\_\_

c). Your clinic's record keeping  
system: \_\_\_\_\_

d). The supervision you receive from  
others: \_\_\_\_\_

e). The supervision you provide to  
others: \_\_\_\_\_

f). The type and amount of continuing  
training available to you  
and your fellow clinical workers \_\_\_\_\_

g). Local religious issues  
affecting your work: \_\_\_\_\_

h). Other (please explain) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

19. At the end of your INTRAH/MOH training, you developed a workplan which you were to implement in your own work place.

a). How much of the work plan have you implemented?(Tick in appropriate box).

- . all of it
- . more than half
- . half
- . less than half
- . none

b). What were the factors that helped you in implementing your workplan?

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c). What were the problems that hindered the implementation of your workplan?

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20. If in the District

- a). Did your DHO/DHV attend the 1988 Management of F.P programme workshop held at Mukono? Yes/No/Don't know
- b). What kind of support have you received from your DHO/DHV in relations to the following:

	<u>Before</u> his/her training	<u>After</u> his/her training
(i) Equipment		
(ii) F.P commodities		
(iii) General supplies		
(iv) Supervision		
(v) Others (specify		

21. If in the Hospital

- a). Did your HS/SNO attend the hospital management F.P. orientation workshop? Yes/No/Don't know.
- b). What kind of support have you received from your HS/SNO before and after the orientation workshop?

	<u>Before</u> his/her training	<u>After</u> his/her training
(i) Equipment		
(ii) F.P commodities		
(iii) General supplier		
(iv) Supervision		

22. Does the DHO/DHV (for those in district) or HS/SNO (for those in hospitals) supervise you? Yes/No

23. If yes How often?

-----  
 -----  
 -----  
 -----

24. Is a checklist used during the supervisory visits?      Yes       No

25. In which areas do you feel you need more supervision

- (i) -----  
 (ii) -----  
 (iii) -----

26. Has your DHO/DHV (for those in district) or HS/SNO (for those in hospitals) helped you to establish F.P services where you work?

Yes.      No.

(a) If yes, list 3 most important factors which help in establishing the F.P service.

- (i) -----  
 (ii) -----  
 (iii) -----

(b) If ~~NO~~ What 4 major factors hindered the establishing of F.P service

- (i) -----
- (ii) -----
- (iii) -----
- (iv) -----

27. In the F.P clinical skills course you attended what was

- (a) Most useful -----  
-----
- (b) Useful -----  
-----
- (c) Not useful at all -----  
-----

28. What else do you think could have been added in the F.P clinical Skills course you attended?

-----  
-----

29. What other MCH activities are you involved in:

-----  
-----  
-----

30. Are these activities included in your work schedule? Yes  No

If yes, how? Please explain.

-----  
-----  
-----

31. What F.P knowledge and skills have you used for other MCH activities? (please specify)

F.P knowledge used

F.P skills used

- 1.
- 2.
- 3.

- 1.
- 2.
- 3.

32. What kind of F.P services do you offer?

- a) Family planning alone
- b) Integrated
- c) Mobile
- e) Other (specify)  -----

33. In what ways do you update your knowledge in family planning?
- a). Seminars
  - b). Refresher course
  - c). Self reading (F.P books and materials)
  - d). On job training
  - e). Others (Specify)  \_\_\_\_\_

34. In what ways do you update your clinical skills in family planning?
- a). On job training
  - b). Refresher courses
  - c). Others (Specify)  \_\_\_\_\_

35. What additional training have you received since after F.P Clinical Skills course?

Please specify \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

36. Has the Core Training Team helped / supported you in the provision of F.P services? If yes, in what ways?

Please specify \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

37. What interaction/communication do you have with the community leaders in the area where you work?

\_\_\_\_\_  
\_\_\_\_\_

38. What support do you receive from the community leaders for the provision of F.P services?

\_\_\_\_\_  
\_\_\_\_\_

39. In what ways do you collaborate with FPAU in your area?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

40. In what ways has your F.P training helped your colleagues with whom you work?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

41. For those who attended refresher course in 1987

a) What knowledge and skills did you gain in the F.P Refresher Course? (3 most useful gains)

Knowledge gained	Skills gained

b) What else should have been included in the refresher course?

-----  
-----

c) What new F.P activities have you been carrying out since you attended the Refresher course?

-----  
-----

Did you receive protocols/guidelines on oral contraceptives, injectables and diaphragm? Yes  No

If Yes,

a). Have you used them? Yes  No.

b). Are you still using them? Yes  No.

c). Who else is using them?

d). In which ways have these protocols/guidelines have been helpful?

-----  
-----

e). What areas of these protocols need improvement? Please specify

-----  
-----

Thank you for your time and for your answers

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**APPENDIX E.3d**

**FP Provider Colleagues Interview Guide**

INTERVIEW GUIDE

DATE

FP PROVIDER COLLEAGUES

- I. WHAT POSITIVE EFFECTS OF THE FP TRAINING PROGRAM HAVE YOU OBSERVED?
  
- II. WHAT NEGATIVE EFFECTS OF THE FP TRAINING PROGRAM HAVE YOU OBSERVED?
  
- III. HAS THE FP PROVIDER SHARED HER NEW SKILLS/KNOWLEDGE WITH YOU AND/OR OTHER COLLEAGUES?
  
- IV. PLEASE DESCRIBE HOW FP ACTIVITIES ARE COORDINATED WITH OTHER MCH/PHC ACTIVITIES.
  
- V. WHAT COULD BE DONE TO IMPROVE THE COORDINATION OF MCH/FP SERVICES?
  
- VI. IF THIS PROGRAM WAS ONLY STARTING, WHAT DO YOU THINK COULD BE DONE DIFFERENTLY (TO IMPROVE THE EFFECTIVENESS OF THE PROGRAM)?

**APPENDIX E.3e**

**FP Client Interview Guide**

FP CLIENT

DATE:

DISTRICT:

PROVIDER:

INTERVIEW GUIDE

- I. HOW MANY CHILDREN DO YOU HAVE:
- II. HOW OLD ARE THE TWO YOUNGEST:
  
- III. WHAT FP METHOD ARE YOU USING NOW:
  
- IV. FOR HOW LONG HAVE YOU USED THIS METHOD:
  
- V. DID YOU USE ANOTHER METHOD BEFORE:  
IF YES: WHY DID YOU CHANGE:
  
- VI. DID THE FP PROVIDER GIVE YOU ANY INFORMATION REGARDING OTHER FP  
METHOD THAN THE ONE THAT YOU ARE USING:  
IF YES, WHAT METHODS:
  
- VII. WHAT DID THE FP PROVIDER TELL YOU ABOUT THE METHOD YOU ARE USING NOW  
(IF NECESSARY PROMPT FOR:  
A. EFFECTIVENESS:  
B. SIDE-EFFECTS:  
C. WHEN TO COME BACK TO THE CLINIC:  
D. ALARMING SIGNS:
  
- VIII. DID THE FP PROVIDER EVER USE ANY PICTURE TO EXPLAIN SOMETHING TO YOU:  
IF YES: DO YOU FIND THAT THESE PICTURE ARE HELPFUL:
  
- IX. ARE YOU SATISFIED WITH THE INFORMATION GIVEN:
  
- X. HAVE YOU HAD ANY PROBLEM OR WORRY WITH THE METHOD YOU ARE USING:  
IF YES: DID THE FP PROVIDER GIVE YOU HELP/ADVICE TO YOUR  
SATISFACTION:
  
- XI. HAVE YOU GIVEN ANY ADVICE ABOUT FP TO YOUR FRIENDS OR RELATIVES:

**APPENDIX E.3f**

**FP Clinic Clients Records Checklist**

CHECKLIST

date:

FP Clinic Clients Records

District:  
Provider:

I. NUMBER OF NEW FP ACCEPTORS DURING ONE MONTH, 6 MONTHS BEFORE THE CLINICAL SKILLS WORKSHOP: \_\_\_\_\_

DEFINITION OF NEW ACCEPTOR:

II. NUMBER OF CONTINUING CLIENTS DURING THE SAME PERIOD: \_\_\_\_\_

DEFINITION OF CONTINUING CLIENT:

III. CONTENT AND QUALITY OF CLIENT RECORDS KEPT DURING THAT PERIOD:

CONTENT

QUALITY

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IV. NUMBER OF NEW FP ACCEPTORS DURING ONE MONTH, 6 MONTHS AFTER THE CLINICAL SKILLS WORKSHOP: \_\_\_\_\_

DEFINITION OF NEW ACCEPTOR:

V. NUMBER OF CONTINUING CLIENTS DURING THE SAME PERIOD: \_\_\_\_\_

DEFINITION OF CONTINUING ACCEPTOR:

VI. CONTENT AND QUALITY OF CLIENT RECORDS KEPT DURING THAT PERIOD:

CONTENT

QUALITY

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---

---

---

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**APPENDIX E.3g**

**FP Clinic Commodity Records Checklist**

CHECKLIST

date:

FP Clinic Commodity Records

District:

Provider:

- I. WHAT COMMODITIES ARE AVAILABLE AT THE CLINIC?
  
- II. HOW MUCH COMMODITIES DOES THE FP PROVIDER ORDER? HOW OFTEN?
  
- III. NUMBER RECEIVED/ORDERED
  
- IV. WHAT KIND OF COMMODITY RECORDS ARE KEPT AT THE CLINIC

**APPENDIX E.3h**

**FP Provider Immediate in Charge Interview Guide**

INTERVIEW GUIDE

DATE:

FP PROVIDER IMMEDIATE IN CHARGE

DISTRICT:

PROVIDER:

- I. WHAT INFORMATION HAVE YOU RECEIVED ABOUT THE FP TRAINING PROGRAM? (SPECIFY WHEN AND FROM WHOM YOU RECEIVED THAT INFORMATION)
- II. WOULD YOU HAVE NEEDED MORE INFORMATION? (PROMPT FOR USE OF INFORMATION)
- III. WHAT POSITIVE EFFECTS OF THE FP TRAINING PROGRAM HAVE YOU OBSERVED?
- IV. WHAT NEGATIVE EFFECTS OF THE FP TRAINING PROGRAM HAVE YOU OBSERVED?
- V. HAS THE FP PROVIDER SHARED HER NEW SKILLS/KNOWLEDGE WITH ANY COLLEAGUES?  
HOW?
- VI. PLEASE DESCRIBE HOW FP ACTIVITIES ARE COORDINATED WITH OTHER MCH/PHC ACTIVITIES:
- VII. WHAT COULD BE DONE TO IMPROVE THE COORDINATION OF MCH/FP SERVICES?
- VIII. IF THIS PROGRAM WAS ONLY STARTING, WHAT DO YOU THINK COULD BE DONE DIFFERENTLY (TO IMPROVE THE EFFECTIVENESS OF THE PROGRAM)?

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**APPENDIX E.3i**

**Medical Superintendent/Senior Nursing Officer Questionnaire**

MDH/INTRAH FF TRAINING PROJECT  
FINAL EVALUATION

MS.QST 1

Questionnaire

date:

Medical Superintendent / Senior Nursing Officer

District:

Hospital:

I. What information have you received about the MDH/INTRAH FF training program?  
(Please specify when and from whom you received that information)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

II. Would you have liked to receive more information? (Please specify how you would have used this information)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

III. What positive effects of the MDH/INTRAH FF training program have you observed?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

IV. What negative effects of the MDH/INTRAH FF training program have you observed?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

V. Please comment on the extent of integration of health services in your district, particularly with respect to FF/MDH activities (Please give specific examples of coordinated activities/programs and indicate your appreciation of the quality of the coordination):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

MOH/INTRAH FP TRAINING PROJECT  
FINAL EVALUATION

MS.QST

VI. What factors do you see as obstacles to the coordination of health services to address the needs of the community?

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VII. How could the coordination of health services be improved?

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VIII. What kind of records are kept by FP service providers?

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IX. What kind of return do FP service providers send? How often? To whom?

<u>Kind of Return</u>	<u>To whom</u>	<u>How often</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

X. From whom do FP providers get supervision?

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XI. What kind of supervision is provided?

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MDW/INTRAH FP TRAINING PROJECT  
FINAL EVALUATION

MS.QST 3

XII. How often are FF providers supervised?

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XIII. How effective do you find this supervision to be?

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XIV. In what ways is it adequate?

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XV. In what ways is it inadequate?

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XVI. Who finally selected the participants to FF clinical courses?

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XVII. What criteria were used for this selection?

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MCH/INTRAM FP TRAINING PROJECT  
FINAL EVALUATION

MS.QST 4

XVIII. How many clinicians have received FP training in your hospital? \_\_\_\_\_

How many FP trainees have been used to create new FP/MCH services: \_\_\_\_\_

How many FP trainees have been used to strengthen existing FP/MCH services: \_\_\_\_\_

XIX. Have you had any new staff who had pre-service FP training? Yes / No

XX. If yes, have you used them in FP services delivery? Yes / No

XXI. How do you assess their level of knowledge and skills upon their posting?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

XXII. Please describe your relationship with the Core Training Team (Please describe precise conditions and state your appreciation of the quality of the relationship):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

XXIII. What do you think should be the activities of the CTT in the future?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

XXIV. If this program was only starting, what do you think should be done differently (to improve the effectiveness of the services delivered)?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Thank you for your time and answers*

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MOH/INTRAH FP TRAINING PROJECT  
FINAL EVALUATION

DHV.QST 1

Questionnaire

date:

District Health Visitor

district:

I. What information have you received about the MOH/INTRAH FP training program?  
(Please specify when and from whom you received that information)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

II. Would you have liked to receive more information? (Please specify how you would  
have used this information)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

III. What positive effects of the MOH/INTRAH FP training program have you observed?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

IV. What negative effects of the MOH/INTRAH FP training program have you observed?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

V. Please comment on the extent of integration of health services in your district,  
particularly with respect to FP/MOH activities (Please give precise examples  
of coordinated activities/programs and indicate your appreciation of the quality  
of the coordination):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

MOH/INTRAH FP TRAINING PROJECT  
FINAL EVALUATION

DHV.GST 2

VI. What factors do you see as obstacles to the coordination of health services to address the needs of the community?

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VII. How could the coordination of health services be improved?

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VIII. What kind of records are kept by FP service providers?

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IX. What kind of return do FP service providers send? How often? To whom?  
Kind of return                      Sent to whom                      How often

<u>Kind of return</u>	<u>Sent to whom</u>	<u>How often</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

X. From whom do FP providers get supervision?

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XI. What kind of supervision is provided?

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MDW/INTRAH FP TRAINING PROJECT  
FINAL EVALUATION

DHV.QST 3

XII. How often are FP providers supervised?

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XIII. How effective do you find this supervision to be?

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XIV. In what ways is it adequate?

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XV. In what ways is it inadequate?

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XVI. Who finally selected the participants to FP clinical courses?

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XVII. What criteria were used for this selection?

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MDH/INTRAH FP TRAINING PROJECT  
FINAL EVALUATION

DHV.GST

XVIII. How many clinicians have received FP training in your district?

\_\_\_\_\_

How many FP trainees have been used to create new FP/MDH services:

\_\_\_\_\_

How many FP trainees have been used to strengthen existing FP/MDH services:

\_\_\_\_\_

XIX. What factors do you think may have helped in the implementation of the Management Workshops participants' workplans?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

XX. Please describe your relationship with the Core Training Team (Please describe precise conditions and state your appreciation of the quality of the relationship):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

XXI. What do you think should be the activities of the CTT in the future?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

XXII. If this program was only starting, what do you think should be done differently (to improve the effectiveness of the services delivered)?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

100

MOH/INTRAH FP TRAINING PROJECT  
FINAL EVALUATION

DMO.QST 1

Questionnaire

date:

District Medical Officer

district:

I. What information have you received about the MOH/INTRAH FP training program?  
(Please specify when and from whom you received that information)

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II. Would you have liked to receive more information? (Please specify how you would have used this information)

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III. What positive effects of the MOH/INTRAH FP training program have you observed?

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IV. What negative effects of the MOH/INTRAH FP training program have you observed?

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V. Please comment on the extent of integration of health services in your district, particularly with respect to FP/MOH activities (Please give precise examples of coordinated activities/programs and indicate your appreciation of the quality of the coordination):

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NDM/INTRAH FP TRAINING PROJECT  
FINAL EVALUATION

DMD.QST 2

VI. What factors do you see as obstacles to the coordination of health services to address the needs of the community?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

VII. How could the coordination of health services be improved?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

VIII. What kind of records are kept by FP service providers?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

IX. What kind of return do FP service providers send? How often? To whom?  
Kind of return                      Sent to whom                      How often

_____	_____	_____
_____	_____	_____
_____	_____	_____

X. From whom do FP providers get supervision?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

XI. What kind of supervision is provided?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

12.

NDH/INTRAH FP TRAINING PROJECT  
FINAL EVALUATION

DMD.QST 3

XII. How often are FP providers supervised?

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XIII. How effective do you find this supervision to be?

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XIV. In what ways is it adequate?

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XV. In what ways is it inadequate?

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XVI. Who finally selected the participants to FP clinical courses?

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XVII. What criteria were used for this selection?

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MDH/INTRAH FP TRAINING PROJECT  
FINAL EVALUATION

DMO.QST 4

XVIII. How many clinicians have received FP training in your district?

\_\_\_\_\_

How many FP trainees have been used to create new FP/MDH services:

\_\_\_\_\_

How many FP trainees have been used to strengthen existing FP/MDH services:

\_\_\_\_\_

XIX. On what criteria were participants to "Management Skills for District Health Teams" workshops selected?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

XX. What factors do you think may have helped in the implementation of the Management Workshops participants' workplans?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

XXI. Please describe your relationship with the Core Training Team (Please describe precise conditions and state your appreciation of the quality of the relationship):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

XXII. What do you think should be the activities of the CTT in the future?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

MOH/INTRAH FP TRAINING PROJECT  
FINAL EVALUATION

DMD.QST 5

XXIII. If this program was only starting, what do you think should be done differently (to improve the effectiveness of the services delivered)?

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Thank you for your time and answers

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INTERVIEW GUIDE

DATE:

DISTRICT HEALTH EDUCATOR

DISTRICT:

- I. WHAT INFORMATION HAVE YOU RECEIVED ABOUT THE INTRAH TRAINING PROGRAM? (SPECIFY WHEN AND FROM WHOM YOU RECEIVED THAT INFORMATION)
- II. WOULD YOU HAVE NEEDED MORE INFORMATION? (PROMPT FOR USE OF INFORMATION)
- III. WHAT POSITIVE EFFECTS OF THE INTRAH TRAINING PROGRAM HAVE YOU OBSERVED?
- IV. WHAT NEGATIVE EFFECTS OF THE INTRAH TRAINING PROGRAM HAVE YOU OBSERVED?
- V. PLEASE DESCRIBE YOUR RELATIONSHIP WITH OTHER HEALTH SERVICES IN YOUR DISTRICT (PROMPT FOR PRECISE CIRCUMSTANCES AND FOR APPRECIATION OF THE QUALITY OF THE RELATIONSHIP):
- VI. PLEASE DESCRIBE YOUR RELATIONSHIP WITH THE CORE TRAINING TEAM (PROMPT FOR PRECISE CIRCUMSTANCES AND FOR APPRECIATION OF THE QUALITY OF THE RELATIONSHIP):
- VII. WHAT DO YOU THINK SHOULD BE THE ACTIVITIES OF THE CTT IN THE FUTURE
- VIII. IF THIS PROGRAM WAS ONLY STARTING, WHAT DO YOU THINK COULD BE DONE DIFFERENTLY (TO IMPROVE THE EFFECTIVENESS OF THE PROGRAM)?

INTERVIEW GUIDE

DATE:

EPAU AREA OFFICERS

DISTRICT:

- I. WHAT INFORMATION HAVE YOU RECEIVED ABOUT THE INTRAH TRAINING PROGRAM? (SPECIFY WHEN AND FROM WHOM YOU RECEIVED THAT INFORMATION)
- II. WOULD YOU HAVE NEEDED MORE INFORMATION? (PROMPT FOR USE OF INFORMATION)
- III. WHAT POSITIVE EFFECTS OF THE INTRAH TRAINING PROGRAM HAVE YOU OBSERVED?
- IV. WHAT NEGATIVE EFFECTS OF THE INTRAH TRAINING PROGRAM HAVE YOU OBSERVED?
- V. PLEASE DESCRIBE YOUR RELATIONSHIP WITH OTHER HEALTH SERVICES IN YOUR DISTRICT (PROMPT FOR PRECISE CIRCUMSTANCES AND FOR APPRECIATION OF THE QUALITY OF THE RELATIONSHIP):
- VI. DO YOU RECEIVE ANY REQUEST FOR SUPPLIES AND EQUIPMENT TO BE USED IN MOH MCH/FP CLINICS? (FROM WHOM)?
- VII. PLEASE DESCRIBE YOUR RELATIONSHIP WITH THE CORE TRAINING TEAM (PROMPT FOR PRECISE CIRCUMSTANCES AND FOR APPRECIATION OF THE QUALITY OF THE RELATIONSHIP):
- VIII. WHAT DO YOU THINK SHOULD BE THE ACTIVITIES OF THE CTT IN THE FUTURE?
- IX. IF THIS PROGRAM WAS ONLY STARTING, WHAT DO YOU THINK COULD BE DONE DIFFERENTLY (TO IMPROVE THE EFFECTIVENESS OF THE PROGRAM)?

APPENDIX E.3j

Orientation of Hospital Management  
Teams Participant Questionnaire

MOH/INTRAH FP Training Project  
Final Evaluation

Orient.QST 1.

Orientation of Hospital Management Teams

Participant Questionnaire

Date: \_\_\_\_\_

District : \_\_\_\_\_

I. What is your current position?: \_\_\_\_\_

II. How long have you held this position?; \_\_\_\_\_

III. What position did you hold before the orientation workshop?:  
\_\_\_\_\_

IV. Are you currently involved in any MCH/FP activity? YES  NO   
If yes, please list the activities you are involved  
in and specify your role/responsibility:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

V. What did you find most useful in the workshop?

\_\_\_\_\_  
\_\_\_\_\_

VI. What do you think was missing from the workshop?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

VII. What are the three most important factors that have helped establish  
FP services in your hospital?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

VIII. What are the three most important factors that have hindered  
FP services in your hospital?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

MOH?/ INIRAH FP Training Project  
Final Evaluation

Orient.QST 2.

IX. Have you received any support for FP activities since the workshop?  
If yes, please describe and comment on the quality of the support  
received

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X. How do you continue updating your knowledge/skills in Family Planning?

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XI. What would you recommend with respect to orientation workshops?

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Thank you for your time and for your answers

MDV/INTRAH FP TRAINING PROJECT  
FINAL EVALUATION

MSDHT.QST 1

Questionnaire

date:

Management Skills for District Health Teams  
Workshop Participant

District:

Name:

I. Who selected you to be a participant in the "Management Skills" workshop?

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II. Do you know why you were selected to be a participant in this workshop? Please state the criteria used:

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III. What were the three most useful skills/knowledge that you gained in the workshop?

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IV. What were the three least useful?

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V. What do you think should have been added to the workshop?

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NDW/INTRAH FP TRAINING PROJECT  
FINAL EVALUATION

MSDHT.QST 2

VI. Were FP activities included in your workplan? If yes, how?

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VII. How much of your workplan have you been able to implement?

- 1. All of it
- 2. Most of it
- 3. About half
- 4. Less than half
- 5. Nothing

VIII. Do you have any document that can give evidence of your progress?

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IX. What factors have helped you in implementing your workplan?

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X. What factors have hindered you?

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XI. Have you used the supervisory tool developed in the workshop?

- A. If not, please state why:
- B. If yes, please explain whether this tool has been helpful to you, and how:

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MOH/INTRAH FP TRAINING PROJECT  
FINAL EVALUATION

MSDHT.QST 3

XII. Have you made any revision to this tool? If yes, please describe the changes that you have made:

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XIII. What other management training have you had either before or after the MOH/INTRAH workshop?

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XIV. What recommendations would you like to make for the future:

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Thank you for your time and for your answers.

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NOV/INTRAH FP TRAINING PROJECT  
FINAL EVALUATION

REF.T.QST 1

Questionnaire

date:

FP Refreshers for Tutors  
Workshop Participant

Name:

- I. What were the three most useful skills/knowledge that you gained in the workshop?
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- II. What were the three least useful?
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- III. What do you think should have been added to the workshop?
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- IV. How far have you gone with the integration of FP in your curriculum?
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- V. Are you teaching FP yourself or are you calling on somebody else?
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

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MOH/INTRAH FP TRAINING PROJECT  
FINAL EVALUATION

REFT.QST 2

VI. What factors have helped you in FP integration and teaching?

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VII. What factors have hindered you?

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VIII. What other FP training have you had since the MOH/INTRAH workshop?

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IX. Are you using your FP knowlege and skills for any other activity besides teaching in the school?

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Thank you for your time and for your answers.

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MDH/INTRAH FP Training Project  
Final Evaluation

VISCO.QST

Visual Communication Workshops

Date:

District:

Participant Questionnaire

I. What is your current position?: \_\_\_\_\_

II. How long have you held this position?: \_\_\_\_\_

III. What position did you hold before the orientation workshop?:  
\_\_\_\_\_

IV. Are you currently involved in any MDH/FP activities?: Yes / No

V. If yes, please list the activities you are involved in and specify your role in these activities/  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

VI. What did you find most useful in the workshop?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

VII. What do you think was missing from the workshop?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

MDH/INTRAH FP Training Project  
Final Evaluation

VISCO.QST

VIII. How much have you used the materials developed in the workshop?  
Please specify the settings and target audiences:

Setting	Target audience	Number of times
_____	_____	_____
_____	_____	_____
_____	_____	_____

IX. How helpful have you found this material to be? Please give concrete examples:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

X. Have you made any revision to this material? Yes / No  
Please explain:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

XI. Have you developed any new material? Yes / No  
If yes: how much have you used it? Please specify the settings and target audiences:

Setting	Target audience	Number of times
_____	_____	_____
_____	_____	_____
_____	_____	_____

XII. What recommendations could you make to improve the effectiveness of MDH/FP programs?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Thank you for your time and answers

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MOH/INTRAH FP TRAINING PROJECT  
FINAL EVALUATION

MSDHT.QST 3

XII. Have you made any revision to this tool? If yes, please describe the changes that you have made:

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XIII. What other management training have you had either before or after the MOH/INTRAH workshop?

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XIV. What recommendations would you like to make for the future:

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Thank you for your time and for your answers.



MOH/INTRAH FP Training Project  
Final Evaluation

EVA.QST

Evaluation Workshop  
Participant Questionnaire

IDENTIFICATION:

- I. What is your current title/position: \_\_\_\_\_
- II. How long have you held this position: \_\_\_\_\_
- III. Where are you stationed: \_\_\_\_\_
- IV. What was your title/position before the Evaluation workshop: \_\_\_\_\_
- V. Where were you stationed before the Evaluation workshop: \_\_\_\_\_
- VI. What did you find most useful to your work in the workshop:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- VII. What do you think should have been missing from this workshop:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- VIII. What specific evaluation activities have you carried out or been involved in since your training:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

MOH/INTRAH FP Training Project  
Final Evaluation

EVA.QST

IX. Has your participation to this workshop had any effects on other people? If yes, please give concrete examples:

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X. What recommendations would you make to develop MOH evaluation capabilities?

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Thank you for your time and answers

MOH/INTRAH FP Training Project  
Final Evaluation

CTT.QST

CTT Member  
Questionnaire

1. When did you become a member of the CTT?  
.....
2. How were you selected and by whom?  
.....  
.....  
.....  
.....
3. What were your previous training and experience?  
.....  
.....  
.....  
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.....  
.....
4. What training did you receive in preparation for, or as a member of, the CTT?  
.....  
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- 5. How do you update your knowledge and skills?  
.....  
.....  
.....  
.....
- 6. What do you think has been missing from your preparation as a CTT member?  
.....  
.....  
.....  
.....
- 7. What have been, in your opinion, the most important activities of the CTT?  
.....  
.....  
.....  
.....  
.....  
.....
- 8. What have been your own responsibilities?  
.....  
.....  
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9. What do you see are/have been the specific skills and contributions of other members of the team (please also include those who have left the CTT).

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.....  
.....  
.....  
.....  
.....

10. What other skills do you think should have been developed or included to improve the effectiveness of the team?

.....  
.....  
.....  
.....

11. What do you see as the main achievements of the FP training program (if any)?

.....  
.....  
.....  
.....  
.....  
.....

12. What do you see as the main weaknesses of the FP training program (if any)

.....  
.....  
.....  
.....  
.....  
.....

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13. What have been the main facilitating factors?

.....  
.....  
.....  
.....

14. What have been the hindering factors?

.....  
.....  
.....  
.....

15. What do you see as the main functions of participants' follow-up?

.....  
.....  
.....  
.....

16. How well do you think these have been achieved?

.....  
.....  
.....  
.....

17. What have been the main facilitating factors?

.....  
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.....  
.....

18. What have been the main hindering factors?  
.....  
.....  
.....  
.....
19. How does CTT coordinate its activities with other divisions of the MOH? (give specific examples and comment on the quality of the coordination)  
.....  
.....  
.....  
.....  
.....  
.....
20. How does the CTT coordinate its activities with District Health Teams? (give specific examples and comment on the quality of the coordination).  
.....  
.....  
.....  
.....  
.....  
.....
21. How does the CTT coordinate its activities with Hospital Management Teams? (give specific examples and comment on the quality of the coordination)  
.....  
.....  
.....  
.....  
.....  
.....

22. What do you think should be done to provide adequate supervision to FP service providers?

.....  
.....  
.....  
.....

23. How do you think FP training should be carried out to contribute to the integration of MOH/PHC services?

.....  
.....  
.....  
.....

24. Has the program, in your opinion, contributed to or adversely affected the integration of MOH/PHC services? Please support your answer?

.....  
.....  
.....  
.....  
.....

25. If the program was only beginning, what do you think should be done differently?

.....  
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26. Please comment on the quality and timeliness (or weaknesses) of technical assistance and support received from INTRAH regional office and consultants:

.....  
.....  
.....  
.....

27. What do you think should be done now to develop FP services? (Please specify training activities for specific personnel categories)

.....  
.....  
.....  
.....

28. What do you think could be the future role of the CTT?

.....  
.....  
.....  
.....

29. What have you gained as a result of your participation in the CTT?

.....  
.....  
.....  
.....

30. What have been negative consequences of your participation in the CTT?

.....  
.....  
.....  
.....

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31. What would you say are your skills now? Please describe how you developed these skills:

.....  
.....  
.....  
.....  
.....

32. What do you see as your own role in the future?

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.....

33. Any additional comments?

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**APPENDIX E.4**

**Data Analysis Techniques**

Knowledge test:

Each knowledge test question was graded on a 0-1 scale: single-answer questions were graded 1 if the answer agreed with the pre-established rule, 0 otherwise; multiple-answers questions were graded according to the percentage of correct answers. Average scores were computed for each respondent, and for each question across all respondents.

Performance Assessment:

Critical tasks were identified for each dimension of performance. A critical task was defined as an elementary task whose execution is necessary to ensure either the safety or the effectiveness of the procedure, given available equipment and recommended procedures.

Dr. Aboda and Mrs. Luyombya identified critical tasks independently. The definitive list was reached by consensus with Dr. Fontaine's assistance.

For each dimension of performance, the score was determined as follows:

- .0: any critical task missing (critical error; performance not acceptable);
- .1: all critical tasks executed as specified, but more than 25% of the non-critical tasks missing (performance acceptable);
- .2: all critical tasks executed as specified and less than 25% of non-critical tasks omitted (outstanding performance).

Average scores were computed for each respondent. Specific indices --based on the proportion of at least acceptable activities-- were computed for each main area of performance: applied knowledge; skills; decision-making.

Questionnaires and Interviews:

Answers to individual questionnaires and interviews were first grouped by geographical area to assess the consistency and/or complementarity of the various respondents' answers.

Indices were computed for participants' assessment of learning adequacy, clinical activities and equipment availability.

Clients and commodities records checklists data were summarized.

Monthly reports data covering 5 years of activity were analyzed for one FP clinic.

**APPENDIX E.5**

**Results**

5. a. Objectives achievement
  - b. Release of Funds
  - c. CTT Capability
  - d. Clinical Trainees
  - e. FP Providers Activities
  - f. Quality of Performance
  - g. Consequences of Training
  - h. Hindering and Helping Factors
  - i. Workshop Study Tours
    - Orientation workshops
    - Management workshops
    - Visual communication
    - Evaluation workshops
    - Study tours
    - Doctor/Nurse teams
  - j. Summary of interviews with: MOH, FPAU and NGO officials:
    - Ag. DMS
    - CNO
    - SNO (T)
    - WHO Advisor
    - ADMS (P)
    - FPAU Officials
    - Busoga Diocese
  - k. Record samples
    - Commodity
    - Client
    - Checklists/supervisory tool
    - Circular
- 1 Draft FP Procedures for Selected Methods

APPENDIX E.5a

Objectives Achievement

MDH/FHI/INTRAH PROJECT ACTIVITIES  
Objectives achievement

Summary

<u>TYPE OF TRAINING</u>	<u>NUMBER PLANNED</u>	<u>NUMBER TRAINED</u>	<u>OBJECTIVES ACHIEVEMENT</u>
1. <u>CEO Program Orientation Tour</u> (Thailand, 1985)		16	
2. <u>Doctor-Nurse Teams FP course</u> (Philippines, 1985)		10	
3. <u>Team building and TOT</u> (Nairobi, 1985)	6	6	100% <sup>a</sup>
4. <u>Orientation for Hospital Management Teams</u>			
. Physicians	57	22	39%
. Senior Nursing Officers	57	32	56% <sup>b</sup>
TOTAL	114	54	47%
(    . Lab Technician	0	1	)
5. <u>Evaluation Workshops</u>			
. In country	56	0	0%
. May 1985 (Chapel Hill)		2	
. Feb. 1986 (Nairobi)		5	
. Aug. 1987 (Nairobi)		6	
6. <u>Clinical FP Skills (Comp.) for Registered Public Health Nurses, Nurses-Midwives</u>			
. Jan.-Feb. 87	15	13	87%
. July-Aug. 87	20	18	90%
TOTAL	35	31	86% <sup>c</sup>
7. <u>Clinical skills for Tutors</u>			
. Jan.-Feb. 88	20	0	0%

<sup>a</sup> See CIT training summary for additional training of CIT members

<sup>b</sup> The figure for S.N.O.s trained includes 1 Nurse Administrator, 1 Nurse Tutor and 1 Registered Nurse who were delegated by their S.N.O..

<sup>c</sup> Including 5 Enrolled Midwives

<u>TYPE OF TRAINING</u>	<u>NUMBER PLANNED</u>	<u>NUMBER TRAINED</u>	<u>OBJECTIVES ACHIEVEMENT</u>
<b>8. <u>Clinical FP skills for Medical Assistants</u></b>			
. Jan.-Feb. 88	20	0	0% <sup>a</sup>
<b>9. <u>Clinical FP skills (Basic) for Assistant Health Visitors and Enrolled Nurses/Midwives</u></b>			
. April 88	20	15	75%
. March 89	20	11	55%
<b>TOTAL</b>	<b>40</b>	<b>26</b>	<b>65%</b> <sup>b</sup>
<b>10. <u>Refresher Courses</u></b>			
. October 87 (Providers)	26	16	62%
. October 87 (Tutors)	26	12	46%
. August 88	15	0	0%
. April 89	29	0	0%
<b>TOTAL</b>	<b>96</b>	<b>28</b>	<b>29%</b> <sup>c</sup>

<sup>a</sup> Activity was to be substituted by EN Training at the request of DMOs.

<sup>b</sup> Original training activity scheduled in September 88 was cancelled. Total includes 3 Registered Nurses or Midwives, 1 Medical Assistant and 1 Nursing Aid

<sup>c</sup> March 89 refresher courses cancelled from revised 1989 workplan

1/3'

<u>TYPE OF TRAINING</u>	<u>NUMBER PLANNED</u>	<u>NUMBER TRAINED</u>	<u>OBJECTIVES ACHIEVEMENT</u>
<u>11. Management Skills for District Health Management Teams</u>			
. May 87, rep. Jan. 88	27	16	59%
. June 87, rep. Feb. 88	22	15	68%
. July 87	22	0	0%
TOTAL	71	31	44%
<u>12. Visual Communications</u>			
. Oct. 88	26	19	73%
. Jan. 89	26	16	62%
TOTAL	52	35	67%
<u>13. Follow-up of trained providers</u>			
. Nov.-Dec. 87 (trained Jan.- Feb. 87)	14	7	50%
. Aug.-Dec. 88 (trained July- Aug. 87)	18	13	72%
. June 89 (trained Apr.-May 88)	15	7	47%
TOTAL	47	27	57%
( . Dec. 86 (trained 84)		17	

\* Clearance for the last workshop was not given by the Training division

**APPENDIX E.5b**

**Release of Funds**

I. October 1986 - November 1987

Until November 1987, all project activities carried out used INTRAH funds. The funds were handled by INTRAH's fiscal agent in Uganda. The required procedure was:

1. Request for funds for scheduled activity by the project coordinator;
2. Approval by INTRAH in the case that requested funds exceed budgeted amount;
3. Receipts and vouchers submitted to fiscal agent within two weeks after completion of the activity;
4. Financial audit of fiscal agent's accounts. Audit reports are submitted to INTRAH.

The delay between the request and the release of funds never exceeded two working days.

Ten activities were carried out with this procedure, including three activities theoretically directly funded by USAID under the FHI project, as FHI funds had not yet been released.

I. December 1987 - July 1989:

INTRAH funds had been entirely consumed while expecting the release of FHI funds. All activities planned between December 1987 and the end of the project relied therefore on FHI funds.

The procedure established by USAID and the MOH includes the following steps:

1. Quarterly financial plan, including detailed budget, submitted to USAID; funds made available to MOH on Bank of Uganda project account within 5 days of budget submission;
2. Request for funds to be addressed by project coordinator to Permanent Secretary, in the form of a Loose Minute explaining in detail how the money will be used. This request for funds has to be approved by:
  - a. ADMS / MOH,
  - b. ADMS / Training,
  - c. DMS,
  - d. Permanent Secretary;
3. Approved request for funds transmitted to Treasury where Government checks are to be issued;
4. Receipts and vouchers submitted to Permanent Secretary after completion of the activity.

A Loose Minute addressed to the FHI Project Coordinator by the Principal Accountant (June 29, 1987) specifies that 5 clear working days should be allowed for the funds to be released.

The review of project files (table attached) shows, however, that:

- (1) While request for funds were, as a rule, submitted between 5 and 6 weeks before the scheduled activity, funds were not once released in time for the beginning of the activity (minimum lag = - 6 days, maximum lag = - 31 days, median lag = - 15 days).
- (2) Two training activities had to be cancelled due to the non release of funds; one had been re-scheduled twice ; all other activities could only be carried out on credit or with funds borrowed from other projects, sometimes with the effect of restricting the scope of the planned activity.
- (3) In two occasions, budgets for which funds had been appropriated by USAID and that had been approved by ADMS/MDH, ADMS/Training and DMS were returned by the Permanent Secretary to the project coordinator for trivial revisions less than two weeks before the scheduled activity date.
- (4) Based on the three activities for which the full sequence is documented:
  - (a) the median total time required for successive approval by ADMS/MDH, ADMS/Training and DMS was 8 days (minimum time 3 days);
  - (b) median time for subsequent approval by the Permanent Secretary was 25 days (minimum time 3 days);
  - (c) median time for release of government checks after Permanent Secretary approval was 33 days (minimum time 31 days).
- (5) In at least one occasion, government checks that had finally been released were frozen because of government budget proceedings.

LOOSE MINUTE

F.H.I. Project Co-ordinator,  
(for the attention of Mrs. Rushota)

F.H.I. PROJECT ACCOUNT

Your Loose Minute dated 29-06-1987 addressed to the Permanent Secretary on the above.

The information you sought are as follows:-

1. Every time you wish to have funds from the above Account released to you, you will address a Request for Funds, in the form of a Loose Minute, to the Permanent Secretary and deliver it either to his Office or to mine. In the L.M. you will explain in detail how the money will be used. Without this full information the Ministry of Finance will not clear the cheque and this will lead to delays. A photo copy of your L.M. will be attached to the cheque when sending it to the Treasury for clearance.

Unfortunately, the Secretary to the Treasury, in his Circular letter dated 18-06-87 addressed to All Accounting Officers, has decided to computerise all Project Accounts (in all Ministries) with effect from 1st July, 1987. This means the operation of the time saving manual cheques now ceases and the Project has to face the delays and frustrations of having cheques printed by the computer. Each time you ~~request~~ money you will allow 5 (five) clear working days.

2. As this Account is not very active and in order not to get its documents mixed up with the Ministry's, as would happen when handled by my staff, I will keep the records myself in my Office. You will obtain any information on the Account from me, therefore, when I am not in the office for more than 24 hours the Senior Accountant will assist.



(K.G. ABURA)

PRINCIPAL ACCOUNTANT

30-06-1987

o.c. Permanent Secretary,  
" ADMS (MCH/FP)  
" Assistant Project Manager,  
USAID  
" Senior Accountant

REQUISITION OF FUNDS AND TYPE OF TRAINING ACTIVITY

TYPE OF ACTIVITY	SCHEDULED DATES	NUMBER TRAINED	DATE FUNDS REQUISITIONED	DATE FUNDS RECEIVED	COMMENTS	OUTCOME
1. Comprehensive Skills.	July 20th Aug 28th 1987	18 N/M	March 1987 (USAID) FHI	Nov. 1987	Used INTRAH funds for the Management workshop	FHI USAID funds used for Management workshops
2. Refresher clinicals & 2 workshops.	October 4-6 and October 11 - 14 1987	28 N/M and Tutors.	21 Sept. 1987	Not released	Used INTRAH Funds.	
3. Follow up.	November 16th December 5th 1987.	7 N/M	July 1987	FHI funds not released.	Used INTRAH Funds & DHS funds re-embursed	

TYPE OF ACTIVITY	SCHEDULED DATES	NUMBER TRAINED	DATES FUNDS REQUISITIONED	DATES FUNDS RECEIVED	COMMENTS	OUTCOME
4. Management Workshop	Jun 11-29th 1988	16	11 Nov.1987	Jan 19th '88	Delayed	Activity carried out
5. Management skills LMHT workshop II	Feb 1988	15	Nov.1987		Delayed	Activity carried out
6. Basic clinical skills	April 18th - May 13th 1988	15	March 1988	19th May '88	Delayed	Funds recieved after activiti borrowed funds to run activity.
7. End of Project Year I and II assessment and planning for Year III.	July 18-29th 1988	-	June 20th 1988	Sept.1988	Delayed	Borrowed and refunded 1988
8. F.P Clinical skills	25th July-2nd Sept. 1988	-	June 16th 1988	Not released Govt. cheques frozen 25/7/88	Activity rescheduled to Aug.29 to Oct.'88 and re-budgeted. Funds not released.	Activity cancelled.
9. Follow-up of service Providers trained in July/Aug. 1987	Aug. 1988.	13 followed up.	Aug. 22nd 1988.	Oct. 1988.	Follow up done in phases Aug, Nov. & Dec.	Some funds borrowed from D.H.S.

TYPE OF ACTIVITY	SCHEDULED DATES	NUMBER TRAINED	DATES FUNDS REQUISTIONED	DATES FUNDS RECIEVED	COMMENTS	OUTCOME
10. Visual Communi- cation I.	October 10th to 29th 1988.		2nd Sept 1988	October 20th 1988.	Some funds borrowed from DHS funds.	Activity carried out.
11. Visual Communi- cation II.	Jan 29th to Feb 17th 1989		6th Dec.1988	Feb 13th 1989	Funds delayed.	
12. Follow up of Visual commuigation Participants.	Feb 16th-18th 1989		19 Dec. 88	Not recieved	Used work- shop II funds which were not enough.	Principal Mukono had to use the Institute funds. Not yet refunded cheque caught in the Govt. freeze.
13. Basic F.P clinical Skills	March 5th to 1st April 1989	11	1st February 1989	March 11th 1989	Activity completed.	
14. Clinical Refresher for those trained Jan/Feb. and July/Aug.87	April 23rd 1989	None	1st March 1989	Not released	Activity cancelled.	
15. Follow-up for S/P trained April/ May 1988.	May 23th to June 10th		21st April 1989	Not released	Follow-up 7 trainees funds borrowed from UNEPI	UNEPI funds not refunded.

APPENDIX E.5c

**Core Training Team Capability**

CTT\_CAPABILITY

1. Follow up of Trained Personnel reports \_

A comprehensive review of the 4 follow-up activities planned and conducted by CTT in 1987, 1988, and 1989 revealed ample evidence that the CTT has capability to do the following:

- a) To plan and conduct follow-up of trained service providers and assess knowledge retention, clinical performance, determine utilization of FP trained personnel and identify constraints.
- b) To use both results and recommendations on the follow-up to review and modify data collection tools and pretest these prior to another follow up activity.
- c) To present a summary of discussion of the findings and make relevant recommendations for improving Training and service delivery.
- d) To utilize follow-up recommendations in curriculum development and revision of update and refresher courses as well as of the standard curricula.

2. Conducting Annual Project Reviews:

A review of the two annual training project reviews (1987 and 1988) conducted by the CTT revealed examples of the capacity and ability of the CTT to do the following:-

- a) Establish an implement a system of project monitoring and evaluation at appropriate stages of the project life that includes
  - comparing project accomplishments with project objectives through a systematic method of data collection including emerging service needs and its interpretation.

.../

- b) Coordinating the NGOs involved in MCH/FP training and service delivery to assess the scope of FP training needs.
- c) Using the results of the reviews to revise training project plans in line with emerging needs unanticipated outcomes and the most effective training for FP service delivery.
- d) Re-allocation of available resources/manpower, material and money focusing on those activities with potential for the most effective multiplied effects.

3. FP Clinical Training:

CTT has independent of INTRAH planned, conducted and evaluated 5 FP clinical training activities for a total of 79 service providers since July 1987 prior to this and with INTRAH technical assistance, CTT revised the comprehensive FP curricula and trained 14 service providers making a total of 83.

Refresher Clinical Training:

The CTT has planned, conducted and evaluated 2 refresher training activities for service providers (16) and Tutors (12) in 1987.

Others:

2 CTT members were co-trainers in 3 FP supplies and logistics, management courses conducted by ESAMI in 1987 while 2 others co-trained in the Visual Communication workshop for service providers, tutors and Health Educators.

Detailed review of the above activities indicate CTT experience and capability in all aspects of training program management both the/<sup>at</sup>macro and micro levels.

CTT\_Preparation:

The current team of 3 full time members and 1 part-time has among them a combination of knowledge and skills developed through training. These include:

- Comprehensive FP clinical skills (3)
- TOT in FP skills which includes adult participatory training methods (4)
- Evaluation skills (3)
- Training needs assessment and Training materials needs assessment (2)
- Management skills for FP programs (3)
- Visual communication skills (2)
- Orientation to PST, IST, S linkages concept (2) and orientation fo MCH/FP/PHC integration (1).

The combined skills result into the planning, implementation and evaluation capability of the CTT team in respect to clinical, management and visual communication training. (see attached list of CTT members training)

CTT\_Curriculum\_development\_and\_review\_capability:

Review of CTT activities in curriculum planning showed that the group has skills and experience in curriculum development, review, revision implementation and evaluation.

- a. With INTRAH technical assistance, the CTT developed comprehensive FP clinical skills (with IUD insertion) curriculum in December 1986.
- b. Independent of INTRAH CTT reviewed the comprehensive FP clinical skills curriculum and developed curriculum for Basic skills (FP without IUD insertion) with INTRAH reviewing it and only providing comments.

- c. With INTRAH technical assistance, CTT developed a clinical refresher curricula for service providers and PST tutors.
- d. 1 CTT participated in development of the Visual communication workshop. All above curricula have been used to prepare 87 FP service providers and tutors.
- e. 2 CTT participated in conducting the Management skills workshop for District Health Teams.
- f. With technical assistance from ACNM, 3 CTT reviewed a TBA TOT curriculum and participated in development of TBA training curriculum.
- g. CTT reviewed the FP curricula with Busoga Diocese Management to include community and PHC orientation required for the Busoga Diocese service providers.

(See attached list of FP Training Program activities conducted by CTT in and out of the MOH/INTRAH Project).

ACTIVITIES IN WHICH CORE TRAINING TEAM (CTT) WERE INVOLVED

<u>ACTIVITY</u>	<u>PARTICIPANTS</u>	<u>DATES</u>	<u>NO OF CTT</u>
1. Orientation of Hospital Management team workshop I	10-Physicians 12- S.N.O	Oct 13 - Oct 17 '86	3 CTT
2. " II	3 - Physicians 3 - S.N.O 1 - Reg. Nurse 1 - Laboratory Technician	Oct 20 - Oct 24 1986	3 CTT
3. " III	9 - Physicians 13- S.N.O 1 - Nurse Admn 1 - Nurse Tutor	Oct 27 - Oct 31 1986	3 CTT
4. Follow up of Trainees trained in April/May 1984	8- Nurse-Midwives trained June 1984  11-Tutors trained April/May 1984	Nov 10 - Dec 5 1986	3 CTT
5. FP Clinical Skills (Comprehensive)	10-Nurse/Midwives 3-PHN 1-Social worker	Jan 5 - Feb 12 1987	5 CTT
6. FP Clinical Skills (Comprehensive)	18-Nurse/Midwives	July 20 - Aug. 28 1987	6 CTT
7* FP Clinical Skills (Basic)	11-Nurse/Midwives (Busoga Diocese)	Feb 14 - March 7 1987	3 CTT
8. Refresher Clinical Course for Service Providers	16 Nurse/Midwives	Oct 5 - Pct 7 1987	5 CTT
9. Refresher Clinical Course for Tutors	12 Tutors	Oct 12 - Oct 14 1987	5 CTT

10.	Follow up of PHN, Nurse Midwives Trained	7 Nurse/Midwives	Nov 16 - Dec 5 1987	3 CTT
11.	Management Skills Course I	4 - DMO 4 - DHV 1 - H/V 3 - CTT 1 - DHI, 1 DNO 1 - M/O	Jan 11 - Jan 29 1988	2 CTT
12.	Management Skills Course II	6 - DMO's 9 - DHV's	Feb 8 - Feb 24 1988	2 CTT
13	FP Clinical Skills (Basic)	13 -Enrolled Nurse/ Midwives	Feb 8 - March 4 1988	3 CTT
14.	FP Clinical Skills (Basic)	15 Enrolled Nurse/ Midwives	April 17 - May 13 1988	5 CTT
15.	Follow up of Nurse/Midwives trained in July/Aug 1987	13 Nurse/Midwives	Aug - Dec 1988 (3 phases)	4 CTT
16.	Visual Communication II	2 H/Educators 3 Comm. Artists 6 N/M Tutors 1 PHN 4 N/M	Jan 30 - Feb 17 1989	1 CTT
17.	FP Clinical Skills (Basic)	10 Enrolled Nurse/ Midwives 1 Medical Assist.	Mar 13 - April 7 1989	3 CTT
18.	Follow up of trainees trained April - May 1988	7 N/Midwives in Health Centres	June 20 - June 28 1989	3 CTT
19.	Follow up of Busoga Diocese EN/M trained Feb/March 1987	8 EN/M in AID POSTS	March 14 - March 18 1988	2 CTT

20*	Supplies and Logistics Management Course I	33:	Area Officer - FP Service Providers - Store Keepers	Nov 22 - Nov 26 1987	2 CTT
*	" II	31:	Area Officers - FP Service Providers - Store Keepers	Nov 29 - Dec 5 1987	2 CTT
*	" III	38:	Area Officers - FP Service Providers - Store Keepers	Dec 6 - Dec 12 1987	2 CTT
21*	Development of Policy Guidelines for TBA training	18:	SMO MCH/FP - FHI Project Coordinator - UCMB - CNO - SNO (T) 3 CTT, Midwifery Supervisor, Registrar N/M, UNICEF Project Manager SWIP, MOLG, MO-Planning MOH. Principal Tutor	May 2 - May 5, 1989	3 CTT
22*	Curriculum Development for TBA training	9:	Training Officer UCBHCA  - SNO (T) - Nurse tutor (PHS) - N/O I/C Kampala Clinic FPAU - Midwifery Tutor - Project Officer SWIP - 3 CTT	May 8 - May 19 1989	3 CTT
23*	TOT Curriculum for TBA's	-	3 CTT ACNM	May 22 - May 25 1989	3 CTT
24*	Participated in Development of OPL Curriculum (Operational level PHC)	-	Trainers of all Programs	Oct 5 - Oct 9 1988	2 CTT

25*	Editing of OPL Training materials	Trainers of all MOH programs	May 17 - May 18 1989	2 CTT
26*	Editing of OPL Training materials		June 27 1989	1 CTT
27*	Involved in the Needs Assessment on Management of FP Logistics and Supplies		April 1987	3 CTT
28*	Involved in Collection and destruction of expired contraceptives		March 1988	4 CTT
29*	FPAU Clinic Review		November 1988	1 CTT
30*	Training of Interviewers involved in the MOH Demographic Health Survey	Nurses, Teachers University students and School leavers	Sept 1988	1 CTT
31*	Training of CHW (U of Makerere)	27 Community workers	June 1989	1 CTT
32*	Participated in UNEPI/ CDD Bio-Annual Project coverage evaluation		July 1989	1 CTT

\* Activities outside MOH/INTRAH Programme

COURSES ATTENDED BY CTT MEMBERS

<u>NAME</u>	<u>COURSES ATTENDES</u>	<u>DATES</u>	<u>PLACE</u>	<u>SPONSOR</u>
Mrs. Laheri Rushota	● Team Building and TOT	April/May 85	Nairobi	INTRAH
	● Evaluation Follow up	Feb/1986	Nairobi	INTRAH
	● CBD Prog. Observation Tour	July 1985	Thailand	INTRAH
	● Management of PHC Programs	July 1986	Arusha	ESAMI
	● PST, IST, S Linkages	Feb 1987	Nairobi	INTRAH
	● Management Skills for FP Programs	Oct 1987	Mombasa	CAFS
	● Evaluation Tools and Strategies	Aug/Sept 1987	Nairobi	INTRAH
Mrs. Mary Luyombya	● Team Building and TOT	April/May 85	Nairobi	INTRAH
	● Management of FP Programs	Sept/Oct 85	California	USAID
	● Evaluation of FP Programs	Oct 1986	Harare	WHO
	● FP Clinical Skills	Feb/Mar 87	Harare	INTRAH
	● Evaluation Strategies and Tools for Trainers	Aug/Sept 87	Nairobi	INTRAH
	● Visual Communication Skills	Oct/Nov 88	Kampala	INTRAH
Miss Joyce Zirabamuzaale	● Management of PHC Programs	July 1986	Arusha	ESAMI
	● TOT		Nairobi	CAFS
	● Supplies and Logistic Management TOT	April 1987	Arusha	ESAMI
	● Evaluation Strategies and Tools for Trainers	Aug/Sept 87	Nairobi	INTRAH
	● Management Skills for FP Programs	Jan 1988	Kampala	INTRAH

4.	Lucy A. Asaba	● FP Clinical Skills	Feb/Mar 1987	Harare	INTRAH
		● Evaluation Tools and Strategies for Trainers	Aug/Sept 1987	Nairobi	INTRAH
		● Observation Tour for VSC Program	Nov 1987	Nairobi	AVSC
		● Management Skills for FP Program	Jan 1988	Kampala	INTRAH
		● TOT	Sept/Oct 1988	Nairobi	CAFS
		● Visual Communication Skills	Oct 1988	Kampala	INTRAH
5.	Dr. Anthony Aboda	● FP Clinical Skills (Dr/Nurse Team)	April 1986	Phillipines	INTRAH
		● Management of PHC Program	July 1986	Arusha	ESAMI
		● TOT	Oct 1986	Nairobi	CAFS
		● PST, IST, S Linkages	Feb 1987	Nairobi	INTRAH
		● Management Skills for FP Program	Oct 1987	Mombasa	CAFS
		● Consultation Skills	Feb 1988	Nairobi	INTRAH
		6*	Mrs Judith N Kaija	● Team Building and TOT	April/May 85
● Supervision and Evaluation	July/Aug 87			CEDPA USA	INTRAH
● Evaluation Strategies and Tools for Trainers	Aug/Sept 87			Nairobi	INTRAH
● Clinical Skills Course	Jan/Feb 87			Kampala	INTRAH
● Management Skills for FP Programs	Jan 1988			Kampala	INTRAH
● CBD Prog. Observation Tour	Sept 1985			Thailand	INTRAH
7*	Dany B. Parma	● Team Building and TOT	April/May 85	Nairobi	INTRAH
		● Evaluation Short Course	May/July 85	Chapel Hill	INTRAH
		● Evaluation Follow-Up	Feb 1986	Nairobi	INTRAH
		● Evaluation Strategies and Tools for Trainers	Aug/Sept 1987	Nairobi	INTRAH

8*	Dr. Margaret Kaisa	<ul style="list-style-type: none"> <li>● Team Building and TOT</li> <li>● CBD Prog. Observation Tour</li> <li>● Evaluation Follow Up</li> </ul>	<p>April/May 85            July 1985            Feb 1986</p>	<p>Nairobi            Thailand            Nairobi</p>	<p>INTRAH            INTRAH            INTRAH</p>
9*	Mrs. Marcella Ochwo	<ul style="list-style-type: none"> <li>● CBD Prog. Observation Tour</li> <li>● Project Management Prog.</li> </ul>	<p>July 1985            Oct 1985</p>	<p>Thailand            Connecticut</p>	<p>INTRAH            INTRAH</p>
10.	Miss S. Katesigwa (Deceased)	<ul style="list-style-type: none"> <li>● Team Building and TOT</li> <li>● CBD Prog. Observation Tour</li> <li>● Natural FP TOT</li> </ul>	<p>April/May 85            July 1985            Mpve,ner 1095</p>	<p>Nairobi            Thailand            Phillipines</p>	<p>INTRAH            INTRAH            INTRAH</p>

\* Trainers left the team

**APPENDIX E.5d**

**Clinical FP Trainees**

FP SERVICE PROVISION  
TRAINED CLINICAL FP PROVIDERS

MOH / NGO	Started FP services	Started and left	Strengthened existing	Strengthened existing and left	Not Providing	TOTAL	Information not available
MOH	24 (45%)	3 (6%)	14 (26%)	6 (12%)	6 (12%)	53 (100%)	16
NGO	17 (71%)	0	3 (17%)	0	2 (11%)	18 (100%)	1
TOTAL	37 (51%)	3 (4%)	17 (24%)	6 (8%)	8 (11%)	71 (100%)	17

### Sample Characteristics

#### Job Title

. Enrolled Midwife	3
. Enrolled Nurse	1
. Registered Nurse	1
. Registered Midwife	1
. Registered Nurse/Midwife	1
. Senior Nursing Officer	1
. Nurse Tutor	2

#### Type of Clinic

. Nursing School	1
. District Public Health Nursing School	1
. Government Hospital	3
. Health Center (beds; no surgery)	1
. Aid Post (NGO)	2
. FPAU Clinic	2

#### Date of INTRAH Training

. June 1987 (Basic)	1
. July-August 1987 (Comprehensive)	2
. October 1987 (Refresher)	3
. December 1987 (Comprehensive)	1
. February 1988 (Basic)	1
. March-April 89 (Basic)	1

Selection procedure and criteria<sup>a</sup>

	<u>Number of Respondents</u>
• <u>FP clinical trainees are selected by:</u>	
• District Management Team:	3
• Medical Superintendent/Senior Nursing Officer	4
• FP Group (?)	1
• <u>Selection criteria include:</u>	
• Midwife or Nurse working and with an interest in MDH/FP	6
• Working in Health Center where services are needed	1
• Qualified Nurse or Midwife	2
• Midwife in Maternity	1
• Assistant Health Visitor in MDH clinic	1
• "Disciplined, not too young, usually a midwife"	1

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<sup>a</sup> collected from Hospital and District Management Teams; information most generally coinciding regardless of source.

**PROVIDERS RATING OF TRAINING ADEQUACY<sup>1</sup>**  
by training area and type of institution

<u>Content Area</u>	INSTITUTION				
	<u>AID POST</u>	<u>FPAU</u>	<u>HEALTH</u>	<u>HOSPITAL</u>	<u>ALL</u>
. IEC	1.38	1.00	0.75	1.42	1.22
. Physical Examination	1.50	0.92	1.00	1.67	1.35
. Oral Contraceptives	1.20	1.40	1.40	1.60	1.43
. IUD	1.13	1.13	1.00	1.83	1.38
. Injectables	1.13	1.25	1.75	1.75	1.47
. Barrier Methods	1.00	1.50	2.00	1.67	1.50
. Natural Family Planning	0.50	0.50	1.00	1.17	0.81
. Surgical Sterilization	1.50	0.00	2.00	1.67	1.25
. Infertility	1.00	0.50	0.00	1.33	0.88
. MCH	0.50	0.00	1.00	2.00	1.00
. S.T.D.	1.25	1.00	1.00	1.67	1.31

Most Useful Training contents:

(8 respondents)

. FP Methods	:4
. History taking and physical assessment	:4
. Practical work	:2
. Management of side effects	:2
. Counselling	:2
. Natural Family Planning	:2
. All topics covered	:1

What was missing from the training:

. IUCD Insertion	:2
. Counselling	:1
. Infertility	:1
. AIDS relation to FP	:1
. Immunization	:1

<sup>1</sup>Rated: 0 if training did not prepare enough; 1 if prepared enough; 2 if prepared very well. Average over respondents by content area.

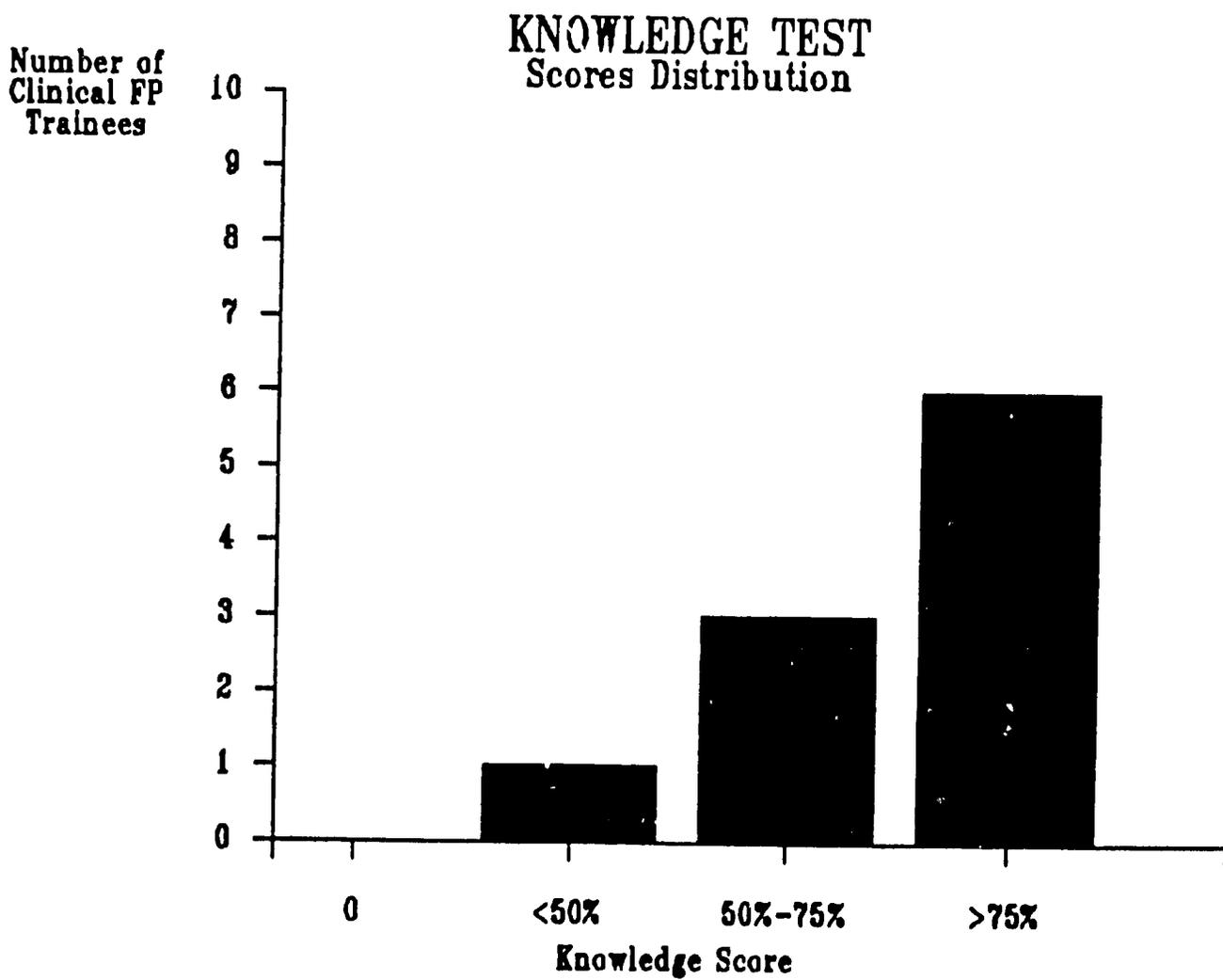
FP Providers and Tutors Knowledge Scores  
(Revised knowledge test, July 1989)

Knowledge Areas	-----										Average score/question
	-----										-----
Population issues	0	0	1	1	1	1	1	1	1	1	0.8
FP Benefits to Mothers	0	0	0	1	0	0	1	0	0	0	0.2 <sup>1</sup>
Physiology	0.80	0.70	1	1	0.70	0.90	0.80	0.90	0.80	0.40	0.80
Physical Examination	0.71	0.70	1	1	0.71	0.60	1	0.86	0.71	0.86	0.82
Contraceptives action	1	0.80	1	1	0.89	1	1	0.89	1	0.78	0.94
D.C. contraindications	0	1	1	1	1	1	1	1	1	0	0.9
D.C. decision making	1	1	1	1	1	0	0	0	0	0	0.5 <sup>2</sup>
Inj. contraindications	1	0	1	1	1	1	1	0	1	0	0.7
IUD decision making	1	1	1	1	1	1	1	1	1	1	1
AIDS transmission	1	1	1	1	1	1	1	1	1	0	0.9
Global Knowledge Score	0.65	0.62	0.90	1	0.83	0.75	0.88	0.66	0.75	0.40 <sup>3</sup>	0.75

<sup>1</sup> Incorrect answer according to rating rule: "reduces maternal mortality and morbidity"

<sup>2</sup> Incorrect answers according to rating rule: "encourages to continue taking the pill" and "prescribes a pregnancy test"

<sup>3</sup> This trainee has actually been posted in maternity since one week after her training and has not provided FP services since.



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### SUMMARY OF FOLLOW UP REPORTS

5 FP service provider follow-up evaluation reports were reviewed covering 1986, 1987, 1988 and 1989. A total of 52 trainees were followed up. 44 were service providers and 8 were tutors.

Of the service providers 29 were working in clinics within hospitals, 8 in aid posts (Busoga Diocese) and 7 in Health centres.

#### Performance/Knowledge

Weak areas of knowledge/performance were reported in the follow-up results as IUD skills (5), diaphragm fitting/removal (4), Natural Family Planning (4), Management of side effects of Depo-Provera (3) Client follow up schedule for various methods (2), record keeping (1) and physical assessment (1).

Recommendations were made in each case for special emphasis in training on IUD, diaphragm, NFP, and management of side effects of injectable FP method. Although clinical refresher course of Oct. 5 - 7 1987 addressed above areas of weakness and developed draft protocols, a number still kept recurring in later follow ups (see above). Areas addressed in the refresher include NFP, IUD, Pills, Depo-provera. Protocols were developed and distributed to service providers.

#### Hindering Factors

A number of recurring hindering factors to service provision were identified at each follow-up. These included lack of vital clinic equipment/commodities/facilities (5), lack of FP protocols or guidelines on procedures and practice (4), unavailability of a record keeping system and stationery (3), and unsatisfactory supervision due to poor relationship between supervisor and supervisee, or lack of trained supervisor or complete lack of supervision (3).

Recommendations for provision of basic FP instruments, commodities and supplies at the clinic was made in each case. There were also recommendations to: develop and make available FP protocols to service providers, to establish a record system and provide record/and reporting forms and in June 1989 report it was recommended that support and the supervisory system for H/Centre service providers should be strengthened.

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It was noted that of the FP service providers followed up each year in general, the group in Busoga Diocese seemed to have less problems with the basic equipment/commodities/supplies than the others. However, none of this group (8) had antiseptic lotions for IUD and only 4 had uterine sounds and 2 had various sizes of IUD.

It was also noted that whereas the total number of vital clinic equipment available at each MOH clinic was less than the number essential, each of the providers followed in June 1989 and who were all at Health Centre level, seemed to have even less number of total essential equipment than those stationed at hospital clinics followed up earlier. For example, out of the 15 vital equipment/supplies list, 5 of the 7 providers had 1 - 5 items each while the other 2 had 6 - 10 items each.

Major Recommendations from Follow-up

The following are recommended in the five reports in the following order of recurring frequency:

- a. Provide each service provider with essential equipment/commodities/supplies (5)
- b. Develop and provide protocols/guidelines for FP practice (4)
- c. Outline a clear information flow and provide record forms and stationery for FP data gathering and reporting (3).
- d. Conduct refresher training on identified weak areas of knowledge and skills (4).
- e. Train more service providers in IUD skills (Busoga Diocese).
- f. Develop checklist for service providers and village health workers on awareness creation (Busoga Diocese).

1984

FOLLOW UP F.P. CLINICAL SKILLS TRAINED JAN/FEB 1987

NO. AND TYPE TRAINED		NUMBER FOLLOWED		NUMBER NOT FOLLOWED		REASONS FOR NOT FOLLOWING	PLACE NOT FOLLOWED
RNM	3	RNM	3	RNM/HV	2	(1 left work site (1 on leave	Mbarara
RNMHV	3	RNMHV	1	RM	1	Security reasons	Kampala.
RN	1	RN/EM	1	RN/EM	1	Security reasons	(Eastern (Region "
RM	2	RM	1	EN	1	Not completed course	Mpigi
EN	1	EM	1	CTT	1	Member of folloe up team	
RN/EM	2	CTT	1	RN	1	Left work place	Kampala
CTT	1						
	<u>14</u>		<u>7</u>		<u>7</u>		
Participants lists.		Follow up report Nov/Dec 1987				Follow up reports.	

TYPE AND NUMBER TRAINED	TYPE AND NUMBER FOLLOWED UP	TYPE AND NUMBER NOT FOLLOWED UP	DISTRICT
RN/M            1	RN/M            1	RM                2	Kampala.
RN               3	RN                3	1 Further study 1 On leave	
RM               8	RM                6	EM                3	2 Kampala
EM/AHV        1	E/M/AHV        1		1 Mukono
EM              4	EM/AHV        1		Desesed.
R/N/EM/AHV   1	EM               1	Total            5	
<u>                  18</u>	<u>                  13</u>	Participants list.	
Source of information Participants list.	Source of information. Follow up report Aug/Dec 1988.		

1/2

TRAINED APRIL/MAY 1988

TYPE AND NUMBER TRAINED		TYPE AND NUMBER FOLLOWED		TYPE AND NUMBER NOT FOLLOWED		REASONS	DISTRICT
RM	1	RM	1	EN	3	Lack of funds.	Mbarara
EM	7	EM	2	EM	5		Kabarole
EN	5	EN/AHV	1				Masindi
EN/AHV	1	EN	2				Tororo
Nursing Aid	1	N/Aid	1				Kamuli
<b>Total</b>	<b>15</b>	<b>Total</b>	<b>7</b>	<b>Total</b>	<b>8</b>		Bushenyi
Source of information Training activity Report April/May 1988.		Source of information Follow up report May/June 1989.					Rukungiri

12/1

UGANDA MOH/INTRAH END OF PROJECT EVALUATION JULY 1989FP SERVICE PROVIDERS BY DISTRICT

DISTRICT	No. of Trained FP Provider Comprenh.	No of Trained FP FP Providers Basic	TOTAL
	Currently provid- ing services	Currently provid- ing services	
Central Regional Kampala/Entebbe	7 + 1 NGO	-	8
Mpigi	1	1	2
Masaka	1	-	1
Mubende	1	2	3
			14
<u>Eastern</u>			
Jinja	1 Govt. 2 NGO	2	5
Kamuli	4 NGOs	6 NGOs	10
Iganga	4 NGOs	1 Govt 6 NGO	11
Tororo	-	2	2
Kumi	1*	-	1
Mbale	1*	2	3
			33
<u>Southwest</u>			
Kabale	2* + 1	-	3
Rukungiri	-	1	1
Bushenyi	-	1	1
Kabarole	2 + 1 NGO	1	4
Mbarara	-	1	1
Masindi	1*	1	2
<u>Northern</u>			
Gulu	1*	-	1
			12
	24 NGOs	54	60

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54 Providers trained in Phase II are providing  
services in the above districts.  
includes,  
24 providers from NGOs

\*\* 6 providers were trained in Phase I

**APPENDIX E.5e**

**FP Providers Activities**

How much of Workplan was implemented

All of it	:1 <sup>1</sup>
Half	:5
Less than half	:1
None at all	:1
N/A	:2

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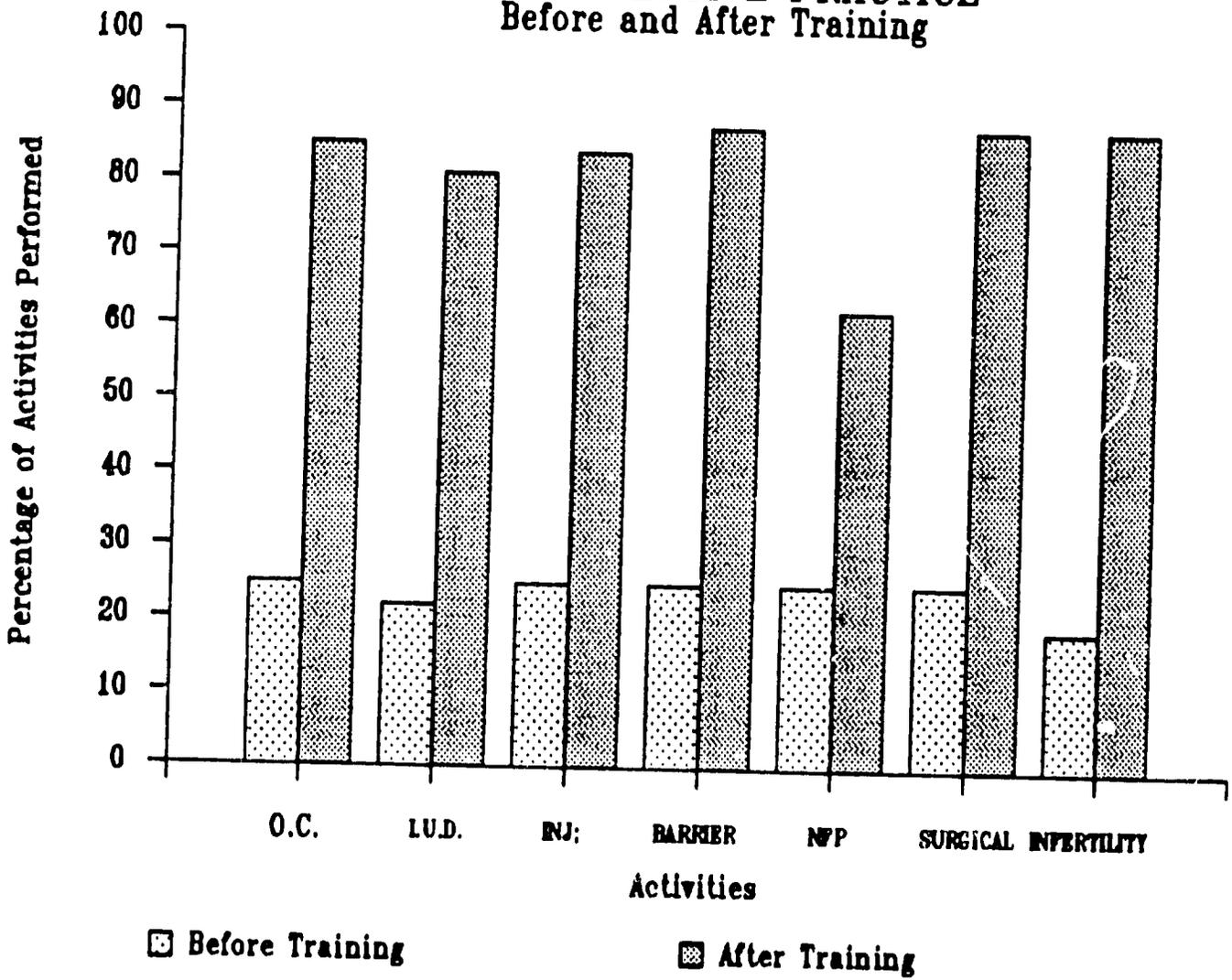
<sup>1</sup> No evidence of implementation

PERCENTAGE OF ACTIVITIES PERFORMED  
BEFORE AND AFTER TRAINING  
BY TYPE OF ACTIVITY AND TYPE OF INSTITUTION

ACTIVITIES	AID POST (NGO)	FPAU	HEALTH CENTER	HOSPITAL	ALL
<u>I.E.C.:</u>					
. Before	0%	12.5%	0%	25%	12.5%
. After	100%	75%	50%	92%	85%
<u>Physical Exam.:</u>					
. Before	0%	50%	0%	0%	12.5%
. After	100%	100%	100%	67%	87.5%
<u>Oral Contraceptives:</u>					
. Before	0%	50%	0%	33%	25%
. After	100%	100%	80%	67%	85%
<u>I.U.D.:</u>					
. Before	0%	37.5%	0%	33%	22%
. After	100%	87.5%	75%	67%	81%
<u>Injectables:</u>					
. Before	0%	50%	0%	33%	25%
. After	100%	100%	75%	67%	84%
<u>Barrier Methods:</u>					
. Before	0%	50%	0%	33%	25%
. After	100%	100%	100%	67%	87.5%
<u>Natural Family Planning:</u>					
. Before	50%	50%	0%	0%	25%
. After	100%	50%	100%	33%	62.5%
<u>Surgical Sterilization:</u>					
. Before	0%	50%	0%	33%	25%
. After	100%	50%	100%	100%	87.5%
<u>Infertility:</u>					
. Before	0%	50%	0%	17%	19
. After	100%	100%	100%	67%	87.5%
<u>Maternal and Child Health:</u>					
. Before	20%	60%	100%	75%	60%
. After	90%	10%	100%	75%	65%
<u>S. T. D.:</u>					
. Before	0%	50%	0%	33%	25%
. After	100%	100%	100%	67%	87.5%

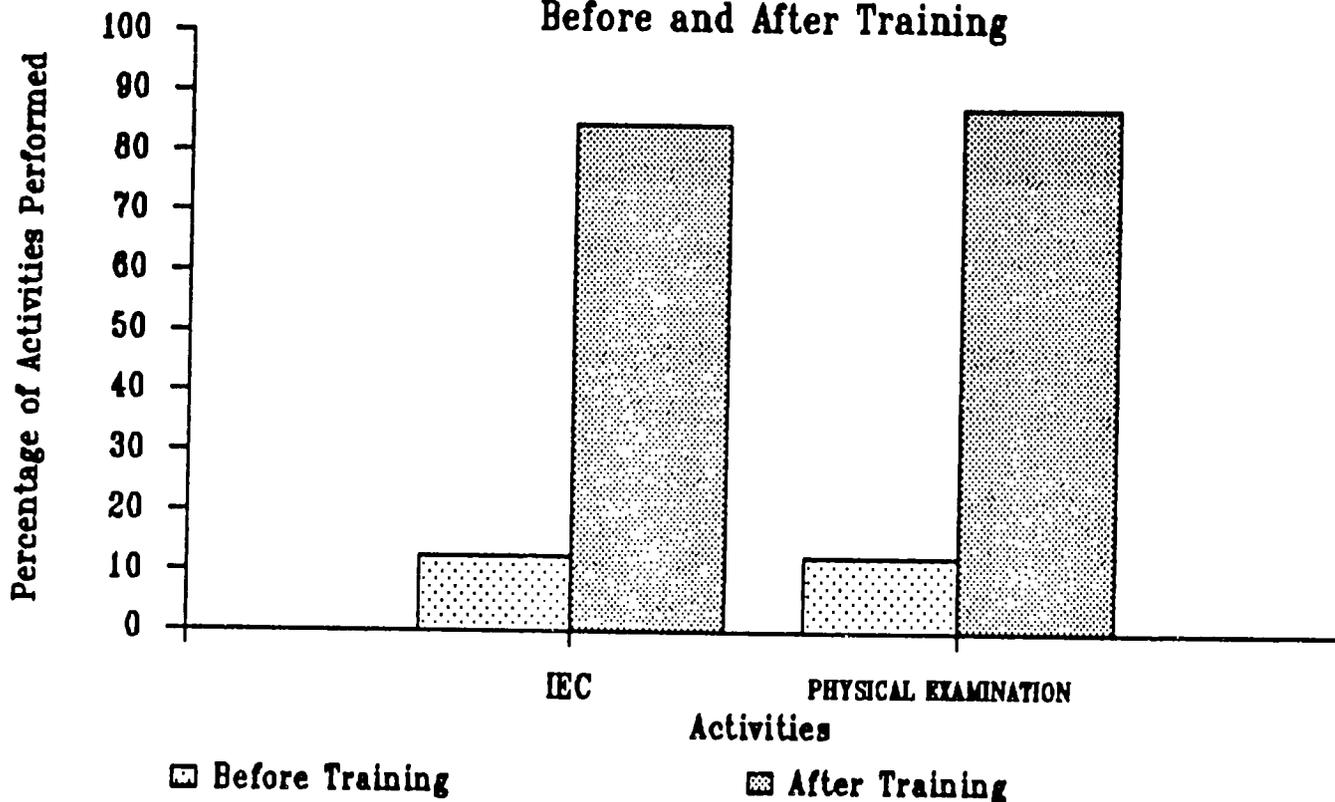
<sup>1</sup> One joined FPAU after FP training

### CONTRACEPTIVE PRACTICE Before and After Training



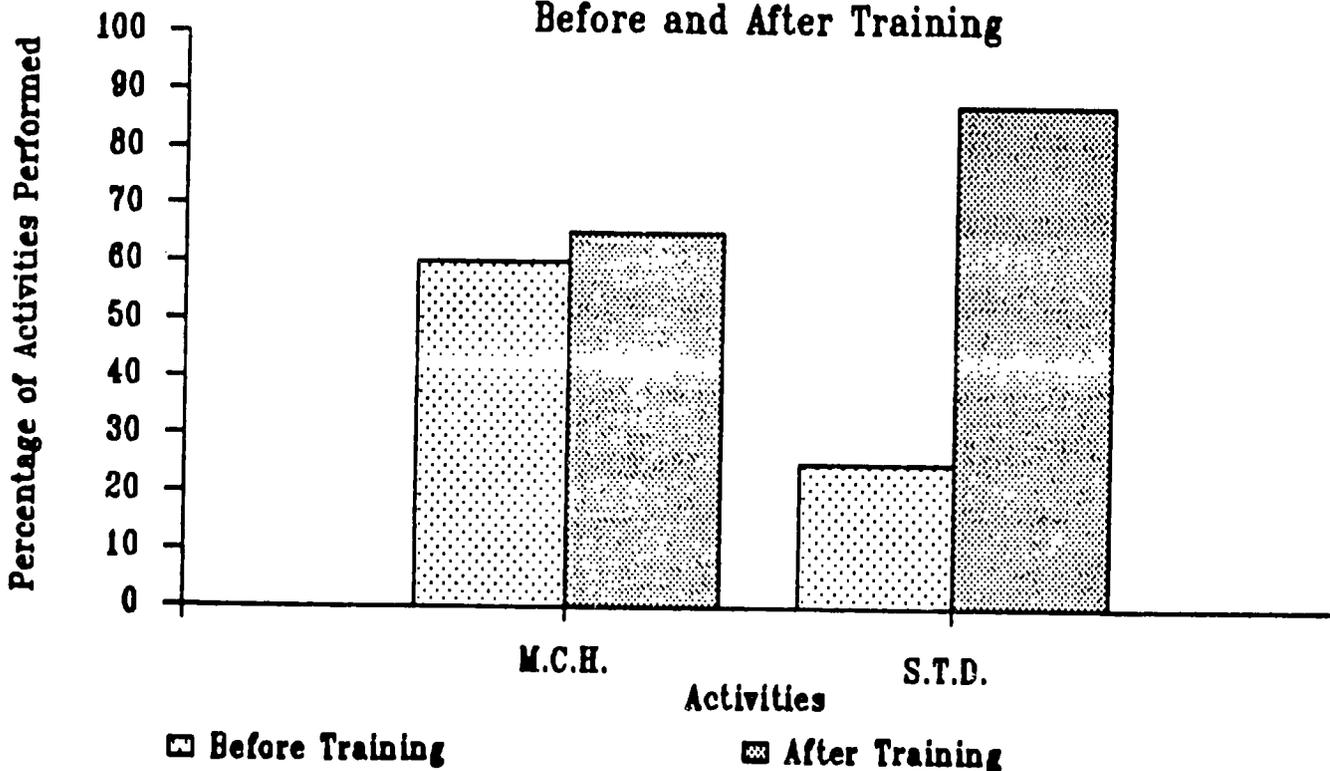
### IEC AND PHYSICAL EXAMINATION

Before and After Training



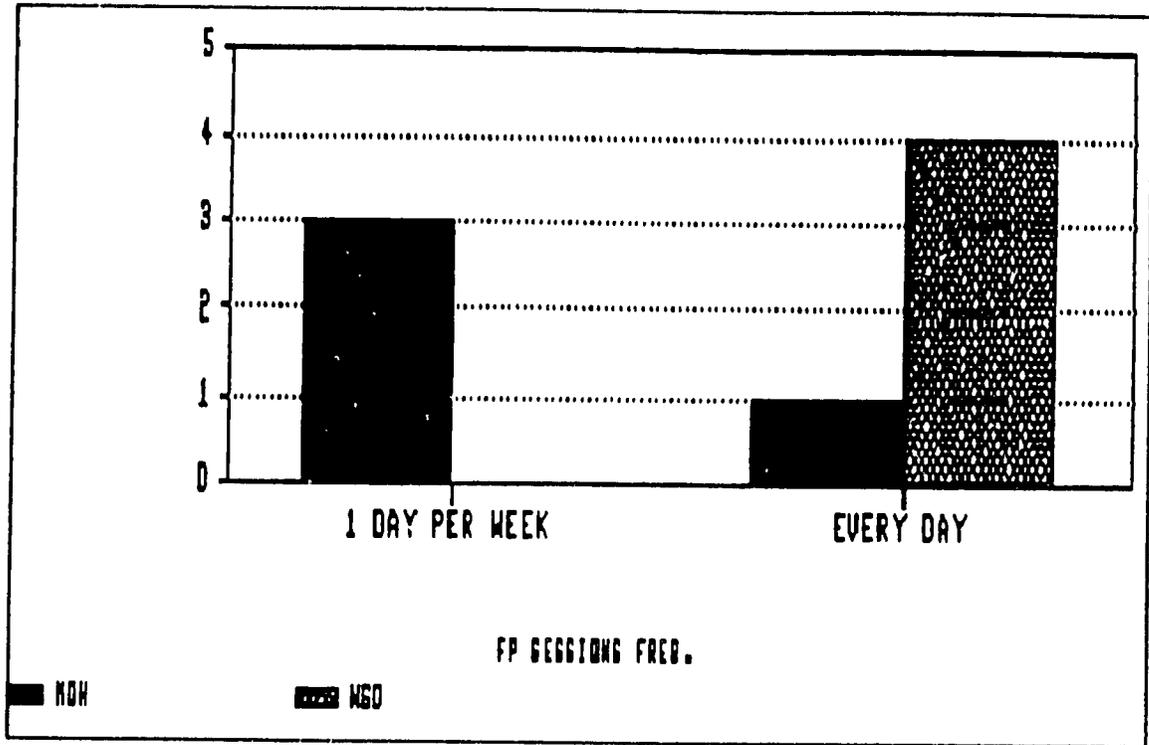
### M.C.H. AND S.T.D. ACTIVITIES

Before and After Training



10

Family Planning Services Availability  
MOH and NGO clinics



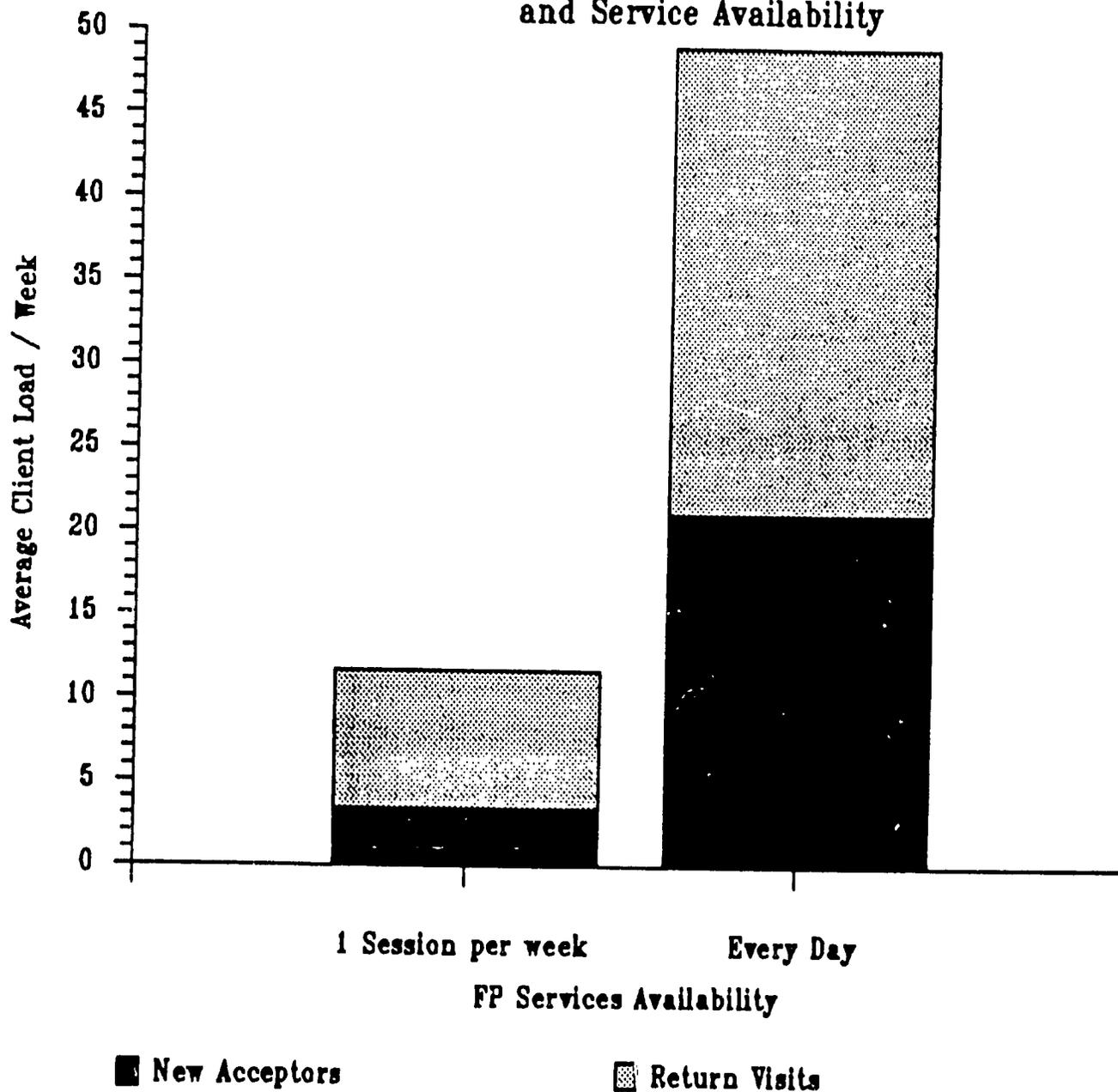
FP Services Availability  
MOH and NGO clinics

While most MOH centers only offer FP services once a week, FP services were available on a continuous basis in the NGO facilities surveyed, including two rural Aid Posts.

Continuous availability of integrated MOH/FP services seems necessary to ensure optimal accessibility to these services, particularly in rural areas.

# Clients Load (Reported for individual Provider)

## and Service Availability



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APPENDIX E.5f

Quality of Performance

PERFORMANCE ASSESSMENT SCORES<sup>1</sup>

1) Comprehensive Clinical FP trainees and Tutors

Q.#	Oral Contraceptives			KNOWLEDGE				SKILLS							DECISION MAKING			Average Score/2			
	1a	1b	10a	IUD	Inj.	NFP	IUD	Inj.	Barrier Methods	IUD	Injectables										
	4	5a	10b	10c	9	2a	2b	2c	2d	2e	3	6a	7	8	5b	5c	6b				
0	2	2	0	2	2	2	2	1	1	1	2	2	2	0	0	2	2	0	0	1.2	
2	2	2	0	2	0	2	0	0	1	0	2	0	0	2	0	0	2	0	0	.8	
0	1	0	0	1	0	2	2	0	0	0	0	0	0	0	0	2	0	0	0	.4	
0	2	2	0	1	2	2	0	2	0	2	2	0	0	0	2	2	2	0	0	.6	
0	2	2	0	1	2	2	0	1	0	0	0	0	0	0	0	2	0	0	0	.6	
0	2	1	0	0	1	2	0	0	0	0	0	0	0	0	0	2	0	0	0	.4	
0	2	0	0	1	0	2	0	2	0	0	0	0	0	0	0	0	0	0	0	.4	
<u>Avg:</u>	.3	1.9	1.3	0	1.1	1	2	.6	.7	.3	.4	.9	.3	.3	.3	.6	1.4	1.1	0	0	.7

2) Basic clinical FP trainees<sup>2</sup>

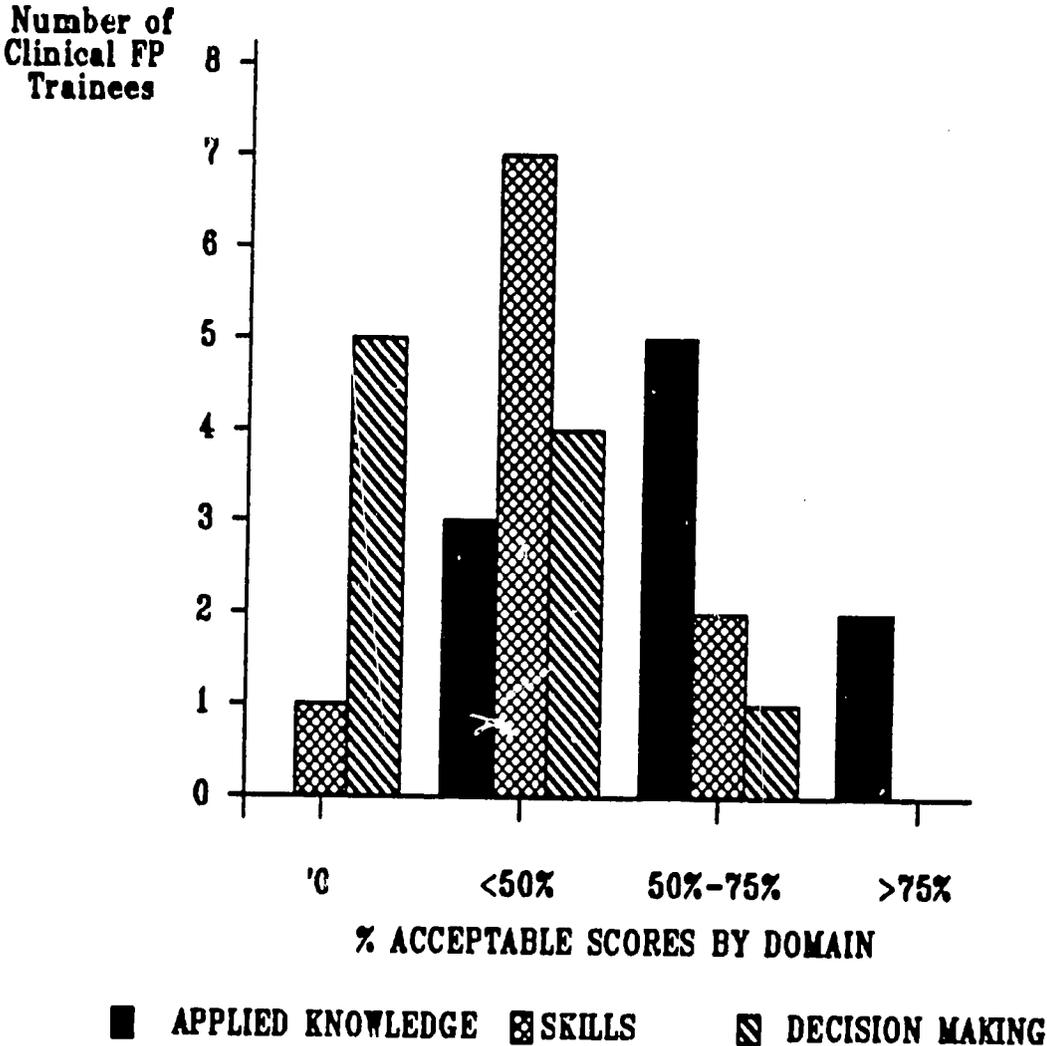
Q.#	Oral Contraceptives			KNOWLEDGE				SKILLS							DECISION MAKING			Average Score/2			
	1a	1b	10a	IUD	Inj.	NFP	IUD	Inj.	Barrier Methods	IUD	Injectables										
	4	5a	10b	10c	9	2a	2b	2c	2d	2e	3	6a	7	8	5b	5c	6b				
0	2	2	0	0	0	2	0	1	1	0	0	0	0	2	0	0	0	0	0	.5	
0	2	2	0	0	2	2	2	1	0	0	1	0	0	2	0	0	0	0	0	.7	
0	2	2	0	0	0	2	0	NA	NA	NA	NA	NA	0	2	0	0	1	1	0	.6	
<u>Avg.</u>	0	2	2	0	0	.7	2	.7	1	.5	0	.5	0	0	0	0	2	0	0	.5	.6

<sup>1</sup>0: Below acceptable; 1: acceptable; 2: outstanding

<sup>2</sup> Basic clinical FP workshops did not include IUD insertion. Two received, however, on-the-job training in IUD insertion. Their performance was therefore also assessed with respect to IUD insertion tasks.

# PERFORMANCE SCORES

## Distribution



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CRITICAL ERRORS  
(Listed by frequency in each area)

	<u>Critical Tasks</u>	<u>Number of Errors</u>
1	<u>Applied knowledge: Oral contraceptives</u>	
	1.1 <u>Absolute contraindications:</u> (Q. 1a)	
	. Cerebro-Vascular Accident	8
	. Genital Malignancy	6
	. Thrombo-embolic disorders	5
	. Undiagnosed abnormal vaginal bleeding	5
	. Pregnancy	5
	. Coronary Heart Disease	4
	. Breast Tumors	3
	. Liver Disease	1
	1.2 <u>Follow-up schedule:</u> (Q. 10)	
	. Within 2-3 months	2
2	<u>Applied Knowledge: IUD</u>	
	2.1 <u>Signs and symptoms of complications</u> (Q. 4)	
	. Part IUD in vagina ext. os	10
	. Missing strings	9
	. Tender fornices ....	8
	. Amenorrhoea	5
	. Heavy bleeding ....	3
	. Cramps/Abd. pain ....	2
	2.2 <u>Indications for removal</u> (Q. 5a)	
	. Excessive bleeding	3
	. PID	1
	2.3 <u>Follow-up schedule</u> (Q. 10)	
	. Within 3 months after insertion	5
3	<u>Applied knowledge: Injectables</u>	
	3.1 <u>Follow-up schedule:</u> (Q. 10)	
	. Every 3 months	0
4	<u>Applied knowledge: Natural Family Planning</u> (Q. 9)	
	Advises client where to go for further instruction if not sure	7



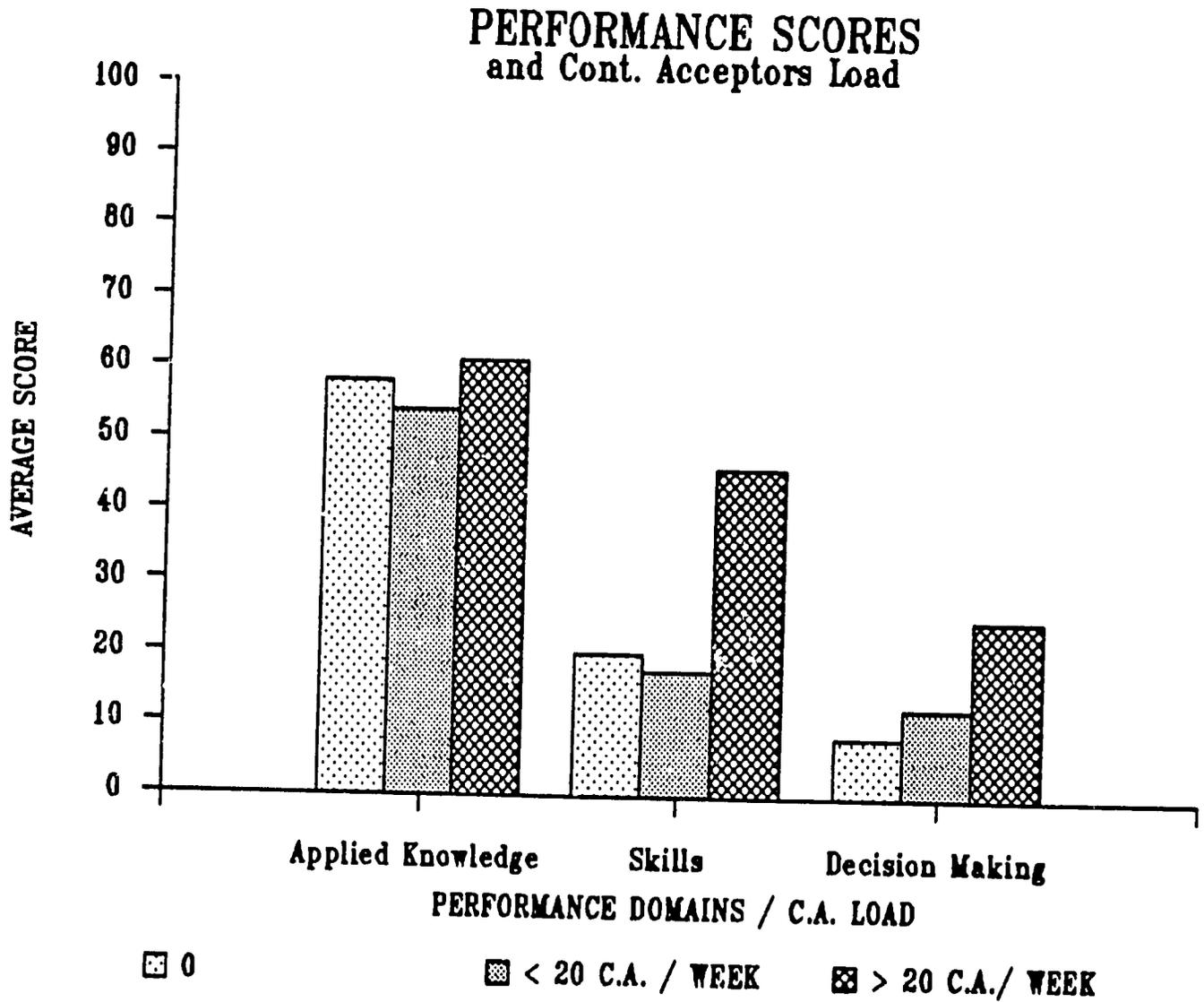
PERFORMANCE EVALUATION  
CRITICAL ERRORS  
(Listed by frequency in each area)

3

(ctd.)

<u>Critical Tasks</u>	<u>Number of Errors</u>
6) <u>Skills: Injectables</u>	
6.1 <u>Depo-Provera injection</u> (Q. 6a)	
• Checks expiry date	7
• Maintains sterility	3
• Shakes bottle	3
• Does not rub site	3
• ... Gives deep injection	2
• Instructs client to come back for next dose	1
7 <u>Skills: Barrier Methods</u>	
7.1 <u>Condom instruction:</u> (Q. 7)	
• Inspects unopened condom	5
• Withdraw penis before it softens	4
• Puts condom on erected penis	3
• Remove condom ...	2
7.2 <u>Foaming tablets instruction</u> (Q. 3)	
• Advises not to wash out foam	2
• Inserts tablet high,..., wait for 5-10 minutes...	0
• Adds more tablets for next act	0
8 <u>Decision Making: IUD</u>	
8.1 <u>Management of client asking for removal</u> (Q. 5b)	
• Finds out from client why ....	6
8.2 <u>Management of abdominal pain complaint</u> (Q. 5c)	
• Obtains information on vaginal discharge	10
• Obtains information on LMP	9
• ... if client feels the threads	9
• Does bimanual exam	6
• Removes or refers client	2
9 <u>Decision Making: Injectables</u>	
9.1 <u>Management of bleeding complaint</u> (Q. 6b)	
• Finds out from client how heavy bleeding is	8
• Examines client to exclude anaemia	8
• Gives appropriate treatment	1

207



20%

APPENDIX E.5g

Consequences of Training

104

1

## Sharing Knowledge with colleagues

<u>Type of Knowledge</u>	<u>According to Provider</u>	<u>According to Colleagues</u>
. Benefits of Family Planning	1	1
. Explained what she learned, knowledge of FP Methods	6	2
. Demonstrated some FP skills		1
. How to supply pills, FP methods		2
. Management of problems		2
. How to teach clients		1
. Shared books		1 <sub>1</sub>

Two in-charges additionally reported that trained providers were dispensing on job training and giving information talks to women groups.

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<sup>1</sup> Information is generally consistent, except in one case where the provider trained claimed not to have shared anything, while colleagues reported she had.

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FP New Acceptors and Returning Visits

FP statistics are not regularly kept. Client and clinic records are of uneven quality. No standard recording and reporting system has yet been generalized by the MOH. The most prevalent system is the one used by FPAU. The Busoga diocese project has also developed and used a standard client form (attached), and a series of registers and reporting standards.

FPAU monthly returns were compiled for Mbale hospital FP clinic since its opening in 1985. Routine visits by clients returning to the clinic after their first registration as "New Acceptors" were consistently considered as "Returning Visits". Average numbers were computed for the first quarter of each year to control for possible seasonal variations.

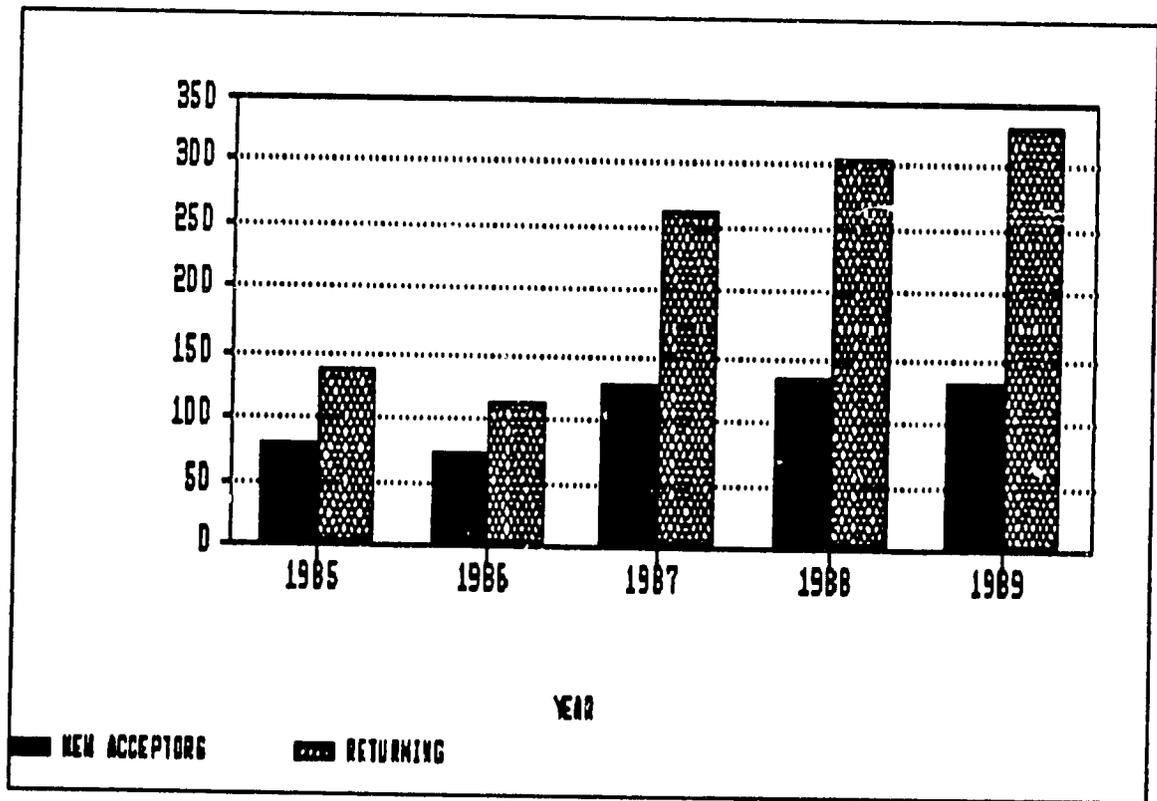


Figure 2

Mbale Hospital FP clinic  
New Acceptors and Returning Visits  
monthly average

1985 - 1989 (first quarter)

The information displayed in this figure seems to indicate that contraceptive diffusion rate remains stable after an initial increase in the first two years. The regular persistent increase of "Returning Visits" may, however, indicate that a growing number of these new clients are satisfied with the services provided and continue using contraceptives.

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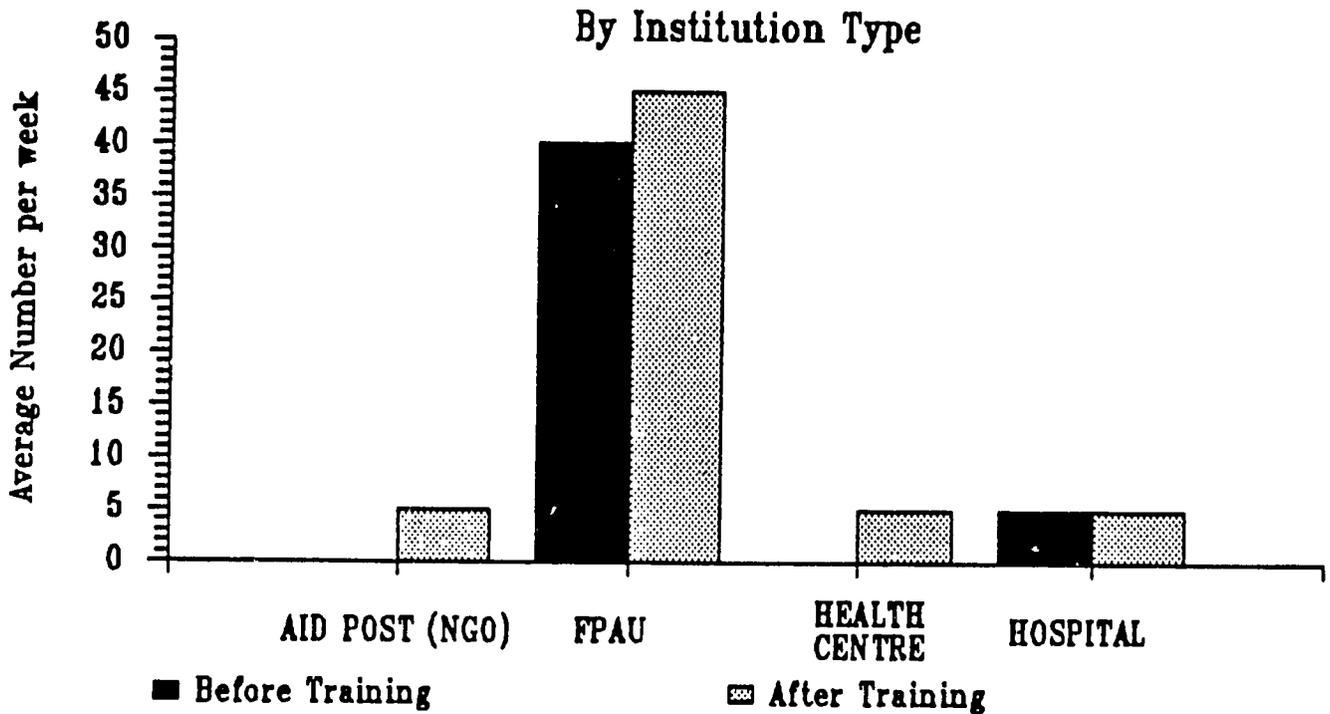
The providers themselves generally report an increase in the average number of clients they themselves see since their training. This increase is more marked for NGOs than for MOH facilities. This may be related to the greater availability of commodities and supplies to NGOs, also to the greater accessibility of the services to the client population.

In all cases, the number of returning visits seems to increase more than the number of new acceptors, which could also be consistent with an improved quality of performance.

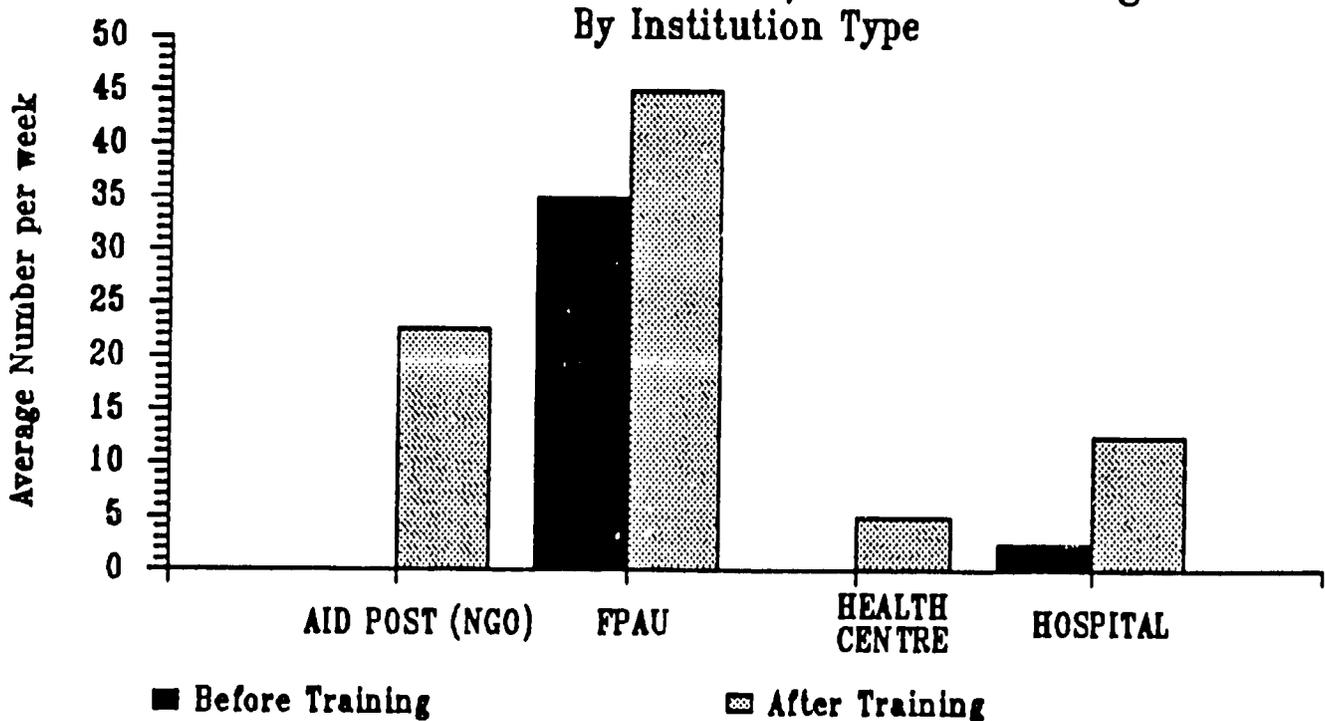
More valid conclusions regarding services quality and client satisfaction could be drawn if we could estimate, for instance, discontinuation and complication rates. The current recording and reporting system does not allow such analyses.

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## New Clients Before/After Training



## Ret. Clients Before/After Training



Client Information and Satisfaction  
(for 5 providers)

I. INFORMATION REGARDING OTHER FP METHODS	2/2	1/1	3/3	2/2	1/4
II. INFORMATION ON					
A. EFFECTIVENESS:	2/2	1/1	2/3	2/2	1/4
B. SIDE-EFFECTS:	1/2	1/1	3/3	2/2	1/4
C. WHEN TO COME BACK TO THE CLINIC:	2/2	1/1	3/3	2/2	4/4
D. ALARMING SIGNS:	1/2	0	2/3	1/2	1/4
III. PROVIDER EVER USED VISUAL AID	2/2	1/1	2/3	0/2	0/4 <sup>1</sup>
IF YES: PICTURE ARE HELPFUL:	2/2	1/1	2/2	NA	NA
IV. SATISFIED WITH INFORMATION GIVEN:	1/2	0/1	3/3	0/2	2/4 <sup>2</sup>
V. HAD ANY PROBLEM OR WORRY	0/2	1/1	0/3	1/2	1/4
IF YES: DID THE FP PROVIDER GIVE YOU HELP/ADVICE TO YOUR SATISFACTION:	NA	0/1	NA	1/1	1/1
VI. HAVE GIVEN ADVICE ABOUT FP TO FRIENDS OR RELATIVES:	2/2	1/1	3/3	2/2	3/4

<sup>1</sup> All clients report at least demonstration of method use with samples

<sup>2</sup> Most clients would like to have more information on short and long term side effects, when can have sexual

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Integration of PHC/MOH/FP Services  
(By district area)

<u>PROVIDER</u>	<u>COLLEAGUE</u>	<u>MS/SNO</u> <u>In charge</u>	<u>DNO</u>	<u>DHV</u>	<u>DHE</u>	<u>FPAU AD</u>
Little integration	Little integration	No integration in the hospital	No integration (FP is vertical)	Little integration	No integration	
Some FP education given in other MCH services	Refer other MCH problems to relevant services			FP talks are offered during other MCH services		
No integration		Little FP education integrated into other MCH services		Some integration	Some integration	
Give FP services alone				All health district programmes integrated supervision by using checklist	Field educator is integrated in PHC activities  FP education is done in PHC	Field educator gives HE in MOH outreach of EPI  FPAU clients are referred to MOH hospital
Immunization, ANC, Health Education and Deliveries		FP is offered every day with other MCH services, YCC, ANC	Deep rooted curative orientation of health services hampered integration			Good working relationship in PHC for both MOH and NGOs.
Good cooperation with community leaders			External donor agencies encourage disintegration by supporting specific programs			Essential drugs invite FPAU as resources or trainers.  UNEPI utilize FPAU field workers  FPAU supplies MOH clinics with contraceptive supplies

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<u>PROVIDER</u>	<u>COLLEAGUE</u>	<u>MS/SNO</u> <u>In charge</u>	<u>DMD</u>	<u>DHV</u>	<u>DHE</u>	<u>FPAU AD</u>
Immunization, ANC, Health Education included in schedule	FP Health Education is given in YCC and ANC and to soldiers	Group and individual FP education provided to ANC				
Recruit mothers for FP after delivery	Home visitors follow up defaulters	Home visiting includes FP				
A.N.C., Immunization, CDD included in schedule		Provider conducts HE on FP in ANC, YCC, and Immunization, provides information to women in maternity, especially those at high risk.	FP service providers are the same ones who provide ANC and immunization.		One Health Center has effected integration, i.e. provides different services each day (!)	
			FP supplies are distributed together with other district supplies			
			Incentives given only for immunization is unfair.			

<u>PROVIDER</u>	<u>COLLEAGUE</u>	<u>MS/SNO</u> <u>In charge</u>	<u>DMD</u>	<u>DHV</u>	<u>DHE</u>	<u>FPAU AD</u>
Involved in other MCH activities, e.g. ANC, immunization, but not included in work schedule	FP provider identify and refer those who need other services	No integration yet in hospital	FP still largely vertical.	Talks are given at every ANC clinic.	Works with Mental Health workers in health education	
Has used FP communication skills to communicate FP benefits only	Provider has advised other Health workers to refer those who need FP services to FP clinic.	Staff should be recruited from the community because they know people behavior	All interested parties in the district should come together to review policies and set priorities and workout strategies.	Leaders need to be educated.  Should be more home visits	Gives guidelines to people in curative / preventive services	
Runs vertical FP service.	Creates awareness among staff through meetings and seminars.	Staff should be moved from one unit to another		Programs should be discussed in the planning stage.	Each DHMT member makes his own plan and discusses it with DMD.	
Communicates to Community Leaders about FP		Senior nursing staff should have more meetings				

**APPENDIX E.5h**

**Hindering and Helping Factors**

PERCENTAGE OF STANDARD EQUIPMENT AVAILABLE  
BY TYPE OF EQUIPMENT  
AND TYPE OF HEALTH FACILITY

	AID POST (NGO)	FPAU	HEALTH CENTER	HOSPITAL	ALL
General Equipment <sup>1</sup>	80	100	20	73	75
Basic MDH/FP Equipment <sup>2</sup>	100	100	100	77	91
Gynecological Eq. <sup>3</sup>	100	100	75	91	93
IUD Insertion Eq. <sup>4</sup>	100	100	0	83	81
Commodities <sup>5</sup>	75	100	33	83	79

<sup>1</sup>Artificial light source, functioning; Storage space for supplies; system for sterilizing equipment; private space; waiting room.

<sup>2</sup>Working weighing scale; working blood pressure cuff; working stethoscope.

<sup>3</sup>Gloves for bimanual exam; specula; scissors; sponge holding forceps

<sup>4</sup>Uterine sound; Tenaculum.

<sup>5</sup>More than one type of contraceptives; condoms; foam or foaming tablets; antiseptic lotion.

Constraints and Hindering Factors  
(By District Area)

<u>PROVIDER</u>	<u>MS/SNO</u> <u>In charge</u>	<u>DMO</u>	<u>DHV</u>	<u>DHE</u>
lack of equipment, supplies, stationary	(Attended Orientation WS)	Poor information flow between MOH and NGOs	Lack of awareness of FP in trained staff	Lack of transport
Lack of continuing and up-to-date information about contraceptives	Lack of constant supplies of some contraceptives			
Shortage of staff				
Lack of visual aids			Lack of trained staff	
Lack of transport				
	Lack of skilled manpower. Low morale in FP service providers: salaries are not sufficient			
<hr/>				
Lack of supplies, stationary				
Supply of contraceptives irregular				
Supervision rare				
Cultural factors				
Too many activities beside FP				
<hr/>				

<u>PROVIDER</u>	<u>MS/SNO</u> <u>In charge</u>	<u>DHO</u>	<u>DHV</u>	<u>DHE</u>
Contraceptive Supplies irregular	(Attended Orientation WS)	Need for reori- entation of health workers to PHC con- cept in totality		
Lack of stationary	Lack of stationary			
Shortage of staff	Lack of FP trained staff			
Lack of transport	Poor salaries			
	Lack of physical facilities			
	Religious beliefs in the community			

Supervision/Support Received

<u>PROVIDER</u>	<u>MS/SNO</u> <u>In charge</u>	<u>DMO</u>	<u>DHV</u>
No supervision received	MS, SNO, DMO, CTT provide supervision: obtain supplies, make sure returns are made, staffing, check commodities shortage and expiry.		
Felt need for supervision in pelvic examination, counselling and referral, managing side-effect of injectables	Supervision is irregular and does not solve problems presented by service providers  Constant evaluation of the program by CTT follow-up encourages providers  DHT members provide on spot supervision, feedback and training on the job monthly.  Supervision is effective in improving reporting and record keeping, there is face to face dialogue with major goal of improving quality of service  FP trained providers are difficult to supervise		
MS/SNO attended orientation workshop, have provided support in FP commodities, general supplies, supervision	FP provider gets supervision from MS and NOs, mostly administrative supervision, weekly.		
Get supervision every week, checklist is used.	Health Visitor provides supervision 3 days a week: practice what have learned, e.g. health education, dispensing pills, records keeping. FP providers follow the advice given		
Need supervision in IUD insertion			

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<u>PROVIDER</u>	<u>MS/SNO</u> <u>In charge</u>	<u>DHO</u>	<u>DHV</u>
Supervised by FPAU area officer. Need more supervision in referral system	MOH MCH/FP provides supervision from Entebbe: visit and check records, interview provider and give fresh information, on average twice a year.	DHT provides supervision of staff, supplies, records, clients monthly or more if there is an emergency need. Keeps DHT well informed of FP activities.  Lacks incentives to give to service provider	Providers supervised monthly by DHT, particularly DHV: guidance, distribution of contraceptives, review problems. Sometimes unable to provide contraceptives; not able to provide clinical guidance
SNO helped establishing the services by obtaining gloves, cotton wool and contraceptives.  SNO supervises twice a week.  Need more supervision in area of bimanual exam and IUCD insertion	Supervision provided by in-charge of the clinic who is working hand in hand with gyn.obs.  In-charge is always present and competent to judge performance.	DHT provides supervision, particularly DHV: assess the quality of FP services, logistic supplies and how used, record keeping, follow-up activities, general performance, conditions of service.  Frequency varies, but at least once every 3 months. Lasts not more than 2 hours.  Not completely effective but provides moral support to health workers.  Record keeping is inadequate because stationary is inadequate.	FP providers should be supervised by DHV, but does not have FP knowledge. Provides only supervision for MCH, EPI, essential drugs and ME activities, only one activity each time: identify where mistakes are made.  Supervision is provided on clinic days, often visit 2 places in the same day.

Perception of the MDH/FHI/INTRAH Program  
Recommendations  
(By District area)<sup>1</sup>

<u>PROVIDER</u> <u>and colleagues</u>	<u>MS /SNO</u>	<u>DHO</u>	<u>DHV</u>	<u>DHE</u>	<u>FPAU</u> <u>Area Officer</u>
CTT helped to re-organize clinic and services	Received information during a workshop held here. CTT should give more information, not just what they are planning to do	Received information in Management Skills Workshop  When trainers come, they give a briefing and are more in contact with DHV  CTT is seen as trainers for vertical FP program, responsible for improvement of knowledge and skills of operational level health workers	Received information during Management Skills workshop.  Receives information regarding selection of health workers for training  Was invited to course closing ceremony	Newly appointed, has not been in contact with CTT. Was informed about it during her training	
	CTT should look into incentives for FP providers	Need to give feedback about performance of trainees, whether they were properly selected.  CTT should be part of the integrated team	Information regarding selection should come in time to give chance for proper selection.	CTT should train service providers at local level. The district team can train after updating on content.	
Identify key people who can help in the community; cooperate with leaders; educate the masses.  Program should provide supplies: gloves, soap, ... and work more with MS on how to obtain supplies	There should be more emphasis on FP skills training, more should be trained within the district	Program should start at the grassroots level, involve community leaders. DHT could monitor a CBD program.	Should train more service providers, especially for large health centers and district hospitals. Could coordinate with District Teams.		

<sup>1</sup> Information given for 4 districts with multiple sources. Similar information was provided by isolated respondents in other districts.

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<u>PROVIDER</u> <u>and colleagues</u>	<u>MS /SNO</u> <u>In-Charge</u>	<u>DMO</u>	<u>DHV</u>	<u>DHE</u>	<u>FPAU</u> <u>Area Officer</u>
CTT visited for follow-ups.	Appreciate the training given.	CTT gives us alternatives for improveaent	CTT informed well in advance when come for fol-low-up; give feed-back on their findings.		
Received protocols on D.C. and is still using them.	Number of FP clients has increased since provider gives lectures on clinic days.	There has been an increase in turn-up of FP clients.	Program created awareness of field supervisors; can now initiate integration with confidence.		
	Complications of methods are reduced	Supervision has improved (integrated with other services)	Supervision should be extended to providers who have not yet been trained.		
	More providers should be trained.	More providers should be trained.	Train DHT in supervisory and clinical skills	Train local people, e.g. CHBC workers for community mobilization.	
		Train intensively community, including TBAs, CBHC workers.	DHT should organize training at district level and train FP providers.		
		Provide clear cut policy on FP.			
		Provide funds for FP as UNEPI does.			
		Provide refreshers for doctors and midwives in private practice			

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<u>PROVIDER and colleagues</u>	<u>MS /SNO In-charge</u>	<u>DMO</u>	<u>DHV</u>	<u>DHE</u>	<u>FPAU Area Officer</u>
	CTT have always followed-up FP providers and advised accordingly; always fulfilled their promises.	Trained personnel can now provide FP services.			
	Providers have acquired accurate information and practical skills for FP services, skills in counselling.	Information came from ADMS/MCH in 1987. Sometime as an official announcement on Radio Uganda calling for participants.			
	More mothers come for FP and Health Education; immunization attendance has increased; men have attended FP.				
	Need more privacy in the clinic, more trained personnel. Medical Assistants should be trained in FP, to be able to supervise providers.	Curriculum should be designed with DHT to suit local needs. Participants need to be followed-up regularly.			
	Training should be done at the district level for close supervision and follow-up.	Program should liaise with other training programs so that training activities are coordinated through Manpower Development Centre.			
	Every health worker should be involved; program should start from the grassroots; RCs and chiefs should be involved.	Operational level courses should be organized at the district level rather than in Kampala. Some District Health Team members are capable of conducting such training programmes.			
	Incentives should be provided.				

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<u>PROVIDER</u> <u>and colleagues</u>	<u>MS /SNO</u> <u>In-Charge</u>	<u>DMD</u>	<u>DHV</u>	<u>DHE</u>	<u>FPAU</u> <u>Area Officer</u>
	CTT has followed-up trainees and then held discussions		Relationship with CTT satisfactory.  Received information on plan of action 88-92, "supermarket approach", team building and management.	Did not receive any information until time of evaluation.  Community has become interested in FP.  Three centers have started to provide FP.	CTT conducts follow-up of trainees, check on contraceptives and destroys expired ones, gives information on people nominated for training
	In-charges of departments need more information to supervise FP providers		Need more information on FP methods and skills	More medical staff should be trained in FP.	Training should continue at the district level to increase coverage.
	CTT should train more staff, hold seminars about FP, pay more visits to FP providers.		Staff from Health Centers and Dispensaries with maternity should be trained.	There should be more publicity about FP in the community.	More people should be trained in communication skills to clients and in clinical skills.
	Midwives should be trained in FP during their basic training				Lower level agents should be trained, e.g. ENM in hospitals and FPAU field educators.
	FP clinics should be well equipped and have adequate space for privacy.				FPAU should be given feedback on areas that need improvement.

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APPENDIX E.5i

Workshops and Study Tours

ORIENTATION WORKSHOP FOR HOSPITAL MANAGEMENT TEAMS

1. CURRENT POSITIONS			
	<u>SNO</u>	<u>TUTOR</u>	<u>AG/MED SUPERINTENDENT</u>
MOH	2	-	-
NGO	-	1	1
CHANGE OF STATION AFTER TRAINING	2	-	-

Total - 4

2 MOH SNO changed station after training but retained position.

1 NGO Acting Med. Suprintendent promoted from Acting deputy.

1 NGO tutor retained both station and position.

2. WHAT THEY LEARNED/MISSED IN WORKSHOP

<u>Most Useful</u>	<u>No of respondents</u>
Update knowledge of MCH/FP	2
Integration of MCH/FP	2
Developing work Plan	1
<u>Missing</u>	
FP Clinical Skills	2

Most useful knowledge included Integration of MCH/FP services (2), Update knowledge of MCH/FP (2) and Developing work plan (1). 20 MOH SNOs stated that FP clinical skills was missing.

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HOSPITAL MANAGEMENT TEAMS1. HOW THEY UPDATE FP KNOWLEDGE/SKILLS

<u>Response</u>	<u>No of Respondents</u>
Reading books about FP	3
Discussion with Providers	2
Too busy with administration	1

2. RECOMMENDATIONS

o Increase number of workshops	3
o District level training	1
o Combine knowledge with skills	1
o Involve more management team members	1
o Organise orientation within hospital	1
o Hospital participants to include enough people at responsibility level to ensure inclusion of plans in budget	1
o Enter into agreements with trainees to undertake specific activities after training	1
o Establish quarterly follow-ups	1
o Provide incentives	1

DHMT WORKSHOPS3. What was learned/Missing?

<u>Most useful</u>	<u>Frequency</u>
o Human Resources Management	8
- Job descriptions	
- Team Building	
- Supervision	
o Planning	8
o Integration of Services	1
o Evaluation	1
o Supplies management	1

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Least useful

- o AIDS 1
- o Content on Management too theoretical 1
- o no answer 3
- o Do not remember 2

Missing

- o Clinical skills 4
- o Field visit to FP Clinic 1
- o Cultural practices influencing contraceptive practice 1
- o Nothing 2

3 out of 4 DHVs and 1 DMO out of 3 wanted FP clinical skills for themselves.

4 DHMT SELECTION CRITERIA TO WORKSHOP

Participants to the Management skills workshop for DHMT all selected at central level.

Criteria used was the responsibilities they have over all district health services including FP.

5. WORKPLAN IMPLEMENTATION

None of the DHMT had completed workplan implementation. Also, only a few could produce evidence of progress. Members of same team differed as to how much of workplan had been implemented. They also differed in number of SDP providing FP in the district.

6. HELPING FACTORS IN WORKPLAN IMPLEMENTATION

Availability of resources:

- Transport 1
- Supplies 2
- Trained Personnel 3

Sharing of Resources

- Team work 1
- EPI Transport 1
- Sharing of what was learned 1

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7. HINDERING FACTORS

- o Funds
  - To buy fuel 4
  - To motivate community 1
  - To buy posters 1
  
- o Personnel
  - Not trained 2
  - Not motivated - salaries late 1
  - Too many programs 1
  
- o Equipment
  - Stationery 1
  - BP Machines 1
  - Logistics 1
  
- o Resources
  - Funds not allocated by DA 1

8. SUPERVISORY TOOL

Usefulness

Only one team found tool useful because it includes all PHC areas.

One team did not use tool because it "has not been approved".

Revision

No revisions 2 teams  
 No revisions 1 DHV

Revisions

- o Used selected District Tool 1
- o Added logistics, personnel appraisal, records 1 DMO
- o Crossed out records 1 team

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9. OTHER MANAGEMENT TRAINING BEFORE OR AFTER

o PHC/PHC Programs	:	2
o Supplies and Logistics	:	2
o UNEPI/Essential Drugs/Continuing Educ.	:	1
o Personnel/Mid level managers	:	2
o Project management	:	1
o None	:	1

All the 3 DMOs had training in management of PHC or UNEPI or essential drugs before or after INTRAH workshop. 3 DHVs also had training in FP supplies and logistics (2) and midlevel managers course (1). Only 1 DHV who had no training at all. Most of the training was done between 1987 - 1988.

VISUAL COMMUNICATION WORKSHOPS:

1. Current Jobs

2. Current Activities

<p>N = 5</p> <p>FP Service Providers - 3</p> <p>Nurse Tutor - 1</p> <p>Deputy Project Manager - 1</p>	<ul style="list-style-type: none"> <li>o Providing FP Service Clients - 4</li> <li>o FP service supervisor/provider - 1</li> <li>o Training - PST Students - 1</li> <li style="padding-left: 20px;">- CBNC workers - 1</li> <li style="padding-left: 20px;">- On Job - 1</li> <li>o Providing MCH/FP Services 1</li> <li>o FP Clinic Management - 1</li> </ul>
-------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

3. WHAT THEY LEARNED/MISSED IN WORKSHOP

<u>Most useful</u>	
o Methodology of developing visuals	- 11
o Developing using local materials	- 3
o Adult learning methods	- 1
<u>Missing</u>	
o Actual practice using designed visuals	1

Methodology for developing visual was liked most (11) especially pre-testing and workplans followed by use of local materials (3). Shortage of time allotted the workshop was cited frequently (4) and 1 respondent wanted real practice using the new visuals.

4. HOW MATERIALS DEVELOPED WAS USED

<u>Setting</u>	<u>Target Audience</u>	<u>Frequency</u>
o ANC Clinic	Expectant mothers	Many times
o Young Christian Fellowship Camp	Youth	3 times
o Youth workshop	Youth	Once
o Sensitization workshop	Community members	4 times
o Mothers Club	Rural mothers/ women	2 times
o FP and Immunization Clinic	FP Clients and mothers	3 times a week
	Medical Staff	Once
o TOT workshop	FP Trainers	Once
o Classroom	PST Students	Once
o ?	Service Providers	?

4 Respondents used the visual materials for educating mothers and clients in MCH/FP Clinics several times. 4 respondents used visual materials for educating community groups between 1 and 4 times while 3 respondents used visual to aid training others.

5. USEFULNESS OF VISUAL MATERIALS USED

o Stimulated and created interest in learners	- 4
o Helped to generate discussion	- 3
o Enhanced understanding of message	- 2
o Helped in summarizing the lesson	- 1

Responses included that students laughed, provider knows clearly message she/he intends to pass and stimulated many questions from clients.

6. CHANGES MADE IN THE MATERIALS

- o Wrote message in local language ) 1
- o Revised the children picture in order )  
to make children seem different ages ) 1
- o Unspecified change ) 1
- o No change ) 1

1 respondent translated message into the local language and revised the family picture to make children look different ages while one reported an unspecified change. 3 respondents did not make any changes.

7. NEW MATERIALS DEVELOPED

<u>Subject</u>	<u>Audience</u>	<u>Progress</u>
"How to use the condom correctly"	Men/Women	Currently undergoing pretesting
"Barrier Methods"	Not specified	Not specified
"Teenage Pregnancy"	Teenagers	Sketches made still to be pre-tested
"Fears and Misconceptions on IUCD"	Women	Incomplete

4 respondents have developed or in the process of developing new materials. The target audiences range from teenagers to women and men. Subjects include barrier methods, teenage pregnancy and IUCD misconceptions.

8. RECOMMENDATIONS

- Train more people : 3
- Refreshers : 2
- Access to materials : 2
- Focus on Rural Community : 1

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EVALUATION WORKSHOPS SUMMARY : 2 PARTICIPANTS

<u>Respondent 1</u>	<u>Respondent 2</u>
1. <u>Title/Position</u>  Before - Biostatistician After - Head of Planning Division	Tutor Ag. Principal
2. <u>What did you Learn?</u>  <u>Most Useful</u>  o Monitoring & Evaluation o Reasons for Evaluation o How to evaluate training	<u>Most Useful</u>  o Evaluation of Training Program
<u>Missing</u>  Time was too short	o Application of computer (does not have access to computer).
3. <u>Evaluation Activities involved in since Program Evaluation:</u>  o 1987/89 UNEPI o 1987 Essential drugs o 1988 AIDS Control Program	Nov. 1986 (First MOH/INTRAH Trainee Follow Up)
4. <u>Effects on Your Participation on others:</u>  o Helped set up monitoring and evaluation unit in late 1986 in planning Division	o Uses it when preparing and using Training designs

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5. Hindering Factors:

- a. Lacked coordination to keep group together.
- b. Lacked follow up (should have come from Planning Division and INTRAH).

5. Recommendations to MOH on evaluation capabilities:

- Managers are not using Health information to make decision so:
1. They should be helped to consolidate capacity to evaluate and monitor their programs.
  2. Bring those trained in evaluation together to share their experiences in evaluation. (Follow-up on trainees be done early)
  3. Develop evaluation capability at all levels particularly at program level.
  4. In doing so, utilize the local resources in the MCH/Programs and Planning Division.
  5. Consider training in country using MCH/FP Division as the locus but fully involving planning as trainee and also facilitators.
1. Maintain evaluation Training for CTT
  2. INTRAH/MOH keep in touch with trainees constantly.
  3. Adequate Resources for evaluation to be assured.
  4. People in other programs should be trained.

EVALUATION WORKSHOP OUT OF COUNTRYWORKSHOP 1 MAY 1985

NAME	PRESENT POSITION	TYPE SUPPORT	HELPING FACTORS	HINDERING FACTORS
Male-Mukasa ADMS(P)	Country Director AMREF	No evidence		Left the country
Dana Parma (CTT)	Med. Assistant Tutor i/c School of Nursing/Midwife.	Assisted developing evaluation tools for F.P Clinical skills Course.		No accommodation in Entebbe/Kampala.
Follow up Evaluation Feb 1986.				
Dr.Margaret Kaisa	Left the country			
Mr.A.Nzabanita	Ag.ADMS(P)	No evidence .		
Mrs.S.Kabwegyere	Student	No evidence .		
Mr. Danny Parma	Med.Assistant Tutor i/c School of Nursing/Midwife	Assisted in developing evalua- tion tools. Evaluation of F.P Training activities.		Lack of accommodation left the C.T.T.

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NAME	PRESENT POSITION	TYPE SUPPORT	HELPING FACTORS	HINDERING FACTORS
Mrs. L. Rushota	F.H.I Project Co-ordinator	Assisted in the Development of evaluation tools - Evaluation of training activities - Follow-up of participants	To be a C.T.T member Counselling other C.T.T Members.	

SUPERVISION AND EVALUATION (CEDPA)

NAME	PREVIOUS POST	PRESENT POST	SUPPORT	HINDERING FACTORS
Mrs. J. Kaija	C.T.T.	Student	Development of evaluation tools - Evaluation of training activities - Follow up of trainees.	Left the team for further studies.

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EVALUATION STRATEGY AND TOOLS FOR TRAINERS AUGUST/SEPTEMBER 1987

NAME	PREVIOUS POST	PRESENT POST	SUPPORT	HELPING FACTORS	HINDERING FACTORS
Mrs.L.Rushota	F.H.I Project Coordinator	F.H.I.Project coordinator	Developing evaluation tools. -Analysing and interpreting Assessment data	Involvement in the evaluation of training activities and analysing Assessment results.	
Mrs.M. Luyombya	C.T.T.	C.T.T.	-Developing, evaluation tools -Analysis data - Interpretation of results.	Involvement in the evaluation of training activities and trainees. - Analysing.the data. -Printing results.	
Lucy Asaba	C.T.T.	C.T.T.	"	"	
Miss.J.Zirabamuzale	Project Trainer (SWIP)				) ) ) ) ) Left the team.
Mrs.J.Kaija	Student				
Danny Parma	Med.Asst. Tutor		"	"	

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STUDY TOUR GROUP I.

NAME	PREVIOUS POSITION	CURRENT POSITION	TYPES OF SUPPORT	HELPING FACTORS	HINDERING FACTORS
Mr. Ojara	P.S	Retired	-	-	Retired soon after tour 2 week
Dr. Etyono	DMS	Consultant CBHCA	<ul style="list-style-type: none"> <li>General policy guidance.</li> <li>. Assigned personnels to Project.</li> <li>. Approved quickly project activities</li> <li>(. Co-operation with Project Staff/agencies.)</li> <li>. Availd opportunity to project Director &amp; Coordinator.</li> </ul>		
Mr. Muggya	Director FPAU	Retired	<ul style="list-style-type: none"> <li>. Availd FPAU clinics for training.</li> <li>. Supply F.P / commodities and Equipments</li> <li>. improved collaboration of FPAU and MOH.</li> <li>. Availd opportunity for consultation and advice</li> </ul>		
Ms. Elangot	Ag. CNO	Deputy CNO	<ul style="list-style-type: none"> <li>. Collaboration in participants selection for training</li> </ul>		

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NAME	PREVIOUS POSITON	CURRENT POSITON	TYPES OF SUPPORT	HELPING FACTORS	HINDERING FACTORS
Dr. Kaijuka	ADMS(MCH/FP)	ADMS(MCH/FP)	<p>Supervision monitoring of Project activities.</p> <ul style="list-style-type: none"> <li>.Assisted in providing transport for project activities</li> <li>.Co-ordination between MOH/USAID.</li> <li>.Procurement of F.P commodities &amp; equipment distribution.</li> <li>. Problem solving (Administrative)</li> <li>. Facilitate in training activities.</li> </ul>		
Mr. Ruberantware	Chief Pharmacist	C. Pharmacist on leave	Helped storage and distribution of F.P commodities and equipments.		
Mrs. M. Ochow	Pro. Co-ordinator	Student Pop. studies London	<p>Planning , organizing and implementing Project activities.</p> <p>Liason with AID and ADMS(MCH/FP) CNO and FPAU and other related organization and Depts.</p>		Left Ministry.

STUDY TOUR GR. II.

NAME	PREVIOUS POST	CURRENT POST	TYPE OF SUPPORT	HELPING FACTOR	HINDERING FACT
Dr. John Mujabi	ADMS(M)	Registrar Uganda Medical Council	Not evidenced		
Dr. G. Olwit	ADMS (T)	D.D.M.S (P.H)	Co-ordination of PST & IST Recommending personnel for training for strengthening F.P services		Transferred from Training Division
Mr. V. Wangola	C.H.I	Rev.Canon	Not evidenced		
Mr. Dan Parma	C.T.T.	Med.Asst. Tutor i/c School of Nursing and Midwifery	Conducted training activities		Not having accomodation in Kampala or Entebbe,
Mr.J.Male-Mukasa	ADMS(P)	Country Director AMREF	Not evidenced		Changed jobs
Mrs.J. Kaija	C.T.T.	Student	Planning organising conducting and evaluating F.P training activities.		Went for furthe studies.

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STUDY TOUR GR. II.

NAME	PREVIOUS POST	CURRENT POST	TYPE OF SUPPORT	HELPING FACTOR	HINDERING FACTOR
Dr. John Mujabi	ADMS(M)	Registrar Uganda Medical Council	Not evidenced		
Dr. G. Olwit	ADMS (T)	D.D.M.S (P.H)	Co-ordination of PST & IST Recommending personnel for training for strengthening F.P services		Transferred from Training Division
Mr. V. Wangola	C.H.I	Rev.Canon	Not evidenced		
Mr. Dan Parma	C.T.T.	Med.Asst. Tutor i/c School of Nursing and Midwifery	Conducted training activities		Not having accomodation in Kampala or Entebbe,
Jr.J.Male-Mukasa	ADMS(P)	Country Director AMREF	Not evidenced		Changed jobs
Mrs.J. Kaija	C.T.T.	Student	Plunning organising conducting and evaluating F.P training activities.		Went for furthe studies.

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NAME	PREVIOUS POST	CURRENT POST	TYPE OF SUPPORT	HELPING FACTOR	HINDERING FACTC
Lydia Muranga	S.M.O FPAU	Ag. Director FPAU	<p>Facillitates in F.P training activities.</p> <ul style="list-style-type: none"><li>- Availled FPAU Clinic and Staff for F.P training activities.</li><li>- Provides equipment and F.P supplies to MOH service providers.</li><li>- Involved in the development of F.P. information system.</li></ul>		

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NAME	PREVIOUS POSITION	CURPENT POSITION	TYPE OF SUPPORT	HELPING FACTORS	HINDERING FACTC
Kaisa (Dr)	CTT	left	<ul style="list-style-type: none"> <li>Co-ordinated AVSC Project.</li> <li>• Initiated F.P information systems.</li> <li>• Established &amp; supervision MCH/FP clinic Mulago.</li> </ul>		Left the countr
M/S Rushota R.	CTT	Project Co-ordinator	<ul style="list-style-type: none"> <li>• Planning</li> <li>• Conducting Evaluation Project activities</li> <li>• Co-ordinate NGO, MOH &amp; International Agencies involved in training liason with MOH division.</li> </ul>	<ul style="list-style-type: none"> <li>-Transport</li> <li>-INTRAH support and guidance from INTRAH Regional Office</li> <li>-Support from ADMS(MCH/FP) &amp; FPAU and USAID mission</li> <li>-Cooperation and team work of CTT Members.</li> <li>-Assistance &amp; coperation from institutions used as its venue.</li> </ul>	<ul style="list-style-type: none"> <li>Communication difficulties.</li> <li>-Delayed releas of funds.</li> <li>Inavailability of training venues.</li> <li>- High drop out of C.T.T.</li> </ul>

DOCTOR/NURSE TEAMS 1986

PARTICIPANTS	CURRENT POSITION	SUPPORT	HELPING FACTOR	HINDERING FACTOR
Dr. G. Mpigika Ms. M. Tumwesigye	D.M.O. Rukungiri FP Service Provider (Kabale)	- Assisted participants for clinical skills selection - Strengthened FP clinical services		Never worked as a team
Dr. A. Aboda Ms. Justine Mukasa	Physician i/c )MCH )Clinic Nurse i/c        )Mulago	FP client referral back-up. Training IST/N/M PST Clinical Instructor Clinical supervisor	Team work	<ul style="list-style-type: none"> <li>. Shortage of FP Service provider.</li> <li>. Limited space</li> <li>. Irregular supply of FP commodities</li> </ul>
Dr. E. Katora Ms. D. Namasoko	M.O. Mbale Resigned	Strengthened FP Clinical Service		Did not work as a team
N.B. INTRAH Semi Annual Report April - Sept 85				
Dr. Asinwe Mrs. Nhura	M.S. Mbarara Hosp. Left service	FP Service Strengthened M.S. Now?		Nurse had no accommodation left.
Dr. Wanamera Mrs. Muyama	Left FP service provider i/c FP clinic	Referral back up <ul style="list-style-type: none"> <li>. Strengthened FP service.</li> <li>. Facilitates training at Mbale FP Clinic</li> </ul>	They worked as team for short time	Dr. Left the country

INTRAH semi Annual report 1986.

APPENDIX E.5j

Summary of Interviews with MOH, FPAU and NGO Officials

SUMMARY OF DISCUSSIONS/INTERVIEWS WITH SENIOR MINISTRY OF  
HEALTH OFFICIALS IN THE MINISTRY HEADQUARTERS

1. Dr. J.H. KYABAGGU, Acting Director of Medical  
Services, MOH Uganda

(Discussion/Interview Summary: July 13, 1989)

MOH/INTRAH Training Program

In general, the program has not had any serious administrative problems and in itself has been "something good" and has made "some impact". Main weaknesses - as with all other programs - is its verticality and lack of "integration" with other training programs.

Constraints: These include the counter funding system - which is beyond MOH scope of influence - and the FP supplies distribution system which has been linked to the general drug distribution system. Sometimes the latter has interfered with FP service provision.

Integration: MOH's goal is to conduct "integrated" training to avoid personnel being called several times in a year for training. Management training is an area where integration could begin and there is need to find other areas where linkages in training could be established. In addition, decentralized training is an MOH objective and requires proper preparation and assistance from the central level.

Integration of services is important if training is to respond in an integrated way.

The Centre for Continuing Education at Mbale is the key resource for training.

The MCH/FP Core Training Team (CTT)

As "integration" takes place, there is need to find ways of re-absorbing the CTT into the "integrated" system. The CTT could provide training in special skills. MOH plans to phase out the CTT and have its role performed within the "integrated" system in future.

There is concern that while the CTT was initially carefully selected and now has capabilities to carry out its work, the members left a vacuum still not yet filled. In future, it would be important to guard against depleting areas of such personnel who are difficult to replace.

Study Tours for Senior MOH and FPAU Officials at beginning of the Project

There was a tremendous change in attitude and the program received much support from the individuals all of whom were in positions to do so. A good example was the distribution of FP supplies from the Central Medical Stores.

2. Mrs. L. WALUSIMBI, Chief Nursing Officer  
Date: July 13, 1989

Personnel should be selected centrally by MOH so that DMOs and DHVs may attend most of the workshops. DMOs and DHVs are not consulted on trainee selected and personnel trained do not go back to their original stations.

SNOs should be educated - those who are in-charge of hospitals should have been the ones oriented.

Integration

Integration is when one person has all the skills. Integration will be achieved by the comprehensive curriculum. However, there is need for in-service training in order to fill gaps.

3. TRAINING DIVISION

Mrs. R.O.M. LEMATIA, SNO (Training) and Mrs. Mabel OKUCHU, SNO (Administration)

(Summary of Interview : July 27, 1989)

Pre-service and In-service Training and Mbale Centre

INTRAH Training started within training division. Training division is responsible for both PST and IST. The Manpower development and Training Centre situated in Mbale conducts and coordinates training activities on behalf of Training Division. It is financed by CIDA and executed by AMREF. Policies are jointly developed by the Mbale Centre and Training Division and implemented by AMREF. Coordination by Mbale Centre is through the AMREF Office (Entebbe) to ADMS (T). Ag. Director of Mbale Centre (Dr. Ojome - Paediatric Consultant) is counterpart to AMREF Medical Training Officer.

Training Focus/Progress

Training focus is both district and community based, so training should be conducted at district level.

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District level training has already started with district administrators being the recipients of two types of workshops:

- a) Managerial level (DMO, DHV, DHI) and
- b) Operational level for those lower than DMO (health educators, health inspectors)

So far 3 workshops have already been run by the Mbale Centre.

The idea of preparing district administrators is for them to go back and "radiate that to the periphery".

There is need for assistance in both strengthening and developing curricula being used in current workshops.

#### Integration

Integration of training programs makes better use of resources. The target to be trained in all the programs is the same - DMOs, DHVs.

In-service training should be integrated. FP is vertical because of its clinical aspects. UNEPI Cold-Chain is also vertical and CDD?

By training district administrators and operational staff using "integrated" curriculum, integration will be achieved through the district workshops.

#### Consequences of FP Training

During phase 1, Nurse tutors and Medical assistant tutors were trained in FP Clinical Skills. Some of these nurse tutors are providing FP services. There has been knowledge loss among the paramedicals because of lack of time to provide FP services due to overload from administrative duties.

Before the FP training program, enrolled nurse schools were not teaching FP but now it is included. FP has also been included in the comprehensive curriculum.

During Phase II, tutors have been trained in Visual Communication Skills and although for them it was a revision, in-depth skills were developed. Some visuals prepared during the workshops are now used by other tutors at Mulago School of Nursing and Midwifery.

#### Training Task Force

The Training Task Force was established by MOH in 1984 for the purpose of coordinating all the training

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activities and streamlining policy matters affecting training e.g. trainee and facilitator allowance rates during training. It meets quarterly in a year. There are two levels; policy and operational. Policy level includes ADMS(T), and ADMS (MCH/FP) among others.

Members of the Task Force include:

ADMS (T)

SNO (T)

Essential Drugs Program Manager

FHI Project Coordinator

Director and Medical Training Officer, Centre for Continuing Education

UNEPI Training Manager

CDD Manager

Planning Unit

MCH/FP (MOH/INTRAH Project) Division

At present it is the feelings of SNO (T) that the FP section of MCH/FP Division is not very involved in these meetings and it should get more involved (See note at end of this summary).

There are no problems in coordinating training of other MCH Programs except FP. (Others include UNEPI, CDD, Essential Drugs). All these others share training reports on completion of a training activity during the meetings.

SNO (T) has not yet witnessed any FP training activity report sharing.

Coordination problems should be avoided by careful planning.

CTT Capability

CTT conducts training in FP Clinical skills. SNO (T) is not aware of what other training skills CTT has.

District level training

FP training has been carried out at the main centres. UNEPI has prepared trainers at district level.

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CTT's first experience in district level training is the forthcoming TOT for TBA trainers.

Note: Review of minutes of the Task Force meetings revealed that FHI Project Coordinator or 1 - 2 CTT members attended 1 meeting in 1985, 3 in 1986, 2 in 1987 and 2 in 1988.

4 Dr. S.N. DARFOOR, WHO Advisor to the MCH/UNFPA Project on Strengthening of MCH/FP

July 14:

The Project

Target is on 8 districts (Arua, Moyo, Mukono, Iganga, Bushenyi, Tororo, Mubende and Hoima). Integrated Family Health services is the focus to improve MCH and FP service. The training program in the project is for middle level managers (District level personnel MPH scholarships) and primary level providers (TBAs and CH workers).

The project is not involved in training FP service providers and no plans have been made on CBD at this point. Training program for CHW is supposed to start January 1, 1990.

Observed constraints

- o Number of trained FP providers is negligible and not able to support CHW/TBAs in service provision.

Conclusions

- o There is urgent need to train FP providers in the project districts.
- o Training should be decentralized to the regions to assure a larger number of providers being trained (Dr. Katumba cautioned that the trainee source is also thin nationwide so that it may be impossible to train large numbers of midwives, nurses or assistant health visitors at present)

Possibilities

- a) MOH/USAID arrangements on filling the gap created by lack of FP providers need to be hastened so that project implementation is not delayed.

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- b) Though the project has no provision for training FP providers, temporary measure may be for UNFPA project to rearrange the activities/funds and train some FP service providers using the MCH/FP CTT - until (a) above is finalised. This would need to be negotiated.

The CTT:

As trainers of TBA trainers, they will establish a good link with service providers.

He referred to the ongoing TBA training plans. Dr. Darfoor sees this group (CTT) as a potential source of national training managers in MCH/FP.

Functions they could perform include the following:

- o He would like to use CTT to train trainers of Trainers for the Project.
- o CTT can assist MCH/FP to standardize MCH/FP training and training curricula.
- o Monitor regional training and help MCH/FP division make training projections.
- o Resource persons for mid-level management training.
- o As the training arm of MCH/FP, can advise the division about strengthening of FP services.

What needs to happen

- o CTT number need to be increased.
- o CTT may need re-orientation in order to conduct training for MCH/FP/PHC integration and training of TBAs.

SUMMARY OF MEETING WITH ADMS (PLANNING)  
(July 24, 1989)

Policy on FP Data

- No written policy in the past/was only implicit.
- Health information in total has not been streamlined.
- No feedback system was built in from planning - no feedback sent to field at present.

In future

The New Health Policy document has streamlined this.

- Some basic health information including MCH/FP will be sent from health units to DMO in each district who will compile and send to Planning Division.
- Planning Division will send feedback to DMO which will be used for further planning.
- Hospital records from MOH and NGOs will also go to the respective DMOs for onward transmission to Planning.
- The data planned to be collected will not be comprehensive - Division managers are empowered to collect comprehensive data as they need.
- Planned Health Information system is in phases and is expected to be effected in all districts by 1992.
- Different donors are funding HIS in different areas (AMREF-CIDA, Italian Govert, etc).
- There are also plans to set up sentinel sites for indepth information in future.
- Printing and production of records will be coordinated by UNICEF in Uganda.

views on CTT

- CTT to be given more time to train more service providers to establish more service sites.
  - CTT has not done much due to financial constraints - release of funds.
  - Integrated training to be explored to establish areas where one can integrate.
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Mrs. Lydia Muranga, Acting Executive Director,  
Family Planning Association of Uganda

(Interview Summary : July 26, 1989)

Discussions centred on Training linkages and coordination with the CTT, FP Commodities records and reporting.

Training, Linkages and Coordination with CTT:

FPAU's clinics are used as practice sites for FP clinical Trainees. FPAU is dissatisfied with its non-participation in CTT activities for planning training and conducting it. This has occurred during this 2nd phase of the MOH/INTRAH Project.

FPAU would benefit from more active involvement in training besides precepting for MOH trainees. This would offer opportunity for FPAU clinic staff to know what experiences trainees should get and help collerate what is taught in classroom with practice. For instance, the FPAU follow up schedule for the pill differs from what MOH/INTRAH CTT teaches. One person from FPAU should be fully involved in the CTT.

FPAU also feels that it is often blamed for any problems related to FP e.g. they were blamed for some expired OCs found in the market which had missed destruction along with others (Office of President did not know that MOH has an FP Unit)

CTT and FPAU have identified their differences related to FP training and practice but the group never went past identification of the differences. There is need to officially communicate in writing and keep an official report of agreements reached in resolving the differences. Dialogue is necessary if problems are to be solved. There are no agreed on procedures of FP practice. MOH/INTRAH training is very comprehensive but trainees may not always be able to utilize all the knowledge gained.

Commodities, Reporting and other Supplies

In 1980, MOH issued a population statement stating it was going to deliver FP services while FPAU would provide IEC. Since then, FPAU cannot attract funding for clinic services and so MOH should take its duties seriously.

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Following the FP Supplies and Logistics Management Workshop in 1987, it was decided that MOH should coordinate FP supplies and information system. DMOs are supposed to supply all units including NGO and FPAU at the district level. However, MOH has not been able to replenish its supplies and FPAU - which obtains supplies from IPPF, has been supplying most of the units in the country.

In April 1989, a circular (see Appendix) detailing the changed FP supplies system was issued by FPAU to FPAU area officers and DMOs. FPAU area officers are now supplying commodities and records to FPAU clinics and private practitioners while DMOs are expected to order direct from FPAU Kampala or MOH and supply all MOH and NGO units in their respective districts. About 20 DMOs have so far acted according to circular.

FP Reporting system for IPPF now requires that FPAU submit number of new acceptors and re-visits. Continuing acceptor items is now dropped from current format.

FPAU Kampala Clinic has on its own initiative began keeping a record of drop-outs on first return visit and is attempting to follow up such clients.

FPAU plans to recruit new Executive Director within the next 6 months.

\* Mr. C.H.M. Barlow

Consultant Administrator started work on July 24 and is on a 6 months consultancy to FPAU.

In discussions with him, he explored what INTRAH is and does and how it relates to USAID country Missions in respect to its training projects.

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**Interview with Mrs. Joy Mukare**  
**Project Manager, Family Planning Project**  
**Multisectoral Rural Development Program**  
**Bugosa Diocese**  
(Interview summary: July 17, 1989)

The FP component of the MRDP was designed in 1985. The MOH was approached by Pathfinder to obtain MOH approval and support. MOH agreed to provide training to FP service providers.

Two MRDP staff went for FP training at Margaret Sander in 1986 and started then to recruit nurses for the project. Most project nurses are employed by MOH.

Recruited nurses received some theoretical training with the assistance of DMOs and FPAU. The project then called on the MOH to provide clinical training.

Busoga project managers reviewed the curriculum developed by the CTT and negotiated for modifications.

While the CTT considered IUD insertion to be a necessary component of CP clinical training, Busoga diocese staff had reservations based on infection risks, septic conditions of practice and low level of demand for IUDs. IUD insertion was maintained in the first workshop and 4 out of the 11 trainees were then allowed to practice IUD insertion. The first follow-up found however that most trainees could not meet necessary conditions. CTT then agreed to exclude IUD from subsequent training activities.

Busoga project managers also requested to include community participation approaches in the training, to remain consistent with the general project approaches. These include: calling on communities to make decisions on whether service units should be expanded; provision of labour and money by the community; selection, training and supervision of Community Health Workers; concepts of Community Health Care; ....

The main positive effect of the training was to serve as an eye-opener to the skills required. Logistics management would not, for instance, have been included without this experience. It was eventually found that this training should have developed this component more.

Other components were still inappropriate: the session on population dynamics should have been narrowed down to what providers really needed; session on diaphragm was useless; the training in itself was clinic-based and did not take enough into account the environment in which people were going to provide the services, e.g. the flexibility required when resources are limited and equipment is not available.

More time should be spent to look at the tasks people are doing in the field, not exclusively at the FP component. Counseling skills should be developed by training with people

from rural areas. Trainees were brought back after 6 months to work on counseling, that is to look for FP clients and not wait for them to come.

Follow-up was very useful: realized that level had gone down and decided to conduct in-service training immediately. Skills and knowledge had gone down. When too many clients were seen, e.g. on immunization day, providers did not take the time to do physical examination.

Project changes included: provision of clinical protocols, as providers do not have the time to look up books; discouraged to attend FP clients on immunization day; helped organize the services; strengthened supervision, by selecting field supervisors to visit providers once a month with a checklist developed by the project; identified providers requiring special support.

Project managers provide quarterly supervision. All project providers come once a month to the center (in 2 groups) to discuss problems.

The resources required to run such programs include: committed manager; high morale for the staff; money to organize training; bicycles, uniforms, bags, motorcycles for the field supervisors.

The project covers 21 areas with 6 to 10 000 people in each. The whole diocese population is about 2,400,000. Immunization coverage in project areas is about 50%; contraceptive prevalence about 10% of women of reproduction age.

The project has established a Management Information System. Client records have been developed on the basis of other existing records, including the MOH project. The MOH stated in 1987 that it would take MIS in charge but it is still working on it. The project will see what MOH comes up with and adopt it. The project's system needs revising, there is some duplication.

Clinics send monthly returns to the center. Summary information is transmitted to Pathfinder, DMOs and FPAU every 3 months.

The Busoga project will require additional assistance from the CTT to: follow up trainees periodically, not once every three years; provide IST to adapt to technology changes and refresher courses. CTT should involve employers of trainees when developing curricula.

CTT has however been very busy as they have a tight program over the whole country. Pathfinder sent some people to help project train trainers.

Districts should distribute supplies and include project staff in training activities.

Major difficulties for creating FP services include: time required to create awareness of FP; lack of privacy in the clinics while there is a need for secrecy; negative image of FP,

associated with prostitutes, murder, dangers for health. Major stimulus for contraceptive use is economic.

Interview with Mr. Patrick Dhikusooka, R.C.  
and Mr. John Aggreybangu, Health Committee Chairman, Kamuli  
Interview Summary  
(July 18, 1989)

The closest health centers are 10 to 15 km away. Opening the health post means: diminution of transport time to obtain treatment; quality and availability of supplies; less waiting time at health center. It is better to come to this post even if there is something to pay. There are demands from other places to build such centers. The post covers the whole sub-county for immunization and malaria. Health workers go out for mobile immunization, hold meetings in villages, but do not necessarily go to people's houses.

Most important problems of health workers include: transport; allowances; housing. Health workers may resign if these problems are not addressed.

Most important problems of people include: cost of living; cost of supplies, e.g. cement; school fees; low cash crops market prices.

Maternal and Child Health problems: most people want a lot of children, even if they don't have money; each wife wants to have a child from her husband; the number of children is a sign of standing.

First translation of FP was "stopping people from giving birth"; this was not well received. People also complain that if you use contraception you can find problems. Husbands want to have many children to give the names of their ancestors.

Now children must have education and the land is getting small.

APPENDIX E.5k

**Record Samples**



FPA: \_\_\_\_\_

Reporting period \_\_\_\_\_ 19\_\_\_\_

Table 4 OTHER SERVICES PROVIDED THROUGH FPA CLINICS AND  
NON-CLINICAL OUTLETS AND REFERRALS

Service category	Total number of visits
General FP counselling, advice, consultation only (not a current user or now acceptor or contraceptives)	
MCH (immunization, ante-natal, post-natal, other preventive and curative health services)	
Pap smear	
Pregnancy test	
Infertility or sterility counselling/treatment	
Other services (list other services): (i)	
(ii)	
(iii)	
<b>Total visits</b>	
Number of clients referred for services to other agency outlets (by FP method or other services); Specify: (i)	
(ii)	
(iii)	
<b>Total referred</b>	

FPA: \_\_\_\_\_

Reporting period \_\_\_\_\_ 19\_\_\_\_

Table 4 OTHER SERVICES PROVIDED THROUGH FPA CLINICS AND  
NON-CLINICAL OUTLETS AND REFERRALS

Service category	Total number of visits
General FP counselling, advice, consultation only (not a current user or now acceptor or contraceptives)	
MCH (immunization, ante-natal, post-natal, other preventive and curative health services)	
Pap smear	
Pregnancy test	
Infertility or sterility counselling/treatment	
Other services (list other services):	
(i)	
(ii)	
(iii)	
<b>Total visits</b>	
Number of clients referred for services to other agency outlets (by FP method or other services):	
Specify: (i)	
(ii)	
(iii)	
<b>Total referred</b>	







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FLEP SUPERVISORY

B. Diocese

CHECKLIST

Project Area \_\_\_\_\_

Date \_\_\_\_\_

Supervisor \_\_\_\_\_

AREA OF SUPERVISION	OBSERVATIONS	RECOMMENDATIONS
1. CLIENT FILE BOX		
2. CLIENT CARDS		
3. CONTRACEPTIVE REG. (a) Tally Sheet (b) Registration Book		
4. HOME VISIT/EDUC. BOOK		
5. COMMODITIES RECORD-KEEPING		
6. COMMODITIES STORAGE		
7. CLINICAL SKILLS		
8. CLIENT FOLLOW-UP		
9. COMMUNITY ASSESSMENT		
10. STERILIZATION ASSESSMENT		

OTHER COMMENTS OR PROBLEMS ENCOUNTERED: \_\_\_\_\_

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**The Pathfinder Fund**  
**IUD DISCONTINUATION FORM**

Project PIN: \_\_\_\_\_  
Reporting Period: \_\_\_\_\_

Total Number of IUDs Inserted During present Quarterly Reporting Period: \_\_\_\_\_  
Total Number of Copper T 380 A Inserted During present Quarterly Reporting Period: \_\_\_\_\_

REASONS FOR IUD REMOVAL:	TYPE OF IUD:					
	// Copper T 380 A		// Copper T 200		// Lippes Loop	
	Count only those IUDs inserted on or after 1 Jan. 1989		Count only those IUDs inserted on or after 1 Jan. 1989		Count only those IUDs inserted on or after 1 Jan. 1989	
	Inserted more than 1 yr. ago	Inserted less than 1 yr. ago	Inserted more than 1 yr. ago	Inserted less than 1 yr. ago	Inserted more than 1 yr. ago	Inserted less than 1 yr. ago
PREGNANCY	*		*		*	
1. Uterine						
2. Ectopic						
EXPULSION						
REMOVAL, Medical Reasons						
1. Bleeding/Pain						
2. Infection/Discharge						
3. Other						
REMOVAL, Non-Medical Reasons						
1. Planning Pregnancy						
2. Other Personal						

\* Note that "Inserted more than 1 yr. ago" column should be blank until January 1990.

Only report IUDs that were inserted at your clinic. Distinguish between IUDs inserted less than or more than one year before removal for complications. This form should accompany the quarterly programmatic report submitted to Pathfinder.

Signature of Project Director \_\_\_\_\_ Date \_\_\_\_\_

Name of Clinic \_\_\_\_\_

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**MULTI-SECTORAL RURAL DEVELOPMENT PROGRAMME**

BUSOGA DIOCESE

CHURCH OF UGANDA

**FAMILY PLANNING CLIENT CARD**

Name... ..Number .....

Health Unit Name .....Date.....  
Surname Others

Address: Village.....

Age.....Marital Status ..... Age at first Marriage.....

Husband's/Father's Name .....

Total number of pregnancies? .....

Number of children Living .....

Ages..... Died.....

Previous contraceptive Practice Yes/No. Method.....

**Medical History**

LMP.....No. of breeding days.....Cycle length .....

Regular/Irregular Flow-light/moderate/heavy .....

Date of last delivery/abortion .....Problems .....

Blood pressure..... Weight.....

Yes No

Breast Feeding: .....Have you ever been severely

Severe Varicosis: .....ill or hospitalised? yes/no

Migraine/Headaches ..... Specify.....

Jaundice: .....

Renal Disease: .....

Hypertension .....

STD: ..... Breasts ..... Normal Abnormal Specify

Diabetes: ..... Uterus .....

Epilepsy ..... Cervix .....

Tuberculosis ..... Ext. Genital .....

PID ..... Viginal .....

Goitre ..... Discharge .....

Other .....

Specify .....Pregnant Yes/No/Not sure

Taking medicine .....

Specify type .....

**Method of Contraception Adopted**

Pill: Type .....No. of cycles: .....

IUD: Type.....Size.....

Injection: (Mgs)..... Condom: No issued.....

Diaphragm: Type.....Size.....

Spermicide: Type.....No. issued.....

Other: .....None: Reason .....

**Remarks/Referrals:**

Practitioner.....Return Date

Return Card.....

filled cut yes/no

NAME.....NUMBER.....METHOD: Pill Injection IUD Barrier Ster

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UNEP  
 SUPERVISORY CHECK LIST MBALE DIST. COUNTY .....  
 HEALTH UNIT ..... SUB-COUNTY.....  
 OFFICER IN-CHARGE..... DATE .....

REFRIGERATOR: .....TYPE .....CONDITION.....  
 TEMPERATURE RECORD: MONTHLY RECORD .....  
 VACCINE CONSUMPTION .....  
 NO. OF DAYS FRIDGE FAILURE IN PRECEDING MONTH (OVER 4 HRS).....  
 VACCINE CARRIER: .....ICE PACKS .....  
 SCALES (SALTER) .....TROUPERS .....  
 OTHERS  
 STEAM STERILIZER .....PLUG NEEDS REPLACEMENT.....  
 SOCKET NEEDS .....

VACCINE STOCK

TYPE	+ B.C.G. DILUENT	POLI'0	D.P.T.	MEASLES	TETANUS
STOCK (DOSES)					
STOCK USED					
EXPIRY DATE					

STATIONERY & EQUIPMENT

	IN STOCK	ORDERED	DELIVERED
IMMUNIZATION TALLY SHEETS	.....	.....	.....
IMMUNIZATION SUMMARY SHEETS	.....	.....	.....
QUARTERY FORMS	.....	.....	.....
REQUISITION SHEETS	.....	.....	.....
IMMUNIZATION MONTHLY RETURNS	.....	.....	.....
YCC CARDS	.....	.....	.....
SYRINGES 2 CC	.....	.....	.....
NEEDLES 25" G X $\frac{5}{8}$ "	.....	.....	.....
NEEDLES 19" G X $1\frac{1}{2}$ "	.....	.....	.....
NEEDLES 23" G X 1	.....	.....	.....
COTTON WOOL	.....	.....	.....
SOAP	.....	.....	.....
BCG SYRINGES	.....	.....	.....

REQUIREMENTS.

1. MONTHLY RETURNS: { COLLECT }
  2. PARAFFIN: { CHECK OR COLLECT EMPTIES }
  3. STERILISATION EQUIPMENT: { CHECK ON CONDITION }
  4. EMPTY VIALS OF VACCINE: { AND LOSSES }
- (COLLECT FOR PROOF OF USAGE)  
 SIGNATURE .....

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Appendix 5k page 11 of 14  
COLD CHAIN MONITORING AT RURAL HEALTH UNITS DMO'S OFFICE (MBALE DISTRICT)  
UNEPI CHECK LIST

DATE.....

1. Static Unit.....
2. Programme .....Number of O/R: .....
3. Fridge Particulars: .....
  - (a) Gas (ii) Gas/Electric (iii) Electric (iv) Solar(v)Kerosene
  - (b) State of plugs and sockets .....
  - (c) Number of gas cylinders.....Full,.....Empty.....
  - (d) Kerosene.....Date of last supply.....
  - (e) Temperature (frequency of recording) .....
4. VACCINE:
  - (a) Vaccine stock in the fridges.....
  - (b) Vaccine storage principle (FIFO) First in, First out.....
  - (c) Vaccine in stock:

<u>Vaccine in stock:</u>		<u>Vaccine Delivered:</u>	
B.C.G.	Diluent.....	B.C.G.	Diluent.....
Measles	diluent.....	Measles	1st or Diluent.....
D.P.T.	.....	DPT	.....
Polio	.....	Polio	.....
Tetanus	.....	Tetanus	.....
  - (d) Vaccine requirements: fill requisition form.
5. Other UNEPI Equipment and storage:
  - (a) Vaccine carriers (number) ..... State.....
  - (b) Ice packs (number) ..... State.....
  - (c) Immunisation cards ..... condition.....
  - (d) Immunization Kits ..... condition.....
  - (e) UNEPI bicycle ..... condition.....
6. UNEPI RECORDS
  - (a) Monthly returns .....Submitted or not.....
  - (b) Tally sheets .....(c) Requisition forms.....
  - (d) B.C.G. cards .....(e) T.T. ....
7. STAFF:
  - (a) Are they trained in Unepi activities?.....
  - (b) How many carry out Unepi O/R activities .....?
  - (c) Is there good working morale and Team work? .....
8. Allowance .....Date of last payment .....
9. Mobilisation participation of
  - (a) Chiefs (b) RC's (c) Community
  - (d) Other Departments (e) Health Committee members
10. General Remarks:
  - (a) Work space .....
  - (b) Staff complaints .....
  - (c) Staff suggestions .....

MONITORING	METHOD	HOW OFTEN	INDICATE PROBLEM.
<u>STATIC HEALTH/C.</u>			
Programme	See if it is there.	Do they follow it?	If not report/ Assist.
ation	See Roster	How many do immunisation	Report/Assist.
Problem incurred by staff while on duty	Invite questions	How often do they face such problems ?	Report/Assist.
<u>COLD CHAIN</u>			
Storage temperature	Ask at what temperature do they keep vaccines ?	Do they keep them daily/weekly	Report /Assist.
Observe unpacking and packing vaccines	Advise if possible	Do they pack <del>4</del> <i>daily?</i> weekly/monthly	Report /Assist.
Temperature at outreach	Ask at what temperature do they keep vaccines at outreach?	Do they go there daily/weekly or monthly?	Report/Assist.
<u>EQUIPMENTS</u>			
<u>Refrigerator</u> Find out at what temperature do they keep vaccines	Ask about max and min. temperatures of safe keeping of vaccines	Do they maintain this temp. daily weekly/monthly	Report/Assist.
Fridge Packing	Observe piles of vaccines & which first second etc last chamber	Is this done everyday weekly monthly?	Report/Assist.
Fridge Failure	Power, no ice in Freezer door does not shut Flame in case of Kerosene	Since when?	Report/Assist. (Assist. of Technician)
Monthly record Temperature	Is it there?	How are recordings A.M/P.M.	Report/Assist.
<u>COLD BOX OR VACCINE CARRIER</u>			
Check for cracks	Observe if major	Since when?	Return to D.M.O if major or Advise the staff to return it.
Check on cleanliness	encourage to clean or a word of thanks if it is clean	Ask if cleaned daily/weekly or monthly	Report/Assist.

- 2 -

MONITORING	METHOD	HOW OFTEN	PROBLEM
Observe lid fitting	if not advise to return	Daily/weekly monthly ?	Assist/report
Check on number, if more than required?	Count & return excess	Since when ?	Assist/report
Ice packs-check on size/numbers	Count return excess	Since when ?	Assist/report
Syringes, Needles, ORS, Stationery, long term equipment etc Returns	Use check list	Every time you visit the units	Assist/report
<u>VACCINES</u>			
Check on numbers (in doses)	Use check list	daily/weekly/monthly	Assist/report
<u>STAFF MOTIVATION</u>			
Ask about good working morale	Do they work as a team?	Since when ? ...2	Assist/report
Do they get allowances	Ask each staff alone for proof.	How often? if not since when?	Assist/report
Relations with the public	Ask who are the influential <i>people</i> of that area	Do they often use them in their work?	Assist/report
Mobilisation	Ask if the public participates in mobilisation of mothers	How often ?	Assist/report
<u>PLACE OF WORK</u>			
Ask the type of place they use	shade/house etc	How often? daily/weekly monthly	Assist/report
Cleanliness	If possible see the place	How often do they sweep the place.	Assist/report

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FAMILY PLANNING ASSOCIATION, OF UGANDA

P.O. Box 30030,  
KAMPALA.

Ref: FPAU/Med/3

From : Ag: Administrator, FPAU.....  
To : Area Officers/District Medical Officers.  
Date : 10/3 1989.  
Topic : DISTRIBUTION OF CONTRACEPTIVES TO NON-FPAU CLINICS.

---

You may recall that during training of logistics management in 1986, a procedure was established for distributing of contraceptives at District level. Following further discussions with the Assistant Director of Medical Services MCH/FP Dr. E.M. Kaijuka, we have agreed that the following procedure for distribution of contraceptives be adopted with effect from April, 1st 1989.

- 1) The District Medical Officers will be distributed with contraceptives from FPAU main stores in Kampala, for distribution to their Health Centres and other Ministry of Health, and Missionary Health Units.
- 2) FPAU Area Officers will distribute contraceptives to only FPAU clinics and the Private Medical Practitioners in their areas.
- 3) The Exchange of contraceptives from Ministry of Health to FPAU will be carried out between the Ministry of Health central stores in Entebbe and FPAU main stores in Kampala.

- 1) ADMS MCH/FP. (Assistant Director Medical Services,
- 2) Chief Pharmacist Ministry of Health.
- 3) Stores Officer FPAU.

APPENDIX E.51

Draft FP Procedures for Selected Methods

DRAFT F.P PROCEDURES FOR SELECTED METHODS

OCTOBER 1987

INSTRUCTING CLIENTS ABOUT THE PILL

Objectives:

1. To get the client to take the pills correctly
  2. To ensure maximum efficiency of the pills
  3. To enable the client to report to the clinic when having problems
- 
1. There are different types of pills which prevent pregnancy. Pills contain medicines which are similar to what woman's body produce.
  2. In this clinic/our country, we have pills which are taken every-day after examination at the clinic.
  3. We advise clients/mothers to start taking the first packet of pills on any day of their menstrual period up to the first 5 days.
  4. When taking pills you must:
    - a) Take one pill every day, preferably, after supper time. This helps to reduce nausea/"feeling sick". Taking pills at the same time helps you to remember.
    - b) Start from the large arrow(show it) on the packet, or the part with many pills of one colour.
    - c) End on the line with fewer coloured pills.
  5. Take pills even if your husband is away or your child is in hospital. If you are admitted in hospital or you are under special treatment tell your doctor or the clinic in case you need to stop the pill.
  6. If you miss one pill, take one as soon as you remember and the one for that day at the usual time.
  7. If you miss two pills in a row, take two pills as soon as you remember and two the next day. Use another means of contraceptive until you finish that packet of pills. Report to the clinic for appropriate advice.
  8. If you miss three or more pills in a row, you may become pregnant. Visit the clinic for advice.

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9. If you miss no pill, but skip a period, you probably should not worry too much, you may be pregnant but this is very unlikely.
10. If you miss one or more pills and skip a period start using another method of family planning and report to the clinic.
11. There are many changes in your body that may occur as a result of taking pills e.g.
  - menstruation occurs every month (regularly)
  - painful menstruation improves
  - heavy menstruation becomes lighterThese are good points of the pills.
12. Sometimes you may have troublesome symptoms. These do not all happen in one person and we expect them to disappear within two to three months of pill use. You may have any of the following:-
  - a) general feeling as in early pregnancy
  - b) frequent headaches
  - c) nausea
  - d) some weight increase
  - e) watery vaginal discharge
  - f) spotting
  - g) dark patches on the face as in pregnancy in some women.
13. Report to the clinic or physician if any of the above symptoms become severe, or happen suddenly.
14. Similarly report any of the following immediately:-
  - : sudden severe headache
  - : blurred vision
  - : sudden severe abdominal pains
  - : sudden severe difficulty in breathing
15. If you have any questions, ask me.

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CLIENT INSTRUCTIONS FOR PROGESTERONE ONLY (MINI PILL)

- Objective:
1. To get the client to take the pills correctly
  2. To ensure maximum efficiency of the pills
  3. To enable the client to report to the clinic when having problems.
1. We have one type of pills which are usually given to mothers who are breastfeeding and their babies have not started being weaned. (show one packet of pills).
  2. We also give these pills when a woman has health problems that may be made worse by the other family planning pills.
  3. These pills are more in one packet compared to other family planning methods, BUT THEY PREVENT PREGNANCY TOO.
  4. When you have been given these pills;
    - a) take one daily every day until you wish to have another baby or you are suitable for changing to other type of family planning pills.

The first packet is started on any day, between first day up to the fifth day of the period/menses.

- b) Take the pills after supper or at bedtime. IT IS IMPORTANT TO TAKE PILLS AT THE SAME TIME IN ORDER FOR THEM TO WORK WELL.
- c) If you miss one pill take it as soon as you remember and the usual one at the regular time. Use a second method of family planning until the next period. e.g. abstain, condoms for your partner, or foaming creams, but not natural family planning.
- d) If you miss two pills, take two pills as soon as you remember and two at the usual time. Use a second family planning method until your next period.
- e) If you do not get a period within 6 weeks since the last one, return to the clinic to check if you are pregnant. To prevent this problem, use a second method during the first three or more months of pill use.
- f) You may have the following expected symptoms, some of which may be troublesome:-

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- spotting (blood spot on your pants) between periods
- irregular periods
- or very infrequent periods such as one or two per year.

As long as you are well when we check you, do not worry. Once your baby is feeding on normal foods and is weaned, we can change you to another method.

- g) If you notice other health problems such as depression, irritability, change in sex drive and other severe conditions, report to the clinic.
- h) What questions do you have?

FOLLOW UP VISIT/SESSION FOR CLIENTS USING COMBINED ORAL CONTRACEPTIVES  
OR PROGESTERONE - ONLY PILLS

A. TIMING: WHEN CLIENT HAS NO PROBLEMS

1. First follow up: between 8 - 12 weeks after initial visit and beginning to take the pills.
2. Subsequent visits:
  - (a) 8 weeks after first follow up.
  - (b) 12 months since beginning to take the pills.
3. Re-supply (a) every three months during the first year i.e. 3 cycles given at a time.  
(b) every six months from 2nd year (6 packets at a time).

B. TIMING WHEN CLIENT HAS PROBLEMS.

1. Take exploratory history of the problems
2. Conduct appropriate physical examination
3. Reassure as relevant to the complaint.
4. Give one month appointment to review the situation or refer to medical officer

C. PROCEDURE OF ROUTINE FOLLOW UP OF CLIENTS USING ORAL COMBINED  
CONTRACEPTIVES

FIRST VISIT

After making the client feel at ease do the following:-

1. Take and record B.P.
2. Ask client: (a) LMP, duration, amount of loss and any problem with the menses.
  - (b) How she has other problems been feeling generally (this question is an indirect way of finding out if side effects are waning (reducing) or being serious).
  - (d) Ask if she could show you the pill packet that she is currently taking the pills.
  - (e) You may ask more questions to review "how to take pills", if necessary e.g. what would you do if you travel away from your home?
3. If all the above questions lead to no problems record the information briefly.
4. Say encouraging words to the client about the progress made and how she is taking her pills.

SECOND ROUTINE VISIT.

1. Conduct as done during the first routine visit.
2. Assess whether the client requires to continue using the pills or change to another method BASED on SIDE EFFECTS OR HOW CLIENT FOLLOWS INSTRUCTIONS FOR TAKING PILLS.

ANNUAL VISIT

1. Asking client how she feels generally since she started using the pills, menstrual history.
2. Conducting a full physical check up, including breast and pelvic examination.
3. Give 6 cycles and ask her to continue until she wishes to have another pregnancy or has matters/problems to be dealt with e.g. does she wish to have tubal ligation.
4. Give her appointment month/date for another annual check up visit.

INSTRUCTING CLIENTS ABOUT IUCD (LIPPES)

1. There are several "loops" which are used. Here we have the plain white ones, and the ones with copper round one part. (show the IUCD to clients; let them touch the IUCDs).
2. Like other methods, loops are used after careful examination by a trained person.
3. Loops are made of materials which are safe in the body, they do not rot.
4. A loop is put in the womb so that it looks like this (show on model or fist). All equipment used for putting in the womb are specially made clean in the clinic.
5. Loops have good points and bad points.
6. GOOD POINTS
  - a) There is nothing to do every day. After the first check up and if all is well one reports once a year for check up.
  - b) It is good for busy people, with husbands who travel often or forgetful ones.
  - c) 97 - 99% of users in one year are sure that pregnancy is prevented.

7. BAD POINTS

Bad points which usually disappear in 2 - 3 months, which may occur are as follows:-

- heavier menstrual flow
- prolonged menstrual flow
- spotting
- expulsion; pregnancy in 1 - 3 users out of 100 in one year
- watery discharge

We usually give you 2 pain killing tablets to take for this.

You must report to the clinic if these problems became prolonged or serious.

8. Report urgently to a hospital/clinic if you get severe pelvic infection recognised by high fever, chills, pussy or smelly discharge.
9. The loop is not suitable for people with more than one sexual partner. The chances of infection increases among such people.
10. When you are wearing a loop it is necessary to do the following to ensure that your loop is inside:-
  - a). Check your sanitary cloth or pads each time you change them before throwing them away.
  - b) After completing the period, with clean hands;
    - lie down with knees bent or put one foot on a chair with the other one on the ground.
    - insert the fore finger and pointing finger far back in the birth canal.
    - feel the opening of the womb which feels like the tip of the nose
    - move your fingers so that you feel the threads of the loop
    - wash your hands again.
11. If you do not feel the threads or have any other problems, use an alternative method and return to the clinic.
12. We usually want to check you 8 weeks after the insertion, then after 6 months and once a year. We record the month when you are due to have the yearly check up on your small card which has the clinic.
13. If you have any questions ask me.

#### GUIDELINES FOR IUD STERILIZATION

At its recent meetings, the IPPF International Medical Advisory Panel formulated guidelines for sterilizing bulk packaged IUDs which are supplied by IPPF to many family planning associations. They may also be supplied in the family planning field by other organisations. These guidelines are set out below to help our readers.

#### GUIDELINES

Any of the following solutions are acceptable for sterilizing IUDs benzalkonium chloride (1:750); aqueous iodine solution (1:2500); isopropyl alcohol (75%).

The iodine solution should be freshly prepared daily as follows: 25ml of 2% tincture of iodine in 1 litre of water, or 7ml of 7% tincture of iodine in 1 litre of water.

The IUDs and inserters should be pre-sterilized for 24 hours in the benzalkonium chloride solution or for 10 minutes in the aqueous solution of the isopropyl alcohol solution. The IUD should not be left in the benzalkonium chloride solution for more than 24 hours at a time as the plastic may become brittle.

Metal instruments should be sterilized in an autoclave or by boiling, depending on the procedure routinely used in the clinic.

Chlorhexidine gluconate (Savlon) should not be used. IUDs should be stored dry, not in a sterilizing solution.

At present it is not recommended that IUDs be sterilized more than three times.

Reference: IPPF Medical Bulletin Volume 19 No. 6 December 1985.

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OBJECTIVES (WHAT THE PROVIDER SEEKS TO ACHIEVE FOR THE PROMOTION OF CONTRACEPTIVE USAGE OF THE DIAPHRAGM)

1. To attract women to use diaphragm and Cream.
2. To enable diaphragm users to fit it in a way that enhances its effectiveness.
3. To give information regarding follow-up visits when using the diaphragm and cream.

1. GENERAL INFORMATION TO CLIENT

1.1. BENEFITS OF A DIAPHRAGM

- It is good for women who have sex occasionally, choose it as a preferred method or have problems with other methods.
- A successful F.P method for many women who use it correctly and like it.

1.2. Showing the smallest and biggest sizes and cream available the F.P service provider says the following.

1.2.1. Each woman is different from another therefore each one has a different measurement in the birth canal for diaphragm fitting. Therefore we measure for diaphragm size that suits you.

1.2.2 The diaphragm must be inserted into the vagina (birth canal) before sexual intercourse.

2. INSTRUCTIONS

2.1. Wash and dry your hands.

2.2. Hold diaphragm (dome down) and squeeze about one table spoonful of this special cream into the middle of the dome (FP service provider shows how to hold the diaphragm and squeezes the cream while client looks on).

2.3. Spread a little cream around the rim of the diaphragm to further make the cream kill the mans seeds (sperms) when you have sexual relations or make love with him.

2.4. INSERTION OF THE DIAPHRAGM

2.4.1 With one hand hold the filled diaphragm (dome down) and press opposite sides of the rim together so that the diaphragm folds (like this: Nurse demonstrates).

2.4.2 Stand up and put one foot on the edge of a chair, bath tub or a toilet or squat or lie on your back.

2.4.3 Spread the opening of the birth canal with another hand and insert the folded diaphragm pushing it down ward and backward along the back wall of the birth passage as far as it can go.

- 2.4.4 Push the front rim up along the roof of the birth canal behind the pubic bone using the index (pointing finger). The pubic bone can be felt on the upper part of the birth passage near the opening.
3. TO CHECK THE PLACEMENT OF THE DIAPHRAGM
  - 3.1. Using the index finger (pointing finger) check for the correct placement of the diaphragm by feeling the opening mouth of the cervix through the diaphragm.
4. AFTER SEXUAL INTERCOURSE (HAVING RELATIONS OR MAKING LOVE/ MEETING YOUR PARTNER)
  - 4.1 Leave the diaphragm in place for at least 6 hours to 8 hours before removing, cleaning, drying and storing it.
  - 4.2. You should apply more cream using a filled applicator of cream and without removing the diaphragm, if you and your partner want to make love before the 6 - 8 hours are over.
  - 4.3 The 6 - 8 hours when you remove the diaphragm are counted after the last love making or sex.
  - 4.4. A well placed diaphragm can be kept inside e.g. when you go out to work or sleeping without problems in case the 6 - 8 hours for removal are over.
  - 4.5. Do not keep the diaphragm in for longer than 12 hours.
5. REMOVAL OF DIAPHRAGM
  1. To remove the Diaphragm you do the following:-
    - 5.1. With washed hands, place the pointing (index) finger behind the front rim of the diaphragm and pull down and out.
    - 5.2. You may also remove the diaphragm by inserting the pointing (index) finger between the diaphragm and pubic bone and pull the rim downward and outward.
    - 5.3. Wash your hands again.
6. CARE OF THE DIAPHRAGM
  - 6.1. Wash the diaphragm with soap and clean water and dry it with a special clean cloth kept for that purpose. Store it in its container and in a good place and away from children's reach.
  - 6.2. Inspect it regularly for holes by holding it to the light.
  - 6.3. It should not be stretched with sharp finger nails.

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- 6.4. It should not be in contact with grease or any medicine for killing germs.
- 6.5. A well kept diaphragm may last for 2 years where the weather is not very hot.
- 7. FOLLOW - UP VISITS
  - 7.1 We ask the client who uses a diaphragm to return to the clinic one week after the initial fitting with diaphragm inside (fitted). This one week allows the user to practice own fitting and see whether the couple likes it.
  - 7.2 If the diaphragm has been liked by the couple, the user reports the clinic to collect more tubes of creame or jelly only or for necessary advice.
  - 7.3 We require a diaphragm user to return for re-assessment in case of need to change diaphragm size if:-
    - (a) The woman needs more 2-3 kg of body weight within a period of ..... since fitting.
    - (b) After child birth
    - (c) If client looses significant body weight.

8. POSSIBLE PROBLEMS USING A DIAPHRAGM

There are usually no health problems when one uses a diaphragm. In a few cases one or so of these problems may occur. To come back to the clinic if such problems occur such as:

- a) Allergy to rubber or cream
- b) Infection of the urinary bladder from the pressure on the urinary passage/tube.
- c) For smelling discharge from the birth canal if diaphragm is left inside for long period.

NB: Allow clients to ask questions any time she wishes to do so.

**APPENDIX E.6**

**Map of Uganda**



APPENDIX E.7

**CTT Profile and Perceptions**

CTT MEMBERS

No.	DATE	1 1984	2 1985	3 1986	4 1986 (Nov.)
1.	SELECTION	<p>WHO:</p> <ul style="list-style-type: none"> <li>o DMS</li> </ul> <p>CRITERIA:</p> <ul style="list-style-type: none"> <li>o FP Clinical Skills</li> <li>o Tutor</li> </ul>	<ul style="list-style-type: none"> <li>o MOH</li> <li>o Not stated</li> <li>o -</li> </ul>	<ul style="list-style-type: none"> <li>o MCH/FP Division</li> <li>o -</li> <li>o -</li> </ul>	<p>CNO</p> <ul style="list-style-type: none"> <li>-</li> <li>-</li> </ul>
2.	PREVIOUS TRAINING AND EXPERIENCE	<p><u>TRAINING</u></p> <ul style="list-style-type: none"> <li>o Nurse-Midwife Tutor</li> </ul> <p><u>EXPERIENCE</u></p> <ul style="list-style-type: none"> <li>o Nurse Tutor</li> <li>o Nurse Admn.</li> <li>o FP Nurse Practitioner</li> </ul>	<ul style="list-style-type: none"> <li>o RN/M/Tutor</li> <li>o N.O.</li> <li>o Midwifery Tutor</li> <li>o Midwifery Superintendent</li> </ul>	<ul style="list-style-type: none"> <li>o MCHB/Obst. Gynae</li> <li>o FP skills</li> <li>o POP &amp; PHC Program Management</li> <li>o MCH/FP Clinic Practice</li> <li>o Lecturer University Makerere</li> </ul>	<ul style="list-style-type: none"> <li>o RN/M/FP</li> <li>o Nursing</li> <li>o Midwifery</li> <li>o FP Service Provider</li> </ul>
3.	KNOWLEDGE AND SKILLS UPDATE	<p>HOW:</p> <ul style="list-style-type: none"> <li>-Attending workshops</li> <li>-Reading</li> <li>- Sharing with Colleagues</li> <li>- Conducting FP Training</li> <li>- Radio programs on Science</li> </ul>	<ul style="list-style-type: none"> <li>+</li> <li>+</li> </ul>	<ul style="list-style-type: none"> <li>+</li> <li>+</li> </ul>	<p><u>SUMMARY</u></p> <ul style="list-style-type: none"> <li>Reading - 4</li> <li>Practice - 4</li> <li>Workshops - 1</li> <li>Radio - 1</li> </ul>
4.	MISSING FROM PREPARATION	<ul style="list-style-type: none"> <li>o Program Evaluation Skills</li> </ul>	<ul style="list-style-type: none"> <li>+</li> </ul>	<ul style="list-style-type: none"> <li>Research &amp; Evaluation</li> <li>*Supervisory Skills in order to teach these</li> </ul>	<ul style="list-style-type: none"> <li>+</li> <li>o Preparation in skills no longer in CTT e.g. NFP</li> </ul>
	10 Additional Skills required	<ul style="list-style-type: none"> <li>o Evaluation of programs</li> </ul>	<ul style="list-style-type: none"> <li>0</li> </ul>	<ul style="list-style-type: none"> <li>O.R. &amp; Evaluation of Programs</li> <li>T O T</li> </ul>	<ul style="list-style-type: none"> <li>+</li> </ul>
		<p>Program Evaluation Skills - 3 NFP skills for 1 CTT - 1 Research - 1 Supervisory skills - 1</p>	<p>Required - O.R. - 1</p>		

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4 CTT said Program Evaluation Skills were missing from the preparation.

One CTT felt special skills lost when a CTT member left team were not replaced e.g. Natural Family Planning and another CTT said research and supervisory skills were missing.

3 CTT felt Program Evaluation Skills should have been developed.

1 CTT wished for operations research and TOT.

MOST IMPORTANT CTT ACTIVITIES

<u>TEAM</u>	<ul style="list-style-type: none"> <li>o Planning/organising Training</li> <li>o Conducting Training</li> <li>o Reviewing/Developing curriculum</li> <li>o Trainee follow-up</li> </ul> <p><u>SUMMARY OF Team Responsibilities</u></p> <ul style="list-style-type: none"> <li>o Training - 7</li> <li>o Curricula developing/ Review/Revision - 3</li> <li>o Trainee Follow Up - 3</li> <li>o NGO Liason - 1</li> </ul>	<ul style="list-style-type: none"> <li>+</li> <li>+</li> <li>+</li> <li>+</li> </ul>	<ul style="list-style-type: none"> <li>+</li> <li>+</li> <li>+</li> <li>+</li> </ul>	<ul style="list-style-type: none"> <li>+</li> <li>+</li> <li>+</li> <li>+</li> </ul> <p>Liasing with NGOs</p>
<p>INDIVIDUAL CTT MEMBER</p>	<ul style="list-style-type: none"> <li>o Coordination of Training activities (with MOH divisions, USAID)</li> <li>o Training (conduct plan etc)</li> <li>o Training Logistics</li> <li>o Welfare of CTT members</li> <li>o Liason with INTRAH/RO</li> </ul>	<p>Not indicated</p>	<p>Training</p>	<ul style="list-style-type: none"> <li>o Trainee invitations</li> <li>o Planning Training Venue tools, materials</li> <li>o Resource persons and clinical sites</li> <li>o Conduct Training Sessions</li> <li>o Trainee supervision during practice</li> <li>o Trainee clinical assessment</li> <li>o Responsible for Reading materials</li> <li>o Writing follow-up reports</li> </ul>
<p>8.</p>	<p><u>SPECIFIC CONTRIBUTION OF OTHER CTT MEMBERS</u></p> <ul style="list-style-type: none"> <li>o Training for NGO - 1</li> <li>o Curriculum Development - 1</li> <li>o Supplies and logistic Management workshop - 1</li> </ul> <p><u>SUMMARY</u></p>	<ul style="list-style-type: none"> <li>o Special skills in Teaching OCs</li> <li>o 1 Communication/counseling</li> <li>o 1 NFP</li> </ul>	<ul style="list-style-type: none"> <li>o Training Evaluation skills</li> <li>o Team spirit</li> <li>o Complementing each other's skills</li> </ul>	<ul style="list-style-type: none"> <li>o Communication skills</li> <li>o Logistics Management</li> <li>o Evaluation skills</li> <li>o FP clinical skills</li> <li>o Training skills</li> <li>o Management skills</li> </ul>

This question was not interpreted uniformly by respondents. However, two members stated that they had each special skills which complemented each others.

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MAIN ACHIEVEMENTS OF THE FP TRAINING PROGRAM

<ul style="list-style-type: none"> <li>o Development of a CTT</li> <li>o New FP Service Delivery Points established</li> <li>o FP Service established at H/Centre level</li> </ul>	<ul style="list-style-type: none"> <li>o Increased FP Trained Personnel</li> <li>o Increased MOH/FPAU/NGOs collaboration</li> <li>o Increased understanding about FP MOH professionals</li> </ul>	<ul style="list-style-type: none"> <li>o CTT</li> <li>o Orienting Hosp and DH Teams on FP</li> </ul>	<ul style="list-style-type: none"> <li>o Trained MOH/NGO Service providers</li> <li>o New FP SDPs established</li> <li>o Equipping other health staff with FP skills e.g. visual comm.</li> </ul>																
<ul style="list-style-type: none"> <li>o Decentralizing Training Regional level.</li> </ul>	<p><u>SUMMARY</u></p> <table border="0" style="width: 100%;"> <tr> <td style="width: 50%;">CTT</td> <td style="width: 50%; text-align: right;">2</td> </tr> <tr> <td>NEW SDPs established</td> <td style="text-align: right;">2</td> </tr> <tr> <td>INCREASED NO OF FP PROVIDERS</td> <td style="text-align: right;">2</td> </tr> </table> <table border="0" style="width: 100%;"> <tr> <td style="width: 50%;">MOH Professionals oriented -</td> <td style="width: 50%; text-align: right;">2</td> </tr> <tr> <td>INCREASED MOH-NGO collaboration -</td> <td style="text-align: right;">1</td> </tr> <tr> <td>FP at H/C Level</td> <td style="text-align: right;">1</td> </tr> <tr> <td>DECENTRALISED TRAINING</td> <td style="text-align: right;">1</td> </tr> <tr> <td>OTHER FP RELATED SKILLS</td> <td style="text-align: right;">1</td> </tr> </table>		CTT	2	NEW SDPs established	2	INCREASED NO OF FP PROVIDERS	2	MOH Professionals oriented -	2	INCREASED MOH-NGO collaboration -	1	FP at H/C Level	1	DECENTRALISED TRAINING	1	OTHER FP RELATED SKILLS	1	
CTT	2																		
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INCREASED MOH-NGO collaboration -	1																		
FP at H/C Level	1																		
DECENTRALISED TRAINING	1																		
OTHER FP RELATED SKILLS	1																		
<p><u>WEAKNESSES OF FP TRAINING PROGRAM</u></p>																			
<ul style="list-style-type: none"> <li>o Concentration on Hosp. based trainees</li> </ul>	<ul style="list-style-type: none"> <li>o Limited collaboration with other programs e.g. EPI, AIDS</li> <li>o Lack of coordination with CNO (posting officer)</li> <li>o Lack of attention to strengthen PST</li> </ul>	<ul style="list-style-type: none"> <li>o CTT not intact</li> <li>o Lack of incentives</li> <li>o Few FP providers trained scattered all over</li> <li>o Lack of resources to support trained persons</li> <li>o Lack of Procedure Manual and Policy on FP</li> </ul>	<ul style="list-style-type: none"> <li>o Cancelling and postponement of Training activities</li> <li>o The difficulties in procurement of funds to run activity</li> </ul>																
<p><u>SUMMARY</u></p>																			
<ul style="list-style-type: none"> <li>- Funds release - 2</li> <li>- Coordination with others weak - 2</li> <li>- PST not strengthened - 1</li> <li>- Lack of incentives and resources - 2</li> <li>- Hospital concentration - 1</li> <li>- Scattered trainees - 1</li> </ul>																			

25/7

13 & 14

Helping Factors	1 Hindering	2 Helping Factors	3 Factors Helping	4 Hindering	5 Factors Helping	Hindering
CTT Cooperation CTT dedication INTRAH RON guidance/ assistance	<ul style="list-style-type: none"> <li>o Delays in fund release</li> <li>o Attention of CTT</li> <li>o Limitation on clinical training sites</li> <li>o Insecurity in some areas</li> </ul>	<ul style="list-style-type: none"> <li>o INTRAH RON Cooperation/ TA</li> </ul>	<ul style="list-style-type: none"> <li>o CIT Team work</li> <li>o Support/ cooperation from INTRAH</li> </ul>	<ul style="list-style-type: none"> <li>o CTT drop-out</li> <li>o Logistics Funds problem</li> </ul>	<ul style="list-style-type: none"> <li>o CTT Team work</li> <li>o Support of each other</li> <li>o Continuous INTRAH RON support</li> </ul>	<ul style="list-style-type: none"> <li>o Reduction of CTT in number and capabilities</li> </ul>

SUMMARY: Helping factors

- CTT cooperation/dedication/ team work - 5
- INTRAH RON support

Hindering factors

- CTT drop-out - 3
- Funds release - 2
- Lack of cooperation with training division - 1
- Clinical sites for practice limited - 1

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FOLLOW UP OF PARTICIPANTS

MAIN FUNCTION

LEVEL/DEGREE OF THEIR ACHIEVEMENT

1	2	3	4	1	2	3	
o Identify areas for refresher to address +		+	-	Achieved	-	- do -	
o Identify problems constraints faced by service provider +	+		+		Achieved		Some follow-ups conducted
o Finding solutions to problems/ constraints +	+		+		Achieved	Not know	-do-
o Create relationship between management and Service provider +					Achieved	Not been	-do-
o Identify weak areas	+				Achieved	Not been	-do-
o Discussion and problem solving with supervisor	+				Achieved	Not been	-do-
o Who has established services	+		+		Achieved	Not been	-do-
o Supervision	+	+				Involved	+
o Motivates participants		+				Involved	Follow up "
o Assess skill/knowledge retention			+			Involved	-do-

2/3

SUMMARY

MAJOR FUNCTIONS OF FOLLOW-UPS

TNA	4
SEE EFFECTS OF TRAINING ON SERVICE	1
SUPERVISION	3
ON JOB PROBLEM SOLVING	3
TRAINEE SUPPORT	2
IMPROVE COORDINATION	1

ACHIEVEMENT

One person reported that all 4 functions she mentioned as having been achieved. One stated some had been achieved, and out of 4 functions mentioned by one respondent only one was reflected as having been achieved.

\* Major functions of follow-ups included TNA (4) supervisory (3), on job problem-solving (3), trainee support (1), to see effects/consequences of training on service (1) and improve coordination (1)

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HINDERING /HELPING FACTORS IN THE FOLLOW-UPS

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<u>HELPING</u>			<u>HINDERING</u>				
1	2	3	4	1	2	3	4
o Transport	o Ability for CTT to be on site	--	CTT cooperation	Delay in funds release	Resources lacking to make a second	--	o Resources (time, funds transport)
o Built in the training program				In-security in some areas	Follow-up		o Timely communication with far off providers
o Early communication							

SUMMARY

<u>Helping</u>	<u>Hindering</u>
<u>Availability of Resource/support</u>	<u>Funds</u>
o Transport	o Delayed release :2
o CTT cooperation	
<u>Methodology</u>	<u>Time</u>
o On site visits by CTT	o To communicate early with providers :1
	o For planning :1
<u>Planning</u>	<u>Others</u>
o Early communication	o In-security in some areas :1

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19, 20 & 21

CTT COORDINATION

CTT MEMBERS	WITH OTHER MCH DIVISIONS	DHT	HMT (Hospital Management team)
1	<ul style="list-style-type: none"> <li>o Through MOH Coordination Committee</li> <li>o Sends reports on each Training Activity</li> <li>o Send workplans (Training plans) when there is any revision</li> </ul>	<ul style="list-style-type: none"> <li>o Communicates with DMOs office (not satisfactory)</li> </ul>	<p>Communicates through Med. Superintendent Office (Fairly satisfactory)</p>
2	<ul style="list-style-type: none"> <li>o If any, it is Individual Personal Contact</li> <li>o Otherwise not well defined</li> </ul>	<ul style="list-style-type: none"> <li>o No specific way</li> </ul>	<p>No answer</p>
3	<ul style="list-style-type: none"> <li>o Discusses possibility of integration of courses (need to improve coordination at this level)</li> </ul>	<ul style="list-style-type: none"> <li>o Not aware</li> <li>o ?? In participants selection and helping start service</li> </ul>	<p>? Needs strengthening</p>
4	<ul style="list-style-type: none"> <li>o Training schedule copied to Training Division + all revisions</li> <li>o Budget approval requests chanelled through Training Division for Training activities</li> <li>o HE/personnel been involved in visual comm. training activities as trainees and co-facilitators.</li> <li>o Nursing division briefed and de-briefed on all main activities</li> </ul>	<ul style="list-style-type: none"> <li>o Basic clinical skill trainees are nominated through the DHT</li> <li>o CTF trained ENMS from H/C in response to DHT requests.</li> <li>o CTF worked hand in hand with DHT on follow ups.</li> </ul>	<ul style="list-style-type: none"> <li>o All hospital based trainees were nominated by HMT.</li> <li>o Problems found during follow up are communicated to HMT.</li> </ul>

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SUMMARY:

<u>Divisions mentioned:</u>	<u>MOH</u>	<u>HOW</u>	<u>CTT Coordination</u>
<u>Training</u> (3)		<ul style="list-style-type: none"> <li>o Training Plans and revisions sent ( 2 )</li> <li>o Attendance at MOH Coordination Committees ( 1 )</li> <li>o Reports on each Training Activity ( 1 )</li> <li>o Budget approval channelled through (T) ( 1 )</li> </ul>	
<hr style="border-top: 1px dashed black;"/>			
<u>Health Education</u> ( 1 )		<ul style="list-style-type: none"> <li>o HE personnel involved in Visual Communication as trainees and one facilitator ( 1 )</li> </ul>	
<u>Nursing Division</u> (CNO) ( 1 )		<ul style="list-style-type: none"> <li>o Briefed and debriefed on main activities ( 1 )</li> </ul>	

- \* 1 CTT member feels there is no well defined coordination method and individual Personal Contact is the method used.
- \* 2 CTT added that the current coordination between CTT and other MOH divisions isnot satisfactory.

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22. SUPERVISION TO FP SERVICE PROVIDERS - WHAT SHOULD BE DONE?

1	2	3	4
Set up a supervisory system central - district level	Set up a <u>supervisory team at district level</u> other than DMO/DHV	<ul style="list-style-type: none"> <li>o Train supervisors at local level.</li> <li>o Provide supervisors with support/ means.</li> <li>o Avail a central support as back up.</li> <li>o Develop supervisory tools</li> <li>o Standardize FP service procedure manual.</li> </ul>	<ul style="list-style-type: none"> <li>o Orient immediate in-charges to FP</li> <li>o Equip the immediate in-charge with supervisory skills</li> </ul>

SUMMARY

- o Central Supervisory System
  - o Back up :1
  - o Direct to District :1
- o District Supervisory System
  - o other than DMO/DHV :1
  - o not specified
- o Preparation of those involved in supervision - 3
- o Equip supervisor with the means - 2
- o Supervisory tools to be developed - 1
- o Standardize FP procedure manual - 1

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23. INTEGRATION

- |                                                                                                                                                                                                                             |                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                       |                                                                                           |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|
| <p>Integrate workshops with other MOH IST e.g</p> <ul style="list-style-type: none"> <li>o Visual Communication skills</li> <li>o Management skills</li> <li>o Evaluation skills</li> <li>o Communication skills</li> </ul> | <ul style="list-style-type: none"> <li>o TNA to be conducted at the local level (district, hospital, NGO areas)</li> <li>o Request for training to MOH should indicate the expected post-training functions of those to be trained</li> </ul> | <ul style="list-style-type: none"> <li>o Integrate those courses that can be integrated (supervision, management).</li> <li>o Orient programmers at district/hospital level to integrate</li> <li>o Strengthen and integrate FP in the PST</li> </ul> | <ul style="list-style-type: none"> <li>o train by region instead of scattering</li> </ul> |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|

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24. FP TRAINING PROGRAM CONTRIBUTION/OR ADVERSE EFFECTS TO INTEGRATION

Contribution

Adverse effects

- |                                                                                                                                       |                           |
|---------------------------------------------------------------------------------------------------------------------------------------|---------------------------|
| <p>1. o Tried to integrate in management skills</p> <ul style="list-style-type: none"> <li>o Tried in Visual Communication</li> </ul> | <p>Both not effective</p> |
| <p>2. No answer</p>                                                                                                                   | <p>--</p>                 |
| <p>3. o Management workshop of DHTS</p> <ul style="list-style-type: none"> <li>o Team oriented to supermarket approach</li> </ul>     | <p>--</p> <p>--</p>       |
| <p>4. Orientation of senior MOH and knowledge skills providers</p>                                                                    | <p>--</p>                 |

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25. RECOMMENDATIONS TO IMPROVE INTEGRATION

Decentralize training

- o Different Training Programs should sit together and identify how they are related to each other and develop a mechanism for implementing coordinated training.
- o Could be done at project development level
- o DHT should conduct TNA
- o Prepare CTT to conduct TOT at regional and district level
- o Project planning activities to include a wider group besides MOH officials
- o District or regional training focus
- o Include research and evaluation
- o Match training with equipment and supplies
- o Strengthen FP in PST programs of nurse midwives, HA and medical assistant
- o Pay CTT a monthly allowance
- o Equip CTT with training skills before they join the team

2021

SUMMARY

- o Decentralize training and planning - 5
- o Improve training coordination - 1
- o Pay CTT - 2
- o Orient top MOH officials - 2
- o Match training with equipment - 2
- o Prepare CTT with needed skills - 2
- o Strengthen FP in PST - 1
- o Research and evaluation - 1

2021

26. T.A AND SUPPORT FROM INTRAH RO  
(TIMELINESS, QUALITY, WEAKNESSES)

- 1.   o Very good
- o CTT involved in planning/  
      conducting activities  
      with INTRAH team

- 
- 2.   o Timely in giving and/or  
      obtaining information on  
      training activities

- 
- 3.   Have been of desired quality  
      and promptness

- 
- 4.   Have not observed any

27. WHAT SHOULD BE DONE NOW TO DEVELOP FP

- o Replace CTT who left
- o Decentralize training
- o TOT for CTT (trainers)
- o Supervisory skills - supervisors
- o Evaluation skills - trainers and  
administrators e.g DHT and hospital  
teams.

- 
- o Put in place a well prepared  
training team for each region
  - o District supervisory team to have  
capacity in identifying training  
needs which - DMO
  - o Develop supervisory skills of  
all staff at all levels.

- 
- o Train more providers in clinical  
skills.
  - o Complete management training for  
DMO/DHV
  - o Standardize FP services
  - o Provide adequate/regular supplies  
and equipment.

- 
- o Strengthen FP into the PST

\* Responses not very specific to question 27 and 26.

Joy

28. FUTURE OF CTT

- 1. o Assist regional trainers in conducting FP training activities - 2
- o Conduct national training of those which cannot be done at regional -1
- o Utilized by others (programs) as a resource - 2
- 2. o Expand the CTT - too "thin" now - 1
- o See how they can work with Health Manpower Development group.
- 3. o Supertrainer train regional/district trainers
- o Provide internal or external consultancy - 1
- o Updates and refreshers for trained service providers - 1
- o Train in an integrated management/supervision program
- 4. Do not know

SUMMARY: Have a role in preparation/implementation of regional/district training - 2

Resource to other programs - 3

Updates/refreshers in clinical skills - 1

Consultancy - 1

Research evaluation - 1

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CTT MEMBER	<u>GAINS</u>	<u>NEGATIVE CONSEQUENCES</u>
1	<ul style="list-style-type: none"> <li>o Confidence in planning and implementing training project activities.</li> <li>o How to interact with NGOs and International organizations.</li> <li>o Meeting/working with Consultants of different specialities.</li> <li>o Different approaches of implementing project activities.</li> </ul>	<ul style="list-style-type: none"> <li>o Limited opportunities to utilize resources gained in other training programs.</li> <li>o Lack of integration with other training programs</li> <li>o Lack of self assessment as a team member.</li> </ul>
2	<ul style="list-style-type: none"> <li>o Learned many <u>new</u> things e.g               <ul style="list-style-type: none"> <li>- task analysis</li> <li>- curriculum development</li> <li>- monitoring learning</li> <li>- developing and using evaluation tools for learners.</li> </ul> </li> </ul>	I don't know!
3.	<ul style="list-style-type: none"> <li>o Special knowledge and skills in various aspects of adult training               <ul style="list-style-type: none"> <li>o Exposed to outside world</li> </ul> </li> <li>o Closer team work in achievement of common goal</li> </ul>	--
4.	<ul style="list-style-type: none"> <li>o Lots of knowledge and skills in FP methods</li> <li>o Exposure to a project activities</li> <li>o Training skills</li> </ul>	<p>Do not know - may be my colleagues can answer this.</p> <p>3 persons may be did not understand the intention in this question.</p>

- 2/2/20

31 & 32                    YOUR SKILLS AT PRESENT      (PERCEPTIONS OF SELF)

SKILLS NOW	OWN ROLE IN FUTURE
1.    o Management skills o Teaching skill o Communication o Planning and organizing o Feedback	o Assist MOH in integrating some aspects of FP training program with other MCH training programs.  o Continue with FP training program to plan, organize, implement and evaluate.
2.    o Ability to identify training needs developed from follow-ups  o Monitoring learning in the clinical area.	Do not know yet!
3.    o Adult training skills o Curriculum development o Visual Aid development o Un-utilizes consultancy skills (training)	To continue training as the program
4.    o FP clinical skills (training and practice) o Training skills (Direct training and TOT)	To continue as CTT if trained further can do TOT.

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33. ADDITIONAL COMMENTS

- o Hope INTRAH Project will be renewed.
- o INTRAH has clear direction
- o Thank you
- o Work has been challenging
- o Work has been at times dissapointing when activities cancelled at last minute.
- o Quality/quantity of FP service seems to be an individual provider's effort not a collective effort.
- o Endless planning caused by cancellations.

We need another training program to fairly distribute the services.

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APPENDIX E.8

Recipients of Results

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8: RECIPIENTS OF RESULTS

1. Dr. J.H. KYABAGGU, Ag. DMS MOH, Entebbe
2. Dr. E.M. KAIJUKA ADMS/MCH/FP Division, MOH
3. Dr. F. KATUMBA, Senior Medical Officer, MCH/FP  
Division, MOH.
4. Dr. OTIM-ODOI, ADMS Training Division, MOH
5. Mrs. Rachael RUSHOTA FHI Project Coordinator
6. Mrs. Mary LUYOMBYA, MOH/FP Division CTT Member
7. Miss Lucy ASABA MCH/FP Division CTT
8. Dr. Anhtony ABCODA, MCH/FP Division, CTT
9. Mr. Paul COHN, Population and Health Officer  
USAID/Kampala
10. Mr. David PUCKETT, Technical Advisor for Child  
Survival, USAID/Kampala
11. Mrs. Lydia MURANGA, Acting Executive Director,  
FPAU, Kampala.